

your
county
cares

CCN

COUNTY COUNCILS NETWORK

**DELIVERING ADULT SOCIAL CARE
IN CHALLENGING TIMES**

Foreword



**Councillor
Colin Noble
CCN Spokesman
for Health
& Social Care**

I am delighted to introduce this County Councils Network report *Delivering Adult Social Care in Challenging Times*, my first as Spokesman for Health and Social Care.

Adult social care is more than just a service that councils provide or the largest area of expenditure. Without the services and support provided by social care, people who have disabilities, mental health problems, a sensory loss, or general frailty may lose the support they cherish, along with the opportunity to live an independent and dignified life.

This report is being published at a time when adult social care is at a significant crossroads. The current route is unsustainable, with reduced Government funding and rising demand for services placing local authorities in an increasingly perilous financial position.

These issues are extremely pertinent in county areas, which are home to the largest and fastest growing older populations in England. We are also faced with some of the most acute demand pressures, with social care contacts rising and an increasing number of people being delayed in hospital due to a shortage of social care capacity.

The historical underfunding of county authorities, coupled with new funding streams for adult social care not reaching their full potential until the end of the Parliament, means that there are significant and immediate funding pressures.

Sadly there is no quick fix to these challenges. County colleagues are working to build upon their history of innovation, integration and partnership working to develop more efficient and effective ways of working. The case studies from CCN member councils in this publication showcase a small cross-section of this work, ranging from delivering integrated services to building the capacity of small providers to deliver services in rural areas.

Despite these challenges, CCN member councils have continued to deliver high quality services that improve outcomes for local residents. Social care users in county areas are the most satisfied with the services they receive and feedback shows that these services also make them feel safer and more secure than service users in other areas.

The prospect of a new way of funding local government being in place by the end of the Parliament, through Business Rates Retention, provides a glimmer of hope that funding and need will be fully aligned. However, it is imperative that Government recognise the immediate and substantial pressures facing adult social care in county areas sooner rather than later.

A handwritten signature in black ink, appearing to read 'Colin Noble', written in a cursive style.

Councillor
CCN Spokesman for Health & Social Care

Background

05

Introduction

08

Analysis & Policy Proposals

10

Think Pieces

29

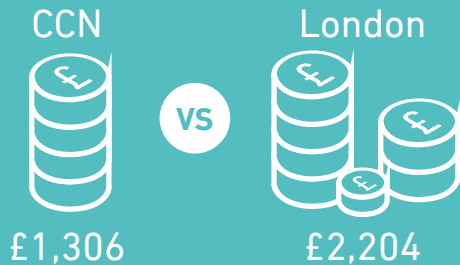
Case Studies

38

Key Statistics

CCN'S SURVEY OF COUNTY DIRECTORS
OF ADULT SOCIAL CARE FOUND

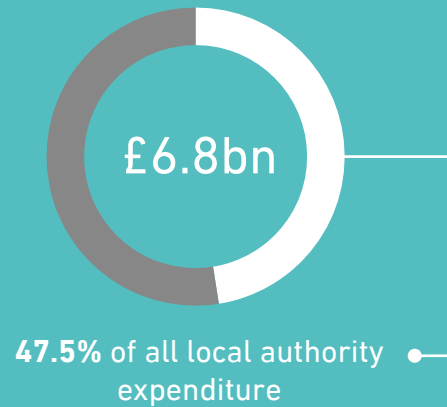
AVERAGE REVENUE EXPENDITURE PER HEAD OF POPULATION 65+ ON ADULT SOCIAL CARE 2016/17



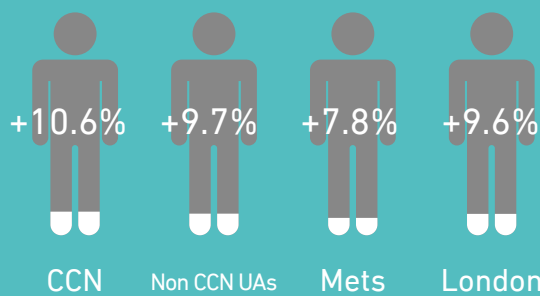
CCN member council on average spend 41% less per head on adult social care than councils in London.

CCN MEMBER COUNCILS

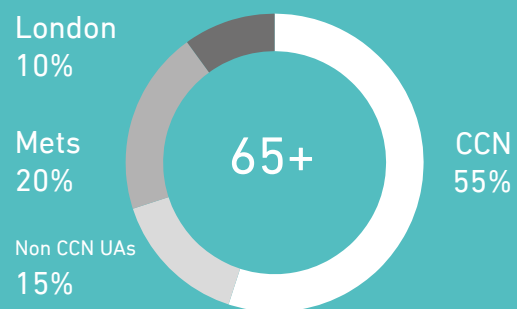
Estimated Adult Social Care Expenditure 2016/17



ESTIMATED CUMULATIVE POPULATION GROWTH 2015/16–2019/20

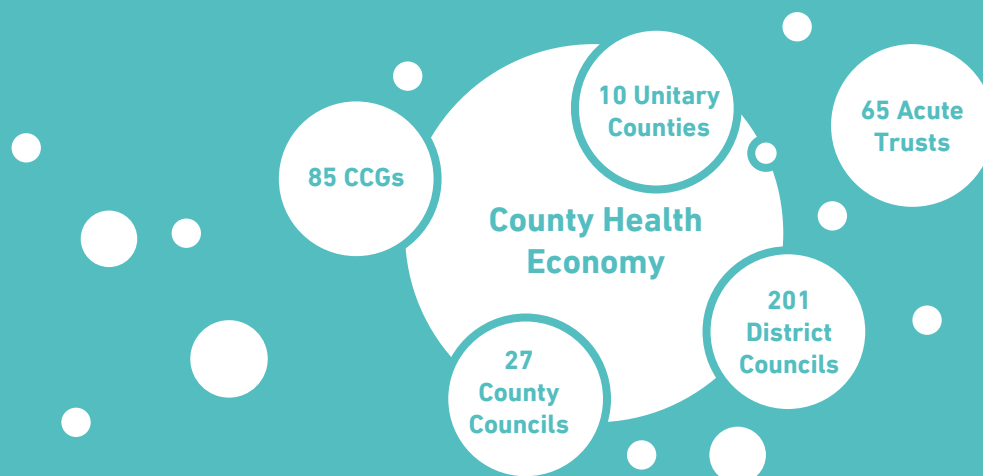


PERCENTAGE OF 65+ POPULATION IN ENGLAND



Complex Health Economies

In CCN member councils there are:



In London there are 32 CCGs & Acute Trusts.

BACKGROUND & INTRODUCTION

Background

Adult social care services provide essential support to working age and older people with disabilities, mental health problems, sensory loss, and general frailty. These life-critical services are vital for local people to maintain their independence, dignity and to have a choice of the type and location of their care.

The public sector has been subject to significant challenges over the course of the last Parliament and these will continue into the next decade. Local authorities across England have seen the level of core Government grant funding they receive reduced by an average of 40% since 2010. Due to the life-critical and demand-led nature of adult social care services, councils have sought to protect budgets in relative terms.¹

The 2015 Spending Review, followed by the 2016 Local Government Finance Settlement, provided access to additional funding for adult social care through the social care precept and the improved Better Care Fund. However, the implementation of the Government's National Living Wage (NLW) from April 2016 has seen much, if not all, of this additional funding diverted to cover increased staffing costs.

At the same time as budgets reducing, local authorities have seen demand for social care services rise significantly. Although a smaller number of people now receive services from councils than at the start of the decade, the complexity of these needs and length care required has increased.

It is now widely recognised by sector leaders and commentators that due to funding and demand pressures, adult social care has reached 'tipping point' and that it is on the cusp of crisis.²



Adult social care services in county areas are faced with the perfect storm of rising demand, declining budgets and increasing public expectations



Introduction

In early 2016 the County Councils Network (CCN) undertook a survey of county directors of Adult Social Care (ASC). This survey sought to gather a current perspective on the financial challenges facing the sector and health and social care integration.

This publication uses the results of this survey, supported by statistical analysis and desk-based research to highlight the challenges and opportunities presenting themselves in county areas. To support this commentary, a number of leading sector figures have provided opinion pieces that clearly articulate some of the key drivers of adult social care demand and cost, such as local care markets.

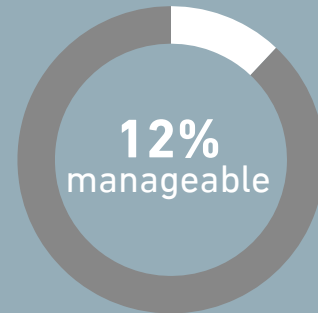
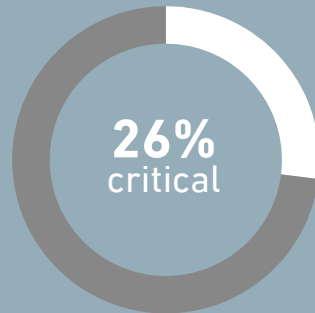
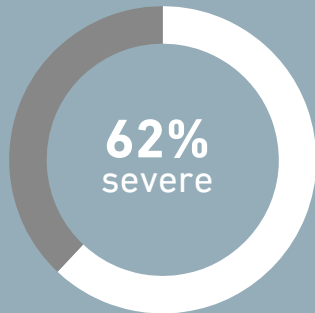
Importantly, this publication also showcases a number of good practice examples from CCN member councils. These highlight how counties are working with partners, such as the NHS and voluntary sector, to deliver joined-up services that improve outcomes for local people across a county footprint.

“CCN member councils have continued to deliver high quality services that improve outcomes for local residents”

Finance & Demand

CCN'S SURVEY OF COUNTY DIRECTORS
OF ADULT SOCIAL CARE FOUND

Budget pressures in adult social care



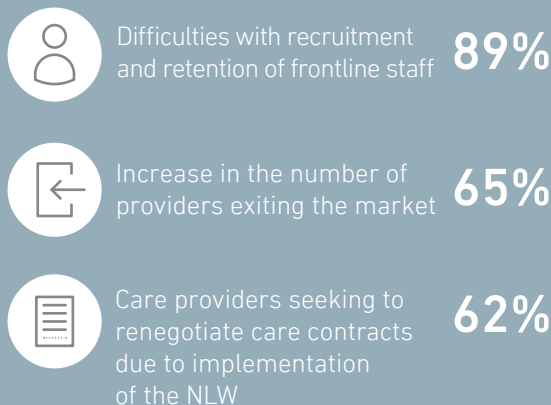
KEY REASONS FOR FINANCIAL PRESSURE ON ADULT SOCIAL CARE



MOST EFFECTIVE APPROACHES TO ADDRESSING THE FINANCIAL PRESSURES FACING ADULT SOCIAL CARE



ASSESSMENT OF LOCAL RESIDENTIAL CARE MARKET



ASSESSMENT OF LOCAL DOMICILIARY CARE MARKET



ANALYSIS & POLICY PROPOSALS

Analysis and Policy Proposals

County Context

Adult social care services in county areas are faced with the perfect storm of rising demand, declining budgets, and increasing public expectations. People are living longer, meaning that the number of people requiring care and support is increasing, as is the complexity of people's needs.

CCN has made a consistent case to Government that county adult social care services have been and continue to be underfunded. Local authorities up and down the country are faced with significant funding challenges now, with no sign of this abating. The impact of this perfect storm is that some county authorities are reporting that they may not be able to deliver a balanced budget before the end of this Parliament.

Government's commitment to reforming the local government funding system, through Business Rates Retention (BRR), is welcome. However, a new funding mechanism brings with it more uncertainty. Until this is finalised there is no guarantee that the needs of those people who require care and support will be fully funded, along with the associated costs of service delivery in county areas.

The Government's push for integrated health and social care services provides a challenging environment for CCN member councils. Counties are striving to maintain the current level and quality of services, whilst working with partners to develop plans to not only transform services, but to place them on a sustainable footing.

The complexity of partnership working in county areas provides an additional challenge for delivering integrated services. This has been made more complex in some counties by some Sustainability and Transformation Plan (STPs) footprints that transcend existing boundaries, which has the potential to fragment social care budgets into smaller geographies.

This section utilises desk-based research, the results of CCN's survey of county directors of adult social care and analysis of key performance indicators to provide analysis of the challenges and opportunities facing county areas. Utilising this information we propose a number of practical steps that Government could take to enable counties to deliver quality, sustainable and user-focused adult social care services.

Analysis and Policy Proposals Funding

The impact of the Government’s deficit reduction programme on the budgets of CCN member councils, like all local authorities, has been severe.

Counties have worked tirelessly to protect expenditure on life-critical services, such as adult social care, in relative terms since the turn of the decade. This is despite experiencing an average reduction of 40% in revenue funding from Government.

Adult social care remains the largest area of expenditure for counties, constituting 42% of all service expenditure in 2015/16 (excluding education) and 43% in 2016/17. However, this masks the true scale of the financial challenge facing county authorities, particularly if they are to maintain, at a minimum, the current quality and level of service delivery to those people most in need.

CCN member councils will see the sharpest decline in Government funding through the Revenue Support Grant (RSG) over the duration of this Parliament, constituting a 93% reduction which is the steepest for any local authority type. By comparison, London (-71%),

Metropolitan Boroughs (-69%) and non-CCN unitaries (-81%) will experience a significant, but less steep, decline in Government funding.

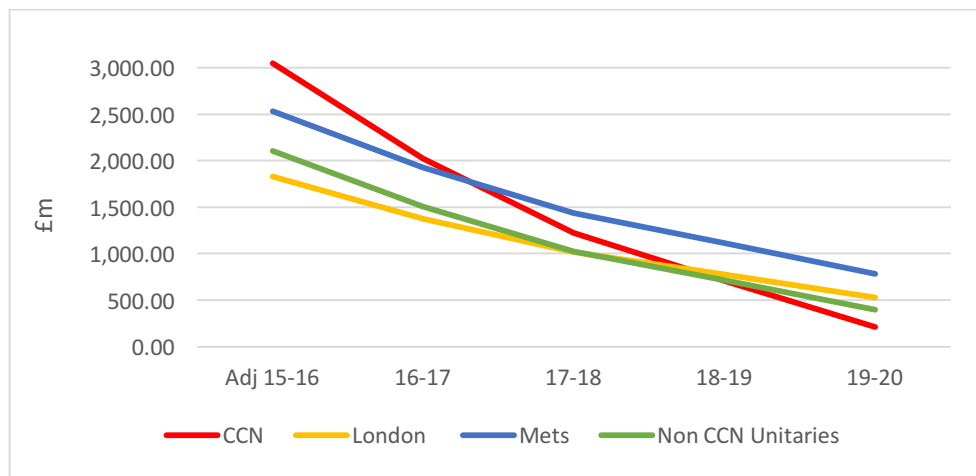


Table 1: Revenue Support Grant 2015/16- 2019/20

The majority of CCN member councils have taken up the Government’s offer of a four-year funding settlement. This will provide some certainty about the minimum level of funding that these councils can expect to receive from Government over the remainder of the Parliament. However, it is widely acknowledged that in a number of counties the trajectory of demand for statutory services, such as adult social care, will mean that this funding will not be sufficient to maintain services.

Recent high profile national reports have stated that adult social care is ‘on the brink’ and at tipping point’.^{3 4} This is a position reflected by the results of the CCN survey of county Directors of Adult Social Care. A significant majority of respondents (88%) stated that the financial pressures facing their departments was either ‘critical’ or ‘severe’.

Analysis and Policy Proposals

Funding

This assessment of the current financial landscape is supported by the Care Quality Commission's (CQC) assertion that in 2015/16 local authorities were reported to have spent £168m more than they budgeted for. Local authorities have a legal obligation to deliver a balanced budget, meaning that funding pressures on adult social care are not as publicly known as those occurring in the NHS. CCN member councils, like other local authority types, are faced with drawing upon reserves to address shortfalls in funding. The use of reserves is a one-off and unsustainable solution to the dearth of funding for local authority financial pressures.

The scale of the challenge in county areas should not be underestimated, with a recent report by PWC stating that Lancashire County Council will have a £92m in-year gap in expenditure for adult social care by 2020/21.⁵ Somerset County Council are also facing significant challenges in delivering a balanced budget as a result of increasing demand and reduced funding, with the council predicting a £12.8m overspend for adult social care by April 2017.⁶ These issues highlight the differences between delivering a balanced budget and a sustainable budget.

Independent research from LG Futures, on behalf of CCN, found that counties were subject to the largest reductions in estimated cash funding, 22.9%, from 2013/14-2015/16, more than other local authority type.⁷

The current inequity in funding is also demonstrated by the fact that CCN member councils will spend an estimated £1,306 per head on the 65 and over population for social care in 2016/17, compared to £2,204 in London, representing a 41% disparity.

These significant variations in funding have been further embedded by the then Government's decision to freeze the Social Care Relative Needs Formula (SCRNF) in 2013/14. This has led to counties not receiving an annual uplift in their share of national funding based on demographic growth. As a result, per capita funding levels for counties will continue to fall relative to other local authority types. These inequities have been further embedded by the use of the SCRNF as part of the formula to distribute additional funding for adult social care through the improved Better Care Fund (BCF).

Adult Social Care Precept & Improved Better Care Fund

The 2015 Spending Review delivered some additional funding for adult social care through the introduction of the social care precept and improved BCF. Government stated that these funding streams taken together:

*'...mean local government has access to the funding it needs to increase social care spending in real terms by the end of the Parliament. This will support councils to continue to focus on core services and to increase the prices they pay for care, including to cover the costs of the National Living Wage.'*⁸

However, the additional funding raised by the adult social care precept in 2016/17 has been fully absorbed by the introduction of the National Living Wage (NLW). The recent Association of Directors of Adult Social Care Services (ADASS) budget survey found that for 2016/17 the social care precept will raise less than two-thirds of the calculated costs of the NLW, which is expected to cost councils £520m, significantly more than the £380m raised through the precept.⁹

Therefore, it should be no surprise that 96% of county directors of adult social care are 'not very confident' that the improved BCF and adult social care precept will counter the financial pressures facing adult social care in their local authority.

Analysis and Policy Proposals

Funding

Our response to the LGFS showed that if every CCN member council applied the social care precept, it would raise the least in counties, per head of 65 and over population, when compared to other local authority types. Proportionally counties will also receive significantly less funding for the improved BCF than other local authority types. For example, the largest disparity occurs in 2018/19 when Metropolitan Boroughs will receive the equivalent of 193% per head funding more than CCN member councils.

Taken as a whole, the funding provided to non-CCN authority areas through the precept and improved BCF per head of population aged 65+ will be significantly higher over the course of this Parliament. This disparity peaks in 2018/19, when London receives 170% more funding per head of population more than CCN councils, this disparity should be considered in the context of the most acute demand-led social care pressures facing county areas that are outlined in this submission.

To reduce the impact of Government funding reductions in the short-term, CCN has been calling for at least £700m of the improved BCF to be frontloaded. This would provide much needed funding to county authorities facing the most acute demographic, demand and financial pressures. Such an approach would not necessarily resolve funding issues for all county authorities, however, it would provide some much needed funding upfront within the existing Government budget envelope.

These new funding streams, coupled with changes to the way in which RSG is distributed as part of the LGFS, have afforded CCN member councils less protection as social care authorities compared to other parts of the sector. These changes resulted in CCN member councils witnessing unexpected levels of funding reductions. CCN argued that due to the absence of a full public technical consultation, the redistribution of RSG within the settlement had not fully taken into account the needs of local populations, both currently and over the four-year Spending Review period.

Business Rates Retention

For the reasons outlined above, Government proposals to fundamentally reform local government funding through Business Rates Retention are welcome. However, given the funding issues facing counties, this reformed funding mechanism must reflect needs and in turn fully remunerate councils for the costs of meeting these.

Recent research by Pixel Financial Management for CCN has called into question whether growth in business rates and council tax income will match the growth in demand-led services such as social care.¹⁰

LA Types	2017/18	% Diff CCN Allocation	2018/19	% Diff CCN Allocation	2019/20	% Above CCN Allocation
CCN	£79.58	–	116.62	–	254.11	–
Met	£110.69	39%	276.86	137%	428.04	68%
London	£137.17	72%	315.09	170%	466.51	84%
UA	£95.32	20%	211.88	82%	324.47	28%
England	£93.67	18%	210.18	80%	322.56	27%

Table 2: Additional Funding Per Head of 65+ Year Old Population- BCF/Social Care Precept Combined

⁵ Statutory Services Budget Review- Lancashire County Council, PWC, September 2016

⁶ 2016/17 Quarter 1 Revenue Budget Monitoring Report, Somerset County Council, 26 September 2016

⁷ Social Care and Health: Funding and Cost Pressure Analysis, LG Futures, January 2016

⁸ Spending Review and Autumn Statement 2015, HM Treasury, November 2015

⁹ ADASS Budget Survey 2016, Association of Directors of Adult Social Care Services, July 2016

Analysis and Policy Proposals

Funding

The research showed that the average increase in spending on adult social care for CCN authorities is likely to be somewhere between 4% and 5% per year (2.0% growth in demand and 2%-3% increase in unit costs). For all but three CCN authorities (based on past performance), the growth in business rates income will be less than the growth in adult social care pressures. Pixel concluded that there is a significant mismatch between the growth in a demand-led service such as social care and the growth in business rates and other sources of income available to local authorities.

In addition, Government are proposing through BRR reforms the devolution of a range of new responsibilities in exchange for retaining a potential additional quantum of approximately £11bn in business rates. The Society of County Treasurers (SCT) recently argued in a letter to Government that the first draw on the additional business rates devolved to councils should be to meet unfunded and underfunded pressures across adult social care, something that CCN fully supports.

The needs-based review and business rates system must provide adequate funding for statutory services over time – this will represent the best for value for money for taxpayers and relieve pressures on other parts of the public sector.

Analysis and Policy Proposals

Quality, Demand & Capacity

The increase in demand for services has led to local authorities having to make difficult decisions about the level of care provided to people with lower level social care needs. This has led to a big reduction in the numbers of older people receiving local authority-funded social care across England- from more than 1.1m in 2009 to 853,615 in 2013/14 – a fall of 26 per cent.¹¹

The changing nature of social care is further reflected by LaingBuisson's analysis of the homecare market. This shows that the number of individuals in England receiving homecare through their local authorities reduced from 415,000 to 279,000 from 2000-2016.¹² At the same time, however, the number of hours of care that each client receives has almost doubled from 6.7 to 13 hours per week– showing that the intensity of needs being managed within people's own homes has risen dramatically.

An ageing population and the increasing prevalence of long-term conditions are putting unprecedented pressure on health and social care services. Whilst the overall numbers of people in receipt of care fell, the complexity of needs has increased. This mixed with a fall in the funding available to meet needs means local authorities creates a difficult environment for local leaders and decision makers.

This situation is exacerbated in county areas as they are home to the largest and fastest growing older populations in England. CCN member councils will experience growth of an average annual rate of 2.0%, over the next five years, compared to the English average of 1.8%. County authorities are also home to a larger proportion of over 75s (9.2%), compared to all other local authority types, including London (5.4%).¹³

Added to this CCN member councils will experience a projected increase of 14.8% in the number of people with a limiting long term illness by 2020/21, higher than all other local authority types.

Analysis and Policy Proposals

Quality, Demand & Capacity

There is genuine concern from key sector figures about the impact of significantly reduced financial settlements on the level of service delivery and meeting needs, including a recent Health Select Committee report that concluded:

...on the evidence we have heard we are concerned that people with genuine social care needs may no longer be receiving the care they need because of a lack of resource.¹⁴

These issues are exacerbated by the unique service delivery challenges faced by counties, in part down to them being on average 70% rural. Factors such as longer travel times, competition for high quality care staff and fewer providers create unique service delivery challenges and are responsible for additional cost pressures not faced by other local authority types.

CCN member councils are working tirelessly to deliver significant efficiency savings and develop new models of care in order to just maintain current levels of service delivery and quality.

“CCN member councils are working tirelessly to deliver significant efficiency savings and develop new models of care in order to just maintain current levels of service delivery and quality.”

Analysis and Policy Proposals

Quality, Demand & Capacity

Quality

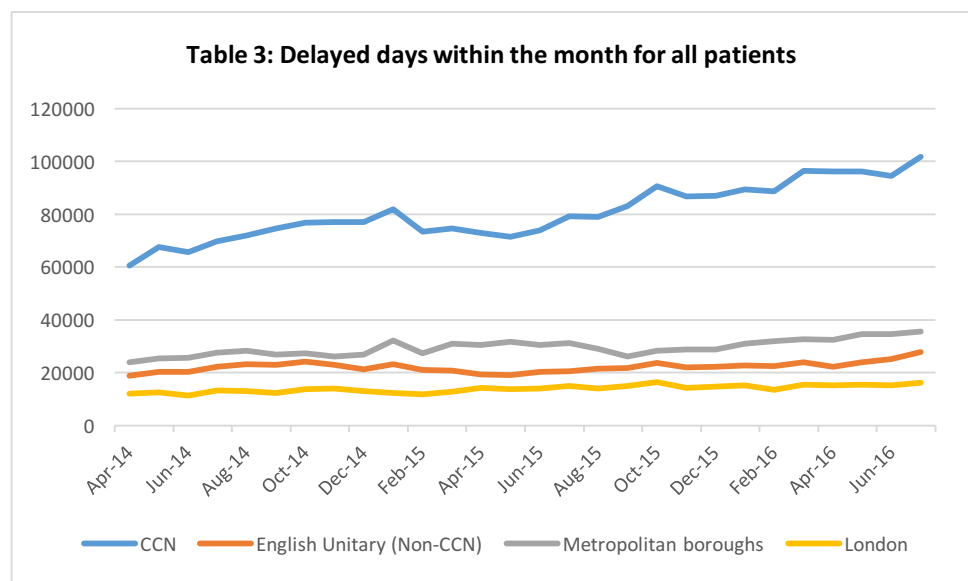
Nationally, CQC have assessed that adult social care services have been able to 'maintain quality', although they are concerned about the 'fragility of adult social care and the sustainability of quality'.¹⁵

CCN member councils have to-date continued to commission and provide quality local services to those most in need. Residents in receipt of adult social care services in county areas not only rank their social care related quality of life as the highest of any local authority type, they also have the highest level of satisfaction with their care and support services. Added to this, service users in CCN member council areas feel that social care services make them feel safer and more secure when compared to other local authority areas.

Delayed Transfers of Care

Delivering high-quality care while achieving good financial management, at the same time as experiencing escalating demand, is a quandary facing counties and other local authorities across England. These challenges, mixed with issues such as the recruitment and retention of social workers, have a direct impact on the capacity of social care to provide suitable, timely and quality care for local residents in need.

The impact of these factors is becoming increasingly evident with key barometers of demand and service availability, such as delayed transfers of care, showing significant increases nationally. For example, CCN members have seen a 68% increase in the number of delayed days within the month from April 2014-July 2016. This increase is significantly higher than in all other local authority types, with Metropolitan Boroughs facing a 49% increase over the same period, non-CCN unitary councils (48%) and London (38%).

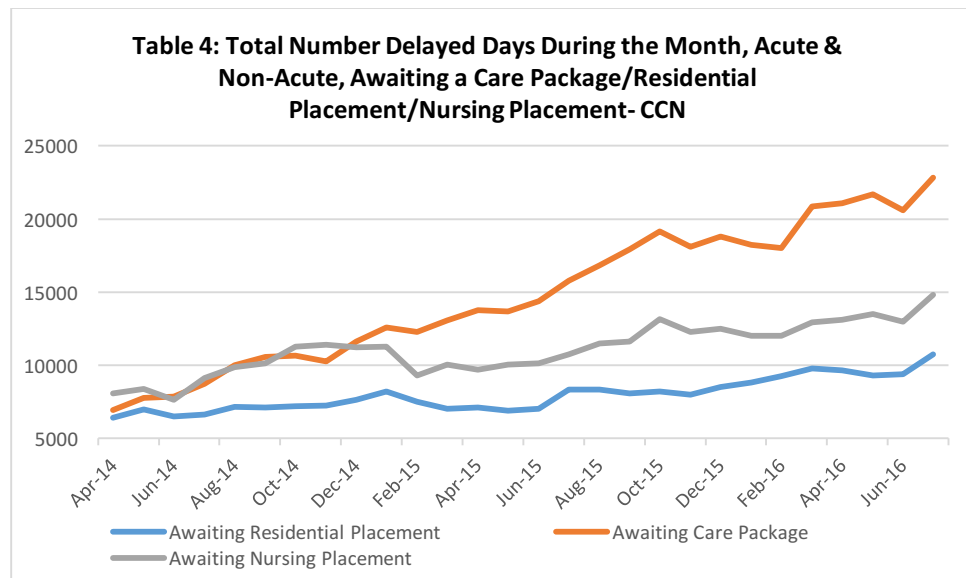


Analysis and Policy Proposals

Quality, Demand & Capacity

In county areas, an increasing number of delays from acute and non-acute settings are being attributed to adult social care. CCN member councils saw the number of delayed days attributable to adult social care during the month rise by 130% from April 2014-July 2016.

More specifically, there are capacity issues across residential, nursing and homecare. CCN member councils have seen the largest percentage increase in delayed days of any local authority type, with the exception of nursing placements. County areas have been subject to a 228% increase in delayed days attributed to awaiting a care package and a 67% increase in the number of days attributed to residential care.



In order to counter the pressures outlined above, counties, such as Oxfordshire County Council are working with health partners to develop innovative solutions to increase capacity within the system (See page 40). The approach in Oxfordshire has been multi-faceted, with additional investment in extra intermediate care beds, the establishment of a multi-disciplinary team, therapy to maximise service-user independence and the ability to move resources as required to alleviate pressure and support patient flow.

Such approaches seek to improve outcomes for patients, as well as reducing unnecessary expenditure on people being cared for in inappropriate care settings.

Analysis and Policy Proposals

Quality, Demand & Capacity

Capacity

The capacity of care providers to continue to deliver quality, safe and sustainable care on behalf of local authorities is increasingly being called into question. Ongoing funding reductions in social care budgets have led to significant downward pressure on the fees paid by CCN member councils for residential, nursing and homecare to providers.

In response to the funding and demand pressures facing county authorities, CCN member councils have utilised the size and scale of their authorities to capitalise on their position as a bulk buyer of care services to negotiate discounts on care packages. However, the downward pressure on fees, coupled with the implementation of the National Living Wage has led to unsustainable pressures in local care markets. Many providers are now teetering on the edge of financial collapse or shifting their business model to focus on the more profitable self-funder market.

These pressures have led to a decline in capacity. This is demonstrated by figures published by LaingBuisson in September 2015 that showed for the first time, capacity loss from closures exceeded, by 3,000 beds, capacity gain from new openings in residential care from October 2014-March 2015.¹⁷

The pressures facing local care markets are immediate and without additional funding from Government will only worsen over the remainder of this Parliament. The Local Government Association (LGA) has used the "fair price of care" calculations to highlight that the immediate pressures threatening the stability of the care provider market could amount to at least £1.3 billion.¹⁸ This is supported by calculations from the United Kingdom Homecare Association (UKHCA) that estimate that the state-funded homecare sector in England requires an additional £360m this year, just to ensure that workers receive the National Minimum Wage (NMW).¹⁹

The impact of the NLW and NMW has led to care providers seeking additional remuneration to cover these costs. This is clearly shown by the results of CCN's survey of county directors of adult social care. Care providers have sought to renegotiate care contracts as a result of the implementation of the NLW in 62% of county residential care markets and 46% of county homecare markets (See page 32).

The result of the dearth of funding has also led to some providers exiting the market. The UKHCA, in their submission to this report, (see page 33) have set out the seriousness of the current landscape:

'Care agencies have begun withdrawing from local-authority contracts, either through closure, or by handing back contracts which they deem uneconomic, with some larger independent and not-for profit homecare providers willing to do so publicly'

A recent example includes Mears who took the decision to hand back a number of homecare contracts to local authorities, including Liverpool and Wirral, on the basis that they felt the funding provided would not allow them to 'meet the requirements of the "national living wage" for care staff, or not delivering the service needed by the user'.²⁰

There is increasing evidence in county areas to support the statement from UKHCA, with 27% of county directors of adult social care stating that there has been an increase in the number of homecare providers exiting the market (see page 9). This issue seems to be further exacerbated in the residential care market, where nearly two-thirds of directors (65%) identified that there had been an increase in providers exiting the market.

¹⁷Government austerity measures have created two-tier long term care market which is failing state supported residents, LaingBuisson, September 2015

¹⁶County Care Markets: Market Sustainability & the Care Act, Laing Buisson, July 2015

¹⁸£2.6 billion could be needed to fix social care, Local Government Association, 13 October 2016

¹⁹Reference to the National Minimum Wage included the National Living Wage for workers aged 25 years and above.

²⁰Why my company is handing homecare contracts back to councils, The Guardian, 30 August 2016

Analysis and Policy Proposals

Quality, Demand & Capacity

If this trend continues local authorities and the NHS will find it increasingly difficult to arrange care at market discounts, or worse, difficult to arrange care at all. This will lead to escalating costs to the health service due to an increase in delayed discharges, with councils and health providers being unable to find quality and affordable residential and nursing placements to reduce demand on acute healthcare.

In their good practice piece for this publication, the UKHCA stated (*See page 43*):

'Counties covering rural areas may need to rethink the general trend towards county-wide homecare contracts a 'one-size-fits-all' approach, giving particular attention to the costs of rural and specialist services, with higher rates for workers' travel'

CCN member councils are developing new approaches to procurement and commissioning in response to the financial, supply and demand challenges in local care markets. Counties are rethinking their practices and increasingly moving away from commissioning care contracts over larger geographical footprints for homecare. For example, Suffolk County Council have procured thirty plus 'lots' to deliver domiciliary care in the county.

Such a practice provides certainty over the future level of business for providers, which in turn provides stability for the recruitment and retention of the social care workforce. This practice also provides greater resilience in the event that a provider goes in to liquidation or is placed on safeguarding alert.

CCN member councils, such as Oxfordshire County Council, have developed outcome-based contracts whereby providers will be incentivised to reduce the level and length of care packages over time, for those who can be enabled to become more independent.²¹

Analysis and Policy Proposals

Partnership, innovation and integration

The Integration Imperative

Government set a clear direction of travel in the 2015 Spending Review, stating that Health and Social Care Plans should be developed and agreed in every local area by 2017, with implementation of these plans by 2020. Integration between health and social care has been put forward as a way to reduce costs, relieve pressure on services and improve user outcomes and experiences.

Soon after this announcement, NHS England published plans that set out the requirement for NHS partners, along with local authorities, to work together to develop Sustainability and Transformation Plans (STPs). These plans are seen as a vital to delivering the efficiency savings set out in the NHS Five Year Forward View.

The delivery of integrated health and social care services is not a new development in county areas. There are numerous examples of large and small scale partnership working that deliver place-based and outcome focused services for local people, such as integrated mental health services in Warwickshire (see page 43).

Counties have been at the forefront of developing new models of service delivery in order to protect vital frontline services within a reduced budget envelope. This has seen the development of new delivery models such as Local Authority Trading Companies (LATCs), some of which are specifically focused on the delivery of adult social care. Using this innovative approach CCN member councils, such as Essex County Council, have established LATCs in order to deliver savings, to grow commercially to generate more income and share benefits with the council.

The Government's commitment to the delivery integrated health and social care services by 2020 has led to a number of new models of service delivery being developed. Accountable Care Organisations (ACOs) are one such model, some of which are being developed as part of the NHS Vanguard programme, with others being considered as part of the Sustainability and Transformation Plan process. Northumberland County Council have been actively involved in the development of an ACO for their county.

There are several factors that will influence the success, or otherwise, of delivering fully integrated health and social care services by 2020 including- funding levels, demand and need, relationships and strength of partnership working.

Analysis and Policy Proposals

Partnership, innovation and integration

The Complexity of Partnership Working

The importance of local relationships in delivering devolution, integration and better outcomes should not be underestimated. The Greater Manchester devolution bid, including health and social care, was underpinned by long-standing sub-regional arrangements that allowed them to take a 'compelling, unified vision to Government about the future of the area'.²²

In general, county areas have more complex partnership arrangements for health and social care than other local authority types. This is a result of the number of public sector partners delivering services across broad and sometimes misaligned geographies, with added complexity in two-tier areas where there are 201 District Councils in operation (See *infographic 4*). Such arrangements have provided a challenging environment for the development of plans for health and social care integration, such as STPs.

This is a view supported by research from Shared Intelligence who highlighted that messy and complex geographies can make the task of building good personal relationships and collaborative working more difficult and time consuming, in particular shire areas with a large number of district councils and CCGs.²³

The importance of co-terminosity and a history of collaborative working are two factors highlighted by Northumberland County Council in their case study about delivering integrated health and social care services (See *page 44*). These historical working relationships mean that 'integrated planning is a default' and also provides the platform for the development of an Accountable Care Organisation ACO.

Analysis and Policy Proposals

Partnership, innovation and integration

Sustainability and Transformation Plans

The development of Sustainability and Transformation Plans and the associated footprints has only served to build further complexity into the health and social care landscape. For example, in counties such as Essex and North Yorkshire, there are three STP footprints in place for each county which transcend historic county boundaries.

There are significant risks that CCN member councils covered by more than one STP footprint will see their social care budgets fragmented. These risks will be exacerbated if counties are required to identify spend on social care services within an STP footprint area and pool these with NHS partners. Such an approach would have a detrimental effect on the ability of local authorities to cross-subsidise peaks and troughs in demand between different areas of service provision across a broader county footprint. There are also difficulties in identifying the true level of expenditure on service provision, as highlighted by the transfer of public health from the NHS to local authorities.

The fact that the 44 STP footprints do not fully align with county boundaries may, in part at least, be a consequence of CCN member councils not being fully engaged in the development of these geographies. CCN's survey of county directors of ASC showed that 58% of respondents felt that their local authority had been actively involved in the development of their STP, whilst the remaining 42% felt that their authority was only partially involved.

The survey also highlighted that Directors did not view the development of STPs as a silver bullet to deliver sustainable services. The majority of Directors (77%) indicated that they were not very confident that STPs will deliver on their stated aim for local services to 'evolve and become sustainable over the next five years', with the remaining 23% confident that STPs would deliver on the stated aim.

In order to deliver the Government's ambition to integrated health and social care by 2020, directors of county ASC indicated that the key enabler of this would be strong system leadership (65%). This was closely followed by sustainable financial settlements (62%) and integrated place-based budgets (62%).

Despite the Government's push for integrated health and social care services, the funding settlements received by the NHS and local authorities are not aligned in their structure. The NHS has received a settlement with more funding received in the earlier years, whereas funding for adult social care will reach its peak in 2019/20. Ideally these settlements would provide sufficient upfront funding for both local health and social care partners to invest in integration.

Added to this, county areas receive significantly less funding for the delivery of health and social care than other local authority types. Independent research by LG Futures, on behalf of CCN, showed that county areas receive £1.98bn less funding for health and social care when compared to the national average.²⁴

Delivering real, long lasting, sustainable transformation and integration will be hampered by the need to address existing budgetary challenges, both in the NHS and adult social care. The NHS has reported year on year deficits, while local authorities are faced with extremely challenging budget settlements. In some local authorities, such as Lancashire County Council, serious doubt has been raised as to whether the legally required balanced budget will be deliverable by the end of this Parliament.²⁵

Analysis and Policy Proposals

Partnership, innovation and integration

Devolution

To-date the devolution of health and social care has been extremely limited, with only Greater Manchester (GM) seeing significant funding and responsibilities fully devolved. The GM deal will see the 37 NHS organisations and councils in the city region taking charge of the £6bn health and social care budget.

By comparison, as part of the Cornwall devolution deal, Government has committed to work with the Council and key partners such as the Council of the Isles of Scilly, NHS Kernow, NHS England to transform health and social care services.²⁶

On the face of it the devolution of powers, responsibility and funding for health and social care should provide the freedoms and flexibilities required to deliver truly local services, shaped around the needs of residents. However, some sector commentators have questioned the extent to which health and social care has truly been devolved to localities. For example, in a recent report the Institute for Public Policy Research (IPPR) stated that 'At the moment, 'devo-health' is more akin to delegation than devolution'.²⁷

Ultimately for true devolution to be delivered, incentives must move away from rewarding contacts with service users and reward the NHS for improving outcomes and preventing people from entering expensive crisis care unnecessarily. This is a position supported by a key finding in the recent Common's Health Committee report into the 'Impact of the Spending Review on Health and Social Care':

'The payment system needs to be reformed, so that it does not continue the perverse incentives which can drive inappropriate hospital admissions'²⁸

Improving and aligning incentives will play a key part in bringing partners together in local areas to improve outcomes for residents, deliver integrated services and in-turn efficiency savings. However, this approach will take time and will not solve the immediate and underlying funding problem that currently exists in social care. But as the County All Party Parliamentary Group (APPG) stated in their report on health and social care integration:

'Crucially, it would allow local areas the freedom and flexibilities to improve outcomes and drive savings and efficiencies across local public services'²⁹

CCN set out in its Spending Review submission that there should not be a one-size-fits all approach to achieving such devolution.³⁰ Any devolution deals should build upon those already agreed in Greater Manchester and Cornwall, but be designed through bespoke negotiation. Each county, or grouping of authorities, has its own unique demand pressures and health economies that will require specific devolution proposals across health and social care that reflect local needs and circumstances.

²⁶ 'Accelerated Health and Social Care Integration', Cornwall Council, 7 June 2016

²⁷ Devo Health- What & Why, Institute for Public Policy Research, August 2016

²⁸ Impact of the Spending Review on Health and Social Care, House of Commons Health Committee, 12 July 2016

²⁹ The State of Care in Counties- The Integration Imperative, County APPG, March 2015

³⁰ Spending Review Submission, County Councils Network, September 2015

Policy proposals for government

- Bring forward at least £700m of the improved Better Care Fund to 2017/18, recognising the existing funding and demand pressures facing adult social care in CCN member councils.
- In the event that deficit reduction targets are loosened, Government should ensure that any additional funding for public services is targeted to protect demand-led frontline services. Underfunded and unfunded pressures for adult social care services in county areas must be fully funded as a matter of urgency to stabilise local services and care markets and help local authorities reduce demand on the NHS.
- Through Business Rates Retention and the Needs Based Review, commit to addressing the unfunded and underfunded pressures facing adult social care in county areas, prior to taking decisions to devolve further funding and responsibilities.

“The pressures facing local care markets are immediate and without additional funding from Government will only worsen over the remainder of this Parliament.”

Policy proposals for government

- Undertake an in-depth review of local care markets to identify the funding required to deliver stable and sustainable care, including sufficient capacity to reduce the number of costly delayed days in acute and non-acute settings.
- Ensure that health and social care integration is delivered at sufficient size and scale in order to reduce the complexity of partnership working, deliver efficiency savings, improve care for residents and has governance arrangements that are transparent and democratically accountable.
- Reform NHS financial incentives to ensure that they promote prevention, early intervention and integration.

“CCN members have seen a 68% increase in the number of delayed days within the month from April 2014 to July 2016. This increase is significantly higher than in all other local authority types.”

Health & Social Care Integration

CCN'S SURVEY OF COUNTY DIRECTORS
OF ADULT SOCIAL CARE FOUND

Delivering an integrated health and social care system



TOP THREE ENABLERS OF INTEGRATION



65%
Strong system leadership



62%
Sustainable financial settlements



62%
Integrated place-based budgets



TOP THREE BARRIERS TO INTEGRATION



85%
Conflicting targets & incentives



73%
Misaligned financial settlements between health & social care



42%
Insufficient funding

INVOLVEMENT IN THE DEVELOPMENT OF LOCAL STP FOOTPRINT

58%
Actively Involved



42%
Partially involved



CONFIDENCE THAT STPS WILL DELIVER ON THEIR POLICY OBJECTIVE FOR LOCAL SERVICES TO 'EVOLVE AND BECOME SUSTAINABLE OVER THE NEXT FIVE YEARS'

77%
Not very confident



23%
Confident



**THINK
PIECES**

Think Pieces KPMG



Joanna Killian
Head of Local
Government
& Partner KPMG
LLP

These are testing times for anyone involved in the provision of health and social care. The NHS – an organisation revered unlike any other in this country finds its operating model under scrutiny like never before. Budgets are being further reduced and the deadlines for delivering substantial cost savings hover ominously on the horizon. Jobs and reputations are on the line. As the current hospital-based model begins to give way to something predicated more on prevention and early intervention, integration and collaboration have become the buzzwords of the moment.

Devolution, sustainability and transformation all swirl around in the mix as well. The Better Care Fund, Sustainability and Transformation Plans, the Care Act, vanguards and Devo Manc all help to provide definition to the landscape; the background against which this story unfolds. This is no game though. This is about defining how we protect the wellbeing of our citizens for years, or even generations, to come. If it were a game however, it would be one where most of the players are having to make up the rules as they go along. These truly are testing times.

County Councils of course have to manage extra complexities. While many unitary councils have co-terminous CCGs and a strong link with a major hospital, Counties typically comprise several Districts, several CCGs and a range of different hospitals. Residents will often look across the border into neighbouring areas for services. And of course where the NHS is organised around big hospitals Counties can find themselves in two or three “sustainability and transformation footprints”!

To support the journey towards integration we have drawn upon KPMG professionals observations of sector best practice to try to consider the best way forward from here. I hope you find it an interesting read

What can we learn from existing integration activity?

Looking at those localities which have already pooled over £100 million – and appear to be succeeding in their integration efforts – KPMG professionals have observed the emergence of several common characteristics:

- All of the major players, including the providers, are represented on the Board;
- The Chief Executives work together in an executive team that supports the Board and runs the system like an organisation;
- All the money is in the pool – the system budget is the only budget;
- GPs are represented by a federation that can speak with one voice; and
- They adapt the national rules to fit their local priorities and to establish the right initiatives.
- Looking at a more detailed level we believe that well-led care systems will typically be able to point to:
 - A shared core purpose; a population based vision, captured on a single page, which is stronger than any vested interest;
 - Shared risks and gains; each partner’s ‘red light risks’ are known and recognised, with all partners helping to resolve or reduce these risks. Gains are captured for the whole system, regardless of when and where within the system they manifest themselves;
 - A clear agreement about collaboration and competition; both are vital aspects of delivering quality and improving efficiency but one is never allowed to trump the other;

“Solving the care integration puzzle”

- An accepted arbitration process; while disagreements are both acceptable and expected, there is an accepted approach to progressing even when no compromise can be quickly reached;
- Defensible and realistic plans; agreement is based on locally deliverable outcomes, not on shared demands that others change; and
- Resilient relationships; people treat each other with respect, behave well, follow the rules, disagree constructively and accept that poor behaviour has consequences.

Sadly however, too few places can claim all the ingredients for success and across the various barriers to successful integration, three seem to come up time and time again.

The first is the pervading culture within healthcare. In KPMG's experience, pilots and pioneers can often flounder the instant that they have to challenge the established cultural orthodoxy. Challenging the system as a whole requires new questions to be raised and existing issues to be reframed or seen from a wholly different perspective. Radically new thinking needs to be welcomed and encouraged.

The second is leadership turnover. We see alliances broken by restructuring, reorganisations and political change. This results in a rate of leadership churn which destabilises integration efforts. Success seems to correlate with a consistent local leadership presence. Successful integrators are likely to have been around for decades, not year, building up trust and insight. They should be left alone to do what they do best.

Finally, there is the problem of an adherence to short term priorities. Regulations and targets drive leaders to focus on short term delivery and survival; something which may not always sit comfortably alongside longer term objectives. The winners in this particular space are those integrators who can deal with the immediate issues without taking their eye off the longer term prize – and investing accordingly.

It is clear that the characteristics of success are more prevalent where there is 'trust' amongst partners. However, in some areas of the UK these relationships are fundamentally broken. The challenge remains how areas find a way to develop a united narrative of what can be achieved together that will serve the needs of the most vulnerable in our society. The role of strong political leadership is a critical factor of success and partners having an understanding and appreciation of different cultures shows a willingness to find a way together through the puzzle of care integration.

Think Pieces The Kings Fund



Richard Humphries
Assistant Director,
Policy

Our recent assessment of the state of adult social care for older people – Home Truths - paints a mixed picture about the impact of austerity on services, spending and outcomes.

Over the last six years local authorities have made valiant efforts to remove over £5bn from budgets whilst protecting services for those with the greatest needs. But they are now struggling to meet legal requirements and the care and support needs of an expanding population that are more acute, complex and costly than ever before. They are running out of road in terms of financial sustainability and legal compliance. This is the product not just of austerity – by 2010 over 80% of councils were already limiting help to people with substantial and critical needs. It reflects the inability of successive governments over the last twenty years to address how we pay for the success story of our ageing population.

For providers, although the picture is mixed, the cumulative impact of squeezed fees has created unprecedented pressure especially those dependent on local authority contracts and with high levels of debt. In home care, where problems exacerbated by growing difficulties in staff recruitment and retention, the position is now critical. The new precept and the 'improved' Better Care Fund money will help but the latter comes too late to address the financial pressures that beset services now.

What does all this mean in county areas? Generally they are more likely to have older populations and therefore higher levels of social care need. They will need no reminding of the logistical and financial challenges of

delivering services – especially home care - across wide geographical areas with dispersed populations.

Many counties will have more affluent people funding their own care – although there are significant differences within as well between counties. In the short term the cross-subsidy from this source will prop up the residential & nursing home market but self-funders will eventually run out of money, and without the benefit of the proposed cap on care costs, will eventually come knocking on the local authority's door. Local authorities will find it increasingly hard to find affordable placements in areas where providers can achieve high occupancy by self-funders. It is also clear that private investment in new provision is being focused on areas with high levels of self-funding. The sharpening polarisation of the market means that the care people get will depend as much on where they live and what they can afford as on what they need. This means it is essential for counties to have a good understanding of their local self-funding population in order to inform their commissioning and market shaping responsibilities, including a robust policy for people with diminishing resources.

Councils face these pressures in the context of wider organisational changes in local government notably devolution deals and the emergence of combined authorities. For the most part these appear to be based largely on urban models to meet urban needs.

A bigger question mark for counties comes from two other directions. One is the fiscal shift towards the phasing out of central government grant that would make the

“Many counties will have some of the most complex health economies in the country, some with chronic historical financial and service challenges that pre-date the current squeeze”

funding of essential services like social care dependent on local levels of property wealth and economic uncertainty. The other is the deepening financial crisis in the NHS, sliding towards its largest deficit in history. The creation of 44 sustainability and transformation (STP) footprints is a welcome move towards planning around the needs of local places rather than separate organisations. It is a way of overcoming the organisational complexities created by the Health and social Care Act 2012 but without another structural upheaval.

But the STP process now appears to be focusing almost exclusively on achieving financial balance and most NHS insiders do not believe that in the short term this is possible. Many counties will have some of the most complex health economies in the country, some with chronic historical financial and service challenges that pre-date the current squeeze. Unlike local authorities, NHS bodies are not legally required to set an annual balanced budget. It has been too easy for painful choices, with which local government is only too familiar, to be fudged or avoided altogether.

Counties bring significant strengths to the debate. They are big enough organizationally to have scale and critical mass, along with a relatively long period of organisational stability and have a wealth of experience of service delivery and strategic change. These are attributes which ought to command the respect of their local NHS partner organisations. But evidence is clear that it is the quality of leadership rather than organisational size that matters most. There is a particular challenge for local politicians in leading public opinion rather than just following it, especially when essential but contentious service changes

are on the table. The smartest STP areas are those that are actively engaging local authority leaders in the process.

So while the scope for councils to shape local services across the health and social care boundaries has never been greater, it is hard to see how the social care system or the NHS can continue in their current form without a very different funding settlement – based on a fresh public debate about what good care costs and how it should be paid for - or a radically different offer to citizens and communities. Something will have to give.

Think Pieces

United Kingdom Homecare Association



Colin Angel
Policy & Campaigns
Director

By almost every indicator, state-funded homecare is increasingly fragile. Homecare providers have felt a repeated squeeze on price from councils, with the additional costs of the National Living Wage this year, and an increasing difficulty recruiting workers in many parts of the country.

Homecare services are fundamental to supporting local communities, enabling people to remain at home (as the majority of older people wish to) and enabling many family carers to remain in employment. Economically, the homecare sector in England also provides employment to over 527,000 people, who pay taxes and spend money in their local community.

Homecare services should also be part of the solution to reducing pressure on local hospital services, yet recent NHS England data show that one in five delayed transfers of care were attributable to homecare packages. The involvement of homecare providers in the creation of Sustainability and Transformation Plans (STPs) becomes particularly important, yet too often independent and voluntary sector providers' knowledge of the market appears to have been overlooked.

Financial pressures in the homecare sector are defiantly increasing. UKHCA's estimates that the state-funded homecare sector in England requires an additional £360 million this year, just to ensure that workers receive the National Minimum Wage, including their travel time, and that businesses remain financially stable and able to operate to minimum regulatory requirements. Yet the vast majority of councils in the country pay significantly below UKHCA's Minimum Price for Homecare of £16.70 per hour.

The additional financial pressures of the new

National Living Wage (NLW) since April 2016 have been massive. Even where careworkers were paid above the new wage levels, many employers are struggling to remain competitive within the local labour markets without increasing pay.

Importantly, costs from NLW do not just apply to the length of a homecare visit (the "contact time"), but to the worker's pay during their whole "working time", including their travel. Yet, providers have repeatedly seen councils offering rate increases which have not taken this into account.

Whether workers are paid separately for travel, or for the time spent providing care, homecare agencies have a legal obligation to ensure that workers' pay averages out to at least the minimum statutory pay rate for their entire working time. This is especially significant where workers cover rural areas, or where very short visits are commissioned as travel becomes a larger proportion of their costs the shorter visits become.

Care agencies have begun withdrawing from local-authority contracts, either through closure, or by handing back contracts which they deem uneconomic, with some larger independent and not-for-profit homecare providers willing to do so publicly. The ADASS Budget Survey identified that almost three quarters (71%) of people affected by market failure of withdrawn were in receipt of homecare services.

In attempts to reduce costs, many councils are contracting with fewer, often larger, providers. At the same time medium and large providers are reducing the number of branches they operate and acquiring services previously operated by smaller organisations. While such consolidation is a normal market behaviour, for counties this is likely to reduce choice of provider in rural locations, or leave parts of a county without cover.

There is also a polarisation in the market between larger organisations better able to absorb low prices, and smaller organisations which are reducing their dependence on local authority contracts or supplying exclusively self-funders. This may be less of a concern for councils in the south of England, but in the Midlands and the North, this is worrying as more rural and smaller urban centres are generally less able to sustain a sufficient number of self-funders.

Careworker recruitment is challenging across the country, but our sense is that recruitment outside urban centres is deteriorating more rapidly, often because housing costs make low-paid care work unattractive, and longer travel time and mileage become uneconomic. Brexit is an exacerbating factor, particularly for counties in the South East, South West and East of England, which generally have a higher dependence on non-British EU citizens than the Midlands and the North.

The financial consequences of public spending cuts cannot be ignored. The overall funding of councils certainly requires action from central government, and the willingness of councils to prioritise spend on social care even further. However, we offer some additional recommendations which may help counties reduce risks to the homecare market instability, at least in the short term.

Councils and providers must work openly and honestly to understand the actual costs of care in their local area. Without knowing the real costs compared to the prices actually paid, the risks to market instability will be harder to judge.

Careworkers' terms and conditions of employment have a significant impact on recruitment and retention. It is particularly important to get right, given the impact of travel time for the workforce in rural areas. The National Living Wage will continue to increase, and councils will continue to need to use the 'Social Care Precept', however inadequate.

Counties covering rural areas may need to rethink the general trend towards county-wide homecare contracts a 'one-size-fits-all' approach, giving particular attention to the costs of rural and specialist services, with higher rates for workers' travel. Contracts which reduce careworkers' travel time by effective clustering of work should be a priority, along with efficient payment terms which improve providers' cash flow.

In the longer term, moving from a system where care is a commodity purchased by the hour to a service commissioned to reduce total demand is urgently needed. For that to be effective, it must include realistic payment by results mechanisms, which work for both the council and the provider sector.

Think Pieces CfPS



Tim Gilling
Deputy Chief
Executive

Health and social care are major public policy priorities. Evidence suggests that the NHS is struggling to maintain the gains achieved over the last few years and social care is increasingly available only to those with the most critical care needs. With councils' social care budgets under pressure and with continuing financial deficits in the acute health sector, the capacity for local health and care systems to meet people's needs in an integrated way is under strain. It is clear that no one organisation acting alone can find an easy solution.

Mechanisms are emerging though, so local partners can come together to plan and implement changes to the way services are commissioned and delivered. Local government is crucial to the success of these local integration arrangements, for example through the Better Care Fund (BCF) and Sustainability and Transformation Plans (STPs). Alongside these initiatives, the NHS is also developing new models of care demonstrated through a number of 'vanguard' projects – for example 'multi-specialty community providers' or 'primary and acute care systems'. Some of these are now becoming known as integrated care organisations or accountable care organisations. The Kings Fund has recently published an analysis of these emerging models (New Models of Care – Kings Fund October 2016).

These mechanisms and models aim to show how local services can become sustainable over the next five years, delivering on a place-

based basis the Five Year Forward View vision of better health, better patient care and improved NHS efficiency. Local government is also taking the initiative, with several devolution deals including actions on health and care as priorities. With no appetite for organisational restructuring, existing responsibilities and accountabilities in the system remain, but this has implications for governance, accountability and public voice across complex planning and delivery footprints.

CfPS has long advocated a strong and influential role for the public and council scrutiny in particular to improve health and care services and secure better outcomes for residents and people who use services. Scrutiny is valuable in facilitating better joint working in areas, using its ability to bring partners together and to focus holistically on the determinants of health and across health and care systems. Outcome focused scrutiny can provide a platform for councillors, professionals and communities to come together around the complexities of health and wellbeing, to help evaluate the planning, delivery and reconfiguration of services.

Our forthcoming publication 'Solving the Puzzle' will provide practical tips about scrutiny of these important issues, building on our existing reports about integration (Piecing it Together) and system resilience (Winter Pressures). A case study from Lancashire County Council will be included about their inquiry day approach to health and social care integration and the Better Care Fund. The inquiry day approach was developed by CfPS as a tool for bringing key stakeholders and partners together to focus on local challenges. Some key messages are emerging from this work:

“Outcome focused scrutiny can provide a platform for councillors, professionals and communities to come together around the complexities of health and wellbeing”

- Scrutiny of plans to tackle major service challenges is fundamental to councils' health and social care scrutiny role
- Scrutiny can add value to local implementation plans by improving the evidence base for decisions and holding system leaders to account for their ambition to improve health and care
- Scrutiny is best when it is proactive rather than passive or reactive. There is a responsibility on system leaders to get the best out of the scrutiny function for the benefit of local people

A three stage approach to developing a common understanding about the value of scrutiny can help. This may be useful when thinking about local approaches to scrutiny of health and care challenges:

- Reflect - on the experience of previous scrutiny contributions to local approaches to health and care challenges
- Identify - opportunities and barriers that can help or hinder scrutiny to influence better health and better services
- Design - a framework for scrutiny of health and care planning and delivery and, where necessary, proposals for service redesign

To build up insight about the value of scrutiny and how to improve it, it's worth thinking about some questions in advance in order to create context for discussions about health and care challenges:

- what is the current level of knowledge about new planning models and new models of care?
- what are the main challenges associated with implementing new planning and delivery models in health and social care?
- what do you think the benefits of closer joint working to solve the challenges will be?
- how should scrutiny contribute to local actions to solve the challenges?

This leads to a shared understanding about:

- who has responsibility for actions in the emerging systems and assess how partners work together to secure better outcomes
- developing shared protocols for joint working and information sharing, together with agreed arrangements for future scrutiny

With BCF plans now being implemented and STPs currently being assessed by NHS England,

“CfPS is keen to champion the role of scrutiny to help ensure that STPs are robust, effective and inclusive and that actions to integrate health and care services meet people’s needs.”

CASE STUDIES

Case Study Cheshire East Council



Councillor Janet Clowes
Cabinet Member for Adult Social Care & Integration

The needs of people living with dementia and their carers are a high priority for Cheshire East Council and we have initiated a number of programmes to support this priority. In particular we have developed an innovative pilot using dedicated workers to support people with a diagnosis of early-stage dementia, their carers and families. Our rationale was based on research that indicates that providing positive support at this early stage can protect people from a spiral of isolation and deteriorating physical and mental well-being.

Cheshire East Council launched the pilot Dementia Reablement Service (DRS) in April 2015. Liverpool John Moores University has since undertaken an independent evaluation of the service and has found that the service has been of substantial benefit with customers reporting that the support was positive in over 98% of cases.

The DRS provides flexible, person-centred, short-term support (up to 12 weeks) to individuals who are living with early stage dementia. The aim is to enable people to continue living their lives as independently and for as long as possible.

Specific outcomes that the service successfully achieved included reducing social isolation and providing good information. The Support Workers role is to identify what is important to the service user and their family, create a

personalised plan and to explore creative and practical tools to give them the confidence and the support that they require to continue to live independently.

The evaluation concluded that the service has provided a stabilising effect on service users' general sense of wellbeing and overall quality of life. There is overwhelming evidence that service users and carers felt more confident about remaining independent for longer at home whilst also feeling more informed about future options. Professionals too, were unanimous in their praise for the service highlighting the ease of referral, integrated working and the linking of otherwise disparate services together.

The positive evaluation of a wide range of interventions from technology applications (apps) to expressive arts suggests that the flexible person-centred approach is effective practice. Key priorities that users and their families identified included access to daytime opportunities and activities, information on financial help and Lasting Power of Attorney, assistive technology, and carers' information.

In addition the average potential social care cost avoidance in the first 12 months was estimated as £4,248.56 per client. The Dementia Reablement Service therefore represents a potentially significant approach by which to reduce the level of formal social care provision required by this important client group whilst maintaining good outcomes.

Health service partners value the service highly as it provides support post a formal diagnosis at memory clinics that reduces demand on both primary and secondary health services.

“Supporting the well-being and independence of those living with dementia and their carers”

Case Study Kent County Council



**Councillor
Graham Gibbens**
Cabinet Member for
Adult Social Care &
Public Health

Encompass MCP Vanguard represents 14 GP practices with a population base of 169,806 patients across Whitstable, Canterbury, Faversham, Sandwich, Ash and the surrounding rural locations. It seeks to deliver an integrated health and social care model that focuses on delivering high quality, outcome focused, person centred, coordinated care that is easy to access and that enables people to stay well and live independently for as long as possible in their home setting. More than that, it seeks to transform local services to deliver proactive care and support, focused on promoting health and wellness, rather than care and support that is solely reactive to ill health. Core to the model of care is the philosophy of health and care services working together to promote and support independence, utilising statutory, voluntary and where appropriate, independent sector services to deliver the right care, in the right place at the right time.

This model is focused on utilising the additional community capacity to reduce demand in secondary care. So far it is delivering £1.6m savings to the NHS through lower tariffs, fewer outpatient follow-ups and A&E avoidance. It continues to work closely with partners in the Community and Acute Trusts to model the planned shift in activity to the community. The community hubs will deliver a broad range of integrated community services ranging from primary care GP and practice nurse services, specialist nursing services, community nursing services, paramedic practitioner services, health prevention and promotion services and voluntary and community services.

The Encompass MCP is working with Kent County Council to integrate social care services at a hub level. A single community hub site within the MCP acts a test bed for further integration of health and social care services in 2016/17 and beyond.

The Encompass MCP has also set out an ambitious vision for whole system redesign at an organisational level, seeking to work in collaboration across the health and care landscape. This will build and implement an innovative workforce redesign model that will enable the local economy to develop and deploy a workforce fit for the future of integrated health and care delivery across current professional boundaries.

The Kent Enablement at Home (KEaH) Service working with the County Council's partners

The Kent Enablement at Home (KEaH) service promotes wellbeing and independence across Kent for people who are returning to their own home from a hospital or residential care home. Supporting over 750 people per month, the service aims to encourage and enable people to lead as independent and fulfilling life as they can, in line with their individual needs by helping them to do more for themselves at home, by learning or re-learning skills that make them feel safe and comfortable in their own homes.

Acute hospitals benefit as service users going home with a package of care tend to have a smoother and quicker discharge making acute beds available for others sooner. Approximately 31% of people coming into a KCC supported care package are referred after an acute hospital stay. The challenge is to ensure that as many people as possible return to their own home with the support of the Enablement service and not into long term residential care. As a result of the KEaH service, long-term residential placements from Acute Hospitals have reduced by 58% and short-term bed usage has reduced by 44% cent since March 2015.

Case Study Oxfordshire County Council



**Councillor
Judith Heathcoat**
Cabinet Member for
Adult Social Care

The Oxfordshire health and social care system has long struggled with the timely discharge of patients from acute and community hospitals to the next stage of their care. This is often known as bed-blocking, which is costly to the system as a whole and can increase people's dependence rather than promoting their independence. Reducing delayed transfers of care requires a system wide solution across health and social care. This is exacerbated in areas such as Oxfordshire with a complex acute hospital and high numbers of community hospital beds.

Plans were drawn up in December 2015 between the County Council, Oxfordshire Clinical Commissioning Group, Oxford Health NHS Foundation Trust and Oxford University Hospitals NHS Foundation Trust to utilise resources outside of hospital to deliver care where it is most needed and to tackle the longstanding issue of delayed transfers of care.

The plan saw the purchase of extra intermediate care beds in a number of the county's nursing homes that have been quality assured by the County Council and CQC and distributed across the county. In addition to the beds additional resources were provided which included:

- Social Work time to work as part of a multi-disciplinary team to undertake required assessments to meet long term outcomes as required.
- Therapy to ensure service users independence is maximised as they continued to get better and therefore do not become institutionalised whilst in the intermediate care bed.
- Implementation of a command and control structure managed via a daily teleconference to prioritise system wide resources both within hospital setting and the community.

This ensured an effective flow of patients from the intermediate care beds into their own home where this was possible.

When the plan went live, all patients who needed on-going care had their discharge co-ordinated via the multi-agency hub. This hub consisted of Social Workers, therapists and nurses from Oxfordshire County Council, Oxford University Hospital and Oxford Health. This enabled a multi-disciplinary approach towards discharge management out of an acute and community hospitals from the point an individual had been identified as needing on-going care to the point where their long term care is in place. Resources were mobilised as required to alleviate pressure and support patient flow.

Delays reduced from 167 at the end of November 2015 to 130 at the end of March to 98 in June 2016. Social care delays reduced from 29 in November 2015 to 11 in June 2016. The on-going target is to reduce delays to 65 by the end of 2016/17.

Whilst further work is needed to sustainably reduce delayed transfers of care in Oxfordshire, the issue remains a high priority for all organisations and is an area that requires a continued collaborative approach. The key areas of good practice for this project so far has been the development of the multi-agency hub and the ability to move resources as required to alleviate pressure and support patient flow. The project was also supported by the introduction of the Council's new Help to Live at Home contracts, which have seen the time taken to source long term home care reduce from 11 days to 5 days. This has supported the flow of people from the intermediate care beds to home where this was possible.

This has been a very successful project with effective multi-disciplinary working being integral to its success.

“Positive results from plans to tackle delayed transfers of care.”

Case Study Northumberland County Council



**Councillor
Susan Dungworth**
Cabinet Member for
Adult Social Care &
Public Health

In Northumberland, the County Council has been working jointly with the local NHS for more than three decades, helped by the fact that for most of that period health and social care commissioning have been coterminous. The Council established in the 1990s a pooled budget with the then Health Authority and integrated care management teams under common line management arrangements.

In 2002 a Care Trust was established, based on the newly established primary care trust for the county. Almost all of the Council's statutory adult social care functions were delegated to the Care Trust, which for a while combined the direct management of most community health and social care professionals with commissioning responsibility for all health and adult social care services. A few years later, changes in national NHS policy required the abandonment of this model, as the expectation was introduced that community health services must be firstly at arm's length, and then in a separate organisation from commissioners of NHS services. For six years, NHS commissioning was centralised across a wider area, and the Council lost the co-terminosity which had supported integrated arrangements.

To maintain the operational links between community health services and social care, the Council agreed to transfer all of the operational social care services in the Care Trust to Northumbria Healthcare NHS Foundation Trust from 2011. Two years later, co-terminosity with health commissioners was restored

with the creation of Northumberland Clinical Commissioning Group, and the Council and the CCG quickly re-established integrated commissioning arrangements. The CCG headquarters is at County Hall, and the Council commissions continuing healthcare services on behalf of the CCG under a partnership agreement.

Key senior management posts, including the statutory Director of Adult Social Services, are joint appointments between the Council and Northumbria Healthcare, with responsibilities which straddle community health and social services. As a result, integrated planning is a default rather than requiring specific initiatives, with many managers at all levels having responsibility for both health and social care services, and the ability to use staff skills and physical resources flexibly across social care and health- including children's services and public health. Case management for adult social care and continuing healthcare follow the same processes and are carried out by the same teams; direct payments for social care and health care are fully integrated; and the closer relationship with acute hospital services has helped the development of joint teams for admission prevention, rapid discharge and reablement.

The Council is now working with its NHS partners on plans to develop an "Accountable Care Organisation", aiming to reduce the obstacles to the development of community-based support created by current NHS financial mechanisms. These plans include the creation of a fully integrated strategic commissioning unit hosted by the Council.

"Integrated Health and Social Care in Northumberland"

Case Study Somerset County Council



**Councillor
William Wallace**
Cabinet Member for
Adult Social Care

In November 2014 Somerset County Council commissioned Community Catalysts to run a local project to help respond to finding innovative solutions to help address the lack of provision for local services to support people with low level care and support needs.

The Micro Enterprise Project has been running for 18 months, and has started to respond to local need in some of the most rural parts of Somerset where it has been difficult to commission a range of services that helps support people to live their lives.

These include statutory and non-statutory support that helps people have their personal care needs met, gain a new skill, make new friends, lead a healthy life or enjoy a leisure activity.

The project has supported over 140 micro providers and has developed the creation of over 60 micro providers and just over 80 new jobs. This project is of central importance to the personalisation agenda and many of these providers have become vital elements of a diverse market that provides real choice to people.

We are seeing how micro services are vital for offering a diverse market for individuals who are funding their own care themselves or through a direct payment or personal budget. They can provide some of the best tailored support arrangements, showing considerable creativity and variety.

The strategic aim of the project is to create innovations in capacity within the care and support market, in shifting the balance from a traditional service led approach to local community driven approaches to:

- Stimulate the market and support enterprise across the county, these include services that help people gain a new skill or make new friends;
- Nurture entrepreneurialism and help get new ideas off the ground, explore new ways of working and imaginative models of support to maximise the community and its resources.
- Promote and support the delivery of independent living, choice and control, by supporting the development of new community micro- enterprises responsive to what people taking a Direct Payment, Personal Budget, Personal Health Budget or own funds want to purchase.
- Demonstrate quality and value by supporting community micro-providers and unregulated services to find cost effective ways to demonstrate their quality. (E.g. approaches such as the Community Catalysts quality pathways and framework developed for small providers).
- Design sustainable support strategies that enable the current micro providers to continue to support themselves and develop closer partnerships with the Council.
- Hold networking events across Somerset that brings micro providers into closer contact with both their local communities and ASC staff.
- Ensure that SCC commissioning activities support the role and opportunities that micro providers have begun to create in Somerset.

This project has planted a seed of change that is proving that we can create capacity by bonding with our communities, we have seen how small amounts of money have made significant differences to people's choices and the type of support they can have, enabling them to take risks in trying something new.

To view a video that shows the experience of a person who used a local micro provider to help her find the right solution to her care and support needs [click here](#).



“Small services are big solutions to care and support in Somerset, when it comes to supporting people in rural areas.”

Case Study Warwickshire County Council



**Councillor
Jose Compton**
Cabinet Member for
Adult Social Care

The overarching aim of a mental health service with integrated social care and health functions is to improve the experience of and outcomes for customers. In mental health it is often difficult to delineate between ‘health’ needs and ‘social care’ needs.

What matters to the individual service user is being supported to have his or her needs and desired outcomes met in the most effective way, without having to tell one’s story several times to different people.

Integrated secondary mental health services in the County emphasise the role of the care co-ordinator, (usually a social worker, community psychiatric nurse or occupational therapist) and their relationship with the service user. Although professionals retain their own specialist and distinct skills it is recognised that social care issues such as safeguarding and Care Act compliance are shared responsibilities.

Warwickshire is a large and diverse county. The Council’s partnership arrangement with one secondary mental health provider allows for consistency of provision across the County, with services being provided on an Integrated Practice Unit model, for people with affective disorders, psychosis, and dementia / organic mental health conditions.

Meeting the challenges of partnership working

A common difficulty where integrated mental health service arrangements exist is that the partnership can feel ‘one-sided’. There is a danger of social care staff broadening their traditional remits to work more generically, without this being reciprocated. Social workers may feel they are working within a predominantly medical model, and experience loss of professional identity.

For these and other reasons a number of local authorities have terminated their Section 75 arrangements, or are considering doing so.

In Warwickshire these challenges exist, but are mitigated by a range of factors which continue to make partnership working possible and successful. These include:

- Strong social work leadership and management, which offers professional supervision, and supports the delivery of the social care agenda
- Robust governance arrangements for the Section 75 Agreement
- Dedicated mental health support services to assist teams with social care delivery, such as an administrative hub, a carers’ service and a Self-Directed Support Team.

Strengthening and evaluating our social work interventions in the future

Warwickshire, in partnership with CWPT, will host a ‘Think Ahead’ Unit, commencing September 2016. This is a fast track qualifying scheme for social workers who will specialise in mental health. The Think Ahead trainees will implement mental health focused social interventions, working with individuals, families and communities. It is hoped they will raise the profile of social work within specialist mental health services, and act as a catalyst for the more widespread application of these methods and approaches.

The Council also hopes to be part of a self-assessment exercise to measure how we are doing in the key role categories outlined in The Role of The Social Worker in Mental Health (2014) and Social Work for Better Mental Health (2016). This self-evaluation should commence towards the end of the year, and will provide useful data to inform the review of our current Section 75 arrangements.

2017 offers the potential for us to participate in a York University study to receive team training in ‘Connecting People with their Communities’ interventions and to evaluate the impact of these upon the lives of mental health service users.

These are exciting opportunities for our integrated mental health services.

“The benefits of an integrated mental health service across Warwickshire”

KEY STATS

9%

The increase in the number of social care contacts experienced by counties from 2009/10-2013/14, against overall reductions in other authority types

15%

The projected increase in counties of people with a limiting long-term illness by 2020/21, higher than all other local authority types

18%

Increase in delayed days during the month in CCN member council areas from 2014/15-2015/16, the highest of any local authority type

28%

The increase in the number of delayed days attributable to CCN member councils from 2015-2016

230%

Increase in county areas in the rate of Deprivation of Liberty Safeguard applications per 100,000 population since 2013/14

80%

Proportion of people in CCN member council areas that had control over their daily life in 2014/15, the highest of any local authority type

79%

Proportion of people in county areas receiving a short-term service where a sequel was lower support, or none in 2014/15, the highest of any local authority type

19.3%

Out of 24, the Social Care Related Quality of Life score in county areas 2014/15, higher than any local authority type



CCN

COUNTY COUNCILS NETWORK

Founded in 1997, the County Councils Network (CCN) is a network of 37 County Councils and Unitary authorities that serve county areas. We are a cross party organisation, expressing the views of member councils to the wider Local Government Association and to central Government departments.

To discuss this report and CCN's work in more detail, please contact:

Michael Chard
Senior Policy Officer
020 7664 3198
michael.chard@local.gov.uk

For media enquiries, please contact:

Ian Burbidge
Media & Communications Officer
020 7664 3018
ian.burbidge@local.gov.uk

Follow us on Twitter

 [@CCNOffice](https://twitter.com/CCNOffice)

 [@CountyAPPG](https://twitter.com/CountyAPPG)

Follow us on LinkedIn

 [County Councils Network](https://www.linkedin.com/company/ccn)