Local Government Association

LGA Adult Social Care Efficiency Programme

The final report

July 2014

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Summary

Councils in 2014/15 will spend nearly £14 billion on adult social care.[1] This accounts for around 35 per cent of a council's budget[2] and as such is the largest area of controllable spend. Grant funding to councils has been cut by an average of 40 per cent in the period of this Parliament and is projected to continue falling.

Since 2010 spending on adult social care has fallen by 12 per cent in real terms as councils have delivered savings of £3.53 billion to adult social care budgets.[3] This has occurred at a time when the number of people looking for support has increased by 14 per cent. Coupled with these unprecedented financial pressures and increases in demand, councils are facing demographic change, significant new legislation on social care and fundamental changes to the local government finance system.

In response to these challenges the LGA, working in partnership with the Department of Health (DH), Department for Communities and Local Government (DCLG) and the Association of Directors of Adult Social Services (ADASS) developed the Adult Social Care Efficiency (ASCE) Programme. The programme, launched in 2011, aimed to support councils to develop transformational approaches to making the efficiency savings required to meet the challenge of reduced funding. The programme is aligned to the ADASS 'Use of Resources' pilots to support efficiency within adult social care services.

Over a third of upper-tier authorities have participated in the three-year programme, working on 44 projects. The 'Final Report' showcases a number of bold and innovative approaches to public service reform that consider workforce optimisation, culture change and creative new delivery models to manage demand, as well as a range of technical and structural transformations.

The majority of councils who participated in the programme were required to deliver savings of 8 to 10 per cent over the three-year period in order to balance the books. The evidence suggests that if a council can retain a relatively balanced gross spend on adult social care, it will be required to deliver 3 per cent savings per annum to meet competing demands from inflationary and demographic pressures alone. Some councils have had to make significantly higher levels of savings.

The big lessons emerging from the programme about how councils are making efficiencies include:

- Agreeing a new contract with citizens and communities. Suffolk, through their transformation programme 'Supporting Lives Connecting Communities', have developed a vision for adult social care in which they have made clear their offer to citizens. The council has saved £38 million over the past four years.

1 ADASS Budget Survey 2014, net expenditure
2 ADASS Budget Survey 2014, net budget excluding education funding
3 ADASS Budget Survey 2014

- Managing demand for state-funded care. Calderdale's 'Gateway to Care' is the contact point for both community health and adult social care. The service focuses on prevention, early intervention and safeguarding. Over 97 per cent of contacts are diverted to solutions delivered within the community or receive short-term support that reduces the need for longer-term care. Hackney's 'Promoting Independence Commitment Statement' is clear, bold and brave in setting out what citizens can expect from the council and what the council expects from citizens and staff. The approach underpins the council's four-year plan to transform adult social care services and to save £20.6 million from the adult social care budget.
- Transforming services. People2People is a social enterprise that delivers the front-end adult social care service for Shropshire County Council. The innovative new model is rooted firmly in the community, offering a vision for social care that challenges the culture of dependency and expectation that can be perpetuated by traditional models of care.
- Improving commissioning, procurement and contract management. Wiltshire's 'Help to Live at Home' service operates an outcome-based approach to commissioning, paying providers to achieve outcomes that improve independence. Efficiency savings now exceed £11 million.
- Developing more integrated services. Northumberland have saved £5 million through their integrated model of care with Northumbria Health Care Foundation Trust. The approach has seen a 12 per cent reduction in residential care while demand for domiciliary care has been maintained at a constant level despite demographic pressures. Richmond's integrated reablement service has saved £2.1 million over the three years, reducing demand for council services, avoiding admissions to hospital and reducing the length of time people stay in hospital.

Developing a new contract with citizens and communities

Councils are beginning to develop a new contract with citizens and communities that means individuals take more responsibility for their own care and families and communities are supported to help those individuals to be as independent as possible. In the future, citizens will have a duty to contribute as well as a right to receive support.

The approach is not about cutting services in response to financial pressures, but about proactively helping and encouraging people to live healthier lifestyles, thus reducing or delaying the need for formal social care services. To deliver this new model of care, there needs to be a fundamental shift in the expectations of individuals, communities and service providers if the most is to be made of diminishing resources while securing public wellbeing.

Suffolk have begun to have a dialogue with staff, citizens and communities to transform attitudes, cultures and behaviours in relation to care and support. Through raising understanding of the need to change, they aim to gain support for the new model of social care being developed.

Managing demand for formal social care

Most councils are going some way to meeting their savings targets by reducing the number of people receiving formal social care. The model of care has changed from one of paternalism to one which promotes independence and manages risk with customers. Councils such as Hackney based their transformation programme on the principle that they will increase

opportunities to promote health and wellbeing, while services will aim to support residents to be as independent as possible with 'minimal interference' from the council. They are bold and clear in their aim to reduce packages of care as people achieve their outcome of becoming more independent. Significantly, only those councils that have developed a model based on decreasing dependency on social care and promoting independence have been able to achieve the higher level of savings that the future requires.

Councils are focusing on developing services such as reablement for older people or recovery models in mental health services which help a person to maximise their potential for independence before putting in longer-term services. Several councils have improved the performance of their reablement service through the programme, with over 60 per cent of people who use the service no longer requiring any ongoing formal care.

The access point to social care has been the cause of much consideration with councils debating whether a generic or specialist front-of-house model offers the best opportunity to divert people who do not require formal care to other solutions. Some areas previously operated a council-wide access point, however a specialist (but frequently more costly) service is now more prevalent and appears to offer the best opportunity to reduce demand for formal social care services. Through this model councils might expect to divert 75 per cent of people towards a solution which can be found within the voluntary sector or from local communities before an assessment or offer of formal help is made.

Transformation

Those councils that have had to achieve savings targets above 10 per cent over the period of the programme have looked at radically new service delivery models which, through offering less formality and bureaucracy, can engender a more innovative environment. People2People in Shropshire offers a person-centred way of delivering social care. Staff and users are involved in running the organisation at all levels. While complying with formal reporting requirements, the social enterprise has the freedom and scope to be innovative.

Making optimum use of the workforce is a key consideration for councils. Detailed analytical work in Kent, Kingston and Central Bedfordshire revealed that individual social workers commission different services, with varying costs, for users presenting similar challenges. Peer development approaches coupled with more robust performance management is being used to address the differences and ensure workforce optimisation.

It is recognised that the most significant element in transforming services to make savings is the transformation in culture and behaviours. Councils recognise that it is not possible to bring about this culture change within a short time frame and participants in the programme suggest that it takes two to three years to even begin to embed a new culture.

Commissioning, procurement and contract management

As in the case of Shropshire, many councils are moving to becoming commissioning organisations, developing new models of care that are separate to the formal council structure. Others are looking to improve the way in which services are commissioned and many are adopting the pioneering approach developed by Wiltshire who procure for outcomes from providers and pay on the achievement of those outcomes.

Councils are working with providers to develop the market in response to need and to negotiate the right price for services to demonstrate value for money. Evidence from the

programme suggests that those councils that rely on the external market are more likely to have lower costs than those delivering in-house services. However performance management of contracts is important to ensure that those commissioning services get the right outcomes for users.

Integration

Councils have embraced the opportunity to integrate services with other public or independent provider services, most notably with the NHS, and are engaging in a dialogue around the use of the Better Care Fund. Richmond, Swindon, Torbay, Northumberland and Calderdale report savings through an integrated approach to service delivery. Evidence from a number of councils suggests that savings from personal health budgets are best realised when operating within an integrated model of care. Others find that an integrated reablement model avoids duplication, brings together a range of intermediate care services to support hospital discharge, avoids admissions to residential care and helps older people in the community.

However the number of examples of councils and partners realising cashable savings from integration is still relatively few. Therefore it seems unlikely that the scale of the savings required for adult social care in the near future will be found through integration with health services alone. To support the sector in this area the LGA is launching a new project working with councils and health partners to explore the efficiency opportunities of health and social care integration.

A range of opportunities

While there are some big lessons emerging from the programme, as well as a comprehensive range of fundamental activities and approaches that most, if not all, councils are taking to make savings, the message from councils is that there is no one magic solution to meet the funding challenge. Instead a relentless focus on all the efficiency opportunities is required. Evidence of successful efficiency approaches include:

- Many councils now operate a policy where no one can be admitted to permanent residential care from a hospital bed. This policy is now being built into the Better Care Fund discussions.
- Those councils making the biggest reductions in admissions to residential care cite the importance of cultural change in the workforce.
- Extra care housing is increasingly being used as a potentially more efficient alternative to residential care, provided it is only used for those with high care needs.
- Many councils are taking actions to bring down the costs of domiciliary care and those that have retendered for domiciliary care services in the past 12 months found that prices continued to fall. This evidence appears to counter what is being stated at a national level about the pressures on costs in this market.
- Peer development approaches, coupled with more robust performance management, are being used to explore and address differences in performance of individual social workers to ensure workforce optimisation.

Those councils that have had to save the most money have achieved this successfully by:

- Having a clear managerial and political vision for social care which is conveyed to staff, stakeholders and customers. The savings delivered are not seen as 'cuts' but have come about through an approach to delivering better outcomes for customers at a lower cost.

- Strong political and managerial leadership for the agreed direction.
- Robust performance management and project management of their savings plans. Councils such as Tameside use key performance indicators to ensure they are on track to manage demand for social care.
- Developing a model of social care that breaks with the traditional paternalistic approach to care and has a much stronger emphasis on empowering citizens to take more control over their lives through promoting their independence.
- Focusing on the evidence that helps councils reduce demand for their services, as well as looking at costs.
- Operating an efficient and well-designed care pathway that focuses on assisting people at the time of their crisis and offers help in a way that does not necessarily lead to the person requiring long-term care and support.
- Implementing significant reductions in admissions to residential care or moving people out of residential care into better, lower-cost supported housing options.
- Developing creative use of personal budgets to drive down costs.
- Most councils have taken on some form of external challenge to their current way of working to help identify and deliver efficiency savings.

Over the duration of this programme participating councils have been tenacious in successfully managing demographic and inflationary pressures. In doing so, they have challenged traditional models, mind-sets and cultures. Despite this the challenges over the coming years are immense. Councils argue that a combination of increasing demographic pressures, which they can manage down no further, and rising costs, which have been held down for too long, added to the fact that they have been relentless in implementing the efficiency approaches that they believe to be possible locally, means that it is unlikely that councils can continue to make cuts of this scale without putting services for vulnerable people at risk.

Section A: Introduction

This is the concluding report from the LGA Adult Social Care Efficiency (ASCE) Programme. The programme was launched in 2011 in response to the significant cuts to council budgets and their impact on adult social care. The aim of the programme is to support councils to develop transformational approaches to making the efficiency savings required to meet the challenge of reduced funding.[4]

The report shares innovative and transformational examples of how councils are bringing together businesses, public sector partners and communities to develop lower-cost solutions to support the most vulnerable in our society.

A challenging context

Social care leaders face unprecedented challenges – demographic change, dealing with the implications of the economic downturn, implementation of the Care Act, new public health responsibilities and fundamental changes to the local government finance system to name a few. Not only are these factors putting a strain on adult social care and public sector services in general, but the repercussions can be seen among users, families and communities.

Increases in birth levels and medical advancements over the recent past have resulted in a growing population with an increasing life expectancy. The Office for National Statistics (ONS) projects that the UK population will increase by 9.6 million people over the next 25 years to a total population of 73 million in 2037.[5] Not only is the population increasing but it is ageing too. The ONS projects that the per centage of people over 85 will double over the next 20 years. The consequence is a surge in demand for care and support in later life and there are likely to be more people with complex health needs. The House of Lords Committee on Public Service and Demographic Change warned in March 2013 that the UK was "woefully underprepared" for the social and economic challenges presented by an ageing society and that a "radically different model" of care would be needed.[6]

Coupled to demographic changes are significant budget reductions. By 2015, central government funding for councils will have been cut by over 40 per cent during the period of this Parliament. The Institute for Fiscal Studies predicts that government spending cuts will continue to 2020.[7] The National Audit Office reports that 52 per cent of all the savings made in councils in 2012/13 were been made in adult social care.[8]

4 See www.local.gov.uk/childrenadultsfamilies
5 See www.statistics.gov.uk
6 Public Service and Demographic Change Committee report, Ready for ageing?, March 2013
7 Public Sector Finances, May 2014, www.ifs.org.uk
8 Adult Social Care in England: Overview, National Audit Office, March 2014

In 2014/15 councils are spending nearly £14 billion on adult social care, which is the largest area of controllable spend in a council budget (around 35 per cent).[9] While in many areas services to safeguard the most vulnerable in society have been protected, funding on social care is not ring-fenced, so it is unlikely that adult social care will escape further cuts in the future.

In response to the changing economic climate and changing needs of the population the Government, in May 2013, published the Care Bill, which received royal assent as the Care Act in April 2014. The Act brings together existing legislation into a new set of laws to build the health and social care system around people's wellbeing, needs and improved outcomes, as well as introducing a range of other measures. The Act is part of a broader landscape of health care reform, aimed at addressing the fragmented delivery of services in some parts of the health and care system. The £3.8 billion Better Care Fund was announced by the Government in June 2013 to provide a single pooled budget to support health and social care services to work more closely together in local areas, with a particular emphasis on shifting resources from acute services into community and preventative settings. The level of financial savings that these initiatives will generate is still unclear.

LGA response, the Adult Social Care Efficiency (ASCE) Programme

In 2011, in response to these challenges, the LGA, working in partnership with the Department of Health (DH), Department for Communities and Local Government and the Association of Directors of Adult Social Services (ADASS), launched the Adult Social Care Efficiency (ASCE) Programme. Over a third of all upper-tier authorities bid to take part in the programme and 54 were invited to participate, working on 44 separate projects. Each project was awarded a grant of around £20,000 to undertake a robust diagnostic of the service that challenged existing delivery models and helped to identify areas for efficiencies.

In most cases councils used the grant to procure an external organisation to review and challenge how they were deploying their resources. Councils used the results of these reviews to inform their 'direction of travel' and efficiency plan in the subsequent three-year delivery period. Some councils used the monies to appoint a manager to assist them in project managing their savings programmes.

Throughout the programme, councils have volunteered performance data and supporting information on their financial position and progress against objectives. Each year Professor John Bolton, appointed by the LGA to act as advisor to the programme, has undertaken visits to each council to capture progress and to provide some constructive challenge to the approach. During the three-year delivery phase, councils were also encouraged to attend events organised by the LGA, which offered the opportunity to share learning and exchange good practice. The results have been captured in a series of outputs that have allowed the sector to benefit from the emerging good practice from within the programme, including for example the approach to outcomes-based commissioning in Wiltshire, demand management in Hackney and the efficiency partnership approach adopted by Kingston and Kent.

In November 2012, the programme published its first report 'The Initial Position', which outlined the findings of the diagnostic phase and the areas of focus of the participating councils. It included pragmatic and aspirational approaches to achieving savings and improving productivity in adult social care budgets. An 'Interim Position Report', published in July 2013,

9 ADASS Budget Survey 2014

then looked to capture the lessons from the first year of delivery, from April 2012 to March 2013.[10] It sought to develop evidence about how savings can be delivered for the benefit of all councils.

The ASCE final report

The aim of the programme has been to work with the sector to help to share ideas, innovation and evidence of what works in making savings in adult social care. Over the past three years, council participants have been working on a range of transformational approaches, often being implemented in very different circumstances and localities.

The Final Report sets out the evidence of the success of the approaches taken and the scale of the challenge in different areas. It highlights a number of new and innovative models and inspiring approaches to making efficiency savings. It looks at how councils are preparing for the next three years, when the financial challenge is expected to be even greater.

Section B draws out some key lessons emerging from the programme, including the need to develop a new contract with citizens and communities, to focus on managing demand, to consider radically new models of service delivery including integrating services with other public and independent providers, and to continue improving commissioning, procurement and contract management.

Section C then applies these lessons to particular areas of social care provision, including how advice and information is delivered, how preventative measures can be put into practice, and how the cost of domiciliary and residential care can be reduced.

Section D pulls together the messages emerging from the projects about the essentials of good management practice that must underpin any wider initiatives.

A final section offers some concluding messages and thoughts for the future.

Case studies from the projects have been interspersed throughout the text and an Annex report includes a précis of the work undertaken in each council over the last three years. Contact details are given for each participating council to facilitate further discussions and the sharing of learning. Readers are strongly encouraged to contact other participants to exchange ideas, information and learning.

Annex can be found at www.local.gov.uk/childrenadultsfamilies

10 See www.local.gov.uk/childrenadultsfamilies

Section B: The big lessons

The majority of councils who participated in this programme were required to deliver savings of between 8 to 10 per cent on their budget over the three-year period in order to balance the books.

The evidence gathered through the ASCE programme suggests that even if a council can retain a relatively balanced gross spend on adult social care, it will be required to deliver 3 per cent savings per annum on average to meet competing demands from inflationary and demographic pressures.

Some councils have therefore had to deliver much higher levels of savings in adult social care in order to balance their books. These councils have generally (but not always) been required to be much more transformational and some have found radical solutions to address their challenges.

The key lessons about how these councils are making savings and plan to make further savings are detailed below. They include: agreeing a new contract with citizens and communities; reducing demand for state-funded care; transforming services; improving commissioning, procurement and contract management; and developing more integrated services.

Lesson 1: Developing a new contract with citizens and communities

In order to manage the funding challenge set out above and ensure the sustainable delivery of personalised care, many councils see that they need a new contract with the citizen and the local community. Changing the way that existing services are delivered will in most cases not be sufficient. There needs to be a fundamental change in the expectations of individuals, communities and service providers if the most is to be made of diminishing resources while securing public wellbeing.

The challenge for councils and partners is to develop a model of social care that encourages behaviour that benefits both the individual and the state, while discouraging behaviour which creates user dependency and attracts further costs. The RSA 2020 Public Services final report calls for a new 'social citizenship' approach where citizens have a duty to contribute as well as a right to receive support.[11]

Although it is early days, some councils have begun to have a constructive dialogue with users, carers and partners as to what this new contract might look like. While the approach will vary by locality, for most it will involve a combination of individuals taking more responsibility for their care and families and communities being supported appropriately to assist. The contract will

11 From social security to social productivity: a vision for 2020 Public Services, the final report of the Commission on 2020 Public Service, 2010

require a change in attitudes, cultures and behaviours, which councils know does not happen quickly.

The well-structured and transparent model of social care that many councils are looking to develop is well captured in the Suffolk programme 'Supporting Lives, Connecting Communities' (SLCC).

Supporting Lives, Connecting Communities in Suffolk

Suffolk have developed a vision for adult social care in which they have made clear their offer to citizens. This comprises three levels of support:

1. Help to help yourself – 'My Life' website is a library of information, advice or signposting to help that is available within the community.
2. Help when you need it, immediate short term help – an integrated approach to enablement, given to a person in a crisis or to support them in recovery. This might include recovery from mental ill-health; rehabilitation from an accident or addiction; recuperation from a medical intervention; or another intervention that might assist them in regaining their independence. A 'Short Term Enablement Plan' (STEP) provides an integrated response for customers.
3. Ongoing support for those who need it – users are given the choice to take the support though a personal budget, which may be based on a direct payment system where customers arrange the services themselves, or through a managed account where the council manages the care for them.

The vision is based on the following assumptions:

- The communities in which people live can be developed so that citizens assist their neighbours to live more independent lives through active engagement in their community.
- When assessing people for care, the council must take an asset-based approach, looking to understand what a person and their family or friends / neighbours might contribute to meeting their own solutions through building on their own skills and strengths.
- The public sector comes together to work as effectively as possible, building on partnerships with other key groups including the wider health community, housing, providers of care, the local community and voluntary organisations – bringing their expertise and experience to assist in finding the best solutions.

A key element of the transformation has been to help staff, citizens and communities understand the need for change and engage with the new model. Feedback from the pilot indicates that practitioners are having a new conversation with users and as a result are putting in place more creative solutions to address needs.

The council aims to roll out the model across the county in 2014. The target is to deliver £4 million of savings by reducing demand for state-funded care.

Over the past four years Suffolk has delivered £38 million in savings in adult social care. Over the next three years the council may need to deliver a further £60 million in savings in partnership with health and the Better Care Fund. The council intends to meet this target by boosting capacity in communities to further develop solutions to meet local needs and, where appropriate, keep people out of the formal care system.

Lesson 2: Managing demand

Councils in the recent past have developed successful approaches to managing demand for services despite increased demographic pressures. Three key approaches have emerged:

- diverting people away from formal care where appropriate
- promoting independence and resilience
- offering preventative interventions prior to assessment for longer-term care.

Diverting people away from formal care

Where it is feasible councils are looking to divert people away from formal care packages. State-funded care makes up just a small proportion of the care and support provided to vulnerable adults in the UK and this proportion is decreasing. The National Audit Office (NAO) in March 2014 reported that the estimated value of informal care and support in 2011 was £55 billion provided by 5.4 million unpaid informal carers.[12] Informal carers are doing more hours of care per week and are getting older, so councils are under pressure to support this valued resource to prevent a crisis.

In 2010/11 the voluntary sector provided £9.1 billion of care services for children and adults in the UK.[13] Just over two thirds of this (£6.2 billion) was directly commissioned by local authorities and nearly one third (£2.9 billion) was provided through its own fundraising activity. The role of the voluntary and community sector is increasing in overall care provision and in 2012/13 over 72 per cent of total spending on adult social care was on services commissioned from private or voluntary sector providers.

Shropshire and South Tyneside Councils have developed a model of care with their local voluntary and community sectors that 'aims' to divert people from formal care to local solutions; Calderdale has developed a similar model with the NHS – see the case example below.

12 Adult Social Care in England: Overview, National Audit Office, March 201

13 National Council for Voluntary Organisations, 2010-11 UK estimate for adult and children's social services combined, UK Civil Society Almanac 2013, accessed at: http://data.ncvo.org.uk/

Calderdale's 'Gateway to Care'
Calderdale Council and the NHS have developed a new integrated front-end service called Gateway to Care. The service, offered as the first point of contact between customers and adult social care, aims to help the customer find a solution to their presenting problem, focusing on prevention, early intervention and safeguarding. The service can divert people away from formal care to a community-based solution or offer a direct 'preventative' intervention which is usually in the form of short-term help to build independence and resilience.

There were 37,000 adult social care contacts to the service in 2013/14. Over 97 per cent of these people received short-term support without need for a further social care or medical assessment. Calderdale attribute this to the fact that it is run by trained staff from health and social care, including nurses and social workers, who are experienced in finding the best solutions without the need for ongoing care.

The service is responsive to need and offers a range of interventions, including a crisis home support service for people who need an emergency response at home. It supports people to remain in their own homes, where making connections in their local community, in the family or among friends can be the main part of meeting their needs. This element of the service is managed by 1.5 FTE staff and assisted 155 older people over a year, who previously would have been referred to the reablement service.

The Gateway to Care service has direct access to short-term residential and other care settings, so that help can be given in a way that does not commit someone to long-term care before attempts to offer other interventions have been exhausted.

The service looks to slow down the need to find an urgent long-term solution for people who approach them. It gives staff time to work with people in a personalised way on the full range of solutions that may be available, thereby promoting independence but in a way that safeguards people's best interests.

Promoting independence and resilience
Many councils have changed their model of care from one of paternalism with protective interventions to one which promotes independence and manages risk with customers. This approach has been well developed in Calderdale, Central Bedfordshire, Croydon, Durham, Gateshead, Kent, South Tyneside, Suffolk, Tameside, Torbay and Hackney, which is detailed below.

Transforming adult social care in Hackney
In March 2012 Hackney agreed a radical four-year saving plan for adult social care with a requirement to save £18 million by 2015/16. In response to the latest settlement for local government, this has been extended to £20.6 million, which is over 20 per cent of the 2011/12 base budget.

The council launched a major transformation programme based on the principle of promoting independence and managing demand for council-funded services. Leaders in Hackney were committed to the programme and in April 2012 a bold 'Promoting Independence Commitment Statement' was published which makes clear what citizens can expect from the council and partners and what the council expects from citizens and communities. The council were clear in this statement that over time they would expect some packages of care to decrease as people were supported to maintain or gain greater independence.

The LGA ASCE grant was used to fund a comprehensive training programme aimed at managers and staff. This comprised three strands of work to bring about the shift in culture that was required:

- Promoting independence through care management. Around half of the savings were to be delivered through the careful reduction of commissioned care package costs. The emphasis was on rethinking the relationship between needs, outcomes and services and depended on gaining the understanding and buy-in of staff, providers, users and carers.
- Redesigning and re-commissioning services. The other half of the savings plan was to be delivered through a number of major projects to redesign services, including transforming day care services; refocusing in-house provision to deliver more specialist and complex services; and the redesign and integration of preventative services.
- More recently the launch of two key demonstration integration projects. The aim of these is to integrate learning disability services and reablement and intermediate care services with health to improve the capability for achieving outcomes and thereby manage down demand.

The council are now part way through the four-year 'Transforming Adult Social Care' programme and are continuing to deliver against the associated savings plan. To date the council has:

- Implemented projects to develop cultural services, redesign preventative services and strengthen reablement. As a result the council has been able to meet targets to reduce the number of new assessments for older people and people with physical disabilities by 52 per cent (while offering preventative and/or support services where appropriate). Over 62 per cent of users who receive a reablement service no longer need any ongoing care.
- Refocused in-house care services to deliver services to meet high and complex needs only. All remaining home care services have been transferred to external providers.
- Redesigned day care services to deliver £300,000 of a £1 million savings target ahead of schedule. The new council-run service will focus on meeting high and complex needs only. Coupled to this, a range of community day opportunities are being developed in partnership with local housing and voluntary sector providers to promote independence for other service users.
- Continued to make substantial savings through improved care and pathway management.
- Established an integrated structure for delivering learning disabilities services which achieved an initial 10 per cent reduction in costs. A detailed business case and model for a fully integrated reablement and intermediate care service has also been developed which will be delivered in 2014.
- Delivered a comprehensive 'promoting independence' training programme for staff working at all levels and in all roles. A recent survey of staff concluded that over 76 per cent believe this model is helping the council respond to the changing nature of care, 71 per cent believe it is supporting innovation and 65 per cent believe it is supporting excellent care.

The programme was re-scoped early in 2014 to include new projects to transform home care and meals and implement care and charging reform.

Further, the Better Care Fund is being used to sustain and develop a range of services that are vital for promoting independence and managing the local health and social care economy.

The council have documented a number of lessons arising through the Transformation of Adult Social Care programme which will be used to inform the continuing journey. In particular they recognise the importance of having a long-term strategic plan in place that take into account the long lead-in times required to deliver the most complex and challenging kinds of service transformation; of communications that support culture change amongst staff and service users; of corporate programme and project management support; and of maintaining the quality and consistency of care management.

In continuing to deliver the transformation programme and make the savings required, the council recognise that promoting independence requires a multifaceted approach which involves a number of public and independent partners. The level of risk associated with the approach is expected to increase over time, which means that continued work to mature the market for care services and contingency planning are very important.

While the models for promoting independence and resilience vary, all provide a range of support that helps people to live independently, even with a long-term condition. This support can include advice and information; engagement with community groups to prevent social isolation; rehabilitation and reablement; equipment and adaptations to the home; use of assistive technology; and carer support so that the person can maintain their health, employment and quality of life. The approach appears to deliver the best outcomes if a council is looking to reduce longer-term demand for services.

Wirral and Kent are implementing an asset-based assessment model which takes a holistic approach to how care and support can be delivered. An individual's personal assets and the positive contributions that they themselves can make to ensure their needs are met, along with the contributions of family, friends, neighbours and so on, are taken into account when determining what care and support can be provided.

Kent, Central Bedfordshire and Wiltshire have all developed approaches to 'promoting independence reviews' of current care packages. This approach is based on several assumptions:

- Many older people when they are not well enough to manage their own care are likely, with the right help and treatment, to make a partial or full recovery.
- Giving a person care when they do not require it is costly and can accelerate their need for more care. When an older person stops doing things to look after themselves, they are likely to deteriorate more rapidly.
- Enabling the older person to get help when they need it but stopping that help when they are likely to have recovered is the most effective way of helping the person get the best outcomes (described in the Wiltshire case example in the Initial Position report).[14]
- Old age has 'ups and downs' in relation to ill health. It is important to gear services around both the better times and those times when a person may not be able to cope. This is one of the reasons why extra care housing may offer a more cost-effective model with better outcomes for older people, as the care available can be flexed up and down as required.

14 Adult Social Care Efficiency Programme - Interim Findings, Local Government Association, 2013

Offering preventative interventions prior to assessment for longer-term care

Most people contacting adult social care in the ASCE authorities will receive some form of preventative intervention before they are assessed for longer-term help. This will include reablement; preparation for employment; using telecare products; equipment and aids to daily living; tackling social isolation; helping recovery and rehabilitation; and providing support that helps to promote greater independence. Sometimes these interventions are being delivered in partnership with the NHS. These services have several aims:

- Tackling social isolation through building befriending circles. It is increasingly acknowledged that social isolation is associated with the prevalence of long-term conditions and particularly dementia, which puts a significant financial burden on health and social care.
- Building resilience in communities to meet some care needs, mainly through use of volunteers.
- Running community, cultural or sporting activities in a way that is socially inclusive, where participants are welcome irrespective of their disability or social care needs. For example in Liverpool cultural services are being provided to support older people with dementia.
- Creating dementia-friendly communities, for example dementia cafes, in line with the concept laid out in the 'Prime Minister's Challenge'.
- Supporting carers better with their informal caring role, for example through the development of carers' centres.

Most councils in the programme offer short-term reablement as a preventative approach to reducing demand for longer-term, more costly care. In most cases councils are reporting positive outcomes from this service. Through the course of the programme there have been some interesting developments in reablement in Calderdale, Durham, Hackney, Kent, Richmond, Tameside, Torbay and Luton. The latter two case study examples are detailed below. Further information on reablement can be found in Section C.

Reablement in Luton

Through the ASCE programme Luton aimed to make efficiencies in its in-house reablement service. Over a period of two years, the council improved performance of the team such that 66 per cent of service users no longer required further domiciliary care from a previous level of 50 per cent of users. The council reports that the biggest single aspect of this improvement was a focus on the recruitment and training of the workforce.

New staff have a 12-week induction period, giving them time to find out if the work suits them and allowing the council time to ensure that they are right for the job. The induction includes on-the-job observation by experienced staff as well as training and development sessions. Existing staff within the reablement service also have comprehensive training and support to help them undertake the reablement tasks.

The new approach has helped to improve recruitment and retention, particularly in one part of the borough where this had historically been a challenge. The council plans to extend the approach by introducing an apprenticeship scheme for new younger carers and offering training and support to adult learning services.

The council has also seen an improvement to working relationships with the health service, both in the hospital and the community. This it attributes to better joint working, particularly in taking 'fit for discharge' patients and helping them in an appropriate way. Occupational

therapists (OTs) play a key role in the service and while they do not work directly in the reablement team, they operate within the social care duty service or the hospital and community health service and from here they support and advise on reablement packages. Nearly all older people who are discharged from hospital and who need care and support go through the reablement service. The service is now looking to make a similar offer to people living in the community.

Over half of the savings that Luton has made over the last three years can be put down to better interventions and reduced costs of care, to which reablement has been a critical contributor. The council is confident that the reablement service, coupled with a decision that there are to be no admissions to permanent residential care from hospital, has led to a 12 per cent reduction in admissions to residential care over the period of this programme (2011 to 2014). In addition, £400,000 of savings have been made in domiciliary care through re-commissioning contracts and entering into a strategic partnership agreement with providers.

Through the ASCE programme Torbay Care Trust has looked at the impact and best use of reablement services.

An integrated approach to reablement in Torbay

Torbay Council took a decision to have a small team of skilled workers to make up their domiciliary care reablement service. In the early stages and in common with reablement programmes elsewhere, referrals were taken for clients requesting a new or increased package of care on discharge from hospital. Frequently these were people who had undergone surgery for a fractured neck of femur or a hip replacement.

A subsequent audit of these service users compared with a similar cohort who did not have reablement indicated that an outcome of 'reduced' or 'no further care' occurred regardless of whether domiciliary care or reablement was delivered, that is they improved naturally. As a result, a decision was made to stop automatic referral to reablement and to ensure that reablement is used on a more targeted basis. Torbay considers that the input of a physiotherapist to the assessment process has given them the best possible insight into the potential for recovery for each person.

Case example:

Miss Smith is a 45-year-old agoraphobic female living alone in a centrally located flat. She has significant mental health problems and is known to the mental health team. She suffers from high levels of anxiety and believes that she has fictitious illnesses which prevent her from participation in the activities of daily living. Miss Smith had become completely dependent on her partner and carer for all personal care, meal preparation, shopping, laundry and housework. Her carer adopted a mothering role, encouraging dependence and shielding Miss Smith from available services. In June 2009 her carer left suddenly. Adult social care and the community mental health team put the following package of care in place to ensure her safety.

Services commissioned pre-reablement

Meals on wheels 7 days per week: cost after client contribution	£7.00
Enabling service 4 hours per week commissioned by t he Community Mental Health Team (2 hours being delivered)	(£28.12)
To purchase daily sandwich, undertake shopping, laundry, housework and to manage client finances. Domiciliary care agency 9.5 hours per week.	£133.00

2 carers, 15 minutes am for personal care	
2 carers, 30 minutes pm for personal care	
2 carers, 1 hour shopping once per week.	
Weekly invoiced cost £168.12 (less client contribution of £45.94)	£122.18
Annually £8,742.24 (less client contribution of £2,388.88)	£6,353.36
In November 2012, Miss Smith was referred to the reablement team, as part of a pilot project aimed at encouraging independence. Miss Smith met with the team leader and agreed initially to practice making her own breakfast with the support workers. She was anxious at the prospect but gained confidence in the support workers as they encouraged her to participate. At the end of six weeks she achieved several goals and is now independent for all personal care and gets dressed every day without prompting. She is able to wash and dry dishes, something which frightened her as she believed she might sustain a cut, she can make her bed, make her own breakfast, make hot drinks throughout the day and is able to put herself to bed independently.	
Services commissioned post-reablement Meals on wheels, no longer required.	£0.00
Enabling service 4 hours per week	£49.21
(3.5 delivered – within contract but an increase flagged to CMHT)	
To purchase daily sandwich, undertake shopping, laundry, housework and to manage her finances.	
Domiciliary care agency, no longer required	£0.00
Weekly invoiced cost £49.21 less client contribution of £45.94	
Annually £2,558.92 (less client contribution of £2,388.88)	
Total package of care per annum.	£170.04
Savings of 15 per cent have been delivered to the domiciliary care budgets from the range of actions taken in Torbay.	

When professionals in adult social care talk about 'prevention' they are usually referring to actions that can be taken to assist older people. However councils are now considering interventions that will also help younger adults to need less formal care and support. Some councils now extend their older people's reablement services to younger adults. Others are developing specific programmes to assist younger adults, based either on the recovery programmes that are developing within mental health services or on 'promoting independence' principles for people with disabilities, including those with more moderate learning disabilities.

Each intervention has a focus on helping the individual maximise their potential for independence and each review will set new targets to be delivered and outcomes to be achieved over the coming period that will assist the person to be more independent than before. These interventions might involve helping someone into permanent or part-time employment; assisting a person to live more independently in supported accommodation; or helping the person engage in community life by offering social contacts and information and advice. The combination of these interventions can significantly reduce the need for formal care and support.

Lesson 3: Transformation

Meeting the financial challenges set out above has, for many councils, involved exploring radically new models or approaches to service delivery. Some councils have moved to externally provided services; others have implemented a radical culture and behaviour change programme to bring about a shift in the relationship with the local community and consequently the demand for formal social care.

Getting the right workforce and making optimum use of the skills and expertise of the team is a key consideration for councils. Patrick Dunleavy, Professor of Public Policy at the London School of Economics, was quoted at a recent LGA event as saying that "the key to productivity is the autonomous ability of the individual to solve a problem". Detailed analytical work undertaken in Kent, Kingston and Central Bedfordshire has revealed that individual social workers commission different services, with varying costs for users presenting similar challenges. Peer development approaches coupled with more robust performance management is being used to explore and address these differences to ensure workforce optimisation.

Councils undertaking large-scale service transformation recognise that it is not possible to introduce the required transformation in culture within a short timeframe. Councils already on this journey identify a period of two to three years before the new culture starts to become embedded. It is a significant challenge for staff to change their practices from a traditional assessment of needs to an approach that promotes independence; also for users and more often carers to change their expectations of the type of care available. The culture and behaviour change involves not just council staff, but a range of key partners who are involved in providing and delivering services.

A number of councils in the ASCE programme have already embedded very different organisational approaches to adult social care delivery in their areas. Below we detail the innovative approach taken in Shropshire.

People2People in Shropshire

People2People is a social enterprise that as of 1 April 2014 delivers the front-end adult social care service for Shropshire County Council. Staff and users are involved in running the organisation at all levels. People2People has an independent board of directors that includes service users, staff (People2People operates as a mutual), council representatives and other specialist non-executive directors. Users form an advisory group and can influence the day-to-day operations as well as more strategic decisions at board level.

While there is a need to comply with council reporting and monitoring requirements, People2People has freedom and scope to be innovative. Processes can be redesigned, changes can be made to the way staff work and consequently to the culture of the organisation. Bureaucracy is reduced and the teams have autonomy regarding funding of all but the most complex support plans. Local team managers can make informed and responsive funding decisions, avoiding lengthy and delayed decision-making and paperwork. Monitoring of performance by the council has been vital to ensure that key standards are being achieved. People2People has initiated its own quality monitoring, including capturing qualitative feedback from users. The monitoring is undertaken by social work student volunteers who carry out clerical tasks in return for shadowing experience and learning.

People2People is modelling a new, innovative and person-centred way of delivering social work, rooting it in the community with practitioners working alongside, and accountable to, local people. The model has demonstrated how care and support can be more accessible, with a greater focus on connecting people to community resources and working closely with

voluntary and community groups to tap into local knowledge and relationships.

The service is providing a more tailored response to people who are referred to social care, offering information and advice and booking people into community contact sessions in their local area. The community contact team provide information on benefits, housing options and so on and they agree a plan for how they will address the needs of the user. If someone requires a full community care assessment this is arranged, but home visits are only offered to those people who really need them, ensuring valuable resources are used to best effect.

People2People peer support volunteers, who have experience of using social care, work alongside practitioners and offer support, guidance and information through the community contact sessions and support planning workshops. All staff are trained in person-centred approaches and social workers carrying out assessments are encouraged to have 'different conversations' to capture information about what really matters to the person and their family, with much shorter recording and form-filling processes. Traditional service solutions are only considered once community-based solutions have been exhausted.

People2People has supported people to achieve outcomes which result in greater independence, strengthened social networks and reduced dependency on formal paid support. People have been enabled to remain in their own homes for longer, to gain confidence and to exercise choice and control. This is evidenced not only in the feedback from users but also in the monitoring of expenditure. Users of the service also report feeling better informed, more confident and therefore more able to take responsibility for their own support.

People who have attended peer support sessions record a feeling of greater empowerment and confidence. In addition, peer supporters themselves report increased confidence and self-esteem through having a purpose, being able to share their own experiences and knowledge and by having a very real sense that they are making a difference.

The effect on staff members, the majority of whom have previously worked in social work roles in the council, appears to be liberating and team members describe a sense of empowerment, motivation and improved job satisfaction. Teams have been encouraged to develop their own new ways of working and to trial new ideas, for example teams in the rural areas in the south of the county have offered 'carers' clinics' in small communities in rooms made available by a local housing provider.

People2People offers a vision for social work that strengthens its community presence and accessibility. By focusing on supporting people to take more control of their lives and to achieve outcomes associated with greater independence and resilience, it is gradually challenging the culture of dependency and expectation that can be perpetuated by some more traditional social care services.

Lesson 4: Commissioning, procurement and contract management

Some councils see themselves as a 'commissioning organisation' and are either divesting all of their directly provided care to the private or voluntary (not-for-profit) sector or are creating new models of care that are separate to the formal council structure. These are most commonly social enterprises or staff-run mutuals – see the case study of People2People in Shropshire under 'Lesson 2'. Similarly Croydon, Wokingham, Cheshire West and Chester, Gateshead, Kingston, Kent, Peterborough and Warrington have all either established such an organisation or are considering doing so. Reducing the costs of the more expensive in-house services continues to be an option explored by many councils.

Many councils are considering adopting the pioneering approach taken in Wiltshire to procure for outcomes from providers. Our earlier ASCE Interim Position Report detailed the early work in Wiltshire and the case study below gives an update of progress to the end of the ASCE programme.

Wiltshire 'Help to Live at Home' service

Wiltshire Council has replaced traditional community care services for older people with an integrated system of care and support. Help to Live at Home (H2LAH) was launched in September 2011. The service reconciles three competing aims of social care reform: personalisation, recovery and prevention.

Assessments for the service are person centred and focus on outcomes, in particular outcomes that leave customers better able to live well with less care. The aim is to first help people to recover their independence and then to reduce their reliance on care and stop it from increasing. In H2LAH, reablement is not a specialist service, it is the aim of all the council's services.

H2LAH has developed an outcome-based approach to commissioning services and pays providers for achieving results rather than hours. Results are outcomes that improve or preserve independence. The council applies financial penalties when customers' outcomes are not achieved and rewards care providers when customers recover faster than planned. Wiltshire Council believes that buying outcomes is a commercial incentive to improve the pay and skills of the care workforce.

The service is delivered by four main providers who have been awarded eight contracts worth £11 million. The reduction in providers has resulted in an improvement in the performance management of contracts. For the providers it has given them security in the market and at least one of the four has offered all staff contracts on a salaried basis rather than an hourly basis.

Over the duration of the programme (2011 to 2013) the service aimed to deliver £7 million of savings for adult social care arising from the wider use of telecare (£2.9 million); improved procurement (£2.2 million); improved outcomes (£1.7 million) and other initiatives (£0.8 million).

Over 1,500 customers access the Help to Live at Home service in any one week (February 2014) and a further 320 self-funders use the service by choice. Outcomes from the service have exceeded expectations and efficiency savings now total £11.6 million. In addition to the financial savings there is now stability in the numbers of older people being placed in residential care despite demographic pressures and for those older people who receive the service, 60 per cent are reabled to live independently within six weeks and require no further service.

The aim is to extend the service to other customer groups.

Lesson 5: Integration

All councils in the programme are actively exploring opportunities to integrate their offer with the services provided by other public or independent providers as a way of reducing costs. In particular, councils are entering into full dialogue with their NHS partners around the integration of health and social care services and the use of the Better Care Fund. It is positive that every council in the ASCE programme talked about having constructive discussions with their local clinical commissioning groups (CCGs) to explore opportunities for joint working.

The need for a dialogue about the Better Care Fund has provided councils with an opportunity to ensure that health and social care share key objectives for the future, such as the need to retain independence for older people and reduce longer-term admissions to residential care. Wirral reported success in encouraging the wider health community to share their target for reductions in admissions to residential care and to look at how they might contribute to this target. There is a view that health can contribute to the delivery of further savings in adult social care through their support in helping to manage demand; however, few places are able to report progress yet.

A number of councils within the ASCE programme are either already providing their services in an integrated way, are part of the Department of Health's Integration Pioneers Programme[15] or are beginning to look at integration as part, if not all, of their solution for better use of resources in the future and for meeting their longer-term funding challenges. Evidence from the programme has revealed some successful models of integration, such as the intermediate care / reablement schemes seen in Swindon, Torbay or Richmond, detailed below; the reduction in admissions to residential care seen in Northumberland; and the Gateway to Care in Calderdale. The reported savings delivered by these integrated approaches are positive. Furthermore, evidence from councils such as Staffordshire on the savings from personal health budgets suggests that personal budgets work best within an integrated model of care.

Richmond 'Rehabilitation and Response Team' (RRRT)

The Richmond Response and Rehabilitation Team was established in October 2013, jointly commissioned by the council and CCG. The service builds on the best aspects of the borough's reablement service and community health intermediate care services. The aim of the service is to offer people a clear care pathway for hospital discharge and the opportunity to receive the level and intensity of rehabilitation services at the time and for the duration they need it, from appropriate highly skilled workers.

This integrated service is managed by the Hounslow and Richmond Community Healthcare Trust (HRCH) with council staff seconded to the trust. It provides flexible services and interventions through three core functions:

- hospital discharge and early supported discharge
- crisis and rapid response
- community rehabilitation support (provided by an external provider).

The service accepts referrals and prevents hospital admissions seven days a week and offers a flexible period of support and/or rehabilitation determined by the person's individual wishes, needs and potential for achieving and/or maintaining independence.

The service has access to six intermediate care beds in a local care home and 50 beds in a local community hospital as well as to specialist clinicians as required eg neurology, falls

15 Barnsley, Cheshire, Cornwall and Isles of Scilly, Greenwich, Islington, Leeds, Kent, North West London, North Staffordshire, South Devon and Torbay, Southend, South Tyneside, Waltham Forest and East London and City, Worcestershire

service and so on. Work is being developed with the mental health trust to better manage those patients who are discharged with a diagnosis of dementia.

Currently, the domiciliary care element is provided by an independent provider who achieves a 50 per cent of success in relation to people needing no further support after they have been helped. The council-funded admissions to residential care which were already low have reduced further from 100 per 10,000 of the older population to 80 per 10,000. The contract with the independent provider looks to specify the outcomes that are required from the contract with a clear set of standards around hospital discharge and low admissions to residential care.

The integrated reablement service has directly contributed £2.1 million in savings to the budget over the last three years. Financial projections show that the service has both reduced demand for council services and reduced lengths of stay in hospital, as well as some admission avoidance.

The direct cashable savings arising from integration are still hard to identify. In some instances it appears that similar levels of savings can be achieved by schemes that councils have developed alongside health rather than integrated with it. Northumberland reports that it has saved £5 million through its integrated model of care but others including Durham, Tameside and South Tyneside have delivered similar levels of saving without integration.

Some councils are, with health, starting to use a risk stratification tool to identify older people who are at risk of needing acute care. Others have developed joint clusters of multi-disciplinary teams based around localities to support people in that area. In both instances councils were finding that demand for their services was increasing. There is some evidence from these new partnerships that social care costs will increase but the NHS will save money. However it would be hard to identify costs in a way that would allow a related shift of budgets within the system.

The evidence from authorities such as Calderdale, Northumberland, Richmond, Swindon and Torbay suggests that there are opportunities for savings through the integration of services with health. However the examples are still relatively few. In response, the LGA are working with national partners and local councils to undertake a programme to further explore the opportunities for efficiencies offered through health and social care integration. At the stage of writing this report, based on the evidence to date, it seems unlikely that the scale of the savings required for adult social care in the future will be found through integration with health services alone.

Section C: Efficiency approaches in practice

This section explores the range of practical approaches being adopted by councils to achieve some of the overarching efficiency objectives outlined in Section B.

Our advice is to consider the options that may best serve your local situation and circumstances and to work with colleagues in the sector to share learning.

Assessment, advice and information

Most councils have adopted a front-of-house arrangement that assists in diverting people who do not require formal care and help away from council assessment services towards solutions from within their families, their neighbourhoods, their communities, the voluntary sector or even sometimes from within their own capabilities. Learning from participants in the programme, there appears to be a number of key questions that councils must answer before designing the front end of their service.

Key question: Should the front end of adult social care be part of a unified approach to council services or should it have a unique point of access?

In the recent past a number of councils determined that the most cost-effective way of managing their customers was to establish a single point of access across the council. Social care managers frequently resisted this approach as there was a belief that the council-wide service would lack the specialist knowledge to find the best solutions for social care clients. In response to these concerns, some councils determined to develop a more specialist social care service which could train staff how to assess risk and find alternative solutions to the problems that were being presented.

The choice facing a council is to run a lower-cost council-wide service which may be less successful in diverting people away from formal social care or a more costly specialist service which has a better opportunity to ensure people get the right help at the right time, including diverting many people to other more appropriate solutions for their care needs. The latter now appears to be the more prevalent model that councils are adopting and this appears to offer the best opportunity to reduce demand for formal social care services.

Social care contact centre in South Tyneside
The contact centre in South Tyneside diverts 75 per cent of social care enquiries to solutions developed by the voluntary sector or in the local community. The council has developed a screening tool for the contact centre which assists staff to make their assessments in a consistent and constructive way.

The council ensures that every person has a follow-up contact six weeks after the initial contact to check on the outcome of the intervention.

Key question: Can the front end of social care be better integrated with the access points for some health services?

A new contact centre model is emerging in some councils that acts as an access point for adult social care and also for some health services. This approach is recommended in the guidance for the Better Care Fund. GPs can use this single point of access for referring patients about whom they are concerned but who do not warrant a hospital admission. It also acts as a single point of referral for people from hospital who need post-hospital care and support.

Evidence from Calderdale's Gateway to Care service suggests that the single point of access can act as a triage for people for health and care. It helps to ensure that most people get the right intervention in a speedy manner, reducing the need for longer-term and more costly support.

The service in Calderdale has both trained social workers and trained nurses who contribute to the triage / assessment of people who are referred to them. Many councils are looking to find the most cost effective way of resourcing such a service, which poses the following key question:

Key question: Which staff are best placed to undertake the initial triage task of taking simple assessments and looking to divert people to other solutions?

Barking and Dagenham and Central Bedfordshire Councils have made a decision that they want the front end of their organisation to be operated by fully qualified and experienced social workers. They believe that this level of resource provides the best judgement and experience to determine when to offer a person a fuller assessment and when it is possible to divert them to a community-based solution. They hold the view that a qualified member of staff can make better judgements about risk and the appropriateness of specific help.

Work undertaken in other councils, for example Kent and Kingston, revealed that, despite the locally published eligibility criteria, different workers (whether qualified or not) apply different thresholds and solutions for people with similar problems. They found that some workers were better than others at diverting people away from formal care solutions or at finding more creative solutions to meet people's needs. A number of councils have introduced peer mentoring for staff, both to assist with risk management and to promote the practices which encourage creative solutions, which also usually cost less. In Shropshire, peer mentoring is undertaken by volunteers who have experience of using social care for themselves or for a family member. They offer practitioners support at the point of initial contact and in support planning workshops.

The different approaches outlined above all rely on well-trained and well-supported staff. This could be seen to be in contrast with those councils which are looking to develop an IT solution to enable customers to self-serve at the initial point of contact.

Many councils, including Stockport, reported that the earlier versions of software aimed at supporting self-assessment tended to focus too much on assisting people to calculate their personal budget and the contribution they would need to make to that budget. They generally put less emphasis on the alternative preventative interventions that might be available and would mean that a person would not need any budget at all.

Councils such as Swindon now advise that it is possible to develop locally modified packages which can show a potential customer the wider options available to them, including solutions in their local community as well as any entitlement to a package of care.

Swindon's 'Quick Heart'
Swindon has developed the use of Quick Heart, a web-based tool to help the public gain access to information and advice about care and community support. The tool is being rolled out through the Citizens Advice Bureau, the council's one-stop shop and Care Line. Local community organisations have played a key role in collating data and information to populate the Quick Heart system.

Savings of £950,000 were achieved in 2013/14 by using Quick Heart to divert people away from formal social care to community-based solutions to their problems. A further savings target of £950,000 has been set for 2014/15.

Delivering preventative services

Most councils will not formally assess someone for care without first offering a set of interventions (often in partnership with the NHS) which are designed to support recovery, rehabilitation or recuperation in a way that might mean the person does not require longer-term support. The most regularly used interventions are 'reablement' and 'telecare'.

Reablement

The evidence from the councils in this programme is that many of them have developed good quality reablement services that as a minimum are assisting 50 per cent of older people at a time of crisis without the need for continuing social care support. Hackney, Kent, Luton, Wiltshire and Durham are all councils who can report a much higher performance, with over 60 per cent of older people no longer requiring a service after the intervention of their reablement team. Luton successfully increased performance of the reablement team to 66 per cent – details are given in Section B.

A number of councils are considering how to ensure that the more expensive elements of the reablement service are targeted at the people who most need them. Some are developing a sophisticated knowledge base to inform them. This can be seen in the Torbay example in Section B. The approach in Torbay is taken from a model where the reablement service is delivered by the community health trust integrating health and social care delivery. Richmond have adopted a similar model, which has demonstrated significant savings for both health and social care.

Some councils, such as Coventry, have reduced their costs by putting the reablement service out for contract. Others have externalised the service, either fully or in part. For example in Wirral a small in-house team provides guidance to external providers to ensure quality and positive outcomes.

The ASCE Interim Position Report cited the Help to Live at Home service in Wiltshire. Here there is no specific reablement service as all domiciliary care is commissioned in such a way as to deliver outcomes that promote independence, replacing the former in-house reablement function. As a result Wiltshire enables 60 per cent of older people who are referred to their services to regain independence (not needing a further service) within six weeks of their receiving domiciliary care.

There are some key lessons about effective reablement that arise from these examples:

- The reablement service relies on well-trained and supported staff that are clear about the outcomes they can achieve with their customers.

- Some customers will recover on their own if offered a good support package designed by a physiotherapist or occupational therapist and do not need the added cost of a reablement worker.
- It is possible to save money by developing the reablement service within the external market – as long as the market sustains the expected outcomes.
- Some people who are dependent on formal or informal care for everyday tasks may be helped through an intensive intervention that is reablement-based and works with them to change their behaviours.
- An integrated approach between health and social care can avoid duplication and bring a range of intermediate care services together to support hospital discharge, assist with admission avoidance and help older people in the community.
- It is important to performance manage this service so it can be measured against the outcomes it delivers.

Councils should be able to predict the future demand for longer-term care and support based on the trajectory of their reablement-based services. Those that are reducing demand by 60 per cent or more can expect to have less longer-term demand.

The unit cost of the intervention is important. Calculating the cost of an episode of reablement and measuring it against the outcomes it delivers will put the business case for more or less investment in the service. Those councils that rely on the external market are more likely to have lower costs, but must ensure that they also get the outcomes they require.

Use of telecare

A growing number of councils are using telecare as part of their increased offer to people, but in a way that saves money. There is a divergence of opinion as to whether telecare should be part of universal offer that helps many older people and is designed to keep people away from formal council services or whether the service should be more clearly focused as part of a care package for those with higher eligible care needs, or both.

In the example below Hampshire has used telecare in a targeted way to reduce the costs of care packages. A similar approach was adopted in Kent and Kingston and highlighted in the ASCE programme's Interim Position Report.

Increasing the use of telecare in Hampshire
Following a tender process, Hampshire developed a partnership with Argenti to optimise the use of telecare as part of the range of tools available to help people with care needs to get appropriate support at a lower cost.

Argenti, with assistance from Tunstall UK, undertook a programme of training to bring about the cultural change required amongst front-line workers to deliver savings through the wider and better use of telecare. They also worked with staff to establish the mechanisms for performance management and project management.

Learning from the project has revealed that the areas that required development for the programme to be successful were:

- getting the process right for selecting the correct equipment and then installing, maintaining and recycling it

- developing a targeted, outcome-based approach that is integrated into broader packages of care, replacing previous solutions
- developing a market and payment strategy for self-funders
- building effective relationships with external providers and commissioners of telecare and complementary services
- becoming a partner in Hampshire's transformation programme, supporting behaviour and systems change and benefits realisation. The programme is clearly linked to changes being delivered in Hampshire with improved reablement and a focus on outcomes.

The council has identified savings in three areas as a result of this work:

- direct savings that can be shown to have arisen from the use of telecare, for example by replacing waking night staff in learning disability establishments
- known avoided costs, for example by preventing an admission to residential care or a domiciliary care visit
- instances where it appears likely that costs have been avoided.

In the first six months after the project went live, Hampshire saved £218,487 or £456 for each person receiving telecare.

Croydon and Tameside have introduced telecare in supported living accommodation for younger adults with learning difficulties or those who have conditions on the autistic spectrum. The assistance can be seen here to be part of the care model which assists in promoting the independence of the service user in a safe and risk-free way.

Many of the councils participating in the programme have made savings or have current plans to deliver savings from the wider use of telecare. However, the evidence suggests that cashable savings are only likely to come through a targeted approach, rather than the universal model, where telecare replaces an existing service, for example medicine management or the delivery of care hours; or where the approach acts as a risk support measure to avoid the need for a higher package of care, for example reducing the likelihood of an admission to residential care.

Avoiding admissions and reducing costs of residential care

The Department of Health's guidance on 'Use of Resources in Adult Care' suggests that a target of less than 40 per cent of the social care budget spent on residential care would reflect best practice.[16] Getting both the costs and the demand for residential care right is an absolutely critical part of managing the resources for adult social care. All councils are looking to design their services so that older people can be helped in a way that may reduce admissions to residential care.

16 See Use of Resources in Adult Social Care, Department of Health, 2009

Avoiding admissions to residential care

The main way of reducing costs is to reduce the need for residential care placements. Councils are approaching this in two ways:

- making the right early interventions to avoid the risk of an admission
- getting the right secondary interventions in place to avoid an unnecessary admission, for example during a crisis.

Stockton, among others, is developing a targeted preventative approach to reduce admissions to residential care, for example by better supporting carers, preventing falls, early diagnosis and support to people with dementia and treatment for older people with incontinence.

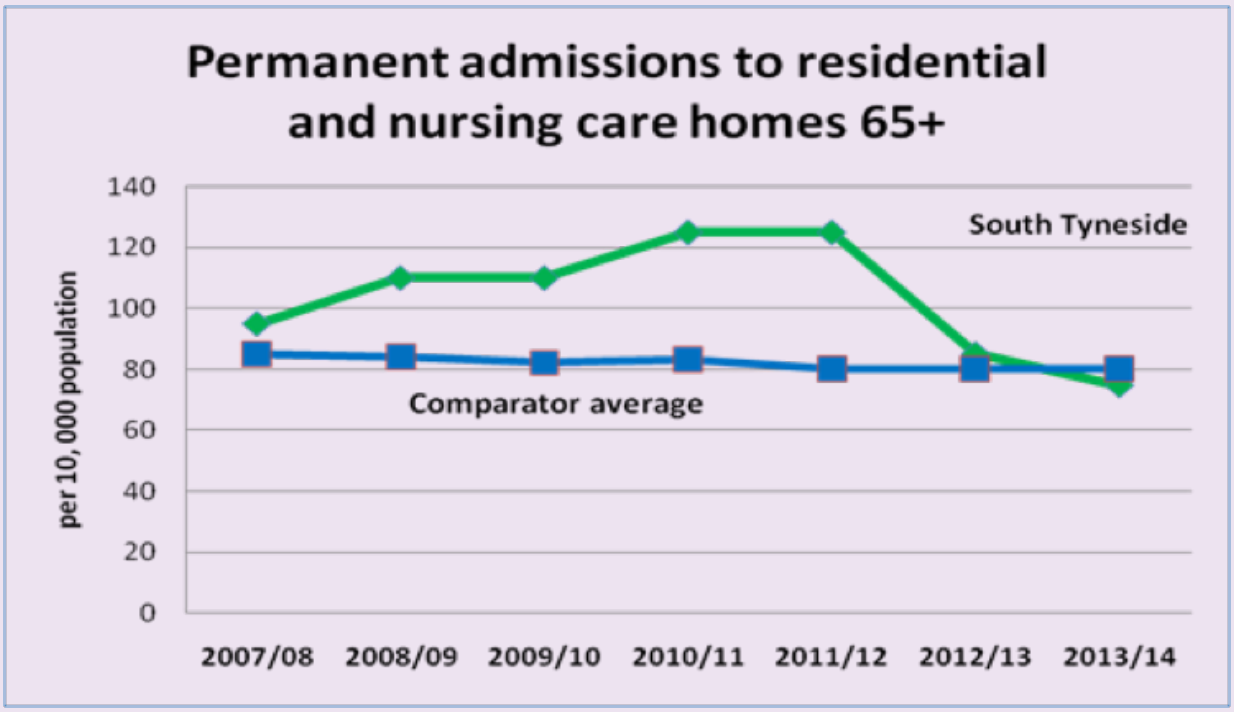
It is important that councils have the right strategies and services in place as well as the right processes to avoid unnecessary admissions. The right services include having both residential and domiciliary care providers who can deliver services that will assist someone on their recovery pathway, rather than unnecessarily accelerating them into a permanent residential care bed. Many councils now operate a policy where no one can be admitted to a new residential care permanent bed from a hospital bed and this policy is now being built into the Better Care Fund discussions.

A large number of councils in this programme have saved money through interventions that have led to reductions in admissions to residential care for older people. Barking and Dagenham, Calderdale, Durham, Enfield, Kent, Lincolnshire, Poole, Northumberland, Tameside, Redbridge, Richmond, Shropshire, Warrington, Wirral and South Tyneside (detailed below) all report reductions over the three-year period, some significant and others declining from an already low base.

Case example: Reducing admissions to residential care in South Tyneside

South Tyneside along with several other councils in the programme looked to reduce admissions to residential care for older people through this programme. Over the previous few years the council experienced an increase in the number of people being assessed as needing residential care, which may have been explained by demographic pressures. Neighbouring authority, North Tyneside, had begun to reduce the number of new admissions through a combination of culture change and tight managerial controls. From a peak of 336 new admissions to residential care at the start of the programme in 2011/12, South Tyneside reduced admissions to 235 in 2013/14, a 30 per cent reduction.

The approach taken by the council was to start with a series of training events which looked at social work assessment practice and developed a shared understanding amongst practitioners about what good looked like when helping a person to deliver their personal outcomes. Local commissioners were active participants in the training programme to ensure that they had an understanding of the type and range of services that older people needed and whether these were readily available in the market.



The training event was seen as critical part of the cultural change that was required to move from a paternalistic model of care to one that focused on the personal wishes of older people and promoted the opportunities for recovery and independence.

Alongside the training programme and the establishment of a new quality and practice group, a number of other changes were delivered. These included:

- a review of both new and existing care packages
- joint working with the clinical commissioning group to develop step-up and step-down beds
- discussions with the health community about the new approach to seek their support, including the involvement of some front-line health workers in the training programme
- increasing support to carers and the establishment of a carers' support fund which was linked to the service user's personal budget
- the development of a new approach to helping older people live with dementia including the establishment of a new integrated services hub
- investment in housing for older people and the implementation of a new strategic approach to meet their housing needs
- greater use of telecare and telehealth as part of packages of care, increasing the volume of equipment issued from 235 items in 2011/12 to 764 items by 2013/14.

The change process was tightly managed by a multi-disciplinary management team across health and social care, the 'Adult Social Care Ratification Panel'. Their terms of reference included agreeing all care packages for residential care including continuing health care; agreeing respite care; receiving reviews; and monitoring all cases where the assessment was leading to a care package above the agreed level of the indicative budget from the local resource allocation system.

Over three quarters of the councils in the programme have plans in place to reduce admissions to residential care, usually through a combination of early intervention, the development of extra care housing as a genuine alternative to residential care and the closure of in-house provision. Bradford, Central Bedfordshire, Cheshire West and Chester, Cumbria, Luton, Darlington, Havering, Hounslow, Lambeth, Liverpool, Luton, Peterborough, Portsmouth, Waltham Forest, Solihull, Swindon, Torbay and Wokingham have all identified investment in extra-care provision for the future.

Those councils that have made the biggest reductions in admissions cite the importance of cultural change among staff in facilitating the change. Staff need to understand how alternative support can help older people to remain in their own homes for much longer than they otherwise would. Introducing tighter panels to manage new admissions linked to strong performance management has also proved crucial to those making the largest reductions. Tameside, Durham, South Tyneside and Calderdale are among those councils that have made the most significant progress in this area.

In addition there are councils which are now making in-roads into reducing the numbers of younger adults going into new residential placements or that are moving people from existing placements back into community-based supported housing. Croydon, Redbridge, Tameside and Peterborough all cite work undertaken to reduce costs in this area, particularly in relation to learning disability services.

Reducing the cost of residential care

Councils report that there is little scope to reduce the costs of residential care for older people. Many have frozen the amount they will pay for placements for the last three years and they feel that this is not sustainable. However, some councils still think that there is room for further discussion with providers about the price of the higher-cost placements, particularly for those with learning disabilities.

Many councils have included new extra care housing schemes for older people or supported housing schemes for younger adults within their regeneration schemes, arranging for some of the capital costs to be met by developers, thus reducing the capital outlay. Most schemes are funded and built by housing associations.

When commissioning extra care housing for older people, councils need to be clear whether they see the schemes as a new housing option for older people or whether they want the schemes to be genuine alternative to residential care and only for those with high care needs. Some providers of care in extra care housing schemes ask councils to fund very significant numbers of care hours for older people with high needs, much greater than older people would receive if they were in a similar residential care placement. Each council needs to take a view about what is the reasonable level of care a person might need. Some have set a cap at around 15 hours a week in line with residential care. If the hours are much higher, the costs of the schemes are likely to be greater than those for residential care placements.

Using capital resources in Portsmouth City Council

Portsmouth City Council has used its capital resources to build a 92-bedded nursing home which is now run by the independent sector (Care UK). The provider is able to offer beds at a reduced price of £470 per week as Portsmouth have met the capital costs of the provision. This gives a net cost for nursing care of £360 per person per week. This is significantly lower than the rate of £700 plus that the council is paying for alternative provision.

The business plan in Portsmouth estimates a £4 million saving over the 25-year life span of the project.

A number of councils have looked to reduce the costs of residential care for younger adults. Residential care is still being used for some adults with high care needs, including some with a history of criminality, or for those with challenging behaviours. Following the Winterbourne Review even those numbers should now be reducing.

Over the last five years a number of tools have emerged to aid councils in calculating what might be the reasonable cost of a placement for a person with high care needs. Wakefield has developed a tool which assists in negotiating with providers through open-book accounting. Many other councils report using a care funding calculator to help them make savings on the costs of some placements.

Reducing costs in domiciliary care

Councils are undertaking the following actions in order to ensure that those with the greatest needs receive domiciliary care:

- tight application of eligibility criteria and rigorous use of management panels
- use of telecare in a targeted way for existing and new service users in order to reduce costs
- increasing the number of people who are using reablement and as a result reducing the number of people requiring longer-term care
- reassessments and care reviews. Kent, Central Bedfordshire and Wiltshire have all developed approaches to 'promoting independence reviews' – see section B for further information.

Many councils in the programme were taking actions to bring down the costs of domiciliary care and those that have retendered for domiciliary care services in the past 12 months found that prices continued to fall. This evidence appears to counter what is being stated at a national level about the pressures on costs in this market. However, some councils, which may have been paying slightly above average for the cost of care, have been able to reduce their costs over the last three years. The actions that councils have taken include:

- re-procurement of domiciliary care with a reduced number of providers who operate within a specified zone for a standard agreed rate. This can be seen in Lambeth, Luton, Kent, Kingston, Peterborough, Poole, Portsmouth, Stockport, and Wirral
- contract renegotiations for some inflexible longer-term arrangements in a framework contract (Hampshire)
- undertaking outcomes-based commissioning and ensuring all domiciliary care has a focus on promoting independence (Wiltshire)
- moving people to a direct payment using a personal assistant and thus reducing the need to procure more expensive care from domiciliary care providers (Barking and Dagenham, Enfield and Waltham Forest)
- undertaking a direct payment audit to claim back over-payments
- creating local social enterprises, including former in-house staff, to provide services and drive down costs (Wokingham)
- electronic home care monitoring (Enfield and Hampshire). The council should determine a system for all providers to use. Additional savings come from transaction costs, as this approach reduces the requirements on the finance staff in the council

- externalisation of some in-house domiciliary care (Havering, Redbridge, Richmond, Southend, Durham – mostly for reablement)
- externalisation of the in-house reablement service, redeploying staff in other in-house services (Coventry)
- reducing the instances requiring two people to carry out a task in providing domiciliary care through better use of equipment and OT assessments
- improved management of income collection, reducing bad debt and increasing income (Cheshire East)
- reviewing charging in the community and increasing contributions from customers
- reducing spend on agency staff for in-house services. This includes tackling high levels of sickness
- reviewing continuing health care
- reducing downtime and increasing capacity in reablement services (Kent)
- phasing out the in-house service through 'natural wastage' (Stockton and Bradford).

It is worth noting that the levels paid for domiciliary care still vary significantly across the country. Of those who reported rates to this programme, the highest was £17 per hour in Wiltshire and the lowest was £10.50 per hour in Liverpool. While some variance is accounted for by the policy decisions of the council, there are also some unaccountable differences between neighbouring authorities.

A number of councils are looking to use direct payments as a lower-cost way of meeting care needs, including Barking and Dagenham who are paying the London Living Wage to personal assistants to provide support to service users. Some councils have recently reviewed their resource allocation system (RAS) in order to ensure that it accurately reflects the costs of meeting people's eligible needs. A recent review by Stockport Council, following work done in Sheffield, has reviewed the RAS and as a result has reduced their costs.

Transforming learning disability services

The initiatives outlined above have led many councils to look at transforming their approach for younger adults with a learning disability. All of the national evidence suggests that, despite reductions being made in expenditure on other service user groups, the spending for adults with a learning disability continues to rise. This can partly be explained by an increase in life expectancy of adults with a learning disability and by a decreasing mortality rate leading to more complex needs.

Croydon's contribution to the programme has been to focus their work on the area of services for adults with learning disabilities.

Learning disability services in Croydon
Croydon aimed to focus specifically on learning disability services to develop a model that delivered better outcomes for users at lower costs.

In early 2012 the council invited Alders to undertake a critical challenge of the service at the time in order to inform a new model of delivery.

Before the challenge, Croydon had already undertaken a number of reviews of higher-cost packages of care and made substantial savings. There had been a significant shift in expenditure from residential care to direct payments for service users and many of these now

lived in the borough in supported accommodation. There was already an assistive technology adviser in post with a brief to 'normalise' the use of the technology to help people live more independent lives. Croydon also had good working arrangements with NHS colleagues, particularly on the more complex cases. This was not a poorly run service.
The challenge showed Croydon that they had scope to reduce the number of more expensive packages of care costing over £1,500 per week. Over half (56 per cent) of placements were in residential care and placed out of the borough. Thirteen per cent of those placements were for older people (aged over 65) for whom an older person's care home may have been a more appropriate option. The diagnostic found that many of the high costs came from placements that were made in a crisis, particularly when an ageing carer had died or could no longer cope. The practice was not assisting people to progress or helping them to find ways of developing more skills towards independence.

It was acknowledged that there needed to be much 'smarter' plans to support people on this journey. There was a requirement for greater access to therapeutic help for those cases where there are challenges in managing the care. Finally, in common with many councils, Croydon's single biggest challenge in social care was how to meet the costs of younger adults coming through from children's to adult services. This warranted special attention.

Croydon developed a plan to address these challenges. A significant cultural shift was needed to ensure that the service was based on the principle of promoting independence. The council adopted the mantra of 'progression not just maintenance'.

Croydon reduced its spending further with the following activities:

- extending the review programme for high cost packages
- developing a strategy for out-of-borough placements
- developing a 'progression pathway' that was integrated into the review process
- identifying those people who were receiving more services than were required to meet their needs, including those receiving 24/7 packages; those in residential care who were also receiving day care; and those making transitions to older people's services
- extending the deployment of assistive technology.

As part of the culture change programme front-line practitioners and commissioners began working more closely together to achieve the best outcomes for customers. They connected the knowledge about the customers' needs with the available services in the local market, creating new services where required. The whole team collaborated to offer the best service option that would promote independence. They then looked for consistency in approach across the service.

A more recent development in Croydon has been the creation of a local authority trading company which has taken on most of the provision that was previously managed within the council. The trading company shares the philosophy and direction set out by the council of helping to create efficient and effective services through promoting independence. The company has given managers a good understanding of the costs of their services and they are incentivised to find efficiency savings in their day-to-day delivery. Managers look for innovative and creative solutions with their customers, for instance addressing the difficult issue of providing transport for disabled people by working with Transport for London. The company has already contributed to the council's savings.

Counter to the trend seen in other local authorities, the service has achieved a balanced budget and met the demographic pressures that it has experienced over the last two years.

A second case study example from Tameside gives a comprehensive list of actions taken to reduce spending on learning disability services.

Reducing costs in learning disability services in Tameside

Tameside also undertook a review of its learning disability service as part of their full savings review of adult social care. Despite new pressures from users transitioning from children's to adult services, the council reduced spend by over 5 per cent over the three years. It has produced a comprehensive list of actions undertaken over the period to reduce spending in this service area, which may prove a helpful checklist for councils that are exploring how to reduce or manage their costs in learning disability services. The actions include:

- reviewing all placements for costs and the service delivered
- moving a number of people each year from more expensive out-of-borough residential placements to local supported accommodation
- radically reviewing the local offer of supported accommodation, including offering some larger-scale services where costs are reduced because of the higher volumes of people being supported
- extending the use of assistive technology in supported housing schemes for adults with learning disabilities and replacing the need for night staff
- transforming day care services, working with local sports and countryside services, among others, to offer a broader range of activities
- wider use of direct payments
- applying for ordinary residence for people who were placed in their own accommodation in other authorities
- reviewing care packages in the community
- reviewing employment services
- reviewing transport arrangements, including eligibility for transport, and managing new contracting arrangements with local taxis better.

The transition from children's to adult services is cited as a huge challenge for councils in the programme. Most councils can predict their future spend for adults with learning disabilities as the majority of the service users who will require support in adulthood receive care and support when they are a child. Many councils are adding extra money to adult social care budgets each year in order to fund those younger disabled children who are moving to adult services through 'transition'. In Tameside, plans are well advanced to create an 'all age disability service' across adults' and children's services in order to reduce this transitionary pressure and plan appropriately for the future.

In response to the increasing costs of this user group and the identification of learning disabilities as an 'ongoing challenge' to ASCE participants, the LGA has launched a new project to look in a more focused way at efficiencies in learning disability services and to share learning with the sector. Five councils from the ASCE programme will look to develop new and innovative approaches to reduce costs in this service. The participating councils are Barking and Dagenham, Darlington, Cumbria, Kent and Wiltshire. The LGA will publish a report on how the councils are delivering savings in learning disability services in 2016 when the project is concluded.

Section D: Getting the fundamentals right

The ASCE Interim Position Report, published in July 2013, included a list of the core fundamental activities and approaches that councils in the programme were taking to deliver efficiencies in adult social care.

The councils that are most financially challenged are developing their programmes around most (if not all) of these approaches. The variation between councils in the amount they are saving in part relates to what they are doing but also depends on how robustly they are managing the delivery of these fundamental activities.

At the conclusion of the programme the list has been revisited and added to. The activities and approaches broadly fall into three categories: those focusing on internal management; those that involve reshaping the service; and those that relate to external parties – customers, partners or suppliers.

Developing effective internal management

Setting a clear vision and direction. Those councils which have set a clear political vision and direction for adult social care will be best placed to face the next set of challenges. In Liverpool the Mayor has a three-year rolling budget and has engaged with citizens on the options for spending on public services. The coalition-run council in Poole has established an all-party 'Star Chamber' to consider all spending options. Extensive engagement with citizens and staff in Cheshire West and Chester has produced positive outcomes in relation to the best ways to deliver savings.

Implementing robust performance and project management. Those councils that faced bigger savings targets have risen to the challenge by radically transforming services and also by implementing robust performance and project management to ensure they are working to their maximum efficiency. Tameside and Hackney developed new performance measurement systems and enhanced the skills of staff to help them meet their business requirement to better manage demand for formal care services. In Hackney, the corporate programme and project team manage the continuing development and delivery of the council's Transforming Adult Social Care Programme (TRASC). This has been key to managing corporate expectations and supporting the delivery of major and high-risk projects.

Operating efficient business processes. All councils began the efficiency journey by ensuring they operated efficient business processes, including maximising the impact of each intervention; reducing staff costs with streamlined processes; reducing downtime in the system (particularly reablement services); and ensuring staff are competently trained and qualified for the tasks they need to undertake. Warrington Council has a guide for staff on how to save money, details of which are given in the Annex. Programmes in Kent and Central Bedfordshire demonstrate the importance of making efficient use of social workers' time and operating an efficient assessment and care management process.

Consistent application of eligibility criteria. All councils are seeking to apply eligibility criteria for services in a consistent manner, particularly focusing on those who have higher levels of need. Reviews are widely used to determine that a person is receiving the right care to meet their needs and to promote their independence. Wiltshire, Central Bedfordshire and Kent have each developed specific 'promoting independence reviews'. Councils are making sure that care packages reflect the right level of resource to meet needs while looking to avoid escalating costs where a more suitable intervention is available. Some councils are looking to ensure that the services people receive are not inadvertently increasing their dependence on care and reducing their ability to be more independent.

Undertaking a 'base budget' exercise. Many councils have reviewed all of their expenditure and shaved off costs where this is possible. This has often included a reduction in subscriptions to national bodies and publications. Some councils have reviewed terms and conditions of staff including a review of car mileage rates. Many councils have reduced the amount they spend on training staff. Southend made savings by rationalising staff accommodation and introducing hot-desking. Visits to the programme participants suggest that many other councils have achieved significant savings by making better use of local authority accommodation.

Assessing the risk of long-term care. Some councils are reviewing their approach to risk. Stockton Council has developed a tool to assess who is at risk of being admitted to an older person's residential care home in the future and how this might be avoided.

Using capital funds to make savings. Portsmouth has used capital monies to make longer term revenue savings. A case example of the work they have done is included in Section C.

Reshaping the service

Moving away from institutional care. Many councils are reducing their use of institutional care, including residential care, day care and transport services. Cheshire East concluded a review of transport services and delivered savings of £1.8 million. Most councils have reduced the amount of day care available and implemented other creative solutions to support people. Reductions in the use of residential care for older people are particularly notable in Calderdale, Durham, Enfield, Havering, Luton, Northumberland, Poole, Richmond, Shropshire, South Tyneside, Swindon, Tameside, Torbay, Warrington and Wirral, some of these from a low starting point. Croydon, Havering and Redbridge also report lower admissions to residential care for younger adults.

Reviewing the range and type of services that are offered. Councils are looking for a more personalised approach to supporting people. Personal budgets, taken in the form of a direct payment (sometimes using personal assistants), can be a cost-effective way of delivering care. Some councils have issued pre-paid cards to help people manage these budgets. Barking and Dagenham, Stockport, Lincolnshire, Enfield, Warrington and Cheshire East have all saved monies through their approach to personal budgets, while Cumbria, Lambeth, Southend, Tameside and Waltham Forest all are developing plans to achieve more savings through this approach. Evidence from Staffordshire suggests that personal health budgets can reap greater efficiencies if delivered in an integrated way.

Most councils have reviewed and reduced their day care activity to ensure that it is targeted only on those whose needs can appropriately be met in this setting and where there are not alternative community-based solutions available. For example this may include older people suffering from dementia or those with learning disabilities who have high care needs.

Use of extra care housing and supported housing as an alternative to residential care. Several councils have put a growing emphasis on the development and use of extra care housing and supported housing. Bradford, Calderdale, Central Bedfordshire, Cheshire West and Chester, Darlington, Redcar and Cleveland, Hampshire, Lambeth, Liverpool, Luton, Peterborough, Portsmouth, Solihull, Swindon, Waltham Forest, Warrington and Wirral all have this within their programme. Coventry and Hartlepool already have an extensive supply of this housing across their areas and are utilising this as an alternative to residential care.

Developing a single service for younger adults across transitions. Darlington and Shropshire have developed a single all-age service to allow better forward planning for individuals and to avoid the challenge of the transition from children's to adult services and then to older people's services. Durham, Lambeth, Swindon and Tameside are all considering this approach. Many councils cite the transition from children's to adult services as the single biggest pressure on the adult social care budgets.

Ending meals on wheels services. A few councils have reviewed and ended the former meals on wheels services. These include Cheshire East, Poole, Portsmouth, Tameside and Waltham Forest.

Working with partners, customers and suppliers

Negotiating the 'right' price for the service to be delivered. All councils have been negotiating with providers to determine the right price for the care required. For some this involves reducing the range of services to be provided in-house. There are a number of approaches and tools available to assist in calculating the right price for care. For example, many councils are using a care funding calculator; Wakefield have adopted an 'open-book accounting' approach which may be of interest to others. Some councils are deliberately increasing their costs by paying the 'living wage' or the 'London Living Wage' to ensure a good standard of care for users. Many believe that there are risks to continuing to pay the current low levels offered to some providers of older people's services.

Demonstrating value for money. Councils are increasingly asking their partners and providers to demonstrate lean business processes and value for money. For example a number of councils have made savings by implementing electronic call monitoring in domiciliary care (introduced by Redcar and Cleveland, Enfield, Hampshire, Luton, Poole and Shropshire). Where partners cannot demonstrate that they are providing value for money in delivering the required care outcomes, councils are reviewing arrangements and exploring alternative solutions.

Ensuring that the right agency is paying for the services required. Many councils are developing new working practices with partners. For example working with the NHS in continuing health care and with housing providers to get best value from the sector, including a review of the former 'Supporting People' funded services. The approaches in Liverpool and Wokingham in securing resources from the housing sector are particularly noteworthy. The application of the 'ordinary residence' rules has had an impact on costs and potential efficiency savings in some areas. When a service user takes up residence in another council area the new council will take up the costs of care. Several councils report savings being delivered through the consequent reduced costs for them. However, Kent has identified an additional £5 million of cost arising from new service users taking up residence in the county.

Maximising the contribution of users. Councils are maximising the contribution that service users make to the cost of their care within the national guidance. Cheshire East has had a strong focus on debt collection which, in 2013/14, reduced debt and increased income by

£2 million. Warrington has introduced a charge for people who want the council to act as an 'appointee' for them.

Working with the Local Enterprise Partnership. Liverpool has developed a partnership with the Local Enterprise Partnership to find new technological solutions to meet the needs of some social care users. In addition, the council has developed a partnership with cultural providers in the city to provide more options for people with care needs.

Working with GPs to assist self-funders. Officers in Poole are working with GPs to assist self-funders in making the best care decisions for themselves and to avoid premature admission to residential care. Poole and Durham have also commissioned night-sitting services to support hospital discharges and to reduce admissions to residential care.

Encouraging the optimum take-up of grants. All councils have looked at the grants that are made available by central government to ensure that they are being used to fund mainstream services locally, for example the carers and reablement grants. The services that were funded through the previous 'Supporting People' grant have been severely reduced following review processes that looked at either the costs or the nature of the service provided. As a consequence some former funded services have now ceased and a limited number are funded for specific services or outcomes.

Section E: Conclusions and looking to the future

The aim of the Adult Social Care Efficiency Programme has been to support councils in developing new and innovative approaches to making the efficiency savings required to meet the challenge of reduced funding. The report has highlighted transformational but practical, evidence-based examples of how councils are responding.

As with any programme of this nature – run over a relatively short time scale, dealing with a challenge of great magnitude and attempting to provide real evidence of cashable savings – there must be caveats around any conclusions. For example, it remains difficult to anticipate the exact impact of preventative measures on longer-term care costs. And while councils such as Northumberland and Richmond can show savings to the NHS from their integrated care models, there is insufficient evidence to determine whether integrated services uniformly produce savings or whether some separately managed arrangements would reap similar benefits. Nevertheless, transformational models, innovative approaches and valuable messages have emerged from the programme.

To date councils have successfully managed demographic and inflationary pressures and are delivering their savings through a combination of reducing the costs of care and better management of the demand for it. The former has been achieved through a combination of cutting back on some non-essential, low-level services, by changes involving staff and the processes they follow and through better procurement. The reductions in demand are being made through delivering models of care that enable people to be more independent and less reliant on the public services. Significantly, only those councils that have developed a model based on decreasing dependency on social care and promoting independence have been able to achieve the higher level of savings that the future may require. Despite the success to date, many councils are now expressing doubts as to whether savings can continue to be delivered at this rate without risking the safety of vulnerable people and staff.

In the discussion below, we summarise some key practical lessons from the participating councils, before briefly looking to the future.

Managing demand

The key ingredients for a cost-effective model of adult social care delivery appear to be:

- To construct the front end of the service in a way that enables citizens to receive timely help and to find solutions that come from within communities before offering formal help from the state. Councils might expect to divert 75 per cent of people towards a solution of this nature before an assessment or offer of formal help is made. It is important to ensure that all key partners understand their role in supporting this approach. Councils like Croydon and Suffolk are looking to build community capacity and engagement into the process of change, while others such as Liverpool are to looking to a wide range of partners, from local industry to housing providers, to assist with solutions. Meanwhile, residents who are to be

supported in this way may require a simple assessment to ensure that they are offered the right advice for their personal circumstances.

- To put in place a range of preventative measures that assist people when they are in crisis and that focus on recovery, rehabilitation and recuperation. These measures must be delivered in a timely way and are best organised either in an integrated model with the NHS or in close alignment with health services. A single point of access to services may assist with this. The preventative measures may include reablement; support into employment; a falls prevention service; an incontinence service; or dementia support. These services will generally not require a full assessment before they are offered and most will be delivered within the user's own home. For all of the services there should be a clear focus on the outcomes required. Over 60 per cent of people who are offered an intervention should require little or no further assistance from adult social care after the service has been completed.
- To provide a strong focus – political, managerial and through practice – on continuing to promote independence, even among those with longer-term needs. This may be through helping people to better manage the condition from which they suffer, supporting them to live as independent a life as is safe for their circumstances and encouraging them to strive to meet their stated outcomes. An admission for a residential care placement should only be considered when other avenues have been explored and have failed. Commissioners should ensure that a range of services, including appropriate housing options, are available that are cost-effective and of good quality, including the availability of personal assistants and the option for users to create their own solutions from within their families and friends.

Reducing the cost of care

Clearly, all services must deliver value for money, both in terms of cost and in the outcomes they deliver. This applies particularly to high-cost residential care placements.

Procurement continues to bring down costs – most notably over the last couple of years in domiciliary care prices – and providers (given the right circumstances) will compete to offer lower prices to win contracts. Costs are also still reducing in residential care for adults with learning disabilities. However, councils are facing new tensions as they try to balance the desire to offer residents a choice of providers in the care market with the realisation that they can achieve lower costs by limiting the number of suppliers with whom they contract.

Another approach to potentially reducing costs has been to establish social enterprises, staff-run mutuals or similar forms of organisation which can operated by the former in-house teams. There are examples of these new bodies beginning to drive down their costs, although not in all cases, so further evidence is needed before any conclusions are made. Councils which have closed down their former in-house services have generally saved more money. Bradford, Hampshire, Hounslow, Kent, Lincolnshire, Peterborough, Portsmouth, Solihull, Waltham Forest and Wokingham all report savings from taking this approach.

Where there is an existing supply in the independent sector, such as residential care, councils are tending to close down their own services. This is usually done in a managed way, phasing out new admissions and using the home for short-stay purposes or intermediate care while the residents who live there can continue to spend their final days in the same residence. These decisions are usually driven by political priorities. There is a range of examples of all these approaches in the programme.

Leading the change

Leadership is an important factor in distinguishing between councils and the level of savings that they are managing to achieve. Those councils, like Hackney, where politicians have agreed a clear direction find it much easier to deliver their savings. It is also important how the change is led within the council. To go beyond the 3 per cent annual savings envisaged by the Treasury almost certainly requires a transformation of practice and culture, which is having to take place in a context where, in most councils, staff and management posts are being deleted.

The councils which have delivered the highest levels of savings have also had firm management support in making decisions about what people can and cannot have. All councils use panels to help with their rationing processes and to ensure consistency in delivering new models of care. Some customers and providers of services would comment on the severity of certain of the judgements made, but it is interesting to note that a number of councils have delivered these changes while fully engaging with the public and retaining support for their actions and decisions.

Looking to the future

Overall councils participating in this ASCE programme have delivered significant savings of around 8 to 10 per cent of their net adult social care budgets over the last three years, which coincides with the rates reported by the National Audit Office earlier this year.[17] The Treasury has anticipated that councils will deliver 3 per cent annual efficiency savings over the next three years. Many councils in the programme are reporting that the requirement for savings over the period is likely to exceed 3 per cent, taking account of demographic and other pressures. In addition, there are the costs of the new Care Act which will have to be met by councils from within existing resources. There is much debate and uncertainty about how much of a new burden this will bring.

The Department of Health has introduced the Better Care Fund to assist health and social care to find these savings together. All councils in the ASCE programme are anticipating using the opportunity created by the Better Care Fund to find savings in the care system through reduced admissions to acute hospitals. Some of these councils have also been encouraging their health partners to 'buy in' fully to a culture of demand management for social care and have included a number of key indicators on this theme in their joint approach. These councils are hoping that the health community will assist them in bringing down demand for social care, for example by reducing admissions to residential care particularly following hospital discharge.

However, discussions with councils suggest that the success of the Better Care Fund in local areas will vary depending on local circumstances and challenges and at the time of this report, the details concerning the Performance Fund element of the Better Care Fund remain unclear. Some councils are optimistic that the Better Care Fund will contribute significantly to future savings while others put forward sounds reasons why it may not. In anticipation that the fund will not find all of the required savings, councils are making new plans for the future. For many, it will be to build on and accelerate what they have already achieved. For some, the challenge will be to move away from the traditional models of care they have so far managed to retain.

17 Adult Social Care in England: Overview, March 2014, www.nao.org.uk

The challenges over the next few years are immense. Indeed, some councils are beginning to believe that they cannot make the level of savings required without putting their basic services for vulnerable people at risk. They would argue that a combination of increasing demographic pressures (which they can manage down no further) and rising costs (which have been held down for too long), added to the fact that they have undertaken all of the efficiency actions they believe possible, means they can cut no further. Some councils have already afforded a level of protection to social care services (adults' and children's) at the expense of other public services, such as buses, libraries and leisure centres.

Managing the pressures, dilemmas and opportunities of the future will not be easy therefore. All councils will require political leadership and vision and strong management skills to go any way towards meeting the budget challenges for the coming years.

Notes

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