



Models for Funding Allocation in Social Care

“The £100 Million Project”

November 2011

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FORWARD

The paper is intended to help councils look at how they might take a **strategic** view of their use of resources in progressing the transformation agenda set out in national policy. The desire has been to hypothecate the allocation of resources by an example adult social care department, to use this to help local authorities look at how they may deliver the changes required whilst improving efficiency, and to consider the implications for future budget and expenditure management. In other words to develop a product which can offer a practical approach to the strategic analysis and planning of future budgets, that can help with efficiency and budget reduction, and at the same time address some of the re-shaping necessary to deliver the essentials of the 'personalisation' agenda.

The White Paper on social care, currently in preparation, will draw upon messages set out in several key national policy documents of the last year such as the government's 'Vision', The Dilnot and Law commission reviews, and 'Think local, Act Personal'. It is already clear however, particularly from the 'personalisation' experience of the last few years, that there are a clear set of things that Councils, with their partners, must address if they are to create the sort of environment needed. These activities can be set out in two groupings: those conducted for the benefit of the whole local community (i.e. universal); and those aimed predominantly at assessed eligible people.

For the first, aimed at whole communities, three areas should be addressed. These involve the provision of:

- **Information to the general public** about staying healthy and involved (backed by local programmes/activities), and about care and support services (including community support) for people who want this. This requires investment in the information itself and in the support arrangements to engage communities. A council's duty to offer a community care assessment to those who request this of course remains.
- **'Market' development** to facilitate the growth of an improved range of service provision, (working alongside service users providers and potential providers)
- **Advisory services** to help anyone, either self-funders or PB-holders, who needs specific (and often specialised) advice on what support and care arrangements could be available to them, and at what price. This needs to include help to secure these arrangements.

For the second, councils need to continue to focus and invest wisely and efficiently on core activities which, even though they absorb the bulk of a council's social care resource, are generally aimed at, and available to, only a minority (i.e. those deemed 'eligible') of their population that may be in need of services. These include:

- **Enabling/re-abling/rehab** programmes aimed at those deemed likely to benefit
- The giving of **personal budgets** (to those eligible for council-funded support)
- The offer of **'care-management'** to those who are deemed to need this, alongside 'protective' /**safeguarding** support to the most vulnerable

So, in setting out a practical approach to the strategic analysis and planning of future council social care budgets, this document seeks to address the imminent requirement for efficiency, whilst at the same time encouraging a focus on wider required 'direction of travel' in the use

of streamlined budgets and re-shaped investment. In other words how to release money both to deliver savings **and** make the right forward-looking investments.

This project was initially commissioned by the National Director Social Care Transformation, as part of the 'Putting People First Consortium, and has been completed under the auspices of ADASS. The paper has been written, and the background work conducted by the Institute of Public Care (IPC) at Oxford Brookes University. Their work has been informed by meetings with four Local Authorities: Oxfordshire, Nottinghamshire, South Gloucestershire and Manchester, and we are very grateful for these councils for their contributions which have significantly helped to shape the paper, and to IPC for its overall construction. We have also drawn on previous work by IPC, Warwickshire County Council, information provided by the Department of Health and the NHS Information Centre through NASCIS, and projects such as "Use of Resources in Adult Social Care" (Department of Health Publication 2009) and "Better Support at Lower Cost" (SSIA – Wales 2011). We have also been assisted by a number of recent publications such as 'How to make the best use of reducing resources: a whole system approach', (ADASS, 2010) and 'Improving Value for Money in Adult Social Care', (Audit Commission June 2011).

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September 2011.

Models for Funding Allocation in Social Care -

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1 Introduction

This paper takes authorities through the issues they might want to consider in making decisions about how to reduce their budget in line with the settlement for local authorities. It is based on a hypothetical local authority budget of £100 million for adult social care.

There is evidence that local and national circumstances has resulted in a variable impact on adult social care across the country. The average position appears to be that budgets will reduce by about 5% per annum over the next three years, including this current financial year. However, the ADASS budget survey (2011) indicated that 150 English Authorities were making a combined total of £1 billion savings in 2011-12, which is closer to 7% of the spend in the previous year. Therefore, this paper assumes that, if a Local Authority had a budget for social care of £100 million in 2010-11, it is likely to be £93 million for 2011-12 and then further reduce to £86 million by 2013-14, the end of the period of this local government settlement (2013-14).

Local authorities face significant challenges in delivering these savings. Approaches differ widely between councils: from budget reductions across the board, to a focus on back office savings, to outsourcing, to more fundamental strategic shifts such as reducing spend on low level services where there is no immediate evidence of a preventive impact, or alternatively increasing investment in communities and redirecting people away from social care.

This paper is intended to be used by all in social care and allied services who need to make decisions about the allocation of resources. It is not suggesting that any one approach is more effective than others. Instead it offers some ideas which Councils might want to explore about their patterns of expenditure within the context of a simple framework. It identifies the balance of resources and allows senior managers and elected members to be clear about their direction of travel and the rationale behind it.

2 A Framework for Analysing the Strategic Balance of Resources

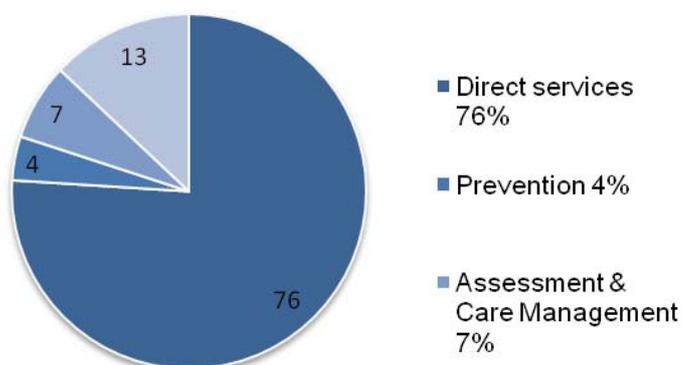
The starting point for this project has been the development of a simple framework which summarises the current patterns of spend within an adult social care budget and allows managers to be clear about the balance between headline expenditure areas. The purpose of this is to set the context within which judgements about resource shifts can be made.

Councils identified the following elements, covering expenditure on all adult social care services from which, they needed to make judgements about overall resource distribution¹.

1. The proportion of the overall budget spent on 'Direct' Social Services', broken down into:
 - a. Residential provision.
 - b. Community based social care provision, including that allocated as Personal Budgets / Direct Payments.
2. The proportion of the overall budget spent on broader prevention services.
3. The proportion of the budget that is spent on support and administrative costs – including those in the form of corporate recharges.
4. The proportion of the budget that is spent on assessment and care management costs, including call centres, front of house services etc.

Figure 1 below displays the average distribution across the four participating authorities:

Figure 1: Average Percentage Distribution across Four Councils



In the four sample Councils on average about 76% of the adult social care budget was spent on **direct social care services**, (the range being from between 70% to 82%). Just over half of this (52%, or some 40% of the total) was spent on residential care for all adult groups. In most Councils, older people's services accounted for over half of total expenditure with smaller proportions being spent on adults with learning disabilities, physical disabilities, mental ill health etc.

The second area was services which are funded as part of **prevention**. Under this heading Councils might include a range of spend from the grants they give to voluntary organisations

¹ Nottinghamshire and Warwickshire have developed other approaches to analysing strategic resources distribution using variations to this framework. More details are enclosed in Appendices 1 and 2.

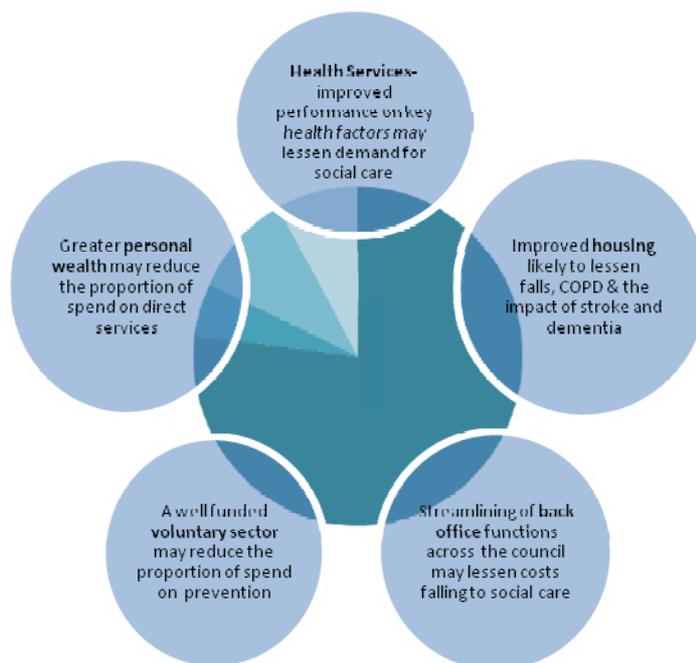
for low level and community based services to investment in services such as intermediate care and re-ablement. This accounted for an average 4% of spend.

The third area related to **support and administrative costs**, including: – commissioning and contracting, finance [including budget management, income collection, procurement, processing payments and staff pay], human resources, training, information technology, administration, democratic services, health and safety, corporate services, senior management and trade union costs. This averaged at about 10% of the four Councils spend on adult social care (although one Council reported a figure as low as 8%). However, we were not able to include an accurate estimate for corporate recharging due to wide variations between authorities as to what did and what did not come under this heading. Somewhat crudely an additional 3% has been added in to accommodate this.

The final area of spend was on **assessment and care management**, which included all forms of social care information and advice services. This accounted for, an average 7% of expenditure.

Although there are no rules for the distribution of resources, these figures feel roughly similar to the proportions that most authorities report. However, these figures are not set in stone and as Figure Two (below) illustrates, there are a range of external factors which impact on decisions about the balance of resources.

Figure 2: Example of the potential impact of allied spending on social care
Other examples of inter-departmental and interagency expenditure that impact on social



care includes:

- Spend by Housing Departments in supporting people services, may reduce the long term demand for care (and health) services.
- In some Councils there is an investment in neighbourhoods and communities that is separate from adult social care but adds a significant contribution to the lives of older or disabled people. These items will all contribute to overall expenditure in a way that is hidden from social care budgets but adds resources to preventive services.
- The cost of transport is sometimes contained within Adult Social Care Budgets – such as concessionary fares and the London Taxi Card Scheme but in other places is located within central budgets.

- Decisions by planning departments on older people resources such as care homes and extra care schemes may have the potential to increase or reduce demand.
- Changes over time in the relative needs and resources of the population will also have a significant influence on demand and distribution of resources, and there are significant differences between authorities in the levels of need to which they have to respond.

If using the simple four part framework in Figure One to plan and monitor future spend then Councils need to be careful to ensure consistency of allocation of data over time. With the four authorities there was much discussion about; accounting for different activities under different headings (this particularly related to non-service areas such as corporate costs, recharges, capital financing and other central recharges), variations in accounting for net and gross costs, including income from, and to, health and other partners and how income from service users was treated. Nevertheless the framework encourages Councils to ask some simple but important questions about its balance of resources:

- Is the balance right between the four key areas of spending, and what will be the impact of reductions or increases in any one area? For example; what proportion *should* be spent on residential care and if residential care becomes part of the personal budget / direct payment mechanism what impact might this have on future expenditure?
- What might be the impact on social care expenditure if, as several councils are planning, their back office functions are reduced?
- Within direct social services in particular, what is the desired balance of funding around which councils should plan, e.g., between the allocation to those in receipt of a direct payment and services purchased by the local authority.
- Where does it make most sense to focus effort in responding to the need for future savings? What might go into the prevention 'pot' in future and how much of that might be derived from health, housing or other local authority sources?

3 Current Approaches to Resource Redirection and Reduction

The simple framework in the previous section is intended to encourage social care leaders to explore an ideal balance of spend with reduced resources. This section considers some of the current approaches, challenges and issues authorities will need to consider in doing this.

3.1 A range of approaches

From evidence provided for this paper by the Department of Health it is clear that there is no predominant approach to securing savings. Councils have experienced the impact of the recent government settlement in different ways, and they are taking different approaches. However, there are a number of common actions that the Department has identified that Councils are planning for this financial year:

- Restructuring, staff reductions and redeployment.
- Pay control or reductions.
- Externalising services.
- Decommissioning or closing some services – notably day care and low level voluntary sector provision or services previously relying on Government Grants.
- Reduction in spend on Supporting People (focus on short-term interventions).
- More stringent ‘needs’ test (Raising eligibility criteria).
- More stringent means test (Increased charges/contributions).
- Partnerships with Health- Focus on re-ablement and prevention.
- Reduced use or unit costs of residential care.
- Reduced use or unit costs of domiciliary care.

Whilst the list may represent a set of actions being taken it does not necessarily mean that any particular selection will automatically deliver the savings required, given, for example, that savings in one area may cause expenditure in another. There is also a balance to be struck between quality, desired outcome and expenditure as the material below illustrates.

3.2 A number of complications

In an environment such as local government the approach to resource reconfiguration is complicated and sometimes what initially looks like a potential saving may not always turn out to be so. For example:

- a) Some Councils take an “even-handed” approach to savings, with every department required to make a similar level of savings across the Board. This can mean that departments with a high proportion of directly delivered services such as social care are disproportionately hit compared to those where it is easier to turn on or turn off expenditure, e.g. highway repairs.
- b) Councils also need to be careful not to double count their savings in adult social care. An example might be to have a commitment to reduce use of residential care whilst at the same time also planning to deliver increased supported or extra care housing as alternatives to residential care.
- c) It may be hard to achieve savings on back office or support functions where these are not in the control of the Director of Adult Social Services.

- d) There are areas where initial savings may result in further expenditure, e.g. tightening eligibility without a strong focus on prevention and diversion can result in people simply being delayed in getting access to care, and then needing more intensive services when they do become eligible.
- e) There are transactional issues which need to be taken into account. For example, when a Council closes an in-house service there is not only a time lag but also there may be a period where there are double running costs may be incurred.
- f) Externalising services needs to be approached carefully. If a council wishes to externalise its own in-house service it follows the rules associated with the Transfer of Undertaking of Permanent Employees (TUPE). This can mean that the immediate savings end up being a tiny proportion of the actual cost of the service - 5% or less might not be uncommon.
- g) Finally some savings may simply take longer to deliver than anticipated:
 - If extensive consultation is required, e.g., a review of contributions policy, review of eligibility, closure of a care centre, closure of a residential care home (which will typically take up to eighteen months from decision to consult to final closure).
 - If the savings rely on new build premises to come on stream e.g., extra care housing, or supported accommodation. A new housing scheme may typically take at least two years (minimum) from planning to opening.
 - A scheme which requires the TUPE transfer of staff may typically take nine to twelve months.
 - A proposal to decommission a voluntary sector or other contract (depending on the terms and conditions of the contract) will take a minimum of six months.
 - A proposal to delete staff posts (and offer redundancy) will take a minimum of six months.

Whatever package is constructed, the delivery of each line of a savings proposal needs to have a clear project plan. It should contain details of what is to be saved and a timetable which identifies milestones such as the period for consultation, the formal decision to be taken by Members, a period for further scrutiny followed by ratification by Full Council, and final implementation. To achieve delivery of the package then requires strong performance management and monitoring whether the anticipated savings are achieved.

Overall, Councils that set their savings in the context of a strong strategic direction are probably going to offer greater coherence and consistency to users and providers of social care and establish an approach which is more likely to be sustainable in the longer term. To make such changes successful there is a need to be clear about where you are going, communicate this to service users and carers, be explicit with partners and providers about how you will behave and what you will be looking for from them now and in future.

4 Taking a Strategic Approach

4.1 Choices in the current system

Most directors will be conscious of balancing the expectations of members with that of government, the needs and expectations of services users, staff and the general public as well as trying to achieve a balance between the immediate pressure to save money as against the long term need to redefine the role and function of social care. However, in essence, choices about saving inevitably fall into one of four categories:

- a) Reducing what is provided.
- b) Being more efficient in ensuring the same service is delivered or developing different types of service offers.
- c) Getting somebody else to fund/deliver provision.
- d) Reducing demand.

Of these four it is likely in the short term that attention will focus on reducing individual resource allocations (within legal requirements) and delivering efficiencies. In the longer term and given the increase in, particularly the older people's, population this is unlikely to be enough. Shifting the cost burden is most likely to arise through the government proposals regarding the future funding regime for social care although there are certainly areas where pooling budgets, even if a lesser sum, between agencies could potentially deliver more than the sum of its parts.

However, the real gains that are most likely to change the proportion of spend away from direct services, lies in lessening demand. In 2003 the Association of Directors of Social Services published 'All our Tomorrows; Inverting the Triangle of Care²', which pointed out that there was an inverse relationship between the cost of services as compared to the number of people who received them with expenditure focussed on those requiring high intensity interventions. The argument was that there needed to be a move towards greater expenditure on prevention - to 'invert the triangle of care'.

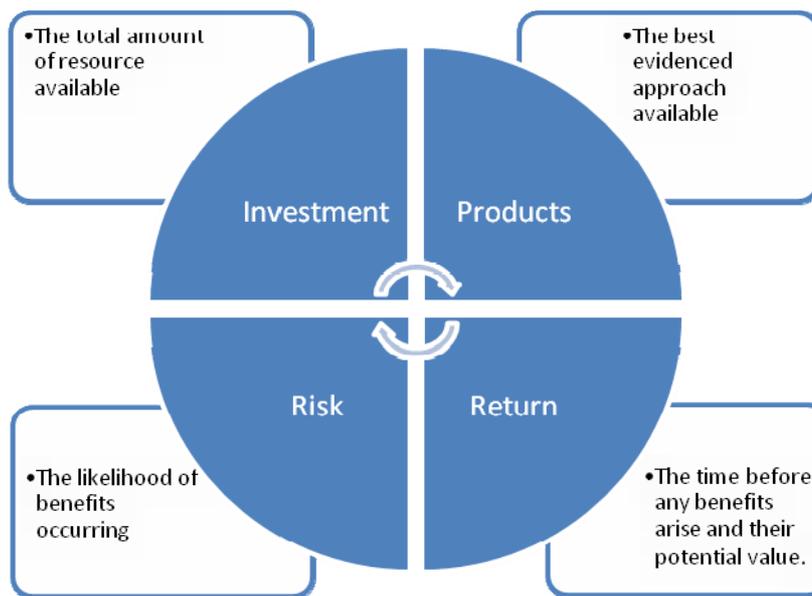
Whilst there was much agreement about this theoretical model, the triangle tends to have remained stubbornly 'uninverted', in no small part due to the lack of evidence to support a wider preventative approach. However, some of that lack of change is also due to a funding system that fails to make a connection between expenditure, activity and outcome. To achieve this social care needs to move from a need to which a level of funding or service provision is dedicated and more into an investment based approach, i.e. if we spend x amount of money then what likelihood of a return is there over a given time period. Figure 3 and the subsequent text illustrates what is meant by this.

4.2 Taking an investment approach

The traditional approach to expenditure assumes that the need for care is fairly static, that the existence of a problem requires a given level of service provision or funding for the person to be cared for. When savings are required the only choice is between getting the same service for a cheaper price or reducing the level of service (which in itself may only fuel further demand). An investment approach to care starts from asking what it is that needs to, or can, be achieved and what is the evidence base that suggests this is possible for that person. The decision then as to what to spend is made on the basis of how much money is needed, to achieve what result, over what time period. With an investment approach high expenditure for a given period may be quite appropriate if it removes the need for longer term expenditure

² 'All our Tomorrows; Inverting the Triangle of Care, ADSS / LGA, 2003

Figure 3. An Investment model for Social Care



Investment

What is the size of the pot taking into account all commissioned resources (organisations and agencies separately pursuing approaches to intervention are rarely likely to be cost effective) whether 'spend' is on one individual or on a whole problem. Is the 'pot' measured only in cash terms or can it be expanded through counting in voluntary effort and the contribution of carers? Is it possible to identify where the financial consequences of a lack of preventative effort currently falls? What contribution might be made by self funders?

Products

What are the target areas of intervention and why have they been chosen (biggest saving, easiest to implement, most amenable to change)? Has any kind of review been done to identify what works best and when does it have most impact. What is the validity or strength of those estimates?

Return

What are the net costs of current activities in the target area over a given time period for a given number of people as compared to what might be the net costs (including start up costs aggregated over target period) of any alternative approach over a given time period for a given number of people. What are the real as compared to hypothetical savings, eg, fewer hospital admissions but building and staffing costs remain the same.

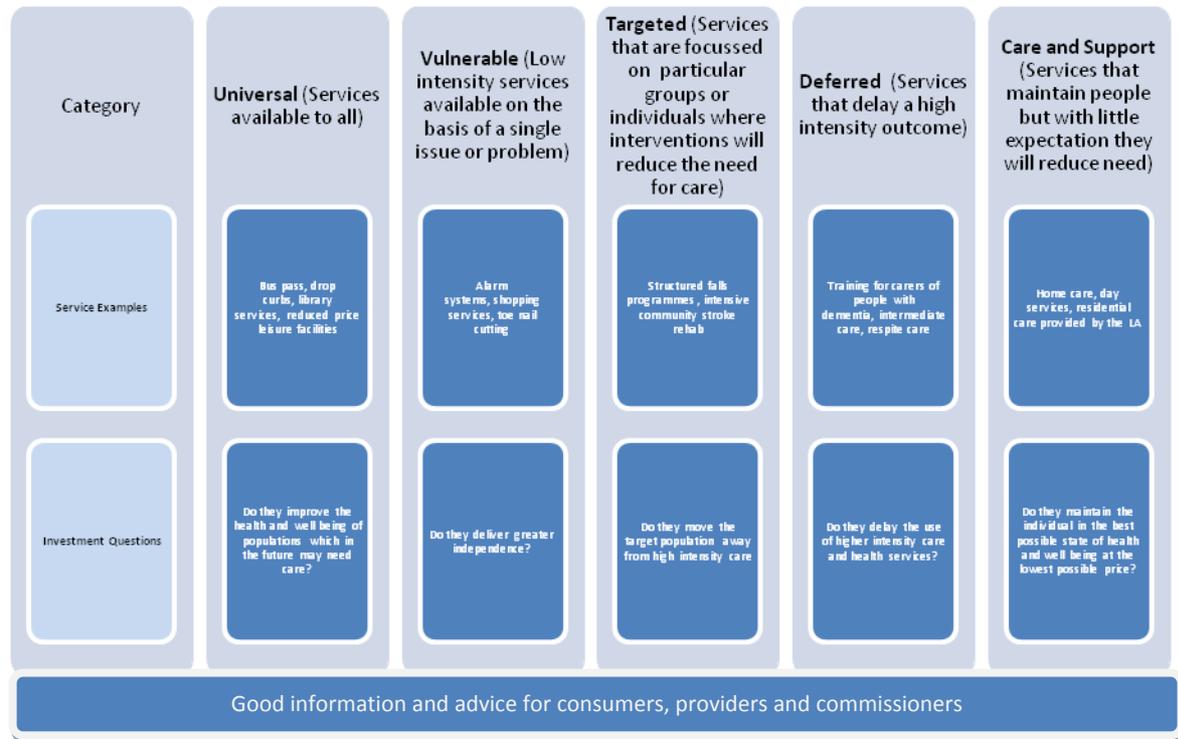
Risk

Finally, risk brings together all of the above factors into a decision making process based around the likelihood of benefits occurring. As part of the risk assessment this needs to take into account:

- When would results begin to show?
- What is the optimum point and timing of any of the proposed interventions?
- What reliance is there on other variables that could help or hinder delivery?
- If it does reduce expenditure will that show in the areas where there is a need to spend money in order to save?

As Figure Four illustrates there are a range of investment questions that might be asked about different types of service provision.

Figure 4 The five service areas of investment decision making



5 Invest to Save?

5.1 Can savings be secured from prevention?

When considering what impact prevention may have, and the resources which need to be put in, it needs to be recognised that:

- Funding low level services may not mean the same thing as investing in prevention – prevention services are those that meet the needs of those who would otherwise come to require more intensive intervention, rather than general support for the population as a whole.
- Some low level services may actually accelerate an older person on a road towards social care, because they encourage people to stop doing things for themselves.
- Community based provision may not always be cheaper than residential / institutional care. Total costs can depend on individual longevity, cost contribution by residents, the level of cross-subsidy from self-funders, ability to distribute funding across organisations, domiciliary care charging etc.

The evidence from a range of literature suggests that prevention is most likely to succeed when it is targeted on specific problems or populations with structured and measurable interventions. In essence there are three tests to be applied across the range of provision in assessing the contribution such targeted interventions might make to people's health and well being:

- How well can we identify populations who are most likely to benefit from any proposed intervention? Obviously the capacity to predict who will need high intensity, high cost care improves the greater the level of need an individual already possesses. Universal provision may reach a large number of older people but amongst that population it is hard to predict who will go on to need high intensity interventions. At the other end of the scale there may be people who have already had a number of hospital or care admissions, where the goal may be not to avoid high intensity health and social care but to delay its take up.
- Is there an evidence base which identifies interventions that will work for the population identified and achieve the desired outcomes and is it possible to monitor the impact that they might have?
- Finally, is the intervention acceptable to the recipient and likely to be followed? For example, community pendant alarms may be a low cost intervention but their success will be limited if their design is unacceptable to service users who may simply choose not to wear them.

Currently the evidence base on prevention is mixed. Some studies³ suggest that there is little evidence that investing in general support for the well-being of older people will prevent them needing care and support. However, studies on re-ablement published by the Department of Health suggest that investing in supporting older people through recuperation

³ The evaluation of the Partnership for Older People's Projects by the PSSRU for the Department of Health - Improving Care and Saving Money – learning the lessons on prevention and early intervention for older people – DH 2010

An evaluation of the impact of community-based interventions on hospital use: a case study of eight Partnership for Older People Projects (POPP), Steventon. A, Bardsley. M, et al, The Nuffield Trust, March 2011

and building their confidence after a medical intervention can reduce demand for personal care.

The Institute of Public Care has carried out two projects looking at the relationship between health and care services and the impact on high intensity care services. The first of these identified dementia; incontinence; falls; strokes; foot care and dental care as particular factors that influence the need for care in older people⁴. The second project, carried out in Oxfordshire⁵, highlighted that in addition to specific conditions, particular groups of older people, i.e. those aged 85 and over, who live alone and are socially isolated (and are likely to be female) are the highest users of the personal care system. This suggests that investment in targeting this group with telecare and social activities may pay dividends. Appendix 1 contains some examples of approaches at the health and social care interface.

Birmingham City Council has taken a positive view about the potential for preventive services and so they continue to invest in them. With support from Birmingham University they are evaluating the impact of their investment, in order to assist them with future decisions. Like Birmingham, other commissioners of preventative interventions across health, social care and housing have to make what are ultimately subjective judgements, but need to do so professionally based on the best available information.

Therefore, in terms of developing an investment based approach to prevention councils should at least be able to:

- ***Identify the total spend on prevention from the range of different sources.***
- ***Identify the key decision points on the care pathway when an enhanced preventative approach may be beneficial. Examine what interventions are delivered when and by whom and what evidence is there that these could be improved.***
- ***Review the impact of hospital care on older people and the consequences for care services. Close monitoring of individuals that move straight from hospital care to residential care should be undertaken and why this was necessary, identified.***
- ***What is the throughput of self funders from residential care into state funding? Are their earlier measures that could have been taken that might either have reduced capital depletion or have avoided people going into residential care in the first place?***
- ***Establish a funding framework which helps to maximise community intervention on achieving greater independence.***

5.2 Can savings be secured from domiciliary care re-ablement?

In a study published in 2010 by PSSRU at The University of York, re-ablement was associated with a significant decrease in subsequent social care service use amongst the population in receipt of services. The costs of the social care services used by people in the reablement group during the 12 months of the study were 60 per cent less than the costs of the social care services used by people using conventional home care services. However, this reduction in social care costs was almost entirely offset by the initial cost of the re-ablement intervention.⁶ This suggests that in target populations who receive re-ablement there is a reduction in the use of subsequent home care. However, this does not necessarily

⁴ Configuring Future Services, CSED 2008

⁵ 'Oxfordshire County Council's research into preventing care home admissions and subsequent service redesign' Taylor, Cairncross and Liveadas., Research, Policy and Planning, 28(2), 2010, pp.91-102

⁶ Home Care Re-ablement Services: Investigating the longer-term impacts (prospective longitudinal study) Glendinning, Jones, Baxter, Rabiee, Curtis, Wilde, Arksey & Forder, University of York 2010

mean that reablement translates into an overall reduction in spending on home care by local authorities with reablement schemes. Neither is there evidence of how long this benefit lasts.⁷

In 2007 The Care Services Efficiency Delivery Team at the Department of Health suggested a number of characteristics of a successful re-ablement services:

- A well trained workforce who are clear on the outcomes that are expected
- A set of measurements which helps demonstrate which people are benefitting from the approach and is able to indicate if any staff need further support and training in the work (it is easy when under pressure for some staff to return to old ways).
- A clear set of business plans which monitor both the financial flows (in relation to any savings made against the investment) alongside a performance framework that monitor the delivery of these plans.
- Leadership within the organisation which is making sure that the service is delivering what might be expected.
- A clear link between the therapists working within the service and the staff delivering the day to day re-ablement.
- Clarity about where the re-ablement programme sits within the care pathway.
- The opportunity for follow up and sustained action by customers after the service has ended e.g. opportunity to participate in exercise classes or to take regular exercise.
- A focus on the emotional as well as the practical and physical needs of older people.

What can be drawn from these studies is that the existence of a re-ablement service does not guarantee savings, indeed there are some examples of poor services which are not well focussed on the outcomes that are being sought. It is important that Councils monitor and manage these services as they would any other area where an investment in a particular approach is expected to deliver a saving. Councils need to have a wider view of reablement than as a short term time limited approach. Some individuals may have needs and conditions that will not respond as quickly as others to a reablement approach but may deliver higher financial gain. Equally some people may not need a standardised period of reablement and will not need services sooner than others.

Reablement services have the potential to secure better outcomes and save money – but only where they are properly targeted and carefully managed and delivered. ***Therefore, in terms of developing an investment based approach to re-ablement councils should be able to:***

- ***Identify the variable impact of re-ablement on individuals receiving the service and from that identify what works best for whom. This would include understanding variations in time spent on reablement by outcome.***
- ***Keep under review, if this is the case, whether re-ablement should remain an in house service or be externalised as most home care has been.***
- ***Commission a more flexible service that is able to tackle health and housing issues as well as social care and hence provide not only better results but diversify the cost base.***
- ***Establish a clear relationship between spend on re-ablement and overall home care spend and if the former is not leading to a diminution in the latter, identify why not.***

⁷ Care Services Efficiency Delivery Programme Homecare Re-ablement Workstream, Retrospective Longitudinal Study, CSED, November 2007

5.3 Can savings be secured in residential care expenditure?

Residential care across all service user groups is the highest area of spend by councils. Therefore, monitoring and forecasting the impact that residential care is having on the care economy is clearly important. It is also a sector currently in turmoil as some of the largest providers of residential care battle against financial problems. However, there are wider concerns expressed by both local authorities and providers about how the current round of savings might impact on the sector. For example councils have commented on the following:

- The costs of residential care in some sectors, particularly learning disability, have increased disproportionately to inflation.
- In some authorities there is evidence that more self funders are running out of money sooner⁸.
- That extra care housing may not be an effective alternative to residential care.
- That residential care for older people is in practice now being equated with dementia care.
- That the balance between health funding and social care funding is not correct given the growing health needs of those in residential care.

Providers say:

- Exercises to drive down price lead to poorer quality services because they are too crude. No attempt is made to equate price with quality or content of service delivered.
- It would be better if authorities came to them and discussed their funding problems and asked what the sector could deliver rather than imposing arbitrary cuts.
- Framework agreements are as cumbersome as past tendering processes but with no deliverable at the end and also that complex contracting processes exclude smaller providers and frontload costs for providers.
- That in terms of the price paid by local authorities for older peoples residential care it is not sufficient to fund life style

Given the significance of residential care in terms of the proportion of the direct services budget it consumes then in terms of the four types of saving it is important to test what is the future potential in both the long and short term to deliver further savings.

Reducing what is provided In recent years state funded placements in residential care have diminished, as has those for people with a learning disability,⁹ and although there looks to have been some increase in self-funders in care homes with nursing the market has not expanded as anticipated. Equally the market has not consolidated as some predicted because although the four largest providers in older peoples services supply over 20% of the beds, there is still a plethora of smaller providers. However, the trend particularly in terms of residential care for older people is for new build provision to be in substantially larger homes than previously existed in order to gain economies of scale. For those local authorities who

⁸ However, The Local Government Information Unit in their report (Independent Ageing: Council Support For Care Self-Funders, Carr-West. J & Thraves. L, Local Government Information Unit, March 201) indicated that over 60% of local authorities did not know how many self funders fell back on state funding each year. West Sussex have recently started a project looking at how they might mitigate the impact of capital depletion amongst self funders through improved financial advice and planning. Nottinghamshire have tried a similar approach with an insurance based product. The Think Local, Act Personal website has material which offers specific advice to self funders about paying for care and obtaining advice, see; <http://www.thinklocalactpersonal.org.uk/Browse/Self-funders/?parent=8609&child=8385>

⁹ Based on the PSSEX returns the purchasing of residential care placements for older people by local authorities has reduced by about 2% per annum for the last 10 years. This shortfall has not been fully met by the small increase in purchasing of care by self-funders

still have their own residential care units there continues to be a trend of outsourcing. Interestingly despite the much reported financial problems of some providers, estate agents state that there is still considerable interest in purchasing care businesses.

Gaining efficiencies In a world where the primary focus is on the delivery of outputs, be that a place, a bed or a unit, of home care, the debate quickly descends to being able to purchase the same level of output at a cheaper price. Some of the recent work of consultants with local authorities has focussed on driving down the price of an existing contract. Apart from running counter to personalisation this will tend to favour large providers who;

- Can reduce their price through reducing their overheads,
- Collectively and in a controlled way reduce quality,
- Have better resource to manage payment in arrears than small local organisations.

The danger is of a vicious cycle. Driving down price leads to poorer quality provision, leads to increased demand (although potentially elsewhere within the system) leads to more people to divide the funding amongst, which in turn leads to the need to drive down price.

However, other ways of delivering efficiencies have been demonstrated by local authorities, eg, using housing innovation to move people with a learning difficulty out of high cost distant residential care placements back to being located in ordinary housing with support in their 'home' local authority, although this may not always save money for the overall public purse.

Change the funding basis There are potentially four factors of importance to the future funding basis of residential care. First, the funding base is inevitably shifting from local authority funding to self funders as inflation combined with the impact of housing equity and occupational pensions steadily erodes the threshold at which people fund their own care. Secondly, the Dilnot review¹⁰ if followed by legislation is inevitably going to change the financial basis on which all care is funded but is still likely to have its profoundest impact on the residential care sector. Thirdly, the Law Commissions report¹¹ has suggested that residential care becomes incorporated into the personal budgets / direct payments approach. Given that there is some evidence¹² that most older people feel they do not make the choice about whether to enter residential care there is the potential for this to be inflationary, if more older people feel pressurised when ill to accept residential care as an outcome. Finally, if the process of transfer of older people out of hospital to the community slows then hospitals may use spare capacity in the residential care sector to provide a cheaper alternative to hospital wards. However, the danger then is that what starts as a temporary placement becomes permanent and the residential care population starts to grow.

Reducing demand Many would argue that this has already been successful given that the state funded population in residential care has not expanded in line with the growth in the wider older people's population. Clearly, Councils have had an impact through the greater use of community based care and through the development of extra care housing although a direct cause and effect relationship has yet to be established. Whether this trend continues is likely to depend on Councils ability to stimulate the private sector growth of specialist housing given the diminution in government housing grants, whether reablement and

¹⁰ Fairer Care Funding: The Report of the Commission on Funding of Care and Support, Department of Health, July 2011

¹¹ Adult Social Care, The Law Commission (No 326), The Stationary Office, May 2011.

¹² What makes older people choose residential care, and are there alternatives?
Pippa Stilwell and Andrew Ker slake, Housing with Care 2004.

prevention can lessen demand for social care and whether in the long term public opinion demands the development of a wider range of alternatives to residential care.

In the more immediate term many authorities are implementing a policy that no older person should move straight from hospital to residential care. The intention is to avoid older people making decisions (or other people making decisions about them) when they are both ill or in recovery and where the potential to make a full recovery may not have been identified.

Therefore, in terms of developing an investment based approach to residential care councils should be able to identify:

- ***What they consider the future demand for residential care will look like for both state and self funded users based on who they think residential care is for and local plans for alternative forms of accommodation¹³.***
- ***As suggested in the prevention section, the impact of self funders on the residential care market and any change in those who move from self funded status to being funded by the local authority.***
- ***Changes in their local market in terms of the financial viability of providers and where help may or may not be needed from the local authority.***
- ***Develop a combined commissioning approach to older people's accommodation across health, housing and social care and in particular a payment framework for purchasing residential care that avoids different elements of public care paying a different price for the same accommodation.***
- ***Whether residential care is increasingly being identified as dementia care and if so what alternatives may need to be developed in the community?***

5.4 Can savings be secured through working with the voluntary sector, social enterprises and mutuals

Much has been made on the need to work in partnership with the voluntary sector. This may be a good way of getting value for money although this is not guaranteed given that the sector covers a wide range of different organisations, funding mechanisms and structures. These may vary from those that are voluntary only in their governance but have full time paid staff and work almost exclusively to state funded contracts to those that are wholly voluntary in income and labour. Mutuals vary in size and type from small local co-operatives through to BUPA as a multinational health and care provider.

No single structure is automatically good or bad. Even those organisations that are voluntary only in their governance arrangements may still be open to innovation, have lower labour costs due to different working terms and conditions from local authorities and offer greater flexibility about their approaches to service delivery. They may also enjoy a higher level of public acceptance.

In recent years most local authorities have begun to change their relationship with the voluntary sector, moving from grants to contracts where there is a defined connection between the fee paid for the service received. Increasingly, this is an arrangement where it might be expected that contracts have a stronger focus on outcomes

New forms of organisation such as Social Enterprises (not for profit organisations who use any surplus made to feed back into a community based project) and Workers Co-operatives are being encouraged by Government. Their value will depend on well motivated workers and

¹³ Buckinghamshire, Hampshire, Oxfordshire and Essex County Councils have all engaged in recent projects in estimating trends and patterns amongst self funders of residential care.

creative energies to keep and sustain new organisations when resources are scarce to fund new enterprises. Some councils are concerned that European procurement rules prohibit them from nurturing such new schemes although this is not usually the case¹⁴.

However, social enterprises that are local authority 'spin outs' are likely to offer something of a mixed benefit. To be successful they may need to initially rely on a local authority block contract (which runs somewhat contrary to personalisation) and be relatively high cost if staff are transferred from the LA to the social enterprise under TUPE arrangements. Yet if they are successful they may then be reluctant to work for local authorities if they can attract higher levels of funding from self funders in an open market.

Clearly what underpins much of the investment debate about the sector is how far, and in what way, should not for profit organisations receive differential treatment from other providers. **Therefore, in terms of developing an investment based approach to the voluntary sector councils should be able to identify:**

- **What roles would the LA expect the sector to perform and is that role defined in terms of the social care Market Position Statement? In particular, can what constitutes best practice / outcomes that the sector might develop / deliver be defined? Incentivising the voluntary sector through payment by results to target those who consume high social care costs could be a key element in long term cost saving**
- **In funding arrangements across the sector there is a need to ensure that the service to be provided does not create a longer term dependency on care and support? Councils may want to work across the local authority and with the health sector to pool funding or to at least establish a common funding framework.**
- **Whether they will adopt a different approach to small local voluntary organisations in ensuring that they are not excluded from bidding for contracts and /or that they are facilitated to advertise their services in a personalised market. In doing so there will be a need to identify how this fits with Council competition rules?**
- **What is value added benefits is it expected that the sector might bring to cost saving discussions? This could be expressed in terms of additional fund raising or in use of volunteers. This might be encouraged through matched funding arrangements.**
- **What strategic role is it expected that social enterprises might play? Will this be in terms of spin outs from the LA.? What incentives might be offered in terms of grants, contracts or guarantees? What financial gain might be anticipated through outsourcing to social enterprises?**

5.5 Can savings be secured through new forms of investment?

Telecare. Government intervention in recent years has strongly encouraged the development of telecare through the Preventative Technology Grant. Whilst there are a number of papers which purport to show the financial benefits of investing in telecare¹⁵ the detailed evidence is hard to find although Councils are likely to gain further evidence when the delayed whole system demonstrator sites report.

There are potentially three areas of saving where the case for investment in telecare should be explored:

¹⁴ See Social Care Procurement A briefing note on procurement, state aid and consultation matters relevant to the provision of social care services, Think Local, Act Personal, http://www.thinklocalactpersonal.org.uk/_library/Resources/Personalisation/Personalisation_advice/2011/23.6.11_SOCIAL_PROCUREMENT_DOC.pdf

¹⁵ See Appendix 1

- **Replacement** – The existence of a range of telecare supports means there is no need for the physical presence of care and support staff, e.g. a telecare device could remind people to take their medication.
- **Reaction** – The existence of a telecare device means that somebody gets a service quicker and hence lessens the need for high cost interventions, e.g. emergency services are alerted quicker if somebody falls over following a stroke.
- **Reduction** – A cheaper service can be offered because telecare equipment can ensure someone's safety, e.g. discharge from hospital takes place sooner because technological devices can safely support their return home.

Social Impact Bonds (SIBs) are a mechanism by which outcome based preventative services might be developed without risk to government, either local or national. "Social Impact Bonds raise funds from non-government investors to pay for the provision of services. If the services make a difference and social outcomes improve, investors receive success payments from the public purse. Those interested in payment by results and outcomes-based commissioning should note that Social Impact Bonds overcome two of the main constraints of traditional outcomes-based contracts:

- By contracting with investors rather than service providers, Social Impact Bonds facilitate the use of a number of service providers to deliver better social outcomes rather than assuming that a single organisation can succeed across the board; and
- By using investment to fund the delivery of services up front, Social Impact Bonds enable social sector organisations to participate in outcomes-based contracts that would otherwise require them to fund their activities before outcomes payments are made".¹⁶

Supported Housing: At one stage obtaining money for a capital investment was a way of saving revenue monies for adult social care. As the social care system has moved away from institutional based delivery to community based alternatives, building and capital resources have become less significant except in respect of supported housing. Investment in Extra Care Housing Schemes for Older People using capital in the form of DH or Housing Based Grants has been one way in which social care revenue budgets have been reduced. In similar way some small housing schemes for adults with learning disabilities or with physical disabilities have created cost effective models of care that mean fewer costs fall to the Council (although not necessarily to the public purse) than alternative provision, e.g. residential care.

Usually these schemes produce savings not only from the capital investment but also from the way in which housing related costs can be kept separate in these schemes (and not funded by the council) compared with residential care where the council has to meet the capital and revenue costs. However, the availability of grants to fund these schemes has diminished and in the case of the DH Extra Care Housing fund, discontinued.

Some Councils are pushing ahead with new schemes either through the use of Section 106 (Planning Gains) agreements to help raise capital or through asking older people to purchase all or part of their property, which helps to limit the capital repayments that any housing provider will have to make. Private Finance Initiatives (PFI) have been used in a small number of social care schemes. The most recent PFI bids for social care services have often been combined with health resources or other community resources to create a new flexible centre whose use may not be limited by current fashions and trends. The jury is still out as to whether PFI can really offer value for money.

¹⁶ Towards a new social economy, Blended value creation through social impact bonds. Social Finance 2010.

With particular regard to sheltered housing three tests can be applied where authorities are considering redevelopment for extra care:

- Would this housing be appropriate, accessible and cost effective as extra care with either no or relatively minor adaptations?
- Is this housing is on a good site for older people but the premises are not appropriate and would need a rebuild?
- Is this building and site not suitable for extra care housing but it does have a reasonable sale value or could be used for other purposes?

In making any of the above decisions not only do costs need to be taken into account but, in any redevelopment, what should the future tenure basis be. Ideally, in any authority the range of housing choice should broadly match the tenure held by older people (over 75% of 65-74 year olds are owner occupiers). Good quality housing into which care and health services can be easily delivered potentially offers long term cost savings and is seen as beneficial by older people if they can continue to retain the bulk of their housing asset.

Therefore, in terms of taking an investment based approach to new ideas and projects Councils need to:

Be wary of either endless pilots or ideas which tend not to get mainstreamed. In the case of using assistive technology most authorities would probably argue that it has not yet been used to its fullest potential. There is a need to put the resource more into the hands of mainstream providers who can integrate its use with other forms of care and maximise its benefits.

Explore, in the longer term and with particular regard to older people, how they can use their land and assets, sheltered housing (if it has not been subject to stock transfer) the planning process and their knowledge of the sector to incentivise private sector housing providers and RSLs (sometimes working in partnership) to develop a wider range of supported housing options.

6 Reallocating the budget

So far this paper has looked at the framework by which we might group current levels of expenditure, traditional approaches to saving and the basis for adopting more of an investment approach in the future. The critical test is what impact might such changes have on a typical budget and how will this then play out in terms of the £100 million budget?

6.1 Adjustments within the framework

In the initial framework four categories were suggested under which expenditure could be allocated. As Figure 5 shows although some of the content may change they basically remain true for the future. The big discussion is about the balance of expenditure between these categories.

Figure 5 Expenditure Categories

Direct services	Access	Support costs	Prevention
<ul style="list-style-type: none">•Direct Payments•Council procured services•Council provided services	<ul style="list-style-type: none">•Assessment•Care Management•Brokerage•Information provision	<ul style="list-style-type: none">•Central charges•Management, and administration•Strategy and research	<ul style="list-style-type: none">•Preventative provision (jointly or single funding)•Directly provided preventative services

Direct Services

This is, and obviously will remain, the biggest area of social care expenditure, although it is an area where councils' direct control over how money is spent will diminish with the growth of direct payments. However, the impact the Council will still have in terms of its facilitation of the social care market, through framework agreements, directly managed services and those areas where the council is still a service provider should not be underestimated. The key question will be in planning ahead what proportion of funding should be devoted to direct services as compared to the other areas of spend as the issues below describe.

- In the councils interviewed it was accepted that there was still scope to reduce spend on residential care for older people and people with a learning disability. Equally, the amount of saving this produces will diminish the higher the level of need that is catered for in the community. For some people residential care might also be their accommodation of choice although the research tends to indicate this is only true for a smaller number than currently accommodated.
- There is some concern about the use of the current spare capacity in residential care and whether this will drive up demand in the future if local authorities have less control over the system. However, if authorities continue to try and force down the price of residential care what will be the impact on quality and the availability of continued provision and is this being monitored?
- What should be the basis for future contracting for services by the local authority in an era of personalised care? Some would argue the market should be left to find its own level. Others continue to see a role for the Council where future demand is unlikely to diminish, to continue to provide for block purchasing in order to achieve more cost effective prices and secure capacity and quality.

- Is there a justification for the Council still providing services or should all provision including reablement be outsourced?
- Are provider costs increasing through a greater need to advertise their services / administer more contractual arrangements?

Access

In very crude terms it might be expected that the costs of care management and assessment would diminish with the growth of direct payments, including some shift of current assessment and care management costs to brokerage. Given the government's expectations about much better information being available to the wider public then these costs may increase:

- How will commissioning information-giving and the creation of adequate advisory services be achieved to benefit the whole community, ie, self-funders and direct payment recipients, as well as those receiving council-managed and purchased services?
- Will the costs of accessing services increase or diminish with the growth of direct payments?
- What kind of budget should Councils put aside to stimulate families and neighbourhoods to provide care and support instead of people relying on state funded provision, and is it even possible to change these expectations?

Support costs

As authorities become less of a direct player in the social care market the need to strategically influence direction and ensure the availability of a range of services, whether for those who self fund or for those funded through direct payments, becomes more crucial. Therefore, whilst some support costs will diminish, others may well increase given a greater need to monitor and understand trends within the market. Examples of the need for monitoring would include:

- Authorities with a high number of self funders need to understand what is happening to that part of the care market in terms of trends in people moving from being self funders to state funded and also in helping self funders manage their finances and divert from residential care.
- The impact that direct payments are having on the social care market and the types of goods and services being purchased.
- Improving and strengthening the capacity of Councils to facilitate and stimulate the local market to ensure provision is available for all care purchasers.
- Testing whether financial recording arrangements are robust enough to monitor the impact of personal budgets and whether more or less expenditure is being incurred through service users making spot purchases as compared to previous Council contracting arrangements.

The level of required savings also clearly cannot be achieved just through reducing back office functions – though Councils need to look at their corporate costs as part of savings in adult social care. It is noticeable that there are some big variations between the way in which these are reported across different Councils which makes it hard to benchmark these from one authority to another.

Prevention

The test for all authorities is how much should be risked by investing in prevention when achieving attributable and/or short term outcomes, remains uncertain. The investment model

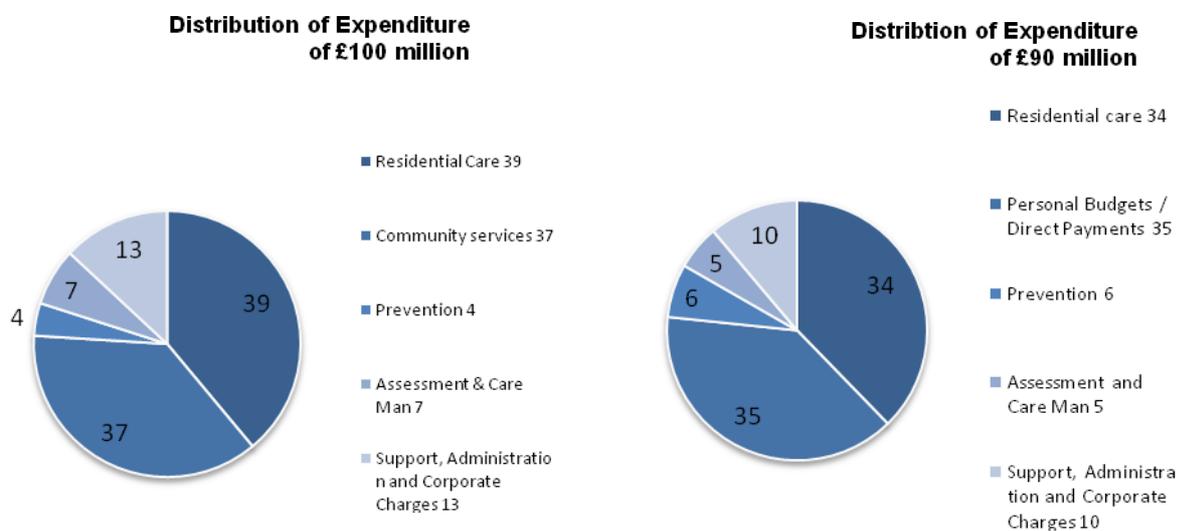
and greater discrimination between prevention, early intervention and low level provision should help this discussion. This is also the area where it helps to have much greater clarity about the current total spend. The suggestion in this paper is that if current expenditure is pooled between the local authority and health services and the contribution the voluntary sector makes is added in, then this is potentially a significant sum. The test is whether that budget can then be targeted onto reducing future demand in a structured and monitorable way.

- Will health 'play ball' in working with social care to reduce those factors that are significant drivers of high level health and care need amongst older people?
- Is it possible to construct a wider investment agenda for prevention in terms of learning disability, physical disability and mental health as well as older people?
- How can a different type of contractual relationship be built with the voluntary sector which encourages it to play a greater part in reducing long term demand?
- Is prevention an area where Councils should be exploring the use of social investment bonds?

6.2 The £100 million

In terms of the fictitious Council with the £100 million budget reduced to £90 million over two years, Figure Six below and the following narrative suggests how the budget might be reduced:

Figure 6 Now and future distribution of a social care budget



Driving the changes

- Lower back-office and support costs
- A greater investment in targeted effective prevention which will reduce demand for more intensive services, improved support to high intensity carers combined with a focussed approach to re-ablement
- Tighter implementation of eligibility criteria.
- Some reduction in care management costs through more people taking Direct Payments. Brokerage costs should not be as high as care management costs. Assessment process in many instances simplified and shared with other functions such as health and supporting people.

- A significant reduction in the use of direct residential care provision due to a combination of alternative living options and more effective prevention combined with a small increase in the number of self funders with fewer people running out of funding and hence moving to state funded residential care.
- Stimulation of voluntary sector through outcome based contracts and matched funding initiatives, which encourages greater targeting of resources.
- Community services secured entirely through personal budgets and direct payments.
- Increased use of shared posts between health and social care where services are directly provided or encouraged through market facilitation.
- Continued savings in staff costs through outsourcing services where possible.

Although as suggested above it is clearly possible to outline a re-defined budget it still relies on a number of potential inflationary pressures being avoided. For example:

- A rise in the costs of residential care possibly through the market collapse of a large provider.
- A need to increase safeguarding arrangements for adults and older people.
- Self funders consuming their capital more quickly than previously estimated.
- National inflation continuing to rise.

Finally, the table below brings together a number of the savings suggestions made throughout this paper and looks at the timescales within which such measures may begin to have an impact.

Example activities and time frame in which savings may begin to occur using the current date as a baseline		
1 year	2 year	3 year
Review cost and benefit of in-house reablement service as against an externalised service.	Decommission any remaining in house residential care, home care or day care provision unless it can be shown the service can be provided cheaper than an external provider to the same standard.	New build extra care housing to come on stream
Increase charges	Where cost savings can be demonstrated ensure externalised social enterprise services start up	Identify and put in place invest to save telecare programme.
Identify and implement potential management savings through combining posts, possibly across children's and adult services or health and social care.	Further reduce out of authority learning disability placements through new supported living scheme coming on stream.	Identify and implement a targeted programme of 10% cost reduction in service provision at the point of transition from children's to adult services for those with a learning disability.
Ensure skill mix is right for mobility tasks, eg, using physiotherapists to oversee programme carried out by personal trainers.	Encourage focus across the Council on reducing costs of centrally supplied services. Encourage greater competition with external suppliers for central functions.	Put in place insurance models for self funders of residential care (if not overtaken by Dilnot and Social Care legislation) and models of improved financial planning for older

Example activities and time frame in which savings may begin to occur using the current date as a baseline

1 year	2 year	3 year
Streamline into a single assessment process across supporting people, social care and health services	Establish with providers more flexible home care working which means fewer wasted visits.	people. Develop with health a combined commissioned health and home care services to focus on prevention
Improve management of sickness absence	Incentivise re-use of aids through user returns	
Make greater use of direct debits to collect fees and charges	Establish with health service a targeted falls programme on those at high risk of care that have had a health service intervention.	
Implement a 'no move from hospital to care home' programme for older people using intermediate care and reablement services.	Develop with voluntary sector a training and support programme for carers of people with dementia	
Develop a staff involvement programme and incentive scheme to identify low level cost savings.	Develop and test a payments by results model to funding home care	
Review low level voluntary sector services and of those that contribute least to independence reduce funding.	Reduce office rental through greater home working	
Improve case review process to rapidly discontinue services when not needed (to have user confidence has to run alongside clearer guarantees that services can also be restored if needed).		
Renegotiate existing contracts without incurring penalties.		

Appendix 1: Examples of preventative investment

Health and Social Care Interface

There is a danger that interventions at the health and social care interface get ignored by both organisations and yet these are often the areas where the demand for more intensive care and health interventions in the future, begin. Of particular importance are activities around falls, strokes, dementia, and continence. Local authorities would do well to read the latest version of reports by the Royal College of Physicians (listed in Appendix 5) and others that focus on these areas¹⁷.

The following list is by no means exhaustive but offers examples of investigations and interventions that may prove valuable:

- Develop falls programmes which identify and work as a priority with those who have had more than one fall requiring a hospital intervention. Make sure the programmes are multifactorial and have a long enough life to deliver proven benefits.
- Examine the relationship between stroke in older people and the demand for care services. Identify which people would have been motivated to make a fuller recovery and the volume of additional rehabilitative effort that could have been used to make a restoration to a level where no care services would have been needed.
- Check if routine questions are asked in health and social care assessments about continence of all older people who have had a fall.
- Use the FRAX¹⁸ tool to measure likelihood of osteoporosis. Easy to complete, risk of fracture is high for people with osteoporosis and there are easy treatments available.
- Identify older women who have had multiple births because the risk of continence problems is considerably greater than for other groups.
- Identify which carers are very elderly and are caring for more than 30 hours a week. Use an analysis of carer breakdown leading to a care home admission as to who should be offered a high level of support to continue caring.
- Develop training programmes to train and support carers of people with dementia (has been shown from a number of international programmes to have a significant impact on improving carers capacity to care better and for longer)
- Develop interventions which ensure that the number of older people leaving hospital malnourished is less than the numbers entering (nationally the numbers of older people entering hospital malnourished is estimated at 148,946, the numbers leaving malnourished is estimated at 157,175¹⁹)

Examples of positive use of telecare

¹⁷ See also the work by Glasby and colleagues at the University of Birmingham as referenced in the sources at the end of this document.

¹⁸ For further information see <http://www.shef.ac.uk/FRAX/>

¹⁹ "Still Hungry to be Heard", Age UK, 2010

The following have recently been reported²⁰:

The Safe at Home project in Northamptonshire saved £1,504,773 over the study period, 'equivalent to £3,690 p.a. for each of the 223 people who received help.

The West Lothian project, started in 1999, has shown:

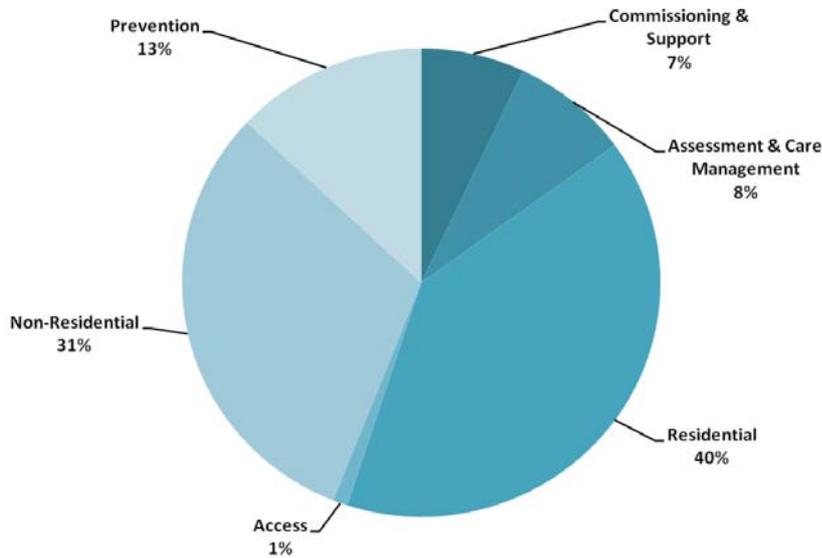
- Delayed discharges reduced to 2.14 per 1,000 compared to national average of 3.48
- Average stay in private care homes reduced from 36 to 18 months between 1999 and 2002
- In 2005, the average cost per person in the intervention group to the Council was £7,121, compared with a cost of £21,840 per person in long term care
- 3,400 hospital bed days were saved (full year equivalent)
- Better, more efficient services provided by multi-disciplinary team
- Service users and carers worries alleviated, contributing to better quality of life.

Analysis of 131 telecare users in North Yorkshire in September 2008 identified what the traditional care package would have been if telecare had not been available and this showed that telecare provided a saving per person of between £1,756 and £12,246, with an average annual saving of £3,600 per person.

²⁰ http://www.thinklocalactpersonal.org.uk/library/Resources/building_a_business_Case_for_Telecare.pdf

Appendix 2: Example Resource Distribution Framework

Gross Expenditure 2010/11



£2.7 million saved

- Review of Day Care
- Home Care Reablement
- Increased Income from Charging
- Review of Low Level Services
- Better inter-agency commissioning
- Reductions in Learning and Development
- Cessation of Council run Welfare Rights Service

Nottinghamshire have looked to categorise their spend without the Corporate Recharges and other related support costs in the following diagram, which represents the average pattern of spend for the local authority.

They have in place a plan designed to deliver £14 million in savings.

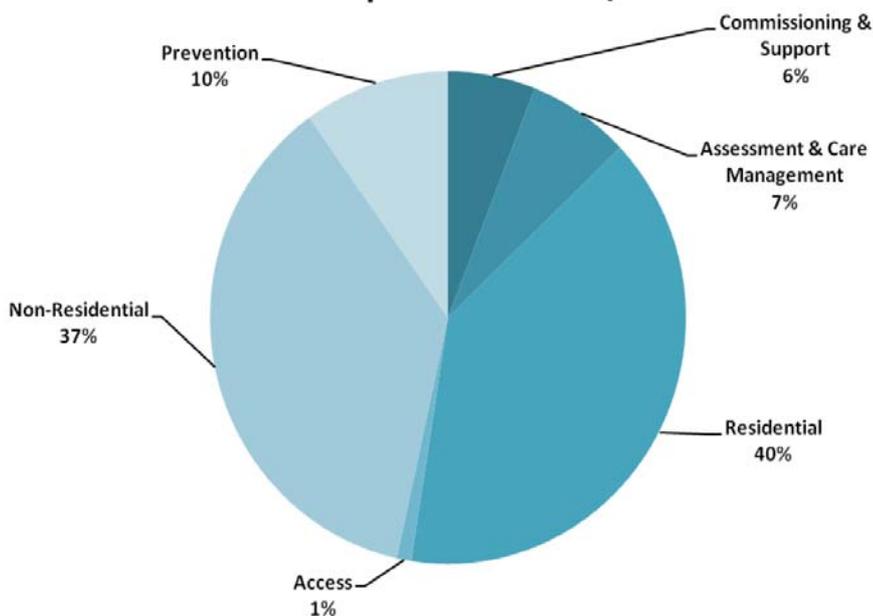
The significant lines in their savings plans includes:

Alternatives to residential care

£6 million saved

- £800,000 saved
- £1.14 million income
- £800,000 saved
- £190,000 saved
- £1.1 million saved
- £900,000 saved

Gross Expenditure 2014/15



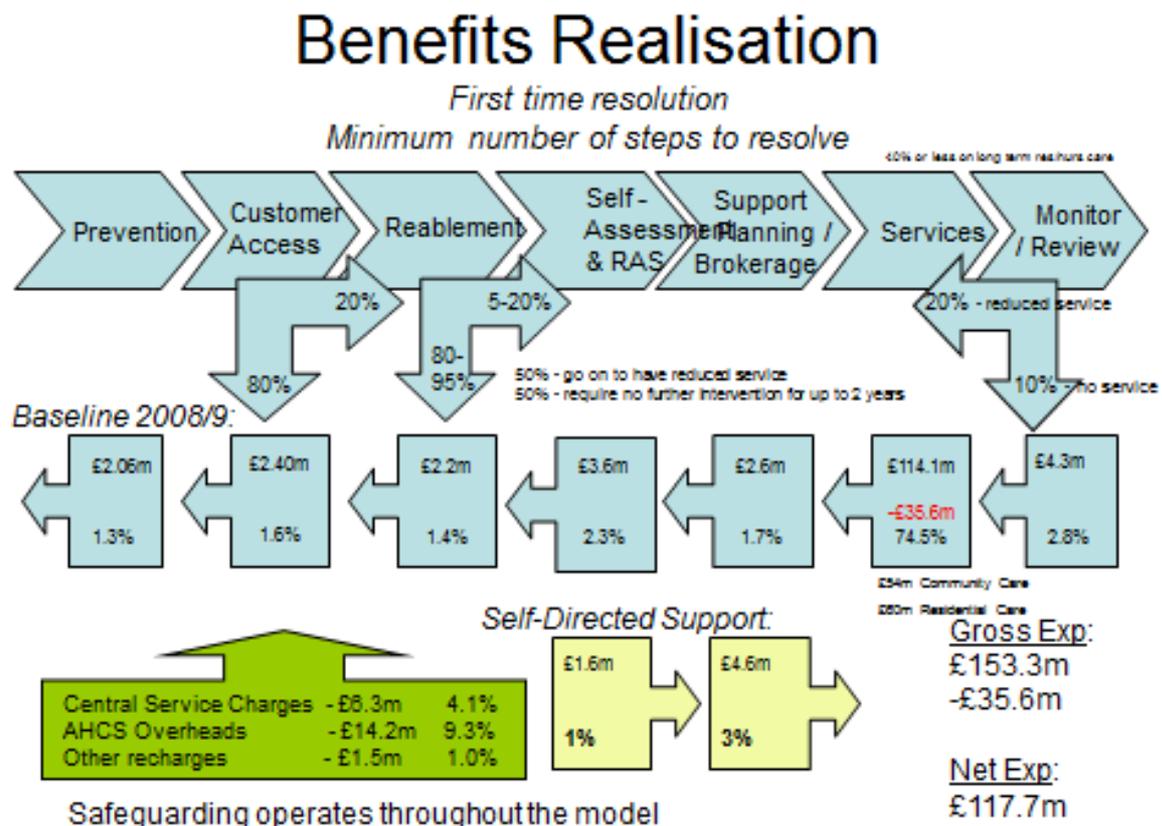
After looking at the impact of their savings plans on their overall budget and taking into account likely demographic change a further breakdown for 2014 has been produced.

Changes include lower commissioning, lower care management and a lower investment in the voluntary sector. The spend on residential care remains at about the 40% mark. Spend on helping people to live at home will rise significantly (funded by the lower costs identified).

Appendix 3: A Complementary Resource Distribution Model

A different approach to looking at the pattern of spend was taken by the Care Services Efficiency and Delivery Team working with managers in Warwickshire. They developed a “benefits realisation model” (Figure Four), which tracks the flow of money through the social care system. (The figures may not be accurate and are at 2008-09 costs).

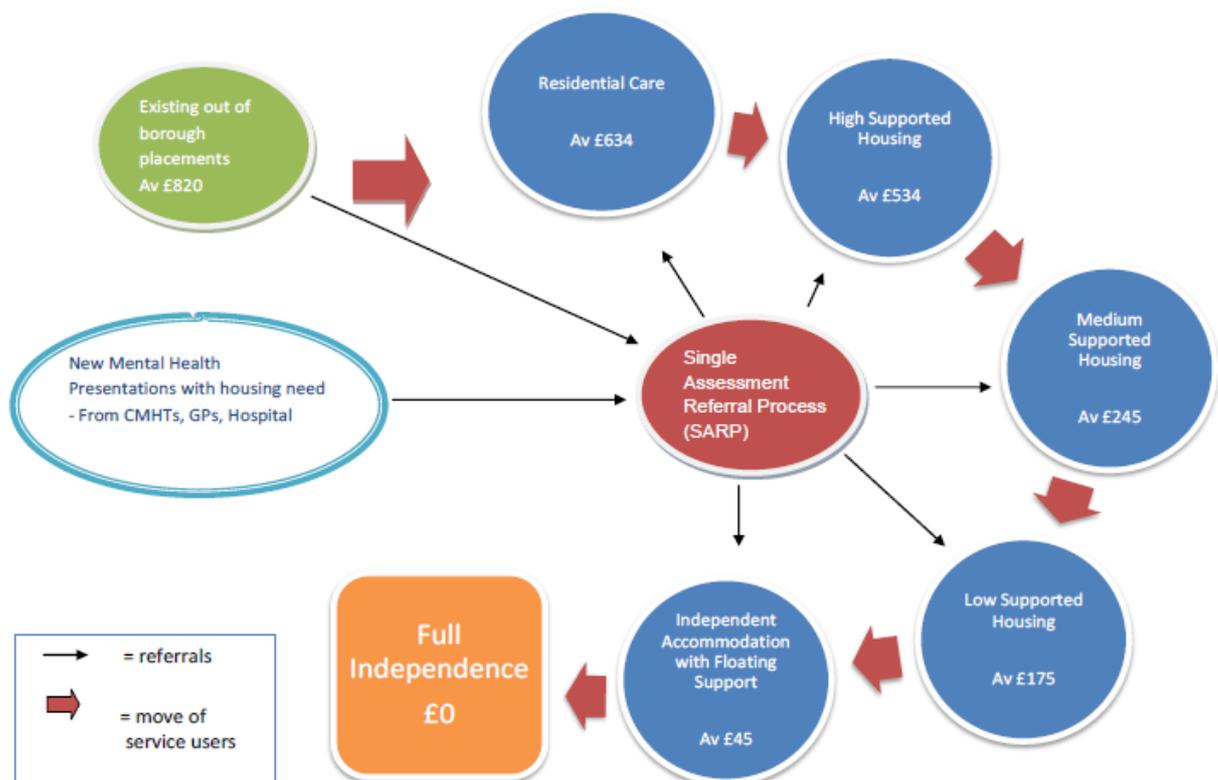
The diagram looks to capture where investments have been made and then looks at how they might make changes to the spend in order to meet both demographic pressures and tightening resources. The County has now developed a software package that helps them monitor these interventions on a regular basis so they can, for example, see if the investment in reablement is reducing the demand for domiciliary care in the way that the model suggests it should.



Appendix 4: A Flow Chart of the Financial Implications of Housing Options for People with a Mental Health Problem

This chart from Westminster City Council shows the range of different ways in which a council might be funding care and support for a mental health service user with eligible needs. It demonstrates how important it is to ensure that a person has the right level of investment to meet their needs. Short term high cost interventions might well help a person move to lower cost solutions.

The flow through the different supported housing options for people with mental health problems and the associated average weekly cost per person.



Appendix 5: Sources

In addition to the footnotes in the main document the following represents a list of source material that has been used in developing the paper. Authorities may find these helpful in terms of developing their own thinking

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