Committee: Healthier Communities and Older People Overview and Scrutiny Panel

Date: 22 October 2015

Wards: All

Subject: Impact of savings in adult social care

Lead officer: Simon Williams Director of Community and Housing

Lead member: Councillor Caroline Cooper-Marbiah

Contact officer: Simon Williams

Recommendations:

A. That the scrutiny panel note this report

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

This report outlines the approach to finding savings in adult social care, using a framework promoting the best use of resources, and summarises the impact overall.

2 DETAILS

As part of the whole council Medium Term Financial Strategy, adult social care has needed to play a full part in finding those savings demanded by the strategy, since adult social care is the single largest controllable budget for the council. The weighting of the savings target is in line with the July 2011 principles of meeting statutory responsibilities and offering some protection to vulnerable groups. For adult social care the target is 1.0 or exactly proportionate to the size of the budget. For CSF it is 0.75 and for CS and E&R it is 1.25.

Agreed savings come to a cumulative total of nearly £29 m between 2011/12 and 2018/19. This is against a net budget of around £55m in 15/16. However so far every year about £1m in growth has been put back into the budget in recognition of pressures from demography, and a smaller amount of funding has been put in for inflation. We are about half way through this savings programme, both in terms of time and the profile of savings taken (£13.8m still to deliver from 2014/15 to 2018/19). On top of this there will be some further savings coming forward in the 15/16 budget round for 16/17 and subsequent years, totalling around £2.9m, as the contribution to the remaining savings still to be found up to 2018/19. See Appendix 5 for details of savings over the years.

Since 2011 the Community and Housing Department has managed its savings programme for adult social care using a framework for the use of resources on a value base. This framework was pioneered by Merton and two other local authorities and is now in more widespread use. A copy of this is attached (Appendix 1). The impact of savings is summarised under these headings.

It should be noted that this report looks at impact on the customer base overall for adult social care. There will of course be specific examples of how customers may be positively or negatively affected by savings: however this is outside the scope of this report

2.1 Prevention

Generally any prevention is being more targeted on interventions which have a clear impact in terms of reducing demand for statutory services, and as such is being targeted on those in higher levels of need. The attached “triangle of intervention” (Appendix 2) was agreed with the voluntary sector in 2010, at that point we signalled an end to investment in Level 4 services and said there would be a focus on outcomes at Level 3. This formed the basis of the Ageing Well programme from 2012-15. Some voluntary organisations have seen a decrease in or ending of funding, and the volume of funded programmes has reduced especially taking into account transport. In the next round of investment (2015-8) the amount of available funding will be halved and we are signalling that it will be targeted still further up the “triangle” going into Level 2.

The other main source of non statutory funding is in accommodation based support under Supporting People, which goes to a range of vulnerable people including victims of domestic violence, offenders, homeless people, and people with mental disorders. The overall level of such support has reduced as part of reductions in this fund, although support has not dropped as much as funding because of tightened contract monitoring. Looking ahead there will be further significant reductions in support offered.

2.2 Recovery

Investment in this area is mainly around our re-ablement service (which supports mostly those being discharged from hospital) and equipment.

We have significantly downsized the in-house re-ablement service in 14/15 but our aim remains to give the opportunity to all those who can benefit from re-ablement to use the service and regain maximum independence. Since 2011/12 Merton has performed well in terms of facilitating timely discharge from hospital (measured through Delayed Transfers of Care due to social care reasons), and usually been among the very best in London. For the first few months of 15/16 however this has been more challenging due to market conditions described below.

Regarding equipment, the range of equipment we will supply is in line with other authorities. The waiting list and waiting times for assessment has not increased. We have achieved better value for money through procurement from a store managed by Croydon. We have tried, and will continue to try, ways of enabling people to access the more common types of equipment without needing assessments at home, for example having an assessment centre where people can come in and trial certain equipment, and offering guided support on our web site.

2.3 Long term support

Overall volumes of support offered have decreased in real terms. The total number of customers receiving services fell from 4326 in 2010/11 to 4095 in 2014/15, despite greater demand due to demography. The decrease has been more marked in numbers in care homes (1133 down to 966) but also is evidence for those receiving home care (1645 to 1549). We are achieving this through an explicit promoting independence approach, whose key principles are also attached (Appendix 3), and including a programme of reviews to see if people still need so much support once we have helped them through the original issue which brought them our way. Looking ahead, between 2015 and 2019 we estimate that a further overall reduction of 15% in terms of volume will be needed to achieve the required savings. This carries a high delivery risk given that all those affected are statutorily eligible for services, but given that the majority of social care spend is in this area (funding the private and voluntary sector to provide support), there is nowhere else to look to achieve the savings target. It is important to state that, whilst we believe that overall it is both possible and necessary to make further savings in this area, each customer has a review based on his/her own needs without a prior determination of the outcome.

The cost of support reduced in real terms up to 14/15 through not offering inflationary uplifts to providers and through quite intensive negotiations where required, using models which calculated how much it was reasonable to pay for a given set of support needs. These procurement savings have formed a major part of the savings achieved to date. However, it is common knowledge that providers now have very limited if any room for further cashable efficiencies based on current models. This is due to a range of national factors such as a legal clarification of what constitutes the national minimum wage, European legislation over matters like sleeping in and paid time to a first call, shortage of people to work in this sector, and providers using greater leverage to increase prices. Because Merton has in recent years paid comparatively less overall to its providers than neighbouring boroughs, we are now finding it increasingly difficult to find providers to take our customers unless we pay more. This is having an impact this year, both in an increase in delayed discharges from hospital as providers do not want to take the more complex part of the work, and in terms of our having to pay higher prices overall which is a cost pressure of around £500k for this year.

Our long term support for people with learning disabilities is based on good support for people in their own homes, good respite for carers, and good day services. We are one of the very few boroughs who still offer specialist residential care respite, although carers would say that this has had to be rationed more and certainly carers experience a marked drop in nights available as they move from children's to adult services. For day services, again we have retained in house day centres because carers and service users say that they want them and because in our view there are a cost effective way of offering reliable support. We have had to cut both staffing levels and transport, with the impact that we offer less door to door transport and we offer fewer tailored programmes to individuals or small groups outside day centres. We are seeking to mitigate the latter impact through recruiting more volunteers. We still offer door to door transport for these who are assessed as needing it under our assisted travel policy.

2.4 Process

We have reduced numbers of staff who are not direct care givers from 265 FTE in 2012/13 to 168 in 2015/16. There are further significant staffing savings to find in this

area amounting to about 30-35 staff. We seek to minimise adverse impact on customers through looking first to non- front line staff wherever possible, and through finding more efficient ways of doing things. Examples of changes are letting Merton Vision manage the whole process for newly visually impaired people rather than insisting on assessing them ourselves, and most recently the closure of one “access team” who did initial screening and responses to referrals in favour of looking more to the voluntary sector to do this. We are four months into this change and to date are not experiencing a negative impact. Due to the disproportionate numbers of non front line posts cut (for example in management and commissioning) it is becoming more challenging to deliver on the full range of management, administrative and commissioning tasks expected of us. As we look for further ways to achieve savings, it is likely that we will be looking to reduce duplication with NHS or voluntary sector processes, and where possible move more processes to be controlled by customers. We are also looking for ways to support our care management staff to spend a higher percentage of their time in contact with customers through a new information system being brought in at the start of 2016, and through using the principles of flexible working.

2.5 Partnerships

Despite the financial pressures described above our partnership with the voluntary sector has remained strong, and adult social care has played a leading role in some of the Compact awards won by Merton. We continue to greatly value the ability to discuss with the sector, frankly and where needed confidentially, how together we can find ways to meet customer needs with less money.

Regarding the NHS, we have long standing partnerships and integrated services in the areas of mental health and learning disabilities. We see this as essential if we to continue to deliver good outcomes with less funding. In early 2013 we agreed with the Clinical Commissioning Group and other NHS partners to extend this integration into the area of older people and people with long term conditions, with three locality teams now having been formed including social care, primary care and community services health staff. We see this as offering a better customer experience and helping us to achieve our staffing efficiency savings through reducing duplication.

2.6 Contributions

Customers contribute to the costs of services according to their means. This income increased from £8.3m in 2011/12 to £9m in 2014/15. There comes a point where there is little point in putting fees and charges up further because very few customers would pay the higher rates when the means test is taken into account. Merton is already among the councils who levy higher charges compared with other similar councils. This is why there are no proposals for future years to make savings by increasing income in this area.

The council gets a contribution from the NHS for the costs of nursing care in nursing homes: given usage of nursing homes has declined it would be difficult to plan for greater income in this area. Finally the council also gets a contribution in 2015/16 from the CCG through the Better Care Fund for keeping social care at a level which is sufficiently responsive for the NHS.

2.7 Have savings impacted on performance and customer experience?

Up to 14/15 performance levels have generally held up well. There are not long waiting times for assessment, safeguarding incidents are handled in a timely way, we have facilitated discharge from hospital effectively, we support more people into employment compared with other London councils. We are average on customer satisfaction levels. We have a quality board to ensure that a focus on customer experience and quality is retained. Appendix 4 shows how some key areas of performance have changed over recent years.

2.8 Conclusion

In general for the years 2011/12 to 2013/14 it has been broadly possible to make efficiency savings with surprisingly low impact on customer experience. However much of this was through squeezing provider prices through procurement, and finding other reasonably palatable ways of saving money. The use of resources framework has given us a systematic and value based way of looking at the totality of our investment and not just the savings, and of discussing plans and options with stakeholders.

2014/15 began to see a change, in that it proved far more difficult to realise the savings in support packages, and we began to see the tailing off of reductions in fees paid to providers.

Looking ahead from 2015/16, savings will be less palatable, especially as there are in reality virtually no further price savings to be found from providers and instead there will be upward pressure on prices, and as we make further staffing reductions from an already reduced base. It will be necessary to monitor very closely the impact and feasibility of savings every year.

3 ALTERNATIVE OPTIONS

One alternative would be not to find savings in this area; however this would not be feasible if the medium term financial strategy is to be delivered. Another alternative would be to look for other ways of finding savings: examples would be closing in house day centres, using a resource allocation system to reduce all personal budgets across the board, or ceasing all investment in prevention. Whilst these alternatives are at present not deemed appropriate or recommended, all options have to be kept under review

4 CONSULTATION UNDERTAKEN OR PROPOSED

Adult social care has sought to share its strategic approach to finding savings with for example the voluntary sector and healthwatch. Whilst the medium term financial strategy has not been formally consulted on because it is a medium term plan subject to change, adult social care consulted on replacement savings for 15/16 and intends to consult on all savings for 16/17.

5 TIMETABLE

Savings are in line with the medium term financial strategy.

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

Appendix 1 summarises the extent of savings being found in adult social care. There are no specific property implications

7 LEGAL AND STATUTORY IMPLICATIONS

Adult social care is broadly a statutory service, with council duties enshrined in law especially the care act. Customers of adult social care have a statutory right to support if they are eligible according to criteria which are now national. Any savings must be planned and implemented in a way which does not breach these statutory duties.

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

Customers of adult social care will inevitably tend to come from protected groups under equalities principles, especially for age and disability. This is why equalities impacts are done for proposed savings.

9 CRIME AND DISORDER IMPLICATIONS

None specific for this report.

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

Adult social care is in the core business of supporting customers and carers to manage risks in their own lives and to use risk criteria to determine the level of urgency and priority for support. Savings have to be planned and implemented in the knowledge that these risks must be managed.

11 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

1 Use of resources framework

2 Layered levels of intervention

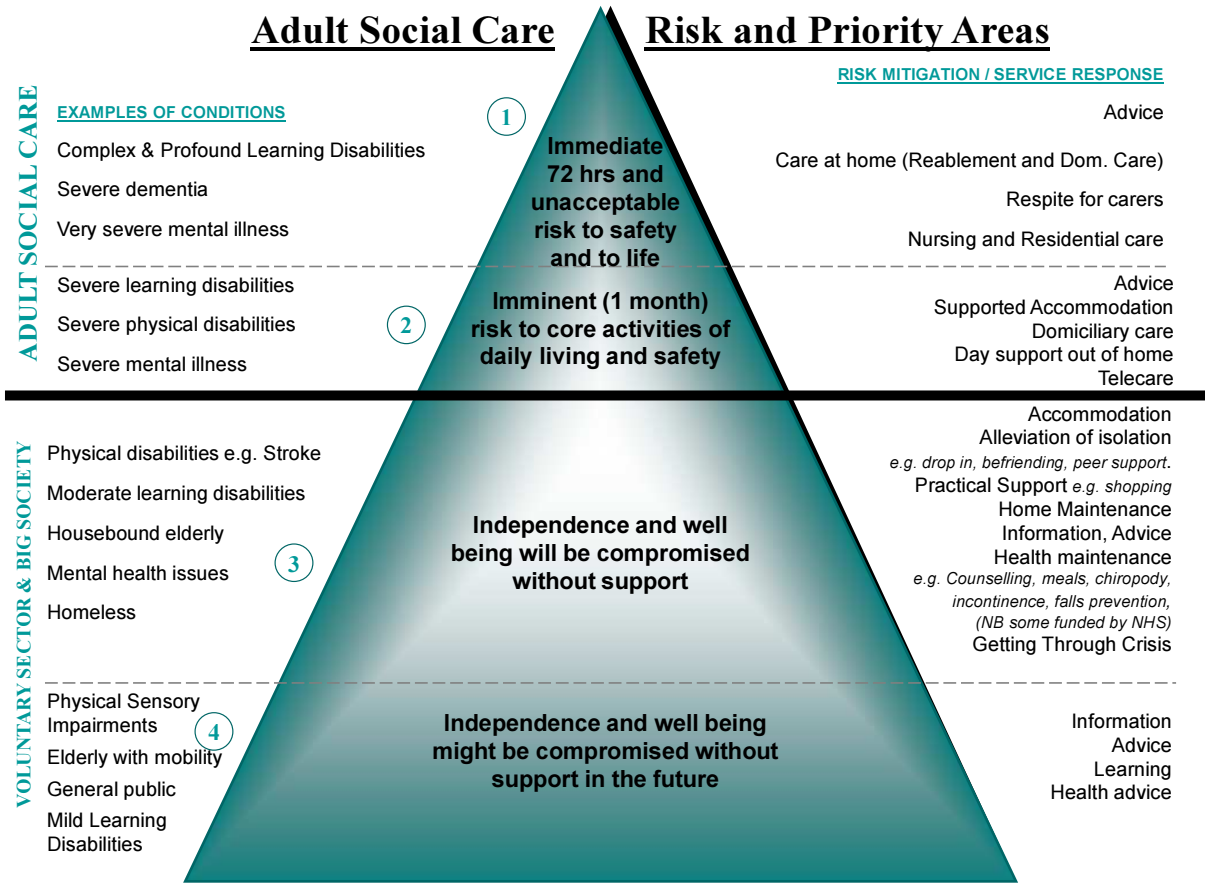
3 Promoting independence principles

4 Key areas of performance in recent years

5 Summary of savings

Appendix 1 – Use of Resources Framework

Appendix 2 – Triangle of intervention



Appendix 3 – Promoting Independence Principles

- People using their own skills and assets and being resilient in finding solutions in their own lives
- Regaining as much independence as possible if they have a crisis/illness
- Family members, with help, supporting their own family members
- Communities (incl. neighbours) supporting their vulnerable members
- Council role is to intervene when we have to, but not in a way which makes people dependent on services. We aim for simple and practical solutions whenever we can and look to assets (individual/family/community) before committing council resources
- When people first come to our attention, we seek to find other solutions rather than the council immediately stepping in e.g. voluntary and faith sectors
- If customers come out of hospital we will re-able where we need to and support people to regain independence as far as possible
- Using technology where we can
- Keeping ongoing support under review

Appendix 4 – Performance Data

TOTAL NUMBER OF ADULTS RECEIVING SERVICES FROM 2010 TO 2015

SERVICE TYPE	2010-11	2011-12	2012-13	2013-14	2014-15	April - June 15
Permanent Residential Home Placement	546	529	517	485	443	336
Permanent Nursing Home Placement	341	344	331	320	307	220

HOME CARE HOURS

Total Home Care Hours	2010-11	2011/12	2012/13	2013/14	2014/15	April 2015-June 15
Total planned home care hours	535,658	523,117	495,134	512,905	670,739	152,701

DELAYED TRANSFERS OF CARE

DELAYS AS RECORDED AT WEEKLY SITREP MEETINGS @ KINGSTON, ST. HELIER AND ST. GEORGES HOSPITALS

YEAR	2010-11		2011-12		2012-13		2013-14		2014-15		April - June 15	
DAYS/DELAYS	Total Days	SS Delays	Total Days	SS Delays	Total Days	SS Delays	Total Days	SS Delays	Total Days	SS Delays	Total Days	SS Delays
No. of Days	NA	20	1152	21	830	23	999	15	1495	35	686	224
No. of Patients	150	5	159	4	142	4	152	8	211	8	107	47

N.B. SS Delays: Social Services Delays

Appendix 5 - Adult Social Care Financial Position

Table showing agreed and proposed savings 2011-2019

Year	Total Agreed Savings	New Savings Proposals identified to date (Oct 2015 Cabinet)	Total Savings Identified	Cumulative Total
2011/12	£4,188,000	0	£4,188,000	£4,188,000
2012/13	£4,099,000	0	£4,099,000	£8,287,000
2013/14	£6,162,000	0	£6,162,000	£14,449,000
2014/15	£2,187,000	0	£2,187,000	£16,636,000
2015/16	£2,014,000	0	£2,014,000	£18,650,000
2016/17	£5,038,000	£200,000	£5,238,000	£23,888,000
2017/18	£1,898,000	£900,000	£2,798,000	£26,686,000
2018/19	£1,133,000	£1,137,000	£2,270,000	£28,956,000
Total Savings	**£26,719,000**	**£2,237,000**	**£28,956,000**	

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