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Think Local Act Personal (TLAP) is a sector-wide commitment to moving forward with personalisation and community-based support, endorsed by organisations comprising representatives from across the social care sector including local government, health, private, independent and community organisations. For a full list of partners visit www.thinklocalactpersonal.org.uk

Towards Excellence in Councils’ Adult Social Care (TEASC) is a programme to help councils improve their performance in Adult Social Care. The sector-led initiative builds on the self-assessment and improvement work already carried out by councils. It is made up of the following organisations:
These are unprecedented times for Adult Social Care – difficult challenges exist alongside great ambitions to promote personalised services that support individuals and their families to live fulfilling and independent lives in their communities. The severe financial pressures facing Adult Social Care, now and in the future, combined with growing complexity of needs and rising expectations are testing commissioners and providers alike as we work to transform the sector into one fit for the 21st century. In such circumstances, it is more important than ever that commissioners, providers and citizens are open and honest with one another about what can be achieved and work together to find solutions.

Of course, we need to continue to press for social care to receive its fair share of resources. But at the same time, we need to make sure that we are maximising the efficiency and effectiveness of the resources that are available so that every pound spent, whether public or private, is spent to best effect. The Towards Excellence in Adult Social Care Board (TEASC) is committed to developing and supporting councils’ ability to achieve this. The Think Local Act Personal (TLAP) Partnership brings together citizens, providers, commissioners and others from across Adult Social Care to focus on sustaining and strengthening personalised and community-based care and support.

Together TLAP and TEASC have commissioned this report. We wanted to understand how resources have been used in Adult Social Care since 2009 and to share recent research, examples and data on how to make the most effective use of resources over the next few years. Undoubtedly, this will not be easy, so we also wanted to introduce some practical tools and guidance for councils and their partners to adapt and use for their local circumstances.

Our aim is to help the political and managerial leadership in councils as they tackle their responsibilities for delivering and developing Adult Social Care services. What is absolutely clear from the work we have done is that this huge task will not be achieved by our local leaders working in isolation. Rather, it is only by working together with people who use services, their carers, the local community, providers and others that viable and acceptable solutions will be found. This truly is a problem to be shared – in sharing we have a much better chance of finding an appropriate answer and so I hope that everyone involved will find this report and the supporting materials helpful.

I would like to thank David Walden and Rachel Ayling, the authors of the report, together with the members of the Project Reference Group and others who have contributed their time and input. We do not suggest a one-size fits all solution but hope that we can stimulate local debate and discussion so you can find your own.

Andrea Sutcliffe
Chair of the TEASC/TLAP Reference Group
Chief Executive, Social Care Institute for Excellence
(The full membership of the Reference Group is at Appendix A)
INTRODUCTION

It is four years since the Department of Health published its influential report on *Use of Resources in Adult Social Care*. Whilst much of its guidance remains valid and important, the financial climate in which Adult Social Care (ASC) is operating has changed very dramatically. In this context, TLAP and TEASC have commissioned work “to support ASC (and in particular elected members) to make the best use of available resources to promote personalisation in a difficult and challenging context”.

The purpose of this report

This report is one of a series designed to support sector-led improvement. It aims to:

- review the evidence about how budget reductions have been achieved so far, and draw out lessons that can be learned
- pull together messages from research and guidance produced since 2009
- reinforce the importance of benchmarking, sharing good practice and developing a stronger, more accessible evidence base
- suggest some next steps, including further tools and guidance that could help the sector manage future budget pressures.

It is accompanied by:

- a data report that analyses national expenditure and activity trends over the last five years
- a self-assessment toolkit for managers, based on the Association of Directors of Adult Social Services’ (ADASS’) whole system approach to making best use of resources.

Whilst suggesting approaches that will be useful from 2013 onwards, the report emphasises that priorities for action will vary from one place to the next. To reinforce this, it includes illustrations of how councils’ performance varies not just between but within regions. Local decision-making matters more than is often acknowledged.

Sector-led improvement

TLAP and TEASC believe that councils’ work to deliver budget reductions in the current economic and policy environment should be assisted through peer reviews, and supported at national level by a more concerted drive to collect and share evidence about cost-effective approaches and solutions. For this reason, we welcome the launch of the Local Government Association’s (LGAs) efficiency programme for Adult Social Care, that is gathering evidence from 44 initiatives across the country.
Over the next few months, we will seek further contributions from all parts of the sector – including not only councils but also private and voluntary sector partners, user-led organisations, and the academic community – and will look at ways of making this evidence more accessible. We are also asking councils to test the new self-assessment toolkit, and to feed back their suggestions about particular areas where stronger evidence and guidance should be produced.

This initiative parallels the work of TEASC’s partner – the national Children's Improvement Board (CIB), whose work on cost-effective children's services, and associated toolkits, has influenced our products. TEASC recognises the importance of continuing to make links with this work, not least because of the number of combined children and adult care departments.

TLAP and TEASC also acknowledge the particular significance of the sector’s interface with the NHS and the priority now being given at both national and local levels to the development of more integrated approaches. However, this report deliberately focuses on the use of councils’ ASC budgets and other resources directly within their control. Whilst it includes references to some important recent guidance and research, detailed consideration of this key and complex partnership area is beyond the scope of this report.

A Problem Shared

The overriding theme of this report, reflected in its title, is that the challenge of achieving further budget reductions will necessitate a truly collaborative approach across the sector.

Some key messages are:

• Elected council members should embrace and communicate a vision of Adult Social Care that stresses the promotion of independence, personalisation and social inclusion.

• Health and Wellbeing Boards should steer the development of more integrated, personalised services, that make best use of resources across sectors.

• Senior council officers should work with both their NHS partners and other councils to develop new, shared frameworks to monitor and manage performance – with an emphasis on ensuring that care and support services offer optimum value for money.

• Local communities should be seen as part of the solution, and truly engaged in the challenge of finding new ways to support people with care and support needs.

• Service providers should work with council commissioners to develop and test innovative ways of improving outcomes for people, with an emphasis on maximising independence, personalisation and social inclusion.

• The energy, commitment and professional skills of staff employed across the sector should be harnessed to find new, better ways of meeting individuals’ needs.

• Above all, priority should be given to co-producing solutions with people themselves and their carers and families – recognising that they are the experts on how their problems can best be resolved.
EXECUTIVE SUMMARY

1) The recent economic downturn in the UK has led to the deepest cuts to local authority budgets in a generation. Although Adult Social Care (ASC) has been relatively protected so far compared with other council services, substantial savings have already been made and more are inevitable from 2013 onwards. This is in the context of a widely recognised gap in the UK between the demand for care and support, and the funding available from the state.

2) Budget reductions to date have impacted variably from one local area to the next, and this is likely to continue. Such reductions are widening existing variations between councils – for example, in the numbers of people receiving statutory ASC services, in the rates of people supported in residential and nursing homes, in the costs of local services, and in the numbers receiving self-directed support. It is clear from the evidence that some ASC departments now face much harder choices than others.

3) Demographic trends are creating additional financial pressures for statutory ASC services – although partly offset by the fact that more people are paying fully or partly for their services. To date, a range of methods has been used by councils to manage the demand, with the effect that the numbers supported by statutory care services have decreased in most but not all places. On the other hand, the people of all ages who require help from councils have increasingly high and complex needs.

4) So far, budget reductions have also impacted variably on different customer groups. By contrast with others, expenditure on services for people with learning disabilities has been steadily rising in most, although not all, places. There is an ongoing imperative for councils to manage costs for this group, whilst also accelerating efforts to develop local community-based and personalised alternatives to residential care. It will be particularly important to continue to disseminate learning from those councils that are achieving better service and financial outcomes in this area.

5) Some traditional methods have been used to deliver a large part of recent cash-releasing savings. For example, fees paid to independent providers of both residential and domiciliary care have been suppressed, and discretionary charges for community services have been increased. There are likely to be diminishing returns from both of these approaches over the next few years.

6) Even more fundamental change will be required from now on. To deliver further budget reductions, councils will need to redouble their efforts to manage the demand for formal social care intervention. The ADASS whole systems framework illustrates positive ways of tackling this challenge, and many of these are referred to in this document. The ongoing priorities are:

- to help people who may be at risk of needing formal health and social care intervention to remain independent for as long as possible
- to build the capacity of communities to support people in new ways
● to prioritise the development of services that support people’s recovery after an accident or episode of ill-health (including reablement, intermediate care, crisis response and telecare)
● to ensure that personalisation works for those with ongoing needs so they are able to plan and direct their own support and have a choice of cost-effective solutions.

7) The ongoing development of these approaches should be underpinned by rigorous examination of the effectiveness of existing ASC services. It is widely recognised that ASC has sometimes offered help in the wrong form and delivered some poor quality services at high cost. Councils’ work to roll out self-directed support is an example of how this problem is being addressed. But recent studies have challenged councils – perhaps more than ever – to be aware of how some services can inadvertently increase rather than reduce people’s dependency. To rectify this, a more comprehensive outcome-based approach is needed. This implies further changes to councils’ approach to assessment, to the way services are commissioned, and to how success is measured.

8) Delivering further budget reductions will only be achieved by working in partnership, especially with the NHS. Over the next few years, developing more integrated service models will be a priority across the country. Whatever specific options are considered in each location, Health and Wellbeing Boards need to be supported to link assessments of the needs and assets of local populations to the development of joint commissioning plans that make the best use of all available resources, and improve the outcomes for communities. In this context, councils and their partners should be explicit, open and transparent about the risks ahead and develop clear plans to mitigate these.

9) But the partnership agenda goes well beyond this. ASC has always been at the hub of a complex web of relationships – with other parts of the state, with private and voluntary sector providers, with community organisations, with the people it serves and with their families. At worst, different parts of the ASC community are now finding themselves in competition with each other for resources. At best, there are many examples of councils managing to co-produce new solutions with their partners – including service providers, community groups and people who use services – both at strategic and individual level.

10) The delivery of budget reductions in ASC from here should not be regarded as just a technical exercise. The sector is entering a period where fundamental change to behaviours and new ways of working are required. There is clear emerging evidence that changes to hearts and minds (including those of individual staff and health professionals) are even more important than changing structures, systems and processes. Only by tackling this can the shared problem be addressed collaboratively.

11) Councils and their partners also have a continuing responsibility to benchmark their performance, to understand the local variation, and to learn from the best. There is a pressing need to develop more appropriate performance indicators and a more robust evidence base, to help achieve a better sector-wide understanding of what works, and to monitor the impact of ASC budget reductions for people and their families.
A PROBLEM SHARED – Making best use of resources in Adult Social Care
Profound changes in councils’ operating environment – including a powerful combination of budget reductions, demographic pressures, technological change, and changing attitudes and expectations – are resulting in the need to re-think the role and purpose of Adult Social Care.

Whilst debate continues about how to close the obvious serious gap between the demand for care and support and the resources available, part of the solution must lie in a fundamental change in the relationship between the state and those it aims to support – maximising independence and avoiding dependency.

This report underlines that the task of making best use of resources in ASC must be underpinned by an understanding of the potential of people to design their own solutions. Equally, it entails taking a whole system view of the resources available – maximising the potential of ASC’s close partnerships with the NHS and other council departments, and harnessing the contributions of staff, volunteers, peer supporters, families and communities.

Dilnot Commission 2011

Current ASC budget pressures should be seen in a context where the national funding arrangements for social care – especially the complex system of contributions from individuals – are recognised to be unsustainable and unfair. The Coalition Government committed itself to implementing the Dilnot Commission’s reform principles and has now announced plans to introduce changes in 2017.

Caring for our Future

The Government published its White Paper on care and support – Caring for our Future – in July 2012. The two key principles guiding the proposed reforms are that:

“we should do everything we can – as individuals, as communities and as a Government – to prevent, postpone and minimise people’s needs for formal care and support. The system should be built around the simple notion of promoting people’s independence and wellbeing.”

“people should be in control of their own care and support. Things like personal budgets and direct payments, backed by clear, comparable information and advice, will empower individuals and their carers to make the choices that are right for them”.

The White Paper adds: “…this will encourage providers to up their game, to provide high-quality, integrated services built around the needs of individuals. Local authorities will also have a more significant leadership role to play, shaping the local market and working with the NHS and others to integrate local services”.

A PROBLEM SHARED – Making best use of resources in Adult Social Care 7
It re-states that Health and Wellbeing Boards – which assume their new responsibilities from April 2013 – are expected to support and promote innovation and integrated working between health, housing, care and support.

Think Local Act Personal – *Making it Real*

Think Local Act Personal is a cross-sector partnership of people and organisations leading the implementation of choice, control and active citizenship by promoting and sharing effective approaches to delivering personalisation and community based support. TLAP’s vision was set out in the 2011 Partnership Agreement and signed up to by central and local government, provider associations and organisations, voluntary and community sector bodies, improvement agencies and user-led organisations.

In 2012, the Partnership published a set of benchmarks – *Making it Real* – for organisations to assess their progress towards delivering personalisation and community based support. *Making it Real* sets out what people who use services and carers expect to see and experience if support services are truly personalised. The progress markers were developed by people and families who use services through co-production with the wider Partnership and are now being adopted by organisations across the sector.

The markers illustrate how standard ways of assessing performance are changing, as the sector re-orients towards addressing the priorities of people themselves.

Reconciling these new approaches with the somewhat old-fashioned framework of national indicators is complex – especially when addressing value for money. This document is – inevitably – still reliant on existing national activity and cost indicators, but stresses throughout the importance of finding new ways of measuring success. In particular, it seeks to be consistent wherever possible with the markers of progress set out in *Making it Real*.

TLAP recognises that budget reductions place great strain on people with support needs, their carers and families. Its support for this piece of work is driven by its strong motivation to ameliorate the impact of such changes on individuals and organisations and to ensure that opportunities to transform services for the wider good are not missed.

TLAP understands that commissioners and senior decision makers currently face very difficult choices over how to meet the needs and expectations of their local populations within a diminishing financial envelope. Whilst the Partnership believes that the quantum of resources in Adult Social Care is fundamentally inadequate, this should not detract from important local efforts to make the best use of the resources available, to learn from best and worst practice and to seize all opportunities to promote personalisation and community based support in this challenging environment.
The Legal Framework

Some of the measures adopted by councils to reduce their budgets over the last few years have been subject to judicial review, and there are some ongoing cases that have not yet been resolved.

In this context, the Government has recognised that the law pertaining to Adult Social Care is unhelpfully complex. In 2011, the Law Commission recommended that there should be a new, simplified statute, and this is being addressed within the draft Care and Support Bill.

It is beyond the scope of this report to list all of councils’ current legal responsibilities, or the proposed changes. However, some of the most important aspects of the existing and emerging legal framework for ASC can be summarised as follows:

- Councils have a clear duty to assess a person, where it appears that they may have needs that could be met by community care services. The draft Care and Support Bill proposes to extend the right to an assessment to more carers.
- Following the assessment, councils must decide whether the person’s needs are eligible needs, by applying eligibility criteria. The draft Care and Support Bill proposes a national minimum eligibility threshold, and aims to ensure that people’s entitlements are portable if they move from one council area to another.
- Where the person is found to be eligible, councils must then ensure the production of a written care and support plan that shows how the person’s needs will be met.
- Councils must provide or arrange appropriate services to meet the person’s eligible needs. So, councils must satisfy themselves that each individual’s eligible needs can be met with the resources available to them. One implication is that an individual’s budget or services cannot be reduced without first establishing that their needs can still be met with the reduced resource. Another implication is that in setting fees for purchased services, councils must have a rational process to ascertain that these fees will cover the costs of providing the required service.
- The draft Care and Support Bill proposes that people should have a legal entitlement to a personal budget. As at present, this may take the form of a direct payment or be managed by the council.
- Councils have a lead co-ordinating responsibility for safeguarding, and must investigate where an adult is at risk or cause an investigation to be made by other agencies in individual cases.
- In exercising their ASC responsibilities, councils must have due regard to the public sector equalities duty and related legislation.
A PROBLEM SHARED – Making best use of resources in Adult Social Care
REDUCING BUDGETS IN A CONTEXT OF DEMOGRAPHIC CHANGE

Well-recognised demographic pressures are significantly affecting the demand for ASC. This chapter suggests it is not so much the growing numbers of people with care needs per se that are creating pressures on statutory ASC budgets. The intensity and complexity of their needs, and of the packages they receive, appear to be more important factors. So, as budget pressures increase, ASC will need to pay attention to the types and volumes of support it offers to people as well as to the numbers entering the formal system.

Overall, the powerful combination of budget reductions and demographic pressures is already creating real dilemmas for the sector. Whilst suggesting that the solutions are likely to vary from place to place, this chapter illustrates some of the difficult choices now facing councils and their partners.

Features of the changing demographic landscape

It is widely accepted that demographic change is creating increased demand for care and support, and that this pattern will continue. Many attempts have been made to quantify the funding gap this will create. In 2011, this evidence was reviewed by the Dilnot Commission, and contributed to its conclusion that the current funding system is unsustainable.

- The population of older people aged over 65 is projected to grow by 50% over the next 20 years, and the numbers who are very old will grow the fastest. There will be corresponding increases in the incidence of dementia.
- The number of working-age adults with learning disabilities will rise by around 30% over the next 20 years. Again, the groups likely to need high levels of support are growing faster than the overall trend. This includes cohorts of people with learning disabilities who are now reaching the older age range.

Other issues examined by Dilnot include concerns about the supply of informal care. The number of informal carers has recently been estimated at 5.3 million, and the value of their contribution may be equivalent to £2.3 billion per week. However:

- Over the next 20 years the supply of care by adult children may grow by 13%, assuming unchanging propensity to care, whilst demand will increase by 55%.
Income, wealth and assets

These demand factors may be offset, financially, by positive trends in incomes, wealth and assets held by individuals – particularly those currently aged over 65.

Because of the growing wealth, including home ownership, of many older people, increasing numbers, or their families, are either paying entirely for their own support, topping up the funding they receive from councils, or contributing substantially through local charges. Future trends are hard to predict. But it is reasonable to assume that for the foreseeable future, older people will be wealthier than in the past, will continue to pay substantially towards the cost of their care within the capping arrangements proposed by the Government and may run out of money, placing unpredictable financial burdens on councils.\(^1\)

Conclusion

The implications for Adult Social Care

An important theme of this report is that, for various reasons, the number of people offered council-funded social care in recent years has reduced in spite of the demographic context. It seems inevitable that this trend, partly reflecting growing pensioner affluence, will continue.

At the same time, councils will face growing dilemmas about how to fund the support of the relatively few people who have very intensive needs, whilst also sustaining investment in primary and secondary prevention, and building the capacity of communities to support the increasing numbers of older and disabled citizens.

There are no longer any easy options. Indeed, this report suggests there will be diminishing returns from some of the methods used to deliver budget reductions so far, and that the ongoing strategic transformation in ASC may not deliver further cash-releasing savings in the short timescales required. Equally, those councils that have been hit hardest by budget reductions – and those that are already well advanced in their change programmes – are likely to find it hardest to make further savings.

So, councils now face real dilemmas, with no wrong or right answers, this is illustrated in Figure A. There may be significant risks associated with whatever course they take, and this will necessitate:

- the use of all available evidence including not only benchmarking data but also national and local economic evaluations
- concerted work to measure the outcomes for the people they serve and for wider communities including those not eligible for ASC support, and to develop improved tools for doing this
- the development – and publication – of explicit risk management strategies
- open and honest dialogue with all their stakeholders
- harnessing the resources of statutory partners, providers, people and communities to co-produce solutions to the many challenges ahead.
### Examples of the Dilemmas Facing Decision-Makers in Adult Social Care

<table>
<thead>
<tr>
<th>Dilemma</th>
<th>VS</th>
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<tbody>
<tr>
<td>Systematically identifying people at risk of needing health and social care, and intervening early to prevent deterioration</td>
<td>Implementing tight eligibility criteria, focussing on keeping people out of the system, signposting people away from statutory services</td>
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<tr>
<td>Developing universal services that promote independence, wellbeing and social inclusion</td>
<td>Focussing on secondary level prevention (including reablement), that targets people who already present with health or social care needs</td>
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<tr>
<td>Responding to the growing demand for intensive support for relatively few people with multiple and complex needs</td>
<td>Safeguarding recent investments in prevention, support for carers, and innovative services that promote independence</td>
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<tr>
<td>Protecting the capacity and quality of residential and nursing home services, in a context of market volatility</td>
<td>Shifting expenditure away from residential and nursing care, towards community-based services</td>
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<td>Working with relatively few selected providers to guarantee a stable supply of local good quality services at a reasonable cost</td>
<td>Stimulating new, more diverse markets to extend choice and control, extending direct payments</td>
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<td>Changing the skill mix of the workforce, encouraging co-production, volunteering and peer-support, fostering the informal care sector</td>
<td>Recognising and valuing the contribution of professionally qualified staff, investing in their continuing professional development</td>
</tr>
<tr>
<td>Protecting and/or developing those back office functions that are critical to the transformation process (eg IT expertise, market analysis, market facilitation, staff training and development)</td>
<td>Protecting front-line services</td>
</tr>
<tr>
<td>Protecting services for existing service users and avoiding legal challenge</td>
<td>Shifting resources to achieve a more equitable allocation of funds, ensuring fairness for individuals and groups</td>
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<td>Trying out new ideas with partners, being open to innovation</td>
<td>Focussing on core statutory responsibilities</td>
</tr>
<tr>
<td>Thinking strategically, being evidence-based, and staying on course.</td>
<td>Having to concentrate on quick fixes, perhaps because of the imperative to deliver cash-releasing savings very soon</td>
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*Figure A: Walking the tightrope*
During the recent period of budget reductions, councils have to a large extent sought to protect Adult Social Care. Nevertheless overall expenditure on ASC reduced in real terms in 2010/11 and 2011/12 and will reduce further in the years ahead as the pressures on council budgets intensify.

This chapter summarises evidence about how the ASC budget reductions have been achieved so far. More details about the five-year trend are available in the statistical overview that is being published alongside this report.

**ASC budgets 2007/8 to 2011/12**

After a period of modest growth, gross current expenditure on ASC services reduced by 1% in real terms in 2010/11 – and by at least 2% in 2011/12 (see Figure B).

**Figure B** Gross current expenditure by customer group (adjusted to 2012 prices)
It should be noted, however, that the financial data for 2011/12 are affected by the changes in the national accounting arrangements in that year, which give a distorted picture of expenditure – especially within services for people with learning disabilities. For the latter group, financial responsibility for over 1,200 people has shifted recently from the NHS to councils, with some councils being far more affected by these changes than others. The overall impact of the accounting changes has been analysed by the Health and Social Care Information Centre in *Personal Social Services: Expenditure and Unit Costs – England 2011/12*. According to this source, the real terms national budget reduction in 2011/12 was between 2% and 7%.

As illustrated in Figure C, the budget cuts have impacted very variably across the country, to the extent that more than one third of councils appear to have increased their ASC budgets, in real terms, in 2011/12. This variation is influenced, although not entirely explained, by the differential impact of the national deficit reduction programme, with councils in London, the North East and North West experiencing the biggest cuts in revenue spending power.18

**Figure C** % change in gross current expenditure 2011/12 – all councils

Evidence from ADASS’ annual budget surveys

ADASS’ annual budget surveys in 2011 and 2012 indicated that reductions of £991m and £891m were planned in 2011/12 and 2012/13 respectively – although the Audit Commission has suggested that the 2012/13 reductions might be higher than this.19 Councils have nevertheless sought to minimise service reductions, and to deliver most of the reductions by re-designing services and achieving efficiencies (see Table A).
Table A: Planned budget reductions, 2011/12 and 2012/13

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<thead>
<tr>
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<th>2011/12</th>
<th>2012/13</th>
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<tbody>
<tr>
<td>Service re-design and efficiency</td>
<td>£681m</td>
<td>£688m</td>
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<tr>
<td>Increased charges</td>
<td>£84m</td>
<td>£77m</td>
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<tr>
<td>Service reductions</td>
<td>£226m</td>
<td>£113m</td>
</tr>
<tr>
<td>Not identified</td>
<td>£13m</td>
<td></td>
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<tr>
<td>Total planned reductions</td>
<td>£991m</td>
<td>£891m</td>
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During the current Spending Review period, councils are also receiving additional funding from the NHS, to be used in ways that benefit the care and health system. This has included £648m transferred from PCTs in 2011/12 and £699m in 2012/13. The Caring for our Future White Paper commits a further £100m in 2013/14 and £200m in 2014/15. So far, a relatively small proportion of the additional funding has been used to fund new services, whilst most has been used to offset demographic pressures and to minimise cuts to services (see Table B).

Table B: Use of NHS transfer 2012/3

| Use to offset demographic pressures. | £74m |
| Used to avoid cuts in services.     | £210m|
| Used to fund new services           | £148m|
| Allocated to working budgets        | £149m|
| Total                               | £699m|

National expenditure and activity trends, 2007/8 to 2011/12

TLAP and TEASC’s Progress in delivering budget savings in Adult Social Care, 2007/8 to 2011/12 provides more evidence about how the budget reductions have been achieved over the last five years. The report includes strong caveats about the quality and appropriateness of some of the national indicators, and stresses their limited use in assessing value for money and productivity.

With these caveats, the national data suggest that there have been significant changes over recent years in patterns of ASC service provision and expenditure, and that these have accelerated since 2010.
Headlines for the period 2007/8 to 2011/12

• The key five-year trends in expenditure, income, costs and activity are summarised in Table C.

<table>
<thead>
<tr>
<th>Table C: Five-year trends in ASC costs and activity (2007/8 to 2011/12)</th>
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<tbody>
<tr>
<td>RESIDENTIAL AND NURSING HOME CARE: Percentage change between 2007/8 and 2011/12</td>
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<tr>
<td>Older People (aged 65+)</td>
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<tr>
<td>----------------------------</td>
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<tr>
<td>Gross current expenditure</td>
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<tr>
<td>Income from charges</td>
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<tr>
<td>Unit costs</td>
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<tr>
<td>Number of people supported by councils in residential and nursing care</td>
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<tr>
<th>COMMUNITY-BASED SERVICES: Percentage change between 2007/8 and 2011/12</th>
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<tr>
<td>Gross current expenditure</td>
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<tr>
<td>Income from charges</td>
</tr>
<tr>
<td>Cost of home care (per person per week)</td>
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<tr>
<td>Cost of day care (per person per week)</td>
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<tr>
<td>Number of people receiving community-based services</td>
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</table>

Note. All financial data are adjusted to 2012 prices

• Over the whole period, there have been modest but important shifts in the way ASC budgets are distributed. Most significantly:
  - there has been a small transfer of resources from residential and nursing care, to community services
  - there has been an overall transfer of resources to services for people with learning disabilities from other groups.
2011/12 saw a change in one aspect of this medium-term trend. Levels of expenditure on community services fell more significantly than expenditure on residential and nursing home care, with the result that the balance of expenditure shifted slightly away from community services.

Figure D illustrates this, by showing changes in the major areas of ASC expenditure between 2010/11 and 2011/12. Caveats should be applied to the data relating to learning disability services. The 2011/12 expenditure figures – particularly those relating to nursing and residential care – are known to be distorted by changes in the national accounting arrangements in that year.* On the other hand, as discussed in Chapter 5, expenditure on learning disability services has steadily increased throughout the last five years, suggesting underlying budget pressures that are distinctive for this group.

Figure D Real terms shifts in gross current expenditure 2011/12

- Over time, the budget reductions from residential and nursing home care have been very important financially, because of the relative size of this budget, and are mostly explained by falls in the numbers of people funded by councils. However, there was a slight increase in new council-funded admissions in 2011/12, raising questions about whether the downward trend in expenditure will prove sustainable.
- Other factors have played a part in containing councils’ expenditure on institutional forms of care over time. These include extensive re-commissioning of councils’ in-house residential provision, and the suppression of fees paid to the independent sector. For older people, physically disabled people, and people with mental health needs there were real terms reductions in the unit costs of these types of services in 2011/12.

* The impact of the so-called “Valuing People Now transfers” is analysed in more detail in TEASC’s recent statistical report, “Progress with Adult Social Care priorities in England, 2011/12”.
For community-based services, as illustrated in Table C, the expenditure reductions have been associated with striking falls in the numbers of people supported amongst all groups except for people with learning disabilities. On the other hand, for those who do receive council support, average expenditure per person per week has escalated.

- Increases in fee income and charges for community services – especially those levied from older people – have also contributed to the net budget reductions achieved by councils, in spite of the very significant fall in the numbers receiving statutory ASC support. Overall, income from fees and charges has risen by 5% since 2007/8 – although it stabilised in 2011/12.

Conclusion

Diminishing returns from traditional methods of reducing budgets

During the recent period of budget reductions, most councils have maintained a steady focus on transforming their service model and improving outcomes for people – and some of the success stories are described elsewhere in this report. However, some more controversial short-term measures have been adopted since the last Spending Review. For example:

- Fees paid to independent providers of both residential and domiciliary care have been suppressed, sometimes quite dramatically. This is in a context where many social care services offer relatively uncompetitive pay and conditions for staff – whilst also attempting to respond to increasing and more complex individual needs. As a result, there are concerns about the quality of some services,20,21,22 and there have been high-profile business failures.

- Discretionary charges for community services have been increased, with the result that some people are deterred from receiving statutory help, and the remainder pay more for their services than in the past.23
Evidence from across the country\textsuperscript{24} suggests that all councils have also implemented efficiency programmes involving a combination of measures including:

- Re-commissioning services from new suppliers
- De-commissioning some services, such as day centres and well-being services in the voluntary sector
- Reviewing the needs of individuals already receiving services, to assess whether a reduced or more cost-effective service could be substituted for the existing package whilst still meeting the person’s needs
- Re-structuring – for example, to reduce management costs
- Reducing expenditure on back office functions, often by using better IT solutions
- Reviewing the skill mix of the workforce
- Streamlining business processes, with associated reductions in staffing costs
- Making more efficient use of capital assets including buildings.

An important consideration for most councils – depending on the steps taken so far – is that there are likely to be diminishing returns from these kinds of approaches over the next few years. Most obviously, many councils know that they must budget for fee increases, at least in line with inflation, to meet the imperative of ensuring a stable supply of good quality services.

As these options run out, and assuming there will be further downward pressure on budgets, the statutory ASC sector will unavoidably need to find new ways of:

- reducing the number of people it supports and/or
- managing the amount of support each person receives and/or
- finding new and more efficient ways of supporting people in communities.

For councils and the communities they serve, there will be both risks and opportunities associated with these changes, and these are examined in chapter 6 of this report.
A PROBLEM SHARED – Making best use of resources in Adult Social Care
The Department of Health’s 2009 *Use of Resources* publication demonstrated wide variation between councils in the way they deploy their resources. These variations have persisted, and may be set to widen as responsibilities are increasingly devolved to councils themselves, in social care as in other areas.

This chapter sets out the evidence of current variations in ASC activity between councils and concludes that local decision-making is a key explanatory factor.

A pattern of local variation is not confined to local government. Even so, there is evidence of public concern and criticism that the variations in quality and outcomes, as well as of formal eligibility criteria, are unfair.\textsuperscript{25}

The variation in ASC barely correlates with demographic factors such as levels of wealth, deprivation or the age profiles of local populations. Equally, it applies within as well as between regions so analysis based on either national or regional averages can conceal substantial differences even between neighbouring councils. For this reason, the graphs in this chapter show all councils, clustered into regions.

**Variation in the number of people supported by statutory ASC services**

Councils vary in the rates of people they support, as a proportion of their populations, and this variation applies within as well as between regions (see Figure E).

**Figure E** Total number of people receiving services during the year (per 100,000 population) – all councils by region

(Source: RAP P1)
The national trend, illustrated in the previous chapter, suggests a steady reduction in the numbers receiving statutory social care services overall. However, this is not true for all councils. For example, in 2011/12, around three-quarters of all councils reduced their numbers whereas the remainder saw an increase. The patterns appear to be volatile – with similar councils experiencing surges or sudden drops in the numbers for reasons that are difficult to explain.

**Variation in the number of older people in residential and nursing home care**

There is similar inconsistency in the numbers of people supported by councils in residential and nursing homes across all age groups. Figure F shows the variation between councils, and again illustrates that this applies within as well as across regions.

**Figure F:** Number of people supported permanently in residential and nursing care on 31st March (per 100,000 population) in 2011/12 – all councils by region

In 2011/12 there was a slight overall rise in the numbers of new admissions. However, by the year end, the numbers supported in residential and nursing care had decreased in around two thirds of all councils, and increased in the other third. The changes either up or down were sometimes quite dramatic (see Figure G). In this respect, it is barely useful to try to identify a national trend.
Variation in the intensity of home care packages

The pattern of home care provision also varies, with councils targeting their services in different ways. On average, 41% of all home care users received packages of more than 10+ hours per week in 2011/12, but there is seven-fold variation between councils in this respect. Again, the variations do not depend on geographical factors (see Figure H).

(Source: RAP H1)
Nationally there has been a very steady upward trend in the proportion of home care packages that are intensive and this has had a significant impact on ASC budgets. Even so, whereas some councils have increased their proportions, others have reduced them over time. There is no available formula for deciding how much home care should be provided – or any evidence that would be helpful in suggesting an ideal balance of intensive versus low-level packages.

Variation in the numbers receiving personal budgets and direct payments

Over the last five years, those receiving self-directed support have steadily increased, so that today just over half of all eligible people receive this form of personalised support.

Nationally, in 2011/12 the numbers receiving personal budgets and direct payments increased by 38% and 9% respectively, but this masks wide local variation. For example, in that year the percentage of people receiving a direct payment increased in 83% of councils, but not in the others, with the result that even within the same region, there is now a ten-fold variation in the rate of people receiving direct payments (see Figure I).

There is currently no available evidence about the impact of the extension of self-directed support and direct payments on overall expenditure. In 2011/12, many councils successfully reduced their budgets whilst extending self-directed support. Others did the opposite. Overall, there is no correlation between changes in councils’ expenditure and changes in the numbers they supported through self-directed support during that year.

Figure I: Number of people receiving direct payments (through self-directed support) per 100,000 population in 2011/12 – all councils by region

(Source: RAP H1)
Conclusions

The significance of local decision-making

Variations between councils highlighted in DH’s 2009 report have persisted since the last Spending Review. A contributing factor – as explained in the previous chapter – is that recent reductions in councils’ revenue spending power have affected some councils much more than others.26

However, it is undeniable that local decision-making is hugely important, and possibly accounts for most of the cumulative variation. Both councils and NHS commissioners have shaped local health and social care services in very different ways, and are now transforming these services at different rates. There is ample evidence that investment by other council departments, as well as other sectors, has an influence on the pattern of local ASC provision.27 For example, the prevalence and effectiveness of community health services is one factor that very clearly affects expenditure and activity in social care. So analysis of the reasons for the variation, and the solutions, should be based upon a holistic view.

Many of the driving factors are ultimately within councils’ control – albeit very difficult to address. These include:

• councils’ political vision and priorities, including the extent to which there is cross-party consensus and a commitment to transforming ASC
• their organisational cultures
• the effectiveness of local partnership arrangements
• the extent and success of cross-departmental approaches
• how ASC budgets are targeted, eg towards different groups of people, and types of provision
• the shape and effectiveness of local services, and the extent to which they promote independence and social inclusion
• the state of local markets, including both the availability and quality of provision, and the options being developed for those using personal budgets
• the costs of local services
• the extent to which genuine efficiencies are being achieved, and the way this is being done
• the extent to which their staff, and those of partner organisations, own the transformation agenda
• councils’ business processes, including their commissioning and market facilitation functions
• expectations of council support locally – which in turn affects the political culture in each locality.
The implications for ASC

The variation between councils is now so great that it may be unhelpful to make generalised recommendations about how the sector should manage future budget pressures. Local solutions will need to be found, that draw upon in-depth local debate, robust analysis, consultation and engagement.

On the other hand, this chapter has illustrated the continued importance of benchmarking. All councils will benefit from comparing their trends with others, as a way of challenging themselves about whether their own patterns are unavoidable.

For this reason, this report is accompanied by a toolkit that encourages the use of nationally available metrics to benchmark performance. However, the toolkit suggests that local analysis of the cost-effectiveness of services will need to go beyond using these data – since in any case, there is ongoing debate about what good looks like in many of these areas, and national targets no longer apply.

TEASC’s approach to helping councils develop their own measures of performance, and its work to collect stronger evidence on cost-effectiveness, is explained in the concluding chapter of this report.
Cost pressures within services for people with learning disabilities present one of the biggest challenges for the sector. Councils are achieving varying success in meeting these challenges. This chapter focuses on the imperative to achieve better value for money for this group overall, and suggests the need for a more robust evidence base in this area.

From a national perspective, there are specific, ongoing financial pressures associated with this service area. Overall, the proportion of ASC expenditure directed to learning disability services has risen from 23% in 2007/8, to 30% in 2011/12. Gross current expenditure increased by 13% in real terms between 2007/8 and 2010/11. In the following year, it is reported to have grown by a further 21% (see Figure J).

**Figure J:** Gross current expenditure on services for people with learning disabilities 2007/8 to 2011/12
Whilst the apparent marked change in 2011/12 is mostly due to the accounting changes described elsewhere in this report, the underlying trends in expenditure, activity and unit costs are nevertheless distinctive for this group. For example, people with learning disabilities are the only group where the numbers supported by the state have been increasing – although the increases have been relatively small.*

There is local variation in this as in most other service areas – and the expenditure increases have not been universal. For example, in 2010/11, i.e. before the impact of the accounting changes associated with Valuing People Now, over a third of councils reduced their expenditure, including the majority in London and the West Midlands (see Figure K).

Figure K: % real terms change in gross current expenditure on learning disability services between 2009/10 and 2010/11 – all councils by region

Almost 2,000 fewer people with learning disabilities live in care homes now compared with 2007/8. As a consequence, the balance of expenditure shifted away from residential and nursing home care until 2011/12 – when expenditure in this area rose, largely as a result of Valuing People Now transfers to some councils. (Analysis provided by the Health and Social Care Information Centre suggests that when the Valuing People Now transfers are taken into account, there was an underlying significant fall in new admissions in 2011/12).

Work to manage the number of people with learning disabilities in residential and nursing home care has been undertaken across all regions – although the proportions of budgets spent on residential care remain much higher in some regions than in others (see Figure L); the regional differences are known to relate to historical legacies from the closure of long-stay hospitals in certain areas as well as to councils’ more recent commissioning strategies.18

* See Table C in Chapter 2.
The average unit costs of residential and nursing care for this group rose by 14% over the whole period. In contrast with the costs of residential care for other groups, these rises continued during 2010/11 and 2011/12, and have happened in spite of extensive efforts by many councils to re-negotiate fees. So, it is likely that the rising costs are related to the increasingly high needs of those people with learning disabilities who remain in residential and nursing home care.

The transformation agenda

Councils’ efforts to contain expenditure in this area are happening in tandem with radical transformation, which is being applied to services for people with learning disabilities perhaps even more than for other groups. Most councils have been engaged in some or all of the following:

- Reviewing the needs of people in potentially inappropriate placements – including those placed out of local areas
- Re-negotiating the costs of services – often by using tools designed to achieve fairness by linking costs more closely to people’s individual needs
- Re-commissioning some services in the community, to ensure better value for money
- Developing a range of more flexible locally-based housing and support, including day and employment opportunities, aimed at maximising independence and promoting social inclusion
- Exploring the potential of solutions like floating support and telecare to support people’s independence and reduce staffing costs
- Improving transition planning for young people entering adulthood
- Extending self-directed support – and placing a strong emphasis on very tailored approaches, co-produced with people themselves.
However, the pace of change has been variable. The exposure of serious abuse at Winterbourne View, a hospital service commissioned by the NHS, has highlighted that some people are still placed in inappropriate and high-cost institutions that “have no place in the 21st century” according to the Department of Health.30 The Department of Health’s review, and the Care Quality Commission’s (CQC’s) themed inspections in 2012, which looked at NHS, private care and social care services,31 have focussed attention again on some of the most important imperatives for both health and social care. The Department is funding a national team which is currently exploring good practice in relation to the five indicators in the Winterbourne View report:

- **Co-production** – involving people who use services in designing and planning them
- **Community building** – moving towards community-based support
- **A capabilities approach to disability** – looking at people’s strengths and promoting what they can do
- **Integrated services** – covering health, care, housing and leisure
- **Personalisation** – as a foundation on which other strategies build.

There is strong and growing evidence that community-based support for people with learning disabilities can be more effective, safer and cheaper than institutional care, including for those with very complex needs.32 See the case studies below.

### CASE STUDY A: Affinity Trust

The Affinity Trust has been working with councils that wish to achieve better solutions for people in expensive out-of-area placements. The Trust can provide many examples of people who are now living much more fulfilling lives nearer to home, at a lower cost to ASC.

**John** has an autistic spectrum condition, and was initially in a specialist placement 50 miles from his home, because it was felt that local providers did not have the expertise to support his needs. However this meant he typically saw his family only once every 3-4 weeks. He has now been able to move back to an area within a mile of his family. Despite initial concerns that he might abscond once moved to his own property, John has settled quickly. He was referring to his new house as “home” within about 10 days of his move and has not tried to abscond once. He has started to know his local community, is building a relationship with a neighbour and sees his family much more often. The costs of his support have reduced by around £1,200 per week compared to the previous placement. (Annual saving: £60,000).

**Peter** was previously supported in a residential home 200 miles from his family. Because of his complex needs and behaviour problems, he received 2:1 staff support during the day and waking night support. Following a carefully planned transition process Peter was supported to move to an assessment and support flat back in his home county. After just four months, he and his family agreed that he was ready to move to his own tenancy. Because of his growing confidence and skills, he now copes with much less support – the costs have reduced from £5,000 to £2,500 per week, with further reductions likely. (Annual saving: £125,000).
Councils A, B and C are three neighbouring outer London boroughs that appear to offer very different support to people with learning disabilities and are achieving different service and financial outcomes.

Council B spends more than its two neighbours in this area, with a high percentage of its budget (59%) directed towards residential care. This relates to the fact that an exceptionally high percentage (52%) of the people it supports are in residential care. Council C’s expenditure for this group is a little lower than the London average, even though it supports more people than its neighbours (in relation to its population size). A high proportion of its budget (52%) goes towards institutional care, even though these people account for only 27% of those it supports. A contributing factor is that this council’s unit costs are exceptionally high (see following table).

Whilst this appears to deserve further investigation within this council, it should be noted that unit costs tend to be higher for those councils that place relatively few people in residential and nursing home care, because the average level of need of those placed is higher.

Council A has the lowest budget and supports fewer people overall (in relation to its population size), but with a high proportion living in the community. Compared with its neighbours, more people with learning disabilities in this council receive self-directed support – including many in the form of direct payments.

There is evidence that Council A is realising better outcomes than its neighbours. For example, 18% of people with learning disabilities supported by this council are in paid employment – this is five times more than Council C and double the London average.

In the 2011/12 Adult Social Care Outcomes Framework (ASCOF) questionnaire survey, 76% of working-age respondents in this council said they felt in control of their lives (compared with 68% and 66% in the other two councils, and 72% for London as a whole). This council’s aggregated quality of life score for people of working age is also higher than for the other two councils featured here.
It must be recognised that the development – including co-production with the person and their family – of flexible, cost-effective and person-centred services in communities can involve painstaking work. It is more difficult in those areas which have traditional service cultures, high-cost community support services, and/or particularly under-developed local markets. The various obstacles and barriers to market development, and ways of overcoming these, are the subject of a range of materials produced by the National Development Team for inclusion as well as TLAP’s National Market Development Forum.

How different councils now face different challenges

Case study B illustrates again that models of provision vary dramatically even between neighbouring councils, so the priorities over the next few years will vary from one locality to the next.

Conclusion

Implications for ASC

Nationally, there is strong evidence of progress in delivering the goals of *Valuing People Now*, with increasing numbers of people with learning disabilities living more independently in their own communities, often with less support, or less expensive support, than in the past. However, progress has been patchy across the country.

It should be noted that expenditure has continued to rise in spite of the good progress in transforming services and extending self-directed support for this group. While there is evidence of striking results being achieved in individual cases, such as those cited in this chapter, there is a dearth of *aggregated* evidence about the comparative costs of the new service models. There is a strong case for reviewing and disseminating the lessons, including the financial lessons, being learned within those councils that have had more success in using positive transformation to contain their costs in this area.
A PROBLEM SHARED – Making best use of resources in Adult Social Care
Chapter 2 of this report showed that, notwithstanding local variations, the overall number of people supported by statutory care services has been steadily decreasing. It concluded that councils will need to redouble their efforts to manage the numbers receiving statutory support. This chapter explores some traditional and newer ways of doing this.

The risks ahead

There are ongoing opportunities for ASC to re-design services so that they successfully promote independence, and reduce people’s reliance on state-funded support.

On the other hand, there is already widespread concern about the impact of the recent budget reductions, shared both by academic researchers and the wider public. Since the last Spending Review, it has not been possible to avoid some difficult service reductions – and undoubtedly there are risks ahead, some of which are outlined below.

• User-led organisations are concerned about the impact of budget cuts on those reliant on support. A minority of people have lost their support entirely, and a larger number have seen cuts to their support hours and/or to their personal budgets.34 Cuts to people’s care packages have been the subject of some recent judicial reviews, and these have tended to reinforce councils’ responsibility to ensure that people’s assessed needs can be met with the resources allocated to them.

• There is a risk of setbacks in councils’ joint work with their partners to improve the quality of provision where this is urgently needed – for example, to meet the aspirations of the Prime Minister’s Challenge on Dementia.

• There is evidence that commissioning practices sometimes over-emphasise price reductions at the expense of service quality.35

• Increasing numbers of people, especially older people, are paying for their own support. There is widely acknowledged unfairness in the current funding system, including evidence that it particularly penalises people whose level of savings is just above the current means test threshold.36

• Informal carers may also be paying a price for service and expenditure reductions – with many already being forced to give up work to care, at the same time as they are faced with the considerable additional costs of disability.37
• Levels of unmet need may be increasing. For example, it has been estimated that of 2 million older people in England with care-related needs, nearly 800,000 receive no support from public or private sector agencies.38

• Needs may be increasing not only because of the demographic trends, but also because of the wider impact of the economic downturn including cuts in welfare benefits. For example, there is some evidence of a rise in people presenting with debt, mental health, employment and housing problems.39

• There is evidence that staff morale, and their levels of confidence in the services they provide, is reducing40,41

• There is also substantial evidence that one of the things the public most dislike about their care arrangements is that their carers often seem to be in a rush.42 This is one of the main reasons why contracting by the minute is being discouraged by academics43 and the Government.44

• Service providers are concerned that the costs of providing services are sometimes not adequately reflected in the fees paid by councils. Again, this issue has been the subject of several judicial reviews, which have tended to reinforce the importance of having rational processes to assess service costs.

• As statutory services become increasingly focussed on those with more intensive needs, opportunities may be missed to intervene early and prevent people’s needs from escalating, and/or to explore the potential for their social inclusion. This may result in costs being stored up for future years.45

• Social care budget reductions are likely to impact on the demand for NHS services – and vice versa. For example, there are risks that they may result in more emergency admissions to hospital, delayed discharges and longer waits for treatment.46

These concerns reinforce the importance of understanding the impact of budget reductions and the outcomes for whole communities – and also of ensuring that local safeguarding arrangements are robust. A particular challenge is that councils have broad responsibilities for the health and wellbeing of whole populations, but it is very difficult to assess the outcomes for people who fund their own support or who are missing out. Councils and their partners are advised to:

• use Joint Strategic Needs Assessments (JSNAs) to assess the needs of their whole populations including those ineligible for social care funding

• continue to implement strategies designed to promote the social inclusion of older and disabled people, and to foster local networks of informal support.

• focus on the development and use of outcome measures, for specific service interventions, for people receiving ASC services, and for whole communities

• in making budget reductions, take close account of the findings of recent judicial reviews

• be mindful of the differential impact for different groups, and ensure that these can be justified in the context of anti-discrimination legislation

• work with partners to develop a shared vision for the health and well-being of local communities, taking steps to mitigate the risks of cost shunts between one sector and another and maximising opportunities to commission jointly.
Overall, the continuing budget pressures will force all councils to make very difficult decisions, which will need to be justified to local stakeholders. Local Accounts – annual council reports on ASC performance and improvement – are one way of ensuring accountability to local taxpayers and wider communities, and can be used to describe both the risks for people needing care services and the steps being taken to mitigate them.47

Traditional ways of managing demand

The imperative to manage the numbers receiving statutory social care is not a new one. Statutory social care has always been tightly rationed, using a combination of means-testing and charging, and the application of eligibility criteria.

The impact of councils’ eligibility criteria has been the subject of much public and policy debate. There is persuasive evidence that the raising of eligibility thresholds has had relatively little impact compared with other measures to manage demand and expenditure over time.48 This is partly because criteria have been interpreted differently both between councils and by individual staff – and therefore inconsistently applied.49 So, as illustrated in Figure M, there is virtually no correlation between the eligibility thresholds applied by councils and the rates of people they support. In any case there has been little change in councils’ thresholds in the period since the last Spending Review, and – with most councils now restricting access to people with critical or substantial levels of need, as well as Government plans to enshrine this in legislation – there is little scope for further change overall.

Figure M: Number of people receiving services (per 100,000 population) by eligibility criteria – all councils
A more creative approach has been to try to shift the balance of care, on the assumption that investment in community services will either prevent people’s needs from escalating, or offer a better alternative to more expensive residential options. But again some of these assumptions are beginning to be challenged, not least because the evidence that traditional community services are preventative is very equivocal. For example, Figure N shows that councils that support higher numbers of people in the community, per population size, also tend to support higher numbers in residential/nursing home care, and vice versa – although there is not a tight correlation. Case study C also illustrates how similar councils may support similar numbers in residential or nursing home care in spite of their very different levels of community support.

Figure N: Comparison between rates of people supported with community services, and rates supported in residential/nursing care during 2011/12 (per 100,000 population) – all councils

The LGA’s initial report on the national ASC efficiency programme emphasises this point, citing evidence that the inappropriate provision of home care can sometimes lead to further loss of independence. According to this report, the notion that “a little bit of help is a preventative measure” may be a myth. Further evidence is contained in a recent study of home care by the Institute for Public Care. It reinforces that care should be geared towards the achievement of specific outcomes, and that where providers are paid on the basis of an hourly rate, there is a perverse incentive to increase rather than decrease the volume of packages. This lesson has been taken on board by Wiltshire, which is one of relatively few councils that have begun to use a payment by results approach to the commissioning of home care (see next page).

Clearly it cannot be assumed that the provision of home care to large numbers of people is automatically preventative. Councils should focus on the type of services they commission, the way they commission them, and the outcomes they are achieving, as well as on the numbers supported. They should be concerted in their work to ensure that services promote independence rather than inadvertently doing the opposite.
Council D and Council E are two adjacent shire counties in the same region, whose levels and patterns of home care delivery appear to be very different.

Council D’s reported level of home care provision has historically been half that of the average for shire counties. The numbers receiving home care increased in 2011/12 but the proportion receiving intensive (10+ hours/week) packages remained fairly steady.

Council E has historically provided high levels of home care, but reduced the numbers in 2011/12. In the same year, its pattern of provision changed quite dramatically, the proportion receiving intensive packages increased and the proportion receiving lower levels of service reduced, suggesting a policy of targeting home care towards those with the highest needs.

Interestingly, these two counties’ use of residential and nursing provision is not so disparate. In 2011/12, council D reduced the numbers it supported in care homes whilst council E saw an increase – but both support fewer people in care homes than their comparator group average.

CASE STUDY C: Variation in the level and intensity of home care

In the same year, its pattern of provision changed quite dramatically, the proportion receiving intensive packages increased and the proportion receiving lower levels of service reduced, suggesting a policy of targeting home care towards those with the highest needs.

CASE STUDY D: Wiltshire’s approach to commissioning home care

Wiltshire has introduced an outcome-based approach to commissioning. Their process begins with an assessment that clearly identifies the customer’s priorities and the required measurable outcomes. There is an emphasis on outcomes that will leave the customer better able to live well with less care. Providers then produce a support plan designed to deliver the agreed outcomes within a stated period of time, which varies from one individual to the next. Progress is reviewed towards the end of that period. Providers are paid for the results they achieve, the council applies financial penalties when customers’ outcomes are not achieved and rewards care providers when customers recover faster than planned.
Conclusion

Thinking differently about demand

The numbers of people supported by councils and their partners depend much less than might be expected on objective factors such as wealth and age. Equally, they have only partly been determined by the traditional methods of rationing.

This has necessitated new ways of thinking about this subject, encompassing deeper consideration of people’s individual choices and assets, and the paths they follow on their routes to receiving statutory social care, and increasing recognition of the importance of promoting independence. The demand for social care has always depended on such factors as:

- The availability of informal care – which is in itself dependent on family structures, population mobility, patterns of work amongst women, cultural attitudes and other social changes
- The impact of other types of service intervention, including, most importantly, primary health care and housing
- The judgements individuals themselves make – eg about how much they are prepared to pay for help and what constitutes value for money in this area
- The existence and use of a hidden economy – with people paying small amounts to friends and acquaintances for tasks like shopping, housework and gardening
- The availability of community networks, such as those created by voluntary and faith organisations, and those stimulated by councils
- Cultural attitudes towards statutory care, and the welfare state generally, which may be changing across generations. Some people have a broad expectation of receiving statutory help, while others are very reluctant to ask for such help
- Political attitudes, including fundamentally different views on the role that should be played by the state.

Furthermore, there is a growing body of evidence that what councils offer is not necessarily what people themselves and their families always want. The limited range of services offered by councils, poor commissioning practices, tight rules about what councils will and will not do, and the emphasis on delivering a prescribed number of hours per week have often created a mis-match between people’s own priorities and the prescribed solutions on offer.52, 53, 54, 55
For these reasons, all of the following are important keys to managing demand:

- Co-producing solutions with customers themselves, and their families – and being flexible about how outcomes are achieved
- Being explicit about the intended outcomes of interventions, and placing a stronger emphasis on the achievement of independence goals
- Prioritising the development of enabling approaches, in the broadest sense, as well as specific service interventions to support people’s recovery after an episode of ill-health
- Challenging the assumption that services will always continue at the same level for relatively long periods of time
- Having a culture, shared by all relevant agencies, that emphasises the promotion of independence and social inclusion
- Empowering people to remain in control of their own lives, by extending self-directed support and direct payments.

Overall, positive strategies are now needed that make the most of the resources, in the broadest sense, of people themselves, and those around them in their communities. This is the main thrust of ADASS’ whole systems approach, and of TLAP’s Building Community Capacity programme. These emphasise the importance of harnessing all the available assets within communities, and of respecting and valuing the contributions that can be made by people themselves and by those around them – see Figure O.

Figure O:
A PROBLEM SHARED – Making best use of resources in Adult Social Care
The academic research on improving the use of resources across all sectors always emphasises the importance of culture change. But, in the widespread debate about achieving efficiencies in ASC, this aspect can too often be neglected. This chapter focuses on the importance of changing attitudes, behaviours and relationships – and suggests that this constitutes one of the most important imperatives for leaders in ASC as they seek to make better use of resources.

Recent studies in health and social care suggest that successful implementation of change is just as important as its planning and design. Understanding the implementation challenges may provide the key to explaining why transformation has sometimes taken so long, or varied so much from place to place. This, at least, was one of the main conclusions of the Total Place pilots evaluation, which described health and social care organisations as “living systems not machines”, and the problems as “wicked not tame”.

Other research into demand management has gone further – by suggesting that behavioural changes may save more money than traditional savings approaches. As councils plan how to make use of their diminishing resources, the task of changing hearts and minds may be even more important than changing structures, budgets and processes.

The Leadership Challenge

The scale of current and future budget reductions is necessitating fundamental changes in the role played by ASC in communities, and new ways of thinking about how older and vulnerable people can be supported. All the relevant literature stresses the importance of having a clear strategic vision, communicating about this, and providing strong leadership at local level – especially in changing local political cultures.

As part of sector-led improvement, the LGA and other organisations are giving a high priority to leadership development. The National Skills Academy for Social Care is developing a leadership strategy, and has recently launched a Leadership Qualities Framework, supported by a programme of development and training. Some of its most important messages are reflected throughout this chapter.
Achieving more widespread understanding of the new vision for ASC

Politicians across all parties, and indeed, most people in society, give high priority to supporting older and vulnerable people in communities. This is one reason why in most places ASC has been relatively protected so far. However, local political cultures, in the broadest sense, may emphasise doing things for people – rather than harnessing their potential, promoting independence and supporting their inclusion into mainstream life. Where councils have been slow to modernise, this is often because of paternalistic attitudes, which value the types of service that may be not be right for future generations, and are not affordable either.

So, perhaps the most fundamental responsibility of elected members and senior officers is to promote the new vision – seeing ASC as playing a key role in, and also benefitting from, wider initiatives to build community capacity.

Prioritising local dialogue

Whilst ASC is responsible for the largest directly-controlled budget of councils, paradoxically it can appear to have a low profile for local people. So, in the current climate, many councils are looking for ways to ensure that local dialogue becomes more mature and meaningful. Improvements in community engagement are an important emerging outcome of sector-led improvement so far. Case study E below illustrates that people’s expressed priorities may change when they are more fully informed about the range of councils’ responsibilities.

CASE STUDY E: Let’s Talk Newcastle

Newcastle City Council is developing exemplary ways of engaging and involving local people in conversations about the difficult decisions it is taking. Its frank approach to sharing information and listening involves a range of methods (including online discussions) that are called: Talkabout, Walkabout, Thinkabout and Decideabout.

The initiative has so far involved over 8,000 people. It has helped the council understand the different level of priority people place on policies and services, and what tolerance people might have for lower levels of service or increased fees and charges. A real benefit of the approach is that it enables a genuine two-way dialogue.

As a result, the quality of the feedback people are able to give the council is much higher than that generated by traditional surveys.

Questionnaire-based approaches have produced very consistent sets of priorities, generally reflecting people’s doorstep priorities – anti-social behaviour, road and pavement maintenance, litter and dog-fouling. The active engagement of Let’s Talk allowed people to become more fully informed about council services.

With enhanced understanding, more people prioritised less immediately visible, but essential services, such as care for vulnerable adults and ensuring a good start in life for children.
CASE STUDY F: Improving local accountability for budget decisions

Westminster’s first Local Account of performance is one of relatively few in the country that headlines the ASC budget story. The document:

- explains why and how it has reduced the numbers of people it supports
- contains a detailed section on getting greater productivity and value for money
- explains how it will help people take personal responsibility and look after themselves.

Being open and transparent

In an era of austerity, local conversations can often become adversarial – and councils may respond defensively. There is some evidence of a recent deterioration in the relationship between councils and local citizens overall. For example, in the course of research carried out in 2011 only one fifth (22%) of senior executives described community trust in their authority as high – compared with 40% one year earlier and 45% three years earlier.69 Better relationships are more likely to be forged where councils are open and transparent – about their current performance, the choices they face, the associated risks, and how they propose to mitigate them.

Creative de-commissioning

The single most difficult aspect of the current change agenda, for both health and social care, is that many services need to be either re-commissioned or de-commissioned to free up resources for new approaches. A recent study published by NESTA70 includes new practical guidance on this subject, and sheds some light on how de-commissioning can be part of a more constructive process of change and renewal. The document sets out international evidence on the lessons that can be learned from organisations that have done it successfully, one of which is featured below. It does, however, include warnings about the investment of time required, and about the transitional costs associated with major service re-configuration. This may of course present particular challenges in the current financial context, in which many ASC departments and their partners are being required to deliver further cash-releasing savings very quickly.
Prioritising individual relationship-building

Some experts have suggested that budget pressures can produce system inertia. Across the health and social care system, this has sometimes been exacerbated by:

- the sheer numbers of partners that ASC leaders need to engage with, especially, perhaps, in large county councils
- organisational upheavals – which disrupt relationships as well as necessitating changes in governance arrangements
- the complexity of the system – including the fact that organisations may have different geographical boundaries as well as different cultures, priorities and processes
- the complexity of local social care markets – which are often characterised by a large number of different types of service provider
- the proliferation of multi-agency programmes and associated senior-level partnership boards
- reductions in management capacity – with fewer managers dealing with an increasingly complex partnership agenda.

In this context, many leaders in health and social care feel pressurised by the time it takes to engage properly with their huge range of potential partners, and such pressures become even more intense when senior managers are preoccupied with what seem like internal budget crises. Yet solutions are more likely to be found by looking outwards. The research suggests that the time taken to build good inter-personal relationships is almost always time well spent and that most good leaders spend most of their time networking.

Further relevant evidence is set out in SCIE’s briefing on integration with the NHS, which draws the key conclusion that: “Securing the understanding and commitment of staff to the aims and desired outcomes of new partnerships is crucial to the success of joint working, particularly among health professionals”. It stresses the importance of involving staff in the initial design of new joint ventures.

CASE STUDY G: Re-commissioning day centres in Thurrock

Through a painstaking but very successful process of engagement with people, Thurrock built a coalition of support for decommissioning its day centres for people with learning disabilities and finding more effective, community-based solutions. This change was ultimately co-produced – with people who used the services and their families themselves becoming the key agents of change.

Thurrock Council eventually closed all of its multipurpose day centres and moved towards a contracting model, supporting the development of a specially created social enterprise run by and for service users – Thurrock Lifestyle Solutions – to provide more targeted, personalised support for adults with learning disabilities.
IMpower have recently completed research to explore the relationship between GPs and ASC in a number of localities. It identifies the fact that GPs play a very important role – and much more so than social workers – in influencing people’s decision to enter residential care. So, if GPs could be helped to understand the role they play in generating demand, and became more familiar with the alternative options available, very significant savings could be made. (IMpower estimate that 60,000 older people could be diverted from residential care every year and an annual saving of £604 million could be achieved this way). Of course, this might include reductions in the numbers of so-called self-funders entering residential care, as these people are usually in contact with their GPs if not with statutory ASC services. IMpower’s conclusion is that for leaders in social care, meaningful interactions with a few people including GPs are often more useful than attending many high-level strategic meetings.

CASE STUDY I: Good outcomes from culture change in Surrey

Surrey is a council that has invested in building relationships between its staff and those of partner organisations, and considers that this investment has been well worthwhile. It has engaged with the Kings Fund’s Leadership Development Programme – which facilitates workshop programmes that bring senior managers from different sectors together, and aims to build understanding and improved relationships. Surrey can demonstrate tangible outcomes from this work.

For example, at Epsom hospital, a review of discharge pathways led to the agreement of mutual goals, and practical steps including the re-location of hospital social workers and changes to their working shifts, so they are now more visible to their clinical colleagues, and to patients and their families. This coincided with the development of a new Acute Medical Unit (AMU), which deals with almost all unplanned admissions and is achieving success in discharging people quickly and appropriately, with social care support wherever needed. Within this unit, a multi-disciplinary team meets every day at an agreed time (to replace more unpredictable consultant ward rounds), within a culture that stresses that everybody has to be there. The change in culture – characterised by staff as respect, trust and working together – has extended through the hospital, especially as junior doctors all spend part of their training within the AMU and get used to its emphasis on team work.

As a result of this culture change, almost no patients from Epsom hospital were discharged to residential care homes during 2012, and only an exceptional minority were discharged to nursing homes.
Understanding the role played by individual staff in committing resources

There is universal recognition that the involvement of staff is key to the successful delivery of change – and there is a very strong economic case for prioritising engagement with them.\textsuperscript{75}

This may be particularly true in ASC, where staff, and perhaps especially social workers, play a major role in rationing resources – whether or not budgets are actually devolved to them. They are also widely recognised to be hampered by the bureaucracy and inflexibility of traditional care management processes.

Three specific examples can be given of how changes in staff attitudes and behaviour might lead directly to efficiencies in ASC, two of which are currently being explored in more depth by the LGA's ASC efficiency programme.\textsuperscript{76}

- There is currently considerable interest in the role played by social workers within ASC processes, including focus on whether some of the tasks they perform could more efficiently be carried out by people without professional qualifications\textsuperscript{77,78}

Use of Resources (2009) suggested that investment in well-trained assessment and care management staff might result in fewer admissions to residential care. However, much does seem to depend on whether individual social workers share the vision of promoting independence and are creative in finding lower cost solutions. So, while some councils have reduced the numbers of professionally qualified staff they employ, or are considering this option, others are thinking about how to develop their professional staff and/or refocus their work, for example, on assessments for people with more complex or multiple needs, to ensure more cost-effective outcomes.\textsuperscript{79}

It is acknowledged that there are particular challenges associated with understanding and changing the role of social workers. The College of Social Work has begun work to produce a business case for social workers, and other useful evidence is likely to emerge from the ongoing independent social work pilots.\textsuperscript{80}

Related to this, councils differ in the extent to which they devolve budgets and decisions to staff. Mindful of the scale of the resources that are – in effect – committed by assessors, many have quite elaborate approval processes which typically include frequent panel meetings chaired by senior managers.\textsuperscript{81} Others are streamlining their processes by emphasising the importance of self-assessment, and genuinely devolving budget decisions to the assessor and the person they are supporting.\textsuperscript{82} These councils stress that staff training and development are critical to the success of such new ways of working. More research is now needed to compare the financial outcomes achieved through the old and new processes, encompassing investigation of how the savings achieved by reducing bureaucracy, including budget approval processes, may be greater than those achieved through top down control.

- The initial report from the LGA’s ASC efficiency programme also suggests that poor quality domiciliary care can increase people’s dependency on services. An implication is that in certain circumstances, better results can be achieved by investing in higher quality, but perhaps more expensive, services that use well-trained staff to work in an enabling way with people. Again, the skills, enthusiasm and attitudes of staff – and the nature of their interaction with the person they support – may be just as important as the organisational model of home care reablement adopted.
The relationship between commissioners and providers

It is widely recognised that councils need to develop their approach to the facilitation of markets and commissioning and procurement of services. Once again, these improvements will depend not only in changes to mechanisms, but also on changes in attitudes, relationships and behaviours – including an increase in openness and trust. Recent judicial reviews, focussing on the level of fees paid to social care providers, have illustrated the risks of allowing adversarial relationships to develop between commissioners and providers, and have reinforced the importance of open dialogue about the costs incurred by providers and about how these can be met within the current limited resource envelope.

A range of relevant resources is available on the website of the National Market Development Forum, including a new protocol for market relations and workshop materials to start a new conversation.

Clearly, there is an imperative for service providers to change their cultures in line with the efforts being made within councils. Across the country and across all sectors, there is evidence that this is happening. At best, this can result in commissioners, providers and the people they serve uniting around a shared understanding of the outcomes to be achieved and their own role in achieving these, with greater transparency about each party’s costs and contributions. These issues are being explored within the LGA’s efficiency programme for ASC and other good sources of evidence are featured below.

USEFUL RESOURCES: constructive suggestions from service providers

The Voluntary Organisations Disability Group (VODG): Gain without Pain: VODG has published 10 case studies that exemplify the particular qualities that it suggests the voluntary sector can often offer. The case studies illustrate the potential of different models of housing and support, day and employment-related services. The report emphasises the distinctive role of service users themselves, pointing out that those who offer help are frequently also those who receive it.

The National Housing Federation (NHF): On the Pulse: The NHF is working to demonstrate how health and social care commissioners can work with housing providers to enable older (and other vulnerable) people to manage changes in their health, to maximise independence and reduce the need for costly interventions. Case studies are included in: Breaking the Mould (2011) and On the Pulse (2012).

CASE STUDY J: Macintyre – Great Interactions

Macintyre’s Great Interactions initiative aims to support the recruitment and development of front-line staff to be enthusiastic advocates of person-centred approaches for people with learning disabilities. Its publication and associated toolkits provide practical illustrations of how the day-to-day attitudes and behaviours of staff can be key to unlocking people’s potential and promoting their independence. The initiative’s strapline is: “it ain’t what you do, it’s the way that you do it.”

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Seeing people as experts in finding cost-effective solutions for themselves

The current drive towards self-directed support has gathered momentum partly as a result of its potential to deliver more cost-effective outcomes – at least for some people. But in fact the imperative to put people themselves in charge of their own solutions applies well beyond ASC and even beyond local government. In the NHS, for example, sharing decision-making with patients leads to better results and saves money. This has been reinforced by the recent positive evaluation of the Personal Health Budgets pilot.

As with any initiative, it is possible to implement self-directed support well – in a way that improves outcomes for people and is cost effective – or in a way that achieves neither of these things. TLAP guidance about the minimum process framework, and more specific guidance on particular aspects of the process, has drawn out key learning about the successful implementation of self-directed support that is useful here. TLAPs current work programme includes more work on approaches to reducing bureaucracy in the self-directed support process and it will publish its learning in this area shortly.

Conclusion

Most councils already understand that the implementation of further budget reduction measures may fail without changes in hearts and minds. But the evidence suggests that this is even more important than is usually realised: it is very likely that savings, including cash-releasing savings, can be achieved by prioritising engagement with staff, partners, providers, people in communities and the recipients of services themselves. In future, achieving changes in behaviour should be an explicit objective for the sector, and should feature more prominently in ASC business plans alongside more traditional budget-reducing measures.

CASE STUDY K: Negotiating with recipients of services about the contribution they will make

As part of its plans to transform learning disability services, Surrey carried out an extensive engagement exercise involving both individuals receiving services and over 500 families. The council found that individuals with learning disabilities, parent/carers, and providers all recognised the financial challenges ahead. Each stakeholder agreed they would contribute to delivering savings if there was a common approach that fundamentally placed the assessed needs of individuals first – and provided that any subsequent strategic or policy direction was informed by that approach. All stakeholders agreed that personalisation was the right approach.
A PROBLEM SHARED – Making best use of resources in Adult Social Care
WORKING TOGETHER
WITH THE NHS

The budget pressures facing both the NHS and social care have resulted in renewed focus on the potential of more integrated care both to improve outcomes and to save money across the whole system.\textsuperscript{95, 96} Whilst detailed consideration of these issues is beyond the scope of this report, this chapter emphasises the importance of this area, stressing the significant potential role of Health and Wellbeing Boards.

In doing so, it presents evidence about two areas – reablement and assistive technology – that should be prioritised for future joint planning and investment by councils and Clinical Commissioning Groups (CCGs), with the caveat that a more systematic approach to evidence-collection is needed in both these areas.

The achievement of closer integration of health and social care is a key objective of both the Health and Social Care Act and Care and Support White Paper – and an expressed priority of people themselves. It is also the focus of intense current activity at local level, as councils and their local partners prepare for the formal establishment of Health and Wellbeing Boards.

It is very widely recognised that even though the development of a more seamless system of care and support has been a policy goal for many years, insufficient progress has been made so far.\textsuperscript{97} From 2013 onwards, a more concerted effort will be needed to tackle this challenge, both to improve people’s experience and to ensure best use of the resources available to councils and their NHS partners.

Specifically, there is a longstanding policy imperative to shift resources from expensive bed-based care by supporting people to maintain their independence in the community. This is a particular priority for people with long-term conditions, including dementia.\textsuperscript{98, 99}

A wealth of examples and case studies exist – for example, about joint approaches that have been successful in helping people to remain at home, avoid unnecessary admissions or return quickly after a spell in hospital.\textsuperscript{100, 101, 102, 103, 104} More are being generated through the King’s Fund’s \textit{Time to Think Differently} initiative.

Evidence about the cost-effectiveness of specific delivery models has so-far proved elusive\textsuperscript{105} – and the White Paper acknowledges that “\textit{there is no one size fits all model}” – but the local development of innovative joined-up services, and the associated development of joint performance assessment frameworks, are undoubtedly key priorities.
Evidence on the use of additional funds transferred from the NHS since 2010

Over the last two years concerns have been expressed that the combination of severe budget pressures affecting both the NHS and local government, and organisational turbulence, might set back the achievement of joint objectives. As described in chapter 2, extra funding has been channelled to social care from the NHS to mitigate these risks, with some positive outcomes. For example, since 2010/11 there has been a reduction in the numbers of delayed transfers from hospital, with the proportion attributable to social care falling faster. Overall, the number of delayed transfers reduced by 7% in 2011/12, and those attributable to social care reduced by 9%.

However, councils have had to use a large proportion of their extra funding to offset demographic pressures and to protect existing community services. This is evidenced in a recent report by MHP Health Mandate, which analyses available data on how the additional money has been spent, and maps the variation using a technique similar to that used to produce the NHS Atlas. The report exhorts councils and their partners to invest in areas that are proven to deliver better outcomes and to be cost-effective. Two of the most important of these are briefly reviewed below.

Reablement

MHP reports that in 2011/12, 18% of the additional funding for social care was allocated by local authorities to reablement services.

In addition, the Government has created a dedicated reablement fund – with £70 million allocated to Primary Care Trusts (PCTs) in 2010/11, £150 million in 2011/12 and £300 million each year for the following three years. The fund is designed to help reduce the numbers of delayed transfers from hospital and is associated with an expectation of more co-ordinated discharge support and fewer emergency re-admissions. There are promising signs that these allocations have helped to build momentum overall – although MHP suggests that not every local partnership has yet developed a transparent development plan.

There is no national data to record the prevalence of related initiatives, but it is clear that reablement, especially homecare reablement, has been placed at the heart of the ASC transformation agenda both nationally and locally. Over the last five years, the vast majority of councils have commissioned or introduced new services, with 52% of these services being commissioned in partnership with health, according to a recent source.

There is now a plethora of different models across the country – but variation in the extent to which these have been evaluated and in the methods used. Whilst some councils have reported positive outcomes including financial benefits, these tend to be offset by the costs of the initial reablement intervention. Overall, while there is international evidence, including longitudinal studies, on the cost-effectiveness of reablement, it is so far unclear whether short-term reductions in the use of home care achieved through home-care reablement in the UK are being translated into an overall reduction in expenditure on home care by councils, or indeed wider financial benefits, over time.
There is a clear case for prioritising this area in the national drive to collect more standardised evidence. In this respect, it is helpful that NHS Benchmarking plans to include homecare reablement in its national audit of intermediate care, from 2013 onwards.

Pending this, it has been suggested that homecare reablement may deliver better medium-term outcomes when it is seen not as a stand-alone service, but as an integral part of the overall approach of councils and their partners. For example, successes achieved by specialist teams can be undermined where people are subsequently transferred to mainstream domiciliary care services that do not have the same focus on promoting independence. The initial report from the LGA’s ASC efficiency programme states: “the view of reablement as a 6 week domiciliary care service will need to change so that everyone in receipt of care is being supported to achieve their goals that assist with independent living”. The report cites Wiltshire’s Help to Live at Home service as an example of this approach being put into practice.

However, according to the MHP report, only 4% of the extra NHS funding for ASC was allocated to telecare services in 2011/12.

This percentage may again give a misleading impression of the importance being attached to this regionally and locally. There is evidence that telecare has been extended to many more UK citizens over the last few years, often as a result of regionally-led initiatives. As a result, there are many useful resources and case studies available – for example – on TLAP’s website. This includes emerging evidence about the costs and benefits of offering telecare in different settings and for different groups. For example, some types of telecare are beginning to be offered by some councils as a universal preventative measure for people with relatively low levels of need. At the other end of the spectrum, it is being used within independent living settings for people with complex behavioural needs – sometimes enabling reductions in staffing levels and thus delivering significant cash-releasing savings. It would be useful to collate and evaluate all this evidence, and to introduce a more systematic approach to evidence-gathering in the future. The publication of more evidence from the ongoing Whole System Demonstrator sites should assist with this work.

The emerging messages from local evaluations are in some ways similar to those for homecare reablement. For example, councils are advised to adopt a business-like approach to telecare delivery, and robust benefits realisation plans, rigorously assessing whether telecare can substitute for other forms of support, rather than being an add-on. Those councils that have made good progress are aiming to make assistive technology an integral part of supporting people in the community, so its potential is considered at every step in the customer journey.

Telehealth and telecare

In December 2011 the Department of Health launched a campaign to support 3 million people over the next five years through the use of telehealth and telecare services. Clearly, the potential of these new technologies has not been sufficiently exploited in the UK to date, and the Government intends that they should play an important role in transforming the way health and social care services are delivered from now on.
They find that the rolling-out of telecare is strongly dependent on spreading awareness and understanding amongst care managers and other professionals in the community, and also across provider agencies. Put another way, the challenge is now to mainstream the use of telecare, as a key aspect of the preventative agenda of councils and their partners.

### Intermediate Care

Looking more widely, homecare reablement, assistive technology and rapid response services all play a part in the spectrum of services categorised as intermediate care which have recently been the subject of a major national audit. The audit report highlights “wide variation in service models being used nationally with differences evident in the extent of multi-agency integration, the scale of services provided, and how intermediate care sits within the full range of health and community services, in each local health economy.” The report notes that intermediate care services are jointly commissioned in only 58% of the local health economies in its study, suggesting clear scope for Health and Wellbeing Boards to ensure the development of more joined-up local investment strategies.

### Personal health budgets

The independent evaluation of the personal health budget pilots, published in November 2012, suggests that these have proved cost-effective. It indicates that the best results are achieved when they are implemented using the principles of self-directed support – when people know how much money is available to them at the start, have the flexibility to choose the services they want and can manage the money in a way that suits them best.

This evaluation is likely to add momentum to the process of rolling out personal health budgets. This is also consistent with the most recent recommendations of the NHS Future Forum. The Forum strongly backs more personalised approaches such as the Year of Care funding model which allow the funding to follow the patient. TLAP aims to support a joint approach, and a good practice toolkit has been produced to help primary care trusts, clinical commissioning groups and other health and care organisations with this work. The toolkit includes two documents that look specifically at the challenge of integrating personal budgets across health and social care, drawing on the learning from pilot areas and early adopters.

### The potential of Health and Wellbeing Boards

From April 2013, Health and Wellbeing Boards are expected to use strengthened collaborative partnerships to make best use of the resources available across sectors. The relevant guidance – which includes case studies of councils that have already made a good start – emphasises the importance of the following:

- **Adopting an asset based approach**: Joint Strategic Needs Assessments (JSNAs) should not only analyse the needs of local communities but also look at their assets.

- **Focussing on outcomes**: Health and Wellbeing Boards are encouraged to adopt an ‘outcomes-based approach’ – and to bear in mind the potential to bring the various national outcomes frameworks together.
- **Promoting integration**: Health and Wellbeing Boards and CCGs will have a duty to encourage integrated working of both commissioners and providers.

- **Engaging the public**: Health and Wellbeing Boards will have a duty to involve users and the public in the development of both the JSNA and the joint health and wellbeing strategy, and to pay due regard to the Public Sector Equality Duty.

There is wide consensus that the development of local joint measures of performance will be key to future success. The Audit Commission has explored potential indicators and produced useful suggestions and guidance in this area.\(^{126}\)

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**CASE STUDY L: Systematic approaches to local joint decision-making**

The Audit Commission’s 2011 report – *Joining up health and social care* – offers guidance on practical approaches that can be adopted to achieve better value for money across the NHS/local government interface. (For example, it gives one illustration – from Essex – of a technique that can be used to identify the top priority areas for joint investment, and then to map how investments and benefits might apply to councils and the NHS respectively).

The report identifies four priority areas for joint commissioning, and suggests the questions to ask and the action to take for each key area, supported by relevant evidence of successful outcomes. The four chosen areas are:

- High or rising emergency admissions
- High or rising admissions to residential or nursing care
- High or rising numbers of people discharged from hospital direct to residential or nursing homes
- Low or falling numbers of people dying at home.

The report emphasises the importance of using and sharing data across agencies. It cites the example of the 22 health and social care partnerships in the North West, who have worked together to compare performance data. Benchmarked scorecards have been developed for each locality, which help to identify areas for joint action and to track progress.
Conclusion

Continuing to prioritise integrated working

It is certain that the next few years will see further pooling of capital assets and budgets across the country, an extension of joint commissioning, shared management, and integrated service provision. There is only fairly limited evidence of the cost-effectiveness of specific approaches – and it is beyond the scope of this report to assess this complex area – but the relevant literature reinforces the importance of four of the themes that are central to this report:

- There is potential to achieve efficiencies by adopting a whole systems approach to budget management.
- In spite of sustained efforts in many parts of the country, progress remains uneven. There is wide variation in levels of investment in community health and care services, including intermediate care, and the outcomes being achieved.
- Structural solutions, by themselves, are unlikely to lead to improvement.
- Local history, leadership and relationships have important roles in building a shared sense of direction and in cementing joint working.
A PROBLEM SHARED – Making best use of resources in Adult Social Care
CONCLUSION
AND NEXT STEPS

This report has emphasised, throughout, that the ASC sector is characterised by disparity and local variation. So, the potential to address the ongoing budget pressures without detriment to local communities will vary markedly from place to place. This chapter draws broad conclusions about the scope for further efficiencies in the sector, and encourages councils to test the self-assessment toolkit that is being produced alongside this report. During 2013, TLAP and TEASC intend to produce further tools and guidance on cost-effective approaches, and would welcome feedback about the particular areas where more evidence should be collected and shared.

The scope for further efficiencies

The Audit Commission’s 2011 report, *Improving value for money in Adult Social Care*, explored nine potential areas of efficiency savings and suggested that at that stage, most councils had tackled some of them but none of them had tackled them all. Chapter 3 of this report showed that – as a result of councils’ work to use both the transactional and transformational methods suggested by the Audit Commission – national patterns of expenditure and activity are starting to shift.127

This report has not sought to minimise the scale of the challenge ahead, or to ignore the risks for local communities. On the other hand it has demonstrated – by illustrating marked regional and local differences between councils – that the scope to deliver further budget reductions varies considerably from one council to the next, and that the solutions will also vary from place to place.

Benchmarking using nationally available data – whatever their limitations in helping to assess good use of resources – can give councils and their partners important clues about the local priorities. This is why TEASC has considered it important to issue each council with a benchmarking report and to produce new, more user-friendly tools to enable them to make their own comparisons.128

At the same time, it is recognised that new performance frameworks will be essential. In this respect there are many promising initiatives already under way. Many regions are currently developing new agreed datasets, and many individual councils are producing their own performance frameworks. From 2013 onwards, the work of Health and Wellbeing Boards to develop local joint performance frameworks will be increasingly important.

To accompany this document – and to stimulate more thinking about how cost-effectiveness can be measured – a self-assessment toolkit has been produced.
This encourages councils to use the ADASS whole system framework as a basis for checking progress in six key areas. TLAP and TEASC hope that the toolkit will be tested, and refined during 2013 on the basis of feedback from the pilot sites. The toolkit is designed to be used flexibly, but our guidance recommends that better insights will be gained by involving a range of partners in the self-assessment process.

Developing the evidence base

Our consultation with councils in the course of developing the toolkit has already highlighted that more reliable evidence is needed on the cost-effectiveness of specific approaches and service interventions.

Over the past two years, ADASS has been collating evidence of efficient practice relating to the whole system framework. This is available on a website maintained by Improvement and Efficiencies South East (IESE). The evidence base will be significantly enhanced by the work of the LGA’s efficiency programme for ASC, which is monitoring work across 44 locations.

TLAP and TEASC now suggest the need for an even more concerted drive to collect and collate evidence about what works, and to develop practical tools for use by both council officers and elected members. It is hoped that testing the toolkit will help to identify particular areas where further evidence and guidance would be useful, and therefore to focus their work during 2013.
APPENDIX A

Membership of the Reference Group

Andrea Sutcliffe (Chair), Chief Executive, Social Care Institute for Excellence, TLAP and TEASC Boards

Oliver Mills, National Programme Director, TEASC

Martin Routledge, Director, TLAP (before Jan 2013)

Sam Bennett, Director, TLAP (from Jan 2013)

Frank Ursell, Chief Executive, Registered Nursing Homes Association, TLAP Board

Sue Bott, Director of Development, Disability Rights UK, Co-chair TLAP

Sarah Norman, Director of Community Services, Wolverhampton, ADASS

Simon Williams, Director of Community and Housing Services, LB Merton, ADASS

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