

Improving value for money in adult social care

June 2011



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Summary

1 Demographic change and financial pressures are combining to create tough times for adult social care. The population is ageing. People with learning disabilities are living longer. At the same time, funding for local councils has been cut, although the NHS will be making more money available for social care. Using the latest national data available, this briefing presents the starting point for local authority decisions on adult social care spending over the next three years. It also sets out the approaches councils have recently taken to improve value for money in adult social care.

Key points on services

- Council spending on adult social care increased in real terms by nearly 16 per cent from 2003/04 to 2009/10. The greatest increase was for people with learning disabilities, where spending rose by 33 per cent.
- Productivity, measured by comparing the amount spent against total activity, has been falling, although this measure takes no account of changes in the quality of services.
- There is wide variation in unit costs, offering opportunities for improvement in efficiency.
- There is also wide variation in the pattern of service. The pace of change in moving from less residential to more community-based care, particularly for older people, has been slow. This is perhaps not surprising given the difficulties involved.
- Progress has been made in providing a more personalised service, partly through the spread of personal budgets where users determine how the funds available for their care should be spent.

Key points on councils' experience in finding savings in 2009/10 and 2010/11

- Councils took action in each of nine different areas: procurement; prevention; back office; staffing; changing the balance of care; personalisation; partnership; assessment and care management; and charging.

- No council addressed all nine areas. Only 20 per cent addressed between six and eight categories.
- We found few innovative examples. Most approaches were tried and tested.

Key points for the future

- Over the next two years or so, councils can make cash-releasing savings by looking to provide the same or similar services at lower cost. This involves improving procurement, reviewing and revising staffing levels and skill mixes; and making back office efficiencies.
- Councils will still need to develop and implement strategies for delivering sustainable, modern, good-quality services, involving large-scale, transformational change. Prevention, personalisation, building community capacity and a shift to independent living in the community are examples of this approach.
- Such transformational change is difficult to achieve and the pace of change so far has been slow.
- Savings from such strategies are at best uncertain and unlikely to be cash releasing.
- These strategies will involve working across health and social care – an area where few councils have so far looked for, or been able to realise, efficiencies.
- Change on this scale will require good data, leadership and strong partnerships with housing, transport and leisure services as well as the NHS.

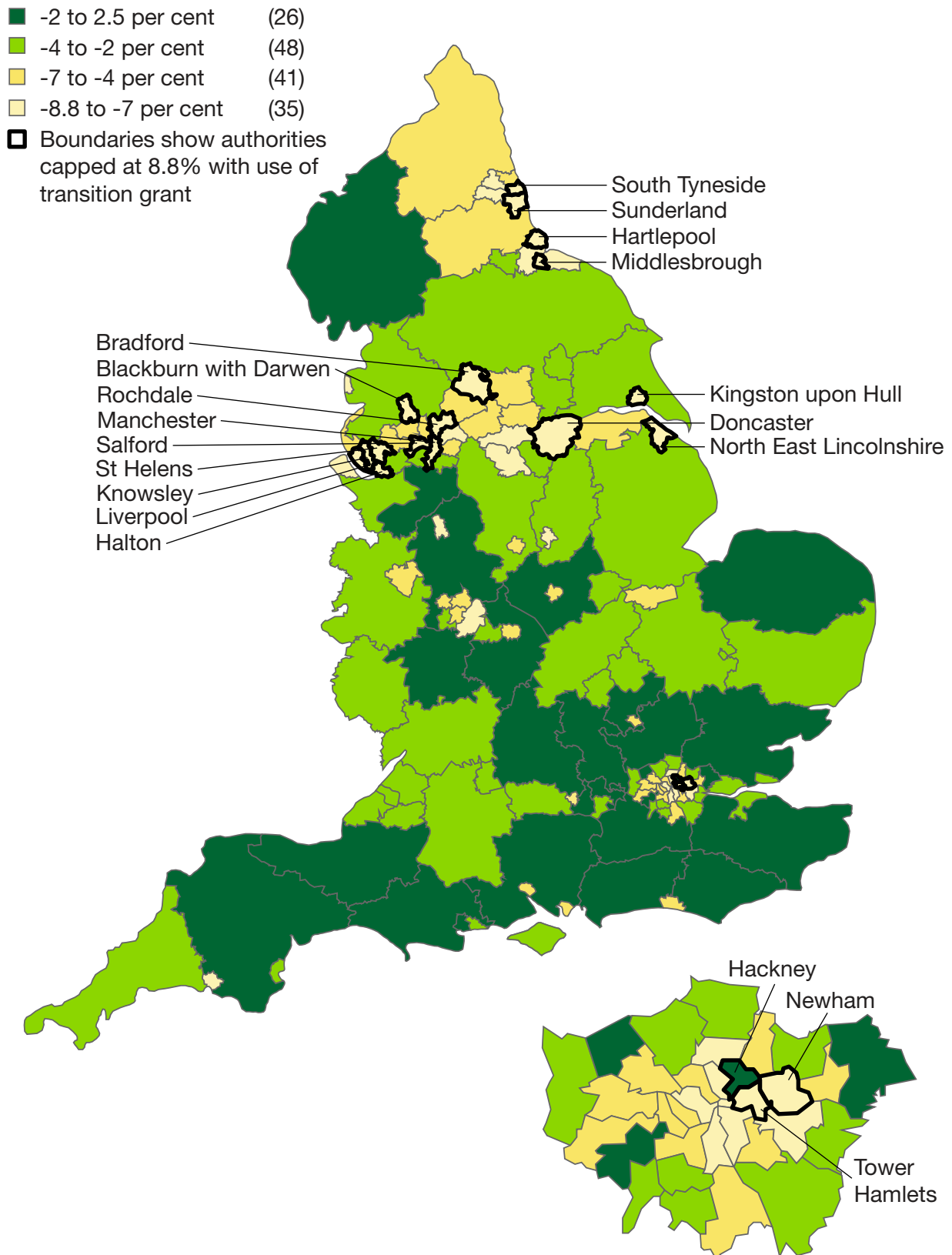
The Commission will publish updates to this briefing as further data becomes available. We will also publish more detailed briefings on assessment and care management and finding efficiencies across health and social care.

Tough times for adult social care

2 Demographic change and financial pressures are combining to create tough times for adult social care. The population is ageing – by 2015, 18 per cent of the population will be aged 65 or over (Ref. 1). People with learning disabilities are also living longer – spending on their needs will increase between 3.2 per cent and 7.9 per cent a year to 2026 (Ref. 2). Funding for local government has been cut. The overall formula grant reduction for 2011/12 hides significant local differences (Figure 1). Councils with the largest cut in ‘revenue spending power’ⁱ are either in the North, particularly the North West, or in London.

ⁱ ‘Revenue spending power’ is a calculation of a council’s spending power from council tax, revenue grants and NHS funding for social care.

Figure 1: **Percentage change in 'revenue spending power' from 2010/11 to 2011/12**



Source: Department for Communities and Local Government (DCLG) Local Government Settlement, January 2011

3 Adult social care budgets are not ring-fenced. Nationally, 39 per cent of total spend on adult social care comes from council tax. In some councils, 80 per cent is funded in this way. Therefore, some councils depend more on the formula grant than others (Ref. 3). Each council with care responsibilities has to make its own decision about how the fall in the formula grant will impact on adult social care services. There are early indications that many councils plan to protect adult social care budgets as far as possible (Ref. 4).

4 Between 2010/11 and 2012/13, the Department of Health (DH) is allocating extra social care funds to councils via the NHS. This will partially bridge the reduction in the formula grant. For 2010/11, DH has allocated £70 million to develop post-discharge and reablement servicesⁱ (£150 million for 2011/12 and £300 million for 2012/13). The NHS and councils will decide locally how to use this money across health and social care. Another £162 million was planned to support social care services (£648 million for 2011/12 and £622 million for 2012/13). The NHS must transfer this money to councils and they must agree together how it will be used (Ref. 5).

5 Councils face challenges in improving value for money. To do this, they can consider how to reduce the costs of services and the efficiency of their processes, while preserving quality and focusing on outcomes. But, at the same time, the transformation of services, including the rollout of personal budgets, remains central to social care policy (Ref. 6, 7, 8). DH's *Use of Resources in Adult Social Care*, published in 2009, highlighted the ways in which councils can improve efficiency and outcomes (Ref. 9).

6 This briefing focuses on people who receive social care funded by councils. Many people, though, arrange and pay for their own care. About 170,000 people pay for their own residential care and use 45 per cent of registered care home places in England (Ref. 10). Councils can still help all people who use care services by providing information and advice.

Spending and activity – the national picture

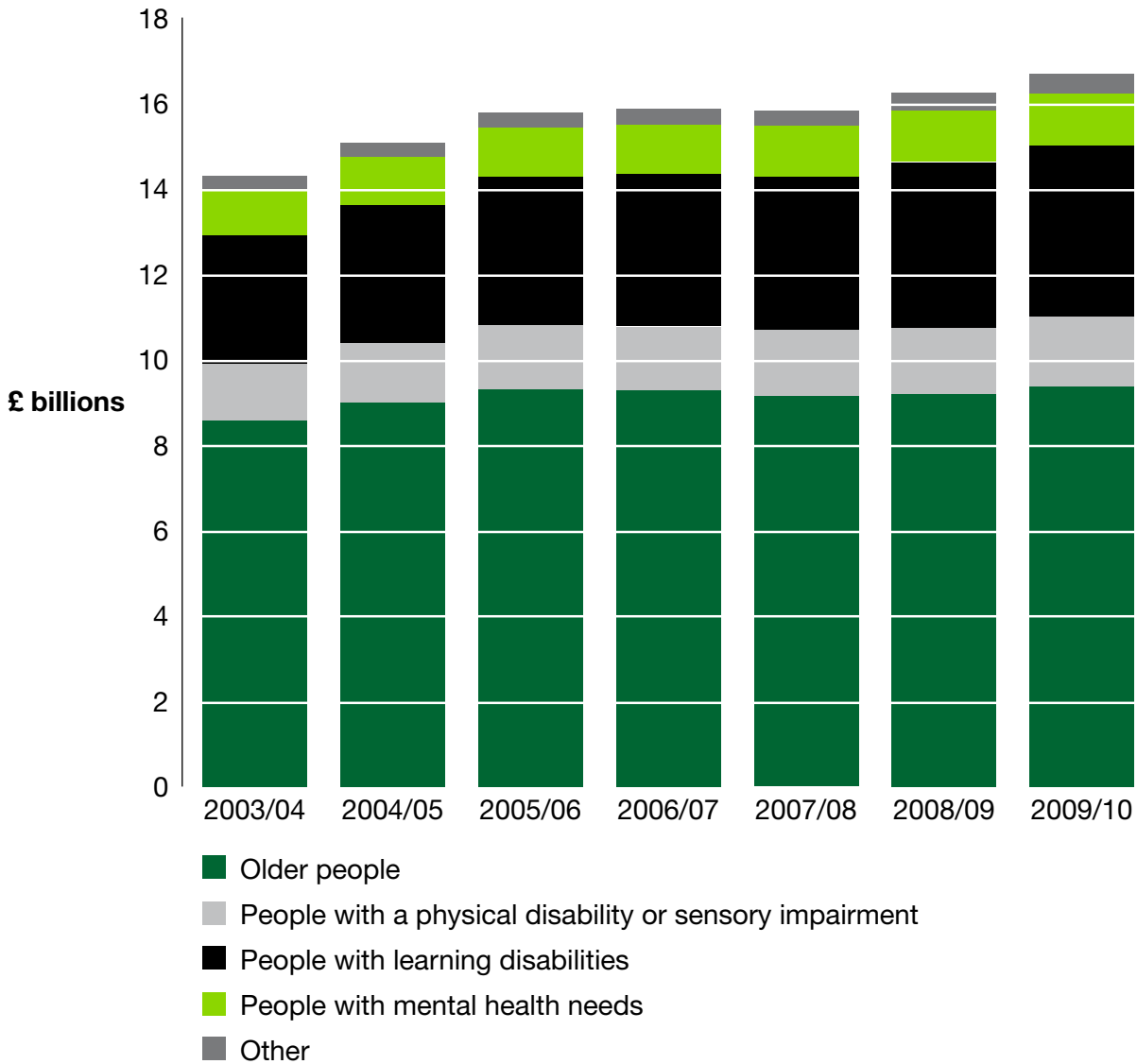
Care spending has increased

7 This briefing uses the most current data available on adult social care spending. This shows that spending on adult social care increased by nearly 16 per cent in real terms, from £14.5 billion in 2003/04 to £16.8 billion in 2009/10 (Figure 2).ⁱⁱ

ⁱ Reablement services aim to help people regain their independence by learning or relearning the skills necessary for daily living. Post-discharge services help people to make the transition from hospital to returning home.

ⁱⁱ A GDP price deflator has been applied to show information from 2003/04 to 2009/10 at 2009/10 prices.

Figure 2: Council total gross current expenditure on adult social care 2003/04 to 2009/10



Source: PSSEXⁱ returns 2003/04 to 2009/10 from The Information Centre for Health and Social Care, adapted by the Audit Commission 2011

8 Spending on all adult social service client groups increased. The greatest increase in spend was on people with learning disabilities, which increased in real terms by 33 per cent from £3.0 billion in 2003/04 to £4.0 billion in 2009/10.ⁱⁱ Spend on older people increased in real terms by 8.7 per cent from £8.6 billion in 2003/04 to £9.3 billion in 2005/06. Since then, though, spend on older people has remained stable in real terms at around £9.4 billion.

ⁱ The Personal Social Services Expenditure (PSSEX1) return is collected and disseminated by The Information Centre for Health and Social Care (see Appendix 1).

ⁱⁱ Learning disability social care funding and commissioning transferred from the NHS to local authorities in April 2009.

Is productivity falling?

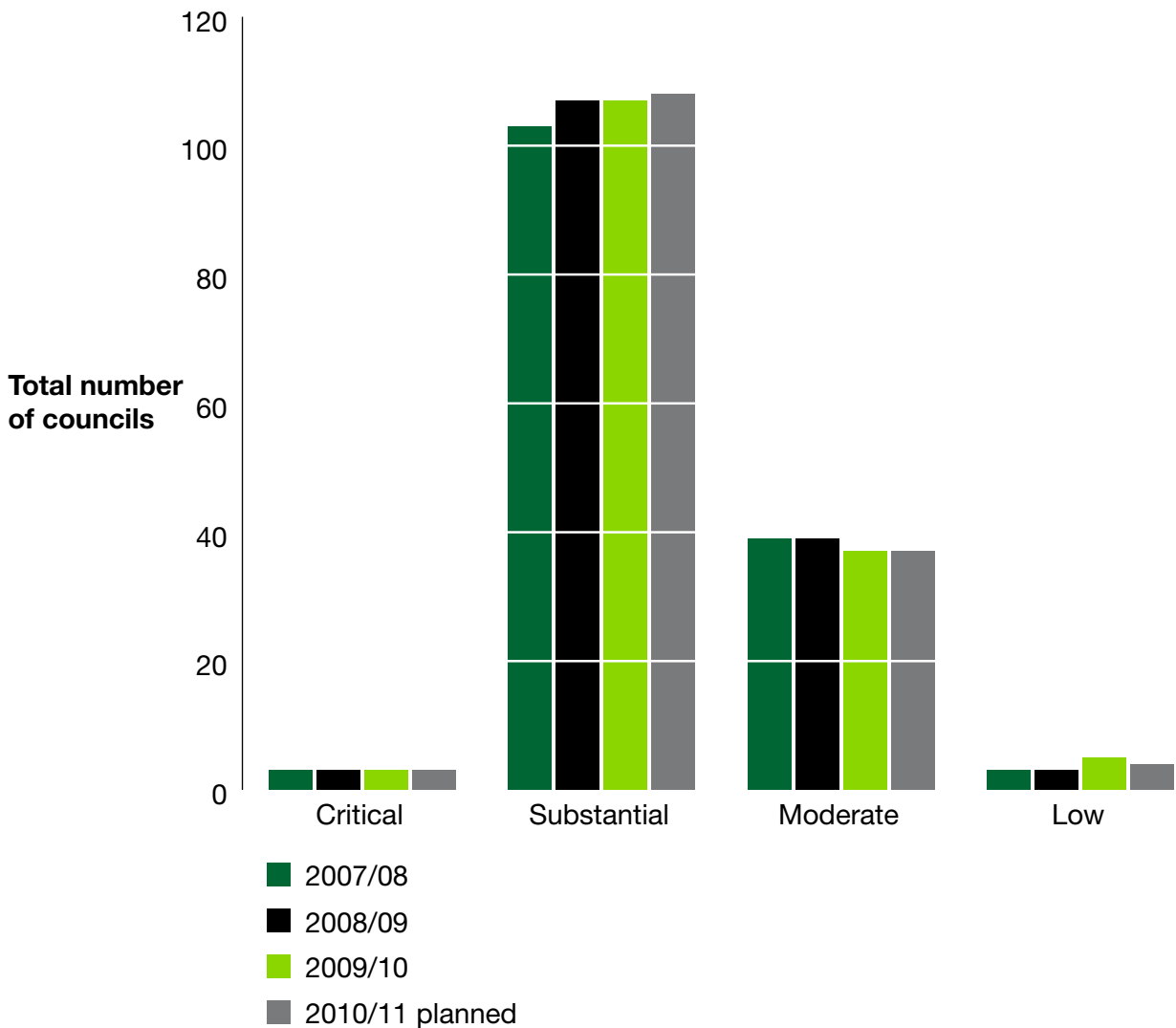
9 Crude 'productivity' estimates compare changes in costs with changes in levels of activity. Our analysis suggests productivity fell between 2005/06 to 2009/10, which is in line with the findings of other commentators (Ref. 3, 11). These productivity estimates, however, take no account of improvements in quality, of changing levels of need among people using services, or of outcomes achieved.

10 For people with learning disabilities, costs have increased while activity levels have been stable. For older people, activity levels have fallen while costs have remained broadly steady. Indeed, the overall volume of care funded for older people has reduced by 8 per cent since 2005/06. Given the ageing population, this fall in activity is notable.

11 The fall in activity for older people does not appear to be a result of councils tightening the Fair Access to Care Services (FACS) eligibility criteriaⁱ threshold. Most councils provide services for people who have 'substantial' needs, with little change over the last four years (Figure 3). Other researchers found that differences in eligibility criteria have little effect on the numbers receiving care (Ref. 12). However, evidence is emerging that councils are now starting to re-evaluate their position on eligibility criteria (Ref. 13).

ⁱ FACS is a framework used by councils to decide whether a person's care needs make them eligible for council-funded care. Councils make a decision as to the level they set the eligibility criteria at from a choice of: critical, substantial, moderate and low.

Figure 3: **Most councils set eligibility criteria to meet substantial needs**



Source: Fair Access to Care Services data from the Care Quality Commission Self Assessment Survey 2009/10, adapted by the Audit Commission 2011

12 It is not clear why the amount of care funded by councils is not increasing, given the increasing number of older people. There are three possible reasons.

- Better prevention services such as reablement keep people at a lower level of need for longer.
- Councils have applied existing eligibility criteria more tightly to concentrate services on the people with the highest needs, providing more intensive (and expensive) packages of care.
- Financial assessments have become more rigorous, resulting in councils needing to support fewer people.

There are still big differences in unit costs

13 All unit costs for providing residential care or day care for older people, and for people with a learning disability, vary significantly. For example, the average weekly spend on residential care for people with learning disabilities provided by councils varied from £262 to £11,282 (Tables 1 and 2). The large differences in unit costs suggest the quality of the data available to councils may be variable.

Table 1: **Unit costs (average weekly spend per person) residential care 2009/10**

Service type	Minimum unit cost	25th quartile	Median unit cost	75th quartile	Maximum unit cost
Provided by the council for people with learning disabilities	£262	£1,159	£1,678	£2,115	£11,282
Provided by the independent sector for people with learning disabilities	£612	£1,006	£1,302	£1,658	£3,072
Provided by the council for older people	£405	£726	£960	£1,220	£7,261
Provided by the independent sector for older people	£331	£419	£455	£522	£907

Source: PSSEX1 2009/10 final data from The Information Centre for Health and Social Care, adapted by the Audit Commission 2011

Table 2: **Unit costs (average yearly spend per person) day care 2009/10**

Service type	Minimum unit cost	25th quartile	Median unit cost	75th quartile	Maximum unit cost
Provided by the council for people with learning disabilities	£25	£234	£295	£383	£1,101
Provided by the independent sector for people with learning disabilities	£12	£146	£234	£320	£1,322
Provided by the council for older people	£9	£72	£97	£152	£4,102
Provided by the independent sector for older people	£2	£42	£63	£97	£917

Source: PSSEX1 2009/10 final data from The Information Centre for Health and Social Care, adapted by the Audit Commission 2011

14 High unit costs will not always be a marker of poor value for money. Indeed, some of the variation in costs can be explained by differences in the needs of the people receiving care, or by differences in the quality of the services provided. For example, some councils are successful in supporting large numbers of people with a learning disability in the community, even those with complex needs. This means that only people with the most complex needs will be cared for in residential care, so the unit costs will be higher.

15 Tables 1 and 2 show differences in unit costs between council provided services and those provided by independent providers. Median unit costs of services provided directly by the council are higher than those in the independent sector. However, the Care Quality Commission (CQC) reports the quality of council-run services and those run by voluntary organisations is generally higher than in the private sector (Ref. 14).

Gathering and using high-quality local data is important

16 High-quality, timely data is essential to inform council decision making. Councils should ensure they are capturing and using good-quality data on the costs of local service provision.

17 Good data enables councils to review, compare and challenge their costs; and to ensure that services of a suitable quality are being provided to people. It also enables councils to understand their local population and people's changing patterns of service use when making decisions. Benchmarking can help councils understand whether their comparative costs are high or low. Such approaches are well established in adult social care. The Audit Commission's [value for money profiles](#) give a broad overview of spending and look at how value for money indicators compare between councils.

18 More timely data would also help councils make effective decisions. There are a few initiatives underway to improve the information on which decision making depends. For example, the Local Government Group is developing an online service that will allow councils to access and compare data (Ref. 15). In addition, DH commissioned the Care Services Efficiency Delivery (CSED) Programme to develop the Tools for Rapid Integration of Public Submissions (Ref. 16). This aims to provide a quicker and more streamlined way for councils to use and submit data to the National Adult Social Care Information Service. It is expected this tool will:

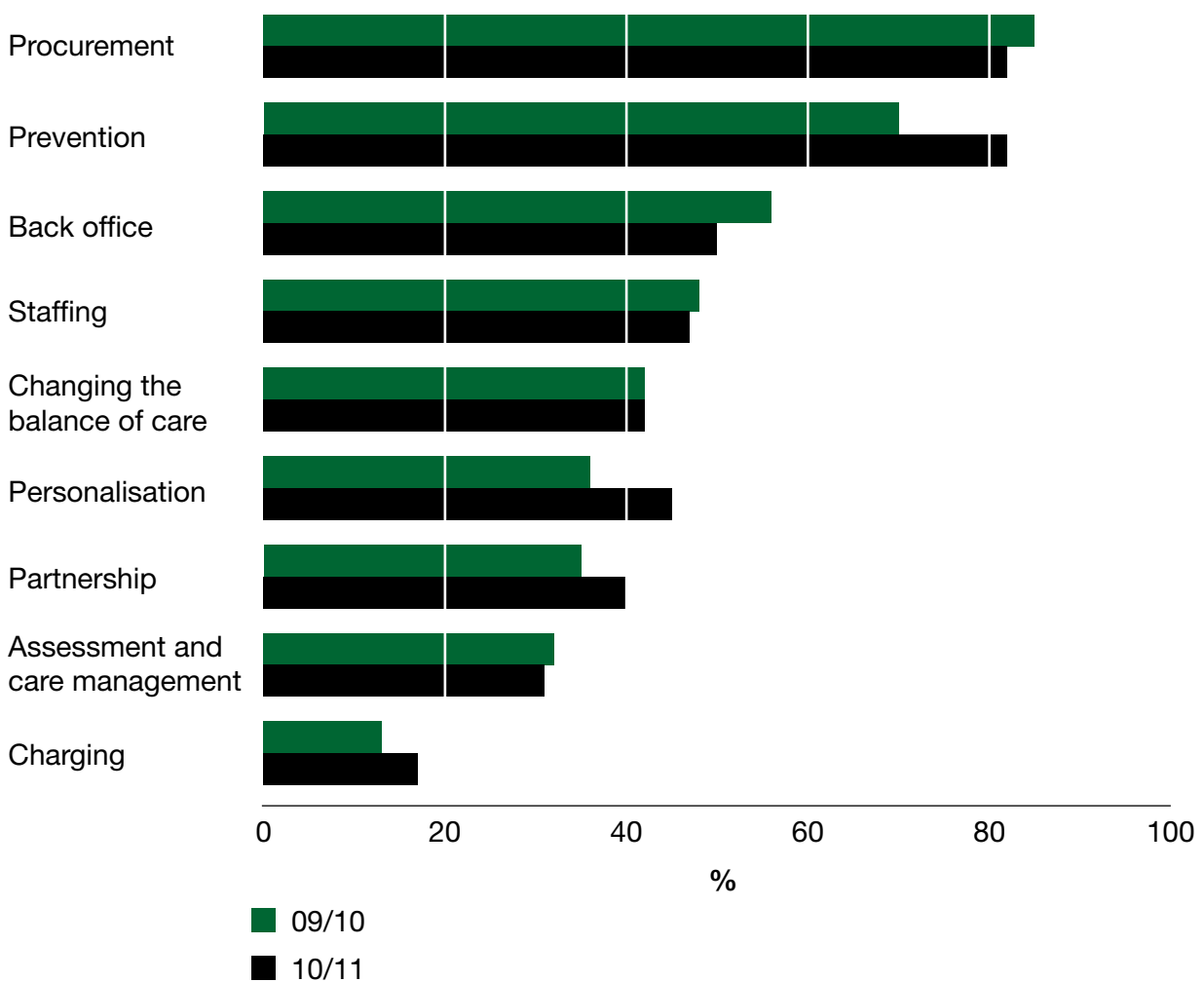
- reduce the effort to produce returns;
- collate disparate data sources into a consistent set of local management information; and
- provide data in real time so councils can use it to inform decision making on value for money.

19 The East Midlands are piloting the tool with a view to wider rollout in 2011/12.

Councils have already made efficiencies

20 The rest of this briefing reviews the opportunities for improving efficiencies in adult social care and councils' steps to secure them. Councils reported efficiencies achieved in 2009/10 and their plans for 2010/11 to CQC in 2010. We have grouped the information into nine categories (Figure 4). A summary of these areas of savings is at Appendix 2.

Figure 4: Council efficiencies in 2009/10 and planned efficiencies for 2010/11



Source: Efficiencies statements (2009/10 and plans for 2010/11) from the Care Quality Commission Self Assessment Survey 2009/10, adapted by the Audit Commission 2011

21 No councils reported savings across all the categories. However, 20 per cent found efficiencies over six, seven or eight categories in 2009/10. Councils need to take an approach to achieving efficiencies that addresses all nine categories. It is important that councils continue to work with partners, in particular the NHS, but also services such as housing, transport and leisure, and with people themselves, to build an approach to value for money that uses resources effectively across the system.

Procurement

22 Personalisation has fundamentally changed the way that councils procure adult social care services. Growing numbers of people are commissioning their own care and support (Ref. 17). Alongside this, some councils are moving towards procuring services based on outcomes rather than cost and volume (Ref. 18).

23 Eighty-five per cent of councils reported efficiencies from improved procurement practices during 2009/10. As well as putting pressure on providers to reduce costs by limiting inflation uplifts to fees, councils adopted more rigorous approaches to reducing costs.

24 Fifty-eight per cent of councils in 2009/10 had made efficiencies through changes to contracts. This was either from: renegotiating contracts; tendering for a new supplier; or by looking at how they reviewed and checked contracts to ensure best value.

Case study 1

Trafford Council

Trafford Council has worked to shape the local social care market. Improvements in quality were made by undertaking reviews across a range of services. Approved lists of providers are used to ensure people using a personal budget can access quality-assured services. This released savings of £1.2 million in 2008/09 and £2.2 million during 2009/10; against an adult social care budget of £68.6 million.ⁱ

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ⁱ Inclusive of Supporting People funding

The council used £150k from the Social Care Reform Grant to provide start up monies through its Innovation Grant to the third sector and user-led organisations to increase the range of services available within the community. Fourteen organisations received funding for a wide range of projects – these included support for people with autism to develop life skills, and an information service led by disabled people.

Through the Citizen Assessor Scheme volunteers are trained to take part in reviews, evaluate tenders, interview potential providers and conduct on-site visits.

Source: Audit Commission

25 Twenty-one per cent of councils were looking for efficiencies through outsourcing. Mostly councils were outsourcing home care provision and then converting remaining services to provide reablement. Councils were also reducing in-house residential provision and transferring care to independent providers. Through personalisation more people are buying their own care. Councils must play an active part in shaping the social care market to ensure the right services are available at the right price.

26 Twelve per cent of councils were using electronic home care monitoring to ensure providers receive payments based on hours of care delivered, rather than commissioned hours.

Case study 2

South Gloucestershire Council

The DH's CSED team worked with South Gloucestershire Council to undertake a project to carry out electronic monitoring for home care. The council reports the extra management information has led to improved quality. The council has reduced the home care budget by £250,000 to reflect expected future efficiencies.

Source: Audit Commission

27 Fifteen per cent of councils were using the Care Funding Calculator to ensure that fees properly matched the care requirements of individual people. Care Funding Calculator tools are free spreadsheets that allow councils to make cashable efficiency gains through negotiating a fair payment level for residential and supported-living placements. Councils in the West Midlands have used the Calculator and are on target to deliver efficiency gains of over £3.84 million over the period 2008-11.ⁱ

28 Twenty-three per cent of councils were reviewing individuals with high-cost care packages. Most councils that were undertaking reviews focused on people in out-of-borough placements. This involved looking for, and sometimes developing, alternative community-based housing within the borough.

Case study 3

Hertfordshire County Council

Hertfordshire County Council has reviewed high-cost care packages for people with learning disabilities, to make efficiencies while improving outcomes for people using services.

- The council has negotiated cuts in fees for high-cost placements from 2010/11 to 2012/13. This will create estimated efficiency savings of £2 million in 2010/11 and £4 million in 2011/12.
- The Positive Moves project is increasing the number of supported-living homes in Hertfordshire for people with learning disabilities. This enables people with high-cost, out-of-county placements to move back into the county. This will create estimated efficiency savings of £1 million 2010/11 and £2 million in 2011/12.
- Introducing individual budgets for people with learning disabilities in 2010/11 will create £500,000 of efficiency savings.

Source: Audit Commission

29 Fifteen per cent of councils were using collaborative procurement. This is most commonly through procurement clubs with other local authorities or through joint commissioning with the PCT.

ⁱ www.westmidlandsiep.gov.uk

Case study 4

West London Alliance

As part of the West London Alliance (WLA) Adult Social Care Efficiency Programme, six London Boroughs have found efficiencies by jointly procuring personal home care. Following a tender exercise the WLA created a framework contract consisting of 25 providers. Each provider agreed an hourly rate and discount prices based on volumes of work it might receive. The six boroughs project a combined saving of £4 million by 2011/12.

Source: Audit Commission

Prevention

30 Seventy per cent of councils report efficiencies achieved by using preventive services. There was also a significant increase in the number of councils who expected to achieve efficiencies in this way in 2010/11. Adult social care preventive services cover a wide range of interventions (Ref. 19). Most fall into one of two categories:

- primary prevention – such as help with small repairs in the home and activities to tackle social isolation; and
- early intervention – services such as reablement and telecare that target people who may soon be at risk of needing more intensive support.

31 Primary prevention services enable people to remain well for as long as possible. They can increase quality of life and reduce future demand for care. Primary prevention also provides opportunities to: engage with local people; draw on the resources and capacity that exist within communities; and build resilience within those communities. However, there was little evidence presented within the council statements of efficiencies from these low-level services. It can be difficult to evidence the impact of primary prevention as the benefits are realised over many years. Therefore, funding for these services may be at risk in the current financial climate (Ref. 20). Further research is needed to support organisations to make an economic case for the cost-effectiveness of primary prevention services (Ref. 21).

Case study 5

Southwark Council

In 2009, Southwark Council invested a million pounds in Southwark Circle,ⁱ a user-led membership organisation for people aged 50 and over. It aims to reduce dependency on care services through building strong and resilient community networks.

Members receive support with practical tasks, and have opportunities to learn new skills and build up their own informal support networks. Those who receive support often help others in other areas where they have a skill base. The approach is built on mutuality and recognises the contribution that older people can make to their community.

The circle now has about 500 members. A model is developing to measure both social impact and cost savings, which are anticipated to become more transparent during year two and three. The circle expects to become self-sustaining at the end of the three-year period.

Source: Audit Commission

32 Early intervention aims to preserve the independence of people who are at risk of developing long-term care needs. Just over half of all councils (54 per cent) made efficiencies by using reablement and intermediate care services.

33 Progress in the implementation and use of reablement varies widely. Some councils are in the early stages of piloting services for a limited number of people and some already offer reablement to everyone who might benefit. Others are redesigning an existing service to take on a reablement role. The impact of reablement in delivering efficiencies varies. Of the 81 councils citing reablement in their efficiency statement in 2009/10, 18 stated the cost savings made. These range from £143,000 to £900,000. Seven councils found people needed less or no care following reablement.

34 Many councils report savings through reablement. However, the evidence from research is less clear. Recent research found that reablement improved the lives of those receiving it. It reported that

ⁱ <http://moderngov.southwarksites.com/mgConvert2PDF>
and <http://moderngov.southwarksites.com/mgConvert2PDF>

current policies promoting home care reablement appear well founded and cost-effective. However, there was no statistically significant difference in the costs of health or social care between those receiving reablement and those not. This suggests it is unlikely that savings will be made in at least the first year – the period reviewed by the research. The study also found practitioners agreed that reablement was most likely to benefit people recovering from an acute illness or a fall, rather than a chronic condition, suggesting future reablement services should be more targeted (Ref. 22).

35 Assistive technology (telecare and telehealth) supports people to remain independent in their own homes while reducing avoidable admissions to hospital and residential care (Ref. 23). A fifth of councils referenced telecare in their efficiency returns. In addition, 12 per cent of councils made efficiencies through equipment and adaptations. DH’s evaluation of the ‘whole-system demonstrator’ sites is due to be published later this year. This should provide a guide to their cost-effectiveness and savings potential across health and social care.

36 The evidence on the impact of prevention is still underdeveloped and sometimes contradictory. For example, the evaluation of the Partnerships for Older People Projects (POPPS) found that ‘a wide range of projects resulted in improved quality of life for participants and considerable savings, as well as better local working relationships’ (Ref. 24). However, recently published research by the Nuffield Trust into a sample of eight projects found there was no difference in hospital admissions between the older people supported by the projects and a matched population with similar health needs and characteristics (Ref. 25). This is an area where there may yet be no clear answers on the impact of different interventions.

Back office

37 Fifty-six per cent of councils reported efficiencies through changes to their back office.ⁱ These include:

- making better use of the estate: selling disused or underused buildings and transferring staff to other locations;
- introducing modern working practices, for example using hot desks and flexible working;
- restructuring back office roles and customer contact;
- reprocurring IT, supplies, stationery, and transport; and
- achieving IT efficiencies through better information and less staff time spent inputting data.

ⁱ Back office activities are the behind-the-scenes work that supports services for the public.

Staffing

38 Forty-eight per cent of councils made savings through changes to staffing. These range from blanket approaches, such as recruitment freezes, to negotiating more flexible working. Initiatives include:

- reviewing the skill mix of the workforce;
- removing management positions but protecting front-line staff;
- implementing policies to reduce the number of sick days;
- reducing the use of agency staff;
- introducing flexible working; and
- only replacing staff when they left if there was a business case to do so.

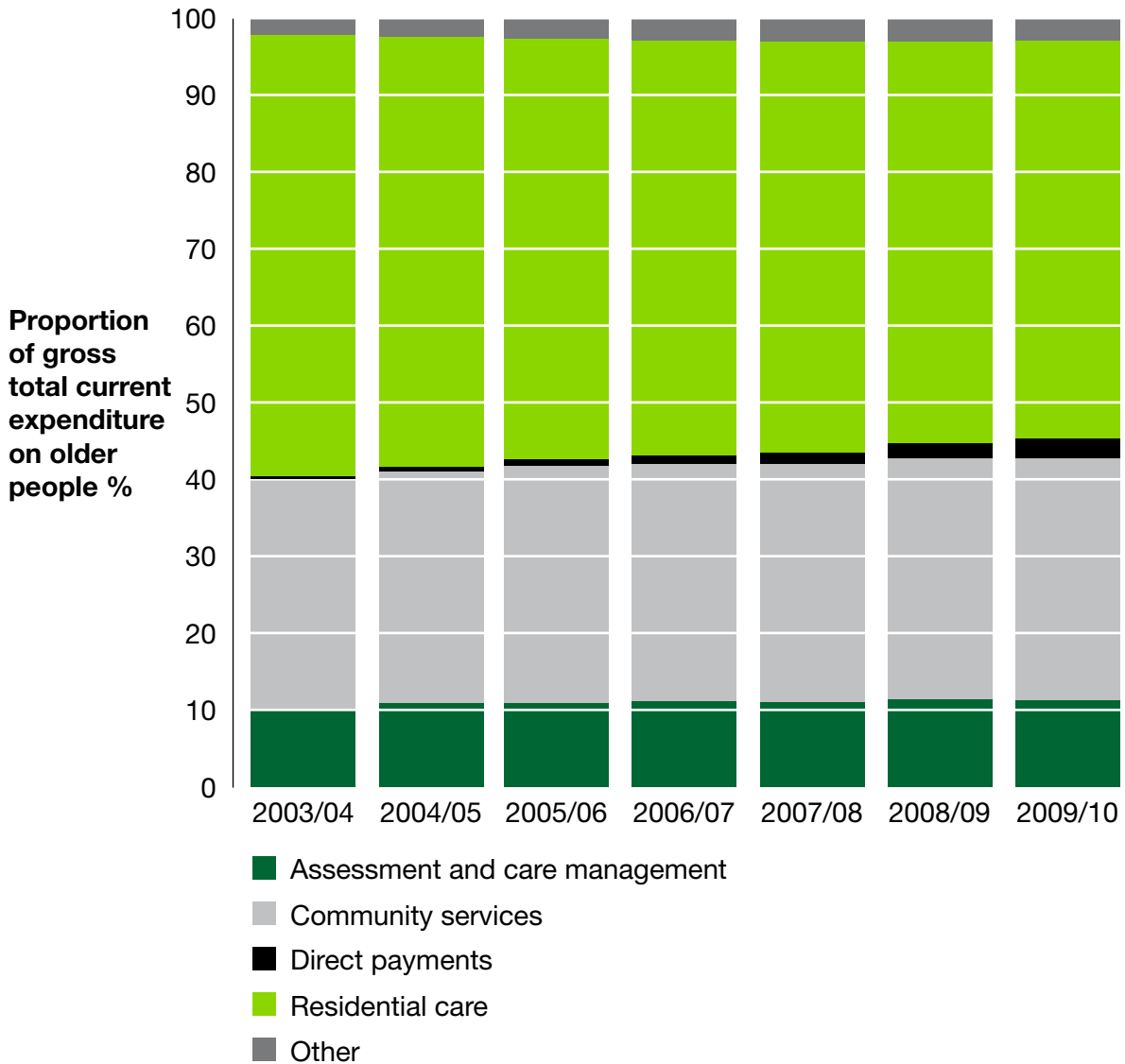
Changing the balance of care

39 Successive governments have stressed the importance of developing community services as alternatives to residential care wherever possible. Supporting people to live independently can offer good value for money, as it can cost less while providing a better quality of life. However, for some people with complex needs, this is not always a low-cost solution, but is nevertheless used for the outcomes it delivers.

40 Forty-two per cent of councils reported making efforts to shift care from residential care homes to community-based settings.

41 The number of care home (residential or nursing) weeks for older people funded by councils fell by 10 per cent from 2005/06 to 2009/10. The real-terms cost of residential and nursing care fell by 4 per cent over the same period. The balance of spending on care services for older people is slowly changing (Figure 5).

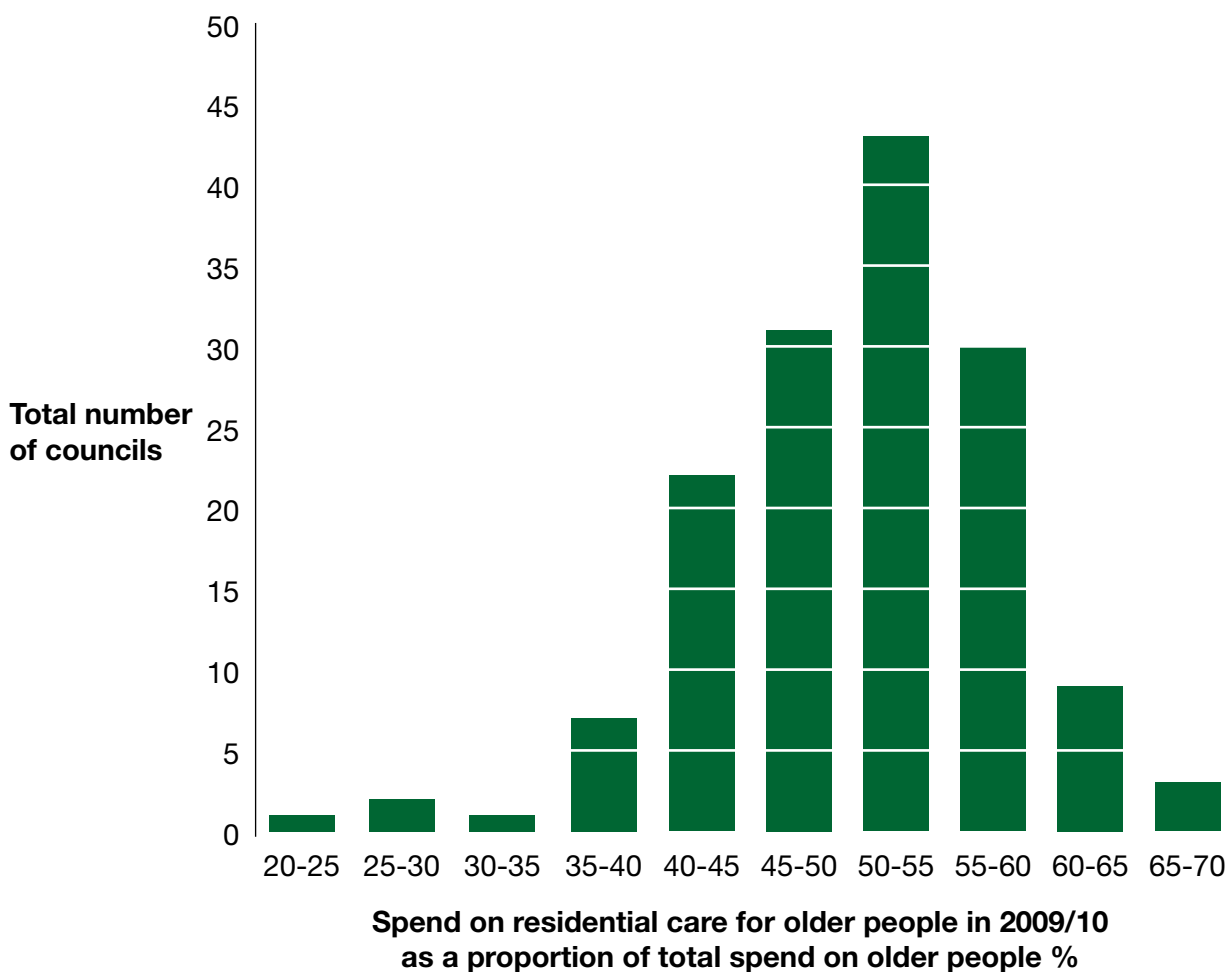
Figure 5: **Community services are slowly increasing in importance**



Source: PSSEX1 returns 2003/04 to 2009/10, *The Information Centre for Health and Social Care*, adapted by the Audit Commission 2011

42 On average, councils spent just over half (£0.52 in the pound) of their older people’s budget on residential and nursing care in 2009/10. But there are important variations among councils (Figure 6).

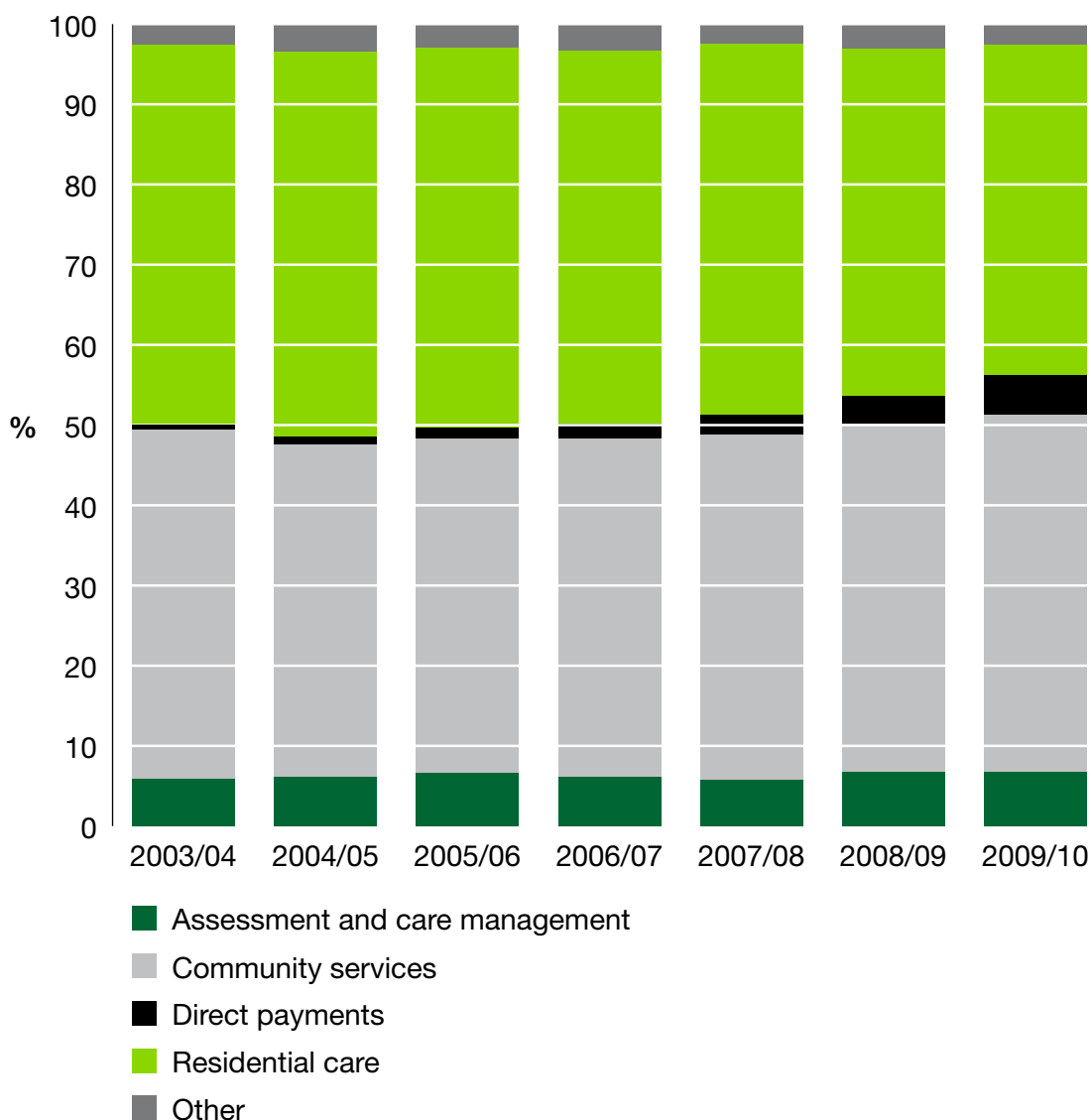
Figure 6: **Some councils still spend a significant portion of funds on older people's residential and nursing care (2009/10)**



Source: Total gross spending from PSSEX1 returns 2003/04 to 2009/10, The Information Centre for Health and Social Care, adapted by the Audit Commission 2011

43 There has been a sharper change in the balance of care for people with learning disabilities (Figure 7). The rate of change increased between 2007/08 and 2009/10.

Figure 7: **Spend on people with learning disabilities is clearly moving towards community services**



Source: PSSEX1 returns 2003/04 to 2009/10, *The Information Centre for Health and Social Care*, adapted by the Audit Commission 2010

44 Some councils have shifted the balance of provision for people with learning disabilities away from residential care towards community-based provision.

Barnsley Council

From 2006/07 to 2009/10, Barnsley Council moved the balance of care for people with learning disabilities towards community-based provision. The council preserved the quality of the Supported Living Service through this period.

Day care was available locally, allowing people with profound and multiple learning disabilities to receive support within their own communities. This decreased transport costs.

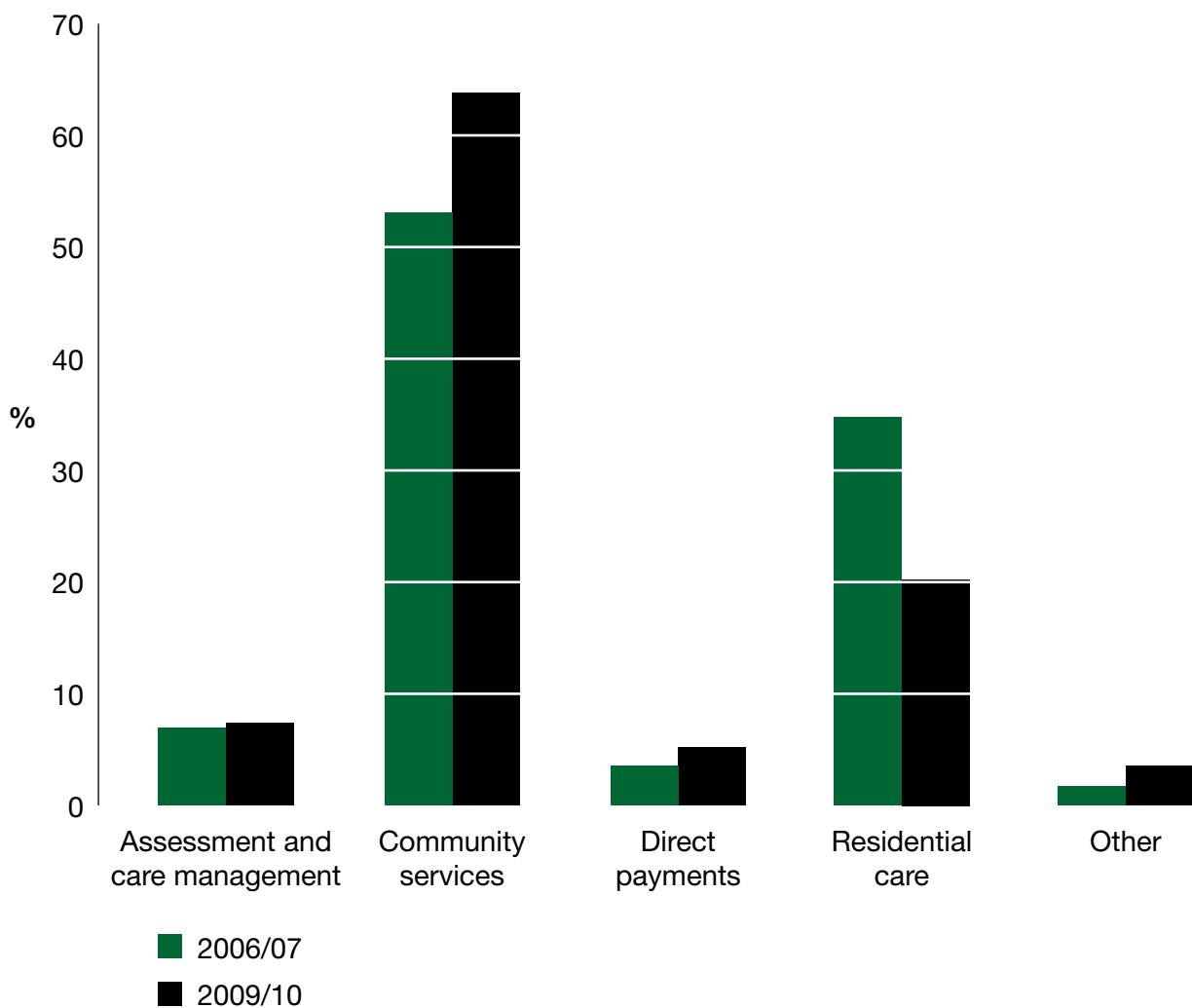
The council is looking for more ways to achieve value for money within its Learning Disability Services. Following work with CSED a number of opportunities have been identified that, if implemented, could save an indicative £1.12 million per annum. These include:

- continuing the move towards independent living;
- lowering unit costs – for example, through remodelling in-house provision and through more use of assistive technology; and
- reviewing high-cost cases.

See Figure 8.

Source: Audit Commission

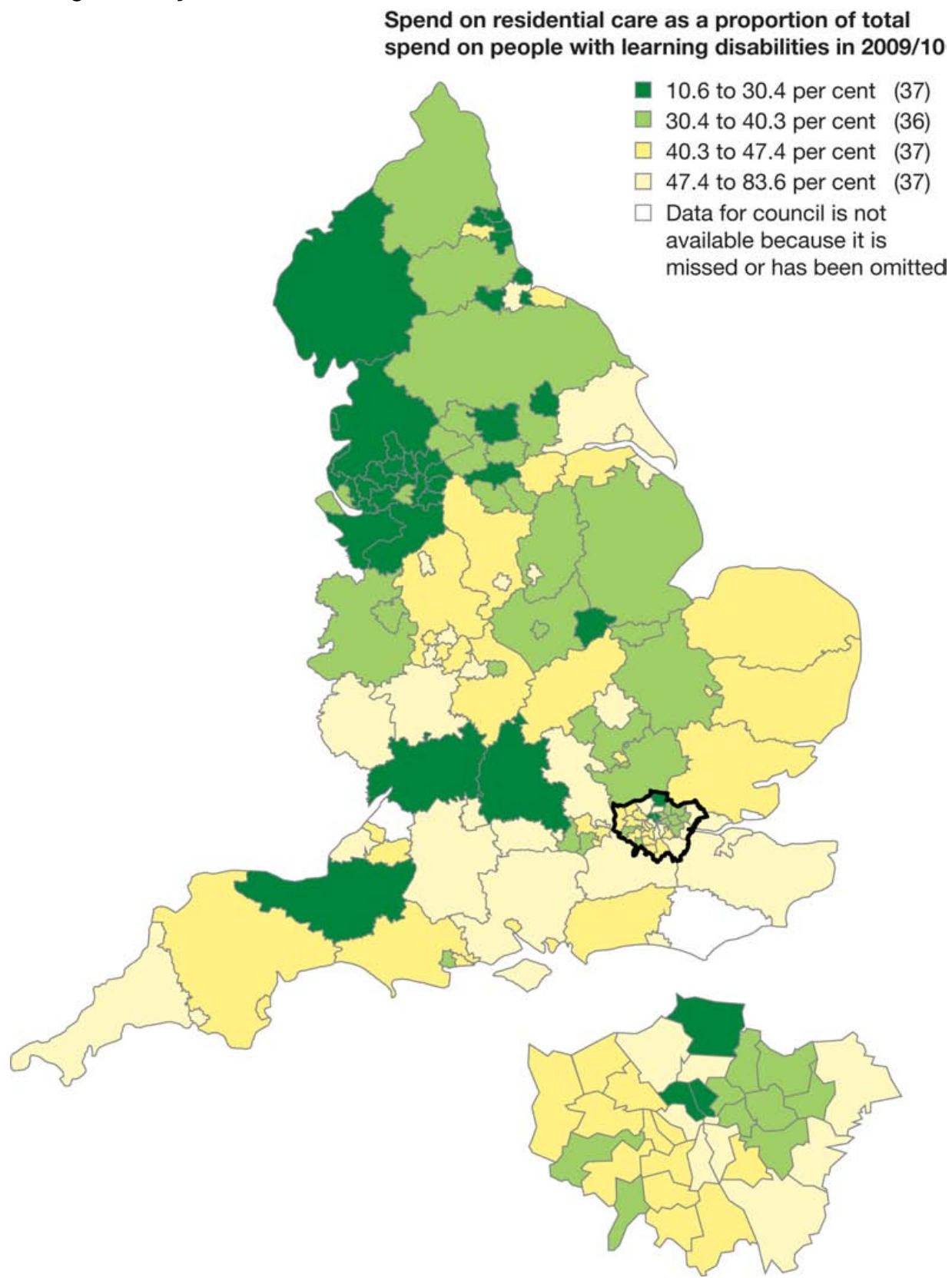
Figure 8: **Barnsley proportion of total spending on learning disabled people 2006/07 versus 2009/10**



Source: PSSEX1 returns 2006/07 and 2009/10, *The Information Centre for Health and Social Care*, adapted by the Audit Commission 2011

45 The proportion spent on residential care for people with learning disabilities varies. In 2009/10, councils in the North West spent the lowest amount of the social care budget for people with learning disabilities on residential care. Councils in London, the South West and West spent the highest proportions (Figure 9). These differences are long-standing and stem from historical legacies from the closure of long-stay hospitals as well as different strategic approaches from councils. They illustrate the long-term nature of patterns of service and the difficulty of achieving transformational change.

Figure 9: Councils vary in the proportion of spend on residential care for people with a learning disability



Source: Final PSSEX1 2009/10, The Information Centre for Health and Social Care, adapted by the Audit Commission 2011

46 The CQC returns show 15 per cent of councils had reviewed traditional day service provision. Councils need to engage with providers, including voluntary and community organisations, to develop alternatives to both residential care and a limited menu of community interventions (Ref. 26).

47 Eleven per cent of councils highlighted increased provision of extra care housing. This is housing that provides care to meet people's needs while enabling them to remain independent within their own home (Ref. 27).

Personalisation

48 Personalisation remains at the heart of social care transformation. The use of self-directed support can offer increased choice and control for people, as well as having a positive impact on people's health and wellbeing. There has been an increase in the proportion of people receiving a personal budget during 2009/10.ⁱ Survey data collected for the period March 2010 to September 2010 shows a further growth of 55 per cent in the number of personal budgets. However progress remains variable across the country (Ref. 28).

49 Thirty-six per cent of councils cited personalisation as a driver of better value for money in 2009/10. This rises to 45 per cent in council plans for 2010/11. Better value came mostly from improved outcomes, not savings. This is in line with our report *Financial management of personal budgets*, published in October 2010 (Ref. 29), and recent work from the Social Care Institute for Excellence (Ref. 30).

50 Savings, if any, came from:

- close analysis of financial data, leading, for example, to decommissioning of some poorly commissioned high-cost care packages;
- people making better use of resources when in receipt of a personal budget and therefore requiring less money to meet their needs;
- improvements in the delivery of personal budgets, including better audit procedures to increase recovery of unused funds; and
- rationalising the range of packages.

Partnership

51 In the CQC returns, 35 per cent of councils referred to partnership working to achieve efficiencies, with 40 per cent planning to work on this area in 2010/11. Co-location of services was the most common efficiency. Councils had also integrated operational teams or management arrangements.

52 Few reported joint commissioning of services with the NHS as a way of achieving better value, although there were exceptions.

ⁱ Council performance on NI130 during 2009/10

Case study 7

Nottinghamshire

The council and PCT made efficiencies through the joint commissioning of intermediate care services. The pilot service in one district developed specialist services for older people with dementia and/or mental health problems. This reduced care home placements, avoiding costs of over £200,000. Plans were in place to roll out the service across the county in 2010/11.

Source: Audit Commission

53 Our report *Means to an End* noted that ‘organisations can usually describe how they now work better together but often not how they have jointly improved user experience. Partnership agreements often fail to include quantifiable outcome measures, and partners rarely monitor them when they do’. (Ref. 31).

54 The health and social care interface will be an increasingly important area. Councils and their health partners will have to decide together how best to spend the funds assigned for joint spending over the next four years. Both need to secure efficiency gains, the NHS through fewer admissions to hospital and councils through helping people to stay in their own homes as long as possible.

55 It will be important for councils and NHS bodies not to concentrate only on their individual costs and savings. One council reported savings to CQC of £700,000 from a targeted project to review both continuing healthcare decisions and care packages between social care and health. But it was not clear whether this simply transferred costs to the NHS, meaning the taxpayer was no better off. The challenge will be for partners to take a whole-system view of efficiencies. Councils and their health partners need to work together to achieve the best possible use of resources for the area to avoid the cost-shunting that has taken place in the past.

56 Partnership working is a complex area, and its effectiveness is influenced by many different local factors which are not yet fully understood. Good evidence on the impact of partnership developments is not always available for:

- interventions that are delivered in partnership (such as POPPS), as noted above; or

- the way in which services delivered by the NHS affect councils, and vice versa (such as the possible link between NHS continence services and care home admissions, or between reablement services and hospital admissions).

57 This is an area we will return to in the final briefing in this series.

Assessment and care management

58 Thirty-two per cent of councils reported efficiencies by reviewing and improving assessment and care management processes. This includes:

- ensuring consistent application of the Fair Access to Care Services criteria; and
- working to reduce the number of assessments that do not result in a service.

59 Assessment and care management will be the subject of a further briefing.

Charging

60 Thirteen per cent of councils reported savings through making changes to their charging policy and processes. Councils achieved savings through improved income collection, recovery of debt and unused funds, and more consistent implementation of charging policy. The Commission has already published a report on councils' charging policies, *Positively Charged* (Ref. 32).

61 Councils also increased debt advice and checks to ensure people who use services were receiving the benefits they were entitled to. One council's benefits team identified an extra £2.2 million of benefits for social care clients, which people could use to offset against care charges.

62 Six per cent of councils increased charges to people in 2009/10. The analysis excludes these councils as this is a way of councils increasing income as opposed to making efficiencies. Increases to charges can have a negative impact on people who use services.

Transactional versus transformational efficiencies

63 Approaches to making efficiencies can be split into two broad categories.

- Transactional: tighter budget management and procurement; better contract management and monitoring; and streamlined processes and systems. These are essentially traditional ways of saving money, although there may be new ways of doing so. They will often be cash releasing. They may also be opportunistic and are achievable in the short term.

- Transformational: where services are redesigned and different approaches to care developed. This builds on the four areas of transformation identified in *Putting People First*: universal services; building social capital; prevention; and personalisation. Transformational efficiencies can also include trends that predate *Putting People First*, such as working with partners to deliver integrated services, and shifting towards community-based models of care. They are likely to be longer term in nature and may not always be cash releasing, but should provide better quality for people who use services.

64 To preserve or improve quality of services, transactional efficiencies must be implemented well. For example, a freeze imposed on fees paid to providers without discussion could affect quality or provoke legal challenge. On the other hand, if local intelligence shows unit costs to be high, negotiation with the provider could identify creative ways to reduce costs and to deliver services in different ways without affecting outcomes.

65 A transformational approach to efficiency involves working across internal and external boundaries. It is important that councils continue to work with partners to build an approach to value for money that uses resources effectively across the system. Evidence shows that integrated approaches to care also deliver better outcomes for people (Ref. 33).

66 Transactional efficiencies will offer cash-releasing savings within this Spending Review period. Transformational efficiencies may result in better outcomes for people as well as savings in the longer term. However, mostly, these savings will take longer to achieve and may be less certain. The pace of transformational change has so far been slow. This is not through lack of will or ideas, it's simply that delivering change and reshaping the market is, in practice, hard and takes time. Our briefing, *More for Less 2009/10* (Ref. 34) pointed to a similarly slow pace of change in the NHS. Councils will need to continue to invest in capacity to manage and lead change programmes.

Conclusions

67 Councils are already taking action that will improve value for money in adult social care in both the short and long term. While we identified some innovations, councils are, in the main, using tried and tested techniques to improve efficiency. Councils have recognised there is no one single answer. They are making efficiencies in several areas; and have been doing so without raising eligibility criteria or increasing charges.

68 But councils have more work to do. National data on spend, on patterns of services and on unit costs show a great deal of variation. Councils must ensure they have the capacity and capability to gather and use high-quality data that will enable them to review, compare and challenge their costs and service quality.

69 All councils now need to work to deliver efficiencies simultaneously in nine key areas: procurement; prevention; back office; staffing; changing the balance of care; personalisation; partnership; assessment and care management; and charging. Only a fifth of councils had plans to deliver efficiencies in six or more of these areas.

70 Transactional efficiencies will offer cash-releasing savings within this Spending Review period, while transformational efficiencies may result in better outcomes for people but are unlikely to yield material savings in the short term, and possibly in the longer term as well.

71 It is important for councils to engage and involve both stakeholders and the community. This is consistent with the Association of Directors of Adult Social Services (ADASS) whole-system view of efficient use of resources, which stresses the contribution made by partners and by people themselves (Ref. 35). Local government has a wider role to play in transforming services through joining up work on housing, culture, leisure and neighbourhoods. And councils must involve people in decisions about changes that will affect their lives.

72 Councils face clear risks and strategic choices in deciding on their savings and service strategies. The policy imperative is to transform services to deliver better outcomes for users. But the pace of change is slow and is unlikely to deliver short-term, or even possibly long-term, savings. Indeed, they may require short-term investment. Focusing management time on transactional efficiencies may deliver savings but will not fundamentally change services.

73 Financing adult social care is also a strategic issue. In the short term, councils may be able to raise charges. Fewer people may receive financial support from the council and a squeeze on overall resources and on fees for residential care may lead to a decline in the quality of services available. It is against this background that the independent Commission on the Funding of Care and Support, chaired by Andrew Dilnott, will report by July 2011.

Appendix 1: Efficiencies Summary

Category	Detail
Procurement	<ul style="list-style-type: none"> ■ Renegotiate terms or unit costs ■ Tender for a new supplier ■ Impose a standard framework for reviewing contracts ■ Revise contract monitoring arrangements, such as electronic monitoring of home care ■ Involve local people in contract monitoring ■ Use the Care Funding Calculator ■ Carry out a targeted review of high cost packages of care ■ Introduce collaborative procurement
Staffing	<ul style="list-style-type: none"> ■ Review the skill mix of the workforce ■ Restructure management positions ■ Reduce the use of agency staff ■ Manage vacancies ■ Manage sickness absence
Back office	<ul style="list-style-type: none"> ■ Manage assets including buildings ■ Set up modern working practices ■ Restructure support roles ■ Reprocure IT, supplies, utilities, stationery, transport
Assessment and care management	<ul style="list-style-type: none"> ■ Consistently apply eligibility criteria ■ Reduce assessments that do not result in a service ■ Review key processes (for example, through a Lean Review)
Prevention	<ul style="list-style-type: none"> ■ Develop effective advice and information services ■ Invest in primary prevention and influence partners to do the same ■ Invest in early intervention
Personalisation	<ul style="list-style-type: none"> ■ Increase take-up of personal budgets (achieving better outcomes for the same resource) ■ Manage the social care market to ensure a range of services are available for people to buy ■ Improve the delivery of personal budgets
Changing the balance of care	<ul style="list-style-type: none"> ■ Commission strategically ■ Move to community-based provision of care ■ Invest in housing such as 'extra care'
Partnership	<ul style="list-style-type: none"> ■ Co-locate services ■ Integrate operational teams ■ Jointly manage services or teams ■ Jointly commission ■ Efficient continuing healthcare arrangements

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Category	Detail
Charging	<ul style="list-style-type: none"> ■ Review charging policy ■ Improve debt recovery practices ■ Develop welfare advice to maximise people's income

Source: Typology adapted from information presented in council efficiency information provided to the Care Quality Commission, Audit Commission 2011

Appendix 2: Method

Personal Social Services Expenditure (PSSEX1)

An analysis of PSSEX1 looked at trends in council spend on adult social care services. The analysis examined council-level spend from 2006/07 to 2009/10 and aggregated spend figures for all councils in England from 2003/04 to 2009/10. All data is from final PSSEX1 returns. The analysis focused on the two groups of highest spend – older people and people with learning disabilities.

An analysis of council level PSSEX1 returns for 2006/07 to 2009/10 looked for trends in council-level gross total expenditure and unit costs in different services. The analysis of gross total expenditure focused on how much of the total budget for older people or for learning disabled people was assigned (as a proportion of the total budget) to the following services:

- assessment and care management;
- day care or day services;
- direct payments;
- equipment and adaptations;
- home care;
- nursing care placements; and
- residential care placements.

The unit cost analysis focused on the variation in residential care and day care directly provided by councils and by the independent sector in 2009/10.

Analyses of gross total current expenditure within the PSSEX1 returns for 2003/04 to 2009/10 were used to look at trends in aggregate spend figures for all councils in England. The analysis focused on how much spend has changed over time for older people and for learning disabled people by considering how the total budget for each group is allocated to different services. The PSSEX1 return separates gross total current expenditure into several services. The analysis groupings were:

- assessment and care management;
- community services (supported and other accommodation, home care, day care, equipment and adaptations, meals, Supporting People added together);

- residential care (nursing care placements and residential care placements added together);
- direct payments; and
- other services.

For each financial year each service category was then calculated as a proportion of the total budget for older people or for people with learning disabilities, to understand the change in spend over time for all councils. Aggregate data from the PSSEX1 returns before 2003/04 was not examined because it did not include the Supporting People funding stream and therefore data from the earlier returns was not comparable with data from 2003/04 onwards.

Productivity analysis

The productivity analysis considered aggregate gross total cost for older people and people with learning disabilities from 2005/06 to 2009/10, deflated by GDP. The areas of activity the analysis includes are:

- nursing homes (resident weeks);
- residential homes – council-owned and other (resident weeks);
- home care (clients);
- day care (clients);
- direct payments (clients); and
- meals (clients) (older people only).

Changes in these areas were weighted by cost to give overall changes in activity levels. These activity changes were divided by changes in costs to give a crude measure of changing productivity for each client group.

CQC efficiencies data

As part of the CQC performance assessment for 2009/10, each of the 152 councils in England presented a short summary of how they had achieved efficiencies in 2009/10ⁱ and how they planned to achieve efficiencies in 2010/11. Some summaries gave the amounts saved; others only gave the focus of the work.

Appendix 3: Acknowledgements

We are grateful to CQC for its support and for sharing data with us, and to the many national organisations and councils who have contributed to this briefing. In particular, thanks to Damon Palmer from DH, to Sarah Pickup, from Hertfordshire County Council (representing ADASS) and to David Walden from the Social Care Institute for Excellence.

ⁱ 2009/10 was the last year of the CSR07 period, during which councils were expected to achieve 3 per cent efficiencies.

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