

## **Predicting and managing demand in social care**

**Discussion paper**

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**April 2016**



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# Predicting and managing demand in social care – Discussion Paper

## 1 Introduction and summary by John Bolton

This paper follows up previous papers of mine, considering how councils with responsibility for adult social care can both effectively manage and predict demand for their services. It reviews a range of work from my direct experience of working with councils across the United Kingdom. It considers the options that are available to councils. It builds on the recently published paper “What are the opportunities and threats for further savings in adult social care?” (Institute of Public Care, 2016)<sup>1</sup>. It is very much a personal view, including anecdotes and personal experiences as well as research evidence, which aims to act as both a prompt for councils and a guide as to what might be considered when they are having to reduce their spend on social care.

The paper shows that demand prediction and management in any one local authority is more complicated than simple population projection, explores the different factors and what in my experience, one can do about them to ensure effective services.

My view is that some demand on adult care is within the influence of the council and the paper explores behaviours and practices that assist. Some councils are better at doing this than others and of course, therefore this has an impact on the different level of pressures that are being experienced across the country. The emphasis for a council that wishes to manage demand has to be on preventive actions and a better range of help for people.

The paper considers the variables that might be considered as part of seeking to understand likely future needs in order to predict future potential demands. Finally, I suggest that if councils do want to manage demand better there has to be a new performance management system in place.

## 2 Background and context

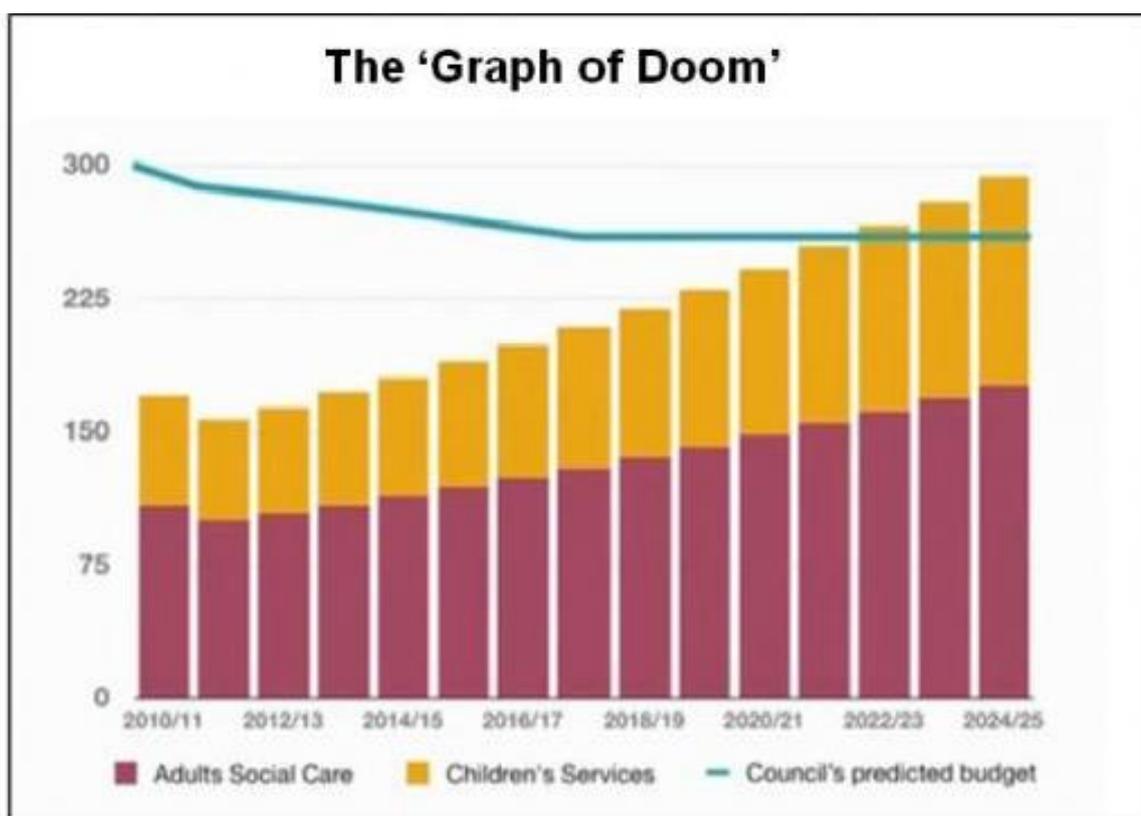
In May 2012, the London Borough of Barnet produced a set of graphs that became known as “the Barnet Graph of Doom<sup>2</sup>”. The graphs showed that if demand for social care continued in the same projected way of growth over the forthcoming ten years that all of the council budget will need to be allocated to adult and children’s services if the budgets continued to fall at the same rate. These graphs were picked up by many in Local Government to argue for more resources from central government. The graph shown in Table 1 demonstrated that if councils carried on their business in the same way there is an inevitable consequence.

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<sup>1</sup> The report can be found on the IPC website <http://ipc.brookes.ac.uk/publications/index.php?absid=839>

<sup>2</sup> Early mention of the graph predated this public paper – probably as early as 2010.

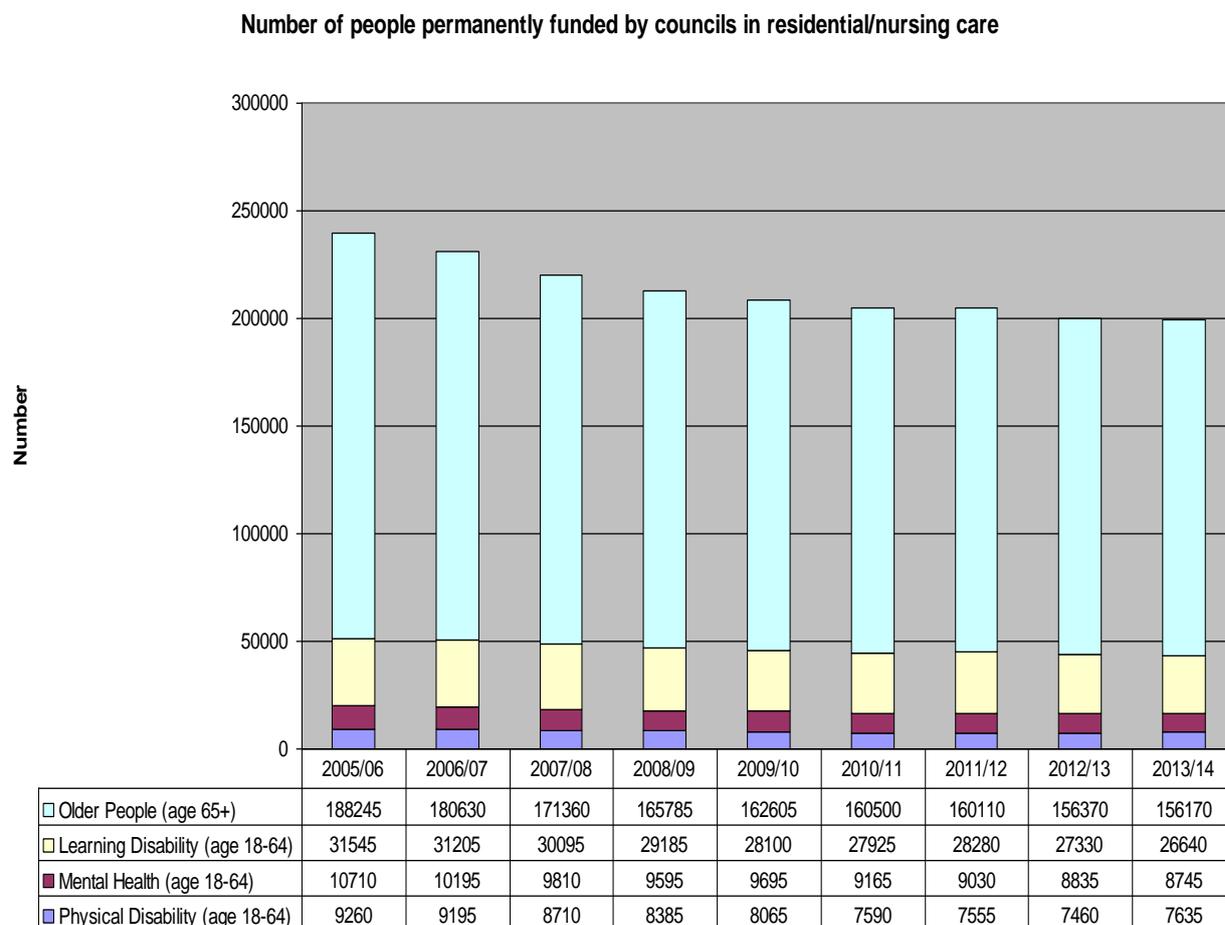
Table 1 - The Barnet Graph of Doom



In my experience, some councils continue to base their predictions for future pressures in social care by using the approach that was employed in this graph – equating demand for social care with changes in the population. However, other data suggests that the picture is rather more complicated. Simple population changes do not match actual demand for care. Table 2 below for example, shows the fall in admissions to state funded residential care over the last decade. It suggests that despite the increasing numbers of older people living longer this is not been reflected in an equivalent increase in use of state funded residential care. (Though the numbers of new older people admitted does vary between councils). Overall there has been a 16% reduction in the numbers of people whose care is paid for by councils in residential care over the last ten years – the lowest reduction is for younger adults who have a learning disability and the highest reduction is for older people (who are still the largest group being cared for in residential care).

There is significant reduction in admissions overall despite the changes in the population and this is not being met through an increase in support for people at home which has remained steady during this period. There may be a small increase in people who may be considered to be “self-funders”, because of improved work pensions and greater owner occupation amongst older people, though as described later in this report they may not be using formal social care help to have their needs met.

**Table 2 - The numbers of people in permanent residential care funded by councils for the last ten years in England**

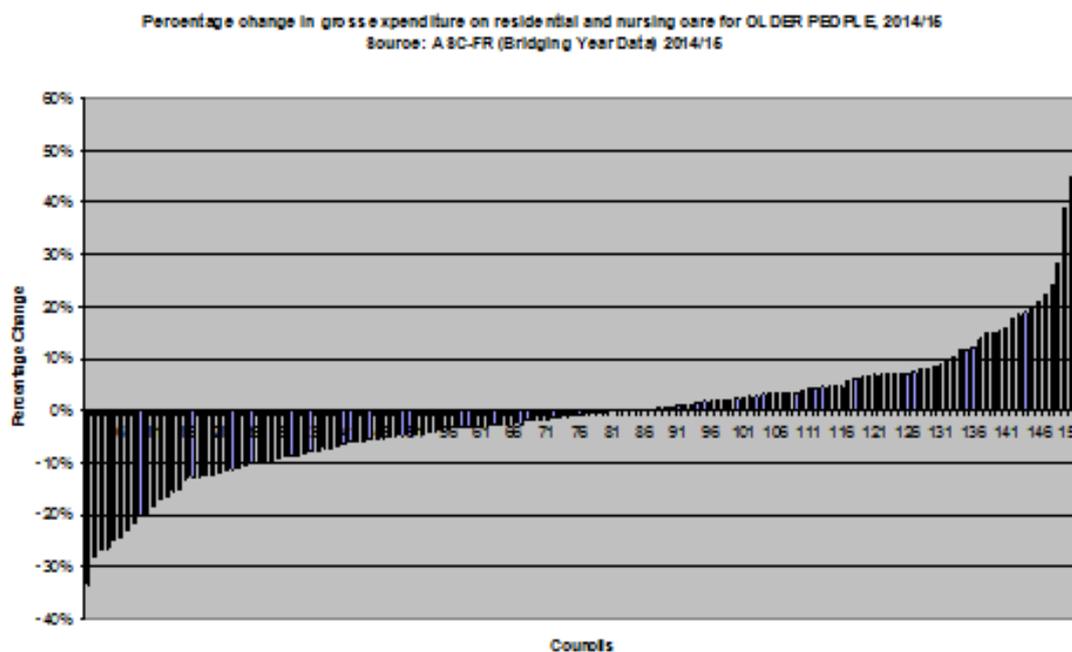


These figures are interesting in themselves, but underneath them is a significant variation between councils as to whether demand continues to rise or is falling. This was first demonstrated in the Department of Health study “Use of Resources in Adult Social Care<sup>3</sup>” published in 2009. The graphs in that study showed the very different proportion of overall spend that was on residential care (compared to other areas of service provision). It concluded that where one lived in the United Kingdom could lead to a very different outcome for a person who needed care and support. For example, there was a big variation between councils for adults with a learning disability with similar care needs as to whether they ended up living in a residential care home or were supported in the community. This pattern for learning disabilities was set from the 1980’s onwards as in-patient hospitals closed and in different parts of the country, people were moved to very diverse settings. In the North-West, most people moved into their own supported housing whilst in the southern part of England more people moved to a residential care placement.

<sup>3</sup> Use of Resources in Adult Social Care – Department of Health 2009

The patterns for older people continue to vary between councils, though many have introduced changes that have reduced their admissions in recent years. (See the Local Government Association's Adult Social Care Efficiency Programme<sup>4</sup>). These findings are exemplified in Table 3 below which indicates that about half of the councils in England experienced a growth in their spend on residential care for older people in 14/15 whilst the other half showed a reduction in their local spend.

**Table 3 - Percentage change in gross expenditure in residential and nursing care for Older People 2014/15<sup>5</sup>.**



One might reasonably conclude from this information that the care a person might receive (within the same legal and policy framework) will depend very much on where in England they live.

So whereas the calculations for the Barnet 'Graph of Doom' are based on a simple arithmetic calculation that shows demand will grow by around 2.5% per annum in line with the growth in the population this is just not happening in many councils - although it does apply in others. The pressures will vary in each council according to the approaches they take to helping people and to managing demand. Therefore, before anyone might want to predict demand they need to understand the local policies and influences on practice that are the drivers of demand for care.

One further point to be noted at this point. The patterns of help in mental health services from social care may be quite different for those from other service-user groups. Councils have over the last decade halved the amount of money they spend on mental

<sup>4</sup> LGA website at [www.local.gov.uk/productivity](http://www.local.gov.uk/productivity) under 'health and social care efficiency' Report December 2015

<sup>4</sup> LGA website at [www.local.gov.uk/productivity](http://www.local.gov.uk/productivity) under 'health and social care efficiency' Report December 2015

<sup>5</sup> Information from National Adult Social Care Information Centre – courtesy of Rachel Ayling (Independent Consultant).

health services<sup>6</sup>. This has meant that there may be much less scope for any further reduction (and there is a good case to suggest there is now an under investment for these people from adult care resources). Despite this staggering reduction in funding there are still variations between councils as to how and where they spend monies for this group of people. Most of the services are run within pooled budget arrangements within the NHS. The Local Authority will look to ensure that it is funding the Approved Mental Health Professional (AMHP) services contributing to assessments when people are in a crisis. Beyond this requirement some councils still have investment in former supporting people services, some in residential care (particularly where people have been placed in establishments as a result of Home Office Orders) and there is a minimum amount of support within the community (usually commissioned from the voluntary sector). On average councils spend 8% of their adult social care budget on these mental health services.

### 3 Factors in managing demand in adult care

The local factors that I would like to suggest are significant in influencing the demand for state funded services in adult social care, in addition to pure demographic changes are:

- The relative wealth in the population (or the opposite in relation to areas of high deprivation).
- The behaviours of key players in the NHS, the performance of intermediate care and the availability of therapists and nurses in the community.
- The effectiveness of the council front door in finding solutions for people and their problems - The effectiveness of short-term help and the approach to preventive help.
- The way in which the needs of people with lower care needs are met including the use of assisted technology.
- The practice and supervision of assessment and care management staff.
- The approaches taken to progression towards greater independence for those with long-term conditions.
- The way in which people with long-term conditions are helped to self-manage their conditions including dementia care.
- The approaches taken to the assets of the person being assessed and the involvement of family and community in a person's solutions.
- The way in which providers deliver outcomes including the availability and vibrancy of the voluntary sector.
- The availability and the nature of supported housing services including Extra-Care Housing for Older People.
- The partnership with carers and carer organisations.
- The use of performance measures to judge the outcomes from the care system.

Below I explore each of these factors in turn, and the issues that require consideration when a council is looking to manage demand in a better way. I then consider how a council might look to project future demand and finally I conclude with suggestions for a new performance framework that might support the activities identified.

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<sup>6</sup> Information from National Adult Social Care Information Centre (NASIS)

### 3.1 The Wealth in the Population

Three considerations might be made when looking at wealth as a predictor of social care needs. First is that within an ageing population it is older wealthier people who are living longer but with better overall health<sup>7</sup>, second that age alone is not a determinant of need and third, that wealthier individuals don't tend to approach the council for help.

The evidence<sup>8</sup> I have seen suggests that it is the number of long-term conditions that a person experiences that is more likely to be a predictor of care than a person's age. Those people with three or more different long-term conditions are those who are most likely to require some care and support. If a council wishes to predict need it might be better to look at the national census incidence of people with five or more requirements for aids to daily living (ADLs)<sup>9</sup>. This is probably the most accurate data that may assist in predicting who might have the level of needs that may be eligible for adult social care.

Those people who know they are likely to fund their own care make decisions usually without the help of the council. They may employ local people to help them (much as a personal assistant might be recruited through a personal budget). Wealthier older people appear to make much less use of the private domiciliary care agencies. However, recent trends suggest that they are as likely to use residential or nursing care homes as part of their solution. Generally, a population with greater wealth is less likely to either need care and support or to approach the council for help.

There is a problem faced in some council areas where wealthier people who placed themselves in residential care (or were placed by families, GPs etc.) then run out of money to pay for their care and call on the council to cover the fees. This has presented a range of problems with unpredictable demand in some council areas. Most councils consider that older people in residential care are likely to remain there for between two and three years before they die – in a nursing home this is likely to be shorter. However, some self-funders not only run out of monies after four or five years in a home (after they have already paid over £150,000 for their care) but they will need to continue to live in that home for a much longer period. Poole Borough Council amongst others have established social workers in GP practices with part of their role to assist self-funding older people to find their solutions to meet care needs without prematurely entering residential care.

Therefore, a council has to consider that wealthier people are less likely to approach a council for help unless they run out of money by which time it may be too late to assist them in finding alternatives. There is of course a higher use of social care from communities with higher levels of deprivation where they are most likely to need state funded care and support and where factors such as ill health are likely to be more prevalent in the population.

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<sup>7</sup> Office of National Statistics data published October 2015

<sup>8</sup> Age, proximity to death and ill-health, in the presence of compression of morbidity: Report for Department of Health – Howdon D, Rice N, ESHCRU, August 2014

<sup>9</sup> The Importance of Multimorbidity in Explaining Utilisation and Costs Across Health and Social Care Settings – University of York Centre for Health Economics 2014 – CHE Paper 96

**Questions you might need to ask:**

- To what extent might the wealth in the population reduce the projections on future demands on state funded social care?
- What are the risks associated with this in relation to older people entering residential care prematurely – and what actions might you need to take to mitigate this risk?

### 3.2 The behaviours of key players in the NHS, the performance of intermediate care and the availability of therapists and nurses in the community

Despite moves to help integrate health and social care there seems to me to be still a big cultural difference between the two main care services. The outcomes that the two systems seek can be very different at times. Over 50% of new demand for long-term social care emanates from people working in the NHS. Most of this demand comes from the acute hospitals<sup>10</sup>. The evidence suggests that one out of every 5 packages of care from hospital over-proscribe what is required to help the person<sup>11</sup>.

This is a significant finding. If this overstatement of needs could be addressed, it would not only release much needed capacity and resources for the health and care sector it might also improve the outcomes for older people. There is a tendency for quite risk-averse practices from hospitals to find social care as a solution when it may be unnecessary. There are several ways in which this might happen:

- There is often a lack of proper capacity for intermediate care services after hospital. This means that older people get packages of care after a hospital episode that then stays with them for the rest of their life when for a significant group a short period of care with a focus on recovery and rehabilitation might enable them to get back on their feet with little or no care.
- The intermediate care that does exist is not focused on helping people regain independence – this is particularly the case for residential intermediate care. Older people are placed in residential care beds at the point of hospital discharge (sometimes placed there by the NHS – in a discharge to assess mode). This is the wrong approach – discharge to recovery would be a better term. In the LGA Efficiency Programme it was found that if older people were placed in a residential intermediate care facility that helped to support recovery and rehabilitation with therapeutic support available there was an 80% chance that an older person would return home. If a similar person was placed in a residential care home with no similar support there was an 80% chance the person would remain in that home for the rest of their life. My work with councils would suggest that about 30% of the permanent placements made direct from an acute hospital to residential care were avoidable. Many councils and NHS staff would not recognise this as a serious issue in demand for social care. There assumptions are based on their usually accurate assessment at the point of discharge where a person needed more support – but did not see the potential for full or part recovery in the medium term.

<sup>10</sup> See the SALT returns from Councils to the National Adult Social Care Information Centre (55% of all new demand for long-term packages emanated from acute hospitals in 2014/15)

<sup>11</sup> LGA website at [www.local.gov.uk/productivity](http://www.local.gov.uk/productivity) <<http://www.local.gov.uk/productivity>> under 'health and social care efficiency' Report December 2015

- The LGA study referred to above found that most practitioners in the acute sector were unaware of the types of help that might be available for older people (though of course these do vary between councils). This does have the consequence that if they are suggesting help to families they offer the better-known and more straightforward solutions e.g. residential care.
- There also seems to be a tendency in hospital to overstate the occasions when a person will require a double-handed service at the point of discharge, where two care workers are required to deliver care. This is not only overstated in a number of cases usually there has not been sufficient thought given to the equipment that might be used to reduce the necessity of this more expensive option.
- The Intermediate Care services can be quite unconnected. The importance of getting both the health care needs of a person – managing the right medication; treatment; recovery support, therapy etc. with meeting a person's care needs is an important part of discharge. The significant reduction in the numbers of district nurses alongside the hard stretched GP services across the UK will significantly impact on supporting older people's recovery. Poor health outcomes are much more likely to lead to the necessity for longer-term social care.
- A study in Torbay<sup>12</sup> found that domiciliary care reablement was significantly over-used when actually for many older people a simple programme set by a physiotherapist which the patient could self-manage (with support) would be a better alternative in delivering the desired outcomes. The study found that in about 50% of the cases that had been referred for the domiciliary care reablement service this alternative would have been much less costly and produced the same (if not better) outcomes. It is worth noting that the same study found that for some older people for whom assessments had suggested that domiciliary care reablement would be unsuitable were those who would benefit most from a concerted focus on improving the outcomes for the patient e.g. those with depression; hoarders; dementia sufferers etc.
- GPs might also see social care support as a solution to some older people's problems when it may be inappropriate. People may require help and advice – support that may be given by the voluntary sector or by a community visiting scheme but does not require the formal care of the social services.
- The health conditions from which older people suffer which are most likely to lead to an admission to a residential care are not often prioritised by local NHS leaders e.g. incontinence (treatable but not often resourced), dementia care, stroke recovery or falls prevention services<sup>13</sup>. There are a number of studies that suggest if these areas were given greater priority significant reductions could be made in demand for social care.

<sup>12</sup> LGA website at [www.local.gov.uk/productivity](http://www.local.gov.uk/productivity)<<http://www.local.gov.uk/productivity>>

<sup>13</sup> Royal College of Physicians (2011). Falling Standards, Broken Promises, Report of the National Audit of falls and bone health in older people 2010, Royal College of Physicians (2010). National Sentinel Stroke Audit; Organisational Audit 2010, Ivers R et al (2000). Visual Impairment and Risk of Hip Fracture. American Journal of Epidemiology 2000; 152, No 7, Alzheimer's Society (2009). Counting the Cost; Caring for people with dementia on hospital wards, Royal College of Physicians National Audit of Continence Care 2010

- It is also worth noting that there is a national shortage of District Nurses (with a 50% reduction in the numbers working in the community over the last decade<sup>14</sup>). Nurses in the community can play an important role in helping people to remain well at home.

One of the services that is regularly offered to older people post-discharge is domiciliary care re-ablement. The study from Torbay was mentioned above as an important piece of learning about the effectiveness of domiciliary care re-ablement and when it might be used (and when it is not appropriate when a person could self-manage their own recovery with support from a physiotherapist). However, the impact of domiciliary care re-ablement to help an older person back on their feet is very variable<sup>15</sup> and outcomes fluctuate significantly between different schemes. As a minimum a scheme might expect that over 40% of older people who have been offered re-ablement will require no further care package but some schemes report a 66% rate of improvement for older people requiring no further care. In many places they do not know the rate of improvement<sup>16</sup>. The reasons for this variation will include:

- Whether there is clarity on the outcomes required from the help offered for both the worker and the customer (See the Wiltshire Model of Outcome Based Commissioning<sup>17</sup>).
- Whether the worker has been appropriately trained.
- The complexity of the tasks required by the worker e.g. helping a person better manage dementia.
- The understanding and involvement in the programme by the customer.
- The involvement and support of both Occupational Therapists and Physiotherapists in the programme.
- Links between health professionals managing the medical condition and the worker offering the re-ablement.
- The views and values of the worker carrying out the final assessment as to whether more service is required (possibly one of the biggest factors affecting the outcomes).

The variability in the outcome for older people who are receiving domiciliary care re-ablement this will make a difference to the predicted demand for social care support required by older people.

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<sup>14</sup> Survey of district and community nurses in 2013 Report to the Royal College of Nursing – University of Kings College, London

<sup>15</sup> Tinetti, M.E., Baker, D., Gallo, W.T., Nanda, A., Charpentier, P. and O'Leary, J. (2002) 'Evaluation of restorative care vs usual care for older adults receiving an acute episode of home care', *Journal of the American Medical Association*, vol 287, no 16, pp 2098–2105.

<sup>15</sup> Lewin, G. and Vandermeulen, S. (2010) 'A non-randomised controlled trial of the Home Independence Program (HIP): an Australian restorative programme for older home-care clients', *Health & Social Care in the Community*, vol 18, no 1, pp 91–99.

<sup>16</sup> Glendinning, C. et al. (2010) Home care re-ablement services: investigating the longer-term impacts (prospective longitudinal study), York/Canterbury: Social Policy Research Unit (SPRU)/Personal Social Services Research Unit (PSSRU)

<sup>17</sup>[http://ipc.brookes.ac.uk/publications/pdf/Wiltshire\\_Council\\_Help\\_to\\_Live\\_at\\_Home\\_IPC\\_Report\\_April\\_2012.pdf](http://ipc.brookes.ac.uk/publications/pdf/Wiltshire_Council_Help_to_Live_at_Home_IPC_Report_April_2012.pdf)

Re-ablement has become an approach to social care – not just a single service. Councils have now started re-ablement opportunities for adults with learning difficulties (see study on Kent in LGA Efficiency Programme – Learning Disability<sup>18</sup>). There is a renewed focus on helping people with moderate and low levels of needs to develop the skills required for day-to-day living and to increase levels of independence. The Kent programme offers a range of different modules that helps to “train” a person in life skills. This is an important programme for people who may have become dependent on Day Care Centres but who may not be eligible in the longer-term for that service. Helping a person acquire new skills and introducing them to community and voluntary activities as part of this (see Tameside case study in LGA Programme) can become a critical part of demand management. The programmes are seen to benefit at least 33% of those who are known to the council’s existing services.

In my view the same set of “training” should also be offered to adults with other disabilities. Helping people to adapt after sight loss or getting the right equipment to a person with hearing loss are all parts of a service that can focus on improving the outcomes and levels of independence for people with care needs. In the 1970s councils employed rehabilitation officers for people with visual and hearing loss. These services need to be re-commissioned to assist people today.

Finally, the recovery model is seen by some mental health professionals as a really helpful way of supporting people recovering from poor mental health. The model focuses on two key aspects of a person’s predicted illness. First on how a person can be helped to understand and self-manage their condition and second on building a support network that can assist in times of crisis (or to avoid a crisis building). There is some evidence that suggests<sup>19</sup> this is a successful way of helping many people manage the risks of their mental ill health and supports people to lead a positive life with less risk of relapse. Again the focus is on short-term assistance that aids the patient in the longer run<sup>20</sup>.

Each of the approaches above warrants their own papers and research. Suffice to say that if a council is focused on all of these “interventions” that it can offer people at the time of a crisis then it is clear that longer-term demands for care can be reduced. These approaches were mostly not available (at scale) ten years ago. This alone means that the approaches that were taken in the past to predict demand based solely on demographic pressures are no longer relevant on their own.

One of the key factors for the NHS and social care is to understand the flows of patients through the acute hospitals. It is important that commissioners understand the numbers of people who are passing through the hospital and have commissioned the right health and care intermediate and community based services to meet the needs of patients at the point of discharge. This is not the best point to undertake an assessment for a longer-term service. That should happen when someone has had the opportunity to see the rate of recovery that they are likely to make. Recovery is best supported by community and intermediate care staff.

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<sup>18</sup> LGA website at [www.local.gov.uk/productivity](http://www.local.gov.uk/productivity)<<http://www.local.gov.uk/productivity>>

<sup>19</sup> What Is Recovery? A Conceptual Model and Explication Nora Jacobson, Ph.D. Dianne Greenley, M.S.W., J.D. 2001

<sup>20</sup> For more information look at The Mental Health Foundation website

New evidence<sup>21</sup> is being presented which shows a number of health and care communities can work in partnership in such a way that manages speedy discharges from acute hospital care and at the same time improves the longer-term outcomes for the patients being helped. It could be argued that this will only happen in a fully integrated care model that is focussed on those longer-term outcomes including speedy discharge and reduced re-admissions back to hospital.

There is evidence that the way in which the NHS and social care work together (or not) can make a 20% variation in the demand for social care in any particular area. Getting all of the above delivered in the best possible way can make a significant difference in the outcomes for older people and their need for care.

#### Questions you might need to ask:

- Have Councils and their NHS partners examined the outcomes that are achieved from the health and care system?
- Are there measures in place to help evaluate the outcomes of different interventions (pieces of help)?
- Have Councils and their NHS partners looked to reduce or eliminate direct admissions from acute hospital to residential care?
- Do Councils and NHS understand the flows of patients through acute hospitals so that they can manage demand? Have services been commissioned to manage these flows?
- Are decisions about the longer-term futures for patients made after intermediate care services have been used?
- Are decisions about longer-term futures for patients made close to the patient?

### 3.3 The effectiveness of the council front door in finding solutions for people and their problems - the effectiveness of short-term help and the approach to preventive help.

One of the findings from the adult social care efficiency programme<sup>22</sup> was the impact that councils might have on demand from the way in which they respond to people who need help. The studies from Shropshire, North Tyneside, South Tyneside, Calderdale and others in that programme all showed that an effective set of staff who are focused on helping people find solutions to their presented problems could help divert people effectively away from formal social care. It seems to me that this raises a new challenge – what we need to understand is not how many people will need help in the future but how can we best help these people. It also requires us to ask whether the same numbers of people require formal care in the way in which we have delivered it in the past.

These councils have found new approaches to divert people to get the right help at the point of initial contact. There was strong evidence that demand for social services was being partly met through diverting people to other places for help or offering short-term help which assisted people in needing less care longer term. This has been the major change in adult social care during the last five years. It is interesting to note that in North Tyneside they have kept a careful track of which people they have helped and how they have helped them. Though 75% of the people who approach them for

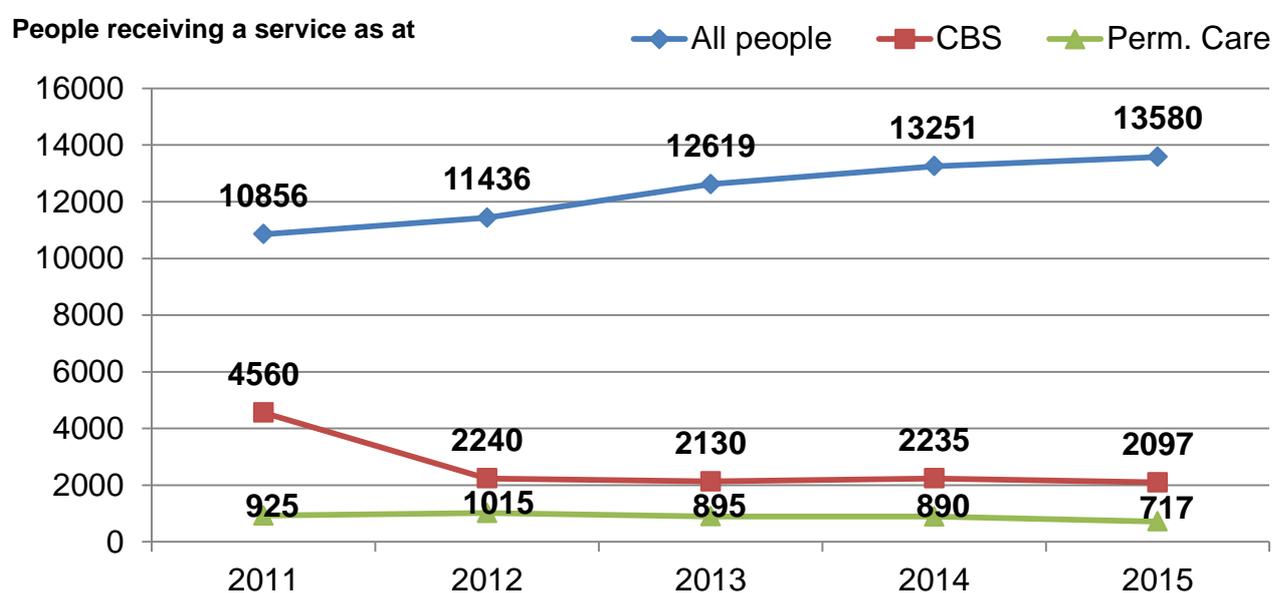
<sup>21</sup> See The National Audit of Intermediate Care 2015

<sup>22</sup> LGA website at [www.local.gov.uk/productivity](http://www.local.gov.uk/productivity)<<http://www.local.gov.uk/productivity>>

assistance are helped at this first point of contact, the data shows that the council is helping more people over the period but in a different way from the past (27,500 calls were received last year).

There are, in particular, two major routes that can assist people – the allocation of assistive technology – from a call alarm system to more sophisticated technology and the use of community resources through their newly established “well-being service”. The former has meant that the Council has now issued over 3300 items of equipment to help people have both more peace of mind and personal security (there are 40,000 older people living in the borough) through assistive technology. The latter has led to a range of support being offered from volunteer befriending services, to practical help or links to community groups and organisations.

**Table 4 – Numbers of people receiving help in North Tyneside**



(CBS = Community Based Services Perm Care – permanent care package)

The approach in North Tyneside is mirrored by the model adopted in Shropshire where their “People2People” service (a social enterprise rooted in the community) helps people with their first point of contact to social care and where possible diverts them to find solutions to meet their needs within the local community/voluntary sector/ or within their own personal resources. The national evidence suggests that 75%<sup>23</sup> of people are diverted from social care at their first point of contact – in part because of inappropriate referrals (people’s lack of knowledge about what social care can and cannot do) and in part because for some people their solutions are best found in the third sector, within their families and their communities. The approaches used in the councils cited might increase the percentage of people helped by up to a further 5-10%. This may require a closer study. Both North Tyneside and Shropshire advise that they follow up customers with a phone call to ensure that they are satisfied that their needs were met by the solutions offered.

<sup>23</sup> Information from National Adult Social Care Information Centre (NASIS)

One note of caution should be stated here. The front door or contact centre at a council will only possibly address the 50% (or less) of potential new customers for social care as the other 50% (or more) will have been referred from the acute hospitals. It is probably safe to suggest that how the front door of a council is set up and how it operates can impact on at least a further 5% (in addition to the expected diversion rate of 75% of contacts) on the total new demand from customers for social care"

The former "supporting people grant" funded services can also provide some lessons as to how a cohort of people might be assisted with short-term help that focuses on resolving specific problems with an aim for the person to "get back on their feet" and to regain independence. These services (many of which have been cut under the recent period of austerity) can have a very positive impact on people's lives. Falls Prevention services have one of the strongest sets of evidence for their effectiveness. The likelihood of a person having a second fall if offered help after their first accident is reduced by 75% saving monies for both the NHS and Social Care. Services can help people rehabilitate from drug or alcohol abuse; homeless people and those recovering from mental ill health can be assisted back into "normal" community living. At the end of the supporting people programme<sup>24</sup> there was an interesting move to commission these services on the basis of payments for results delivered. In other words, the providers of these services were paid according to the outcomes they delivered. More is written on this below.

There are a number of ways in which people can be helped when they approach social care for assistance. How the council responds to these people can have a significant impact not only on the demand for social care but on the likely outcomes for these individuals. Councils can inadvertently "suck people into the care system" when it is unnecessary because there are better ways of helping those who come in a crisis.

#### Questions you might need to ask:

- Is the first point of contact with the public established to help people find solutions to the problems they face?
- How engaged are the community and voluntary sector in the diversion of people from formal care to meet their needs?
- How much does the council understand the flows of people through their two front doors (the community and the hospital)?

### 3.4 The way in which the needs of people with lower care needs are met including the use of assisted technology

One of the biggest variations between councils is the way in which they use domiciliary care to help people. The percentage of recipients receiving low levels (5 hours of care or less per week) of domiciliary care (compared to more intensive packages) can vary between 1% of the customers up to 60% of all people receiving domiciliary care<sup>25</sup>.

There is a challenge for councils to determine the best way to help people. In the past (supported by the Department of Health's Performance Assessment Framework that encouraged council to formally help more people to live at home) larger numbers of

<sup>24</sup> A Government Funded Grant, which ended in 2010, aimed at supporting people who needed support to live independently in the community.

<sup>25</sup> This is information which is no longer collected by the National Adult Social Care information Centre

older people were supported with a little bit of domiciliary care. This was often called preventive care by policy makers and staff who were assessing people's needs. As resources have become tighter councils have started to look closely at who is being helped and how they are being helped. Many councils have reviewed the numbers of people receiving low levels of care and determined that there are better ways to help these people than a limited use of domiciliary care. This can be seen in three different cohorts:

- Those receiving care in order to monitor risks including the anxiety of the person (where assistive technology and community alarm services can help).
- Those receiving a visit to ensure medications have been taken (where assistive technology can again help).
- Those receiving help because of social isolation – where community contact, volunteer visitors and reconnecting with family may be better solutions.

In a number of councils that participated in the Local Government Association's Adult Care Efficiency Programme up to 50% of people who were previously offered low levels of care were found a better way of receiving the help they needed.

In the last decade evidence has further emerged<sup>26</sup> that a little bit of help may be bad for the person. When a person stops carrying out tasks that they could previously undertake with some difficulty they are likely to experience some deterioration in their condition. One of the studies (HSURCS) even suggests that this can speed the pathway to the need for further services and increases the likelihood of death. Therefore, the new evidence<sup>27</sup> suggests that what was previously described as preventive actions may in fact offer the opposite for some people. The study undertaken by the Commission for Social Care Inspection on the use and application of eligibility criteria by councils found that those councils with the more generous (higher thresholds) of eligibility also had the highest admissions to residential care. Further evidence that a little bit of care may not be "preventive". It is however worth noting that for over half of older people who are admitted to residential care they will not have received any formal care prior to their admission.

It seems to me that this implies that those carrying out assessments of older people will need to understand both the negative and the positive way in which offering formal care can either help or hinder a person. So there is a similar message here as in the previous section – there has been significant variation between councils as to how they have helped people. This can make a major impact on the "demand" for formal care. In those councils where practitioners (from health and social care) still want to offer small amounts of domiciliary care there will be very different patterns of demand from those who look to find alternative ways of helping people. The national evidence will suggest that this can have as much as a 10% impact on demand for care.

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<sup>26</sup> HSURCS (2000) - Health Services Utilization and Research Commission (HSURC) The Impact of Preventive Home Care and Seniors Housing on Health Outcomes (Summary report no. 14).2000. This is further developed in their 2002 paper.

<sup>26</sup> Cutting the Cake Fairly – evidence provided by London School of Economics 2008 – Commission for Social Care Inspection report for DH October 2008

<sup>27</sup> A review of the evidence cluster found in the RIPFA study is on their website:

[http://ripfa.org.uk/publications/evidenceclusters/doc\\_download/189-evidence-cluster-01](http://ripfa.org.uk/publications/evidenceclusters/doc_download/189-evidence-cluster-01)

Linked to the response at the front door and how assessments are undertaken is a further model that should be helpful to social workers, which examines how people respond in a crisis. Some therapists might argue that it is at a time of crisis that a person is best placed to examine what is happening to them and to look at changes they might make in life style etc. which could maximise opportunities for improvements in their lives. It can be strongly argued that no one should make a long-term assessment for a person's needs when they are in a crisis. It is important to care and support a person through a crisis but in a way that gives them the right opportunity to recover, take stock and experience help in a particular way that might maximise their longer-term life chances. This will happen when a person has a serious illness e.g. a stroke or a cancer diagnosis and so it should happen for most people who come for help in some form of crisis. This is not a debate about eligibility – as most people will be eligible for help. It is about what is the right help to offer in a personalised way at the right time for each person. The focus should always be on the long-term outcomes rather than on the immediate crisis (albeit when support is required it must be offered).

As a minimum perhaps no older person should be assessed for their longer-term needs from a hospital bed<sup>28</sup>. How a council responds to a person in a crisis can either accelerate them into the formal care system or can hold them and offer the right care and support which will focus on their longer-term outcomes maximising opportunities for independence. The kind of response offered will make a difference in the overall demand for longer-term care.

In several of the sections above reference has been made to the use of assistive technology in supporting people to live at home. There are five different ways in which assistive technology might assist someone:

- Helping a person feel safer and more secure (community alarms; personal alarms, door sensors and other devices to help a person feel secure).
- Offering an aid to daily living (gadgets, reminders and prompts to assist with daily tasks).
- Helping with an assessment of need (e.g. Just Checking that helps to monitor the activities and movements within the home).
- Tracking devices (using GPS) to monitor a person's movement when they are at risk.
- Helping to manage a long-term condition (measuring vital signs) – sometimes called telehealth.

The range of modern equipment can either directly assist a person to carry out tasks of care (and reduce the need for personal care) or can monitor a person so that they are more secure and safe. These cannot replace personal care but for some people in particular circumstances they can reduce the need for formal care. They work best when linked to other actions that are in place to support a person to live more independently. They work across all the service user groups that might be helped by adult social care. The extent of their use in practice varies significantly from one council to another. They can account in part for the levels of care a person might need. They can contribute towards helping to manage demand better and at a lower cost. Like other aids and adaptations they rarely sit in isolation but part of a programme of care

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<sup>28</sup> Intermediate Care – Halfway Home Updated Guidance for the NHS and Local Authorities 2009

and support. There is some emphasis on personal responsibility to use the equipment sensibly and effectively for which some people will also require support.

It has been hard to estimate the impact directly on demand for care from the use of equipment. Several of the studies focus on “avoided costs” created by the use of the equipment rather than actual cashable savings and lower demand.

#### Questions you might need to ask:

- Does the council consider all of the options to meet a person’s needs when they approach for help?
- Does the council (and its partners) recognise that a little bit of the wrong care may increase a person’s needs?
- Is there a strategy in adult care for the use of assistive technology in all of the areas identified above?

### 3.5 The practice and supervision of assessment and care management staff

I think that the importance of the practices of front line assessment and care management staff (including those helping people long term and undertaking reviews) in actually determining and managing demand is often underestimated – but it is a key factor. This was confirmed with findings in both Kent and Kingston-upon-Thames in case studies within the LGA Efficiency Programme. Practice and risk assessment thresholds vary significantly from one social worker to another. Local eligibility criteria (or national) and local panels to manage the scale of help people received were not as significant as the practice of individual workers in determining what help some people receive and in what way. Some workers are much more likely to find “safer” and more risk-averse solutions for people than others. Some workers are much more likely to suggest a permanent placement in a residential care home than others.

Another of the variations in practice was the way in which assessment staff worked with carers. There were workers who saw their role in trying to take “the problems away” from the carers and there were those who worked alongside the carers to find solutions with them. The former tended to arrange much higher cost packages of care than the latter group. To some degree this is fairly obvious but in the LGA studies it was apparent that managers did not understand sufficiently the particular biases of individual workers and how that was impacting on demand.

It is not surprising given the critique of care workers over the last decade for missing abuse when it occurs that the risk-averse practices with a strong emphasis on safe-guarding with larger packages of care was the dominant culture in both councils in the study. There were however some workers who worked closely with carers, other family members, community members, voluntary sector and other parties to help people find solutions using local assets rather than formal care. This practice at the front line can make an impact on who gets care; how care is delivered; and the size and nature of care packages. This is an underestimated part of the demand equation in adult care.

In exploring the issues around carers it is also worth noting that some Councils report that relatives living a distance away from their elderly parents are more likely to demand higher levels of care than those living in closer proximity. In Torbay when they reviewed

a number of people who were receiving domiciliary care and looked to change the way in which people were helped<sup>29</sup>. This was welcomed by the older people but often challenged by distant relatives. This may be balanced by evidence that in some rural areas there can be strong informal support within the local community.

#### Questions you might need to ask:

- Are the differing practices of staff recognised and discussed within the social work teams?
- Does the council support staff who work with customers to help them manage their risks?
- Does the council work in partnership with carers?
- Does a culture of safeguarding predominate?
- Are panels used to help support best practice or as places to ration resources?

### 3.6 The approaches taken to progression towards greater independence - The way in which people with long-term conditions are helped to best self-manage those conditions including dementia care

Most councils have services that could be described as supporting recovery, re-ablement and rehabilitation. Only a few councils understand the effectiveness of the services they have commissioned in relation to the outcomes they deliver. For other councils re-ablement and recovery are not a description of specific services but a strong philosophy about an approach to social care for everyone – whatever their condition and circumstances. In this approach – sometimes called the “promoting independence model” the sole aim of any social care help is to work alongside the customer to find ways of assisting them that maximise the opportunities for greater independence and least possible reliant on the state for care. This is certainly not a philosophy based on eligibility or on not helping people with lower needs. It is based on helping everyone in a particular way – focussing on agreed outcomes that promote independence.

This approach is clearly shown in the “Progression Model” which was introduced by the social care consultancy “Alder” into services for adults with a learning disability. The approach is simple. Every person who has a learning disability should have a care plan which focuses on maximising the person’s potential for greater independence. For those with higher care needs and possible challenging behaviours the focus should be on working to reduce the circumstances where the challenges are presented. This is usually achieved through health and social care professionals working together. Wiltshire County Council has jointly commissioned such a service with the NHS and early signs show significant opportunities to help people in a different way. The team that works direct with both providers of care and individual customers can already show reduced needs for the level of care and support that some people need (saving money and improving the life experiences of the customers<sup>30</sup>).

The progression model operates then for everyone starting in a personalised way at the current needs, challenges and experiences of the customer and designs a personalised set of help that will enable the service user to live a more independent life. A person

<sup>29</sup> LGA website at [www.local.gov.uk/productivity](http://www.local.gov.uk/productivity)<<http://www.local.gov.uk/productivity>>

<sup>30</sup> LGA website at [www.local.gov.uk/productivity](http://www.local.gov.uk/productivity)<<http://www.local.gov.uk/productivity>> - study on Learning Disability published in 2015.

with lower levels of needs might be assisted in a way that they require much less formal support from the care system – undertaking work in the community; paid employment and living with a greater degree of independence. This approach very much lends itself to people who are living in the community but have become dependent on formal care in a way that may be unnecessary in the longer term. This is not about solely closing day centres but enabling and empowering people to move into different settings. Nottinghamshire County Council have a contract with their community support providers where the value of a 5-year contract reduces each year as they help people to become more independent.

In my view the model that has been applied in learning disability services can equally apply to other people who need help from social care. There is a new emphasis from both health and social care as to how any person with a long-term condition (or a multiplicity of conditions) may be helped to live with that (those) conditions. People can be helped to understand their condition better and what circumstances makes their life more or less difficult. So working in a personalised way with a person who has dementia (and their carer(s)) can deliver improved outcomes for the person.

In Wiltshire, I have noticed that one of the major domiciliary care providers has a specific service that focuses on supporting older people with dementia to remain at home. The outcomes from this service are very impressive. There is much consideration and discussion as to how a person with dementia can be supported. The combination of a good diet, regular exercise, cognitive reasoning exercises, and assistive technology that can help a person remain safe all appear to contribute to the well-being of a person assessed to have a dementia. Councils need to consider if their dementia strategy is looking to support people (and their carers) to remain at home or is inadvertently driving people into residential/nursing care?

It is important that customers, their families and local networks understand and can actively participate in the approach to promoting independence. It needs to be both carefully explained (when it is not understood) and the person should be encouraged to set their own objectives. This can be frustrating for workers as some people are modest about their own potential or can feel very pessimistic at times of crisis. Overall, my personal experience is that once the approach is explained it is strongly welcomed and most people want to maximise their own opportunities for independence.

My recent experience in one council was that there were over 100 people who had experienced mental health crisis in the past and been placed in residential care. These people no longer had significant mental health needs but remained in their placements. These had not been reviewed in a way that considered whether any of these people might have moved on to a lower level care setting. This highlights the value of an outcome-focussed review for a person in a care setting. Each review might consider – what are the key objectives for the coming period and how might the way in which we support someone aid their move to greater independence?

I think that those councils (and there are a growing number) that use a philosophy of promoting independence are likely to experience much less demand and pressure on their services than those who offer a more traditional approach. Council which have in recent years introduced this approach to their staff have found that demand has been reduced in a way that can give front line social workers enormous job satisfaction and a really strong sense of purpose. In relation to predicting reduced demand this is more

problematic as there might be a risk of double counting with some of the earlier approaches identified in this paper. The early evidence from the learning disability sector is that demand which has been rising for services from this group can be managed in a flat line as new people with needs come into the service at the same time as others regain greater independence and have lower needs.

#### Questions you might need to ask:

- Do reviews regularly take place which aim to promote independence?
- Is there a philosophy to support practice that offers progression for customers with long-term needs?
- Does the council maximise opportunities for its customers to maximise opportunities for greater independence?

### 3.7 The approaches taken to the assets of the person being assessed and community development approaches

A more recent approach to social care has a strong focus on the assets that a person may have and builds the way in which their care needs can be met on the personal, family and community resources that are available to them – relying less on the formal care system<sup>31</sup>. The main concept in the model focuses again on the nature of an assessment. Traditionally assessments can focus too much on what the person can't do – “eligible needs”. The focus is to meet the needs from the perception of the deficits a person has. However, the asset-based model does just that. It focuses on what resources a person might have to assist them in meeting their needs and how these resources can be aligned to maximise the opportunities for the person with support needs.

This approach is sometimes linked to an Australian model of community development where a focus on the council is to help people with care needs to be more actively engaged in their communities which builds the available assets for them in a quick and easy way. The Australian approaches<sup>32</sup> have tended to focus on the opportunities for younger adults with learning difficulties but these are now widened for other groups in the population. Early evidence from those adopting these approaches shows that there is potential<sup>31</sup> to create more sustainable solutions for people at a lower cost reducing direct demand on the public sector. Usually the approach has strong elements of the “promoting independence” model within its core beliefs.

One particular way in which this approach has been promoted is within the “Shared-Lives” Services<sup>33</sup>. In this approach people with care needs are matched with people in the community who have spare accommodation. The proprietors not only offer the accommodation (paid for by the customer) but also degrees of care and guidance depending on the person's needs. This is a form of care that is much less institutional

<sup>31</sup>See papers/case studies from Sam Newman at OLM Systems Consultancy including “How Essex County Council is changing the delivery of adult social care support” and “Financial Austerity in Social Care we have to change the conversation”

<sup>32</sup>[What is asset-based community-driven development \(ABCD\)...](https://sustainingcommunity.wordpress.com/2013/08/15/what-is-abcd/)<https://sustainingcommunity.wordpress.com/2013/08/15/what-is-abcd/> 15 Aug 2013 - ABCD is built on four foundations (Kretzmann, 2010; Kretzmann & McKnight, 1993; Mathie .... Canberra: Royal Australian Planning Institute. [Asset Based Community Development \(ABCD\) - Altogether](#) ...[www.altogetherbetter.org.uk/.../5-assetbasedcommunitydevelopment.pdf](http://www.altogetherbetter.org.uk/.../5-assetbasedcommunitydevelopment.pdf)

<sup>33</sup>Shared Lives Plus - Shared Lives, Small Community ...[sharedlivesplus.org.uk/](http://sharedlivesplus.org.uk/)

that the traditional care settings and introduces the customer to community living with much less risk. Some Councils have invested in this approach in recent years as it offers a lower cost service (than the residential or supported living alternatives) with reported very positive outcomes for the customers.

It seems to me that the asset-based models do not change the demand for care in the system but can have an impact on the way in which that demand is met. The focus is always on better outcomes with the indirect gain of lower costs.

The same can also be said of the way in which families are involved in the assessments for people for whom they may have some caring responsibilities. Some social workers feel that they should take problems away from the family carers and look to protect them from the stresses and strains that can be associated with carer responsibilities. However, it is important that the family carers are (where appropriate and where they are directly involved in giving part of the care) involved in designing and developing the care plan with the service user. It is always likely that a carer is more likely to make a really important contribution to the care package if they have been directly involved. Evidence from the LGA case studies show that where carers are involved the final care plan is more likely to be less intensive and more focused on better outcomes for everyone involved

#### **A question you might need to ask:**

- To what extent do the assessment processes in the council build on the assets of the person being assessed?

### **3.8 The way in which providers deliver outcomes including the availability and vibrancy of the voluntary sector – commissioning for outcomes**

I hope that you will agree that this paper shows that in many councils the approach to the delivery and design of social care is changing. Some of the changes are driven by commissioners but much of it is being changed by the practice of front line workers. There is a question as to whether those people who provide services have either been kept involved in these changes or have looked themselves as to how they might contribute to the financial challenges facing care. Many providers of social care still seem to be wedded to the more traditional approaches that have been used for many years.

In part this is understandable. Much of local authority commissioning in recent years has been focused on efficient procurement and getting services at the lowest cost. There has been a very small focus on quality and even less of a focus on the outcomes for individuals and populations that might be expected to be delivered. Many providers still deliver care in ways that only create a strong dependency on the services being delivered. There is rarely a focus on improving outcomes and promoting greater independence. There are of course some notable exceptions to this, but many providers, including those in the third sector still have a very strong focus on increasing the size of care packages for individuals without a focus on how they might assist a person to do more for themselves. Some politicians consider the not-for-profit and voluntary sector providers are part of the solution for contracting care services now and in the future. This is not my view. A minority of providers (including some third sector providers) are keen to help people live more independent lives but this has been a

minority. Most seem to run their business models on the basis that people will need more care and that they will be in the best position to deliver that care.

Advocates operating for these providers more often than not see themselves pursuing more care for customers than looking for ways to assist a person regain independence. Again of course there are exceptions – but they are a minority of individuals within these sectors. Some providers of care are keen to contribute to the solutions of tighter budgets whilst others quite rightly retain a focus on being paid the right amount for the (quality) care they deliver. In many places the council is seeking the help of the community and voluntary sector to assist them in finding new ways to help people and in some places they are rising to that challenge. Examples of this have already been cited in this paper.

In my personal experience one particular resource that can have a very positive impact on the care required in an area is a Carers Centre. A place where carers can get both practical and emotional help in both a formal and informal way play a massive contribution to the care needs with a place. The benefits that the informal networks can create for people who are carers cannot be calculated. I think this relates to the point made previously about the importance of involving the carers in any care plan in a constructive way both examining their personal contribution to the care required and how the council will support them in doing that.

It is also worth noting that some voluntary organisations bring with them a significant set of resources to support their communities. This may be money raised from charitable efforts; endowments, properties etc. or it may be talented individuals who want to contribute back to society. Other organisations are 100% reliant on council or public moneys to carry out their activities. Organisations (often with a national base but not inevitably) such as MIND, MENCAP, Age (UK) and others are likely to bring with them a wealth of resources which needs to be considered as part of the commissioning task. It is one reason why the voluntary sector may offer good value for money in some instances. It is therefore really important that councils work with them as partners even if in the end some services might be directly commissioned from them in an open tender. Seeking the support of this sector has always been important it will prove to be even more so as councils look to find new ways of managing demand and meeting needs.

I have also noticed that increasingly local authority commissioners are looking to change the way in which services are commissioned, with a strong focus on the outcomes that a provider can be rewarded for delivering. Nearly always these are outcomes that promote independence for (and with) the customer. In examining various approaches to this commissioning agenda I have seen at least four approaches:

### 3.8.1 [Setting clear outcome-based performance standards for each contract against which the provider can be measured.](#)

This is the simplest approach to outcome based commissioning. It does not require any payment mechanism to reflect the outcomes but does hold the providers to account for the outcomes they are delivering. This is more likely to affect the award of continued contracts than any immediate reward for the performance that is delivered. It does require a simple set of measures by which the outcomes are to be judged. It is probably easier to undertake this with a limited number of providers. It does require the whole

system to understand the approach. One simple approach that has already been taken to this includes that adopted by the National Audit of Intermediate Care (NAIC) who have developed measures for an integrated health and care system.

The lack of real incentives in this model may mean that providers of care are not motivated to make the changes required. Under the current procurement approach adopted by many councils the incentives tend to favour providers who can deliver more care and they are not incentivised to deliver less. The way in which care is delivered will make a difference to whether a person is helped to regain independence or if they become more and more reliant on the care provided. The organisation requires a strong focus on performance management of the contracts in place. This in turn means that it is best introduced into a market where there are fewer providers who can be more closely monitored. This approach might be best used to look at the outcomes from Intermediate Care Services or Supported Living/Extra Care accommodation. This approach has been used by Coventry City Council<sup>34</sup>.

### 3.8.2 Setting a clear set of outcomes for each customer against which providers can be measured.

This approach requires a major shift in the approach of the assessment and care management teams. Each assessment should involve agreeing with the customer what the potential outcomes might be. The outcomes should focus on those that will assist the person in being more independent over time. Many people regard both Occupational Therapists and Physiotherapists as particularly effective in taking this approach. This should then be linked to the payments made to the provider of care who should be incentivised to deliver the agreed outcomes in the best time scale. This model may work for most types of service user.

The approach seeks a change in both assessment procedures and the behaviours and attitudes of providers. There is a risk that the transaction costs in the system increase as all parties need to agree both the defined outcomes and the cost of delivering these. Again this may be best managed with fewer providers who have the scale and capacity to manage the delivery of the system and put their investment into staff training and support. It requires sophistication from providers to ensure that they are offering the right type of care in the right way e.g. different care for people who are recovering from a medical intervention or those with a dementia. This approach has been used by Wiltshire County Council<sup>35</sup>.

### 3.8.3 Setting a budget for a service which will reduce over time (with same volumes of people being helped) as providers deliver better outcomes for customers (who will need less care).

This model appears to work best when there are a set of service users who are likely to need longer-term support but where they are most likely to benefit from a period of help that focuses on promoting their independence through rehabilitation, recovery or skills training. This appears to be suitable as an approach to help adults with learning disabilities. The interventions on offer may range from helping people with

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<sup>34</sup> See case study in Emerging practice in outcome-based commissioning for social care - Discussion paper April 2015 Institute of Public Care

<sup>35</sup> See above paper on Emerging Practice and Wiltshire Council Help to Live at Home Service – An Outcome-Based Approach to Social Care Case Study Report April 2012 Institute of Public Care

developmental challenges to modify their behaviours to helping train for greater independence (often supplemented with telecare). The approach clearly incentivises the provider to deliver improved outcomes to reduce demand for the level of service in the longer term.

There is a risk that providers will be incentivised to reduce the service on offer for people without having done the necessary preparation work to help people learn how to adapt and live with less support. There is a further risk that a provider who cannot deliver the outcomes will be financially stretched in a way that will put the service at risk. This approach may be best developed with a few trusted providers who can demonstrate they can deliver the improvements required. As with all these approaches a careful monitoring of the customer is important to ensure that the outcomes delivered meet their personal and specific requirements. This approach has been used by Nottinghamshire County Council<sup>36</sup>.

#### 3.8.4 Commissioning a lead provider to deliver services to a sub-set of the population where the cost can be calculated based on an optimum performance where the provider will deliver improved outcomes that will mean that a percentage of people will require less or no care over a given period of time.

This approach puts much of the onus onto the provider. They will need to have therapists working for them alongside care workers in order to produce the best possible outcomes for customers. The model developed with Mears Group PLC<sup>37</sup> suggests that the model will be cost effective if the proportion of people who only require short-term care increases and more people are helped to remain at home without the need to go into residential care. This is the most radical of the approaches and is likely to produce the best cost options for both providers and councils. The provider makes a profit when they can out-perform the way in which the current system works. It is not the cost per hour that counts but the outcomes that are delivered.

The model is both radical and to me it is probably most challenging for commissioners and providers. It requires a full understanding of the outcomes achieved within the current system and what would be required to improve it. However, both the transaction costs would be low, as the councils will assess that someone is eligible for a service and the provider will then determine how they will best help them and there are limited brokerage costs involved. This does mean that many customers will not have a “choice” of service – though that may be an illusion in the current system. It may also mean that the personal budget is a movable feast – as with all of these approaches the personal budget along with the level of service is expected to reduce for many customers over time. However, whichever approach is adopted both the interventions and the care plan will always be personalised for each individual as they respond to the interventions on offer in different ways. The closest version of this approach is being developed in Torbay Council<sup>38</sup>.

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<sup>36</sup> See case study in Emerging practice in outcome-based commissioning for social care - Discussion paper April 2015 Institute of Public Care

<sup>37</sup> Paper available from Mears Group PLC - Consideration of paying for outcomes from a set of the population for domiciliary care – Professor John Bolton 2015

<sup>38</sup> See case study in Emerging practice in outcome-based commissioning for social care - Discussion paper April 2015 Institute of Public Care

If Councils are going to look to actively manage demand better as resources become scarcer and they want to do this in a way that improves outcomes for their customers then it seems to me that there will continue to be moves towards variations on outcome based commissioning including payments by results and commissioning for populations. I know of at least one major care provider (Mears Group) which is keen to work with councils who want to develop this approach for domiciliary care. They are already paid in this way for some of the housing functions for which they have responsibility. The calculations made for Mears Group<sup>39</sup> suggest that this approach might reduce stated needs by about 5% because of the improved outcomes delivered for customers.

#### Questions you might need to ask:

- What are the circumstances where the council might consider commissioning services for the outcomes they deliver?
- Have we assessed the robustness of the outcomes delivered by providers in other ways?

### 3.9 The availability and the nature of supported housing services including extra-care housing for older people

Many Councils have over the last decade looked to find suitable alternative housing schemes for people with care needs. These are places where care may be readily available when required but will only be offered, as it is needed by the residents. There is some expectation that within the communities formed by people living in close proximity that some informal care will be offered and that the stimulation of community living with help to alleviate loneliness or depression that can be factors in old age that will increase the need for care. The most common schemes are “Extra-Care Housing” for Older People (ECH) and “Supported Living Schemes” for adults with learning difficulties.

It might be thought that these schemes will contribute to helping with management of demand for costlier placements. Some have argued that these schemes are about half of the cost (to the Council – but not to the tax payer because of the housing costs could be met by Central Government through either Housing Benefits and /or Capital Grants)) of similar residential care placements. These same people might argue that these are “better” environments in which people might live and receive their care. There are many schemes that would fit this description where a combination of good leadership from the staff encouraging people to live active lives and promoting a strong sense of well-being helps promote a good quality of life with less care required.

However, I have also seen places for both older people and adults with learning disabilities where this is a strong ethos of the resident’s being encouraged to rely heavily on staff and to be offered and receive large amounts of care. In one ECH scheme I observed some residents were receiving three times as much care as a person would receive if they were placed in a residential care establishment. This relates as much to the philosophy and ethos of the scheme as to any inherent understanding of the needs of people living there. This operates as a microcosm of what might be happening in any community or council area. It is not just the

<sup>39</sup> See paper from Mears group PLC - Consideration of paying for outcomes from a set of the population for domiciliary care

environment in which people live that makes a difference but the way in which people are supported when care is required.

This can be a particular challenge in supported living schemes for adults with learning difficulties. Sometimes councils note that the staffing arrangements can make these places more expensive than residential care with no noticeable difference in outcomes for the residents. Both types of accommodation can be liberating and promoting independence or they can be institutional and creating longer-term dependency.

In the 2000's in Coventry, I saw the numbers of new admissions of older people to residential care were halved. One of the contributors to this was the building of new extra-care housing and the closure of the council run residential care homes. Many people who had previously lived within residential care moved to the new housing schemes. For most people this proved to be a stimulating and positive move. It gave people new hope and new energy and for some it transformed their lives. It also significantly reduced the costs of care in Coventry. If this approach is going to work it has to be based on the principles of promoting independence and is more likely to be cost effective if new residents might have been considered for residential care as an alternative.

The reasons for covering this approach within this paper are that many councils have successfully reduced admissions to residential care across the board for all groups of potential service users. However, each placement and each care package must be considered carefully to ensure that the opportunities for a person to maximise their own independence are available as well as good quality care available when it is needed.

In my view all care should start as a short-term offer of help to give a person the maximum opportunity for recuperation and recovery. This is a very important part of the commissioning task when new schemes are being developed. One senior and experienced commissioner suggested to me that on average any extra care housing scheme for older people should be based on an average of 12 hours per resident of care and support per week. This should give ample scope to offer less care to those who will not require it and to offer intensive care when people are experiencing a crisis and not coping very well with personal care. As a maximum it is suggested that there would need to be an exceptional reason why a person might be allocated over 14 hours of care in an extra-care housing programme.

The issues related to volumes of people who are cared for in different settings is obviously critical to managing demand. In addition to these factors the costs of the services are also important (but not explored in this paper). Some argue that those in residential care now have more complex needs (even though there are fewer people) and these will cost more than those with lower levels of need. This may particularly apply to paying for the care and support of younger adults.

This sits alongside a parallel consideration as to whether community care services are always lower cost than residential care. This issue does warrant some comment. The main differences between the two models of care are the way in which the housing element is funded. In community based housing schemes the housing is funded by the individual through their own resources (which might include Housing Benefit). This is not part of the cost of care, which is treated separately and is the part paid for directly by the council.

In residential care all of the housing related costs are included with the care costs as a gross cost to the customer or the council if they are paying the bill. In practice this means that from the point of view of a Council paying for care the costs of residential care are approximately £100 per week more expensive than community housing (supported living etc.). For some individuals who live alone and where the costs are high with double-up care visits and where intensive night time support is required the cost of a community housing support can be more expensive. This should only happen in very specific circumstances.

However, some councils have developed housing support schemes that end up being more expensive than the residential care that could meet those individual needs. Generally, one should be able to work on the assumption that housing a person in the community and delivering their care and support to them is a lower cost option than residential care. Where the costs are higher there is often an over-provision of the care needed. Some Councils in my experience have looked to make a policy that a person's needs should be met in the place that costs the lowest amount. That is both illegal and unnecessary. Councils should plan to meet needs in a cost effective way focussing on the outcomes for the person. The outcomes should always look to maximise opportunities for greater independence. This both drives down the costs and empowers the customer.

#### Questions you might need to ask:

- What kind of outcomes do the extra-care housing or supported living schemes deliver in our area?
- Do our providers help people to gain/regain independence or do people who live in these places become more dependent on formal care?
- Do any customers receive more than 14 hours of formal care per week – if so why?

### 3.10 Approaches to “prevention”

At the heart of this paper is an assumption that councils are looking to maximise the opportunities available to them to offer solutions for people that might help prevent or reduce their likely need for care. The assumptions are based on a four-stage view of prevention<sup>40</sup> outlined in my contribution to the RIPFA publication ‘Re-imagining Adult Social Care’ developing the earlier work of the Institute of Public Care.

- **The Public Health Approach:** If people were encouraged to take more exercise; eat more healthily; drink less alcohol; maintain healthy friendships and live a purposeful life they are much less likely to experience the long-term conditions that would lead them to requiring care in older age.
- **The right help at a time of crisis:** There are short-term bits of help that people may need in a crisis to hold them and offer care but to work with them to find longer-term solutions that may be outside the formal care system.
- **Reablement, Recovery, Rehabilitation and Recuperation:** Services should always focus on looking at how to assist people to recover from the problems they have experienced or to find the best ways of overcoming them.

<sup>40</sup> See Chapter in “Reimagining Adult Social Care” by John Bolton- What would a new model of prevention and independence look like? Published by Research in Practice for Adults (RiPFA) 2015.

- **Helping people to self-manage their long-term conditions:** people who are diagnosed with long-term conditions that mean they require care and support should always be advised and assisted in ways that help them to best manage and live with those conditions.

#### Questions you might need to ask:

- Does the council have a preventive strategy for adult care?
- Do we know if our preventive strategy is assisting the council in managing demand for formal care services?
- Do we know which parts of the strategy work best and which ones require review?

## 4 New performance measures to judge the outcomes from the care system

The section above has looked at the ways in which a council might actively seek to manage demand for social care. Hopefully it has shown that by focusing on the two “front doors” for the council – the community and the acute hospital - and by focusing on the interventions that are available to a person at a time of crisis that demand for formal social care can be reduced.

The way in which a council responds to a person in need at a time of crisis is absolutely critical to the likely longer-term prospects for that person. Understanding when is the right time to undertake a formal assessment for longer-term care is also important along with a strong focus on helping people to better self-manage their long-term conditions.

The council needs to develop a preventive strategy that builds on the evidence available. Most of all the philosophy of social care needs to build on the importance of assisting people to maximise their life opportunities and to support greater moves towards independence. Councils should know the outcomes that different services deliver for them. The effectiveness of the interventions that are available need to be measured. The current performance system (ASCOF<sup>41</sup>) does not quite achieve this so councils need to develop new measures to assist in this task.

Managing demand requires in my view, a specific and detailed performance system so that it is clear on which interventions work and in what circumstances. The system has to both be able to monitor the flow of people through the care system but also the outcomes for people at the various stages of the care pathway. Some Councils have already started to do this e.g. Nottinghamshire County Council that has developed their approach. The basis for this approach to performance might have as its headlines:

- A set of measures that looks to ensure that 75% of people referred from the community are diverted appropriately at the point of first contact; that a further 50% of people referred from the acute trust require no more than short-term care; that a further 10% of people are helped through reablement and recovery services which limits their need for longer term care; that a further 5% of people have a reduced package each year as they move towards greater independence.

<sup>41</sup> Adult Social Care Outcome Framework – Depart of Health

- A set of measures that judges in detail the performance of each service or offer that is made to those seeking help from adult social care and the outcomes delivered by that service e.g. ensuring that the reablement services help sufficient people to regain independence.
- A set of measures that examine the performance of individual workers in relation to their assessments of need and their proposed solutions.
- A set of measures for the reviews that take place and the numbers of people with an outcome based care plan that has been delivered in the previous year.
- A set of measures for each provider of care on the outcomes from their services.

These measures can be developed locally to suit circumstances. They might set broad targets for the whole care system e.g. to reduce new admissions to residential care and there will need to specific targets for service managers in relation to their responsibilities. Managers should be held to account for delivering their agreed targets and these should be reviewed and monitored at least on a quarterly basis (in some cases where there are higher volumes monthly data is required).

These measures are crucial to both monitor the effectiveness of the current system and to help see patterns that might assist in predicting future demand.

## 5 How might we now predict demand with all the variables considered?

I hope that this paper shows that there are a range of actions that may be considered by councils if they are going to look to manage or reduce demand for adult social care. Most councils will consider that they have done some or most of these actions, though evidence suggests that the outcomes from different approaches by councils continue to vary. Therefore, councils will still want to consider what future demand will look like for their council. I suggest that the following factors are crucial in predicting future demand:

- The people in the population who reported in the national census that they had five or more requirements of aids to daily living (ADLs). This cohort are much more likely to determine who in the population may require care – rather than using age as a proxy.
- The likely impact of wealth on that group of people and consider that only a small proportion of those will end up seeking state funded care (bearing in mind the risk of self-funders who have entered residential care and who run out of money). This may change in England if the legislation changes and of course does not apply in Northern Ireland where all care is free.
- The patterns of demand from recent years in the council's area for each specific service user group (Older People, Younger Adults with Learning Difficulties, Younger Adults with Physical Disability, Younger Adults recovering from mental-ill health etc.). There are likely to be different patterns of care for each group and varying impacts on demand management.

## 5.1 Future demand for older people's services

If the pattern for the last five years in a council has been an upward increase in demand for services for older people, then I think that that council can consider that insufficient work has been done on demand management and they should consider the interventions that are required to help reduce demand (as listed above). The route that is shown in Table 5 might assist them in considering future demand. Their current demand will be in an upward direction shown in a to b. The current predicted demand is likely to be at around 2.5%<sup>42</sup> per annum growth - shown in the graph as a steady rise.

When they first introduce a range of new interventions (preventive interventions) they ought to begin to see a fall-off in demand as shown from b to c in table 5. This can be monitored as to the level and rate of reduced demand. After two to three years of action, demand is stabilised as a flat line (shown as c to d in the Table) but after a further two years it is likely that a small increase in demand will start to be experienced unless new ways of managing demand are discovered from d to e.

Before beginning to predict future demand a Council must make an honest self-appraisal as to which point they have reached in Table 5 for each of the main groups of their customers. A council should look at the interventions that are helping to manage demand and understand if they are operating in an effective way. The council should challenge itself as to whether it is maximising the way in which it can reduce demand. A council can reflect as to whether it has had a period of time within the last 5 years when demand has been shown to be falling (because it has been well managed). There are some places where demand is falling solely because they have tightened eligibility criteria. This is not what is being considered in this paper. The council should be able to produce evidence that it is reducing demand because it is offering better help to people in the right way at the right time. Future demand will depend on what has happened in the past i.e. have new preventive interventions worked effectively to manage demand? What is happening at the present – can we continue to reduce demand through these interventions?

Councils should experience a period of time when demand will fall as a result of better interventions for people in a crisis. This can be reasonably be inserted within the calculations to predict both current and future demand. It is worth noting that the downward trend in demand for services for older people has been happening for the last ten years – this is not a recent phenomenon. Why have councils not predicted this?

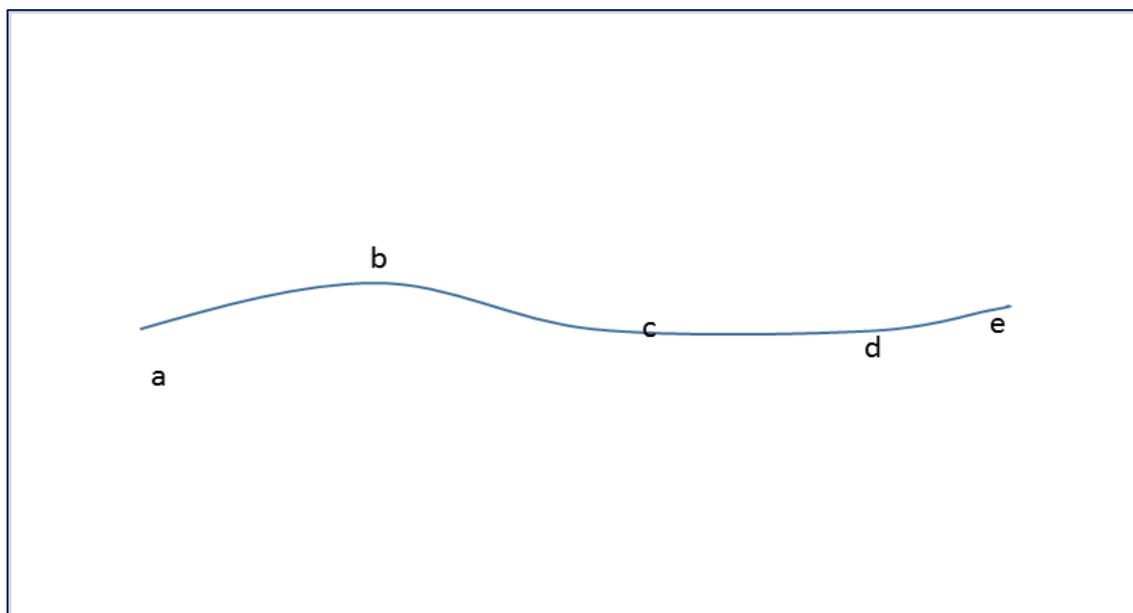
The key data that might indicate whether demand is being well managed for older people is in my experience that a council might expect to see about a one third reduction in new admissions of older people to residential care without a commensurate impact on the demand for domiciliary care (over a period of about 4 years). Older people may require more intensive packages of domiciliary care but this is offset by a combination of improved performance in re-ablement; reduced use of low intensity packages of care; and lower long term care packages emanating from acute hospital at point of discharge. This might be achieved from a base-line year determined by the council but 2010 might be a good starting point. Different councils have been seeing

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<sup>42</sup> Figure from Department of Health's projections on demographic pressures.

this reduction in demand but a number have achieved this 30% reduction over the last decade.

**Table 5 – Future demand for adult social care for older people**



#### Questions you might need to ask:

- Have we better managed demand for services for older people in the last five years, which can be shown through reductions in people receiving longer-term help?
- How long might we sustain these reductions? What have we not yet used to assist us in managing demand?
- Have we had discussions with our key partners – particularly the NHS and the Community and Voluntary Sector on how they will continue to assist us with this approach?
- What new evidence has emerged on which we should now act to continue to sustain these reductions?

## 5.2 Future demand on services for adults with learning disabilities

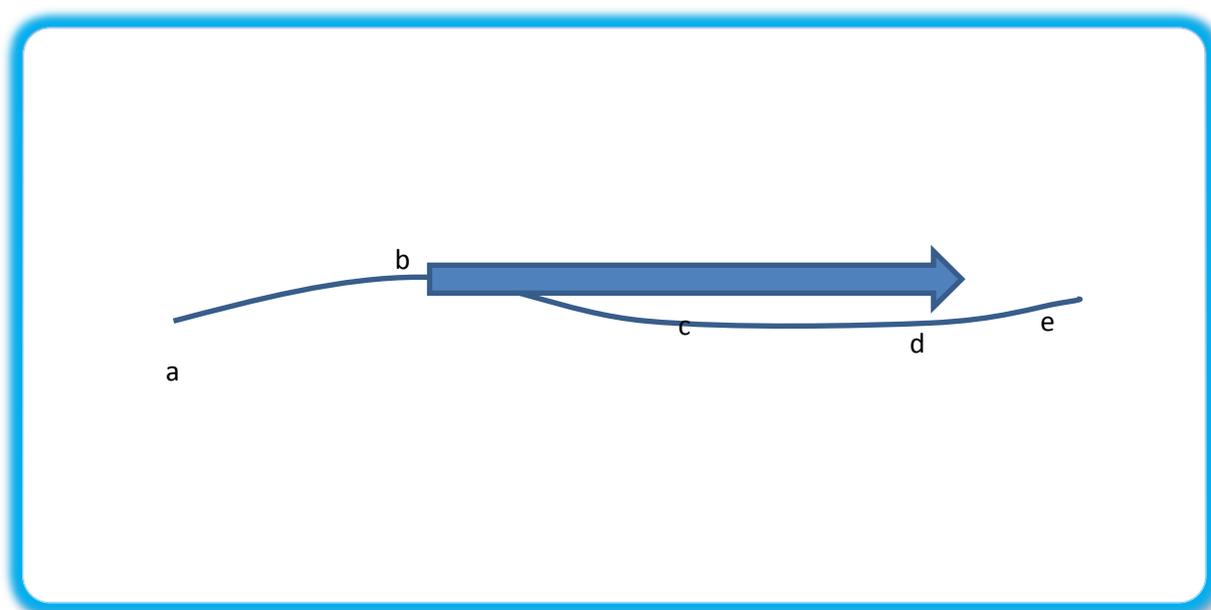
For adults with learning disabilities I think that any reduction in demand through effective interventions that reduces the level of care a person needs are likely to be offset by new younger people coming through transition requiring care and support. For people within the care system there is much that can be done to help people progress to a level where they may need less formal care and support in the longer run. This may require some re-commissioning of current services and a stronger focus on helping people maximise their opportunities for independence (as described in the text above). Obviously, the experience of these younger people and how they have been helped through childhood to manage the challenges they face will impact on the level of this new demand. Those younger people that have been prepared for independent living through childhood are of course likely to require less support than those that have been offered a protective environment.

There are regional variations in the range and type of services that adults with learning difficulties will receive. For those living in the North West there is a much lower use of residential care than for those living in the South West. This does not necessarily mean lower costs for independent living as some places put very high staffing levels into their schemes. The argument presented earlier in this paper that it is not the care setting that necessarily drives up costs - it is the philosophy of care within each setting that makes the biggest difference.

It is more likely in this client group (shown in Table 6) that though demand may stop rising as interventions to reduce demand have an impact, reductions achieved are only likely to be marginal and it is more likely that a flat line of demographic pressures will be found. In my experience there are a small group of councils that have radically transformed their approach to supporting younger adults with learning disabilities who can demonstrate that their spend on the service has flat lined in the last few years. That is the spend has remained similar whilst absorbing new demand.

So if demand is rising as shown in Table 6 from a to b it may then be realistic to plan on the basis of a flat line for the next few years from b to e. This will mean that the council is using their version of the “progression model” in helping people to live more independent lives with less demand on care staff. Again this is likely to be sustainable for a few years and it will depend on the needs of the younger people entering the service in the longer run as to the scale of future growth. This can be best predicted from an examination of the school population. More councils are looking to manage transitions from an earlier age (usually 14 years) in order to ensure that patterns of care that may increase dependency have not been established during the person’s teenage years. In many councils they have younger people passed through transition from very expensive placements where the outcomes being delivered are unclear.

**Table 6 Future demand for adult social care for people with learning difficulties**



**Questions you might need to ask:**

- Do we have programmes in place to focus on improving the lives of adults with learning difficulties in a way that assists them move to greater independence?
- Are these programmes operating effectively – can we measure a fall in demand for individual customers?
- Does our transition programme support this approach?
- Are the costs of our learning disability services beginning to flat-line?

In other client groups one might aspire for a flat line in relation to new demand. There is some evidence that people receiving a direct payment receive a higher cost package of care than those receiving care contracted by the council (though the pattern is inconsistent). Any council needs to understand its own position on this. Over the last five years many councils have reviewed these packages and some have made reductions in what people can now receive. Of course a combination of the better use of aids and adaptations including assistive technology alongside some practical support with rehabilitation and reablement may also mean that for some disabled people their care needs may have reduced over time. The national data suggests that the numbers of people being helped from these groups is fairly stable. There is less evidence or explanation as to what might be the drivers that could help better meet the outcomes from these groups.

Some senior managers in social care argue that there is a new cohort of older people and younger adults with disabilities living at home who have more complex conditions and greater morbidity than they have seen in the past. In addition there are more people with dementias that may mean they need more intensive care either in the home or in specialist residential care. This may well be the case (though I have not yet found any research literature to support). In any model of care there will be those for whom either palliative care or short-term intensive care is required. The key issues in this paper is how to both limit the number who may fit this category and when they do to maximise the resources available to assist them by ensuring other people are given help in a way that reduces their long term needs.

## 6 Conclusion

It has become much harder to predict the patterns of social care and the impact that an ageing population will have on demand for the future. Some councils have managed demand in a very positive way focussing on improved outcomes for the people it helps and reducing costs and demand through these approaches. This is not universally done and varies between councils and between practitioners in councils. An honest self-evaluation of what a council has achieved and what it might be able to achieve is required before looking to predict current and future demand. The role and contribution that the NHS can make to this should not be underestimated though in many places this is not understood either by councils or by the NHS. It is unfortunate that government policy has not really focused on this opportunity as part of its austerity measures.

I hope that this paper will give some food for thought in those places that have not yet started the journey as well as assisting those who are constantly looking for new ways to better manage demand and improve outcomes.

**John Bolton, April 2016**