Use of Resources in Adult Social Care

Putting **People** First
Transforming Adult Social Care

A guide for local authorities

October 2009

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Introduction by the Care Services Minister

I am delighted to commend this guide on the Use of Resources in Adult Social Care to all stakeholders. I know that the demographic demands and the changing nature of our society will mean that the use of social care may continue to increase. This makes it even more important for us all to find the most cost-effective ways of delivering the best outcomes for people who need care and support.

This guide has been produced to stimulate discussion and debate in local authorities, with customers and with those providing services, as to how to commission and shape services for tomorrow. Much of the best practice of local authorities has taken five or more years to develop. Many of the solutions do not appear overnight. We are encouraging every local authority to learn more from each other about how to take innovation forward and spread best practice around the country.

I believe the focus should always remain on getting the best quality outcomes for the service user and their carers. Our examples from local local authorities can demonstrate that many of the innovations that are being developed achieve these quality outcomes at a lower cost – this is because the models make the right use of staff skills, new technologies or different housing solutions.

Helping people in ways that remove or reduce their need for care and support is the first principle. The second principle is that when people do need longer-term care and support they can receive this in the most appropriate setting to meet their agreed outcomes through personal budgets and self-directed support. We are publishing this document at the same time as we are having the debate on the longer-term funding of social care so we know that whatever system is in place we are making the best use of resources.

I am pleased that the Association of Directors of Adult Social Services (ADASS) has endorsed this publication and has urged its members to read and to use it. We will continue to work with ADASS to promote innovations and new practice as they emerge. I am confident that the combined work of housing services, health services and social care can produce positive outcomes for many of those who need care and support. The commitment of local authorities to this approach is really encouraging.

Phil Hope
Minister for Care Services
October 2009

Executive summary

Good use of resources is a balancing act between user expectations and the priorities of adult social care services and wider local authority services. Only when all of these are met can a local authority deliver efficient, effective and economic adult social care in an affordable and accountable manner. This will include meeting local and central government priorities.

When talking about efficiency it may be helpful to keep the following definition in mind – that a system is likely to be most efficient when it is getting the right people, at the right time into the right part of the system (i.e. offering the right service response). This is also a good definition of how to ensure that a system produces the best outcomes for people.

Local authorities continue to be faced with the challenges of making best use of resources and evidencing value for money at every opportunity. In undertaking the work for this guide, we have come across a whole range of imaginative and creative local authorities that are using resources extremely well in some areas.

Efficiency and effectiveness in service outcomes should work hand-in-hand. The Department of Health recognises that we will in future need to focus on Quality, Innovation, Productivity and Prevention (QUIPP) in both health and social care. QUIPP will be central to the development of best practice and how local authorities that use resources effectively, by encouraging local authorities to:

- develop lean processes for the assessment of people's needs and access to services;

- develop preventative measures that can defer or delay people needing longer-term services (the biggest single savings can be made from reducing use of residential care and creating better community-based services delivering better outcomes);

- develop more cost-effective interventions that achieve better outcomes at lower costs; and

- assist people to construct their own packages of care through personal budgets and to help them procure these services in the most cost-effective way.

The Griffiths Report into community care, published in 1988, placed a strong emphasis on the importance of establishing services to help people live in their own homes and retain independence, dignity and choice. This emphasis on prevention and early intervention is reinforced in *Putting People First*, which sets the policy framework for this guide.

The data in the guide show very different approaches to the use of resources and the delivery of the policy across the country. The guide aims to encourage local authorities to continue to use new ways of working that enable people to remain in their own homes for longer and in more cost-effective ways. It draws on examples of excellent practice from local authorities that have already demonstrated good use of resources across the provision of adult social care services. The guide has been endorsed by the Association of Directors of Adult Social Services.

The guide raises a number of questions that local authorities might find helpful. It asks

what priority has adult social care been given by the local authority? It does not provide the answer but suggests that local authorities should know and understand the consequence of decisions they have made in the past to invest or otherwise in social care. Even within social care, the priorities between different sets of people with needs may vary between local authorities. The guide recommends that local authorities understand their patterns of spend in adult social care and ensure that this spend matches their local priorities. It also recognises that the answer is more complex, because investment in other local authority services such as community centres, libraries, leisure and other activities may all be making a major contribution to the quality of lives of people who may need care and support.

The guide is a discussion document for commissioners of services. It poses the key questions that commissioners might find it helpful to ask themselves. For whom should we be commissioning services and what kind of services should we be planning for tomorrow? Do we understand and know about the most cost-effective ways of delivering services and can we both learn from other local authorities and contribute to the debate?

The guide considers some of the early evidence from personal budgets, which suggests that there may be opportunities created through dialogue with service recipients and their carers to build more effective services that will meet people's outcomes at lower costs. However, for this to occur the right opportunities have to be there, e.g. access to housing or new technology to help support people in the community.

Evidence shows that getting the basics of the business processes right is critical both to manage the use of the money and to plan. Examples of local authorities that are doing this effectively feature in the guide. One of the key solutions is how to use the available technology to help run the business and to ensure that the business drives the technology and not vice versa. The paperless office exists – it is in Dudley and in Newcastle.

The guide offers a range of evidence to help local authorities continue the move to support people in their communities and to continue the trend of reduced use of residential care. It encourages local authorities to grasp the Public Service Agreement (PSA) targets to increase supported housing options for people who are socially excluded and which support independence and well-being in later life.

1. Introduction

This guide is designed to assist local authority senior managers make a self-assessment of their use of resources. It offers advice on how they can make shifts in the balance of the use of their money in order to develop both efficient and effective services. It aims to help senior managers make decisions about the way in which social care for adults is being given priority within the local authority. At times, it will challenge current commissioning and procurement arrangements but it also offers alternative approaches, which may deliver better outcomes in a more cost-effective way in the longer term. It recognises that some of the interventions that will lead to transformational reform for adult social care will take a minimum of five years to deliver. Now is a good time to start!

The key questions

It is clear that there is a variety of mechanisms for establishing whether local authorities are making effective use of their adult social care resources. We have identified the key questions that local authorities should be asking themselves:

- Where is the money being spent and how different is the pattern of our spend from that of other comparable local authorities? If there is a significant variation, do we have an explanation for this?

- Do we have a medium-term financial strategy that includes adult social care? Does this help us plan for the future by matching the resources available with the known demands?

- Do we have a robust efficiency statement that is producing 3% efficiencies year-on-year for the Comprehensive Spending Review (CSR) 2007? Do we need to find more or less than 3% to meet our corporate financial targets, and what is the impact of this on adult social care?

- Can we track our use of resources and the impact they are making on future projections of needs? Have we set clear outcomes for our investment in preventative services, and are we tracking performance?

- Are we commissioning the right range of affordable services for the future, including those that support prevention? Are we deploying our resources effectively with our health partners? Do we understand our own data (including the patterns of spend and the unit costs)? Do we investigate variations, and are we able to explain them satisfactorily, and/or take action?

- In developing stronger partnerships and more integrated working with health and housing, do we know other local spend data on care and support such as NHS spend on 'care closer to home', Supporting People and/or other capital and revenue funding streams?

- What is the impact of personal budgets (and in future personal health budgets) on our overall budget, and of service users getting the right services to meet the agreed outcomes?

The guide is structured to address the following four areas of a local authority's spend in order to help it establish whether it is making good use of resources within the current policy agendas:

- the personalisation agenda;

- understanding adult social care resources;

- understanding where the money is being spent; and

- the value-for-money agenda.

The regulators (the Care Quality Commision and the Audit Commission) are being encouraged to explore these areas when making a fair and informed judgement about how local authorities are using their resources in delivering adult social care services.

There are several local authorities with an excellent record of accomplishment in the use of resources and we have cited some of them within this document. Some local authorities appear to have a long history of re-shaping their services to achieve the right overall balance. Others have made major strides in more recent years or have tackled one particular key area. We have used case examples from over 30 local authorities that have changed the shape of their local services. Not all of them have done everything – but the answer does rest with the very best practice – and we need to identify this in order to promote the best use of resources.

Of course, there are local authorities that are doing well and have not come to our attention – we hope this guide will encourage them to share their case examples to assist others in their search for answers to their own problems. More recently, we have heard about work in Tameside and in Hammersmith

Case study

Hertfordshire County Council takes meeting its efficiency targets seriously – saving nearly £5 million in 2007/08, with a target of £8 million for 2008/09.

Savings have been achieved in a number of ways, by:

- commissioning a new range of services over the last five years – including a specialist dementia extra-care facility developed with the local PCT, and new housing options for adults with learning disabilities (helping save money as part of the delivery of personal budgets);

- re-engineering processes including assessment and care management;

- developing a commercial option for simple aids and equipment;

- using re-ablement and developing intermediate care;

- keeping a close eye on the 'bottom line'; and

- achieving the right balance between outcomes and the resources available.

and Fulham with the local primary care trust (PCT) where they have looked closely at each other's patterns of spend to help plan future investments. We have heard of other local authorities, such as Bristol, Wiltshire and North Somerset, that are continuing to find new solutions to reduce use of residential care.

We do not necessarily recommend every approach that local authorities have shown us. However, we are asking local authorities to ensure that they have considered the options open to them and their communities as they look to make the best use of their resources to shape and commission the services for tomorrow.

We are sure that there are other examples that we have missed. We are keen to build up a database of good practice and so would invite any local authority to submit to us a brief summary of what they have done and the efficiencies they have achieved.
These should be sent to john.bolton@dh.gsi.gov.uk

Within the context of the use of their resources, an excellent local authority will:

- **be able to demonstrate how it has given priority for adult social care within its other competing priorities;**

- **be clear about how it has proportioned its resources between different groups of people;**

- **understand its patterns of spend and its costs for services – it should be managing its resources to deliver good quality outcomes and be able to meet predicted demands;**

- **be commissioning services to ensure a good supply at an affordable cost – it will have set as its starting point the need for a range of services to support people to live in their own homes (or suitable community alternatives) and a supply of residential care;**

- **have a balance of services available, with not more than 40% of its overall adult social care budget being spent on residential care (or a plan to reach this target);**

- **be working in partnership with the PCT to share investments that improve outcomes for their customers and will have agreed how to share the benefits and risks in such a way that encourages joint working;**

- **achieve efficiencies through a system focused on early intervention, prevention and re-ablement – i.e. where good information and advice, practical support, appropriate housing options, re-ablement and joint working between health and social care assist people in living fulfilled and independent lives, thereby reducing the number of people entering or requiring ongoing support from social care;**

- **have an efficiency statement within its medium-term financial strategy, which makes clear how it will deliver 3% cashable savings for the CSR period; the efficiencies will focus on re-shaping the services that involve a strategic shift towards prevention, rather than making cuts in services;**

- **be moving towards the personalisation of services in a measured way, with a Resource Allocation System (RAS) or a similar mechanism for showing the resources available to the individual that is transparent and sustainable;**

- **procure services in an effective way – it will be mindful of both the needs of service users and the ability of providers to deliver good quality care;**

- **have robust systems in place to monitor and review the effectiveness of their procurement and contracting arrangements so that underperformance of commissioned services can be identified early and remedied; and**

- **be working with other local authority departments and agencies to harness their activities and resources in order to achieve the greatest efficiencies in addressing shared outcomes for people who have care and support needs.**

Consultants

Local authorities should consider whether they are getting value for money from the consultants they employ to add capacity to their organisation – particularly in helping with value for money. Local authorities may want to consider the overall costs of employing temporary (agency) staff and in particular of employing external consultancy firms, in order to undertake a detailed analysis and make recommendations on their use of resources. In-house staff (including performance and finance staff) should be able to handle much of what this document recommends. If local authorities think they lack the skills to undertake this work, they should consider employing a consultant who will work alongside existing staff so that they can build

their own capacity to carry out this type of analysis. Set a maximum amount that one might spend on external support – e.g. no more than 1% of one's budget.

An Audit Commission study in 1993 (*Taking Care*) found that agency costs associated with residential care added 5% to the total cost. Other studies have found the percentage rising to 10%. Local authorities should always be reviewing the additional costs that they incur through employing agency staff.

Note for readers

In addressing these questions, local authorities will make extensive use of information from a range of national and local sources. All the data used in this guide are drawn from sources that are already in the public domain. The National

Adult Social Care Intelligence Service (NASCIS) has been set up by the NHS Health and Social Care Information Centre. It is available to local authorities through www.nascis.ic.nhs.uk and provides access to the data which can be downloaded or analysed online to support your investigations. (Local authorities will be required to register to access the data.)

Access to the data held within the NASCIS analytic tools is available to local authority users via a registration process. Further details on the registration process and NASCIS are provided in Appendix 1.

The graphs in Chapter 3 use net current expenditure from 2007/08 revenue outturns, in particular RO1, RO3 and RS returns that are available from Communities and Local Government. The totals include the element of the Supporting People grant that is directly spent on social care-related services. A review of the PSSEx1 (Personal Social Services Expenditure) form has just been completed and some changes are being proposed for the future.

The main source of data used throughout this report is the 2007/08 PSSEx1 return. The figures used from this return are mainly gross current expenditure, with client contributions used at the end of Chapter 4.

However, there are some weaknesses within the current data which mean that not everything can be taken at face value. We have tried to note these through the document. There are a few issues that the reader may wish to consider (see Appendix 1).

2. Implementing personalisation: self-directed support and personal budgets

Self-directed support[1] is a fundamental part of social care transformation. *Putting People First* includes a commitment to make personal budgets the norm for people who are eligible for ongoing social care. This will mean that:

- assessment is led by the person and focuses on the outcomes that they and their family want to achieve;

- the person knows the amount of money that is likely to be available to achieve these outcomes before they decide how to use the money;

- there is advice and support available to help people plan support arrangements that will achieve the agreed outcomes, and to raise concerns about those arrangements should they not work well; and

- support arrangements make the most use of natural support and mainstream services.

Figure 2A:

1 The personalisation toolkit www.personalisation.org.uk explains in detail how local authorities can implement self-directed support.

A holistic approach to social care transformation

Social care transformation will only be effective if the key aspects of *Putting People First* are implemented together. **Choice and control** runs through all aspects of the policy – the whole of a transformed social care system needs to focus on enabling people to achieve the outcomes they want. These changes require **co-production** – working with disabled and older people and their families, along with providers, voluntary organisations and statutory services – to achieve the right result. The diagram above demonstrates this holistic approach. This means that local authorities need to work with their partners to:

- develop **universal services** (including information and advice) that help people maintain their independence;

- offer targeted **early intervention** that prevents needs escalating and avoids unnecessary use of intensive social care and health services;

- develop **self-directed support** as the norm for people who have longer-term social care needs; and

- develop the use of **social capital**, including through user-led organisations, so that people can meet their needs with the least recourse to specialist services.

Local authorities that have made early progress are able to demonstrate what this holistic approach means in practice.

Case study

Oldham Metropolitan Borough Council has implemented self-directed support at the same time as increasing investment in early intervention and restructuring in-house services. The local authority has employed Neighbourhood Access and Prevention Officers to work with people who do not get a social care service. It has also reduced the use of intensive home care packages by offering all residents over the age of 80 a better community alarm service, linked to a rapid response team. The home care service now provides a re-ablement service to new customers.

The local authority has implemented self-directed support for people who need ongoing support and has restructured in-house services to provide more flexible support arrangements. External providers no longer have block contracts, and are expected to work more flexibly. The work done by care managers has also changed. In some cases, support planning is carried out by the person, a family member or life coach rather than by local authority staff.

As a result, the local authority has regained control over the budget and has been able to shift money from care management and long-term care packages to re-ablement, well-being services and early intervention. More people are getting help at an earlier stage, with overall spending almost level.

Implications of self-directed support for use of resources

Self-directed support has the potential to contribute to a major shift in the way local authorities use resources. An increase in the number of people with personal budgets will require a decrease in bulk purchasing by local authorities, so that more resources can be deployed according to individual choice. Possible implications for the use of resources include:

- reduced use of residential care;

- more use of mainstream services;

- more investment in advice and information; and

- more investment in external support planning and brokerage.

Coupled with the use of targeted early intervention and re-ablement, this will support the shift of resources away from intensive social care and healthcare towards support and services that enable people to develop or maintain themselves to live in the community with no or minimal formal support.

Challenges

Local authorities have identified a number of financial issues and risks with implementing self-directed support. Learning is beginning to emerge on how local authorities are addressing these issues. The most common are:

- developing a Resource Allocation System (RAS) that is simple, sustainable and fair;

- resolving differences in the costs of services for older people and younger adults;

- a risk that the attractiveness of personal budgets will increase demand;

- a risk of double running costs if people use personal budgets in new ways; and

- a risk of increasing the time and cost of the assessment and support planning process.

Resource allocation: Local authorities are expected to develop up-front and transparent methods for the allocation of resources to eligible people. There is no formal requirement to have an RAS. However, most local authorities are adopting this approach, and commercial solutions are being developed. At this stage, there is no preferred model. The Association of Directors of Adult Social Services (ADASS) is leading a project to develop a common framework for resource allocation. This will set out a possible approach to issues such as equity between younger adults and older people,[2] but it is unlikely that we will move to a common national RAS.

Increased demand: There is limited evidence that self-directed support might lead to increased uptake from people who are eligible for social care. Most local authorities are implementing re-ablement as an integral part of their new business process. This can provide a strategy to manage demand by reducing the number of people who need ongoing support.

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2   More information about this project is available at www.officefordisability.gov.uk/working/independent-living/ilr-research.php

Double running costs: Local authorities are developing strategies to manage the market so that it becomes more responsive to the choices that people make about their support. This includes restructuring in-house services, introducing more flexible approaches to contracting and procurement, and reviewing services provided by the voluntary sector.[3] Some services are also developing a role in early intervention and short-term support.

Business process: There was some evidence from the individual budget pilots that care management costs could increase, though this may have resulted from double running costs inherent in pilot projects. Local authorities can manage this risk by developing a more streamlined business process. There is scope to develop external capacity for support planning (including peer support), and for people and families to play a bigger role. A current Department of Health and Office for Disability Issues project is exploring the scope for streamlining assessment and care management by developing user-led support, advocacy and brokerage. Investing in better advice and support planning for a wider population, including self-funders, may pay off in the longer term by improving individual outcomes and the need for re-assessment, reducing residential care admissions and increasing use of social capital. Local authorities will need to remember that they are legally responsible for agreeing to all assessments, so they cannot delegate that responsibility to third parties.

Some local authorities have identified savings from within their current infrastructure as a consequence of looking to transform their adult social care. Some local authorities are exploring a three-pronged approach to their business:

Case study

Manchester City Council has made major changes to in-house services as part of social care transformation. As the local authority began to implement self-directed support, it wanted to give people more choice on how to use personal budgets. The local authority has compared the costs of its in-house services with those offered by external providers, and has worked to get more accurate unit costs of services. This has helped the local authority develop a resource allocation system and to plan budgets based on more realistic cost information.

The local authority has begun work to convert in-house services into trading units, monitoring income and spending over a two-year period. This will show how services need to be restructured to take account of how people are choosing to use personal budgets and how much money is being spent on early intervention through in-house services. The local authority expects to achieve savings of £1.4 million from the project.

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3   Department of Health (2009) *Personalised contracting and procurement*

Case study

Dudley Council worked with the Care Services Efficiency Delivery Team to map the process they had in place to undertake assessments for older people – mapping all the parts of the process onto a long strip of brown paper covered about 40 feet of floor space! It then considered how the process could be made simpler and easier for both staff and customers, which led to a much more streamlined process. Linking the process to the IT software used for client records created a paperless office, with all transactions from assessments to reviews being carried out and electronically recorded within the new simple process. This has led to a much more effective and cost-efficient system.

- contact and assessment services with a focus on quick solutions and signposting to the right places to get help;

- re-ablement and assessment services with a focus on recovery programmes leading to assessment with self-directed support (including personal budgets); and

- co-ordination services which focus on support planning, brokerage, safeguarding and reviews.

One large local authority reported £1.7 million worth of savings through creating a structure that reduced management overheads while still protecting the numbers of frontline staff.

Both the Gloucestershire and East Sussex systems are still being developed but both have already shown massive potential to help ensure that business processes are managed efficiently and that services are being delivered within budget.

Evidence on the current position

There is little information as yet from the national data returns to show the progress and results from implementing self-directed support. Evidence collected by In Control from their pilot sites suggests that a number of service users have identified lower-cost packages of care to meet their agreed outcomes than their indicative resources allocated to them.[4] The article cites case examples from Cambridgeshire, Hertfordshire, Northamptonshire, Worcestershire and the City of London. In Worcestershire, the care packages with personal budgets for adults with learning disabilities were around 16% lower than the traditional services. In Hertfordshire and Northamptonshire, the costs of care packages through personal budgets cost less than the indicative sums allocated through their RAS. The findings of the individual budget pilots were that these were cost neutral overall.

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4   Petch A (2009) 'Progress Reports on Personal Budgets', *Community Care*, 26 June 2009

The evidence on direct payments shows:

- despite increasing take-up, direct payments make up only around 3% of personal social services spending – though this is beginning to rise;

- variation across the country, but also between groups, with much higher take-up among people with physical disability; and

- older people have not benefited to the extent that would be expected given the numbers using social care services.

Early evidence from the ADASS survey of local authorities suggests that this varied pattern has continued. Some local authorities have switched early to self-directed support being the norm, and have achieved a high degree of take-up. Others are at a very early stage. The Department of Health expects that every local authority will be offering personal budgets as a matter of normal practice during 2010. Not everyone will wish to take their personal budget as a direct payment, but we expect the numbers of direct payments to grow as personal budgets are rolled out further.

Summary

Self-directed support is at the heart of the Government's vision to transform public services. Some lessons are beginning to emerge from early implementation:

- Local authorities need to implement self-directed support as part of a holistic approach to social care transformation, alongside re-ablement and early intervention.

- These changes need to be linked to work to reshape the market and restructure in-house services to increase efficiencies and provide better choice.

- Local authorities that have made early progress are beginning to identify solutions to challenges and risks.

The Government's vision for social care includes a commitment that every customer approaching social care for care or support after April 2012 will go through a process of self-directed support with a personal budget.

3. Adult social care resources

In this chapter we look at what is driving adult social care spending and where and how local authorities receive their funding.

Understanding local authorities' drivers of adult social care resources

The direction of travel for adult social care is set out in *Putting People First*, which emphasises the importance of finding ways to support people in a manner that allows them to retain their ability to live in the community and gives them choice and control over the services they receive. An understanding of the good use of adult social care resources starts with understanding this philosophy, and its implications for adult social care spending.

The basic premise of this guide is that the key to local authorities' good use of resources is getting the right outcomes for people who need social care. This includes personal social services spend on:

- older people, including those with mental health needs;
- adults under 65 with physical or sensory impairment;
- adults under 65 with learning disabilities;
- adults under 65 with mental health needs; and
- other adult services (e.g. asylum seekers, substance abuse).

There will never be enough money to deliver everything that local authorities may want to deliver. This is because:

- there will always be a finite budget for social care and other funding;
- there is elastic and increasing demand, particularly with changing demography and increasing care needs; and
- local authorities have many competing priorities – but some of them may indirectly help with the provision of social care.

Government sets the budget for public spending on a three-yearly cycle known as the Comprehensive Spending Review (CSR). The 2007 CSR set the budget for 2008–11. However, the recent 2009 Budget may change the third year of the CSR for central government departments.

Money for local authorities is allocated from government by HM Treasury to Communities and Local Government (CLG). It is then distributed to local authorities using a funding formula.

> **There is no specific sum of monies allocated by the Government for adult social care.**

Resources for social care are wrapped up in the monies allocated to local authorities to deliver all of their various services and priorities.

> **It is up to local authorities to decide how they allocate and spend their monies.**

Local authorities have flexibility and can determine locally, through public engagement with their constituents and key stakeholders, how much is spent on adult social care and other local service priorities.

Other sources of local authority funding

The Department of Health allocates monies to local authorities in the form of grants, most of which are now included in the Area Based Grant. Again, this money passes from the Department to CLG and is then distributed as a non-ringfenced grant to local authorities, which also includes the Supporting People allocations (from CLG). The only major ringfenced grant at present is the Social Care Reform Grant, which is distributed to local authorities to help them make the transformation required in *Putting People First*.

Some local authorities will add to their overall resources for adult social care from their collection of local authority tax.

Local authorities can also add further monies to their budgets from revenue raised through charging for services. This is explored further over the page.

The various sources and exact proportions of spend on adult social care are not known but approximately £2 billion comes from charges, £1.3 billion from Department of Health grants and the rest of the spend comes from CLG and local taxation (which totals around £16 billion). A recent report by the Local Government Association – *A fairer future – fit for the future: a new vision for adult social care and support* –

argued that the proportion of the funding of social care from local taxation has increased over the last five years and is now about 38% of the total spend.

Understanding local patterns of spend

The first question that local authorities may want to examine is what proportion of the local authority's total budget (excluding the schools budgets and the housing revenue account) is allocated to social care. Figure 3A shows a significant range in the proportion of monies spent. This will vary according to the range of other local priorities and will of course vary between shire counties, where the district local authorities carry some of the responsibilities, and London boroughs, metropolitan and unitary authorities, who have a wider range of responsibilities (see Figure 3A below).

When examining the spend on adult social care, always consider what other monies a local authority may be spending that could indirectly contribute to positive outcomes for people who may also have social care needs, e.g. investment in: community centres, free swimming for over 65s, neighbourhood wardens, housing alarm schemes, Supporting People programmes, community information, street scene layout, libraries, transport, parks, etc. The returns that we have used in this document draw from the PSSEx1 (Personal Social Services Expenditure) returns from local authorities to the NHS Information Centre – this includes information on Supporting People spends by local authorities. At the time of writing, CLG has just published a benefits

realisation report on Supporting People to coincide with the CLG Committee's inquiry into Supporting People. This could be considered alongside this publication (see www. communities.gov.uk/publications/housing/financialbenefitsguide).

Monies now included within the remit of the Directors of Adult Social Services' budgets may include spending in areas that have not, in the past, been recognised as part of social care funding. These might include capital budget and housing investment programmes such as bids to the Homes and Communities Agency or public finance initiatives, spending on homeless hostels, budgets for free bus passes and other areas, which might affect the wider picture.

Clearly there are other factors which require consideration within the context of relative expenditure on social services, such as:

- demographic profile;
- geography and local transportation infrastructure;
- local employment market and wage levels; and
- affluence and deprivation, affecting how much individuals contribute to services or fund all of their care for themselves.

Within this context, an excellent local authority will have a clear understanding of why its proportion of expenditure on adult social

Figure 3A: Gross total expenditure per older person and deprivation
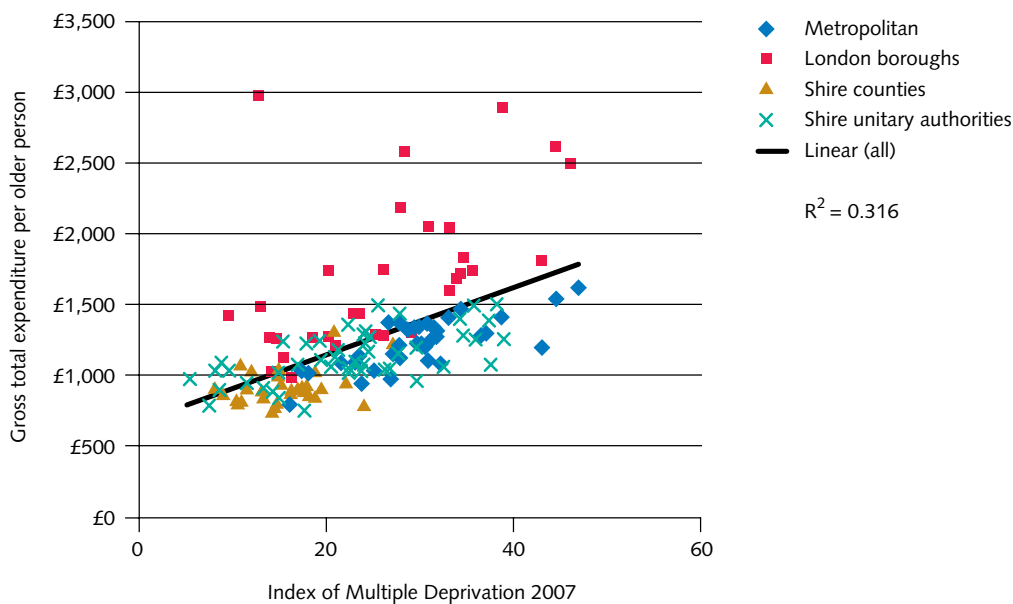
Source: Commission for Social Care Inspection (2008) *Cutting the cake fairly: CSCI review of eligibility criteria for social care*

care, illustrated in the graphs in Appendix 2, is different from other equivalent local authorities and, more importantly, what lessons it might be able to learn from similar local authorities.

Local authorities might also want to use Figure 3A to examine spend per head. This tracks the spend by local authorities against the level of deprivation in their areas. This data is from 2006/07 and may give a local authority a further indicator of their potential level of spend. Those above the line are spending more than the deprivation levels might indicate and those below the line are spending less. It should be noted that this spending pattern relates to the period before the recent changes to the funding formula for allocations to local authorities from CLG. Different eligibility thresholds are often cited as reasons for different levels of spend. However, the Audit Commission's finding in the Commission for Social Care Inspection report *Cutting the cake fairly* was that Fair Access to Care Services guidance to local authorities only has a very limited impact on spend per head by the local authority despite its impact on many individuals.

There is growing evidence that the levels of investment that primary care trusts (PCTs) make in similar areas have a significant impact on social care spending. Local PCTs' investment in good primary care for older people can reduce both the emergency admissions to hospital and the consequent demands for social care from older people. We intend to undertake some further work to understand the shared impact that a PCT's spending priorities can have on a local authority and

vice versa. We are certainly learning from the Partnerships for Older People Projects (POPPs) that there are some investments that can save both health and social care monies. Similarly, NHS investment in early assessment services for people with dementia can produce significant savings for social care, particularly in relation to residential care (National Dementia Strategy – Impact Assessment – economic case for early assessment and memory services).

The Institute of Public Care at Oxford Brookes University reports that joint health and social care investment in dental care, podiatry services, incontinence, dehydration monitoring (liquid intake), falls prevention and stroke recovery services has a positive impact on admissions to residential care.
Care Services Efficiency Delivery/ Institute of Public Care (2008) *Configuring Joint Preventive Services – A Structured Approach to Service Transformation and Delivering Better Outcomes for Older People* (see www. dhcarenetworks.org.uk/_library/ Resources/CSED/CSEDProduct/ Configuring_Joint_Preventive_ Services_v1.0.pdf)

There are significant variations in the investment that PCTs may be making in other service areas, e.g. long-term conditions, mental health services and services for adults with

learning disabilities. Some local authorities and PCTs operate pooled budgets but the proportion of investment in these budgets from the two organisations may vary. Other local authorities prefer less formal arrangements but still achieve joint investments to deliver services that are more effective. The Audit Commission is currently undertaking a study to determine if pooled budgets deliver more cost-effective outcomes. There are no right or wrong answers here but the level of investment from the PCT may determine the investment in certain areas from the local authority. The 'bottom line' is that there is an inescapable need to develop a mature 'whole system' approach with the local health community, within which the evidence about the impact of investment decisions by

each partner on the other can be constructively addressed.

- Factors that will impact on local authorities' spending patterns include historical practices, demographics, deprivation, high–low local authority tax or high–low income generation).

- Local authorities could examine and compare the England average and the family groupings (this document only uses England averages as examples). All of this information is available from the NHS Information Centre.

- One of the key pieces of evidence on use of resources (and future planned use of resources) will come from the commissioning

Case study

The London Borough of Croydon and Croydon PCT have developed a range of services together which have resulted in a significant reduction in older people's emergency admissions to hospital as well as reductions in admissions to residential and nursing care.

The core of the service is an investment by the PCT in primary care services to set up a 'virtual ward' in the community. Using a software predictor tool developed by the King's Fund (called the Predicting and Reducing Re-admissions (PARR) Combined Model) about 1,500 people who are most at risk of a first hospital admission (and consequent admission to residential care) have been identified. Primary healthcare services are targeted at these people. The local authority has invested in a 24-hour emergency response service, which supports ambulance crews when they attend an older person and believe a hospital admission can be avoided through a degree of support. The PCT and the local authority work closely with their providers and a vibrant voluntary sector to ensure that people are supported to live in their own homes.

No one in Croydon is discharged from hospital to a different residence from that which they were admitted without an intermediate care assessment based on a model of recovery/re-ablement. This has led to fewer admissions to residential care. Other local authorities such as Bradford and Coventry are now also taking this approach.

Case study

Tameside Council has been developing a balanced scorecard for health and social care activity and data. It compares the data on admissions to care homes, admissions and discharges from hospital, those using intermediate care and those using community-based services. The local authority works on shared objectives:

- Reduce non-elective hospital admissions.

- Reduce lengths of stay in hospital.

- Reduce admissions to residential care and nursing homes.

A panel regularly monitors the full picture to both track investments and to examine the actions it should take to improve the outcomes it is seeking.

It is this analysis that should inform the joint commissioning decisions. The local authority's current challenge is to reduce the increasing A&E admissions from people over 65, particularly as it is known that a number of these admissions are for a short period of time.

strategies of the local authority, which may be underpinned by appropriate analysis and a business case for making change based on the Joint Strategic Needs Assessment (JSNA).

- There are four key documents to support a local authority in its approach to better use of resources:

  — The local authority's **annual budget statement** (produced around January/February each year).

  — This should be linked to **the medium-term financial strategy** for the local authority.

  — The **commissioning strategies for each service area** (which ought to be a joint strategy with the PCT following the JSNA).

Guidance on JSNAs can be found at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097.

4. Where is the money spent?

The pattern of adult social care spending

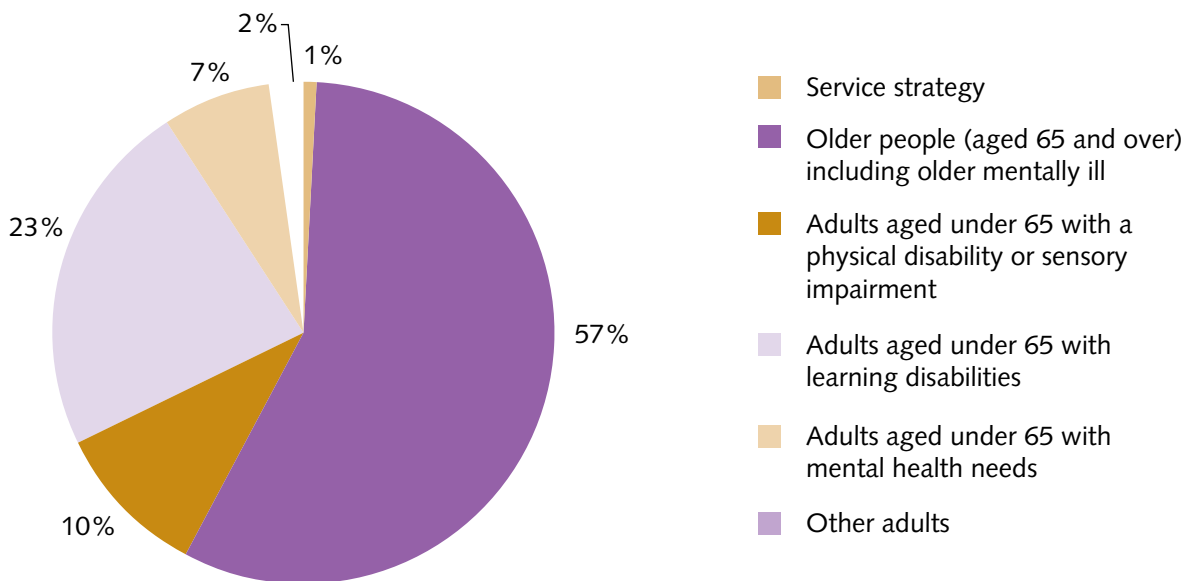There are two simple ways of looking at this:

- The balance of spend between different client groups.

- The balance of spend within client groups in different service categories.
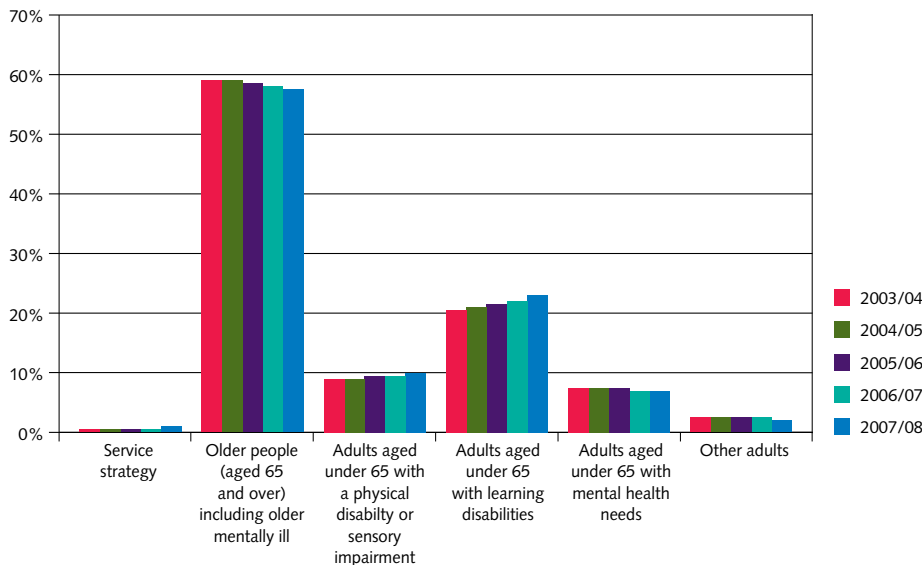
The balance of spend between different client groups

The recent pattern of spend reported by local authorities shows that there is a much faster growth in spend on services for adults with learning disabilities than there is for

older people. This can be analysed by taking the overall local authority spend on adult social care (found in Personal Social Services Expenditure data) and then dividing the proportion between the main client groups. These proportions for the national picture are shown in Figures 4A and 4B below. Each local authority will have a different demographic profile from the national picture, but this data will give you a starting point from which to discuss the way that resources are allocated between different client groups.

Figure 4A: Proportional spend on each client group (2007/08)

- Service strategy
- Older people (aged 65 and over) including older mentally ill
- Adults aged under 65 with a physical disability or sensory impairment
- Adults aged under 65 with learning disabilities
- Adults aged under 65 with mental health needs
- Other adults

Figure 4B: Changes in pattern of spend over the last five years (2003–08)

Information gathering

Local authorities may want to ask the following:

- Does it really know and understand its pattern of spend?
- Is this something about which it is content?
- Does it want to change the pattern of spend?
- Does it have robust and costed plans as to how it might achieve this?

Local authorities can compare themselves against other local authorities, against national averages and against the average in the 'family' in which a local authority is placed. Local authorities should understand their proportion of spend and be able to link it to their demographic pressures, levels of deprivation and local health needs. The data can then be presented and discussed within the local authority to establish why it shows what it does.

Appendix 4 contains graphs showing the proportion of spend for domiciliary care and assessment and care management for all major client groups. Significant differences in the proportion of monies allocated are demonstrated in these graphs and this can form the basis of a series of exploratory questions within the local authority.

Questions to consider include whether one client service area appears to be increasing its proportion of overall spend at the expense of another service area without adequate reason. For example, some local authorities are reducing the proportion of spend on older people despite local authorities' claims that this is the fastest growing part of their population. Spending patterns may be changing because of the success of new service models, e.g. the growth of re-ablement services and the use of new technologies to help people to live at home.

Using the National Adult Social Care Intelligence Service is a useful starting point for conducting analysis, both for a local authority and for benchmarking against the local authority 'family'.

The rest of this chapter focuses on the way in which local authorities use the money they have. It encourages local authorities to look at how they can reduce their use of higher-cost services (which may include residential care for some people) and to prevent people from using social care where this may not be necessary in the longer-term. It focuses on best practice from local authorities which have changed the offer that is available for people and delivered better outcomes. This section includes better use of housing options, using new technologies, working in partnership

with health and other services and developing services that prevent or reduce the likelihood of people needing care.

Is the balance of spend on residential care justified? There are significant differences between authorities on their use of residential care. There is a three-fold difference for older people and a seven-fold difference for adults with learning disabilities between local authorities in the number of admissions to residential care (taking into account their demographic variations).

Local authorities have reported a wide range of spending, with the proportion of spending on older people's residential care varying between up to 70% of the adult social care budget and as low as 30% of the budget (see Figure 4C below).

Figure 4C: Proportion of local authorities' spend on older people that is spent on residential care, 2007/08
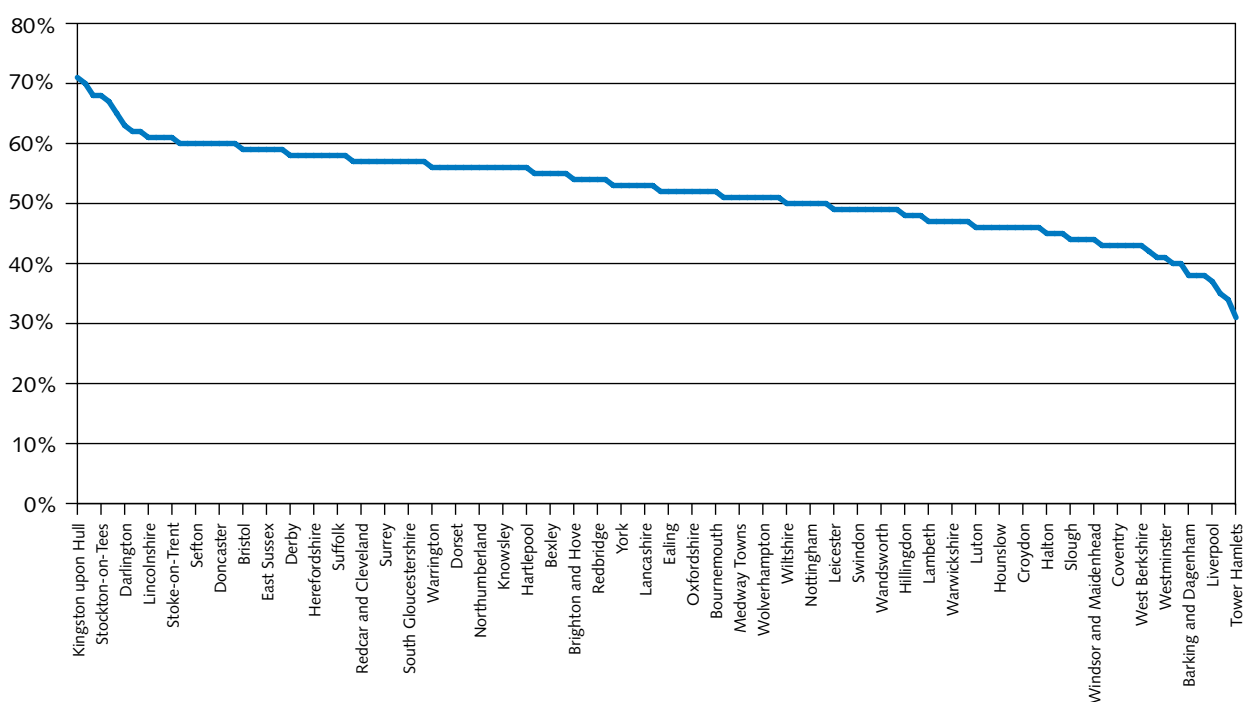
Options for reducing spend on residential care services

Our current view is that the most likely way that local authorities can release monies for investment in the future is to reduce the proportion of spend on residential care. This has been happening at a slow rate over the last five years – for older people there has been a 2% annual reduction in the **number** of residential places purchased by local authorities while they have, on average, spent over 5% on paying **increased fees** (year on year). Decommissioning residential care may yield the most redeployable resources.

Residential care provides an essential environment for many people to receive the care and support they need. However, the Government's policy for all client groups is that people should have the option to remain in their own homes (or suitable alternatives in the community) if that is possible and if that is what they want. In some places, people are being placed in residential care because there is no alternative to meet their care needs in the community. This guide shows how a number of local authorities are now creating these community options – usually at a lower cost than residential care and which deliver services that people want to help them to stay in their own community.

The proportion of spend on residential care could be affected by a number of features:

- High costs being paid for a relatively small number of people.

- Large numbers being admitted.

- Tight eligibility criteria only supporting people with high care needs.

- Supply available that needs filling (e.g. an in-house contract that guarantees full occupancy).

- A high number of self-funders who made their own arrangements but later become the financial responsibility of the local authority.

These in turn will be impacted by:

- emergency admissions to hospital;

- options for post-hospital care and recovery;

- arrangements made for hospital discharge;

- availability of intermediate care and re-ablement services;

- availability of community nursing services, including community matrons and other support for people with long-term conditions;

- availability of domiciliary care support;

- availability of therapists;

- availability of falls services;

- availability of podiatry and foot care services;

- availability of emergency and rapid response services;

- availability of suitable housing options (which might include making major adaptations (Disabled Facilities Grants), having specifically adapted housing (e.g. for a wheelchair user), or having supported housing or sheltered housing, which can support people's recovery period);

- utilisation of assistive technologies (telecare and/or telehealth); and

Figure 4D: Percentage of patients aged 65+ discharged to residential homes, 2006/07
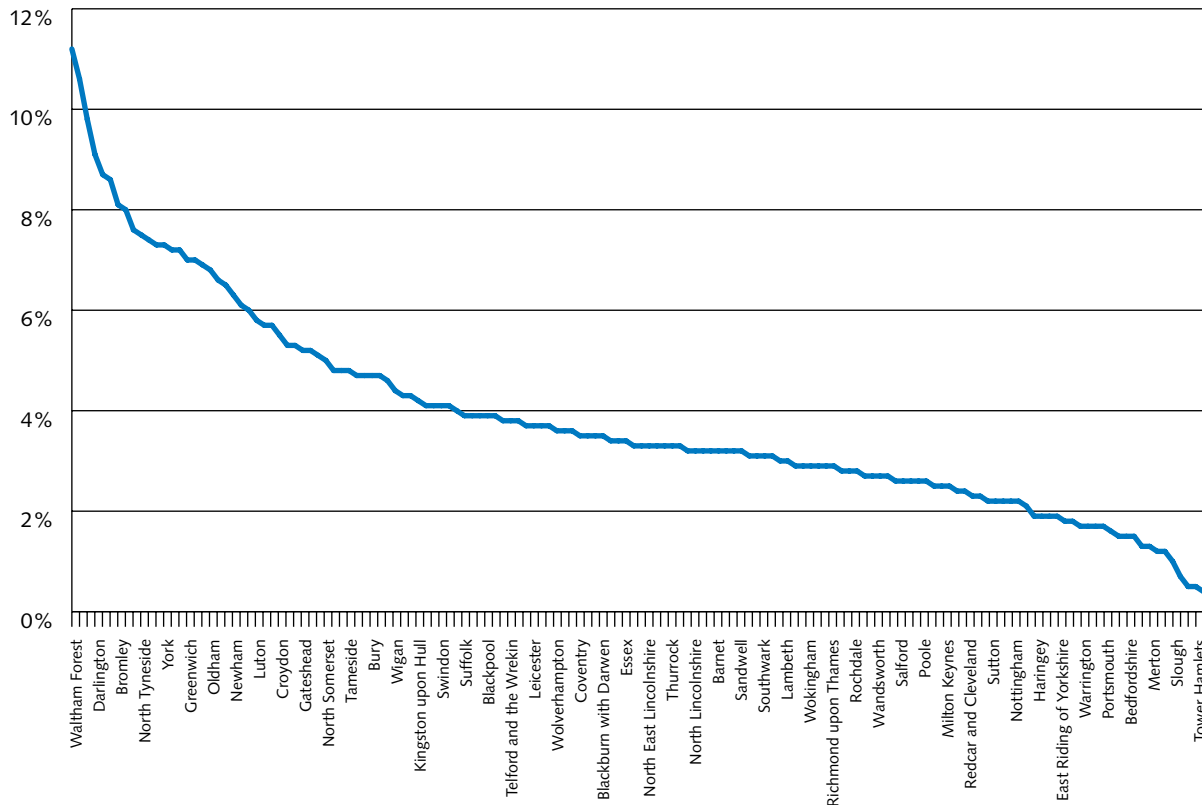
- availability of family carers and other sources of informal support.

Some local authorities have a policy that no one should have to move or change their accommodation as a result of a hospital admission without a proper recovery time with an opportunity for re-ablement.

There is a view within the Department of Health (supported by the work of Care Services Delivery Efficiency Team (CSED)) that in some cases people have been assessed as needing long-term care when specific interventions or actions may, in the medium term, reduce the need for a higher level of care. Previous Audit Commission reports have clearly demonstrated that some older people are admitted prematurely to long-term care and, if given time to recuperate, are able to manage with a less intensive level of care – but it can be too late if their homes have been given up in the meantime (Show me the Way to Go Home – Audit Commission). This is a powerful message for reducing the numbers of people in nursing and residential care, as well as in domiciliary care.

CSED's Forecasting Length of Stay and Cost (FLoSC) model predicts the future cost of current residents by analysing local data on length of stay. Early results suggest that the
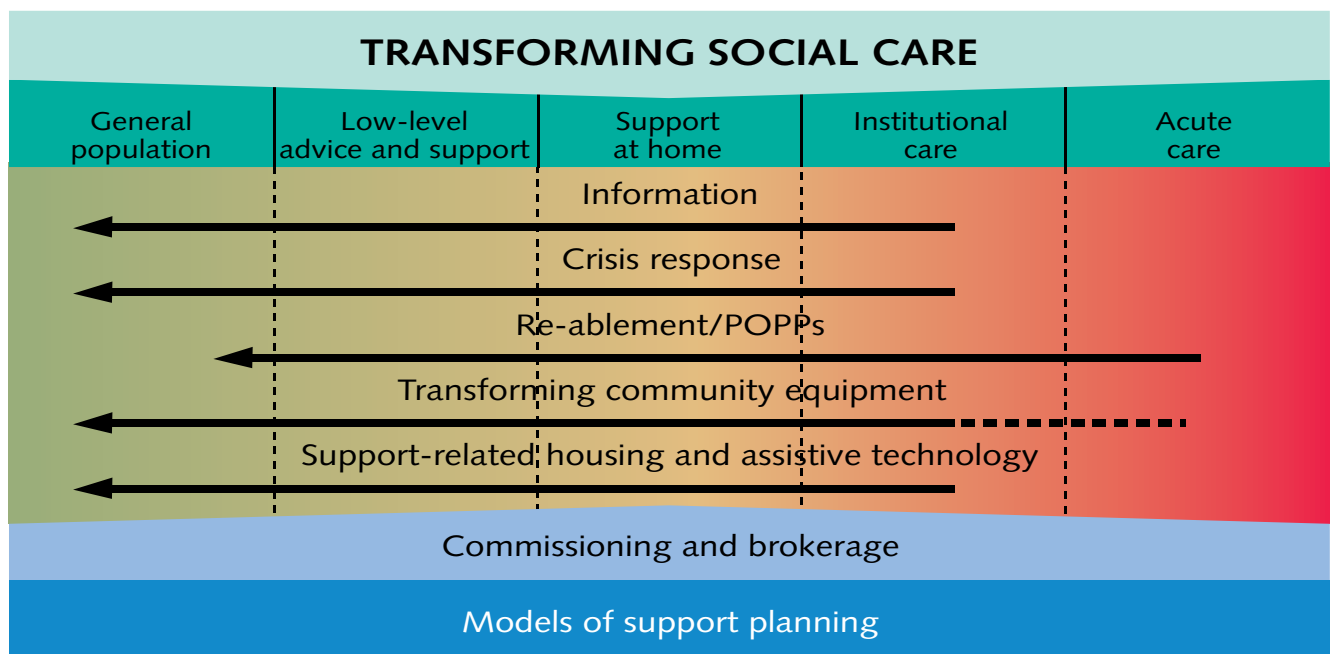
year-on-year reduction can be up to 25% and this is a measure of the scale of the opportunity if new admissions to residential and nursing care can be avoided. FLoSC is supported by Westminster University's Health and Social Care Modelling Group and can be downloaded from their website at: www.healthcareinformatics. org.uk/FLoSC.

> **The single biggest discovery by adult social care in the last decade is that many older people will recover from ill-health with the right treatment and support.**

There is some evidence that 25% of the admissions to nursing care do not need the nursing element of that care within six months of the admission – however it would not be appropriate to move someone at that stage. We need to ensure that older people have the right recovery period before making longer-term decisions for their care.[5]

Figure 4E shows the CSED team's work towards reducing the level of care that people may require.

Figure 4E: People choose less-dependent options: this is typically more cost effective

TRANSFORMING SOCIAL CARE

| General population | Low-level advice and support | Support at home | Institutional care | Acute care |

Information

Crisis response

Re-ablement/POPPs

Transforming community equipment

Support-related housing and assistive technology

Commissioning and brokerage

Models of support planning

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5   Challis D et al (2007) "Dependency in older people recently admitted to care homes', *Age & Ageing* 29 (3):255–60; Bebbington A et al (2000) *Longitudinal study of elderly people admitted to residential and nursing homes: 42 months on*, Personal Social Services Research Unit, University of Kent at Canterbury; and Millard PH et al (2001) 'The inappropriate placement of older people in nursing homes in England and Wales: a national audit', *Quality in Ageing* 2(1):16–25

Case study

Southwark Partnerships for Older People Project (POPP) hospital discharge pathway

The skills mix of hospital discharge teams was reconfigured to provide home-based support for a wider and more complex group of clients. The Mental Health Intermediate Care team became an integral part of the discharge process, intervening in complex discharge cases and providing advice and training to increase the discharge teams' capacity to deal with mental health issues. This enabled discharge teams to tackle potential barriers to returning home, such as depression and anxiety. Therapy input was increased, with occupational therapists and physiotherapists tackling more complex cases and providing home-based rehabilitation and adaptations to promote independent living. The community geriatrician provided support to the discharge teams, attending monthly multi-disciplinary teams, clinics at day hospital and intermediate care units.

Placing social workers in the elderly wards in the two hospital trusts resulted in the early identification of those patients potentially requiring intermediate care and in the proactive planning of discharge, so that patients could be discharged as soon as they were medically fit. As the hospital discharge teams gained experience, patients with more complex needs were able to be taken home for rehabilitation or re-ablement to maximise their potential of remaining in their home.

Evaluation data indicates:

- a reduced length of stay on elderly wards;

- a 12% reduction in placements in residential and nursing home care;

- reductions in the average size of social care packages from over 16 hours per week to under 12 hours per week;

- that although increased care packages may have been required for those cases where placement in residential care was avoided, this was balanced by reductions in overall hours spent on care by the discharge teams; and

- that inputs from occupational therapists, physiotherapists, the Mental Health Intermediate Care team and the use of telecare equipment have enabled more appropriate care packages.

Intermediate care services

In July 2009, the Department of Health issued new guidance on intermediate care, entitled *Intermediate Care – Halfway Home: Updated Guidance for the NHS and Local Authorities.*

Intermediate care services are jointly commissioned between primary care trusts (PCTs) and local authorities. They may aim to offer both step-down facilities (aiding hospital discharge) and step-up facilities (avoiding admission to hospital). They may offer a range of services, from intensive residential care support to domiciliary care rehabilitative services.

The updated intermediate care guidance makes clear that no older person at risk of admission to long-term care should have their needs assessed in an acute hospital setting, and that they should not be directly admitted to long-term residential care from an acute hospital bed unless there are exceptional circumstances. Some local authorities already have a policy of not allowing a patient to be discharged from hospital to live in a different setting to that in which they resided before their admission, without a period of intermediate care. Other local authorities have a policy of encouraging people into residential care because they consider it to be cheaper than supporting them to live at home. The reimbursement policy may have encouraged the rapid turnover of patients, with some moving to residential care

rather than intermediate care because they are 'borderline' and their eventual discharge destinations are uncertain. This is despite the fact that people at risk of premature admission to long-term care are a target group to receive intermediate care. All of these local policies are likely to have an impact on the numbers in residential care.

Local authorities can ensure that they have in place effective intermediate care services – where a person who is not coping well at home can have a full assessment, with the option of some help to cope with daily living. Intermediate care services can provide time for recovery from illness, from medical interventions or from other life events (e.g. bereavement). This may enable the individual to return home with the right package of care or without the need for any help. In the best performing local authorities, approximately 50% of older people using re-ablement-based intermediate care return home without requiring any package of care. Published in January 2009 by the Department of Health, *Benefits of Homecare Re-ablement for people at different levels of need* sets out data from 14 services across 13 local authorities, with the majority supporting only those at substantial or critical levels of need (see www.dhcarenetworks.org.uk/csed/Solutions/homeCareReablement/prospectiveLongStudy).

This will reduce the number of people needing help to live at home – and offer better outcomes for the individuals themselves.

Local authorities need to ensure that they have the right range of intermediate care services – those that can focus on home care

re-ablement, on meeting the needs of people with dementia and on offering appropriate recovery periods from other conditions that may help to reduce admissions to nursing care and to residential care. Some professionals have interpreted the 'normally for six weeks' time period in the original guidance too rigidly, so that people who may need longer than this have been excluded from services. The updated guidance makes it clear that certain conditions may require longer recovery periods than others, e.g. stroke recovery. Local authorities with high admissions to either nursing or residential care are likely to have some gaps in their intermediate care services.

Joint working to support people with long-term conditions or complex needs

As set out in the Department of Health's guide to long-term conditions and self-care, *Your health, your way*, people with complex health and social care needs, largely associated with long-term conditions, benefit greatly from joint health and social care assessment, care management and flexible support interventions. As well as improving the outcomes for individuals, the evidence strongly suggests that joint approaches reduce demand on both health and social care systems (see www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_097588).

Case study

The approach taken by the **Isle of Wight** to reduce the use of residential care and to support people in their own homes was to meet a political commitment to offer free domiciliary care to everyone who was over 80 and eligible for the service. This gave a strong message to both staff and the public that people could and should be supported to live in their own homes where this was feasible. The local authority had to build its capacity to support people in their own homes and arrange the domiciliary care supply. It used the in-house domiciliary care service to act as a re-ablement service to assist people who may not need long-term care and built the capacity of the private domiciliary care market so that it could manage the increased demand. In the first year following the introduction of the free care policy, it reduced new admissions to residential care by 40%. Its results since then have been less spectacular but it has continued to see a fall year-on-year of new admissions (a further 14% in the second year of the policy). The local authority more than saved the monies that the free care cost it, with a net saving of £2 million in the first year. It is not necessarily the free care alone that delivered the change. The key message here was that the councillors and the senior officers made a clear commitment to reduce the use of residential care where they could support people to remain in their own homes.

Using predictive tools

There are some excellent examples of local authorities (e.g. Croydon, Devon and Barking and Dagenham) that are using software and screening tools available to PCTs (e.g. the Predicting and Reducing Readmissions Combined Model and EARLI) which can identify older people who may be at risk of an emergency admission to hospital. They are working with their local PCTs to target services at this group of older people to prevent or delay admissions to hospital but also to have an impact on admissions to residential care. All these local authorities report significant impacts on their admission rates. The Unique Care model (which involves a co-ordinated approach between health and social care and uses the EARLI screening tool) also reports significant results. See Appendix 2 for further case studies.

Getting the right housing model in which to meet people's care needs

The importance of supported and extra-care housing

One of the drivers that may impact upon admissions to residential care is the availability of the right type of housing. A number of people with newly acquired disabilities (often following an accident) spend time in residential care while they wait for their local authority to arrange the right housing.

One of the most significant ways in which local authorities have been able to reduce their spend on residential care (and increase the level of support for people to live in their own homes) has been the growth of supported housing. In general, we may expect to see two main areas of long-term supported housing, which are:

● for people with learning disabilities; and

● for older people (sometimes referred to as extra-care housing, very-sheltered housing or assisted living).

These forms of housing and support are, in general, lower in cost to local authorities – though this may depend on the level of capital borrowing required to fund new schemes and on the criteria for admissions to schemes. These issues have been explored by the Joseph Rowntree Foundation in its publications, including *Costs and outcomes of an extra-care housing scheme in Bradford*, Theresia Bäumker, Ann Netten and Robin Darton (November 2008).

In essence, these schemes separate out the housing-related costs (which can be met from self-purchasers, housing rent that is covered by housing benefit for people on low incomes and by Supporting People Grants) from the care costs, which will be met from community care budgets. The overall cost to the taxpayer is still lower in most cases, according to a study undertaken by HM Treasury with Coventry City Council in 2006. There is growing evidence that even people with medium–high care needs can be supported in their own homes with the right staffing, technology, aids and adaptations. This is recognised in the Government's national housing strategy for an ageing society, *Lifetime Homes, Lifetime Neighbourhoods*, and in the accompanying guide for commissioners on producing accommodation with care strategies, *More Choice, Greater Voice*.

Case study

14-bed supported housing scheme for older people with dementia

Hertfordshire Council and PCT have worked together to create a 14-bed supported housing scheme for older people with dementia. The scheme offers dignity and privacy for older people, with their own flats and tailored care packages. This combines the benefits of their own space with the opportunity for communal activities. This scheme has an excellent reputation because of the way it is managed and the way in which the care staff can effectively handle the associated risks.

Many local authorities have found it helpful to ensure that a policy of promoting supported housing is included in their local delivery framework (LDF) document. This is the main planning document used by local authorities to determine their priorities when allocating planning permission. Where local authorities have included the need for additional extra-care housing in their LDF, it has been more straightforward for both local authorities (alongside their partners, e.g. housing associations) and private-sector builders to get planning permission for these developments.

Extra-care housing has developed into two distinct models:

- The first offers extra-care housing to older people as an alternative to residential care. This model is favoured by those who are very conscious of limited resources and, on average, the unit cost of the accommodation is much cheaper than the equivalent price of residential care.

- The second model is based on the principle of a 'retirement community', with a range of people with mixed levels of needs. There is an indication that this creates an active community with a proportion of people with high care needs. There are risks that this model can present a higher overall unit cost for care (to the state) than alternative provision such as residential care.

The Department of Health is currently working with 27 local authorities, the Homes and Communities Agency and housing partners to support the implementation of the £80 million Extra Care Housing grant programme (2008–11). Comprehensive information on this and other capital and revenue funding streams for Extra Care Housing is available from the Department's Putting People First Delivery Team at www.dhcarenetworks.org.uk/IndependentLivingChoices/Housing.

Some research (e.g. from the Joseph Rowntree Foundation) suggests that there is a risk that the care needs of older people may start to increase if they live in an environment where these needs may be met more easily. This may not necessarily happen as a matter of course

Case study

Very-sheltered housing in Wolverhampton

Wolverhampton City Council has developed a strategy to develop very-sheltered housing as a direct alternative to residential care. Consultation showed that older people were very reluctant to enter residential care and saw it as an option of last resort. These findings were similar to the findings of the Department of Health report ('The F Factor') which concluded that admission to residential care was as a result of older people needing immediate access to care, often driven by fear.

Although a number of very-sheltered housing models exist, the Wolverhampton model consists of:

- self-contained flats held on assured tenancy agreements that give a legal right of occupation;

- a social club offering a wide range of social, learning and healthy living activities, which are available to older people living in the scheme and wider community;

- a café/restaurant;

- a 24/7 dedicated on-site care team to respond flexibly to tenants' care and support needs; and

- a preventative, rehabilitative, person-centred practice.

Schemes generally have 40–50 flats and cater for a mixture of fitter and frailer older people aged over 55. This balance is closely monitored by an allocation team to ensure that no scheme has a disproportionately high number of older people with greater support needs. This allows for an average support package of 10–12 hours per week throughout the scheme, which is fully flexible to meet individual needs and unexpected changes in circumstances.

Wolverhampton has eight very-sheltered housing schemes, providing 368 units of accommodation, with another scheme scheduled to open in November 2009. Very-sheltered housing is a partnership between a registered social landlord, who manages the physical building, and a care provider, who manages and organises day-to-day activities at the scheme and provides 24-hour support for residents should they need it. The local authority retains 100% nomination rights for all people entering very-sheltered housing when it has provided free land as part of this partnership arrangement.

The investment made by the local authority to develop very-sheltered housing has had a significant impact on the number of older people living in residential care and consequently on the adult social care budget. In 1997 there were 814 people aged 65 and over living in residential care funded by the local authority. Overall, during the decade from 1997, demographic growth indicated a potential rise in the number of people in residential care from 814 to around 1,050. However, during this period the number actually fell from 814 to 588, indicating that 400–500 frail older people's needs were being met through the alternative services developed as part of the reconfiguration process, which included very-sheltered housing, intermediate care and respite care.

An evaluation of the first very-sheltered housing scheme (Broadway Gardens) was carried out in 1996 after the scheme had been open for two years. The evaluation looked at the effect of the scheme on 36 tenants in terms of cost to social care and the dependency levels of service users. The evaluation showed that, had service users continued to receive the same level of care at the end of two years of joining the scheme as they received just prior to joining the scheme, their care costs would have been 50% higher. This means that this very-sheltered housing scheme produced savings on care costs of over £123,000 over the two-year period.

Two further schemes were evaluated (Langley Court and Bridge Court). In this evaluation exercise, the weekly cost of care prior to the service user joining the scheme was calculated and was measured against the cost of a place on the scheme. In this exercise, the equivalent annual savings to the adult social care budget were £93,132 (48%) for Langley Court and £108,888 (24%) for Bridge Court. The 24% saving at Bridge Court, the most recent scheme, would have been significantly higher (33%) but for the first time an element of Supporting People funding was included towards the cost of support services.

The average cost to the adult social care budget of a funded placement in a very-sheltered housing scheme, for a person with less than £16,000 capital, is £125 per week (for care and support). This compares well with the net cost of a place in a residential care home (£250 per week). Comparisons with people receiving care in the community are more difficult to make because of the wide variation in care packages, but a typical package would be ten hours' domiciliary care (£135 per week), two daycentre attendances (£40) and five delivered meals (£15), amounting to £190 per week (not including 24-hour access to care or support services).

The only social care means test applied to very-sheltered housing scheme users is a capital test, i.e. people with more than £16,000 capital are required to pay the flat rate weekly fee (£105) themselves. In all other cases this fee is paid from the adult social care budget. However, service users who receive Attendance Allowance make a payment directly to the scheme provider of at least 85% of the allowance.

but may occur if people are not encouraged to stay active and keep independent. This will depend on the culture of the housing environment. If people live in an environment where care needs are increasing, then costs will increase too. These principles apply to all client groups.

Local authorities (and their housing association and PCT partners) are now demonstrating that people with relatively high care needs can live good-quality lives and have their needs met in Extra Care Housing schemes.

Local authorities need to be aware of the different models and approaches to Extra Care Housing when considering and evaluating their approach.

Younger adults

For adults with physical and sensory impairments, access to the right kind of adapted and specially designed housing can make a very significant difference to the ability of someone to live independently.

For adults with mental health needs (and for those recovering from substance misuse), it is important that they can get access to housing (they should receive priority as vulnerable people under housing legislation). The most common and the most cost-effective model is seen as 'floating support', where people can have access to help when they require it as well as day-to-day support where that is agreed within the care plan.

The greatest increase in supported housing over the last decade has been for people with learning disabilities. This is in part a reaction to the high prices now being charged for some specialist residential care in this sector and an increase in the price of residential care (a 7.5% average increase across the country in 2007/08 according to the Association of Directors of Adult Social Care (ADASS)/Local Government Association Budget Survey). The development of supported housing schemes has also shown that some people with moderate learning disabilities can benefit from their own tenancies and with the use of alarm systems and 'floating support' (available as required), people can live fulfilling lives. For those with greater needs there is still the option of developing care packages that can support people to live in their own homes – this has proved to be a particularly popular option for people with learning disabilities when they explore the use of their personal budgets. However, it is noticeable that the increase in the number of supported housing units for people with learning disabilities has not led to a reduction in the number of residential care beds being purchased, despite that being the policy intention of a number of local authorities.
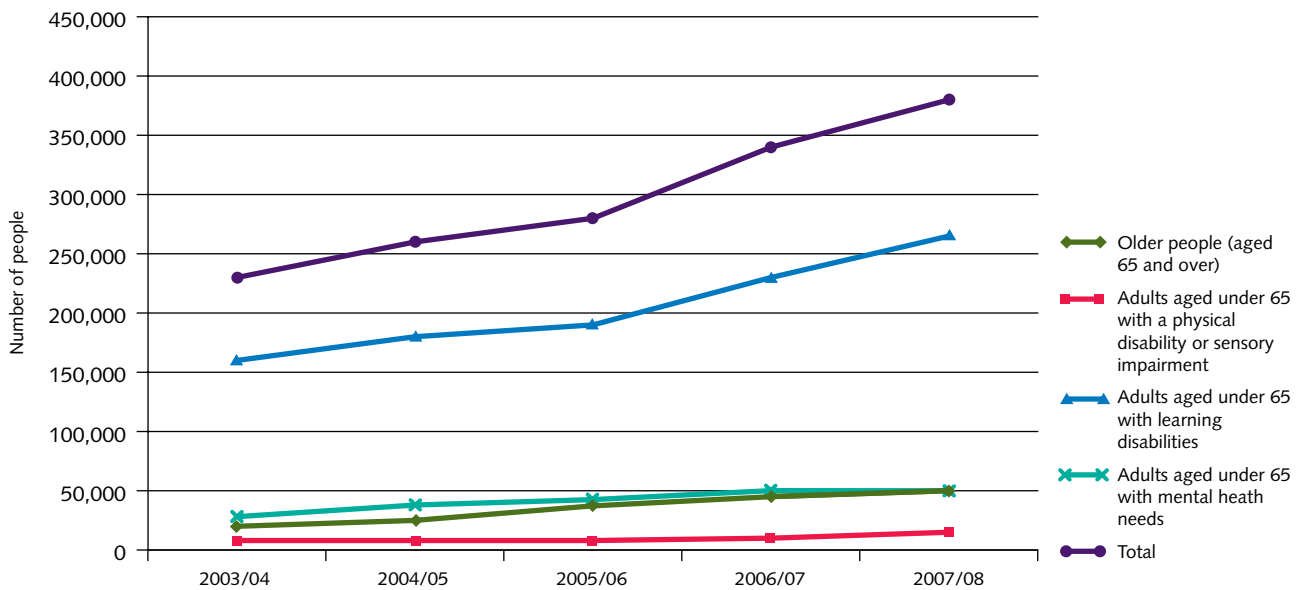
Figure 4F: Proportion of local authorities' spend on adults with physical disabilities that is spent on residential care
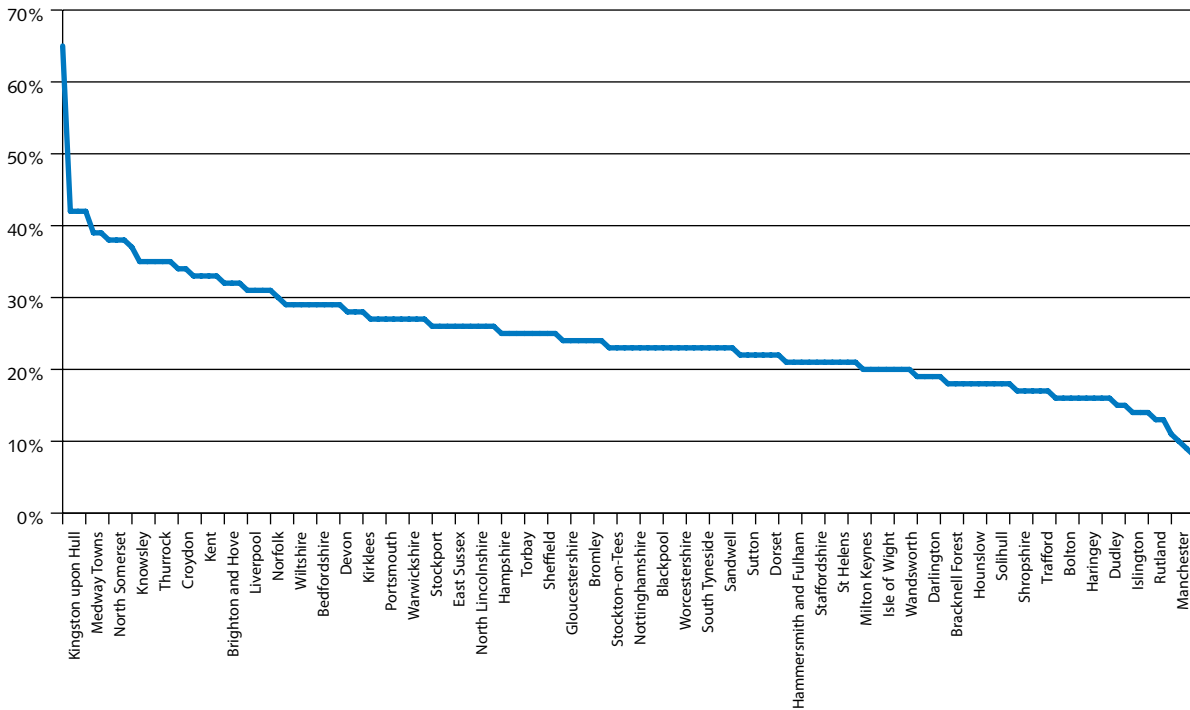
Figure 4G: Proportion of local authorities' spend on adults with mental health needs that is spent on residential care
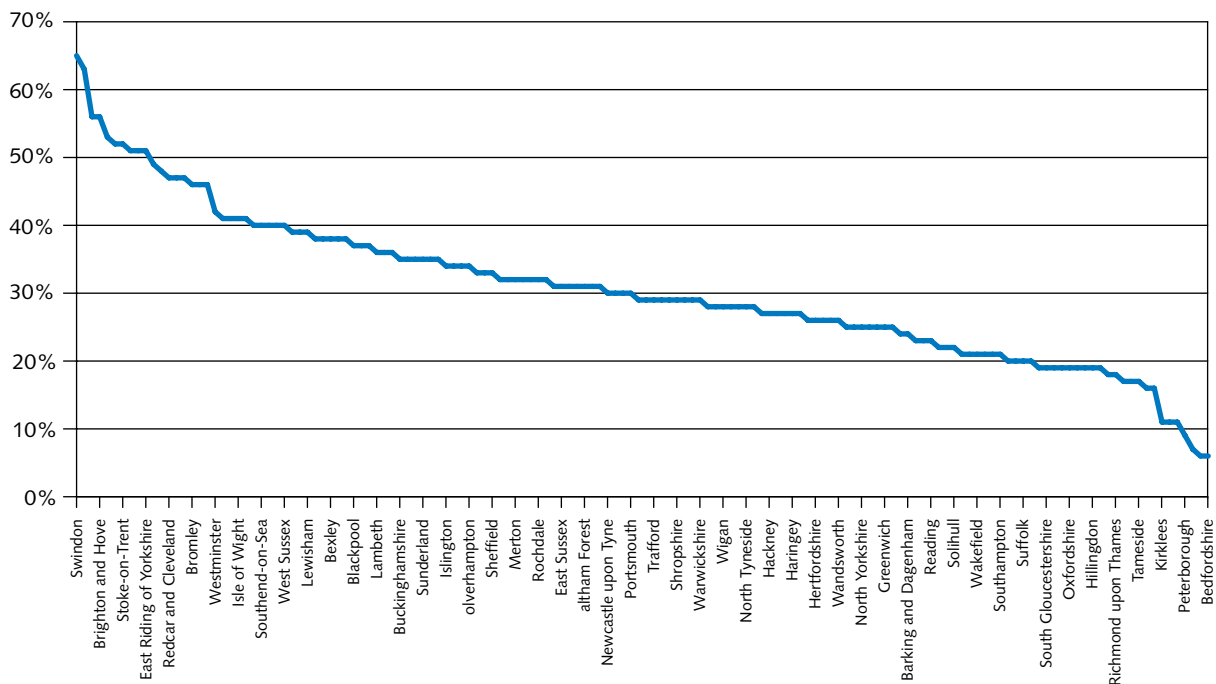
Figure 4H: Supported and Extra Care Housing trends between 2003/04 and 2007/08

Providing flexible support to people living in the community

People who need support consistently tell us that they want to remain as independent as possible. In short, they want choice and control over support that is personalised to their particular needs, not 'one size fits all'. However, current practices and service configurations do not always support this vision, and as a result people are often trapped in inflexible services that limit choice and control.

Work by the Department of Health on support-related housing has shown that by investing in flexible support linked to housing, local authorities and the NHS could make substantial savings and enable many more people to remain living safely in their own homes. However, in many areas, local authorities

and the NHS have not actively developed these approaches. Changing this requires an integrated approach to housing, health and social care, and a much greater focus on meeting housing needs as well as related support and care needs.

Below are some examples to show how flexible support can lead to better outcomes and substantial savings. We have included examples of low, medium and intensive support, but in each case, people have been able to reduce the level of support they need. See the appendices for more information and additional case studies.

Low-level support example

SMaRT (Support Management and Response Team), Nottingham Community Housing Association

Background

The SMaRT service covers over 1,000 people living in supported accommodation and in their own homes. This includes people with learning disabilities and mental health needs, homeless people, female victims of violence, ex-offenders and people with drug and alcohol issues. People can press the SMaRT button in their home to speak with an experienced support worker. If necessary, a mobile response team can swiftly attend.

Benefits

The service has directly saved over £0.5 million per year by replacing night staff and making sure that access to floating support is better linked to need. The service enables people who would otherwise be in high-cost residential care or hospitals to live in their own homes.

In addition, there are examples of other low-level support to help older and vulnerable people to maintain their independence at home through home improvement agencies and handyperson services in the recent report by Foundations, *Connecting with Health and Care*. Further details at: www.foundations.uk.com/ resources/quality_mark/connecting_with_ health_and_care

Medium-level support example

Doing It Your Way, Worcestershire County Council

Background

Doing It Your Way is the first stage of implementing self-directed support in Worcestershire. The project has so far supported 73 people with learning disabilities and their families to plan new individualised support arrangements, making use of a range of housing options linked to flexible support. James, aged 25, moved from living with his parents to his own adapted bungalow bought through shared ownership. His parents continue to provide part of his support. After 30 years of living in residential care, Donna has moved into her own home, employing personal assistants to provide support. She is now a volunteer in a local charity shop.

Benefits

Outcomes: Improvements in health, control, dignity, safety and social contact.

Costs: Estimated cost saving to the local authority is 16% – around £400,000 per year (compared with residential care or conventional supported accommodation).[7]

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7   An evaluation by Worcestershire County Council and In Control is available at:
     www.dhcarenetworks.org.uk/Personalisation/Topics/Latest/Resource/?cid=5311

Intensive support example

Ponders Bridge House – enabling people with enduring mental illness to move from hospital/residential care to sustainable community-based living, Islington.

Background

Islington Adult Services and Islington PCT each identified that they were incurring high mental-health-related costs due to over-reliance on institutional care.

The agreed solution was a jointly developed 'step down' facility with 12 purpose-built flats to take people out of hospital/residential settings and place them in a 'time-limited, recovery-focused environment'. The aim was to equip people with severe mental health needs to live independently in the community on a long-term basis.

Benefits

Outcomes: Since it opened in April 2006, seven people have successfully 'moved on' to a community-based tenancy, i.e. around 60% of the original 12 tenants have been effectively rehabilitated from a position of high dependence requiring residential/hospital care to the point where they can sustain their own tenancy in the community.

Costs: Support costs at Ponders Bridge House are significantly less per year (around £19,000) than the hospital, residential and other costs of supporting the individual tenants in the year before they moved in. To date, the split of savings from lower care and support costs has been 27% for adult social care and 73% for the PCT.

Use of assistive technology to support people in their own homes

Following the Department of Health's guidance *Building Telecare in England* and the Preventative Technology Grant arrangements (2006–08), local authorities are beginning to make wider use of assistive technologies to support people to remain in their own homes. This varies from simple call systems to alert a central point when a person has had an emergency, to using sensors to track key activities that may then trigger an alarm. Assistive technologies are widely used among older people. However, there are examples of local authorities using them to provide additional support for people living in the community who may receive floating support rather than have staff available 24 hours a day. Examples include people recovering from mental health problems, drugs or alcohol abuse and adults with moderate levels of learning disabilities living in the community. Telecare can also support carers, particularly those caring for people with dementia. North Yorkshire County Council is rolling out assistive technologies across its county (covering a very large area) and working with the local district local authorities, which are running call centres to support this mainstream activity. In the first year of the programme, it calculated that it saved just over £1 million that would otherwise have been spent on domiciliary or residential care for the recipients.

The Department of Health is undertaking a two-year research project to find out how technology can help people to manage their own health and maintain their independence. The Whole System Demonstrator programme is believed to be the largest randomised control trial of telecare and telehealth in the world to date. Further details at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_100946

Case study

Innovation, choice and control – telecare in North Yorkshire

North Yorkshire County Council approach to telecare: In 2005/06, 42 people were selected to test the telecare approach in an urban and a rural area. Key issues from that early work included the need to: ensure that telecare was part of mainstream referral, assessment and care management systems; have good procurement skills; have systems in place for installation, maintenance and decommissioning; implement a response system when people need assistance; and develop excellent partnership working with providers and local district local authorities.

Resources: The initial investments included Local Public Service Agreement funding of £70,000 for the two pilots and the Preventative Technology Grant of £871,000 to employ four community telecare change agents, service level agreements worth approximately £10,000 per year with seven housing providers for monitoring centres and the purchase of equipment. In addition, North Yorkshire invested a further £942,000 as well as the £70,000 to housing providers for lifelines to increase prevention opportunities in the community and additional equipment.

Staff role: The role of the community telecare change agents is to: take a countywide approach to training and development of staff in both adult and community services and partner agencies; raise telecare awareness and skills; support joint assessments; and undertake public relations and installation training. They keep up-to-date with evolving technology, play a key role in performance monitoring and ensure consistency in countywide processes.

Outcomes and achievements: Between April 2008 and March 2009, 4,595 people attended awareness, public relations and installation training sessions. Staff have gained significant experience in a range of technologies. The service is seen as supporting people's chosen outcomes and meeting their changing needs. The approach is assisting staff to manage risks when providing customised services. People speak of how the service has helped them to carry on living at home, giving them more confidence and peace of mind. All staff in social care have received awareness training, with new staff targeted soon after arrival. The local authority has created a training pack and guidelines for fitting equipment and developed long-term conditions pathways for a range of conditions with the PCT. Work is ongoing with a range of providers to embed personalised technology for people with learning disabilities as part of support, and short-stay residents at older person's homes can try telecare before having it installed at home.

Evaluation: All new telecare users during September 2008 were subject to an evaluation. Their care managers identified what the traditional care package would have been if telecare had not been available, and what the actual telecare-enhanced packages of care were. Some 46% of the traditional packages would have been residential, elderly mentally ill or nursing and 54% at home. Those who would have had more than ten hours of home care saw a reduction in the number of hours needed, while the trend for those who would have received seven hours or less was a reduction in the number of hours, with some people needing no further support. Analysis indicated a net average annual efficiency per person of between £12,246 and £1,756 per area, averaging at £3,654 countywide – a 38% reduction in care package costs.

The projected saving for one year is £1,108,609. Spreadsheets of costings and efficiencies are available along with a range of case studies and quality of life statements at: www.northyorks.gov.uk/index.aspx?articleid=3198 or contact adrienne.lucas@northyorkshire.gov.uk.

Staffordshire County Council's use of the Just Checking system
Background
Staffordshire County Council was prompted to look for alternative solutions to help manage the projected increase in people with dementia living within the community, the pressure on residential placements budgets, the need to support carers better and the requirement to reduce hospital admissions.
The local authority found a solution to these problems with the Just Checking system, which uses easy-to-fit and unobtrusive sensors to monitor a person in their home and provides a chart of activity via the internet. The information is used to ensure greater accuracy in the assessment or review process, leading to care or support plans that are 'made to measure' and flexible in order to meet individual lifestyles.
Benefits
The system costs £14 per week (equivalent to one hour's home care), is portable and can be used many times over. CSED's review of a sample of 20 cases indicates that the system will deliver cashable efficiencies across the wider health and social care system arising from:

- more accurate assessments, leading to targeted timing and sizing of care packages and support;
- delaying or preventing residential placements; and
- improved independence, choice and control for all client groups.

A sample of 20 people demonstrated net savings of £120,000 (£6,000 per person). If all 85 installations saved this amount, total annual savings would be £510,000.

The Just Checking system is also being used in Herefordshire and Warwickshire within the West Midlands.

Services for adults with learning disabilities

Work by the Department of Health (see Figure 4I) has looked in more detail at spending on people with learning disabilities. This shows that local authorities that spend most of their budget on residential and nursing care spend more money and get lower outcomes (in relation to real employment and leisure opportunities) than local authorities that have developed a wider range of housing and support options. The case study 'A tale of two nations' shows these results in more detail. The Department's three-year strategy, *Valuing People Now*, recognises this imbalance and places significant emphasis on improving the housing choices and pathways for people with learning disabilities.

Figure 4I: Proportion of local authorities' spend on adults with learning disabilities that is spent on residential care
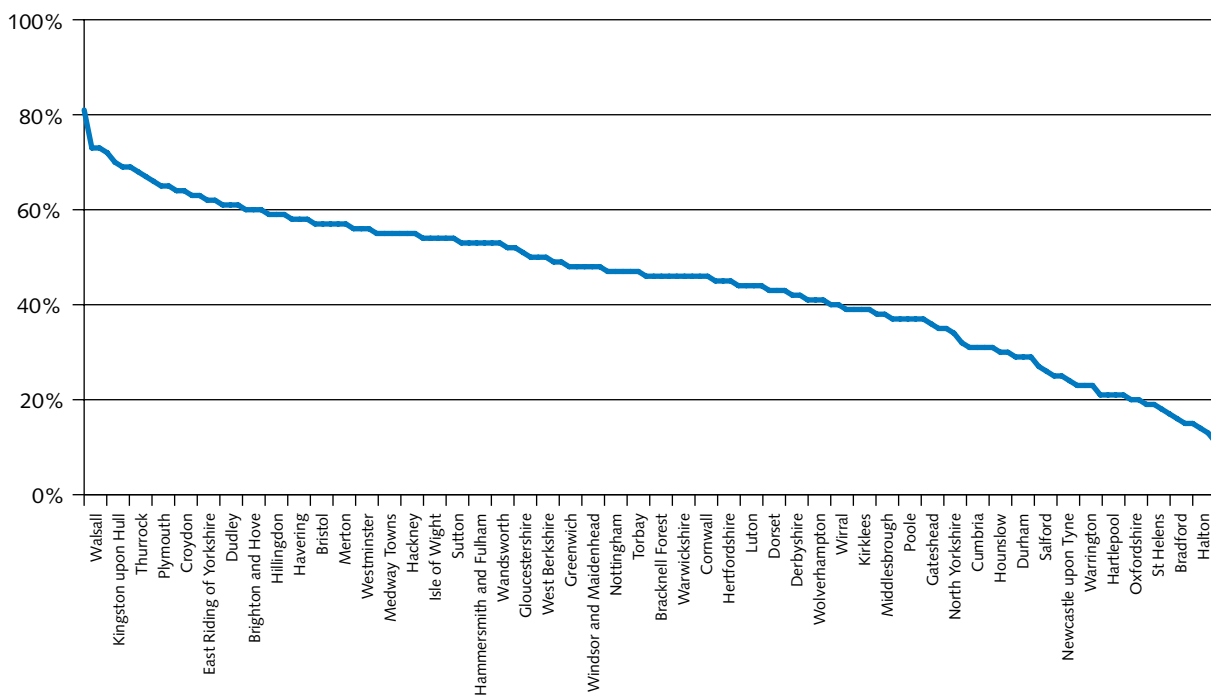
Case study

A tale of two nations

Local authorities in England spend on average 22% of their adult social care budget on services for people with learning disabilities. This spend has grown rapidly over the last ten years, and represents a significant budget pressure for local authorities. In 2007, the Department of Health worked with ADASS to examine in more detail how local authorities spend money on people with learning disabilities. This showed that:

- spending on people with learning disabilities has grown more rapidly than the overall trend;

- local authorities spent over half the budget on residential and nursing care for a relatively small number of people;

- the patterns of spending vary greatly between local authorities, with some spending most of their budget on residential and nursing care; and

- local authorities that spend a high share of their budget on care tended to spend more overall but achieve worse results than local authorities with low use of residential and nursing care.

Careland and Communityland

We found that the country could be divided into two 'nations' – 'Careland' and 'Communityland'. The local authorities that fell into these two groups had the highest and lowest share of spending on residential and nursing care respectively. We called the remaining local authorities 'Middle England'. We looked at the figures two years later, and found that the same patterns still hold.

Tables 1 and 2 show the number of local authorities that make up Careland and Communityland. All but eight of the local authorities in Communityland are in the North West, North East and Yorkshire and the Humber regions. Most of the 38 local authorities in Careland are in London, the South East, the South West and the West Midlands. The differences in the patterns of spending appear to be clearly linked to the history of service development. For example, in the North West, resettlement of people from long-stay hospitals relied on supported housing instead of on residential care.

Table 1: Careland and Communityland

	Careland	Middle England	Communityland
East Midlands	2	6	1
East of England	2	8	0
London	10	20	3
North East	1	5	6
North West	0	1	21
South East	7	11	1
South West	6	8	2
West Midlands	6	7	1
Yorkshire and the Humber	4	8	3
	38	74	38

Table 2: Careland and Communityland

	Careland	Middle England	Communityland
County council	9	17	8
London borough	10	20	3
Metropolitan authority	4	13	19
Unitary authority	15	24	8
	38	74	38

Tables 3 and 4 show local authority spending on people with learning disabilities in 2007/08 and how this money was used. Local authorities in Communityland spend less than 25% of the budget on residential nursing care. They appear to have a lower overall spend, with spending growth about the same as other local authorities. However, when changes in Supporting People spend is taken into account, the underlying spending growth is lower in Communityland. These local authorities spend a lot more on supported accommodation, and slightly more on day services, direct payments and care management. Local authorities in Careland have a high overall spend and use nearly two-thirds of the budget on residential and nursing care, leaving less available for all other services.

Table 3: Median local authority spend on adults with learning disabilities (2007/08)

	Careland	Middle England	Communityland
Local authority spend (per head of adult population)	£110.97	£105.95	£101.47
Spending increase in 2007/08	6%	4%	3%
Spending increase over the last three years	24%	20%	18%

Table 4: Median local authority spend per head of adult population (2007/08)

	Careland	Middle England	Communityland
Residential and nursing care	£73.17	£48.95	£23.81
(% of total spend on care)	64%	48%	24%
Supported accommodation/home care/other	£12.45	£21.21	£40.71
Day services	£18.46	£21.81	£23.44
Direct payments	£1.84	£2.32	£3.00
Care management	£6.26	£6.35	£7.34

Table 5 shows a summary of performance information for 2007/08 relating to people with learning disabilities. Local authorities in Communityland help more people to live at home, have fewer people living in residential and nursing care, have fewer out-of-area placements, and more people get direct payments compared with Careland. Local authorities in Communityland tended to achieve better star ratings in 2007/08.

Table 5: Summary (number of people per 100,000 population (2007/08))

	Careland	Middle England	Communityland
People helped to live at home (PAF AO30)	259	286	350
People living in care homes	118	102	64
People living out of area	47	40	22
People with learning disabilities who receive direct payments	27	29	35
Average star rating for 2007/08	2	2	3

Conclusions

This work has shown that local authorities in England have radically different patterns of commissioning for people with learning disabilities. The findings show that local authorities that have invested in a wider range of housing and support options spend less and get better results than local authorities that have tied up most of their budget in residential and nursing care

Crisis response services

There is evidence to suggest that effective crisis or rapid response services can have a positive impact on the care pathway and outcomes for older people. Key features of more effective services include:

- a single integrated point of access;

- generically trained community support staff able to modify the package if necessary;

- links to intermediate care services and medicines management; and

- alternatives to the standard ambulance response.

The proportion of the money spent by a local authority on residential care will give a simple way of understanding what flexibility and options a local authority has to develop new services, deliver efficiencies (see Chapter 5), create community-based options and promote independence.

Milton Keynes Rapid Assessment and Intervention Team
Background
The Milton Keynes Rapid Assessment and Intervention Team is part of a wider range of intermediate care services, funded by Milton Keynes Council and Milton Keynes PCT. It is jointly managed, providing short-term, intensive, integrated care and rehabilitation to support individuals in their own home or enable individuals to return to their own home after an illness or accident.
Costs of the service are approximately £500,000 and are shared between the local authority and the PCT, at a ratio of 33% to 66%.
A particular feature of the scheme is that when patients are ready for discharge from hospital, assessment of their needs is made by the team immediately when the patient returns home, reducing potential delay in discharge arrangements.
Benefits
Benefits support the personalisation agenda, including: seamless and integrated service delivery with positive user and carer feedback on being treated with dignity; patients' confidence in the service and in the service's ability to help them to regain their independence; positive staff feedback; an increase in the number of hospital and residential care admissions avoided; and faster discharging from hospital.

The underlying philosophy of the service is re-ablement and so 70% of service users discharged from the service required no further support.

In addition, over a 12-month period:

- 722 hospital admissions were avoided; and
- 100 admissions to residential or nursing home care were avoided.

Total cash savings to health and social care were £3 million (the largest proportion to health but with a minimum of £400,000 to social care).

Norfolk POPP 'night owls'

'Night owls' are generic workers capable of responding to a range of health, social care or domestic problems which cannot wait until morning without leaving someone in discomfort or distress, yet do not need a response from the emergency services. The service is free and can be directly accessed by any older person or someone on their behalf. Night owls have close relationships with other services such as out-of-hours GPs, social workers, district nurses and housing personnel. The night owls team operates 365 nights a year with three to four staff members on duty through the night. During 2007/08 the team helped 2,256 older people across Norfolk. Tasks performed included helping people who had fallen, cleaning up after a flood, comforting someone after a burglary, reassuring relatives who live too far away to help, and supporting other professionals.

Some 21% of visits were to people who had fallen and without the service would have needed an ambulance. A similar percentage of people needed help with continence care and 5% needed help with catheters or stoma bags. This has resulted in savings to services and in releasing time for more appropriate activities. In 2007/08:

- 981 ambulance callouts were avoided;
- an estimated 442 A&E attendances and 95 hospital admissions were avoided; and
- gross savings from all of the above were estimated at £302,000.

Salford Rapid Response Service
Background
The rapid response service in Salford is an integrated health and social care service and part of intermediate care services. It is multi-agency, with single line-management arrangements and a pooled budget agreement. Its primary purpose is to treat and support people who have experienced a health and social care crisis in the community or in step-up residential or nursing home care, and also to avoid unnecessary hospital and long-term residential care admissions. It is accessed through a single entry point, with skilled advanced-practitioners assessing need within four hours of referral. It has a strong re-ablement focus with the goal of helping people to regain and maximise their independence.
Benefits
Around 2,300 people were referred to the service in 2007/08 and the financial efficiencies identified below are based on an analysis of 868 of those service users. Outcomes: Reduced admissions to hospital and residential care; reduced number of visits to A&E; maintenance of independence; and reduced stress and anxiety for patients. Costs: Savings for 2007/08 are estimated at a minimum of £1 million, with £689,000 to health and £378,000 to social care because of diversion from hospital and residential placements.

Modernising daycare services

Over the last decade, local authorities have been considering the most effective way of meeting the needs of people who need care and support during the day. In some cases, this may lead people to need to be in a care environment during the day so that they can remain living in the community. Historically, local authorities have delivered this service through day centres. This is where a local centre is open from 10am until 4pm (typically) and where people can have their needs met. This may also be a form of respite service where people who may be doing the caring in the evenings and at weekends can get a break or continue in employment while the person who needs care can remain in a warm and safe environment. Some day centres offer a range of activities, which may promote stimulation and interest for their members. Others may focus on specific programmes, such as helping adults with disabilities cope with aspects of daily living or prepare for work opportunities.

Though the cost of the day centres is not often expensive, associated costs such as transporting people to and from day centres can contribute as much as half of the overall cost. Helping younger adults with learning disabilities to learn

how to travel to day centres independently is a common way of both helping people achieve greater independence and reducing costs.

New alternatives to daycare have begun to emerge as part of person-centred planning and, more recently, with the development of personal budgets. Some local authorities are beginning to move away from day centres as the way to assist people who need opportunities to be active during the day. Many local authorities no longer run day centres for younger adults with physical disabilities, encouraging them instead to use personal budgets to undertake activities which are more personal to them. Some local authorities are now beginning to offer new choices to younger adults with learning disabilities.

There are risks to the approach – some local authorities appear to have increased their costs when they have closed their centres. The key issue appears to be getting the balance right between the need for flexible staffing alongside reducing the costs of accommodation and transport.

For older people, the need for social interaction in an environment which can offer care is usually the key issue. Some people have begun to use their personal budgets to enable them to use personal assistants or carers to take them to the community activities in which they used to engage. In Herefordshire, they have found that their investment in village halls has meant that some people prefer to join in the local activities rather than to wait for the local authority bus to take them to the nearest day centre, which can be an hour's ride away. In Gloucestershire, 'village agents' are putting people in touch with activities within their own communities. As personal budgets begin to be rolled out across the country, we expect to see a lot more imaginative solutions to the way in which people receive care and support during the day.

Thurrock Council has modernised its day opportunities programmes for younger adults with learning disabilities. It started by closing all of its large multi-purpose day centres, recognising that a combination of the running costs of the centres and transport costs amounted to a high proportion of the costs. There are a number of strands to the new opportunities programmes. Shop frontages around the borough have been rented in key locations on bus routes where people can come as a base to undertake day opportunity programmes. A community company – Thurrock Lifestyle Solutions – has been set up and has seven directors with learning disabilities (supported by staff) who run the services that people need.

The most important part of the service is having flexible staff available to work with individuals or groups on the opportunities that they have identified will meet their outcomes. The programme has a budget of £1.5 million for about 140 people. £1 million of this is in fixed costs (mostly staffing), with £500,000 directed towards personal outcomes – about £70 per person per week. Thurrock Council says that freeing up that level of resources is what has assisted it in transforming its services.

5. Delivering value for money

Local authorities may want to ask whether the investments being made are delivering the right outcomes for people receiving services (or who should be receiving services).

Taking this a stage further, local authorities may want to ask the following questions:

- Do the services work together to contribute to the ability of people to live independently or do they drive people towards more institutional care? Do the local authority's services maintain individual independence or pull people into the system and reduce their independence?

- Are there choices for how people wish to live their lives and maintain their independence?

- Do the health and local authority systems work together to achieve these outcomes? For example, if the admission rate of older people to hospital is high, this may contribute to more people needing health and social care support.

Commissioning and procurement

Local authorities now understand the prime role and significance of commissioning.

> **Commissioning – identifying needs to be met and procuring services to meet those needs.**

Within the commissioning cycle is the process of monitoring services to ensure that quality is sustained at the level specified in the contract with the service provider. However, local authorities have been slow to specify the

outcomes they want delivered and realised from the contract. In the age of personalisation, there is a trend towards local authorities procuring a framework contract, allowing the service users to negotiate the precise details of the services they want directly with the provider. Thurrock Council has moved significantly towards outcome-based contracts with their domiciliary care providers. Coventry City Council's contract with Crossroads, which allows service users to take control over their package of care in negotiation with the provider, and Barking and Dagenham's model of individual service funds are good examples of new and emerging contracts.

The recent trend is for local authorities to specify the services they want from a contract. Where they procure large volumes of business through a tendering process, they may pay less for the services than if they purchase on a one-off contract. However, there are some exceptions to this. For example:

- In older people's residential care, a long-established provider (who has paid off any borrowing on the property) may still be able to offer a lower price than a new provider building a purpose-built modern establishment and having to cover the associated loans.

- In the domiciliary market, because of the transaction costs, there is little difference between the price paid by self-funders and that paid by local authorities buying in bulk. Different providers will offer to meet the costs of services at different prices. For example, one national domiciliary care provider has been able to run its domiciliary

care contracts at a loss. This is because it makes a good profit on its residential care and sheltered housing services. This 'loss leader' will only operate for a short time but should enable the provider to get a strong foothold in the local market. Local authorities are beginning to use the benefits of new technology – for example for billing or for time monitoring – and this is starting to reduce the providers' costs.

Much has been written and said about how local authorities may secure better value in the market through procurement. There is a view that if local authorities worked together in a consortium (termed 'collaborative procurement') they could secure better prices for the products they wish to purchase. This is extremely unlikely in residential care for older people, where providers argue that local authorities are purchasing care below the real cost in the market (which is supported by some recent evidence from the Joseph Rowntree Foundation). However, this is more likely to be achieved in high-cost/low-volume services, e.g. in some more specialist areas.

There is a study of the former 'in-house' services in Sandwell where costs were significantly reduced through reducing turnover and sickness levels, cutting back on administration, focusing care staff on working more directly with their service users and sustaining occupancy in care homes by reducing turnover. This shows that in some areas there may be possibilities for still greater efficiency in the delivery of care for older people.

Unit costs of adult social care

Methodology

The unit cost of a service is calculated by dividing the total spend (numerator) in a service area by the activity (denominator). For example, the spend on residential care divided by the number of older people in residential care (each week) gives the unit cost. Some of this data is provided in local authorities' Personal Social Services Expenditure data and Referrals, Assessments and Packages of Care for Adults (RAP) data.

Background to using unit costs to understand value for money

There are various views about whether it is possible to reduce unit costs. In the early 1990s, the approach taken by many local authorities was to 'externalise' in-house services in order to obtain a similar service at a much lower price. These lower prices were obtained through the payment of lower wages and fewer pension rights and sickness payments for staff and by removing the associated on-costs for local authorities.

Over the last decade, the TUPE (Transfer of Undertakings – Protection of Employment) regulations have significantly reduced the opportunity for reducing unit costs in this way as staff who are moved from local authority services to external providers may have their terms and conditions (including their pension) protected when they move.

The other approach to reducing unit costs is to reduce the amount of money offered to a private or not-for-profit provider for a

service they are offering. For example, in 2007/08, a small number of local authorities made no uplift for inflation on the rates they paid for residential care. Others undertake 'reverse auctions' where the lowest bidder is awarded the contract, sometimes without due regard to quality (the four examples of this in England and Scotland have all met with serious problems regarding the delivery of contracts within the final price quoted).

There are a number of factors that may influence the unit cost of a service. These include:

- property prices;

- the local wage market;

- the supply of staff and terms and conditions of staff (leave, sickness, etc);

- the proportion of return sought by the provider;

- the age of the property and recent capital investment;

- the nature of the contract with the local authority;

- the transport costs;

- the inclusion of travel time; and

- the quality offered (physical environment or staff).

Generally:

- unit costs are higher when the service is provided in-house, or by one of the larger national providers of care;

- unit costs are lower where services are provided by locally based providers who

are well established or by not-for-profit organisations; and

- the best way to reduce unit costs is by focusing on productivity and efficiency in a service.

There are growing attempts (linked to personalisation) to consider the costs of care for a person (rather than a service).

Information gathering

For local authorities, there are also a number of factors they may wish to consider when looking at these unit costs:

- Is the local authority paying gross or net to its suppliers?

  — If gross, the local authority pays the full cost of the care to a supplier and then collects the contribution from the client. This may show a higher level of expenditure than in those local authorities where they pay net.

  — If net, the local authority pays only its own contribution, leaving the service user/family to pay their contribution (including any top-up) to the supplier/ service provider.

- There is also the question of 'top-ups' where a user of the service (or their representative) may be making an additional contribution to the cost of care in order to purchase a place of their own choice. These will be paid direct to the provider by the user (or their representative) and can therefore distort the overall unit cost of the service as seen by the local authority.

- There is clear guidance from the Chartered Institute of Public Finance and Accountancy on the apportionment of overheads but this does not appear to prevent local authorities from placing different interpretations on the rules and therefore has an impact on their final unit costs.

Local authorities may wish to consider how many people are being funded.

A local authority may be paying what appears to be a high unit cost but this may be reflecting good practice by including the higher premium for a small number of people with high care needs. The key issues here are being clear about what service is being offered and understanding, investigating and explaining variations in costs. An example may be a voluntary sector day centre that appears better value until you look at the range of additional services being offered by the in-house daycare centre.

Local authorities may also wish to know the spread of costs across providers.

There is some evidence that while local authorities agree an annual level of up-lift or inflation to the basic price, they do not do this consistently for all contracts. In recent years many local authorities have offered an increase in line with inflation of circa 2.5%. However, the overall spend by local authorities on residential care has risen by 5% (with a 2% fall in occupancy). This is because local authorities negotiate individual contract deals with each provider. These contracts may be:

- planned (a new contract with a new provider); or

- unplanned (finding a placement in an emergency and being prepared to pay more); or

- more expensive for people with higher care needs.

Local authorities cannot legally cap the amount they pay to meet someone's assessed needs. If they can only secure the service at a higher price, they may have to pay in order to meet someone's needs appropriately.

Current information about unit costs

The Personal Social Services Research Unit (www.pssru.ac.uk) produces an annual report on unit costs in health and social care. Below we have highlighted some of its key findings from 2008/09 data. Local authorities need to be careful when interpreting the data below. In some cases, the figures are calculated from quite small samples. We have presented the figures so that you can consider how you would find similar costs for the models of services in your area. There is no doubt that the variance between unit costs for similar services in different parts of the country requires more investigation. More work needs to be undertaken to understand the most effective cost models for services, for example in the different models of supported housing for different client groups.

The average revenue cost of an in-house residential care service for an older person was £478 per week (with a highest price of £679 per week). This figure equates to a £945 establishment cost per permanent resident per week (when all public costs are taken into consideration). This is twice the amount that

most local authorities pay the independent and private sector for residential care, although many of these homes specialise in dementia care, which would receive a higher premium in the independent sector market.

The costs of sheltered housing do not vary significantly between providers (nor between the local authority and the independent sector). It appears that local authorities have lower unit costs than housing associations for very-sheltered housing. As the variance seems to depend on the level of staffing, this may be affected by the dependency levels of those living in the accommodation.

Local authority staffed hostels for people with mental health needs come out at £604 per resident per week, but local authority group homes come out at £252 per resident per week. Voluntary sector staffed hostels come out at £531 per resident per week, while voluntary sector places with on-call staff come out at £344 per resident per week. Private sector residential services are £412 per week. NHS intensive psychiatric care costs £590 per patient per day, with an average cost of £7,258 per patient stay. NHS inpatient services for people with mental ill-health cost £225 per day (£1,575 per week). Daycare services are more expensive in health settings (£66 per day), while the figures for local authority and voluntary organisations are similar (£42 per day).

For services for adults with learning disabilities, the average cost for group homes is £1,307 per week; for fully staffed residential settings it is £1,437 per week. Supported living schemes for people with high care needs, if housing, daycare and health costs are included, come

out at £1,562. Semi-independent living schemes (for people with moderate and lower levels of needs) cost £693 per week.

Value for money summary

The Government's strategy for delivering value for money rests on three pillars that have been put in place in successive Spending Reviews:

1. **clear and accountable objectives;**

2. **challenging budgets that fund the delivery of these objectives; and**

3. **value for money programmes which ensure that additional spending is matched by reform.**

Efficiency returns and local authorities' 3% efficiency targets

Background to the Comprehensive Spending Review settlement and efficiency targets

For 2008–11, the local government settlement set out:

- 1% growth in real terms (with inflation standing at 2.5%); and

- requirements for local authorities to find 3% efficiency gains to meet demographic pressures.

The settlement means that local authorities have to find cashable efficiencies just to stand still and meet existing policy commitments.

Background to the changes in local authority allocation methodology

At the same time as the Comprehensive Spending Review (CSR), changes were made to the Relative Needs Funding formula used to calculate the distribution of grant and other monies to local authorities. Overall, London and some counties received lower growth, while northern and some metropolitan authorities gained higher growth – some up to 9%. A damping mechanism has been put in place, which ensures that there is a minimum 2% increase (2008/09).

- Local authorities need to know their settlement, including the potential impact:

  — If the local authority did well from the new formula, how much of the growth has been allocated to social care, as this may affect whether adult social care is working to deliver services that are more efficient;

  — If it did badly from the settlement, how is the adult social care department preparing for this?

Background to the current efficiency agenda

Overall, HM Treasury expects local authorities to demonstrate that they are delivering additional 3% cashable efficiencies **each year** over the current CSR period. Local authorities can do this in a number of ways:

- reducing input costs (as identified above – this is relatively hard to achieve);

- simplifying processes and increasing productivity and outputs by removing bureaucracy (relatively small efficiencies to be released);

- planning better for the future by improving effectiveness and reducing unplanned costs; and

- changing allocations by reducing the number of people requiring support, for example by preventative measures (see below).

According to the Gershon efficiency exercise, which covered government efficiency savings for the period 2004–07, one way to evidence 3% efficiency value for money savings is if an organisation is able to continue to deliver its objectives to the same service standards with fewer (3% less) resources.

> **Local authorities that are not able to deliver efficiencies often resort to making cuts and affecting outcomes.**

The 2007 CSR value for money programme (the Operational Efficiency Programme), is taking a close look at a number of cross-cutting areas:

- back office/IT;

- collaborative procurement;

- asset management/sales;

- property; and

- local incentives/empowerment.

Local authorities should be aware that the following might be considered as alternatives to real efficiencies:

- tightening eligibility criteria (though evidence shows that in practice this produces minor savings);

- closing services, e.g. day centres or in-house services. This may be feasible as long as it is part of a medium-term plan. It is not financially viable to close places or services if alternatives are not already in place for users, and ultimately savings may not be as great as first considered. To mitigate the risk, robust business cases outlining the benefits of change are required to justify investment or disinvestment; and

- cutting posts. Again local authorities need to watch for short-term gains at the expense of longer-term benefits.

Local authorities will wish to be aware of the following:

- Every local authority is expected to have a three-year medium-term financial strategy. This should identify how the local authority will deliver services within planned budgets for the 2008–11 CSR period. Local authorities should review these strategies to determine how efficiencies in social care are being planned.

- In addition, every year local authorities will produce an efficiency statement that will reference adult social care. Local authorities will wish to review these statements and make a judgement as to how robust they are and the likelihood of delivery.

Prevention

The most effective way of reducing costs is to reduce the number of people requiring support to live at home. This is not the same as reductions due to tightening eligibility criteria.

Over the past decade, local authorities have used the tightening of eligibility criteria as the most common method to try to reduce costs. Recent reports from the Commission for Social Care Inspection have questioned the appropriateness of this strategy and it is unclear how much money has really been saved. Indeed, anecdotal evidence suggests that care managers merely recast their assessment information to ensure that users meet the new eligibility criteria. Over the last five years, a new debate has begun around 'prevention'.

We all need to be clear what is meant by prevention. In social care, there is often confusion between:

- those services that support people's general well-being, including some low-level social care services; and

- those services that can demonstrate that they prevent or delay the need for social care support.

Well-being services are very popular with the public and there is growing evidence of their ability to improve people's mental health and general well-being. It is difficult, however, to track directly whether people are being prevented from needing social care support in the future. The evidence of their ability to produce savings is not strong at present, and

spending on them should therefore not be seen as a way of reducing pressure on budgets. Nevertheless, investment is important for other reasons, including:

- to provide open access support outside Fair Access to Care Services (FACS) thresholds. The evidence suggests that authorities with limited investment of this nature face greater difficulties in maintaining thresholds for care-managed services;

- developing the social capital element expected by Putting People First and Social Care Transformation; and

- as part of an overall local authority place-shaping strategy to promote health and well-being (where the contribution from social care may be relatively small compared with the overall corporate total). The Comprehensive Area Assessment is likely to focus on interagency working of this nature.

This section focuses on services where there is clear and robust evidence of their ability to prevent or delay people from needing social care support.

A word about savings and efficiencies

The terms 'savings' and 'efficiencies' tend to be bandied about rather loosely in discussions about prevention, and difficulties arise where there is no clear distinction between 'cashable' and 'non-cashable'. 'Cashable' is self-explanatory – tangible resources are released which can be invested elsewhere or taken out of the budget to achieve reductions in spend. 'Non-cashable' refers to situations where better use can be made of existing resources. This

could mean enabling the same resources to be used to meet the needs of a larger group of people (i.e. delivering increased throughput, thereby producing a 'capacity gain'), or it could be about enabling the service to become more focused on the sort of people whose needs it is really designed to meet (thereby allowing the service to produce better outcomes).

It is important to be clear about which type of preventative interventions will produce which category of saving (or efficiency). Non-cashable savings can be just as important to achieve as cashable savings, as they allow better use of overall resources. One could argue that non-cashable savings are best referred to as efficiencies.

The other important dimension to consider here is the issue of 'net savings'. By definition, cashable savings can only be delivered where net savings have been achieved – in other words where the investment in the preventative action is delivering a higher level of savings. With non-cashable savings it is also possible to produce net savings, it is just that it will not be possible to extract them from the system and use them for other purposes.

Net savings are not the only important outcome from preventative actions. For example, a number of preventative approaches produce savings that reduce the **gross** cost of provision. In other words, the service is actually cheaper to provide than the bottom line on the expenditure side of the calculation suggests. When looked at in conjunction with the outcome benefits to users, these kinds of investment may have a more positive cost/benefit analysis than would appear at first sight.

We should be aware that investments in one part of the system could produce benefits in another part. The Partnerships for Older People Projects (POPP) programme has demonstrated that investments in social care interventions can produce capacity gains in the acute health sector. It is **not** acceptable to see this as a reason for doing little on prevention. In fact the opposite is the case. It provides the firm evidence of the fundamental inter-connectedness of health and social care. It is a finding that should strengthen health and social care working together to make best use of their collective resources. That requires positive leadership and clear thinking about how to treat the sharing of risks and benefits of joint investment strategies.

To deliver the best outcomes, local authorities and their primary care trusts (PCTs) will need to work together on shared inputs to achieve agreed outcomes. This may not require pooled budgets but, as a minimum, an agreement on which party invests its money in which areas. The Joint Strategic Needs Assessment (JSNA) will be the starting point and lead to joint commissioning strategies, where these decisions about investment in prevention will develop.

The growing evidence for prevention

Efficiency and prevention are about ensuring that 'the right person is brought into the right part of the system at the right time'. Not only is this the way to deliver greater efficiency and a clearer focus on prevention, it also secures the best outcomes for people. The following sections highlight some of the preventative interventions that demonstrate the most evidence of effectiveness in achieving this.

Case finding and early intervention services

One emerging development is the ability to identify people who are at risk of needing intensive health or social care. New evidence is emerging from using software available to PCTs that it is possible to identify older people who are most at risk of an emergency admission to hospital and to focus interventions on them to reduce this risk. It is probable that the same older people at risk of an emergency hospital admission are those at risk of needing higher levels of social care support in the future. Projects undertaken by the London Boroughs of Croydon (working with the PCT using their PARR software) and Barking & Dagenham and Brent (working with GPs using the EARLI questionnaire) have indicated that it is possible to target support to identify individuals and to reduce their need for intensive care. Similar approaches are being taken in Poole and East Sussex, where information from accident and emergency units in acute hospital trusts and information from ambulance trusts has been used to reduce crisis admissions.

The Department of Health has commissioned Nuffield Trust to investigate whether some of the approaches developed for health could be deployed in social care. In other words, whether a predictive modelling tool can be developed which uses routinely collected data from social care and health to predict the likelihood of individuals requiring intensive or high-cost social care at some point in the near future. If achievable, it opens up the possibility of greater efficiencies in targeting preventative

approaches. Early and indicative findings from the study suggest that it is possible to design and use such a tool to help local authorities target interventions accordingly.

The Brent POPP Integrated Care Co-ordination Service (ICCS) is a 'holistic' service targeted at older people over 65 who may be at risk of avoidable hospital admission or premature admission to institutional care, or who may be causing concern due to medical, physical, emotional or social issues. It undertakes assessments and co-ordinates a range of interventions for identified needs – operating across health, social care and other organisational boundaries as required. Interventions include odd jobs around the home, assistance with moving into accommodation that is more appropriate, benefits and pensions advice or referrals to health and social care providers, podiatrists, occupational therapists, etc.

Findings

- Overall, the ICCS is extremely cost effective in reducing hospital A&E attendances, admissions to hospital and hospital bed days.

- The development of savings builds up over time due to the continuing accrual of savings after the ICCS has closed the case.

- Assuming no other sources of savings, the ICCS would break even (i.e. savings minus costs), if it prevented 5–6 bed days per client per year – in fact, it saves between 14 and 29 bed days.

- It results in 2–6 fewer inpatient admissions and 3–7 fewer A&E attendances.

- There is a dramatic reduction in falls. In the first month of service, 21% of people experienced a fall – this reduced to 4% of cases by the fifth month.

- More people are helped to live at home but no measurable effect on admissions to nursing and residential care was found.

- The impact on hospital activity is corroborated by other evidence.

Intermediate care and re-ablement

For older people, the growth of intermediate care services, enhanced with re-ablement programmes, has helped people recover from medical interventions and other life events such as bereavement. People at risk of needing long-term nursing care can be helped by having time to recover so their longer-term needs can be met either in residential care or in their own homes. The most significant finding has been the Care Services Efficiency Delivery (CSED) programme studies on re-ablement domiciliary care services, where up to 50% of older people who were offered a short-term package of re-ablement-based care did not require further social care support at the end of their treatment (medical care or intervention). The evidence indicates that this has an impact in delaying a person's need for further care by over two years.

There is a growing body of evidence that indicates that re-ablement services can help many disabled people, in particular people with newly acquired disabilities (sensory and physical impairments). Some local authorities are now beginning to offer re-ablement-based services to all older people referred to them, to assist with exercise, diet and aspects of daily living as a preventative measure. This can include having occupational therapists working in extra-care housing and residential care to help people remain mobile and retain skills for daily living.

Falls prevention – an issue for social care as well as for health

Falls prevention programmes have begun to identify people who have had a fall so that action can be taken to prevent a recurrence. The consequences of falls can be significant

Leicestershire County Council HART Service
Background
In response to a Best Value review and utilising Promoting Independence funding, a pilot homecare re-ablement service was established and evaluated in 2000 by De Montfort University.
Benefits
The De Montfort study showed that conventional homecare resulted in over 70% of packages being maintained and only 5% no longer required at the first six-week review, while after a phase of homecare re-ablement, only 17% had a maintained package and 58% no longer required homecare. Subsequently, the service has continued to improve its results and a longitudinal study published in 2007 shows that, 24 months after leaving a phase of homecare re-ablement, 40% of people still did not require a homecare package. The data for 2007/08 shows that the service achieved a 63% reduction in commissioned hours when compared with the start of the re-ablement phase.

– life changing, and in many cases life threatening, for older people. Falls have an impact on both NHS and social care services. Falling can precipitate loss of confidence, the need for regular social care support at home, or even admission to a care home. Fractures of the hip require major surgery and inpatient care in acute and often rehabilitation settings, ongoing recuperation and support at home from NHS community health and social care teams. In addition, hip fractures are the event that prompts entry to a care home in around 15% of cases. Indeed, fractures of any kind can require a care package for most older people to support them at home.

The additional direct cost (per person) to commissioners of NHS care and social aftercare is estimated to be £10,000 to the NHS and £5,400 to social care during the first two years after a hip fracture. There is therefore a strong case for social care involvement in the planning and delivery of falls prevention services.

In *Building a Society for All Ages*, the Government's ageing society strategy, there is a section that covers the prevention package element which includes best practice information on how to shape services to prevent and treat falls and fractures, including a guidance note for developing local JSNAs. There is also a resource pack on footcare for commissioners and service providers.

New evidence of effectiveness

Findings from the POPPs pilots are beginning to provide a stronger evidence base that demonstrates that particular approaches can save money for both the health and social care economy. (The final findings from these pilots will be published at the end of 2009.) To date, evidence suggests that:

- joint health and social care intensive management of people with long-term conditions or complex needs will lead to a reduction in costly placements and improved outcomes for individuals;

- there is value in building rapid response services in the community – particularly to older people and older people with mental health problems;

- early intervention work with people with dementia can reduce the longer-term impacts. This is further highlighted in the new National Dementia Strategy, which includes the economic case for intervention (see *Living well with dementia: A National Strategy*, www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Olderpeople/NationalDementiaStrategy/DH_083355);

- out-of-hours crisis response services can lead to reductions in hospital admissions and the consequent need for high-cost care packages (including residential care); and

- support for residential care homes can reduce the need for nursing care placements and hospital admissions.

Access to work

The final area for prevention, which in the main benefits younger adults, is access to work. Evidence points to work or employment being of most benefit for some people with mental health problems and those with physical or learning disabilities, as it promotes independence and social inclusion. In the same way that the pathway to care is critical for an older person and needs careful management, access to work is a pathway that may require intensive support at key stages as well as the option of follow-up support if things do not go as planned.

In summary, if people are supported into work, they are less likely to need ongoing social care support, or may need lower levels of personal support in the case of someone with a physical impairment. (See *Valuing Employment Now: real jobs for people with learning disabilities*, www.dh.gov.uk/en/Publicationsandstatistics/ Publications/PublicationsPolicyAndGuidance/ DH_101401.)

Integrated working

Lord Darzi's NHS Next Stage Review, *High Quality Care For All*, highlighted the benefits of integrated working to deliver 'care closer to home'. Local authorities may be working with PCTs to make shared investments where this will lead to better outcomes for individuals, and in some cases reduce longer-term costs. The Director of Adult Social Services also has a key role in providing leadership to harness the activities and resources of others (particularly housing, leisure, community development/ regeneration, The Pension Service, community safety, etc) as part of a corporate approach to promoting the well-being of local citizens. In large part, this is what is referred to in the 'Universal Services' section of the Putting People First quadrant diagram and will make an important contribution to the social inclusion and well-being of the local population.

Many local authorities are starting to invest in services that help promote people's independence and reduce their need for

Evaluation of Bradford's Health in Mind POPP programme, which provides intensive support teams to support older people with mental health problems at risk of institutional care in the community, found that:

- 26% of users were prevented from being admitted to a care home;

- for a further 13% of users, admission to hospital was prevented or delayed;

- 15% were supported to be discharged from hospital earlier than would have been the case; and

- there was a 29% reduction in the number of homecare hours immediately after intervention.

When operating at full capacity, the intensive support teams are expected to produce net savings of around £550,000 per year.

intensive social care. However, there is little evidence to date that local authorities are tracking their money flows to show the return (cashable efficiency savings) on their investment. On the other hand, if local authorities are not investing in preventative measures, they may have difficulty meeting their efficiency targets.

Summary

Local authorities need to be aware that if a high percentage of their spend is on residential care and they have no plans to reduce this they will:

- **have less room to deliver efficiencies;**

- **have less opportunity to decommission or change the shape of their services; and**

- **be likely to face uncertain prospects about their financial stability over the medium term.**

Local authorities will want to ensure that their efficiency statements are robust and are reviewed against the delivery required, while sustaining the availability of good quality services. The easiest way of judging value for money is whether a local authority is meeting its 3% efficiency target through service redesign rather than through cuts in services. Embedding value for money across local authorities to achieve savings also means releasing savings to reinvest in further service improvements.

What would 'good' look like?

The following framework may be helpful in assessing how far a social care authority, with its health partners, is progressing in making best use of its resources through a strategic shift towards prevention and early intervention.

Performance indicators

Top quartile performance (or confident reducing trend) on:

- proportion of spend on institutional care (40% is a possible local target);

- proportion of long-term care home placements made straight from hospital (at or below 3% is a possible local target);

- number of emergency bed days per head of population;

- delayed transfers of care;

- numbers of older people supported in residential or nursing care homes per head of population;

- numbers of fractured necks of femur; and

- number of patients registered with GPs as having dementia and as a percentage of the expected number in the local 65+ population with dementia.

Policy

- A comprehensive and well articulated prevention strategy in place, with an accompanying performance framework that is actively managed.

- A Local Area Agreement that is aligned to support the vision of prevention, efficiency and well-being.

Governance

- Whole system governance arrangements in place for driving forward the prevention, efficiency and well-being agenda, linked structurally to the Local Strategic Partnership.

- Joint agreements with the NHS about the use of resources to achieve efficiencies in the whole system.

- Older people and younger adults involved in governance arrangements.

Interventions

- Arrangements in place to deliver the 'universal offer' (i.e. advocacy and advice services available to all to enable prevention and self-management).

- Proactive approaches in place to identify older people at risk of deterioration in order to intervene early (i.e. case finding and case co-ordination).

- A comprehensive range of non-case-managed 'well-being services', probably commissioned from the third sector.

- The mainstream application of telecare.

- A reasonable volume of extra-care or supported housing.

- Well-functioning re-ablement and intermediate care services.

- Formal arrangements in place for joint working between health and social care to support people with long-term conditions or complex needs.

- Joint pathways in place for falls, dementia (early intervention) and stroke.

If you have any queries or comments on this guide, please email John Bolton or Damon Palmer at the following email addresses:

John.Bolton@dh.gsi.gov.uk
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Appendix 1 – Issues about data

1. Issues about the data being used and how it might be interpreted

Pooled budgets

The PSSEx1 form (Personal Social Services Expenditure) reports the total spend (primary care trust (PCT) and local authority) where the local authority is the lead partner (with a separate column showing the PCT's contribution). Where the PCT is the lead partner, only the local authority's contribution is shown on the PSSEx1. This can affect the total spend (it will be higher as a gross figure if the PCT is contributing at a high level to a number of pooled budgets).

Residential care

The PSSEx1 form currently includes spend on both residentially based respite care and intermediate care within the definitions of spend on residential care. There will also be differences between those local authorities that pay gross and those who pay net for residential care. (Those who collect contributions from service users (or the NHS) and then pay the full amount will have higher levels of spend than those authorities who only pay their contribution to the provider and expect service users (or the NHS) to pay their contributions direct.)

Preserved rights

We also recognise that the Preserved Rights Grant that was issued as a result of the community care reforms in the 1990s may have had a perverse impact in keeping people inappropriately in residential care placements – particularly younger adults with learning disabilities. We are currently reviewing this grant and would want to see any future policy direction for these younger adults clearly supporting the principles and vision laid out in *Valuing People Now*.

Learning disability commissioning transfer

We would also recognise that for some local authorities the transfer of commissioning responsibility from PCTs to local authorities may present some short-term challenges with regard to some local authorities inheriting a range of new residential care services, which had previously been funded and staffed by health services. It is hoped that, over time, local authorities will be able to decommission older models of residential care and replace them with supported-housing schemes for those who are able to live within community-based housing. It is recognised, like many of the changes that are taking place across the country, that it will take time to deliver these changes.

2. The National Adult Social Care Intelligence Service

What is the National Adult Social Care Intelligence Service (NASCIS)?

NASCIS has been designed by the NHS Information Centre in conjunction with the Department of Health, the Association of Directors of Adult Social Services (ADASS)

and other national bodies, to provide a single national resource of timely, relevant and useful information for social care services across England. It aims to:

- offer increased ease of access to and use of social care information;

- improve the integrity of information used for local decision making by providing consistent data and indicators;

- support local benchmarking and enable users to efficiently map time-series analyses and trends against similar local authorities; and

- offer a platform for improved integration of health and social care data via inclusion of Joint Strategic Needs Assessment (JSNA).

NASCIS is a collection of data, tools and resources designed to meet the varied needs of service planners, managers, researchers and policy makers, among many others, to aid activities such as planning, performance management and service improvement. Elements of NASCIS include the following:

- **An online analytical processing tool:** Providing quick, easy and flexible access to a wide range of social care information – enabling you to use an authoritative, common set of data for performance management and benchmarking purposes.

- **Standard reports:** Showing the different elements of adult social care data in a range of comparative, thematic and profile reports.

- **Additional tools:** These include Projecting Older People Population Information (POPPI); Projecting Adult Needs and Service Information (PANSI); and Forecasting Length

of Stay and Cost (FLoSC), developed by the Care Service Efficiency Delivery (CSED) programme.

- **The NASCIS library:** The latest key documents, combined with an intuitive, intelligent search facility that focuses on nearly 200 carefully selected social care and health online resources.

What data is available?

All of the national data collections held by the NHS Information Centre are available through NASCIS. For each collection we have loaded three years' worth of data. We aim to load the data as quickly as possible; sometimes we will make provisional data available, where it is in local authorities' interests to have access to the data quickly – for example, to support commissioning strategies. The data collections are recognised as national statistics, and so where we do make data available before all of the usual checks are completed to meet the standards set out by the UK Statistics Authority, we often need to restrict access. The NASCIS website will make it clear where this is the case.

The data held on NASCIS includes:

- referrals, assessments and packages of care (RAP), including data for 2008/09;

- 2008/09 adult social care combined activity return (ASC-CAR) data;

- historical RAP and ASC-CAR data covering the period 2005/06 to 2007/08 (allowing customers to undertake time-series analyses);

- the initial 2008/09 national indicator set (NIS) measures specific to social care; and

- PSSEx1 data, including data for 2008/09 (which is being made available through NASCIS initially as provisional).

Over time, we will make more data available through NASCIS, such as key health and wellbeing information to support JSNA.

The registration process

Access to the NASCIS tools is available to all users by following a self-registration process on the NASCIS tools page at http://nascis.ic.nhs.uk.

Users accessing the NASCIS tools require a single username and password to log in. This will give access to both the online analytical processing tool and the standard reports within NASCIS. The user ID authentication will be administered by our contact centre.

Users can register for an account by completing the self-registration form for which they will have to specify a username and password and provide other details such as name and email address. Once the user is registered and the account has been activated, they will then have secure access to the NASCIS tools.

If you have any queries regarding the user registration process, please contact the NHS Information Centre's contact centre on 0845 300 6016 or via email at enquiries@ic.nhs.uk.

Appendix 2 – Good practice examples

In Poole, the Partnership for Older People Project (POPP) pilot demonstrated the effectiveness of its case-finding approach by decreasing both the number of people admitted to hospital in an emergency and the 'occupied bed days' resulting from such admissions. Based on the evidence of net savings to the acute sector, the primary care trust (PCT) has re-profiled investment going into the acute sector over the next five years with the aim of shifting a greater number of services to primary and community settings. The PCT has provided new funding of approximately £680,000 for a new borough-wide joint intermediate care service.

Through the POPP in Devon, 'complex care teams' including GPs, community matrons, community nurses and psychiatric nurses, physiotherapists, social workers and the local voluntary sector, are working together across the county in 23 GP practice cluster areas as a single service at primary care level. The teams identify older people at risk of losing their independence by using a mix of predictive risk tools and activity data (e.g. GP out-of-hours calls, ambulance non-conveyed, A&E information), and provide co-ordinated care to prevent further decline, hospitalisation and long-term care. As well as reducing admissions to institutions, they are also reducing costs by eliminating duplication and by simplifying and strengthening joined-up assessment and care planning in health and social care.

Willow Housing and Care Hospital Discharge Service – ensuring that housing facilitates prompt discharge from hospital for older people
Background
In 2004, delayed discharge from hospital was an urgent issue in Brent. One cause of delays was that the homes of some older people needed to be made suitable before they could return safely. Willow approached Brent Council and offered to provide a service to facilitate the timely discharge from hospital of older people to independent living, with flexible tailored levels of support to sustain independence. Brent Council has funded a support worker since October 2004.
Benefits
Outcomes: In 16 out of 20 cases reviewed, independence had been maintained for at least two-and-a-half years after the support was given. In one case, the outcome was unknown and in three cases independence had not been sustained for that length of time. Costs: Net savings in the region of £420,000 per year (including a £35,000 recurrent reduction in delayed transfer of care reimbursements) from running costs of around £41,000 per year.

Hestia Project – a supported housing initiative for women with chaotic lifestyles, Endeavour Housing Association

Background

In 1998, Endeavour Housing Association, Middlesbrough Council, Cleveland Police, Cleveland Probation Service, Barnardo's and South Tees Health Trust identified that they shared a small number of particularly vulnerable and excluded women service users. Many had problems with drugs and alcohol, offending and anti-social behaviour, and many had children. The Hestia Project provides good-quality housing in ten properties and delivers individual, flexible and intensive support services to the women through a dedicated co-ordinator who links the agencies and service users. The aim is to prevent problems from escalating, thus reducing admissions to hospital and contacts with the police and social services.

Benefits

Outcomes: Reduced admissions to hospital; reduced visits to A&E; reduction in offending behaviour; reduction in the turnover of properties where the women live (and of homelessness) and reduction of children being taken into care.

Costs: £120,000 annual saving in direct costs (£12,000 per client).

Supported Living Outreach Team (SLOT), Birmingham

Background

SLOT is a specialist outreach team which has enabled 26 people who previously lived in specialist out-of-area placements and forensic services to move back to the city and live in ordinary housing. The team includes specialist NHS staff with experience in behavioural approaches and support planning. Each person has moved into private rented housing with day-to-day support using people recruited from the local area and employed by non-specialist third-sector providers. Individual support planning helps people to build links with the local area, find work and get to know people. The outreach team provides advice, crisis intervention and training, and is available 24 hours per day. This input reduces gradually over time.

Benefits

Outcomes: Large reductions in challenging behaviour, offending and use of medication. Eight people no longer need any specialist support.

Costs: Cost savings average around 33% (£50,000 per person per year).

Hollingside – supported living as an alternative to residential placements for adults with learning disabilities

Background

Redcar and Cleveland's budget for those with learning disabilities has experienced severe growth pressures in recent years. Commissioners identified that one reason for this was a shortfall in supported living alternatives to residential care for adults with mild learning disabilities.

Their solution was to develop Hollingside. It opened in 2007 and has six self-contained flats for people with mild learning disabilities with on-site support in the day. Most of the tenants moved into Hollingside from a residential college or following the collapse of a tenancy, i.e. despite only having mild learning disabilities, all tenants needed to develop their individual living skills. Without these skills, residential or 24-hour supported living would be needed.

Benefits

The net cost (after rents) per customer at Hollingside for 2007/08 was approximately £5,820. This compares favourably with the costs of supporting the tenants in alternative settings: three would require a local authority residential home, two would require a local authority hostel for the homeless and one would require a local authority residential mental health facility.

Estimated full-year savings on ongoing support costs for the six current customers in 2007/08 were in the region of £105,000. Support levels have recently increased, but annual savings of £75,000 per year or £12,500 per person are still anticipated.

Coventry Learning Disabilities Services

During the past three years, great strides have been taken to provide a range of local living options for citizens of Coventry with a learning disability. The starting point was that 113 individuals had been placed in out-of-city placements. The aim was to support people to have increased choice and control over their lives and within their home city, remaining closer to their family, friends and community, and enable those who had previously moved out of Coventry the opportunity and choice to return home.

Through the implementation of a joint commissioning plan, Coventry City Council has evidenced better value for money by providing services at lower costs locally. It has done this through working in partnership with the Housing Strategy unit/team to develop supported accommodation, and with the independent sector to deliver good-quality residential care in the city.

It established a Change Team to create the service specifications and models for new services, as well as co-ordinate the change processes for individuals. This approach has supported people to achieve their aims of moving from residential care to supported living, or back to residential care in Coventry with the aim of living more independently in the community.

Coventry City Council has delivered eight new supported living schemes and five specialist residential schemes, creating 84 new places (57 supported living and 27 residential).

To date 76 people have moved, with 20 people returning to Coventry from out-of-city placements. No one has been required to leave the city due to a lack of appropriate living options over the past two years.

Over the past three years, approximately £3.2 million from the local authority's Strategic Housing Regeneration Fund was used to fund the development of supported-living schemes for people with learning disabilities.

Learning disabilities commissioning efficiencies

	2006/07 £	2007/08 £	2008/09 £	Total £
Supported-living schemes	(21,000)	(129,460)	(34,006)	(184,466)
Residential care homes		(100,469)	(131,681)	(232,150)
Total efficiencies achieved	**(21,000)**	**(229,929)**	**(165,687)**	**(416,616)**
Net budget	**10,582,910**	**12,164,244**	**14,116,868**	
Efficiencies as % of budget	**0.2%**	**1.9%**	**1.2%**	

In summary, the cumulative local authority efficiencies from 2006 to 2009 are £416,000. Efficiencies have also been delivered for the PCT. The efficiencies are against the backdrop of an ever-increasing budget of around £1.5 million each financial year, matching additional spend. The budget for 2009/10 increases to £15.7 million. The commissioning efficiencies are contributing to the ongoing management of budgets and have reduced the overall financial pressure in this area. There are plans to develop a further six supported living schemes over the next two years to create an additional 40–50 places, with one scheme being funded through a Section 106 agreement with a private developer.

Selective hospital discharge support services, Wirral Metropolitan Council
Background
The initial service was established in 2003 by the local authority's homecare team and occupational-therapy-supported discharge service, when it was realised that many users were common to both services but that their approaches were counterproductive. A selective hospital discharge support service was established and operated very effectively for a number of years. In August 2007, this evolved into an intake and assessment service that operates on a deselection basis, thereby more than trebling the activity in its first year; it is still growing today.
Benefits
In 2003/04 with the selective hospital discharge support service, 94% of people did not require a homecare package following a phase of re-ablement and 24 months later 87% had still never required a homecare package. The much-enlarged deselection service in 2007/08 saw 50% of people requiring no subsequent homecare package and a further 35% enjoying a reduced homecare package, resulting in an overall 64% reduction in the level of commissioned hours required when compared with the start of the re-ablement phase.

Within the Southwark POPP, four locality-based multi-disciplinary teams (MDTs) were established to address the health, social care, therapy and mental health/well-being needs of a group of older people.

Each locality team meets monthly and formulates up to five multi-disciplinary action plans.

Evaluation indicates that interventions by the MDTs appear to have produced a reduction in hospital admissions of 19%, a reduction in A&E attendance of 25% and a reduction in the number of residential care placements.

East Sussex's POPP, 'Independence First', involves a range of targeted preventative interventions and has found an overall net financial return on investment for the whole programme of between 15–35%. This is largely attributable to reduced health service activity. Data from pre- and post-intervention surveys show that:

- older people's quality of life had improved;

- older people were less likely to have used hospital services for an emergency or overnight stay in the previous three months; and

- older people were likely to make better use of community and outpatient services.

Gloucestershire County Council has started to develop a business model to track the flow of customers through the system, recording how many people are assessed, those referred for re-ablement and those who still require longer-term services. It will enable the local authority to manage its budget and track the flow of people through the system, helping it to measure the performance of the re-ablement services.

East Sussex County Council has developed a business model to ensure that all the business processes are linked together through technological solutions. The new systems focus on commissioning, procurement, payments and contract compliance and create a link between all the main software to make the procurement, payment and monitoring of contracts more cost effective.

Appendix 3 – More case examples

The graphs below show the variances in the proportion of local authority spend on adult social care (from the RO3, RO1 and RS return). These graphs are indicative and not all local authorities are shown.

Figure A1: Allocation from metropolitan authorities (excluding school funds) (2007/08)
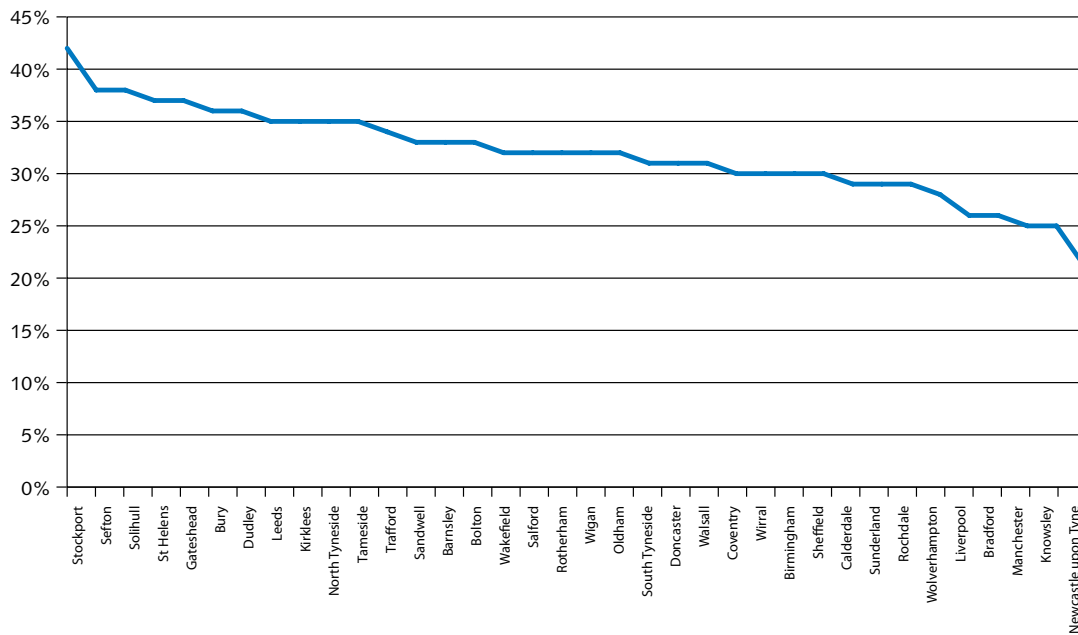
Figure A2: Allocation from London boroughs (excluding school funds) (2007/08)
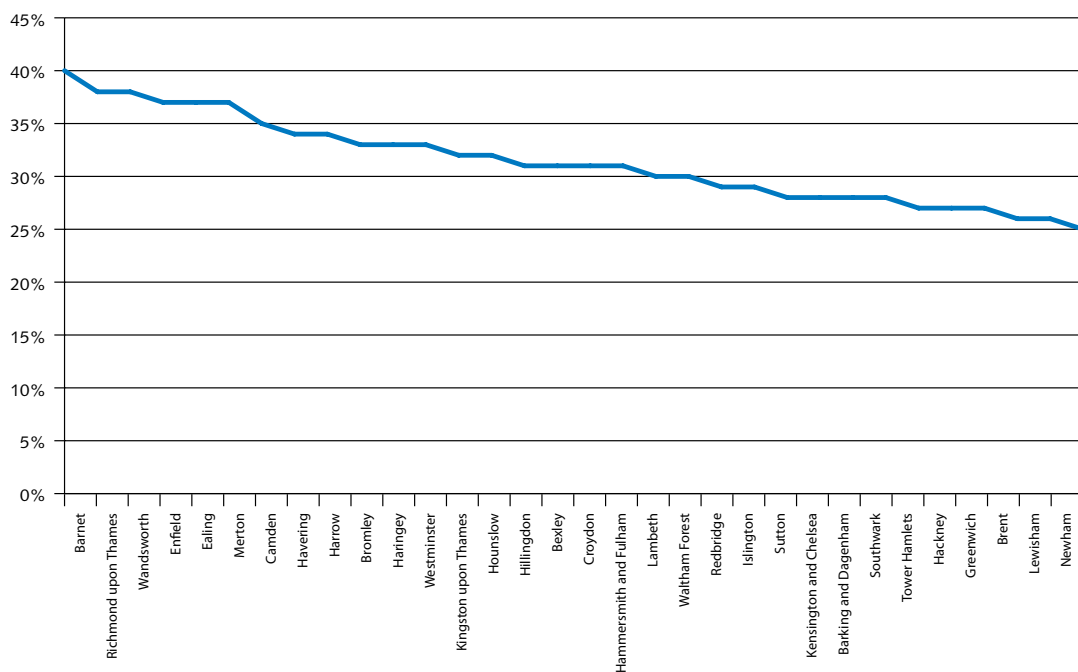
Figure A3: Allocation from county local authorities (excluding school funds) (2007/08)
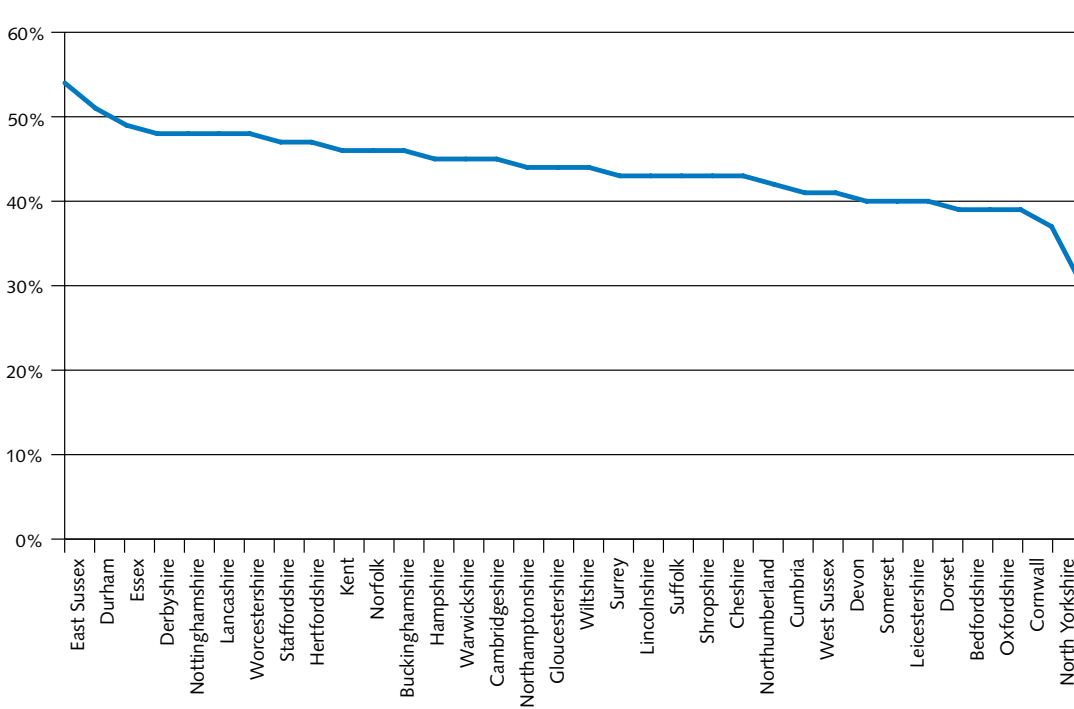
Figure A4: Allocation from unitary authorities (excluding school funds) (2007/08)
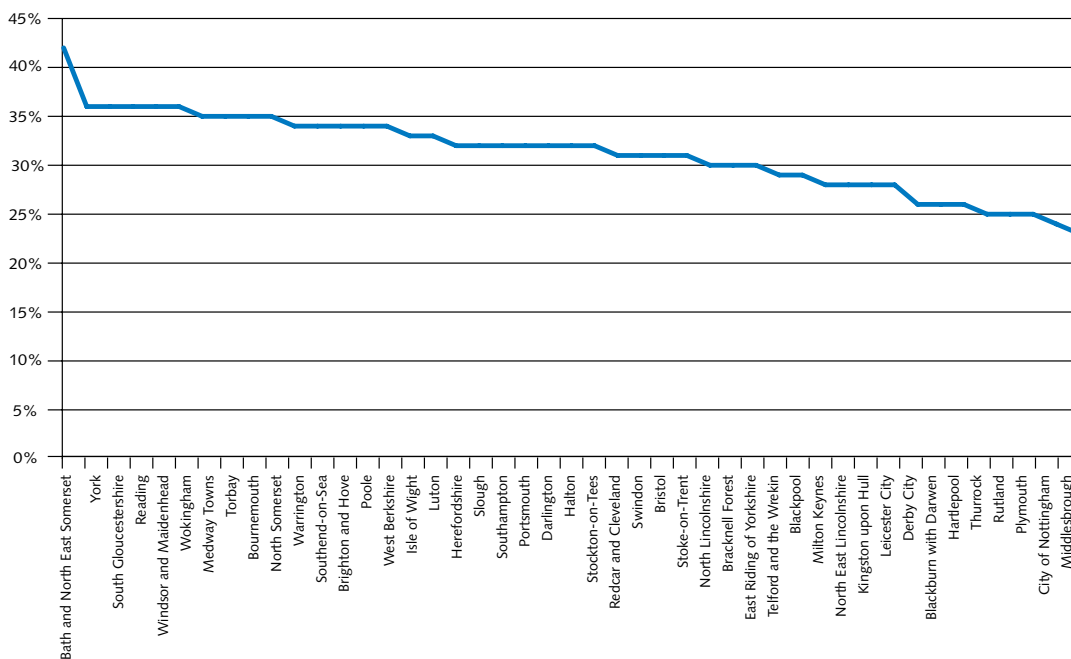
Figure A5: Direct payment expenditure as a proportion of gross current expenditure (2007/08)
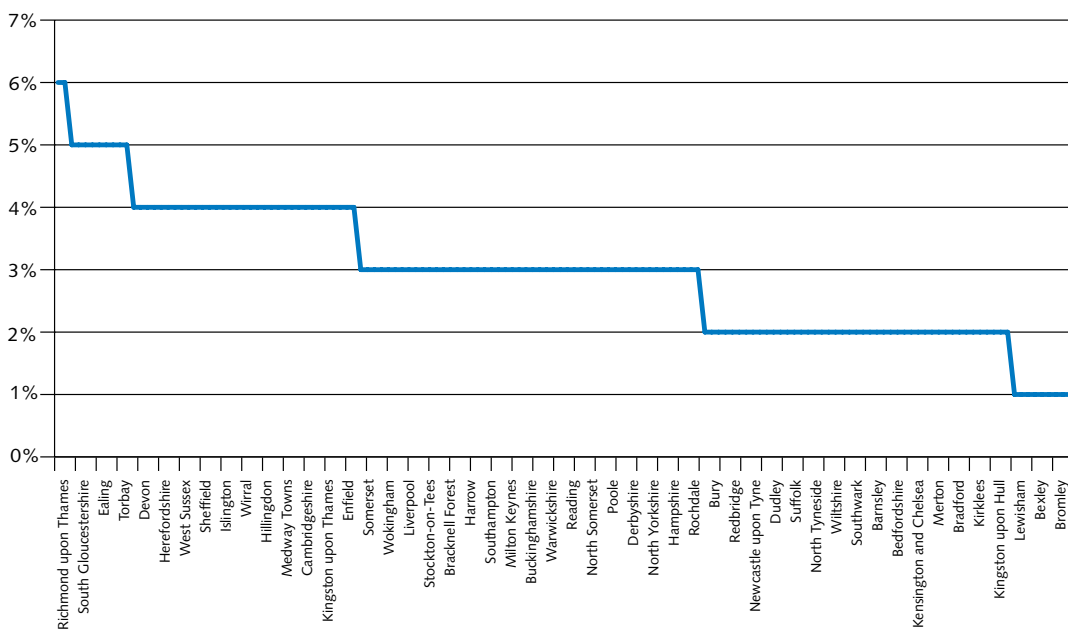
Figure A6: Proportion of local authorities' spend on older people that is spent on day and domiciliary services (2007/08)
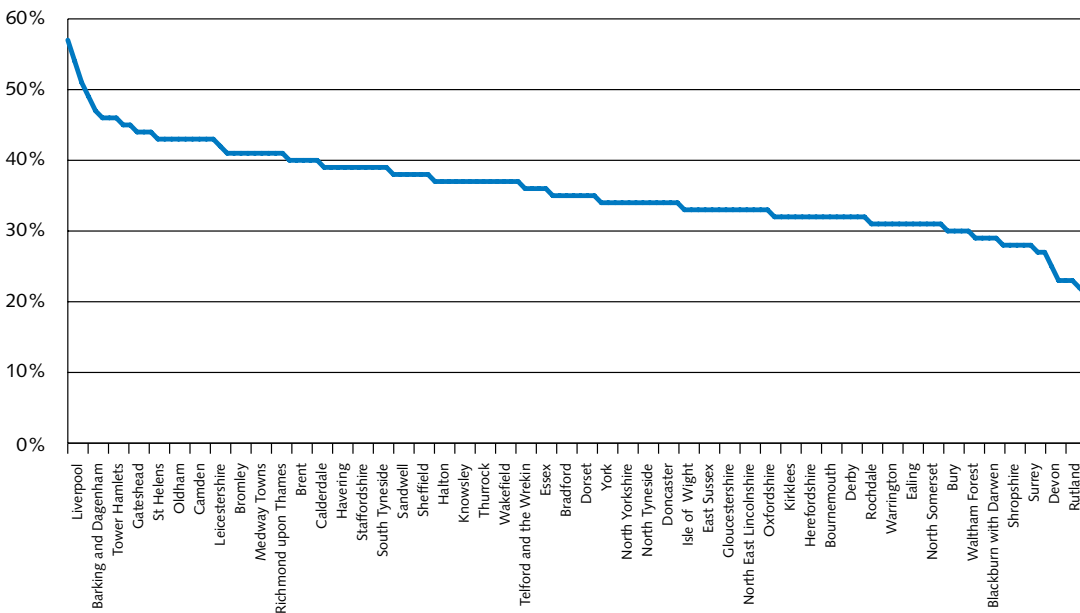
Figure A7: Proportion of local authorities' spend on adults with physical disabilities that is spent on day and domiciliary services (2007/08)
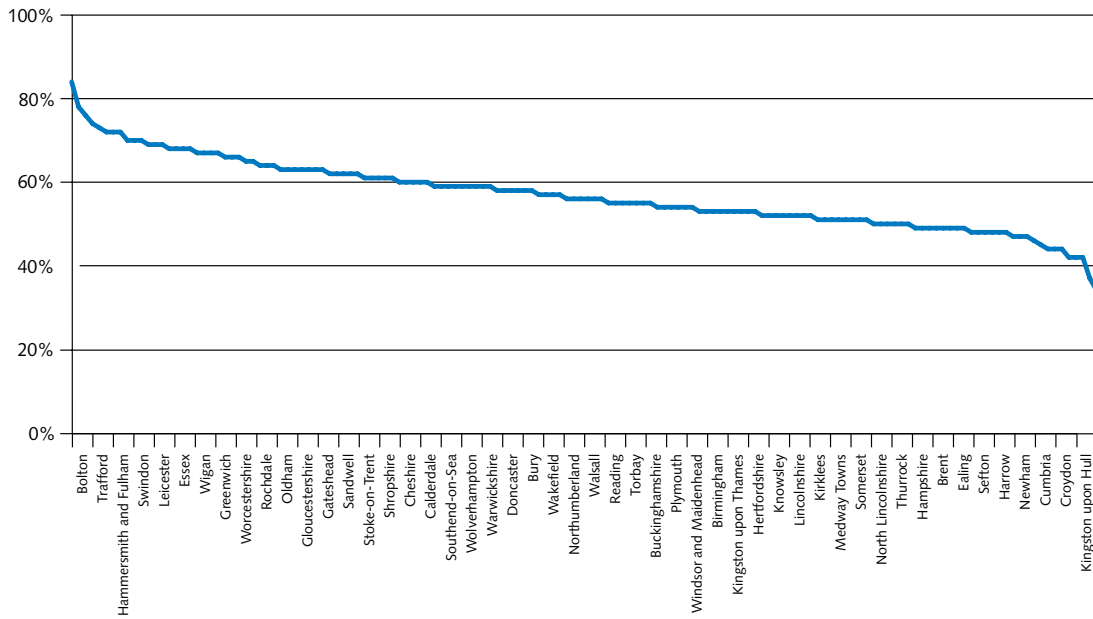
Figure A8: Proportion of local authorities' spend on adults with learning disabilities that is spent on day and domiciliary services (2007/08)
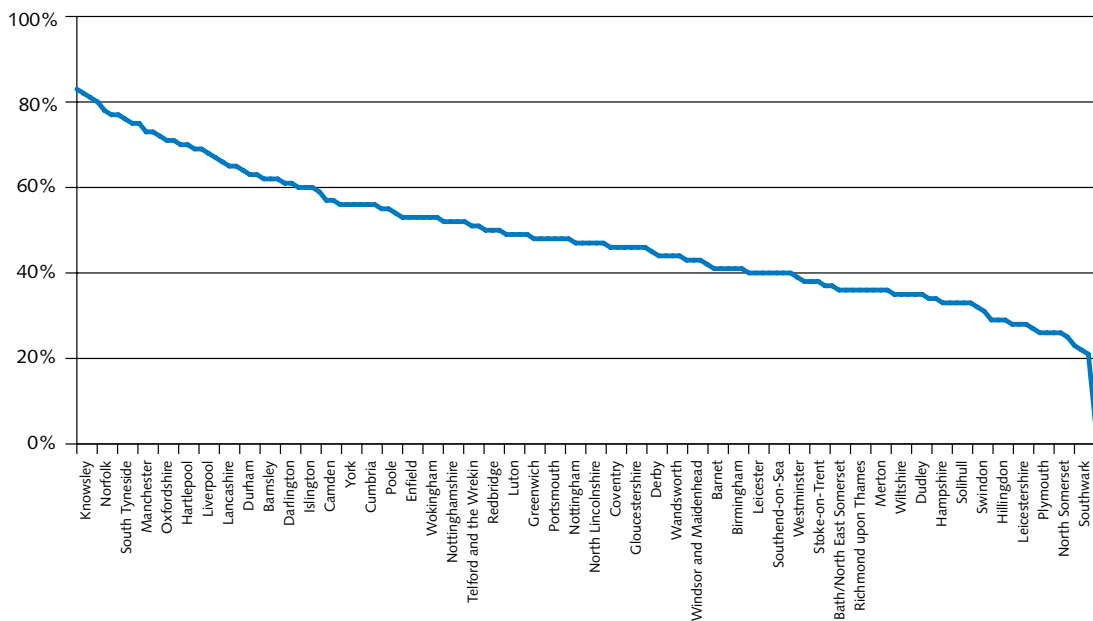
Figure A9: Proportion of local authorities' spend on adults with mental health needs that is spent on day and domiciliary services (2007/08)
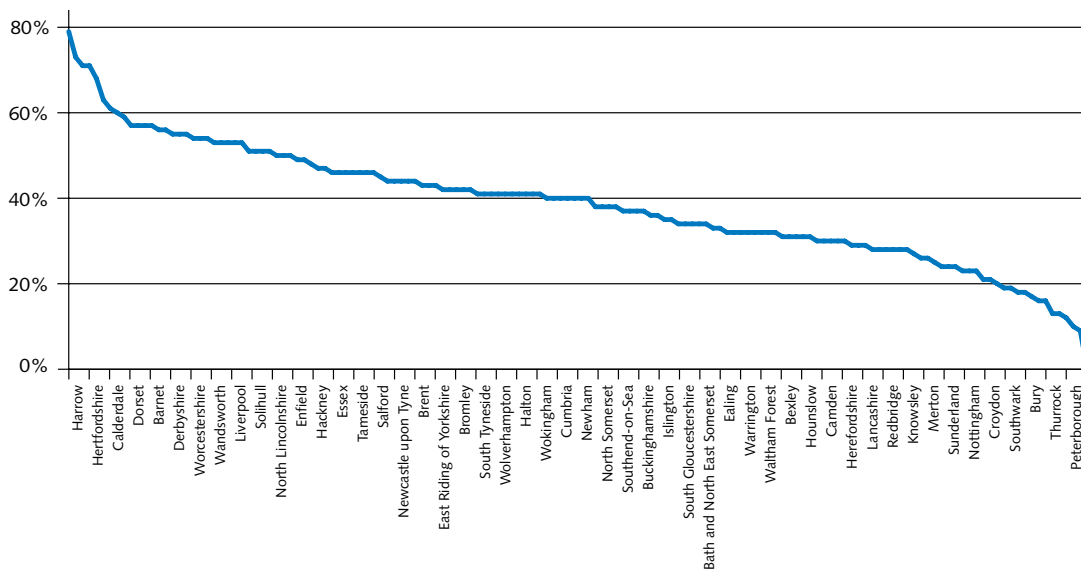
Figure A10: Proportion of local authorities' spend on older people that is spent on assessment and care management (2007/08)
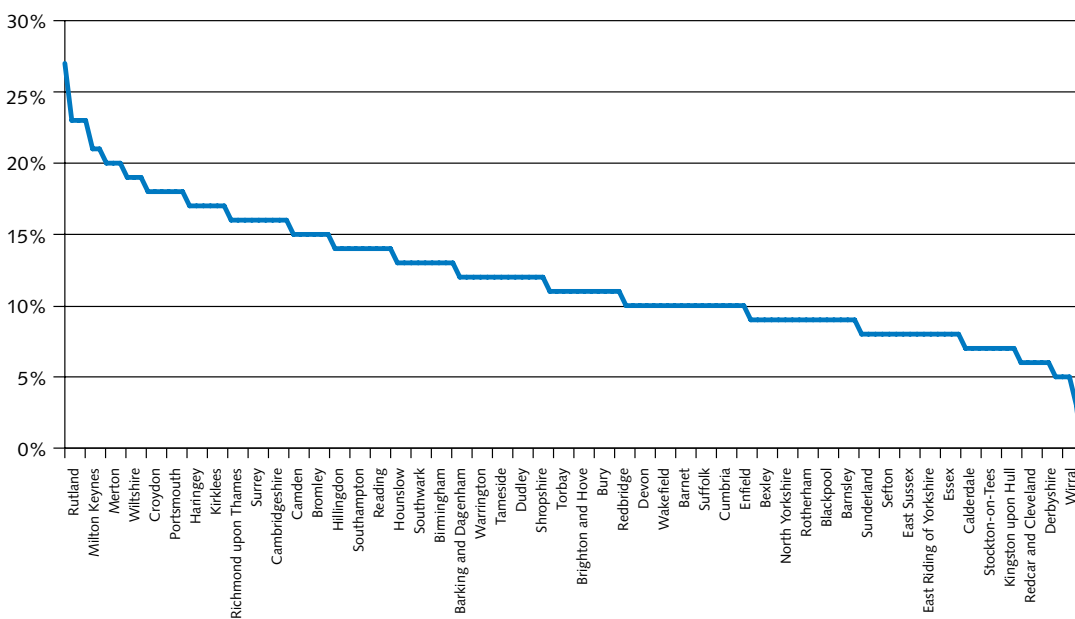
Figure A11: Proportion of local authorities' spend on adults with physical disabilities that is spent on assessment and care management (2007/08)
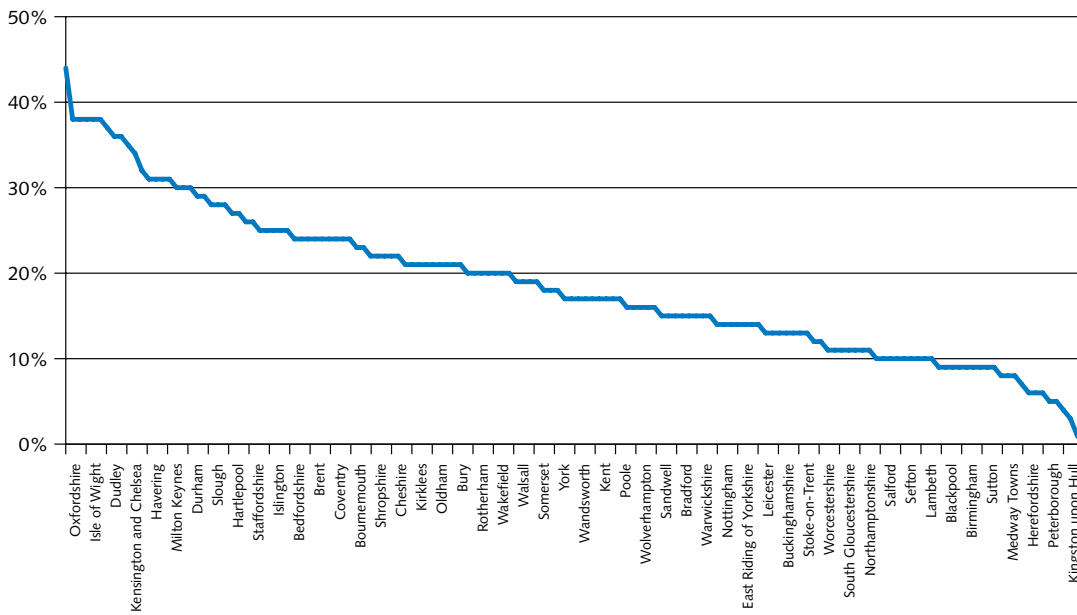
Figure 12: Proportion of local authorities' spend on adults with learning disabilities that is spent on assessment and care management (2007/08)
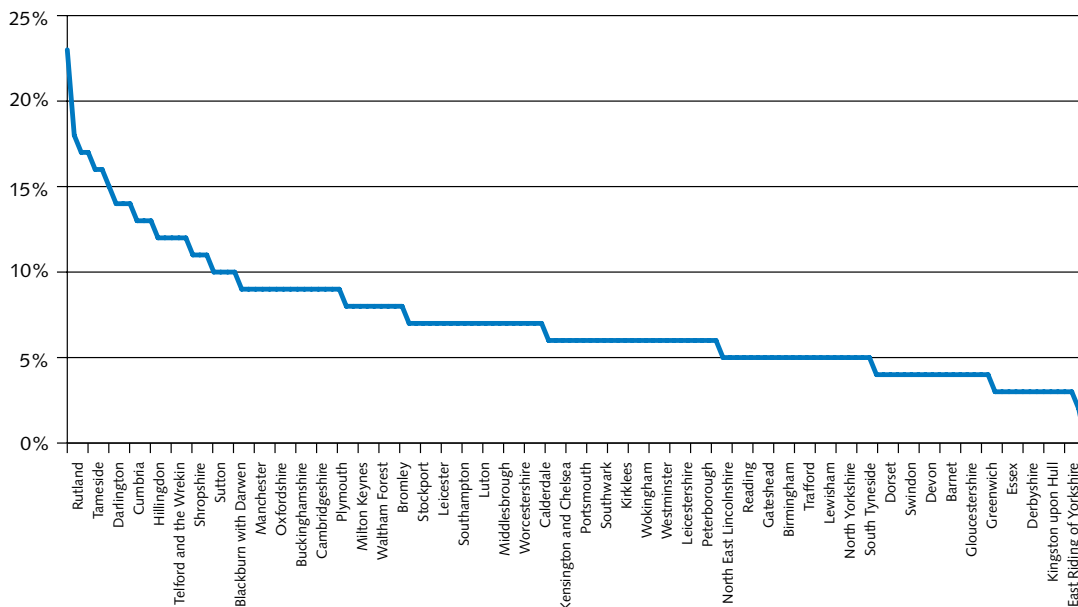
Figure A13: Proportion of local authorities' spend on adults with mental health needs that is spent on assessment and care management (2007/08)
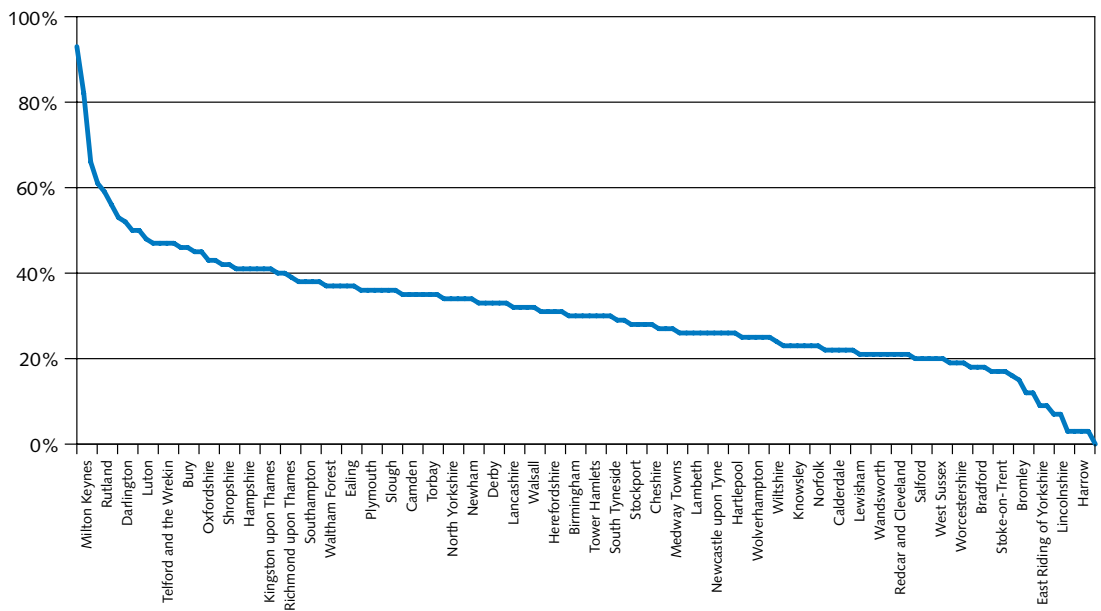
Appendix 4 – Sources of information

Data on individual local authorities

Department for Work and Pensions Research and Statistics: Tabulation tool

Includes information on age and gender of claimant, duration of their spell on benefit and geographical locations of claimants.
http://research.dwp.gov.uk/asd/tabtool.asp

Dr Foster Intelligence Key Indicators Graphical System (KIGS)

Provides comprehensive presentation of local authority PAF indicators for benchmarking.
www.drfosterintelligence.co.uk/localgovernment/kigs.asp

Health Inequalities Intervention Tools

Tools and associated documents for all local authorities and PCTs in England.
www.lho.org.uk/health_inequalities/Health_Inequalities_Tool.aspx

Health Poverty Index

www.hpi.org.uk/

Health Profiles

www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES

Indices of Deprivation 2007

www.communities.gov.uk/communities/neighbourhoodrenewal/deprivation/deprivation07/

National Centre for Health Outcomes Development – Clinical and Health Outcomes Knowledge Base

www.nchod.nhs.uk/

Personal Social Services Expenditure (PSSEx1) data

www.ic.nhs.uk/social-care

Revenue Outturns – www.local.communities.gov.uk/finance/stats/lgfs/2009/lgfs19/index.html

Projecting Adult Needs and Service Information (PANSI)

National Statistics population-based forecasts to 2025 for adults aged 18–64 with LD, PD and MH needs, DLA claimants and performance data projections.
www.pansi.org.uk

Projecting Older People Population Information (POPPI)

National Statistics 65+ population projections to 2025 for local authorities to district level, with prevalence and performance projected onto population estimates.
www.poppi.org.uk

Referrals, assessments and packages of care for adults

www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information/community-care-statistics-2006-07:-referrals-assessments-and-packages-of-care-for-adults-england

Appendix 5 – General information

Better Commissioning Learning Improvement Network

www.dhcarenetworks.org.uk/
BetterCommissioning/
BetterCommissioningLIN/

Care Services Efficiency Delivery (CSED)

CSED helps local authorities to identify more efficient ways of delivering adult social care. Includes solutions for: Assessment and Care Management; Demand Forecasting and Planning; Better Buying; Homecare Re-ablement; Crisis Response; Care Pathway Planning and Support; Assistive Technology; and Support Related Housing.
www.dhcarenetworks.org.uk/csed/

Emergency Admission Risk Likelihood Index (EARLI)

A validated tool to predict emergency admission in older people.
www.improvementfoundation.org/resource/
view/unique-care-earli-tool

In Control

www.in-control.org.uk

Information Centre for Health and Social Care

www.ic.nhs.uk

King's Fund PARR software

PARR – 'Patients at Risk of Re-hospitalisation' helps PCTs use routine data to predict the risk of emergency re-admission to hospital.
www.kingsfund.org.uk/research/projects/
predicting_and_reducing_readmission_to_
hospital/

NHS IC – National Adult Social Care Intelligence Service (NASCIS)

http://nascis.ic.nhs.uk/

Pre-Budget Report 2008

www.hm-treasury.gov.uk/prebud_pbr08_
index.htm

Prevention and early intervention

This website contains the key learning on prevention and early intervention from the POPPs and other relevant programmes. As well as guidance and self-assessment tools it contains examples of good practice and evaluation reports.
www.dhcarenetworks.org.uk/prevention/

Putting People First

www.dh.gov.uk/en/Publicationsandstatistics/
Publications/PublicationsPolicyAndGuidance/
DH_089665

UK National Statistics

www.statistics.gov.uk

DH Department of Health