Local Government Association

Managing demand in adult care

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Evidence drawn from:

- Local Government Association Adult Social Care Efficiency Programme

  http://www.local.gov.uk/productivity/-/journal_content/56/10180/3371097?_56_INSTANCE_0000_templateId=ARTICLE
- Local Government Association Care and Health Improvement Programme

  http://www.local.gov.uk/documents/10180/11779/Efficiency+Opportunities+through+health+and+social+care+integration
- Institute of Public Care – Predicting and managing Demand in Adult Social Care

  https://ipc.brookes.ac.uk/publications/Predicting_and_managing_demand.html

Do we need a different approach?

- We assess people at the point of crisis
- We give them services quickly
- We assess for risk not for assets
- Social Work practice contributes to demand for social care
- Low level services can accelerate a persons need for more care

Risks of institutionalisation – residential care/ domiciliary care/day care

Not just one solution

1. Personalisation
2. Community and asset based approaches
3. Prevention and early intervention
4. Integrating health and social care

1. Personalisation

- Recognises there is a unique solution for each person's circumstances – some of which the person who will use any services is the best person to control
- Strongly linked to personal budgets (Direct Payments) but not mainstream for most councils
- Holistic approach – but has led to higher costs for packages of care even where the cost of the service may be lower (contracted versus PA costs)
- This changes the way in which services are provided/commissioned
- Links well to asset-based assessments
- Strong emphasis on the customer at the heart of the assessment – less room for progression

2. Community and asset-based models

- Asset-based assessments start with what a person can do and in understanding the network of support that is already available to support and help someone and then builds on that network
- Local Area Co-ordination: Focus on building resilient communities which become part of the solution (based on Australian model for adults with learning disabilities – Bartnik. E) – focus on “ordinary lives” and integrated community. English focus on all service users
- Shared- Lives model for housing options
- Hard to link the approach to demand for formal care

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3. The evidence for prevention

Universal help – Public Health agenda	• Focus on keeping well and active • Focus on keeping people out of formal care system
Short term help for those in crisis	• Focus on outcomes for short interventions • For example equipment including assistive technology
Targeted help for those with eligible needs	• Focus on recovery model in mental health • Focus on reablement for older people
Targeted help for those with LTC	• Progression for adults with Learning Disabilities • Help people live with dementia • Helping people live with long term conditions

Does integration always deliver better outcomes?

- Linking the current approaches to health and social care together in an integrated system can deliver poor outcomes for older people with:
  - Higher admissions to residential and nursing care
  - More use of domiciliary care
  - More non-elective re-admissions

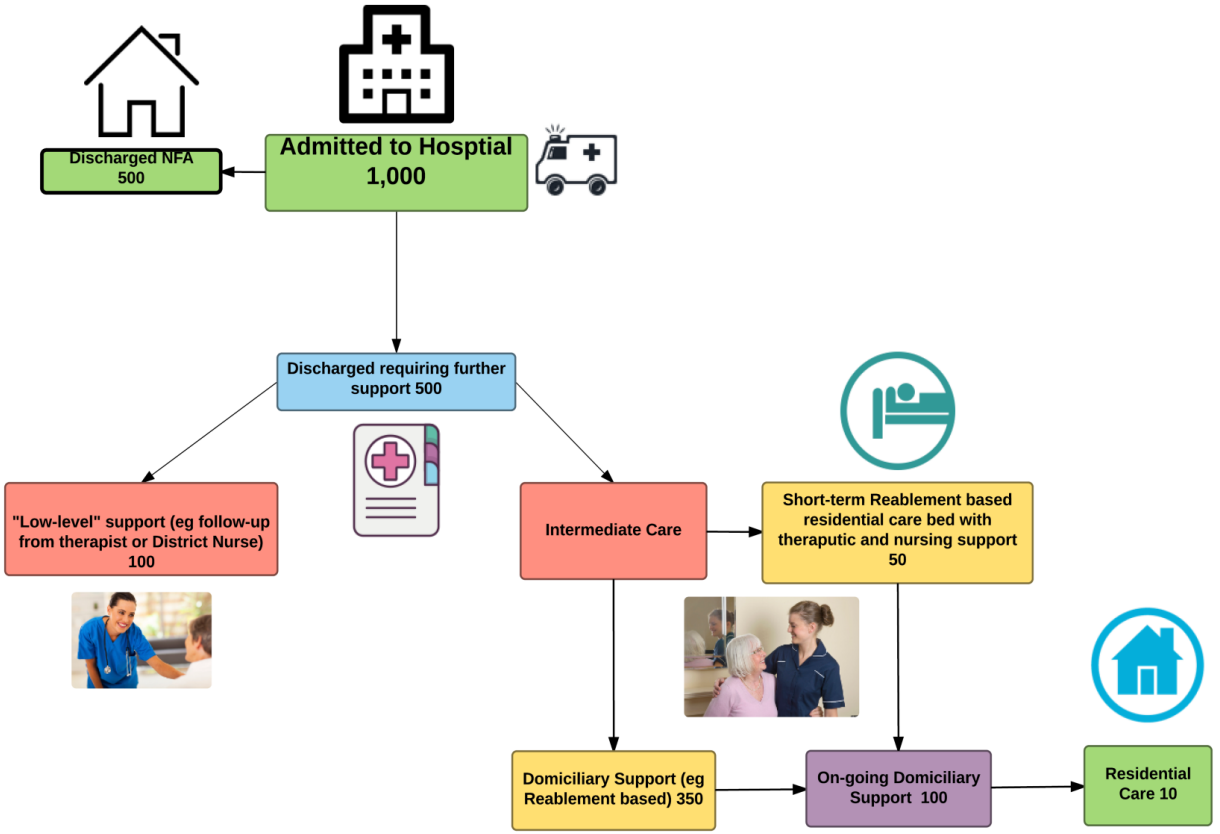
  $\Rightarrow$ Which makes the system financially unsustainable
- Evidence from England in 2000s – Solihull, Peterborough, Knowsley, Wiltshire, Barking and Dagenham and others

Study by Newton (Europe) in 5 Health and Care Communities

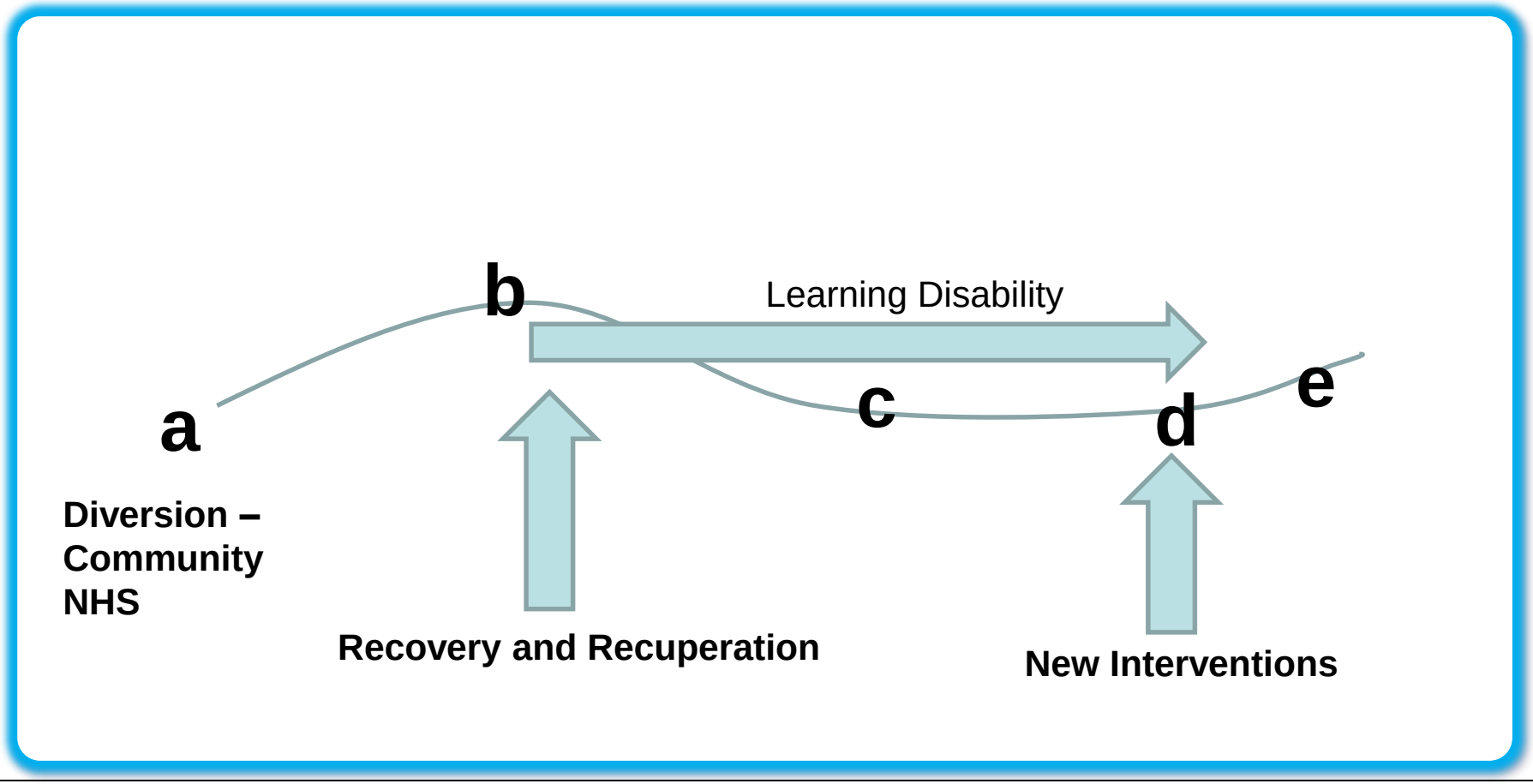
- Missed opportunities in community to avoid hospital admissions – e.g. falls prevention
- Missed opportunities for discharge home
- Overstated needs for older people requiring discharge support – includes overuse of reablement for those who might manage their own recovery
- Many professionals don't know what is available – often offer simplistic solutions including domiciliary care or residential care
- Those delivering front line care need a different skill mix to maximise efficiency and effectiveness

$\Rightarrow$ 2.5% efficiency savings from getting this right

Flows through the system



Managing demand in social care – Progression Model



Some key performance measures for a care system

- Two-thirds of people should be diverted/signposted at the front door (not acute hospital)
- Over 70% of people should be offered help which focusses on rehabilitation, recovery, recuperation and reablement – including therapeutic help – this should be over 90% for discharged patients
- Two thirds of these people should require no further formal care and support
- No one should be admitted from a hospital bed to permanent residential/nursing care

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More key measures

- No more than 15% of domiciliary care hours should be supporting a person for 10 hours or less
- No more than 30% of the budget should be spent on supporting people in residential/nursing care
- All care packages should be based on medium term goals that assist the person to move to a greater degree of independence

Demand is managed by:

- How we respond when people approach us for care
- Reducing new admissions to residential care
- Moving people from residential care to supported housing (that promotes independence)
- Focusing on help that supports recovery/progression
- Using community/family/ neighbourhood solutions rather than formal care
- Not proscribing “dollops of formal care” as an easy solution
- Avoiding risk averse practices – particularly at point of hospital discharge
- Reducing requirements for double-ups through better use of equipment and quicker reviews
- Helping people live with long-term conditions
- Commissioning for outcomes