Department of Health

Putting **People First**

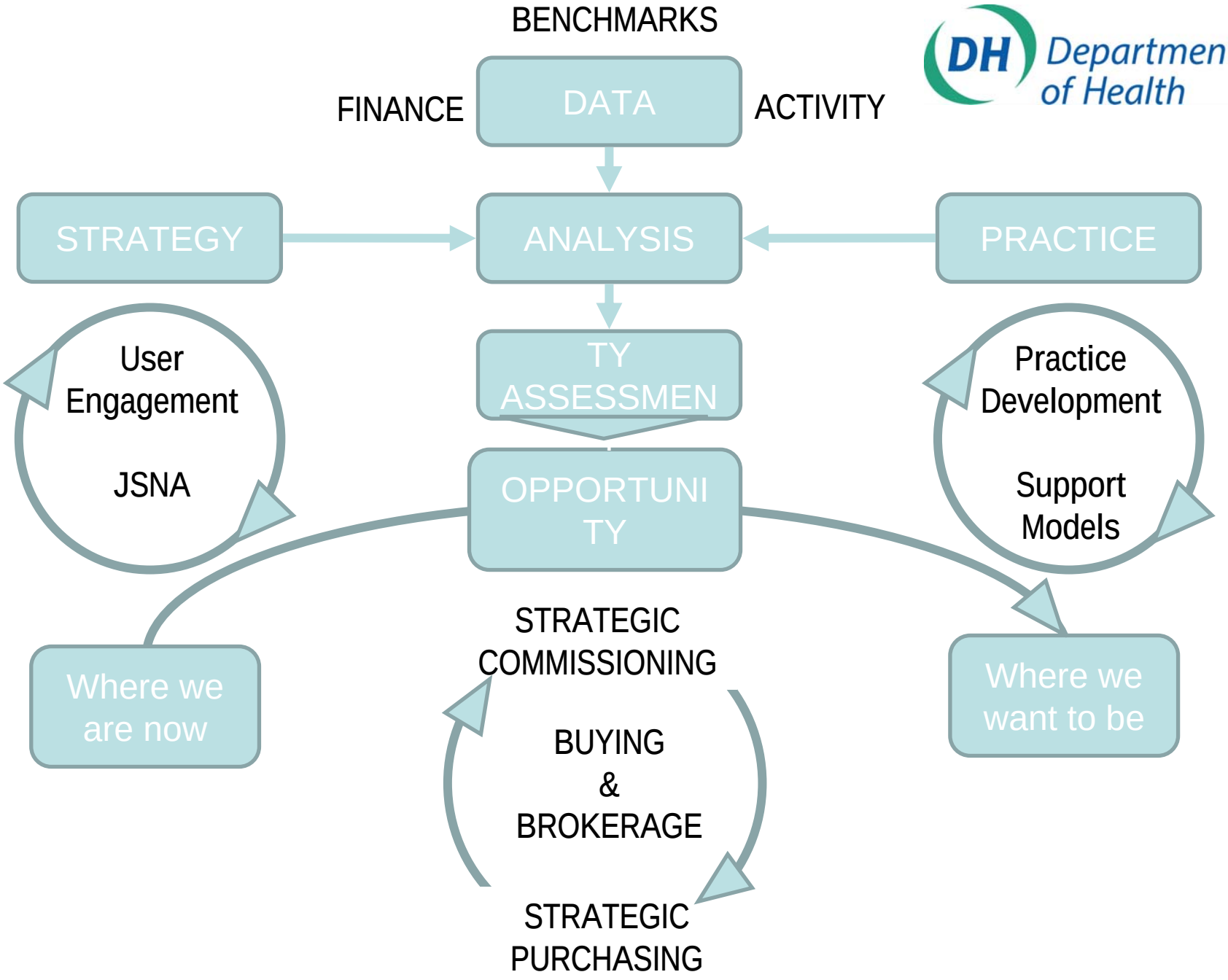
Transforming Adult Social Care

Stockton – Learning Disability Opportunity Assessment - Summary

Method and Contents

The draft opportunities identified in this presentation are based on :

- An initial round of interviews with staff/ managers and a brief review of key documents
- A review of nationally available financial information **(Annex A),** which enabled benchmark comparisons to be made.
- An analysis of activity and cost data held on the adult social care client database **(Annex B),** which helped with the analysis of the impact of current practices
- Case file reviews for 26 recent residential admissions and 14 recent reviews **(Annex C),** which informed our view of current approaches to the assessment an support of people with Learning Disabilities (LD)
- **Annex D** – Contains good practice case studies referred to


BENCHMARKS
FINANCE
DATA
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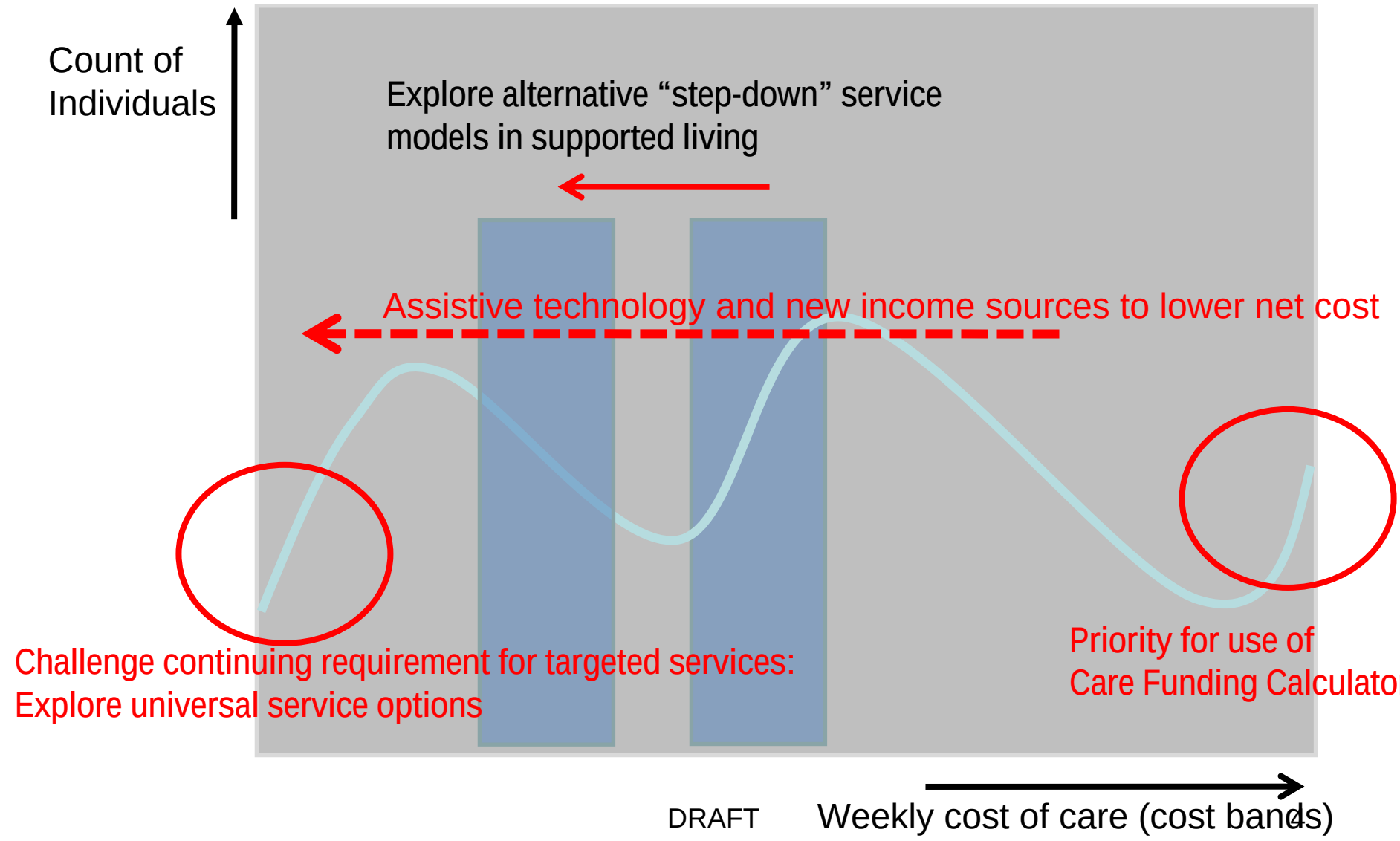
OPPORTUNI TY
Where we are now
STRATEGIC COMMISSIONING
BUYING & BROKERAGE
STRATEGIC PURCHASING
Where we want to be


Count of Individuals
Explore alternative “step-down” service models in supported living
Assistive technology and new income sources to lower net cost
Challenge continuing requirement for targeted services: Explore universal service options
Priority for use of Care Funding Calculator
Weekly cost of care (cost bands)

STRATEGIC SUPPORT

TACTICAL SUPPORT

STRATEGIC OPPORTUNITY ASSESSMENT

- Data acquisition
- Data analysis
- Data interpretation
- Strategy analysis
- Practice analysis
- High level benefits estimation
- Use of alternative support models

TACTICAL ASSISTANCE

- Use of Care Funding Calculator
- Procurement support
- Negotiations with providers
- Development of business cases for individual support packages

Process review and re-engineering

The headline from the benchmarking exercise is that:

- Stockton's spending on support for people with learning disabilities is:
  - £140 per head aged 18-64. This is low compared to an average of £156 ph by similar authorities
  - Higher than the lowest spending quartile of comparable authorities as they on average spend £129 ph on LD
  - 25.5% of its total adult social care spending compared to national norm of 23% (2007-8 average per DH Use of Resources Publication -2009)

To reduce spending to the:

  - Average level by the lowest spending quartile of similar authorities requires Stockton to spend 8% (£1.2m) less p.a.
  - Level that would represent 23% of total spending requires Stockton to spend £1.5m less p.a.

- Deprivation in Stockton is comparatively low for its group of comparative authorities i.e. it might want its spending to be below average levels for the group. If this is the case saving opportunities of between £1m and £2m might exist. The question is where are these savings opportunities?

The good news is that Stockton has many strengths that it can build on:

During the last five years Stockton has:

- Gradually shifted the balance of its support for people with LD away from Res/ Nursing care i.e. spending on it has only increased from £5.85m to £8.2m (40%) in the last 5 years while spending on Community/ Other has increased 81% in the same period from £3.45m to £6.25m.
- Effectively contained increases in the cost per person supported at a time when LD inflation has been high nationally e.g. in the last 4 years the cost per person supported in:
  - Residential/ nursing care has increased by just 1.4%
  - The Community has increased by 20%.
- Unit costs for accommodation based support in Stockton are well below the Unitary Council Average

But, significant challenges remain:

- Over the last five years:
  - Demand has escalated i.e. the numbers supported in the community and supported in residential / nursing care have both increased. There is no evidence that this increasing trend will change soon
  - Consequently LD costs have increased 54% while overall adult social care costs have increased by just 32%. This rate cannot be sustained.
- Stockton is still placing a high proportion of people in residential care i.e. 2008-9 33% of new LD clients were supported in residential care
- Residential numbers are high. They now represent (1.6 per '000 aged 18-64 versus an average of 1.1 for similar authorities)
- Despite recent increases numbers supported in the community are relatively low (3 people per '000 aged 18-64 in the community versus an average of 4.2 by similar authorities i.e. switching from residential to community support should be possible if affordable community options exist or can be created.
- Effecting this switch may not, however, be as easy as it sounds as:
  - Unit costs for Community based support (except home care) are above national averages i.e. making savings by substituting community based care for residential care will not always be straight forward
  - Staff report and case reviews confirmed their is a lack of suitable housing in Stockton for people with LD

This highlights the need for Stockton to seek to:

- Improve the cost effectiveness of its community support for people with learning disabilities,
- Increase the range of housing options available for people with LD, and
- Replace residential support with more cost effective community alternatives.

Future Opportunities

We believe there are opportunities to improve cost effectiveness by:

1. Reduce the number of people with LD supported in residential care by reducing the flow into residential care and where possible over time transferring people who do not need to be in residential placements into appropriately supported community settings
2. Ensure community support is good value for money so that people directed away from residential care can be supported effectively at lower cost than the residential alternative
3. Undertaking high cost case reviews to ensure high cost support (residential and community) is necessary and economically procured

1. Reducing numbers supported in residential care

- On average comparable authorities support 1.1 per ‘000 aged 18-64 in residential care.
- Currently Stockton supports 1.6 per ‘000 this way.
- To match the average numbers would need to reduce by around 50 to 120. This is a 29% reduction and seems ambitious, but there is evidence, from our review of case files (See Annex C), that residential numbers are higher than necessary:
  - 9 new entries to residential care appeared premature (Issue 7)
  - 5 new entrants to residential care in “Mid Life” could potentially have been avoided if skills of daily living and other support had been provided whilst the individual was living with their family carers (Issue 8)
  - 5 “interim” placements “drifted” and became permanent (Issue 9)
  - 8 people appeared to have entered residential care because of a lack of suitable supported housing options (Issue 11)
  - The majority of reviews identified supporting living options for residential/ adult placement clients, but support plans did not contain actions to achieve the desired “move on” (Issues 4 and 5)

1.1 To reduce numbers in residential care will require a focus on:

- **Reducing transitions from children's services:** 35% (4 out 11) of new residential admissions in 2008-9 were aged 18-21 and we saw 5 case files where effective transition planning was not evident (Issue 6). Transitions can be anticipated and good planning coupled with training in daily living skills will reduce numbers entering residential care.
- **Reducing mid-life transitions:** 35% (4 out 11) of new admissions in 2008-9 were aged 40-59 and our case file reviews found 3 residential admissions where support to carers might have delayed the need for support and would have allowed more time for daily living skills training (Issue 2), which would reduce numbers going to residential care.
- **Enabling people who are capable and want to live in the community to do so. To do this Stockton should:**
  - Review current residential cases that cost between £300-£600 p.w. Currently there are between 38 and 68, **(slide 43)**. The aim would be to check they need residential support? If not, plan their move on. We highlight this group as cost can be a proxy for support needs i.e. unnecessary placements are more likely to be in, but not exclusive to, this group.
  - To identify other candidates outside this price banding ask care managers. Their knowledge of individuals will be key to identifying people with the potential to move on.
- **Ensuring there are sufficient suitable housing options for people with LD:**
  - Issue 11 identified 8 cases where admission to residential care seemed to be because there was an absence of suitable supported housing options.

1.2 The value of the opportunity to support people at lower cost in the community:

- Based on case study evidence (e.g. Hollingside) each person supported in a step down facility would cost around £12k p.a. less than typical residential costs e.g. if the above enabled residential numbers to be reduced by:
  - 25% of the scope of 50 identified, this would save £150k net.
  - 50% of the scope of 50 identified, this would save £300k net.
  - 75% of the scope of 50 identified, this would save £450k net.
  - 100% of the scope of 50 identified, this would save £600k net.

2. Ensure community support is good value for money by:

- Some case files show a risk averse approach is leading to higher than necessary ongoing support costs:
  - Issue 1 Annex C: Details 13 cases where elements of support seem excessive in relation to the individuals capabilities. Possibly indicating a risk averse approach
  - Issue 13 Annex C: Identifies 6 clients who have support that could probably be reduced if they had lighter touch support from a peer support network (possibly facilitated by a volunteer e.g. the KeyRing model).
- Over servicing is evident in high and in low cost cases. Two good ways of eliminating some of this are to:
  - Ensuring that very low levels of support are Vfm and people “move on” where safe. In some cases Peer Support networks (see KeyRing Case Study at Annex D) might be a light touch alternative)
  - Using assistive technology where possible to reduce manual support costs. For example as an alternative to night cover or to reduce transport costs. (See the Cheshire and SMaRT case studies – Annex D)

2.1 Ensuring very low levels of support are good vfm.

- Reviews need to focus on promoting independence so ongoing care and support costs reduce over time where possible.
  - Issue 3 Annex C: Identifies 5 cases that may well have benefited from a more proactive review process, and
  - The “Doing it Your Way” case study (Annex D) illustrates possible benefits
- At present there are up to 137 LD clients who have community support packages costing £1 to £99 p.w. Assuming weekly support costs average £50 a:
  - 10% saving would equate to £35k p.a.
  - 20% saving would equate to £70k p.a.

2.2 Use assistive technology (AT) where possible to reduce manual support costs.

- Although we noted 3 cases where AT was being used very well we also identified a low level of AT awareness by practitioners and 2 cases where using it could save money (Issue 12 Annex C). AT could be an alternative to:
- Transport costs. At 28/02/10 there were 187 LD clients who regularly have transport support costing £365k p.a. A saving of:
  - 10% would equate to £35k p.a.
  - 20% would equate to £70k p.a.
- Night cover. At present there are 40 clients with “Sleep In” support that costs around £225k p.a. A saving of:
  - 10% would equate to £25k p.a.
  - 20% would equate to £45k p.a.

3. Undertaking a high cost case reviews to reduce long-term support costs:

- The East Midlands region has recently used the Care Funding Cost Calculator to the price paid for a small number of very high cost cases is reasonable . As a result £4.5m has been saved. This is a 21% reduction in the price being paid on the cases reviewed.
- There is a good probability that Stockton could also benefit from using the calculator or by undertaking a high cost case review because our case reviews noted:
  - All 5 cases where we thought better transition planning could have resulted in lower ongoing support costs cost more than £1,400 p.w. (Issue 6 – Annex C)
  - 18 out of county places (9 of these cost more than £1,000 p.w.) (Issue 10 – Annex C)
  - That care managers negotiate prices with providers (Issue 14 – Annex C). In our experience care managers often lack the negotiating skills needed to get the best prices. Each of the 3 cases cited cost more than £1,600 p.w.

3.1 Opportunity from undertaking high cost case reviews

- 53 residential clients currently have weekly costs of more than of £1,000.
- Collectively these cost around £4.4m p.a. Therefore a saving of:
  - 10% would equate to £440k p.a.
  - 20% would equate to £880k p.a.
- There are also 3 community clients who currently have weekly support packages costing more than £1,000. The Care Funding Cost Calculator could also be usefully applied to these and some minor savings might be achieved.
- The Coventry case study at Annex D is an example of how a targeted case review could be implemented and could be beneficial

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Stockton – Learning Disability Opportunity Assessment – Annex A Benchmarking Data

Stockton spends a relatively high amount supporting people with Learning Disabilities (LD)

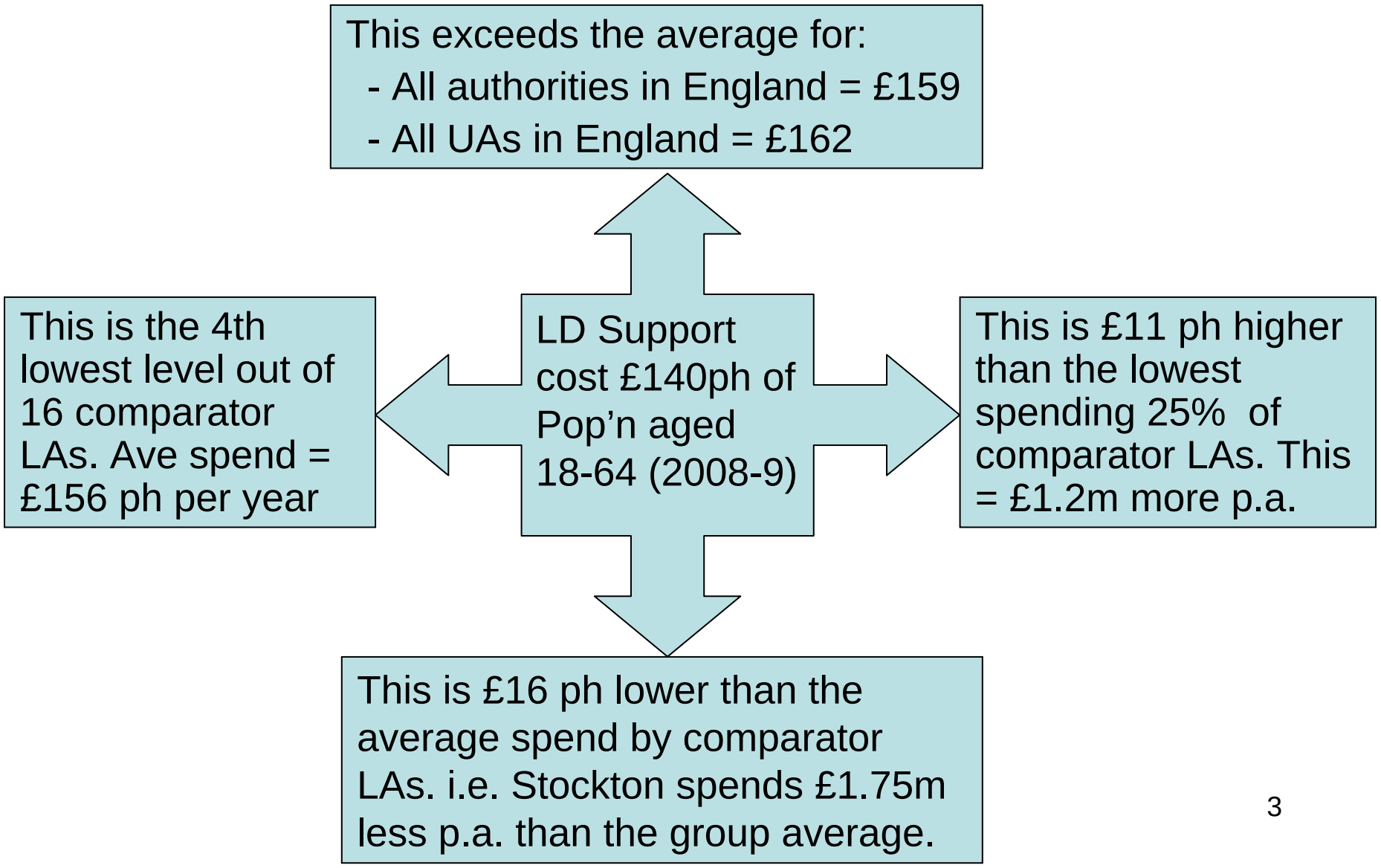
Summary:

- It spends a comparatively low £140 per head of its population aged 18-64 on support for people with LD
- It spends a higher than average share of its ASC budget on LD (25.5% versus an England average of 23%)
- LD spending is rising faster than ASC spending overall (54% since 2004-5 compared to 32% overall)
- It spends 54% of its LD budget on Residential or Nursing care.

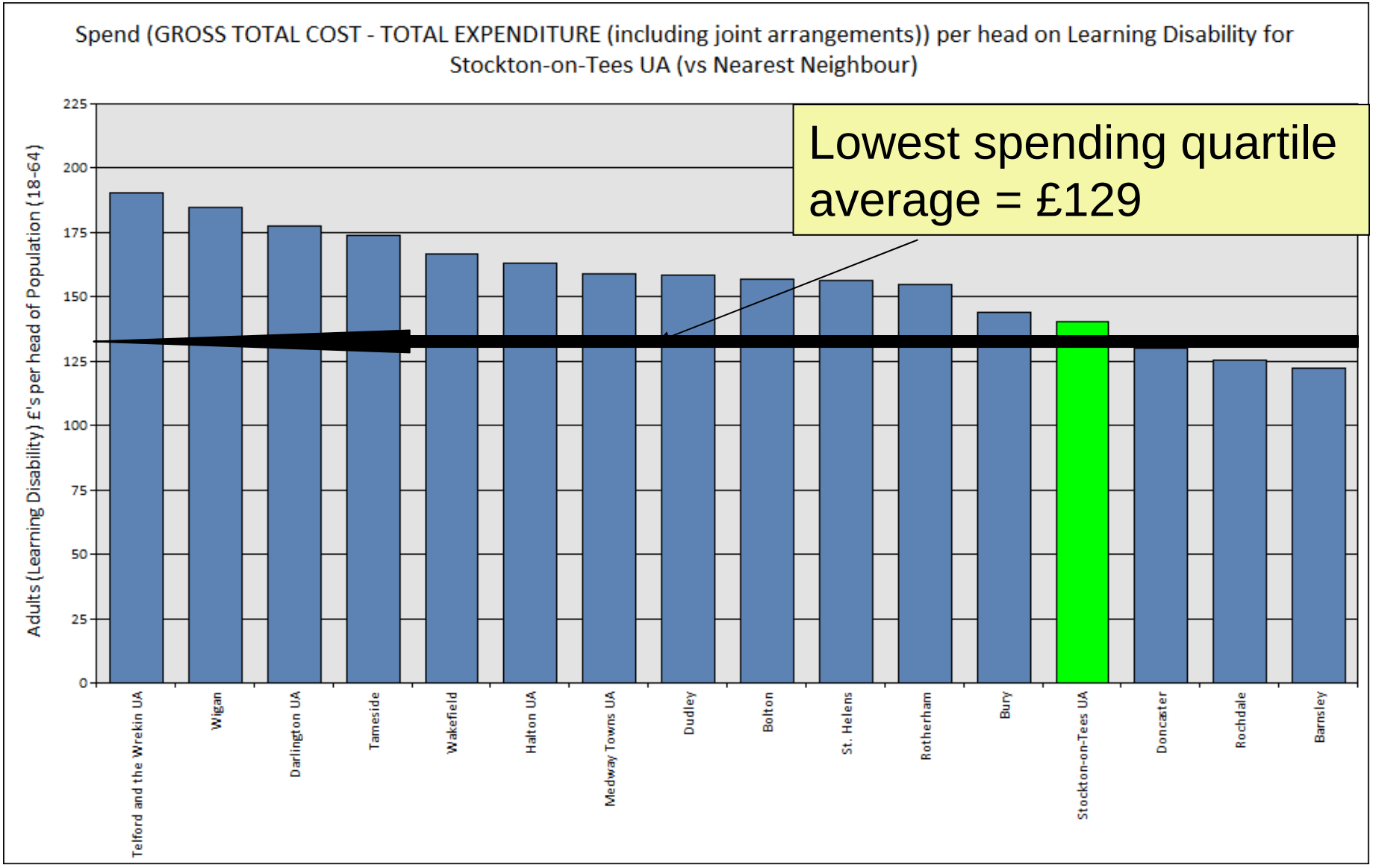
Questions raised:

- Could it spend less per head without negatively affecting outcomes
- Is this proportion what is needed and is the increase equitable for other client groups?
- Is this rate of growth sustainable and what can be done to address the rate of increase?
- Is 54% the optimum proportion? or would a different proportion be more cost effective?

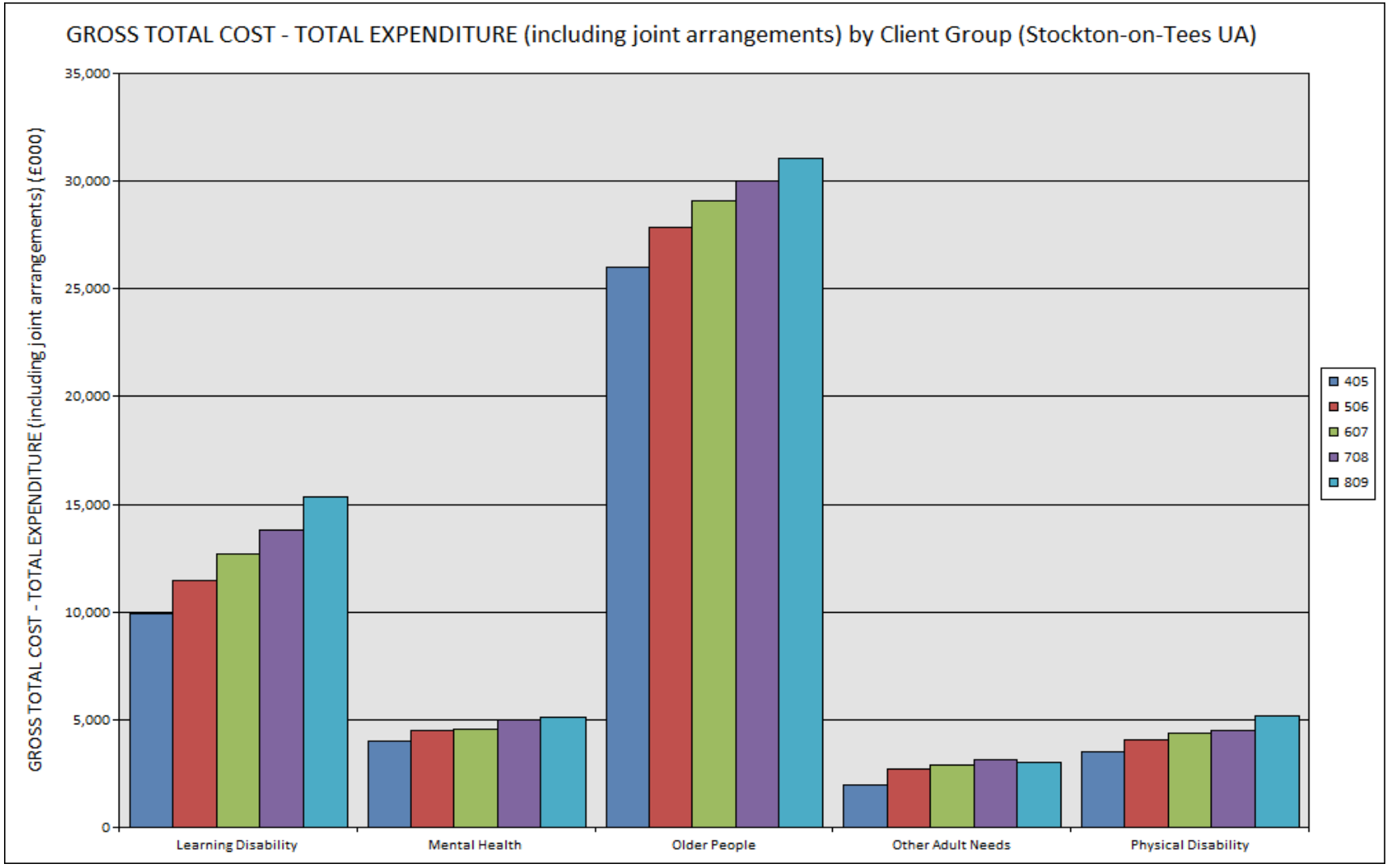
Whether spending £140 ph on LD is appropriate depends on the level of need within the local population, but the lowest spending quartile of similar authorities spend £11ph less. This gives a potential saving of £1.2m p.a.



Gross spending on Learning Disability Support per head aged 18-64 Vrs comparator authorities



Spending on LD has increased 54% from £10m in 2004-5 to £15.3m in 2008-9. This rate of growth means that LD is accounting for an increased share of total ASC expenditure year on year (See next slide).



Gross spending on LD now accounts for 25.5% of total gross spending by Adult Social Care. Up from 21.75% in 2004-5. If spending was in line with the England average of 23% Stockton would be spending £1.5m less on LD.

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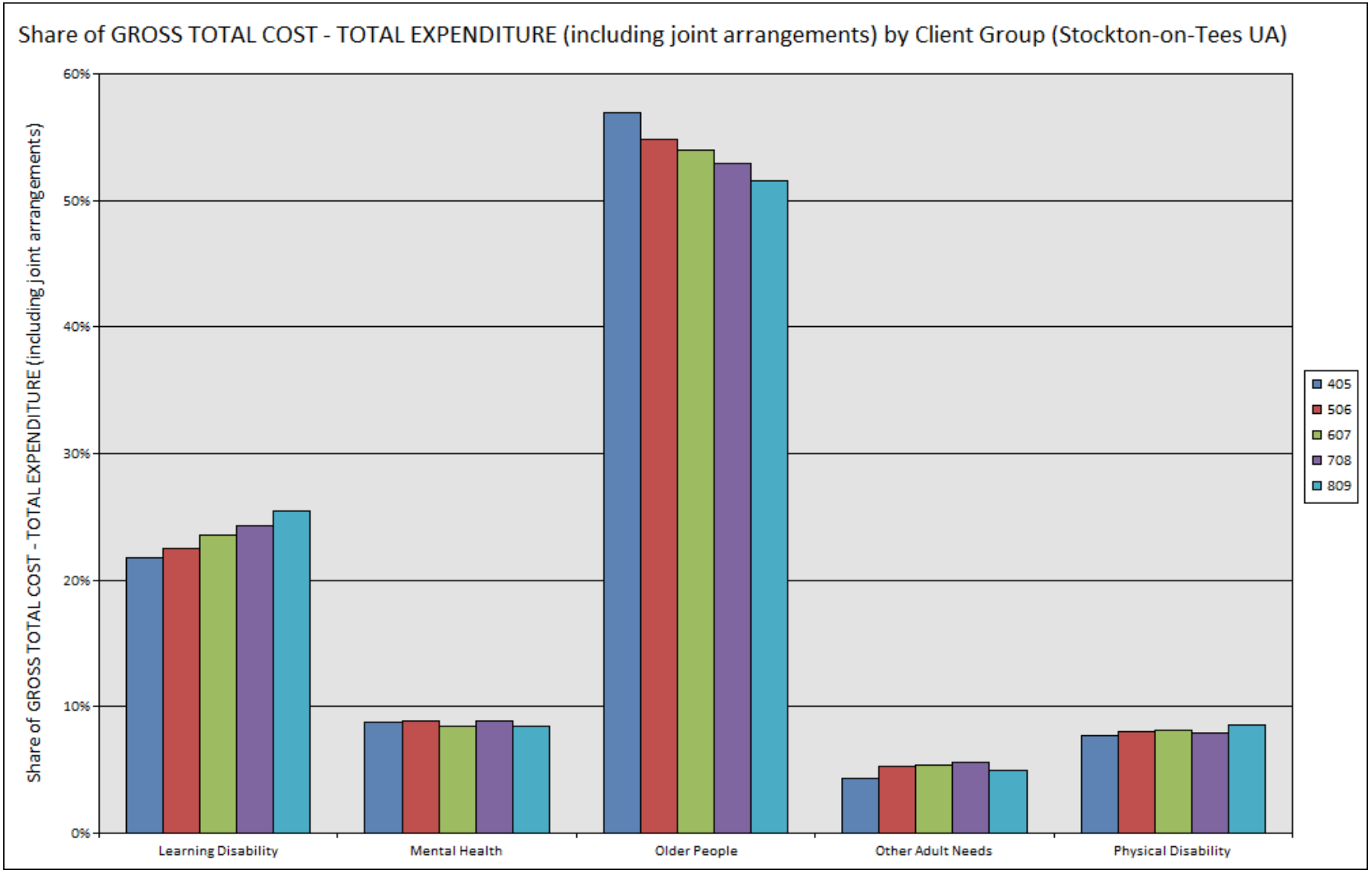
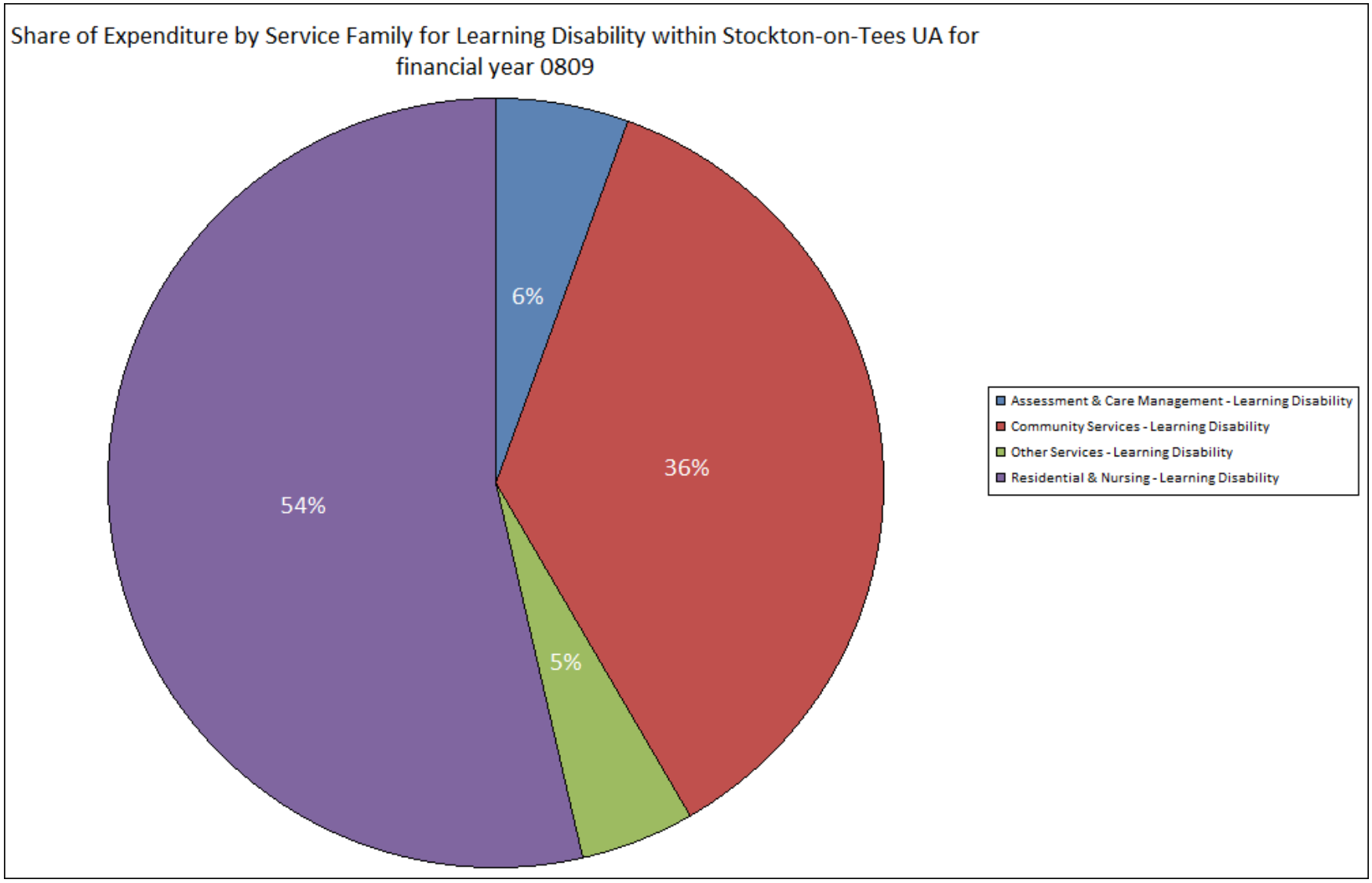


The proportion of spending to support people with LD in residential or nursing care has decreased from 58% in 2004-5 to 54% in 2008-9. This is a positive sign, but 54% still represents a high proportion (See next slide).

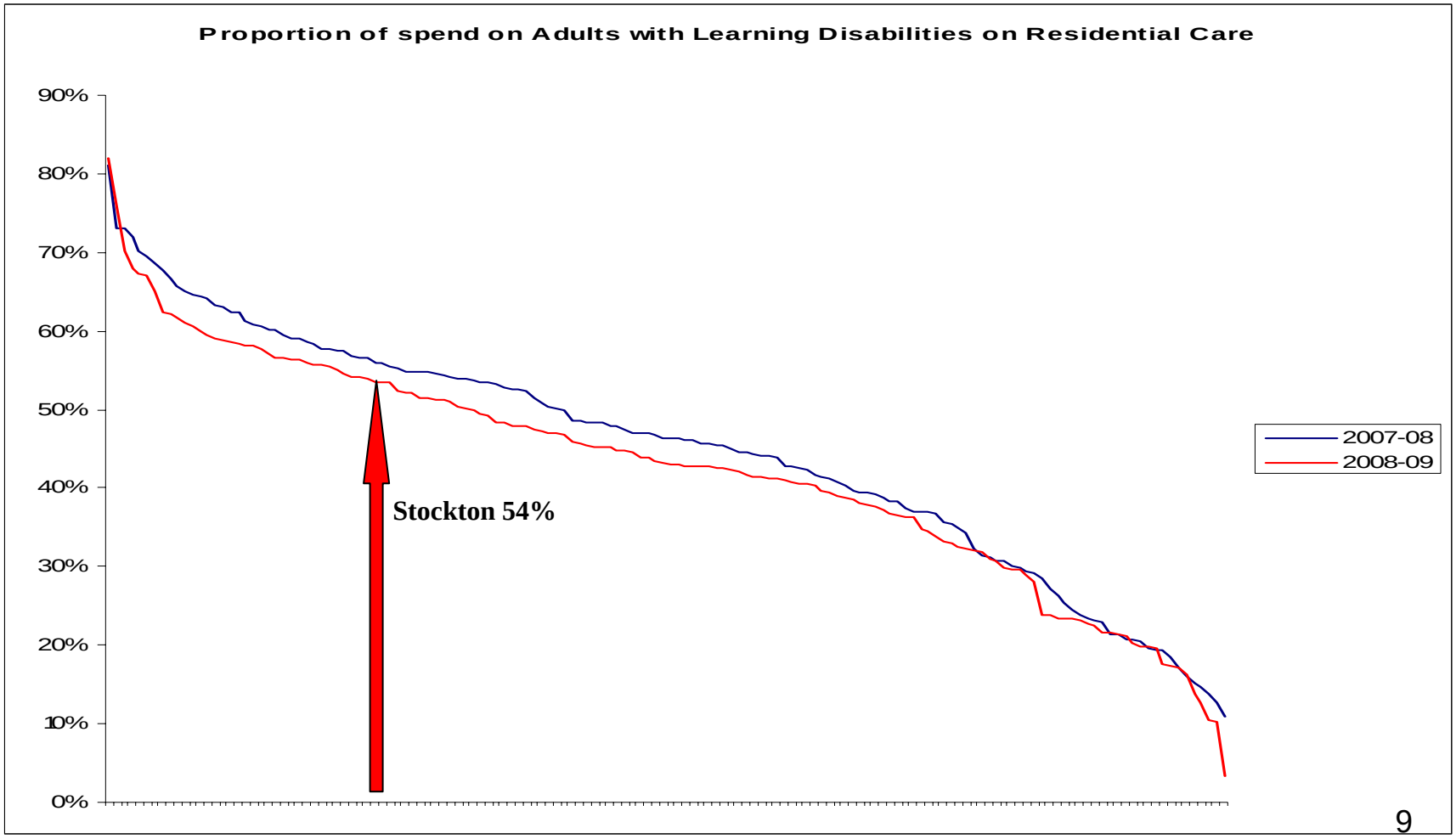


How reasonable is spending 54% of total gross spending on support for people with LD on residential/ nursing care?

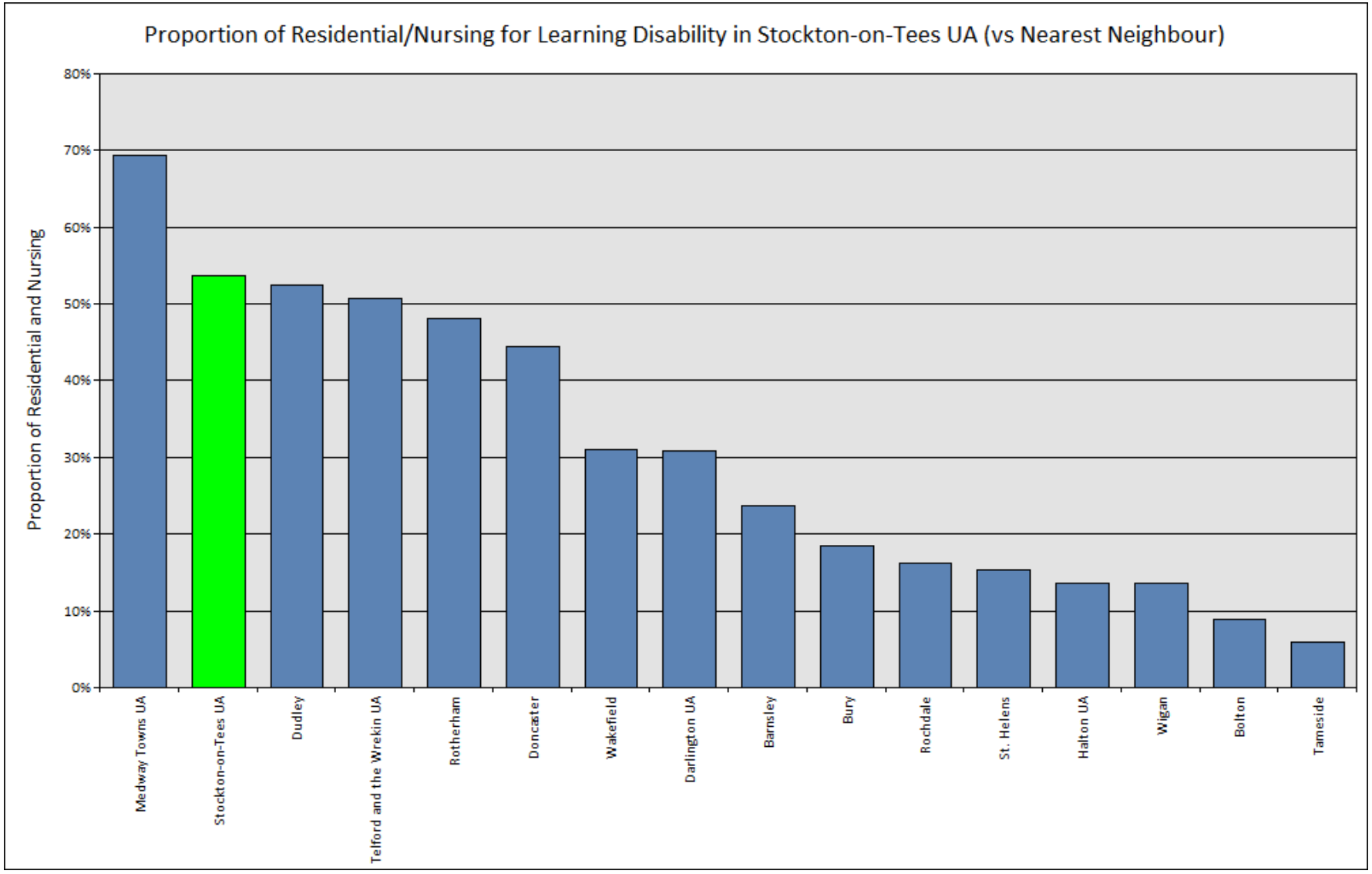
- Nationally 54% is significantly above the median i.e. it looks high in an all England context
- 54% is very high relative to comparable authorities as it is:
  - The 2nd highest proportion out of 16
  - 23% higher than the average proportion by comparable authorities (31%)
  - More than 3 times higher than the average by lowest spending quartile* of comparable authorities (15%)
- To reduce the proportion of its LD spending on residential/ nursing care in line with the Average would require Stockton to spend £3.5m (or 43%) less on residential/ nursing care per annum.

* Calculation excluded the lowest two authorities as they appear to be outliers

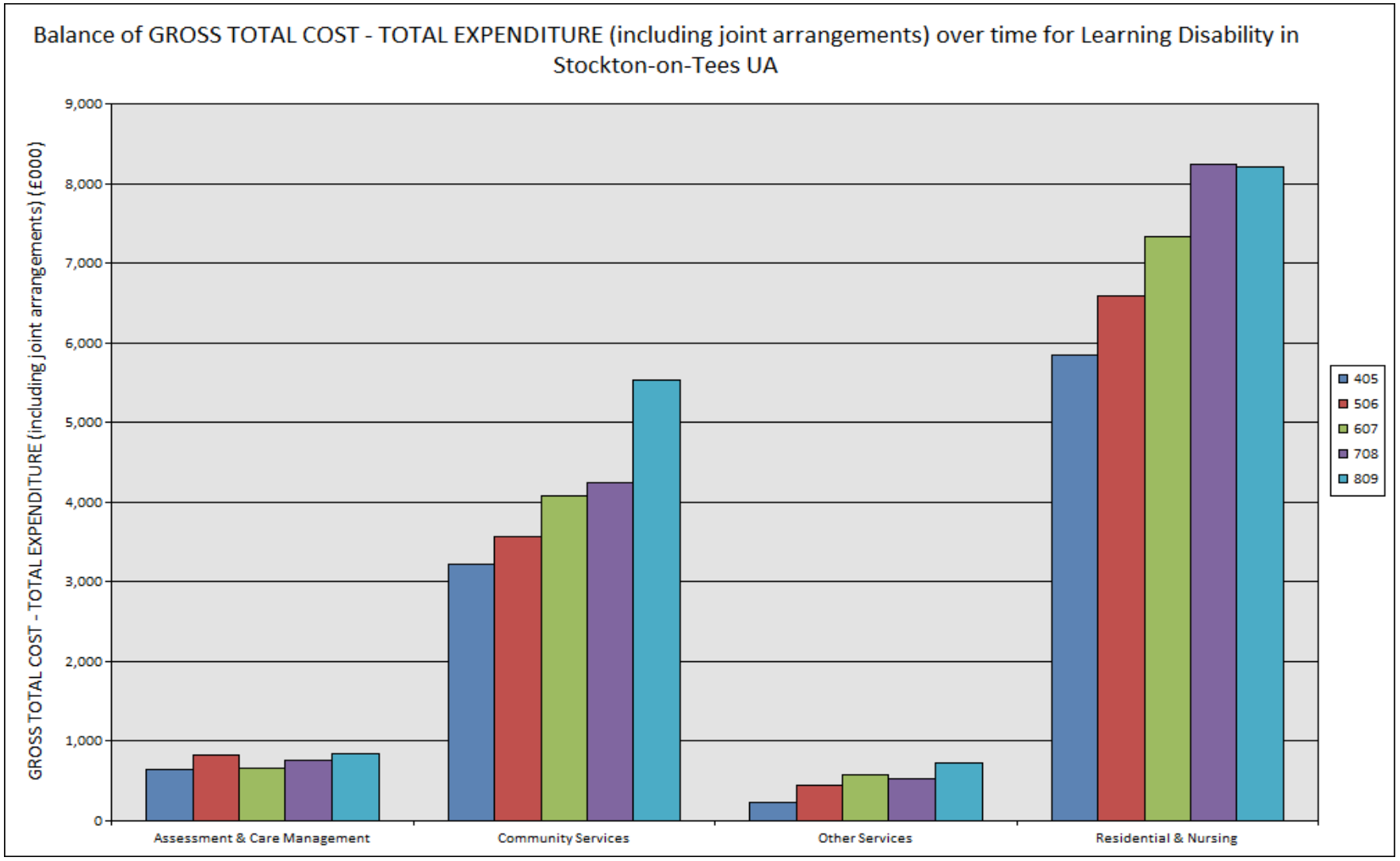
Nationally spending 54% of the LD budget on residential/ nursing care is well above the median position (National data is for 2007-8 and was reported in Use of Resources in Adult Social Care by DH (Oct 2009) updated to show 2008-9 position as well)



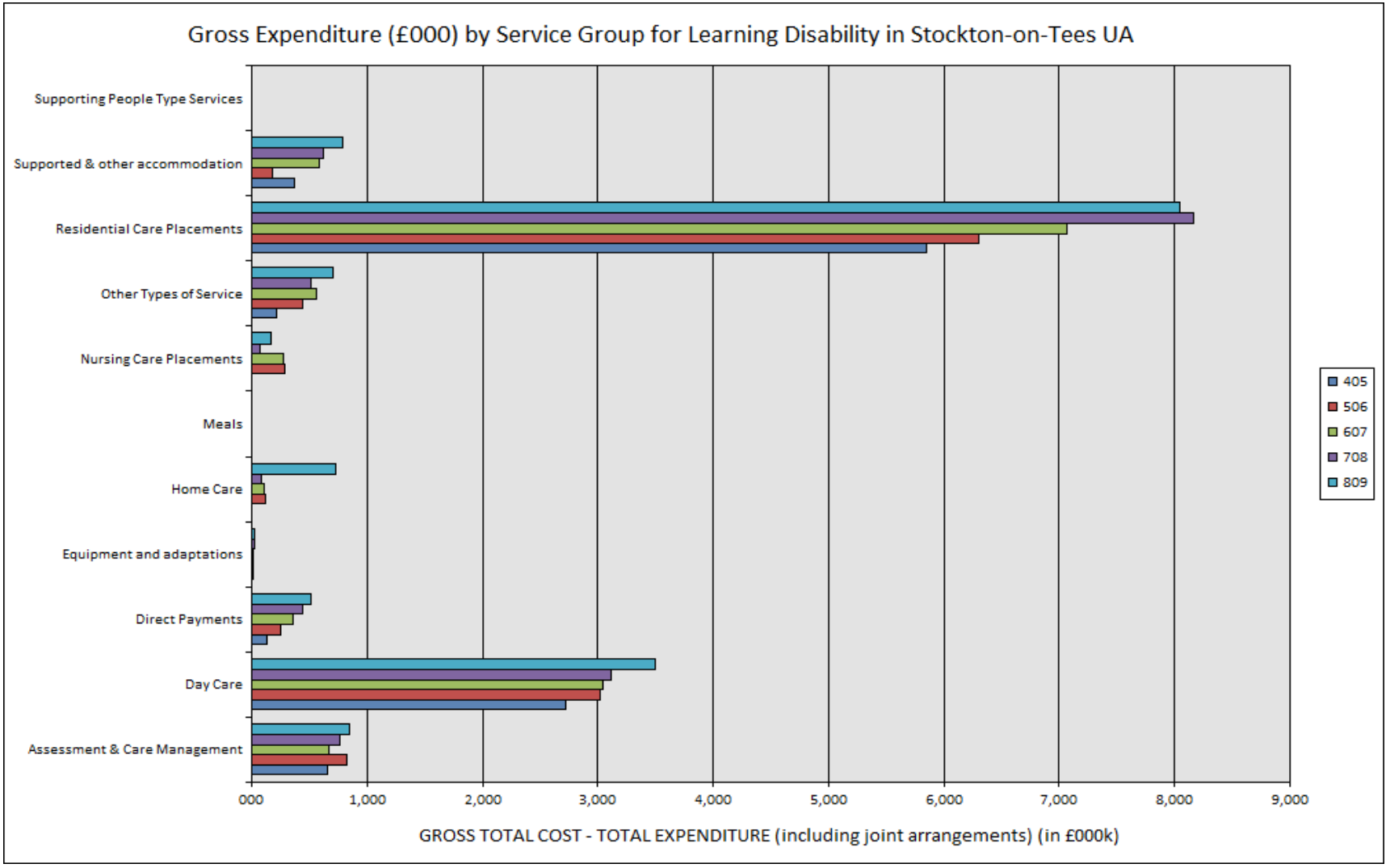
54% of LD Gross Spending on Res/ Nursing care is very high. It is the 2nd highest out of 16 comparable authorities



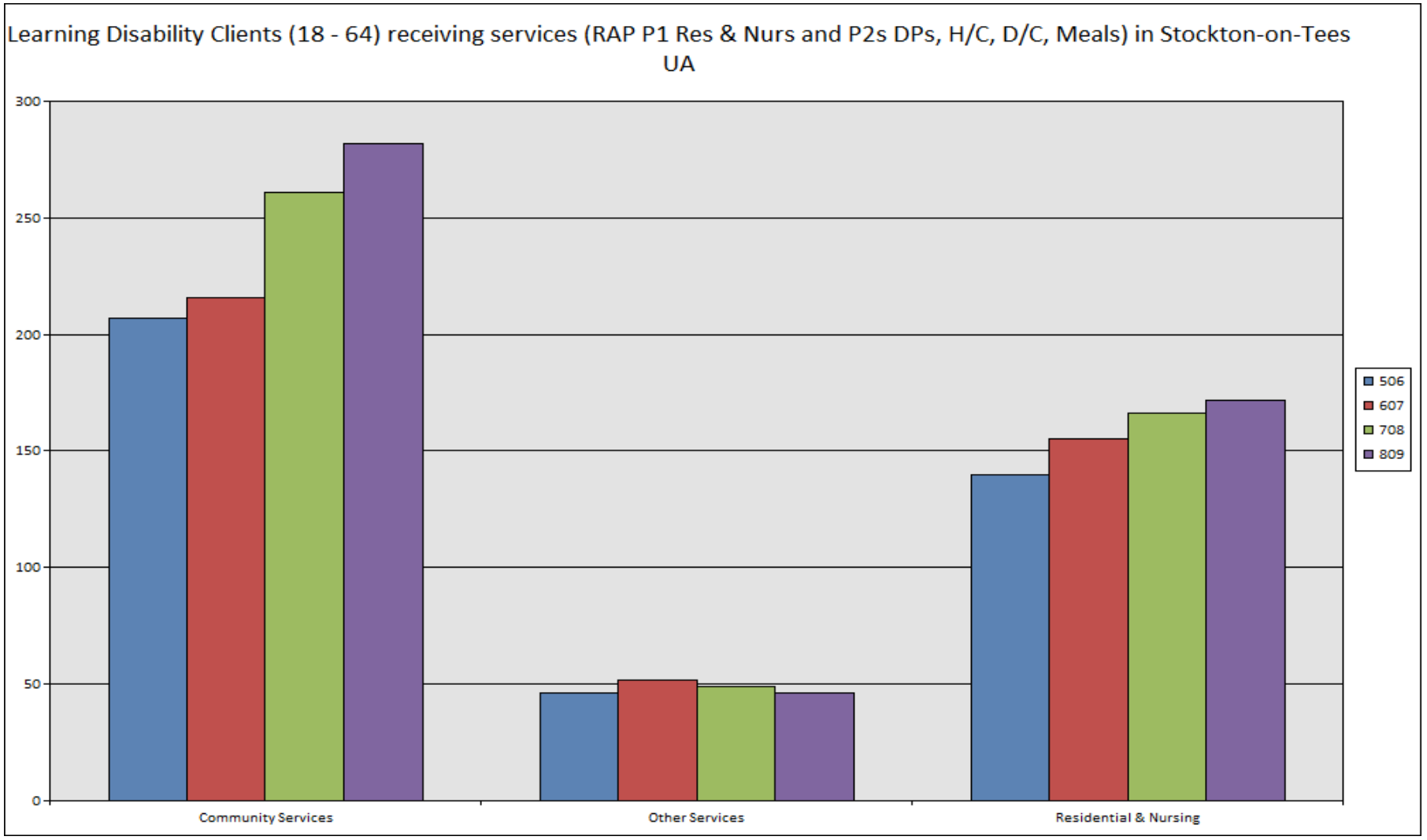
The balance of support in Stockton is shifting gradually away from Res/ Nursing care i.e. spending on it has only increased from £5.85m to £8.2m (40%) in the last 5 years while spending on Community/ Other has increased 81% in the same period from £3.45m to £6.25m.



A detailed analysis of gross spending shows a shift in spending from residential to community support is beginning. The concern is that significant increases in community support and supported living are NOT being matched by reductions in residential/ nursing care.



The shift in the balance of client numbers from Residential/ Nursing Care to Community Support is much less than the shift in spending in the last for 4 years i.e. in 2005-6 36% of the 312 LD clients were supported in Residential Care and in 2008-9 34% of the 500 clients were in Residential Care.



Units costs – Unit costs for accommodation based support in Stockton are well below the Unitary Council Average, whereas most community based support unit costs (except home care) are above average. This highlights the need to explore how to get better Vfm from community support providers.

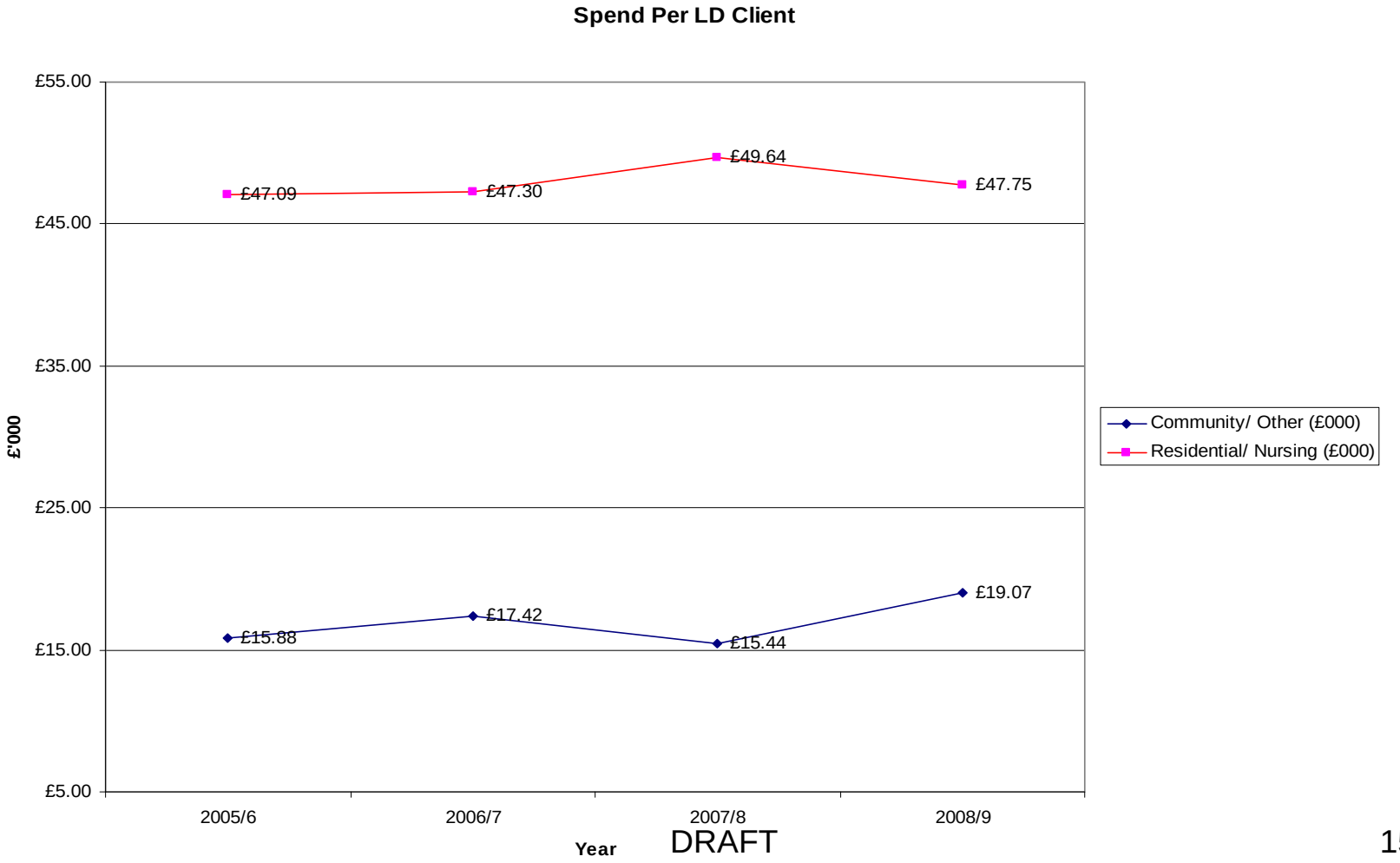
Learning Disability Unit Costs (Gross Cost) **All data from PSSEX1**	**Stockton (£)**	**UA Average (£)**	**Diff (£)**
Nursing Care for People with LD per week	528	1,225	-697
Residential Care for People with LD per week	965	1,116	-151
"In House" cost of Residential Care per week	1,527	1,871	-344
"Outsourced" cost of Residential Care per week	920	1,060	-140
Exp. on home care per LD adult in receipt at 31/03	370	391	-21
Exp. on dir payments per LD adult in receipt 31/03	131	186	-55
Exp. per day care session for LD adults	276	157	+119
Exp. per LD day care session client pw - In Hse	247	155	+92
Exp. per LD day care session - Outsourced	588*	150	+438
Exp. Per LD day care client at 31st March	400	329	+71

* Data looks incorrect

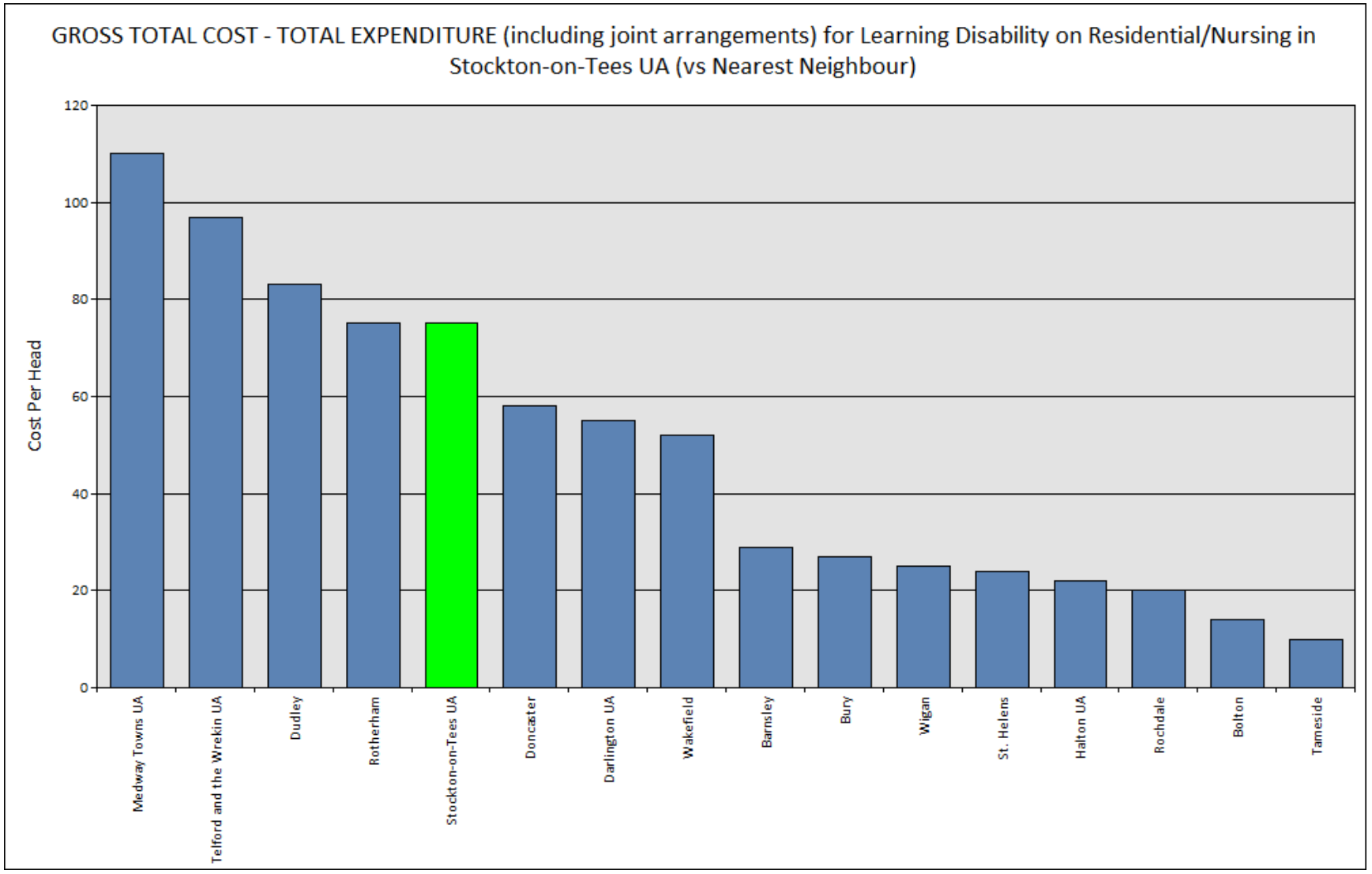
In the last 4 years the cost per person supported in:

- **Residential/ nursing care has increased by just 1.4%**
- **The Community has increased by 20%.**

Given that the LD residential market has experienced high inflationary pressures in recent years this performance reflects well on Stockton and its efforts to achieve Vfm.



At £75 residential/ nursing care spending per head of the population aged 18-64 is the 5th highest in the comparable group i.e. there might be scope to reduce this area of spending.



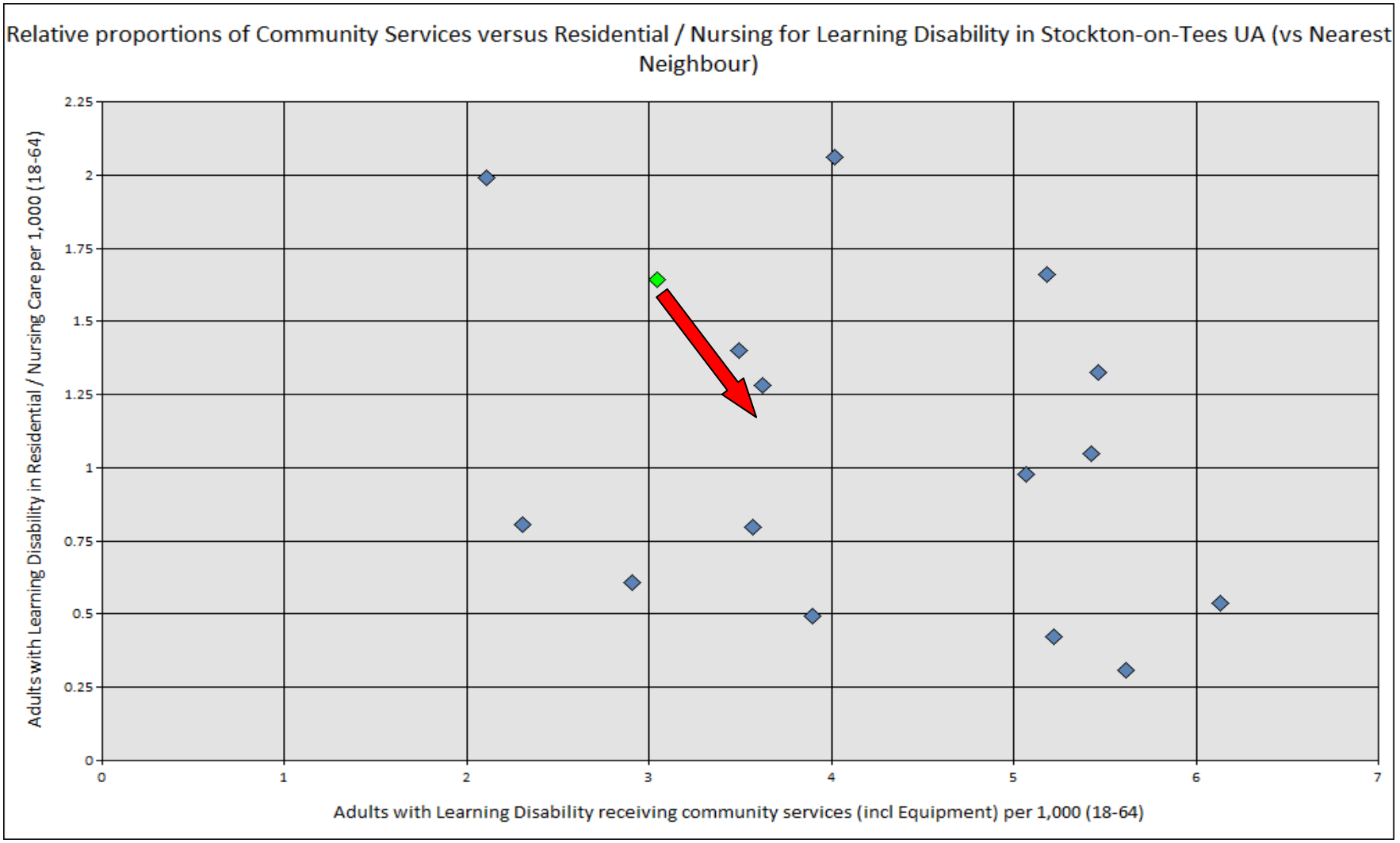
At £75 per head aged 18-64 spending on Residential and Nursing care for people with LD is relatively high. It is:

- £21 per head per annum higher than the average (£54 per head) for the 16 comparable authorities*
- £52 per head per annum higher than the average (£23 per head) spending by the lowest spending quartile of comparable authorities*

- To spend in line with the:
  - Average would require Stockton to spend £2.3m less p.a. on Residential and Nursing care
  - Lowest spending quartile would require Stockton to spend £5.7m less p.a. on Residential and Nursing Care

*Each calc. excludes the two lowest spending authorities as their data appear to be outliers

Residential/ Nursing numbers have increased over the last four years from 140 to 172 and now represent 1.6 per '000 aged 18-64. This makes Stockton the 4th highest user of Residential/ Nursing care in its comparison group whereas only 3 authorities support a lower proportion of people with LD in the community i.e. there appears to be scope to support more people in the community and less in residential care.



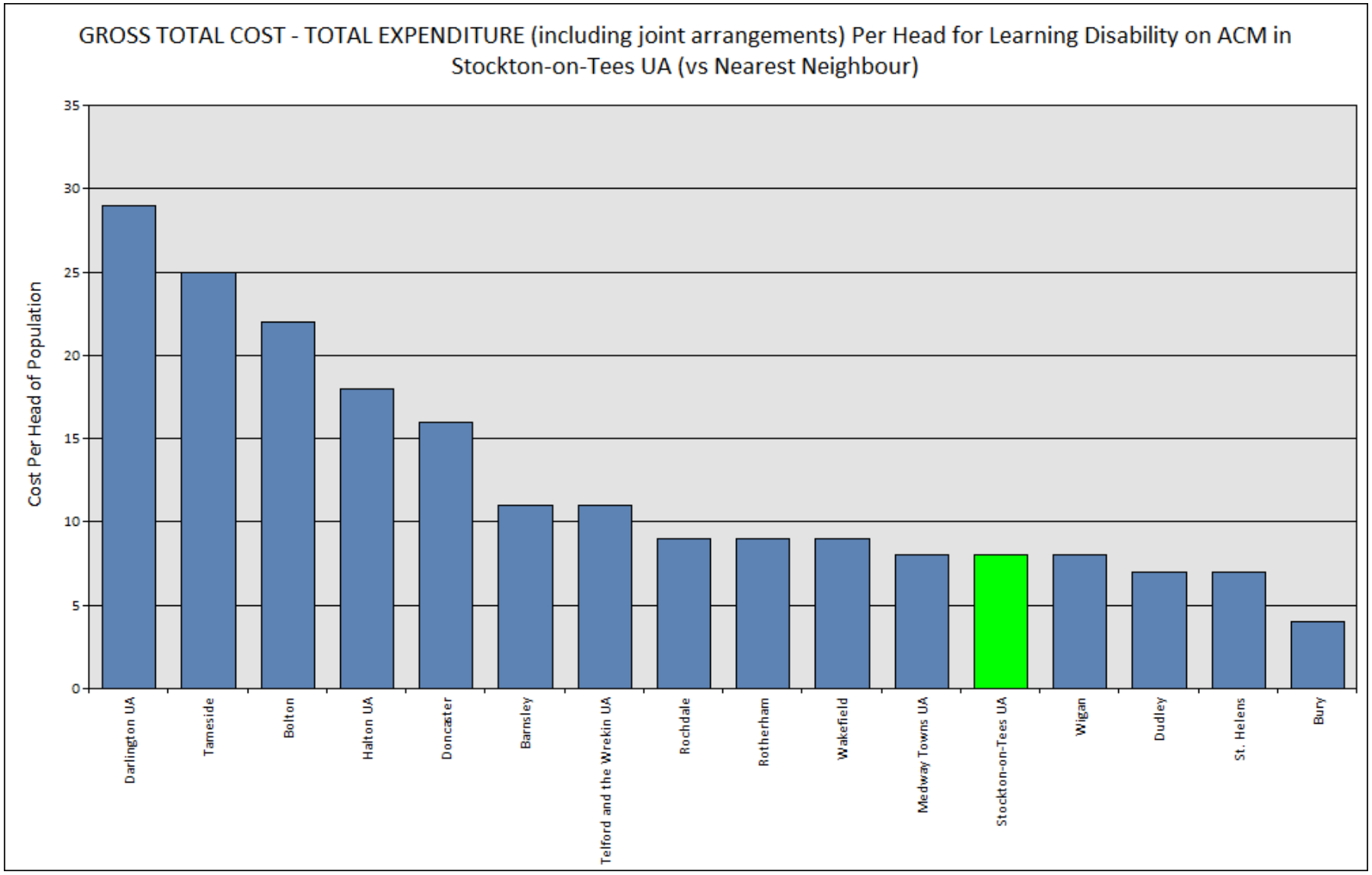
Shifting the balance of support is not without its risks:

- Unit costs for community based support (except home care) are above the average for Unitary Authorities, whereas
- Unit costs for residential/ nursing care are below average
- Staff tell us and our case reviews tend to confirm that there is a lack suitable housing with support for people with LD to live in the community in Stockton
- At £8 per head aged 18-64 spending on Assessment and Care Management (ACM) is comparatively low at present i.e. only four of the comparative authorities spend less on ACM. It will be important to ensure there are sufficient ACM resources to support increasing numbers in the Community

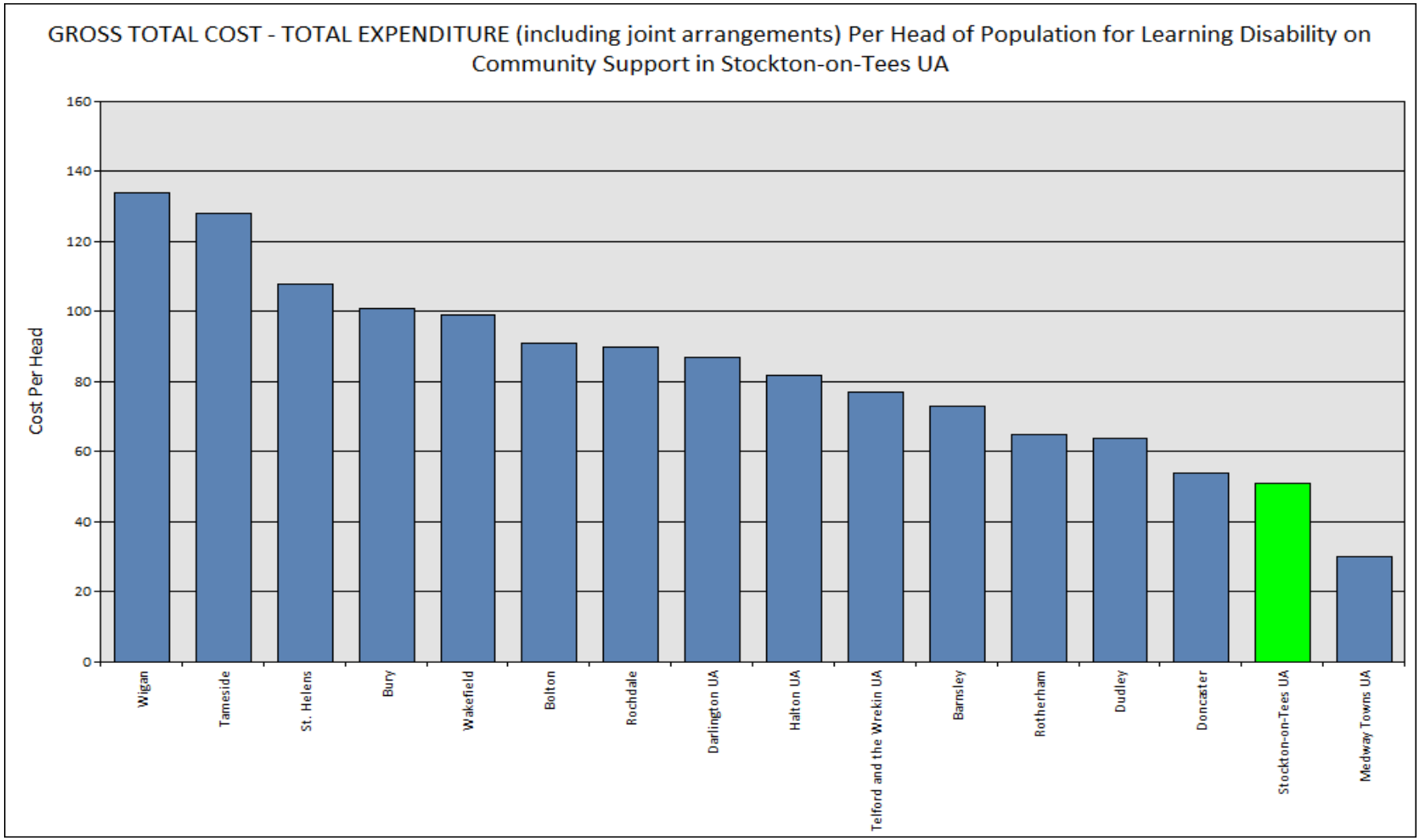
Conclusion:

- Making savings by substituting community based care for residential care will not always be straight forward and Stockton needs to ensure it:
  - Develops a wide range of affordable community based support services for people with LD,
  - Has sufficient ACM resources to review the cost effectiveness of current care and support packages and support an increasing number of clients in the community.

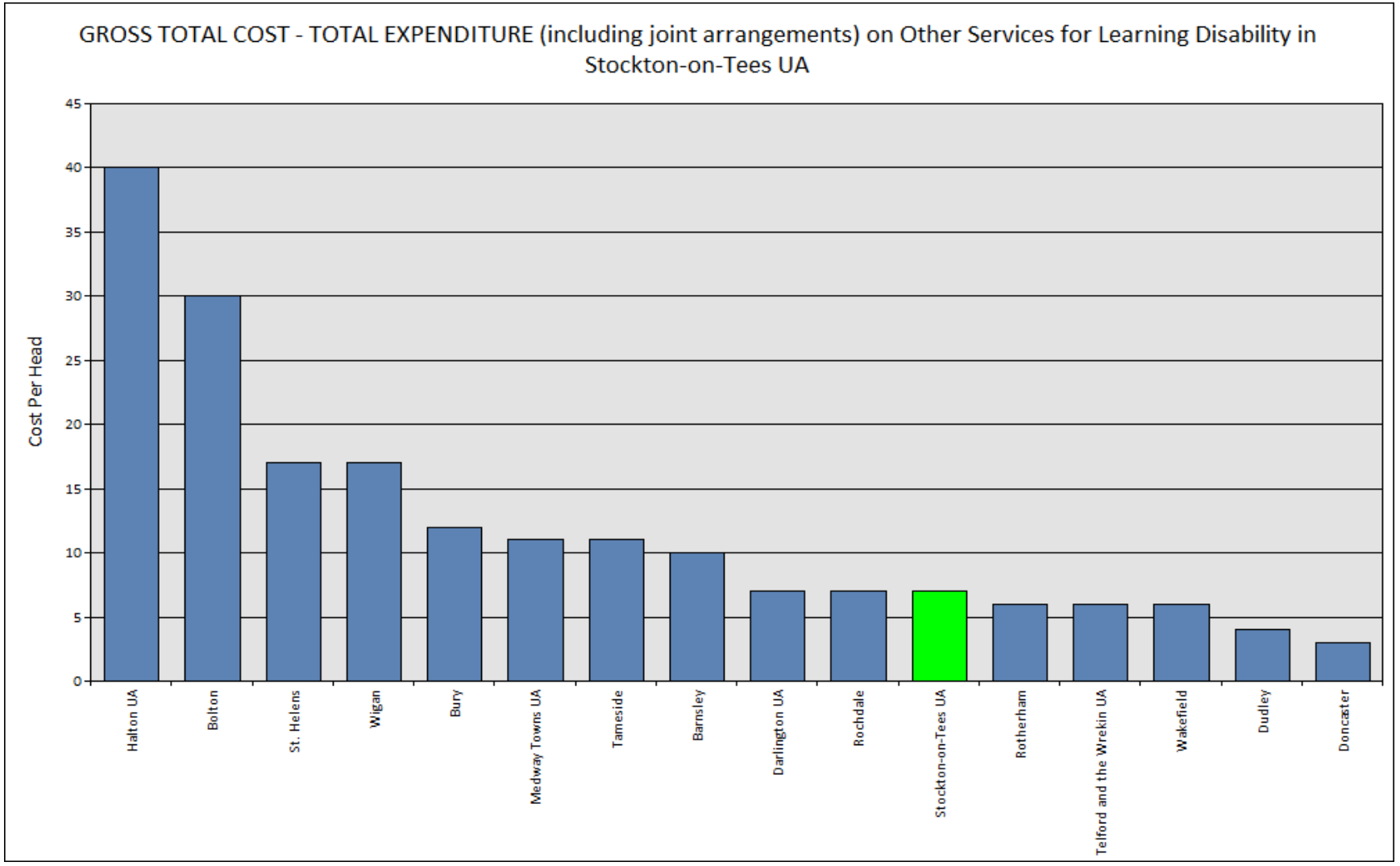
At only £8 per head spending on ACM is below the average for the comparison group i.e. only four of the comparable authorities spend less per head on ACM.



At £51 per head spending on "Community" support is the 2nd lowest level in the comparison group i.e. there is scope to increase spending on "Community" support as an alternative to residential care where community based support is more cost effective for individual clients.



At £7 per head spending on "Other" support is also relatively low i.e. 6th lowest in the comparison group. This gives further evidence that a shift in resources from residential care towards Community/ Other support should be possible.



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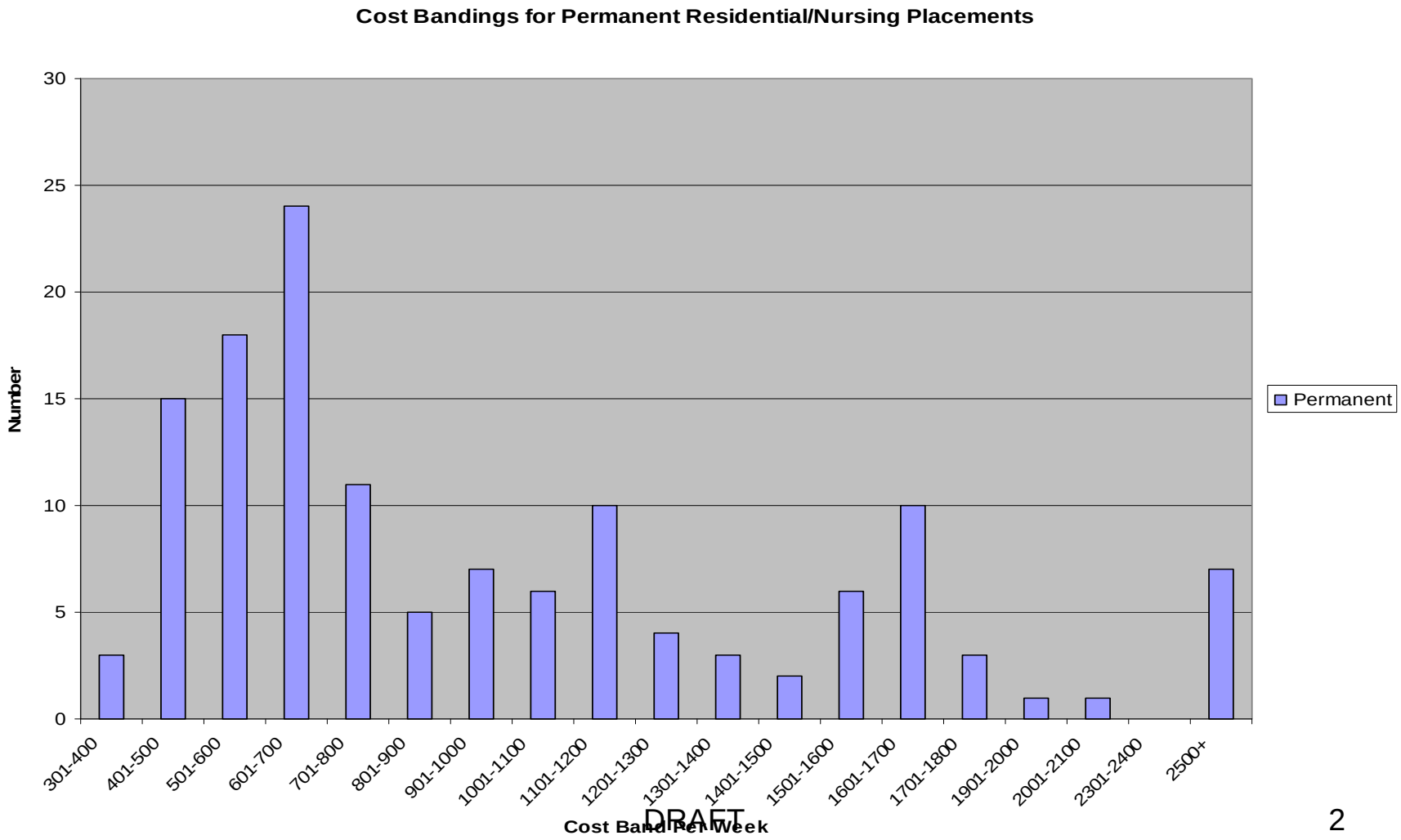
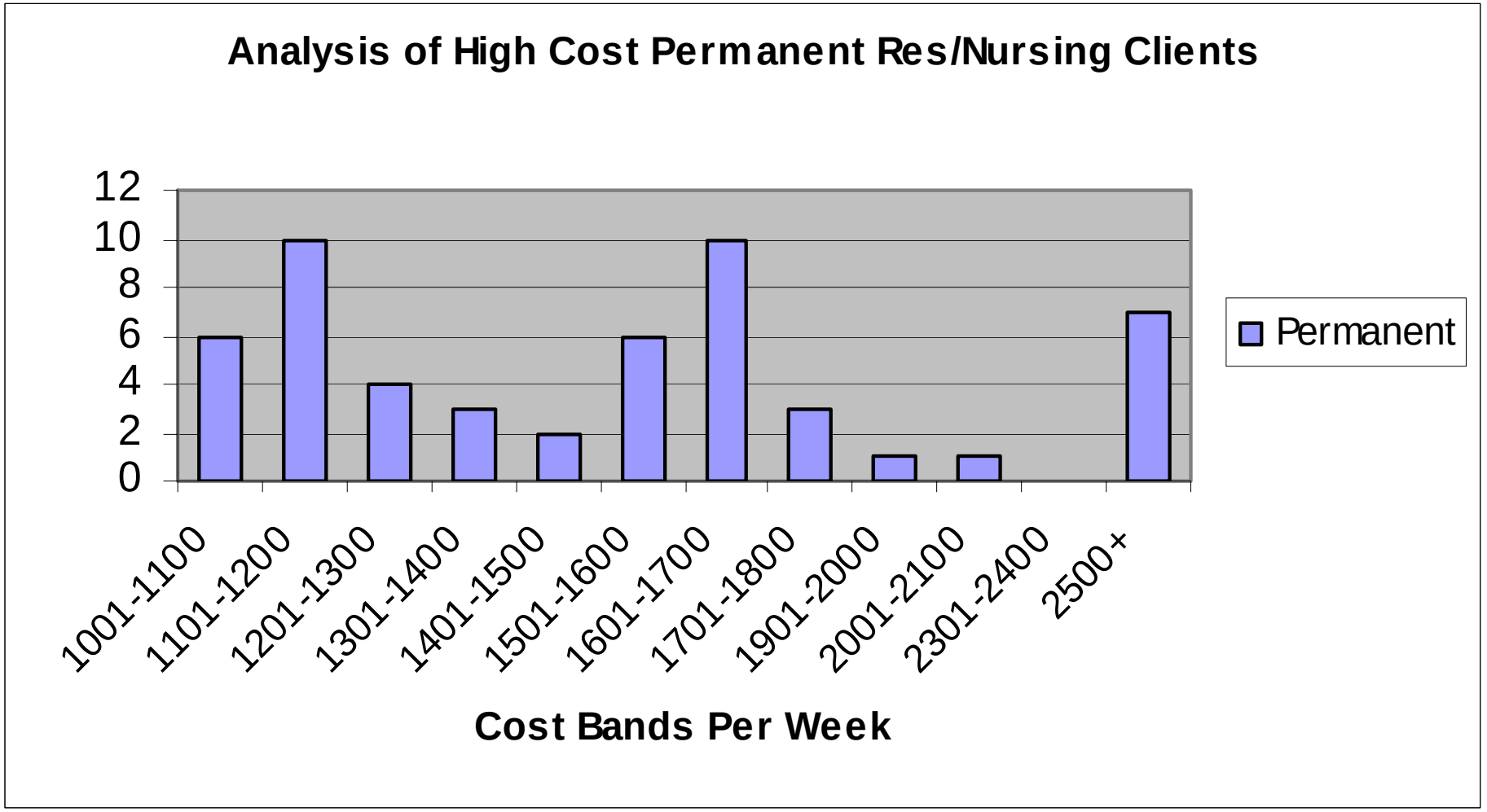
Stockton – Learning Disability Opportunity Assessment – Annex B Local Data

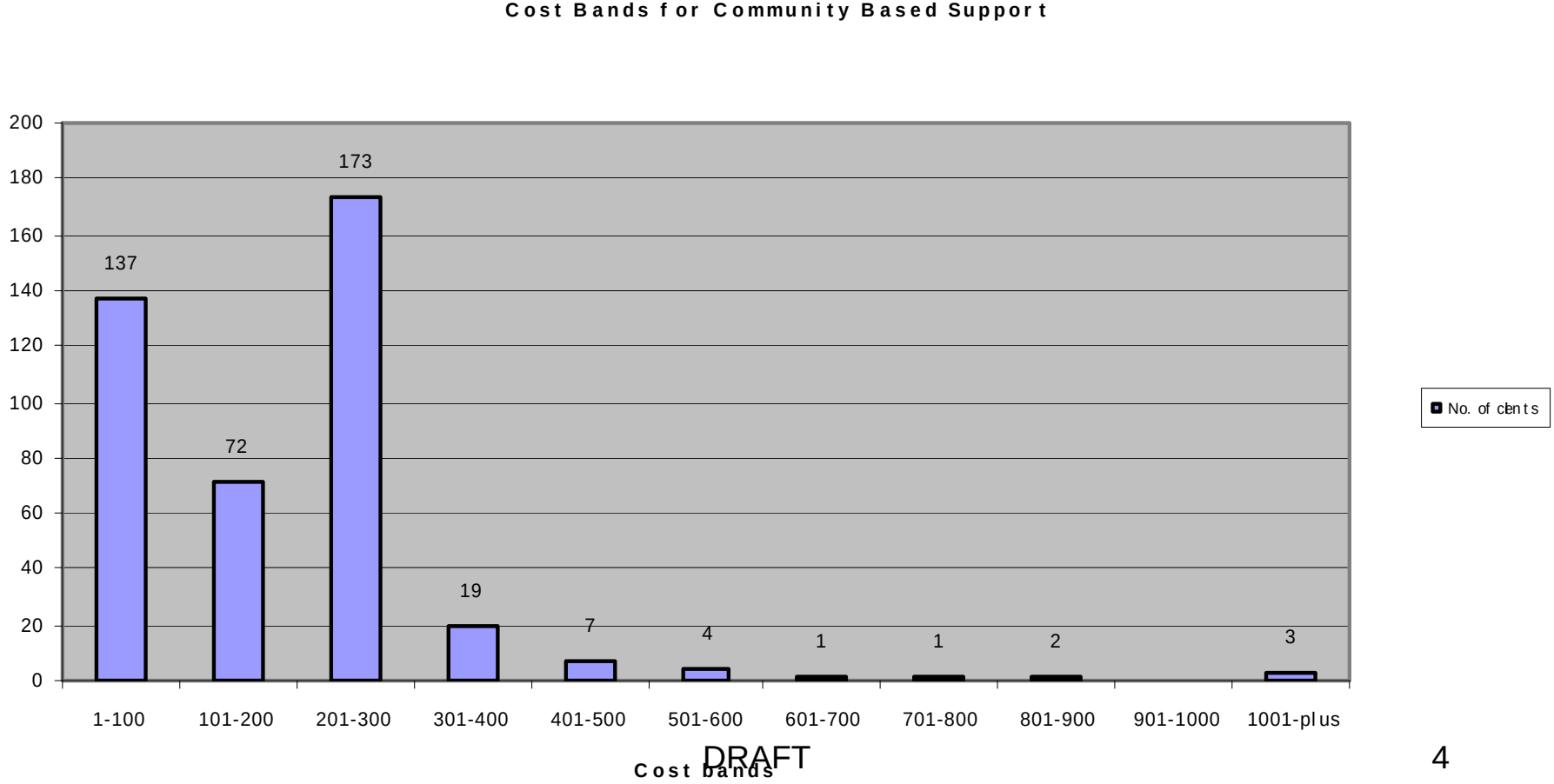
Assuming lower cost = lower needs, at 28th February 2010 Stockton had 60 residential clients costing £300-£700 p.w. Most (but, not necessarily all) candidates for "step down" to community support will be in this sub-population.



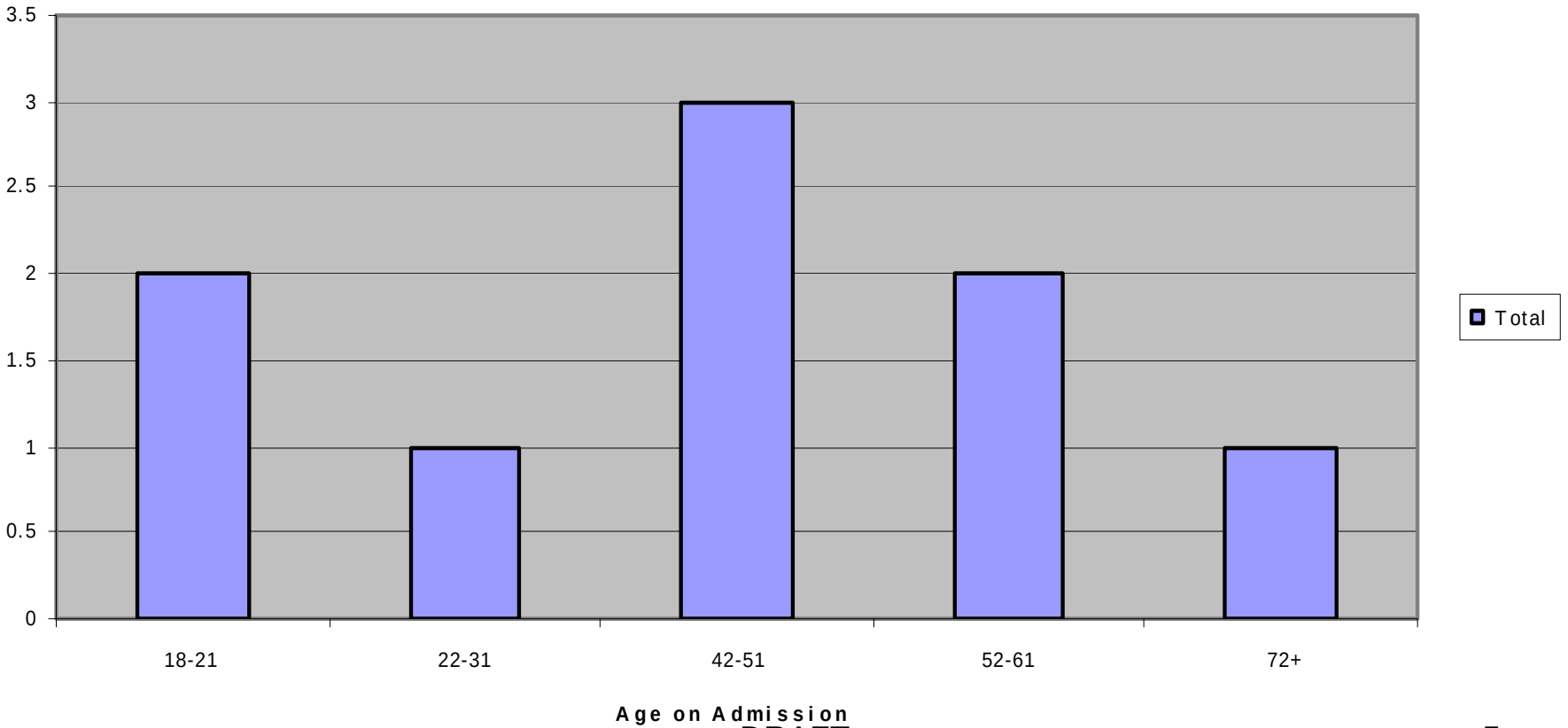
There are at least 53 residential/ nursing placements that cost more than £1000 p.w. Annual expenditure on these is in the region of £4.4m i.e. a 10% saving = £440k, 20% = £880k. Additional savings may also be available by reviewing high cost community packages although at 28th February 2010 there were only 3 community packages costing more than £1,000 p.w.



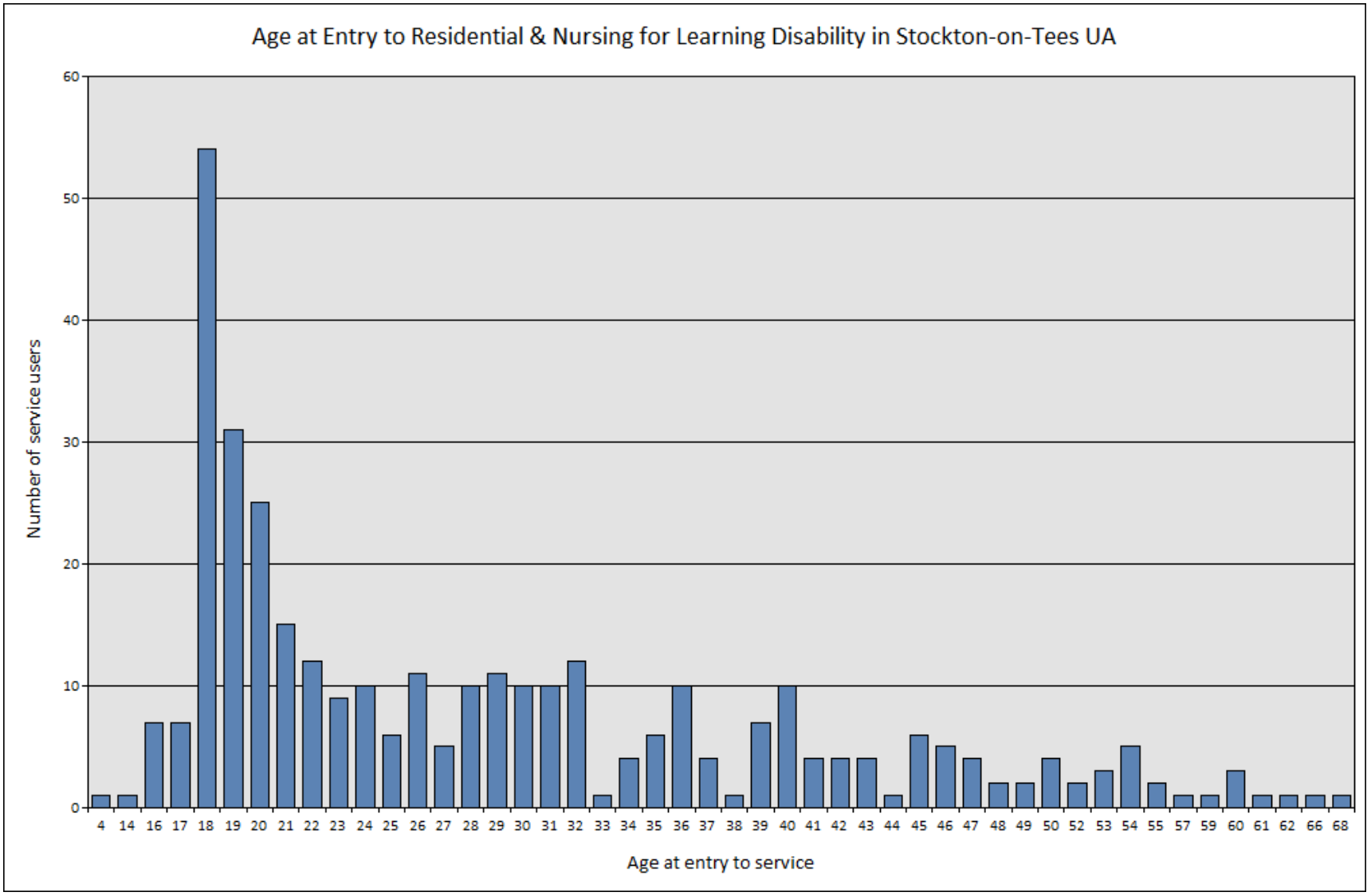
At 28th Feb 2010 Stockton had 60 LD clients with community based support packages costed at £1-£99 p.w, plus another 77 uncosted with low level support. Case files show that some low levels of support are "historic" and a proportion of this group of people could probably "move on" to even greater independence. Annual spending on this group is in the region of £350k i.e. a 10% reduction would save £35k p.a. and 20% would save £70k p.a.



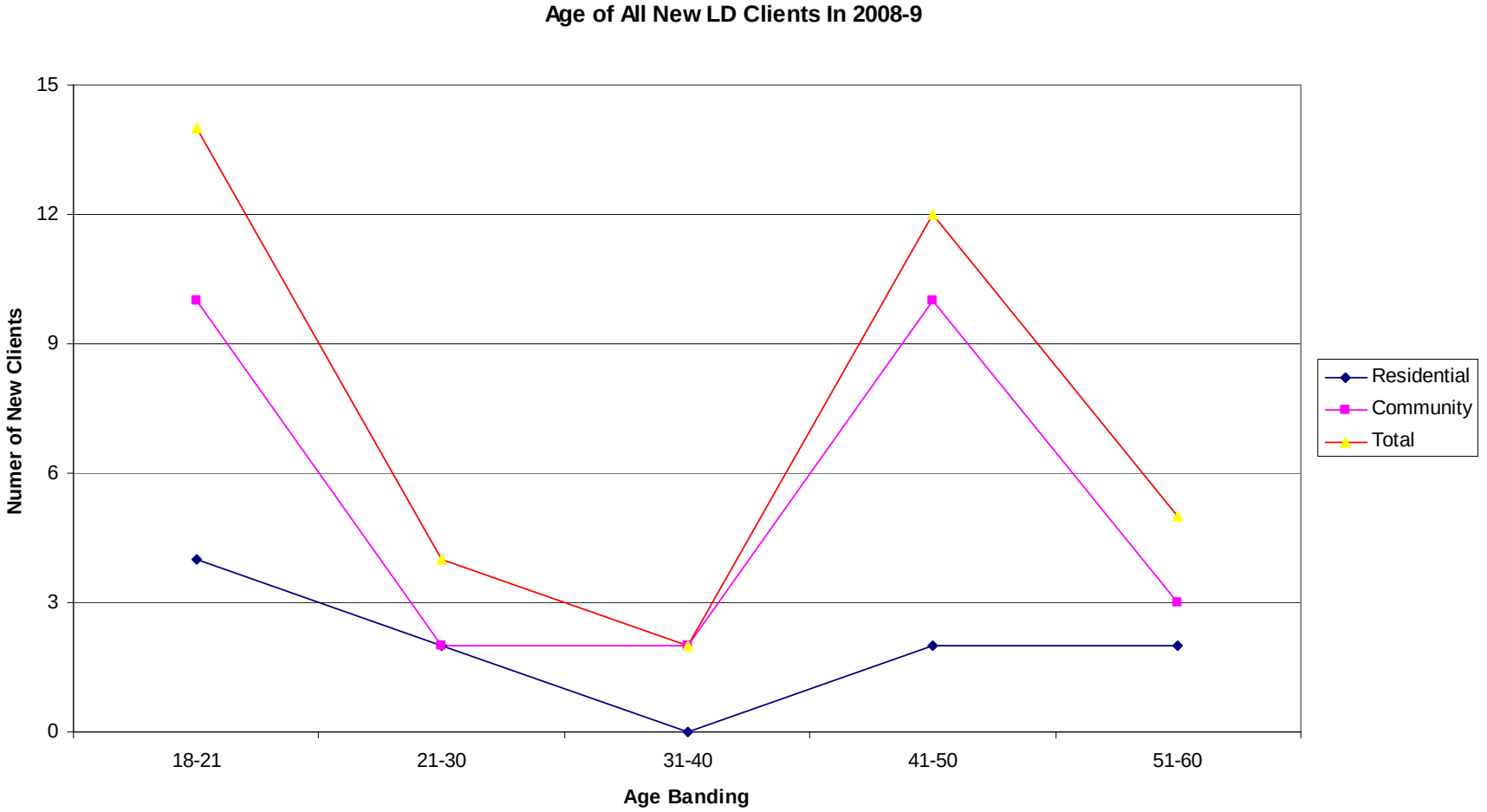
There were 9 new entries to residential care in 2008-9. Of these:
- 2 were transitions from children's services aged 18 to 21
- 5 were mid-life transitions aged 42 to 61
Targeted daily living skills training might lower the proportion of transitions to go into residential care.



An analysis of the age of entry of all residential/ nursing clients shows how important it is to manage transitions from Children's Services.



In 2008-9 Stockton had 33 new LD service users. There are clear peaks when people are in transition from Children's Services (42%) and in mid life (also 42%). 1/3rd (11) entered residential care and 2/3rds were supported in the Community.



“Sleep In” night cover is estimated to cost £225k p.a.

- At 28th February 2010 40 LD clients had “Sleep In” night support
- Average net weekly cost was £107
- Estimated annual cost = £225k

Savings Scope: The deployment of AT with an on call response support team could yield savings of between £25k p.a. and £45k p.a.

Annual LD Transport Costs are estimated to be around £365k.

- Based on snap shot at 28th February 2010
- 187 LD clients had transport support
- Average journey cost was £4.10
- On average they had 9.13 journey's per week
- Average cost of transport was £37.42 p.w.
- Projected Annual Cost = £365,000

Savings Scope: Support with route planning and the deployment of AT to support people on journeys could yield savings of between £35k and £70k p.a.

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Stockton – Learning Disability Opportunity Assessment – Annex C Review of Case Files

Stockton LD Case File Review

- Cases reviewed:
- ➢ 26 most recent Residential Care and Nursing Care placements (although some turned out to be transfers).
- ➢ 14 most recent reviews.

RC and NC Cohort

- 11 were new placements from home.
- 1 was previously self funded RC.
- 5 were transfers from another RC home.
- 1 was from a hostel.
- 1 was from Supported Living.
- 1 was from an APS to NC.
- 2 were transfers from RC to NC.
- 1 was from extended respite placement.
- 2 were transfers from RC to Supported Living.
- 1 was from a foster home.

Admissions from Home – age range

- 4 people were 19-29 yrs old.
- 1 person was 30-39 yrs old.
- 2 people were 40-49 yrs (transfers to SL).
- 2 people were 50- 59 yrs old.
- 1 person was 60-69 yrs old.
- 1 person was 70-79 yrs old.

FACS Criteria

- 7 were deemed to be Critical.
- 18 were assessed as Substantial.
- 1 was deemed to be Moderate.

OOC/County Placements

- 4 were placed in OOC specialist college.
- 9 were placed in OOC RC.
- 1 was placed in OOC NH.
- 10 were placed in county RC (+ 2 transfers to SL).
- 2 were placed in county NH.

Review Cohort

- 5 were reviews where the individual was in a RC/NC home.
- 7 were reviews where the person lived with parents.
- 2 were reviews where the person was supported independently in the community.

Key Findings From The Case File Review

Issue 1: A well balanced risk assessment undertaken with service users, carers and providers can reduce the need for support and over provision.

13 of the cases reviewed suggested a risk averse culture leading to over provision for people in residential care (RC + additional 1:1 support hours allocated + day services/opportunities), supported living or at home with family.

e.g.

- *JD– 25 yr old woman. £763 wk. Previously a self-funder who moved from a hostel to RC with 1:1 + DS 5x wk.*
- *DA – 32 yr old woman. £1,195 wk. Previously lived at home with support from parents and care package costing £375 wk + ILF . Now has RC with 1:1 + DS 5x wk .*
- *IO – 44 yr old man. £1,005 wk. Moved from RC to SL with 24/7 cover and DS 5x wk.*
- *KL - 42 yr old woman. £666 wk. for home care 31.5 hrs wk. (shared costs with flat mate), including 5 hrs flexible hrs over w/end; shared sleep located in another house shares (costs between 4), DS 5x wk + £251 transport.*

A risk averse culture may lead to over provision.

Issue 2: Support to carers can delay or prevent high cost provision.

- In most of the cases reviewed, separate carers' assessments were not in evidence.
- Little mention of support/ services to carers on some files e.g. respite, social work support/casework; some use of DP's.
- Only 3 cases seen where more support to carers **might** have changed outcome and prevented admission to residential care and 2 more cases where this was less likely (see notes).

e.g.

- *WJ – 74 yr old man.£420 wk. Cared for by sister and brother in law who were unable to cope any longer. Received respite.*
- *RL – 40 yr old man. £1,700 wk. joint funding .Cared for by parents in 80's. Unable to cope any longer. Went to DS 5xwk.*
- *CG – 51 yr old woman. £953 wk. Cared for by sister who worked and no longer able to cope. Received DS 5x wk, DP, home care, community support and respite.*

Inadequate support to carers sometimes leads to family breakdown and crises that are resulting in more expensive care needs.

Issue 3: Good reviews that explore a range of opportunities and options with service users, carers and providers can lead to less dependency and lower support costs.

- Reviews were timely in most cases but the quality was found to be variable. They generally looked at quality of current services and whether needs were being met but not at cost or value for money.
- About 50% of reviews did not seem to prompt changes or strive to promote independent living but seemed to accept the status quo.
- Issues/alternative service solutions identified at review were not followed through but no reasons given e.g. referral to Assertive Outreach team and for Person Centred Planning.
- There was some evidence of a minimal reduction in costs following review in 3 of the cases seen. 4 increased and 7 remained the same.

Case Examples

- *KL - 42 yr old woman. £666 wk. for home care 31.5 hrs wk. (shared costs with flat mate), including 5 hrs flexible hrs over w/end; shared sleep ins located in another house (costs shared between 4), DS 5x wk + £251 transport. OT assessment states very able. How is progress being monitored? Possible use of telecare for travel support and night time cover. KeyRng also a possibility.*

- *MM - 42 yr old man in RC £1,100 wk. Possible he could manage with reducing support in RC using assistive technology to monitor epilepsy; currently pay for overnight supervision. Alternative support related housing also possible e.g. Smart.*

- *LP - 42 yr old woman. £80 wk for 5 hrs community support. Referred to Assertive Outreach for grief issues but outcome unknown .Lives with father. No reference to learning daily living skills to promote independence and prevent more expensive care, possibly RC at a later date.*

- *AM - 44 yr old woman. OOC RC £738 wk in 2007. Attends college for skills development, literacy etc. but no clue as to how these have increased. Review does not explore alternatives. SL may be an option. File states that she is motivated to do a lot of things and although needs support in many areas could be encouraged to develop further skills. This seems not to be followed up.*

- *FL - 52 yr old woman. £546 for interim RC+ £254 for DS + £41 for transport = £841 wk. Plan to reduce DS to 2-3 hrs and move towards SL. The longer she is in RC the more dependent she will become. What is happening re developing life skills at the DS? What is the RC doing to help gain skills and promote independence?*

Some reviews are failing to promote independent living and the potential for change. These result in inefficient support that and do not enable effective outcomes.

Issue 4: Quality support plans (PCP) that are ambitious and innovative can be more efficient and effective.

- Some good care plans were seen that explored and eliminated service options for individuals where the reasoning was evident and the best service choice made within existing resources. The good plans tended to include the use of telecare and were clear about objectives e.g. to reduce packages as skills developed.
- However, plans on a number of case files lacked ambition and innovation, focussing on what the person was unable to do rather than what their aspirations were and what they wanted to achieve. i.e. the medical rather than the social model of disability.
- In most cases it was difficult to 'hear' the users voice; carers views were better noted.
- Practitioners say they have had no training in PCP and that referrals can only be made to one person to provide this service. They get no feedback as to whether the plan has been completed or its content to inform the care and support package. e.g.
  - *JD– 25 yr old woman. £763 wk. Previously a self-funder who moved from a hostel to RC with 1:1 + DS 5x wk. Plan does not explore alternatives or opportunities; mentions funding would be required if attended college but not pursued. Focus on physical/practical needs.*
  - *RL – 40 yr old man. RC. £1,700 wk joint funding. Cared for by parents in 80's. Unable to cope any longer. Went to DS 5x wk. Plan does not explore alternatives or opportunities such as potential for employment.*
  - *RD – 57 yr old man. £348 wk. Previously lived at home with brother and then rehab unit. Now in RC with 1:1 2 hrs wk. Plan does not pursue alternative housing options.*

Some times unimaginative support planning is not achieving change or promoting independent living at lower cost.

Issue 5: Outcomes based SMART objectives that are agreed and monitored with providers offer an incentive to achieve change.

- Many care and support plans seen lacked clear objectives of how needs would be met so there was no way of monitoring progress with providers.

- In particular, there seemed to be a general lack of plans for skills development or training for employment opportunities by provider organisations especially day services.

- Where objectives were set, close monitoring was not apparent so that resources could be changed and people moved on in a timely way; it may be that lack of appropriate resources meant there was no where to move them onto?

- Evidenced in same case examples as previous slide (and notes).

Additional Examples

- *AM - 44 yr old woman. OOC RC £738 wk in 2007. Attends college for skills development, literacy etc. but no clue as to how these have increased. Review does not explore alternatives. SL may be an option. File states that she is motivated to do a lot of things and although needs support in many areas could be encouraged to develop further skills. This seems not to be followed up.*
- *FL - 52 yr old woman. £546 for interim RC+ £254 for DS + £41 for transport = £841 wk. Plan to reduce DS to 2-3 hrs and move towards SL. The longer she is in RC the more dependent she will become. What is happening re developing life skills at the DS? What is the RC doing to help gain skills and promote independence?*
- *KL - 42 yr old woman. £666 wk. for home care 31.5 hrs wk. (shared costs with flat mate), including 5 hrs flexible hrs over w/end; shared sleep ins located in another house (costs shared between 4), DS 5x wk + £251 transport. OT assessment states very able. How is progress being monitored?*

A lack of goal setting and evaluation leads to low through put with some people getting stuck in 'the system' and resources remaining static. This is leading to over supply and over provision.

Issue 6: Effective planning for tansitions informs commissioning, leading to appropriate and more cost effective supported living/housing options.

- Where transitions planning is not robust and timely, residential care placements are likely to increase out of county especially for specialist provision whereas local supported living/other housing options might be the preferred solution. Noted in 5 cases:

e.g.

- *OS – 19 yr old man. £2,936 wk. Specialist OOC college placement.*
- *RW – 22 yr old woman. £1,730 wk (50% CHC). Specialist OOC college placement .*
- *JS – 20 yr old man. £1,434 wk. County RC home. APS proposed but not realised.*

- Future plans also need to be clear for young people living at home and attending college otherwise 'drift' may occur and aspirations unrealised.

Lack of effective transitions planning can put pressure on residential care budgets over a longer period of time in both children to adult services, and adult services to older people's.

Issue 7: People with support needs, sometimes of a minimum nature, can be catered for at lower cost for longer, sometimes avoiding residential care, through better service solutions.

- This issue can occur when better service solutions are not pursued even when identified in support plans.
- In the case file review this was seen in at least 9 cases:

e.g.

- *JS – 20 yr old man. £1,434 wk. County RC home. APS/SL proposed but not followed through.*
- *CH – 58 yr old man. £653 wk. Admitted to RC from home. Plan is good as it explores needs widely. Looked at share for SL but first match not acceptable and seemingly not followed up.*
- *DA – 32 yr old woman. £1,195 wk. Possibly over resourced package including RC, 1:1's and DS. Asked for SL; file says this will be looked at when settled in RC. "Health needs are not complex and are stable and predictable; no interacting symptoms that are difficult to control or manage . Care is given at routine intervals".*

Premature placements of people with minimum support needs into residential care some times leads to long-term institutionalisation and incur longer-term costs .

Issue 8:Assessments/reviews/support plans that address change and potential emergencies will help to prepare individuals and carers for the future.

Although individuals/carers may have some input from DS, community support services or DP, unless this is tasked with increasing independence , there is risk of RC/NH in later life.

7 cases were seen where this might occur. Three examples include:

- *JB - 56 yr old. Lives with sister since mother's death. DP £153 p.w. (8 hrs to relative and 1 overnight respite).*
- *LP – 42 yr old woman. Lives with father. £79.45pw - 5 hrs community support.*
- *KG – 21 yrs. Lives with parents and brother. Received 10 hrs DP for skills development. Was at college. Cancelled due to ill health.*

11 cases were seen where this had occurred. Three examples include:

- *WJ - 74 yr old man. Placed from sister's home. Unable to cope.*
- *JD - 53 yr old woman. Admitted when father died.*
- *DA - 32 yr old woman. Lived with parents; dependent on them for all care needs.*

Individuals who remain at home with minimal or no support are at greater risk of RC/NC when parents/family die or who are no longer able to cope.

Issue 9: Interim placements, sometimes made in a crisis, with resultant long term residential care costs can be managed better and at lower cost by improved planning with service users, carers and providers.

- This issue can arise due to lack of planning and/or appropriate housing provision especially supported living accommodation.
- Majority of people appear not to have been admitted to RC in a crisis.
- Interim placements can drift rather than clear goals set to “move people on”.
- This was seen in at least 5 cases. Three specific example are:
  - *FL - 52 yr old woman. £546 for RC+ £254 for DS + £41 for transport = £841 wk. Placed from hospital with a view to SL.*
  - *CH – 58 yr old man. £653 wk. Admitted to RC from home. Looked at share for SL but first match not acceptable and seemingly not followed up.*
  - *DA – 32 yr old woman. £1,195 wk. Possibly over resourced package including RC, 1:1’s and DS. Asked for SL; file says this will be looked at when settled in RC.*

Interim placements in residential care due to crises can drift and become long term causing institutionalisation and incurring longer-term costs.

Issue 10: Avoiding out of county placements can reduce pressure on budgets and enable better planning with individuals and providers.

- In 18 cases people were placed out of county
- In 8 cases this was to secure specialist provision for autism, mental health needs or for dementia
- This suggests that collating unmet needs and service deficits from care plans will better inform demands forecasting so that commissioners can improve planning.

A lack of planning with service users, carers and providers sometimes leads to the inappropriate continuation of costly out of county placements often with long term financial commitment.

Issue 11: Proactive market development and engagement with housing providers builds a wide range of flexible, readily available housing options

- Lack of 'join up' with Supporting People initiatives seen in case files; unknown if any of support costs are SP funded or if SP is additional.

- Deficit of suitable 'high level' and other supported living accommodation leading to over servicing and the use of OOC resources (linked to Issue 9).

e.g.

- *CG - 51 yr old woman with Down's syndrome and dementia in OOC RC placed from sister's home. 'Extra support' model is suggested on a 'core and cluster' basis.*
- *EA - 53 yr old man and RH, 66 yr old man both with LD and dementia also might have been accommodated in an extra support housing model.*
- *WJ - 74 yr old man with LD. Placed from sister's home into RC. A different 'extra support' model is suggested.*

An undeveloped market limits the supply of housing options and choice for service users as well as increasing spending through the over provision in residential care or high level supported living resources whilst waiting for appropriate accommodation.

Issue 12: The appropriate use of telecare can support re-skilling, promote independent living and help to manage risk.

- Telecare has real potential to impact on staffing budgets e.g. as a substitute for ongoing domiciliary support, transport etc.

- Practitioners are generally unaware of the potential of AT although it had been used in 3 cases reviewed (i.e. CH – 47 yr old woman, IO and GO – 44 and 40 yr old men moved to SL. Additional potential for waking night cover?)

- Additional possible opportunities seen in case examples:
- *MM - 42 yr old man in RC £1,100 wk. Possible he could manage with reducing support in RC using AT to monitor epilepsy; currently pay for overnight supervision.*
- *KG - 21 yr old woman, FL - 52 yr old woman, WK - 21yr old man, AG - 46 yr old woman, LB - 24 yr old woman all of whom have transport costs paid but who may have potential to use telecare as a substitute. Ditto OS – 19 yr old man in the future.*

The under use of telecare is limiting the range of service solutions that are available i.e. efficiency opportunities are being missed.

Issue 13: Support related housing models such as KeyRing can decrease dependency and increase confidence as well as help to develop social capital in local communities.

- Supported Living has already been identified as a service required in a number of cases.
- Future potential for a less intensive support related housing model such as KeyRing was seen at least 6 cases:
- *OS- 19 yr old boy at special OOC residential college for a year. Has been referred for SL.*
- *RW - 22 yr old girl special OOC residential college.*
- *KL - 42 yr old woman, IO – 44 yr old man and GO – 40 yr old man all recently moved into SL.*
- *WK - 21yr old man currently living at home and attending college.*
- The development of range of other support related housing models would potentially meet the needs of 50% or more of the people reviewed all with a view to decreasing costs or being cost neutral e.g. Extra support model.
- Any SRH models developed should aim to develop daily living skills and reduce dependency and be contracted on the basis of outcomes achieved.

The under use of support related housing is limiting the range of efficient and cost effective service solutions available to people with LD.

Issue 14: Contract prices for external provision that are negotiated centrally are more consistent in meeting similar needs.

- The care funding calculator used as a negotiating tool with should help secure a better and more consistent price .
- The establishment of a brokerage service would release A & CM capacity and develop capability.

e.g.

- *MH - 31 yr old woman. Care package increased from £314 p.w. at home to £1600 p.w. (50/50 with health).*

- *OS- 20 yr old boy at special OOC residential college for a year. Has been referred for SL. Costs £2,936 p.w.*

- *RW - 22 yr old girl also at special OOC residential college . £1730 wk. 50% CHC but seems to have more intensive care and support needs than OS above (2:1 for some things).*

Contracts that are negotiated by practitioners on an individual basis with providers do not always achieve value for money.

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Annex D – Learning Disability Good Practice Support Services - Case Studies

SMaRT - Support Management and Response Team - Nottingham Community Housing Association

Background
The SMaRT service covers over 1,000 people living in supported accommodation and in their own homes. This includes people with learning disabilities, mental health needs, homeless people, female victims of violence, ex-offenders and people with drug and alcohol issues. People can press the SMaRT button in their home to speak with an experienced support worker. If necessary, a mobile response team can swiftly attend.
Benefits
The service has directly saved over £0.5 million per year by replacing night staff and making sure that access to floating support is better linked to need. The service enables people who would otherwise be in high cost residential care or hospital to live in their own homes.

Doing it Your Way - Worcestershire County Council

Background
Doing it your way is the first stage of implementing self-directed support in Worcestershire. The project has so far supported 73 people with learning disabilities and their families to plan new individualised support arrangements, making use of a range of housing options linked to flexible support. James, aged 25, moved from living with his parents to his own adapted bungalow bought through shared ownership. His parents continue to provide part of his support. After 30 years of living in residential care, Donna has moved into her own home, employing personal assistants to provide support. She is now a volunteer in a local charity shop.
Benefits
Outcomes: Improvements in health, control, dignity, safety and social contact. Costs: Estimated cost saving to the council is 16%, around £400,000 per year (compared with residential care or conventional supported accommodation)[1]

[1] An evaluation by Worcestershire CC and In Control is available at www.dhcarenetworks.org.uk/Personalisation/PersonalisationResources/Type/Resource/?cid=5311

Modernised Day Opportunities for Adults with LD - Thurrock

Background
Thurrock started by closing all of its large multi-purpose day centres, recognising that a combination of the running costs of the centres and transport costs contributed to a high level of the costs. There are a number of strands to the new opportunities programmes. Shop frontages around the borough have been rented in key locations on bus routes where people can come as a base to undertake day opportunity programmes. A community company – Thurrock Lifestyle Solutions – with 7 Directors with learning disabilities (supported by staff) was set up to run the services that people need.
Benefits
The most important part of the service is flexible staff available to work with individuals or groups on the opportunities that they have identified will meet their outcomes. The programme has a budget of £1.5 million for about 140 people. £1 million of this is in fixed costs (mostly staffing) with £500,000 directed towards personal outcomes – about £70.00 per person per week. Thurrock say that freeing up that level of resources is what has assisted them in transforming their services.

Hollingside - Supported Living as an Alternative to Residential Placements for Adults with Learning Disabilities - Redcar

Background
Redcar and Cleveland's LD budget has experienced severe growth pressures in recent years. Commissioners identified that one reason for this was a shortfall in supported living alternatives to residential care for adults with mild LD. Their solution was to develop Hollingside. It opened in 2007 and has six self-contained flats for people with mild LD with on site support in the day. Most of the tenants moved into Hollingside from a residential college or following the collapse of a tenancy i.e. despite only having mild LD all tenants need to develop their individual living skills. Without these skills, residential or 24-hour supported living would be needed.
Benefits
The net cost (after rents) per customer at Hollingside for 2007-8 was around £5,820. This compares favourably with the costs of supporting the tenants in alternative settings i.e. 3 of whom would require a local authority residential home, 2 a local authority homeless hostel and 1 a local authority residential mental health facility. The estimated full year savings on ongoing support costs for the 6 current customers in 2007-8 were in the region of £105,000. Support levels have recently increased, but annual savings of £75,000 p.a. or £12.5k per person are still anticipated.

Returning High Cost Out of Area Placements – Coventry

Background

Coventry identified 113 individuals with Learning Disabilities who had been placed in Out of City Placements. The aim was to enable people to have the choice to return home. A Change Team was established to create the service specifications and models for new services needed and to co-ordinate the change processes for individuals.

Over the past three years, approximately £3.2 million from the Council's Strategic Housing Regeneration Fund (SHRF) was used to fund the development of supported living schemes for people with learning disabilities. This enabled a joint commissioning plan which delivered 8 new supported living schemes and 5 specialist residential schemes, creating 84 new places (57 supported living and 27 residential) to be implemented.

Benefits

This approach has supported people to achieve their outcomes of moving from residential care to supported living, or back to residential care in Coventry with the aim of living more independently in the community.

To date 76 people have moved, with 20 people returning to Coventry from out of city placements. No one has been required to leave the city due to a lack of appropriate living options over the past two years.

In summary, the cumulative local authority efficiencies from 2006 to 2009 are £416k. Efficiencies have also been delivered for the PCT.

KeyRing Living Support Networks

Background
Living Support Network's (LSN) are networks of people who need some support to live safe and fulfilling lives in the community. Each LSN aims to stimulate mutual support by Members and a volunteer helps each Member to realise their full potential by fully using their talents. Typically, a Network has ten people. They live in properties (from all types of tenure) in a defined geographic area. People with support needs occupy nine properties and a Community Living Volunteer lives rent-free in the tenth and provides at least 12 hours of their time each week to support Members flexibly and to encourage peer support.
Benefits
To assess the cost effectiveness of LSN's CSED reviewed 3 networks in detail. It found that each LSN was cost effective as each substituted for alternative forms of support that would have cost more e.g. floating support and day care. Members also tend to approach the volunteer in the first instance. This saves social services duty team resources. In summary the 3 networks supported 26 people for an annual cost of £110k and net benefits were calculated to be £36k.

Assistive Technology (AT) - Cheshire

Background

Cheshire aimed to improve risk management in supported living accommodation, particularly at night time by ensuring that AT was a key consideration in all assessments. The main pieces of equipment purchased were door sensors so that people who needed support when they left their rooms could be given assistance when they needed it, epilepsy sensors which meant that thirty minute checks were no longer needed and bed sensors for people at risk of falling.

The response to any alarm alert is from staff on duty in the same accommodation as the service user, or accommodation nearby. The staff are employed by the provider to provide support to service users in the accommodation during the daytime and are learning disability trained staff. Alternatively one of the four local housing trust centres respond (on a geographical basis) and guarantee to attend any property in Cheshire, cross tenure, within one hour of an alert. This service is part of the service users' support plan and costs the Learning Disability service £9.52 per week. It is subject to the Fairer Charging policy although a charge is rarely levied on care/support packages for this client group. The type of response provided is dependent on the agreed risk assessment for each person.

As the small pilot was successful it was decided to expand and make technology available to people supported by in-house services - over 300 people. Social work teams are able to refer individuals whom they believe will benefit from some technological solution.

Benefits

Substantial savings have been made as a result of reviewing risk assessments in the light of the technology. In total, net savings for the financial year 2007/08 were estimated at about £200,000. This was predicted to increase in 2007/8 when the full year effect of savings, for example staff, is realised.