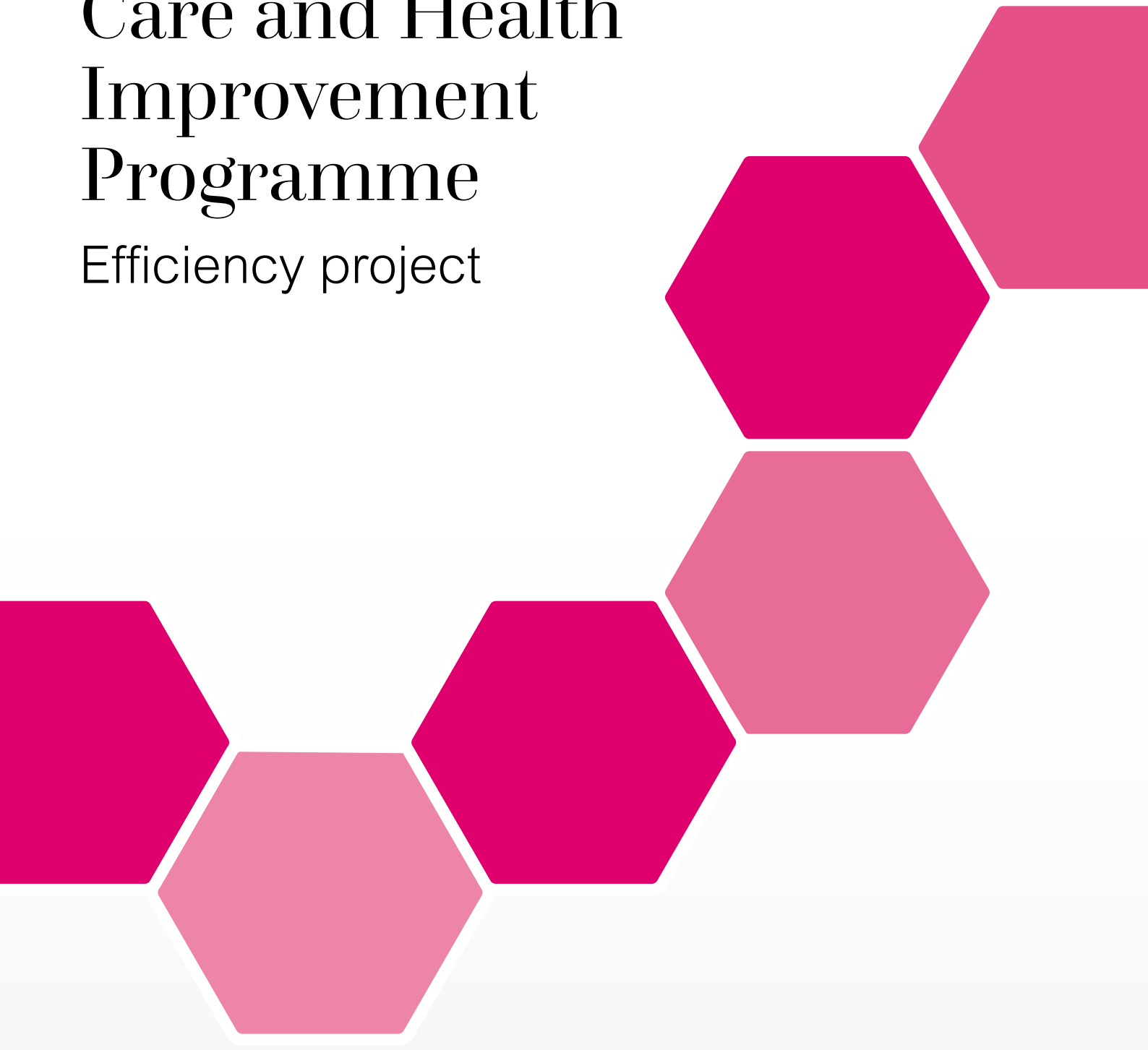
Local Government Association

Care and Health Improvement Programme

Efficiency project



This report and the work described within it is part of the Care and Health Improvement Programme, which provides support for social care, integration and health as well as supporting the transforming care programme for people with learning disabilities and/or autism. The sector-led improvement programme for care and health, is led by the Local Government Association and co-produced and delivered with ADASS, the Association of Directors of Adult Social Services in England.

Contents

Introduction

The financial challenges faced by adult social care are well documented. The LGA estimates that adult social care faces a funding gap of £2.3 billion by 2019/20, including an immediate and annually recurring pressure of £1.3 billion to stabilise the provider market.[1]

The first priority must be to address current underfunding and instability in adult social care in order to build a sustainable future, as set out in the LGA's Autumn Budget 2017 submission and the submission to the Local Government Finance Settlement, as well as many other statements.

At the same time, councils and their partners have been taking innovative and committed action to find new approaches that will allow them to manage their scarce resources and achieve the greatest efficiency while still ensuring high-quality services for residents.

The LGA has been working with care and health partners to support them in this, helping them find new ways to work with residents and stakeholders that will maximise positive outcomes with less resources. The efficiency project has shown how a range of initiatives and approaches adopted by systems can deliver cost effective and sustainable care. This includes developing new contracts with citizens and communities, managing demand for social care, working more collaboratively with health and other providers as well as transforming services, cultures and behaviours'.

Findings from the earlier LGA efficiency project and evidence based case study examples can be found at www.local.gov.uk/our-support/efficiency-and-income-generation/care-and-health-efficiency.

More recently the LGA has focused on working with those services or systems that are finding it more difficult to find effective solutions in a context of rising demand, often variable supply, rising costs and the challenge of working across systems and providers. Recent evidence arising from this work can be found in the learning disability services efficiency project report[2] and the work looking across care and health systems assessing the efficiency opportunities through integration.[3]

In 2016/17 the CHIP team worked alongside 10 councils that proposed a range of innovative solutions to assist in achieving greater efficiencies from their adult social care budgets. The projects that were being run by councils could be described under three main headings:

- managing demand for social care by offering residents a different type of service
- more effectively using the capacity in communities to help find new care solutions
- working closer with partners in the NHS to reduce pressures in the care and health system.

This report looks at the ten projects and draws conclusions as to what other councils might learn from them. The findings will be of particular interest to directors and assistant directors of adult social care, heads of service or transformation, or change managers leading projects to develop more efficient and sustainable approaches to supporting vulnerable practice.

1 www.local.gov.uk/parliament/briefings-and-responses/lga-autumn-budget-submission-2017

2 www.local.gov.uk/sites/default/files/documents/lga-learning-disability-s-d9a.pdf

3 www.local.gov.uk/sites/default/files/documents/lga-efficiency-opportunit-b9c.pdf

The efficiency report captures the development of these projects over a year, presenting the progress to date. The projects in Bristol, Somerset, Wiltshire and Swindon were already underway when they joined the LGA project, and it is clear to see the progress they have made. Of particular interest is the approach taken in Somerset to the development of social enterprises as both a cost effective way of meeting demand and reducing shortage of supply in rural areas. In addition the continued focus on how people are helped when they approach adult social care is clearly demonstrated in the projects in both Poole and Bristol where significant progress has been made. There are however lessons to learn from each project in relation to some of the challenges faced and how they were overcome.

Common themes have emerged from this project which reinforce messages from earlier work. First is that when councils are looking to develop joint work with partners, including the NHS or their main providers of care, there are often barriers and obstacles to overcome before any savings can be delivered. Frequently this involves the need to change behaviours as well as systems and processes, which takes time and can be frustrating for partners even where there is a strong willingness to improve results. Second, that there are still some service areas that have proved very hard to transform in a short period of time. This is most notable in services for younger adults with a learning disability. Though our previous projects have shown significant benefits in places like Kent and Darlington, more recent work in Swindon and Wiltshire shows how this has to be carefully managed to improve independent outcomes and deliver savings at the right pace for those service users involved.

Managing demand in the social care sector

The LGA efficiency project has demonstrated that by supporting people in different and better ways councils can manage some of the demand that is within the care system. Those councils successfully managing demand focus on prevention, for example diverting people from services; giving them the kind of support that will defer or delay the need for further help; and supporting them in a way that may reduce their longer term dependence on some services (even though they may rely on other less expensive services).

All of these forms of 'preventive interventions' have been demonstrated in the work of councils in the efficiency project. The greatest progress in managing state funded care has come from councils taking one or more of these three approaches:

1. ensuring initial enquiries are dealt with more effectively and engagingly
2. the support given to people to recover, rehabilitate and recuperate from critical events in their lives (including reablement of older people)
3. getting the right services for people with longer term conditions that assist them to live with those conditions.

Details of these approaches have been further developed in the work of Professor John Bolton in his papers for the Institute of Public Care on predicting and managing demand and the more recent work by iMPOWER:

Predicting and managing demand in social care
ipc.brookes.ac.uk/publications.html

Six Steps to Managing Demand in Adult Social Care – a performance management approach
ipc.brookes.ac.uk/publications.html

Mission: Possible – iMPOWER 2017
www.impower.co.uk/insights/mission-possible-how-to-save-3-billion-and-promote-independence-in-adult-social-care

A different conversation at the front door

Earlier LGA reports highlighted work in North Tyneside, South Tyneside and Shropshire where the way in which they looked to help people at their first point of contact has made a big difference to those people. The messages from these councils have been amplified through the work of Bristol City Council and the Poole Borough Council in this project.

Both Bristol and Poole focused attention on the help that they offered local citizens when they approached the councils for support. Both councils have developed response services which offer a more solution based conversation than they had previously (this is sometimes referred to as a strength based approach – focusing the service user on the immediate solutions that may be available to them through their families, their wider networks or through very practical help). Early evidence from the new service in Bristol has been very positive suggesting that the approach is effective in both linking people more strongly to their communities and to finding solutions for more people outside the formal care system. It is estimated that about 75 per cent of people who approach councils for help can be assisted through this process with better results for themselves.

Practice example:

Bristol City Council

Bristol City Council has saved £26 million from a number of efficiency programmes over the last three years. This came about by reducing social work staff, closing day centres (and replacing them with community hubs), closing in-house residential care homes and outsourcing all of the provision of domiciliary care.

In seeking to find further savings to balance its budgets, Bristol has adopted a new model of support for adults in their communities, which it calls the 'three tier model'. This has some similarities to models adopted by other councils with a strong emphasis on:

- helping people to find solutions within their own communities, families, assets and local networks
- helping people get the right support – often short term – when it is required
- helping people live as independent a life as possible.

Front line workers aim to have a conversation with the person seeking help which looks to find a solution to their problems within their local community, the voluntary sector or from within their extended family. Staff undertaking these conversations are helped by a prompt tool which assists them in leading the conversation to find positive solutions with people.

Bristol has seen real benefits from changes in the way in which it has conversations with people when they first come to social care for help. It has found that 52 per cent of service users do not require a full social work assessment which might lead to an allocation of monies for formal services. In the past 94 per cent of people who asked for help received an assessment. In addition, more older people are receiving a reablement offer which leads to 54 per cent of people not requiring a longer term service.

Over two thirds of service users said that they felt positive about the way in which they had been helped and the remainder were neutral. No users expressed negative comments about the approach. In addition, there is clear evidence that staff morale has improved as they have felt engaged and involved in the development of the new model. To date the approach has saved the council £6 million in the first financial year of operation with fewer people receiving a social care service than before the model was introduced.

Bristol is now focusing its efforts on continuing to find better ways of meeting need as pressures on the health and care system continue to grow. There has been an increase in Mental Health Act assessments, more help offered to carers and more safeguarding referrals in the last year. There continue to be pressures from the hospitals to reduce delays. Though admissions to residential care and the number of people requiring domiciliary care have fallen, costs continue to rise at a faster rate which is putting pressure on the adult care budget.

Throughout the implementation of the three tier model, the council feels that the programme has benefited by having an external partner who has offered both help and challenge in the change process. Senior managers accept that the cultural change required to transform the approach has required their leadership working in a co-production model with staff and service users. The council reports that the benefits of the approach are clear within the first full year of the new operating model. It wants to continue to build on this approach into the next three years, integrating more closely with other change programmes.

Table 1: The three tier model of care and support in Bristol City Council

Promoting wellbeing	Early help and prevention, enabling people to live more independently for longer	Directing people to lower cost options and solutions	Delaying or avoiding the need for more intensive, higher cost care and support

SAFEGUARDING

Help to help yourself (Tier 1)
Accessibile, friendly, quick, information, advice, advocacy, universal services to the whole community, prevention.

Help when you need it (Tier 2)
Immediate help, could be short term, avoiding admission or longer term, transition from child to adult services or disabled adult leaving parental home. Minimal delays, no presumption about long-term support, goal focussed.

Help to live your life (Tier 3)
Self directed, personal budget based, choice and control, highly individualised.

RIGHT SKILLS, RIGHT PEOPLE

Source: Bristol City Council

Over recent months the work that Bristol has done around demand management and the three tier model has led it to develop a single adult's change programme called 'Better Lives'. This is a long-term programme which is taking a whole systems approach to transformation, bringing together work streams on demand management, workforce development, commissioning and partnership working. The approach aims to deliver the required cost savings whilst ensuring that residents are provided with good quality support at the time they need it, taking a preventative approach and optimising technology solutions where appropriate.

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Practice example:

Poole Borough Council

Poole Borough Council has adopted a similar approach to Bristol in managing the community facing 'front door' to adult social care, though it has managed the change process more through a strong focus on internal processes.

First of all, the council evaluated the way in which it handles calls, with the business support function identifying those that are intended for existing staff and those which are new referrals. Help Desk staff taking the new referrals have been supported to have a different conversation when people ask for support, finding out about their 'assets' – their networks, community links and skills – as well as what they need in terms of support.

The managers of the service have worked with staff to develop clear protocols and procedures as to how they might better respond to new enquiries. The emphasis was to empower staff to have conversations with customers which focus on finding resolutions, rather than just receiving referrals as they did in the past. Although the majority of the workforce were keen to develop the new approach, changing the culture through the organisation from the traditional approach (the deficit model[4]) to their new asset based approach required significant leadership and support to front line staff.

Poole has employed some existing resources to appoint visiting officers as part of its Help Desk, where it is seen that a little bit of further contact with the service user (more than a simple phone conversation) might help find the desired resolution.

Poole has indicated that these 'wellbeing collaborative link officers' have made a significant difference to how it operates. Managers have, in addition, brought into the same location a group of voluntary sector providers so that conversations can take place about who is best placed to assist particular service users. A further key addition has been the placement of a housing officer within the new ASSIST (Autism Spectrum Service for Information, Support and Training) Team.

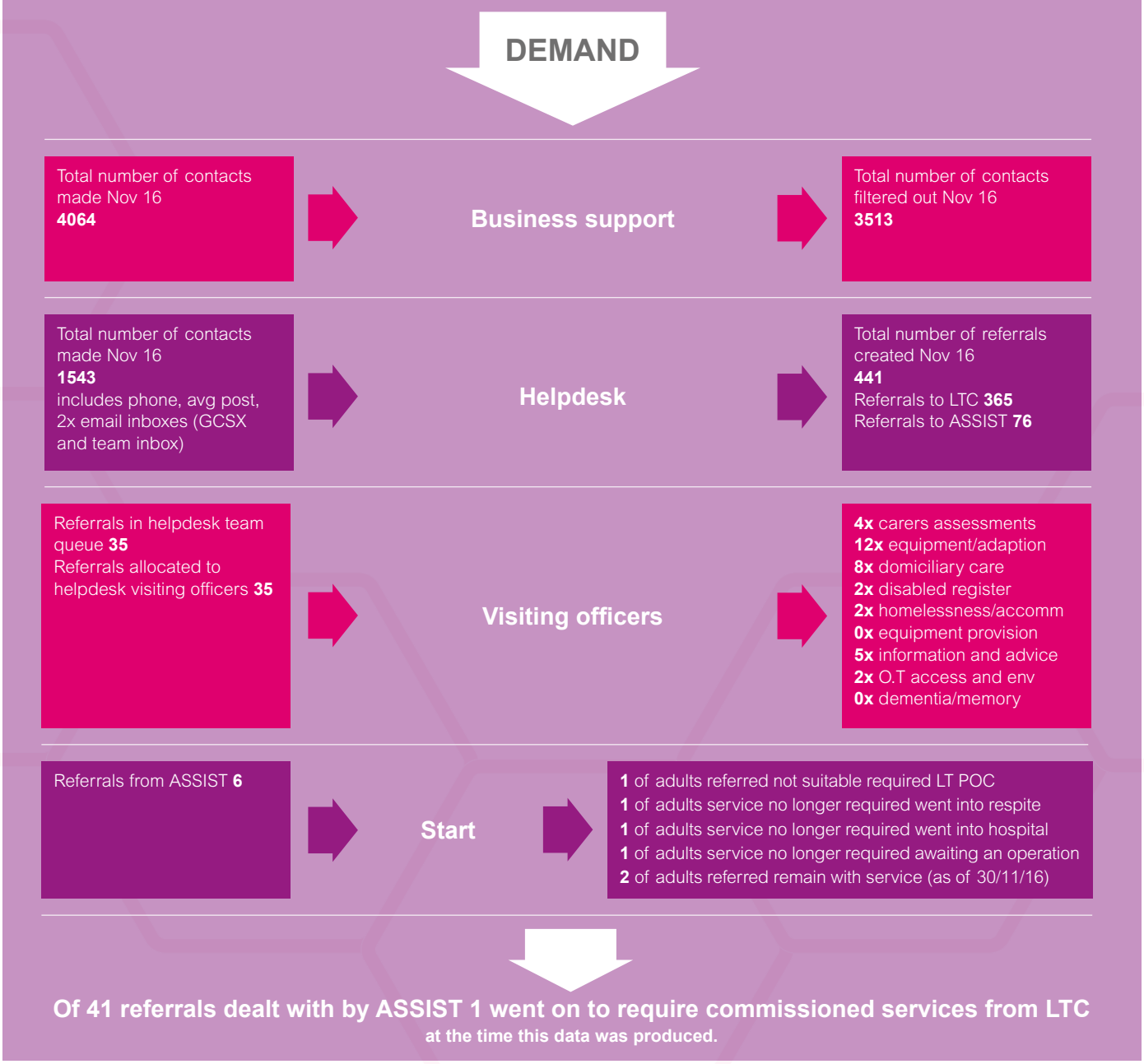
The council believes that there are a number of strengths in the ASSIST service including:

- a clear new process with standardised and understood approaches
- direct referral and linkages between the ASSIST teams where appropriate
- new efficient and effective forms and ICT system functionality
- operating approaches and a new distinction between long and short term support to manage demand in the most effective way
- a clear escalation procedure including effective triage and urgent care pathways
- an in-house telephone system which filters out switchboard calls and current 'known' adults before getting to ASSIST
- effective information and advice.

The new service was formally launched on 1 November 2016. Early data indicates that the service had an immediate impact, even in its first month, as shown in the chart below. The progress has continued over the first year.

4 The service user is a passive recipient of professional support. The approach generates dependencies which result in a trajectory of increasing needs.

Table 2: Early impact of the demand model in Poole Borough Council



*The START team is the in-house domiciliary care reablement-based service.

Source: Poole Borough Council

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Promoting independence for adults with a learning disability or with learning disabilities

One area where councils have made less progress in delivering more cost effective solutions has been in improving services for adults with learning disabilities. The LGA previously published a report on opportunities to make efficiencies within learning disabilities services. Positive examples from this work includes: improved outcomes for adults with learning disabilities in Kent County Council with realised savings; and progress made by Darlington Borough Council social work teams helping adults move from residential care into supported living.

The report can be found on the web site at www.local.gov.uk/sites/default/files/documents/lga-learning-disability-s-d9a.pdf

Swindon and Wiltshire councils used a combination of approaches to improve outcomes and reduce overall costs for services to adults with learning disabilities. In Wiltshire, managers found that using one of the cost-funding calculator tools enabled them to have a better dialogue with providers on the costs of care. It has linked this with a joint programme developed with its neighbours in Swindon using an approach called the 'progression model'. This is designed to help assess the longer-term needs for adults with a learning disability, maximizing independence for this group of service users. Together, they aim to offer a more outcome-based service for their service users which should improve the overall wellbeing of the group and reduce their costs.

Practice example:

Swindon and Wiltshire Councils

Swindon and Wiltshire have worked collaboratively to better manage demand and costs in learning disability services. They looked to develop a better understanding of the potential of current service users to gain greater independence with support and also worked together to understand better the costs of delivering care by their local providers.

The initial focus was on people with high cost care packages – most of whom were placed in residential care on a permanent basis. There was an expectation that the two councils had many providers in common and that their approach to work with providers collaboratively to introduce 'progression' for their customers would occur in partnership. However, when they examined the market and their placements they realised that this was not the case, and they shared very few providers. They did however discover that they both had staff working in care management for adults with learning difficulties who would benefit from adopting the progression model in their assessments and reviews for adults with a learning disability.

Swindon and Wiltshire jointly commissioned training for four social work staff from each council in the progression approach, as well as a number of commissioners and contract managers for learning disability services. The training and coaching sessions enabled these staff to develop an asset based model for their assessments, to undertake 'motivational interviewing', to develop negotiating skills and to focus on the outcomes that would best enable their service users to develop greater levels of independence.

This has proved an important aspect of staff development in both councils. They are now building on this approach to ensure that all staff understand how they can empower service users and enable them to gain skills towards independence. There is however a recognition that for some users, there may need to be a prior investment in new resources that support progression in order to lower care packages in the longer run.

Once an individual's outcomes have been determined and a care plan developed, the council can hold providers to account for the delivery of those outcomes (in a way that has not happened in the past). The estimate from both councils was that around 75 per cent of adults with learning disabilities could benefit positively from this approach. For the model to work best, the NHS needs to be part of the process, in particular when psychiatric support is required to help those with challenging behaviours. This is a resource which is not always available.

In Wiltshire, staff realised that they could do more to understand the real costs of care for this client group. They began to use the Care Cost Funding Calculator that had been developed by iESE for local government (available from www.iese.org.uk/care-funding-calculator) although there are a number of tools available. They are piloting this tool with a provider of care to agree a realistic cost for care – in some places this has meant that the price has increased and in others it has gone down. The council is keen to agree a price for care that improves outcomes for its service users. Commissioning officers are working closely with reviewing officers in order to ensure a consistent approach. The two councils are sharing learning from the pilot and working together to understand how the tool can be best used.

Swindon is working with an efficiency partner across all service areas, including in learning disabilities. A diagnostic review has shown that savings might be made in either the productivity of care management or in supporting people to move to supported living from residential care or to need less care in the community as they are assisted towards more independence. The council has recently made available 26 new units (bungalows) of supported housing for adults with learning difficulties. The accommodation is purpose-built and equipped with assistive technology to help people live independently. This will contribute to its ability to move more people from residential care and supported living and as a consequence to make some savings in its budgets.

It is positive that neighbouring councils can work collaboratively to ensure that they share learning and developments in this area, that is, contract officers are now contacting each other when undertaking a review of a common provider to share information. They both have plans which should deliver savings in the coming months though both acknowledge that any savings may be required to fund future packages of care for younger people moving into adult care.

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Supporting people to live at home

Efficient and sustainable domiciliary care is essential if health and care systems are to achieve a paradigm shift away from acute and residential care to support more people in their own homes and communities.

Three councils in the LGA efficiency project focused on improving and sustaining the domiciliary care market. Somerset worked with an external consultancy to develop a new and innovative community-based solution. Community Catalysts helped the council to find new carers from within their rural communities to form social enterprises providing a range of care and support to vulnerable people locally. Details of this work can be found in the next section.

Norfolk County Council and the London Borough of Waltham Forest helped to manage demand for domiciliary care, developing different approaches to commissioning local services. Waltham Forest has worked with health colleagues and service users to develop a model which they are about to pilot in part of the borough. Norfolk has developed a closer partnership with its local providers to collaborate in developing a more sustainable local care market. Steady progress has been made over the last eighteen months although there is still more to be done.

All the practice examples demonstrate that if a council wants to implement a change programme with its suppliers (providers of care) this will always need to be a carefully managed process and will take time.

Practice example:

Norfolk County Council

Norfolk, like many counties, is concerned about how it might maintain and sustain its domiciliary care market. It began a procurement process aimed at establishing a framework structure for home support, with a series of dialogue sessions with local providers in order to secure the right services. An invitation was sent to all 100 providers on its accredited provider list. The commissioners made clear in the conversations and subsequent tender documentation that they would aim to secure ten to 20 strategic framework providers for each part of the county, giving 30 to 40 key providers across the county in total.

As part of this market improvement project, a price banding system is being developed to account for differences in costs and resources of delivering services in urban and more rural areas. The local priority is to ensure that there is basic level of agreement about the price of the service and that this reflects the costs of providers. The average local rate in Norfolk is £15.90 an hour for block contracts and £17.08 for care purchased on a 'spot' basis. As with many other councils which have experienced pressures in their domiciliary care market, one of the aims for this work was to ensure that the new banded cost model will result in the elimination of spot price premiums and that the main part of home support services will be delivered under the framework (reducing additional costs from spot contracting).

From the outset of the project, the council sought the support of the five local clinical commissioning groups (CCGs) to work alongside it in securing the market and to work in integrated ways where possible. However the CCGs determined to undertake their own procurement (they were prepared to pay a higher premium for care when required by the NHS) and were under pressure to renew contracts within particular time frames.

In addition to this the council were very interested in moving towards a more outcome-focused approach to domiciliary care which was not an objective shared with health services. The council however considers that the process it has adopted has meant that providers have engaged with it in a spirit of collaboration to get the best possible service.

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Practice example:

Waltham Forest Council

Waltham Forest is developing a more outcome-based delivery of personal care and support. It is keen to develop its approach both with practitioners (occupational therapists, social workers and district nurses/community matrons) as well as with a selected local care provider.

In May 2017, the council piloted an approach that was developed locally in one geographical area. Service users who took part have been invited to join a user-led reference group alongside others identified at local events run by the design team. All of these service users have already experienced a period of reablement and are already receiving 15 hours or more of care each week.

The council is also having discussions with its software providers to develop systems so that data on outcomes can be captured across all agencies and recorded.

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Community based solutions

There are a number of things that have impacted on the provision of adult social care in recent years. This includes key policy approaches such as the implementation of personal budgets and the growing desire for customers to have more control over the services they receive. The work in Barking and Dagenham on personal budgets, included in the earlier LGA adult social care efficiency report[5] illustrates some of the impact of these changes. There has also been much written about the untapped assets that are available to people from their communities and how to assist residents to access these resources. We have highlighted the work of village agents previously in our programme.

Somerset Council, like many others, has been challenged in commissioning services that help support people to remain in their own homes living independent lives. Providers have struggled to maintain capacity within their workforce to meet the growing demands for traditional care and support, particularly in rural areas. The council's community development project has taken an innovative approach to recruiting and developing the local care market in some of the most rural parts of the county.

Practice example:

Somerset Council

The aim of the development in Somerset was to secure a new and efficient source of care for people to remain in their own homes within the communities where they lived, whether those were in urban areas or more rural areas.

The council commissioned support from Community Catalysts, a social enterprise and community interest company, which harnesses the power of partnerships, working closely with community groups, local councils, health trusts, CCGs, policy makers and other voluntary and private sector organisations. Its mission is to enable people who need care and support to be able to get help in ways, times and places that suit them. Its support, which has been developed in a number of other places across the UK, has resulted in innovative and sometimes quirky, local solutions to local challenges.

The approach is based on a strong belief that within every community there are people who have the capacity to care and this capacity just needs to be unlocked. In Somerset, the plan was to encourage and support local people who could provide care within their local community, to set up a social enterprise. Community Catalysts would provide advice and support in the process. After two years of work within local communities in Somerset, there are now 178 social enterprises that offer low-cost flexible care to older or disabled people and their families living in the same area. Of the 178 providers, 103 offer personal care services, including complex care. This is often alongside home help, domestic and social support. The remaining 75 providers solely offer a home help service including support, companionship, domestic support, gardening, cleaning, trips out, and transport.

5 www.local.gov.uk/sites/default/files/documents/lga-efficiency-opportunit-b9c.pdf

The enterprises offer care to 700 people, collectively delivering 3,600 hours per week (average of 20 hours per week per provider), divided between self-funders and public funded customers.

There are a number of important features that have made this possible in Somerset (and elsewhere):

- A skilled and knowledgeable coordinator employed for two years to understand local demand and help to develop self-sustaining solutions. The coordinator had the right combination of local knowledge, health and social care expertise. This has enabled them to support local people to understand their needs, provide coaching and expert support and help link to local sources of advice, developing sustainable networks.
- A locally-rooted Community Catalyst working at a neighbourhood level through community structures and networks, helping to strengthen what is already working well. (Somerset has both a number of Village Agents and Community Health coaches who have provided important information to link potential helpers with those who have needs).
- The back-up of a national organisation and UK wide network sharing learning and helping to address barriers (Community Catalysts).
- The buy-in from the whole system from senior leaders to front line staff: Community Catalysts supports areas to understand and value these new approaches and make the systems change necessary to enable community enterprise to thrive
- A comprehensive approach to risk and quality management
- Strong buy-in from commissioners in the local council.

It has proved hard to calculate the savings to the council from this model. However an early estimate has suggested that delivering services through this approach should have saved over £800,000 over the last financial year – the savings model is set out below:

Savings model for developing micro-enterprises in Somerset

The costs saving delivered by 32 community micro-enterprises is £11,226 a month or £134,712 a year. In September 2017 this figure had grown to 207 community enterprises. Applying these figures to all 207 community enterprises supported by Community Catalysts, Somerset projects the annual cost savings delivered would be £871,418 a year.

Perhaps more importantly in many cases the catalyst has made provision available in areas where it has proved difficult to recruit paid carers in the past. In addition, anecdotal evidence suggests that individuals who work in the social enterprises frequently exceed their paid hours or responsibilities as part of their goodwill towards local people for whom they have some caring responsibilities.

The innovative project has proved successful on a number of levels:

- Micro-providers have established local links and networks deep into the heart of communities in Somerset.
- They link people with local support networks and solutions before they have the need to come to the council for state-funded help and support.
- Micro providers are being employed by community driven projects led by local need. For example, in South Petherton the parish council has employed a micro-provider for five hours a week to help local people connect with and find local resources. This means that the micro-provider is able to offer one point of contact for its local community to sign

post people to both statutory and community information and support, including health connectors and GP surgeries.

- A peer support network has been formed where micro-providers support each other and share information, challenges and solutions.
- A robust community development model is emerging where there is a strong community response for directing preventative and accessible services for local people.

Somerset is closely monitoring the early indicators of how the project has supported both greater access and choice for cost effective and local quality services.

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Working in partnership with the NHS

Throughout the LGA efficiency project, there have been councils which have sought to gain efficiencies through greater collaboration or integration with the NHS. There have been some successful partnerships – the long standing integrated model developed in Northumberland has shown better management of older people's care with lower admissions to residential care and the joint intermediate care model developed in Richmond upon Thames has shown similar gains. However, there are still relatively few examples of how integration can deliver savings while maintaining or improving outcomes for patients or service users.

In 2016 the LGA commissioned Newton to work with five health and care systems to assess the efficiency opportunities through more integrated models. The subsequent report shows both the opportunity for savings but also the complexity of the decision making processes which drove costs in the system.[6]

It is in this context, where we already understand that integration is challenging (particularly in short time periods), three councils are working on very different projects, aiming to show the benefits of better collaboration between health and social care. Newcastle City Council is looking to develop an IT solution to enable GPs and social workers to more easily share data and improve the experience, support and efficiency of care. Nottingham City Council is working with its acute care provider to see if it could assist in reducing the lengths of hospital stay for patients with elective (planned) surgery. The county council in Nottinghamshire had some time ago embedded social care staff into integrated care teams alongside community NHS and voluntary sector staff. As part of the LGA efficiency project it is seeking an evaluation of the cost-effectiveness of the social care role, within the context of those teams.

These projects are all ongoing. However at this interim stage there is learning to be shared for the benefit of others aiming to develop more collaborative approaches with health.

6 www.local.gov.uk/sites/default/files/documents/lga-efficiency-opportunit-b9c.pdf

Practice example:

Newcastle City Council

Newcastle City Council's project is to enable better information sharing between GPs and community-based social workers. The project looked to give healthcare professionals 24 hour access to live social care data. This might help them to make informed clinical decisions faster and give social workers data that would assist them in carrying out assessments of need for adult service users. The project looked to develop a digital platform which could draw down particular data from the electronic patient record with the GP and from the social work client record maintained by the council.

The proposal was that a summary of the patient's record from the GP and from the client's record in the council would be available for the other party to see, subject to consent, when they were making an assessment. The patient's summary would contain the following data in a simplified format:

- patient demographics (basic data – age, address, etc.)
- problems
- diagnoses
- medication (current, past and issues)
- risk and warnings
- procedures
- investigations
- blood pressure measurements
- encounters, admissions and referrals.

Social care would offer its client information in a simplified format including:

- current social worker or team, including contact details, telephone number, email and main carer details
- some demographic information to help check the identity of the person
- details of the current support plan or notification that no support plan is in place
- details of the services commissioned or direct payments.

This project was overseen by Newcastle Information Network (NIN) and the Integration Taskforce which included key partners from the local health and social care economy. While these groups fully supported the programme, there are some concerns that there might be GP practices that would be reluctant to share information in this way with social care. It was therefore determined that the project would start with a small number of 'volunteer' GPs who would be willing to pilot the early use of the software.

Acquisition of the appropriate software proved more complex than had initially been anticipated, causing delays to the development of the programme. Early difficulties have now been overcome and the programme was piloted this year. It is projected that users will have quicker and more informed assessments due to speedier and more effective communication between GPs and social care.

Though the council is not yet in a position to share evidence of improved outcomes or efficiencies, there is learning that can be shared for the benefit of others, including the key governance questions that were posed. The council has used the Information Sharing Gateway (ISG) portal to host its governance arrangements.

Officers in Newcastle suggest that any other areas that are considering a similar project might draw on the following web sites and resources:

Information Sharing Gateway:
www.informationsharinggateway.org.uk/About

Health Care Gateway:
healthcaregateway.co.uk/

MIG GP Domains:
healthcaregateway.co.uk/services/detailed-care-record/

GP Connect:
digital.nhs.uk/article/1275/GP-Connect

Great North Care Record:
www.greatnorthcarerecord.org.uk/

For further information contact:

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Practice example:

Nottingham City Council

Nottingham City Council is working in partnership with the Nottingham University Hospitals Trust (NUH) to evaluate if improved pre-operation planning will lead to:

- reduced lengths of stay in hospital
- reduced delays at the point of discharge.

In a pilot project led by the city council, social workers contributed to the pre-planning for people who were going to have procedures on the urology unit. They looked to contribute to the pre-operative assessments that patients were receiving prior to elective surgery.

The review found that the staff who were undertaking these pre-operative assessments were generally asking the right questions and helping people prepare for their surgery. Patients were helped to understand how they could best manage their own discharge and recovery after the operation. However, it was thought that a written record of the advice in the form of a leaflet would assist patients in understanding the process.

A key lesson from the pilot was that there should always be a referral to the community multi-disciplinary team. Here the referral will be jointly screened by adult social care and community health colleagues where there was a likelihood that a person might need some support following surgery – for elective surgery the pre-planning is most important. Social care can contribute to reducing both length of stays and delays when this is done well as part of a multi-disciplinary team.

For further information and access to the full evaluation report please contact:

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Practice example:

Nottinghamshire County Council

Nottinghamshire County Council undertook a project to evaluate the value for money and cost-effectiveness of having social care professionals embedded within integrated care teams, considering the value to health and the value to social care sectors separately. The evaluation sought to identify what the particular impact was of having the social care role within the multi-disciplinary team setting, in both financial and non-financial terms, rather than asking what the benefits of integrated care teams were generally.

Suggestions for next steps in developing the model were also sought, particularly as slightly different working models had developed over time in the three health planning units: Bassetlaw, Mid Nottinghamshire and South Nottinghamshire, with Mid Nottinghamshire teams being the most mature. Nottinghamshire County Council commissioned Nottingham Trent University to lead the evaluation, working in partnership with an external consultancy, People Too.

A literature review carried out at the start of the evaluation revealed that previous studies did not appear to distinguish sufficiently on the differential impact of co-located or other forms of multi-disciplinary teams from those which were fully integrated, bringing health and social care staff together under a single management approach. They reported that there was little understanding shown in the research on how social workers operate within integrated care teams and how this varied from their work in a standard setting. The research team wanted to understand the benefits to social care from integrated working as a contribution to both the work in Nottinghamshire and to national research in this field.

The evaluation considered the outcomes being delivered by having a social worker within the integrated care team, compared to social work being delivered from a district social work team. Matched case examples allowed this comparison to be made, using both process and outcome data. Data gathered included changes to demand for the services, the cost of delivering it, changes to knowledge of team members and changes to organisational practices. Interviews took place with both staff and users of the services. Alongside other research in this field the researchers used the following proxy-measures to determine the outcomes of integrated practice:

- hospital admission rates
- hospital re-admission rates (within 30 days)
- admission rates to residential/nursing homes – respite
- admission rates to residential/nursing homes permanent
- delayed discharges from hospital
- number of presentations at accident and emergency units
- numbers of ambulance call-outs.

The final evaluation report has yet to be published, however interim progress reports based on one of the three pilot teams found cause for optimism from joint working. There is some evidence emerging that the integrated teams make better and more cost effective decisions for their patients than the comparator non-integrated teams in the county. Researcher observations and qualitative feedback from staff indicates that teams working in an integrated way save time (as they could communicate more easily about the needs of their customers) and that the speed of responses from staff is much quicker.

The researchers particularly want to distinguish between working in a 'multi-disciplinary way' and working in an 'integrated way'. They believed they could show that in the latter approach the sum of the parts were greater than any individual contribution. The final report is due to be published at the end of 2017 and will be of national interest in offering a positive template for others.

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Summary

The practice examples cited above demonstrate some of the approaches that councils are taking in response to the increasing demands on adult social care with less resources. They can help to inform work in other areas and support the sector led improvement approach facilitated by the LGA.

The projects in both Bristol and Poole demonstrate that the way in which the council responds to people who are seeking advice or help can be critical as part of the contribution to managing the growing demand on care services. It appears clear that a well-run front door can help to ensure that people's needs are adequately met in more informal ways (outside of the state funded care system). Somerset has developed a group of social enterprises that have managed to meet the short-fall that had previously existed in the formal care market. Community Catalysts encouraged people to come forward to offer care from more rural communities where it had previously been hard to find formal carers. At the same time Norfolk, another rural county, believes that it has stabilised its care market by increasing what it pays to fewer providers.

The programme shared between Wiltshire and Swindon, not only shows how councils can better collaborate and learn together as they develop new approaches. It also shows that they can create opportunities to reduce some costs and some of the demand on their services for adults with learning disabilities, a user group that has until now experienced increasing costs and growing demand for support.

Nottingham City has shown that working collaboratively with its local acute hospital can reduce lengths of stay, freeing up bed space for new patients.

The independent evaluation of integrated teams in Nottinghamshire County Council shows early positive results and is likely to be of national interest when published later in the year. Over the longer term, Newcastle may also demonstrate results from its record sharing with GPs both in terms of improved outcomes and possibly financial benefits.

Finally, Waltham Forest has shown that a careful and targeted approach to commissioning domiciliary care for improved outcomes for older people is likely to produce results in the near future.

A key message from all of these projects is that getting the right process in order to make both cultural change and drive efficiencies is a very important part of managing change. It is clear that this needs to be well managed and well led. Senior managers have to understand and to develop the new practices that are required to make these changes. They have to both understand the data that is driving the changes and the skills required from their workforce. Staff at all levels need good support to assist them in developing their skills to carry out the new tasks that many of these changes require.

This report does not sit in isolation but is part of a wider LGA efficiency programme, aimed at supporting councils to remain efficient and effective. If you wish to find out more visit www.local.gov.uk/our-support/efficiency-and-income-generation/care-and-health-efficiency where you will find a wealth of evidence and information that is designed to assist councils which are making changes.

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