1. Shared Lives

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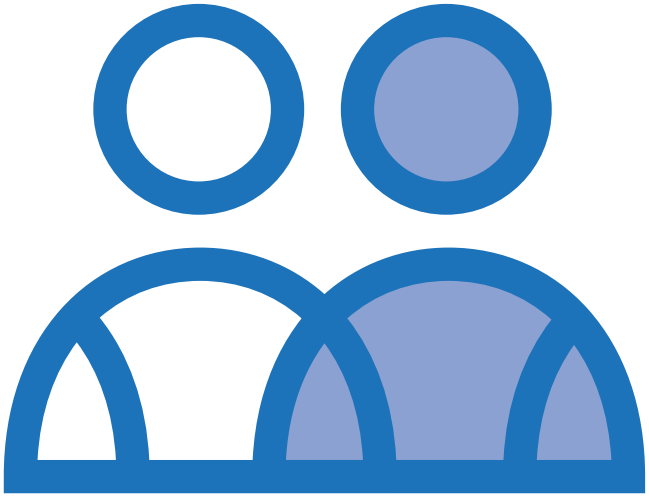

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Shared Lives services, formerly known as Adult Placement, involve the provision of care and support in the homes of ordinary people to individuals placed there by the local authority.

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

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

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

1. Introduction

This case study is based on an evaluation of the quality, outcomes and cost-effectiveness of Shared Lives services (formerly known as Adult Placement) in south east England, conducted in 2009[1]. The study found that most Shared Lives schemes provide: 'care that is good or excellent, care that meets national minimum standards, positive experiences and outcomes for people, high levels of satisfaction among stakeholders, and value for money', delivering high quality support at a relatively low price.

2. Description

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

- Placements are part of organised Shared Lives Schemes that approve and train Shared Lives Carers, receive referrals, match the needs of service users with Shared Lives Carers, and monitor the placements.
- 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 at any one time.
- 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 breaks; day-time support; rehabilitative or 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 run by a local authority) will receive referrals, match a service user with a carer, draw up a Placement Agreement, and monitor and support the placement. A Separate Carer Agreement (in effect a contract to provide a service between Scheme and Shared Lives carer) sets out 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 particularly in the working week.

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. You can be friends and even hug like mates, but you can't do that with staff 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.'
>
> Service user

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 a small residential home in terms of the family setting and the emphasis on community links, along with 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[2]. The number of clients placed in 'adult placements' in England was 4,200 at 31 March 2010, an increase of 5 per cent from 4,000 in 2009[3]. Over three quarters (76%) of these clients were aged 18-64 with a learning disability.

In Scotland, national care standards for 'adult placement services' were issued in 2003, under the Regulation of Care (Scotland) Act 2001[4], and adult placement schemes have been regulated since April 2005. The Care Commission registers and inspects adult placement services, not individual placement providers. In the 2009 study, only two of the schemes had logged any safeguarding concerns over the preceding 12 months and both of these had been dealt with appropriately. Where the Shared Lives scheme has three adults living in it at the same time, it may also have to be licensed as a house in Multiple Occupation under the Civic Government (Scotland) Act 1982 (Licensing of Homes in Multiple Occupation) Order 2000[5].

Shared Lives carers are self-employed. The Government has recently passed legislation extending current foster care relief to include Shared Lives carers from 6 April 2010, with the aim of bringing into line the tax treatment of carers who, like foster carers, share their homes and daily family life with an adult or child placed with them by a local authority.

3. Evidence of cost effectiveness

Comparing CSCI ratings for Shared Lives schemes in south east England with care home ratings, the NAAPS/IESE survey in 2009 found that 79% of Shared Lives schemes were rated excellent or good, compared with 69% of care homes. Service users in all four schemes in the evaluation identified a number of successful outcomes: living the life they wanted; having choices and being in control; developing confidence/skills/independence; and having different experiences.

A Business Case for Shared Lives[6] estimates that to develop a scheme that could support 85 service users would require an investment of £620,000 for a five year period. Based on data from the 2009 study, over the same period, it could generate net savings of £12.99 million by reducing the need for costlier services, residential care in particular.

Using the 2009 data, A Business Case for Shared Lives calculates that the average unit cost of a Shared Lives placement including board and lodging and management costs is £419 per week, and for long-term support – £293 per week (see Table 1). A flat-rate weekly management charge for all types of placement is included.

Applying the comparable PSSEX unit cost data from PSSRU indicated potential savings per placement of between £46 and £995 per week depending on the type of service user (see Table 2); with the greatest potential savings obtained from long-term placements for people with learning disabilities. For a new scheme, it was estimated that savings per person would not be realised until the second year of operation.

Potential savings were also indicated by the 2009 study for other types of Shared Lives placements, such as day-time support and floating support, however, the financial data are less reliable.

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 achieve successful outcomes – ie that cost-effectiveness is greater in the larger schemes. In A Business Case for Shared Lives, a level of 85 placements is assumed. Greater efficiencies can be realised when tasks such as planning and delivering training, recruiting and maintaining an Approval Panel, or developing quality assurance systems can benefit a large number of service users.

Shared Lives placements are suitable for a wide range of groups; however, they appear to be most widely used to provide support to people with a learning disability. From Table 2, it is clear that this is also the group where potential savings are greatest.

5. Resources required – staff, training, IT

According to A Business Case for Shared Lives[7], it takes between 11 and 16 months to establish the structure of a new scheme before it can recruit carers and become operational.

The 2009 study obtained data on 18 schemes. On average there were 11 Shared Lives carers to one full-time equivalent (FTE) staff, 17 service users and 24 placements to one FTE. Average staffing levels were: 0.8 FTE manager, 3.3 FTE placement workers and 0.7 FTE administrators.

Payment levels are usually decided according to the needs of the service user, rather than the hours worked, with a range of bands for rates of payment. In 2009, rates ranged between £267 and £653 per week for a longer term placement (including board and rent). Payments for short breaks varied between £159 and £550 per week. Costs for separate day-time placements of service users in long-term placements were usually met by the sponsoring authority.

Five schemes charged a weekly flat rate management fee for long-term placements. The average charge was £58 per week. There was insufficient information to calculate

Table 1
Range of weekly payments to Shared Lives carers and management costs

	Range		Overall care cost	Management charge	Unit cost Shared Lives
	Min	Max	(mean)	(mean)	(mean)
All-in price for long-term placement, including board and lodging (£ per week)	**267**	**653**	**361**	**58**	**419**
Support in long-term (£ per week)	**151**	**430**	**235**	**58**	**293**

Source: NAAPS/IESE (2009) A Business Case for Shared Lives

Table 2
Potential savings

Type of service	**National unit cost per week £**	**Shared Lives unit cost £ per week** (overall mean)	**Potential savings per unit £ per week if person is supported in Shared Lives rather than elsewhere**
Learning disability residential care	**1,059**	**419**	**640**
Older people residential care	**465**	**419**	**46**
Physical disability residential care	**780**	**419**	**361**
Mental health residential care	**602**	**419**	**183**
Learning disability supported living	**1,288**	**293**	**995**

Source: NAAPS/IESE (2009) A Business Case for Shared Lives

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, temporary absences 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[8], 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 the 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 picked out as 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.

8. Sources of further information

NAAPS UK: http://www.naaps.org.uk/

NAAPS UK ltd 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.naaps.org.uk/en/shared-lives-membership/naaps-scotland/?PHPSESSID=587e2827f8f239dbaecef263b330bc0b

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

NAAPS/IESE (2009) A Business Case for Shared Lives, NAAPS

Bernard S (2006) Adult Placement Counts: A survey of Adult Placement Schemes in Scotland, Scottish Executive/NAAPS Scotland

Scottish Executive (2002) National Care Standards: Adult Placement Services, Edinburgh: Scottish Executive

1 NAAPS and Improvement and Efficiency South East (September 2009) An Evaluation of the Quality, Outcomes and Cost-effectiveness of Shared Lives Services in South East England, NAAPS and IESE

2 Bernard S (2006) Adult Placement Counts: A survey of Adult Placement Schemes in Scotland, Scottish Executive/NAAPS Scotland

3 NHS Information Centre (2011) Community Care Statistics: Social Services Activity, England – 2009-10 (initial release)

4 Scottish Executive (2002) National Care Standards: Adult Placement Services, Edinburgh: Scottish Executive

5 http://www.nationalcarestandards.org/184.html

6 NAAPS/IESE (2009) A Business Case for Shared Lives, NAAPS

7 NAAPS/IESE (2009) A Business Case for Shared Lives, NAAPS

8 NAAPS/IESE (2009) A Business Case for Shared Lives, NAAPS

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2. 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

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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.

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

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

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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.

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[1]. 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 Counsel, there are an estimated 1,100 ECH schemes in the UK. The evaluation concluded that overall costs increased as a result of people moving into the Rowanberries 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 tenure development of 46 self-contained apartments, developed as 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 a lift and wheelchair access throughout its four storeys. There is a range of communal facilities including: a cafe/restaurant, activities room, laundry, hairdresser and assisted bathrooms.

Twenty-four hour care is provided on site by MHA. In addition, MHA provide a day centre and a domiciliary care team which provides services to the local community including enablement and rehabilitation. The scheme accommodates a wide range of care needs: some residents have come from nursing home settings, while others moved in from their own home. The balance of dependency at the end of the first six months of the scheme's operation was: 12 residents with high needs

(requiring 20 hours or more per week or four or more calls per day); 12 with medium needs (requiring 10 hours or more per week or three calls per day); 10 with low care needs (requiring five hours or more per week or two calls per day) and 13 with dementia. Rowanberries aims to offer a bespoke service to people with dementia with staff trained in dementia care. The scheme is registered as a domiciliary care provider with the Care Quality Commission.

Residents were aged between 59 and 92, with a mean of 78 years. Eighty per cent had previously been living in a private household, eight per cent in sheltered or supported housing, and 10 per cent moved from a care home. The majority of the scheme's residents (59%) had been owner occupiers, and just over half (53%) had been living alone before moving into the scheme. About 40% of the residents needed help to go outdoors, use stairs or steps, have a bath or wash all over; 40% were identified as having some cognitive impairment; and 16% were severely cognitively impaired.

3. Evidence of cost effectiveness

The analysis is based on data obtained from 40 of the original residents of Rowanberries, 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 services in their former homes.

The broad cost components of the analysis which together represented the total weekly cost of a resident's living arrangement were:

- Health care service cost
- Social care service cost
- Capital costs of the accommodation converted to an annual equivalent cost
- Running (maintenance and/or management cost of housing
- Other living expenses.

The sum of these costs (see Table 1) gives an average cost per person of £380 per week before moving in, compared with £470 six months after moving into Rowanberries. At £470, the estimated weekly package costs in Rowanberries are comparable with residential care (£483 per week in 2007), although the people moving into ECH are considerably less dependent.

The difference in the costs of social care before and after moving in was mainly driven by an increase in the costs of support services and the costs of home care received (an average of £89 per week per resident, 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 after moving in, compared with 10% before moving to Rowanberries, but 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 £51.60 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 £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 accommodation resulted in an average cost to residents of £110 per person per week before moving into Rowanberries, and £141 per week after the move. A limited increase 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 substantially reflecting the small number of people who were previously in public 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 costs for care were met by Bradford Adult Services Department regardless of income, savings

Table 1
Costs before and after moving to Rowanberries

	In previous home		In Rowanberries
	40 residents	22 residents	22 residents
Health care costs	**123.5**	**121.0**	**53.3**
Day hospital	3.6	6.5	0.0
GP at surgery	2.3	2.4	1.5
GP at home	3.4	2.6	2.3
Nurse at GP surgery	1.9	1.5	2.1
Nurse at home	77.9	71.8	35.0
Therapist	1.1	0.5	6.1
Chiropodist	0.7	0.8	1.4
A&E department	0.7	0.7	0.3
Outpatient appointment	5.2	4.9	3.9
Inpatient stay	26.9	29.5	0.8
Social care costs	**73.7**	**65.1**	**193.4**
Day centre	20.2	12.6	0.0
Lunch club	0.2	0.3	0.0
Meals on wheels	3.7	2.6	0.0
Restaurant at scheme	0.0	0.0	19.8
Social worker	9.2	9.3	33.3
Home care	40.4	40.3	88.6
Well-being charge (activities, support)	–	–	51.6
Accommodation costs	**119.9**	**110.0**	**141.1**
Owner-occupied			
Self-reported	111.1	93.9	-
Locational analysis	120.0	116.1	-
Maintenance	7.8	7.8	-
Rented			
Rent only	73.9	72.8	84.1
Maintenance and management	13.5	11.9	57.0
Repairs allowance	13.4	13.5	-
Additional housing costs			
Water rates	4.9	4.9	-
Hot water and heating (individual)	5.1	5.1	-
Living expenses	78.0	77.9	77.8
Personal expenses	7.6	7.6	7.6
Total cost per resident per week	**403**	**382**	**473**

Source: Bäumker, T, Netten A, & Darton R (2008) Costs and outcomes of an extra-care housing scheme in Bradford, York: JRF

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 health care service. Overall, health service costs fell after people had moved, by an average of £68 per resident per week. The greatest single difference related to nurse visits at home – a mean decrease of £37 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 an inpatient at hospital were more likely to see a nurse since living at Rowanberries. It appears that residents had better access to health care resources rather 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 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 and that of the person who had moved to Rowanberries.

Approximately £360 per week was estimated to be the average cost falling on the public sector per Rowanberries resident (equivalent to about 75% of the formal costs). The figure includes estimates of the subsidised capital cost, housing benefit payments towards rent and service charge, care package funding by social services, and the average amount of benefits/allowances received.

It seems that direct costs to social care authorities may be less for the scheme because Attendance Allowance and Housing Benefit can be claimed to cover a significant proportion of the well-being charge and 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 that they were previously entitled to, 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 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 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 owner 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 home 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 assumed for calculating annual capital costs, and differences in the proportion of residents coming from social housing.

5. Resources required – staff, training, IT

Funding for the purpose-built scheme was received from the Department of Health's Extra Care Housing Funding Initiative which met 46% of the capital costs, while the local authority contributed the land to the developer at 'best consideration'. Details of staffing arrangements were not available, however, average rents were £63.50 per week, and the service charge was £39.25 per week. The price of care was set independently of resident dependency levels at £91.92 per place. The Extra Care Housing Toolkit[2] provides guidance on staffing and skills required for running an ECH scheme.

6. Strengths

Rowanberries ECH delivered positive outcomes for both residents and carers. Residents reported high levels of satisfaction with care received, significant improvement 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.

The findings indicate that residents of Rowanberries had improved access to social and health care services, along with 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 than 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 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 is based on a relatively small sample in an ECH scheme. A clearer indication of the costs and benefits of ECH will be available when the national evaluation of ECH by PSSRU is available in the autumn of 2011.

8. Sources of further information

Bäumker, T, Netten A, & Darton R (2008) Costs and outcomes of an extra-care housing scheme in Bradford, York: JRF. http://www.jrf.org.uk/publications/costs-and-outcomes-extra-care-housing-scheme-bradford

Housing LIN (2006), *Extra Care Housing Toolkit*, CSIP, Department of Health. http://www.housinglin.org/Topics/type/resource/?cid=1508&

1 Bäumker, T, Netten A, & Darton R (2008) Costs and outcomes of an extra-care housing scheme in Bradford, York: JRF

2 Housing LIN (2006), *Extra Care Housing Toolkit*, CSIP, Department of Health

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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 half a million pounds over ten years

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As part of Bradford POPP, a network of mental health well-being cafés for older people was established, along with a community involvement team.

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Over a ten-year period, the initiative is projected to achieve net benefits of more than half a million pounds.

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A significant reduction in depression, along with some improvements in social inclusion and well-being, was found in service users.

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The well-being cafés are now part of mainstream services and the number of sessions has been increased.

1. Introduction

This case study is based on the evaluation of the Bradford Partnership for Older People Programme (POPP), Health in Mind, conducted by the University of Bradford[1]. The Health in Mind programme aimed to expand mental health support across specialist, mainstream and third sector services through a 'whole system' change to services for older people with mental health problems. Health in Mind involved four inter-related projects, including a Mental Health Community Involvement Project (CIP), which funded a network of mental health well-being cafés and the development of a community involvement team. The evaluation team concluded that:

> 'There is evidence to suggest that the CIP is already providing good value for money'.

2. Description

The Community Involvement Project (CIP) aimed to improve capacity in the community and voluntary sector to provide support for older people, both those with, 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, through the network of well-being cafés.
- Enable older people with mental health needs and their carers to maintain relationships with their local self-defined communities, by developing a continuum of social inclusion support.
- Optimise existing, and unlock untapped, mental health support across community and voluntary sector networks.
- Better understand how to meet the needs of people marginalised within current mental health services.

2.1 Well-being cafés

Building on a pilot project run by the Bradford Alzheimer's Society, 12 'sessional' well-being (originally called mental health) cafés were established, providing open-door access to mental health support, and acting as a first point of contact for people with emerging needs. The cafés also provided informal access for carers to find support.

The 12 well-being cafés were developed to an initial specification which included expected outcomes for participants, service development outcomes, along with specification of facilities, information provision and structured activities, including the gradual inclusion of education and advice sessions. Users and carers could 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 delivered by the Alzheimer's Society, and the Meri Yaadain (My Memories) café for South Asian people, were focused specifically on people 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 Eastern Europeans, one for South Asians, and one for the African/Caribbean community.

Cafés provided lunch and a range of activities including entertainment, a programme of educational talks and discussions with guest speakers, and opportunities for informal contact with health and social care practitioners (e.g. memory assessment, social work, benefits advice, NHS health educators) that would be available to listen, provide advice, and act as a signpost to support. Health and well-being advice and activities included exercise classes, podiatry, nutrition, telecare and pharmacy. The evaluation identified a delicate balance between social activity and formal health and social care input in the informal setting of the well-being café.

The project team's Café Coordinator compiled a list of contact details for willing speakers and activity providers for café hosts to invite. These included speakers from statutory health and social care organisations, such as the Community Mental Health Teams, meals services, ambulance services and Patient Advice and Liaison; voluntary sector organisations; the fire service; and organisations giving advice on benefits and disability aids. Information about a wide range of entertainers was also offered.

The involvement of organisations through the well-being cafés had an additional benefit of creating an environment where service providers were able to hear older peoples' views and learn how to improve communication with older people, particularly those with mental health problems.

Data obtained from 76 attendees at the well-being cafés and other funded services indicated that the cafés were attracting a group with identifiable mental health needs. 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 and maintain supportive relationships with their peers and wider communities. Funding was provided to support a range of activities including socialising, exercise (eg, walking, tai chi), personal development (eg, IT skills programmes), arts and cultural activities (eg, creative writing, cinema, and theatre), trips out (eg, pub/café lunches) and education.

In the year 2007-2008, £270,719 was allocated for 80 activities, including a broad range of events such as exercise, trips out, massage, and information and education. The grants ranged from £40 to the maximum amount of £5,000, with an average of £3,384. The development of mechanisms for funding the well-being activities involved intensive consultation with community groups, voluntary organisations and development workers.

It was specified that the activities should reflect Bradford's diverse population: some sessions were tailored to the needs of particular communities of interests, and 'hosted' by organisations representative of these groups, e.g. BME communities, older lesbians and gay men.

The project successfully engaged a range of groups, including small community groups unaccustomed to applying for funding, through

targeted outreach work to rural areas and to black and minority ethnic groups, and supported them through the development, application and monitoring procedures. Project Officers provided free training. As a result, a great deal of knowledge was acquired regarding successful approaches for engaging with traditionally hard to reach groups.

Free specialist mental health training was provided by the project team to a range of groups and organisations that would not otherwise have been able to afford, or have access to, it. The project acted as a successful hub that made contact with groups that were previously unknown to statutory services and the larger voluntary sector organisations and provided opportunities for building relationships.

The activities of the Community Involvement Project were planned to reach 350 people and their carers. Quarterly report data indicate that this estimate was significantly exceeded. There was a steady growth in the numbers attending the well-being cafés (from 217 in 2006-7 to 329 in 2007-8) and taking part in the well-being activities (426 to 2215). Numbers 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.

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 tentative and dependent on the achievement of target outcomes in the coming years.

The costs used in the analysis were the actual costs for the first two years and the proposed budget 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 of 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 well within the margin of error of the data used for calculating the benefits.

Only the project costs were measured as no data were available to measure additional costs incurred by some of the organisations involved in the CIP. Implicitly, this assumes that the budget provided to these organisations fully covered their costs. There is some evidence to suggest that additional costs were borne by the organisations themselves.

Valuation of user benefits, such as well-being, is inherently problematic. The most appropriate economic approach is contingent valuation of 'willingness to pay'. An alternative cost saving was used which valued the activities as if they were 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 comparison was made with an alternative entertainment activity - a visit to the cinema.

The value of well-being café attendance was set at £31 per person session, this rate being the cost of local authority day care; and the value of well-being activities was set at £6.50 per person session, this being approximately the cost of a cinema ticket with some refreshment. In view of the number of participant sessions, the analysis is very sensitive to the value set.

Measurement of the benefits of the CIP was based on the estimated number of sessions per participant in the well-being cafés and well-being activities. Overall, it was assumed that the participants at well-being cafés attended 75% of the time, and that the participants in the well-being activities participated in two thirds of the activities which were assumed to take place on a weekly basis on average (i.e. 8 weekly meetings per quarter). Growth of the number of users was extrapolated on the basis of existing trends up to a maximum defined by the number of well-being cafés and the number of activities that could be funded from the budget.

Based on these assumptions and the data from the report, the CIP would generate net benefits valued at £574,930 over a 10-year period (see Table 1). The evaluation concludes

that the CIP is providing very good value for money, ie, well-being cafés and community involvement team.

There are some caveats about the use of the cost saving approach: the results do not fully account for a number of additional benefits, such as improved access to information about available services for some participants, as well as some additional costs to the voluntary sector, and lastly, some of the benefits are notional rather than 'cashable'. Nevertheless, it appears fairly clear that the programme activities were capable of delivering significant benefits, both to the health service, social care and the growing population of older people with mental health needs.

While the cafés had unanticipated set-up and running costs for host organisations, they resulted in improved networking across the voluntary and statutory sector. Participants reported enjoying the time spent in cafés and valued the well-being activities provided.

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

	Costs	Benefits	Net measurable benefit
	£	£	£
Year 1	313,868	40,044	-273,824
Year 2	575,818	314,274	-261,544
Year 3	556,470	441,097	-115,373
Year 4	567,495	550,176	-17,319
Year 5	567,495	774,660	207,165
Year 6	567,495	774,660	207,165
Year 7	567,495	774,660	207,165
Year 8	567,495	774,660	207,165
Year 9	567,495	774,660	207,165
Year 10	567,495	774,660	207,165
Total			**574,930**

Figures from Health in Mind Programme Evaluation (2008)

A significant reduction in depression scores was observed over time[2], alongside reported improvements by some end users with respect 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 within 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.

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 PCT developed activities through the CIP activity fund for groups of older people who were lacking 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 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 comprise 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 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 were areas which 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 from well-being to formal health care within community locations. This has the advantage of providing an access route through social 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

Downs M et al (2008) Health in Mind Programme Evaluation: Final report to the Programme Board, University of Bradford

www.bradfordhealthinmind.nhs.uk/.../bradford_HealthinMindEvaluation_finalReport_300608.pdf

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1 Downs M et al (2008) Health in Mind Programme Evaluation: Final report to the Programme Board, University of Bradford

2 Z=-1.739, p=.041

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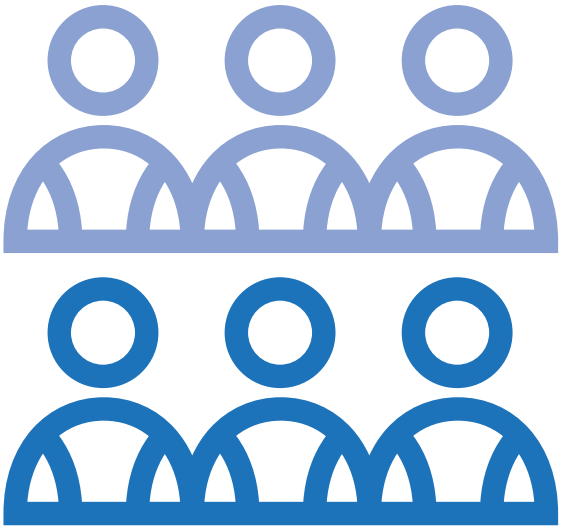
4. LinkAge Plus

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



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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.

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There were benefits to both taxpayers 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.

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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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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 pilots[1,2] completed in 2009. LinkAge Plus was a programme exploring 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 wellbeing. 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 support for older people at a local 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 'model' 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 choice
- Achieve efficiencies through joint working
- Strengthen partnership working.

Taken together, these activities represent a 'LinkAge Plus approach'.

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, PCTs and voluntary organisations can develop new approaches to widening access, joining up services and gaining a better understanding of the needs and preferences of older people seeking help and support. Examples included: establishing single access gateways; enhanced contact centres; 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 included: increasing older people's sense of safety and security such as fitting smoke alarms and raising awareness on how to live a safe and healthy lifestyle; 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 (walks, Tai Chi classes, chair-based 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.

Promoting social inclusion and community cohesion

A variety of services was developed to encourage older people to socialise and widen their social networks, reducing social isolation and exclusion. Examples included: coffee mornings; classes; special interest groups; outings; exercise activities; outreach and befriending; voluntary work; older people's forums helping to give older people a voice on local issues; and maximising older people's income and benefits.

Capacity building

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

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 which is based on the 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 taxpayer over the following five years.

The key findings are:

- A holistic approach to service delivery requires some up-front investment over the two-year pilot period, but quickly

Table 1
Holistic approach to service delivery illustrati

Year	
Discount factor at 3.5%	
Holistic overheads of LinkAge Plus	
Holistic ongoing costs	
LinkAge Plus outreach costs	
Holistic savings of LinkAge Plus	
Holistic savings – lagged six months	
Present value of holistic costs	
Present value of holistic benefits	
Net present value – benefits minus costs	
Cumulative net present value	
Net present value benefit per £1 spent £1.77	

Source: Watt P and Blair I (2009) The business case for LinkAge Plus, DWP

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 following the investment 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 these services with 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 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 two years, 688 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.

3.1.1 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 three rows relate to set-up and ongoing costs (including outreach costs) – which are limited to the two years of the pilot.

Estimated savings flow from this approach on the basis that there were 2,909 and 4,467 contacts in the two year investment period

ative example: Nottinghamshire First Contact scheme

Pilot investment period	1	2	3	4	5	Total
1	0.9662	0.9335	0.9019	0.8714	0.8420	0.8135	
£18,515	£78,284						
£62,226	£172,120						
£45,712	£97,348						
£189,459	£324,989	£82,960	£82,960	£82,960	£82,960	£82,960	
£94,730	£257,224	£203,975	£82,960	£82,960	£82,960	£82,960	
£126,453	£335,992						£462,445
£94,730	£248,526	£190,412	£74,825	£72,295	£69,850	£67,488	£818,126
-£31,724	-£87,467	£190,412	£74,825	£72,295	£69,850	£67,488	£355,680
-£31,724	-£119,190	£71,222	£146,047	£218,342	£288,192	£285,830	

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 around £189,000 and £325,000. These savings would probably take a little time to materialise, so the next row lags behind them by six months (ie 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 voluntary 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 services for a fire safety visit. Such visits are likely to lead to the fitting of a smoke alarm, which yields benefits to both the older person who is less likely to die or be injured in a fire and the taxpayer in terms of reduced response costs for the fire service. The business case report applied a research-based figure of around £2,400 for the cost of a fire to the taxpayer, and £31,000 a year for the value of preventing death or injury to the individual. Based on an estimate of the impact of fitting a smoke alarm on the numbers of deaths and fires, the calculated expected value of benefits to the taxpayer and the older person was £14 and £1 respectively per fire safety referral. The Office of the Deputy Prime Minister[3] puts the cost of a smoke alarm at £10.38. Putting these values together – 824 referrals to the fire and rescue service in the first year and 1,404 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

Exercise classes, particularly Tai Chi, provide benefits to taxpayers and participants by reducing the likelihood of falling and breaking a hip. The cost of a person falling and breaking a hip to the taxpayer is estimated at about £20,000, and the cost to the individual in terms of possible death or morbidity is about £14,000. Research indicates that 15 weeks of Tai Chi classes reduce the relative risk of falling by 47.5%. Further research on the prevalence of hip fractures enables the estimation in the reduction in absolute risk of a hip fracture that is likely to result from one Tai Chi class. The business case report applied this risk reduction to the estimates of the taxpayer costs that hip fractures entail, calculating expected taxpayer savings at £4.29 per class. In addition, there is an expected benefit of £2.90 per class to the participant from the increased likelihood of avoiding pain and possible death from hip fracture (benefits which have been assumed to persist for the five years after the initial investment period). The cost to the participant for an exercise class was £2 with a taxpayer subsidy of £1.18.

3.2.3 Crime reduction

The Association of British Insurers[4] 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 likelihood of a burglary, causing an absolute reduction of likelihood of burglary of 2.5%. The Home Office[5] estimated the cost of a burglary at £3,268 which can be split into a £2,120 cost to the victim and £1,148 cost to the taxpayer. On the basis of these figures, a crime visit that results in target hardening of the older person's home can be expected to save the taxpayer about £29 and the older person visited about £53. When 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.

3.2.4 Home adaptations

There is evidence to suggest that adaptations 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 £74 and to the older person of £50. Home adaptations costs averaged £77.26. However, £10 was commonly paid by the older person so this figure was adjusted to £67.26. 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 the 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 Nottinghamshire 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 7,376 checklists completed in the period from July 2006 to June 2008. On average each checklist/contact resulted in 2.2 additional referrals to agencies, the main ones being to 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 made available. 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 locality 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

Davis H and Ritters K (2009) LinkAge Plus national evaluation: End of project report, Research Report No 572: Department for Work and Pensions

Watt P and Blair I (2009) The business case for LinkAge Plus, Research Report 573: Department for Work and Pensions

1 Davis H and Ritters K (2009), LinkAge Plus national evaluation: End of project report, Research Report No 572, Department for Work and Pensions

2 Watt P and Blair I (2009) The business case for LinkAge Plus, DWP

3 ODPM (2006). The Economic Costs of Fire: estimates for 2004, Office of the Deputy Prime Minister, April

4 ABI (2006) Securing the Nation: The case for safer homes, Association of British Insurers

5 Home Office (2005) The economic and social costs of crime against individuals 2003/04, London, Home Office

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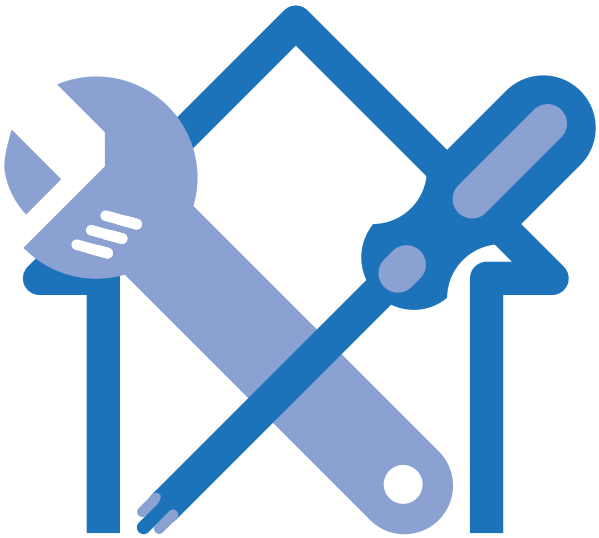
5. Care and Repair

a programme providing a repairs and adaptations programme for older people in Wales, estimated to save £15 million a year



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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 as at risk of hospital admission, or awaiting hospital discharge.

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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.

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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 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 or residential care. Care and Repair Cymru describe how investing in the RRAP will equate to a £7.50 saving for every £1 invested through 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 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 who are to be discharged from hospital have a safe home to which to return. It also has a significant 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.

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 work may include:

- Small ramps and home access.
- Door entry.
- External/internal rails.
- Hand grips.
- Cover way to w.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/stair/wall safety.

Table 1
Estimated costs and savings of RRAP to health and social care 2008-09

	A **No of jobs having direct impact** (assumed rate of 10% of total)	**B** **Av. cost of hospital stay per day**	**C** **Av. length of stay in hospital**
Hospital Discharge	**491**	**378**	**10**
Hospital Prevention*	**1,016**	**378**	**10**
Accident Prevention*	**1,016**	**£9,460** (Av. cost to health)	

* There may be some double counting relating to jobs directly preventing hospital admission and those which prevent an accident at home.

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.

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 hospital discharge figure (from total of 4,915, ie assumed that 10% counted as directly leading to a hospital discharge[1]).
- 1,016 RRAP jobs taken into account for hospital prevention figure (from total of 10,163, ie assumed that 10% counted as directly preventing hospital admission).
- £378 average per day for hospital stay (2008-09 figures).
- 10 days average length of stay.
- Minus the cost of RRAP (average of £118 per RRAP case – 2008-09 figures).
- £9,460 average cost to health of a home accident (2008-09 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 £7.50 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 (+£4,500 on-costs) - this agency had one dedicated handyperson to RRAP.
- Works completed in total = 650.
- Works completed by Handyperson = 629.
- Works completed by contractor = 21.
- Average cost of handyperson job = £67.
- Average cost of contractor job = £170.

D **Total cost to health** (AxBxC)	**E** **Av. cost of RRAP job**	**F** **Total cost of RRAP jobs** (AxE)	**G** **Estimated saving** (D-F)
£1,856,000	**£118**	**£58,000**	**£1,798,000**
£3,840,000	**£118**	**£120,000**	**£3,720,000**
£9,611,000	**£118**	**£120,000**	**£9,491,000**

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[2] 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 2008/9 represented an increase in the volume of work in 86% of the agencies: 15,186 case referrals; 14,890 people helped; and 15,473 jobs completed. There is an average of 706 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 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 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)[3].

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 weakness reflects 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[4].

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 6286

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

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

Heywood F and Turner L (2007) Better Outcomes, lower costs: Implications for health and social care budgets of investment in housing adaptations, improvements and equipment: a review of evidence, JRF

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

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

3 Heywood F and Turner L (2007) Better Outcomes, lower costs: Implications for health and social care budgets of investment in housing adaptations, improvements and equipment: a review of evidence, JRF

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

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6. Self Assessment

in a project for older people cost an average of £88 per assessment compared to an average cost of £286 for assessment by a care manager

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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 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 low level services within assessment and care management arrangements. This study was part of a wider pilot within the 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.

Information in this report is based on an article in the British Journal of Social Work[1], 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 only 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 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 help and advice through telephone contact or a one-off visit. They also researched existing services in the area to enable a wider range of options to be provided. The facilitators were NVQ 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 commission usual community services (Careline, meals) 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 (ie the type of 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 lower. The difference was due to: self assessment being less costly in terms of the reduced number of hours required from 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 manager assessment 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 just under 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 for each group, and was significantly (statistically) more expensive when provided by care managers, compared with self assessment facilitators (an average of £286 against £88 respectively). Providing the assessment contributed to over 82% of the total costs in the care management group compared to 53% attributed to the self 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 assessment group but the results related to one service user only). For all commissioned services the mean cost was £73.19 for the self assessment group and £60.17 for the care management group: a difference that was not statistically significant.

The majority of services 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 assessment (contributing to 19% of the total costs for the self assessment group and only 3% in the care management group).

Table 1
Service receipt, average cost among users and contribution to total over six months (n=100)

	Contribution to total cost (%)	
	Self Assessment	Care Manager Assessment
Providing Assessment	53%	82%
Commissioned Services:		
Careline	20.3%	10%
Delivered Meals	19.4%	3.1%
Day Centre	0%	3.1%
Referral to OT	0.04%	0.2%
Units of Advice:		
Shopping Service	0.5%	0%
Meal Preparation	0%	0.03%
Domestic Tasks	0.4%	0%
Exercise/Health	0.08%	0.03%
Aids/Community Equipment	1.2%	0%
Transport	1.5%	0%
Benefits/Finance	0.2%	0%
Home Maintenance	0.9%	0.10%
Library	0.2%	0.03%
Other	2.6%	0.4%

Source: Clarkson P et al (2010)

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 amounts 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

Clarkson P et al (2010) Targeting, care management and preventative services for older people: The cost effectiveness of a pilot self assessment approach in one local authority, *British Journal of Social Work*, 40, 2255-2273

Carole Kilshaw, St Helens Council, 01744 676789

1 Clarkson P et al (2010) Targeting, care management and preventative services for older people: The cost effectiveness of a pilot self assessment approach in one local authority, *British Journal of Social Work*, 2010, 40, pp2255-2273

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

Money Matters case study seven

IRISS
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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.

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IBs are most cost 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) pilot programme undertaken in 2008. Thirteen local authorities ran pilot projects in England from November 2005 to December 2007. The pilot sites implemented different approaches and systems for introducing IBs; the detail of these can be found in the main report (see references at the end).

The evaluation indicated that those who received an IB experienced slightly better outcomes, and that IBs are more cost 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 exercise greater choice and control over how their support needs were met and the services they received. It aimed to shift the focus of support arrangements from service inputs to user-defined outcomes. Individual budgets give a clear allocation of cash, or a notional sum, to an individual to control the way money is spent to meet their care needs. IBs can bring together a variety of income streams from different agencies, as well as social care (unlike personal budgets).

Pilot sites adopted a range of approaches to implementation in terms of:

- **Incremental approach** – most sites offered IBs (at least initially) to one user group or team of care managers at a time
- **New structures and processes** – including: outcome-focused assessment; development of a RAS; and changes to the care planning process
- **Cost of IBs** - the average gross cost of an IB was £11,450 (median £6,610; standard deviation £15,810; minimum £72; maximum £165,000). On average, approximately £11,760 was for annual recurrent funding (n=278; median £6,580; standard deviation £16,860) and one-off payments (n=46; median = £675; standard deviation £1,500)

- **Management of IBs** - in the majority of cases the IB was managed as a direct payment. In about half the cases the IB was paid as a direct payment into a personal bank account, and for a further 16% the budget was paid into a joint bank account of the budget holder and/or another person. The local authority organised services for 20% of budget holders.

Table 1 below shows how people used their budgets:

Table 1
Patterns of use of IBs

Service/ type of expenditure	%	Mean annual expenditure
Personal assistant	59%	£8,520
Home care (agency)	22%	£7,290
Home care (in-house)	5%	£5,700
Meal services	5%	£690
Equipment – telecare	2%	£160
Equipment – other	10%	£870
Adaptations	3%	£670
Leisure activities	37%	£1,960
Planned short breaks	22%	£2,650
Child care	1%	£1,850
Health and dental services	2%	£900
Accommodation	1%	£830

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

Additional services/expenditure identified included: decorating or gardening service; holiday and sickness cover; transport (taxi service and car cleaning); gym membership; internet access; personal needs; and alternative therapy or private health care.

3. Evidence of cost effectiveness

A randomised controlled trial (RCT) was designed to investigate the effectiveness of the pilot programme, which reported the impact in terms of outcomes and cost effectiveness. A key objective was to identify whether the approach improved outcomes for people by giving them greater control over the type of support they accessed, and over the way that support was organised and delivered. However, 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 36% 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) and divided it by the mean difference in costs to obtain a ratio. Simulations were made within the evaluation data in order to consider whether these ratios were likely to be interpreted as indicating that IBs would 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.

To ensure comparison of like with like in relation to cost effectiveness analysis, the evaluation focused on recurrent expenditure and used weekly costs drawing on the content of the support plan records (n=268).

Cost effectiveness was analysed against two outcomes: ASCOT social care outcomes measure and the GHQ-12[1] measuring psychological well-being. The findings were broadly encouraging for the new arrangements:

- Across all user groups combined there is some evidence that IBs are more cost effective in achieving overall social care outcomes, but no advantage in relation to psychological well-being.
- Cost effectiveness evidence in support of IBs is strongest for mental health service users on both the outcome measures examined. Mental health

service users self-reported quality of life was significantly higher for those in the IB group than for those in the comparison group (statistically significant). There was also a tendency for psychological well-being to be better for those in the IB group, although these findings were not statistically significant.

- There appears to be a small cost effectiveness advantage for IB over standard support arrangements for younger physically disabled people using either of the outcome measures. Younger physically disabled people in the IB group were significantly more likely to report higher quality of care and were more satisfied with the help they received.
- For people with learning disabilities, IBs were found to be cost effective with respect to social care, but this advantage was only visible when the data covered only people who had support plans in place. Standard care arrangements appeared to be slightly more cost effective than IBs with respect to psychological well-being.
- For older people, there was no sign of a cost effective advantage for either IBs or standard support arrangements using the social care 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 £279 per week compared with £296 in the comparison group; this was not statistically significant. Breakdown by user group of social care costs is provided in Table 2 overleaf.

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 identify unmet health needs, leading to increased use of health services.

The four different aspects of care and support planning and management were: assessment (including self assessment); planning; putting the plans in place (including support brokerage); and ongoing management. The frequency of contact with a local authority social worker or care coordinator was higher for IB holders than for people in the comparison group. Support planning is a personalised process and therefore it's perhaps not surprising that it takes up more time. When converted into costs, the average cost of care coordinator support for the IB group was higher than for the comparison group: £18 compared to £11 per week. This difference was statistically significant.

The analysis suggests that (once confounding factors are accounted for) IB holders tended to use fewer resources than users in the comparison group. The analysis model predicted that the support package of a person with the average characteristics in the sample with an IB would cost approximately £29 less than for an identical case in the comparison group. This difference is not statistically significant.

When pooling data across the sample as a whole, the IB group were significantly more likely to report feeling in control of their daily lives, the support they accessed and how it was delivered. Significant differences were not found between the IB and comparison groups in the other outcome domains (personal dignity, safety, meals and nutrition, social participation and involvement, occupation and accommodation, cleanliness and comfort) although the direction of effect suggests that the IB group experienced slightly better outcomes.

4. Application – where it might be appropriate

This approach is applicable to all user groups, though the impact and cost effectiveness does vary. It appears most applicable to 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.

Table 2
Weekly cost of IB and comparison group

		Number	Overall weekly cost
Overall	**IB group**	**268**	**£279**
	Comparison group	250	£296
Mental health	**IB group**	**35**	**£149**
	Comparison group	33	£152
Physical disability	**IB group**	**90**	**£310**
	Comparison group	88	£334
Learning disability	**IB group**	**70**	**£359**
	Comparison group	63	£390
Older people	**IB group**	**73**	**£228**
	Comparison group	66	£227

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 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 £13,100 (median £10,660 with estimates ranging from £918 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 £51,710 (median £47,000) would be required.

- **Market management** – due to the early stage within the pilot process, 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 (£5,120 for contract renegotiation and £5,320 for transitional arrangements). Another authority reported that a contracts officer would be required at a cost of £1,030.

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 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 service users. 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 resources from services that are jointly funded with other departments and organisations (eg 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. http://php.york.ac.uk/inst/spru/research/summs/ibsen.php (accessed 10/3/11)

1 The GHQ 12 is a widely used version of the General Health Questionnaire used to test psychological well-being

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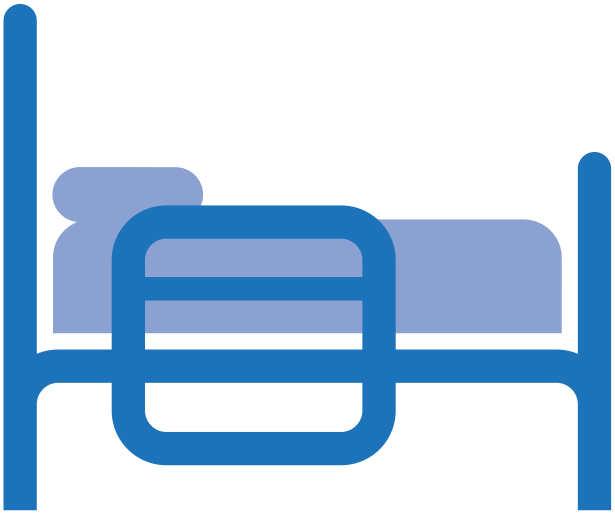
8. Southwark Hospital Discharge

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

–

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 (POPP)[1] to develop the Healthy Ageing in Southwark project. This consisted of two workstreams, the Hospital Discharge (HD) Pathway 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, Guys 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 improve the patient journey from hospital to home and for patients to be adequately supported to be as independent as possible. It was also developed because it was suspected 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 screened patients to identify those likely to have health and social care needs on discharge, and those patients 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 around complex discharges and provide advice and training to the HD team around mental health issues.

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 Community Geriatrician who was involved in the discharge process and provided expert clinical guidance and linked 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 locality MDT meetings and home visits.
- Rehabilitation support workers were based in the hospital and carried out rehabilitation support and assistance with activities of daily living (ADLs) within people's own homes for six weeks on discharge.
- 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 usage and compliance.

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 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 £1million in 2006-7[2].

The POPP evaluation found evidence of:

- increased intermediate care use and an increased percentage 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.

There was also some evidence that care home placements for some patients had been avoided due to the HD pathway intervention, 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 assisting with discharges. There was a significant increase in the percentage and number of people 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 7.7% (24) 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 628 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 rose by 18%[3]. Staff training in mental health interventions also increased from an average of 15 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[4].

3.3 Reduced length of stay for patients on elderly wards

The HD pathway project made a significant impact on reducing the length of hospital stay for patients. This was attributed to the 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 Guys and St Thomas's Hospital.

3.4 Impact of pathway on residential placement and care package use

Interviews with hospital discharge staff revealed that staff thought 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, such as depression and anxiety, care home placements were avoided and successful discharge home was facilitated. 75% of all care home placements in Southwark came 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.

Figures also showed a decrease of 24 admissions to care home placements in 2006-2007, representing a 12% reduction. This equalled annual savings of £511,680. However, in 2007-2008, care home placements rose to 197[5]. Nonetheless, compared with the pre-POPP period, a total of 25 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 (2007-2008 figures), this equates to estimated savings of £720,000 overall.

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

	Kings College Hospital		Guys and St Thomas's	
	Year before appt of EIW	Year after appt of EIW	Year before appt of EIW	Year after appt of EIW
Number of discharges		603		658
Average LOS	34.6	30.9	21.7	19.4
Bed days		18,633		12,765.2
Number of beds days required if LOS had stayed the same		20,863.8		14,278.6
Potential bed days saved from reduced LOS		2,231		1,513
Bed days saved per patient		3.7		2.3

Source: Research and Development Centre (October 2008) Partnerships for Older People Project Evaluation Report
Adapted by IPC March 2011

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, 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/rehabilitation 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 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, 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 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 to see care home placements as a last resort, and supported more older people to return home, in line with the known preferences of the majority of older people to live at home as long as possible[6].

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-active 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 break down. 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 in 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 wider 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 to identify patients at risk of care home placement. This then triggers appropriate MDT interventions to prevent admission.

The appointment of a Voluntary Sector Coordinator (VCS) 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, if 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 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 reduced length of patient stay. Therefore, not all of these savings could be realised by the PCT or Social Care.

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 outcomes are best met for the local 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 for Home-care re-ablement http://www.csed.dh.gov.uk/homeCareReablement/prospectiveLongitudinalStudy/

Local Government Improvement and Development: Partnerships for Older People Projects (POPP) http://www.idea.gov.uk/idk/core/page.do?pageId=7977231

Partnerships for Older People Project http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Olderpeople/PartnershipsforOlderPeopleProjects/index.htm

research and development centre (rdc): Partnerships for Older People Project (POPP) evaluation reports http://www.researchdevelopmentcentre.nhs.uk/popp.php

1 http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Olderpeople/PartnershipsforOlderPeopleProjects/index.htm

2 Local Government Improvement and Development - Partnerships for Older People Projects (POPP) http://www.idea.gov.uk/idk/core/page.do?pageId=7977231

3 Research and Development Centre (October 2008) Partnerships for Older People Project Evaluation Report, Southwark PCT

4 Local Government Improvement and Development - Partnerships for Older People Projects (POPP) http://www.idea.gov.uk/idk/core/page.do?pageId=7977231

5 Research and Development Centre (October 2008) Partnerships for Older People Project Evaluation Report, Southwark PCT

6 Croucher K (2008) Housing Choices and Aspirations of Older People, London: DCLG

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