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What are the opportunities and threats for further savings in adult social care?

Paper by Professor John Bolton

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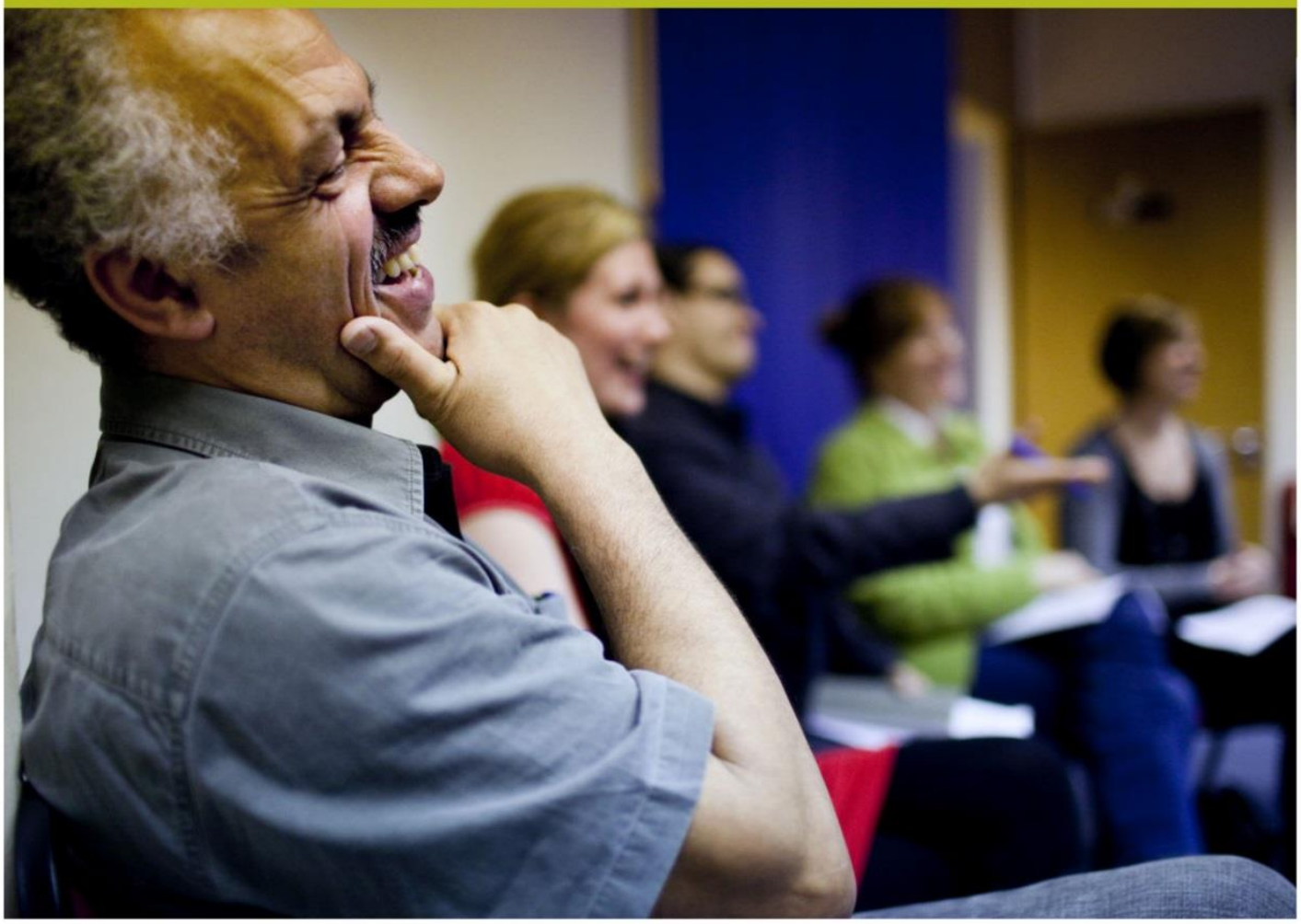

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Executive Summary

The paper looks to both understand the ways in which councils in England have delivered savings over the past five years in adult social care and to suggest what options (if any) councils might have in how they approach a period of continuing financial challenges. This latest occasional paper on practice and service development published by the Institute of Public Care at Oxford Brookes University (IPC) is a personal view by John Bolton based on three major sources. These are: a specific piece of work commissioned by the Department of Health with six councils during the 2015 Comprehensive Spending Review in Government[1]; the findings from the Local Government Association's Adult Social Care Efficiency Programme[2]; and the author's direct work with a number of councils assisting them in finding savings over the last five years.

The six councils visited for the DH study have delivered savings of around 20% or more of their gross budgets in the 4 years to 2014/15. These savings were made across the board, with a strong focus on prioritising people with the greatest needs and different (lower cost) ways of meeting the needs of others.

Overall in the evidence available it appears that 20% came from squeezing prices paid to providers of care (these may not be seen as cashable savings only not spending monies councils had previously allocated for "demographic pressures and costs"), 20% from reducing numbers of managers and staff, 20% from reducing the spend on the former supporting people grant funding and third sector services and 25% from demand management and promoting independence. Other savings have come from a range of action varying from straightforward closures of specific services, from reduced central charges, increasing income from customers and the NHS and other miscellaneous actions. The findings of the study from the 6 councils was that they had minimal room to deliver further savings without a major impact on what is offered or in meeting statutory obligations.

Areas that were considered for potential further savings (based on earlier work in the initial report to the LGA) included:

- Bringing down costs and prices: the findings were that there is little or no further scope for savings through competitive tendering and squeezing prices, but there is still some room for councils to externalise in-house provision; and there is evidence from councils that there may be room for negotiating costs of care for adults with high levels of learning disabilities, and for those with needs arising from mental health and other complex conditions.

[1] This work was not directly published though most of the findings are contained within this report.
[2] There are currently five reports in this study over a five year period and all are accessible from the Local Government Association's web-site.

- Personal Budgets: Studies have shown that most of the reported savings that have been delivered through personal budgets involved people moving from residential to community care. There is very limited scope for making savings in this area though many councils have used their resource allocation system as a means of tightening the spend on individual packages of care. Barking and Dagenham Council could demonstrate that when direct payments were used as the main way of funding care packages that these could be delivered at a lower cost than contracted care.
- Staffing including Assessment and Care Management costs: there has been a 10% reduction in staffing costs achieved in the last 5 years (£170m); the report identifies a number of ways in which further savings might be made (e.g. computerised systems, front-line staff solving problems and avoiding need for formal assessment, reablement, and others are described). However, it also warns that continuing to reduce front line assessment spend is more likely to overall increase expenditure on packages of care.
- Integration between health and social care: there is little sign that integration with the NHS has so far led to decreased use of resources and saved money. Examples were found of extra pressure on LAs caused by sub-optimal treatment by NHS of patients needing social care though co-ordinated or better integrated arrangements could help to reduce this pressure[3]. There is some new evidence that is worth considering about where efficiencies might arise from better integrated service[4].
- Managing demand and prevention: the most common approach for managing demand and delivering savings has been through tightening eligibility criteria. Several councils have found new approaches to divert people to get the right help at the point of initial contact. This has been the major change in adult social care during the last five years. Alongside this approach to diversion a care model called "Promoting Independence" has developed an effective approach to demand management. This approach combines three basic principles from adult care: getting prevention right, avoiding the wrong type of help which can increase dependence, and a more careful approach to using institutional care.

The report concludes that there may still be some scope in most councils to introduce or refine the model of care and approach to social care which looks to both avoid the use of formal care where that is safe but helps people in other ways; ensures that the maximum opportunities for recovery and recuperation is consistently offered; not rushing to make an assessment when someone is in a crisis (e.g. at the point of hospital discharge) and avoiding residential or other institutional solutions where this is feasible. These opportunities can be best achieved if the NHS adopts similar approaches for its work and collaborates in partnership with adult care to deliver improved outcomes for people at risk of needing social care.

1 Introduction

Over the last decade councils have been expected to make efficiency savings in adult social care every year. During the 2000s efficiency savings were expected from councils at around 1.5% per annum. This figure has risen since 2010 to a 3% efficiency gain expected each year. This has led to the Local Government Association (LGA) and

[3] Growing Older Together – NHS Confederation Report January 2016
[4] LGA website at www.local.gov.uk/productivity<http://www.local.gov.uk/productivity> under 'health and social care efficiency' Report December 2015

Association of Directors of Adult Social Services (ADASS) paper asserting that: *"Adult social care spending has therefore been kept under control through a combination of budget savings of 26 per cent (the equivalent of £3.53 billion over the last four years), the NHS transfer and at least £900 million of savings from other council services. The service is now under extreme pressure and facing financial crisis."*[5] This discussion paper looks at this issue and makes proposals for a change in emphasis in the policies for adult care in order to continue to meet the challenge of reduced monies being available from the tax payer.

There is a significant variation in the financial challenges faced by councils. For example the London Borough of Sutton has reported a reduced gross[6] spend in adult social care by 36% over the last five years whereas there are a number of councils that show a growth in their gross spend in adult social care of up to 20% during the same period.[7] (These figures do also include the transfer of specific monies from the NHS in 2011/12 to fund existing services for adults with learning difficulties which means that the stated "growth" is not as high as shown and the proportion of reduced expenditure is larger than stated.)

The author of this paper has written previously on the topic of how councils might approach saving money in councils[8] [9][10]. These reports have highlighted the way in which councils have tried to manage their expenditure in three main ways: bringing down costs and prices; increasing income (from customers, grants and partners [especially the NHS]); and finding effective ways of managing demand for social care. Before last year's comprehensive spending review the Department of Health commissioned work to examine how savings were being delivered in six councils in England. The aim was to better understand how they had made savings, their plans for the future and the risks that may exist in the system as a result of their previous or planned future actions. The six councils were Blackburn with Darwen; Derby City; London Borough of Hackney; North Tyneside; Nottinghamshire and Tameside. These will be referred to as "the six councils" throughout this paper.

This report first considers what has been happening within these six councils and then goes onto consider evidence from these councils and elsewhere on the opportunities for further savings in adult care.

[5] Adult social care funding: 2014 state of the nation report – Local Government Association and Association of Directors of Adult Social Services – published 2014

[6] In the paper ADASS and others use the net spend of Adult Social Care (ASC) from where they provide their figures – I have used gross spend where the information is available as the net spend figure does not include income to councils (from customers and the NHS) which has increased during the period being considered

[7] Data collected from returns by councils to Department of Communities and Local Government by Kings Fund. They include all capital charges as well as all income and expenditure.

[8] Use of Resources in Adult Social Care – Department of Health 2010

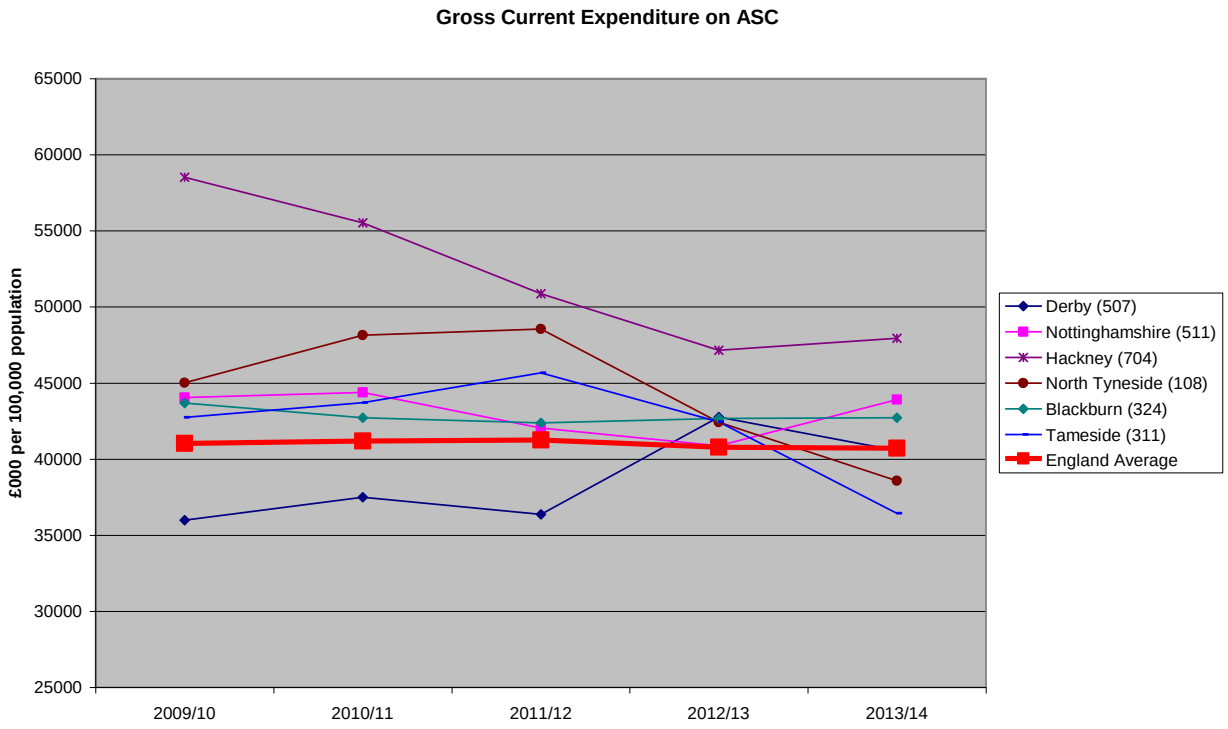
[9] Better Support at Lower Cost" published by the SSIA Cymru (Social Services Improvement Agency in Wales) in 2011

[10] All the LGA reports can be found at: http://www.local.gov.uk/web/guest/productivity/journal_content/56/10180/3371097/ARTICLE

2 Trends in Adult Social Care within the six councils

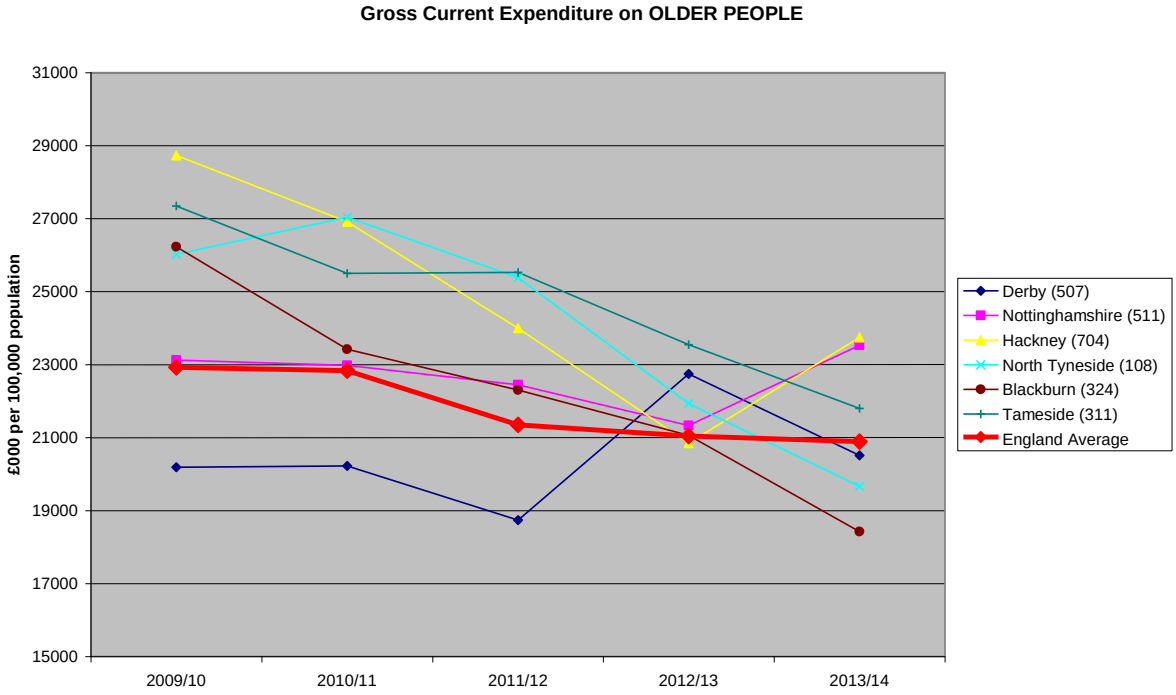
The chart below (Table 1) shows the expenditure from the six councils in relation to adult social care. It is important to note these figures as they show that the councils started from different points though their spend per head is beginning to come much closer together since they started to deliver savings. (Unfortunately the only data that is publically available takes the data up to 2013/14). It is worth noting that these graphs are drawn down from the NASCIS national database. The figures do not always tally with those figures that have subsequently been obtained from these councils (which are shown in the graphs below in the next section).

Table 1 – Spend per head of population on ASC



The largest service area where savings have been made in Adult Social Care has been in services for older people. This has mostly been achieved through a significant reduction in the number of state funded placements in residential care but also with a strong emphasis in all of these councils on diverting older people with lower care needs away from formal care (e.g. less use of domiciliary care). Typically, their approaches are designed to ensure that people's needs are met in a different way, either through the use of community alarms and telecare (for which some customers are charged) or through community activities including volunteering and befriending services. In the six councils there has been a significant reduction in the spend per head on older people (except in Derby (from a very low base) and in Nottinghamshire in last year).

Table 2 –Spend per head of population on Older People's Services



The reduced spend on older people's services has focused in two areas on residential care (see table 3 below) and on reduced support in the community. For the councils where increases have incurred these may be explained either by higher prices being paid (as in the previous year in Nottinghamshire) or increases in admissions to residential care. North Tyneside and Blackburn with Darwen have both brought their spend from well above to below the national average. Derby City are the only council to increase their spend (very slightly) during the period being considered. They are also a council which continues to run some of its older people's services in-house (including residential care homes). There is strong political support to sustain these local services and to keep them "in-house". A further feature which relates to the increase in expenditure in Nottinghamshire is that their early progress to integration with the NHS led to an increase in social care expenditure on older people. This has more recently started to be addressed as the NHS has developed a closer understanding of how to assist the council in managing demand for care.

The data in Table 3a shows the numbers of older people being admitted to residential care in the six councils. All of them have experienced a reduction in numbers at a variable rate. Across the United Kingdom new admissions to residential care for older people funded by councils has been reducing at a steady rate (about 2% per annum in England) for over ten years (see Table 3b below). This presents a real challenge for some of the providers of residential care, many of whom developed business plans which assumed that the fact that older people were living longer was more likely to lead to an increase in demand for residential care. This has not yet been the case.

Table 3a –Numbers permanently supported in residential and nursing homes in six councils

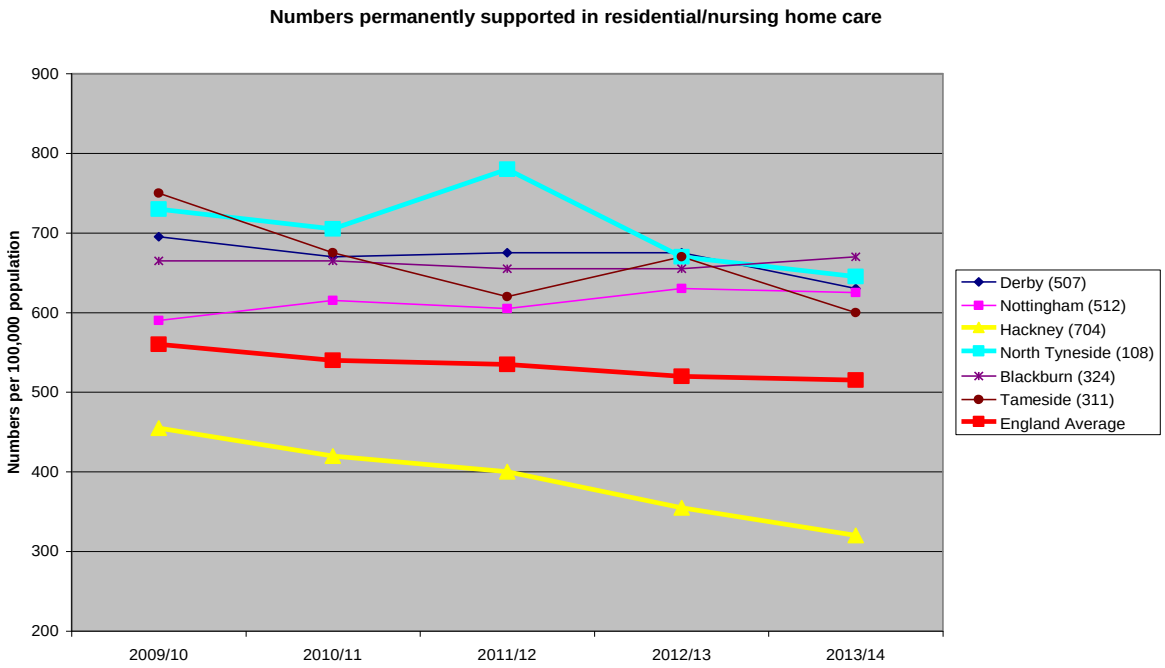
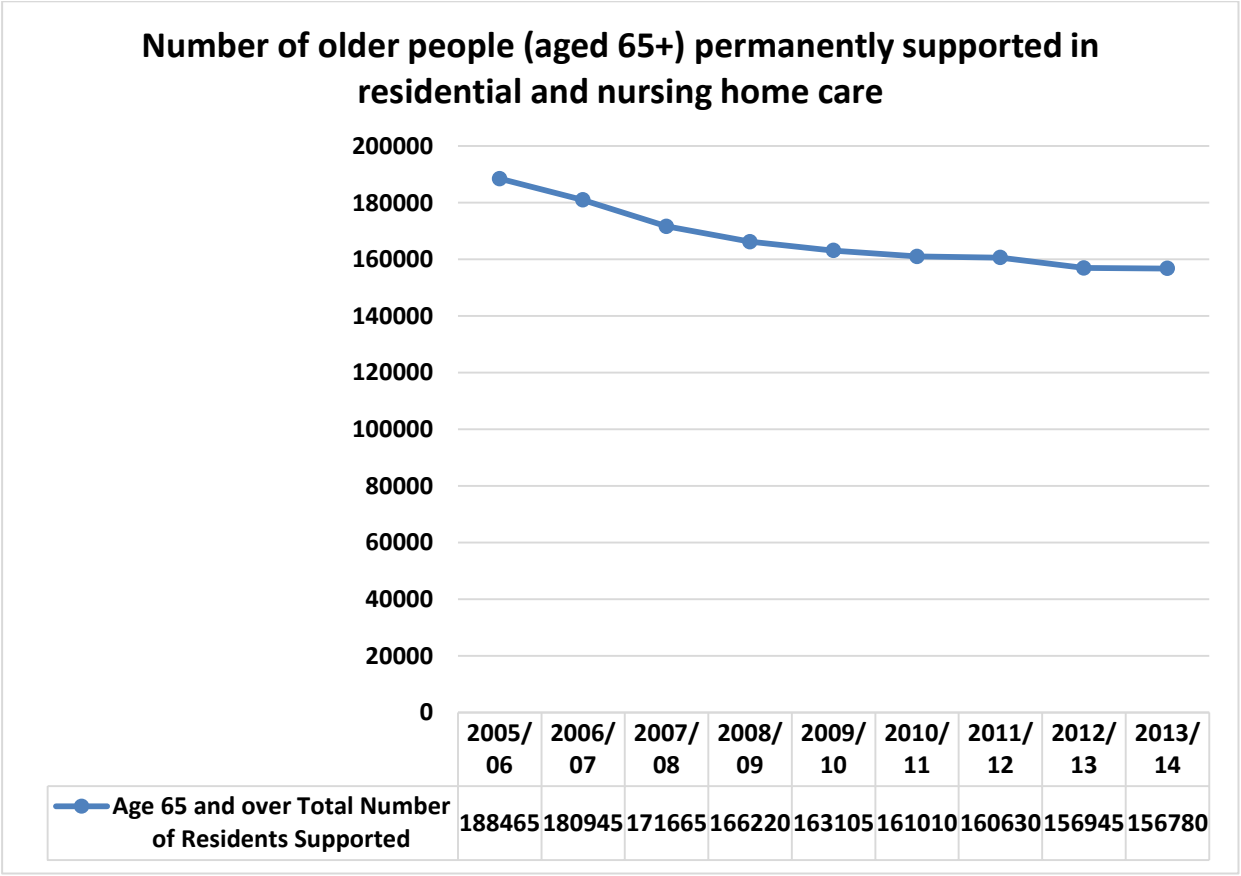


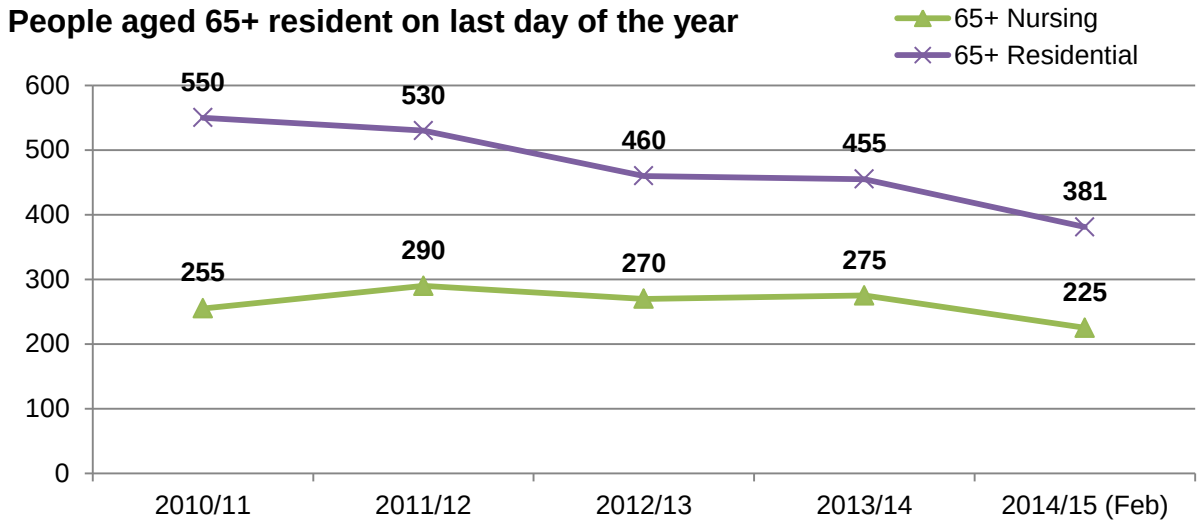
Table 3b – Numbers of older people in permanent residential care in England



	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Age 65 and over Total Number of Residents Supported	188465	180945	171665	166220	163105	161010	160630	156945	156780

North Tyneside shows that every year for the past five they have had a reduction of state-funded residents in care homes. Five years ago Use of Resources in Adult Social Care[11] suggested that there was possibility to reduce state funded admissions of older people to residential care by one third in many councils – North Tyneside have achieved this over the five-year period. This may mean there is little room for further reductions in new admissions.

Table 4- North Tyneside older people in residential care or nursing homes



However, the picture is not consistent. In some areas councils have had a concerted effort to look at better ways of helping people to avoid an admission to residential care. In others the demand has continued to grow. All of the six councils in the study have experienced a decrease over the last five years. However if one looks at the national picture for last year (2014/15) one might find a very mixed picture with just under half of councils showing a growth in their spend on residential care and just under half showing a decrease. This presents a significant challenge for government policy – why is there such a discrepancy between the practice between councils?

The evidence[12] from the LGA studies suggests that in some places up to one third of admissions to residential care for older people are avoidable. Of course, this will not be the case for those who have achieved this level of reduction in recent years. This issue is further examined in the section on "managing demand" (Section 4.4).

[11] Use of Resources in Adult Social Care – Department of Health 2010
[12] All the LGA reports can be found at:
http://www.local.gov.uk/web/guest/productivity/journal_content/56/10180/3371097/ARTICLE

Table 5 – Changes in spend on residential and nursing care

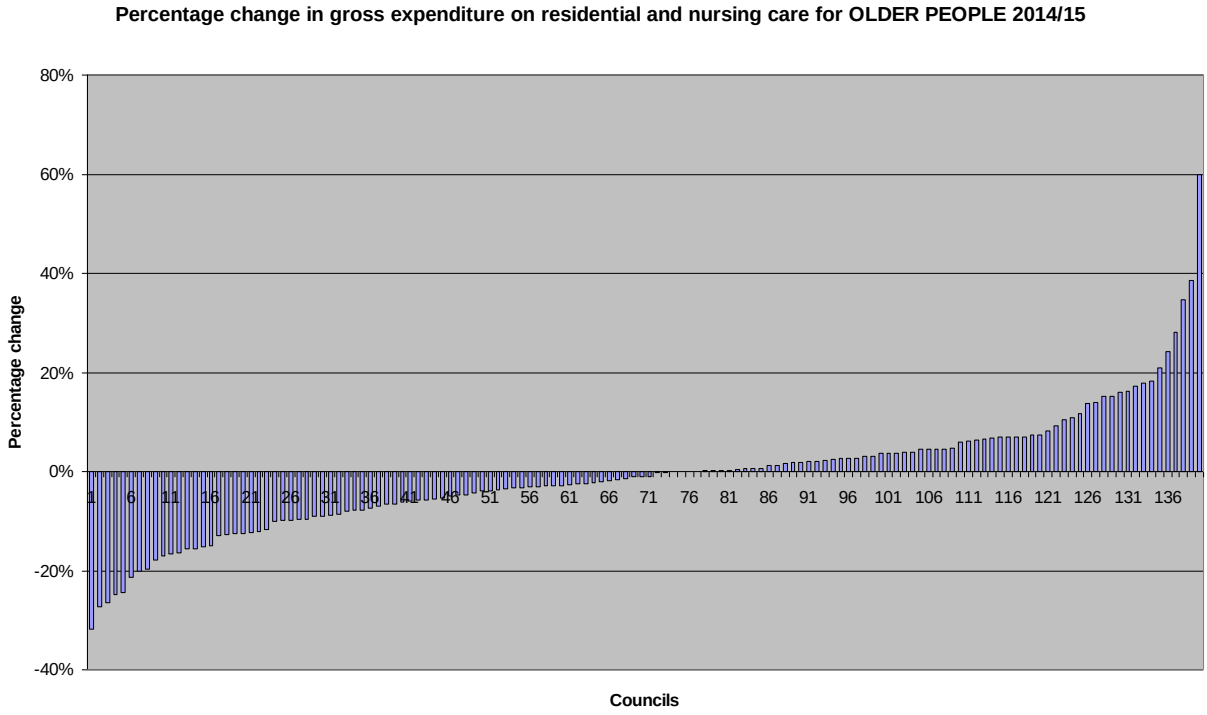


Table 6a shows that the spend on formal community-based support (domiciliary care or day care) is falling but at a low rate in most councils even though it is possible that more people are actually being helped but in a different way (as shown later in the North Tyneside evidence – Table 15 below). This has to be considered alongside table 6b below which shows an increase in the spend on Direct Payments as a direct result of government policy. Direct payments now account for an average of 17% of councils' total ASC spend on community services for adults (a rise from 10% in 2009/10 though it appears the increase is beginning to flatten out[13]).

Data for Adult Social Care[14] shows that slightly more people are approaching adult social care for help but more of these are being diverted away from the formal care system to get the help they need. About 65% of those who are assessed for services actually go on to receive a package of care. There is a reduction of 4% in the numbers of people receiving services in 13/14 compared to 12/13 of which half of this reduction is for residential care. The figures look much lower when compared to the reported figures from the period 2001-2009. The number of people being helped reached a peak in 2008. One explanation that contributed to the peak was that councils were measured within the national performance framework on the number of people they helped. Councils were incentivised to maximise this figure. Both local studies undertaken at the time and anecdotal evidence from local authority performance leads suggest that councils took every opportunity to maximise the figure to increase their scoring in the star ratings that were used. The downward trend in the numbers being helped began to accelerate when these measures were abandoned. (The new ASCOF[15] measures were introduced in 2009).

[13] Data from National Adult Social Care Information Centre (NASCIS) 2015
[14] Data on Adult Social Care – National Institute for Health Research – King and Wittenberg 2015
[15] ASCOF – Adult Social Care Outcomes Framework – DH 2009 (updated each year).

Table 6a – Spend per head on community based services for all people

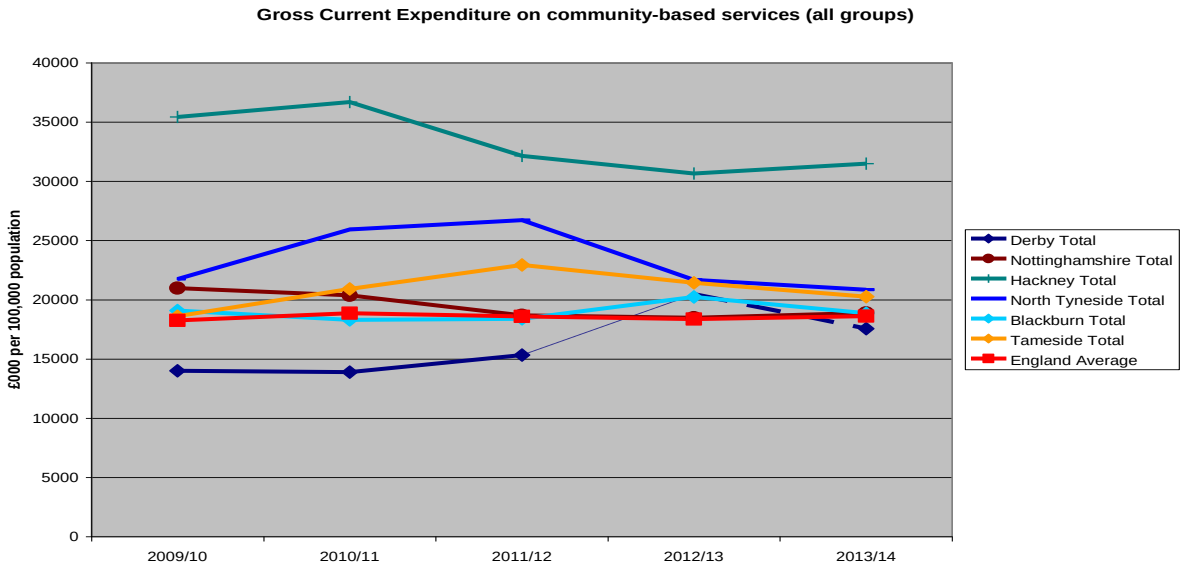
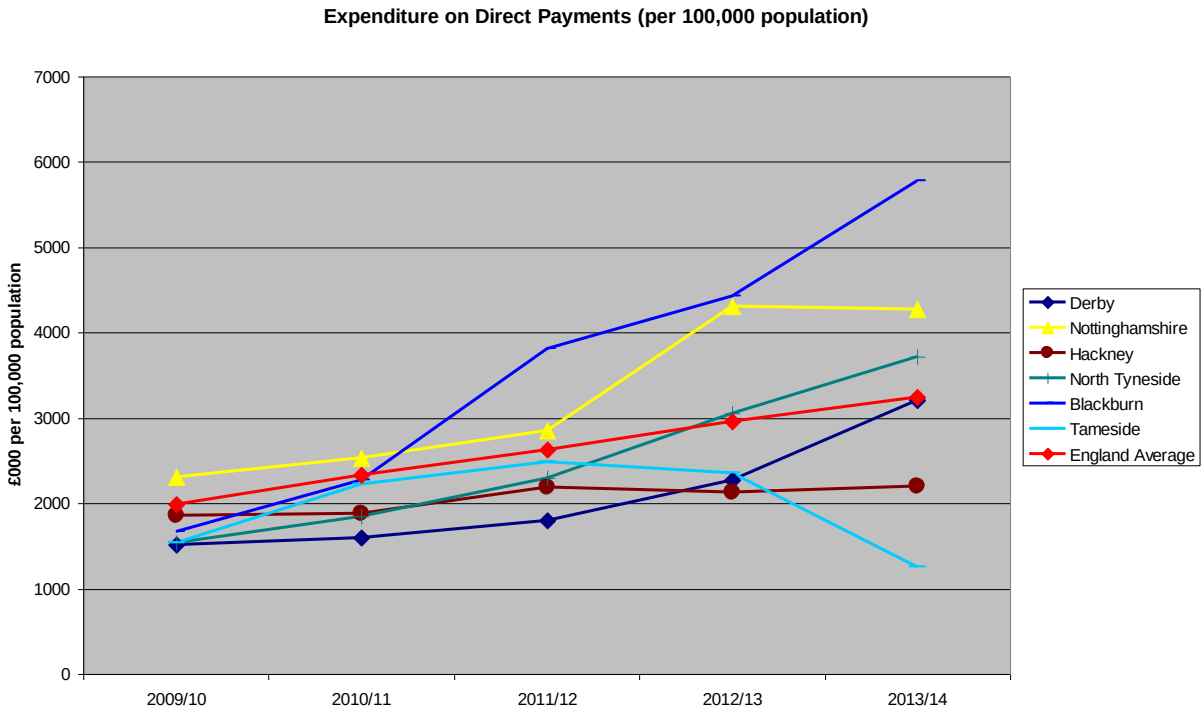


Table 6b –Spend per head on Direct Payments



When considering the combined spend on Direct Payments and Domiciliary Care the picture shows a small growth in the numbers being helped at home. So whilst the spend on domiciliary care might be marginally falling this is more than compensated for by the increase in Direct Payments where more people will be employing their own formal carers to carry out tasks that might previously be carried out by care agencies or in-house home helps. Derby City, Nottinghamshire and North Tyneside are all out-performing the national average in relation to the proportion of users receiving a Direct Payment.

The author's direct work with councils has shown that it is often the lower cost packages of domiciliary care that are avoidable and which can be replaced by better community based alternatives. In a number of councils, reviews of packages for older people receiving 5 hours or less have shown that up to 50% can be replaced with alternative options. Many of these relate to either tackling social isolation and/or addressing issues of community safety. Some councils have replaced a domiciliary care check-up visit with assistive technology e.g. a pendant alarm to press in an emergency or a pill-dispenser to ensure that medications are taken. It is sometimes family members (who live some distance away) who are more reluctant than the person themselves to lose the formal domiciliary care for their elderly relatives (as reported by social workers undertaking reviews[16]).

Whilst the spend on services for older people has been decreasing this has not been the case for adults with learning disabilities. For the latter group, spend has continued to rise (in line with expected demographic pressures). Within these six councils there are two (Hackney and Tameside) who have looked to tackle this phenomenon and there are signs that their spend on learning disability services is beginning to be controlled. Most councils will have made plans for younger people with learning disabilities to move from children's to adults' services at around the age of 18 (this may change with recent legislation to 25 years of age). The numbers coming forward for services has increased over recent years. The rate of new people seeking help has increased at a much faster rate than people leaving the service. This has proved to be a challenge for most councils alongside the fact that adults with learning disabilities are living much longer than had been expected in the previous century. Most councils have accepted this pressure as a matter of fact.

For the first time a number of councils have been looking at how they might reduce their costs through a combination of paying less for services (either re-negotiating the price of residential care or moving people from residential care into lower cost supported housing schemes) or through assisting them to live a more independent life style and need less care and support. Tameside and Hackney Councils have both undertaken major pieces of work in this area which have led to a decrease in their costs. (Previous work also found this was happening in the London Borough of Croydon and more recent work in Darlington Borough Council, Wiltshire and Kent County Councils)[17]. This approach has not been universally adopted by councils.

There are some specific challenges that need to be overcome when councils are looking to reduce costs in this way. Most councils find some initial reluctance from both the carers (usually parents) of people using the services as well as from many of those providing services. Some people will cite the previous policy paper for Learning Disabilities – Valuing People Now[18] whilst others will cite the strong emphasis on choice in Care Act as limiting the options for councils to move people into lower cost placements (even if their needs can be best met in this new environment). Also, the entitlement to personal budgets can potentially make it difficult when people are living in a communal setting where the overall costs are shared between a number of different

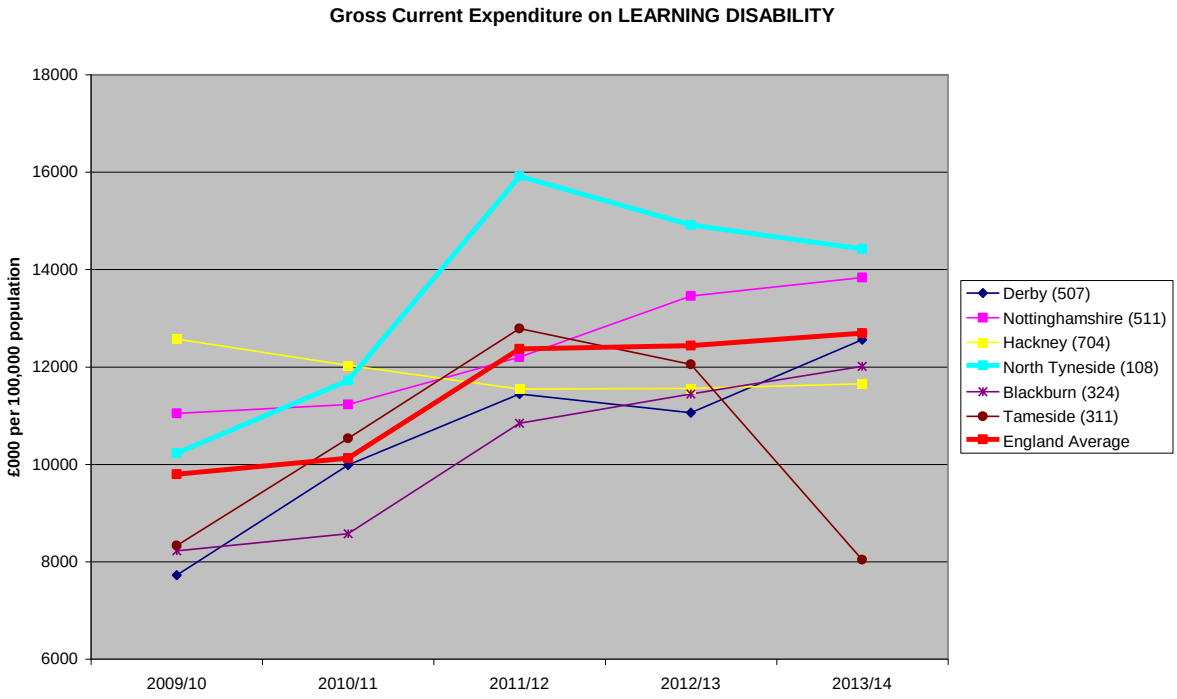
[16] In the Final LGA report can be found at: http://www.local.gov.uk/web/guest/productivity/journal_content/56/10180/3371097/ARTICLE

[17] There are case studies within the LGA Adult Social Care Efficiency Programme – Study on Learning Disability.

[18] Valuing People Now: a new three year strategy for people with learning disabilities Department of Health (2009)

customers. However, these problems have been successfully overcome in the councils cited. In some councils there is scope for further savings in re-examining the way in which they have established their supported living services where the costs have ended up being higher than for residential care. In other councils there are still higher than expected numbers of adults with learning disability who remain in residential care when there may be better options for them (as cited in the Winterbourne View[19] response report).

Table 7 – Spend per Head on Adults with Learning Disability Services



3 The savings made by the six councils

The six councils have all made significant savings (shown in summary in Appendix One) in their adult social care budgets. There are variations in both the levels of savings that have been required (to balance their books) and in the impact that this has had on the gross budgets of the councils (see Table 8 below). Some of the councils had growth to their Adult Social Care Budget (from council resources and from the NHS) whilst others have had to make cash savings to balance their books. Savings delivered by the councils up to 2014/15 are all around 20%+ of the gross 2010/11 budget. From these figures it appeared that councils had to deliver around 15% savings (3% per annum) in order to both meet both demographic and inflationary pressures to pay for services in the care market. For Nottinghamshire this looks higher at around 20% over the four years. In Tameside the spend has fallen more (as a percentage) than the others as income and grants have also reduced. Tameside has had to make a higher level of savings than the other councils when considering their gross spend.

[19] Transforming care: A national response to Winterbourne *https://www.gov.uk/government/uploads/system/.../final-report.pdf*

The chart (Table 8) also shows why the gross spend must be considered rather than the more basic figure that shows the net spend. For example Derby City has made the highest proportion of "savings" of their net budget but when income, NHS funding and other income is considered their actual level of reduced expenditure is relatively low at 4.7%. (Please note that the transfer of funds for learning disability services to existing customers from the NHS has been removed from the calculations – though these monies are not always considered when calculating changes in spend on social care during this period).

In Appendix One, the table shows the areas in which the six councils have made most of their savings. Staffing makes up a significant proportion the staffing savings were divided between front line posts and administrative, commissioning and other support functions. Reducing the expenditure on services that were previously part of the Supporting People Grant regime was another high area in five out of six of the councils examined. In some councils this expenditure might not be shown against adult social care but would be within the Housing Department's Budgets (again this might indicate that some of the savings/growth figures for councils are at risk of being misleading). For Nottinghamshire, Derby City, Tameside and North Tyneside savings delivered from better managing demand (reduced need for formal care services) made up the highest proportion of their savings delivered. In others (Blackburn and Hackney) savings from "Commissioning" was the highest figure. This mostly relates to reduced contract costs and ending other services. Nottinghamshire and Hackney have made savings from programmes to modernise day care services. All of the councils have increased their charges during this period.

Most councils have increased their income collected from customers over the period. The national total of income collected is now at £2.8 billion. This now accounts for almost 20% of the cost of care. For those commentators who think that the Government should provide free personal care there would require a significant increase in the amount of public subsidy to balance the figure.

Table 8 - Gross Spend and percentages saved by six councils

£m	Hackney	Notting-hamshire	Derby City	North Tyneside	Blackburn with Darwen	Tameside
Gross Spend in 2010/11	117.095	302.039	67.683	86.146	57.059	96.707 (spend in 10/11)
Gross Spend in 20014/15	101.203 Less LD transfer £2.898 £98.305	309.94 Less LD transfer of 12.000 297.94	64.463	81.038 Less LD Transfer 5.000 76.038	47.431 + 1.2 overspend = 48.631	71.944
Reported Savings Delivered from 2010/11 to 2014/15	21.316	65.55	22.963	20.747	17.076	18.056

£m	Hackney	Notting-hamshire	Derby City	North Tyneside	Blackburn with Darwen	Tameside
Savings: reported (2010/11 to 2014/15), % reduction against 2010/11 gross spend	21.6%	21.8%	34%	24%	29.9%	18.7%
Savings: Reduction in Gross Spend, 2009/10 to 2014/15	16.0%	1.4%	4.7%	11.7%	16.8%	25.6%

It has proved hard at times to track the movements of monies within each of the six local authorities. "Net expenditure" figures on adult social care can disguise the fact that these budgets have been reinforced (sometimes in an unplanned way, in-year) by use of council reserves or other financial movements within the council's accounting mechanism. There have been different approaches to the way in which councils treat both income and their own on-costs (the costs of the council infra-structure) and how these are apportioned to adult social care as the overall budgets of the council reduce. (In some cases the councils on-costs have had to increase as the spend on adult social care becomes a higher proportion of the overall spend). In Nottinghamshire there have been increases in the budget both as a direct result of political decisions to fund inflationary increases to the care market and some new monies from the NHS. As a result of these internal adjustments it may appear that the spend in Nottinghamshire has not decreased as fast as some of the other places. However when an examination of the savings on which they have delivered takes place (21.8% of their gross budget) and consideration is given to the future options open to them the position looks much more challenging for the council.(This is shown in Table 8).

Throughout the rest of this report there are examples and case studies showing how the evidence from these six councils contributes to the wider debate on how savings have been or might be made within adult social care. All of the six councils reported that they had little further room to deliver savings without having a major impact on what is offered or in meeting their statutory obligations.

All of the 6 Councils have delivered savings across all areas though with different emphasis between them, with the figures within a similar range as to that found in the LGA Adult Social Care Efficiency Studies[20] Councils report in both the DH study and the LGA study that there has been a strong focus on prioritising people with greatest needs and looking at new and different (lower cost) ways of meeting the needs of those with lower needs. This has included approaches to reablement and recovery in all service user groups (a common theme in all six of these councils). Some of these issues will be explored further later in this report.

[20] All the reports can be found at: http://www.local.gov.uk/web/guest/productivity/journal_content/56/10180/3371097/ARTICLE

The six councils are not representative of all of the councils in England. These six have all had to make considerable savings. There are places which have not had the same level of challenges as these councils. There continues to be considerable disparity between the social care offer from one council to the next in England. There are major differences in the outcomes that a customer will receive depending on where they live. These six councils were reviewed because they had made significant savings and were still operating a sustainable model of social care (though they will all be stretched when continued reductions in their budgets hit them over the coming years). The lessons from these six councils show that savings can be made in:

- Reducing some staffing;
- Reducing the costs of some services;
- Working with the NHS to improve outcomes for citizens through a focus on recovery and recuperation;
- Developing an asset based approach which values each customer's own; contribution to the solutions of meeting their care needs;
- Ensuring the focus on spend on lower level services is linked to outcomes that those services deliver;
- and developing their approach to personalised services noticeably in transforming their approach to Day Care.

4 Interactions between councils and local NHS

In 2012-13 the Department of Health introduced the Better Care Fund (BCF). This was in the middle of the period being studies in the Local Government Association Efficiency Programme. This pooled budget encouraged councils and the NHS to work collaboratively to develop or protect services that assisted in either keeping older people out of hospital or to ensure speedy discharge when patients became fit following a hospital admission. Other reports are now starting to evaluate the impact of this initiative. The critics of the initiative always comment on the high levels of bureaucracy that have been created to support this policy direction. The aim of the Better Care Fund is to assist councils and the NHS to work more collaboratively to find solutions to shared issues around supporting older people in the community.

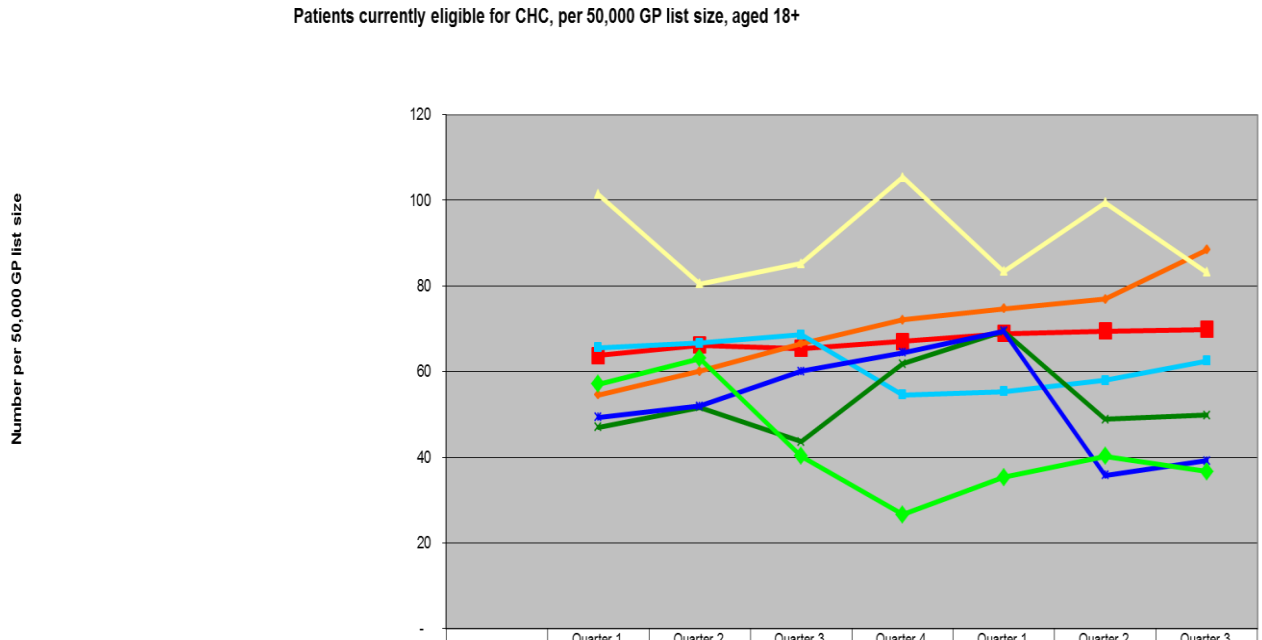
However sitting behind the BCF debate has been a long-standing dispute between the NHS and Social Care about the criteria and interpretation of the guidance on "Continuing Health Care". This is the guidance that aims to assist local councils and the NHS determine who might qualify for free personal care because their needs are fundamentally health related. (Albeit that most older people who need care do so because of ill health). The guidance is open to considerable interpretation and often leads to conflicts between the two funding bodies (the NHS or the Council) as to who is responsible for which part of a person's care. This has led to considerable variations in practice across England. The opportunity for an older person to have their care funded by the NHS would be considered to be a post-code lottery.

Table 9 shows the spend in each of the six councils by the NHS on continuing health care per 50,000 of the population. It shows that a person is twice as likely to get their long-term care paid for in North Tyneside than in the London Borough of Hackney. There is no simple explanation of this beyond local practice. So whereas in both North

Tyneside and Tameside interpretation of the guidance leads to the funding of care packages by the NHS above the English average in the other four councils they are well below the national average. This will have a direct impact on the funding of social care in each area.

It is not uncommon to find in a local authority savings plan a target to increase the proportion of people who are being supported in a care placement with a continuing care package. It is not uncommon to find in a Clinical Commissioning Group's budget a plan to decrease the number of people who are being supported through continuing health care. This is an area of conflict between health and social care that may warrant more attention from government if it wants to take integration between the parties more seriously

Table 9 – Continuing Health Care spend by Clinical Commissioning Groups



	Quarter 1, 2013/14	Quarter 2, 2013/14	Quarter 3, 2013/14	Quarter 4, 2013/14	Quarter 1, 2014/15	Quarter 2, 2014/15	Quarter 3, 2014/15
England Average National	63.7	66.1	65.4	67.1	68.9	69.5	69.9
NHS Tameside and Glossop Clinical Commissioning Group	54.5	60.0	66.5	72.1	74.7	77.0	88.4
NHS Blackburn With Darwen Clinical Commissioning Group	65.6	66.7	68.6	54.6	55.4	58.0	62.5
NHS North Tyneside Clinical Commissioning Group	101.4	80.5	85.2	105.4	83.4	99.5	83.2
Nottinghamshire CCGs (average)	47.0	51.6	43.6	61.8	69.4	48.8	49.8
NHS Southern Derbyshire Clinical Commissioning Group	49.3	51.9	60.1	64.4	69.5	35.8	39.2
NHS City and Hackney Clinical Commissioning Group	57.1	63.1	40.2	26.6	35.3	40.2	36.7

So despite the development of the BCF these and other issues still set a serious conflict in the relationship between health and care. One solution to this challenge is for councils and CCGs to pool their nursing home and residential care budgets and to share the consequent risks – as is happening in some parts of the country (but not within the councils in this study). The six councils all reported policy developments from CCGs or Foundation Trusts that were directly putting pressure back onto Social Care Budgets. These included:

- Changes in mental health services where reduced beds were leading to the use of inappropriate residential care as an alternative for some people (with local authorities meeting some or all of the costs).

In Blackburn with Darwen there are 17 people with high and complex mental health needs who have resided in the Calderstone NHS Trust Hospital. These have all been funded by NHS England. There is now a clear plan to move these patients into suitable placements in the community/residential care. This transfers £1.4 million of costs to the local authority from the NHS. This alone is a 2.5% pressure on the local adult social care budget.

- Acute Hospitals moving older people straight from a hospital bed to a residential care bed in a bid to "discharge to assess" leading to higher admissions to residential and nursing care homes (where costs are met by local authority).
- People with complex behaviour problems (sometimes related to past criminal activity) being moved from high level hospital environments into intensive residential care with the costs moving from the NHS to Social Care. This can sometimes happen in spite of strong resistance from NHS professionals to moving people on into lower support placements when their behaviour appears to have been modified. Last year the move of five people with a history of past offending from high-cost NHS funded placements to community supported living cost Blackburn with Darwen £300,000.

  Nottinghamshire and Derby City used to have their social work teams integrated within their local Mental Health Provider (Foundation) Trusts. The service was managed within the Trust under a pooled budget. Both councils have separately decided to end their joint arrangements and to bring the social work teams back under the control of the local authority. The main reason in both cases was the escalating costs arising from the increased use of residential care placements which had to be funded by the local authority. The teams still work closely with colleagues in mental health and are co-located. The separation of the management arrangements has enabled the local authorities to get a tighter grip on the budgets and spend is now being brought back within the limits set.
- A persistent practice within many acute hospitals for senior consultants to advise on residential care as a solution for older people before a proper assessment is made – making it harder to undertake the assessment when family and sometimes the person thinks that is the best solution (when sometimes there are realistic and better alternatives).
- The use of inappropriate residential care beds by the NHS in a policy called "discharge to assess". The older person is placed in a bed with not opportunity for rehabilitation or other therapeutic support and they are expected to settle into the accommodation whilst an assessment takes place. This can be a further inappropriate use of residential care and can lead to additional costs for the local authority as many people end up long-term in the bed in which they were placed direct from hospital.
- A shortage of District Nursing, reducing the capacity of community services to support some older people at home. An increase in basic nursing tasks (medicine checks and changes of bandages etc) or more "double-handed visits" can sometimes be undertaken as part of domiciliary care packages without compensation or training from NHS staff.
- A lack of continence nurses to assist older people recover their control after medical interventions. This is the second highest reason for admissions to residential care so a poor service can lead to higher admissions.
- A lack of therapists to support people after a stroke which can lead to a person needing more social care (or for a longer period).

- Disinvestment by the NHS in learning disability services including a reduction in Community Psychiatric Nurses to help support people with challenging behaviours.

There are also other areas where there have been shifts in costs within the public sector. Another large area relates to the costs of housing and also the Benefits' budgets. When people move from residential care to "supported living" the housing-related costs and the costs of day to day living pass from adult social care to either housing or benefits. There is a significant incentive for councils to avoid these costs though they still are met from public funds. However, in practice councils have often used the monies that were "saved" to put in additional resources (staffing) into these schemes. This has led to some schemes costing more money than the residential care from which people have moved. Even where short-term resources may be required to help people settle into new schemes it is generally the case that after a short period the costs can reduce as people get used to doing more for themselves and they can begin to need less support.

Finally Local Authorities have been shifting resources between each other with the use of the "Ordinary Residence" principle. This was being used by one council to force another council to pick up the costs of the care for which they were previously responsible. This has had a very negative impact on councils in the south-east – Surrey, Kent and Hampshire have all experienced increased costs as councils who had placed people in residential care homes in these areas in the past have found that people have settled in these areas now in supported living schemes.

Of course all of these issues have to be laid alongside the new shift in resources from the NHS to social care which has helped adult care budgets over recent years. There are high expectations in all councils that the Better Care Fund will act as a buffer to reduce the impact of the proposed further reductions in local authority budgets.
The report will now explore the options for further savings in adult social care, the opportunities and the risks.

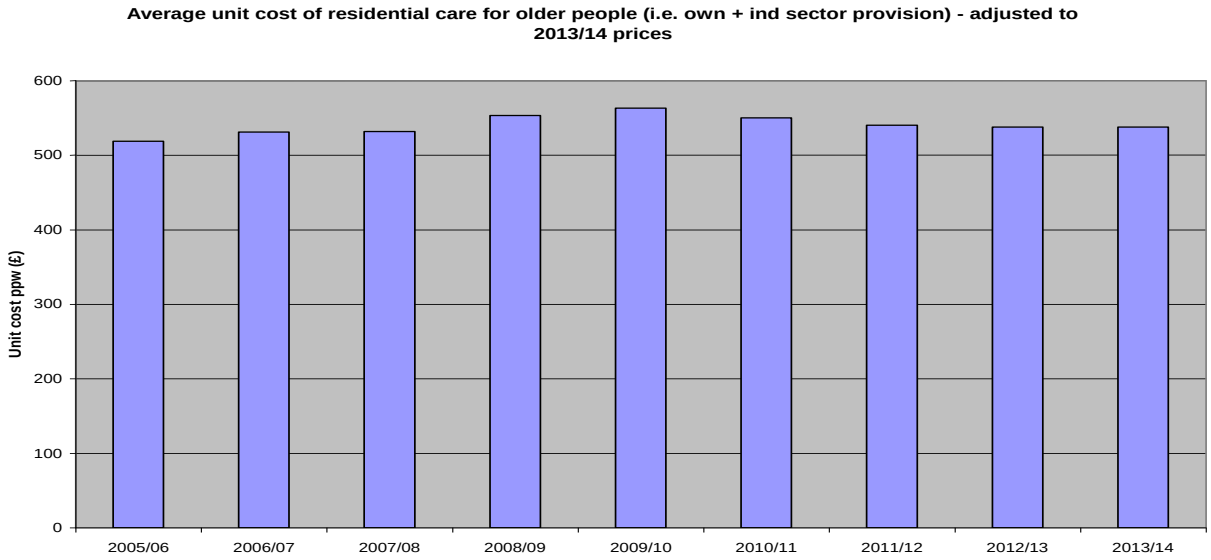
5 Can the cost of care be further reduced?

5.1 Residential care

The cost of care to councils has been reduced in recent years through a combination of fierce competitive tendering and councils refusing to pay any inflationary costs for care. The figures below show the average unit cost of residential care in England paid by councils for older people from 2005/06 –2013/14[21]. It is worth noting that the average costs started to fall after 2008 and this can partly explained by the closure or transfer to the private sector of previously run in-house care homes.

[21] Source PSSEx1 (National Adult Social Care Intelligence Service 2014)

Table 10– Average Unit Costs of Residential Care since 2005-06

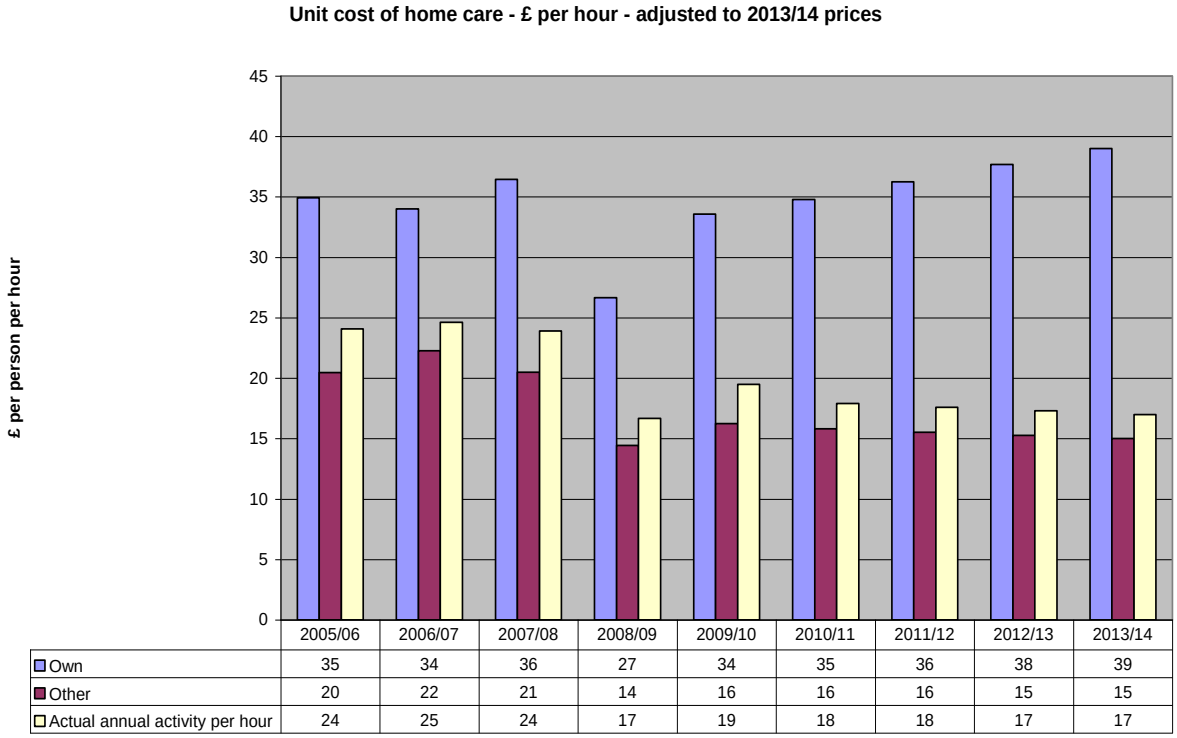


5.2 Domiciliary care

The latest report from the United Kingdom Home Care Association (UKHCA) shows that most councils are not paying the minimum requirements for domiciliary care.[22] After the publication of the report the UKHCA's Policy Director, Colin Angel, said: "The price of an hour of homecare is a vital question for local and central government, statutory regulators, trades unions and the public. It is essential that a viable regulated homecare sector is available to support the care of older and disabled people who choose to remain at home. The prices councils pay for care must cover the costs of the workforce, including - as a minimum - full-compliance with the prevailing National Minimum Wage, including the time spent travelling between service users' homes." The chart below which shows the average unit cost of domiciliary care from 2005/06-2013/14 demonstrates that whilst services run by councils continued to increase over this five year period the prices paid by councils to the independent sector remained static for the 4 years after a reduction from 2006/07 – 2010/11[23].

[22] A Minimum Price for Homecare – United Kingdom Home Care Association 2015
[23] Source PSSEx1 (National Adult Social Care Intelligence Service 2014)

Table 11 – Unit Costs of Home Care since 2005-06.



	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Own	35	34	36	27	34	35	36	38	39
Other	20	22	21	14	16	16	16	15	15
Actual annual activity per hour	24	25	24	17	19	18	18	17	17

5.3 Commissioning and Procuring services

Councils have given a particular focus to how they procure services and the associated costs. This is not the same as "commissioning" services which requires a much more in depth examination of the local care market, its sustainability and how it will meet local needs through delivering the best outcomes. There has been a focus on price of services (rather than either the quality of those services or the outcomes that they deliver). It is unlikely that there is further scope for additional savings from this approach in the future. It is more likely that the evidence will show that paying for lower quality and rushed care may have led to poorer outcomes and higher longer term costs.

However, Table 11 shows that there may be further scope for councils to reduce their costs by further externalising their current in-house provision (though the TUPE rules[24] associated with such an exercise limit the amount of savings that can be made). Coventry City Council closed their in-house services in 2014 allowing existing providers in the City to pick up new business; this led to a £1.5 million saving in the costs of care to the council[25]. Of course some councils transferred all of their domiciliary care services to the independent sector some years ago and would not have access to that level of savings.

In the study of the six councils they had all reduced their spend on commissioning budgets by reducing the costs of the services they procure. All of these councils had frozen payments (i.e. not paid an inflationary increase) for their providers for at least two

[24] TUPE refers to the "Transfer of Undertakings (Protection of Employment) Regulations 2006" as amended by the "Collective Redundancies and Transfer of Undertakings (Protection of Employment) (Amendment) Regulations 2014". The TUPE rules apply to organisations of all sizes and protect employees' rights when the organisation or service they work for transfers to a new employer.
[25] Evidence from Local Government Association Adult Social Care Efficiency Programme Final Report July 2014

years during this period. Nottinghamshire froze their payments for two years but then were under obligation to increase the rates they paid for residential care. Sometimes a freeze of payment is described by councils as a "saving". This occurs where the council in setting its budget has made an allowance for inflation within the base budget. If that money is then not spent it can be described as a "saving". Councils will treat this in different ways and therefore it is not always easy to track cashable savings.

Councils in many places have procured domiciliary care at lower cost during the last five years and have looked to reduce the costs of their learning disability services (across the board) often using a fairer pricing tool to help identify what prices should be negotiated. These savings can only be made once. About 18% of the savings delivered in these six councils came from better procurement and negotiating on prices (including price freezing). As part of a procurement exercise the County has reduced the number of suppliers with whom it has contracts for domiciliary care. In taking this approach and guaranteeing the providers who win the contracts a higher volume of work they have been able to secure a lower hourly rate overall. However, there are some in Nottinghamshire who consider that the price might have gone down too low. This is evidenced by a combination of difficulty in securing any supply of workers in the wealthier and more rural parts of the county. This approach saved £835,000 in Nottinghamshire.

In Hackney they have an ambitious plan to bring the costs of residential care for adults with learning disabilities down to the level they pay for older people with higher care needs (£700 per week per placement – net cost to the council). This would bring further savings but no other council has achieved a level close to this so it is unlikely to be achieved as generally the costs of a residential placement for a younger adult with learning disability are much higher than the costs for an older person.

This approach by councils is increasingly being challenged as new evidence appears that shows that councils are not paying sufficient attention to the costs of care when setting the rates they are prepared to pay providers. Recent Judicial Reviews have found against councils for the approaches they have taken. For example, there have been judgements in Pembrokeshire (2012)[26] and Torbay (2014)[27] that councils must be transparently open to the costs of care and pay attention to the real costs when agreeing to the prices it will pay local providers. In Nottinghamshire they took a policy decision to not make any inflationary increases for their providers in 2010/11 and 2011/12 and this equated to a "saving" to the value of £12 million. By 2013/14 they reviewed the costs of care with Providers in Nottinghamshire and found that they needed to increase their fees to the value of £10 million across the county.

A further indication of the impact of low costs in the care sector is the reported growing difficulties in a number of geographical areas in recruiting and retaining care worker staff. A number of councils have reported growing fragility in their care market with more providers being financially challenged. There will certainly be upward pressure on the price of care associated with the increase in the national minimum (living) wage. A number of councils are already committed to ensuring that all staff are paid at the rate of the "National Living Wage" (or London Living Wage for London Boroughs). The rise in the national minimum wage from £5.93 in 2010 to £6.50 in 2014 is not reflected in the

[26] See Mills and Reeve Review of Judicial Review Judgement of December 2011 published 5th January 2012
[27] See "Local Government Lawyer" report on Judicial Review Judgement on Torbay December 2014

prices paid by councils for domiciliary care (in the diagram above). The figure will rise to £6.70 per hour in the coming financial year. The London Living Wage is now £9.15 and the National Living Wage £7.85 per hour. Providers will not be able to sustain their business if councils cannot afford to fund these increases. One might argue that if prices go down any further then the quality of services provided will become at even more serious risk. One of the consequences of this approach has been that some providers have determined that the only way to sustain their businesses in these circumstances is cramming in a larger number of calls. Other national leaders in this care sector have stated that if the present price war continues they will not be able to sustain their business at all and will pull out of the care market. This would have serious consequence for the longer term delivery of care.

There is still evidence from councils that there may be room for negotiating costs of care with providers of residential care for adults with learning disabilities, mental health care placements and for younger adults with other complex needs (including the costs of supported living accommodation). There have been a number of initiatives in recent years to find a fair price for this care including the various care funding calculator tools that are available to councils[28]. Some Councils have already used these tools and have made savings in the costs of these placements. As with a number of these products results are inconsistent as to what councils have achieved through their use (in part because other factors play a part beyond that which the tools can demonstrate). To some degree the questions for these services relate more to whether they are appropriate places to provide the right kind of care in the first place (e.g. as shown in the Winterbourne View Enquiry[29]). The model of care that should be offered to people is explored later in this paper in the section on “promoting independence”.

One might consider that the government has done much within the care industry to help the pay of the lower paid worker, to focus on the training and skills of the workforce and they have been very directive with councils to stop 15 minute visits for domiciliary care. However, it might be said that these policy directions have been apparently ignored in a number of places in order to help deliver the savings required to balance the council’s budgets.

The conclusion must be that overall the scope for further price reductions has become negligible in terms of the savings that might be achieved. It is much more likely that a combination of rulings from judicial reviews, the increases in the national minimum wage aligned to recruitment and retention challenges for care workers will push up the price of care in the coming years.

[28] The Care Funding Calculator (CFC) tools are free excel based systems designed to provide transparency and greater information to the negotiation and placement of adults with Learning Disabilities, Mental Health and Physical Disabilities in Residential and Supporting Living placements. They are designed to provide cashable efficiency gains through ensuring a fair payment level for residential and support living placements. They have been designed by various organisations including – iESE, OLM, Improvement and Efficiency (West Midlands), thinklocalactpersonal et al.

[29] See report Winterbourne View Time for Change - Transforming the commissioning of services for people with learning disabilities and/or autism – NHS England 2014

5.4 Other approaches to efficiency and saving money

The publication "*A Problem Shared*"[30] commissioned by the national programme board for sector-led improvement – TEASC - described how the sector was taking two different approaches to saving monies. Their evidence and the Local Government Association's reports on Adult Social Care Efficiency suggested that the vast majority of savings from adult social care in the early stages of the Coalition Government were achieved by freezing fees, closing down some in-house services, increasing charges from customers, gaining more income from the NHS) and housing partnerships (Supported Housing schemes and Extra Care Housing using the former Supporting People Grants), and cost cutting following a review of management and staff. These are often referred to as "transactional savings". The second approach, which councils were beginning to turn their attention to at that time was "transformational savings", which have considered new approaches to the delivery of social care, often with a focus on managing demand through preventive and diversionary care programmes. These appear much harder to deliver.

The Local Government Association's final report on its Adult Social Care Efficiency programme[31] highlighted four areas in which councils have saved monies over the last four years through more transformational ways. These include:

- Using direct payments as an alternative to contracted services (e.g. through personal budgets):

  - greater efficiency from increased productivity amongst staff and through better procurement (as outlined above);
  - integration with the NHS or other partners (e.g. housing); and
  - through managing demand for services through better preventive interventions.

This section considers each of these approaches in turn.

5.4.1 Savings from the use of Direct Payments and Personal Budgets

There is evidence that many councils have yet to mainstream the use of Direct Payments for adult social care at the rate that might have been expected from both of the last two Governments. Though councils are reporting increases in the percentage of people who are receiving a personal budget (an agreed set of money from which services can be purchased to meet someone's care needs), less than half of the people are taking this in the form of a Direct Payment where they service user has direct control over the way in which their personal care is delivered.

Evidence from Barking and Dagenham[32] who have one of the highest rates for Direct Payments does indicate that they have run this as a lower cost approach to delivering care (even when the London Living Wage is awarded to all paid carers) than contracting

[30] http://www.thinklocalactpersonal.org.uk/_library/Resources/Useofresources/1_UoR_A_Problem_Shared_full_report.pdf

31 The report can be found at: http://www.local.gov.uk/web/guest/productivity/journal_content/56/10180/3371097/ARTICLE

32 The report can be found at: http://www.local.gov.uk/web/guest/productivity/journal_content/56/10180/3371097/ARTICLE

through agencies for the care to be paid (about 5% lower costs). However, this is an exception from the general findings about the cost effectiveness of Direct Payments. Any system based on micro-level purchasing by individuals (which is the direct consequence of direct payments) is almost by definition likely to be more expensive unless people genuinely find alternatives to having paid employees. Most of the case studies that show lower costs from Direct Payments involve people moving from residential care to community living. The 2008 IBSEN report on the impact of Individual Budgets[33] found no discernible savings arising from this approach (though it reported that there was some potential for savings in the future) and the Social Care Institute for Excellence (SCIE) 2009 literature review[34] reported similar findings with no savings arising from the approach when the set up costs and transactional costs were taken into consideration.

Many councils with a much smaller percentage of their clients on direct payments have reduced their expenditure in recent years through a combination of clawing back money from customers (direct payments) accounts which had not been spent on meeting their care needs and/or though tightening the criteria for their resource allocation systems. There has been a strong focus on ensuring people only receive what councils consider to be the minimum budget in order to meet their needs.

Table 12 - comparing standard packages of care with Direct Payments for each client group per Council (Average spend per week per customer in £s)

	Nottingham-shire		Blackburn with Darwen*		North Tyneside		Hackney		Tameside		Derby	
	Std	DP	Std	DP	Std	DP	Std	DP	Std	DP	Std	DP
Older People	130	190	154	477	158	156	362	240	162	100	229	183
LD	149	286	908	241	379	368	342	280	99	00	186	242
MH	91	91	61	645	115	54	49	85	23	113	215	95
PD	152	306	143	446	161	227	235	333	143	244	333	132

In the study of the six councils was observed that generally younger adults receiving a direct payment were costing a higher amount than younger adults who were receiving standard packages of care. It will be expected that as councils look to tighten their budgets, these costs will become much closer. The evidence suggests that on average the cost of care packages given in the form of a direct payment are higher than that which is delivered through standard contracted care. With some exceptions this is confirmed in Table 12 for the six councils. The table shows Direct Payments are higher in Nottinghamshire and in Blackburn (except for adults with learning disabilities); in North Tyneside the costs are closer for the two approaches though slightly higher in services for people recovering from mental ill health and younger adults with a physical disability; in Hackney and Tameside the costs are lower for older people but higher for other client groups; in Derby they are lower for older people, younger adults with a

[33] The IBSEN project - National evaluation of the Individual Budgets Pilot Projects 2008
[34] The implementation of individual budget schemes in adult social care – SCIE Research Briefing 20 March 2009

physical disability and for people with mental-ill health and only higher in learning disability services.

The table shows the data returns from councils. It is worth noting that the associated support and transactions costs associated with Direct Payments are not included in these figures so in order to calculate the full cost of a Direct Payment the additional on-costs should be added.
All councils are looking to ensure that their resource allocations systems give the minimum payment to meet the person's needs. None of them think that they have solved the problem of how to best design a resource allocation system and this continues to be a major stumbling block for the delivery of personal budgets. Derby City are building an approach to personalisation which relies on personal, community and family assets to help meet someone's care needs – which in some cases can reduce the costs. The support planning process always looks at the assets someone has to meet their needs before any budget is set. This may explain why in Derby City the direct payment costs are lower than the standard packages. For all of the councils there is some inconsistency with the data.

There may be little scope for further reductions in this direction as councils may find they become at risk from Judicial Review if they are not offering sufficient monies to meet customers' needs. The Care Act 2014 also places a stronger emphasis on the rights of a customer once their needs have been assessed to ensure that their needs are met through their personal budget. Overall, Government policy has always stated that this approach is cost neutral and should not be a means of saving money. Derby show that there is some limited opportunity through their "asset-based" approach.

In conclusion it appears that there may be some savings that can be found from historic generous high cost packages of care for some younger adults but these opportunities are reducing as more reviews have delivered savings. There are new risks from the changes to the Independent Living Fund and to the "rights" in the Care Act.

5.4.2 Efficient processes and more transactional savings

It is probable that there is always scope for increased efficiencies in the processes that councils use to assess people to understand their care needs and to allocate the resources to make sure their needs are met. In the LGA programme[35] there were case studies from Kent, Central Bedfordshire and Kingston-upon-Thames where councils had found that by changing the processes for assessment and making them simpler, productivity in relation to increased numbers of assessments and reviews could be significantly increased (by up to 100%). Over the period of the last five years the sector has reported £170 million reduced spend on assessment and care management (about 10% reduction)[36]. Given earlier findings from The Department of Health[37] that showed a strong correlation between investment in assessment and care management and lower admissions to residential care it is important for councils to be increasing the effectiveness of their assessment and care management staff rather than making false economies by having to reduce the staff with the possible consequences that the

[35] The report can be found at:
http://www.local.gov.uk/web/guest/productivity/journal_content/56/10180/3371097/ARTICLE
[36] http://www.thinklocalactpersonal.org.uk/_library/Resources/Useofresources/1_UoR_A_Problem_Shared_full_report.pdf
[37] Use of Resources in Adult Social Care – Department of Health 2010

numbers in residential care rise (costing more money than the savings made from staff reductions). None of the councils in the LGA study actually made direct savings from their increased activity but they used the additional capacity to ensure that their assessments and in particular their review systems were working to best effect. All of these councils also adopted the "promoting independence" model that is covered later in this paper. They used the increased productivity to help make savings in reduced costs of care. So in Kent the "promoting independence" reviews that were introduced ensured that older people who were receiving services and who were recovering from the crisis that led them to need those services in the first place were under more constant review.

In the six councils that were studied they had all relied heavily on reducing their spend on management and staffing including some front line staff. Councils have reviewed their staffing costs, their management structures, the posts that they have in management, administration and at the front line. This review of staffing is has typically contributed to about 20% of the savings made in councils in Adult Social Care. (Redundancy and Pension costs will have had to be met and this is not shown in the ASC budgets for the six councils in this study). There used to be a correlation between high investment in assessment and care management staff and lower admissions to residential care for the council. Recent work[38] demonstrates more that it is the culture within the assessment teams that most determines the outcomes for customers and the consequential costs. The study demonstrated that social workers operate within their own personal risk thresholds when assessing a person's needs. The workers individually are usually quite consistent in their practice but there is a wide range of what is acceptable practice between different social workers. Some workers are much more likely to place people in residential care than others. Some workers develop services to meet needs alongside carers others look to "take the problem away" from the carer. Overall it is not so much local or even national eligibility criteria that establish how a council will help someone but more the personal values and thresholds operated by individual workers. This is certainly an area on which councils might want to focus more attention if they both want to achieve greater consistency in practice and to ensure that people don't receive higher care packages than is necessary to meet their needs. It does appear that the use of "panels" of senior managers to check on care packages has not solved this inconsistency in practice.

In this study it was found that one of the biggest transformational changes delivered by the councils was their approach to managing day opportunities and day care for people who needed care and support. Most councils have reduced the number of day care centres and have helped people use personal budgets to find alternative sources of day care support – for some they are now deemed not to be eligible for this type of care. £7.5 million was saved from the six councils in changing the way in which they operated their day care for both younger adults with learning disabilities and for older people. Day Care can be an important service as part of respite care to help carers by offering a safe and stimulating place for people with care needs to attend during the day. However, over time it can become a place for "vulnerable" people which can institutionalise them and make them more dependent on the need for care. Across the country day centres are becoming less popular with older people, there are very few buildings left for adults with physical disabilities and for adults recovering from mental ill health. There are still relatively high numbers of adults with learning disabilities using

[38] Newton (Europe) in Kent County Council study in LGA Adult Social Care Programme

these centres – often because there are no other alternatives. Some councils have in recent years closed these centres to offer personal budgets as an alternative approach in order to help people spend their day time in a way that is more geared to their personal needs. (Though there is some evidence from councils that this is a more expensive way of meeting needs). Nottinghamshire, in particular tackled this in an innovative way.

Nottinghamshire ran 35 different day care services across the county in 2010 when they launched a consultation which aimed to reduce the number of centres to 13 – one for each "locality" in the county. This approach required the new centres to be able to cater for anyone with respite care needs, with people from all ages and conditions attending the same centre. Nottinghamshire would focus the day centres as respite care for people with relatively high care needs – mostly older people with dementia and younger adults with profound learning disabilities (often combined other physical disabilities or challenging behaviours). At the same time they rationalised and reduced the amount of transport required to help people get to these centres (and this was charged for separately outside people's personal budgets). There still are some voluntary sector day centres in the county (in addition to the 13 council run places) which customers could choose to attend using their personal budgets and the amount to fund that was fixed at a set rate.

The approach to develop an inter-generational model of day care, once it was agreed by the Council and set in motion, led to a 20% reduction in people using any form of day care and a further 12% of people who switched from a council run to an independently run centre. The overall reduction in costs to the county council from this transformation came to £3.8 million. There may have been some small additional costs as some other people switched to take on a direct payment to ensure their eligible needs were met. Most of those who no longer attended day centres had low or no eligible needs and therefore did not qualify for a personal budget.

This is an innovative approach by Nottinghamshire County Council and has proved to be generally popular with the customers using the new services. There are plans to make a further saving with the closure of at least one or more of the centres. The aim is to combine services onto a single site where people's needs can still be met but at a lower cost.

Tameside's approach included encouraging local societies, sports clubs and associations to include in their activities opportunities for adults with learning disabilities who could use small personal budgets or their own personal resources to undertake community activities in a productive and positive way. Not only did this save money but also greatly improved the life experience of these younger adults. Just over £10 million was saved by the six councils from their respective projects which looked to transform day care services from all of the client groups (mostly in learning disability and older people's services).

Overall it appears that there are risks associated with cutting back on assessment and care management staff. Most councils have however made reductions in these front line staff and saved money as a result. Some councils have achieved this through improved processes but the longer term impact of these savings on the overall costs of the service is not known. There is considerable ongoing discussion about how assessment and care management staff should be used in a care pathway. Some

councils have introduced computerised systems (as above); whilst others have focussed more of their front line reception staff time on helping people solve their problems so that they don't require a formal assessment. Others have used interventions such as reablement to reduce people's longer term needs for care and have used that process to undertake the assessment for a person's longer term needs. New models are emerging where the formal assessment may not be undertaken by a trained social worker. This may reduce the longer term costs of the service without impacting on the costs of care. However it is too early to make a judgement about the best way to deliver this important part of the process in the most cost effective way. Linked to their approach to "promoting independence" (outlined below) councils now typically operate a three level assessment process:

Level 1 – The contact centre that looks to assist people by helping them to find solutions within their family; their wider networks; their local community or the voluntary sector. This would divert about 70% away from a formal social care assessment.

Level 2 – A set of short term services that will help someone in a crisis and will focus on finding resolution and recovery from the presented problems. There is usually a menu of options which include physiotherapy/ occupational therapy/ assistive technology/ domiciliary or day care reablement/ volunteer visitors/ short-term support workers/ carers support services/ living with dementia support services and other similar help (some of which was previously funded under the "supporting people" grant regime). This set of services might typically meet the needs of a further 15% of those who need help.

Level 3 – An assessment for a personal budget which will support a person to live with one or more long-term condition. The focus of the assessment would still be on delivering positive outcomes for the person and will have a strong focus on how to assist the person maintain or regain as much independence as is feasible given their personal circumstances.

It is recognised that it is the culture within the assessment and care management teams that is the major contributor to the ultimate costs for the service (rather than the structure or the processes). Those staff that look to assist people to stay out of the formal care system and those who look to assist people in maximising their opportunities for independence are likely to deliver better outcomes at lower costs.

In conclusion it appears that Councils have made significant savings from transformational change and by looking at the way they have traditionally done things. The larger audit and managerial consultancies including "efficiency partners" working in the sector are still confident that there is potential for greater efficiencies and further transformational changes in some parts of this sector. However, as resources become tighter councils will not have the money to pay for these consultancies. In addition not all the claims that have been made to councils have been converted into cashable savings. For those councils who have not entered into a transformational programme there is likely to be scope for savings. For those who have run their own programmes (sometimes with assistance from efficiency partners) the scope for further savings is likely to be limited.

5.4.3 Health and Social Care Integration

Over the last year there has been a big Government policy push to bring health and social care closer together. This approach to integrated health and care is expected to bring greater efficiencies to the health and care system. The policy in England has been recently focussed on the arrangements for discharge from hospital through a policy called "The Better Care Fund" where resources are pooled between the NHS and the Local Councils to look to improve outcomes for older people through speedier discharge and better co-ordinated services in the community. It is still too early to show the potential benefit of this approach. Section 3 (above) clearly shows that health and social care spend are inter-dependent. From the six councils in the study there was as much evidence of the behaviours and practices of the NHS putting additional pressure on social services budgets as there was the other way round. This needs careful examination in any future settlement – there needs to be a balance to see the issues from the point of view of both sides. It is early days to identify whether the Better Care Fund will achieve the hoped for gains for the NHS and Social Care – though all of the councils in the study would like it to.

However, lessons from the past (in particular the failure of a number of the early Care Trusts to survive) as well as the issues identified above suggest the need for caution about the potential for cashable savings for councils as a result of health and social care integration. There are risks that the policy might lead to more risk-averse practices in both the NHS and social care that could lead to increased demand for care and NHS services that will stretch councils'/CCGs budgets even further. There is for example evidence in some areas that the NHS is directly procuring nursing and residential care beds from the care market and placing older people directly into these beds – "called discharge to assess beds" – giving the local authority notice that they will have to assess these older people to determine whether they will require these beds longer term. This is not good use of resources according to the Department's own guidance[39], and is likely to lead to much more cost in the system and yet has been widely supported by NHS England to help alleviate the acute hospital crisis during the last winter (2014/15). Councils report that they have not been able to prevent the NHS from procuring these beds (often at a higher price than the local authority would pay) and they have used the pooled budget for this purpose.

Despite the best efforts in some places to work in an integrated way the NHS and Social Care are fundamentally concerned about different outcomes. The NHS is measured by the speed with which it can process and intervene to help patients find the right medical help and then to move them out of hospital. Social Care has a stronger focus on the longer term outcomes for a person who has been in hospital and how they might be assisted to regain a degree of independence. Though community health services may share the same aims as social care their outcomes are currently not measured within the NHS performance system. This has particularly showed itself over the last winter (2014/15) where there has been severe pressure put on acute hospitals through higher admissions. The hospitals have been driving speedier discharges to assist with their challenges, to the point where in some places have (with the support of NHS England and local Clinical Commissioning Groups) been buying residential and nursing care beds themselves to get older people out of hospital beds and into a safe place. However this has led to real pressures in the social care system both by filling up

[39] Intermediate Care Intermediate Care – Halfway Home Updated Guidance for the NHS and Local Authorities 2009

existing resources but also by increasing admissions to residential care at a cost to councils. Many of these admissions would have been avoided by a different approach. In Kent the work[40] by Newton (Europe) demonstrated that if an older person was discharged direct from a hospital to a nursing or residential care home that had no facilities to support recovery or rehabilitation then 80% of those older people remained in the home where they were placed. If they were discharged to an intermediate care bed – where a bed had been specifically commissioned to support the older person's discharge back home – then 80% returned to their own homes and required less long term care. The answer has to be that the two parties should work in a collaborative way to understand the flow of patients and to commission the right level of support to help people post-acute hospital discharge. This is not what is currently happening despite the push for more integrated approaches.

A recent study commissioned by the Local Government Association and undertaken by Newton (Europe) has tracked the pathway of older people through the health and care systems. The field work is currently on-going. However their earlier findings from an interim report have some quite significant findings[41]. The study found that there was still help that could be offered to older people at an earlier stage that would avoid an admission to an acute hospital. Significantly they also found that one in five older people being discharged from hospital were over prescribed the level of care that they actually required to help them. There were four areas where this might happen:

- being placed in a residential bed when they would have recovered at home;
- or being proscribed double handed care when it was unnecessary;
- or being offered domiciliary care reablement when a simple plan from a physiotherapist which the person could have managed themselves;
- or proscribing more domiciliary care than was required.

These all add significant costs to the care system as well as removing important capacity. The conclusion from this study is there may be a 2% efficiency gain from delivering a transformational programme which both keeps older people out of hospital and gets the best possible recovery programme at the point of discharge. There are early signs from a transformational programme happening in Glasgow City Council that delayed discharges can be reduced whilst delivering better outcomes for older people – which will continue to aim to reduce the costs for both health and care.

There is however a strong push for greater integration on the ground between primary, community and social care. This was certainly happening in all six of the councils though the plans for this were still being discussed. However, the councils did report some concerns that the new dialogue was leading to the NHS making even more referrals to social care. In many cases these might be identified as inappropriate and in others there were better alternatives to help people. A new learning exercise is taking place, and it is not yet possible to evaluate the impact on the demands for care or the outcomes for the people.

In the study of the six councils it was clear that there are two main routes to access social care. The first is through a contact centre (see section below) and the second is through an acute hospital. There has been a growing demand for social care from

[40] Not published but Newton agreed this report could share their findings.
[41] www.local.gov.uk/productivity<http://www.local.gov.uk/productivity 2015

acute hospitals. This is now the current challenge that needs to be met by Councils. In Blackburn with Darwen they reported that between 2011/12 and 2013/14 the numbers of people being referred from secondary (acute) care to the adult social care services has more than doubled. Councils are using the opportunities created by the Better Care Fund to examine the best way of responding to the demands now coming from the hospital. The councils in this study have yet to create single joint teams with the NHS to tackle this issue. In some areas the complexity of commissioners and providers in the NHS world adds to the reasons why this is not progressing as fast as local authorities might wish.

It is worth noting that Derby City have bought an IT software package which is jointly owned with Derbyshire County Council, the two main Acute Hospitals serving the city and the county, and the two Provider Trust for Community Services along with the Mental Health Trust. This package helps them to track the outcomes for older people within the health and care system to enable a better targeting of resources for those who are "frequent flyers" in the health and care system. This approach has been adopted (not necessarily with the same software) in a number of places. Tameside also have established a new joint service which receives referrals from health and social care professionals to seek to reduce hospital admissions. There was some early success from these initiatives though both councils (Derby and Tameside) reported that it was hard to demonstrate the impact on acute admissions (as they continued to rise even when a number of older people were being helped to stay out of hospital) and for the money to move from the acute sector to these services.

Finally, two of the six councils in the study have demonstrated that their local approach to integration with local mental health trusts has not worked sufficiently for them to continue with the shared arrangements. They have now abandoned their integrated teams. These Local Authorities observed that their partners in the NHS tended to use bed based resources (residential care) far more (putting some of the costs onto the local authority) than would be considered sensible or appropriate by social care. Both Nottinghamshire and Derby City have abandoned their integrated service in favour of a strong partnership with co-located staff but with separate accountabilities for the budgets.

If this very specific evidence about mental health services (that has been noted by the author as happening elsewhere) is added to the general evidence that many of the previous integrated Care Trusts in England did not survive because of increased costs, it is likely that some of the newer models may meet the same fate. The various Care Trusts from the last tranche had significant overspends in their budgets. At one stage this was happening even in Torbay, which is often cited as the most successful integrated Care Trust. There is concern in some social care circles that if adult social care is passed over to be run by the NHS then there will be higher costs for care and poorer outcomes for citizens. The evidence that is available from many of the former Care Trusts and some current examples e.g. Swindon, suggests that councils that put their adult social care into NHS Trusts have not been able to make the transformational changes that are now required to deliver cost effective social care. This is not to decry the work of social care in Northumberland and Torbay where the Care Trusts still survive and are all making savings in adult social care[42]. They do not however make bigger or better savings than their non-integrated counterparts. The case for health and

[42] Evidence from Local Government Association Adult Social Care Efficiency Programme Final Report July 2014

social care integration saving money is yet to be made and the practice that might reduce spend has yet to be widely observed.

In conclusion the work currently commissioned by the Local Government Association on the cost benefits of health and social care integration may assist with these developments[43]. It is clear from the evidence laid out in Section 2 B that there are inter-dependencies between health and social care. These can cause serious tensions between both parties and lead to cost shunting. To resolve this it would seem that a more integrated approach is the solution. This will need to be comprehensive and clear on the risk-taking between local authorities (if they retain their role in social care and with Health and Well-Being Boards) and the NHS. There is much work to do in this area before savings will materialise. Greater clarity from Government on the issues raised in 2B could reduce the current tensions that can emerge between the partners who are both looking to manage scarce resources and deliver their efficiency targets.

5.4.4 A new approach to social care demand management?

So, if the opportunity to produce further efficiencies through either price reductions, greater efficiency or through integration with the NHS are limited for adult social care what other option might there be? The final option is for councils to manage demand for their services more effectively. Over the last decade (and even longer) councils have been managing demand for social care through a number of measures. The most common approach has been through tightening eligibility criteria – though the evidence is uncertain as to how much money this has actually saved councils. Many voluntary organisations and other commentators suggest that the reduced numbers of people being helped by councils is as a direct result of the move by councils to tighten their eligibility criteria to only meeting the needs of those with critical and substantial needs. The review of this approach by councils undertaken by the Commission for Social Care Inspection[44] did not conclusively show whether this was the case or not – they did find a small number of customers who had lost out as a result of this action by councils. However, all councils would report that managers have had to work within a clearer set of eligibility criteria (changed from April 1st 2015 by the new Care Act) when determining who might get state funded services.

Earlier in the paper the evidence cited showed that the biggest single change in adult care over the last decade has been in the reduction in the use of residential care for state funded customers. There has been a steady decline in admissions to residential care (as funded by local authorities) despite the increase in the older people's population during this period. There are similar declines from other service user groups (as shown in the table 13 below).

[43] Work being undertaken by Newton (Europe) for the Local Government Association in 2015[43] www.local.gov.uk/productivity<http://www.local.gov.uk/productivity

[44] Cutting the Cake Fairly – Commission for Social Care Inspection report for DH October 2008

Table 13 - The numbers of people in permanent residential care funded by councils for the last ten years in England

2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
OP188465	180945	171665	166220	163105	161010	160630	156945	156780
PD 9300	9255	8770	8485	8175	7710	7680	7595	7785
MH10885	10420	9980	9865	9950	9435	9300	9135	9040
LD 32960	33080	31930	31790	30865	30790	31370	30460	29855
241885	234125	222710	216735	212525	209345	209440	204670	203960

OP is Older People; PD is younger adults under 65 with a physical disability; MH is younger adults under 65 with mental ill health; and LD is younger adults under 65 with a learning disability

The decline in numbers entering residential care has been strongly led by government policy for much of the last 30 years. The emphasis has been on "helping people to remain in their own homes" and over time councils have discovered new and better ways of helping people and as a consequence have reduced their admissions. Like other transformational changes in social care this has happened at a very different rate between one council and the next.

One of the most significant variables in the care system is in the outcomes from older people who are discharged from hospital (as described earlier in this paper). My direct work with councils suggests that in some places up to 20% of admissions from hospital to residential care for older people are avoidable[45]. This is a significant area that some councils have targeted to assist in reducing expenditure whilst improving outcomes for older people. This approach is not always understood, let alone adopted by NHS Partners.

The DH publication[46] Use of Resources in Adult Social Care included a list of the factors that might impact on admissions to residential care for younger adults:

- Availability of Housing supply;
- Services to help people prepare for housing;
- Access to Housing;
- Specialist Housing;
- Adapted housing;
- Availability of supported Housing;
- Supported Tenancies and contract agreements;
- Floating support;
- On-site support;
- Use of Telecare; and
- Assessment and Care Management Staff with time to work on the solution.

[45] See Case Study from Hackney in http://www.local.gov.uk/web/guest/productivity/journal_content/56/10180/3371097/ARTICLE
[46] Use of Resources in Adult Social Care – Department of Health 2010

The report produced similar lists of the factors that might assist in reducing admissions for older people into residential care. The actions that were being taken in councils began to change the way in which care was being delivered and what became available in the local offer. Many councils have halved their rates of new admissions to care over the last decade. The thinking that has led to these transformational changes has contributed to wider thinking in social care about how different approaches to the delivery of care achieve different outcomes for the population. One of the key pieces of learning has been that the traditional way in which social care has been offered has followed an assessment that is usually made when a person is in their most vulnerable state and then delivers support to them in a way that may increase their longer-term dependency on care. Ensuring that a person is safe and offered good care whilst starting a programme to support recovery and their rehabilitation may reduce their longer term needs for care. This means not rushing to make an assessment for their long-term needs until the crisis has subsided and the opportunities for recovery are further explored.

Furthermore, the setting in which an older person lives does not assist in making this assessment. There is some evidence that older people living in some Sheltered Housing or Extra Care Housing Schemes are as likely to be admitted to residential care, whereas in other places quite the opposite will happen and people will be kept out of residential care. It's not what the place is called – it's the service that is offered that appears to make the difference. Some places focus on helping older people to live more independent lives whilst others inadvertently only encourage dependency on the care that is readily available. A PSSRU study[47] found that there were benefits for older people who lived in such housing schemes. The main finding was that the overall cost per person increased after a move from the community to extra care housing, but that this increase was associated with improved social care outcomes. Costs in extra care housing were slightly lower for the matched sample, compared with care homes (£374 and £409 per week respectively at 2011 prices). There was a slight improvement in physical functioning and the level of cognitive functioning was stable in the extra care housing sub-sample. This contrasted with slight declines in both physical and cognitive functioning in the matched care home sample. So, the study was unable to show conclusively that these benefits were delivered at a lower cost (because of the complexity of the funding streams for housing) – but it is clear that there are cost benefits for councils from this approach. However, interestingly the model has not taken off in the way in which some expected. (See the SHOP report produced for the Housing LIN[48]).

There are other approaches used by councils to "manage demand". In the study of six councils it was found that councils were both managing demand through reviews of the amount of care people receive and through looking to offer alternative lower cost care services.

All of the councils had made savings through using the process of reviews of existing customers to look to see how their needs were being met and whether these could continue to be met in a less expensive way. This is in addition to specific work that

[47] Netten, A., Darton, R., Bäumker, T. and Callaghan, L. (2011) *Improving Housing with Care Choices for Older People: An Evaluation of Extra Care Housing*, Personal Social Services Research Unit, University of Kent, Canterbury

[48] Strategic Housing for Older People – a set of useful resources packs - http://ipc.brookes.ac.uk/shop.html

councils have undertaken in looking to bring down the price they pay for higher cost services. (Blackburn with Darwen had reduced the costs of placements by £600,000 last year). All the councils had saved money through undertaking reviews which led to a conclusion that the person could be better supported in the community and away from the residential care setting in which they had lived. (Blackburn with Darwen report that they saved £240,000 in 2014/15 from tighter and more focussed reviews).

All six councils were actively promoting alternatives to residential care as a way of reducing costs. The most common strategy was to develop alternative housing options for people with care needs. These typically included Extra-Care Housing for Older People and Supported-Housing for Younger Adults. The costs of the accommodation and the daily living costs transfer away from councils into housing and benefits payments typically saving a council over £150 per resident per week. There is some evidence however that these models of care can be (both short and longer term) more expensive than residential care. The environment can become risk averse and create dependency on care services which are readily available. These models only work to save money when they are clearly linked in with and part of a "promoting independence" strategy. There is also an additional problem for social care when the delivery of services for a group of people has to be shared between those living in a particular residence as it is much harder to work with customers through personal budgets. If each person is assessed separately and a standard resource allocation applied the costs are likely to be higher because the benefits of sharing the overheads and other costs can get lost in the calculations.

6 The case for "prevention"

The evidence for prevention is growing. But first one needs to be clear about what we mean by the term. I will use an analysis based on four different[49] approaches:

- the public health approach;
- the lower level targeted approach;
- the recovery and rehabilitation approach;
- and the longer term approach to those with current care needs (sometimes called the progression model).

6.1 Public health preventive measures

The public health approach recognises that [50] if all citizens took greater responsibility for their own health they could reduce the risk of the diseases that may impact on the quality of their life in old age. There are many papers that show that even if people take up exercise in their 50s they can reduce risks of longer term illnesses.[51] Overall if people smoked less, ate healthy diets, consumed less alcohol and took better exercise then longevity of life is more likely to be accompanied by less disease and illness. In older age need for social care is most likely to be determined by poor health. Most of these

[49] The £100 Million Project – paper for ADASS written by Professor Andrew Kerslake and Professor John Bolton 2011. This approach to "prevention" was developed by Professor Kerslake at the Institute of Public Care in the late 2000s.
[50] Nice Draft Guidelines - Preventing disability, frailty and dementia in later life.
[51] E.g. - Paper written for the American College of Sports Medicine by Robert S. Mazzeo, Ph.D., FACSM or see Web Site – Be Fit Over Fifty which lists the evidence.

conditions can be avoided (prevented). In Britain the public health agenda has not often focused so much attention on the benefits of preparing for older age. Much of their excellent work has been with younger people and their families. Public health policy should also focus on active and healthy living for older people – from fifty years of age onwards. This could reduce demand for social care in the longer run, though it may be thirty plus years before any benefits are realised (as most social care for older people is used by people who are over 85). One of the most talked about challenges facing older age is that of memory loss and dementia, including Alzheimer disease. The evidence is growing that good exercise can reduce the risks of these conditions. How much is that message promoted within the United Kingdom?

6.2 Targeted preventive interventions

There are a whole set of people who may experience a single difficult episode in their life from which the right kind of help can find solutions so that the circumstances do not occur again. These are people who clearly have needs at a time of crisis. This is where getting the right short term help for them in the right way can reduce or eliminate their need for longer term care. This is where a service (or set of interventions) can be set up for a single purpose to help rehabilitate and assist people get back on their feet following a serious problem.

These services range from Falls Prevention Services (where after a first fall a further similar event can be avoided through a simple assessment and following a number of clear actions[52]) to homeless services (helping people to resettle into permanent accommodation); services for drugs and alcohol abusers; services for people suffering from domestic violence (to help people change their situation); bereavement counselling services (to prevent people from "giving-up" when they lose a loved one) etc. Many of these services were commissioned under the former "Supporting People" funding regime[53]. Subsequent work[54] shows that services should be specifically commissioned with a focus on delivering outcomes which assist someone to regain independence from reliance on the state for services. Services should be short-term in their nature; avoid creating longer-term dependencies (on formal care services) and should be outcome focused in relation to the customer regaining their independence as much as is feasible given their circumstances. (The term "promoting independence" may be misleading as in reality the programmes should assist people in creating fulfilling and meaningful relationships (dependencies) outside of formal care as well as helping people to be as physically fit as they are able).

Within the NHS, these services are linked with risk assessment models that have been developed in recent years which aim to identify which patients are most at risk of a hospital admission to ensure that they are both managing their conditions (diseases) and getting the right help. These tools such as the predictive tools developed at the Nuffield Trust [55] can show that identifying the right population with the right targets can

[52] There are many papers on this topic – but World Health Organisation report – WHO Global Report on Falls Prevention in Older Age 2007 summarises much of the evidence
[53] See the House of Commons Library - The Supporting People programme RESEARCH PAPER 12/40 16 July 2012
[54] Supporting People Payment by Results pilots – Final Evaluation Department of Communities and Local Government 2014
[55] Choosing a predictive risk model: a guide for commissioners in England – Nuffield Trust - Geraint Lewis, Natasha Curry and Martin Bardsley November 2011

reduce unnecessary admissions to hospital but also to residential care for older people. The critique of these schemes for social care is that they can be risk averse and actually assume that an increase in care provided might reduce health risks – this is not proven. In addition the risk models have a strong medical basis and so emerging thinking about how important the assets that a person has to determine their likely outcomes are not usually considered. So a person who has a supportive family, an active community network and their own resilience is more likely to need less formal state help than a person living on their own in isolation. Some of the early examples of councils and NHS partners (usually GPs) using the risk assessment tools shows that there is likely to be more demand for social care services as a result of their deliberations. Whether this is of benefit to the patient and reduces costs in the NHS (whilst increasing costs to social care) is not yet demonstrated. The NHS must also focus on the interventions that are more likely to reduce a person moving to a long term residential/nursing care bed. One study[56] suggested that this should include: improved dementia care services; incontinence services to assist older people to improve their continence; falls prevention services; podiatry services; and stroke recovery services. If the NHS gave greater priority to each of these service areas it is almost certain that admissions to residential care could be further reduced.

In addition, in the recent LGA Efficiency Programme[57] a number of the case studies of councils show how the way in which their first contact point with customers is arranged can make a difference to the longer term outcomes for customers. The case studies from South Tyneside; Barking and Dagenham; Calderdale (a joint enterprise with the NHS) and very specifically the social enterprise model from Shropshire all demonstrated that about 75% of people approaching social care for help could have their needs met through positive action but outside of the formal care system. This is a very different outcome than that achieved by councils who interpret recent government policy as meaning that all people should have the right information about “care services” as part of their first contact, where typically this figure is less than 50%. In both South Tyneside and Shropshire they contact people three to four weeks after they have received help to ensure that was offered was meeting their needs. This is not about eligibility criteria, but rather about getting the right help to people at the right time. If in addition to this approach a short term intervention based on recovery is then offered to those who do have some care needs it is likely that up to 90% of people can be helped without the need for longer term care. One of the key principles is not to make a decision about someone’s longer term care when they are in a crisis. The help that is offered should contain the crisis, and examine the opportunities for recovery and for resolution before the longer term assessment is made.

Councils will have to balance their combined responsibilities to ensure that preventive and well-being services are available to people alongside ensuring those who require it have the right information and advice. It is worth noting that only a very small percentage of enquiries to councils come direct from the public. Most referrals are made by other professionals working in the community.

The work in Kent[58] has demonstrated that one can begin to recognise the different responses that people may require at the point of a simple assessment. This approach

[56] The £100 Million Project – paper for ADASS written by Professor Andrew Kerslake and Professor John Bolton 2011

[58] Newton Europe

may identify the distinction for those who need care between those where a strong focus should remain on recuperation and rehabilitation and those where efforts should focus on reducing longer term costs. For the latter the interventions should focus on helping people manage and live with their conditions to look to slow the person's decline (where possible). Both of these approaches are very important but each requires a separate service design with a range of interventions to assist. The common themes include the importance of promoting independence and on the outcomes that achieve this.

However, in the study of the six councils it was found that all of them had radically reviewed their spend on the services previously commissioned through the "Supporting People" Grant – these were mostly "preventive services" targeted at vulnerable people who might not have met the social services eligibility criteria. The Supporting People Grant was awarded to councils by the Department of Communities and Local Government to help people who had low level community needs that used to be covered by additional costs under Housing Benefit. It was not intended to supplement the costs of social care though evidence suggested (from the returns submitted to the Government) that quite a large part of the grant has been used by councils to fund parts of the social care service. This was particularly the case for supported living schemes (mostly for adults with learning disabilities) and for extra-care and very sheltered housing for older people.

The services funded with this grant also included support for people who were homeless; experiencing domestic violence; had drug or alcohol abuse problems; sufferers from mental ill health; ex-offenders and others who may be categorised as "vulnerable people". The grant was no longer ring-fenced in 2010 and was absorbed into the general settlement for local authorities at a lower level. In some councils the administration of the previous grant and the commissioning and funding services associated with the monies had been managed within the Housing Services, others allocated it within the Adult Social Care Directorates. In all of these six councils it appears the monies were put into the ASC budgets and then reduced following a review of the services being commissioned. Five of the six councils could still see how the previous grant was being administered and what was being spent on which services; in one council the grant was fully absorbed into the ASC base budget. All of the councils reported making significant reductions to the services which had been commissioned in this area. 21% of the savings made by the five councils was from this area of spend.

The Councils reported that a percentage of these savings were genuine "efficiencies" achieved – for example – by making reasonable reductions in the unit costs of these services. It can be argued that the Supporting People Services were characterised by some services with very high unit costs. Many councils were able to reduce the costs of these services by recommissioning the old services at a more reasonable rate.

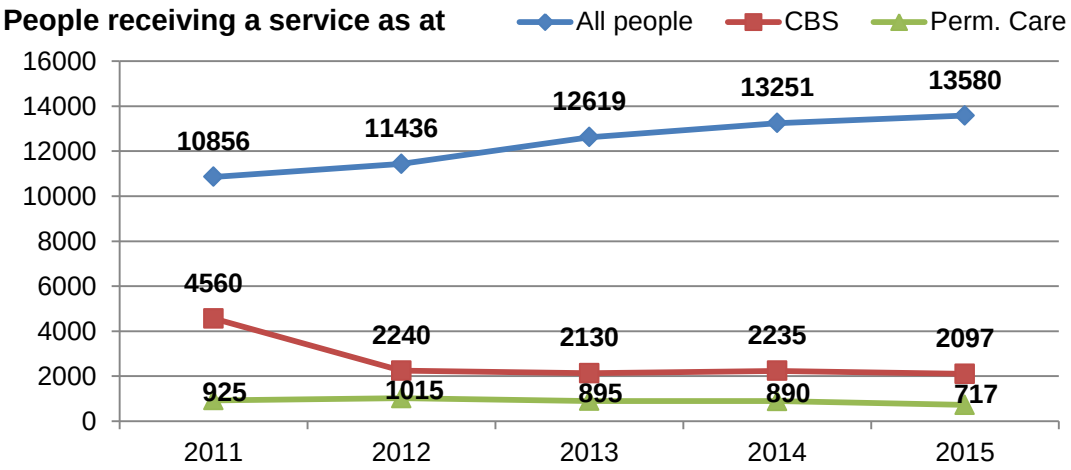
However, there are some risks identified in all these council areas and these savings may "bounce back" on them as people who were previously helped by these services will seek assistance in different ways. This is most likely to impact elsewhere on Homelessness Services, NHS Mental Health Services or the resources of the Police and Courts.

On the other hand, several of these councils had found new approaches to divert people to get the right help at the point of initial contact. There was strong evidence

that demand for social services was being partly met through diverting people to other places for help or offering short-term help which assisted people in needing less care longer term. This has been the major change in adult social care during the last five years. It is interesting to note that in North Tyneside they have kept a careful track of which people they have helped and how they have helped them. Though 75% of the people who approach them for assistance are helped at this first point of contact, the data shows that the council is helping more people over the period but in a different way from the past.

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

Table 14 – Numbers of people receiving help in North Tyneside



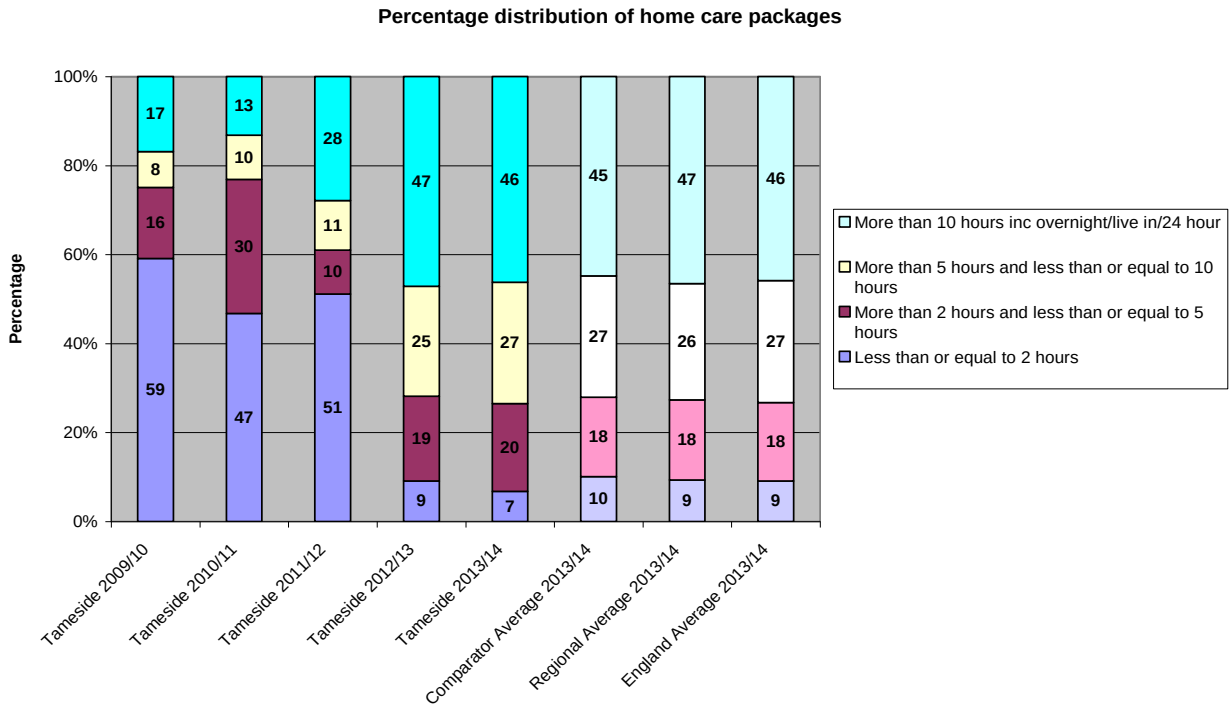
CBS = Community Based Services Perm Care – is a permanent care package

In a similar way to North Tyneside, Nottinghamshire has radically refocused their front of house services in recent years. Their corporate contact centre has a customer service section for adults' care – the Adults Access Service. This Access Service has a strong focus on finding resolution for people who approach them for help without always having to use the valuable resources of the social work assessment and care management staff. The customer services are supported by an Occupational Therapy Team who can deal with immediate and simple requests for help. Between the two teams they can address and meet the needs of 76% of people who approach them for help. In 2014 5,720 people were helped by the team with only 1274 people requiring a fuller assessment. They have also introduced a simple system so that when a full assessment is required this can be booked direct into the diary of the worker who will conduct that assessment. This has both speeded up the process and enabled people to be assured that they are receiving proper attention.

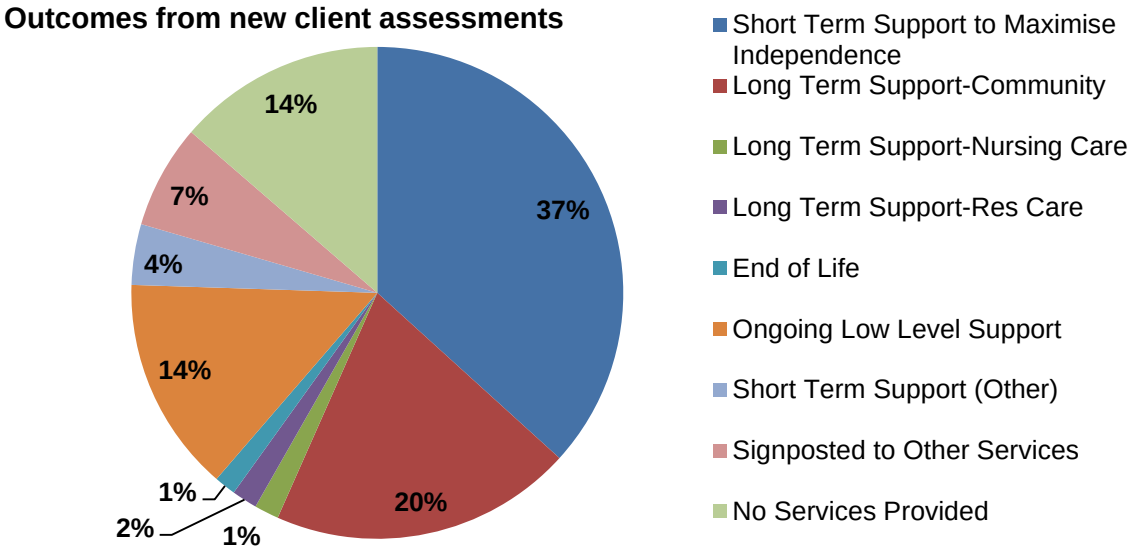
It should also be noted that the Access Service has a Safeguarding Team to whom it can directly refer people (most referrals of this nature come from other professionals). The staff did report that about 40% of the referrals to this team did not result in a full safeguarding enquiry and they considered there is more work to do both locally and nationally to help all professionals to know what genuinely constitutes a safeguarding matter. It is not good use of resources when 40% of referrals that have been investigated don't require further action.

Other councils could demonstrate very similar strategies (notably Tameside) where alternative ways of helping as many people were the key messages being relayed. Tameside used to help a lot of people with a little bit of home care (69% of home care hours); this has now been replaced with alternative community support.

Table 15 Tameside - Change in proportion of hours allocated for domiciliary care



In North Tyneside for those who are deemed to be in need of a formal social care assessment the following outcomes occur. From 1552 assessments undertaken 570 received a short-term service to help maximise their recovery to independence; 309 required longer term assistance and 220 were referred back to the community based services offered from the well-being services.



The conclusion from the study of the six councils is that people are still receiving help but not in the way in which we have recorded this assistance in the past. There may be a tension in the wider care and support system as to how to both build an evidence base about the best way to help people whilst also looking to sustain these new (low-level) offers of help as the resources become scarcer. At the same time as these new alternative services were being developed other contracts and grants to voluntary organisations were being reviewed and in some cases ended.

Most councils have reviewed the funding they have directly offered voluntary organisations in their area. Voluntary organisations are being asked to prove their value to the care system and to demonstrate that the outcomes they produce contribute to improved outcomes (possibly with lower costs) for customers of formal care. Some councils have continued to invest in some services that offer a genuine alternative to formal care (e.g. befriending services to tackle social isolation or other “well-being" services to help maintain people in the community). About £4 million was taken from the voluntary sector’s expenditure in these six councils over the five year period.

6.3 Recovery and Recuperation

There are a further set of services which have an equally strong focus on recovery, reablement, recuperation and rehabilitation. They may not be easily distinguishable from those described in the above paragraph. They include reablement-based domiciliary care; rehabilitation for people with newly acquired physical impairments; the recovery model for mental health service users; promoting independence help for people with learning disabilities. These may also include employment services; housing support and other allied assistance that can help people to regain all or part of their independence. Some councils run or commission services where up to two thirds of people who receive the service no longer need the help after a 12-week period. For other places this impacts on less than half of the people who receive the intervention. If every council were optimising the potential to help people regain independence then they could further reduce demand for care services in a positive way - i.e. by helping

people in the right way at the right time with the right intervention. There are a range of international studies that support this approach.[59] [60] [61] [62].

One of the best ways that this set of preventive services can be seen to be most effective is in relation to hospital discharge arrangements and out-of-hospital care. The help and range of interventions that are offered to an older person at the point of their discharge will make a big difference to the longer term outcomes for them and their likely need for more or less care. This has a significant impact on the costs in the health and care system. In Better Support at Lower Costs[63] a study in the Vale of Glamorgan showed that for every one million pounds saved by speedier discharges cost the health and care system two million pounds. This implies an imperative to establish the right Intermediate Care Services (those services available between hospital and returning home) which should include good nursing; therapy (from a range of different therapists); reablement-based domiciliary or residential intermediate care; continence services; and dementia care support services;.

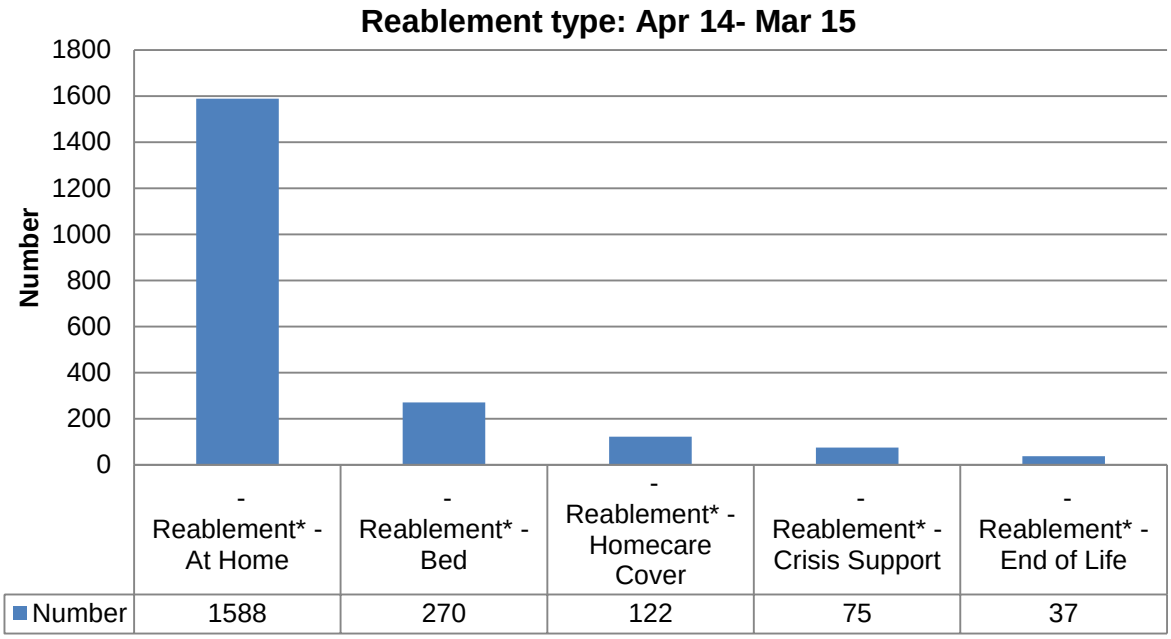
At present good practice is too often determined by the speed at which all the processes and assessments take place not on the outcomes that are achieved by the interventions on offer. It is almost certain that savings could be made for the NHS and Social Care if there was a stronger focus on recovery and rehabilitation following a medical intervention rather than the sole measured outcome being the speed of discharge. Health and social care need to understand the flows of people through the system and ensure that sufficient support is commissioned from all of the professionals who are required. This might set the agenda for better integrated services. It is noticeable that one of the places that did survive as a Care Trust (even though it has had a number of financial challenges) has been Torbay. One of the most significant features about Torbay is its investment in District Nursing Services which are critical to the success of the integrated service.

The NHS has developed the concept of “discharge to assess”. This has powerful roots from the policy laid out in the DH Guidance – Halfway Home (2010) where it is clearly stated that no one should be assessed in a hospital bed for their longer term care. However, in some NHS communities this approach has been misused as demonstrated in the previous section on health and care integration. This is not an excuse for discharging older people to residential care beds and waiting to see what happens. The whole system has to be commissioned with the right interventions delivering the best possible outcomes for older people.

[59] Care Services Efficiency Delivery (CSED) Programme (2007) Homecare re-ablement workstream, discussion document HRA 002, London: DH.
[60] Tinetti, M.E., Baker, D., Gallo, W.T., Nanda, A., Charpentier, P. and O'Leary, J. (2002) 'Evaluation of restorative care vs usual care for older adults receiving an acute episode of home care', Journal of the American Medical Association, vol 287, no 16, pp 2098−2105.
[61] Lewin, G. and Vandermeulen, S. (2010) 'A non-randomised controlled trial of the Home Independence Program (HIP): an Australian restorative programme for older home-care clients', Health & Social Care in the Community, vol 18, no 1, pp 91−99.
[62] Glendinning, C. et al. (2010) Home care re-ablement services: investigating the longer-term impacts (prospective longitudinal study), York/Canterbury: Social Policy Research Unit (SPRU)/Personal Social Services Research Unit (PSSRU)
Many of the studies are summarised in the Social Care Institute for Excellence paper along with other studies - Reablement: a cost-effective route to better outcomes – April 2011 – Research briefing 36.
[63] Better Support at Lower Cost” published by the SSIA Cymru (Social Services Improvement Agency in Wales) in 2011

As a result of recent transformation programmes, for most councils including those in the study, as soon as a person is identified as having care needs that require a formal service they are usually then passed onto a short-term service. For older people this is usually the domiciliary care re-ablement service. Illustrative evidence is drawn from North Tyneside which shows the services offered to older people who need support (most of whom are referred post discharge from the Acute Hospital).

Table 16 – The numbers of older people receiving reablement and type of help offered



Of the 2,092 older people who were helped by the services above – 68% of them required no further support after their short term intervention. This is well in line with the best performing re-ablement services in the UK. Recent work in Kent County Council has actually demonstrated that one of the variables in the outcomes from reablement is the appropriateness of the assessment before the work starts - is domiciliary care reablement the right intervention to assist a particular person? In addition the assessments both during the process and afterwards can dramatically change the outcomes for the older person. In a trial pilot period in Ashford, Kent, 90% of older people did not require further domiciliary care, though some were offered help in other ways (including assistive technology and community support).

The model of reablement was being used in all the councils with other service user groups. Nottinghamshire (through their outcomes based contract), Derby (through its transitions service) Tameside and North Tyneside had developed specific services to assist adults with a learning disability to become more independent. Hackney was managing this process through contracts with providers and the support of assessment and care management staff. All of the mental health services were looking to use the "recovery model" to support people. There were some solid anecdotes of this practice leading to lower costs and better outcomes though it was not widely or universally applied by the mental health trusts in each of the areas. Finally there has been a move to focus on rehabilitation for people with physical disabilities to focus on helping people live as independent as possible with the right equipment and support for daily living. E.g. North Tyneside has a contract with the RNIB (Royal National Institute for Blind

People) which focuses on helping people live with the loss of sight experienced by someone in older age.

In the six councils in this study between them they saved £38 million through the combination of alternative and short term interventions directly contributing to an average of 5% reduction in their combined spend (though of course there were investments in the specific services to obtain these). In each council the question is how much more potential is there for further reduced demand from these approaches? This is explored later in this report in the section on "Prevention".

6.4 Deferring or reducing longer term costs

The final set of preventive interventions is concerned with how people who have a longer term chronic health problem can be assisted to either better manage their condition or to use assistive technology and other help to manage the condition and reduce the need for more intensive care. This approach (sometimes called the "progression approach") is now being adopted in helping adults with learning disabilities. This starts with the belief that everyone however severe their disability can be assisted in some way (even in some cases quite small steps) to be helped to do more for themselves. This may mean assisting a person with challenging behaviour to modify their actions and to even change their conduct over time; it may mean assisting a person to move from a residential care setting into a more independent living setting in the community, or a person who attends a day centre to join a sheltered workshop or a person who is in a workshop to find suitable employment outside of a care setting.

Nottinghamshire County Council has recently awarded a new contract for its community based support services for younger adults (most of the service helps adults with learning disabilities). Here the contract price has been agreed with four main providers to offer the services across the county. All the providers have a guaranteed number of people to support. However the contract requires that all providers focus on helping their customers move to greater independence. The value of the contract will reduce at 4% per annum for two years and then at 2% for the final five years. This reduction will be offset by providers as they help people to need less direct care and support as they achieve greater independence. Providers are rewarded either for delivering outcomes in a speedier manner or for finding less formal support to help individuals (or groups of individuals). This is one of a number of moves by councils to consider commissioning for outcomes as an approach to work in partnership for providers to achieve this. So far in the second year of the contract over £900,000 has been saved through this approach.

Hackney adult social care has reduced their spend on adults with learning disabilities over each of the last four years. This has been achieved despite the numbers of new customers approaching the council for help (through transition from children's to adult's services). The reduction in spend has been achieved as part of a clear strategic approach which has contained the following elements:

- The need to bring down the cost of more expensive placements.
- The need to meet the needs of some people who were in residential care within the supported living accommodation in the Borough.
- A strong focus for all customers in the design of their care packages (post reviews) on outcomes that promote their independence.

- The need to ensure that the supported living is fit for purpose and offers value for money.
- The wider use of assistive technology.
- The rationalisation of day care which is likely to lead to the closure of one day opportunity sites.
- A reduction in the staffing working in assessment and care management in this service area.

In Hackney though the numbers of adults with a learning disability has slightly decreased the costs have reduced. The small increase in numbers in the last year has not been met by an increase in costs. The combined costs of residential and supported living have remained stable even when all demand is met.

Table 17 – Numbers of people with a learning disability in residential care and the cost of that care

There is a rise in service user numbers whereas the costs are maintained at a steady rate.

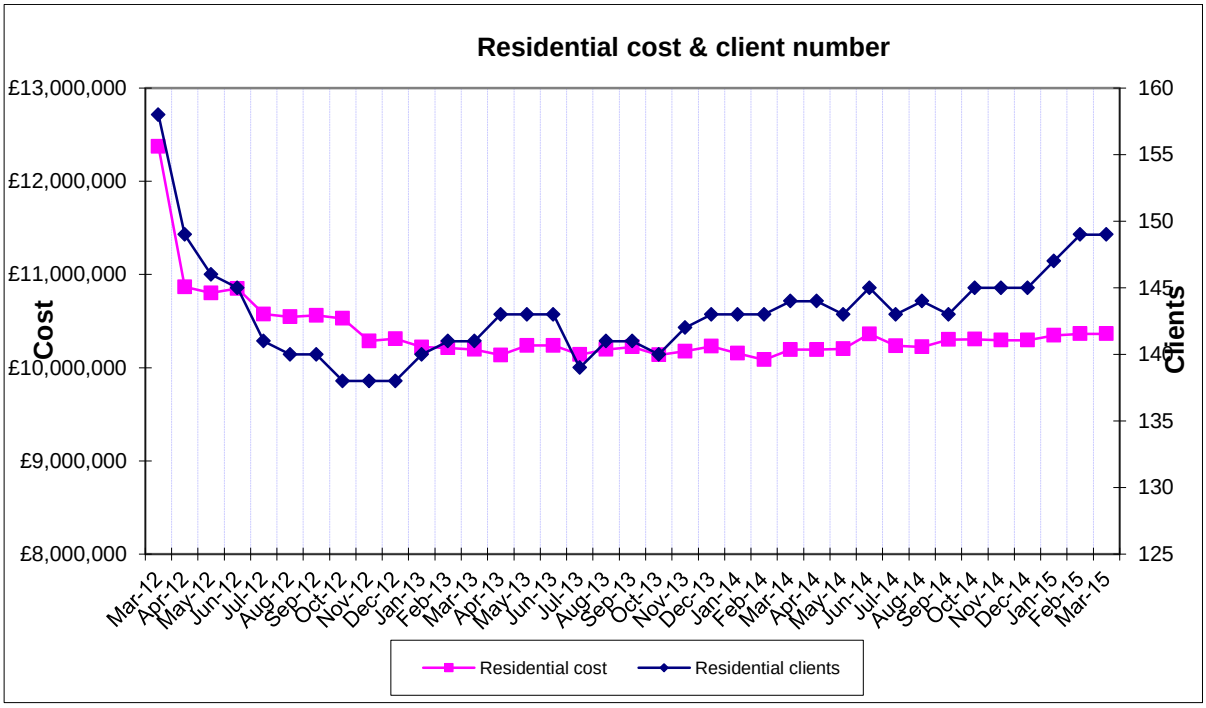
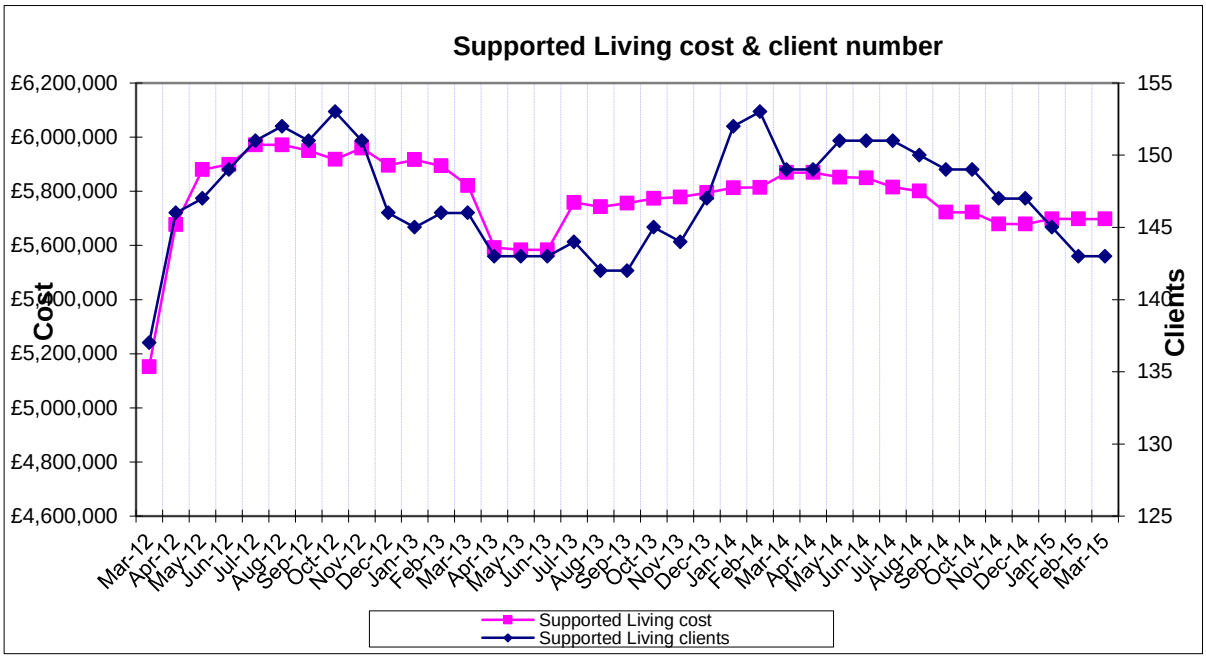


Table 18- Numbers of people with a learning disability in supported living schemes and the cost of that care



Whatever the objective is for a particular person, a review sets a goal to enable the person to have a greater control over their life than they previously had attained. There is evidence from some councils[64] that this approach can help every person in the service. It may be quite slow progress for some – but for others who have always lived or been supported in a way that has encouraged them (and their carers) to be dependent on local services it can be liberating in a relatively short period of time. The biggest set of savings have been found in helping people to move from residential to supported living accommodation. A small cautionary note needs to be placed here. It is just as possible for a community based housing settings (such as supported accommodation or extra care housing) to build dependency up for their customers as it is for them to work with customers to promote their independence. The costs of some community based settings are more expensive than residential care when this occurs.

A further example of this higher level of prevention is how people with memory loss or dementia diagnosis are assisted. There is much being written about the best ways of helping people who have a dementia or memory loss diagnosis to manage their condition.[65] There do appear to be ways in which the speed of the disease impacting on the person can be mitigated, at least in some circumstances through the use of some cognitive development work. There are a range of assistive technologies that can assist with both this and in helping manage risks for people with the condition. This may include tracking devices to assist with those who may get lost as well as aide memoires for daily living from medicine dispensers to warning devices for gas, electric and water. How a person (and their carer) is set up and helped is likely to be critical for their outcome. (This does not just involve social care services. For example in Surrey, the Fire and Rescue Service now heavily prioritises people with dementia for fire alarms –

[64] From the Local Government Association Efficiency Programme
[65] Best practices interventions to improve quality of care of people with dementia living at home; Adelaida Zabalegui, Jan P.H. Hamers, Staffan Karlsson, Helena Leino-Kilpi, e,Anna Renom-Guiteras,Kai Saks,Maria Soto, Caroline Sutcliffe, Esther Cabrera

because of statistics about where most household fires happen. Locally, the fire officers are good at alerting Adult Social Care to people with dementia who could benefit from devices that go beyond fire alarms. The Department of Health Dementia Strategy [66] indicated that if people with a diagnosis received the right help there was a 26% less chance that they would end up in residential care.

6.5 Comments on Preventive approaches

It would be fair to say that most councils are following all or part of these preventive interventions in their approach to adult social care. However, there are very different levels and types of interventions and investment being developed from one council to the next[67]. In addition, many councils do not have any performance measures in place which would indicate how well they are doing in delivering these outcomes for people. Where the evidence does become available (e.g. the outcomes from reablement or admissions to residential care) it shows very different outcomes from one council area to another. Almost certainly this will relate to the interventions and help available to people when they are in crisis and the community assets that are available to assist people. In one council[68] they can track their spend in each of the four areas cited above – and this might be a possible blue print for others to follow:

Level 1	£1,274,359	8%
Level 2	£3,849,291	25%
Level 3	£7,081,511	46%
Level 4	£3,158,193	21%

The evidence suggests that over the last 5 years, domiciliary care is being offered to fewer people but at a much more intensive level. However, there is still significant variability between councils as to amount and what is offered from that service[69]. In some areas people still can receive a little bit of domiciliary care whilst in others this is now almost entirely targeted on those with higher care needs. In some councils those with lower care needs may be supported by assistive technology; friendship and community support groups or volunteers[70]. One might argue that the traditional approach to procuring domiciliary care through "time and task" has not delivered the best outcomes for older people. Some councils are now beginning to procure domiciliary care through an outcome based approach and are working with providers to refine this[71].

[66] Living well with dementia: A National Dementia Strategy Department of Health 2009
[67] One example of this might be the Newquay Pathfinder. Partnership between a GP practice in Cornwall (being extended to others) and Age UK.
http://www.cornwall.gov.uk/media/6162062/Newquay-pathfinder-Evaluation-proof3.pdf.
[68] Work undertaken by iMPOWER (consultancy) with Kirklees Council
[69] There has been a significant shift in the intensity of home care over the last ten years.
In 2005/6 the reported figure per older person per week was £119, and the reported hourly rate was £20. Giving an average of 5.95 hours per person per week
In 2011/12, the equivalent figures were £177/£17 – average of 10.41 hours ppw.
In 2013/14, it was £193/£17 – average of 11.35 hours ppw. So, the average intensity has more than doubled in less than a decade
[70] See Age UK information on tackling social isolation or SCIE's information pack on SCIE Research briefing 39: Preventing loneliness and social isolation: interventions and outcomes
[71] See separate paper on Outcome Based Commissioning by Professor John Bolton (April 2015) IPC.

There is some evidence that giving people small amounts of care may exacerbate these people's needs for further care. Two pieces of evidence may draw us to this conclusion – a study from Canada in 2000[72] and evidence collected during the review of eligibility criteria by the Commission for Social Care Inspection (CSCI) in 2007 – "Cutting the Cake Fairly"[73]. The Canadian study shows that when older people are given formal social care their care needs are likely to increase. Once people stop doing things for themselves they are likely to deteriorate. The evidence provided to CSCI showed that those councils that were giving more domiciliary care also had higher admissions to residential care. So social care needs to tread a careful line between offering people the care they need and not making them so dependent on that care that they can do less for themselves. It is possible that giving people low levels of social care may actually lead to poorer outcomes for them. That is why the finding from the LGA Study referred to earlier[74] that the NHS is over-proscribing social care is a very risky approach for both care and health services. A model of care that supports recovery as the first and prime intervention is what is required, and a focus on outcomes from the services offered.[75]

Despite many attempts to study the evidence no one has yet to find the link between low level services and reduced need for care[76]. There is a compelling argument that older people are likely to live more fulfilled lives when they are actively engaged in family and/or community life. During the LGA Efficiency programme it was not possible to demonstrate the link between "building community capacity" and lower need for care services. However, the argument for this approach has a strong appeal and some councils continue to develop these community based services but as resources get tighter these are areas that may be subject to reduced funding (both the LGA study[77] and in the six councils it was found that councils were now "saving" monies by reducing funding to the voluntary and community sector.) This approach is linked to a development which is often called "the asset-based approach". In this model the assessment starts with an evaluation of all of the assets available to a person to help them meet their needs – from within themselves; their families and their neighbours (or wider community). There is some evidence that this approach both enhances the quality of experience for the customer (because they are not seen as a victim of their circumstances) and puts them in control of what happens for them as well as potentially reducing some of the formal care costs.

6.6 Promoting Independence

Promoting Independence brings together three different models of social care and looks at the growing evidence that is available to support the approach. It considers the evidence for prevention and the different types of preventive activity that might be effective; it also considers the evidence that a little bit of the wrong type of help may increase a person's need for longer term dependency on care; and it considers the

[72] HSURCS (2000) - Health Services Utilization and Research Commission (HSURC) The Impact of Preventive Home Care and Seniors Housing on Health Outcomes (Summary report no. 14).2000. This is further developed in their 2002 paper.
[73] Cutting the Cake Fairly – evidence provided by London School of Economics 2008 – Commission for Social Care Inspection report for DH October 2008
[74] www.local.gov.uk/productivity<http://www.local.gov.uk/productivity 2015
[75] See also Atul Gawande book : "Being Mortal" October 2014
[76] National Evaluation of Partnerships for Older People Projects: final report –January 2010
[77] [47]All the reports can be found at:
http://www.local.gov.uk/web/guest/productivity/journal_content/56/10180/3371097/ARTICLE

evidence that institutional care, however well-intentioned is not necessarily the best way to help a person find their independence.

It is this combined evidence that has led a number of councils[78] to develop the "promoting independence" model of social care. It has at its heart six main principles:

- The first help anyone should be offered is to see how the problem they have presented can be solved without recourse to formal care.
- For those who do need some care and support this should first be based on looking to offer recovery based services or more specialist services to assist them to live with their condition whilst maximising their opportunities for independence.
- No assessments for longer term services should be made in a rush before a range of appropriate interventions are considered.
- All customers who need a longer term care package should still receive this with a focus on working towards outcomes that are likely to help the person become more independent.
- Commissioning of services should be focussed on working alongside providers to deliver the outcomes that the above interventions could deliver. Providers should be rewarded for delivering outcomes that promote independence.
- Assessments for long-term care should normally be carried out at home, except in exceptional circumstances.

This combined approach of promoting independence should be highly personalised for each individual customer. No two people will react in the same way to the same treatment/support plan. Each set of interventions should be tailored to the needs and aspirations of each individual as long as they focus on outcomes that promote independence.

There is also the challenge of changing the practice of providers who have generally been slower to absorb the promoting independence approach into their business model. Most providers are reliant in their business plans on high occupancy levels (for residential care) and high volumes of care hours for domiciliary care, so they have not been minded to focus on outcomes that might assist their customers to need less care. There are some signs that in small pockets this is changing. The most recent study of the development of outcomes based commissioning shows that this trend has some traction[79] – though its focus remains with council funded services. The best example of this approach so far is the one adopted by Wiltshire Council and their providers of domiciliary care.[80] It would be a real gain if the culture and practices of "promoting independence" could be followed by all providers of care. This is a long journey and would need a major policy push from Government if it were to succeed. In fact some argue that it is the provider market that puts this policy most at risk of failure.

So, if there was a much wider acceptance in social care that it is not the entitlement to care that is critical but getting the right intervention to assist a person to retain their independence, then a new lower cost model for care might be further developed. Of

[78] First cited in 2006 at Coventry City Council's Seminar for Adult Social Care
[79] Paper from Professor John Bolton – "Outcomes Based Commissioning – a Review", April 2015 (still in draft)
[80] Wiltshire Council- Help to Live at Home Service – An Outcome-Based Approach to Social Care Case Study Report - April 2012

course there are already some local authorities who have used variations of this approach in their overall savings and efficiency programmes. In fact, most of those councils who have had to make the best use of their resources in recent years have adopted some if not all aspects of this approach (several of these are described in the case studies of councils shown on the LGA web site).[81]

As the model of promoting independence emerges it also becomes clear that this might be the approach that should be adopted for health and social care integration. Evidence suggests that older people get poor outcomes from the NHS. The specific evidence suggests that in particular the way in which dementia care; incontinence care; falls prevention and stroke recovery is managed continues to directly impact on poorer outcomes for older people and directly puts pressure on the social care services [82]. If both health and social care could work together to ensure the following conditions are in existence it is possible to achieve better outcomes at lower costs:

- A strong focus on supporting recovery after any medical intervention.
- A set of out of hospital care services exist to support this aim including bedded provision where the purpose is to assist people to return home (with an 80% target for the services).
- An emphasis on helping patients to better manage their long-term conditions with clearer advice and support. This is linked to both physiotherapists and occupational therapists playing an important role in supporting front line care staff.
- Front line care workers understand the medical conditions of people they assist in a way that they can help the person self-manage.
- Priority given to managing the conditions which put older people at risk of an admission to residential care – incontinence recovery; dementia care support; falls prevention and stroke recovery.
- Outcome focused assessments which look to how the patient can be best assisted to retain/regain their independence.
- A focus on longer term outcomes for people not short term gains for one service area.
- A performance system which measures success in the terms described and incentivises the behaviour required.

There are a small number of health and care economies which are exploring this approach. Suffolk, Sheffield, Rotherham, Glasgow and Nottinghamshire all are developing integrated approaches which aim to both reduce delayed discharges and to improve outcomes for older people. The impact of the model will deliver savings for both health and care.

[81] All the reports can be found at: http://www.local.gov.uk/web/guest/productivity/journal_content/56/10180/3371097/ARTICLE
[82] Various papers from Professor Andrew Kerslake – Institute of Public Care including £100 Million Project – a paper commissioned by ADASS in 2011

7 Opportunities and challenges

7.1 Future Budget Pressures in these councils

All the six Councils reported budget pressures are likely to increase through the coming years these came from a number of possible pressures. They included:

- The costs of implementing the Care Act – particularly with the reductions in assessment and care management staffing that have already occurred.
- The high risk that changes to the Independent Living Fund will have a big impact on the funding for younger disabled adults which will fall on local authorities[83].
- The costs of implementing the new guidance on Deprivation of Liberty Assessments (DOLS).
- The costs of sustaining the care market and paying the required price for care (after a period of holding down inflationary increases) - as demonstrated in Section 3 above.
- The risks associated with managing demand with a potential increase in people being placed in residential care – which could be exacerbated if assessors rush their work because of time pressures.
- Increasing pressure from Acute Hospitals to meet more people's needs in a shorter time-frame, combined with shortages of district nursing – this can result in more requests for "double-handed visits" for post-hospital care (even though some councils are resisting this new pressure).
- All the councils reported that the pressures on the older people's services would depend on both a clear care pathway to assist people diagnosed with memory loss/ dementia and how demand from the acute hospitals is managed.
- All the councils reported that pressure continued in the learning disability budgets because of the increasing numbers of younger adults coming through transition from children's services who had quite complex care needs, alongside an ageing population with changing care needs.
- In some places there is the challenge of meeting the needs for those refugees who have no recourse to public funds but are still staying in Britain. Last year Hackney spent £495,000 to help 37 people who were in need of help.

And

- The recognition that those seeking help have more complex care needs and are likely to need higher cost packages of care.

The biggest single risk in Nottinghamshire they considered applied in the mental health services where the reduced spend in the NHS and Social Care has had an impact on the ability of the team(s) to meet their range of statutory duties. In the service they find that the combination of the AMP Service (assessments under the mental health act); the responsibilities for after care under Section 117 and orders from courts to provide supervision as well as reports for the courts to assess a person's mental health; the increase in safeguarding referrals to the teams and the new responsibility as a result of

[83] North Tyneside estimate a £1 million impact on their ASC spend.

the guidance on DOLS (Deprivation of Liberty Assessments that are now required) etc has put real pressure on the time of the assessment and care management teams. There are times now when they cannot fulfil all of their statutory requirements in a reasonable timescale.

It is also noticeable that the proportion of the resources being spent on residential care has increased (as shown in Figure Three above) from 17% to 30% of the budget. It is rare that permanent residential care offers a solution for a person who is recovering from mental ill health but pressures in the system (shortage of alternative offers from either NHS or Community Services) may create an increase in admissions. The numbers of individuals in care homes in Nottinghamshire has actually reduced which is clearly part of the council's policy. They will require a good set of support workers in the community to sustain this performance. The service is uncertain if this can be sustained.

All six of the councils have made savings in their adult social care budgets. In Nottinghamshire the savings have enabled the County to meet inflationary costs and demographic pressures with only a relatively small reduction in their gross budget (in part because of the contributions from the NHS and from the Council), however in Tameside, Derby, Blackburn with Darwen and Hackney the savings have not only met these pressures but also include a reduced spend on adult social care.

All of these councils have made some progress in the areas that have been identified – reducing management and staffing costs; the costs they pay for care (better procurement); managing demand for care through preventive measures; transforming the way in which services are run (particularly day care); offering alternatives to residential care; operating tighter eligibility criteria for customers and offering lower cost packages of care to meet their needs. The six councils were able to demonstrate that they were still helping a large cohort of people – though many of these (particularly older people) were being helped in a very different way and outside of the formal care system. In parallel to this some voluntary sector organisations (and in particular the former supporting people funded services) have lost their grants or commissioned budgets whilst others have had funding to meet needs in a different but lower cost way.

There is little sign that integration with the NHS – even where progress has been made such as in Tameside – has led to decreased use of resources. In fact there is a risk that the NHS will identify new demands for social care to meet. This still requires close monitoring.

The overall finding is that there is little room for most of these councils to find further savings through either efficiencies or through transformation. For the future, all of the councils are relying on the Better Care Fund (BCF) to produce the additional resources (which won't be available from their local council) to both meet needs and balance their books. North Tyneside find that their local CCG is projecting a £6 million overspend which may require a revised plan for the BCF (currently the NHS is contributing £8.7 million to the ASC budget – about 10% of the gross spend – this will need to continue to rise if the council is to fund services at the same level). Hackney, Blackburn, Tameside and Derby City are all almost totally reliant on the monies from the NHS to sustain their social care services for the next three years. Nottinghamshire still has other savings options but a close examination of these shows that they will need to replicate the savings they have already made over again. This is very unlikely to be achieved.

Where further saving plans are in place for the next three years the proposals are for more of the same. Councils will continue to reduce their staffing and look to reduce demand for services. There is no further opportunities for these councils to reduce the prices they pay for services. There are small opportunities for further transformation. (For example, Blackburn with Darwen has brought in consultants to assist them with a £2.8 million saving programme for older people. This is well short of the ten million pounds that the council requires them to save over the next three years).
Derby City recently had a peer review set up by the Local Government Association to examine their use of resources. The recommendations from that review highlighted three areas where there might be additional savings in social care:

- Still too many older people in nursing care – probably because of the lack of investment in District Nursing.
- Too many people going into long term care from an acute hospital bed.
- Political commitment to in-house services means they retain some high unit costs services.

If there were improvements in each of these areas there is probably about £2 million further savings to be found – short of the current projected target of £15 million over the next two years (even if some additional income came to the council via the Better Care Fund).

In order to find any further savings in adult social care the following areas will require more exploration - and sharing the learning from those councils that have already achieved this:

- A continued emphasis on the importance of preventive interventions as shown in the section above on managing demand. All of the areas identified should be pursued with rigour supported by a strong performance management culture. Many (but not all) councils have already started on this journey.
- This would include a strong emphasis on how to access solutions that might enable people to remain out of the formal care system. The growing evidence from the Shropshire approach as well as those highlighted in this report from the six councils in the study should be more widely promoted.
- Personal Budgets offer little further opportunity to reduce costs and they should not be seen in this light.
- The focus for health and social care integration should be on achieving the best possible outcomes for customers that help retain or sustain their independence. This should work alongside a continued focus on avoiding unnecessary admissions to institutional care (including for self-funders) – made clear to the NHS as well as to social care.
- Less emphasis on the eligibility criteria and a stronger focus on outcomes that help people live more independent lives – getting the right kind of help at the right time.
- Concerted work to re-define our understanding of “risk” and to work out how to ration resources in a way that takes a person’s personal as well as their financial assets into account, but is nevertheless “fair”.

Looking at the six councils they have achieved most of the things that are possible. Some of “pockets” of potential savings left. (For example, one might argue that Derby

could close their residential care homes run in-house which are valued by local politicians).Spend on residential care for younger adults could reduce further in some of these councils, but often – as demonstrated above – this is out of the council's direct control.. The consultancy advising Blackburn have shown how £3 million can be delivered but this is well short of the £10 million they need to find (based on their current projections). There is a growing cohort of councils who have now made significant savings in adult social care and are unsure what further opportunities there are for them. It is accepted that some councils have not really started on this journey (as they have not yet experienced the same pressures) but these are a minority of adult social care directorates. It is particularly worth noting that councils have halved their expenditure on services to people with mental-ill health over the last decade. There will be consequences for this within the rest of the care system (NHS, Prisons, and Police etc).

The six councils in the study all identified a range of new pressures, for which they are unclear if any funding will be made available.

8 Conclusion

There are still opportunities for councils to develop their approaches to managing demand and this may lead to further reductions in costs for adult social care. However, these opportunities are far outweighed by the growing pressures that are currently being experienced in the sector. A range of policy impacts; market demands and increasing complexity of need are likely to add enormous strain in the short-term and medium-term future.

Professor John Bolton
February 2016

APPENDIX ONE

A list of the savings delivered by the six councils

Areas in which savings were made £m	Hackney	Notting-hamshire	Derby City	North Tyneside	Blackburn with Darwen	Tameside
Staffing and management costs % of savings	2.238 11%	13.400 20%	2.482 11%	5.416 26%	4.513 26%	3.968 22%
Supporting People	6.000	10.000	8.142	5.181	.640	150* Former SP Budget absorbed into commissioning costs
Managing commissioning costs	2.073	7.722 (+£2 million from not paying inflation)	3.749	0.630	7.615	3.175
Managing Demand including reduced use of residential care	6.586	16.796	6.976	6.826	2.341	5.989
Continuing Health Care						602
Day Centre Modernisation	0.300	3.800	1.007		1.002	1.702
Review of Voluntary Sector		2.522	0.883	0.090		762
Reduced staff training	0.200	1.100	0.350	0.060		
Applying ordinary residence		0.435				670
Infrastructure and Supplies		0.742	0.195	0.595	0.395	1.038

Areas in which savings were made £m	Hackney	Notting-hamshire	Derby City	North Tyneside	Blackburn with Darwen	Tameside
Adult Placements		0.151			0.035	
Miscellaneous	0,415	4.964	2108	0.258		
Charging for customers	0.900	3.585	1.145	0.941	0.535	Income loss
Total		65.55	22.963	20.747	17.076	18.056