Making best use of reducing resources in adult social care

3. Optional tool 1
What good looks like

Self-assessment optional tools

Introduction

This tool is intended as an optional reference tool, which can be used to support the completion of a 'Use of Resources' self-assessment. It is the sequel to an equivalent tool that was produced in 2011/12, and has been updated to take account of more recent requirements for the sector such as the Care Act 2014 and Better Care Fund and more recent research.

It includes:

- **descriptors of 'what good looks like' for each of the headings in the self-assessment tool**
- **references to recent sources of research and guidance**
- **case studies and other case examples.**

The case studies are derived from the LGA's Adult Social Care Efficiency (ASCE) Programme that tracked the process of delivering efficiency savings in 44 locations over 2 years: www.local.gov.uk/productivity/-/journal_content/56/10180/3371097/ARTICLE

These are referenced as follows:

ASCE(1)
Adult Social Care Efficiency Programme, Interim report, 2013

ASCE(2)
Adult Social Care Efficiency Programme, Final report, 2014

ASCE(2) (Annexe)
Adult Social Care Efficiency Programme, Annexe to the final report, 2014.

In the context of sector-led improvement, we hope that councils will feed back about their experience of using this toolkit, and continue to share their own evidence of what is working (and especially local service evaluations).

What good looks like[1]

Prevention

1.1	Information and Advice[2]	• an information and advice strategy that complies with the requirements of the Care Act 2014, and is designed to ensure that the whole system is coherent and efficient • an 'asset-based' approach, that aims to build people's capacity to access and use information, and find good solutions for themselves • some targeting of information and advice (including health promotion materials) to 'at risk' groups and communities • specific advice (including financial advice) for self-funders who may be considering long-term care options, to help them make informed financial choices and to arrange their own support where possible • excellent operational coordination (including the sharing of databases) between information and advice providers across professional/governmental/sector boundaries, ensuring that the system is easy for people to navigate, avoids duplication and makes optimum use of all organisations' expertise and resources • online tools that help divert people away from formal social care to community based solutions that meet their needs • improvements demonstrated through public reporting on the effectiveness of information and advice (including customer satisfaction), in line with the Care Act guidance • success evidenced through the development of local performance indicators, including customer feedback (in line with Care Act requirements)
1.2	Initial Access	• an operational focus on responding to crises, on reablement, and on short term support, to minimise the number of people who need long-term care and support • specialist ASC first contact services (and/or integrated contact services) that focus on early intervention, prevention and safeguarding • effective early screening and signposting to a range of community based solutions • Success evidenced through a reduction in the percentage of new contacts that result in assessment and a long-term care package. (NB some councils have a target that 75 per cent of people who approach the council will be assisted so they need no further help.) **ASCE(2) Case Study: Calderdale's Gateway to Care** **ASCE(2) Case Study: South Tyneside's social care contact centre** **ASCE(2) Case Study: People2People in Shropshire**

1.3	Health and wellbeing[3] (See also section 6.2 – Building Community Capacity)	• community-wide strategies, 'owned' across council departments and by other agencies, to reduce health inequalities and promote social inclusion and active citizenship (See also section 5.1)
		• specific development activity (for example, to tackle social isolation, build 'dementia-friendly communities', and support carers) that is clearly linked to analysis of local needs and priorities (See also section 6.2)
		• evidence-based public health intervention, supported by local evaluation, addressing such issues as:
		◦ healthy lifestyles intervention such as smoking cessation, stimulating physical activity and a good diet
		◦ improved uptake of vaccinations
		◦ mental health promotion and mental illness prevention across all age groups
		• an operational focus on supporting and developing people to manage their own health and wellbeing.
		• Improved access to mainstream services and facilities (such as transport, leisure, cultural services and education)
		• universal access to some social care services such as simple aids to daily living and community alarms.
		Success evidenced; eg through evaluations of specific service interventions, and the use of outcome measures such as the NHS Outcomes Framework
		ASCE(2) Case Studies: see section 6.2 below

1.4	Targeted Prevention[4]	• sound analysis of the factors that put people at most risk of requiring greater care and support, and the groups that would most benefit from targeted early intervention.
		• targeted case-finding of at risk groups, supported by tailored interventions
		• use of the available national and local evidence on 'what works' and what is cost-effective
		• investment in primary and community health care services, targeted at conditions that are important for maintaining independence – eg
		◦ dental care
		◦ podiatry services
		◦ incontinence services
		◦ dehydration monitoring
		• falls prevention initiatives, underpinned by performance monitoring and evaluation
		• jointly agreed and implemented care pathways for people with long-term conditions, including:
		◦ integrated stroke pathways
		◦ early diagnosis and intervention for people with dementia
		• an implemented strategy to support carers, underpinned by analysis of the main local reasons for 'carer breakdown'. (A strategy is likely to be more cost-effective if it targets those most at risk; eg those caring for people with dementia, those who care for 30+ hours per week etc.)
		• success evidenced through the use of a local joint performance framework, which includes benchmarking where this is feasible, and is designed to capture both the cost-effectiveness of specific service interventions and the outcomes being achieved across the locality (See also section 5.1)
		ASCE(2) (Annexe): Stockton's targeted preventative approach

Recovery

2.1	Re-ablement for older people[5]	• A policy that no decisions will be taken about the long-term support plan until after a period of preventative intervention, or recovery and/or rehabilitation. Plus, a system that ensures that people's needs are kept under continuous review thereafter (and does not assume that their support plan will always remain the same). (See also section 3.1.) • Reablement being offered to many older people at risk of needing long-term support (including people with long-term conditions), but with targeting based on the council's experience during piloting and evaluation. (NB It is known that some people can recover without reablement, and some take longer than 6 weeks to gradually regain their independence.) • reablement staffed trained, equipped and performance managed in a way that maximises the number of people who are fully re-abled, and require no further support from the council (Target = 60 per cent) • adaptations, community equipment and telecare routinely considered as part of a reablement package • shared assessments and good operational coordination with community healthcare services – with straightforward access to occupational therapy and/or physiotherapy support where indicated; • good operational coordination with housing; a holistic approach that can address housing as well as health and social care issues • monitoring, review and challenge of the cost of the in-house reablement service (where applicable), including consideration of whether to commission this service from the independent sector • consideration being given (or steps already being taken) to extend reablement as an integral part of the adult social care approach – for example, reflected in domiciliary care contracts with external providers • SMART targets for the initial reablement period (eg relating to the cost of the reablement intervention, the number of people who will not require ongoing support after reablement, and the number who will require less support) • Success evidenced through use of a local performance framework designed to measure the costs and benefits over the medium term. (This is likely to encompass planned reductions in the use of home care, and in expenditure on home care, over time.) **ASCE(2) Case Study: An integrated approach to reablement in Torbay** **ASCE (2) Case Study: Wiltshire's Help to Live at Home Service.** **ASCE(2) (Annexe): Kent – increasing the efficiency of the reablement service** **ASCE(2) (Annexe): Tameside – focussing the reablement service** **ASCE (2) (Annexe): Outsourcing the reablement service in Coventry, Havering, Wirral**

2.2	Reablement for other adult groups[6]	• extension of the reablement model to younger people (eg through the use of the mental health recovery model, and use of 'promoting independence' principles with disabled people including people with moderate learning disabilities) • (See also 2.3, 3.5, 3.6, 3.7)
2.3	Equipment and Assistive Technology[7]	• a mainstreamed approach, which routinely considers the potential of assistive technology as an integral part of people's care and support packages • targeting of telecare towards groups whose care needs, or risks, could be reduced through the provision of assistive technology • a rigorous approach to ensure that assistive technology substitutes for other interventions and/or reduces a specified risk • good processes for selecting and installing the right equipment • market development and a payment strategy for self-funders • evaluation of the costs and benefits of specific items (such as relatively expensive hi-tech solutions that may nevertheless be cost-effective in particular circumstances) • training and development – targeting both council staff and other relevant agencies – to spread awareness of the potential and importance of assistive technology, and how it can be accessed (eg 'telecare champions') • project management and a performance framework to ensure that benefits (including financial benefits) are realised • success evidenced through rigorous ongoing monitoring of the costs and savings being achieved **ASCE(2) Case Study: Increasing the use of telecare in Hampshire.** **ASCE(2) (Annexe): Use of assistive technology in Kent** **ASCE(1): Case Studies: Kent, Kingston**
2.4	Crisis Response	• access to social care support 7 days/week, in the context of jointly agreed plans to support hospital discharges and prevent unnecessary hospital admissions • assessment and reablement support widely available in the community, including at short-notice, to avoid long-term packages and placements being offered 'in a crisis' **ASCE(2) Case Study: Richmond's 'Rehabilitation and Response Team (RRRT)**

2.5	Hospital Discharge[8]	• agreed multiagency protocols and targets, relating both to reductions in the length of stay and to improved outcomes for people being discharged
		• an implemented policy – owned by partners – that aims to ensure that few or no people are admitted permanently to care homes from hospital
		• established and successful team work both within hospitals and between acute and community services, within a culture that strongly emphasises multi-disciplinary team work, understanding of each other's roles, and mutual respect
		• access to community-based reablement for most older people leaving hospital, as a substitute for the immediate provision of a long-term placement or package (see also section 2.1)
		• access to volunteer schemes that support people with practical tasks on leaving hospital
		• Success evidenced through use of a local joint performance framework. (This is likely to encompass fewer delayed discharges, reductions in the average length of hospital stay (QIPP target: 25 per cent reduction), fewer unscheduled re-admissions, and fewer (or no) people being admitted to residential care from hospital). (See also section 5.1)
		ASCE(2) (Annexe): Poole's services for people leaving hospital
2.6	Intermediate Care[9]	• jointly agreed and implemented pathways for people with long-term conditions
		• operational coordination between the range of relevant services and initiatives (eg homecare reablement, night-time care at home, telecare, crisis response, stroke rehabilitation, bed-based intermediate care, home from hospital services, COPD services etc) – with consideration being given to further service integration (See also sections 5.1 and 5.2)
		• Success evidenced through use of a local performance framework. (This is likely to encompass reductions in the average length of hospital stay, fewer unscheduled hospital admissions, fewer unscheduled re-admissions, and reductions in the numbers supported short-term and permanently in residential and nursing home care). (See also 5.1, below)
		ASCE(2) (Annexe): Tameside's intermediate care service **ASCE(2) (Annexe): Warrington's improved processes (including joint work with health)**

Long-term support

3.1	Personalised support that promotes independence and is regularly reviewed[10]	• personalised care and support delivered in all service settings, including in care homes, that respects people's right to exercise the choice and control that is right for them • processes for informing people of their personal budget, and of their right to take this in the form of a direct payment, in line with Care Act requirements • Assessments and support plans based on specified, measureable outcomes that make sense to people. An emphasis on identifying people's assets, supporting their independence and wellbeing goals and harnessing the 'in kind' contribution they and their carers and families can make (See also 6.2 and 6.3). • different options available for managing personal budgets, with each option offering genuine opportunities for self-direction • use of innovative methods to maximise people's control over resources and budgets whilst achieving economies of scale (eg pooled personal budgets, Individual Service Funds, etc) • resource allocation systems that (a) work fairly and (b) ensure that people continue to receive appropriate levels of funding to meet eligible needs – taking account of the changing nature of the local care and support market and changes in unit costs • personal budgets and direct payments delivered through proportionate and cost-effective business processes, including effective systems for collecting unspent monies (See also 4.4) • active consideration being given to an integrated approach alongside the 'rolling out' of personal health budgets • planned reviews of the outcomes being realised by individuals, within a system and culture that supports people to increase their independence over time wherever possible • success evidenced through the use of a local performance framework that reflects the 'Making it Real' benchmarks. **ASCE(2) (Annexe): Direct payments and use of personal assistants in Barking and Dagenham, Enfield** **ASCE(2) (Annexe): 'Promoting independence reviews' in Kent and Wiltshire** **ASCE(2) (Annexe): Reviewing long-term care packages in Central Beds** **ASCE(2) (Annexe): Reviewing the RAS in Stockport**

3.2	Reducing inappropriate admissions to care homes	• Analysis of the factors that may be contributing to high rates of admissions, combined with action to tackle these issues. These may include such factors as:
		
		  ◦ inadequate investigation and treatment for common factors that lead to care home admission (eg incontinence, recurrent falls, dementia) (See also section 1.4)
		
		  ◦ oversupply of care home places in the locality
		
		  ◦ capacity in age-friendly housing (including sheltered accommodation and extra care housing) (See also section 3.8)
		
		  ◦ availability of aids, telecare adaptations, and care and repair services (See also section 2.3)
		
		  ◦ availability of both step-up and step-down intermediate care and re-ablement services. (See also section 2.6)
		
		  ◦ investment in good discharge planning and post-discharge support (See also section 2.5)
		
		  ◦ systematic use of comprehensive geriatric assessment, either in people's own homes or in hospital
		
		  ◦ availability of specialist support for people with dementia and for end-of-life care at home. (See also section 3.9)*
		
		  *This list is adapted from: 'Making our health and care systems fit for an ageing population', Kings Fund 2014
		
		• Priority being given to reviewing the needs, wishes and outcomes being achieved for people placed in out-of-area, 'assessment and treatment' and hospital institutions. Action (including joint action) being taken to develop cost-effective alternatives in local communities and to move those who are inappropriately placed.
		
		• Success evidenced through use of a local performance framework. (This is likely to encompass a reduction in new admissions to residential and nursing home care; increases in the proportion of the budget being spent on community-based support; and improving outcomes.)
		
		ASCE(2) Case Study: Reducing admissions to residential care in South Tyneside
		ASCE(2) (Annexe): Reducing use of residential care in Barking and Dagenham, Calderdale, Durham, Enfield, Kent, Lincolnshire, Poole, Northumberland, Tameside, Redbridge, Richmond, Shropshire, Stockton, Warrington, Wirral.

3.3	In-house provision	• good understanding of the role played by in-house services within the wider market, and a clear rationale for retaining in-house provision where this applies
		• rigorous ongoing monitoring (including benchmarking) of the cost-effectiveness of these services (including analysis of the extent to which they are 'subsidised' for people using personal budgets and direct payments, and whether this is justified)
		• (Wherever applicable), well-planned and managed processes for decommissioning and re-commissioning – including programme plans that accurately identify the transitional costs and optimum timescales for closures/ transfers, and emphasise the involvement of customers and their families, and staff.
		• Success evidenced by demonstrable reductions in the relative cost of in-house services (in cases where their higher costs are not justified by better quality/outcomes) and/or by good outcomes from re-commissioning exercises.
		ASCE(2) Case Study: People2People in Shropshire (social enterprise model)* **ASCE(2) (Annexe): Bradford's review of in-house care homes** **ASCE(2) (Annexe): Development of social enterprises or staff-run mutuals – eg in Croydon*.**
		* (NB The ASCE study includes several examples of councils that have established social enterprises, but most are at an early stage and the evidence of their cost-effectiveness is so far mixed).
3.4	Day Opportunities	• clarity and multiagency agreement about the role and purpose of day services (and day centres) within the whole system of community based support
		• business plans for day centres (including any joint facilities), that are clear about the contribution they will make in promoting independence and social inclusion, and include target unit costs
		• a more cost-effective, diverse and culturally-sensitive range of day opportunities being developed with people and their carers, including improved access to mainstream community health, leisure, employment, training and education services, and the development of other forms of support for people who are socially isolated. (See also section 6.2)
		• Success evidenced through use of a local performance framework. (This should include routine monitoring of the unit costs of specific building-based services and the outcomes being achieved, and also enable good understanding of whether/how people are using the relevant parts of their personal budgets to secure better value from this money.)
		ASCE(2) (Annexe): Reviewing day services in Hackney, Havering, Stockton, Tameside.

3.5	Employment[11]	• priority explicitly given by the whole council to supporting disabled people (and people with mental health needs) into paid work
		• an employment strategy for disabled people encompassing good joint work across agencies (with consideration to bringing funding streams together where this might facilitate better outcomes)
		• people's work aspirations reinforced through good career and skills preparation in schools and colleges
		• A range of training, employment and volunteering options in place. Development plans increasingly underpinned by local evidence (and benchmarking) of the cost-effectiveness of specific training and supported employment models.
		• success evidenced by an increasing proportion of those receiving council funded support in paid employment, and increasing numbers of disabled people employed by the council (and other major local employers)
3.6	Learning Disability Services[12]	• achievement of culture change, with an emphasis on promoting independence, across staff at all levels, and in provider services
		• use of direct payments to enable individuals to arrange cost-effective support in the community
		• reviews of placements and packages, using standard assessment tools (eg Care Fund Calculator)
		• re-commissioning of supported living and other services (eg day services) where this is indicated
		• use of assistive technology to help people to live more independent lives
		• use of knowledge about people's needs and desired outcomes to inform market developments
		• use of mainstream services such as transport, combined with enablement and training to help increase people's independence
		• Forward planning – to support people who are in transition to older age or who live with elderly parents. Also, to support younger people in transition (see also section 3.7).
		• success evidenced by an increase in the number of people living independently (or with support) in the community, reduced costs where this is indicated (eg through benchmarking), improved independence outcomes, and the balancing of the learning disability budget.
		ASCE(2) Case Study: Learning disability services in Croydon **ASCE(2) Case Study: Reducing costs in learning disability services in Tameside** **ASCE(2) (Annexe): Learning disability audit tool in Wakefield** **ASCE(2) (Annexe): Assertive reviews for people with learning disabilities in Torbay**

3.7	Transitions	• early identification of young people entering adulthood, with early assessment in line with Care Act requirements, and agreed and implemented protocols to plan and arrange their transition
		• 'ownership' across agencies (including education, health and social care) of the importance of supporting young people's aspirations and desired outcomes (eg to live in inclusive communities, and get a job): emphasis on 'planning lives', not 'planning services'
		• person centred approaches used both for social care and health planning
		• intelligence about the young people entering the adult social care 'system' built into medium-term service and financial planning
		• success evidenced through improved and more cost-effective outcomes for young people
		ASCE(2) (Annexe): Single all-age services in Darlington and Shropshire **ASCE(2) (Annexe): Improved services for young people in transition in: Hartlepool, Lambeth, Swindon, Tameside, Warrington.**
3.8	Housing and support[13]	• coordinated housing and social care strategies based on shared analysis of needs and priorities, and of the assets available in communities (including the potential to extend shared ownership schemes)
		• improved access to mainstream housing, and to other suitable housing options, for older and disabled people regardless of their housing status (ie renting, shared ownership or owner occupied)
		• extra care housing used as an alternative to residential care for people with high care needs, but with controls on the level of care each person might receive in these schemes
		• speedy, prioritised access to low-level adaptations where there is evidence (eg linked to a falls prevention strategy) that this will be cost-effective
		• benchmarking of the unit costs of specialist support, plus models such as Individual Service Funds and pooled personal budgets considered where appropriate as ways of achieving 'economies of scale', in cases where a group of people choose to be supported by the same provider
		• The development of a range of models (eg Shared Lives, Good Neighbour schemes, Community Living Networks, live-in carers) to maximise choice, control and independence. These developments underpinned by the use of national and local evidence (including benchmarking wherever possible) of the cost-effectiveness of these specific service models.
		• Success evidenced by an increasing proportion of disabled people (and those with mental health needs) living independently, with or without support. Also, through benchmarking of expenditure on specialist housing and support, and of the associated unit costs.
		ASCE(2) (Annexe): Liverpool's partnership with housing providers

3.9	Continuing Care and End of Life Care[14]	• processes in place for allocating Continuing NHS Care and NHS nursing care funding, with national practice guidance consistently adhered to and monitored
		• agreed policies and co-ordinated services in the community, for people who need intensive health and social care support at the end of life
		• 'Gold Standards Framework' adopted across agencies as the basis for improving patients' experience at the end of life, with an increasing proportion of deaths occurring at home
		• success evidenced through use of local joint performance frameworks, to monitor the achievement of agreed activity, expenditure and outcomes targets
3.10		• agreed multiagency protocols, and good safeguarding processes and practices, embedded across sectors and well monitored
		• safeguarding responsibilities prioritised within the council's service and financial planning processes
		• safeguarding processes implemented in a way that is efficient and proportionate to individual circumstances and enables people to make informed decisions, plan for problems that may arise and stay in control in a crisis
		• success evidenced through the use of a local multiagency performance framework that is based on nationally recognised standards (eg 'Making Safeguarding Personal'), and public reporting in line with Care Act requirements

Business processes

4.1	Culture Change[16]	• a local shared vision that sets out the values that need to be promoted across all agencies, including an emphasis on: supporting people to take responsibility for their own health and maintain their independence; promoting the social inclusion of older and disabled people; and valuing and encouraging the community's contributions
		• strong political and managerial leadership for the agreed direction
		• a live programme of organisational development, designed to achieve culture change across ASC (and also across the council and partner agencies)
		• A workforce development strategy, based on identification of the required new behaviours, competencies and professional standards for staff. (This should include a strong emphasis on such areas as promoting independence, helping people to find new, alternative forms of support, and on multidisciplinary team working.)
		• individual performance management (including peer development approaches) that recognises the important role played by frontline staff in allocating health and care resources, and supports the development of the required new skills and competencies
		• Particular emphasis being given to the inclusion of NHS clinicians in culture change initiatives, recognising their influence on creating 'demand' for ASC interventions including residential and nursing home care. Concerted work to ensure a shared agenda, with clinicians well-informed about the potential to support people well within the community, the role played by ASC and the resource implications for the whole system.
		• Success evidenced through the use of a local performance framework. This is likely to encompass targets applied across the whole sector, incorporating those applied by CQC - in relation to staff development. Also, local measures of the extent of staff engagement. (In view of the growing evidence that 'culture change' strongly impacts the use of resources, councils may also wish to develop their own measures of success in achieving 'culture change' and 'improvements in relationships', and to map these against their service and financial performance.)
		ASCE(2) Case Study: Transforming Adult Social Care in Hackney **ASCE(2) (Annexe): Culture change in Calderdale, Central Beds, Croydon, Durham, Gateshead, Kent, South Tyneside, Suffolk, Tameside, Torbay.**

4.2	Performance management	• active engagement of council leaders in the effective delivery of ASC transformation
		• robust performance management, including the use of key performance indicators (activity as well as outcome indicators) to ensure the council is managing the demand for social care
		• understanding and monitoring of unit costs across all services, with action being taken to reduce costs where there is scope to do so
		• benchmarking of data, including financial data, with comparator local authorities
		• programme and project management of ASC transformation, including budget reduction measures
		• identification and management of risk, including those associated with budget reductions
		• openness to external challenge (including peer challenge) to help achieve transformation and to identify efficiency savings
		• success evidenced through the delivery of efficiency savings using a transformational approach - that focusses on managing the demand for formal care and support, and improving cost-effectiveness
		ASCE(2) (Annexe): Strong performance management approaches in Hackney, Tameside.
4.3	Outcome focus[17]	• strategic plans (including health and well-being strategies) identifying the outcomes to be achieved for whole communities, and increasingly supported by outcome-based monitoring frameworks (See also section 5.1)
		• individual support plans geared to delivering individuals' agreed required outcomes (with an emphasis on those that will help the individual live more independently) (See also 3.1)
		• processes to identify, and support the achievement of specified individual outcomes becoming embedded within both in-house and commissioned services
		ASCE (1) and (2) Case Study: Wiltshire Help to Live at Home Service

4.4	Streamlining business processes[18]	• business processes that place an emphasis on early prevention and reablement, reducing or delaying the process of assessment for formal long-term care
		• efficient processes at every stage of the 'customer journey', so that people experience a fast and seamless response including:
		◦ easy access to good quality preventative information, advice and signposting (See also 1.1)
		◦ efficient and effective initial contact services (See also 1.2)
		◦ reablement introduced as an integral part of the process for those who may need long-term support (See also 2.1)
		◦ assessment processes that are kept to a minimum, are proportionate to risk, are coordinated between council staff and with other agencies (to avoid duplication), and do not cause difficulty or distress
		◦ fast and efficient processes for transferring between staff teams (where this applies)
		◦ fast, transparent and efficient processes for agreeing personal budget allocations (both indicative and final)
		◦ fast and efficient processes for agreeing and allocating direct payments where this is the chosen approach
		◦ efficient and proportionate methods for producing support plans (with an emphasis on empowering individuals to do this for themselves or with help from informal sources, and at their own pace). Clear information about what the councils needs to see in plans to sign them off.
		◦ transparent and proportionate processes for signing off support plans that provide swift decisions and clear reasons for requiring amendments to plans
		◦ proportionate monitoring (including financial monitoring) and review systems
		◦ good systems for retrieving unspent elements of direct payments
		• supportive IT systems that manage case records in line with Care Act requirements, reduce bureaucracy and duplication, allow easy exchange of information between staff, and enable the collection of timely and accurate data for use in performance and financial monitoring (See also section 4.5)
		• Success evidenced through the use of a local performance framework that uses benchmarking data where available. (This is likely to encompass the monitoring of customer satisfaction, reductions in waiting times, and reductions in the number of 'unnecessary' assessments carried out. Also, reductions in the unit costs of assessment and reviews where benchmarking suggests these are unjustifiably high.)
		ASCE(2) (Annexe): Waltham Forest – streamlining business processes **ASCE(2) (Annexe): Warrington's guide for staff on how to save money** **ASCE(1): The work of Newton in Kent**

4.5	Care Act implementation[19]	• financial modelling – eg to estimate the budget required to meet care costs for self-funders, and to estimate the likely increase in requests for deferred payments
		• consideration of ways to conduct proportionate assessments (including for self-funders wishing to start a care account) including use of the third sector and self-assessments
		• consideration of the financial impact of anticipated increases in the volume of assessment and service provision for carers
		• identification of the potential impact of Care Act implementation on the current workforce (eg new skills, capacity and configuration) (See also section 4.6)
		• reviews of financial processes, information and advice systems and IT to meet Care Act requirements
		• success evidenced through readiness to implement the Care Act within required timescales, and financial plans based on robust financial modelling
		ASCE(2) (Annexe): Poole – specialist post for self-funders

4.6	Workforce planning[20]	• strategic analysis of the local ASC workforce (including other employers and sectors), identifying priority gaps in people, knowledge, competencies and skills; and recruitment and retention pressures
		• mechanisms (eg a strategic workforce plan) for addressing workforce issues across the locality; a multiagency approach to improving recruitment and retention in priority areas, including realistic assessment of the potential link to local wage levels
		• Thorough analysis of statutory ASC processes (and of how these will change in the context of Care Act implementation) – identifying the tasks, resources and professional skills required to complete each task.
		• Identification of the new roles (including joint roles) that will need to be created in the context of ASC transformation, integration with health and Care Act implementation
		• Staff being deployed in a way that makes best use of scarce professional skills. A workforce redesign plan being implemented, using change management processes that are based on best practice.
		• benchmarking where useful and applicable; eg of the council's relative expenditure on management, assessment and care management, strategic and support functions
		• Success evidenced through the implementation of a local change programme, and routine monitoring of workforce data. (This is likely to encompass improvements in areas such as recruitment and retention, reductions in the use of agency staff; and a reduction in sickness/absence, not only within the council's ASC department but also across the wider ASC sector including services commissioned from the independent sector. Also, improved recruitment to hard-to-fill roles such as personal assistants.)
		ASCE(2) Case Study: People2People in Shropshire (social enterprise model) **ASCE(2) (Annexe): New workforce strategies in Central Bedfordshire, Kent, Kingston**
4.7	Equalities Impact	• A live equalities strategy supporting continuous improvement (including an approach to personal budgets delivery that works for all customer groups).
		• active promotion of equality and human rights within ASC (and reflected in commissioning and contracting processes), including adherence to the ban on age discrimination
		• routine collection of equality information in compliance with the public sector equality duty
		• equality impact assessments completed for all aspects of the transformation agenda including all budget reduction measures
		• success evidenced through the use of a local performance framework, rigorous equality impact assessments, and effective mitigating actions

Partnership

5.1	'Whole systems approach'[21]	• a shared vision, informed by extensive community engagement, that emphasises prevention and promoting independence
		• A JSNA that includes sound analysis of the needs, priorities and assets of local communities, supporting the identification of priorities and targets. (This should encompass recognition that new ways of working will influence the 'demand' for health, housing and social care, with the implication that demand cannot be measured simply by recording demographic trends.)
		• a health and wellbeing strategy that emphasises a preventative and co-ordinated approach, identifies early priorities, and includes clear and measurable outcomes
		• A shared view of the costs and efficiency of the health and social care system, and clarity about how to intervene to drive these in the right direction. Increasing alignment of expenditure (by the council and its NHS partners) to agreed priorities, with these priorities agreed jointly. (This should encompass agreement both about both investment and disinvestment priorities, and financial planning that aligns the savings targets of both organisations).
		• Specific commissioning plans that are agreed across agencies and linked to the health and wellbeing strategy. Active consideration of the use of pooled budgets and/or joint commissioning and/or service integration where there is a clear local business case for the identified new model.
		• ongoing work to develop a shared base of intelligence (including indicators and systematic feedback from customers), to demonstrate improved outcomes, quality and efficiency savings across the health and wellbeing system
		• a plan for the use of the Better Care Fund (BCF) that complies with national conditions (eg in relation to the planned reductions in activity)
		• a risk framework that identifies risks to the delivery of jointly agreed plans (including the BCF) and how these will be managed
		• A proactive approach to jointly measuring 'return on investment' recognising that one organisation's financial investment in a particular area might result in larger financial benefits to the other, and vice versa. Increasingly sophisticated methods used to enable investment and benefit to be transparent and fairly balanced between partners, with the triple aims of improving user experience, improving user outcomes and reducing the total cost of care.
		• success evidenced through the use of a local joint performance framework including budget monitoring

| 5.2 | Joined-up service delivery [22] | • A recent track record of ensuring a more seamless response for people, and making better use of joint resources (eg through closer integration of service provision) in some service areas. (See, for example, 2.1, 2.3, 2.5, 2.6). On the basis of learning about the costs and benefits of recent local initiatives, plans to extend integrated working further.

• this may include, for example:

• successful multi-disciplinary team work being extended across the front line (including, for example, alignment of staff to clusters of practices, and/or increasing use of single assessment processes and shared care plans)

• integrated reablement and intermediate care services (see also sections 2.1, 2.2, 2.3, 2.5)

• integrated and cost-effective specialist services for people with learning disabilities and mental health needs

• exploration of the potential of integrated personal budgets to achieve best use of health and care resources at individual level

• success evidenced through the use of a local joint performance framework including budget monitoring (See also Sections 1, 2 and 3 above)

ASCE (2) Case Study: Northumberland's integrated model of care
ASCE (2) (Annexe): Integrated services in Calderdale, Richmond, Swindon, Torbay
ASCE (2) (Annexe): Personal health budgets in Staffordshire |
| 5.3 | Market Facilitation[23] | • Analysis of the current structure of the market (both state-funded, self-funded and charitably-funded), and where it needs to be in future. (This should include analysis of the council's share in the market, and how third party income is distributed.) This analysis shared through a publically available Market Position Statement.

• full involvement of customers and other citizens in identifying the market development priorities, in designing and evaluating services, and in shaping new approaches (See also 6.3)

• commissioning strategies that aim to secure a sustainable and high-quality market that offers flexible, personalised services, improved outcomes (including increased independence), and value for money

• new market facilitation capacity, skills and competencies identified and embedded in the organisation

• active partnerships with (and support for) providers to embed new ways of working and to stimulate further innovation (See also 6.2 and 6.3)

• information about the availability and quality of services published (using accessible routes and formats); to support both ASC customers and self-funders to make informed purchasing decisions

• success evidenced through the use of a local performance framework including budget monitoring |

5.4	Procurement[24]	• a collaborative environment in which commissioners and providers share information, and work through challenges together to improve outcomes and ensure market stability
		• negotiations based on increasing transparency about the costs of support (using techniques such as 'open book accounting') and a willingness to share risks
		• use of tools to assess the individual costs of support in residential (and other) settings, designed to ensure equity and fairness in the process of agreeing individual fees (See also 3.2)
		• A procurement strategy and work plan in ASC that mesh with relevant corporate strategies, and are compliant with legal processes and corporate standing orders. Efficient processes that minimise unnecessary bureaucracy and burdens for providers, and are resourced to ensure adherence to timescales.
		• A range of procurement methods being used, tailored to deliver the required service and financial outcomes. Consideration being given to contracts that reward responsive behaviour (and the delivery of good outcomes) by providers. (See also section 4.3)
		• efficient and effective methods to support individuals to buy care and support services for themselves (eg standardised contractual templates for some services, widely available unit costs etc)
		• efficient and proportionate contract monitoring processes, encompassing agreement about the respective roles of commissioners, regulators and providers in managing performance
		• benchmarking of unit costs, of NHS services, residential and nursing care, specialist housing and support, home care, day care, personal assistants and other relevant services
		• robust (but proportionate) quality assurance processes across all services including registered services
		• success evidenced through the use of a local performance framework including a quality/outcomes framework, and benchmarking of unit costs
		ASCE(2) (Annexe): Re-procurement exercises in Hampshire, Luton, Portsmouth **ASCE(2) (Annexe): Re-negotiating fees for learning disability services in Wakefield** **ASCE(2) (Annexe): Savings achieved through electronic monitoring of home care in Enfield, Hampshire**

Contributions

6.1	Community Engagement[25]	• a culture of openness and transparency by the council and its partners - including about the current financial context, budget dilemmas, opportunities and risks • The development and use of diverse methods, tools and techniques to engage with people who use ASC services, the public and key stakeholders - with increasing emphasis on the use of the internet to facilitate two way dialogue, and on the inclusion of hard-to-reach groups. (This should include opportunities for local citizens to contribute to the debate about making best use of resources.) • the development of joint approaches to engagement, to minimise duplication (and 'consultation fatigue') and make best use of relevant resources across councils, CCGs, Healthwatch and community organisations • the Local Account used as a way of engaging with communities and improving accountability to them • Success evidenced – eg through more and better quality feedback being received. Also, monitoring of the costs of engagement initiatives across agencies, and continuous assessment of the usefulness of different methods. **ASCE(2) (Annexe): Extensive community engagement in Cheshire West and Chester**
6.2	Building Community Capacity[26]	• a new 'contract' with citizens and communities – with people taking more responsibility for their health and care, and communities supported to help individuals to stay independent • mapping of the assets and resources available in communities, including those in the private, voluntary and informal sectors • joined-up approaches which make use of the many available sources of local knowledge and support • active promotion of social inclusion (eg through the stimulation of volunteering, social support networks, befriending schemes, peer support, improved access to sports and leisure activities for disabled people, etc). • Promotion of 'dementia-friendly' communities • Success evidenced – eg through support plans that increasingly make use of 'informal' sources of support, and through assessment of the cost-effectiveness of specific local initiatives. **ASCE(2) Case Study: Supporting Lives, Connecting Communities in Suffolk** **ASCE(2) Case Study: People2People in Shropshire** **ASCE(2) (Annexe): Liverpool's Local Enterprise Partnership**

6.3	Co-Production[27]	• customers and other citizens routinely involved in the design, planning and delivery of new approaches
		• At individual level, an emphasis on co-production using a range of techniques (eg involvement of ULOs, use of peer support, circles of support, community navigators etc), with the aim of maximising the contributions that can be made by people themselves, their family carers and local informal networks. This underpinned by use of the emerging national evidence base on the cost-effectiveness of specific approaches, plus rigorous local evaluation.
		• use of a wide range of qualitative information about people's experience of using new forms of support (including through person-centred information collected from support planning and reviews), that is shared across the organisation and externally
		• success evidenced – eg through support plans that increasingly make use of 'informal' sources of support, and through active involvement of citizens in the ASC transformation process
6.4	Fairer Contributions	• a 'Fairer Contributions' policy, which applies equally to those directly funded by the council and those receiving direct payments, and is fully compliant with relevant legal guidance
		• consideration given to whether the council 'subsidises' the costs of some services, and if so, whether these subsidies are applied equitably (See also 3.3)
		• efficient and timely systems for calculating and collecting customer contributions (and for retrieving unspent monies from Direct Payments)
		• success evidenced; eg through benchmarking of income from sales, fees and charges with the council's comparator group
		ASCE(2) (Annexe): Reviewing charges in Bradford, Peterborough, Poole, Shropshire, Stockport, Tameside, Waltham Forest, Warrington **ASCE(2) (Annexe): Improved management of income collection, and reducing bad debt, in Cheshire East**

Useful resources and guidance

1 General/background

ADASS: Budget surveys 2013, 2014

ADASS/IPC: The case for tomorrow. Facing the beyond, 2012

ADASS/PPF: Paying for Long-Term Care in England, 2011

Audit Commission: Tough Times 2013

Commission on the future of health and social care in England: a new settlement for health and social care, Kings Fund 2014

CQC: State of Care 2012/13, 2013

CQC/IPC: The stability of the care market and market oversight, England, 2014

House of Lords: Ready for Ageing? (Public Service and Demographic Change Committee report, March 2013)

Improvement and Efficiency South East (IESE): SCENE website – case studies

Kings Fund: Paying for social care – beyond Dilnot, 2013

Kings Fund: Making our health and care systems fit for an ageing population, 2014

Kings Fund: Commission on the future of health and social care in England (Barker Commission), 2014

LGA: The financial context of Adult Social Care Reform, 2012

LGA: Adult Social Care Efficiency Programme – interim findings, 2013

LGA: Adult Social Care Efficiency Programme – the final report, 2014

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Nuffield Trust: Care for older people: projected expenditure to 2022 on social care and continuing health care for England's older population

Nuffield Trust: NHS and social care funding: the outlook for 2021/22., 2012

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TEASC: Progress with adult social care priorities 2012/13

TEASC/TLAP: A Problem Shared: Making best use of resources in Adult Social Care, 2013

TLAP: Making it Real: marking progress towards personalised and community-based support (resources)

University of Birmingham (HSMC): Turning the welfare state upside down? Developing a new adult social care offer. Jon Glasby et al, 2013

Benchmarking
Department of Health: Statistical neighbours comparison tool, 2014 https://www.gov.uk/government/publications/adult-social-care-efficiency-tool

Information Centre for Health and Social Care: NASCIS online analytical processor

Skills for Care: NMDS-SC Dashboards

Self-Funders
IPC: Understanding the self-funding market in social care: a toolkit for commissioners, 2013

LGiU: Council support for care self-funders, 2011

OPM: Older people who self-fund their care, Clive Miller et al, 2013

PPF/IPC: People who pay for care: quantitative and qualitative analysis of self-funders in the care market, 2011

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ADASS/SOCITM: The development of online services for information and advice supporting the Care Act 2014

Age UK: Information and Advice for Local People – Evidence Review, 2013

TLAP: case studies and tools: http://www.thinklocalactpersonal.org.uk/SiteSearch/?page=doSearch&keywords=information+and+advice&x=24&y=10

3 Health, wellbeing and social inclusion

Age UK: Agenda for Later Life: policy priorities for Active Ageing, 2012

British Red Cross: Taking stock: assessing the value of preventative support, 2012

Campaign to End Loneliness: Loneliness and isolation toolkit for health and wellbeing boards, 2011

Henwood, M: Beyond eligibility: universal and open access support and social care, 2012

Kings Fund: Improving the public's health: a resource for local authorities, 2014

LGA: Ageing Well legacy and resources: http://www.local.gov.uk/ageing-well

LGA: Combating loneliness: a guide for local authorities, 2012

LGA: Money well spent? Assessing the cost-effectiveness and return on investment of public health interventions, 2013

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London School of Economics/PSSRU: An analysis of the economic impacts of the British Red Cross support at home service. J. Dixon et al, 2014

SCIE: Preventing Loneliness and Social Isolation: Interventions and outcomes (Research Briefing 39), 2011

University of Birmingham (HSMC): Is integration or fragmentation the starting point to improve prevention? Robin Miller, 2014

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Carers UK: State of Caring 2014

Cornwall CC: Newquay pathfinder – evaluation, 2014

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OPM: Reablement: a guide for frontline staff, 2012

SCIE: Maximising the potential of reablement. SCIE Guide 49, 2013

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Centre for Mental Health: Investing in recovery: making the business case for effective interventions for people with schizophrenia and psychosis, 2014

Centre for Mental Health: Making recovery a reality in your community, 2013

Centre for Mental Health: Recovery, public mental health and wellbeing, 2012

Emerson, E et al: Prevention and social care for adults with learning disabilities, 2011

Mental Health Foundation: Starting Today – the future of mental health services, 2013

North West Mental Health Improvement Programme: Commissioning for mental health outcomes in the North West, 2011

7 Equipment and assistive technology

Department of Health: Research and development work relating to assistive technology 2013/14, 2014

Kings Fund/WSDAN: Evaluating telecare and telehealth interventions, 2011

Kings Fund: Telecare and Telehealth resources: http://www.kingsfund.org.uk/topics/telecare-and-telehealth

Nuffield Trust: Impact of telehealth and telecare – the Whole System Demonstrator project resources http://www.nuffieldtrust.org.uk/our-work/projects/impact-telehealth-and-telecare-evaluation-whole-system-demonstrator-project?

8 Hospital discharge

Age UK: Right care, first time: services supporting safe hospital discharge and preventing hospital admission and readmission, 2012

Royal Voluntary Service: Avoiding unhappy returns: radical reductions in readmissions, achieved with volunteers. Cardiff: Royal Voluntary Service, 2013.

9 Intermediate care

Kings Fund: Older people and emergency bed use: exploring variation, 2012

NIHR/University of Bristol: Interventions to reduce unplanned hospital admission – a series of systematic reviews, 2012

NHS Benchmarking Network: National Audit of Intermediate Care, 2013 and associated materials: http://www.nhsbenchmarking.nhs.uk/partnership-projects/National-Audit-of-Intermediate-Care/year-two.php

10 Personalisation

In Control: Individual service funds for Homecare, 2013

NHS England: Integrating personal budgets – early learning, 2012

NHS England: Personal health budgets guide, 2014

SCIE: Personalisation: A rough guide, 2012

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NDTi: The use of personal budgets for employment support, 2014

NDTi: The cost-effectiveness of employment support for people with disabilities: final detailed research report, 2014

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NDTi: Families and personalisation project – 'Better Lives', 2012

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TLAP: Personal health budgets – including people with learning disabilities, 2014

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IPC/Skills for Care: Evidence review – housing and social care, 2013

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Royal College of General Practitioners: RCGP commissioning guidance in end of life care: guidance for GPs, clinical

commissioning group advisers and commissioners in supporting better care for all people nearing the end of their life. Thomas K, Paynton D, 2013

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LGA/ADASS: Making Safeguarding Personal, Guide 2014

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London Borough of Hackney: Promoting Independence Commitment Statement. http://www.hackney.gov.uk/Assets/Documents/Adult-Social-Care-Services-commitment-statement.pdf

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SITRA: Payment by results. Comparing payment by results across public services and in housing-related support, 2013

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ADASS/Department of Health: Informatics specification for Care Act Implementation – core systems

Audit Commission: Reducing the cost of assessments and reviews, 2012

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TLAP: Self-directed support: reducing process, increasing choice and control, 2013

19 Care Act implementation

ADASS: Presentations: http://www.adass.org.uk/SE_Care_Act_Consultation_Presentations/

ADASS: The Lincolnshire model (slide pack): http://www.adass.org.uk/the-lincolnshire-model/

LGA: Implementing the Care and Support reforms (resources)

LGA: Care Act implementation: governance and programme management (resources)

LGA: Understanding the costs of the Care Act in 2015 (resources)

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Skills for Care: Implementing the Care Act diagram, 2014

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Coalition for Collaborative Care: House of Care resources

TLAP: Co-production (resources)

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