London Borough of Hammersmith & Fulham

Cabinet

8 MARCH 2010

LEADER
Councillor Stephen Greenhalgh

A FRAMEWORK FOR INVESTMENT IN PREVENTION AND EARLY INTERVENTION FOR ADULTS

Wards: All

This paper sets out a strategic approach to prevention and early intervention for H&F that seeks to reduce reliance on long term care. There are 3 key elements:

- A targeted case-finding approach that identifies people with long term conditions and particular risk indicators that mean they are likely to become high cost users of health and social care services without specific early interventions.
- Extending reablement to become the standard offer so that all adults are supported to achieve optimal independence.
- An innovative approach to establishing a self-financing model of low-support for anyone who needs help.

CONTRIBUTORS

AD QCP
DFCS
ADLDS

HAS A PEIA BEEN COMPLETED? YES

Recommendations:

1. **To support the framework for prevention and early intervention as set out in this report, and to agree to reserve £685k to implement a predictive risk modelling system.**

2. **To award a grant of £50k in 2010 and £50k in 2011 to The Stroke Association to support strokes prevention and reablement.**

3. **That authority be delegated to the Director of Community Services, in conjunction with the Leader, to award grant funding of up to £685,000 over the next 3 years for the provision of a Low-Level In-Home Support Service as described in paragraph 13 of this report.**

4. **That expenditure on the above initiatives, totalling £1.470m, be met from PCT Health Gain funding of £0.340m and available Social Care grants of £1.130m.**

1. EXECUTIVE SUMMARY

1.1 There is growing evidence both internationally and in the UK that a well-structured programme of prevention and intervention services can improve quality of life for individuals and lead to reduced reliance on high cost services, delivering long term value for money. This paper sets out a strategic approach to prevention and early intervention for H&F that seeks to reduce reliance on long term care. There are 3 key elements:

- A targeted case-finding approach that identifies people with long term conditions and particular risk indicators that mean they are likely to become high cost users of health and social care services without specific early interventions. This model is based on sharing data at the individual level between the Council and PCT and jointly commissioning interventions designed to reduce emergency admissions, acute bed days and admissions to care homes (care home placements account for 67% of adult social care funding).

- Extending reablement* to become the standard offer so that all adults are supported to achieve optimal independence.

- An innovative approach to establishing a self-financing model of low support for anyone who needs help. This model seeks to tackle loneliness and social isolation, which have been shown to have a profound impact on health and the ability of the individual to manage their condition(s). It is founded on the principle of individuals being able to contribute both time and/or money and being universally available to anyone rather than operating excluding (needs based) criteria. It is a model that becomes self-funding in 3 years and offers local employment opportunities.

1.2 Each of these elements need pump-priming money to support a coherent programme of work in order to deliver longer term benefits. Such a programme would form part of the broader polysystems development and address health and social care in a holistic way, recognising that the financial benefits will accrue in different parts of the system and that both risks and benefits will need to be shared.

1.3 There is now an opportunity to use £1.3m carried forward from specific government grants in a strategic way to support this programme. Dedicating these resources to pump-priming the programme of prevention and early intervention as set out in this report will support the Council and the PCT in achieving a strategic shift that will reduce future demand for high cost care.

---

*'reablement' is a term used by the Department of Health that refers to support for people to regain function and optimise their ability to manage independently.

2. PREVENTION & EARLY INTERVENTION IN H & F

2.1 Like all Councils, Hammersmith & Fulham cannot fund every social care need that exists within our population. However, given demographic trends, it would be unsustainable to focus (through ever-tightening eligibility criteria) our finite resources solely on those people with the highest and most expensive care and support needs. Instead, we must seek to build up services and community infrastructures that assist people in remaining in their own homes, accessing support from their local communities, and being given good guidance about available services. Our prevention strategy must therefore include:

- Services that prevent people from requiring admission to hospital and intensive social care.
- Targeted services that support people in living in the community as far as possible and foster independence rather that reinforce dependence.
- Effective information and signposting systems for accessing wider ranging services, especially for people who do not meet our FACS eligibility criteria.
- More innovative ways of working, which jointly underpin both the prevention and polysystems agendas.
- Approaches that reduce social isolation and which build strong, self supporting communities.

2.2 Achieving a strategic re-orientation towards the promotion of improved health and wellbeing requires a time limited investment now to reduce future care and support costs. Preventative interventions will progressively reduce demand for traditional high dependency, reactive services so that over time a significant shift in our patterns of investment will occur.

3. NEEDS OF THE POPULATION

3.1 H&F provides adult social care services to approximately 4000 local residents. The majority are people over the age of 65, although getting older is not in itself a reason for needing support. Broadly, our approach to prevention will apply across all care groups and is not age specific. However, given demands generated by some residents as they get older, this report has some focus on the older population.

3.2 It is difficult to make precise estimates of the overall needs of the older population as research evidence is variable. Many people will not begin to experience any significant difficulties until they are much older

and, of the over 65s population, 20% are estimated to need care costing less than £1000 during all their retirement years. 20% are likely to need care costing more than £50,000 (Shaping the Future of Care Together Green Paper). To meet the fiscal challenge ahead we need to reduce the proportion of people in H&F who have high cost needs and support more people to remain healthy through their retirement years.

3.3 Nationally, about 1.2m people used social care services organised by their local authority in 2005 (15% of over 65s). In H&F, we currently provide ongoing social care to 2500 over 65s (14.3%), who meet our Fair Access to Care (FACS) eligibility criteria. Approximately a further 6000 people over 65 years (6%) use services locally provided by voluntary organisations.

3.4 The General Household Survey can be used to provide estimates of the numbers of people who experience a level of difficulty with daily living, including at a very low level. Based on 2001 data, this suggests that 6010 older people in H&F will have some needs broken down as follows: 1350 (22%) very high, 1000 (17%) high, 1450 (24%) moderate and 2210 (37%) low. It is important to note that these categories do **not** correspond with FACS levels and thresholds of difficulty are much lower. However, this indicates that there are older people in H&F who are not currently in touch with services and could benefit from more preventive approaches.

4. WHAT IS 'PREVENTION'?

4.1 The term 'prevention' in this context can be understood as a policy framework which seeks to maintain independence and health by actively intervening with the right service at the right time. Conceptually, prevention operates across a continuum of several overlapping levels:

- Primary prevention = **promoting wellbeing** through good information, healthy lifestyles, low level in-home services, safer neighbourhoods, etc.

- Secondary prevention = **early intervention** to halt or slow down functional deterioration through case finding, befriending, reablement services, etc.

- Tertiary prevention = **complex care** to minimise the impact of disability and health conditions through integrated health and social care assessment, rehabilitation, case management, etc.

5. WHAT IS THE EVIDENCE OF EFFECTIVENESS AND COST EFFECTIVENESS?

5.1 There is strong and well established international evidence that a systematic, multi-faceted prevention approach both improves outcomes and reduces overall costs across social care and health.

5.2 Primary prevention has the weakest evidence base, although this is largely attributable to the technical difficulties of controlling for other confounding factors in the evaluation studies of these types of interventions. Nevertheless, systematic meta-analysis of existing studies on low intensity support services[†] consistently concludes that users of these services generally experience improved confidence, an enhanced sense of wellbeing, and better health outcomes.

5.3 Likewise, befriending and similar voluntary initiatives to reduce social isolation have been shown to significantly reduce admissions to hospital and care homes. Longitudinal studies on the impact of reablement by CSED suggest that between 20% & 80% of service users either need a reduced service, or no service at all, following a reablement intervention (while there is wide variation between programmes, the results for reablement participants are nearly always significantly better than for control groups).

5.4 At the tertiary prevention end of the spectrum, there is strong evidence that maximising the independence and function of adults through early, integrated health and social care services improves outcomes and reduces costs by reducing the number of people who develop complex needs or end up in a crisis requiring hospitalisation[‡]. In the UK, there is growing evidence of greater effectiveness and lower costs from the 29 Partnerships for Older People Projects (POPP). Initial results indicate a mean net cost reduction of £410 per person in these programmes – mainly from reduced emergency hospital bed days.

5.5 Overall, the evidence suggests that prevention is most effective and cost effective when it is targeted at:

- Specific proven interventions (e.g. falls prevention, reablement).
- Low intensity interventions which both meet immediate practical needs and improve resilience by building up networks of support and inclusion.
- Reducing unplanned hospital admissions and emergency bed days (which in turn reduces demand for high intensity social care services) through an integrated health & care response.

[†] See for example Joseph Rowntree Foundation, 2000

[‡] Successful US models, for example, include Kaiser Permanente, the Veteran's Administration, and Evercare – studies on the latter showed a 50% reduction in hospital admissions with similar mortality.

- People who are currently unknown to the system but who are at high risk due to having multiple impacting factors (e.g. social isolation, inappropriate housing, and health problems/long term conditions).

6. PROPOSED APPROACH

6.1 On this basis, a three pronged approach to embedding prevention in Hammersmith and Fulham is proposed:

6.1.1 The use of case finding (via predictive risk modelling) to target preventative interventions at people most at risk of hospital admission (and therefore intensive social care provision).

6.1.2 Extending STARS (Short Term Assessment and Re-ablement Service) so that reablement is the default option for access to homecare services.

6.1.3 Commissioning, via a contestable process, Low-Level In-Home Support Service for people aged 50+ through a (paid) membership organisation (along similar lines to the Circle model operating in Southwark).

Each of these three elements is discussed in turn below.

7. TARGETED CASE FINDING AND INTERVENTIONS

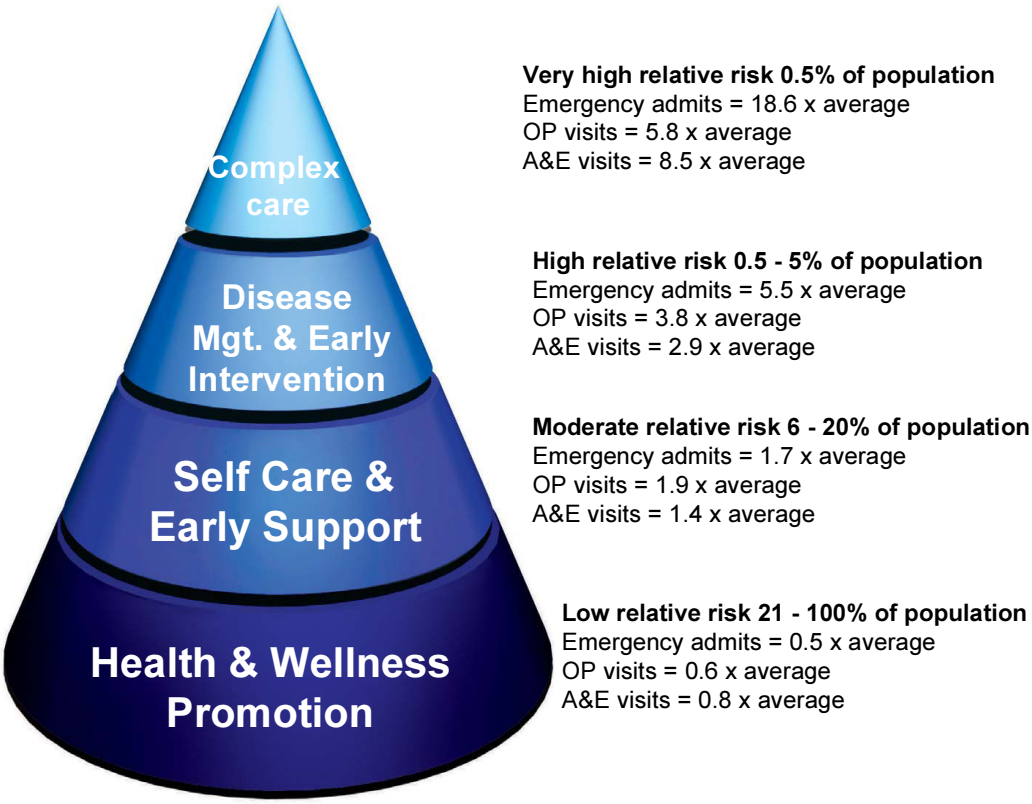
7.1 Case finding and early intervention with those at risk of functional decline using a validated screening tool is now well established as a central component of prevention strategies in both health and social care.

7.2 There are various manual or form-based approaches available (EARLI – a questionnaire for at-risk older people is one of the best); however, IT/electronic based systems have the important advantage of being able to stratify the entire population at very regular intervals (eg., fortnightly) to provide real-time information about people at risk who might benefit from early follow-up. The gold standard of IT based case finding systems is the King's Fund/Nuffield Trust *Combined Predictive Model* which uses a comprehensive dataset of inpatient, outpatient, accident and emergency and general practice records to segment the population by relative risk of unplanned hospital admission at any point in time.

7.3 This modelling is reliable and it identifies patients before they become high users of services. This is critical as many case finding tools rely on identifying existing high users using 'threshold models' which are

predisposed to selection bias and regression to the mean[§]. Threshold models generally have 'low sensitivity in detecting patients who will have high admissions in the following year' (Lewis, 2007). The Combined Model is being used successfully by Croydon's *Virtual Wards* initiative (with a 30% reduction in unplanned hospital admissions and annual net savings initially estimated at £1 million per year), and in Warwickshire and Devonshire. It is also an integral part of the Redbridge polysystems development.

Diagram 1: Population Segmentation Using Combined Model



Source: Adapted from the Combined Predictive Model Final Report (King's Fund, 2006)

7.4 The combined model currently uses health data only to predict the risk of future health events. The Nuffield Trust is interested in working with H&F to develop the model further, so that it also draws upon social care and housing data which will improve both the reliability of the model (housing status for example is closely correlated to risk of hospital and care home admission), and also allow it to explicitly predict future social care as well as health needs and expenditure. Implementing data sharing protocols between the PCT and Council, and populating social care records with NHS numbers (both underway) will make development of this wider model viable.

7.3 That is, individuals are selected because they are already very high users (outliers) who represent an extreme. Thus, threshold models suffer from the problem of regression to the mean whereby those who are extreme one year (e.g. in terms of number of admissions and costs) are rarely extreme the next – rather such patients are likely to improve (regress towards the mean) even without intervention.

7.5 In the meantime, it is nonetheless logical to set up and use the (health based) Combined Model as our case finding system for both health and social care since unplanned hospitalisation is well established as an important predictor of increased social care needs, particularly care home admission. For example, of the 141 H&F residents who were admitted for the first time into permanent residential or nursing home care in 2008-09, 104 had had an acute admission in the previous four years and 58 had their last acute admission in the previous quarter prior to entering long term care (56% of the 104 who had been admitted). Analysis completed by the Nuffield Trust also supports the notion that risk of unplanned hospital admission is also a clear indicator of risk of developing high social care needs.

8. TARGETED INTERVENTIONS

8.1 The second part of the proposed approach is to tailor health and community support interventions for each population segment, based on their predicted risk level. Depending on an individual's level of risk, he/she would be streamed into various health and care interventions as shown in Table 1 below.

Table 1: Health and community support interventions in each segment[**]

Health & Wellness Promotion	• Physical activity, smoking cessation, & healthy eating programmes • Tackling poverty, employment, and poor housing • Information, advice, & advocacy to access resources • Promoting active ageing & volunteering • Community safety initiatives • Access to education, leisure, & community groups • Social marketing ('Change for Life') • Social & physical regeneration
Self Care & Early Support	• Health trainers / navigators • Expert patient & self management programmes • Dietary advice & support • Handy person & home safety checks • Self care plans • Peer health mentoring & coaching • Assistive technology • Medicines use reviews • Befriending services • Supporting carers •
Disease	• Nutrition & dietetic intervention • Early detection through primary care screening (QOF+)

[**] These interventions are cumulative rather than exclusive, so even those with complex care needs may well benefit from 'lower level' services

Management & Early Intervention	and diagnosis • Further individualised case finding through questionnaires, contact checklists, mini assessments etc • Practical support with gardening, shopping etc • Disease specific care pathways for common conditions based on NICE guidelines • Community matrons • Aids, equipment, & home adaptations • Supported employment and day opportunity services • Retinal screening, vascular checks, foot-care, & vaccinations • Reablement and rehabilitation • Telecare • Falls clinics • Psychological therapies • Self directed support (SYC)
Complex Care	• Hospital at Home/unscheduled care • End of Life care services • Integrated, inter-disciplinary health and social care teams • Personal budgets in health and social care.

8.2 We will be able to formulate specific (re)commissioning plans based on data from the Combined Model once we have it in place. Clearly, any service developments will be an integral part of the polysystems design/blueprint, and explicitly sharing risks, costs, and benefits across health and social care is key to the success of this approach. In many cases, existing services may be better targeted at higher risk clients through the risk stratification data which the Combined Model will provide.

9. INVESTMENT REQUIRED FOR TARGETED INTERVENTION

9.1 It is difficult to estimate at this stage the investment needed to establish a comprehensive, preventative response to people identified as at heightened risk. Time limited 'pump-priming' funding will enable us to establish new interventions (and enable some double-running costs while services are re-commissioned) until the new services begin to take effect and reduce demand. The typical timeframe for preventative services to begin to reduce demand for traditional social care services is between one and three years.

9.2 The PARR+ (Patient At Risk of Re-hospitalisation) predictive modelling tool is being procured to be implemented within the local health economy in April 2010. Discussions have taken place with Nuffield Institute on how to develop this tool into a combined model that will incorporate social care and housing data and design indicators of future social care demand. Funding is required to support this work and to commission suitable interventions.

9.3 It is therefore proposed to allocate £685K non-recurrent funding over 2010/11 and 2011/12 to pump-prime this targeted intervention work stream. A separate business case will be presented to demonstrate the evidence base for selected interventions, their impact on future levels of demand and timescale for delivering savings. Evidence of effectiveness will inform on-going funding within newly designed poly-systems services.

9.4 Two specific areas that would augment our prevention focus (and potentially generate downstream savings) in the short term are (1) extending STARS and (2) putting in place low level home support, as discussed further below.

10. EXTENDING REABLEMENT/STARS

10.1 There is now a body of evidence from Councils across England which shows that reablement services can help users to become more independent and reduce their ongoing hours of home care. If properly implemented and run, a reablement service can therefore lead to significant long term savings in home care as well as better outcomes for clients.

10.2 Data from STARS indicates that it is achieving similar outcomes to those delivered by reablement services in other Councils. Specifically, clients who go through STARS are less likely to receive long-term ongoing home care and have smaller ongoing home care packages than those clients who are referred through other teams. This is summarised in the table below:

Route to (standard/ agency) home care	**Percentage of clients with ongoing home care (after six weeks post referral)**	**Change in home care package (hours/ week) from week 1 to week 6**
STARS	50%	-23%
Other teams	84%	No change

10.3 Around half of the users who leave STARS have no ongoing package of care and, of those that do, the care package is reduced during their period with STARS. However, the number of service users who have been referred to STARS is relatively small. There are currently around 1,300, OP (Older People) and YPD (Younger Persons' Disability) homecare service users, but fewer than 300 of them have been through the STARS service.

10.4 Extending the STARS service to include all intake referrals is therefore a logical step in augmenting our preventative service offer. To meet our MTFS target of £1m saving it will be necessary to increase productivity and re-allocate some existing staff to reablement activity. In addition, it

is proposed to develop a specific focus on assessment and care navigation for people who have experienced stroke to improve the quality of experience for stroke sufferers in H&F and support optimal reablement for these service users.

11. INVESTMENT REQUIRED FOR REABLEMENT

11.1 This additional activity will assist in achieving the savings target of STARS and would meet the Department of Health grant requirements to improve the quality of stroke services. It is proposed to allocate £80k of the stroke grant to STARS over 2010/11 and 11/12, with a further £100k going to The Stroke Association over 2010/11 (£50k) and 2011/12 (£50k) to implement their peer support service. This service, which is already commissioned in many of our neighbouring boroughs, provides practical support and information to those affected by stroke, and assists in improving hospital discharge, rehabilitation, and social outcomes for stroke survivors and their carers.

11.2 Evidence of effectiveness of these interventions will inform on-going funding within newly designed poly-systems services.

12. GRANT AWARD PROCESS FOR THE STROKES GRANT

12.1 A market assessment identified The Stroke Association as the only third-sector organisation based in the borough which has the existing specialisation to provide re-ablement support services to local people affected by strokes.

13. ESTABLISHING LOW-LEVEL IN-HOME SUPPORT SERVICE FOR PEOPLE AGED 50+

13.1 The service will coordinate the delivery of low-level in-home support to the over-50's in Hammersmith and Fulham. This non-assessed social support service will be provided under the Council's wellbeing powers, subsidised by service users on a subscription basis. The service will be on offer to all Borough residents over the age of 50, whether or not they are FACS (Fair Access to Care Services) eligible and will maximise the potential of older people to contribute positively to their community as well as meeting their basic social care needs at a point before they become eligible for state support.

13.2. A similar service is currently running in Southwark Council as the Southwark Circle and has been extensively analysed by LBH&F.

13.3 There is a significant and increasing body of research to suggest that services which build relationships and tackle loneliness and social isolation can improve both the physical and emotional wellbeing of individuals, as well as preventing or delaying the onset of various

health-related conditions which cost the state billions of pounds every year. Many older people also value practical help with their everyday tasks, and this help can support them to stay independent and feel positive. However, the FACS eligibility criteria means that this support is only available through the Council once people already have high levels of need.

13.4 Establishing low-level support which operates in a socially inclusive way is one way of addressing this situation and implementing early intervention. The Low-Level In-Home support service is a promising model and is a membership based service that delivers flexible 'on demand' support with life's practical tasks (from DIY to gardening to technology) and a 'plug-n-play' social network for building and maintaining relationships around shared interests and hobbies. The service will be available to all residents over the age of 50 irrespective of their FACS eligibility.

13.5 The service will focus on primary prevention (maintaining independence, good health and promoting wellbeing) and some secondary prevention (screening and case finding to identify individuals at risk of specific health conditions or events - such as strokes or falls – and support for those who have existing low-level social care needs) in the following ways:

- Primary prevention – the service would help maintain independence, health and wellbeing by providing universal access to good quality information about local services, promoting health and active lifestyles, delivering practical services and on-demand help with small tasks, promoting a positive image of older people, and enabling social contact between older people.

- Secondary prevention – the service would act as an 'early warning' system by putting mechanisms in place to ensure that those 'at risk' of suffering health related problems, strokes or falls are identified and referred to the appropriate agency as and when required.

13.6 Service users will be required to pay a Membership subscription towards the cost of the service. The estimated subscription fee is from £30 per quarter.

13.7 The Council intends that the service will become self sustaining (from April 2013) once established with the ongoing cost paid for by users from their own pocket or from their individual budget where they are social care eligible. A low level in-home support service set up on this basis would generate savings to both health and social care through the prevention and substitution of activities otherwise funded through the Council. Initial estimates are that these savings would equate to approximately £322k per year by the fifth year of operation.

14. NEED FOR DELEGATED AUTHORITY ON THE LOW-LEVEL IN-HOME SUPPORT SERVICE

14.1 The funding made available by Health Gain Fund must be disbursed by the 31st of March 2010 or the funding must be returned.

- Funding has been disbursed to the Council.

14.2 Given current timescales, a recommendation for award of Service cannot be completed in time for 8 March 2010 Cabinet meeting date.

14.3 Presuming that the request for Delegated Approval is given on 8 March 2010, the Award Report must be signed by 31 March 2010.

15. PROCUREMENT PROCESS ON THE LOW-LEVEL IN-HOME SUPPORT SERVICE

15.1 The procurement process will utilise the grant giving process of the Third Sector Investment Fund. The CSD Procurement Team will lead the procurement of the service but will follow the grant giving process.

15.2 The grant process has been chosen due to:

- the emphasis on building the capacity of third-sector organisations within the Borough;
- the service development and specification having input from the Community Liaison Team which administers the Third-Sector Investment Fund grant;
- limiting this funding to third-sector charitable or social enterprise organisations only; and
- the service complementing other capacity building services the Council is funding.

15.3 The grant process will be only be open to third-sector organisations. The service will be advertised, at a minimum, on the Council's website.

16. INVESTMENT REQUIRED FOR LOW-LEVEL IN-HOME SUPPORT SERVICE

16.1 The cost of establishing this type of programme in Hammersmith and Fulham is estimated as up to £685k over 3 years. It is proposed that this is joint funded with the PCT through use of Health Gain Funding. As it is a subscription service, it will become self sustaining once established with the ongoing cost paid for by users from their own pocket or from their individual budget where they are social care

eligible. It is expected the project will payback this level of investment during Year 4 – details attached as Appendix A.

16.2 A low level home support service set up on this basis would generate savings to both health and social care through the prevention and substitution of activities otherwise funded through the Council. Initial estimates are that these savings to the Council would equate to approximately £322k per year by the fifth year of operation.

16.3 It is proposed to commit up to £345k non-recurrent Council funding (allocated over 2009/10, 10/11 and 11/12) to commission, via a contestable process, low-level in-home support for people aged 50+ through a (paid) membership organisation (along similar lines to the Circle model operating in Southwark).

16.3.1 Allocations are as follows:

Health Gain Fund allocation of £130k over 2009/2010.
Health Gain Fund allocation of £170k over 2010/2011.
Allocation top-up of £40k over 2009/2010 from either
a) underspend from Carer Support of £342k or
b) allocation from Connected Care budget of £150k)

17. PREVENTION APPROACH & FUNDING DECISIONS

17.1 Non-recurrent funding of £1.21 million is carried forward from social care grants as shown below:

Table 1: Social Care grant carry forwards (non-recurrent)

Description	**Amount (£k)**
PCT Joint Finance	93
CSD Share of LD Pooled Under spends (2007/08 & 2008/09)	231
Training Grants	499
Carers Grant	207
Stroke Grant	180
Total	**£1,210**
(PCT Health Gain Grant 09/10, 10/11)	+340

17.2 Cabinet agreement is sought to use these funds and £340K PCT health gain funds to pump-prime a programme of prevention and early intervention with investment over 3 years.

18. COMMENTS OF THE DIRECTOR OF FINANCE AND CORPORATE SERVICES

18.1 Case-finding to identify people likely to become high cost users of health and social care services, and preventing that happening.

18.1.1 The proposal is to reserve £685k for this now, with a case being made subsequently for exactly which interventions will be carried out with the people identified, to prevent their use of high cost social care. This is supported by the Director of Finance, but when the case is made for expenditure on specific interventions, there must be evidence that they will work.

18.2 Extending reablement to all adults:

18.2.1 There is £180k carried forward stroke grant and £90k for 09/10. It is proposed to allocate £170k to expand STARS over 2010/11 and 2011/12, with a further £100k going to the Stroke Association over 2010/11 and 2011/12 to implement their peer support service. This is straightforward financially and will help the MTFS savings target of £1,000k for reablement be achieved in 2010/11.

18.3 Self-financing model of low support for anyone who needs help:

18.3.1 The proposal is that a total of up to £685k is spent over 2010/11, 2011/12, and 2012/13 to pay for the start up costs of this service. Of that total, £340k will come from council sources and £340k from 'Health Gain' funding from the PCT. After three years the scheme is planned to be self-financing. The plan is that both the Council and the PCT will make savings by the scheme avoiding members' calling on council services, once the scheme achieves a sufficient number of members.

18.3.2 or the Council 'payback' (i.e. when the £340k of expenditure is matched by £340k of savings) is planned to arrive in year 4 of the scheme (see Appendix A). After Year 4, annual net savings of £284k are forecast. The position set out in Appendix A is indicative and would depend on the outcome of testing the market to find out which provider was most capable of providing this service at a fair price.

There are two significant risks:

18.3.2.1 Firstly, that the number of members (and therefore income) fails to achieve a level that enables the provider to cover its costs, and the council to achieve the planned savings.

18.3.2.2 Secondly, that the activities of the scheme fail to prevent members using Council services, thus causing the Council to fail to achieve its savings targets. It is in the nature of prevention activities that the relationship between cause and effect cannot always be certain.

18.3.3 For the purposes of sensitivity analysis the impact of a lower growth rate in membership has been modelled at Appendix B. If the growth rate were cut by half, then the funding required by a provider from the Council (including Health Gain funding) would rise to £961k (or if funding remained at £680k, the provider would make a loss of £281k). Savings would still occur but they would not pay back the expenditure within five years. Member numbers would reach 5357 by the end of year 5 rather than the 7248 members that generate the financial projections in Appendix A.

18.3.4 A provider has made the case for a £680k payment from the Council over the first three years, on the basis that they would make losses while member numbers were still building up. We need to establish what the profit or loss position for a provider would be in year 4 and beyond.

18.3.5 If the member numbers remained below target beyond year 3 the savings in Council spend might never be achieved. If they were losing money there is a risk that a provider would stop the project after the first 3 years. In that scenario the Council would have spent £680k for little benefit. Conditions need to be applied to the grant to enable the Council to halt payment if membership targets are not achieved.

18.3.6 It is recommended that the savings assumptions, both direct and preventative, are tested for reasonableness with managers closely concerned with the delivery of those services.

18.3.7 The financial gains from this project could be significant, but come with some degree of risk. It is recommended that the projected savings are not incorporated into the MTFS until there is clear evidence that the affected council budgets are underspending.

18.4 Sources of Funding:

18.4.1 The sources of funding are £1,210k of unspent grants currently on the balance sheet, plus £340k mainly from ‘Health Gain’ already committed to the Council from the PCT. None of these sources of funds have been committed for any other purpose. Of the balance sheet items, £730k is non-ringfenced.

19. COMMENTS OF THE ASSISTANT DIRECTOR (LEGAL AND DEMOCRATIC SERVICES

19.1. Officers should ensure that the process for the award of the grants referred to in this report is transparent, fair and non discriminatory.

19.2 Legal Services will work with officers to draw up the terms and conditions for the award of the grants.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	Background Papers (Specification & EMT report)	Christian Harris, 5374	CSD

Appendix A

Circle Project														
Payback Calculation														
All figures in £s														
	Council						*Health*							*Total Council and Health Yrs 1 to 5*
	Yr 1	*Yr 2*	*Yr 3*	*Yr 4*	*Yr 5*	*Total Yrs 1 to 5*	*Yr 1*	*Yr 2*	*Yr 3*	*Yr 4*	*Yr 5*	*Total Yrs 1 to 5*		
Payment to Circle	221,510	92,325	26,165	0	0	340,000	221,510	92,325	26,165	0	0	340,000		680,000
Savings														
Direct	5,237	29,643	72,931	118,246	159,996	386,053	7,388	35,577	77,802	120,946	163,649	405,361		791,414
Preventative	5,915	32,371	77,308	123,803	167,514	406,910	23,805	121,245	287,749	461,092	623,893	1,517,784		1,924,694
Allow 1 yr for prevention	-5,915	-26,456	-44,937	-46,495	-43,712	-167,514	-23,805	-97,440	-166,504	-173,343	-162,801	-623,893		-791,407
Sub-Total	5,237	35,558	105,301	195,554	283,798	625,449	7,388	59,382	199,047	408,695	624,741	1,299,253		1,924,701
Savings Less Payments	-216,273	-56,767	79,136	195,554	283,798	285,449	-214,122	-32,943	172,882	408,695	624,741	959,253		1,244,701
Cumulative	-216,273	-273,039	-193,903	1,650	285,449		-214,122	-247,065	-74,183	334,511	959,253			
Payback				This Yr On	This Yr On					This Yr On	This Yr On			
Better Value	12,325	98,377	244,693	391,857	530,212	1,277,464	0	0	0	0	0	0		1,277,464

Appendix B

Circle Project														
Payback Calculation - Sensitivity if Membership Growth Rate is Halved														
All figures in £s														
	Council						*Health*							*Total Council and Health Yrs 1 to 5*
	Yr 1	*Yr 2*	*Yr 3*	*Yr 4*	*Yr 5*	*Total Yrs 1 to 5*	*Yr 1*	*Yr 2*	*Yr 3*	*Yr 4*	*Yr 5*	*Total Yrs 1 to 5*		
Payment to Circle	320,245	160,662	140,094	0	0	621,000	175,335	87,963	76,702	0	0	340,000		961,000
Savings														
Direct	5,042	14,808	34,191	69,991	112,787	236,819	7,127	18,101	36,313	71,589	115,362	248,492		485,311
Preventative	5,702	16,171	36,195	73,280	118,087	249,435	22,976	60,973	134,731	272,925	439,805	931,410		1,180,845
Allow 1 yr for prevention	-5,702	-10,469	-20,024	-37,085	-44,807	-118,087	-22,976	-37,997	-73,758	-138,193	-166,880	-439,805		-557,892
Sub-Total	5,042	20,510	50,362	106,186	186,067	368,167	7,127	41,077	97,286	206,320	388,287	740,097		1,108,264
Savings Less Payments	-315,202	-140,152	-89,732	106,186	186,067	-252,833	-168,208	-46,886	20,584	206,320	388,287	400,097		147,264
Cumulative	-315,202	-455,354	-545,086	-438,900	-252,833		-168,208	-215,094	-194,510	11,811	400,097			
Payback										This Yr On	This Yr On			
Better Value	11,823	47,369	114,564	231,943	373,766	779,464	0	0	0	0	0	0		779,464