management charges for short breaks, day-time support or kinship support. Other costs may include special equipment or adaptations to the carer’s home, late cancellation, personal absence of the service user, and costs associated with carer recruitment such as advertisements, approval panel costs, GP reference fees, CRB checks, and carer training.

Service users have a licence agreement for their room in someone’s home; the rental element of this is eligible for housing benefit.

6. Strengths

The Shared Lives approach fits well with current government policy objectives to promote personalisation and the Big Society, by providing service users with a placement individually matched to their needs, and involving lay people in providing the service and maintaining a consistent relationship with the service user. Shared Lives gives service users access to family and community life, provided by ordinary people and families.

The service is very flexible, offering different amounts and types of support according to the individual’s changing needs and preferences.

The evaluation found high levels of satisfaction among service users and carers. More than three-quarters of the focus groups of service users, carers and staff agreed that the scheme achieves the following outcomes:

- Living the life the person wants
- Developing the person’s confidence, skills and/or independence
- Ongoing relationship between the person and the carer
- Having choices and being in control
- Having different experiences
- Wider social networks
- Increase in self-esteem,

All stressed the reciprocal nature of the relationship between carers and service users as a key distinguishing feature of the service.

7. Weaknesses and potential pitfalls

According to A Business Care for Shared Lives*, the main weaknesses of Shared Lives services are around financial issues. Problems were identified in the 2009 evaluation with financial systems, including difficulties in calculating some unit costs, and problems with transparency and fairness of tariffs for payments and charges. The 2009 study found inconsistencies in the way housing benefit rules were applied, inequitable payments for carers, fragmented payments, and difficulties accessing help to claim correct welfare benefits. NAAPS has however, during the past year produced a payment model for Shared Lives together with tools that should bring about a more rational and consistent approach to placement payments. They have also more recently produced guidance on outsourcing Shared Lives Schemes which includes guidance for Commissioners, as well as Scheme members.

CSCI (now CQC) inspection reports indicate that lack of appropriate care management involvement was the single most problematic issue for Shared Lives services. The 2009 study found that quality assurance systems were patchy or non-existent or unsatisfactory by CSCI in eight of the schemes which were studied.

The other potential problem area is recruitment of sufficient numbers of possible Shared Lives carers. The wider the pool of possible carers, the greater the likelihood that suitable referrals can be matched to an appropriate placement. Finding the right placement is critical to a successful outcome.

Focus groups with service users, carers and workers in four schemes highlighted the need to raise awareness of the schemes among the general public, in order to widen the pool of potential carers. NAAPS is currently recruiting a national Communications and Engagement Officer for this purpose.

1. Shared Lives compared with traditional residential placements, savings range from £46 to £995 per week, depending on the individual.

This case study was compiled for IRISS by the Institute of Public Care July 2011

1 NAAPS and Improvement and Efficiency South East (September 2009) An Evaluation of the Quality, Outcomes and Potential Pitfalls of Shared Lives in South East England. NAAPS and IESE
5 Social Services Activity, England – 2009-10 (initial release)
7 Social Services Activity, England – 2009-10 (initial release)
8 Social Services Activity, England – 2009-10 (initial release)
Shared Lives services, formerly known as Adult Placement, involve the provision of care and support in the homes of ordinary people to help individuals with learning disabilities.

Service users, carers and staff find that the service provided offers choice, control, greater independence and self-esteem for service users.

Compared with traditional residential placements, savings range from £46 to £995 per week, depending on the service user.

Shared Lives services are well supported by people with learning disabilities.

1. Introduction

This case study is based on an evaluation of the impact of the Shared Lives scheme in south east England, conducted in 2009. The study found that mainstream social care schemes provide ‘care that is good or excellent, care that meets national minimum standards, positive experiences and outcomes for people, high levels of satisfaction and a high proportion of people, delivering high quality support at a relatively low cost’.

2. Description

Shared Lives service is provided by individuals and families who provide care or support to people placed with them in their own home by local authority. NAPPS UK is now the National Association of Adult Persons Schemes, formerly the National Association of Adult Placement Schemes. NAAPS UK has characterised the key features of the service as:

- People using Shared Lives services have the opportunity to be part of the carer’s family and social networks.
- Carers can use their family home as a resource.
- Placements provide committed and consistent relationships.
- The relationship between the carer and the person placed with them is of mutual benefit.
- Carers can support up to three people care.
- Carers do not employ staff to provide care to the people placed with them. The carers taking part in the scheme can provide long-term accommodation and support; short-break/day-time support; rehabilitation; intermediate support; and kinship support where the carer acts as ‘extended family’ to someone living in their own home.

Carers are recruited, trained and supported by a Shared Lives scheme co-ordinator. The scheme usually runs on a per placement basis, carers receive referrals, match a service user with a carer, draw up a Placement Agreement, and monitor and support the placement. A Shared Lives carer is expected to provide a service between Scheme and Shared Lives carers cannot provide the care of which the scheme and the carer will work together and the roles and responsibilities with parties. Carers usually hold 24-hour responsibilities over the cost of a Shared Lives placement including board and lodging (£ per week).

3. Evidence of cost effectiveness

The Shared Lives scheme is an option for a wide range of people including people with learning disabilities. Shared Lives schemes are about small residential homes in family settings the family setting and the emphasis on community links, along with the matching process and care ratio. A survey in 2006 identified 15 schemes provided a service between Scheme and a carer, draw up a Placement Agreement, receive referrals, match the needs of service users with Shared Lives carers, and monitor the placements.

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The matching process is a key factor in a successful placement. Service users report that the relationship between themselves and their carer is a critical factor affecting the quality of service: ‘You’re allowed to have a relationship with your carer who is kind and even hug the maties, but you can’t do that with people in other places.’

Service user

‘There’s more to do now. I like being part of a family and supporting a football team and going to the pub.’

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1. Introduction

This case study is based on evaluation of the quality, outcomes and cost-effectiveness of Shared Lives services (formerly known as Adult Placement, then as Shared Lives services, and more recently as Adult Placement). In south east England, the service is currently in its fifth year of operation. The study found that many Shared Lives services schemes provide: care that is good or excellent, care that meets national standards, positive experiences and outcomes for people, high levels of satisfaction for carers, and value for money, delivering high quality support at a relatively low price.

2. Description

Shared Lives services are provided by individuals and families who provide care or support to people placed with them in their own home by service users. The NAAPS/IESE survey in 2009 found that 79% of Shared Lives schemes were rated as ‘good’ or ‘outstanding’. There was no difference between short-term and long-term placements. However, it is expected that they will spend some time apart, and participants will need access to the workplace.

The matching process is a key factor in a successful placement. Service users report that they are well-supported in their relationships with their placements. Service users report that they are well-supported in their relationships with their placements.

3. Evidence of cost effectiveness

Comparing CSCI ratings for Shared Lives schemes in south east England with carers’ evaluations, the NAAPS/IESE survey in 2009 found that 79% of Shared Lives schemes were rated excellent or good, compared with 57% of care homes. Service users in four such schemes in the south east were living in their own homes. The schemes in south east England with care home placements, such as day-time support and respite care, can deliver a high quality Shared Lives service. The 2009 study concluded that there may be more to do now. I like being with staff in other places."

4. Application – where it might be appropriate

The 2009 study concluded that there may be a scheme size below which it is difficult to deliver a high quality Shared Lives service and successful outcomes. The cost-effectiveness is greater in the larger schemes. A Business Case for Shared Lives estimates that a level of 85 placements is assumed. Greater efficiency can be realised through tasks such as planning and delivering training, recruiting and maintaining an Approval Panel, and achieving quality assurance systems. A Business Case for Shared Lives estimates that a level of 85 placements is assumed. Greater efficiency can be realised through tasks such as planning and delivering training, recruiting and maintaining an Approval Panel, and achieving quality assurance systems. A Business Case for Shared Lives estimates that a level of 85 placements is assumed. Greater efficiency can be realised through tasks such as planning and delivering training, recruiting and maintaining an Approval Panel, and achieving quality assurance systems.

Table 1

<table>
<thead>
<tr>
<th>Range of weekly payments to Shared Lives carers and management costs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Range</strong></td>
</tr>
<tr>
<td>All-in-price for long-term placement, including board and lodging (5 week)</td>
</tr>
<tr>
<td>Support in long-term placement</td>
</tr>
</tbody>
</table>

Source: NAAPS/IESE 2008 A Business Case for Shared Lives

Table 2

<table>
<thead>
<tr>
<th>Range</th>
<th>Overall charge (mean)</th>
<th>Management charge (mean)</th>
<th>Unit cost Shared Lives (mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td>361 58 419</td>
<td>319 491</td>
<td>293</td>
<td></td>
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</table>
Shared Lives services, formerly known as Adult Placement, involve the provision of care and support in the homes of ordinary people to people with learning disabilities, providing choice, control, greater independence and adult placement schemes have been well-suited to people — on the service user.

1. Introduction

This case study is based on an evaluation of the Money Matters case study one Shared Lives scheme (formerly known as Adult Placement in south east England, conducted in 2009). The study found that many of the key features of the service as: 

a. People using Shared Lives services have the opportunity to be part of the carer’s family and social networks.

b. Carers can use their family home as a resource.

c. Placements provide committed and consistent relationships.

d. The relationship between the carer and the person provided with them is of mutual benefit.

e. Carers can support up to three people care.

f. Carers do not employ staff to provide care to the people they are provided with. The carers taking part in the scheme can provide: long-term accommodation and support; short-break; day-time support; rehabilitation; intermediate support; and kinship support where the care acts as ‘extended family’ to someone living in their own home.

Carers are recruited, trained and supported by a Shared Lives scheme co-ordinator. The service usually involves the person receiving, receiving referrals, match a service user with a placement and support the placement. A Shared Lives carer does not act as a key worker or in contract to provide a service between Scheme and Shared Lives carers can be in the way in which the scheme and the carer will work together and the roles and responsibilities of both parties. Carers usually hold 24-hour responsibility for the people they support in long-term placements. However, it is expected that they will spend some time apart, and personal time in the work.

The matching process is a key factor in a successful placement. Service users report that the relationship between themselves and their carer is a critical factor affecting the quality of service: ‘You’re allowed to have a relationship with your family and even hug the mates, but you can’t do that with staff in other places.’

2. Description

Shared Lives is a service provided by individuals and families who provide care and support to people placed with them in their own home by a local authority. NAAPS UK(formerly the National Association of Adult Placement) characterises the key features of the service as: Shared Lives carer) sets out the way in which a carer, draw up a Placement Agreement, receive referrals, match the needs of service users with Shared Lives carers, and monitor the placements.

People using Shared Lives services share the same home, work and live with their care. Shared Lives carers, receive referrals, match the needs of service users with Shared Lives carers, and monitor the placements.

Such services are well-suited to people with learning disabilities, delivering high quality support at a relatively low price. Compared with traditional residential placements, range from £46 to £995 per week, depending on the service user.

— Shared Lives services appear particularly well-suited to people with learning disabilities.

3. Evidence of cost-effectiveness

The Shared Lives scheme is an option for a wide range of people including people with learning disabilities, older people and people with mental health needs. Shared Lives differs from small residential homes because of the shared family setting and the emphasis on community living and the matching process and the care ratio. A survey in 2006 identified 15 schemes operating across 19 local authorities in Scotland from the statutory and independent sectors. The number of clients placed in adult placements in England was 4,200 in 31 March 2010, an increase of 5 per cent from 4,000 in 2006. Over the same period, the number of clients aged 18-64 with a learning disability. In Scotland, national care standards for adult placements services were introduced in 2003, under the Regulation of Care (Scotland) Act 20014, and adult placement services have been regulated since April 2005. The Care Commission registers and inspects adult placements and she has referred to national statistics for the period of study.

The 2009 study concluded that there may be a scheme size below which it is difficult to deliver a high quality. Shared Lives services are an example of the successful outcomes of Shared Lives is good or excellent, care that meets national minimum standards, positive experiences and value for money’, and the roles and responsibilities of both parties. Carers usually hold 24-hour responsibility for the people they support in long-term placements. However, it is expected that they will spend some time apart, and personal time in the work.

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6. Strengths

The Shared Lives approach fits well with current government policy objectives to promote personalisation and the Big Society, by providing service users with a placement individually matched to their needs, and involving lay people in providing the service and maintaining a consistent relationship with the service user. Shared Lives gives service users access to family and community life, provided by ordinary people and families.

The service is very flexible, offering different amounts and types of support according to the individual’s changing needs and preferences. The evaluation found high levels of satisfaction among service users and carers. More than three-quarters of the focus groups of service users, carers and staff agreed that the service achieves the following outcomes:
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- Increase in self-esteem

All stressed the reciprocal nature of the relationship between carers and service users as a key distinguishing feature of the service.

7. Weaknesses and potential pitfalls

According to A Business Care for Shared Lives’, the main weaknesses of Shared Lives services are around financial issues. Problems were identified in the 2009 evaluation with financial systems, including difficulties in calculating some unit costs, and problems with transparency and fairness of tariffs for payments and charges. The 2009 study found inconsistencies in the way housing benefit rules were applied, insubstantial payments for carers, fragmented payments, and difficulties accessing help to claim correct welfare benefits. NAAPS has however, during the past year produced a payment model for Shared Lives together with tools that should bring about a more rational and consistent approach to placement payments. They have also more recently produced guidance on outsourcing Shared Lives Schemes which includes guidance for Commissioners, as well as Scheme members.

8. Sources of further information

NAAPS UK: http://www.naapps.org.uk/NAAPS UK is the UK network for family-based and small-scale ways of supporting adults to live independently and to contribute to their families and communities, including Shared Lives.

NAAPS UK (Scotland): http://www.naapps.org.uk/uk/shared-lives-membership/naapps-scotland/DFE/DFE551D/5827E7819353bac0ae2626b33007cb0.

http://www.scie.org.uk/publications/ataglance/ataglance02.asp


1. NAAPS and the Institute of Research and Innovation in Social Services (IRISS) are independent and wholly autonomous organisations.

This case study was compiled for IRISS by the Institute of Public Care.

Money Matters reviews of cost effective initiatives

www.moneymatters.org.uk

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The other potential problem area is recruitment of sufficient numbers of possible Shared Lives carers. The wider the pool of possible carers, the greater the likelihood that suitable referrals can be matched to an appropriate placement. Finding the right placement is critical to a successful outcome.

Focus groups with service users, carers and workers in four schemes highlighted the need to raise awareness of the schemes among the general public in order to widen the pool of potential carers. NAAPS is currently recruiting a national Communications and Engagement Officer for this purpose.

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NAAPS UK’s bid to the UK network for family-based and small-scale ways of supporting adults to live independently and to contribute to their families and communities, including Shared Lives.

NAAPS UK (Scotland): http://www.naaps.org.uk/uk/shared-lives-membership/naaps-scotland

instituteforpubliccare.org.uk

Money Matters reviews of cost effective initiatives

www.iniss.org.uk

1. Shared Lives compared with traditional residential placements, savings range from £46 to £995 per week, depending on the individual.

Money Matters case study one

Table 2

<table>
<thead>
<tr>
<th>Type of service</th>
<th>National unit cost per week £</th>
<th>Shared Lives unit cost £ per week (average)</th>
<th>Potential savings per unit £ per week if person is rather than elsewhere</th>
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</thead>
<tbody>
<tr>
<td>Learning disability residential care</td>
<td>1,059</td>
<td>419</td>
<td>640</td>
</tr>
<tr>
<td>Older people residential care</td>
<td>465</td>
<td>419</td>
<td>46</td>
</tr>
<tr>
<td>Physical disability residential care</td>
<td>780</td>
<td>419</td>
<td>361</td>
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<tr>
<td>Mental health residential care</td>
<td>602</td>
<td>419</td>
<td>153</td>
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<tr>
<td>Learning disability supported living</td>
<td>1,288</td>
<td>293</td>
<td>955</td>
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</tbody>
</table>

or tenancy, although residents did pay the well-being charge. There was evidence of more than a 50% reduction in health care costs after the move. National estimates of unit costs (per visit or per hour as appropriate) were used for each of the social care services. However, in both situations, the public purse is picking up the bill. The increase in the take-up of these benefits and allowances following moves to Rowanberries represents people receiving income support who were previously entitled to it, rather than an increase in public expenditure. In terms of outcomes, residents reported no significant improvements overall in their self-perceived health after moving into Rowanberries. However, they did report a significant improvement in their quality of life, and a decrease in their level of unmet need across seven areas. The most significant improvement was in terms of social participation and involvement; nearly two-thirds reported that they had a good social life after moving into Rowanberries, whereas half of residents said that they had not had much or were socially isolated in their previous homes. Residents also reported increased feelings of control over daily living. These improvements appear to be associated with better access to the care services and support provided by Rowanberries.

The study provides valuable evidence that when the costs of moving into ECH are measured comprehensively, they are substantial, but that ECH allows a better take-up of the benefits and allowances for which they were eligible. The findings indicate that residents of Rowanberries had improved access to social and health care services, and therefore better take-up of the benefits and allowances for which they were eligible.

7. Weaknesses and potential pitfalls

The overall cost of the scheme per resident per year was higher than at Rowanberries, but mainly due to the higher costs of social care and accommodation.

The savings achieved in terms of health care were not transferred over to social care, providing little incentive to social care providers to invest in this kind of housing with care provision. There were no significant improvements in physical health among residents after six months living in Rowanberries.

8. Sources of further information


Housing LIN (2006), Extra Care Housing Toolkit, CSSR, Department of Health.


This case study was compiled for IRSS by the Institute of Public Care.

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4. Application – where it might be appropriate

Rowanberries ECH delivered positive outcomes for both residents and carers. Residents reported high levels of satisfaction with care received, significant improvements in their quality of life, and a decrease in their levels of unmet need across seven domains. Carers’ costs were significantly reduced when residents moved into Rowanberries.

Extra-care housing widens the options available to older people in terms of housing with care, providing a positive alternative to residential care with an emphasis on maintaining independence and empowerment.
Extra-care housing widens the housing options for older people, providing self-contained accommodation, flexible access to 24-hour care, accessible housing, and an emphasis on empowerment.

The Rowanberries extra-care housing scheme in Bradford improved social care outcomes for residents and their quality of life, as well as delivering cost savings for carers.

Overall health costs for residents of Rowanberries fell by £68 per week after moving into the scheme, while take-up of benefits increased.

—

Overall costs increased as a result of people moving into the Rowanberries ECH scheme, due mainly to increased social care and accommodation costs.

### Table 1

<table>
<thead>
<tr>
<th>Health care costs</th>
<th>In previous home</th>
<th>In Rowanberries</th>
</tr>
</thead>
<tbody>
<tr>
<td>In resident</td>
<td>123.5</td>
<td>121.0</td>
</tr>
<tr>
<td>In non-resident</td>
<td>53.3</td>
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<table>
<thead>
<tr>
<th>Description</th>
<th>In previous home</th>
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</thead>
<tbody>
<tr>
<td>Day hospital</td>
<td>3.6</td>
<td>6.5</td>
</tr>
<tr>
<td>GP at surgery</td>
<td>7.3</td>
<td>3.0</td>
</tr>
<tr>
<td>GP at home</td>
<td>3.4</td>
<td>2.6</td>
</tr>
<tr>
<td>Nurse at GP surgery</td>
<td>1.9</td>
<td>1.5</td>
</tr>
<tr>
<td>Nurse at home</td>
<td>0.1</td>
<td>0.8</td>
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<tr>
<td>Social worker</td>
<td>0.7</td>
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<tr>
<td>AE department</td>
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<tr>
<td>Outpatient appointment</td>
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<tr>
<td>Inpatient stay</td>
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<tr>
<td>Social care costs</td>
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<td>Day centre</td>
<td>20.2</td>
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<tr>
<td>Lunch club</td>
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<td>0.3</td>
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<tr>
<td>Meals on wheels</td>
<td>3.7</td>
<td>2.8</td>
</tr>
<tr>
<td>Restaurant at scheme</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
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<td>9.3</td>
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<td>40.3</td>
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</table>

<table>
<thead>
<tr>
<th>Accommodation costs</th>
<th>In previous home</th>
<th>In Rowanberries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupation</td>
<td>119.9</td>
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<tr>
<td>Owner-occupied</td>
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<tr>
<td>Self-reported</td>
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<td>Livestock analysis</td>
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<td>Maintenance</td>
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<td>Rented</td>
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<tr>
<td>Rent-only</td>
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<tr>
<td>Service and management</td>
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<tr>
<td>Repairs allowance</td>
<td>40.0</td>
<td>40.3</td>
</tr>
<tr>
<td>Additional housing costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water rate</td>
<td>4.9</td>
<td>4.9</td>
</tr>
<tr>
<td>Hot water and heating (individual)</td>
<td>5.1</td>
<td>5.1</td>
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<tr>
<td>Living expenses</td>
<td>78.0</td>
<td>77.9</td>
</tr>
<tr>
<td>Personal expenses</td>
<td>7.6</td>
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</tr>
</tbody>
</table>

Total cost per resident per week

Extra-care housing widens the housing options for older people, providing self-contained accommodation, flexible access to 24-hour care, accessible housing, and an emphasis on empowerment.

The Rowanberries extra-care housing scheme in Bradford improved social care outcomes for residents and their quality of life, as well as delivering savings for carers.

Overall health costs for residents of Rowanberries fell by £580 per week after moving into the scheme, while take-up of benefits and allowances increased.

Overall costs increased as a result of people moving into the Rowanberries ECH scheme, due mainly to increased social care and accommodation costs.

1. Introduction

This case study is based on a 'before-and-after' evaluation for the Joseph Rowntree Foundation of the costs and outcomes of an extra-care housing scheme in Bradford completed in 2008. Extra-care housing (ECH) is an intermediate tier of housing, care and support for older people, which has widely promoted as a means of maintaining independence, and as an alternative to residential care for older people. It has attracted significant government and local authority support, and is thought to be a viable way of reducing social care costs. The evaluation concluded that overall costs increased as a result of people moving into the ECH scheme, but this was associated with improved social care outcomes and perceived quality of life.

2. Description

There is no official definition of ECH, however it is usually taken to include: self-contained accommodation, access to 24-hour care and other facilities, a fully accessible environment, and an emphasis on supporting and maintaining independence.

The Rowanberries extra-care housing scheme is a purpose-built mixed tenures development of 46 self-contained apartments, developed as part of a joint project between Bradford Adult Services and the Methodist Homes Housing Association (part of the MHA Care Group). The scheme comprises 20 one-bedroom and 26 two-bedroom apartments. The building has lift and wheelchair access throughout its four storeys. There is a range of communal facilities including: a café/restaurants, activities room, laundry, hairdresser and assisted bathrooms. Twenty-four hour care is provided on site by a dedicated care worker with the Care Quality Commission as the provider. The level of care provided by Rowanberries is comparable with residential care (E483 per week in 2007), although the people moving into ECH are considerably more independent.

The difference in the costs of social care before and after moving in was mainly driven by an increase in the costs of support to the residents and the costs of home care received (an average of £69 per week before moving, compared with £40 before moving to Rowanberries). The mean number of hours of home care received was 0.68 hours per week per resident before moving to Rowanberries, compared with 4.95 hours after moving in. In addition, 45% of residents reported seeing a social worker at a lower frequency. Costs of support and assistance in emergencies, medication ordering and administration, and contacting and arranging appointments with other professionals were estimated as equivalent to the ‘well-being charge’ of £58 per week.

The comparison of social care costs was complicated by whether or not meals in the restaurant were treated as living expenses or social care. Given that all except one resident in the sample stopped receiving meals-on-wheels or using a lunch club after moving in, some of the higher overall costs were due to higher accommodation costs (not unexpected for a new purpose-built scheme). Accommodation costs included an annualised capital cost of £54 per person per week, based on a 60-year scheme life, revenue costs of £57 per person per week including staff costs, repairs, utilities and local costs. The method of costing is shown below. Resident accommodation costs of £110 per person per week before moving into Rowanberries, and £141 per week after moving. A limited survey in the overall net housing stock was estimated as a result of the moves into ECH.

The level of capital subsidy for accommodation costs increased significantly following the introduction of small number of people who were previously in private sector housing. Equally, care and support costs increased as these would have been self-funded by some residents in their previous homes, but were not charged for in the scheme. In Rowanberries, all the extra-care housing was provided by Bradford Adult Services Department regardless of income, savings being assured.

Accommodation costs included an annualised capital cost of £84 per person per week, based on a 60-year scheme life, revenue costs of £57 per person per week including staff costs, repairs, utilities and local costs. The method of costing is shown below. The comparison of social care costs was complicated by whether or not meals in the restaurant were treated as living expenses or social care. Given that all except one resident in the sample stopped receiving meals-on-wheels or using a lunch club after moving in, some of the higher overall costs were due to higher accommodation costs (not unexpected for a new purpose-built scheme). Accommodation costs included an annualised capital cost of £54 per person per week, based on a 60-year scheme life, revenue costs of £57 per person per week including staff costs, repairs, utilities and local costs. The method of costing is shown below. Resident accommodation costs of £110 per person per week before moving into Rowanberries, and £141 per week after moving. A limited survey in the overall net housing stock was estimated as a result of the moves into ECH.

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### 1. Introduction

This case study is based on a 'before-and-after' evaluation for the Joseph Rowntree Foundation of the costs and outcomes of an extra-care housing scheme in Bradford completed in 2008. Extra-care housing (ECH) is a form of housing with care which has been widely promoted as a means of maintaining independence, and as an alternative to residential care for older people. It has attracted support and capital funding from the government. According to the Elderly Accommodation Coalition (EAC), there are an estimated 100 ECH schemes in the UK. The evaluation conducted as part of the study was to quantify the costs associated as a result of moving into the Rowanberries ECH scheme, but this was associated with improved social care outcomes and perceived quality of life.

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### 3. Evidence of cost effectiveness

The analysis is based on data obtained from 40 of the original residents of the ECH scheme, with a follow-up after six months of 22 residents. The findings suggest that the costs associated with living in the scheme were higher than when people received care in their former homes. The broad cost components of the analysis, which together represented the total weekly cost of a resident in the scheme, were:

- **Health care service cost**
- **Social care service cost**
- **Capital costs of the accommodation**
- **Running (maintenance and/or repair) cost**
- **Other living expenses**

The sum of these costs (see Table 1) gives an average weekly cost per resident of £483 before moving in, compared with £470 six months after moving into Rowanberries. At £470, the estimated weekly package costs in 2007 were:

- **Personal expenses**
- **Water rates**
- **Repairs allowance**
- **Additional housing costs**
- **Gifts and bequests**
- **Interest on investments**
- **Meals on wheels**
- **Laundry**
- **Meals at scheme**
- **Locational analysis**
- **Assessment and management**
- **Chiropodist**
- **A&E department**
- **Doctor visits**
- **Total cost per resident per week**

### Table 1

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<tr>
<td>Social worker</td>
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Overall costs increased as a result of people moving into the Rowanberries ECH scheme, due mainly to increased social care and accommodation costs.
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An additional key element of care is that of unpaid, informal carers. Care-giving includes: direct financial expenditure for example, laundry and travel; paid and unpaid time spent caring; costs of giving up career opportunities; and accommodation costs. Based on an analysis of these costs, the average cost to the carer was calculated to be £80 per week before the person moved into Rowanberries, and £25 per week after the move. In addition, more than one-third of carers thought that their own quality of life had improved after the move to Rowanberries. They were more likely to see a nurse since living at Rowanberries, and £25 per week after the move. In addition, more than one-third of carers thought that their own quality of life had improved after the move to Rowanberries.

The study provides cautious evidence that when the costs of moving into ECH are measured comprehensively, they are substantial, but that ECH appears to deliver important benefits to residents and informal carers in terms of improved social care outcomes and quality of life.

4. Application – where it might be appropriate

The high level of satisfaction reported by residents with the care received (95%) indicates the suitability of extra-care housing for a range of older people with a wide variety of needs. The study concluded that someone with 24-hour care needs would be better off financially paying the well-being charge than they would be in residential care, especially if they were previously an inpatient occupier. In contrast, people with lower care needs might find it more advantageous to take up the benefits and allowances for which they were eligible.

The findings indicate that residents of Rowanberries ECH had improved access to social care and housing services, along with a better take-up of the benefits and allowances for which they were eligible.

7. Weaknesses and potential pitfalls

The overall cost of the scheme per resident per week was higher if residents had remained in their formal homes, due mainly to the higher costs of social care and accommodation. The savings achieved in terms of better access to health care and housing were not transferred over to social care, providing little incentive to social care providers to invest in this kind of housing with care provision.

There were no significant improvements in self-perceived health among residents after six months living in Rowanberries. The study concluded that the findings were due to a small sample in an ECH scheme. A clearer indication of the cost benefit ratio of ECH will be available when the national evaluation of ECH by PSSRU is published in the autumn of 2011.

8. Sources of further information


The evaluators raise a number of methodological points which highlight the need to be cautious in assuming the findings will apply equally to all other ECH schemes, for example, variation on costs across the country, the 60% of needs. The study is based on a relatively small sample of seven areas. Carers’ reported increased feelings of control over daily living. These improvements appear to be associated with better access to the care services and support provided by Rowanberries.

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The findings indicate that residents of Rowanberries ECH had improved access to social care and housing services, along with a better take-up of the benefits and allowances for which they were eligible.
or tenancy, although residents did pay the well-being charge. There was evidence of more than a 50% reduction in health care costs after the move. National estimates of unit costs per day varied as a result of health care service. Overall, health service costs fell after people had moved, by an average of £38 per resident per week. The greatest single difference was in the number of visits at home – a mean decrease of £57 per week. Although the proportion of residents who were seen by a nurse at home increased (32% before compared with 73% after the move to Rowanberries), the mean number of consultations per resident decreased from around 22 to 11 visits in six months. The proportion of residents accessing hospital services, such as accident and emergency, outpatient appointments and inpatient stays was slightly lower in all instances after the move to Rowanberries. Residents who had previously been inpatient were more likely to see a doctor at Rowanberries. It appears that residents had better access to health services than an increase in health needs.

An additional key element of care is that of unpaid, informal carers. Care-giving costs included: direct financial expenditure for accommodation costs, which, for example, in residential care are nearly all covered by the social care budget, however, in both situations, the public purse is picking up the bill. The increase in the take-up of these benefits and allowances after moving to Rowanberries represents people receiving income which they were previously entitled to, rather than an increase in public expenditure. In terms of outcomes, residents reported significant improvements overall in their self-perceived health after moving into Rowanberries. However, they did report a significant improvement in their quality of life, and a decrease in their level of unmet need across seven areas. The most significant improvement was in terms of social participation and involvement; nearly two-thirds reported that they had a good social life after moving into Rowanberries, whereas half of residents said that they had felt lonely and socially isolated in their previous homes. Residents also reported increased feelings of control over daily living. These improvements appear to be associated with better access to the care services and support provided by Rowanberries. The study provides cautious evidence that when the costs of moving into ECH are measured comprehensively, they are substantial, but that ECH achieves better outcomes for residents and informal carers in terms of improved social care outcomes and quality of life.

4. Application – where it might be appropriate

The high level of satisfaction reported by residents with the care received (95%) indicates the suitability of extra-care housing for a range of older people with a wide variety of needs. The study concluded that someone with 24-hour care needs would be better off financially paying the well-being charge than they would be in residential care, except if they were previously an inner occupier. In contrast, people with lower care needs might not necessarily have a financial incentive to move to the Rowanberries as it would be more advantageous for them to continue to pay for care in their former home. The evaluators raise a number of methodological points which highlight the need to be cautious in assuming the findings will apply equally to all other ECH schemes, for example, variation on costs across the country, the 60-year life span of the scheme in Bradford, York: JRF. Information on costs and outcomes of an extra-care housing scheme in Bradford, Housing LIN (2006), Extra Care Housing Toolkit, CSIP, Department of Health. The overall cost of the scheme per resident per week was higher if residents had remained in their former homes, due mainly to the higher costs of social care and accommodation. The savings achieved in terms of health care costs were not transferred over to social costs, providing little incentive to social care providers to invest in this kind of housing with care provision. There were no significant improvements in self-perceived health among residents after six months living in Rowanberries. The findings indicate that residents of Rowanberries had improved access to social and health care services, as well as better take-up of the benefits and allowances for which they were eligible.

7. Weaknesses and potentials and pitfalls

The overall cost of the scheme per resident per week was higher if residents had remained in their former homes, due mainly to the higher costs of social care and accommodation. The savings achieved in terms of health care costs were not transferred over to social costs, providing little incentive to social care providers to invest in this kind of housing with care provision. There were no significant improvements in self-perceived health among residents after six months living in Rowanberries. The findings indicate that residents of Rowanberries had improved access to social and health care services, as well as better take-up of the benefits and allowances for which they were eligible.

2. Extra-care housing widens the housing options for older people providing self-contained accommodation, flexible access to health and social care, assisted housing, and an emphasis on empowerment

Bäumker, T, Nattan, A & Darton R (2008) Costs and outcomes of an extra-care housing scheme in Bradford, York: JRF. Information on costs and outcomes of an extra-care housing scheme in Bradford, Housing LIN (2006), Extra Care Housing Toolkit, CSIP, Department of Health. The overall cost of the scheme per resident per week was higher if residents had remained in their former homes, due mainly to the higher costs of social care and accommodation. The savings achieved in terms of health care costs were not transferred over to social costs, providing little incentive to social care providers to invest in this kind of housing with care provision. There were no significant improvements in self-perceived health among residents after six months living in Rowanberries. The findings indicate that residents of Rowanberries had improved access to social and health care services, as well as better take-up of the benefits and allowances for which they were eligible.

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A significant reduction in depression scores was observed over time, alongside reported improvements by some and users alike with regard to social inclusion and well-being.

### 4. Application – where it might be appropriate

This approach based on prevention and early intervention is appropriate for older people with mental health needs and their carers, both with organic and functional mental health problems.

Although initially it was expected that carers would attend the cafés, as the programme developed, this restriction was dropped. The well-being cafés and activities provide a useful alternative to day care, which may be of particular interest to people with a personal budget.

In Bradford, the cafés are now fully embedded and mainstream services and the number of sessional cafés has increased from 12 to 19.

### 5. Resources required – staff, training, IT

The CIP Project Officers were qualified as Peer Educators (or enrolled on the course) which gave them the skills to deliver mental health training free of charge for community and voluntary sector organisations. Café organisers reported that preparation for and running each café took an unanticipated amount of time: one estimated around 25 hours per café. In addition, they identified a need for a basic overview of mental health and information regarding conflict resolution.

Staffing requirements specified that a member of the CMHT should attend each café session. Although initially it was expected that carers would attend the cafés, as the programme developed, this restriction was dropped. The well-being cafés and activities provide a useful alternative to day care, which may be of particular interest to people with a personal budget.

In Bradford, the cafés are now fully embedded and mainstream services and the number of sessional cafés has increased from 12 to 19.

### 6. Strengths

Health in Mind achieved a significant increase in the capacity of voluntary and community organisations to support older people with mental health problems through the provision of the well-being cafés and well-being activities, optimising existing, and unlocking untapped, mental health support. The project was successful in raising awareness of older peoples’ mental health issues across the community and voluntary sector. Training and education needs were identified and addressed, for example, the RTC developed services through the CIP activity fund for groups of older people who were not well engaged in the skills or capacities to develop their own community groups. The project team was also able to foster networking between different groups and organisations.

The well-being cafés were perceived to be serving several purposes: early identification of people with a mental health need; seeing people over an extended period of time; acting as a step-down to other services. There were benefits not just for those who only used the well-being cafés and activities, but also for those who were referred on to another service. The cafés also had considerable success in overcoming some of the stigma attached to discussing mental health, and reduced social isolation was reported by attendees, both during the time they were at the café, and also outside of the café because of friendships that had been formed at the café. There were many reports about how enjoyable attendance at the cafés was for service users and/or their carers. The CIP served a significant number of older people from BME communities. The larger ethnic minority groups in Bradford were well represented in the cafés: in particular, Indian older people who comprised 4.9% of service users. The evaluation noted the importance of simple application procedures for grants for well-being activities and the need to ensure speedy transfer of funds for activities. The evaluation also highlighted the need to continue assessment of education and training needs for host groups; and to improve integration between primary health care services and the community and voluntary sector.

### 7. Weaknesses and potential pitfalls

Café organisers reported an unexpected amount of time involved in both setting up and running the cafés. Some café hosts reported feeling disconnected from sources of professional advice and support. Links with specialist mental health services and knowledge about older peoples’ mental health areas were areas which some café hosts identified as problematic.

### 8. Sources of further information


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2. £ 473,200

### Table 1

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<thead>
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Figures from Health in Mind Programme Evaluation (2008)
1. Introduction

This case study draws on the evaluation of the Bradford Partnership for Older People Programme (POPP), Health in Mind, conducted in the University of Bradford. The Health in Mind programme aimed to expand mental health services for older people, both those with mental health problems and those at risk of developing mental health problems.

The objectives of the project were to:

- Equip service users and carers with the knowledge, skills and resources to actively manage and plan for future care needs.
- Enable older people with mental health needs and their carers to find support.
- Identify and address social and economic barriers to accessing needed care and support.
- Build on existing good practice.
- Develop new initiatives to help older people and their carers.
- Improve capacity in the community.
- Enable older people with mental health needs and their carers to maintain social relationships and access to community activity.
- Create a successful hub that made contact with groups that were previously unknown to statutory services and voluntarily supported them through the development, building of relationships, and advice sessions.
- Users and carers could access free specialist mental health training, although the period was extended to three years.
- Community Mental Health Teams, although the first point of contact for people with emerging mental health needs, were projected to increase to an annual total of 2,160 people attending well-being cafés and 3,000 people taking part in well-being activities by year four. The largest age group taking part was the group aged 75-84.

2. Well-being cafés

Building on a pilot project run by the Bradford Alzheimer’s Society, 12 ‘well-being’ cafés (socially-focussed mental health activities) were established, providing open-door access to mental health information and services - a first point of contact for people with emerging needs. The cafés allowed for open access for carers to find support.

The 12 ‘well-being’ cafés were developed to an initial specification which included expected outcomes for particular groups, and organisational and sectoral outcomes, along with specifications of facilitation, intervention provision and provision for carers, including the gradual inclusion of education and advice sessions. The evaluation aimed to identify and potentially benefit from the involvement of the Community Mental Health Teams, although the regular attendance of specialist mental health staff in the well-being cafés had mixed results.

Cafés ran monthly in a variety of locations throughout the authority. Two cafés - one delivering the Bradford Alzheimer’s Society’s memory cafe for South Asian people, women with dementia; nine of the cafés were not dementia-specific. The cafés served a range of black and minority ethnic groups across the authority: one café was for Europeans, one for South Asians, and one for African Caribbean community.

Cafés provided lunch and a range of minority and other social events in both the Well-being cafés as well as in the larger voluntary sector, providing opportunities for building relationships.

Free specialist mental health training was provided to a range of sector workers, including the gradual inclusion of education and advice sessions.

Data obtained from 76 attendees at the well-being cafés and other funded services and well-being activities. In the case of well-being cafés, the largest age group taking part was the group aged 75-84.

3. Evidence of cost-effectiveness

Changes in the design of the Health in Mind programme and the relatively short period of implementation completed at the time of the analysis mean that conclusions about long-term sustainability and value for money are tentative and dependent on the achievement of projected cost outcomes in the coming years.

The costs used in the analysis were the actual costs for the first two years and the proposed cost for the forthcoming two years. The Year 4 proposed funding was assumed to be maintained until Year 10 (see Table 2). It should be noted that, ideally, all costs should be measured in constant prices for the base year (i.e. 2007/8). However, no attempt was made to adjust the budget values on the grounds that the changes would have been within the margin of error of the data used for calculation purposes.

Only the project costs were measured as no data were available to measure additional costs. Therefore, indirect costs involved in the CIPW imply that the project would be wholly or fully covered their costs. There is some evidence to suggest that additional costs were borne by the organisations themselves. Valuation of the outcomes is a difficult one, as the ‘willingness to pay’. An alternative cost saving would be from the reduction of services, if it was replacing set costs of equivalent activities. In the case of well-being cafés, the comparison was with day care, although it is clear that many of the users of the café would not have otherwise used day care facilities.

In the case of the well-being activities, a cost benefit analysis was conducted to determine the net benefits of more than net benefits of more than “willingness to pay. A” alternative cost saving would be from the reduction of services, if it was replacing set costs of equivalent activities. In the case of well-being cafés, the comparison was with day care, although it is clear that many of the users of the café would not have otherwise used day care facilities.

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1. Introduction

This case study is based on the evaluation of the Bradford Partnership for Older People Programme (POP), Health in Mind, conducted in the University of Bradford. The Health in Mind programme aimed to expand mental health support across different communities, with a focus on older people and mental health problems. The objectives of the project were to:

- Enable older people with mental health needs and their carers to access mental health support and relationships with their local self-defined community.
- Achieve a range of black and minority ethnic groups not dementia specific. The cafés served a range of black and minority ethnic groups, with one café being specifically for the African/Caribbean community.
- Provide a weekly community meal and activity providers for café hosts to invite.
- Provide a list of contact details for willing speakers to provide support for café hosts and activity providers.
- Provide a range of activities from socialising, exercise (e.g., walking, tai chi), personal development (e.g., IT skills programmes), arts and cultural activities (e.g., creative writing, cinema, art classes), trips out (e.g., pub/café lunches) and educational talks and discussions with guest speakers.
- Include a range of activities from socialising, exercise (e.g., walking, tai chi), personal development (e.g., IT skills programmes), arts and cultural activities (e.g., creative writing, cinema, art classes), trips out (e.g., pub/café lunches) and educational talks and discussions with guest speakers.

In the year 2007-2008, £270,719 was allocated to the project, with a steady growth in the numbers of attendees. In the first year, 2,000 people attended the well-being cafés with an average of 73 people per café. In the second year, the number of attendees was 73 years (range 49-93). With identifiable mental health needs. The mean age of attendees was 73 years (range 49-93). The mean age of attendees was 73 years (range 49-93).

2. Description

The Community Involvement Project (CIP) (1998-2003) was a 5-year initiative to support four inter-related initiatives in the Bradford district to provide support for older people, both those with, and those at risk of developing, mental health problems. The project aimed to develop a programme of support to enable older people with mental needs and their carers to build relationships with their peers and wider communities. Funding was provided to support a range of activities, including socialising, exercise (e.g., walking, tai chi), personal development (e.g., IT skills programmes), arts and cultural activities (e.g., creative writing, cinema, art classes), trips out (e.g., pub/café lunches) and educational talks and discussions with guest speakers. The evaluation of the CIP found that the initiative had an impact on a wide range of entertainer. The mean age of attendees was 73 years (range 49-93).

2.2 Well-being Activity Fund (WAF)

In partnership with the Voluntary and Community Sector (VCS), the project aimed to develop a programme of support to enable older people with mental needs and their carers to build relationships with their peers and wider communities. Funding was provided to support a range of activities, including socialising, exercise (e.g., walking, tai chi), personal development (e.g., IT skills programmes), arts and cultural activities (e.g., creative writing, cinema, art classes), trips out (e.g., pub/café lunches) and educational talks and discussions with guest speakers. The evaluation of the CIP found that the initiative had an impact on a wide range of entertainers. The mean age of attendees was 73 years (range 49-93).

3. Evidence of cost effectiveness

Changes in the design of the Health in Mind programme and the relatively short period of implementation completed at the time of the evaluation mean that conclusions about long-term sustainability and value for money are not otherwise available. The evaluation mean that conclusions about long-term sustainability and value for money are not otherwise available. The evaluation mean that conclusions about long-term sustainability and value for money are not otherwise available.
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This study is based on the evaluation of the Bradford Partnership for Older People Programme (PPR), Health in Mind, conducted in the University of Bradford. The Health in Mind programme aimed to expand mental health support across community and primary care networks.

A significant reduction in—half a million pounds. The initiative is projected to achieve a ten-year period, the development of a Community Mental Health Involvement Project (CIP), which funded a network of mental health well-being cafés and the development of a community involvement to mental health problems. The Community Involvement Project (CIP) was funded by the University of Bradford1. The Health in Mind programme aimed to expand mental health support across community and primary care networks.

The objectives of the project were to:

- Better understand how to meet the needs of people marginalised within the network of well-being cafés.
- Enable older people with mental health needs and their carers to access free specialist mental health training was also offered.
- Free specialist mental health training was also offered.
- Increase uptake of mental health support, and acting as a first point of contact for people with emerging mental health problems.
- The well-being cafés were replaced with a range of activities for participants, such as educational talks and discussions with guest speakers, and information and education. The grants covered a list of contact details for willing speakers and practitioners (e.g. memory assessment, social work and telephone advice, mental health support across community and primary care networks.

2.2 Well-being Activity Fund (WAF)

In partnership with the Voluntary and Community Sector (VCS), the project aimed to develop a programme of support to enable older people with mental needs and their carers to build networks and develop relationships with others like themselves.

The evaluation concluded that the activities should reflect the interests of groups and organisations that would be representative of the community's interests, and 'hosted' by Bradford's diverse population: some sessions were targeted at the African/Caribbean community.

Well-being activities involved intensive development of mechanisms for funding the project. Costs incurred by some of the organisations were assumed to take place on a weekly basis, and that the changes would have been well within the margins of error of the data used for calculations.

Only the project costs were measured as no data were available to measure additional costs. A number of organisations involved in the CIP, implicitly, that this estimate was significantly exceeded.

Changes in the design of the Health in Mind programme and the relatively short period of implementation completed at the time of the evaluation mean that conclusions about long-term sustainability and value for money are tentative and dependent on the achievement of the project outcomes in the coming years.

The costs used in the analysis were the actual costs for the first two years and the proposed costs for the project. The Year 4 proposed funding was assumed to be maintained until Year 10 (see Table 2). It should be noted that, ideally, all costs should be measured in constant prices of the base year (i.e. 2007/08). However, no attempt was made to adjust the budget values on the grounds that the changes would have been well within the margins of error of the data used for calculations.

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A significant reduction in depression scores was observed over time\(^2\), alongside reported improvements by some and users alike with respect to social inclusion and well-being.

### 4. Application – it might be appropriate

This approach based on prevention and early intervention is appropriate for older people with mental health needs and their carers, both with organic and functional mental health problems.

Although initially it was expected that carers would attend the cafés, as the programme developed, this restriction was dropped. The well-being cafés and activities provide a useful alternative to day care, which may be of particular interest to people with a personal budget.

In Bradford, the cafés are now fully embedded within mainstream services and the number of sessions per café has increased from 12 to 18.

### 5. Resources required – staff, training, IT

The CIP Project Officers were qualified as Peer Educators (or enrolled on the course) which gave them the skills to deliver mental health training free of charge for community and voluntary sector organisations.

Café organisers reported that preparation for and running each café took an unanticipated amount of time: one estimated around 25 hours per café. In addition, they identified a need for a basic overview of mental health training and information regarding conflict resolution.

Staffing requirements specified that a member of the CMHT should attend each café session.

### 6. Strengths

Health in Mind achieved a significant increase in the capacity of voluntary and community organisations to support older people with mental health problems through the provision of the well-being cafés and well-being activities, optimising existing, and unlocking untapped, mental health support. The project was successful in raising awareness of older peoples’ mental health issues across the community and voluntary sector. Changes in health and education needs were identified and addressed, for example, the PCT developed activities through the CIP activity fund for groups of older people who were not represented in the skills or capacities to develop their own community groups. The project team was able to foster networking between different groups and organisations.

The well-being cafés were perceived to be serving several purposes: early identification of people with a mental health need; seeing people over an extended period of time; acting as a signpost to other services. There were benefits not just for those who only used the well-being cafes and activities, but also for those who were referred on to another service. The cafés also had considerable success in overcoming some of the stigma attached to discussing mental health, and reduced social isolation was reported by attendees, both during the time they were at the café, and also outside of the café because of friendships that had been formed at the café. There were many reports about how enjoyable attendance at the cafés was for service users and/or their carers.

The CIP served a significant number of older people from BME communities. The larger ethnic minority groups in Bradford were well represented in the cafés: in particular, Indian older people who comprised 4.9% of service users, more than four times the prevalence found in the wider population (1.2%).

### 7. Weaknesses and potential pitfalls

Café activities reported an unexpected amount of time involved in both setting up and running the cafés. Some café hosts reported an unexpected amount of time involved in both setting up and running the cafés. Some café hosts

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Table 1: Estimated costs and benefits over 10 years of well-being cafés and well-being activities

<table>
<thead>
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<th>Year</th>
<th>Costs</th>
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</tbody>
</table>

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Money Matters: reviews of cost effective initiatives

www.iniss.org.uk

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3. Health in Mind

provides a network of mental health well-being cafés for older people, predicted to achieve net benefits of over £300 million pounds over ten years.

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### 8. Sources of further information


www.bradfordhealthinmind.nhs.uk/.../bradford_mh_cigna.pdf

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shahidur.rahman@bradford.gov.uk

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2. Zhang S et al (2011) Integrating social prescribing for people who would not normally make contact with groups and activities. The evaluation noted the importance of simple application procedures for grants for well-being activities and the need to ensure speedy transfer of funds for activities. Other points highlighted by the evaluation included the need to continue assessment of education and training needs for host groups; and to improve integration between primary health care services and the community and voluntary sector.

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July 2011

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Design by corinne.co.uk

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IRISS would like to acknowledge the following sources of information:

- [Money Matters](http://www.moneymatters.co.uk)
- [IRISS Register of Evidence](http://www.iriss.org.uk)
- [IRISS Case Studies](http://www.iriss.org.uk)

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**Note:** The figures in Table 1 are estimates based on the available data.
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6. Strengths

Health in Mind achieved a significant increase in the capacity of voluntary and community organisations to support older people with mental health problems through the provision of the well-being cafés and well-being activities, optimising existing, and locking untapped, mental health support. The project was successful in raising awareness of older peoples’ mental health issues across the community and voluntary sectors. Costs and education needs were identified and addressed, for example, the PCT developed the CIP activity fund for groups of older people who were not yet embedded in the skills or capacities to develop their own community groups. The project team was also able to foster networking between different groups and organisations.

The well-being cafés were perceived to be serving several purposes: early identification of people with a mental health need; seeing people over an extended period of time; acting as a signpost to other services. There were benefits not just for those who only used the well-being cafés and activities, but also for those who were referred on to another service. The cafés also had considerable success in overcoming some of the stigma attached to discussing mental health, and reduced social isolation was reported by attendees, both during the time they were at the café, and also outside of the café because of friendships that had been formed at the café. There were many reports about how enjoyable attendance at the cafés was for service users and/or their carers. The CIP served a significant number of older people from BME communities. The larger ethnic minority groups in Bradford were well represented in the cafés: in particular, Indian older people who comprised 4.9% of service users, more than four times the prevalence found in the wider population (1.2%).

7. Weaknesses and potential pitfalls

Café organisers reported an unexpected amount of time allocated in both setting up and running the cafés. Some café hosts reported feeling disconnected from sources of professional advice and support. Links with specialist mental health services and knowledge about older peoples’ mental health were areas where some café hosts identified as problematic.

The term ‘dementia café’ was dropped as potentially off-putting to some service users and their carers.

There is a need to ensure that GPs are aware of these kinds of services, as the Health in Mind CIP services reported a disappointing number of referrals from GPs.

A certain amount of distance from the local authority was seen as beneficial for the well-being activity fund. Once networks are developed with community groups, other statutory services can become usefully involved and services can be integrated across a continuum of care between formal and informal mental health care within community locations. This has the potential for avoiding an increase in accessing prescription for people who would not normally make contact with groups and activities.

The evaluation noted the importance of simple application procedures for grants for well-being activities and the need to ensure speedy transfer of funds for activities. Other points highlighted by the evaluation included the need to continue assessment of education and training needs for host groups; and to improve integration between primary health care services and the community and voluntary sector.

8. Sources of further information


www.healthinmindevaluationfinalreport.pdf
Shahidur Rahman
shahidur.rahman@bradford.gov.uk

This case study was compiled for IRISS by the Institute of Public Care 
Money Matters reviews of cost effective initiatives

www.iriss.org.uk

3. Health in Mind

provides a network of mental health well-being cafés for older people, to predict to achieve net benefits of over £3 million pounds over ten years.

Table 1

<table>
<thead>
<tr>
<th>Costs</th>
<th>Benefits</th>
<th>Net measurable benefit</th>
</tr>
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<tbody>
<tr>
<td>£</td>
<td>£</td>
<td>£</td>
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<tr>
<td>Year 1</td>
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</tr>
<tr>
<td>Year 2</td>
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</tr>
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<td>Year 3</td>
<td>556,470</td>
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<tr>
<td>Year 4</td>
<td>575,818</td>
<td>314,274</td>
</tr>
<tr>
<td>Year 5</td>
<td>556,470</td>
<td>441,097</td>
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<tr>
<td>Year 6</td>
<td>575,818</td>
<td>314,274</td>
</tr>
<tr>
<td>Total</td>
<td>£574,930</td>
<td>£54,044</td>
</tr>
</tbody>
</table>

Figures from Health in Mind Programme Evaluation (2008)
in Nottinghamshire, and the unit cost of a contact was £31.77. The analysis assumes that each of these contacts leads, on average, to a saving of 2.2 subsequent contacts and the consequent savings for the first two years were £195,000 and £325,000. These savings would probably reduce over time as materialises, so the next one lags behind them by six months (as half the benefits each year have moved forward to the next year).

Savings in the five years after the initial two year investment period were imputed to represent permanent improvements in the ability of local partners to work together. Savings were calculated in the business case analysis on report basis with little funding contributions from partner agencies (Fire and Rescue, Nottinghamshire PCT, and Basestall PCT). This was used to represent the value placed on the holistic approach to service delivery: £82,960.

3.2 Services facilitated by LinkAge Plus

LinkAge Plus facilitated many services resulting in a range of benefits, some of which are not quantifiable. However, the business case report provided examples where this was possible in relation to referrals to the fire service, exercise classes, crime reduction, and home adaptations.

3.2.1 Fire and rescue services

One of the signposts of LinkAge Plus provides referral to the fire and rescue services for a safety visit. Such visits are likely to lead to the fitting of a smoke alarm, which yields benefits both to the older person who is less likely to die or be injured in a fire and the taxpayer in terms of reduced response cost, exercise classes, crime reduction, and home adaptations.

3.2.2 Exercise classes

The Association of British Insurers assumes a 5% prevalence of burglary of 5% a year (approximate rate for Nottinghamshire) and that target hardening (which refers to the strengthening of the security of a building in order to reduce or minimise the risk of attack or theft) halves the cost of a burglary causing an absolute reduction of likelihood of burglary of 2.5%. The Home Office estimated the cost of a burglary at £32,688 which can be split into £2,500 for the cost to the individual and £11,148 cost to the taxpayer. On the basis of these figures, a crime risk that results in target hardening of the older person’s home can be expected to save the taxpayer £29 and the older person £12. These savings are compared with the £14.46 average cost of referral, significant net benefits remain effective for the five years following the initial investment period.

4. Application – where it may be appropriate

It seems likely that this approach would work with other user groups beyond older people, given that the aims of LinkAge Plus were to bring together various forms of mutual help, services, and support at a local level in a way that adds value, building on the aims and objectives of partner organisations.

5. Resources required – staff, training, IT

The costs of the two-year pilot of the First Contact holistic approach in Nottingham were £96,000 for overheads and set-up, £234,000 for ongoing costs, and £143,000 for outreach costs.

6.68 staff and volunteers were trained and 7,376 checklists completed in the period from July 2008 to June 2009. On average each checklist contact resulted in 2.2 additional referrals to agencies, the main ones being the fire service, pension service and community safety groups. The average cost of a completed checklist was calculated at £31.77.

6. Strengths

The holistic approach to service delivery facilitated by LinkAge Plus has resulted in improved partnership working across the voluntary and statutory sectors, improved access, removed duplication, and enabled the sharing of resources.

The evaluation of First Contact reported improved outcomes, with access to services greatly increased and simplified by the single point of entry, which ensured all relevant services were considered. For individuals, the main benefits were improved well-being, independence and safety. A key benefit from this work was the close relationship with the Community Outreach Workers who could use such referrals to maintain contact with those at risk of isolation.

7. Weaknesses and potential pitfalls

The approaches in the plot are locally specific reflecting existing cultures and working arrangements, therefore there is no one ‘off the shelf’ model which can be easily picked up and replicated by other local authorities.

8. Sources of further information


The LinkAge Plus pilots developed holistic service models, with an emphasis on accessibility, engaging older people, tackling social exclusion, promoting well-being and partnership working.

There were benefits to both purchasers and older people from a holistic approach to service delivery, which facilitated key services to help maintain independence and improve the well-being of older people.

Combining the costs and benefits of a holistic approach to service delivery with related services, eg. exercise classes, fire and rescue services, may achieve a net present value of £2.65 per £1 invested.

Additional benefits to older people in terms of well-being and independence may be monetised at £1.40 per £1 invested.

**Table 1**

<table>
<thead>
<tr>
<th>Holistic approach to service delivery</th>
<th>Pilot investment period</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<th>Total</th>
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</tr>
</tbody>
</table>
The LinkAge Plus pilots developed holistic service models, with an emphasis on accessibility, engaging older people, tackling social exclusion, promoting well-being and partnership working.

There were benefits to both care providers and older people from a holistic approach to service delivery, which facilitated key services to help maintain independence and improve the well-being of older people.

Combining the costs and benefits of a holistic approach to service delivery with related services, eg. exercise classes, fire and rescue services, may achieve a net present value of £2.65 per £1 invested.

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### Table 1

<table>
<thead>
<tr>
<th>Holistic approach to service delivery illustrative example: Nottinghamshire First Contact scheme</th>
<th>Pilot investment period 1</th>
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<th>3</th>
<th>4</th>
<th>5</th>
<th>Total</th>
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<td></td>
</tr>
<tr>
<td>LinkAge Plus communication costs</td>
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<td>£82,960</td>
<td>£82,960</td>
<td>£82,960</td>
<td></td>
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<tr>
<td>LinkAge savings – lagged six months</td>
<td>£94,730</td>
<td>£257,224</td>
<td>£203,975</td>
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<td>£82,960</td>
<td>£82,960</td>
</tr>
<tr>
<td>£94,730</td>
<td>£248,526</td>
<td>£190,412</td>
<td>£74,825</td>
<td>£72,295</td>
<td>£69,850</td>
<td>£67,488</td>
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<tr>
<td>-£31,724</td>
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<td>Cumulative net present value benefit per £1 spent</td>
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<tr>
<td>Total net present value benefit per £1 spent</td>
<td>£1.77</td>
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</tr>
</tbody>
</table>

### 1. Introduction

This case study is based on the national evaluation and business case reports of the LinkAge Plus pilots published in 2009. LinkAge Plus was a programme to introduce holistic working between central and local government and the voluntary community sector to improve outcomes for older people, improving the quality of life and well-being.

There were benefits to both care providers and older people from a holistic approach to service delivery, which facilitated key services to help maintain independence and improve the well-being of older people.

### 2. Description

The aim of LinkAge Plus was to bring together the various forms of mutual help, services and initiatives to deliver a holistic approach to service delivery that will level in a way that added value, building on the aims and objectives of partner organisations. There was a range of activities undertaken by each pilot area, but no single LinkAge Plus ‘modell’ followed. However, all projects were designed to:

- Engage, with, and involve older people in service design
- Reflect the diversity of older people’s needs and aspirations
- Be accessible in terms of location, opening times etc
- Promote independence and well-being
- Improve customer experience and widen access
- Achieve efficiencies through joint working
- Strengthen partnership working.

Tackled together, these activities represent a ‘LinkAge Plus approach’.

### 3. Evidence of cost effectiveness

Due to the range of services and initiatives undertaken by the pilot areas, it was difficult to quantify all the costs and benefits. However, an illustrative example in the business case report which is based on Nottinghamshire First Contact pilot for the holistic element, and other pilots for the service elements, details the way in which a two-year investment in holistic service delivery and the related services could deliver benefits to the individual and the whole system.

The key findings are:

- A holistic approach to service delivery requires some up-front investment over the two-year pilot period, but quickly begins to bring net savings, breaking even in year three.
- The net present value of savings up to the end of the five year period is £1.80 per £1 invested. This is likely to be higher over a longer period.
- LinkAge Plus can facilitate services that cost effective in their own right, including fire and crime prevention, and reduced falls associated with balance classes and home adaptations.
- Combining the costs and benefits of the holistic services with the holistic approach to service delivery increases the net present value in year five to £2.65 per £1 invested.
- In addition to taxpayer savings there are benefits to older people monetised at £1.40 per £1 invested.

#### 3.1.1 Costs and cost benefits

<table>
<thead>
<tr>
<th>Year</th>
<th>Pilot investment period 1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Health outcomes of LinkAge Plus</td>
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<td>£32,480</td>
<td>£82,960</td>
<td>£82,960</td>
<td>£82,960</td>
<td>£82,960</td>
<td></td>
</tr>
<tr>
<td>LinkAge savings – lagged six months</td>
<td>£94,730</td>
<td>£257,224</td>
<td>£203,975</td>
<td>£82,960</td>
<td>£82,960</td>
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<td>£94,730</td>
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<td>-£31,724</td>
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<td>£69,850</td>
<td>£67,488</td>
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<tr>
<td>Net present value of holistic benefits</td>
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<tr>
<td>Cumulative net present value benefit per £1 spent</td>
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<td>£1.77</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
The LinkAge Plus pilots developed holistic service models with an emphasis on accessibility, engaging older people, tackling social exclusion, promoting well-being and partnership working.

There were benefits to both carers and older people from a holistic approach to service delivery, which facilitated key services to help maintain independence and improve the well-being of older people.

Combining the costs and benefits of a holistic approach to service delivery with related services, eg. exercise classes, fire and rescue services, may achieve a net present value of £2.65 per £1 invested.

Additional benefits to older people in terms of well-being and independence may be monetised at £1.40 per £1 invested.

### 1. Introduction

This case study is based on the national evaluation and business case reports of the LinkAge Plus pilots1-3 compiled in 2009. LinkAge Plus was a programme to deliver holistic working between central and local government, and the voluntary and community sector to improve outcomes for older people, improving their quality of life and well-being. Around £10 million was invested by the Department for Work and Pensions in LinkAge Plus over a two-year period in eight pilot areas. The LinkAge Plus pilots demonstrate how working in partnership, involving older people and delivering services that aim to give a ‘little bit of help’ with daily living, can make a difference to the quality of life for older people in a cost effective way.

### 2. Description

The aim of LinkAge Plus was to bring together the various forms of mutual help, services and partnerships that are offered to service older people in a way that added value, building on the aims and objectives of partner organisations. There was a range of activities undertaken by each pilot area, but no single LinkAge Plus ‘model’ followed. However, all projects were developed to:

- Engage with and involve older people in service design
- Reflect the diversity of older people’s needs and aspirations
- Be accessible in terms of location, opening times etc.
- Promote independence and well-being
- Improve customer experience and widen contact
- Achieve efficiencies through joint working
- Strengthen partnership working.

Taken together, these activities represent a ‘LinkAge Plus approach’.

### 3. Evidence of cost effectiveness

Due to the range of services and initiatives undertaken by the pilot areas, it was difficult to quantify all the cost and benefits. However, an illustrative example in the business case report is based on the Nottinghamshire First Contact pilot. First Contact for the holistic element, and other pilots for the service elements, details the way in which a two-year investment in holistic service delivery and the related services could deliver benefits to the individual and the taxpayer over the following five years.

#### 3.1 Costs and cost benefits

The costs and savings of the holistic approach are summarised in Table 1 over the two-year pilot period. The key findings are that:

- A holistic approach to service delivery requires some up-front investment from the two-year pilot period, but quickly begins to bring net savings, breaking even in year three.
- The net present value of savings up to the end of the five year period is £1.80 per £1 invested. This is likely to be higher over a longer period.
- LinkAge Plus can facilitate services that are cost effective in their own right, including fire and crime prevention, and reduced falls associated with balance classes and home adaptations.
- Combining the costs and benefits of the holistic approach to service delivery increases the net present value in the example to £2.65 per £1 invested.
- In addition to taxpayer savings there are benefits to older people monetised at £1.40 per £1 invested.

### 3.1.1 Costs and cost benefits

<table>
<thead>
<tr>
<th>Year Pilot investment</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
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<td>£522,960</td>
<td>£2,642,446</td>
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<td>LinkAge Plus holistic savings – lagged six months</td>
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<td>£1.40</td>
<td>£1.40</td>
<td>£1.40</td>
<td></td>
</tr>
</tbody>
</table>

Source: LinkAge Plus pilot study reports 2009-10. wrought by the Nottingham: First Contact scheme are detailed in Table 1. The Treasury discount rate is applied and the following benefits relate to up-front and ongoing costs (including outreach costs) – the latter are lifted to the five years of the analysis. Estimated savings flow from this approach on the basis that there were 2,909 and 4,467 contacts in the two-year investment period.

### 4. Conclusion

- A range of approaches were adopted across the eight pilot areas, examples of which are described below.
- Improved information and access for older people

Areas of work focused on how local authorities, PCGs and voluntary organisations developed new approaches to widening access, joining up services and gaining a better awareness of the needs and preferences of older people seeking help and support. Examples included: establishing single access gateways; enhanced contacting processes; access to specialist housing and employment services; improved websites and development of information packs for older people.

#### Benefits for older people

A range of services was developed that provide that ‘little bit of help’ in order to promote older people’s well-being and independence, and prevent or delay the onset of more intensive support. Examples include increasing older people’s sense of safety and security such as fitting smoke alarms or security systems. Engaging older people in activities that help them to develop and sustain social networks; improving physical health through establishing falls prevention initiatives and physical activity schemes (walking, Tai Chi classes, chair and exercises etc); focus on outreach and opportunities for socialisation to promote older people’s mental health; opportunities for leisure, learning and volunteering; and initiatives to assist older people with transport provision such as organising volunteer drivers.

### Capacity building

A key feature of the pilots was building capacity in both the statutory, voluntary and community sectors. This included improving skills, knowledge and understanding, new techniques and processes and a more people-centred approach to the design and delivery of services.

### Holistic approach to service delivery

The illustrative example of a holistic approach to service delivery is based on the Nottinghamshire pilot: First Contact. First Contact is an approach that enables older people to access services through a single point of contact, using a system where an agent of one of the partner organisations meets with the client and completes a simple ‘needs checklist’. Over the two years, 50 staff and volunteers were trained and 7,376 checklists completed, with an average of 2.2 additional referrals to agencies per completed checklist. The main referrals were to the fire service, pension service and community safety groups. First Contact enabled older people to receive a wide variety of services without the need to contact all the various organisations themselves.

### 3.1 Costs and cost benefits

Over the full seven years of the analysis, there is an estimated net present value per £1 spent of £1.77 for the taxpayer, due to imputed savings in reducing repeated contacts and the increased ability of partners to work together. The costs and savings of the holistic approach based on Nottingham’s First Contact scheme are detailed in Table 1. The Treasury discount rate is applied and the following benefits relate to up-front and ongoing costs (including outreach costs) – the latter are lifted to the five years of the analysis. Estimated savings flow from this approach on the basis that there were 2,909 and 4,467 contacts in the two-year investment period.

1. Introduction

2. Evidence of cost effectiveness

3. Holistic approach to service delivery

4. Conclusion

### Additional Information

The LinkAge Plus pilots developed holistic service models with an emphasis on accessibility, engaging older people, tackling social exclusion, promoting well-being and partnership working.

There were benefits to both carers and older people from a holistic approach to service delivery, which facilitated key services to help maintain independence and improve the well-being of older people.

Combining the costs and benefits of a holistic approach to service delivery with related services, eg. exercise classes, fire and rescue services, may achieve a net present value of £2.65 per £1 invested.

Additional benefits to older people in terms of well-being and independence may be monetised at £1.40 per £1 invested.

### Table 1

<table>
<thead>
<tr>
<th>Year Pilot investment</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Net present value of holistic savings</td>
<td>£118,515</td>
<td>£77,284</td>
<td>£82,226</td>
<td>£172,120</td>
<td>£136,251</td>
<td>£619,574</td>
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<td>£97,348</td>
<td>£234,980</td>
<td>£522,960</td>
<td>£522,960</td>
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<td>£522,960</td>
<td>£522,960</td>
<td>£522,960</td>
<td>£522,960</td>
</tr>
<tr>
<td>Holistic savings – lagged six months</td>
<td>£82,960</td>
<td>£82,960</td>
<td>£82,960</td>
<td>£82,960</td>
<td>£82,960</td>
<td>£414,800</td>
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<td>Holistic outreach cost per referral</td>
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<td>£335,992</td>
<td>£10,412</td>
<td>£74,325</td>
<td>£72,295</td>
<td>£1,188,125</td>
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<tr>
<td>Cumulative net present value</td>
<td>£31,724,000</td>
<td>£88,457</td>
<td>£140,412</td>
<td>£74,325</td>
<td>£72,295</td>
<td>£385,600</td>
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<tr>
<td>Net present value benefits minus costs</td>
<td>£69,985</td>
<td>£67,486</td>
<td>£89,850</td>
<td>£76,486</td>
<td>£91,126</td>
<td>£382,215</td>
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<tr>
<td>Net present value benefit per £1 spent</td>
<td>£1.40</td>
<td>£1.40</td>
<td>£1.40</td>
<td>£1.40</td>
<td>£1.40</td>
<td>£1.40</td>
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</tbody>
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in Nottinghamshire, and the unit cost of a contact was £31.77. The analysis assumes that each of these contacts leads, on average, to a saving of 2.5 subsequent contacts and the consequent savings for the first two years were around £99,000 and £32,000. These savings would provide additional little collateral materialises, so the next one lapses behind them by six months (as half of the benefits each year have been moved forward to the next year).

Savings in the five years after the initial two year investment period were imputed to represent permanent improvements in the ability of local partners to work together. Savings were calculated in the business case analysis report based on funding contributions from partner agencies (Fire and Rescue, Nottinghamshire PCT, and Bassetlaw PCT). This was used to represent the value placed on the holistic approach to service delivery: £82,960.

3.2 Services facilitated by LinkAge Plus

LinkAge Plus facilitated many services resulting in a range of benefits, some of which are not quantifiable. However, the business case report provided examples where this was possible in relation to referrals to the fire service, exercise classes, crime reduction, and home adaptations.

3.2.1 Fire and rescue services

One of the signposting services that LinkAge Plus provides is referral to the fire and rescue service in the first year and £48 in the second year – indicates a stream of taxpayer benefits over the period of investment and the following five years.

3.2.2 Exercise classes

The Association of British Insurers4 assumes a 5% prevalence of burglary of 5% a year (despite estimates that target hardening which relates to the strengthening of the security of a building in order to reduce or minimise the risk of attack or theft) halves the likelihood of a burglary causing an absolute reduction of likelihood of burglary of 2.5%. The Home Office4 estimates the cost of a burglary at £3,268 which can be split into a £2,200 cost to the victim and £1,148 cost to the taxpayer. On the basis of these figures, a crime risk that results in target hardening of the older person’s home can be expected to save the taxpayer £227.60 and the older person lived an additional year with a cost of £8,914. These savings are compared with the £14.46 average cost of referral, significant net benefits are projected and assumed to persist over the five years after the investment period.

3.2.3 Crime reduction

There is evidence to suggest that adaptations can reduce falls by 51%. Applied to the prevalence and cost of hip fractures, this suggests expected benefits of home adaptations to the taxpayer of about £70 and to the older person of £53. Home adaptations costs averaged £77.36. However, £10 was unlikely paid by the older person so this figure was adjusted to £61.82. It was assumed that adaptations remained effective for the five years following the initial investment period.

4. Application – where it might be appropriate

It seems likely that this approach would work with other user groups beyond older people, given that the aims of LinkAge Plus were to bring together various forms of mutual help, services and support at a local level in a way that adds value, building on the aims and objectives of partner organisations.

5. Resources required – staff, training, IT

The costs of the two-year pilot of the First Contact holistic approach in Nottingham were £96,000 for overheads and set-up, £234,000 for ongoing costs, and £143,000 for outreach costs.

688 staff and volunteers were trained and 3,776 checklists completed in the period from July 2004 to June 2006. On average each checklist contact resulted in 2.2 additional referrals to agencies, the main ones being to the service, pension service and community safety groups. The average cost of a completed checklist was calculated at £31.77.

6. Strengths

The holistic approach to service delivery facilitated by LinkAge Plus has resulted in improved partnership working across the voluntary and statutory sectors, improved access, removed duplication, and enabled the sharing of resources.

The evaluation of First Contact reported improved outcomes, with access to services greatly increased and simplified by the single point of entry, which ensured all relevant services were accessed.

For individuals, the main benefits were increased well-being, independence and safety. A key benefit from this work was the close relationship with the Community Outreach Workers who could use such referrals to make contact with those at risk of isolation.

7. Weaknesses and potential pitfalls

The approaches in the pilot are locally specific, reflecting existing cultures and working arrangements, therefore there is no one ‘off the shelf’ model which can be easily picked up and replicated by other local authorities.

8. Sources of further information


8. Available from the Institute for Research and Innovation in Social Services (IRISS) website: www.iriss.org.uk

This case study was compiled for IRISS by the Institute of Public Care

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The Institute for Research and Innovation in Social Services (IRISS) is a charitable company limited by guarantee.
In Nottinghamshire, and the unit cost of a contact was £31.77. The analysis assumes that each of these contacts leads, on average, to a saving of £2.2 subsequent contacts and the consequent savings for the first two years were £19,890 and £32,305. These savings would probably include little or no materialisation, so the next one laps behind them by six months (as all the benefits each year have been moved forward to the next year).

In the five years after the initial two year investment period was invested to represent permanent improvements in the ability of local partners to work together. Savings were calculated in the business case analysis report based on funding contributions from partner agencies (Fire and Rescue, Nottinghamshire PCT, and Basestall PCT). This was used to represent the value placed on the holistic approach to service delivery: £82,960.

3.2 Services facilitated by LinkAge Plus

LinkAge Plus facilitated many services resulting in a range of benefits, some of which are not quantifiable. However, the business case report provided examples where this was possible in relation to referrals to the fire service, exercise classes, crime reduction, and home adaptations.

3.2.1 Fire and rescue services

One of the signposting services that LinkAge Plus provides is referral to the fire and rescue service in the first year and 1,484 in the second year – indicates a stream of taxpayer benefits over the period of investment and the following five years.

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The Association of British Insurers assumes a 5% prevalence of burglary of 5% a year (approximate rate for Nottinghamshire) and that target hardening (which refers to the strengthening of the security of a building in order to reduce or minimise the risk of attack or theft) halves the risk of being burgled, causing an absolute reduction of likelihood of burglary of 2.5%. The Home Office estimated the cost of a burglary at £3,268 which can reduce falls by 55%. Applied to the prevalence and cost of hip fractures, this suggests expected benefits of home adaptations to the taxpayer of about £70 and to the older person of £55. Home adaptations costs averaged £77.36. However, £31 was typically paid by the older person so this figure was adjusted to £46.74. It was assumed that adaptations remained effective for five years following the initial investment period.

4. Application – where it might be appropriate

It seems likely that this approach would work with other user groups beyond older people, given that the aims of LinkAge Plus were to bring together various forms of mutual help, services, and support at a local level in a way that adds value, building on the aims and objectives of partner organisations.

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The costs of the two-year pilot of the First Contact holistic approach in Nottingham, were £36,000 for overheads and set-up, £234,000 for ongoing costs, and £143,000 for outcomes.

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The holistic approach to service delivery facilitated by LinkAge Plus has resulted in improved partnerships working across the voluntary and statutory sectors, improved access, removed duplication, and enabled the sharing of resources.

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7. Weaknesses and potential pitfalls

The approaches in the pilot are locally specific, reflecting existing cultures and working arrangements, therefore there is no one ‘fit the shelf’ model which can be easily picked up and replicated by other local authorities.

8. Sources of further information


Department for Work and Pensions


4. LinkAge Plus

The holistic approach to service delivery of the LinkAge pilots maintaining independence and improving well-being, achieves a net present value of £2.65 for every £1 invested.
4. Application – where it might be appropriate

Currently the RRAP is only available to owner-occupiers or private tenants. It is currently not available for RSL or council tenants. However, a review of adaptations undertaken by the Welsh Assembly Government in 2005 highlighted the need to increase the scope of RRAP to include these tenures.

The greatest savings are related to the assumed level of accident prevention. It is likely therefore that the RRAP approach is particularly applicable to those people most likely to have an accident at home, for example older people who are at risk of falling.

5. Resources required – staff, training, IT

The RRAP operates in a similar way to Safety at Home schemes run by most Care and Repair agencies. Research has shown that the average capital costs involved in Safety at Home type services (figures which can then be used to reflect RRAP job costs), are in the region of £150 per job. It is anticipated that the maximum capital cost per job in each home will not exceed £350. The revenue costs required to deliver the RRAP reflect:

- Initial costs for a part-time administrator to administer the programme.
- Initial work in agreeing protocols, service access criteria and referral processes, and some briefing/training and information packs (agencies already had operational partnerships with Health and Social Services, and many had Safety at Home and Emergency Pressure schemes).
- In 2006/07 the revenue sum was increased to provide for a RRAP co-ordinator post which services the partnership, eg, maintaining awareness (across staff in health and social care), monitoring referrals and expenditure.

Overall, the volume of work undertaken by the RRAP programme in 2008/09 represented an increase in the volume of work in 2005/06 of the agencies: 15,186 case referrals; 14,890 people helped; and 15,473 jobs completed. There is an average of 705 jobs completed in Welsh counties on an annual basis at an average cost of £118. Most agencies have a small bank of reliable contractors and a or two handypersons dedicated to this work.

6. Strengths

The RRAP meets many key objectives for local and national policies – in Wales this includes the National Housing Strategy, as well as local health and well-being strategies and older people’s strategies. It provides preventative services that are closely related to client need and support personal choice and independence. Furthermore, this programme provides a framework of effective local support for vulnerable clients in terms of both hospital discharge and hospital prevention.

The programme demonstrates that by targeting resources effectively, a RRAP enables a quick local response to vulnerable older and disabled people, and can save money across the health and social care sectors. These findings are supported by a review of evidence relating to investment in housing adaptations, improvements and equipment by Heywood and Turner (2007). The RRAP is well respected, which is reflected in the fact that it has consistently received core funding from the Welsh Assembly Government, unlike care and repair schemes elsewhere which often experience funding problems.

There is currently a limited understanding of client satisfaction and the impact of the service on individual outcomes.

7. Weaknesses and potential pitfalls

The main weakness reflects high levels of demand outweighing funding for the programme. Furthermore, there is no recognised strategy for addressing work over 100%, which may leave some clients vulnerable. There is still some lack of awareness among local partners and complexities associated with joint working. Health professionals do not always have a strong awareness or understanding of housing related services and definitions of what represents a hospital discharge can differ. There is some reluctance amongst health professionals to define some referrals as contributing to hospital discharge, as the issues that contribute to hospital discharge are often complex and quite often not housing related (eg delayed transfers of care targets for health).

It can sometimes be difficult to achieve both best value and economics of scale in the Third Sector. However, work is being undertaken to look at regional collaboration and collective procurement.

There is currently a limited understanding of client satisfaction and the impact of the service on individual outcomes.

8. Sources of further information

Neil Williams, Head of Agency Performance and Funding, Care and Repair Cymru. Telephone 029 2057 8316 Care and repair Cymru at www.careandrepair.org.uk

Welsh Assembly Government (2005) Review of housing adaptations including disabled facilities grant – Wales, WAG


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Money Matters case study five

July 2011

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The Rapid Response Adaptations Programme in Wales provides a fast small repairs and adaptations service to older people, identified by health and social care staff at risk of hospital admission, or awaiting hospital discharge. Assuming 10 per cent of repairs and adaptations led to a hospital discharge or avoided an accident and hospital admission, the total cost saving to health and social care was estimated at £15 million in one year. The service focuses on hospital discharge and reducing hospital admissions. Information in this report is based on data obtained from the Rapid Response Adaptations Programme Annual Performance Report 2008-09 and from communication with the Head of Performance and Funding at Care and Repair Cymru. The programme has been shown to facilitate an immediate response to specific needs by providing minor adaptations such as ramps and handrails, to enable people to return to their own homes following hospital discharge. These adaptations have also shown to prevent the need for admission to hospital for older and disabled people who are no longer safe or appropriate for older and disabled people. The intention of the programme, which sets it apart from other repair services, is to enable Care and Repair agencies to provide a quick response service to problems identified by local authority or health staff. The Care and Repair agency receives the referrals and instructs a suitably qualified contractor or handyperson to carry out the required work. There is a 15-day maximum target date for completing the works from referral. Referrals come from a range of statutory and health sector organisations, and are channelled through Care and Repair agencies.

### 1. Introduction

This case study provides information regarding the Rapid Response Adaptations Programme (RRAP). The RRAP was introduced by the Welsh Assembly Government in 2002 on a national basis and is unique to Wales. The Welsh Assembly Government continues to support this programme and £2,094,000 was made available in 2010-11 to Care and Repair Agencies across Wales and Care and Repair Cymru to support the RRAP.

### 2. Description

The RRAP provides a small rapid response adaptations/repair service for older and disabled people which ensures that they can continue to live in a safe home environment as comfortably as possible. This service is complementary to the adaptation work funded by local authorities through the Disabled Facilities Grant and Home Repair assistance. The service focuses on hospital discharge and reducing hospital admissions. The aim of the programme is to ensure that older and disabled people who are to be discharged from hospital have a safe home to which to return. It also has a key role in preventing hospital admissions by addressing problems of homes that are no longer safe or appropriate for older and disabled people. The intention of the programme, which sets it apart from other repair services, is to enable Care and Repair agencies to provide a quick response service to problems identified by local authority or health staff. The Care and Repair agency receives the referrals and instructs a suitably qualified contractor or handyperson to carry out the required work. There is a 15-day maximum target date for completing the works from referral. Referrals come from a range of statutory and health sector organisations, and are channelled through Care and Repair agencies.

### 3. Evidence of cost effectiveness

The RRAP provides a framework across Wales for targeting resources for effective support for older and disabled clients, in terms of both hospital discharge and hospital prevention. The critical outcomes demonstrated by RRAP include the potential for well targeted and strategically managed services to address key elements of service speed, client focus and added value. In 2008-09, 15,473 Rapid Response adaptations were delivered, of which 10,163 aimed to prevent hospital admission and 4,915 enabled hospital discharge. Estimates for cost savings detailed in Table 1 below are based on the following figures:

- £9,460 average cost to health of a home accident (2008-09 figures).
- 10 days average length of stay in hospital.
- £378 average per day for hospital stay (2008-09 figures).
- £118 average daily cost of contractor job = £170.

The above estimate of cost effectiveness does not take into account costs in relation to staff and other costs. Further work by one agency estimated that the following costs were incurred in one year:

- RRAP Revenue fund for administrator, on costs and technical support = £20,000.
- RRAP Capital (some of which is turned into handyperson revenue support based on an agreed schedule of works) + £70,400.
- Handyperson salary costs = £24,258 (14,540 on-costs in total). The group eligible for the service are older and physically disabled people who are owner- occupiers or private tenants and:
  - in hospital or who have recently been discharged from hospital where the circumstances require urgent intervention, or
  - who wish to continue to live at home as independently and safely as possible, and whose homes require small works to enable them to do so.

The type of eligible work may include:

- Small ramps and home access e.g. stair/wall safety.
- External/internal rails.
- Hand grips.
- Cover way to w.c.
- Toilet and outhouse upgrading.
- Leveling paths.
- Partial rewiring.
- Upgrading heating to essential rooms.
- Access to toilet facilities.
- Community safety alarms.
- Safety in the home eg additional lighting, electrical safety, hot water safety, floor/ stair/slab safety.

### Table 1

<table>
<thead>
<tr>
<th>No. of jobs having direct impact (assumed rate of 10% of total)</th>
<th>Av. cost of hospital stay per day</th>
<th>Av. length of stay in hospital</th>
<th>Total cost to health (Av x D)</th>
<th>Av. cost of RRAP job</th>
<th>Total cost of RRAP jobs (Av x D)</th>
<th>Estimated saving (D-F)</th>
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</thead>
<tbody>
<tr>
<td>Hospital Discharge</td>
<td>491</td>
<td>378</td>
<td>10</td>
<td>£1,856,000</td>
<td>£118</td>
<td>£55,800</td>
</tr>
<tr>
<td>Hospital Prevention*</td>
<td>1,016</td>
<td>378</td>
<td>10</td>
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</tbody>
</table>

Based on the figures above, which assume that 10% of each type of RRAP case directly leads to quicker discharge, admission prevention and accident prevention (based on research and what is acceptable to all partners involved), it is calculated that the total cost saving of RRAP to the health and social care sector in 2008-2009 was £15,008,000. Taking into account other costs associated with the project, it could be estimated that a £75 saving is made for every £1 invested through RRAP.

The above estimate of cost effectiveness does not take into account costs in relation to staff and other costs. Further work by one agency estimated that the following costs were incurred in one year:

- RRAP Revenue fund for administrator, on costs and technical support = £20,000.
- RRAP Capital (some of which is turned into handyperson revenue support based on an agreed schedule of works) + £70,400.
- Handyperson salary costs = £24,258 (14,540 on-costs in total). The group eligible for the service are older and physically disabled people who are owner- occupiers or private tenants and:
  - in hospital or who have recently been discharged from hospital where the circumstances require urgent intervention, or
  - who wish to continue to live at home as independently and safely as possible, and whose homes require small works to enable them to do so.

The type of eligible work may include:

- Small ramps and home access e.g. stair/wall safety.
- External/internal rails.
- Hand grips.
- Cover way to w.c.
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The Rapid Response Adaptations Programme in Wales provides a fast small repairs and adaptations service to older people, identified by health and social care staff at risk of hospital admission, or awaiting hospital discharge.

Assuming 10 per cent of repairs and adaptations led to a hospital discharge or avoided an accident at home, the total saving to health and social care was estimated at £15 million in one year. The service demonstrates the benefits of a targeted approach to repairs and adaptations, particularly for people at risk of a fall at home.

1. Introduction

This case study provides information regarding the Rapid Response Adaptations Programme (RRAP). The RRAP was introduced by the Welsh Assembly Government in 2002 on a national basis and is unique to Wales. The Welsh Assembly Government continues to support this programme and £2,094,000 was made available in 2010-11 to Care and Repair Agencies across Wales and Care and Repair Cyrmu to support the RRAP.

Information in this report is based on data obtained from the Rapid Response Adaptations Programme Annual Performance Report 2008-09 and from communication with the Head of Performance and Funding at Care and Repair Cyrmu. The programme has been shown to facilitate an immediate response to specific needs by providing minor adaptations such as ramps and handrails, to enable people to return to their own homes following hospital discharge. These adaptations have also been shown to prevent the need for admission to hospital for older and disabled clients, in terms of both longer safe or appropriate for older and disabled people who are to be discharged from hospital where the programme has a direct impact.

The aim of the programme is to enable older and disabled people who are owner-occupiers or private tenants and to prevent hospital admission, the total saving to health and social care was estimated at £15 million in one year. The type of eligible work may include:

- Small ramps and home access.
- Door entry.
- External/interior rails.
- Hand grips.
- Cover way to e.g.
- Toilet and outhouse upgrading.
- Levelling paths.
- Partial rewiring.
- Upgrading having to essential rooms.
- Access to toilet facilities.
- Community safety alarms.
- Safety in the home e.g. additional lighting, electrical safety, hot water safety, floor/ stair/wall safety.

2. Description

The RRAP provides a small rapid response adaptations/repair service for older and disabled people which enables that they can continue to live in a safe home environment as comfortably as possible. This service is complementary to the adaptation work funded by local authorities through the Disabled Facilities Grant and Home Repair Assistance. The service focuses on hospital discharge and reducing hospital admissions.

The group eligible for the service are older and physically disabled people who are owner-occupiers or private tenants and:

- are in hospital or who have recently been discharged from hospital where the circumstances require urgent intervention, or
- wish to continue to live at home independently and safety as possible, and whose homes require small works to enable them to do so.

3. Evidence of cost effectiveness

The RRAP provides a framework across Wales for targeting resources for effective support for older and disabled clients, in terms of both hospital discharge and hospital prevention. The critical outcomes demonstrated by RRAP indicate the potential for well targeted and strategically managed services to address key elements of service speed, client focus and added value.

Assuming 1% per cent of repairs and adaptations were delivered, of which 10,163 had no direct impact on hospital admission and 4,915 enabled hospital discharge. Estimates for cost savings detailed in Table 1 below are based on the following figures:

- £9,460 average cost to health of a home accident (2008-09 figures).
- £118 per RRAP case – 2008-09 figures.
- £1 invested through RRAP.

By 2008-09, 15,473 Rapid Response adaptations were delivered, of which 10,163 were incurred in one year:

- £9,460 estimated saving (AxE).
- £118 per RRAP job.
- £58,000 (£118 per RRAP job x 500 jobs).

Average cost of contractor job = £170.

Average cost of handyperson job = £67.

Works completed by contractor = 21.

Works completed by Handyperson = 629.

Works completed in total = 650.

£9,460 average cost to health of a home accident (2009-08 figures).

Based on the figures above, which assume that 10% of each type of RRAP case directly leads to quicker discharge, admission prevention and accident prevention (based on research and what is acceptable to all partners involved), it is calculated that the total cost saving of RRAP to the health and social care sector in 2008-2009 was £15,009,000. Taking into account other costs associated with the project, it could be estimated that a £750 saving is made for every £1 invested through RRAP.

The above estimate of cost effectiveness does not take into account costs in relation to staff and other costs. Further work by one agency estimated that the following costs were incurred in one year:

- RRAP Revenue funding for administrator, on costs and technical support = £20,000.
- RRAP Capital (some of which is turned into handyperson revenue support based on an agreed schedule of works) + £70,400.
- Handyperson salary costs = £24,258 (+£4,500 on-costs) - this agency had agreed schedule of works) + £70,400.
- £70,400 net additional saving (from total of £20,000 RRAP revenue funding for administrator).
- £9,460 average cost to health of a home accident (2008-09 figures).
- Average cost of handyperson job = £67.
- Average cost of contractor job = £170.

Table 1

<table>
<thead>
<tr>
<th>Hospital Discharge</th>
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</tr>
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<tbody>
<tr>
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<td>491</td>
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</tr>
<tr>
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<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Total cost to health (Av.x100)</td>
<td>£1,856,000</td>
<td>£3,840,000</td>
</tr>
<tr>
<td>Estimated saving (D-F)</td>
<td>£9,491,000</td>
<td>£3,720,000</td>
</tr>
</tbody>
</table>

The above table provides information regarding preventing hospital admission and those which prevent an accident at home.
The Rapid Response Adaptations Programme in Wales provides a fast small repairs and adaptations service to older people, identified by health and social care staff at risk of hospital admission, or awaiting hospital discharge.

Assuming 10 per cent of repairs and adaptations led to a hospital discharge or avoided an accident at home, the total cost saving to health and social care was estimated at £15 million in one year.

The service demonstrates the benefits of a targeted approach to repairs and adaptations, particularly for people at risk of a fall at home.

1. Introduction
This case study provides information regarding the Rapid Response Adaptations Programme (RRAP). The RRAP was introduced by the Welsh Assembly Government in 2002 on a national basis and is unique to Wales. The Welsh Assembly Government continues to support this programme and £2,194,000 was made available in 2010-11 to Care and Repair Agencies across Wales and Care and Repair Cymru to support the RRAP.

Information in this report is based on data obtained from the Rapid Response Adaptations Programme Annual Performance Report 2008-09 and from communication with the Head of Performance and Funding at Care and Repair Cymru. The programme has been shown to facilitate an immediate response to specific needs by providing minor adaptations such as ramps and handrails, to enable people to return to their own homes following hospital discharge. These adaptations have also been shown to prevent the need for admission to hospital where these adaptations have been provided.

2. Description
The RRAP provides a small rapid response adaptations/repair service for older and disabled people which enables them to continue to live in a safe home environment as comfortable as possible. This service is complementary to the adaptation work funded by local authorities through the Disabled Facilities Grant and Home Repair Assistance. The service focuses on hospital discharge and reducing hospital admissions.

The aim of the programme is to ensure that older and disabled people are able to be discharged from hospital have a safe home to which to return. It also has a key role in preventing hospital admissions by addressing problems of homes that are no longer safe or appropriate for older and disabled people. The intention of the programme, which sets it apart from other repair services, is to enable Care and Repair agencies to provide a quick response service to problems identified by local authority or health staff. The Care and Repair agency receives the referrals and instructs a suitable qualified contractor or handyperson to carry out the required work. There is a 15-day maximum target date for completing the works from referral. Referrals come from a range of statutory and health sector organisations, and are channelled through Care and Repair agencies.

The group eligible for the service are older and physically disabled people who are owner-occupiers or private tenants and:
- are in hospital or who have recently been discharged from hospital where the circumstances require urgent intervention, or
- who wish to continue to live at home as independently and safely as possible, and whose homes require small works to enable them to do so.

The type of eligible repair work may include:
- Small ramps and home access.
- Door entry.
- External/internal rails.
- Hand grips.
- Cover way to e.c.
- Toilet and outhouse upgrading.
- Levelling paths.
- Partial rewiring.
- Upgrading heating to essential rooms.
- Access to toilet facilities.
- Community safety alarms.
- Safety in the home eg additional lighting, electrical safety, hot water safety, floor/shair/wall safety.

3. Evidence of cost effectiveness
The RRAP provides a framework across Wales for targeting resources for effective support for older and disabled clients, in terms of both hospital discharge and hospital prevention.

The critical outcomes demonstrated by RRAP indicate the potential for wider targeted and strategically managed services to address key elements of service speed, client focus and added value.

In 2008-09, 15,473 Rapid Response adaptations were delivered, of which 10,163 aimed to prevent hospital admission and 4,915 enabled hospital discharge. Estimates for cost savings detailed in Table 1 below are based on the following figures:

491 RRAP jobs taken into account for health benefits (2008-09 figures).
4,915 RRAP jobs taken into account for hospital prevention figure (from total of 10,163, ie assumed that 10% counted as hospital prevention figure (from total of 10,163, ie assumed that 10% counted as directly preventing hospital admission).
4,915 RRAP jobs taken into account for hospital prevention figure.”

Based on the figures above, which assume that 10% of each type of RRAP case directly leads to quicker discharge, admission prevention and accident prevention (based on research and what is acceptable to all partners involved), it is calculated that the total cost saving of RRAP to the health and social care sector in 2008-2009 was £15,009,000. Taking into account other costs associated with the project, it could be estimated that a £75,000 saving is made for every £1 invested through RRAP.

The above estimate of cost effectiveness does not take into account costs in relation to staff and other costs. Further research by one agency estimated that the following costs were incurred in one year:

RRAP Revenue funding for administrator, on costs and technical support = £20,000.
RRAP Capital (some of which is turned into handyperson revenue support based on an agreed schedule of works) = £70,400.

Handyperson salary costs = £24,258 (£14,500 on-costs, £9,758 of which they had one dedicated handyperson to RRAP).
Works completed in total = £65,000.

Average cost of contractor job = £87.
Average cost of handyperson job = £170.
Average cost of hospital discharge stay per day = £118.
Average cost of handyperson job = £67.
Average cost of RRAP job = £170.

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4. Application – where it might be appropriate

Currently the RRAP is only available to owner-occupiers or private tenants. It is currently not available for RSL or council tenants. However, a review of adaptations undertaken by the Welsh Assembly Government in 2005 highlighted the need to increase the scope of RRAP to include these tenures.

The greatest savings are related to the assumed level of accident prevention; it is likely therefore that the RRAP approach is particularly applicable to those people most likely to have an accident at home, for example older people who are at risk of falling.

5. Resources required – staff, training, IT

The RRAP operates in a similar way to Safety at Home schemes run by most Care and Repair agencies. Research has shown that the average capital costs involved in Safety at Home type services (figures which can then be used to reflect RRAP job costs), are in the region of £110 per job. It is anticipated that the maximum capital cost per job in each home will not exceed £350. The revenue costs required to deliver the RRAP reflect:

- Initial costs for a part-time administrator to administer the programme.
- Initial work in agreeing protocols, service access criteria and referral processes, and some briefing/training and information packs (agencies already had operational partnerships with Health and Social Services, and many had Safety at Home and Emergency Pressure schemes).
- In 2006/07 the revenue sum was increased to provide for a RRAP co-ordinator post which services the partnerships, eg, maintaining awareness (across staff in health and social care), monitoring referrals and expenditure.

Overall, the volume of work undertaken by the RRAP programme in 2008/09 represented an increase in the volume of work in 2007/08 of the agencies: 15,186 case referrals; 44,890 people helped; and 15,473 jobs completed. There is an average of 705 jobs completed in Welsh counties on an annual basis at an average cost of £118. Most agencies have a small bank of reliable contractors and one or two handypersons dedicated to this work.

6. Strengths

The RRAP meets many key objectives of local and national policies – in Wales this includes the National Housing Strategy, as well as local health and well-being strategies and older people strategies. It provides preventative services that are closely related to client need and support personal choice and independence. Furthermore, this programme provides a framework of effective local support for vulnerable clients in terms of both hospital discharge and hospital prevention.

The programme demonstrates that by targeting resources effectively, a RRAP enables a quick local response to vulnerable older and disabled people, and can save money across the health and social care sectors. These findings are supported by a review of evidence relating to investment in housing adaptations, improvements and equipment by Heywood and Turner (2007)1.

The RRAP is well respected, which is reflected in the fact that it has consistently received core funding from the Welsh Assembly Government, unlike care and repair schemes elsewhere which often experience funding problems.

7. Weaknesses and potential pitfalls

The main weaknesses reflect high levels of demand outweighing funding for the programme. Furthermore, there is no recognised strategy for addressing work over £350, which may leave some clients vulnerable.

There is still some lack of awareness among local partners and complexities associated with joint working. Health professionals do not always have a strong awareness or understanding of housing related services and definitions of what represents a hospital discharge can differ. There is some reluctance amongst health professionals to define some referrals as contributing to hospital discharge, as the issues that contribute to hospital discharge are often complex and quite often not housing related (eg delayed transfers of care targets for health).

It can sometimes be difficult to achieve best value and economies of scale in the Third Sector. However, work is being undertaken to look at regional collaboration and collective procurement.

There is currently a limited understanding of client satisfaction and the impact of the service on individual outcomes.

8. Sources of further information

Neil Williams, Head of Agency Performance and Funding, Care and Repair Cymru. Telephone 029 2057 9526 Care and repair Cymru at www.careandrepair.org.uk

Welsh Assembly Government (2005) Review of housing adaptations including disabled facilities grant – Wales, WAG


1 These assumptions (10%) were based on historical research and information received when developing the programme in 2002

2 Welsh Assembly Government (2005) Review of housing adaptations including disabled facilities grant – Wales, Wales


4 WAG (2011) Sustainable Social Services for Wales: A framework for action

This case study was compiled for IRISS by the Institute of Public Care

July 2011

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Design — www.believein.co.uk

Money Matters case study five

Money Matters reviews of cost effective initiatives

www.iriss.org.uk

5. Care and Repair

A programme providing a repairs and adaptations programme for older people in Wales, estimated to save £15 million a year –
Money Matters: reviews of cost effective initiatives

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Telephone 029 2057 6286

Care and repair Cymru at www.careandrepair.org.uk

Welsh Assembly Government (2005) Review of housing adaptations including disabled facilities grant – Wales, WAG

3.3 Advice and signposting
The self assessment group was offered more advice regarding preventative services, compared to those assessed by care managers who did not appear to make as much use of the resource information available concerning these services. Those in the self assessment group received significantly (statistically) more units of advice on a wider range of services than those receiving the traditional care management assessment approach. A mean difference of four services compared to one service respectively. The mean cost of providing advice and signposting to other services was £14.02 for the self assessment group and £3.20 for the care management assessment group: a difference that was statistically significant.

4. Application – where it might be appropriate
The self assessment pilot project focused on older people over the age of 55 years. Since the pilot ended, the service has been mainstreamed for all adult services. It now sits within the access and review team. The self assessment process is therefore applicable across adult social services but targeted on those with low-level needs.

5. Resources required – staff, training, IT
This pilot was part of a Department of Health programme with £100,000 funding for the first year. Two members of staff were seconded to work on the pilot for a year, as well as a project manager. No specific bespoke training was deemed necessary. Following the pilot, the service has been mainstreamed across all adult social services and there are no additional ongoing costs.

6. Strengths
The self assessment approach fits well with current government policy objectives to promote personalisation and prevention, putting people in control of identifying what will help them to improve their lives. The service is flexible, offering different elements and types of support according to the individual’s needs. For example, an individual may just need to be provided with an information pack, or they may need a one-off visit to better identify their needs, or the self assessment may be judged to reflect a self referral where the person is eligible for care and support services.

The approach also fits with the government’s prevention agenda and widens access to information and advice. People have been able to access the service who would not necessarily have come to light through a traditional assessment and care management approach. Thus, the self assessment approach is better able to reach those who may not feel it appropriate to contact social services directly, or who are not eligible for care and support, but still have needs to be addressed.

The approach targets assessment resources on a group traditionally neglected by the usual social services response. Not all potential users require the additional costs of a care manager. If such users can be identified, this can invoke significant cost savings whilst offering an assessment approach with similar benefits in terms of the range of services available and satisfaction with the process. High levels of satisfaction were reported equally across both groups of service users in terms of: ease of use; information; and overall satisfaction.

The networking with other agencies and organisations that took place as a result of investigating what services were available and through discussion about individual cases was seen by staff as a positive consequence of the self assessment approach.

7. Weaknesses and potential pitfalls
Some care managers were slow to appreciate the benefits of this preventative approach and felt in some instances they were being asked to provide advice and information which did not use their social work expertise. On reflection, it was felt that the approach could have been ‘sold’ to care managers better in the beginning to gain their support and understanding, by highlighting the benefits in terms of the prevention agenda and the benefits to the service users.

The completion of the self assessment online was sporadic and it was felt that this option had not been publicised effectively.

8. Sources of further information
Carole Kilshaw, St Helens Council, 01744 737863

A self assessment pilot provided a service to older people with low level needs and access to a range of services.

Overall the approach was cheaper than an assessment by a professional care manager and did not affect satisfaction levels: assessment by a care manager cost an average £286, compared with £88 by a self assessment facilitator.

The pilot shows how a targeted —

1. Introduction

This case study provides information regarding a pilot study in one authority in North West England to examine the use of self assessment for older people aged 55 years and over in assessing care needs and care management arrangements. The study was conducted in one authority to promote self assessment for older people who would normally fall outside the existing eligibility criteria for adult social care, and a larger evaluation of eleven pilot sites investigating self assessment for older people and adults with physical disabilities funded by the Department of Health.

In this report the words ‘service user’ or ‘user’ refer to an individual of any age who uses or needs to use the services of adult social care or children’s social services. The term ‘older people’ refers to those aged 55 years and over. The terms ‘care manager’ and ‘assessment worker’ are used interchangeably to refer to the professionals responsible for assessing an individual’s needs and identifying services to meet those needs.

2. Description

This pilot project linked access to assessment for older people with lower level needs to the provision of a range of preventative services through the self assessment approach. The self assessment was seen as a means of widening access to advice and assistance for older people who would have previously only met milt eligibility criteria for low level needs and so may have been denied access to services. The approach was intended to generate resource savings by implementing an assessment approach that reduced the amount of time-consuming paperwork and procedures.

The pilot involved a sample of 100 service users aged 55 years and over. They were referred as normally to the council’s assessment and care management system, following which they were randomly allocated by the team manager either to undertake a self assessment arranged and assisted by the self assessment facilitators (n=54), or to a professional assessment by a care manager (n=46).

3. Evidence of cost effectiveness

Overall, despite some components of the self assessment arrangements generating higher costs than traditional assessments (such as advice about preventive services), total costs were £286 cheaper per user only within the self assessment group. The cost of the self assessment was £173.19 for the self assessment facilitators and £60.17 for the care management group: a difference that was not statistically significant.

The majority of service users had contact with Caroline services (a community alarm service supplemented in some cases by a key safe service and/or a door alarm). Slightly more users in the self assessment group received delivered meals, and this reflected significantly higher costs than for those receiving traditional care management assessment (contributing to 19% of the total costs for the self assessment group and only 3% in the care management group).

### Table 1

<table>
<thead>
<tr>
<th>Service</th>
<th>Self Assessment</th>
<th>Care Manager Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral to OT</td>
<td>0.04%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Day Centre</td>
<td>0%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Meal Preparation</td>
<td>0%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Aids/Community Equipment</td>
<td>0%</td>
<td>10%</td>
</tr>
<tr>
<td>Transport</td>
<td>0.3%</td>
<td>0%</td>
</tr>
<tr>
<td>Benefits/Finance</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Library</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Home Maintenance</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Shopping Service</td>
<td>0.5%</td>
<td>0%</td>
</tr>
<tr>
<td>Domestic Tasks</td>
<td>0.4%</td>
<td>0.03%</td>
</tr>
<tr>
<td>Day Centre</td>
<td>0%</td>
<td>0.03%</td>
</tr>
<tr>
<td>Exercise/Health</td>
<td>0.08%</td>
<td>0%</td>
</tr>
<tr>
<td>Careline</td>
<td>19.4%</td>
<td>20.3%</td>
</tr>
<tr>
<td>Housing and Home Improvement Services</td>
<td>53%</td>
<td>82%</td>
</tr>
<tr>
<td>Day Centre</td>
<td>53%</td>
<td>82%</td>
</tr>
<tr>
<td>Units of Advice</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Food</td>
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A self assessment pilot provided a service to older people with low level needs and access to a range of services.

Overall the approach was cheaper than an assessment by a professional care manager and did not affect satisfaction levels; assessment by a care manager cost an average £286, compared with £88 by a self assessment facilitator.

The pilot shows how a targeted self assessment approach can offer value for service users 

1. Introduction

This case study provides information regarding a pilot study in one authority in North West England to examine the use of self assessment for the assessment of low level needs and low level services in community care. The pilot study looked at a self assessment approach to promote self assessment for older people who would normally fall outside the existing eligibility criteria for adult social care, and a larger evaluation of eleven pilot sites investigating self assessment for older people and adults with physical disabilities funded by the Department of Health.

Information in this report is based on an article in the British Journal of Social Work, and from communication with the project manager for the pilot at St Helens Council. The pilot programme offers evidence of how local authorities can target resources through assessment and how self assessment approaches can offer value for service users whilst generating resource savings.

2. Description

This pilot project linked access to assessment for older people with lower level needs to the provision of a range of preventative services through a self assessment approach. The self assessment was seen as a means of widening access to advice and assistance for older people who would have previously not met eligibility criteria for low level needs and so may have been denied access to services. The approach was intended to generate resource savings by implementing an assessment approach that reduced the amount of time-consuming paperwork and procedures.

The pilot involved a sample of 100 service users aged 55 years and over. They were referred as normally to the council’s in-house assessment and care management system, following which they were randomly allocated by the team manager either to undertake a self assessment arranged and assisted by the self assessment facilitators (n=54), or to a professional assessment by a care manager (n=46).

Those completing the self assessment were assisted by self assessment facilitators. The facilitators (two posts) were posts created specifically for the pilot and their role included publicising the self assessment service, making contact with service users who had completed a self assessment, and providing ongoing advice and support through telephone contact or a one-off visit. They also researched existing care management arrangements in the area to enable a wider range of options to be provided. The facilitators were trained by Level 3 staff who had previous local authority experience with older people.

Following on from the self assessment, the facilitators responded to information collected via the completion of self assessment forms by service users. Once they had identified their needs, the facilitators were able to signpost them to relevant services using a service directory which included advice on minor aids, a falls prevention service, carers’ services, housing and home improvement services and community support services. The facilitators were also able to provide statutory community care services (Careline, meal services) via a “streamlining” of statutory community care assessment. Care managers were also able to offer users advice on low level services through a helpline facility from the self assessment pilot team. It was, therefore, possible to compare the assessment and service outcomes for individual users who undertook a self assessment with those who were assessed by a care manager, as they all had the chance of receiving the same wide range of services from the same source (the intended difference not the service received).

3. Evidence of cost effectiveness

Overall, despite some components of the self assessment arrangements generating higher costs than traditional assessments (such as advice about preventive services), total costs were £286 for the service users who undertook self assessment being less costly in terms of the unit cost (minutes of hours required) for the self assessment facilitators; and secondly, the facilitators were relatively a less costly resource with a lower unit cost.

The evidence from the study also suggests that there are resource savings in terms of both ‘back office’ costs such as savings of time on paperwork and gathering information, and also ‘front office’ costs in terms of what happens in the assessment and who provides it.

3.2 Commissioned services

In terms of the costs of services commissioned for the two groups of service users, the costs were higher for those in the self assessment group (except for day care where costs were higher for those in the care management group). The self assessment group but the results related to one service user only (see Table 1 opposite). For all commissioned services the mean cost was £73.19 for the care management group and £60.17 for the care management group: a difference that was not statistically significant.

Table 1

<table>
<thead>
<tr>
<th>Service receipt, average cost among users and contribution to total over six months (n=100)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community Services</strong></td>
</tr>
<tr>
<td>Provisioning</td>
</tr>
<tr>
<td>Commissioned Services:</td>
</tr>
<tr>
<td>- Careline</td>
</tr>
<tr>
<td>- Delivered Meals</td>
</tr>
<tr>
<td>- Day Centre</td>
</tr>
<tr>
<td>- Referral to OT</td>
</tr>
<tr>
<td>Units of Advice:</td>
</tr>
<tr>
<td>- Shopping Service</td>
</tr>
<tr>
<td>- Meal Preparation</td>
</tr>
<tr>
<td>- Domestic Tasks</td>
</tr>
<tr>
<td>- Exercise/Health</td>
</tr>
<tr>
<td>- Ads/Community Equipment</td>
</tr>
<tr>
<td>- Transport</td>
</tr>
<tr>
<td>- Benefits/Finance</td>
</tr>
<tr>
<td>- Home Maintenance</td>
</tr>
<tr>
<td>- Library</td>
</tr>
<tr>
<td>- Other</td>
</tr>
</tbody>
</table>

Source: Clarke et al (2010)

The majority of services users had contact with Caroline services (a community alarm service supplementation in some cases) and only 2% in the care management group.
A self assessment pilot provided a service to older people with low level needs and access to a range of services.

Overall the approach was cheaper than by a professional care manager and did not affect satisfaction levels: assessment by a care manager cost an average £286, compared with £88 by a self assessment facilitator.

The pilot shows how a targeted self assessment approach can achieve a positive outcome for service users while generating resource savings.

1. Introduction

This case study provides information regarding a pilot study in one authority in North West England to examine the use of self assessment for older people and its impact on care and management arrangements. This study was commissioned to investigate the cost and benefits of promoting self assessment for older people who would normally fall outside the existing eligibility criteria for adult social care, and a larger evaluation of eleven pilot sites investigating self assessment for older people and adults with physical disabilities funded by the Department of Health.

Information in this report is based on an article in the British Journal of Social Work1, and from communication with the project manager for the pilot at St Helens Council. The pilot programme offers evidence of how local authorities can target resources through assessment and how self assessment approaches can offer value for service users whilst generating resource savings.

2. Description

This pilot project linked access to assessment for older people with lower level needs to the provision of a range of preventative services through a self assessment approach. The self assessment was seen as a means of widening access to advice and assistance for older people who would have previously met only the eligibility criteria for low level needs and so may have been denied access to services. The approach was intended to generate resource savings by implementing an assessment approach that reduced the amount of time-consuming paperwork and procedures.

The pilot involved a sample of 100 service users, aged 55 years and over. They were referred as normally to the council’s assessment and care management system, following which they were randomly allocated (by the team and care management system, following which) to a professional care manager (n=46), or to a professional care manager arranged and assisted by the self assessment pilot team. It was, therefore, possible to compare the assessment and service outcomes for individual users who undertook a self assessment with those who were assessed by a care manager, as they all had the chance of receiving the same wide range of services (i.e. the self assessment was the intended difference not the service received).

3. Evidence of cost effectiveness

Overall, despite some components of the self assessment arrangements generating higher costs than traditional assessments (such as advice about preventive services), total costs were £286 cheaper than traditional assessment and facilitated by self assessment being less costs in terms of the number of hours required for self assessment facilitators; and secondly, the facilitators were relatively a less costly resource with a lower unit cost.

The evidence from the study also suggests that there are resource savings in terms of both ‘back office’ costs such as savings of time on paperwork and gathering information, and also ‘front office’ costs in terms of what happens in the assessment and who provides it.

The variation in costs associated with the self assessment approach versus the traditional care management group are summarised in Table 1 opposite.

3.1 Assessment

The evidence from this study suggests that those who received the self assessment generated lower costs in terms of the assessment process itself. Overall, the self assessment facilitators spent less than half the time of care managers in activities related to the assessment process. The self assessment facilitators reported taking less time than care managers in telephone consultations with users, case discussions (such as with team leaders), paperwork and travel time.

The assessment was the most expensive component of each group, and was significantly (statistically) more expensive when provided by care managers, compared with self assessment facilitators (an average of £215 compared to £88 respectively). Providing the assessment contributed to over 82% of the total costs in the care management group compared to 53% attributed to the service assessment facilitators.

3.2 Commissioned services

In terms of the costs of services commissioned for the two groups of service users, the costs were higher for those in the self assessment group (except for day care where costs were higher for those in the care management group) and the results related to the self assessment group or the traditional care management group but the results related to the self assessment group.

Table 1

<table>
<thead>
<tr>
<th>Service/Receipt</th>
<th>Average Cost Service Users Self Assessment</th>
<th>Average Cost Service Users Care Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Home Maintenance</td>
<td>£16.67</td>
<td>£9.00</td>
</tr>
<tr>
<td>2. Meal Preparation</td>
<td>£16.22</td>
<td>£18.42</td>
</tr>
<tr>
<td>3. Library</td>
<td>£0.04</td>
<td>£0.03</td>
</tr>
<tr>
<td>4. Day Centre</td>
<td>£0.04</td>
<td>£0.03</td>
</tr>
<tr>
<td>5. Transport</td>
<td>£0.04</td>
<td>£0.03</td>
</tr>
<tr>
<td>6. Exercise/Health</td>
<td>£0.04</td>
<td>£0.03</td>
</tr>
<tr>
<td>7. Adls/Community Equipment</td>
<td>£0.04</td>
<td>£0.03</td>
</tr>
<tr>
<td>8. Benefits/Finance</td>
<td>£0.04</td>
<td>£0.03</td>
</tr>
<tr>
<td>9. Home Maintenance</td>
<td>£0.04</td>
<td>£0.03</td>
</tr>
<tr>
<td>10. Library</td>
<td>£0.04</td>
<td>£0.03</td>
</tr>
<tr>
<td>11. Speech Pathology</td>
<td>£0.04</td>
<td>£0.03</td>
</tr>
<tr>
<td>12. Other Services</td>
<td>£0.04</td>
<td>£0.03</td>
</tr>
</tbody>
</table>

The majority of service users had contact with Careline Services (a community alarm service supplemented in some cases by a key safe service and/or a door alarm). Slightly more users in the self assessment group received delivered meals, and this reflected significantly higher costs than for those receiving traditional care management arrangements (contributing to 19% of the total costs for the self assessment group and only 3% in the care management group).

and there are no additional ongoing costs.

Following the pilot, the service has been mainstreamed across all adult social services.

No specific bespoke training to work on the pilot for a year, as well as a year. Two members of staff were seconded for assessment by care managers who did not appear to make as much use of the resource information available concerning these services. Those in the self-assessment group received significantly more units of advice on a wider range of services than those receiving the traditional care management assessment: a mean difference of four services compared to one service respectively.

The completion of the self-assessment online was not seen by staff as a positive consequence and through discussion about individual cases investigating what services were available and satisfaction with the process.

Benefits to the service users.

In the beginning to gain their support and have been ‘sold’ to care managers better and felt in some instances they were being asked to provide advice and information which did not use their social work experience. Our reflection, it was felt that the approach could have been ‘sold’ to care managers better in the beginning to gain their support and understanding, by highlighting the benefits in terms of the prevention agenda and the benefits to the service users.

The completion of the self-assessment was sporadic and it was felt that this option had not been publicised effectively.

3.3 Advice and signposting

The self-assessment approach fits well with current government policy objectives to promote personalisation and prevention, putting people in control of identifying what will help them to improve their lives. The service is flexible, offering different means and types of support according to the individual’s needs. For example, an individual may just need to be provided with an information pack, or they may need a one-off visit to better identify their needs, or the self-assessment may be judged to reflect a self-referral where the person is eligible for care and support services.

The approach also fits with the government’s prevention agenda and widens access to information and advice. People have been able to access the service who would not necessarily have come to light through a traditional assessment and care management approach. Thus, the self-assessment approach is better able to reach those who may not feel it appropriate to contact social services directly, or who are not eligible for care and support, but still have needs to be addressed.

The approach targets assessment resources on a group traditionally neglected by the usual social services response. Not all potential users require the additional costs of a care manager. If such users can be identified, this can invoke significant cost savings whilst offering an assessment approach with similar benefits in terms of the range of services available and satisfaction with the process.

High levels of satisfaction were reported equally across both groups of service users in terms of ease of use, information, and overall satisfaction.

The networking with other agencies and organisations that took place as a result of investigating what services were available and through discussion about individual cases was seen by staff as a positive consequence of the self-assessment approach.

6. Strengths

The self-assessment approach fits well with current government policy objectives to promote personalisation and prevention, putting people in control of identifying what will help them to improve their lives. The service is flexible, offering different means and types of support according to the individual’s needs. For example, an individual may just need to be provided with an information pack, or they may need a one-off visit to better identify their needs, or the self-assessment may be judged to reflect a self-referral where the person is eligible for care and support services.

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6. Weaknesses and potential pitfalls

Some care managers were slow to appreciate the benefits of this preventative approach and felt in some instances they were being asked to provide advice and information which did not use their social work expertise. Our reflection, it was felt that the approach could have been ‘sold’ to care managers better in the beginning to gain their support and understanding, by highlighting the benefits in terms of the prevention agenda and the benefits to the service users.

The completion of the self-assessment online was sporadic and it was felt that this option had not been publicised effectively.

6. Sources of further information

Carole Kilshaw, St Helens Council, 0734 679789

7. Weaknesses and potential pitfalls

Some care managers were slow to appreciate the benefits of this preventative approach and felt in some instances they were being asked to provide advice and information which did not use their social work expertise. Our reflection, it was felt that the approach could have been ‘sold’ to care managers better in the beginning to gain their support and understanding, by highlighting the benefits in terms of the prevention agenda and the benefits to the service users.

The completion of the self-assessment online was sporadic and it was felt that this option had not been publicised effectively.
The self assessment group was offered
3.3 Advice and signposting
The self assessment group was offered more advice regarding preventative services, compared to those assessed by care managers who did not appear to make as much use of the resource information available concerning these services. Those in the self assessment group received significantly (statistically) more units of advice on a wider range of services than those receiving the traditional care management assessment: a mean difference of four services compared to one service respectively.

The mean cost of providing advice and signposting to other services was £14.02 for the self assessment group and £3.20 for the care management assessment group: a difference that was statistically significant.

4. Application – Where it might be appropriate
The self assessment pilot project focused on older people over the age of 55 years. Since the pilot ended, the service has been mainstreamed for all adult services. It now sits within the access and review team.

The self assessment process is therefore applicable across adult social services but targeted on those with low-level needs.

5. Resources required – staff, training, IT
This pilot was part of a Department of Health programme with £100,000 funding for the first year. Two members of staff were seconded to work on the pilot for a year, as well as a project manager. No specific bespoke training was deemed necessary.

Following the pilot, the service has been mainstreamed across all adult social services and there are no additional ongoing costs.

6. Strengths
The self assessment approach fits well with current government policy objectives to promote personalisation and prevention, putting people in control of identifying what will help them to improve their lives. The service is flexible, offering different formats and types of support according to the individual’s needs. For example, an individual may just need to be provided with an information pack, or they may need a one-off visit to better identify their needs, or the self assessment may be judged to reflect a self referral where the person is eligible for care and support services.

The approach also fits with the government’s prevention agenda and widens access to information and advice. People have been able to access the service who would not necessarily have come to light through a traditional assessment and care management approach. Thus, the self assessment approach is better able to reach those who might be appropriate for social services directly, or who are not eligible for care and support, but still have needs to be addressed.

The approach targets assessment resources on a group traditionally neglected by the usual social services response. Not all potential users require the additional costs of a care manager. If such users can be identified, this can invoke significant cost savings whilst offering an assessment approach with similar benefits in terms of the range of services available and satisfaction with the process. High levels of satisfaction were reported equally across both groups of service users in terms of ease of use; information; and overall satisfaction.

The networking with other agencies and organisations that took place as a result of investigating what services were available and through discussion about individual cases was seen by staff as a positive consequence of the self assessment approach.

7. Weaknesses and potential pitfalls
Some care managers were slow to appreciate the benefits of this preventative approach and felt in some instances they were being asked to provide advice and information which did not use their social work expertise. On reflection, it was felt that the approach could have been ‘sold’ to care managers better in the beginning to gain their support and understanding, by highlighting the benefits in terms of the prevention agenda and the benefits to the service users.

The completion of the self assessment online was sporadic and it was felt that this option had not been publicised effectively.

8. Sources of further information
Carole Kilshaw, St Helens Council, 0744 079788

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This case study was compiled for IRISS by the Institute of Public Care July 2011
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Design—www.katiebrown.co.uk
Mone Matters reviews of cost effective initiatives www.iriss.org.uk
Comparison group 66 £227
Comparison group 63 £390
Learning disability IB group 70 £359
Comparison group 88 £334
Physical disability IB group 90 £310
Comparison group 33 £152
Mental health IB group 35 £149
Comparison group 250 £296

pilot sites were £286,630 (minimum £128,470; national average was £334,450 (range £222,950 to £486,460). It was estimated that an additional £15,350 (median £10,000 with estimates ranging from £989 to £35,800) would be needed to meet the training needs of the workforce.

Among the pilot sites there was a variety of organisational arrangements: some authorities employed dedicated staff to undertake a wide range of activities, and others allocated these activities to a range of individuals and organisations. Average set-up costs for all pilot sites were £286,630 (minimum £128,470; maximum £486,460). Where there was a project management dedicated team, the average was £334,450 (range £222,950 to £486,460). The costs reported were dominated by the costs of salaries and associated on-costs (National Insurance and superannuation).

The introduction of IBs represents a major cultural shift in the organisation and provision of social care. It will require additional resources to ensure systems are in place to reflect local needs and circumstances. The set-up costs of introducing IBs will vary depending on an individual organisation’s progress towards self directed support and the information and administrative systems that will need adapting. Costs will also depend on the approach adopted: whether authorities attempt to address all or a selected number of user groups and/or teams or geographical locations in the first instance. The degree to which external agencies and processes to support direct payment arrangements are already in place will impact on the requirements for supporting IBs. Furthermore, some authorities identified a two-year set up period, while others felt one year would be sufficient. Among the pilot sites there was a variety of organisational arrangements: some authorities employed dedicated staff to undertake a wide range of activities, and others allocated these activities to a range of individuals and organisations. Average set-up costs for all pilot sites were £286,630 (minimum £128,470; maximum £486,460). Where there was a project management dedicated team, the average was £334,450 (range £222,950 to £486,460). The costs reported were dominated by the costs of salaries and associated on-costs (National Insurance and superannuation).

Table 2
Weekly cost of IB and comparison group

<table>
<thead>
<tr>
<th>Number</th>
<th>Overall weekly cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>IB group 268 £279</td>
</tr>
<tr>
<td></td>
<td>Comparison group 250 £296</td>
</tr>
<tr>
<td>Mental health</td>
<td>IB group 35 £149</td>
</tr>
<tr>
<td></td>
<td>Comparison group 33 £152</td>
</tr>
<tr>
<td>Physical disability</td>
<td>IB group 90 £310</td>
</tr>
<tr>
<td></td>
<td>Comparison group 88 £304</td>
</tr>
<tr>
<td>Learning disability</td>
<td>IB group 70 £359</td>
</tr>
<tr>
<td></td>
<td>Comparison group 63 £390</td>
</tr>
<tr>
<td>Older people</td>
<td>IB group 73 £228</td>
</tr>
<tr>
<td></td>
<td>Comparison group 66 £227</td>
</tr>
</tbody>
</table>

5. Resources required – staff, training, IT

The anticipated advantages of this new system were seen to include: the ability to meet not only personal care needs, but also a range of other needs; continuity and choice of carer; the chance to pay family and other workers; and greater flexibility over how and when to use support services. IBs allowed people to exercise a level of choice and control that they would not have been able to exercise under previous arrangements: ‘...seeing people who’ve had very, very traditional style support for a very long time, living much more independent lives than they had done’. ‘People are living, not existing’.

It was felt that this different approach to service provision would renew engagement with voluntary sector organisations, and produce greater flexibility on the part of service providers.

7. Weaknesses and potential pitfalls

IBs imply major changes and challenges in:

- Development of systems – some authorities will have administrative systems that are more easily adapted to the needs of implementing IBs than others. Average costs to adapt and develop local systems were reported as £43,594 (median £24,970).
- Workforce development – the level of training and development required will depend on the degree to which care managers are working in an outcome focused way. On average, it was estimated that an additional £15,350 (median £10,000 with estimates ranging from £989 to £35,800) would be needed to meet the training needs of the workforce.
- Support planning and brokerage – in order to ensure that support planning and brokerage arrangements were in place, an average of £51,740 (median £41,000) would be required.
- Market management – due to the early stage within the pilot stage, few sites reported additional resources that would be required in this area. However, one authority reported that an additional £10,440 would be required for market management (£5,000 for cost renegotiation and £5,400 for transitional arrangements). Another authority reported that a contracts officer would be required at a cost of £1,350.
- Changing the attitudes and culture of care managers and other staff. Particularly resistance and aversion to risk was reported among some teams working with mental health service users and with older people.
- Funding and developing alternatives to IB while resources are still tied up in relatively long-term block contracts.
- Developing resource allocation systems.
- Disaggregating social care resources from services that are jointly funded with other departments and organisations (e.g. health).

Service providers may experience reduced demand for traditional services and new pressures to provide different types of services in different ways if they are to remain viable. There was a view that currently there is a lack of choice of alternative provision: not all service providers are seen as being positive in changing to meet the potential change in demand. Providers may need help to prepare for this new approach at a time when commissioning resources are limited.
The Individual Budgets (IBs) Pilot Programme tested the introduction of cash and notional individual budgets for users of adult social care in thirteen local authorities.

1. Introduction

This case study is based on an evaluation of the Individual Budgets (IBs) programme undertaken in 2006. Thirteen local authorities can pilot individual budgets from November 2005 to December 2007. The pilot sites implemented different regimens and were assessed to introduce IBs; the details of these can be found in the main report (see references for introducing IBs).

The evaluation indicated that those who received an IB experienced slightly better outcomes, and that IBs are more effective in achieving overall social care outcomes than traditional approaches.

2. Description

IBs are central to the Government’s ‘personalyisation’ agenda. The Individual Budgets programme sought to develop new systems and the focus of support arrangements from service users’ and the services they received. It aimed to shift the type of support they accessed, and over the way that support was organised and delivered, for many individuals there were delays in the implementation of their IB which resulted in less than half of those who received an IB actually having a support plan in place at six months. Only 39% of those who had a support plan had the arrangements in place for more than a month. The cost effectiveness analyses reported in the evaluation computed the mean difference in each outcome measure (such as ASCOT) over the period 12 months and divided it by the mean difference to obtain a ratio. Simulations were made when evaluating whether these ratios were likely to be seen as cost effective. That is, they asked whether policy built on individual budgets is likely to achieve better user outcomes at a cost that is worth paying.

3. Evidence cost effectiveness evidence in support

A randomised controlled trial (RCT) was designed to investigate the effectiveness of IBs at a key objective was to understand whether the approach improved outcomes over and above basic arrangements for support. The evaluation indicated that those who received an IB experienced slightly better outcomes, and that IBs are more effective in achieving overall social care outcomes than traditional approaches.

Table 1 shows how people used their budgets.

<table>
<thead>
<tr>
<th>Service/ type of expenditure</th>
<th>Mean annual expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal assistant</td>
<td>£3,520</td>
</tr>
<tr>
<td>Home care (agency)</td>
<td>£1,290</td>
</tr>
<tr>
<td>Home care (in-house)</td>
<td>£5,700</td>
</tr>
<tr>
<td>Meals services</td>
<td>£1,160</td>
</tr>
<tr>
<td>Equipment – telecare</td>
<td>£290</td>
</tr>
<tr>
<td>Equipment – other</td>
<td>£380</td>
</tr>
<tr>
<td>Adaptations</td>
<td>£380</td>
</tr>
<tr>
<td>Leisure activities</td>
<td>£330</td>
</tr>
<tr>
<td>Planned short breaks</td>
<td>£2,350</td>
</tr>
<tr>
<td>Child care</td>
<td>£1,850</td>
</tr>
<tr>
<td>Health and dental services</td>
<td>£2,000</td>
</tr>
<tr>
<td>Accommodation</td>
<td>£1,000</td>
</tr>
</tbody>
</table>

One-off payments reported in support plans included: kitchen, bedroom or bathroom equipment; safety devices; ramps; mobility aids; courses; and computer equipment.

4. Application – where it might be appropriate

This approach is applicable to all use groups, though the impact and cost effectiveness does vary slightly. It is suited for those with mental health service users and young people with physical disabilities. IBs are also suited to some people with learning disabilities – likely to be those who need lower level services.
The Individual Budgets (IBs) Pilot Programme tested the introduction of cash and notional individual budgets for users of adult social care in thirteen local authorities.

IBs are most effective for mental health service users in terms of psychological well-being and social care outcomes; they are also cost effective for younger people with physical disabilities.

Overall, people with an IB felt significantly more in control of their everyday lives, the support they accessed, and how it was delivered than other service users.

Personal budgets are now being rolled out across adult social care in England.

1. Introduction

This case study is based on an evaluation of the Individual Budgets (IB) programme undertaken in 2008. Thirteen local authorities can pilot individual budgets from November 2005 to December 2007. The pilot sites implemented different IB schemes and were asked to introduce IBs; the details of these can be found in the main text (see references for further information). The evaluation indicated that those who received an IB experienced slightly better outcomes, and that IBs are more effective in achieving overall social care outcomes than traditional approaches.

2. Description

IBs are central to the Government's 'personalisation' agenda. The Individual Budgets programme sought to develop new systems within local authorities that offered opportunities for individuals to take more control over their support needs were met through the way money was spent to meet their care needs.
Personal budgets are now being offered to people with physical disabilities. IBs are also suited to people with psychological well-being or mental health service users in their terms of psychological well-being. The findings were broadly encouraging for the new arrangements: psychological well-being. The Individual Budgets (IBs) programme was designed to investigate the effectiveness of personal budgets and the impact in terms of outcomes and cost effectiveness. A key objective was to identify whether the approach improved outcomes for IB holders and delivered better care to budget holders. Management of IBs – in the majority of cases the IB was managed as a direct payment. In addition, the IB was paid as a direct payment to a personal bank account, and for a further 16% the IB was paid into a joint bank account of the budget holder and/or another person. The local authority organised services for 20% of IB holders.

Table 1 below shows how people used their budgets.

<table>
<thead>
<tr>
<th>Service/Type of funding</th>
<th>Mean annual expenditure</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal assistant</td>
<td>£8,520</td>
<td>59%</td>
</tr>
<tr>
<td>Home care (agency)</td>
<td>£7,290</td>
<td>24%</td>
</tr>
<tr>
<td>Home care (in-house)</td>
<td>£5,700</td>
<td>5%</td>
</tr>
<tr>
<td>Meal services</td>
<td>£2,160</td>
<td>1%</td>
</tr>
<tr>
<td>Equipment – telecare</td>
<td>£180</td>
<td>1%</td>
</tr>
<tr>
<td>Equipment – other</td>
<td>£870</td>
<td>10%</td>
</tr>
<tr>
<td>Adaptations</td>
<td>£610</td>
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</tr>
<tr>
<td>Leisure activities</td>
<td>£470</td>
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<tr>
<td>Planned short breaks</td>
<td>£2,650</td>
<td>1%</td>
</tr>
<tr>
<td>Child care</td>
<td>£1,850</td>
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</tr>
<tr>
<td>Health and dental services</td>
<td>£540</td>
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</tr>
<tr>
<td>Accommodation</td>
<td>£830</td>
<td>1%</td>
</tr>
</tbody>
</table>

One-off payments reported in support plans included: kitchen, bedroom or bathroom equipment; safety devices; ramps and mobility aids; courses; and computer equipment. Additional services/expenses identified included: decorating or gardening services; holiday and sickness cover; transport (taxi/safe travel and car cleaning); gymnastics, internet access; personal needs; and alternative therapy or private health care.

3. Evidence of cost effectiveness

A randomised controlled trial (RCT) was conducted to investigate the effectiveness of personal budgets. The impact in terms of outcomes and cost effectiveness was assessed using a key approach focused on the type of support they accessed, and the way that support was organised and delivered. For many individuals there were delays in the implementation of their IB which resulted in less than half of those who accepted an IB actually having a support plan in place at six months. Only 39% of those who had a support plan had had the arrangements in place for more than a month. The cost effectiveness analyses reported in the evaluation computed the mean difference in each outcome measure (such as ASCOT) or ratio of cost differences to a unit of difference. Ratios were used as a means of evaluating whether these ratios were likely to be seen as cost effective. That is, they asked whether the cost of building on individual budgets is likely to achieve better user outcomes at a cost that is worth paying. To ensure comparison of like with like in relation to cost effectiveness analysis, the evaluation focused on recurrent expenditure and used weekly costs drawings on the content of the support plans. Cost effectiveness was analysed against two outcomes: ASCOT social care outcomes measure and the GHQ-121 measuring psychological well-being. The findings were seen as broadly encouraging for the new arrangements: IB holders reported higher use and higher cost effectiveness advantage for IB over standard support arrangements using the social outcomes measure. In relation to psychological well-being, standard arrangements looked slightly more cost effective than IBs. The average value of funding within IBs across all user groups was £11,450 (median £6,610; standard deviation £72; maximum £156,000). On average, approximately 80% of IBs consisted of recurrent funding (15%–78%, median £8,580; standard deviation £2,301). Standards for meeting one-off payments (n=46; median £875; standard deviation £1,650). IB holders reported higher use and higher costs of health care services than the comparison group. Although it is difficult to know why this is the case, it is possible that spending more time in support planning for an IB may have allowed care coordinators to optimise health needs, leading to increased use of health services.

The Individual Budgets (IBs) Pilot Programme tested the introduction of cash and notional individual budgets for users of adult social care in thirteen local authorities.

IBs are most effective for mental health service users in terms of psychological well-being and social care outcomes; they are also cost effective for younger people with physical disabilities.

Overall, people with an IB felt significantly more in control of their everyday lives, the support they accessed, and how it was delivered than other service users.

Personal budgets are now being rolled out across adult social care in England.
### 5. Resources required – staff, training, IT

The introduction of IBs represents a major cultural shift in the organisation and provision of social care. It will require additional resources to ensure systems are in place to reflect local needs and circumstances. The set-up costs of introducing IBs will vary depending on an individual organisation’s progress towards self-directed support and the information and administrative systems that will need adapting. Costs will also depend on the approach adopted: whether authorities attempt to address all or a selected number of user groups and/or teams or geographical locations in the first instance. The degree to which external agencies and processes to support direct payment arrangements are already in place will impact on the requirements for supporting IBs. Furthermore, some authorities identified a two-year set up period, while others felt one year would be sufficient.

Among the pilot sites there was a variety of organisational arrangements: some authorities employed dedicated staff to undertake a wide range of activities, and others allocated these activities to a range of individuals and organisations. Average set-up costs for all pilot sites were £286,630 (minimum £128,470; maximum £486,460). Where there was a project management dedicated team, the average was £334,450 (range £222,950 to £486,460). The costs reported were dominated by the costs of salaries and associated on-costs (National Insurance and superannuation).

Other component costs were:

- **Development of systems** – some authorities will have administrative systems that are more easily adapted to IBs. Costs will also depend on the degree to which organisations need to implement new systems and develop local systems were reported as £43,594 (median £24,970).
- **Workforce development** – the level of training and development required will depend on the degree to which local care managers are working in an outcome focused way. On average, it was estimated that an additional £15,310 (median £10,500 with estimates ranging from £9,380 to £30,600) would be needed to meet the training needs of the workforce.
- **Support planning and brokerage** – in order to ensure that support planning and brokerage arrangements were in place, an average of £55,710 (median £45,083) would be required.

### 6. Strengths

The anticipated advantages of this new system were seen to include: the ability to meet not only personal care needs, but also a range of other needs; continuity and choice of care worker; the chance to pay family and other carers; and greater flexibility over how and when to use support services.

IBs allowed people to exercise a level of choice and control that they would not have been able to exercise under previous arrangements: ‘... seeing people who’ve had very, very traditional style support for a very long time, living much more independent lives than they had done’. ‘People are living, not existing.

It was felt that this different approach to service provision would renew engagement with voluntary sector organisations, and produce greater flexibility on the part of service providers.

### 7. Weaknesses and potential pitfalls

IBs may have major advantages and challenges in:

- **Organisational arrangements**, processes, culture and professional roles within local authority adult social care services; in the roles of voluntary and user-led organisations; and in the expectations and responsibilities of social care service providers. In particular, major change is needed in the activities and processes undertaken by front line staff (care managers/social workers).
- **Changing the attitudes and culture of care managers and other staff.** Particular resistance and aversion to risk was reported among some teams working with mental health service users and with older people.
- **Funding and developing alternatives to IB while resources are still tied up in relatively long-term block contracts.**
- **Developing resource allocation systems.**
- **Disaggregating social care services** from services that are jointly funded with other departments and organisations (e.g. health).

Service providers may experience reduced demand for traditional services and new pressures to provide different types of services in different ways if they are to remain viable. There was a view that currently there is a lack of choice of alternative provision: not all service providers are seen as being proactive in changing to meet the potential change in demand. Providers may need help to prepare for this new approach at a time when commissioning resources are limited.

### 8. Sources of further information

- **Social Policy Research Unit, University of York.**
- **GHQ 12**
  - The GHQ 12 is a widely used version of the General Health Questionnaire used in medication wellbeing studies.
  - www.iriss.org.uk
  - Registered in Scotland: No 3137 40. Scottish Charity No: SC037882. Registered Office: Brunswick House, 51 Wilson Street, Glasgow  G1 1UZ
  - The Institute for Research and Innovation in Social Services (IRISS) is a charitable company limited by guarantee. Registered in Scotland: No 019356. Scottish Charity No: SC024752. Registered Office: Duchess House, 9 Wilson Street, Glasgow. G1 6DZ
  - www.iriss.org.uk

### Table 2

<table>
<thead>
<tr>
<th>Overall</th>
<th>IB group</th>
<th>Comparison group</th>
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<tbody>
<tr>
<td>£286,630</td>
<td>£279,970</td>
<td>£279,970</td>
</tr>
<tr>
<td>£334,450</td>
<td>£326,970</td>
<td>£326,970</td>
</tr>
<tr>
<td>£334,450</td>
<td>£318,970</td>
<td>£318,970</td>
</tr>
<tr>
<td>£334,450</td>
<td>£303,970</td>
<td>£303,970</td>
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<tr>
<td>£334,450</td>
<td>£288,970</td>
<td>£288,970</td>
</tr>
<tr>
<td>£334,450</td>
<td>£274,970</td>
<td>£274,970</td>
</tr>
</tbody>
</table>

---

The above text is a natural representation of the document as per your requirements.
Table 2
Weekly cost of IB and comparison group

<table>
<thead>
<tr>
<th>Number</th>
<th>Overall</th>
<th>weekly cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>IB group</td>
<td>268</td>
<td>£279</td>
</tr>
<tr>
<td>Comparison group</td>
<td>250</td>
<td>£296</td>
</tr>
<tr>
<td>Mental health IB group</td>
<td>35</td>
<td>£149</td>
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<tr>
<td>Comparison group</td>
<td>33</td>
<td>£152</td>
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<tr>
<td>Physical disability IB group</td>
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<td>£310</td>
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<tr>
<td>Comparison group</td>
<td>88</td>
<td>£334</td>
</tr>
<tr>
<td>Learning disability IB group</td>
<td>70</td>
<td>£359</td>
</tr>
<tr>
<td>Comparison group</td>
<td>63</td>
<td>£390</td>
</tr>
<tr>
<td>Older people IB group</td>
<td>73</td>
<td>£228</td>
</tr>
<tr>
<td>Comparison group</td>
<td>36</td>
<td>£227</td>
</tr>
</tbody>
</table>

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- Development of systems – some authorities will need administrative systems that are more easily adapted to reflect local needs and circumstances.
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- Support planning and brokerage – in order to ensure that support planning and brokerage arrangements were in place, an average of £51,710 (median £10,660 with estimates ranging from £918 to £35,800) would be required.
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It was felt that this different approach to service provision would renew engagement with voluntary sector organisations, and produce greater flexibility on the part of service providers.

7. Weaknesses and potential pitfalls

IBs imply major changes and challenges in:

- Organisational arrangements, processes, culture and professional roles within local authority adult social care services; in the roles of voluntary and user-led organisations; and in the expectations and responsibilities of social care users. In particular, major change is needed in the activities and processes undertaken by front line staff (care managers/social workers).
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- Developing resource allocation systems.
- Disaggregating social care resources from services that are jointly funded with other departments and organisations (such as health).

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8. Sources of further information

Social Policy Research Unit, University of York.

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Design www.iriss.org.uk
Money Matters – case study seven

Money Matters reviews cost effective initiatives
www.iriss.org.uk

This case study was compiled for IRISS by the Institute of Public Care July 2011
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Design www.iriss.org.uk

7. Individual Budgets are most cost effective for mental health service users in terms of psychological well-being and social care outcomes

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4. Application

This service model has particular potential where there is a need to reduce delayed discharges, because of its success in reducing older people’s length of stay in hospital. The approach could also be considered by commissioners who have a high level of admission to care homes from the acute sector.

Some elements of the HD pathway approach could be applied where social and health care organisations are experiencing a high level of hospital patients with complex mental illness, where this is preventing safe and sustainable discharge. For example, screening, understanding and planning for the impacts of mental illness on hospital discharge may be a useful way to deliver effective discharge planning. Likewise, this approach may be useful where intermediate care/home healthcare services have not traditionally included people with mental health issues.

There is a potential synergy between early rehabilitation in the hospital setting and rehabilitation services. Where local authorities wish to develop reablement services, they could consider where these initiatives are best situated. For example, in the community as an ‘in-take’ team, or within the hospital setting providing rehabilitation care prior to, and continued post, discharge.

5. Resources required

The evaluation did not break down the costs between the two different strands of the POPP. The total POPP funding over the two years of the project was £1.8 million. The staff resources required are outlined in the description of the service.

The Early Intervention Worker could be replicated elsewhere in hospital discharge teams by putting a social worker in place to organise early screening, care finding, planning and support for people returning to hospital as a result of care package breakdown. Overall, hospital staff felt discharge planning was more targeted and resulted in a more efficient outcome of time in hospital. Given the success of the HD model in reducing length of hospital stay, Kings College Hospital mainstreamed this post.

The Rehabilitation Support Workers providing with support with activities of daily living (ADLs) and follow-up as part of the HD pathway team contributed to a holistic approach to rehabilitation and care planning throughout the HD pathway.

The Community Geriatrician with links to the acute sector, provided a bridge between secondary and primary care, and strengthened the wider community pathway. For example, the Community Geriatrician developed a case finding tool to help professionals in the community such as GPs and HD teams identify patients at risk of care home placement. This then triggers appropriate MDT interventions to prevent admission. The appointment of a Voluntary Sector Coordinator (VSC) went some way in alleviating social isolation by referring people to befriending services and other community support groups.

This type of market facing intervention has the potential to widen service provision and may help to stimulate and develop the local voluntary sector market. Alternatively, brokerage services are to be developed to assist service users with making care arrangements, this knowledge and specialist could be harnessed by brokerage organisations.

7. Weaknesses/potential pitfalls

Although significant savings were made, not all of these savings could be accrued by Southwark Health and Social Care. This was evaluated under the ‘payment by results’ arrangements to control financial risk is particularly pertinent given the current funding position of health and social care. If all local authorities with their health partners are considering such approaches, it is important that time and effort is put into developing constructive relationships at the start of any venture to secure agreement about how savings will be released into the system to ensure outcomes are best for the population. Agreement over adequate arrangements to control financial risk is particularly pertinent given the current funding position of health and social care.

8. Sources of further information

Department of Health: Prospective Longitudinal Study about the ‘payment by results’ arrangement
Partnerships for Older People Project Development: Partnerships for Older People (POPP) evaluation reports http://www.researchdevelopmentcentre.mhs.ryr.uk/POPP.php

7. Money Matters case study eight
1. Introduction

Southwark was awarded £1.8 million from the Department of Health’s Partnerships for Older People’s Project (POPP) to develop the Hospital Discharge Pathway Project. This consisted of two workstreams, the Hospital Discharge Project and the Community Pathway Re-design Project. This case study is based on the evaluation of the HD Pathway element of the POPP which identified positive outcomes in terms of intermediate care, hospital discharge and reduced length of stay.

2. Description of the service

Two acute care trusts were involved in the pilot, Guy’s and St Thomas’s Hospital, and Kings College Hospital. The Hospital Discharge teams in each trust were re-configured to be more rehabilitation focused, with the aim to reduce the number of elderly people hospital to home and for patients to be adequately supported to return home independently. It was also developed because it was supported by the Multidisciplinary Team (MDT) that too many patients were spending unnecessary time in hospital, despite being medically fit to return home.

The focus of the HD pathway project was early intervention via case finding. This was established by ensuring that the hospital discharge teams were aware of patients to identify those likely to have health and social care needs at discharge, and those likely to have complex discharge issues.

The team was reconfigured in the following way:

- An Early Intervention Worker (EIW) was employed in both acute trusts to work on the elderly wards to identify at an early stage in a patient’s hospital stay, those with health and social care needs in order to arrange for earlier assessments and interventions.
- A Mental Health Intermediate Care team (MHIC) was established to intervene particularly early around discharge needs and provide advice and training to the HD team around mental health issues.

3. Evidence of cost effectiveness

The evaluation reported that although it was not possible to measure precisely the costs and benefits, it was likely that the Hospital Discharge Discharge pathway project was self-financing due to the reduced length of stay in the acute trusts and care home placements. After the first year of the HD project, it was estimated potential savings were achieved in the region of £1 million in 2006-7.

Table 1

<table>
<thead>
<tr>
<th>Year before</th>
<th>Year after</th>
<th>Year before</th>
<th>Year after</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of discharges</td>
<td>603</td>
<td>568</td>
<td></td>
</tr>
<tr>
<td>Average LOS</td>
<td>4.6</td>
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</tr>
<tr>
<td>Bed days</td>
<td>12,633</td>
<td>12,362</td>
<td></td>
</tr>
<tr>
<td>Number of beds</td>
<td>8,659</td>
<td>stayed the same</td>
<td></td>
</tr>
<tr>
<td>Potential bed days saved</td>
<td>2,251</td>
<td>2,251</td>
<td></td>
</tr>
<tr>
<td>Bed days saved per patient</td>
<td>3.7</td>
<td>2.3</td>
<td></td>
</tr>
</tbody>
</table>

4. Impact of pathway on residential placement and care package use

Interviews with hospital discharge staff highlighted that staff felt the HD pathway intervention had a positive impact on the number of home admissions and care packages. Staff felt that through rehabilitation approaches and addressing mental health issues, many fewer elderly people who needed care home placements were admitted. The care home placements were avoided and successful discharge home was facilitated for 75% of all care home placements in Southwark from the hospital setting, so it is likely that some reduction in care home placements occurred as a direct result of the HD intervention. Additionally, some case studies showed where care home placements had been avoided as a result of the HD pathway.

Over the project lifetime, average length of stay on elderly wards fell by 2.3 days and 3.7 days in two hospitals, while the proportion of patients receiving intermediate care and returning home increased.

The initiative achieved estimated potential savings of over £1 million through reduced length of stay in hospital and reductions in care home placements.

The role of the Early Intervention Worker was mainstreamed in one of the hospitals at the end of the POPP.
Money Matters  case study eight
Southwark Hospital Discharge
Institute of Public Care
ipc.brookes.ac.uk

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Southwark was awarded £1.8 million from the Department of Health’s Partnerships for Older People (POPP) project to develop the Hospital Discharge Pathway Project. This consisted of two workstreams, the Hospital Discharge Pathway (HD) project and the Community Pathway Re-design Project. This case study is based on the evaluation of the HD Pathway element of the POPP which identified positive outcomes in terms of intermediate care, hospital discharge and reduced length of stay.

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A Community Geriatrician was involved in the discharge process and provided expert clinical guidance and liaison with the hospitals to assist with fast tracking/case finding of patients. An assessment process was developed to establish those patients at risk of going into a care home so that adequate interventions could be put in place to assist them returning home. These patients would then be monitored accordingly by the Community Geriatrician via four local MDT meetings and home visits.

The focus of the HD pathway project was early intervention via case finding. This was established by ensuring that the hospital discharge teams identified patients to identify those likely to have health and social care needs on discharge, and those likely to have complex discharge issues.

The team was reconfigured in the following way:

- An Early Intervention Worker (EIW) post. An estimated 2,231 bed days were saved for Kings College Hospital and another 1,513 bed days were saved in Guy’s and St Thomas’s Hospital.

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- A Voluntary Sector Coordinator (VSC) was appointed to develop stronger links between the voluntary sector and social and health care agencies and enable more joined up and holistic interventions.

- The Southwark Primary Care Trust Medicines Management and Pharmacy team also supported hospital discharge by providing assistance with medicine management and assessing patients’ medicine use and compliance.

It also provided bed-based care outside of the acute environment to enable patients to make decisions about their longer term future.

- Occupational Therapists and Physiotherapists who assessed patients’ ability to mobilise safely and independently within their homes and in the community.

- A Mental Health Intermediate Care team (MHIC) service was established to intervene early for patients with early stage in a patient’s hospital stay, those with health and social care needs in order to arrange for earlier assessments and interventions.

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- An Early Intervention Worker (EIW) post. An estimated 2,231 bed days were saved for Kings College Hospital and another 1,513 bed days were saved in Guy’s and St Thomas’s Hospital.

3. Evidence of cost effectiveness
The evaluation reported that although it was not possible to measure precisely the costs and benefits, it was likely that the Hospital Discharge Pathway project was self-financing due to the reduction in length of stay for elderly wards to identify, at an early stage, those likely to have health and social care needs on discharge, and those likely to have complex discharge issues.

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- Figures showed a decrease of 24 admissions to care home placements in 2006–2007, representing a 15% reduction. This equalled annual savings of £51,680. However, in 2007–2008, care home placements rose to 197. Nonetheless, compared with the pre-POPP period, 31% of all care home placements were averted as a result of the HD pathway over the POPP period. Given that each placement would have cost Southwark £553 per week, £115,000 was averted in the quarter ending June 2007 to 14.9% (51) in the quarter to March 2008. Figures also showed a decrease of 24 admissions to care home placements in 2006–2007, representing a 15% reduction. This equalled annual savings of £51,680. However, in 2007–2008, care home placements rose to 197. Nonetheless, compared with the pre-POPP period, 31% of all care home placements were averted as a result of the HD pathway over the POPP period. Given that each placement would have cost Southwark £553 per week, £115,000 was averted in the quarter ending June 2007 to 14.9% (51) in the quarter to March 2008.

3.2 Increase in mental health referrals
There was also an overall increase in Mental Health Intermediate Care (MHIC) service referrals and service use. MHIC consultations increased from an average of 6.8 referrals per annum pre-POPP to 44 during the POPP. This equated to a rise of more than 300% in referrals for different interventions to the MHIC in the first year of the project 2006–2007.

3.3 Reduced length of stay for patients on elderly wards
The HD pathway project made a significant impact. Evaluations found evidence of the following...

- increased intermediate care use and an increased uptake of patients returning home with support as a result of the HD pathway.

- increased mental health referrals

- reduced length of stay for patients on elderly wards.

The HD pathway project resulted in a significant increase in the number of patients returning home with support from the HD team in both acute trusts. At Guy’s and St Thomas’s this percentage rose from 5.3% of patients in the quarter ending June 2006 to 14.9% a year later. Figures for Kings College Hospital rose from 27.7% (20) in the quarter ending June 2007 to 14.9% (51) the quarter to March 2008.

3.4 Impact of pathway on residential placement and care package use
Interviews with hospital discharge staff revealed that staff felt the HD pathway intervention had a positive impact on the number of care home admissions and care packages. Staff felt that through rehabilitation approaches and addressing mental health issues, there would then be a reduction in need for care home placements and a decrease in bed days saved.

Table 1

<table>
<thead>
<tr>
<th></th>
<th>Number of discharges</th>
<th>Average LOS</th>
<th>Bed days</th>
<th>Number of beds required if LOS had stayed the same</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Average LOS</td>
<td></td>
<td>Potential bed days saved from reduced LOS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Bed days saved per patient</td>
</tr>
<tr>
<td>Kings College Hospital</td>
<td>603</td>
<td>4.5</td>
<td>1,635</td>
<td>20,863.8</td>
</tr>
<tr>
<td>Guys and St Thomas’s Hospital</td>
<td>658</td>
<td>4.9</td>
<td>1,513</td>
<td>14,278.6</td>
</tr>
</tbody>
</table>

Potential bed days saved from reduced LOS: 4,822

Bed days saved per patient: 3.7

Table 1 Bed days saved by reduced length of stay (LOS)

The HD pathway project is self-financing due to the reduction in length of stay in the acute trusts. At Guy’s and St Thomas’s this reduction from 5.3% of patients in the quarter ending June 2006 to 14.9% a year later. Figures for Kings College Hospital rose from 27.7% (20) in the quarter ending June 2007 to 14.9% (51) the quarter to March 2008.

There was a significant increase in the number of patients returning home with support from the HD team in both acute trusts.

Figures also showed a decrease of 24 admissions to care home placements in 2006–2007, representing a 15% reduction. This equalled annual savings of £51,680. However, in 2007–2008, care home placements rose to 197. Nonetheless, compared with the pre-POPP period, 31% of all care home placements were averted as a result of the HD intervention over the POPP period. Given that each placement would have cost Southwark £553 per week, £115,000 was averted in the quarter ending June 2007.

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As part of Southwark POPP, the hospital discharge teams in two hospitals were reconfigured to be more rehabilitation focussed.

Over the project lifetime, average length of stay on elderly wards fell by 2.3 days and 3.7 days in the two hospitals, while the proportion of patients receiving intermediate care and returning home increased.

The initiative achieved estimated potential savings of over £1 million through reduced length of stay in hospital and reductions in care home placements.

The role of the Early Intervention Worker was mainstreamed in one of the hospitals at the end of the POPP.

1. Introduction

Southwark was awarded £1.8 million from the Department of Health’s Partnerships for Older People’s Project (P OPP) to develop the Healthy Ageing in Southwark Project. This consisted of two workstreams, the Hospital Intermediate Care Project and the Community Pathway Re-design Project. This case study is based on the evaluation of the HD Pathway element of the POPP which identified positive outcomes in terms of intermediate care, hospital discharge and reduced length of stay.

2. Description of the service

Two acute care trusts were involved in the pilot, Guy’s and St Thomas’s Hospital, and Kings College Hospital. The Hospital Discharge teams in each trust were re-configured to be more rehabilitation focussed, with the aim to reduce length of stay to an elderly care home and for patients to be adequately supported on discharge.

It was also developed because it was supported by the Multi-Disciplinary Team (MDT) that too many patients were spending unnecessary time in hospital, despite being medically fit to return home.

The focus of the HD pathway project was early intervention via case finding. This was established by ensuring that the hospital discharge teams identified patients to identify those likely to have health and social care needs on discharge and that those patients can have complex discharge issues. The team was reconfigured in the following way:

- An Early Intervention Worker (EIW) was employed in both acute trusts to work on the elderly wards to identify, at an early stage in a patient’s hospital stay, those with health and social care needs in order to arrange for earlier assessments and interventions.

- A Mental Health Intermediate Care team (MHIC) was established to intervene particularly early, focusing on acute discharge issues and provide advice and training to the HD team around mental health issues.

3. Evidence of cost savings

The evaluation reported that although it was not possible to measure precisely the costs and benefits, it was likely that the Hospital Discharge Pathway project was self-financing due to the reduction in length of stay in the acute trusts and care home placements. After the first year review of the HD project, it was estimated potential savings were achieved in the region of £1 million in 2006-7.

Evidence of evaluation found evidence for:

- increased intermediate care use and an increased proportion of patients returning home with support as a result of the HD pathway;

- increased mental health referrals;

- reduced length of stay for patients on elderly wards.

The evaluation also showed that care home placements for some patients had been avoided as a result of the HD pathway and that the support delivered post discharge contributed to more patients being independent at home.

3.1 Increased intermediate care use and percentage of patients returning home with support

The intermediate care service was actively being used and assistings with discharges. There was a significant increase in the percentage of patients referred to intermediate care and discharged home with support from the HD team in both acute trusts. At Guy’s and St Thomas’s this percentage rose from 5.3% of patients in the quarter ending June 2006 to 14.9% a year later. Figures for Kings College Hospital rose from 27% (24) in the quarter ending June 2007 to 14.9% (51) the quarter to March 2008.

3.2 Increase in mental health referrals

There was also an overall increase in Mental Health Intermediate Care (MHIC) service referrals and service use. MHIC consultations increased from an average of 986 interventions pre-POPP to an average of 1,348 during the POPP period, which represents a rise of 114%. Specialist assessment and planning carried out by the MHIC service more than quadrupled. Staff training in mental health interventions also increased from an average of 0.32 staff annually pre-POPP to 4.4 during the POPP. This increased to a rise of more than 300% in the quarter to March.

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<td>12,765</td>
<td>12,765</td>
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<td>2.3</td>
</tr>
</tbody>
</table>

Kings College Hospital: Year after pre-POPP

Guy’s and St Thomas’s Hospital: Year after pre-POPP

Adapted by IPC March 2011

www.iriss.org.uk Money Matters | reviews of cost effective initiatives

Institute of Public Care
ipc.brookes.ac.uk
4. Application

This service model has particular potential where there is a need to reduce delayed discharges, because of its success in reducing older people’s length of stay in hospital. The approach could also be considered by commissioners who have a high level of admission to care homes from the acute sector.

Some elements of the HD pathway approach could be applied where social and health care organisations are experiencing a high level of hospital patients with some form of mental illness, where this is preventing safe and sustainable discharge. For example, where screening, understanding and planning for the impacts of mental illness on hospital discharge may be a useful way to deliver effective discharge planning. Likewise, this approach may be useful where intermediate care/break down services have not traditionally included people with mental health issues.

There is a potential synergy between early rehabilitation in the hospital setting and reablement services. Where local authorities wish to develop reablement services, they could consider where these initiatives are best situated. For example, in the community as an ‘in-take’ team, or within the hospital setting providing reablement care prior to, and continued post, discharge.

5. Resources required

The evaluation did not break down the costs between the different strands of the POPP. The total POPP funding over the two years of the project was £1.8 million. The staff resources required are outlined in the description of the service.

The Early Intervention Worker could be replicated elsewhere in hospital discharge teams by putting a social worker in place to organise early screening, case finding and planning, either by reconfiguring current staff or by employing someone externally. Where there are high levels of unnecessary admissions to care homes in the community and where there is little case finding work in both the hospital and community setting, it may be applicable to consider the post of a Community Geriatrician who holds clinical cases and reviews them as appropriate within the wider MDT context. The Voluntary Sector Coordinator (VSC) identified how voluntary sector services could contribute to the discharge process and help people to live independently in their own home.

6. Strengths

In Southwark, the HD pathway project helped to change practitioners’ mind-sets about early hospital care homes placements as a last resort, and supported more elderly people to return to home, in line with the known preferences of the majority of older people to live at home as long as possible. A number of good practice principles underpin the pathway approach: the HD pathway primarily looks at the patient pathway and identifies difficult interfaces between services that can adversely affect patient outcomes. For example, barriers to safe and sustainable discharge, such as depression and anxiety are identified and planned for. Having a Mental Health Intermediate Care (MHIC) team to advise and intervene on a case by case basis, as well as providing wider training to the HD team, helped to overcome unnecessary obstacles to ensure successful discharge and support at home. The EIW contributed directly to reducing length of stay in hospital. Interviews with hospital staff showed the usefulness of the EIW; many reported that pro-actively case finding enabled the gathering of screening information on patients. This, in turn, helped social workers in the MDTs to prioritise better and to allocate their cases for early assessment. Staff felt that such early intervention and consequent care planning was successful in keeping people from returning to hospital as a result of care package breakdown. Overall, hospital staff felt discharge planning was more targeted and resulted in a more efficient outcome of time in hospital. Given the success of the EIW post reducing length of hospital stay, Kings College Hospital mainstreamed this post.

The Rehabilitation Support Workers providing support with activities of daily living (ADLS) and follow-up as part of the MDT team contributed to a holistic approach to rehabilitation and care planning throughout the HD pathway.

The Community Geriatrician with links to the acute sector provided a bridge between secondary and primary care, and strengthened the wider community pathway. For example, the Community Geriatrician developed a case finding tool to help professionals in the community such as GPs and HD teams identify patients at risk of care home placement. This then triggers appropriate MDT interventions to prevent admission.

The appointment of a Voluntary Sector Coordinator (VSC) went some way in alleviating social isolation by referring people to befriending services and other community/ support groups. This type of market facing intervention has the potential to widen service provision and may help to stimulate and develop the local voluntary sector market. Alternatively, brokerage services are to be developed to assist service users with making care arrangements, this knowledge and specialism could be harnessed by brokerage organisations.

7. Weaknesses potential pitfalls

Although significant savings were made, not all of these savings could be achieved by Southwark Health and Social Care. This was evaluated under the ‘payment by results’ model, where PCTs pay acute trusts for every number of care home placements as a last resort, and significantly can adversely affect patient outcomes. For example, practitioners’ mind-sets to see care home placements as a last resort, and supported more elderly people to return to home, in line with the known preferences of the majority of older people to live at home as long as possible. A number of good practice principles underpin the pathway approach: the HD pathway primarily looks at the patient pathway and identifies difficult interfaces between services that can adversely affect patient outcomes. For example, barriers to safe and sustainable discharge, such as depression and anxiety are identified and planned for. Having a Mental Health Intermediate Care (MHIC) team to advise and intervene on a case by case basis, as well as providing wider training to the HD team, helped to overcome unnecessary obstacles to ensure successful discharge and support at home. This, in turn, helped social workers in the MDTs to prioritise better and to allocate their cases for early assessment. Staff felt that such early intervention and consequent care planning was successful in keeping people from returning to hospital as a result of care package breakdown. Overall, hospital staff felt discharge planning was more targeted and resulted in a more efficient outcome of time in hospital. Given the success of the EIW post reducing length of hospital stay, Kings College Hospital mainstreamed this post.

This case study was compiled for IRRIS by the Institute of Public Care

Money Matters

focus on rehabilitation reduced the length of time in hospital and the number of care home placements generating savings of over £1 million
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Where there are high levels of unnecessary admissions to care homes in the community and where there is little case finding work in both the hospital and community setting, it may be applicable to consider the post of a Community Geriatrician who holds the MDT role and reviews them as appropriate within the wider MDT context. The Voluntary Sector Coordinator (VSC) identified how voluntary sector services could contribute to the discharge process and help people to live independently in their own home.

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7. Weaknesses/ potential pitfalls

Although significant savings were made, not all of these savings could be accrued by Southwark Health and Social Care. This was exacerbated under the ‘payment by results’ system where PCTs pay acute trusts for every admission and do not get savings back from system where PCTs pay acute trusts for every admission. If local authorities with their health partners are considering such approaches, it is important that time and effort is put into developing constructive relationships at the start of any venture to secure agreement about how savings will be released into the system to ensure outcome benefits are best for the population. Agreement over adequate remuneration and financial risk is particularly pertinent given the current funding position of health and social care.

8. Sources of further information


Partnerships for Older People Project (POPP) evaluation reports

http://www.researchdevelopmentcentre.nhs.uk/ popp.php


2. Local Government Improvement and Development

http://www.idea.gov.uk/idk/core/page.do?pageId=7977231

Southwark PCT

3. Research and Development Centre (October 2008)

http://www.idea.gov.uk/idk/core/page.do?pageId=7977231

4. Research and Development Centre–October 2008

Partnerships by Older People Project Evaluation Report

http://www.idea.gov.uk/idk/core/page.do?pageId=7977231

5. Research and Development Centre–October 2008

Partnerships for Older People Project (POPP)

http://www.idea.gov.uk/idk/core/page.do?pageId=7977231