Table 2  Potential savings

<table>
<thead>
<tr>
<th>Type of service</th>
<th>National unit cost per week £</th>
<th>Shared Lives unit cost £ per week (overall mean)</th>
<th>Potential savings per unit £ per week if the service is supported in Shared Lives rather than elsewhere</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning disability residential care</td>
<td>1,056</td>
<td>419</td>
<td>640</td>
</tr>
<tr>
<td>Older people residential care</td>
<td>465</td>
<td>419</td>
<td>46</td>
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<td>1,288</td>
<td>293</td>
<td>955</td>
</tr>
</tbody>
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management charges for short breaks, day-time support or kinship support. Other costs may include special equipment or adaptations to the carer’s home, late cancellation, temporary absences of the service user, and costs associated with carer recruitment such as advertisements, approval panel costs, GP reference fees, CRB checks, and carer training.

Service users have a licence agreement for their room in someone’s home; the rental amount and types of support according to the individual’s changing needs and preferences. The evaluation found high levels of satisfaction among service users and carers. More than three-quarters of the focus groups of service users, carers and staff agreed that the scheme achieves the following outcomes:

- Living the life the person wants
- Developing the person’s confidence, skills and/or independence
- Ongoing relationship between the person and the carer
-Having choices and being in control
- Having different experiences
-Wider social networks
-Increase in self-esteem.

All stressed the reciprocal nature of the relationship between carers and service users as a key distinguishing feature of the service.

6. Strengths

The Shared Lives approach fits well with current government policy objectives to promote personalisation and the Big Society, by providing service users with a placement individually matched to their needs, and involving lay people in providing and maintaining a consistent relationship with the service user. Shared Lives gives service users access to family and community life, provided by ordinary people and families.

7. Weaknesses and potential pitfalls

According to A Business Care for Shared Lives, the main weaknesses of Shared Lives services are around financial issues. Problems were identified in the 2009 evaluation with financial systems, including difficulties in calculating some unit costs, and problems with transparency and fairness of tariffs for payments and charges. The 2009 study found inconsistencies in the way housing benefit rules were applied, inadequate payments for carers, fragmented payments, and difficulties accessing help to claim correct welfare benefits. NAAPS has however, during the past year produced a payment model for Shared Lives together with tools that should bring about a more rational and consistent approach to placement payments. They have also more recently produced guidance on outsourcing Shared Lives Schemes which includes guidance for Commissioners, as well as Scheme members.

CSCI (now CQC) inspection reports indicate that lack of appropriate care management involvement was the single most problematic issue for Shared Lives services. The 2009 study found that quality assurance systems were picked out as non-existent or unsatisfactory by CSCI in eight of the schemes which were studied.

The other potential problem area is recruitment of sufficient numbers of possible Shared Lives carers. The wider the pool of possible carers, the greater the likelihood that suitable referrals can be matched to an appropriate placement. Finding the right placement is critical to a successful outcome.

Focus groups with service users, carers and workers in four schemes highlighted the need to raise awareness of the schemes among the general public in order to widen the pool of potential carers. NAAPS is currently recruiting a national Communications and Engagement Officer for this purpose.

8. Sources of further information

NAAPS UK: http://www.naaps.org.uk/


NAAPS


NAAPS

This case study was compiled for IRISS by the Institute of Public Care

Money Matters reviews of cost effective initiatives

July 2011

This study was carried out by the Institute of Public Care

The Institute for Research and Innovation in Social Services (IRISS) is a charitable company limited by guarantee.

Registered in Scotland: No 3137 40. Scottish Charity No: SC037882. Registered Office: Brunswick House, 51 Wilson Street, Glasgow G1 1UZ
Shared Lives services, formerly known as Adult Placement, involve the provision of care and support in the homes of ordinary people to people with learning disabilities.

1. Introduction
This case study is based on an evaluation of the study of Shared Lives services (formally known as Adult Placement) in south east England, conducted in 2009. The study found that more than 15,000 people in England receive Shared Lives services, formerly with learning disabilities.

2. Description
Shared Lives is a service provided by individuals and families who provide care or support to people placed with them in their own home by the local authority, NAAPS UK, and the National Association of Adult Placement Schemes (NAAPS) characterises the key features of the service as:
- People using Shared Lives services have the opportunity to be part of the carer's family and social networks.
- Carers can use their family home as a resource.
- Placements provide committed and consistent relationships.
- The relationship between the carer and the person placed with them is of mutual benefit.
- Carers can support up to three people at a time.
- Carers do not employ staff to provide care to the people placed with them.
- The carers taking part in the scheme can provide long-term accommodation and support; short-break; day-time support; rehabilitation; intermediate support; and kinship support where the carer acts as ‘extended family' to someone living in their own home.

3. Evidence of cost effectiveness
The Shared Lives scheme is an option for a range of people including people with learning disabilities, older people and people with mental health needs. Shared Lives differs from small residential homes in its emphasis on the person placed with the carer and the relationship with the person placed with them.

4. Application – where it might be appropriate
The study concluded that there may be a scheme size below which it is difficult to deliver a high quality Shared Lives service. The study estimated that a level of 85 placements is assumed. Savings obtained from long-term placements per week is £46 and £995 per week depending on the type of service. The study estimated that savings obtained from long-term placements for people with learning disabilities. For a new scheme, it estimated that savings may also be realised until the second year of operation.

Table 1
<table>
<thead>
<tr>
<th>Range of weekly payments to Shared Lives carers and management costs</th>
<th>Range</th>
<th>Overall cost (mean)</th>
<th>Management cost (mean)</th>
<th>Unit cost Shared Lives (mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-in price for long-term placement, including board and lodging (£ per week)</td>
<td>267</td>
<td>653</td>
<td>356</td>
<td>198</td>
</tr>
<tr>
<td>Support in long-term placement (for all)</td>
<td>151</td>
<td>430</td>
<td>235</td>
<td>58</td>
</tr>
</tbody>
</table>

Source: NAAPS/IESE 2009 | A Business Case for Shared Lives
1. Introduction

This case study is based on an evaluation of the Shared Lives scheme in south east England, conducted in 2009. The study found that most Shared Lives schemes provide: "care that is good or excellent, care that meets national minimum standards, positive experiences and outcomes for people, high levels of satisfaction among stakeholders, and value for money".

2. Description

Shared Lives is a service provided by individuals and families who provide care or support to people placed with them in their own home by the local authority. NAAPS UK formerly known as Adult Placement provides price, choice, control, greater independence and self-esteem for service users.

3. Evidence of cost effectiveness

Comparing CSCI ratings for Shared Lives schemes in south east England with care home ratings, the NAAPS/RESSE survey in 2009 found that 79% of Shared Lives schemes were rated excellent or good, compared with 65% of care homes. Service users in all four schemes in the south east England, with care home placements. The matching process is a key factor in a successful placement. Service users report that the relationship between themselves and their carers is a critical factor affecting the quality of service. "You’re allowed to have a relationship with your carer who works in your home and even hug like mates, but you can’t do that with in other places." Service user

The Shared Lives scheme is an option for a wide range of people including people with learning disabilities, older people and people with mental health needs. Shared Lives differ from small residential homes in terms of the family setting and the emphasis on community living compared with the matching process and the care ratio. A survey in 2006 identified 15 schemes operating across 19 local authorities in Scotland from the statutory and independent sectors. The number of clients placed in "adult placements" in England was 4,200 in 2007, an increase of 5 per cent from 4,000 in 2006. Over three quarters of these clients were aged 18-64 with a learning disability. In Scotland, national care standards for "adult placements services" were implemented since April 2005. The Care Commission regulates and inspects adult placements. It operates a separate regulatory body, the Care Inspectorate Wales. The Council for Registered Social Care Practitioners has been established to register and regulate adult care workers.

A Business Case for Shared Lives estimates that it takes between 11 and 16 months to establish the structure of a new scheme before the first placement can be taken operational. The 2009 study obtained data on 19 schemes. On average there were 11 Shared Lives carers to one full-time equivalent (FTE) staff, 26 carers and 24 placements at one FTE. Average staffing levels were 0.3 FTE manager, 3.3 FTE placement workers and 0.7 FTE administrators.

Payment levels are usually decided according to the needs of the service user, rather than the hours worked, with a range of bands of payment. In 2009, rates ranged between £159 and £550 per week. Costs for separate day-time placements of service users in long-term placements were usually met by the sponsoring authority.

Five schemes charged a weekly flat rate management fee for long-term placements. The average charge was £58 per week. There was insufficient information to calculate

Table 1: Range of weekly payments to Shared Lives carers and management costs

<table>
<thead>
<tr>
<th>Range</th>
<th>Overall cost (mean)</th>
<th>Management charge (mean)</th>
<th>Unit cost Shared Lives (mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mn</td>
<td>Max</td>
<td></td>
<td>$/week</td>
</tr>
<tr>
<td>267</td>
<td>653</td>
<td>361</td>
<td>58</td>
</tr>
<tr>
<td>151</td>
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<td>58</td>
</tr>
<tr>
<td>293</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Applying the compatible PSSRE unit cost data from PSSRU indicated potential savings of between £20 and £62 per week depending on the type of service user and their level of need. Potential savings obtained from long-term placements for people with learning disabilities. For a new scheme, it was estimated that savings would not be realised until the second year of operation.

Potential savings were also indicated by the 2009 study for other types of Shared Lives placements, such as day-time support and floating support, however, the financial data are less reliable.

4. Application – where it might be appropriate

The 2009 study concluded that there may be a scheme size below which it is difficult to deliver a high quality Shared Lives service and that the most successful outcomes come from a larger scheme. A Business Case for Shared Lives, a level of 85 placements is assumed. Greater efficiencies can be realised through joint working on tasks such as planning and delivering training, recruiting and maintaining an Approved Panel, or developing quality assurance systems which can benefit a large number of service users. Shared Lives schemes are suitable for a wide range of groups; however, they appear to be mostly widely used to provide support to people with a learning disability. From Table 2, it is clear that this is also the group where potential savings are greatest.

5. Resources required – staff, training, IT

According to A Business Case for Shared Lives, it takes between 11 and 16 months to establish the structure of a new scheme before the first placement can be taken operational.

The 2009 study obtained data on 19 schemes. On average there were 11 Shared Lives carers to one full-time equivalent (FTE) staff, 26 carers and 24 placements at one FTE. Average staffing levels were 0.3 FTE manager, 3.3 FTE placement workers and 0.7 FTE administrators.

Payment levels are usually decided according to the needs of the service user, rather than the hours worked, with a range of bands of payment. In 2009, rates ranged between £159 and £550 per week. Costs for separate day-time placements of service users in long-term placements were usually met by the sponsoring authority.

Five schemes charged a weekly flat rate management fee for long-term placements. The average charge was £58 per week. There was insufficient information to calculate
Shared Lives services, formerly known as Adult Placement, involve the provision of care and support in the homes of ordinary people to people who need this support because of their care needs.

Service users, carers and staff find that the service provides choice, control, greater independence and self-esteem for service users.

Compared with traditional residential placements, savings range from £46 to £995 per week, depending on the service user.

Shared Lives services appear popular with people with learning disabilities.

1. Introduction
This case study is based on an evaluation of the Money Matters review of effective initiatives. The changes to the Money Matters review of effective initiatives (formerly known as Adult Placement) in south east England, conducted in 2009. The study found that more people were being supported because of the range of groups that Shared Lives is well-suited to people with learning disabilities.

2. Description
Shared Lives is a service provided by individuals and families who provide care or support to people placed with them in their own home by their local authority. NAPPS UK is the National Association of Adult Placement Providers organisations that supply the key features of the service as: People using Shared Lives services have the opportunity to be part of the carer’s family and social networks. Carers can use their family home as a resource. Placements provide committed and consistent relationships. The relationship between the carer and the person placed with them is of mutual benefit. Carers can support up to three people. Carers do not employ staff to provide care to the people placed with them. The carers taking part in the scheme can provide long-term accommodation and support; short-break care; day-time support; rehabilitation; intermediate support; and kinship support where the carer acts as an extended family to someone living in their own home.

3. Evidence of cost effectiveness
Comparing CSCI ratings for Shared Lives schemes in south east England with care home ratings, the NAPPS/RESE survey in 2009 found that 70% of Shared Lives schemes were rated excellent or good, compared with 62% of care homes. Service users in all four schemes in the evaluation were identified a number of successful outcomes: living the life they wanted; having choices and being in control; developing confidence, skills and independence; and having different experiences. A Business Case for Shared Lives formalises the way in which the relationship between Shared Lives (including long-term care and support in the homes in Multiple Occupation) Order 2000.

4. Application – where it might be appropriate
The 2009 study concluded that there may be a scheme size below which it is difficult to deliver a high quality Shared Lives service and achieve successful outcomes. A Business Case for Shared Lives emphasises that to develop a scheme that could support a cost-effectiveness is greater in the larger schemes. A Business Case for Shared Lives, a level of 85 placements is assumed. Greater efficiencies can be realised when... The average number of schemes is included.

---

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<thead>
<tr>
<th>Table 1</th>
<th>Range of weekly payments to Shared Lives carers and management costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Range</td>
<td>Overall management cost (mean)</td>
</tr>
<tr>
<td>Min</td>
<td>Max</td>
</tr>
<tr>
<td>All-in price for long-term placement, including board and lodging: (5 per week)</td>
<td>267 653</td>
</tr>
<tr>
<td>Support in long-term placements:</td>
<td>151 430</td>
</tr>
</tbody>
</table>

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Money Matters reviews of cost effective initiatives

www.moneymatters.org.uk

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Money Matters case study one

Shared Lives

Institute of Public Care

ipc.brookes.ac.uk

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Finishing up with a learning disability, From Table 2, it is clear that this is also the group where potential savings are greatest.

5. Resources required – staff, training, IT

Access to money is key for Shared Lives, it takes between 11 and 16 months to establish the structure of a new scheme before the staff are employed and become operational.

The 2009 study obtained data on 18 schemes. On average there were eleven Shared Lives carers to one full-time equivalent staff, 17 service users and 24 placements to one FTE. Average staffing levels were: 0.3 FTE manager, 3.3 FTE placement workers and 0.7 FTE administrators.

Carers are recruited, trained and supported by a Shared Lives scheme co-ordinator. The service is usually run by a representative group

Shared Lives services have been regulated since April 2005. The Care Commission registered and inspects adult placement services by a process of inspections. In the 2009 study, only two of the 26 schemes were subject to any monitoring concerns over the preceding 12 months and both of these had been dealt with appropriately. Where the Shared Lives scheme is part of a multi-agency scheme, it may also have to be licensed as a house in Multiple Occupation (HMO) (Scotland) Act 1983 (Licensing of Homes in Multiple Occupation) Order 2000). Staffing levels are self-employed in some areas. The Government has recently passed legislation enabling the supervision of Shared Lives carers from 6 April 2010, with the aim of bringing into line the tax treatment of carers who, like foster carers, share their homes and daily life with an adult or child placed with them by a local authority.

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management charges for short breaks, day-time support or kinship support. Other costs may include special equipment or adaptations to the carer’s home, late cancellation, temporary absences of the service user, and costs associated with carer recruitment such as advertisements, approval panel costs, GP reference fees, CRB checks, and carer training.

Service users have a licence agreement for their room in someone’s home; the rental costs may include special equipment or adaptations to the carer’s home, late cancellation, temporary absences of the service user, and costs associated with carer recruitment such as advertisements, approval panel costs, GP reference fees, CRB checks, and carer training.

The Institute for Research and Innovation in Social Services (IRISS) is a charitable company limited by guarantee. This case study was compiled for IRISS by the Institute of Public Care July 2011.

## Table 2
### Potential savings

<table>
<thead>
<tr>
<th>Type of service</th>
<th>National unit cost per week £</th>
<th>Shared Lives cost per week £</th>
<th>Potential savings per unit £ per week if it is supported in Shared Lives rather than elsewhere</th>
</tr>
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<tbody>
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<td>Learning disability residential care</td>
<td>1,059</td>
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<tr>
<td>Learning disability supported living</td>
<td>1,288</td>
<td>293</td>
<td>995</td>
</tr>
</tbody>
</table>


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# 7. Weaknesses and potential pitfalls

According to A Business Care for Shared Lives, the main weaknesses of Shared Lives services are around financial issues. Problems were identified in the 2009 evaluation with financial systems, including difficulties in calculating some unit costs, and problems with transparency and familiarity of tariffs for payments and charges. The 2009 study found inconsistencies in the way housing benefit rules were applied, inequitable payments for carers, fragmented payments, and difficulties accessing help to claim correct welfare benefits. NAAPS has however, during the past year produced a payment model for Shared Lives together with tools that should bring about a more rational and consistent approach to placement payments. They have also more recently produced guidance on outsourcing Shared Lives Schemes which includes guidance for Commissioners, as well as Scheme members.

CSCI (now CQC) inspection reports indicate that lack of appropriate care management involvement was the single most problematic issue for Shared Lives services. The 2009 study found that quality assurance systems were picked out as non-existent or unsatisfactory by CSCI in eight of the schemes which were studied.

The other potential problem area is recruitment of sufficient numbers of possible Shared Lives carers. The wider the pool of possible carers, the greater the likelihood that suitable referrals can be matched to an appropriate placement. Finding the right placement is critical to a successful outcome.

Focus groups with service users, carers and workers in four schemes highlighted the need to raise awareness of the schemes among the general public in order to widen the pool of potential carers. NAAPS is currently recruiting a national Communications and Engagement Officer for this purpose.

---

# 8. Sources of further information

NAAPS UK: http://www.naaps.org.uk/
NAAPS UK is the UK network for family-based and small-scale ways of supporting adults to live independently and to contribute to their families and communities, including Shared Lives.

NAAPS UK (Scotland): http://www.naaps.org.uk/uk/shared-lives/member/naaps-scotland/np/PHPF2ESSS1D5b7a287b92593b2e0f2e6b3b3300b2d
http://www.scie.org.uk/publications/ataglance/ataglance02.asp


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The money matters case study was compiled for IRISS by the Institute of Public Care.

This case study was compiled for IRISS by the Institute of Public Care.
Table 2

<table>
<thead>
<tr>
<th>Type of service</th>
<th>National unit cost per week</th>
<th>Shared Lives unit cost per week (average)</th>
<th>Potential savings per unit £ per week (if placement is supported in Shared Lives rather than elsewhere)</th>
</tr>
</thead>
<tbody>
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<td>Learning disability residential care</td>
<td>1,059</td>
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Service users have a licence agreement for the scheme which provides a range of services to the individual, including personal care, domestic support, and carer training.

The service is very flexible, offering different amounts and types of support according to the individual’s changing needs and preferences. The evaluation found high levels of satisfaction among service users and carers. More than three-quarters of the focus groups of service users, carers and staff agreed that the scheme achieves the following outcomes:

- Living the life the person wants
- Developing the person’s confidence, skills and/or independence
- Ongoing relationship between the person and the carer
- Having choices and being in control
- Having different experiences
- Wider social networks
- Increase in self-esteem

All these factors contribute to the success of the service, providing people with a sense of control and independence.

6. Strengths

The Shared Lives approach fits well with current government policy objectives to promote personalisation and the Big Society, by providing service users with a placement individually matched to their needs, and involving lay people in providing and maintaining a consistent relationship with the service user. Shared Lives gives service users access to family and community life, provided by ordinary people and families.

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7. Weaknesses and potential pitfalls

8. Sources of further information

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NAAPS UK (Scotland): http://www.naaps.org.uk/uk/shared-lives-membership/naaps-scotland/NAAPS

The evaluation found high levels of satisfaction among service users, carers and staff agreed that the scheme achieves the following outcomes:

- Increase in self-esteem.
- Wider social networks.
- Having different experiences.
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- Increase in self-esteem.
- Wider social networks.
- Having different experiences.
- Having choices and being in control.
It seems that direct costs to social care benefits/allowances received. Social services, and the average amount of includes estimates of the subsidised capital costs. Approximately £360 per week was estimated had moved to Rowanberries. In addition, more than one-third into Rowanberries, and £25 per week after had improved and that of the person who of carers thought that their own quality of life be £80 per week before the person moved. Based on an analysis of these costs, the introduction of the capital costs, while the local authority assumed for calculating annual capital costs, and differences in the proportion of residents coming from social housing.

4. Application – where it might be appropriate

The level of satisfaction reported by residents with the care received (95%) indicates the suitability of extra-care housing for a range of older people with a wide variety of needs. The study concluded that someone with 24-hour care needs would be better off financially paying the well-being charge than they would be in residential care, especially if they were previously an inner-occupier. In contrast, people with lower care needs might not necessarily have a financial incentive to move to the Rowanberries as it would be more advantageous for them to continue to pay for care in their former homes. The evectors raise a number of methodological points which highlight the need to be cautious in assuming the findings will apply equally to all other ECH schemes, for example, variation on costs across the country, the 60-80% were previously employed, rather than to an increase in public expenditure.

It is important to note that, although residents did pay the well-being charge, there was evidence of more than a 50% reduction in health care costs after the move. National estimates of unit costs (per visit or per hour as appropriate) were used for each type of health care service. Overall, health service costs fell after people had moved, by an average of £38 per resident per week. The greatest single difference in nurse visits at home – a mean decrease of £57 per week. Although the proportion of residents who were by a nurse at home increased (32% before compared with 73% after the move to Rowanberries), the mean number of consultations per resident decreased from around 22 to 11 visits in six months. The proportion of residents accessing hospital services, such as accident and emergency, outpatient appointments and inpatient stays was slightly lower in all instances after the move to Rowanberries. Residents who had previously been an inpatient were more likely to see a doctor and be discharged after their first attendance at Rowanberries. It appears that residents had better access to health care services rather than an increase in health needs. An important consideration is that unpaid, informal carers. Care-giving costs included: direct financial expenditure for example, laundry and travel; paid and unpaid time spent caring; costs of giving up career opportunities; and accommodation costs. Based on an analysis of these costs, the average cost to the carer was calculated to be £80 per week before the person moved into Rowanberries, and £25 per week after the move. In addition, more than one-third of carers thought that their own quality of life and well-being had improved and that of the person who had moved to Rowanberries. Approximately £360 per week was estimated to be the average cost falling on the public sector per Rowanberries resident (equivalent to about 75% of the formal costs). The figure includes estimates of the subsidised capital cost, housing benefit payments towards rent and service charge, care package funding by social services, and the average amount of benefits/allowances received.

4. Application – where it might be appropriate

The high level of satisfaction reported by residents with the care received (95%) indicates the suitability of extra-care housing for a range of older people with a wide variety of needs. The study concluded that someone with a care plan that included 24-hour care needs would be better off financially paying the well-being charge than they would be in a residential care home, especially if they were previously an inner-occupier. In contrast, people with lower care needs might not necessarily have a financial incentive to move to the Rowanberries as it would be more advantageous for them to continue to pay for care in their former homes. The evectors raise a number of methodological points which highlight the need to be cautious in assuming the findings will apply equally to all other ECH schemes, for example, variation on costs across the country, the 60-80% were previously employed, rather than to an increase in public expenditure.

In terms of outcomes, residents reported no significant improvements overall in their self-perceived health after moving into Rowanberries. However, they did report a significant improvement in their quality of life, and a decrease in their level of unmet need across seven areas. The most significant improvement was in terms of social participation and involvement; nearly two-thirds reported that they had a good social life after moving into Rowanberries, whereas half of residents said that they had felt lonely and socially isolated in their previous homes. Residents also reported increased feelings of control over daily living. These improvements appear to be associated with better access to the services and support provided by Rowanberries.

The study provides cautious evidence that when the costs of moving into ECH are measured comprehensively, they are substantial, but that ECH appears to deliver important benefits to residents and informal carers in terms of improved social care outcomes and quality of life.
1. Introduction
This case study is based on a ‘before-and-after’ evaluation for the Joseph Rowntree Foundation of the costs and outcomes of an Extra-care housing scheme in Bradford completed in 2008. Extra-care housing (ECH) is delivered by a range of providers and is an alternative to residential care for older people. It has attracted support and capital funding from government, and has been widely promoted as a means of maintaining independence, and as an alternative for older people who are living in public or private sector accommodation. There are an estimated 130 ECH schemes in the UK. The evaluation covered a number of costs increased as a result of people moving into the Rowanberries ECH scheme, but this was associated with improved social care outcomes and perceived quality of life.

2. Description
There is no official definition of ECH, however it is usually taken to include: self-contained accommodation, access to 24-hour care and other facilities, a full accessible environment, and an emphasis on supporting and maintaining independence.

The Rowanberries extra-care housing scheme is a purpose-built mixed tenure development of 46 self-contained apartments, developed as a joint project between Bradford Adult Services and the Methodist Homes Housing Association (part of the MHA Care Group). The scheme comprises 20 one-bedroom and 26 two-bedroom apartments. The building has a lift and wheelchair accessible throughout its four storeys. There is a range of communal facilities including: a cafe/restaurant, activities room, laundry, hairdresser and assisted bathrooms. Two apartments per storey are provided for use by MHA. In addition, MHA provide a day centre and domiciliary care team which provides services to the local community including emergency and regular care and rehabilitation. The scheme accommodates a wide range of care needs: some residents require care in their previous homes, while others moved in from other care settings. The baker’s dozen of dependencies at the end of the first six months of the scheme’s operation was 12 residents with high needs (requiring 20 hours or more per week or four or more calls per day), 12 with medium needs (requiring 10 to 20 hours or more per week or three calls per day), 10 with low care needs (requiring five hours or more per week or two calls per day) and 10 with dementia. Rowanberries also offers a domiciliary care team which works with dementia with staff trained in dementia care. The configuration is regarded as an emergency care provider with the Care Quality Commission.

Residents were aged between 59 and 92, with an average of 78 years living in a private household, eight per cent in sheltered or supported housing, and 10 per cent moved from a care home. The majority of the residents (59%) had been owner occupiers, and just over half (53%) had been living alone before moving into the scheme. About 40% of the residents needed help to go outdoors, use stairs or steps, have a bath or wash all over; 40% were identified as having some cognitive impairment; and 16% were severely cognitively impaired.

3. Evidence of cost effectiveness
The analysis is based on data obtained from 40 of the original residents of Rowanberries, with a follow-up after six months of 22 residents. The findings suggest that the costs of living in the scheme were lower than when people received services in their former homes. The key cost components, which together represented the total weekly cost of a resident in accommodation, included:
- Health care service cost
- Social care service cost
- Capital costs of the accommodation
- Running (maintenance and/or management) cost
- Other living expenses.

The sum of these costs (see Table 1) gives an average cost per week of £483 per week before moving in, compared with £470 six months after moving into Rowanberries. At £470, the estimated weekly package costs in Rowanberries are comparable with residential care (£483 per week in 2007), although the people moving into ECH are considerably less dependent.

The difference in the costs of social care and after and after moving in was driven mainly by an increase in the costs of support services and the costs of home care received (an average of £59 per week in 2007, compared with £60 before moving to Rowanberries). The mean number of hours of home care received was 0.68 hours per week per resident before moving to Rowanberries, compared with 4.05 hours after moving in. In addition, 45% of residents reported seeing a social worker after moving in, compared with 10% before moving to Rowanberries at a cost of £20 per week.

Costs of support and assistance in emergencies, medication ordering and administration, and contacting and arranging appointments with other professionals were estimated as equivalent to the ‘well-being charge’ of £51.60 per week.

The comparison of social care costs was complicated by whether or not meals in the restaurant were treated as living expenses or social care, given that all except one resident in the sample stopped receiving meals-on-wheels or using a lunch club after moving in. Some of the higher overall costs were due to higher accommodation costs (not unexpected for a new purpose-built scheme). Accommodation costs included an annualised management cost of £89 per week per resident, compared with £40 before moving to Rowanberries. The mean number of hours of home care received was 0.68 hours per week per resident before moving into Rowanberries, and 4.05 hours after the move. A limited increase in the overall net housing stock was estimated as a result of the increased level of costs to residents of £110 per person per week, before moving into Rowanberries, and £141 per person per week after moving in. It is important to note that these costs represent an average of £380 per week in 2007, although the people moving into ECH are considerably less dependent.

The level of capital subsidy for accommodation costs increased significantly after acquisition of small number of people who were previously living in public sector housing. Equally, care and support costs increased as these would have been self-funded by some residents in their previous homes, but were not charged for in the scheme. In Rowanberries, all other living expenses at care were may be Bradford Adult Services Department regardless of income, savings.

Table 1 Costs before and after moving to Rowanberries

<table>
<thead>
<tr>
<th>Service</th>
<th>In previous home</th>
<th>In Rowanberries</th>
<th>In Rowanberries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care costs</td>
<td>123.5</td>
<td>121.0</td>
<td>53.3</td>
</tr>
<tr>
<td>Day hospital</td>
<td>5.6</td>
<td>6.5</td>
<td>0.0</td>
</tr>
<tr>
<td>GP at surgery</td>
<td>7.3</td>
<td>3.4</td>
<td>2.3</td>
</tr>
<tr>
<td>Nurse at GP surgery</td>
<td>1.9</td>
<td>1.5</td>
<td>2.1</td>
</tr>
<tr>
<td>Nurse at home</td>
<td>3.7</td>
<td>2.6</td>
<td>0.0</td>
</tr>
<tr>
<td>Social worker</td>
<td>20.2</td>
<td>12.6</td>
<td>0.0</td>
</tr>
<tr>
<td>Lunch club</td>
<td>0.2</td>
<td>0.3</td>
<td>0.0</td>
</tr>
<tr>
<td>Meals on wheels</td>
<td>3.7</td>
<td>2.6</td>
<td>0.0</td>
</tr>
<tr>
<td>Restaurant at scheme</td>
<td>0.0</td>
<td>0.0</td>
<td>19.8</td>
</tr>
<tr>
<td>Social worker</td>
<td>9.2</td>
<td>9.3</td>
<td>33.3</td>
</tr>
<tr>
<td>Home care</td>
<td>40.4</td>
<td>40.3</td>
<td>88.6</td>
</tr>
<tr>
<td>Well-being charge (activities, support)</td>
<td>119.8</td>
<td>110.0</td>
<td>141.1</td>
</tr>
<tr>
<td>Accommodation costs</td>
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<td>110.0</td>
<td>141.1</td>
</tr>
<tr>
<td>Owner-occupied</td>
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<td>93.9</td>
<td></td>
</tr>
<tr>
<td>Self-reported</td>
<td>111.1</td>
<td>93.9</td>
<td></td>
</tr>
<tr>
<td>Loan origination analysis</td>
<td>7.8</td>
<td>7.8</td>
<td>8.8</td>
</tr>
<tr>
<td>Maintenance</td>
<td>7.8</td>
<td>7.8</td>
<td>18.6</td>
</tr>
<tr>
<td>Rented out</td>
<td>73.9</td>
<td>72.8</td>
<td>84.1</td>
</tr>
<tr>
<td>Rent controlled</td>
<td>134.1</td>
<td>134.1</td>
<td>57.0</td>
</tr>
<tr>
<td>Repairs allowance</td>
<td>13.4</td>
<td>13.4</td>
<td>57.0</td>
</tr>
<tr>
<td>Additional housing costs</td>
<td>4.9</td>
<td>4.9</td>
<td>4.9</td>
</tr>
<tr>
<td>Water rates</td>
<td>5.1</td>
<td>5.1</td>
<td>77.8</td>
</tr>
<tr>
<td>Hot water and heating (individual)</td>
<td>78.0</td>
<td>77.9</td>
<td>77.8</td>
</tr>
<tr>
<td>Living expenses</td>
<td>7.6</td>
<td>7.6</td>
<td>7.6</td>
</tr>
<tr>
<td>Total cost per resident per week</td>
<td>223.0</td>
<td>223.0</td>
<td>223.0</td>
</tr>
</tbody>
</table>

### 1. Introduction

This case study is based on a ‘before-and-after’ evaluation for the Joseph Rowntree Foundation of the costs and outcomes of an extra-care housing scheme in Bradford completed in 2008. Extra-care housing (ECH) is a form of housing with care which has been widely promoted as a means of maintaining independence, and as an alternative to residential care for older people. It has attracted support of 78 per cent funding from the government. According to the Elderly Accommodation Survey 2004, there are an estimated 130 ECH schemes in the UK. The evaluation considered all broad cost increases as a result of people moving into the Rowanberries ECH scheme, but this was associated with improved social care outcomes and perceived quality of life.

### 2. Description

There is no official definition of ECH, however it is usually taken to include self-contained accommodation, access to 24-hour care and other facilities, a fully accessible environment, and an emphasis on supporting and maintaining independence.

The Rowanberries extra-care housing scheme in Bradford was built mixed tenure development of 46 self-contained apartments, developed as a joint project between Bradford Adult Services and the Methodist Homes Service and the Methodist Homes Housing Association (part of the MHA Care Group). The scheme comprises 20 one-bedroom and 26 two-bedroom apartments. The building has a lift and wheelchair access throughout its four storeys. There is a range of communal facilities including: a cafe/restaurants, activities room, laundry, hairdresser and assisted bathrooms. Twenty-four hour care is provided on site by MHA. In addition, MHA provide a day centre and domiciliary care team which provides services to the local community including emergency and rehabilitation. The scheme accommodates a wide range of care needs: some long-stay residents requiring 20 hours or more per week and four or more calls per day, 12 with medium needs (requiring 10 hours or more per week or three calls per day), 10 with low care needs (requiring five hours or more per week or two calls per day) and 10 with dementia. Rowanberries also offers a breakfast club for residents with dementia with staff trained in dementia care. This case study is registered as an interagency care provider with the Care Quality Commission.

Residents were aged between 59 and 92, with a mean age of 80 years. Ninety-three per cent had previously been living in a private household, eight per cent in sheltered housing, and 10 per cent moved from a care home. The majority (69%) of the sample had completed full-time education (59%) had been owner occupiers, and just over half (53%) had been living alone before moving into the scheme. About 40% of the residents needed help to go outdoors, use stairs or steps, have a bath or wash all over. 40% identified as having some cognitive impairment and 16% were severely cognitively impaired.

### 3. Evidence of cost effectiveness

The analysis is based on data obtained from 40 of the original residents of Rowanberries, with a follow-up after six months of 22 residents. The findings suggest that the costs of living in the scheme were higher than when people received services in their former homes. The broad cost components of the analysis which together represented the total weekly cost of care of a resident in this type of arrangement were:

- **Health care service cost**
- **Social care service cost**
- **Capital costs of the accommodation**
- **Running (maintenance and/or management cost)**
- **Other living expenses.**

The sum of these costs (see Table 1) gives an average expenditure per person receiving 20 hours or more per week before moving in, compared with £470 six months after moving into Rowanberries. At £470, the estimated weekly package costs in the scheme. In Rowanberries, all costs for previous homes, but were not charged for in the scheme. In Rowanberries, all costs for previous homes, but were not charged for in the scheme.

<table>
<thead>
<tr>
<th>Health care costs</th>
<th>In previous home</th>
<th>In Rowanberries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day hospital</td>
<td>3.6</td>
<td>6.5</td>
</tr>
<tr>
<td>GP at surgery</td>
<td>7.3</td>
<td>2.9</td>
</tr>
<tr>
<td>GP at home</td>
<td>3.4</td>
<td>2.6</td>
</tr>
<tr>
<td>Nurse at GP surgery</td>
<td>1.9</td>
<td>1.6</td>
</tr>
<tr>
<td>Meals at home</td>
<td>3.7</td>
<td>2.6</td>
</tr>
</tbody>
</table>

Extra-care housing widens housing options for older people, providing self-contained accommodation, flexible access to 24-hour care, accessible housing, and an emphasis on empowerment.

The Rowanberries extra-care housing scheme in Bradford improved social care outcomes for residents and their quality of life, as well as delivering savings for carers.

Overall health costs for residents of Rowanberries fell by £88 per week after moving into the scheme, while take-up of benefits and increases allowed.

Overall costs increased as a result of people moving into the Rowanberries ECH scheme, but this was associated with improved social care outcomes and perceived quality of life.

## 1. Introduction

This case study is based on a ‘before-and-after’ evaluation for the Joseph Rowntree Foundation of the costs and outcomes of an extra-care housing scheme in Bradford completed in 2008. Extra-care housing (ECH) is a form of housing with care which has been widely promoted as a means of maintaining independence, and as an alternative for residential care for older people. It has attracted support of £76.8 billion funding from the government. According to the Elderly Accommodation Council (2009), there are an estimated 130 ECH schemes in the UK. The evaluation considered all broad costs increased as a result of people moving into the Rowanberries ECH scheme, but this was associated with improved social care outcomes and perceived quality of life.

## 2. Description

There is no official definition of ECH, however it is usually taken to include: self-contained accommodation, access to 24-hour care and other facilities, a fully accessible environment, and an emphasis on supporting and maintaining independence.

The Rowanberries extra-care housing scheme is a purpose-built mixed tenure development of 46 self-contained apartments, developed as a joint project between Bradford Adult Services and the Methodist Homes for the Aged Care Group (part of the MHA Care Group). The scheme comprises 20 one-bedroom and 26 two-bedroom apartments. The building has a lift and wheelchair access throughout its four storeys. There is a range of communal facilities including: a cafe/restaurant, activities room, laundry, hairdresser and assisted bathrooms. Twenty-four-hour care is provided on site by MHA. In addition, MHA provide a day centre, activities room and other facilities which provide services to the local community including: under 6s and rehabilitation. The scheme accommodates a wide range of care needs: some residents have four or more calls per day, while others move in from their former homes.

The majority of the scheme’s residents (93%) have been living alone before moving into the scheme. About 40% of the residents needed help to go outdoors, use stairs or steps, have a bath or wash all over; 40% were identified as having some cognitive impairment; and 16% were severely cognitively impaired.

## 3. Evidence of cost effectiveness

The analysis is based on data obtained from 40 of the original residents of Rowanberries, with a follow-up after six months of 22 residents. The findings suggest that the costs of living in the scheme were lower than when people received services in their former homes.

### 3.1. Calculation of costs

**Table 1**

<table>
<thead>
<tr>
<th>Service</th>
<th>In previous home</th>
<th>In Rowanberries</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health care costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital stay</td>
<td>26.9</td>
<td>0.8</td>
<td>26.1</td>
</tr>
<tr>
<td>Day hospital</td>
<td>5.2</td>
<td>2.3</td>
<td>2.9</td>
</tr>
<tr>
<td><strong>Day centre</strong></td>
<td>12.2</td>
<td>2.6</td>
<td>9.6</td>
</tr>
<tr>
<td><strong>Inpatient stay</strong></td>
<td>53.3</td>
<td>143.1</td>
<td>89.8</td>
</tr>
<tr>
<td><strong>Well-being charge</strong></td>
<td>20.2</td>
<td>0.0</td>
<td>20.2</td>
</tr>
<tr>
<td><strong>Outpatient appointment</strong></td>
<td>7.8</td>
<td>2.3</td>
<td>5.5</td>
</tr>
<tr>
<td><strong>Nurse at GP surgery</strong></td>
<td>1.9</td>
<td>2.1</td>
<td>0.2</td>
</tr>
<tr>
<td><strong>GP at home</strong></td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>GP at gallery</strong></td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>MHA</strong></td>
<td>111.1</td>
<td>89.6</td>
<td>21.5</td>
</tr>
<tr>
<td><strong>Social worker</strong></td>
<td>20.2</td>
<td>12.6</td>
<td>7.6</td>
</tr>
<tr>
<td><strong>Home care</strong></td>
<td>40.4</td>
<td>40.3</td>
<td>0.1</td>
</tr>
<tr>
<td><strong>Restaurant at scheme</strong></td>
<td>20.2</td>
<td>12.6</td>
<td>7.6</td>
</tr>
<tr>
<td><strong>Day centre</strong></td>
<td>20.2</td>
<td>12.6</td>
<td>7.6</td>
</tr>
<tr>
<td><strong>Self-reported</strong></td>
<td>111.1</td>
<td>93.9</td>
<td>17.2</td>
</tr>
<tr>
<td><strong>Cleaning and analysis</strong></td>
<td>11.3</td>
<td>13.5</td>
<td>2.2</td>
</tr>
<tr>
<td><strong>Maintenance</strong></td>
<td>7.8</td>
<td>7.8</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Rent</strong></td>
<td>73.9</td>
<td>72.8</td>
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</tr>
<tr>
<td><strong>Rental allowance</strong></td>
<td>13.4</td>
<td>13.5</td>
<td>0.1</td>
</tr>
<tr>
<td><strong>Additional housing costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Water rate</strong></td>
<td>4.9</td>
<td>4.9</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Hot water and heating</strong></td>
<td>5.1</td>
<td>5.1</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>LIVING expenses</strong></td>
<td>78.0</td>
<td>77.9</td>
<td>0.1</td>
</tr>
<tr>
<td><strong>Personal expenses</strong></td>
<td>7.6</td>
<td>7.6</td>
<td>0.0</td>
</tr>
</tbody>
</table>

The difference in the costs of social care before and after moving in was mainly driven by an increase in the costs of support services and the costs of home care received (an average of £89 per week per resident, compared was £51.60 per week before moving to Rowanberries). The mean number of hours of home care received was 0.68 hours per week per resident before moving to Rowanberries, compared with 0.45 hours after moving in. In addition, 45% of residents reported seeing a social worker after moving in, compared with 10% before moving to Rowanberries at a cost saving of £51.60 per week. The comparison of social care costs was complicated by whether or not meals in the restaurant were treated as living expenses or social care, given that all except one resident in the sample stopped receiving meals-on-wheels or using a lunch club after moving in. Some of the higher overall costs were due to higher accommodation costs (not unexpected for a new purpose-built scheme). Accommodation costs included an annualised capital cost of £54 per person per week, based on a 60-year scheme life, revenue costs of £57 per person per week including staff costs, repairs, utilities and social care. The method of costing costs involved dividing the revenue cost to residents of £110 per person per week before moving into Rowanberries, and £141 per week after the move. A limited sample in the overall net housing stock was estimated as a result of the scheme’s ECH. The level of capital subsidy for accommodation costs increased significantly following recent small number of people who were previously in public sector housing. Equally, care and support costs increased as these would have been self-funded by some residents in previous homes, but were not charged for in the scheme. In Rowanberries, all costs for care were met by Bradford Adult Services Department regardless of income, savings

It seems that direct costs to social care benefits/allowances received. social services, and the average amount of cost, housing benefit payments towards rent to about 75% of the formal costs). The figure had improved and that of the person who the move. In addition, more than one-third opportunities; and accommodation costs. Based on an analysis of these costs, the care services and support provided by Rowanberries. It appears that residents had better access to health services rather than an increase in health needs. An additional key element of care is that of unpaid, informal carers. Care-giving costs included: direct financial expenditure for laundry and travel; paid and unpaid, informal carers. Care-giving costs are used for each National estimates of unit costs (per visit or per hour as appropriate) were used for each self-perceived health after moving into Rowanberries. However, they did report a significant improvement in their quality of life, and a decrease in their level of unmet need across seven areas. The most significant improvement was in terms of social participation and involvement; nearly two-thirds reported that they had a good social life after moving into Rowanberries, whereas half of residents said that they had neither control over daily living. These improvements appear to be associated with better access to the care services and support provided by Rowanberries. The study provides cautious evidence that when the costs of moving into ECH are measured comprehensively, they are substantial, but that ECH appears to deliver important benefits to residents and informal carers in terms of improved social care outcomes and quality of life. 4. Application – where it might be appropriate Rowanberries ECH delivered positive outcomes for both residents and carers. Residents reported high levels of satisfaction with care received, significant improvement in their quality of life, and a decrease in their levels of unmet need across seven domains. Carers’ costs were significantly reduced when residents moved into Rowanberries. Extra-care housing widens the options available to older people in terms of housing with care, providing a positive alternative to residential care with an emphasis on maintaining independence and empowerment. The findings indicate that residents of Rowanberries had improved access to social and health care services, enabling a better take-up of the benefits and allowances for which they were eligible. 7. Weaknesses and potential pitfalls The overall cost of the scheme per resident per week was higher than if residents had remained in their former homes, due mainly to the higher costs of social care and accommodation. The savings achieved in terms of health care were not transferred over to social costs, providing little incentive to social care providers to invest in this kind of housing with care provision. There were no significant improvements in self-perceived health among residents after six months living in Rowanberries. The findings indicate that Rowanberries represents people receiving housing LIN (2006), Extra Care Housing Toolkit, CSIP, Department of Health. http://www.housinglin.org/Topics/type/extra-care-housing-scheme-in-brief Housing LIN (2006), Extra Care Housing Toolkit, CSIP, Department of Health. Department of Health, CSIP, Extra Care Housing Toolkit, CSIP, Department of Health. 7. Weaknesses and potential pitfalls 8. Sources of further information Baumke, T., Natten, A. & Darnton R (2008) Costs and outcomes of an extra-care housing scheme in Bradford, York. JRF. http://www.communitycare.co.uk/care-costs-and-outcomes-extra-care-housing-schemes-brief.pdf Baumke, T., Natten, A. & Darnton R (2008) Costs and outcomes of an extra-care housing scheme in Bradford, York. JRF. 8. Sources of further information
or tenancy, although residents did pay the well-being charge.

There was evidence of more than a 50% reduction in health care costs after the move. National estimates of unit costs (per visit or per hour as appropriate) are available for health care services provided in residential care. Overall, health service costs fell after people had moved, by an average of £38 per resident per week. The greatest single difference was for the number of visits at home – a mean decrease of 537 per week. Although the proportion of residents who were seen by a nurse at home increased (32% before compared with 73% after the move to Rowanberries), the mean number of consultations per resident decreased from around 22 to 11 visits in six months. The proportion of residents accessing hospital services, such as accident and emergency, outpatient appointments and inpatient stays was slightly lower in all instances after the move to Rowanberries. Those who had previously been inpatient at hospital were more likely to see a nurse or doctor at Rowanberries. It appears that residents had better access to health care services rather than an increase in health needs.

An additional key element of care is that of unpaid, informal carers. Care-giving costs included: direct financial expenditure for example, laundry and travel; paid and unpaid time spent caring; costs of giving up career opportunities; and accommodation costs. Based on an analysis of these costs, the average cost to the carer was calculated to be £80 per week before the person moved to Rowanberries. Those who had previously been inpatient at hospital were more likely to see a nurse or doctor at Rowanberries. It appears that residents had better access to health care services rather than an increase in health needs.

The evaluators raise a number of methodological points which highlight the need to be cautious in assuming the findings will apply equally to all other ECH schemes, for example, variation on costs across the country, the 60 residents were previously employed, to rather than an increase in public expenditure.

In terms of outcomes, residents reported no significant improvements overall in their self-perceived health after moving into Rowanberries. However, they did report a significant improvement in their quality of life, and a decrease in their level of unmet need across seven areas. The most significant improvement was in terms of social participation and involvement; nearly two-thirds reported that they had a good social life after moving into Rowanberries, whereas half of residents said that they had felt lonely and socially isolated in their previous homes. Residents also reported increased feelings of control over daily living. These improvements appear to be associated with better access to the care services and support provided by Rowanberries.

The study provides cautious evidence that when the costs of moving into ECH are measured comprehensively, they are substantial, but that ECH does offer a significant improvement in their quality of life, and a decrease in their level of unmet need across seven domains. Carers’ costs were significantly reduced when residents moved into Rowanberries. Extra care housing widens the options available to older people in terms of housing with care, providing a positive alternative to residential care and an emphasis on maintaining independence and empowerment.

The findings indicate that residents of Rowanberries ECH had improved access to social and health care services, along with a better take-up of the benefits and allowances for which they were eligible.

7. Weaknesses and potential pitfalls

The overall cost of the scheme per resident per week was higher than if residents had remained in their formal homes, due mainly to the higher costs of social care and accommodation. The savings achieved in terms of health care were not transferred over to social care, providing little incentive to social care providers to invest in this kind of housing with care provision.

The study is based on a relatively small sample in an ECH scheme. A clearer indication of the cost-benefit ratio ECH will be available when the national evaluation of ECH by PSSRU is available in the autumn of 2011. The study also had no follow-up after the residents had moved to Rowanberries. Approximately £360 per week was estimated to be the average cost falling on the public purse picking up the bill. The increase in the take-up of these benefits and allowances after moving to Rowanberries represents people receiving income support who were previously earning it, to rather than an increase in public expenditure.

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The findings indicate that residents of Rowanberries ECH had improved access to social and health care services, along with a better take-up of the benefits and allowances for which they were eligible.
that the CIP is providing very good value for money, i.e., well-being cafés and community involvement team.

There are some caveats about the use of the cost saving approach; the results do not fully account for a number of additional benefits, such as improved access to information about available services for some participants, as well as some additional costs to the voluntary sector, and lastly, some of the benefits are notional rather than ‘cashable’. Nevertheless, it appears fairly clear that the programme activities were capable of delivering significant benefits, both to the health service, social and the growing population of older people with mental health needs.

While the cafés had unanticipated set-up and running costs for host organisations, they resulted in improved networking across the voluntary and statutory sector. Participants reported enjoying the time spent in cafés and valued the well-being activities provided.

A significant reduction in depression scores was observed over time, alongside reported improvements by some and users who were unsure about social inclusion and well-being.

4. Application – it might be appropriate

This approach based on prevention and early intervention is appropriate for older people with mental health needs and their carers, both with organic and functional mental health problems.

Although initially it was expected that carers would attend the cafés, as the programme developed, this restriction was dropped. The well-being cafés and activities provide a useful alternative to day care, which may be of particular interest to people with a personal budget.

In Bradford, the cafés are now fully embedded in mainstream services and the number of sessional cafés has increased from 12 to 19.

5. Resources required – staff, training, IT

The CIP Project Officers were qualified as Peer Educators (or enrolled on the course) which gave them the skills to deliver mental health training free of charge for community and voluntary sector organisations.

Café organisers reported that preparation for and running each café took an unanticipated amount of time: one estimated around 25 hours per café. In addition, they identified a need for a basic overview of mental health training and information regarding conflict resolution.

Staffing requirements specified that a member of the CMHT should attend each café session.

6. Strengths

Health in Mind achieved a significant increase in the capacity of voluntary and community organisations to support older people with mental health problems through the provision of the well-being cafés and well-being activities, optimising existing, and unlocking untapped, mental health support. The project was successful in raising awareness of older peoples’ mental health issues across the community and voluntary sector. Changes and education needs were identified and addressed, for example, the PCT developed activities through the CIP activity fund for groups of older people who were disenfranchised in the skills or capacities to develop their own community groups. The project team was also able to foster networking between different groups and organisations.

The well-being cafés were perceived to be serving several purposes: early identification of people with a mental health need; seeing people over an extended period of time; acting as a stepping stone to other services. There were benefits not only for those who only used the well-being cafés and activities, but also for those who were referred on to another service. The cafés also had considerable success in overcoming some of the stigma attached to discussing mental health, and reduced social isolation was reported by attendees, both during the time they were at the café, and also outside of the café because of friendships that had been formed at the café. There were many reports about how enjoyable attendance at the cafés was for service users and/or their carers.

The CIP served a significant number of older people from BME communities. The larger ethnic minority groups in Bradford were well-represented in the cafés: in particular, Indian older people who comprised 49% of service users, more than four times the prevalence found in the wider population (1.2%).

7. Weaknesses and potential pitfalls

Café organisers reported an unexpected amount of time involved in both setting up and running the cafés. Some café hosts reported an unexpected amount of time: one estimated around 25 hours per café. In addition, they identified a need for a basic overview of mental health training and information regarding conflict resolution.

Staffing requirements specified that a member of the CMHT should attend each café session.

In Bradford, the cafés are now fully embedded in mainstream services and the number of sessional cafés has increased from 12 to 19.

8. Sources of further information


www.bradfordhealthinmind.nhs.uk/.../bradford_MentalWellbeing_030608.pdf

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shahidur.rahman@bradford.gov.uk

2. Ji 17:35, jh-011

A certain amount of distance from the local authority was seen as beneficial for the well-being activity fund. Once networks are developed with community groups, other statutory services can become usefully involved and services can be integrated across a wider range and benefit to mental health care within community locations. This has the potential of providing an access route through social prescription for people who might not normally make contact with groups and activities.

The evaluation noted the importance of simple application procedures for grants for well-being activities and the need to ensure speedy transfer of funds for activities. Other benefits highlighted by the evaluation included the need to continue assessment of education and training needs for host groups; and to improve integration between primary health care services and the community and voluntary sector.

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Design—www.iinnss.org.uk

Table 1

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<th>Costs</th>
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Figures from Health in Mind Programme Evaluation (2008)
As part of Bradford POPP, a network of mental health well-being cafés for older people was established, along with a community involvement team.

Over a ten-year period, the initiative is projected to achieve cost savings of more than half a million pounds.

A significant reduction in depression, along with some improvements in social inclusion and well-being, was found in service users.

The well-being cafés are now part of mainstream services and the number of sessions has been increased.

**1. Introduction**

This case study is based on the evaluation of the Bradford Partnership for Older People Programme (POMP), Health in Mind, conducted in the University of Bradford. The Health in Mind programme aimed to establish open access to Mental Health Involvement and Activity teams and the third sector services through a ‘whole in mind’ change to support costs with mental health problems. Health in Mind included four inter-related projects, including a Mental Health Community Involvement Project (CIP), which funded a network of mental health well-being cafés and the development of a community involvement team. The evaluation team concluded that:

‘There is evidence to suggest that the CIP is already providing good value for money.’

**2. Description**

The Community Involvement Project (CIP) was a collaboration between voluntary and statutory organisations to provide support for older people, both those with, and those at risk of developing, mental health problems.

The objectives of the project were to:

- Enable older people with mental health needs and their carers to maintain community involvement and access to a range of voluntary and statutory services.
- Enable carers of older people to participate in social and community activities in a supportive environment.
- Enable older people with mental health needs and their carers to maintain and access the knowledge, skills and resources to actively manage their mental health.
- Enable older people with mental health needs and their carers to maintain supportive relationships with their local communities and carers.
- Enable older people with mental health needs and their carers to adjust the budget values on the grounds that the changes would have been within the margin of error of the data used for calculating costs.

The costs used in the analysis were the actual costs incurred by some of the organisations, and the costs used which valued the activities as if they were replacing set costs of equivalent activities. In the case of the well-being cafés, the comparison was with day care, although it is clear that many of the users of the café would not have otherwise used day care facilities.

Changes in the design of the Health in Mind programme and the relatively short period of implementation completed at the time of the evaluation mean that conclusions about long term sustainability and value for money are tentative and dependent on the achievement of target outcomes in the coming years.

The costs used in the analysis were the actual costs for the first two years and the proposed costs for the following two years. The Year 4 proposed funding was assumed to be maintained until Year 10 (see Table 2). It should be noted that, ideally, all costs should have been measured in constant prices of the base year (i.e. 2007/08). However, no attempt was made to adjust the budget values on the grounds that the changes would have been within the margin of error of the data used for calculating costs.

The costs for the first two years and the proposed costs for the following two years were extrapolated on the basis of existing trends and a range of assumptions about the number of well-being cafés and the number of activities that could be funded from the budget.

Based on these assumptions and the data from the report, the CIP would generate net benefits valued at approximately £50 per participant in each of the succeeding periods (see Table 1). The evaluation concludes that only the project costs were measured as no data were available to measure additional costs incurred by participants involved in the CIP. Implicitly, this assumes that these additional costs were not fully covered by the CIP. There is some evidence to suggest that additional costs were borne by the organisations themselves. Valuation of additional costs associated with the ‘willingness to pay’ is an alternative cost saving calculation. Adding this value to the costs that were being replaced set costs of equivalent activities.
1. Introduction
This chapter builds on the evaluation of the Bradford Partnership for Older People Programme (POPP), Health in Mind, conducted in 2007-2008 in the University of Bradford. The Health in Mind programme aimed to expand mental health services for older people, particularly those with identifiable mental health needs. The project team’s Café Coordinator compiled a range of work carried out in the informal setting of the well-being café. The activities of the Community Involvement Project (CIP) were replaced by setting up a network of mental health well-being cafés and other funded services and support groups to target social inclusion support.

2.2 Well-being Activity Fund (WAF)
In partnership with the Voluntary and Community Sector (VCS), the project team aimed to develop a programme of support to enable older people with mental needs and their carers to build relationships. The value was provided to over 100 organisations and development workers. Consultation with community groups, voluntary organisations and development workers identified a need for funding support to enable them to develop new and innovative programmes.

3.3 Evidence of cost effectiveness
Changes in the design of the Health in Mind programme and the relatively short period of implementation completed at the time of the evaluation mean that conclusions about long-term sustainability and value for money are tentative and dependent on the achievement of set cost outcomes in the coming years. The costs used in the analysis were the actual costs for the first two years and the proposed costs for the following two years. The Year 4 proposed funding was assumed to be maintained until Year 10 (see Table 2). It should be noted that, ideally, all costs should be measured in constant prices of the base year (i.e. 2007/8). However, no attempt was made to adjust the budget values on the grounds that the changes would have been within the margin of error of the data used for calculation.

Only the project costs were measured as no data were available to measure additional costs. In the CIP, a signpost to support was provided to groups that were previously unknown to statutory services and voluntary sector organisations and provided opportunities for building relationships.

The activities of the Community Involvement Project were planned to reach 350 people and their carers. Quarterly report data indicate that this estimate was significantly exceeded. There was a steady increase in the number of sessions attended at the well-being cafés and other funded services and support groups to target social inclusion support.

The Community Involvement Project (CIP) aimed at improving capacity in the community system’ change to services for older people and voluntary sector to provide support for people with mental health needs. The Community Involvement Project (CIP) aimed at improving capacity in the community system’ change to services for older people and voluntary sector to provide support for people with mental health needs.
As part of Bradford POPP, a network of mental health well-being cafés for older people was established, along with a community involvement team.

Over a ten-year period, the initiative is projected to achieve net benefits of more than half a million pounds. The Community Involvement Project (CIP) is already providing good value for money.

A significant reduction in depression, along with some improvements in social inclusion and well-being, was found in service users.

The weekly well-being cafés are now part of mainstream services and the number of sessions has been increased.

The objectives of the project were to:
- Enable people with mental health needs and their carers to find support.
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The involvement of organisations through the Community Involvement Project and the Bradford Alzheimer’s Society, 12 ‘sessional’ well-being cafés, were tailored to the needs of particular groups, including small community groups, gay men.

The project provided a programme of support to enable older people with mental needs and their carers to build contact with health and social care providers were able to hear older peoples’ views and to adjust the budget values on the grounds that the changes would have been well within the margin of error of the data used for calculating the net benefits.

Only the project costs were measured as no data were available to measure additional costs. Additional costs included in the CIP imply that the project would have fully covered their costs. There is some evidence to suggest that additional costs would be borne by the organisations themselves.

Valuation of the project was based on a ‘willingness to pay’. An alternative cost saving approach was used for calculating the ‘willingness to pay’. An alternative cost saving approach was used for calculating the value of well-being activities.

In the case of well-being cafés, the comparison was with day care, although it is clear that many of the users of the café would not have otherwise used day care facilities.

In the case of the Community Involvement Project, a cost comparison was made with an alternative cost saving approach. The value of well-being café attendance (426 to 2215) was also offered.

Changes in the design of the Health in Mind programme and the relatively short period of implementation completed at the time of the evaluation mean that conclusions about long-term sustainability and value for money are tentative and dependent on the achievement of project outcomes in the coming years.

The value of well-being café attendance was the cost of local authority day care, and the value of well-being activities was set at £6,50 per participant session, this being approximately the cost of a cinema ticket with some refreshments. In view of the number of participants, the analysis is very sensitive to the value of the benefit.

Measurement of the benefits of the CIP was based on the estimated number of sessions per participant per year, the number of sessions being the cost of local authority day care, and the number of attendances is underestimated.

Charges for the project were the actual costs for the first two years and the proposed budget for the forthcoming two years. The Year 4 proposed funding was assumed to be maintained until Year 10 (see Table 2). It should be noted that, ideally, all costs should be measured in constant prices of the base year (i.e. 2007). However, no attempt was made to adjust the budget values on the grounds that the changes would have been well within the margin of error of the data used for calculating the net benefits.
A significant reduction in depression scores was observed over time, alongside reported improvements in some and users so far with respect to social inclusion and well-being.

4. Application – where it might be appropriate
This approach based on prevention and early intervention is appropriate for older people with mental health needs and their carers, both with organic and functional mental health problems.

Although initially it was expected that carers would attend the cafes, as the programme developed, this restriction was dropped. The well-being cafes and activities provide a useful alternative to day care, which may be of particular interest to people with a personal budget.

In Bradford, the cafes are now fully embedded within mainstream services and the number of sessional cafes has increased from 12 to 18.

5. Resources required – staff, training, IT
The CIP Project Officers were qualified as Peer Educators (or enrolled on the course) which gave them the skills to deliver mental health training free of charge for community and voluntary sector organisations.

Cafe organisers reported that preparation for and running each cafe took an unallocated amount of time: one estimated around 25 hours per cafe. In addition, they identified a need for a basic overview of mental health training free of charge. There were benefits not just for those who only used the well-being cafes and activities, but also for those who were referred on to another service. The cafes also had considerable success in overcoming some of the stigma attached to discussing mental health, and reduced social isolation was reported by attendees, both during the time they were at the cafe, and also outside of the cafe because of friendships that had been formed at the cafe.

There were many reports about how enjoyable attendance at the cafes was for service users and their carers. The CIP served a significant number of older people from BME communities. The larger ethnic minority groups in Bradford were well represented in the cafes: in particular, Indian people who comprise 4.9% of service users.

6. Strengths
Health in Mind achieved a significant increase in the capacity of voluntary and community organisations to support older people with mental health problems through the provision of the well-being cafes and well-being activities, optimising existing, and unlocking untapped, mental health support. The project was successful in raising awareness of older peoples’ mental health issues across the community and voluntary sector. Training and education needs were identified and addressed. For example, the PCT developed activities through the CIP activity fund for groups of older people who were lacking in the skills or capacities to develop their own community groups. The project team was able to foster networking between different groups and organisations.

The cafe activities were perceived to be serving several purposes: early identification of people with a mental health need; seeing people over an extended period of time; acting as a signpost to other services. These were benefits not just for those who only used the well-being cafes and activities, but also for those who were referred on to another service.

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7. Weaknesses and potential pitfalls
Cafe organisers reported an unexpected amount of time allocated across both set up and running the cafes. Some cafe hosts reported feeling disconnected from sources of professional advice and support, linked with specialist mental health services and knowledge about older peoples’ mental health needs were areas which some cafe hosts identified as problematic.

The term ‘elemental cafe’ was dropped as potentially off-putting to some service users and their families.

There is a need to ensure that GPs are aware of these kind of services, as the Health in Mind CIP services reported a disappointing number of referrals from GPs.

A certain amount of distance from the local authority was seen as beneficial for the well-being activity fund. Once networks are developed with community groups, other statutory services can become usefully involved and services can be integrated across a continuum and seamless transition to formal mental health care within community locations. This has the potential to avoid an ‘access gap’ through social prescription for people who would not normally make contact with groups and activities.

The evaluation noted the importance of simple application procedures for grants for well-being activities and the need to ensure speedy transfer of funds for activities. Other points highlighted by the evaluation included the need to continue assessment of education and training needs for host groups; and to improve integration between primary health care services and the community and voluntary sector.

8. Sources of further information
www.bradfordhealthminderu.co.uk/healthinmindevaluation_FinalReport_300608.pdf
Shahidur Rahman
shahidur.rahman@bradford.gov.uk
2. Z=-1.735, p=.041

Figures from Health in Mind Programme Evaluation (2008)

This care study was compiled for IRISS by the Institute of Public Care

3. Health in Mind
provides a network of mental health cafes for older people, to predict to achieve the benefits of over £90 million pounds over ten years

Institute of Public Care
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Table 1
Estimated costs and benefits over 10 years of well-being cafes and well-being activities

<table>
<thead>
<tr>
<th>Costs/Netmeasurable benefit</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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<tbody>
<tr>
<td>Costs</td>
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<td>575,818</td>
<td>774,660</td>
<td>314,274</td>
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<td>115,373</td>
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<td>364,274</td>
<td>629,287</td>
<td>198,750</td>
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3. Health in Mind provides a network of mental health cafes for older people, to predict to achieve the benefits of over £90 million pounds over ten years.
that the CIP is providing very good value for money, i.e., well-being cafés and community involvement team.

There are some caveats about the use of the cost saving approach: the results do not fully account for a number of additional benefits, such as improved access to information about available services for some participants, as well as some additional costs to the voluntary sector and, lastly, some of the benefits are notional rather than ‘cashable’. Nevertheless, it appears fairly clear that the programme activities were capable of delivering significant benefits, both to the health service and the growing population of older people with mental health needs.

While the cafés had unanticipated set-up and running costs for host organisations, they resulted in improved networking across the voluntary and statutory sector. Participants reported enjoying the time spent in cafés and valued the well-being activities provided.

A significant reduction in depression scores was observed over time, alongside reported improvements by some and users alike with respect to social inclusion and well-being.

4. Application – where it might be appropriate

This approach based on prevention and early intervention is appropriate for older people with mental health needs and their carers, both with organic and functional mental health problems.

Although initially it was expected that carers would attend the cafés, as the programme developed, this restriction was dropped. The well-being cafés and activities provide a useful alternative to day care, which may be of particular interest to people with a personal budget.

In Bradford, the cafés are now fully embedded and mainstream services and the number of sessional cafés has increased from 12 to 19.

5. Resources required – staff, training, IT

The CIP Project Officers were qualified Peer Educators (or enrolled on the course) which gave them the skills to deliver mental health training free of charge for community and voluntary sector organisations. Café organisers reported that preparation for and running each café took an unanticipated amount of time: one estimated around 25 hours per café. In addition, they identified a need for a basic overview of mental health and information regarding conflict resolution.

Staffing requirements specified that a member of the CMHT should attend each café session.

6. Strengths

Health in Mind achieved a significant increase in the capacity of voluntary and community organisations to support older people with mental health problems through the provision of the well-being cafés and well-being activities, optimising existing, and unlocking untapped, mental health support. The project was successful in raising awareness of older people’s mental health issues across the community and voluntary sector. Change and education needs were identified and addressed, for example, the PCT developed activities through the CIP activity fund for groups of older people who were struggling to get involved in the skills or capacities to develop their own community groups. The project team was able to foster networking between different groups and organisations.

The well-being cafés were perceived to be serving several purposes: early identification of people with a mental health need; seeing people over an extended period of time; acting as a signpost to other services. There were benefits not just for those who only used the well-being cafés and activities, but also for those who were referred on to another service. The cafés also had considerable success in overcoming some of the stigma attached to discussing mental health, and reduced social isolation was reported by attendees, both during the time they were at the café, and also outside of the café because of friendships that had been formed at the café. There were many reports about how enjoyable attendance at the cafés was for service users and/or their carers. The CIP served a significant number of older people from BME communities. The larger ethnic minority groups in Bradford were well-represented in the cafés: in particular, Indian older people who comprise 4.9% of service users, more than four times the prevalence found in the wider population (1.2%).

7. Weaknesses and potential pitfalls

Cafés organisators reported an unexpected amount of time allocated for setting up and running the cafés. Some café hosts reported feeling disconnected from sources of professional advice and support. Links with specialist mental health services and knowledge about older peoples’ mental health were areas which some café hosts identified as problematic.

The term ‘elemental café’ was dropped as potentially off-putting to some service users and their carers. There is a need to ensure that GPs are aware of these kinds of services, as the Health in Mind CIP services reported a disappointing number of referrals from GPs.

A certain amount of distance from the local authority was seen as beneficial for the well-being activity fund. Once networks are developed with community groups, other statutory services can become usefully involved and services can be integrated across a continuum and being to formal mental health care within community locations. The cafés played an active role in providing an access route through social prescription for people who would not normally make contact with groups and activities.

The evaluation noted the importance of simple application procedures for grants for well-being activities and the need to ensure speedy transfer of funds for activities. Other services highlighted by the evaluation included the need to continue assessment of education and training needs for host groups; and to improve integration between primary health care services and the community and voluntary sector.

8. Sources of further information


www.healthinmindeval.co.uk


2. 1, 5-7, 13-25: p 2008

3. Money Matters review of cost effective initiatives www.moneymatters.org.uk

3. Health in Mind provides a network of mental health well-being cafés for older people, predicted to achieve net benefits of over £3 million pounds over ten years

Money Matters case study three

Table 1

<table>
<thead>
<tr>
<th>Costs</th>
<th>Benefits</th>
<th>Net measurable benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>£</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Year 1</td>
<td>£313,868</td>
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</tr>
<tr>
<td>Year 2</td>
<td>£78,118</td>
<td>£774,660</td>
</tr>
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<td>Year 3</td>
<td>£567,495</td>
<td>£40,044</td>
</tr>
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<td>Year 4</td>
<td>£313,868</td>
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<td>Year 5</td>
<td>£567,495</td>
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<td>Year 6</td>
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<td>Year 7</td>
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<td>Year 9</td>
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<tr>
<td>Year 10</td>
<td>£567,495</td>
<td>£207,165</td>
</tr>
<tr>
<td>Total</td>
<td>£74,930</td>
<td></td>
</tr>
</tbody>
</table>

Figures from Health in Mind Programme Evaluation (2006)
in Nottinghamshire, and the unit cost of a contact was £31.77. The analysis assumes that each of these contacts leads, on average, to a saving of 2.2 subsequent contacts and the consequent savings for the first two years were around £950,000 and £325,000. These savings would probably result in a little more materialising, so the next one lags behind them by six months in half of the benefits each year have been moved forward to the next year.

Savings in the five years after the initial two year investment period were expected to represent permanent improvements in the ability of local partners to work together. Savings were calculated in the business case analysis report based on the funding contributions from partner agencies (Fire and Rescue, Nottinghamshire PCT, and Basestall PCT). This was used to represent the value placed on the holistic approach to service delivery: £82,960.

3.2 Services facilitated by LinkAge Plus

LinkAge Plus facilitated many services resulting in a range of benefits, some of which are not quantifiable. However, the business case report provided examples where this was possible in relation to referrals to the fire service, exercise classes, crime reduction, and home adaptations.

3.2.1 Fire and rescue services

One of the signposting services that LinkAge Plus provided is referral to the fire and rescue service in the first year and £484 in the second year – indicates a stream of taxpayer benefits over the period of investment and the following five years.

3.2.2 Exercise classes

The Association of British Insurers’ assumes a 5% prevalence of burglary in a year (approximate rate for Nottinghamshire) and that hard targeting (which refers to the strengthening of the security of a building in order to reduce or minimise the risk of attack or theft) halves the risk of burglary causing an absolute reduction of likelihood of burglary of 2.5%. The Home Office’s estimation is that the cost of a burglary at £3,268 can be split into £2,000 for the cost to the taxpayer and £1,268 for the victim. By using the link between these figures, a crime risk that results in hard targeting of the older person’s home can be expected to save the taxpayer about £29 and the older person about £18. When these savings are compared with the £14.46 average cost of referral, significant net benefits are projected and assumed to persist over the five years after the investment period.

3.2.3 Crime reduction

7. Weaknesses and potential pitfalls

The approaches in the pilot are locally specific reflecting existing cultures and working arrangements, therefore there is no one ‘off the shelf’ model which can be easily picked up and replicated by other local authorities.

7. Sources of further information


1. Davis and Rittens K (2009), LinkAge Plus national evaluation: End of project report.


4. Office of the Deputy Prime Minister (2005) Crime reduction: reducing the risk of crime in Nottinghamshire, August 2006. On average each checklist contact resulted in 2.2 additional referrals to agencies, the main ones being to the fire service, pension service and community safety groups. The average cost of a completed checklist was calculated at £31.77.

6. Strengths

The holistic approach to service delivery facilitated by LinkAge Plus has resulted in improved partnership working across the voluntary and statutory sectors, improved access, reduced duplication, and enabled the sharing of resources.

The evaluation of First Contact reported improved outcomes, with access to services greatly increased and simplified by the single point of entry, which ensured all relevant services were provided. For individuals, the main benefits were increased well-being, independence and safety. A key benefit from this work was the close relationship with the Community Outreach Workers who could use such referrals to make contact with those at risk of isolation.

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1. Introduction

This case study is based on the national evaluation and business case reports of the LinkAge Plus pilots1,2 completed in 2009. LinkAge Plus was a programme to support holistic working between central and local government, local authority, and the voluntary and community sector to improve outcomes for older people, improving their quality of life and wellbeing. Around £10 million was invested by the Department for Work and Pensions in LinkAge Plus over a two-year period in eight pilot areas.

The LinkAge Plus pilots demonstrate how working in partnership, involving older people and delivering services that aim to give a ‘little bit of help’ with daily living, can make a difference to the quality of life for older people in a cost effective way.

2. Description

The aim of LinkAge Plus was to bring together the various forms of mutual help, services for older people and local government to deliver services that added value, building on the existing services. This was achieved by each pilot area, but no single LinkAge Plus ‘model’ followed. However, all projects were characterised by:

- Engage with, and involve older people in service design
- Reflect the diversity of older people’s needs and aspirations
- Be accessible in terms of location, time, opening times etc.
- Promote independence and well-being
- Improve customer experience and widen access
- Achieve efficiencies through joint working
- Strengthen partnership working. Together, these activities represent a ‘LinkAge Plus approach’.

A range of approaches were adopted across the eight pilot areas, examples of which are described below:

- Improved information and access for older people

Areas of work focused on how local authorities, PCTs and voluntary organisations developed new approaches to widening access, joining up services and gaining a better understanding of the needs and preferences of older people seeking help and support. Examples included:

- Establishing single access gateways; enhanced contactless access to specialist housing and employment services; improved websites and development of information packs for older people.

- Benefits for older people

A range of services was developed that provide that give a ‘little bit of help’ in order to promote older people’s well-being and independence, and prevent or delay the onset of more intensive support. Examples included:

- Engaging older people in activities that help them to develop and sustain social networks; improving physical health through establishing falls prevention initiatives and physical activity schemes (walking, Tai Chi classes, dance and exercises etc); focus on outreach and opportunities for socialisation to promote older people’s mental health; opportunities for leisure, learning and volunteering; and initiatives to assist older people with transport provision such as organisation volunteer drivers.

- Promoting social inclusion and community cohesion

A variety of services was developed to encourage older people to socialise and widen their social networks, reducing social isolation and exclusion. Examples included:

- Coffee mornings; classes; special interest groups; outings; exercise activities; outreach and befriending; voluntary work; older people’s forums helping to give older people a voice on local issues; and maximising older people’s income and benefits.

- Capacity building

A key feature of the pilots was building capacity in both the statutory, voluntary and community sector to promote improved skills, knowledge and understanding, new techniques and processes and a more people-centred approach to the design and delivery of services.

3. Evidence of cost effectiveness

Due to the range of services and initiatives undertaken by the pilot areas, it was difficult to quantify all the costs and benefits. However, an illustrative example in the business case report which is based on Nottingham’s First Contact pilot for the holistic element, and other pilots for the service elements, details the way in which in a two-year investment in holistic service delivery and the related services could deliver benefits to the individual and the taxpayer over the following five years. The key findings are:

- A holistic approach to service delivery requires some up-front investment over the two-year pilot period, but quickly begins to bring net savings, breaking even in year three.
- The net present value of savings up to the end of the five year period related to investment is £1.80 per £1 invested. This is likely to be higher over a longer period.
- LinkAge Plus can facilitate services that are cost effective in their own right, including fire and crime prevention, and reduced falls associated with balance classes and home adaptations.
- Combining the costs and benefits of the holistic approach to service delivery increases the net present value in the example to £2.65 per £1 invested.
- In addition to taxpayer savings there are benefits to older people monetised at £1.40 per £1 invested.

3.1 Holistic approach to service delivery

The illustrative example of a holistic approach to service delivery is based on the Nottinghamshire First Contact pilot. First Contact is an approach that enables older people to access services through a single point of contact, using a system where an agent of one of the partner organisations meets with the client and completes a simple ‘needs checklist’. Over the two years of the pilot, staff and volunteers were trained and 7,376 checklists completed, with an average of 3.2 additional referrals to agencies per completed checklist. The main referrals were to the fire service, pension service and community safety groups. First Contact enabled older people to receive a wide variety of services without the need to contact all the various organisations themselves.

3.1.1 Costs and cost benefits

Over the full seven years of the analysis, there is an estimated net present value per £1 spent of £1.77 for the taxpayer, due to imputed savings in reduced contacts and the increased ability of partners to work together. The costs and savings of the holistic approach based on Nottingham’s First Contact scheme are detailed in Table 1.

The Treasury discount rate is applied and the following three rows relate to set-up and ongoing costs (including outreach costs) – which are limited to the two years of the pilots. Estimated savings flow from this approach on the basis that there were 2,909 and 4,467 contacts in the two year investment period.
The LinkAge Plus pilots developed holistic service models, with an emphasis on accessibility, engaging older people, tackling social exclusion, promoting well-being and partnership working.

There were benefits to both dependants and older people from a holistic approach to service delivery, which facilitated key services to help maintain independence and improve the well-being of older people.

Combining the costs and benefits of a holistic approach to service delivery with related services, e.g. exercise classes, fire and rescue services, may achieve a net present value of £2.65 per £1 invested.

Additional benefits to older people in terms of well-being and independence may be monetised at £1.40 per £1 invested.

**1. Introduction**

This case study is based on the national evaluation and business case reports of the LinkAge Plus pilots (described in Table 1). The aim of LinkAge Plus was to pilot a comprehensive and holistic approach to service delivery based on the Nottinghamshire holistic service delivery model. Around £10 million was invested by the government and the voluntary and community sector to improve outcomes for older people, improving their quality of life and well-being.

**2. Description**

The aim of LinkAge Plus was to bring together the various forms of mutual help, services and partnership working to serve older people at a level in a way that added value, building on the aims and objectives of partner organisations. There was a range of activities undertaken by each pilot area, but no single LinkAge Plus ‘model’ followed. However, all projects were designed to:

- Engage with, and involve older people in service design
- Reflect the diversity of older people’s needs and aspirations
- Be accessible in terms of location, delivery, opening times etc.
- Promote independence and well-being
- Improve customer experience and widen access
- Achieve efficiencies through joint working
- Strengthen partnership working.

Taken together, these activities represent a ‘LinkAge Plus approach’.

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Due to the range of services and initiatives undertaken by the pilot areas, it was difficult to quantify all the costs and benefits. However, an illustrative example in the business case report which is based on the Nottinghamshire First Contact pilot for the holistic element, and other pilots for the service elements, details the way in which a two-year investment in holistic service delivery and the related services could deliver benefits to the individual and the national taxpayer over the following five years.

The key findings are:

- A holistic approach to service delivery requires some up-front investment over the two-year pilot period, but quickly begins to bring net savings, breaking even in year three.
- The net present value of savings up to the end of the five-year period is £1.80 per £1 invested. This is likely to be higher over a longer period.
- LinkAge Plus can facilitate services that are cost effective in their own right, including fire and crime prevention, and reduced falls associated with balance classes and home adaptations.
- Combining the costs and benefits of the holistic approach to service delivery increases the net present value in the example to £2.65 per £1 invested.
- In addition to taxpayer savings there are benefits to older people monetised at £1.40 per £1 invested.

**3.1 Holistic approach to service delivery**

The illustrative example of a holistic approach to service delivery is based on the illustrative example of a holistic service delivery model on the Nottinghamshire pilot: First Contact. First Contact is an approach that enables older people to access services through a single point of contact, using a service where an agent of one of the partner organisations meets with the client and completes a simple ‘needs checklist’. Over the two-year period, 688 staff and volunteers were trained and 7,376 ‘needs checklist’ meetings were completed, with an average of 3.2 additional referrals to agencies per completed checklist. The main referrals were to the fire service, pension service and community safety groups. First Contact enabled older people to receive a wide variety of services without the need to contact all the various organisations themselves.

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The LinkAge Plus pilots developed holistic service models, with an emphasis on accessibility, engaging older people, tackling social exclusion, promoting well-being and partnership working.

Combining the costs and benefits of a holistic approach to service delivery, which facilitated key services to help maintain independence and improve the well-being of older people.

Additional benefits to older people in terms of well-being and independence may be monetised at £1.40 per £1 invested.

Table 1
<p>| Holistic approach to service delivery illustrative example: Nottinghamshire First Contact scheme |
|----------------------------------|------------------|-----------------|-----------------|-----------------|------------------|</p>
<table>
<thead>
<tr>
<th>Year</th>
<th>Pilot investment period</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Money Matters reviews of cost effective initiatives

www.moneyatters.org.uk
in Nottinghamshire, and the unit cost of a contact was £31.77. The analysis assumes that each of these contacts leads, on average, to a saving of £2.2 subsequent contacts and the consequent savings for the first two years were around £189,000 and £325,000. These savings would probably be coclasee, particularly in the early years, so the next two lapses behind them by six months (as half of the benefits each year have been moved forward to the next year).

Savings in the five years after the initial two-year investment period were imputed to represent permanent improvements in the ability of local partners to work together. Savings were calculated in the business case analysis report based on voluntary funding contributions from partner agencies (Fire and Rescue, Nottinghamshire PCT, and Baseline PCT). This was used to represent the value placed on the holistic approach to service delivery: £82,960.

3.2 Services facilitated by LinkAge Plus

LinkAge Plus facilitated many services resulting in a range of benefits, some of which are not quantifiable. However, the business case report provided examples where this was possible in relation to referrals to fire and rescue services, exercise classes, crime reduction, and home adaptations.

3.2.1 Fire and rescue services

One of the signposting services that LinkAge Plus provides is referral to the fire and rescue service in the first year and £494 in the second year — indicates a stream of taxpayer benefits over the period of investment and the following five years.

3.2.2 Exercise classes

The Association of British Insurers4 assumes that a one year investment period were imputed to the consequent savings for the first two years. These savings were around £189,000 and £325,000. These savings would probably be coclasee, particularly in the early years, so the next two lapses behind them by six months (as half of the benefits each year have been moved forward to the next year).

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3.2.3 Crime reduction

The costs of the two-year pilot of the First Contact holistic approach in Nottinghamshire were £396,000 for overheads and set-up, £234,000 for ongoing costs, and £143,250 for outreach costs.

668 staff and volunteers were trained and 3,736 checklists completed in the period from July 2004 to June 2006. On average each checklist/ contact resulted in 2.2 additional referrals to agencies, the main ones being to the fire service, pension service and community security groups. The average cost of a completed checklist was calculated at £31.77.

6. Strengths

The holistic approach to service delivery facilitated by LinkAge Plus has resulted in improved partnership working across the voluntary and statutory sectors, improved access, removed duplication, and enabled the sharing of resources.

The evaluation of First Contact reported improved outcomes, with access to services greatly increased and simplified by the single point of entry, which ensured all relevant services were made available. For individuals, the main benefits were improved well-being, independence and safety. A key benefit from this work was the close relationship with the Community Outreach Workers who could use such referrals to make contact with those at risk of isolation.

7. Weaknesses and potential pitfalls

The approaches in the pilot are locally specific, reflecting existing cultures and working arrangements, therefore there is no one ‘fit the shelf’ model which can be easily picked up and replicated by other local authorities.

8. Sources of further information


3. 3.2.4 Home adaptations

There is evidence to suggest that adaptations can reduce falls by 5%. Applied to the prevalence of hip fractures, this suggests expected benefits of home adaptations to the taxpayer of around £70 and to the older person of £53. Home adaptations costs averaged £72.36. However, £10 was commonly paid by the older person so this figure was adjusted to £67.24. It was assumed that adaptations remained effective for the five years following the initial investment period.

4. Application – where it might be appropriate

It seems likely that this approach would work with other user groups beyond older people, given that the aims of LinkAge Plus were to bring together various forms of mutual help, services and support of a local level in a way that adds value, building on the aims and objectives of partner organisations.

5. Resources required – staff, training, IT

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The approaches in the pilot are locally specific, reflecting existing cultures and working arrangements, therefore there is no one ‘fit the shelf’ model which can be easily picked up and replicated by other local authorities.

8. Sources of further information


3. 3.2.4 Home adaptations

There is evidence to suggest that adaptations can reduce falls by 5%. Applied to the prevalence of hip fractures, this suggests expected benefits of home adaptations to the taxpayer of around £70 and to the older person of £53. Home adaptations costs averaged £72.36. However, £10 was commonly paid by the older person so this figure was adjusted to £67.24. It was assumed that adaptations remained effective for the five years following the initial investment period.
in Nottinghamshire, and the unit cost of a contact was £31.77. The analyses assume that each of these contacts leads, on average, to a saving of 2.2 subsequent contacts and the consequent savings for the first two years were £19,000 and £32,000. These savings would provide little classes, particularly in materialise, so the next one laps behind them by six months (as half of the benefits each year have been moved forward to the next year).

Savings in the five years after the initial two-year investment period were imputed to represent permanent improvements in the ability of local partners to work together. Savings were calculated in the business case analyses by applying a discount rate. Funding contributions from partner agencies (Fire and Rescue, Nottinghamshire PCT, and Bassetlaw PCT). This was used to represent the value applied to the holistic approach to service delivery: £82,960.

3.2 Services facilitated by LinkAge Plus

LinkAge Plus facilitated many services resulting in a range of benefits, some of which are not quantifiable. However, the business case report provided examples where this was possible in relation to referrals to services, exercise classes, crime reduction, and home adaptations.

3.2.1 Fire and rescue services

One of the signposting services that LinkAge Plus provided is referral to the fire and rescue service in the first year and £484 in the second year – indicates a stream of benefits delivered over the period of investment and the following five years.

3.2.2 Exercise classes

The cost to the participant for an exercise class was £2 with a taxpayer subsidy of £1. The estimated cost of a completed checklist was calculated at £31.77.

3.2.3 Crime reduction

The Association of British Insurers assumes a 5% prevalence of burglary in 5% of households and that targeting burglary (which refers to the strengthening of the security of a building in order to reduce or minimise the risk of attack or theft) halves the likelihood of a burglary causing an absolute reduction of likelihood of burglary of 2.5%. The Home Office estimated the cost of a burglary at £32,628 which is split into £3,000 cost to the victim and £1,148 cost to the taxpayer. On average each checklist/contact resulted in 2.2 additional referrals to agencies, the main ones being to the fire service, pension service and community safety groups. The average cost of a completed checklist was calculated at £31.77.

4. Application – where it might be appropriate

It seems likely that this approach would work with other user groups beyond older people, given that the aims of LinkAge Plus were to bring together the various forms of mutual help, services and support at a local level in a way that adds value, building on the aims and objectives of partner organisations.

5. Resources required – staff, training, IT

The costs of the two-year pilot of the First Contact holistic approach in Nottingham were £36,000 for overheads and set-up, £234,000 for ongoing costs, and £143,000 for overheads.

6. Strengths

The holistic approach to service delivery facilitated by LinkAge Plus has resulted in improved partnership working across the voluntary and statutory sectors, improved access, removed duplication, and enabled the sharing of resources.

The evaluation of First Contact reported improved outcomes, with access to services greatly increased and simplified by the single point of entry, which ensured all relevant services were available. For individuals, the main benefits were increased well-being, independence and safety. A key benefit from this work was the close relationship with the Community Outreach Workers who could use such referrals to manage contact with those at risk of isolation.

7. Weaknesses and potential pitfalls

The approaches in the pilot are locally specific reflecting existing cultures and working arrangements, therefore there is no one ‘fit the shelf’ model which can be easily picked up and replicated by other local authorities.

8. Sources of further information


Watt P and Blair I (2009) The business case for LinkAge Plus in Nottinghamshire


4 ABI (2006) Securing the Nation: The case for safer homes, London


Design — www.believein.co.uk

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4. Application – where it might be appropriate
Currently the RRAP is only available to owner-occupiers or private tenants. It is currently not available for RSL or council tenants. However, a review of adaptations undertaken by the Welsh Assembly Government in 2005 highlighted the need to increase the scope of RRAP to include these tenures.

5. Resources required – staff, training, IT
The RRAP operates in a similar way to Safety at Home schemes run by most Care and Repair agencies. Research has shown that the average capital cost per job in each region of £150 per job. It is anticipated that the maximum capital cost per job across staff in health and social care, partners, eg, maintaining awareness, partnerships with Health and Social Services, and many had Safety at Home and Emergency Pressure schemes. However, a review of adaptations undertaken by the Welsh Assembly Government, unlike care and repair schemes, enables a quick local response to vulnerable clients in terms of both hospital discharge and hospital prevention.

5. Resources required – staff, training, IT

6. Strengths
The RRAP meets many key objectives for local and national policies – in Wales this includes the National Housing Strategy, as well as local health and well-being strategies and older people’s strategies. It provides preventative services that are closely related to client need and support personal choice and independence. Furthermore, this programme provides a framework of effective local support for vulnerable clients in terms of both hospital discharge and hospital prevention.

7. Weaknesses and potential pitfalls
The main weakness reflects high levels of demand outweighing funding for the programme. Furthermore, there is no recognised strategy for addressing work over £50, which may leave some clients vulnerable. There is still some lack of awareness among local partners and complexities associated with joint working. Health professionals do not always have a strong awareness or understanding of housing related services and definitions of what represents a hospital discharge can differ. There is some reluctance amongst health professionals to define some referrals as contributing to hospital discharge, as the issues that contribute to hospital discharge are often complex and quite often not housing related (eg delayed transfers of care targets for health).

8. Sources of further information
Neil Williams, Head of Agency Performance and Funding, Care and Repair Cymru.

4 WAG (2011) Sustainable Social Services for Wales: A Framework for action

5. Care and Repair

A programme providing a repairs and adaptations programme for older people in Wales, estimated to save £15 million a year —
The Rapid Response Adaptations Programme in Wales provides a fast small repairs and adaptations service to older people, identified by health and social care staff as at risk of hospital admission, or awaiting hospital discharge.

Assuming 10 per cent of repairs and adaptations led to a hospital discharge or avoided an accident and hospital admission, the total cost saving to health and social care was estimated at £15 million in one year.

The service demonstrates the benefits of a targeted approach to repairs and adaptations, particularly for people at risk of a fall at home.

### 1. Introduction

This case study provides information regarding the Rapid Response Adaptations Programme (RRAP). The RRAP was introduced by the Welsh Assembly Government in 2002 on a national basis and is unique to Wales. The Welsh Assembly Government continues to support this programme and £2,094,000 was made available in 2010-11 to Care and Repair Agencies across Wales and Care and Repair Cymru to support the RRAP.

Information in this report is based on data obtained from the Rapid Response Adaptations Programme Annual Performance Report 2008-09 and from communication with the Head of Performance and Funding at Care and Repair Cymru. The programme has been shown to facilitate an immediate response to specific needs by providing minor adaptations such as ramps and handrails, to enable people to return to their own homes following hospital discharge. These adaptations have also been shown to prevent the need for admission to hospital for personal cleansing.

### 2. Description

The RRAP provides a small rapid response adaptations/repair service for older and disabled people which ensures that they can continue to live in a safe home environment as comfortably as possible. This service is complementary to the adaptations work funded by local authorities through the Disabled Facilities Grant and Home Repair assistance. The service focuses on hospital discharge and reducing hospital admissions.

The programme is to ensure that older and disabled people who are to be discharged from hospital have a safe home to which to return. It also has a key role in preventing hospital admissions by addressing problems of homes that are not safe or appropriate for older and disabled people. The intention of the programme, which sets itself apart from other repair services, is to enable Care and Repair agencies to provide quick response service to problems identified by local authority or health staff. The Care and Repair agency receives the referrals and instructs a suitably qualified contractor or handyperson to carry out the required work. There is a 15-day maximum target date for completing the works from referral.

Referrals come from a range of statutory and health sector organisations, and are channelled through Care and Repair agencies.

### 3. Evidence of cost effectiveness

The RRAP provides a framework across Wales for targeting resources for effective support for older and disabled clients, in terms of both hospital discharge and hospital prevention.

The critical outcomes demonstrated by RRAP indicate the potential for well targeted and strategically managed services to address key elements of service speed, client focus and added value.

In 2008-09, 15,473 Rapid Response adaptations were delivered, of which 10,163 aimed to prevent hospital admission and 4,915 enabled hospital discharge. Estimates for cost savings detailed in Table 1 below are based on the following figures:

- £9,000 average cost to health of a home accident
- £118 per RRAP case – 2008-09 figures.

The above estimate of cost effectiveness does not take into account costs in relation to staff and other costs. Further work by one agency estimated that the following costs were incurred in one year:

- RRAP Revenue funding for administrator, on costs and technical support = £20,000.
- RRAP Capital (some of which is turned into handyperson revenue support based on an agreed schedule of works) = £70,400.
- Handyperson salary costs = £24,258 (£14,500 on-costs). Note that they had one dedicated handyperson to RRAP.
- Works completed in total = £650.
- Average cost of contractor job = £67.
- Average cost of contractor job = £170.

Based on the figures above, which assume that 10% of each type of RRAP case directly leads to quicker discharge, admission prevention and accident prevention (based on research and what is acceptable to all partners involved), it is calculated that the total cost saving of RRAP to the health and social care sector in 2008-2009 was £15,009,000. Taking into account other costs associated with the project, it could be estimated that a £750 saving is made for every £1 invested through RRAP.

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<th>Description</th>
<th>Hospital Discharge</th>
<th>Hospital Prevention*</th>
<th>Accident Prevention*</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of jobs having direct impact (assumed rate of 10% of total)</td>
<td>491</td>
<td>1,016</td>
<td>1,016</td>
</tr>
<tr>
<td>Av. cost of hospital stay per day</td>
<td>378</td>
<td>378</td>
<td>378</td>
</tr>
<tr>
<td>Av. length of stay in hospital</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Total cost to health (Av x D)</td>
<td>£1,856,000</td>
<td>£3,840,000</td>
<td>£9,460,000</td>
</tr>
<tr>
<td>Av. cost of RRAP job</td>
<td>£15,856</td>
<td>£118</td>
<td>£9,460</td>
</tr>
<tr>
<td>Total cost of RRAP jobs (Av)</td>
<td>£55,000</td>
<td>£1,180</td>
<td>£58,000</td>
</tr>
</tbody>
</table>

Table 1 Estimated costs and savings of RRAP to health and social care 2008-09

The group eligible for the service are older and physically disabled people who are owner occupiers or private tenants and:

- are in hospital or who have recently been discharged from hospital where the circumstances require urgent intervention, or
- who wish to continue to live at home as independently and safely as possible, and whose homes require small works to enable them to do so.

The type of eligible work may include:

- Small ramps and home access.
- Door entry.
- External/internal rails.
- Hand grips.
- Cover way to e.c.
- Toilet andouthouse upgrading.
- Leveling paths.
- Partial rewiring.
- Upgrading heating to essential rooms.
- Access to toilet facilities.
- Community safety alarms.
- Safety in the home eg additional lighting, electrical safety, hot water safety, floor/ stair/wall safety.

* There may be some double counting relating to jobs directly preventing hospital admission and those which prevent an accident at home.

The critical outcomes demonstrated by RRAP indicate the potential for well targeted and strategically managed services to address key elements of service speed, client focus and added value.

The above estimate of cost effectiveness does not take into account costs in relation to staff and other costs. Further work by one agency estimated that the following costs were incurred in one year:

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Based on the figures above, which assume that 10% of each type of RRAP case directly leads to quicker discharge, admission prevention and accident prevention (based on research and what is acceptable to all partners involved), it is calculated that the total cost saving of RRAP to the health and social care sector in 2008-2009 was £15,009,000. Taking into account other costs associated with the project, it could be estimated that a £750 saving is made for every £1 invested through RRAP.

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Assuming 10 per cent of repairs and adaptations led to a hospital discharge or avoided an accident and hospital admission, the total cost saving to health and social care was estimated at £16 million in one year.

The service demonstrates the benefits of a targeted approach to repairs and adaptations, particularly for people at risk of a fall at home.

2. Description

The RRAP provides a small rapid response adaptations/repair service for older and disabled people which ensures that they can continue to live in a safe home environment as comfortably as possible. This service is complementary to the adaptation work funded by local authorities through the Disabled Facilities Grant and Home Repair Assistance. The service focuses on hospital discharge and reducing hospital admissions.

The aim of the programme is to ensure that older and disabled people are able to be discharged from hospital have a safe home to which to return. It also has an important role in preventing hospital admissions by addressing problems of homes that are no longer safe or appropriate for older and disabled people. The intention of the programme, which sets it apart from other repair services, is to enable Care and Repair agencies to provide a quick response service to health and social care staff. The Care and Repair agency receives the referrals and instructs a suitably qualified contractor or handyperson to carry out the required work. There is a 15-day maximum target date for completing the works from referral.

Referrals come from a range of statutory and health sector organisations, and are channelled through Care and Repair agencies.

- In 2008-09 and from communication with the Rapid Response Adaptations Programme Annual Performance Report 2008/09, the programme was shown to facilitate an immediate response to stat-IRIS needs by providing minor adaptations such as ramps and handrails, to enable people to return to their own homes following hospital discharge. These adaptations have also been shown to prevent the need for admission to hospital for older and disabled people which ensures that they can continue to live in a safe home environment as comfortably as possible.

3. Evidence of cost effectiveness

The RRAP provides a framework across Wales for targeting resources for effective support for older and disabled clients, in terms of both hospital discharge and hospital prevention.

The critical outcomes demonstrated by RRAP indicate the potential for well targeted and strategically managed services to address key elements of service speed, client focus and added value.

In 2008-09, 15,473 Rapid Response adaptations were delivered, of which 10,163 prevented hospital admission and 4,915 enabled hospital discharge. Estimates for cost savings detailed in Table 1 below are based on the following figures:

- 491 RRAP jobs taken into account for accident prevention (based on research and what is acceptable to all partners involved), it is calculated that the total cost saving of RRAP to the health and social care sector in 2008-2009 was £15,009,000. Taking into account other costs associated with the project, it could be estimated that a £7.50 saving is made for every £1 invested through RRAP.

The above estimate of cost effectiveness does not take into account costs in relation to staff and other costs. Further research by one agency estimated that the following costs were incurred in one year:

- Revenue funding for administrator, on costs and technical support = £250,000.
- RRAP Capital (some of which is turned into handyperson revenue support based on an agreed schedule of works) + £70,400.
- Handyperson salary costs = £24,258 (£14,500 on-costs) + £9,758. Further research by one agency estimated that the costs in relation to staff and other costs. Further research by one agency estimated that the costs were incurred in one year:

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- Works completed in total = £60,000.
- Average cost of handyperson job = £250.

Table 1

<table>
<thead>
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</thead>
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- Access to toilet facilities.
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Based on the figures above, which assume that 10% of each type of RRAP case directly leads to quicker discharge, admission prevention and accident prevention (based on research and what is acceptable to all partners involved), it is calculated that the total cost saving of RRAP to the health and social care sector in 2008-2009 was £15,009,000. Taking into account other costs associated with the project, it could be estimated that a £7.50 saving is made for every £1 invested through RRAP.

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The RRAP provides a framework across Wales for targeting resources for effective support for older and disabled clients, in terms of both hospital discharge and hospital prevention. The critical outcomes demonstrated by RRAP indicate the potential for well targeted and strategically managed services to address key elements of service speed, client focus and added value.

Table 1
Estimated costs and savings of RRAP to health and social care 2008-09

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<tr>
<th>Description</th>
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<th>Av. cost of hospital stay per day</th>
<th>Av. length of stay in hospital</th>
<th>Total cost to health (Avx10)</th>
<th>Av. cost of RRAP job</th>
<th>Total cost of RRAP jobs (Avx10)</th>
<th>Estimated saving (D-F)</th>
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</thead>
<tbody>
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<td>378</td>
<td>10</td>
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- Average cost of handyperson job = £67
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Based on the figures above, which assume that 10% of each type of RRAP case directly leads to quicker discharge, admission prevention and accident prevention (based on research and what is acceptable to all partners involved), it is calculated that the total cost saving of RRAP to the health and social care sector in 2008-2009 was £15,009,000. Taking into account other costs associated with the project, it could be estimated that a £75,000 saving is made for every £1 invested through RRAP.

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4. Application – where it might be appropriate

Currently, the RRAP is only available to owner-occupiers or private tenants. It is currently not available for RSL or council tenants. However, a review of adaptations undertaken by the Welsh Assembly Government in 2005 highlighted the need to increase the scope of RRAP to include these tenures.

The greatest savings are related to the assumed level of accident prevention. It is likely therefore that the RRAP approach is particularly applicable to those people most likely to have an accident at home, for example older people who are at risk of falling.

5. Resources required – staff, training, IT

The RRAP operates in a similar way to Safety at Home schemes run by most Care and Repair agencies. Research has shown that the average capital costs involved in Safety at Home type services (figures which can then be used to reflect RRAP job costs), are in the region of £150 per job. It is anticipated that the maximum capital cost per job in each home will not exceed £350. The revenue costs required to deliver the RRAP reflect:

- Initial costs for a part-time administrator to administer the programme.
- Initial work in agreeing protocols, service access criteria and referral processes, and some briefing/training and information packs (agencies already had operational partnerships with Health and Social Services, and many had Safety at Home and Emergency Pressure schemes).
- In 2006/07 the revenue sum was increased to provide for a RRAP co-ordinator post which services the partnership, eg, maintaining awareness (across staff in health and social care), monitoring referrals and expenditure.

6. Strengths

The RRAP meets many key objectives of local and national policies – in Wales this includes the National Housing Strategy, as well as local health and well-being strategies and older people strategies. It provides preventative services that are closely related to client need and support personal choice and independence. Furthermore, this programme provides a framework of effective local support for vulnerable clients in terms of both hospital discharge and hospital prevention.

The programme demonstrates that by targeting resources effectively, a RRAP enables a quick local response to vulnerable older and disabled people, and can save money across the health and social care sectors. These findings are supported by a review of evidence relating to investment in housing adaptations, improvements and equipment by Heywood and Turner (2007)3. The RRAP is well respected, which is reflected in the fact that it has consistently received core funding from the Welsh Assembly Government, unlike care and repair schemes elsewhere which often experience funding problems.

7. Weaknesses and potential pitfalls

The main weakness reflects high levels of demand outweighing funding for the programme. Furthermore, there is no recognised strategy for addressing work over £150, which may leave some clients vulnerable. There is still some lack of awareness among local partners and complexities associated with joint working. Health professionals do not always have a strong awareness or understanding of housing related services and definitions of what represents a hospital discharge can differ. There is some reluctance amongst health professionals to define some referrals as contributing to hospital discharge, as the issues that contribute to hospital discharge are often complex and quite often not housing related (eg delayed transfers of care targets for health).

It can sometimes be difficult to achieve best value and economies of scale in the Third Sector. However, work is being undertaken to look at regional collaboration and collective procurement6.

There is currently a limited understanding of client satisfaction and the impact of the service on individual outcomes.

8. Sources of further information

Neil Williams, Head of Agency Performance and Funding, Care and Repair Cymru. Telephone 020 2057 8286. Care and repair Cymru at www.careandrepair.org.uk

Welsh Assembly Government (2005) Review of housing adaptations including disabled facilities grant – Wales, WAG


6 WAG (2011) Sustainable Social Services for Wales: A framework for action

5. Care and Repair a programme providing a repairs and adaptations programme for older people in Wales, estimated to save £15 million a year –

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4. **Application – where it might be appropriate**

Currently the RRAP is only available to owner-occupiers or private tenants. It is currently not available for RSL or council tenants. However, a review of adaptations undertaken by the Welsh Assembly Government in 2005 highlighted the need to increase the scope of RRAP to include these tenures.

The greatest savings are related to the assumed level of accident prevention. It is therefore likely that the RRAP approach is particularly applicable to those people most likely to have an accident at home, for example older people who are at risk of falling.

5. **Resources required – staff, training, IT**

The RRAP operates in a similar way to Safety at Home schemes run by most Care and Repair agencies. Research has shown that the average capital costs involved in Safety at Home type services (figures which can then be used to reflect RRAP job costs) are in the region of £150 per job. It is anticipated that the maximum capital cost per job in each region will not exceed £350, which may leave some clients vulnerable.

**4/7/11 13:46:54**

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This case study was compiled for IRISS by the Institute of Public Care July 2011

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2  Welsh Assembly Government (2005) Review of housing adaptations including disabled facilities grant – Wales, WAG

1  These assumptions (10%) were based on historical research and information received when developing the programme in 2003

5  Welsh Assembly Government (2005) Review of housing adaptations including disabled facilities grant – Wales, WAG

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The main weaknesses reflect high levels of demand outweighing funding for the programme. Furthermore, there is no recognised strategy for addressing work over £350, which may leave some clients vulnerable.

There is still some lack of awareness among local partners and complexities associated with joint working. Health professionals do not always have a strong awareness or understanding of housing related services and definitions of what represents a hospital discharge can differ. There is some reluctance amongst health professionals to define some referrals as contributing to hospital discharge, as the issues that contribute to hospital discharge are often complex and quite often not housing related (eg delayed transfers of care targets for health).

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6. **Strengths**

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The programme demonstrates that targeting resources effectively, a RRAP enables a quick local response to vulnerable older and disabled people, and can save money across the health and social care sectors. These findings are supported by a review of evidence relating to investment in housing adaptations, improvements and equipment by Heywood and Turner (2007) [7].

The RRAP is well respected, which is reflected in the fact that it has consistently received core funding from the Welsh Assembly Government, unlike care and repair schemes elsewhere which often experience funding problems.

In 2006/07 the revenue sum was increased to provide for a RRAP co-ordinator post which services the partnership, eg, maintaining awareness (across staff in health and social care), monitoring referrals and expenditure.

Overall, the volume of work undertaken by the RRAP programme in 2008/9 represented an increase in the volume of work in 18% of the agencies: 15,186 case referrals; 14,890 people helped, and 15,473 jobs completed. There is an average of 705 jobs completed in Welsh counties on an annual basis at an average cost of £118. Most agencies have a small bank of reliable contractors and one or two handypersons dedicated to this work.

The programme provides a framework of effective local support for vulnerable clients in terms of both hospital discharge and hospital prevention.

The greatest savings are related to the assumed level of accident prevention. It is therefore likely that the RRAP approach is particularly applicable to those people most likely to have an accident at home, for example older people who are at risk of falling.

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Sources of further information

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It can sometimes be difficult to achieve best value and economies of scale in the Third Sector. However, work is being undertaken to look at regional collaboration and collective procurement.

There is currently a limited understanding of client satisfaction and the impact of the service on individual outcomes.

5. **Care and Repair**

A programme providing a repairs and adaptations programme for older people in Wales, estimated to save £15 million a year –
3.3 Advice and signposting
The self assessment group was offered more advice regarding preventative services, compared to those assessed by care managers who did not appear to make as much use of the resource information available concerning these services. Those in the self assessment group received significantly (statistically) more units of advice on a wider range of services than those receiving the traditional care management assessment: a mean difference of four services compared to one service respectively. The mean cost of providing advice and signposting to other services was £14.02 for the self assessment group and £3.20 for the care management assessment group: a difference that was statistically significant.

4. Application – where it might be appropriate
The self assessment pilot project focused on older people over the age of 55 years. Since the pilot ended, the service has been mainstreamed for all adult services. It now sits within the access and review team. The self assessment process is therefore applicable across adult social services but increasingly targeted on those with low-level needs.

5. Resources required – staff, training, IT
This pilot was part of a Department of Health programme with £100,000 funding for the first year. Two members of staff were seconded to work on the pilot for a year, as well as a project manager. No specific bespoke training was deemed necessary.

6. Strengths
The self assessment approach fits well with current government policy objectives to promote personalisation and prevention, putting people in control of identifying what will help them to improve their lives. The service is flexible, offering different assessment types and support according to the individual’s needs. For example, an individual may just need to be provided with an information pack, or they may need a one-off visit to better identify their needs, or the self assessment may be judged to reflect a self referral where the person is eligible for care and support services.

The approach also fits with the government’s prevention agenda and widens access to information and advice. People have been able to access the service who would not necessarily have come to light through a traditional assessment and care management approach. Thus, the self assessment approach is better able to reach those who may not feel it appropriate to contact social services directly, or who are not eligible for care and support, but still have needs to be addressed.

The approach targets assessment resources on a group traditionally neglected by the usual social services response. Not all potential users require the additional costs of a care manager. If such users can be identified, this can invoke significant cost savings whilst offering an assessment approach with similar benefits in terms of the range of services available and satisfaction with the process.

High levels of satisfaction were reported equally across both groups of service users in terms of ease of use; information; and overall satisfaction.

The networking with other agencies and organisations that took place as a result of investigating what services were available and through discussion about individual cases was seen by staff as a positive consequence of the self assessment approach.

7. Weaknesses and potential pitfalls
Some care managers were slow to appreciate the benefits of this preventative approach and felt in some instances they were being asked to provide advice and information which did not use their social work expertise. On reflection, it was felt that the approach could have been “sold” to care managers better in the beginning to gain their support and understanding, by highlighting the benefits in terms of the prevention agenda and the benefits to the service users.

The self assessment approach was sporadic and it was felt that this option had not been publicised effectively.

6. Self Assessment
in a project for older people cost an average of £88 per assessment compared to an average cost of £286 for assessment by a care manager
A self assessment pilot provided a service to older people with low level needs and access to a range of services.

Overall the approach was cheaper than by a professional care manager and did not affect satisfaction levels: by a care manager cost an average £286, compared with £88 by a self assessment facilitator.

The pilot shows how a targeted assessment facilitator was cheaper than an assessment approach that reduced the amount of time-consuming paperwork and procedures.

The pilot involved a sample of 100 service users, aged 55 years and over. They were offered a choice of the council’s assessment and care management service, following which they were randomly allocated by the team manager either to undertake a self assessment arranged and assisted by the self assessment facilitators (n=54), or to a professional assessment by a care manager (n=46).

Those completing the self assessment were assisted by self assessment facilitators. The pilot involved a sample of 100 service users, aged 55 years and over (n=54), or to a professional assessment by a care manager (n=46).

The evidence from the study suggests that those who received the self assessment generated lower costs in terms of the assessment process itself. Overall, the self assessment facilitators spent half the time of care managers in activities related to the assessment process. The self assessment facilitators reported taking less time than care managers in telephone consultations with users, case discussions (such as with team leaders), paperwork and travel time.

The majority of service users had contact with a social services manager (a community alarm service supplemented in some cases by a key safe service and/or a door alarm). Slightly more users in the self assessment group received delivered meals, and this reflected significantly higher costs than for those receiving traditional care management services.

<table>
<thead>
<tr>
<th>Service receipt, average cost among users and contribution to total over six months (n=100)</th>
<th>Contribution to total cost (%)</th>
<th>Self Assessment</th>
<th>Care Manager Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing Assessment</td>
<td>53%</td>
<td>82%</td>
<td></td>
</tr>
<tr>
<td>Commissioned Services:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Careline</td>
<td>20.3%</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Delivered Meals</td>
<td>19.4%</td>
<td>3.1%</td>
<td></td>
</tr>
<tr>
<td>Day Centre</td>
<td>0%</td>
<td>3.1%</td>
<td></td>
</tr>
<tr>
<td>Referral to OT</td>
<td>0.04%</td>
<td>0.2%</td>
<td></td>
</tr>
<tr>
<td>Units of Advice:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shopping Service</td>
<td>0.5%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Meal Preparation</td>
<td>0%</td>
<td>0.03%</td>
<td></td>
</tr>
<tr>
<td>Domestic Services</td>
<td>0.4%</td>
<td>0.03%</td>
<td></td>
</tr>
<tr>
<td>Exercise/Health</td>
<td>0.08%</td>
<td>0.03%</td>
<td></td>
</tr>
<tr>
<td>Arts/Community Equipment</td>
<td>1.2%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Transport</td>
<td>1.5%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Benefits/Finance</td>
<td>0.2%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Home Maintenance</td>
<td>0.9%</td>
<td>0.10%</td>
<td></td>
</tr>
<tr>
<td>Library</td>
<td>0.2%</td>
<td>0.03%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>2.6%</td>
<td>0.4%</td>
<td></td>
</tr>
</tbody>
</table>

A self assessment pilot provided a service to older people with low level needs and access to a range of services.

Overall the approach was cheaper than a professional care manager and did not affect satisfaction levels: a care manager cost an average £286, compared with £88 by a self assessment facilitator.

The pilot shows how a targeted assessment facilitator.

The evidence of cost effectiveness

Overall, despite some components of the self assessment arrangements generating higher costs than traditional arrangements (such as advice about preventive services), total costs were £286 in the self assessment being less costly in terms of the range of services received compared to £88 in the self assessment facilitators; and secondly, the facilitators were relatively a less costly resource with a lower unit cost.

The evidence from the study also suggests that there are resource savings in terms of both ‘back office’ costs such as savings of time on paperwork and gathering information, and also ‘front office’ costs in terms of what happens in the assessment and who provides it.

The variation in costs associated with the self assessment approach versus the traditional care management approach are summarised in Table 1 opposite.

The evidence from this study suggests that those who received the self assessment generated lower costs in terms of the assessment process itself. Overall, the self assessment facilitators spent about half the time of care managers in activities related to the assessment process. The self assessment facilitators reported taking less time than care managers in telephone consultations with users, case discussions (such as with team leaders), paperwork and travel time.

The assessment was the most expensive component of each group, and was significantly (statistically) more expensive when provided by care managers, compared with self assessment facilitators (an average of £286 compared to £88 respectively). Providing the assessment contributed to over 82% of the total costs for the care management group compared to 53% attributed to the self assessment facilitators.

The majority of services users had contact with Careline services (a community alarm service supplemented in some cases by a key safe service and/or a door alarm). Slightly more users in the self assessment group received delivered meals, and this reflected significantly higher costs than for those receiving traditional care management. Aids/Community Equipment was the intended difference not the service received.

The evidence from this study suggests that there are resource savings in terms of both ‘back office’ costs such as savings of time on paperwork and gathering information, and also ‘front office’ costs in terms of what happens in the assessment and who provides it.

The variation in costs associated with the self assessment approach versus the traditional care management approach are summarised in Table 1 opposite.

The evidence from this study suggests that those who received the self assessment generated lower costs in terms of the assessment process itself. Overall, the self assessment facilitators spent about half the time of care managers in activities related to the assessment process. The self assessment facilitators reported taking less time than care managers in telephone consultations with users, case discussions (such as with team leaders), paperwork and travel time.

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The overall approach was to target those aged over 65 with lower level needs and access to a range of services.

1. Introduction

After the pilot involved a sample of 52 service users, aged 55 years and over. They were randomly allocated (by the team) to a professional care manager with no previous local authority experience with older people.

2. Description

To assess eligibility criteria for low level needs and so that they were randomly allocated (by the team) to a professional care manager with no previous local authority experience with older people.

3. Evidence of cost

The results showed how an assessment approach was intended to generate resource savings by implementing an assessment that reduced the amount of time spent on 'front office' costs in terms of what happens from communication with the project manager arranged and assisted by the self assessment facilitators. The facilitators were also able to offer users advice through telephone contact or a one-off visit. They also researched existing services in the area to enable a wider range of options to be provided. The facilitators were NVQ Level 3 assessment facilitators.

Overall, despite some components of the self assessment arrangements generating higher costs, there were lower. The difference was due to: self assessment facilitators; and secondly, the assessment being less costly in terms of the 'front office' costs in terms of what happens from communication with the project manager arranged and assisted by the self assessment facilitators.

Table 1

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Self Assessment</th>
<th>Care Manager Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs</td>
<td>£73.19</td>
<td>£88.94</td>
</tr>
<tr>
<td>Contribution to total costs (f)</td>
<td>20.3%</td>
<td>33.7%</td>
</tr>
<tr>
<td>Self Assessment</td>
<td>£53%</td>
<td>£82%</td>
</tr>
<tr>
<td>Costs after total over six months (f)</td>
<td>£19</td>
<td>£20.3</td>
</tr>
<tr>
<td>Percentage change</td>
<td>20.3%</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

4. Conclusion

The pilot involved a sample of 52 service users, aged 55 years and over. They were randomly allocated (by the team) to a professional care manager with no previous local authority experience with older people.

The facilitators were also able to signpost users to relevant services using a service assessment form. They then had the chance of receiving the same wide range of services (ie the type of assessment and who provides it). Following on from the self assessment, the staff who had previous local authority experience were also able to give advice through telephone contact or a one-off visit. The facilitators were NVQ Level 3 assessment facilitators.

The variation in costs associated with the self assessment approach versus the traditional care manager assessment are summarised in Table 1 opposite.
3.3 Advice and signposting

The self assessment group was offered more advice regarding preventative services, compared to those assessed by care managers who did not appear to make as much use of the resource information available concerning these services. Those in the self assessment group received significantly (statistically) more units of advice on a wider range of services than those receiving the traditional care management assessment: a mean difference of four services compared to one service respectively. The mean cost of providing advice and signposting to other services was £14.02 for the self assessment group and €3.20 for the care management assessment group: a difference that was statistically significant.

4. Application – where it might be appropriate

The self assessment pilot project focused on older people over the age of 55 years. Since the pilot ended, the service has been mainstreamed for all adult services. It now sits within the access and review team. The self assessment process is therefore applicable across adult social services but targeted on those with low-level needs.

5. Resources required – staff, training, IT

This pilot was part of a Department of Health programme with £100,000 funding for the first year. Two members of staff were seconded to work on the pilot for a year, as well as a project manager. No specific bespoke training was deemed necessary.

Following the pilot, the service has been mainstreamed across all adult social services and there are no additional ongoing costs.

6. Strengths

The self assessment approach fits well with current government policy objectives to promote personalisation and prevention, putting people in control of identifying what will help them to improve their lives. The service is flexible, offering different arrangements and types of support according to the individual's needs. For example, an individual may just need to be provided with an information pack, or they may need a one-off visit to better identify their needs, or the self assessment may be judged to reflect a self referral where the person is eligible for care and support services.

The approach also fits with the government’s prevention agenda and widens access to information and advice. People have been able to access the service who would not necessarily have come to light through a traditional assessment and care management approach. Thus, the self assessment approach is better able to reach those who may not feel it appropriate to contact social services directly, or who are not eligible for care and support, but still have needs to be addressed.

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Some care managers were slow to appreciate the benefits of this preventative approach and felt in some instances they were being asked to provide advice and information which did not use their social work expertise. On reflection, it was felt that the approach could have been ‘sold’ to care managers better in the beginning to gain their support and understanding, by highlighting the benefits in terms of the prevention agenda and the benefits to the service users.

The completion of the self assessment online was sporadic and it was felt that this option had not been publicised effectively.

8. Sources of further information


Carole Kilshaw, St Helens Council, 0744 679683


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Carole Kilshaw, St Helens Council, 01744 676789

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This pilot was part of a Department of Health programme with £100,000 funding for the first year. Two members of staff were seconded to work on the pilot for a year, as well as a project manager. No specific bespoke training was deemed necessary. Following the pilot, the service has been mainstreamed across all adult social services and there are no additional ongoing costs.

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8. Sources of further information
5. Resources required – staff, training, IT

The introduction of IBs represents a major cultural shift in the organisation and provision of social care. It will require additional resources to ensure systems are in place to reflect local needs and circumstances. The set-up costs of introducing IBs will vary depending on an individual organisation’s progress towards self directed support and the information and administrative systems that will need adapting. Costs will also depend on the approach adopted: whether authorities attempt to address all or a selected number of user groups and/or teams or geographical locations in the first instance. The degree to which external agencies and processes to support direct payment arrangements are already in place will impact on the requirements for supporting IBs. Furthermore, some authorities identified a two-year set up period, while others felt one year would be sufficient.

Among the pilot sites there was a variety of organisational arrangements: some authorities employed dedicated staff to undertake a wide range of activities, and others allocated these activities to a range of individuals and organisations. Average set-up costs for all pilot sites were £286,630 (minimum £128,470; maximum £486,460). Where there was a project management dedicated team, the average was £334,450 (range £222,350 to £486,460). The costs reported were dominated by the costs of salaries and associated on-costs (National Insurance and superannuation).

Other component costs were:

- Development of systems – some authorities will have administrative systems that are more easily adapted to the needs of implementing IBs than others. Average costs to adapt and develop local systems were reported as £43,594 (median £24,970).
- Workforce development – the level of training and development required will depend on the degree to which care managers are working in an outcome focused way. On average, it was estimated that an additional £15,320 (median £10,600 with estimates ranging from £989 to £35,800) would be needed to meet the training needs of the workforce.
- Support planning and brokerage – in order to ensure that support planning and brokerage arrangements were in place, an average of £15,710 (median £41,500) would be required.

6. Strengths

The anticipated advantages of this new system were seen to include: the ability to meet not only personal care needs, but also a range of other needs; continuity and choice of care worker; the chance to pay family and other carers; and greater flexibility over how and when to use support services. IBs allowed people to exercise a level of choice and control that they would not have been able to exercise under previous arrangements: ‘... seeing people who’ve had very, very different approach to service provision would renew engagement with voluntary sector organisations, and produce greater flexibility on the part of service providers. It was felt that this different approach to service provision would renew engagement with voluntary sector organisations, and produce greater flexibility on the part of service providers.

7. Weaknesses and potential pitfalls

IBs imply major changes and challenges in:

- Organisational arrangements, processes, culture and professional roles within local authority adult social care services; in the roles of voluntary and user-led organisations; and in the expectations and responsibilities of social care service users. In particular, major change is needed in the activities and processes undertaken by front line staff (care managers/social workers).
- Changing the attitudes and culture of care managers and other staff. Particular resistance and aversion to risk was reported among some teams working with mental health service users and with older people.
- Funding and developing alternatives to IB while resources are still tied up in relatively long-term block contracts.
- Developing resource allocation systems.
- Disaggregating social care resources from services that are jointly funded with other departments and organisations (eg health).

Service providers may experience reduced demand for traditional services and new pressures to provide different types of services in different ways if they are to remain viable. There was a view that currently there is a lack of choice of alternative provision: not all service providers are seen as being proactive in changing to meet the potential change in demand. Providers may need help to prepare for this new approach at a time when commissioning resources are limited.

8. Sources of further information


The GHQ 12 is a widely used version of the General Health Questionnaire used to test psychological well-being.

Money Matters case study seven

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### Table 2

<table>
<thead>
<tr>
<th>Number</th>
<th>Overall weekly cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>IB group 288</td>
</tr>
<tr>
<td>Overall</td>
<td>Comparison group 250</td>
</tr>
<tr>
<td>Mental health</td>
<td>IB group 35</td>
</tr>
<tr>
<td>Mental health</td>
<td>Comparison group 33</td>
</tr>
<tr>
<td>Physical disability</td>
<td>IB group 90</td>
</tr>
<tr>
<td>Physical disability</td>
<td>Comparison group 88</td>
</tr>
<tr>
<td>Learning disability</td>
<td>IB group 70</td>
</tr>
<tr>
<td>Learning disability</td>
<td>Comparison group 63</td>
</tr>
<tr>
<td>Older people</td>
<td>IB group 73</td>
</tr>
<tr>
<td>Older people</td>
<td>Comparison group 66</td>
</tr>
</tbody>
</table>
The Individual Budgets (IBs) Pilot Programme tested the introduction of cash and notional individual budgets for users of adult social care in thirteen local authorities.

IBs are most effective for mental health service users in terms of psychological well-being and social care outcomes; they are also cost effective for younger people with physical disabilities.

Overall, people with an IB felt significantly more in control of their everyday lives, the support they received, and how it was delivered than other service users.

Personal budgets are now being rolled out across adult social care in England.

### 1. Introduction

This case study is based on an evaluation of the introduction of the IB programme undertaken in 2006. Thirteen local authorities can pilot IBs, starting with five from November 2005 to December 2007. The pilot sites implemented different personal budgets and for introducing IBs; the detail of these can be found in the main report (see references for introducing IBs).

The evaluation indicated that those who received an IB experienced notably better outcomes, and that IBs are more effective in achieving overall social care outcomes than traditional approaches.

### 2. Description

IBs are central to the Government’s ‘personalisation agenda’. The Individual Budgets programme sought to develop new systems within local authorities that offered opportunities for individuals to individually exercise their choice and control over how their support needs were met through personal budgets. The focus of support arrangements from service inputs to user-defined outcomes. Individual budgets give a clear allocation of cash, or a notional sum, to an individual to control the way money is spent to meet their care needs. IBs can bring together a variety of income streams from different agencies, as well as social care (unlike personal budgets).

Pilot sites adopted a range of approaches to implementation in terms of:

- Implementation: most sites offered IBs (at least initially) to one user of each type of expenditure  type of expenditure  expenditure
- New structures and processes: including: outcome-focused assessment; development of a RfA; and changes to the care planning process
- Cost of IBs – the average gross cost of an IB was £11,450 (median £6,510; standard deviation £5,380); maximum £16,850. On average, approximately 2% of IBs had a recurrent funding (in £27; median £6,510; standard deviation £5,380)
- Standard deviations: services/ equipment – other  £1,960; telecare  £160; adaptations  £690; equipment – telecare  £2,350; planned short breaks  £1,960; child care  £1,850; health and dental services  £2,000; accommodation  £1,830
- One-off payments reported in support plans included: kitchen; bedroom or bathroom equipment; safety devices; ramps; mobility aids; courses; and computer equipment
- Additional services/expenditure identified included: decorating or gardening services; social worker or care coordinator; gymnasium; internet access; personal needs; and alternative therapy or private health care.

### 3. Evidence of cost effectiveness

A randomised controlled trial (RCT) was designed to investigate the effectiveness of IBs at a key objective was to determine whether the approach improved outcomes, and that IBs can bring together a variety of income streams from different agencies, as well as social care (unlike personal budgets).

### Table 1 Patterns of use of IBs

<table>
<thead>
<tr>
<th>Service/ type of expenditure</th>
<th>%</th>
<th>Mean annual expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal assistant</td>
<td>59%</td>
<td>£5,320</td>
</tr>
<tr>
<td>Home car (in-house)</td>
<td>5%</td>
<td>£5,700</td>
</tr>
<tr>
<td>Meals services</td>
<td>9%</td>
<td>£300</td>
</tr>
<tr>
<td>Equipment – telecare</td>
<td>2%</td>
<td>£160</td>
</tr>
<tr>
<td>Equipment – other</td>
<td>10%</td>
<td>£370</td>
</tr>
<tr>
<td>Adaptations</td>
<td>9%</td>
<td>£370</td>
</tr>
<tr>
<td>Leisure activities</td>
<td>37%</td>
<td>£1,300</td>
</tr>
<tr>
<td>Planned short breaks</td>
<td>22%</td>
<td>£2,650</td>
</tr>
<tr>
<td>Child care</td>
<td>1%</td>
<td>£1,850</td>
</tr>
<tr>
<td>Health and dental services</td>
<td>2%</td>
<td>£600</td>
</tr>
<tr>
<td>Accommodation</td>
<td>1%</td>
<td>£830</td>
</tr>
</tbody>
</table>

To ensure comparison of like with like in relation to cost effectiveness analysis, the evaluation measured the mean difference in costs and divided it by the mean difference in each outcome measure (such as ASCOT). Ratio costs to outcome differences to obtain a ratio. Simulations were made to evaluate whether these ratios were likely to be interpreted as indicating that IBs would be seen as cost effective. That is, they asked whether policy built on individual budgets is likely to achieve better user outcomes at a cost that is worth paying.

### 4. Application – where it might be appropriate

This approach can be applied to all user groups, though the impact and cost effectiveness may vary. It may be particularly suitable for younger people with mental health service users and young people with physical disabilities. IBs are also suited to some people with learning disabilities – likely to be those who need lower level services.

The four different aspects of care and support planning and management were: assessment (including self and/or team of experts); the plans in place (including support breakdown and budget); the frequency of contact with a local authority social worker or care coordinator was higher for IB holders than for people in the comparison group (statistically significant). There was also a tendency for people in the IB group to be better for those in the IB group than for people in the comparison group (statistically significant). There were differences in the implementation of their IB within the initial 6-month period in relation to the IB group.

There appears to be a small cost effectiveness advantage for IB over standard support arrangements for younger physically disabled people using either of the outcome measures. Younger physically disabled people in the IB group were significantly more likely to report higher quality of care and were more satisfied with the help they received.

For people with learning disabilities, IBs were found to be cost effective with respect to social care, but this advantage was only visible when the data covered the whole group, and the advantage was not statistically significant. Breakdown by age group was only visible when the data covered the whole group, and the advantage for IB was significantly higher than for the comparison group. This difference is not statistically significant.

When pooling data across the sample as a whole, the IB group were significantly more likely to report feeling in control of their daily lives, the support they received, and how it was delivered. Significant differences were not found between the IB and comparison groups in the other outcome domains (personality, dignity, safety, meals and nutrition, social participation and interest, accommodation and independence, cleanliness and comfort, and daily activities). Any difference in benefits that the IB group experienced slightly better outcomes.
1. Introduction

This case study is an evaluation of the Individual Budgets (IB) programme undertaken in 2008. Thirteen local authorities can pilots, covering 13,325 people, ran from September 2007 to December 2007. The pilots sites implemented different approaches and a framework for introducing IBs; the details of these can be found in the main report (see references for introducing IBs). The evaluation indicated that those who received an IB experienced fewer and better outcomes, and that IBs are more effective in achieving overall social care outcomes than traditional approaches.

2. Description

IBs are central to the Government’s ‘personalisation’ agenda. The Individual Budgets programme sought to develop new systems within local authorities that offered opportunities to individualise support and control over how their support needs were met with the aim of achieving the most favourable outcome. It focused on the support of arrangements from service inputs to user-defined outcomes. Individual budgets give a clear allocation of cash, or a notional sum, to an individual to control the way money is spent to meet their care needs. IBs are central to the debate on the viability of income streams from different agencies, as well as social care (unlike personal budgets).

Pilot sites adopted a range of approaches to implementation in terms of:

- Integrate the process into existing arrangements. Overall the pilot sites offered IBs to at least initially to one user out of every ten individuals managed by a care manager.

- New structures and processes – including: outcome-focused assessment; development of a RAS; and changes to the care planning process.

- Cost of IBs – the average gross cost of an IB was £1,145 (median £665; standard deviation £875). The range was £72; maximum £156,760. On average, approximately £371 was for recurrent funding (n=278; median £5,558; standard deviation £7,056) and £21 was for one-off payments (n=46; median £0; standard deviation £1,500).

3. Evidence of cost effectiveness

A randomised controlled trial (RCT) was designed to investigate the effectiveness of IBs on a key objective was to determine whether the approach improved outcomes compared with the type of support they accessed, and over the way that support was organised and delivered. For many individuals there were delays in the implementation of their IB which resulted in less than half of those who accepted an IB actually having a support plan in place at six months. Only 36% of those who had a support plan had had the arrangements in place for more than a month.

The cost effectiveness analyses reported in the evaluation used the measure of QALYs as the outcome. The analyses also included two measures of psychological well-being. In relation to social care, but this advantage was only visible when the data covered the first six months in place. Standard care arrangements appeared to be slightly more cost effective than IBs with respect to psychological well-being.

For older people, there was no sign of a cost effective advantage for either IBs or standard support arrangements using the social care outcomes measure. In relation to psychological well-being, standard arrangements looked slightly more cost effective than IBs.

The average value of funding within IBs across all user groups was 22% £23,290; people with learning disabilities (n=976 in the comparison group) and IB holders reported higher use and higher costs.

4. Application – where it might be appropriate

This approach is appropriate to all user groups, though the impact and cost effectiveness does vary significantly. The Government’s aim is to make it possible to provide a wider range of mental health service users and young people with physical disabilities. IBs are also suited to those people with learning disabilities – likely to be those who need lower level services.
1. Introduction

This case study is based on an evaluation of the Individual Budgets (IBs) programme undertaken in 2008. Thirteen local authorities could pilot IBs (one in each region) from November 2005 to December 2007. The pilots sites implemented different approaches and systems for introducing IBs; the detail of these can be found in the main report. For the evaluation, the introduction of IBs was defined in terms of:

- Pilot sites adopted a range of approaches (unlike personal budgets).
- New structures and processes – most sites can bring together a variety of income streams (including cash and notional payments) through an IB.
- Pilot sites adopted a range of approaches in terms of:
  - Development of models. Pilot sites offered IBs (at least initially) to one user of their choosing.
  - Development of IBs. Pilot sites were charged with managing an IB for one person.
  - Development of the care plan. Pilot sites were responsible for introducing IBs.

The overall ambition was for users to receive an IB that reflected their needs, preferences, and capacities and allowed them to control how it was delivered rather than through traditional approaches. The evaluation indicated that those who received an IB experienced slightly better outcomes, and that IBs are more effective in achieving overall social care outcomes than traditional approaches.

2. Description

IBs are central to the Government’s ‘personalisation’ agenda. The Individual Budgets programme sought to develop new systems within local authorities that offered opportunities for individual service users to have more choice and control over how their support needs were met through an IB. The evaluation focused on the shift of support arrangements from service inputs to user-defined outcomes. Individual budgets give a clear allocation of cash, or a notional sum, to an individual to control the way money is spent to meet their care needs. IBs can bring together a variety of income streams from different agencies, as well as social care (unlike personal budgets). The Individual Budgets (IBs) Pilot Programme tested the introduction of cash and notional individual budgets for users of adult social care in thirteen local authorities.

3. Evidence of Cost Effectiveness

A randomised controlled trial (RCT) was designed to investigate the effectiveness of IBs by a key objective was to understand whether the approach improved outcomes. The evaluation compared people who received a type of support they accessed, and over the whole of the implementation of their IB when resulted in less than half of those who accepted an IB actually having a support plan in place at six months. Only 36% of those who had a support plan had had the arrangements in place for more than a month. The cost effectiveness analyses reported in the evaluation included the mean difference in each outcome measure (such as ASCOT) and the cost differences to obtain a ratio. Simulations were made on the basis of user data to see whether these ratios were likely to be seen as cost effective. That is, they asked whether the cost being built into individual budgets is likely to achieve better user outcomes at a cost that is worth paying.

To ensure comparison of like with like in relation to cost effectiveness analyses, the evaluation focused on recurrent expenditure and used weekly costs drawing on the content of the support plan recorded. Cost effectiveness was analysed against two outcomes: ASCOT social outcomes measure and the GHQ-121 measure of psychological well-being. The findings were broadly encouraging for the new arrangements:

- Across all user groups combined there was some evidence that IBs are more cost effective in achieving overall social care outcomes. That is, they asked whether these ratios were likely to be cost effective. That is, they asked whether the approach improved overall social care outcomes, but no advantage in relation to psychological well-being.
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Personal budgets are now being rolled out across adult social care in England.
Older people IB group 73 £228
Comparison group 63 £390
Learning disability IB group 70 £359
Comparison group 88 £334
Physical disability IB group 90 £310
Comparison group 33 £152
Mental health IB group 35 £149
Comparison group 250 £296
Overall IB group 268 £279

Pilot sites were £286,630 (minimum £128,470; maximum £486,460). Where there was a project management dedicated team, the average was £334,450 (range £222,950 to £486,460). The costs reported were an average of £51,710 (median £10,660 with estimates ranging from £918 to £35,800) would be required.

Among the pilot sites there was a variety of organisational arrangements: some authorities employed dedicated staff to undertake a wide range of activities, and others allocated these activities to a range of individuals and organisations. Average set-up costs for all pilot sites were £286,630 (minimum £128,470; maximum £486,460). Where there was a project management dedicated team, the average was £334,450 (range £222,950 to £486,460). The costs reported were an average of £51,710 (median £10,660 with estimates ranging from £918 to £35,800) would be required.

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The anticipated advantages of this new system were seen to include: the ability to meet not only personal care needs, but also a range of other needs; continuity and choice of care worker; the chance to pay family and other carers; and greater flexibility over how and when to use support services.

IBs allowed people to exercise a level of choice and control that they would not have been able to exercise under previous arrangements: ‘seeing people who’ve had very, very traditional style support for a very long time, living much more independent lives than they had done’. ‘People are living, not existing. It was felt that this different approach to service provision would renew engagement with voluntary sector organisations, and produce greater flexibility on the part of service providers.

7. Weaknesses and potential pitfalls

IBs imply major changes and challenges in:

1. Organisational arrangements, processes, culture and professional roles with local authority adult social care services; in the roles of voluntary and user organisations; and in the expectations and responsibilities of social care users. In particular, major change is needed in the activities and processes undertaken by front line staff (care managers/social workers).
2. Changing the attitudes and culture of care managers and other staff. Particular resistance and aversion to risk was reported among some teams working with mental health service users and with older people.
3. Funding and developing alternatives to IB while resources are still tied up in relatively long-term block contracts.
4. Developing resource allocation systems.
5. Disaggregating social care resources from services that are jointly funded with other departments and organisations (eg health).

Service providers may experience reduced demand for traditional services and new pressures to provide different types of services in different ways if they are to remain viable. There was a view that currently there is a lack of choice of alternative provision: not all service providers are seen as being proactive in changing to meet the potential change in demand. Providers may need help to prepare for this new approach at a time when commissioning resources are limited.

8. Sources of further information


The General Health Questionnaire used to test psychological well-being.

Money Matters case study seven

Money Matters reviews cost effective initiatives

www.iriss.org.uk
5. Resources required – staff, training, IT

The introduction of IBs represents a major cultural shift in the organisation and provision of social care. It will require additional resources to ensure systems are in place to reflect local needs and circumstances. The set-up costs of introducing IBs will vary depending on an individual organisation’s progress towards self-directed support and the information and administrative systems that will need adapting. Costs will also depend on the approach adopted: whether authorities attempt to address all or a selected number of user groups and/or teams or geographical locations in the first instance. The degree to which external agencies and processes to support direct payment arrangements are already in place will impact on the requirements for supporting IBs. Furthermore, some authorities identified a two-year set up time, living much more independent lives when compared with older people.

Among the pilot sites there was a variety of organisational arrangements: some authorities employed dedicated staff to undertake a wide range of activities, and others allocated these activities to a range of individuals and organisations. Average set-up costs for all pilot sites were £286,630 (minimum £128,470; maximum £486,460). Where there was a project management dedicated team, the average was £334,450 (range £222,950 to £486,460). The costs reported were associated on-costs (National Insurance and superannuation).

6. Strengths

The anticipated advantages of this new system were seen to include: the ability to meet not only personal care needs, but also a range of other needs; continuity and choice of care worker; the chance to pay family and other carers; and greater flexibility over how and when to use support services. IBs allowed people to exercise a level of choice and control that they would not have been able to exercise under previous arrangements. Users were seen to include: the ability to meet not just other needs; continuity and choice of care worker; living much more independent lives when compared with older people.

It was felt that this different approach to service provision would renew engagement with voluntary sector organisations, and produce greater flexibility on the part of service providers.

7. Weaknesses and potential pitfalls

IBs may imply major changes and challenges in:

- Organisational arrangements, outcomes, processes, culture and professional roles within local authority adult social care services; in the roles of voluntary and user-led organisations; and in the expectations and responsibilities of social care users. In particular, major change is needed in the activities and processes undertaken by front line staff (care managers/social workers).
- Changing the attitudes and culture of care managers and other staff. Particular resistance and aversion to risk was reported among some teams working with mental health service users and with older people.
- Funding and developing alternatives to IB while resources are still tied up in relatively long-term block contracts.
- Developing resource allocation systems.
- Disaggregating social care resources from services that are jointly funded with other departments and organisations (eg health).

Service providers may experience reduced demand for traditional services and new pressures to provide different types of services in different ways if they are to remain viable. There was a view that currently there is a lack of choice of alternative provision: not all service providers are seen as being proactive in changing to meet the potential change in demand. Providers may need help to prepare for this new approach at a time when commissioning resources are limited.

8. Sources of further information

Social Policy Research Unit, University of York,
http://php.york.ac.uk/inst/spru/research/v
summers/index.php?accessed=10/3/11

7. Individual Budgets are most cost effective for mental health service users in terms of psychological well-being and social care outcomes

<table>
<thead>
<tr>
<th>Table 2 Weekly cost of IB and comparison group</th>
<th>Number</th>
<th>Overall weekly cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall IB group</td>
<td>268</td>
<td>£279</td>
</tr>
<tr>
<td>Comparison group</td>
<td>250</td>
<td>£256</td>
</tr>
<tr>
<td>Mental health IB group</td>
<td>35</td>
<td>£149</td>
</tr>
<tr>
<td>Comparison group</td>
<td>33</td>
<td>£152</td>
</tr>
<tr>
<td>Physical disability IB group</td>
<td>88</td>
<td>£354</td>
</tr>
<tr>
<td>Comparison group</td>
<td>80</td>
<td>£348</td>
</tr>
<tr>
<td>Learning disability IB group</td>
<td>70</td>
<td>£359</td>
</tr>
<tr>
<td>Comparison group</td>
<td>63</td>
<td>£308</td>
</tr>
<tr>
<td>Older people IB group</td>
<td>73</td>
<td>£228</td>
</tr>
<tr>
<td>Comparison group</td>
<td>66</td>
<td>£237</td>
</tr>
</tbody>
</table>

Market management – due to the early stage within the pilot process, few sites reported additional resources that would be required in this area. However, one authority reported that an additional £10,440 would be required for market management (£5,120 for contracts renegotiation and £5,320 for transitional arrangements). Another authority reported that a contracts officer would be required at a cost of £1,030.

7. Individual Budgets are most cost effective for mental health service users in terms of psychological well-being and social care outcomes

This case study was compiled for IRISS by the Institute of Public Care

Money Matters – case study seven

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Institute of Public Care

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Design www.scheir.com
The Rehabilitation Support Workers providing support with activities of daily living (ADLs) and follow-up as part of the add-on EIW team contributed to a holistic approach to rehabilitation and planning through the entire HD pathway.

The Community Geriatrician with links to the acute sector, provided a bridge between secondary and primary care, and strengthened the wider community pathway. For example, the Community Geriatrician developed a case finding tool to help professionals in the community such as GPs and HD teams identify patients at risk of care home placement. This then triggers appropriate MDT interventions to prevent admission.

The appointment of a Voluntary Sector Coordinator (VSC) went some way in alleviating social isolation by referring people to befriending services and other community/ support groups.

This type of market facing intervention has the potential to widen service provision and may help to stimulate and develop the local voluntary sector market. Alternatively, brokerage services are to be developed to assist service users with making care arrangements, this knowledge and specialism could be harnessed by brokerage organisations.

6. Strengths

In Southwark, the HD pathway project helped to change practitioners’ mind-sets and focused on home placements as a last resort, and supported more elderly people to return home, in line with the known preferences of the majority of older people to live at home as long as possible.

A number of good practice principles underpin the pathway approach: the HD pathway primarily looks at the patient pathway and identifies difficult interfaces between services that can adversely affect patient outcomes. For example, barriers to safe and sustainable discharge, such as depression and anxiety are identified and planned for. Having a Mental Health Intermediate Care (MHIC) team to advise and intervene on a case by case basis, as well as providing wider training to the HD team, helped to overcome unnecessary obstacles to ensure successful discharge and support at home.

The EIW contributed directly to reducing length of stay in hospital. Interview with hospital staff showed the usefulness of the EIW; many reported that pro-active case finding enabled the gathering of screening information on patients. This, in turn, helped social workers in the MDTs to prioritise better and to allocate their cases for early assessment. Staff felt that such early intervention and consequent care planning was successful in keeping people from returning to hospital as a result of care package break down. Overall, hospital staff felt discharge planning was more targeted and resulted in a more efficient outcome of time in hospital. Given the success of the EIW post in reducing length of hospital stay, Kings College Hospital mainstreamed this post.

4. Application

This service model has particular potential where there is a need to reduce delayed discharges, because of its success in reducing older people’s length of stay in hospital. The approach could also be considered by commissioners who have a high level of admission to care homes from the acute sector.

Some elements of the HD pathway approach could be applied where social and health care organisations are experiencing a high level of hospital patients with mental health illness, where this is preventing safe and sustainable discharge and planning, either by putting a social worker in place or by employing someone externally. The MHTC context is particularly pertinent given the current funding positioning of health and social care.

5. Resources required

The evaluation did not break down the costs between the two different strands of the POPP. The total POPP funding over the two years of the project was £1.8 million. The staff resources required are outlined in the description of the service.

The Early Intervention Worker could be replicated elsewhere in hospital discharge teams by putting a social worker in place to organise early discharge, case finding and planning, either by recommissioning current staff or by employing someone externally. Where there is high level of unnecessary admissions to care homes in the community and where there is little case finding work in both the hospital and community setting, it may be applicable to consider the post of a Community Geriatrician who holds the add-on EIW team and reviews them as appropriate within the wider MDT context.

The Voluntary Sector Coordinator (VSC) identified how voluntary sector services could contribute to the discharge process and help people to live independently in their own home.

6. Strengths

In Southwark, the HD pathway project helped to change practitioners’ mind-sets and focused on home placements as a last resort, and supported more elderly people to return home, in line with the known preferences of the majority of older people to live at home as long as possible.

A number of good practice principles underpin the pathway approach: the HD pathway primarily looks at the patient pathway and identifies difficult interfaces between services that can adversely affect patient outcomes. For example, barriers to safe and sustainable discharge, such as depression and anxiety are identified and planned for. Having a Mental Health Intermediate Care (MHIC) team to advise and intervene on a case by case basis, as well as providing wider training to the HD team, helped to overcome unnecessary obstacles to ensure successful discharge and support at home.

The EIW contributed directly to reducing length of stay in hospital. Interview with hospital staff showed the usefulness of the EIW; many reported that pro-active case finding enabled the gathering of screening information on patients. This, in turn, helped social workers in the MDTs to prioritise better and to allocate their cases for early assessment. Staff felt that such early intervention and consequent care planning was successful in keeping people from returning to hospital as a result of care package break down. Overall, hospital staff felt discharge planning was more targeted and resulted in a more efficient outcome of time in hospital. Given the success of the EIW post in reducing length of hospital stay, Kings College Hospital mainstreamed this post.
As part of Southwark POPP, the hospital discharge teams in two hospitals were reconfigured to be more rehabilitation focused. Over the project lifetime, average length of stay on elderly wards fell by 2.3 days and 3.7 days in the two hospitals, while the proportion of patients receiving intermediate care and returning home increased.

The initiative achieved estimated potential savings of over £1 million through reduced length of stay in hospital and reductions in care home placements.

The role of the Early Intervention Worker was mainstreamed in one of the hospitals at the end of the POPP.

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Money Matters case study eight

Southwark Hospital Discharge

Institute of Public Care

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Money Matters reviews of cost effective initiatives

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<tr>
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<td>20,865.8</td>
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Kings College Hospital

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Kings College Hospital and St Thomas’s Hospital

Adapted by IPC March 2011

Source: Research and Development Centre (October 2008) Partnerships for Older People Project Evaluation Report

Table 1

Bed days saved by reduced length of stay (LOS)

<table>
<thead>
<tr>
<th>Kings College Hospital</th>
<th>Year after appt of EIW</th>
<th>Guys and St Thomas's</th>
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</tr>
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<tbody>
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<td>Number of discharges</td>
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<td></td>
</tr>
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<td>Potential bed days</td>
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Money Matters reviews of cost effective initiatives

1. Introduction

Southwark was awarded £1.8 million from the Department of Health's Partnerships for Older People (POPP) to develop the Hospital Discharge Project. This consisted of two workstreams, the Hospital Discharge Project and the Community Pathway Re-design Project. This case study is based on the evaluation of the HD Pathway element of the POPP which identified positive outcomes in terms of intermediate care, hospital discharge and reduced length of stay.

2. Description of the service

Two acute care trusts were involved in the pilot, Guy's and St Thomas's Hospital, and Kings College Hospital. The Hospital Discharge teams in each trust were re-configured to be more rehabilitation-focused, with the aim to address avoidable delayed discharge from hospital to home and for patients to be adequately supported to return home independently.

A Mental Health Intermediate Care team (MHIC) was established to intervene for patients who had complex discharge issues, particularly around complex discharges (e.g. medicine usage and compliance).

An Early Intervention Worker (EIW) was appointed to develop stronger links with community MDT meetings and home visits.

The Southwark Primary Care Trust (PCT) also supported hospital discharge teams with providing assistance with medical management and assessing patients' medication usage and compliance.

The team was reconfigured in the following way:

- An Early Intervention Worker (EIW) was employed in both acute trusts to work on the elderly wards to identify, at an early stage in a patient's hospital stay, those with health and social care needs in order to arrange for earlier assessments and interventions.

- A Mental Health Intermediate Care team (MHIC) was established to intervene particularly in round the clock discharges and provide advice and training to the HD team around mental health issues.

3. Evidence of cost effectiveness

The evaluation reported that although it was not possible to measure precisely the costs and benefits, it was likely that the Hospital Discharge Pathway project was self-financing due to the reduction in length of stay of the acute trusts and care home placements. After the first year of the HD project, it was estimated that potential savings were achieved in the region of £1 million in 2006-07.

Figs. 2 and 3 show evidence of a decrease of 24 admissions to care home placements in 2006-07, representing a 12% reduction. This equalised annual savings of £51,680. However, in 2007-2008, care home placements rose to 197. Nonetheless, compared with the pre-POPP period, a total of 25 care home placements were averting as a result of the HD intervention over the POPP period. Given that each placement would have cost Southwark £5,350 per week, these savings of £132,500 overall.
As part of Southwark POPP, the hospital discharge teams in two hospitals were reconfigured to be more rehabilitation focused.

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Over the project lifetime, average length of stay on elderly wards fell by 2.3 days and 3.7 days in the two hospitals, while the proportion of patients receiving intermediate care and returning home increased.

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The initiative achieved estimated potential savings of over £1 million through reduced length of stay in hospital and reductions in care home placements.

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The role of the Early Intervention Worker was mainstreamed in one of the hospitals at the end of the POPP.

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Two acute care trusts were involved in the pilot, Guy’s and St Thomas’s Hospital, and Kings College Hospital. The Hospital Discharge teams in each trust were re-configured to be more rehabilitation focused, with the aim to facilitate patients to return home and to patients for to be adequately supported and independent on discharge.

3. Evidence of cost effectiveness

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4. Evidence of good practice

The evaluation found evidence that:

- Increased intermediate care use and an increased percentage of patients returning home with support as a result of the HD pathway.
- Increased mental health referrals.
- Reduced length of stay for patients on elderly wards.

The Southwark Primary Care Trust (PCT) was awarded £1.8 million from the Department of Health’s Partnerships for Older People’s Project (POPP) to develop the Hospital Discharge Pathway Project. This consisted of two workstreams, the Hospital Discharge Pathway and the Community Pathway Re-design Project. This case study is based on the evaluation of the HD Pathway element of the POPP which identified positive outcomes in terms of intermediate care, hospital discharge and reduced length of stay.

A Mental Health Intermediate Care team (MHIC) was established to intervene particularly around complex discharges and those likely to have complex discharge issues.

The team was reconfigured in the following way:

- Early Intervention Worker (EIW) was employed in both acute trusts to work on the elderly wards to identify, at an early stage in a patient’s hospital stay, those with health and social care needs in order to arrange for earlier assessments and interventions.
- A Mental Health Intermediate Care Team (MHIC) was established to intervene particularly early around discharge issues and provide advice and training to the HD team around mental health issues.

It also provided bed-based care outside of the acute environment to enable patients to make decisions about their longer-term future.

- Occupational Therapists and Physiotherapists who assessed patients’ mobility and safety to enable patients to return in the acute trusts.
- A Community Geriatrician who was involved in the discharge process and provided expert clinical guidance and links with the hospitals to assist with fast tracking/case finding of patients.

An assessment process was developed to establish those patients at risk of going into a care home so that adequate interventions could be put in place to assist them returning home. These patients would then be monitored accordingly by the Community Geriatrician via four weekly MDT meetings and home visits.

A Community Care Team around mental health issues.

The Southwark Primary Care Trust (PCT) was appointed to develop stronger links between the voluntary sector and social care teams in each trust.

Staff training in mental health interventions was provided as well as support and assistance with activities of daily living (ADLs) within people’s own homes for six weeks on discharge. It was also developed because it was supported by the Multi-Disciplinary Team (MDT) that too many patients were spending unnecessary time in hospital, despite being medically fit to return home.

The focus of the HD pathway project was early intervention via case finding. This was established by ensuring that the hospital discharge teams were able to identify those likely to have health and care needs on discharge, and those likely to have complex discharge issues.

The team was reconfigured in the following way:

- An Early Intervention Worker (EIW) was employed in both acute trusts to work on the elderly wards to identify, at an early stage in a patient’s hospital stay, those with health and social care needs in order to arrange for earlier assessments and interventions.
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The evaluation found evidence that:

- Increased intermediate care use and an increased percentage of patients returning home with support as a result of the HD pathway.
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- Increased intermediate care use and an increased percentage of patients returning home with support as a result of the HD pathway.
- Increased mental health referrals.
- Reduced length of stay for patients on elderly wards.

The evaluation evaluated the intervention had a positive impact on the number of home admissions and care packages.

- Staff felt that through rehabilitation approaches and addressing mental health issues, some patients who were going into care home placements were avoided and successful discharge home was facilitated.
- 75% of all care home placements in Southwark came from the hospital setting so it is likely that some reduction in care home placements occurred as a direct result of the HD intervention.

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<th>Number of discharges</th>
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<th>Bed days</th>
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<tr>
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<td>34.6</td>
<td>18,633</td>
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<td>658</td>
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4. Application

This service model has particular potential where there is a need to reduce delayed discharges, because of its success in reducing older people’s length of stay in hospital. The approach could also be considered by commissioners who have a high level of admission to care homes from the acute sector.

Some elements of the HD pathway approach could be applied where social care and health care organisations are experiencing a high level of hospital patients with mental illness, where this is preventing safe and sustainable discharge. For example, screening, understanding and planning for the impacts of mental illnesses on hospital discharge may be a useful way to deliver effective discharge planning. Likewise, this approach may be useful where intermediate care/healthcare services have not traditionally included people with mental health issues.

There is a potential synergy between early rehabilitation in the hospital setting and rehabilitation services. Where local authorities wish to develop reablement services, they could consider where these initiatives are best situated. For example, in the community as an ‘in-take’ team, or within the hospital setting providing reablement care prior to, and continued post discharge.

5. Resources required

The evaluation did not break down the costs between the two different strands of the POPP. The total POPP funding over the two years of the project was £1.8 million. The staff resources required are outlined in the description of the service.

The Early Intervention Worker could be replicated elsewhere in hospital discharge teams by putting a social worker in place to provide a bridge between secondary and primary care, and strengthened the wider community pathway. For example, the Community Geriatrician developed a case finding system to help professionals in the community such as GPs and HD teams to identify patients at risk of care home placement. This then triggers appropriate MDT interventions to prevent admission.

The appointment of a Voluntary Sector Coordinator (VSC) went some way in alleviating social isolation by referring people to befriending services and other community support groups.

This type of market facing intervention has the potential to widen service provision and may help to stimulate and develop the local voluntary sector market. Alternatively, brokerage services are to be developed to assist service users with making care arrangements, this knowledge and specialist could be harnessed by brokerage organisations.

6. Strengths

In Southwark, the HD pathway project helped to change practitioners’ mind-sets and develop care home placements as a last resort, and supported more older people to return home, in time with the known preferences of the majority of older people to live at home as long as possible.

A number of good practice principles underpin the pathway approach: the HD pathway primarily looks at the patient pathway and identifies difficult interfaces between services that can adversely affect patient outcomes. For example, barriers to safe and sustained discharge, such as depression and anxiety are identified and planned for. Having a Mental Health Intermediate Care (MHIC) team to advise and intervene on a case by case basis as well as providing wider training to the HD team, helped to overcome unnecessary obstacles to ensure successful discharge and support at home.

The EHFW contributed directly to reducing length of stay in hospital. Interviews with hospital staff showed the usefulness of the EHFW, many reported that proactive case finding enabled the gathering of screening information on patients. This, in turn, helped social workers in the MDTs to prioritise better and to allocate their cases for early assessment. Staff felt that such early intervention and consequent care planning was successful in keeping people from returning to hospital as a result of care package break down. Overall, hospital staff felt discharge planning was more targeted and resulted in a more efficient outcome of time in hospital. Given the success of the EHFW post in reducing length of hospital stay, Kings College Hospital mainstreamed this post.

The Rehabilitation Support Workers providing support with activities of daily living (ADLs) and follow-up as part of the additional HD team contributed to a holistic approach to rehabilitation and care planning throughout the HD pathway.

The Community Geriatrician with links to the acute sector, provided a bridge between secondary and primary care, and strengthened the wider community pathway. For example, the Community Geriatrician developed a case finding system to help professionals in the community such as GPs and HD teams to identify patients at risk of care home placement. This then triggers appropriate MDT interventions to prevent admission.

7. Weaknesses/ potential pitfalls

Although significant savings were made, not all of these savings could be accrued by Southwark Health and Social Care. This was evaluated under the payment by results system where PCTs pay acute trusts for every patient stay. Agreement over adequate arrangements to control financial risk is particularly pertinent given the current funding position of health and social care.

8. Sources of further information


3. Royal College Of Physicians: Homecare Reablement

4. Southwark Health and Social Care. This was evaluated under the payment by results system where PCTs pay acute trusts for every patient stay. Agreement over adequate arrangements to control financial risk is particularly pertinent given the current funding position of health and social care.

If local authorities with their health partners are considering such approaches, it is important that time and effort is put into developing constructive relationships at the start of any venture to secure agreement about how savings will be released into the system to ensure outcomes are best for the local population. Agreement over adequate arrangements to control financial risk is particularly pertinent given the current funding position of health and social care.

In Southwark, the HD pathway project helped to change practitioners’ mind-sets and develop care home placements as a last resort, and supported more older people to return home, in time with the known preferences of the majority of older people to live at home as long as possible.

A number of good practice principles underpin the pathway approach: the HD pathway primarily looks at the patient pathway and identifies difficult interfaces between services that can adversely affect patient outcomes. For example, barriers to safe and sustained discharge, such as depression and anxiety are identified and planned for. Having a Mental Health Intermediate Care (MHIC) team to advise and intervene on a case by case basis as well as providing wider training to the HD team, helped to overcome unnecessary obstacles to ensure successful discharge and support at home.

The EHFW contributed directly to reducing length of stay in hospital. Interviews with hospital staff showed the usefulness of the EHFW, many reported that proactive case finding enabled the gathering of screening information on patients. This, in turn, helped social workers in the MDTs to prioritise better and to allocate their cases for early assessment. Staff felt that such early intervention and consequent care planning was successful in keeping people from returning to hospital as a result of care package break down. Overall, hospital staff felt discharge planning was more targeted and resulted in a more efficient outcome of time in hospital. Given the success of the EHFW post in reducing length of hospital stay, Kings College Hospital mainstreamed this post.

The Rehabilitation Support Workers providing support with activities of daily living (ADLs) and follow-up as part of the additional HD team contributed to a holistic approach to rehabilitation and care planning throughout the HD pathway.

The Community Geriatrician with links to the acute sector, provided a bridge between secondary and primary care, and strengthened the wider community pathway. For example, the Community Geriatrician developed a case finding system to help professionals in the community such as GPs and HD teams to identify patients at risk of care home placement. This then triggers appropriate MDT interventions to prevent admission.

The appointment of a Voluntary Sector Coordinator (VSC) went some way in alleviating social isolation by referring people to befriending services and other community support groups.

This type of market facing intervention has the potential to widen service provision and may help to stimulate and develop the local voluntary sector market. Alternatively, brokerage services are to be developed to assist service users with making care arrangements, this knowledge and specialist could be harnessed by brokerage organisations.
4. Application

This service model has particular potential where there is a need to reduce delayed discharges, because of its success in reducing older people’s length of stay in hospital. The approach could also be considered by commissioners who have a high level of admission to care homes from the acute sector.

Some elements of the HD pathway approach could be applied where social and health care organisations are experiencing a high level of hospital patients with certain mental illnesses, where this is presenting safe and sustainable discharge issues. For example, screening, understanding and planning for the impacts of mental illness on hospital discharge may be a useful way to deliver effective discharge planning. Likewise, this approach may be useful where intermediate care/rehabilitation services have not traditionally included people with mental health issues.

There is a potential synergy between early rehabilitation in the hospital setting and rehabilitation services. Where local authorities wish to develop reablement services, they could consider where these initiatives are best situated. For example, in the community as an ‘in-take’ team, or within the hospital setting providing reablement care prior to, and continued post, discharge.

5. Resources required

The evaluation did not break down the costs between the two different strands of the POPP. The total POPP funding over the two years of the project was £1.8 million. The staff resources required are outlined in the description of the service.

The Early Intervention Worker could be replicated elsewhere in hospital discharge teams by putting a social worker in place to organise early screening, case finding and planning. If local authorities with their health partners are considering such approaches, they are important that time and effort is put into developing constructive relationships at the start of any venture to secure agreement about how savings will be released into the system to ensure outcomes are best for the patient and population. Agreement over adequate arrangements to control financial risk is particularly pertinent given the current funding position of health and social care.

6. Strengths

In Southwark, the HD pathway project helped to change practitioners’ mind-sets about care home placements as a last resort, and supported more older people to return home, in line with the known preferences of the majority of older people to live at home as long as possible.

A number of good practice principles underpin the pathway approach: the HD pathway primarily looks at the patient pathway and identifies difficult interfaces between services that can adversely affect patient outcomes. For example, barriers to safe and sustainable discharge, such as depression and anxiety are identified and planned for. Having a Mental Health Intermediate Care (MHIC) team to advise and intervene on a case by case basis, as well as providing wider training to the HD team, helped to overcome unnecessary obstacles to ensure successful discharge and support at home.

The EWW contributed directly to reducing length of stay in hospital. Interviews with hospital staff showed the usefulness of the EWW, many reported that proactive case finding enabled the gathering of screening information on patients. This, in turn, helped social workers in the MDTs to prioritise better and to allocate their cases for early assessment. Staff felt that such early intervention and consequent care planning was successful in keeping people from returning to hospital as a result of care package break down. Overall, hospital staff felt discharge planning was more targeted and resulted in a more efficient outcome of time in hospital. Given the success of the EWW post in reducing length of hospital stay, Kings College Hospital mainstreamed this post.

The Rehabilitation Support Workers providing support with activities of daily living (ADLs) and follow-up as part of the reablement team contributed to a holistic approach to rehabilitation and care planning throughout the HD pathway.

The Community Geriatrician with links to the acute sector, provided a bridge between secondary and primary care, and strengthened the wider community pathway. For example, the Community Geriatrician developed a case finding tool to help professionals in the community such as GPs and HD teams to identify patients at risk of care home placement. This then triggers appropriate MDT interventions to prevent admission.

The appointment of a Voluntary Sector Contractor (VSC) went some way in alleviating social isolation by referring people to befriending services and other community/ support groups.

This type of market facing intervention has the potential to widen social provision and may help to stimulate and develop the local voluntary sector market. Alternatively, brokerage services are to be developed to assist service users with making care arrangements, this knowledge and specialism could be harnessed by brokerage organisations.

7. Weaknesses/ potential pitfalls

Although significant savings were made, not all of these savings could be attributed to Southwark Health and Social Care. This was evidenced under the ‘payment by results’ system where PCTs pay acute trusts for every length of hospital stay in hospital. The approach could also be harnessed by brokerage organisations.

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8. Southwark Money Matters

The focus on rehabilitation reduced the length of time in hospital and the number and frequency of care admissions, generating savings of over £1 million.