social care
institute for excellence

Future of care
Number 1
Second edition
March 2017

Total transformation of care and support

Creating the five year forward view for social care

Introduction

The Five Year Forward View sets out a case for upfront investment in the NHS to transform it into a service which reaches people in their homes and communities with early, effective interventions and builds partnerships with people with long-term health conditions and their families. It is widely accepted that this will only succeed where social care makes the same transformation. Social care has a track record of transforming services, such as delivering personal budgets, asset-based approaches and co-production. Both systems share similar goals. It is now time to bring health and care transformation together.

This paper explores the potential for scaling up the most promising examples of care, support and community health services, initially using data from Birmingham City Council, modelling their outcomes and costs. Originally published in November 2016, it has been updated to include additional models.

Our aim is to start a series of national and local discussions which re-imagine how we can lead good lives, in good places for people with support needs – building on well-evidenced innovative models from across the UK.

> *"Total transformation must change systems and processes, but first it must change hearts and minds. We need language that we all understand – that enables managers to explore ways to improve services whilst balancing budgets, but also helps people to think about how their communities can flourish."*
>
> **Clenton Farquharson, person who uses services and** Director, Community Navigator Services

Key messages

- Adult social care has repeatedly demonstrated its capacity for transformation: pioneering de-institutionalisation, personal budgets and more recently, asset-based approaches.
- Health and care systems will not provide good services that meet rising demand without realigning around people and communities.
- There are five areas where transformation needs to take place:
  1. Helping all people and families to stay well, connected to others and resilient when facing health or care needs.
  2. Supporting people and families who need help to carry on living well at home.
  3. Enabling people with support needs to do enjoyable and meaningful things during the day, or look for work.
  4. Developing new models of care for adults and older people who need support and a home in their community.
  5. Equipping people to regain independence following hospital or other forms of health care.
- If the sector scales up promising practice, economic modelling shows that outcomes can be improved and costs reduced.
- The sector needs to have difficult, challenging and creative local conversations involving people who use services and others, which create space to move forward together.
- Further research and economic modelling is needed on the promising practices to build a business case for proper and effective investment in truly integrated care and health.

A vision for transformed care

Health and care systems are under unique pressure from falling budgets and rising demand.

Incremental change is not an option. Now is the time to re-build adult community care and health systems from the bottom up. We need to re-shape service interventions – not only around a more individual understanding of people's needs, but also around the creativity and capacity of individuals and families and leadership within communities. Too often in the past, the potential of people and communities to contribute to better services has been overlooked.

Building a 'good life'

Our vision is for every area to have the difficult, honest and creative local conversations which release 'stuck' systems and create space for moving forward together.

These conversations start not with questions about services and budgets, but with 'What does a good life look like in this area and what are we all willing to do to achieve it?'

This question can lead on to considering the five key ways in which health and care systems try to help older and disabled people build a good life, and the most promising local and national models for transformational change in each.

1. Helping people and families to stay well, connected to others, and resilient when facing health or care needs.
2. Supporting people and families who need help to carry on living well at home.
3. Enabling people with support needs to do enjoyable and meaningful things during the day, or look for work.
4. Developing new models of care for adults and older people who need support and a home in their community.
5. Equipping people to regain independence following hospital or other forms of health care.

Evidenced and promising models

Models which are currently peripheral in each of these five areas must become the centre of the new system.

We have identified six well-evidenced models, which demonstrate how to combine scarce state resources with the capacity of individuals, families and communities. Local areas can use these models to consider the impact they may have in their own area. They can also enable frontline workers to shape more fulfilling roles and draw more effectively on the voluntary, community and social enterprise sector.

Every local area needs to build its own solutions, but there are also many transferable features which the most promising models have in common. Some models are already well-evidenced and nationally available, like Shared Lives and Age UK's Living Well service (below).

For promising models which are not yet widely researched, we have produced a logic modelling template (See Appendix B). Local areas can use this template to consider the potential risks of incremental investment based on emerging evidence. This is not a model for time-limited pilots, but for investments which start small and plan to scale up what works, transferring resources from less cost-effective services.

Re-imagining health and care

If we can work with a number of local areas to re-imagine social care and develop costed models which feel like a better and more sustainable system, we have the opportunity to build a national case for investment. This could be the missing piece in the Five Year Forward View for the NHS and a significant step towards integration which works for and with people, families and communities, combining their capacity with the resources, expertise and back-up of health and care services. This draws on the first three of five principles outlined by the Realising the Value partnership:

1. Implement person- and community-centred ways of working across the system, using the best available tools and evidence.
2. Develop a simplified outcomes framework, focused on what matters to people.
3. Continue to learn by doing, alongside further research.

Promising models of care

Promising practice in relation to the five areas of transformative change are outlined below. Further blogs and information are available at www.scie.org.uk/future-of-care

1. **Helping people and families to stay well, connected to others, and resilient when facing health or care needs**

- **Local Area Coordination** aims to support residents in the local community to 'get a life, not a service', empowering individuals to find community-based solutions instead of relying on traditional services.
- **Community Connectors** services help people to use and enjoy local community groups and activities to help people maintain their independence and benefit from peers and support networks.
- **Social prescriptions** are a tool for clinicians to work with patients to determine wider social and lifestyle aspects of their health, and direct them to non-medical sources of support, services and care.
- **Community Agents** provides advice and support to older people and vulnerable adults, in particular those who are isolated. Many of them need general support and have level social care and health needs.

2. **Supporting people and families who need help to carry on living at home**

- **Age UK's Living Well** scheme aims to improve prevention and resilience amongst older people with multiple long-term conditions by providing low-level support to day-to-day living and utilising asset-based resources to promote empowerment and wellbeing.
- **Reablement** services provide personal care, help with daily living activities and other practical tasks, usually for up to six weeks. Reablement encourages people who use services to develop the confidence and skills to carry out these activities themselves and continue to live at home.

3 **Helping people to do enjoyable and meaningful things during the day, or look for work**

- **Community enterprises** are very small (typically fewer than eight workers) local ventures that offer people the help they need to live the life they want. Community enterprises offer services and support that link to the social care, housing and health sectors.
- **Employment enterprises,** often micro-enterprises that help people – for instance with learning disabilities – to find training and employment.
- **Kent Pathways Service** supports adults with learning disabilities to become more independent. People learn or re-learn skills that will help them to become more independent and need less support.

4 **New models of care for adults and older people who need support and also somewhere to live**

- **Shared Lives** is a service that provides family-based support for older people and people with disabilities. It enables people to experience ordinary family and community life and receive personal care outside more traditional care settings.
- **Extra Care** is a type of housing offering older people purpose-built accommodation that is supported by 24-hour on-site staff.

5 **Equipping people to regain independence following hospital or other forms of health care**

- **Kent County Council** hospital discharge project introduced social care discharge coordinators into hospitals to support the discharge process. They identify people who can be safely supported outside the hospital and then use a 'reablement approach' to ensure that they achieve maximum independence.
- **Royal Volunteer Service, Hospital to Home** staff and volunteers are embedded in community hospitals and acute trusts and work closely with staff and discharge teams to identify older people on wards who might need support on discharge.
- **British Red Cross Support at Home** volunteers support people with a minimum of two long-term conditions, with a focus on smoothing the process of settling back into a routine and help people to regain their confidence and independence after a hospital admission.

Scaling up what works – summary

We looked at the available evidence around the costs and benefits associated with the implementation of a range of different schemes. The quality of the evidence was evaluated and six models were selected which could potentially be scaled up in Birmingham. The table below sets out a summary of the findings from this process, based on real data supplied by Birmingham City Council.

Promising models	Primary characteristic of target population	Existing beneficiaries (Birmingham)	Potential beneficiaries (Birmingham)	Potential barriers to expansion	Key enablers for implementation	Potential net saving PA (Birmingham)
1. Helping people to stay well, connected to others, and resilient when facing health or care needs						
Community Agents	Older people living alone	N/A	2,700	Raising awareness, recruiting proactive community agents, mapping community services	Developing positive relationships with key agencies to link users effectively to available services	£900,000 ASC
2. Supporting people and families who need help to carry on living well at home						
Living Well home-based care	Older people with multiple long-term conditions	N/A	1,000 users	Lack of available staff and volunteers	Recruitment and training of coordinators and local volunteers	£1.0m ASC £1.4m NHS
3. Enabling people with support needs to do enjoyable and meaningful things during the day, or to look for work						
Kent Pathways Service	Adults with a learning disability	N/A	146	Identifying those most likely to benefit	Effective staff consultation and engagement	£250,000 ASC

4. Developing new models of care for adults and older people who need support and a home in their community						
Shared Lives	People with learning disabilities or mental health needs	78 people with learning disabilities with live-in arrangements 10 people with mental health needs with live-in arrangements	52 additional users with live-in arrangements (one with mental health needs)	Lack of potential carers for live-in arrangements Additional costs incurred when moving clients from existing care settings	Investment of around £250,000 required for each new set of 75 arrangements Time is required to see the full benefits. Once the coordinator has been recruited it will be two years until the break-even point for the scheme is reached	£1.3m ASC
5. Equipping people to regain independence following hospital or other forms of health care						
Kent County Council hospital discharge project	Mostly older people	N/A	N/A	Resistance to new processes	Additional intensive support from respected social workers who are prepared to challenge the status quo is required to embed new ways of working Clear success measures and escalation routes are also required	£4.6m ASC
British Red Cross Support at Home	Older people whose day-to-day activities are very limited	N/A	1,357	Lack of available volunteers to run service at scale	Sharing the costs with health organisations	£167,000 ASC £444,000 NHS
Total financial benefit						£7.5m ASC* £1.8m NHS

*The total financial benefit figure for adult social care (ASC) assumes that there is potential for double counting of benefits because of the small overlap between the target populations for the three schemes. The value of this duplicated benefit has been estimated as approximately £0.8m PA and deducted from the net total.

The following provides more detailed information on six models which were scaled up using data from Birmingham City Council.

Helping isolated older people – Community Agents

Community Agents focuses on people aged over 60, especially those who need help to remain independent and to stay at home. Community Agents is a first point of contact for people with low-level social needs. Support includes shopping, cleaning, gardening, form filling and accessing social activities. Community Agents assesses the needs of clients referred into the service, discusses options and then refers to relevant activities or services.

The service is not currently used in Birmingham. This information is based on its operation in Redcar and Cleveland.

Current users and outcomes

Most people who used Community Agents in Redcar and Cleveland were over 60. During 2013/14:

- 486 people in Redcar and Cleveland benefitted from the service
- 2% of those using the service stayed in their own homes for longer
- 9% needed lower-level care packages.

Those referred to the scheme reported a perception of improved health and wellbeing, including feeling less anxious and isolated, and more confident.

Potential benefits to Birmingham

If the Community Agents service was introduced in Birmingham and it supported 2,700 older people a year (same proportion as Redcar and Cleveland), and the same benefits could be achieved as in Redcar and Cleveland, Birmingham could achieve a **net saving** of approximately £900,000 per year to the local authority, with estimated costs of approximately £520,000 per year.

The cost of the service per person is £192 per year.

Current financial benefits

Based on Redcar and Cleveland's data:

- £12,078 saving for every person, per year, who stayed in their own home for longer
- £2,797 saving for every person, per year, whose need for an increased care package is delayed
- Approximately £158,000 total net savings to Redcar and Cleveland Borough Council per year

Implementation issues

A key enabler to implement this scheme is being able to develop positive relationships with key agencies, and to link users effectively to available services.

Successful implementation will also need to raise wide awareness of the project within the local area; recruiting a proactive community agent; mapping available services in the community.

The scheme in Redcar and Cleveland was jointly funded by the Borough Council and the local Foundation Trust. Implementation in a new areas would need to consider the provision, or not, of joint health and social care funding.

Building wellbeing and resilience – Living Well

The Living Well scheme aims to improve prevention and resilience amongst older people with multiple long-term conditions by providing low-level support to day-to-day living and utilising asset-based resources to promote empowerment and wellbeing.

The process begins with a conversation between the person and the voluntary sector coordinator, who helps them to identify their goals and coordinate a management plan. Trained volunteers provide support to build social networks around the individual to help them become better connected to their community, be more physically and socially active and subsequently have better health outcomes. Practical support, navigation and coordination are provided in order to boost self-confidence and self-reliance, leading to reduced adult social care spend and primary/community health benefits.

Current users and outcomes

The scheme focuses on older people, with a minimum of two long-term conditions.

The following outcomes are based on the first 325 older people on Cornwall's programme:

- 27% reduction in A&E attendances
- 37% reduction in non-elective admissions
- 20% average improvement in wellbeing
- 20% of people supported to become a volunteer
- 8% reduction in social care costs.

In 2015, the Living Well programme was extended to eight new sites across the country, each aiming to support a further 500 to 1,000 older people per year.

Potential benefits to Birmingham

If the Living Well programme was introduced in Birmingham and it supported 1,000 older people per year, and the same benefits could be achieved as in the Cornwall site (reduction in A&E attendances, improvements in wellbeing etc.), the following financial benefits could be possible:

- £1.2m in savings per year to the local authority
- £1.6m in savings per year to the health economy
- £1m per year in wider social benefits

With estimated costs of £400,000 per year.

Estimated current financial benefits per year

Based on Cornwall's data:

- £1,181 gross benefits from a reduction in social care costs, for every person on the scheme
- £1,598 in gross benefits per person from reduced A&E attendances, and reduced non-elective admissions.

The costs are estimated to be £400 per person.

Living Well is estimated to be saving approximately £400,000 to the local authority and £500,000 to the health economy in Cornwall, per year.

Estimated costs of the Living Well programme in Cornwall are £130,000 per year.

Implementation issues

Implementing Living Well locally requires the recruitment and training of coordinators and volunteers. In order to scale the service up, it is estimated that a team of 67 volunteers and 12 coordinators is required to provide support for up to 800 people.

Once set up, the maximum cost of this level of Living Well support is likely to be around £400 per person, per year.

Putting funding in place, identifying volunteers and coordinators locally, and managing the recruitment and training processes are the biggest challenges to operating at scale.

Enabling people to learn useful skills – Kent Pathways Service

The Kent Pathways Service supports adults with learning disabilities to become more independent. It can help to improve independence by developing life skills so less help is needed. It helps to improve independence in an area of life. This could be making new friends, getting fit or active, or travelling independently.

People are supported for between one and 12 weeks, free of charge to the person, to learn or re-learn skills that will help them to become more independent and need less support.

The Kent Pathways Service helps with: preparing for work, cooking, housework, budgeting, shopping, keeping safe, keeping well, finding a college course, finding out what equipment can help and how to use it, and finding work.

Current users and outcomes

The Pathways Service is not used in Birmingham. The following data is based on its use in Kent. The scheme focuses on adults in Kent with a learning disability.

- As at January 2017, 559 people have been supported by the service across the county since it was introduced. There are currently 240 people using the service
- 7% of people with a learning disability accessing long-term support from the Council use the Kent Pathways Service
- The evaluation of a six month-long pilot in Dover & Thanet found that 97% of people who use services were living more independently at the end of the 12-week programme.

Potential benefits to Birmingham

If Birmingham introduced Care Pathways and it was taken up at the same rate (7% of people with learning disabilities who access long-term support), then 146 people would be supported.

Assuming the same benefits could be achieved as in Kent, Birmingham could achieve approximately £250,000 in **net savings** per year.

The scheme was implemented by restructuring two Independent Living Service teams and three Kent Care Pathways teams (encompassing nurses, care managers, occupational therapists etc. who support people with learning disabilities), so there were no changes to staff grades or overall headcount. Therefore, the evaluation stated that there was no additional staffing costs to Kent County Council.

If a higher proportion of people were targeted, the estimated savings would be higher.

Estimated current financial benefits

In Kent, the scheme has led to less use of long-term support resulting in:

- £1,716 in net savings per person on the scheme per year
- £285,000 estimated savings to Kent County Council per year.

Implementation issues

Successful implementation of this scheme requires effective staff consultation and staff engagement. The scheme in Kent was done without incurring any additional staffing costs, through the restructuring of existing teams. If a new area to implement the scheme does not have the appropriate staff already in place (notwithstanding the need to restructure), then this could incur additional costs.

Implementation also requires the identification of the most appropriate beneficiaries of the scheme.

Alternative accommodation-based care – Shared Lives

Shared Lives is a service that provides family-based support for older people and people with disabilities. It enables people to experience ordinary family and community life and receive personal care outside more traditional care settings. The people receiving the service are matched with a compatible carer who will use their own home to provide that person with longer-term support or a short-term break. The Care Quality Commission regulates local Shared Lives schemes.

The schemes are responsible for recruiting and training carers, matching the needs of people who use services to carers and monitoring the success of each arrangement.

The service aims to provide a clear alternative to traditional forms of accommodation-based care for vulnerable adults. Expected benefits include an increase in the quality of available accommodation-based care, and a reduction in local authority spending on the provision of both long-term and short-term care placements.

Current use

173 people use Shared Lives in Birmingham:

- 120 are live-in arrangements
- 26 are short breaks
- 31 are people using day support.

Who used Shared Lives:

- 145 with learning disabilities
- 7 older people
- 11 with mental health needs
- 5 with physical disabilities
- 3 with dementia
- 2 others.

Estimated current financial benefits

Estimated benefits per year based on current provision of Shared Lives in Birmingham indicate:

- £26,000 net cost savings for every person with learning disabilities who has a live-in arrangement in place, when compared to alternative packages
- £8,000 net cost savings for every person with mental health needs who has a live-in arrangement in place, when compared to alternative care packages.

Shared Lives is estimated to be saving £2m per year for Birmingham City Council.

Potential benefits for Birmingham

Based on 2015/16 data:

- 51 more people with a primary support reason of learning disability might potentially benefit from live-in arrangements (out of a total of 2,177 people). Providing Shared Lives services would be expected to deliver an additional £1.3m of benefits
- One person who currently receives long-term mental health support (out of 461) might potentially benefit from live-in arrangements. Providing Shared Lives services would be expected to deliver an additional £8,000 of benefits.

Shared Lives could save an additional £1.3m per year for Birmingham City Council.

Potential benefits elsewhere

If the Shared Lives scheme was rolled out in another city which does not currently offer a Shared Lives type intervention:

Shared Lives could save 1 to 2% of the adult social care budget.

Implementation issues

An investment of around £250,000 is required to set up 75 new Shared Lives arrangements (based on 50 for people with learning disabilities and 25 for people with mental health needs). One coordinator is needed for every 25 carers.

Once the coordinator has been recruited, it could be six to seven months before the first carer is matched to someone and up to two years until the break-even point for the scheme is reached.

The main limiting factor for large-scale, rapid expansion is likely to be the lack of potential carers available for live-in arrangements.

Improving the speed and ease of hospital discharge (Kent County Council)

Kent County Council realised that over half of the people who use services that they supported in residential placements had come via an acute hospital. In many of these cases, an improved discharge process putting in place an appropriate care package could have facilitated an earlier, safe return home – which was the preference of people who use services. A process for discussing specific cases in daily hospital team meetings was developed and social care discharge coordinators were introduced to provide support and challenge to their colleagues.

The revised process improves the speed and ease of hospital discharge by enabling early identification of people who can be safely supported outside the hospital. A 'reablement approach' can then ensure that they achieve maximum independence. This process has clear benefits for the person and produces benefits for the local authority and the hospital by ensuring that the person is discharged to the most appropriate care setting in a timely manner. The local authority is expected to benefit from a reduction in higher-cost care packages and care home placements and the hospital is expected to benefit from fewer delayed discharges.

Current use and benefits in Kent

Most people who use the service in Kent are aged over 65.

Early evidence suggests there has been:

- 36% reduction in short-term placements for over 65s
- 34% reduction in long-term placements for over 65s
- £4.1m saving.

Potential benefits in Birmingham

The evidence from Kent suggests that there could be a reduction in the cost of long- and short-term adult social care placements of approximately 13%.

This could result in potential savings, per year, in Birmingham of:

- £4.2m in long-term placements
- £490,000 in short-term placements.

Improved hospital discharge processes in Birmingham could deliver £4.6m savings per year as a result of reduced placement costs.

Implementation issues

One of the biggest challenges to rolling out the Kent approach is the complexity of implementing the required change management process. Behavioural change can be difficult to achieve when there is resistance due to differences in historical working practices and a lack of trust between team members.

The change process can be facilitated by ensuring that experienced team members and managers are part of the design and implementation of the new process and by ensuring that sufficient back-fill resource is provided to cover time allocated to the process. Embedding new ways of working requires additional intensive support from respected social workers who are prepared to challenge the status quo. Clear success measures are required to ensure that goals are being achieved.

Rebuilding confidence after a hospital stay – British Red Cross Support at Home

The British Red Cross Support at Home scheme provides volunteers to support people with a minimum of two long-term conditions, through a flexible support package for up to 12 weeks.

The support can smooth the process of settling back into a routine and help people to regain their confidence and independence after a hospital admission. The service includes: rebuilding confidence, collecting prescriptions, offering companionship, and assistance with shopping.

Current users and outcomes

The scheme is not currently used in Birmingham. This data is based on the use of the scheme across the rest of the UK.

Between 2007 and 2012, over 5,000 people used the British Red Cross Support at Home scheme. Evaluation showed that it resulted in:

- less use of homecare workers, care from family or friends and general help
- reductions in falls, malnutrition and depression
- improved safe discharges from hospital, wellbeing and coping skills
- increased support for carers and sign-posting
- enhanced patient advocacy.

Potential benefits for Birmingham

Approximately 45,220 older people in Birmingham are very limited in their day-to-day activities. If British Red Cross volunteers supported 3% of them (c1,360), and assuming the same benefits could be achieved as outlined above, the scheme would have the following implications for Birmingham:

- £167,000 in net savings to adult social care (£339,000 gross savings)
- £444,000 in net savings to the health system (£616,000 gross savings).

This assumes that the costs of the scheme (£345,000) are split equally between the local authority and the CCG.

Estimated current financial benefits

A 2013/14 evaluation of Support at Home services across the UK showed the scheme provided a range of financially quantified benefits to the private individual (such as savings to the individual as a result of less use of family and friends). However, we used only the financial quantified benefits to the health and care systems. This was calculated on the following savings per person per year:

- £250 savings to adult social care as a result of less use of publicly-funded homecare workers
- £454 savings to the health care system as a result of fewer falls, instances of malnutrition and depression.

The scheme is estimated to cost £254 per person per year.

For the evaluation cohort of 52 people per year, the British Red Cross Support at Home Scheme:

- costs approximately £13,000
- saves adult social care approximately £13,000
- saves the health service approximately £24,000.

Implementation issues

Volunteers would need to be recruited and trained to implement the scheme.

This scheme is estimated to provide financial benefits to both the local authority and the CCG, assuming the costs of providing the scheme are shared between the two. Therefore, any implementation should consider the need for joint funding.

Conclusions and next steps

Health and care systems need to transform if they are to meet the needs of the future.

This paper outlines some models for policy-makers and planners to consider.

It is the start, not the end of the journey. This research demonstrates that some models have the potential to deliver significant savings and outcomes if they are scaled up. We also know that there are many emerging examples of practice that show early potential to transform care if rolled out.

We would like to encourage local areas to have a conversation about how they can transform care. Appendix A outlines an approach to those conversations which areas may wish to use.

In the coming months, we will consult local areas about what they want to see from the total transformation of social care.

We would like to hear from you if you have examples of evidence-based models of care that you think need to be part of the total transformation of social care and support.

Please contact ewan.king@scie.org.uk

Further blogs and information will be made available at www.scie.org.uk/future-of-care

Further information

www.scie.org.uk/future-of-care

Nesta – Realising the Value
www.nesta.org.uk/project/realising-value

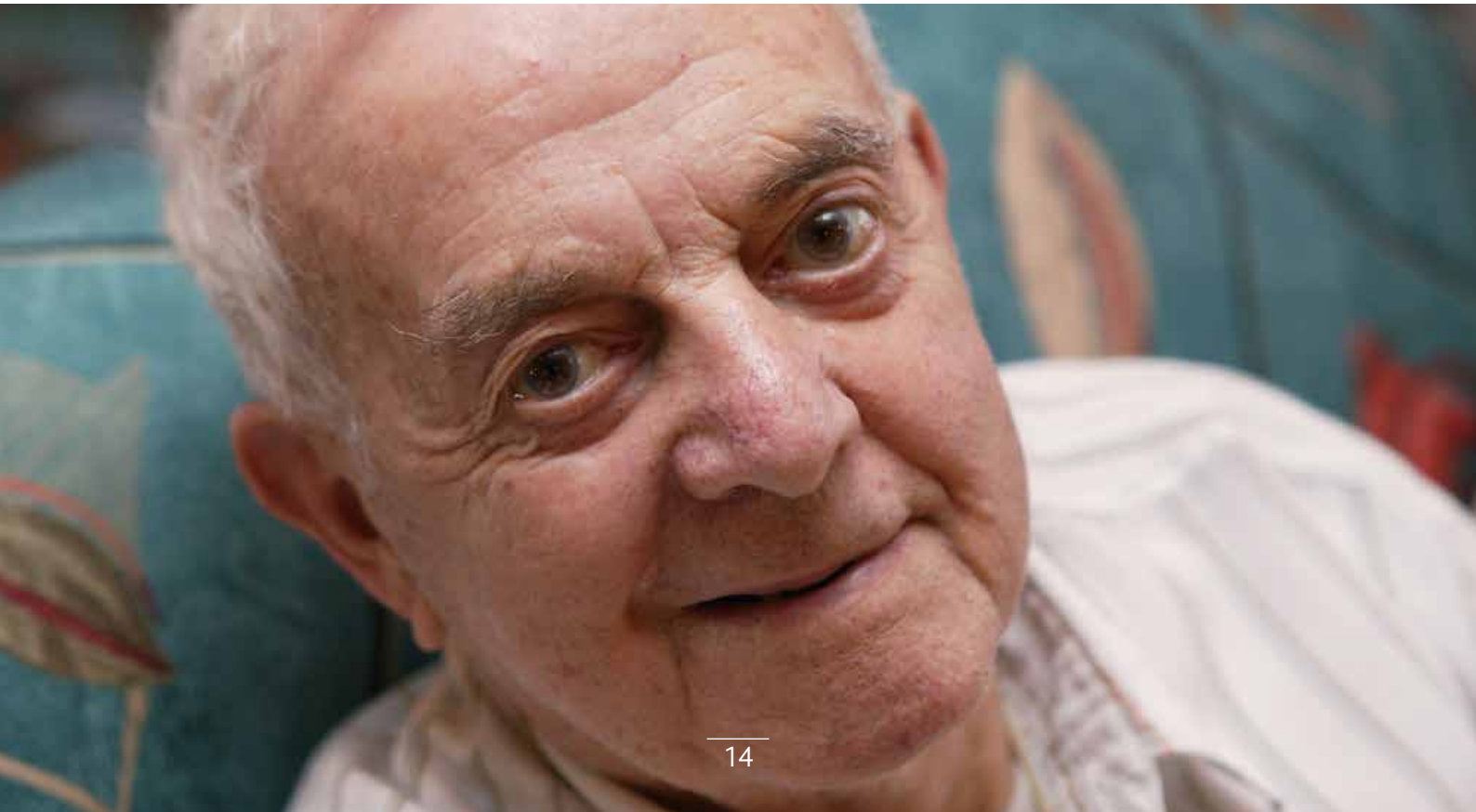
Think Local, Act Personal – Building Community Capacity
www.thinklocalactpersonal.org.uk/Browse/Building-Community-Capacity/

SCIE Prevention resource
www.scie.org.uk/prevention

SCIE Co-production resource
www.scie.org.uk/co-production

SCIE consultancy support
www.scie.org.uk/consultancy

> *"As someone who uses services I would ask that they look at total transformation holistically. Not just as savings – but how they can improve those services to help people and communities to flourish."*
>
> **Clenton Farquharson, person who uses services and Director, Community Navigator Services**



Appendix A

Template for local total transformation conversations

This is a template for conversations with local citizens and stakeholders about transforming health and care. Organisations can use the template to help guide those conversations.

1 Establish shared goals

The following is a set of shared goals that you may wish to adopt.

'We believe that:

- The goal of health and care services is to help older, vulnerable or disabled adults who have ongoing support needs to live well and have a good life. That means living independently at home wherever possible, with opportunities to spend time with other people and to do things which are meaningful to that individual.
- Current ways of supporting adults do not consistently result in everyone achieving all of their goals and living well where they want to live. People and families are not always helped enough to look after themselves and each other. And the budget for adult services has reduced significantly and will reduce again. So lots needs to change.'

2 Agree on what will make a difference

Evidence suggests that there are five main ways in which people who need support can be helped to live well. You may want to use these as the basis for agreement.

1. Helping all people and families to stay well, connected to others, and resilient when facing health or care needs.
2. Supporting people and families who need help to carry on living well at home.
3. Enabling people with support needs to do enjoyable and meaningful things during the day, or look for work.
4. Developing new models of care for adults and older people who need support and a home in their community.
5. Equipping people to regain independence following hospital or other forms of health care.

3 Develop a joint approach

Agree how you will approach the development and delivery of work, and agree realistic parameters. You may wish to use the following as a starting point for discussion with local citizens:

'For each of the key areas which we have agreed are most likely to make a difference, we will:

- Describe what we do at the moment and how much it costs. We will tell you what inspectors, staff and local people say works and what they would like to change.
- We will be honest about the amount of money we are likely to have in the future.
- We want to combine what is working best in this area, with what is working best in other places, so we will describe some models from here and other places which we think should get more investment and those which we think could be reduced as a result.
- We will listen to what you think, publish a report on what local people have said and then draw up a public plan informed by those views, explaining the reasons for our decisions.'

'We know that there are things that only services can do (e.g. provide personal care to people who are not receiving that care from a friend or family member) and things only communities can do (e.g. being good friends and neighbours so that fewer older people are lonely). We hope that together we can design a system which makes the best use of the resources of the council, the NHS and charities, along with what people and communities want to contribute themselves. The new system will not be perfect and it will remain under pressure, but we think that, working with you, we can all make a better system than the one we would have if council and NHS leaders tried to make all the difficult decisions on their own.'

A Word version of this template is available to download at www.scie.org.uk/future-of-care/total-transformation/template

Appendix B

Developing logic models for promising models

Where models are currently used on a small scale, they can be caught in the 'evidence trap': the numbers using them only enable small-scale, largely qualitative evaluations, which typically conclude that they are promising but 'more research is needed'.

Some small-scale models already have sufficient evidence of outcomes and cost-effectiveness or savings to justify ambitious scale-up programmes. For others, a logic modelling approach would enable cases to be made for incremental investment based on testing the model's outcomes against those which it claims will be delivered.

We recommend using Nesta's Theory of Change approach to identify the model's inputs, activities, assumptions and intended short- and longer-term outcomes and impacts for its target group(s). To make incremental investment in the model feasible, it is necessary to identify tangible reductions in, or avoidance of, costs to the system, as well as the outcomes most valued by the individuals and families using the service.

Savings could come from:

- the model being lower cost than traditional alternatives (e.g. Shared Lives)
- people typically needing to use support for a shorter time (e.g. hospital discharge support or reablement)
- people being less likely to use another service, or use of that service being delayed
- people being less likely to re-enter the service or another service (failure demand).

To develop a theory of change, you need to identify:

- **Inputs:** The contributions of staff, volunteers, resources and of the people who need support themselves and their families.
- **Costs:** Overall and unit costs of those inputs. E.g. how much does the model cost per individual or family it works with?
- **Changes:** The changes which the model aims to support people to make: e.g. lonely older people become more connected to others and feel less lonely.
- **Outcomes:** The key short- or longer-term health and wellbeing outcomes associated with those changes. This does not have to be an exhaustive list: instead focus on one or more outcomes which are likely to be associated with greater cost-effectiveness or savings, alongside the outcomes most valued by people themselves.
- **Savings:** The expected impact on health and care spend associated with those outcomes which are expected to have a tangible impact on costs and spending. How much will be saved or what typical cost is avoided each time the outcome is achieved?

This will enable you to set targets for the initial phase of the programme, based on the new intervention achieving sufficient cost-reducing outcomes to balance its costs.

An investment plan will be needed which includes regular review of the level of investment so that decision-makers can respond to good and poor outcomes.

Poor outcomes should lead to the intervention being redesigned, reduced or discontinued.

Good outcomes should lead to increasing investment.

Unless transition funds or social investment has been identified, this will usually require consideration of which other parts of the system may need to see reduced investment.

Nesta's Theory of Change model
www.nesta.org.uk/resources/theory-change

Additional support

If your area would like help with constructive local conversations about transforming social care, please contact SCIE at trainingandconsultancy@scie.org.uk

About SCIE

The Social Care Institute for Excellence (SCIE) is the leading improvement agency for the care sector in the UK, and an independent charity.

Our ambition is to improve the lives of people who use care and support services. We identify and share knowledge about what works. And we help to put that knowledge into practice through our accessible resources and tailored support services for organisations that plan, commission or deliver care.

Our **freely available resources** – including guides, e-learning and videos – focus on the practicalities of improving the way care and support is planned, commissioned and delivered.

Our cost-effective, **CPD-accredited training** and **consultancy services** can help you to tackle particular issues in your organisation or area.

Our research and evaluation services identify the developing evidence base and inform difficult decisions.

Find out more and register for free SCIE ebulletins at www.scie.org.uk

social care
institute for excellence

Future of care
Number 1
Second edition
March 2017

Total transformation of care and support

Creating the five year forward view for social care

Health and care systems need to transform if they are to meet the needs of the future.

This paper outlines some models for policy-makers and planners to consider.

It is the start, not the end of the journey. This research demonstrates that some models have the potential to deliver significant savings and outcomes if they are scaled up. We also know that there are many emerging examples of practice that show early potential to transform care if rolled out.

Future of care
The SCIE Future of care series aims to stimulate discussion amongst policy-makers and planners about the future of care and support, based on analysis of developing evidence and projections for the future.

Thanks to Birmingham City Council, PPL, Shared Lives, Nesta and Clenton Farquharson for their support in developing the second edition of this paper.

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