CARE, HEALTH & WELLBEING
OVERVIEW AND SCRUTINY COMMITTEE

TITLE OF REPORT: Evidence Session – OSC Review "helping people to stay at home safely"

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SUMMARY

1. Care, Health & Wellbeing Overview and Scrutiny Committee have agreed that the focus of its review in 2018-19 will be "helping people to stay at home safely".

2. At the Overview and Scrutiny Committee on the 18th June 2018, Committee agreed that the review will consider how health, social care and voluntary services support people's confidence and independence to live safely in their own home. The review will centre on the 6 core themes of

   - Assistive technology and digital information;
   - Enablement services;
   - Housing options to support independent living;
   - Commissioning for enablement outcomes;
   - Emergency and community services;
   - Personalisation and choice.

3. The Committee will consider the range and extent of current activity in these areas, with a view to agreeing a set of recommendations.

4. This report will focus upon one of the six core themes, commissioning for enablement services and outcomes. The background and context for the approach and the evidence base. The report will also highlight how enablement can take place in different forms e.g. use of equipment, digital technologies and the use of trained enablers e.g. travel trainers, occupational therapists. This report will highlight the ongoing work in Adult Social Care to promote enablement and independence for people with learning disabilities.

5. A presentation from Behnam Khazaeli and Louise Hill will focus on case studies (highlighted in the appendix of the report) demonstrating how enablement can help people stay safe at home or move on from care to become independent. The case studies will focus on the work of the Achieving Change Together team.

Background

6. What is Enablement? - In recent years, an increasing number of reablement services have been developed by local authorities and/or the NHS. It is believed that reablement services can lead to major improvements in the well-being and independence of vulnerable people, as well as enabling cost effective care provision. Reablement services "provide personal care, help with activities of daily living and other practical tasks for a time-limited period, in such a way as to enable users to develop both the confidence and practical skills to carry out these activities

themselves" (Glendinning et al 2010).

7. There is sometimes confusion between organisations as to what exactly is included in re-ablement (Bridges and James, 2012); there is overlap with other forms of intermediate care services; and reablement services themselves can take many different forms.

8. One attempt to differentiate between intermediate care services and reablement suggests "A reablement service is about enabling people to regain or retain self-care function for themselves, rather than providing input that replaces that function" (Parker, 2014). This definition emphasises the "restorative, self-care element" of reablement.

9. The Reablement For All (2010) learning guide differentiates between intermediate care and reablement as follows:

   > "Intermediate care patients have a defined clinical need, and intermediate care services are clinician-led. In contrast, reablement service users have a social care need (which may result from a clinical need) and reablement services are not clinician-led and tend to adopt a social model of support. Reablement users can include people who have been through a period of intermediate care. However, reablement users also include those who have not been in hospital and are not at high risk of admission to hospital or a care home, but who need support to continue living independently. Many people who would not be eligible for intermediate care may be able to access reablement."

10. There is no single delivery model for reablement. Reablement services may include services such as personal care, practical support, prompting for medication, teaching people exercises to help regain mobility, providing information and signposting, and obtaining equipment for users. They are very much tailored to the individual's needs and preferences.

11. Enablement is sometimes called re-ablement or re-enablement. Enablement gives adults the opportunity and confidence to relearn and regain some of the skills they may have lost because of:

    - Poor health
    - Disability
    - or after a spell in hospital

12. Reablement has been defined as 'services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living'. Enablement is 'doing with' rather than 'doing for' the individual to enhance autonomy and/or independence. There is no blueprint for the provision of reablement services although the consensus is that they are short-term interventions to enable people to develop confidence and practical skills to carry out daily living activities and thus prevent people being admitted to hospital or long-term residential care for as long as possible.

13. Enablement can be:

    - carried out at a person's home
    - delivered by specially trained enablers e.g. occupational therapists

- for up to a 6 weeks (although this is not prescriptive)

14. Some of the defining features of a reablement service can be described as:

    - Helping people to do things for themselves, rather than doing things to or for people
    - Time-limited
    - Outcome-focused
    - Setting and working towards specific goals agreed with service user
    - Treats assessment as something that is dynamic not static
    - Builds on what people currently can do and supports them to regain skills to increase their confidence and independence.
    - Aims to maximise users' long-term independence, choice and quality of life
    - Aims to reduce or minimise the need for ongoing support after the period of reablement

15. **What does the evidence base tell us?**
    Reablement has been found to be cost-effective in terms of improving health and social care outcomes for service users. Glendinning et al (2010) found that, in terms of health-related quality of life, at a willingness to pay threshold of £30,000 per outcome gain, there was a 99% probability that reablement was cost-effective if both health and social care costs were considered (and just under 100% if social care costs alone were included). For social care related outcomes, using the same threshold level, they found a 78% probability that reablement was cost-effective (98% if only social care costs were included).

16. Lewin et al (2013) found that individuals who had received a reablement service were less likely to use any kind of home care service over the next three years or a personal care service for nearly five years, compared to individuals who had received a conventional home care service.

17. 23% of users of a home care reablement scheme offered by Norfolk County Council ceased the service with no further requirement for support. Care hours for those going on to longer term care were reduced by 90% (Allen and Glasby 2010).

18. Outcomes in respect of reablement services in Glasgow (based on 181 service users) demonstrated that, where service users fully completed reablement, service delivery achieved and exceeded the target reduction in ongoing homecare hours provision: the target reduction was 30% whereas analysis indicated that a 51.5% reduction had been achieved (Joint Improvement Team 2014).

19. In Northern Ireland, it has been reported that approximately 4750 older people benefitted from reablement in 2014. This supported them to live independently at home and 45% were able to be discharged with no statutory service required (Health and Social Care Board 2014).

20. In Wales, over 70% of people who had received reablement services did not need further ongoing support, representing a benefit to not only service users but to Local Authorities and Local Health Boards (Social Services Improvement Agency 2013).

21. The Social Care Institute for Excellence (SCIE) has published a SCIE guide based on research and practice evidence about the effectiveness and cost-effectiveness of

reablement (SCIE, 2013). It draws on approximately 10 studies published between January 2011 and November 2012 including 2 randomised controlled trials. The underpinning research for this review shows that "reablement is a very promising practice". In particular, there is good evidence that reablement 'improves service outcomes (prolongs people's ability to live at home and removes or reduces the need for standard home care)". Studies indicate a slightly higher cost than traditional home care but suggest a strong probability of cost savings in the long term.

22. The evidence base around enablement continues to grow nationally, there is a limited amount of very high-quality evidence available, there are pockets of evidence (as highlighted above) which suggest that reablement services are cost-effective, have positive outcomes for the user and for health and social care staff, and can be delivered in many different ways. The latter means there are inconsistencies across the country in relation to spending on reablement services and what is defined as a reablement service.

23. The evidence base also demonstrates that although there is no single 'gold standard' delivery model for reablement, there are several examples nationally of different service delivery models. It is not clear from the evidence how effective these models are. These may be helpful to consider when looking at service options, but caution must be taken in classifying them as 'best practice' models of delivery.

24. **Reablement, different types of approaches / models**
    There are two main approaches which are recognised for reablement. The intake and assessment model accepts all referrals of adults who are being considered for home care or for social services support. It then screens out anyone not likely to benefit. It can be accessed by people with a wide range of needs or circumstances.

25. The selective or targeted model focuses on people in a particular situation or who are referred through specific routes. This could be people leaving hospital but also those in the community who have a high risk of requiring admittance to hospital or care home. This type of service focuses on those people who have the potential to benefit the most and therefore is more selective.

26. **Assistive technology** - Assistive technology is often used as an umbrella term that includes assistive, adaptive and rehabilitative devices for people. Assistive technology promotes greater independence by enabling people to perform tasks that they were formerly unable to accomplish, or had great difficulty accomplishing, by providing enhancements to, or changing methods of interacting with, the technology needed to accomplish such tasks. Within local authority's telecare services include a wide range of technologies, such as sensors, that help an individual to be safe and often within their own home. Alongside Telecare, Telehealth services allow remote monitoring of health-related issues such as blood pressure. Members have already received a report on the use of assistive technology in Gateshead as part of the evidence gathering.

27. **Occupational Therapists** - The wider prevention agenda and the development of specific reablement services provide real opportunities for occupational therapists. Their growing involvement has been recognised in the emerging evidence, by the Department of Health (Nicholson and Kerslake 2011). Occupational therapists can use such skills, together with their knowledge of the medical, physical, emotional and cognitive impact of disability and injury, to ensure that reablement is tailored to an individual's needs and potential for independence. An implicit aim of reablement is to

reduce the care hours required to support people at home, or to develop their independence so that they can remain in their own home. While reduction in care hours is a key indicator of positive outcomes, it is also important to measure the difference that reablement makes to the service user's occupational performance.

28. **Travel training** - Travel Training gives people with special educational needs or disabilities the confidence and skills to travel independently on buses, trains and walking routes. Being able to travel on public transport is a key life skill and another form of enablement. Members have already received a report/session detailing Gateshead's use of travel training to support people with Learning Disabilities in Gateshead as part of the evidence gathering.

29. **Equipment** - Equipment, adaptations and assistive technology can support reablement, promote independence and contribute to preventing the need for care and support. An accessible and safe home environment enables an individual to retain independence, and can provide reassurance for informal carers, often enabling them to continue with activities they might otherwise have to give up, including employment

30. The Gateshead Equipment Service is commissioned by NGCCG on behalf of itself and the Council with NGCCG acting as Lead Commissioner through a Section 75 (s75) agreement. The service is provided by South Tyneside Foundation Trust (STFT), through a Standard NHS Contract. Gateshead Equipment Service provide the following activity:

    - referrals from prescribers
    - ordering equipment
    - delivery / distribution of equipment
    - training on how to use equipment
    - collection of equipment which is no longer required
    - recycling and reconditioning equipment

31. The service is demand-led and covers the purchase and maintenance of the equipment. Equipment offered includes:

    - Home nursing equipment, such as pressure relief mattresses and commodes;
    - Equipment for ADLs, such as adult and children's special seating, shower chairs, raised toilet seats, teapot tippers and liquid level indicators and beds;
    - Minor adaptations, such as grab rails, lever taps, improved domestic lighting, and improving the use of contrasting colours;
    - Moving and handling equipment;
    - All walking frames (mobility equipment) e.g. walking sticks, walking frames and crutches;
    - Equipment for short term loan, including wheelchairs but not those for permanent wheelchair users, as these are prescribed and funded by different NHS services.
    - Communication aids for people who are speech-impaired (adult and children);
    - Equipment such as fall alarms, gas escape alarms, health state monitoring and 'wandering detectors' for people who are vulnerable;
    - Pressure relieving care equipment, suction machines and Vac machines;
    - Occupational Therapy special orders for adult and children such as bariatric equipment e.g. walking aids and bathing and bespoke equipment especially for children e.g. walking frames and beds

An information session on Gateshead Equipment Services can be arranged for members if they would like to find out more about the service.

32. **The approach to enablement in Gateshead**
Bridging Service - To enable people to leave hospital as soon as they were ready for discharge, the Council needed a service that is responsive and has staff available to start within two hours. Gateshead as per the rest of the UK is facing huge market pressures across Home Care.

33. There is a significant pressure on people returning home from hospital with a long-term package of care. The pressure is even greater in the winter period where demand increases It was agreed to pilot over a three-month period a new approach with the independent sector providers. A small team of salaried staff who will deliver support to enable people with a long-term care to be discharged and receive support for a short period of time waiting a long-term package of care.

34. The pilot was evaluated and overall was a success as we enabled over fifty people to return home on the day they were fit to leave hospital. Overall satisfaction from service users and their families was really high with the vast majority rated the service good to excellent.

35. Following the pilot, the Council agreed that the service was required all year round and have commissioned the service with three providers (Clece Care, Comfort Call and Dale Care) from September 2017 to March 2019. Over 100 people have been supported within the first three months since the service has been reintroduced with the majority moving to a long-term package within two weeks of receiving the bridging service.

36. There is an opportunity to look at he Bridging service in the future to see if enablement can be built into the delivery model, thus enabling people to be discharged but also receive enablement over a short period of time.

37. **Independent Sector Home Care Market**
The Home Care Market across Gateshead and the rest of the UK is struggling to meet the required demands. Providers are leaving the market and those who remain are struggling to recruit and retain a quality workforce to meet the demanding pressures.

38. Services such as the Bridging Service have been created and have proved successful in meeting the required outcomes such as getting people out of hospital in a timely manner. However, the opportunity to increase enablement within Gateshead needs to be explored as highlighted above with the Bridging Service to see if this could be incorporated.

39. Two providers within the Home Care market have suggested that they could employ enablement workers to look at people they support and where possible look at reducing either the length of visits or the visits all together. One of the providers has also said the workers would look at alternative ways to meet the needs in a more costly way such as local community support such as befrienders, luncheon clubs etc.

40. The current Home Care model for Gateshead is being reviewed with Newcastle Gateshead CCG in a joint approach. Gateshead as per the rest of the UK is facing huge market pressures across Home Care. There is a significant pressure on people returning home from hospital with a long-term package of care. The pressure is even greater in the winter period where demand increases.

41. The current generalist home care contracts are designed on a traditional time and task approach with Providers carrying out tasks as described in a Care and Support Plan with very limited scope to adopt an enablement approach.

42. It is therefore recommended to look at investing in an enablement approach with the new model. There is an opportunity to pilot this with current providers to develop an evidence base before remodelling the current approach. The commissioning team would like to take a pilot approach where each of the three block providers recruit 2 workers each for a 6-month period to look at reducing packages for people who are already within their services. The incentives for providers are to reduce packages which in turn will free up workers to support other people who are waiting for care to commence. The pilot would enable Gateshead to test out an enablement approach and help build the evidence base to help inform the remodelling of the new Home Care model for Gateshead.

43. All the national and regional research shows that an enablement approach does reduce cost pressures to Local Authorities long term budgets. We need to measure the impact for Gateshead and whether there is an opportunity to either prioritise our existing resources for people who have identified long term needs or increase capacity via either additional resources or different delivery approaches for alternative commissioned contracts.

44. **Enablement service (PRIME) -** the PRIME service delivered by Gateshead Council has been in place since December 2016 and in this time has supported, on average, 1300 service users each year, to remain independent. The main focus on PRIME is around prevention and to support people out of health services and long-term support. PRIME was created with an increased capacity by reducing the number of people working on long term Home Care provision. As part of Enablement the below services are also being provided:

    - Overnight service has proven to be instrumental in maintaining people at home, minimising res care admissions. Staffing resources are being doubled in this area.
    - TSI interventions in PIC and PRIME provision is effective in maintaining people in their own homes
    - PIC IC home discharge levels have been at an effective level (73%), facilitating opportunities for people to remain at home.
    - PRIME and Rapid Response services actively used (particularly NEAS use of RR service) to prevent admissions into residential care and acute hospital admissions
    - OT introduction into PRIME is paying dividends in determining effective lifestyle and environmental interventions for people, enabling them to remain in their own homes
    - Rapid Response service is providing immediate support (average response time of 27 minutes) to people in a crisis in their own homes serving to stabilise individuals and (if need be) providing Enablement support. Service has won the 'Putting People First Personalisation award at the 2017 North East Care Awards in November 2017 for its instant person centred, crisis support.
    - Step-down trusted assessor routes into PRIME and PICs are now firmly established, facilitating seamless discharges.

45. **Next steps**

Overview and Scrutiny Committee is asked to consider the evidence base presented within the report and consider Gateshead current approach to enablement and give views on:

- The evidence base both locally and nationally
- How Gateshead continues to develop an enablement approach
- Proposals to further embed enablement as part of commissioned models moving forward

Appendix 1 - The ACT Team – a case study which demonstrates embedding an enablement approach

1. The ACT team is a new team which has been developed to review service users who have complex needs, primarily people with a Learning Disability with the aim of working with these people to promote independence which in turn will result in less dependency on long-term statutory services. The case study below demonstrates that by embedding enablement into the approach through various methods e.g. assistive technology, travel training etc. the long-term benefits to supporting people to becoming independent.

2. Equipment may be provided as part of the enablement service to promote independence. People with learning disabilities (LD) have poorer health than the general population, much of which is avoidable. These health inequalities often start early in life and result, to an extent, from barriers they face in accessing timely, appropriate and effective health care. The impact of these health inequalities is serious. As well as having a poorer quality of life, people with learning disabilities die at a younger age than their non-disabled peers

3. Additionally, recent years have seen significant challenges around social care budgets, and this, coupled with rising demand for services, means that all councils have had to examine different ways of delivering care and support to people with learning disabilities. At an individual level, it can be a challenge to find the right balance between ensuring safety and enabling supported independence.

4. Services commissioning social care at Gateshead Council are in the process of carrying out changes in the way customers access its services and the way the Council responds. One of the drivers for change is increasing funding pressures across the public sector which has contributed to significant reorganisation and significant budget reductions across all service areas. While services have already made significant budget cuts as part of its financial plan at a time when there continues to be increasing pressure on services. Failure to prepare for and change ways of working to deal with these challenges significantly increases the risk of services not being sustainable.

5. Care Wellbeing & Learning (CWL) is keen to focus on ensuring the optimum outcome is achieved for service users. The approach aims to assist with the opportunities for LD service users to reach their personal potential, within the financial envelope the council is operating within.

   <u>Making Gateshead a Place Where Everyone Thrives</u>

6. Gateshead Council's aim is to make Gateshead a place where everyone thrives. This approach aims to enable the achievement of the best possible outcomes for the people of Gateshead and to make sure that, as a council, it listens to and understands what matters most to local people, whilst always standing up for the most vulnerable and those in need.

7. To achieve this, it acknowledges a radical rethink is required about the way it works as a council, the way we spend the money, the way we work with partner organisations, businesses and how we work with our local people and communities.

   To work towards this goal five pledges have been developed agreed by Council**:**

   - Put people and families at the heart of everything we do.
   - Tackle inequality so people have a fair chance.
   - Support our communities to support themselves and each other.

- Invest in our economy to provide sustainable opportunities for employment, innovation and growth across the borough.
- Work together and fight for a better future for Gateshead.

8. **Implementation**
   In 2017 discussions took place within Care Wellbeing and Learning (CWL) directorate related to addressing continuing budget pressures / reductions within Adult Social Care - Learning Disabilities team. A decision was made to develop a new more in-depth, dynamic model for adults with a learning disability that could:

   - implement a new approach through a more multi-disciplinary team with specialists in assessment, reablement, occupational therapy and travel training to work together and dynamically respond to those fluctuating needs by offering the right amount of support at each point in time to ensure maximum safe independence; improve the outcomes delivered for service users following the assessed support commissioned by Gateshead Council.

   - commission services provided to adults with learning disabilities that reflect the corporate Thrive agenda to maximise everyone's potential; capture learning to improve systems and process; and ensure that the financial envelope available to the directorate/service is managed effectively.

9. By adopting a more in-depth and dynamic approach to reviewing support packages, their focus was to explore how the current LD commissioning of social care can be adapted to ensure the most appropriate and reasonable packages of support are in place, which enables service recipients to enhance their independence, reasonable choice and control for service users, improve value for money and develop a more diverse and responsive market. It aimed to challenge the notion that more care is better care by analysing what level of care is needed, reasonable and appropriate, whilst improving value for money from current and new providers and continuing to provide what a user needs. Specifically, to identify how outcomes for people with LD can be improved, while simultaneously delivering enhanced financial efficiencies within existing and future budget envelopes. The achieving change together team was set up to give impetus to these new approaches.

10. **Aims and scope -** The scope of the ACT team is defined and understood regarding the

areas of contact-point expenditure across the Council and CCG for the delivery of health and social care. There are a range of changes that the project considered including:

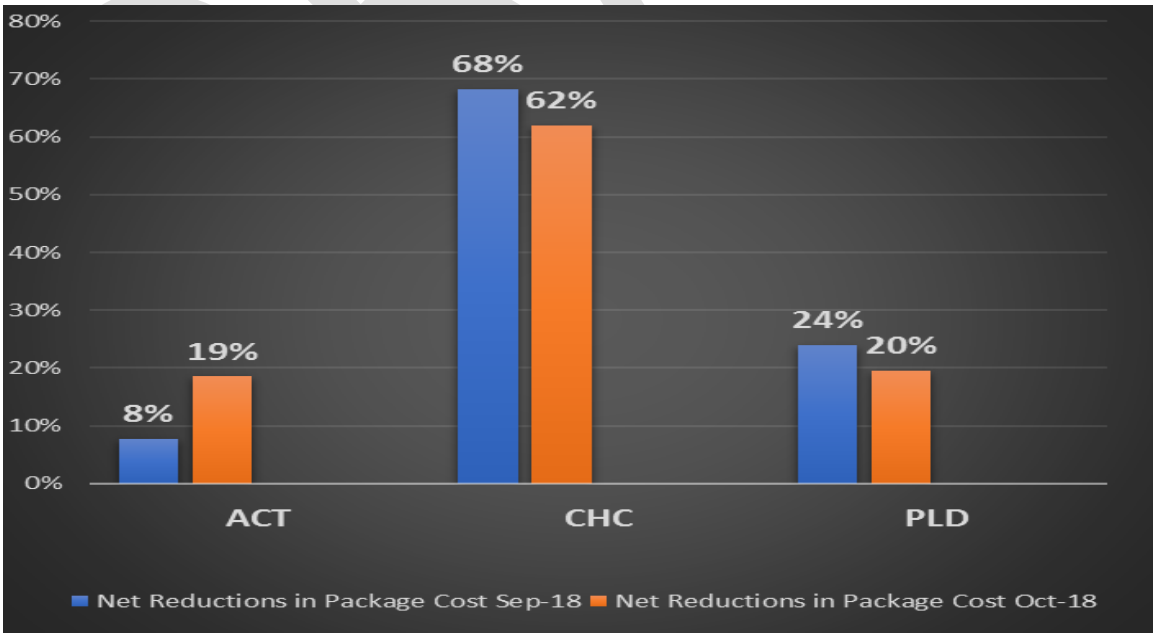
- Agreeing a team vision and priorities to ensure staff understand how this fits in with the new framework.
- Revisiting the depth of assessment and review - staff to assess individual needs.
- Focus on ISLs developing clear pathways from residential into and out of ISL - reablement officers to go into ISL's and observe to build up an in-depth knowledge of clients to improve assessment.
- Work with providers on maximising the development of service user's independence, particularly to the extent that support needs may be reduced by opportunities for example in paid employment, volunteering and independence.
- Re-commissioning (including decommissioning where appropriate) of specialist learning disabilities health resources.

11. Outcomes

Monetary savings

Net Reductions in Package Cost											
	Sep-18	Oct-18	Row Labels	Total Reviewed	No. of No Change	No. of Reductions	Value of Reductions	No. of Increases	Value of Increases	Total Net Movement	Total of Reductions due to CHC	Sum of Movement not related to CHC
ACT	8%	19%	ACT	16	4	10	-£343,403	2	£892	-£342,511	-£263,611	-£78,900
CHC	68%	62%	LOC 2	0	0	0	£0	0	£0	£0	0	0
PLD	24%	20%	PLD	3	0	3	-£83,575	0	£0	-£83,575	0	-£83,575
			Grand Total	19	4	13	-£426,978	2	£892	-£426,086	-£263,611	-£162,475

At 31st October 2018



12. Improved Outcomes - Case Study 1

AD lives in a 24-hour residential care setting and has lived there since 2013. AD has a learning disability and epilepsy which presents with limited verbal responses, and he is prone to having partial and complex seizures. 8 weeks ago, AD suffered a suspected stroke which has severely impacted upon his mobility and resulted in right sided

weakness.

It was identified that the staff were having difficulty in managing AD with his overnight needs. When staff were carrying out agreed checks, this could wake AD, resulting in him believing it was time to get up. He was therefore not getting enough sleep and tiredness may have put him at increased risk of seizure or falls.

It was agreed that the 'Just checking' system would be used to establish AD's movements during the night. Staff had reported that AD was becoming confused and agitated particularly during the night which was why it was recommended that this system be used. It was also recommended that an epilepsy sensor could be put in place to monitor his seizures. This equipment was installed by Care call in AD's room covertly as he does not cope well with changes to his room and has a history of being destructive with any new equipment.

'Just checking' was in place for 6 weeks and identified that there was movement during the night. It was difficult to ascertain if the movement was staff having to attend when the epilepsy sensor was reacting to movement or if it was AD's movements. It was also established that AD was shuffling himself to the end of the bed which was causing the sensor to go off. It was established that when staff were attending to the sensor alarm AD would again have difficulty going back to sleep and this continued to have an impact on his sleep pattern.

Further discussion took place with the Provider and Care Call and the use of surveillance equipment was considered as although AD would still be under constant supervision, it was felt that this would be the least restrictive option for AD which would allow staff to monitor AD's movements without disturbing him. There was a best interest decision carried out under the current DOLS authorisation that this was the least restrictive option.

It has also been identified that AD had experienced a few falls since his stroke and fall sensors have been recommended and put in place, so staff will be alerted to his standing position when out of bed. Staff report that the surveillance equipment is working really well and has allowed the provider to continue to support AD, rather than having to move him to an alternative placement which would have had a detrimental impact on his behaviours and wellbeing or to an increase in support being requested by service provider.

Case Study 2
TC currently lives in a 24-hour residential care setting. When TC moved to this setting in 2013 it was identified as a temporary move following the passing of his mother who was his main career. At the time it was identified that TC had completed a 'My Homes' form. Over the years, TC has had additional 'My Homes' forms completed, which identified that TC wanted to have level access property, quiet and with a friends or friends.

During a review undertaken by the ACT team, TC had stated that he was not happy living at his current property. A meeting took place which was attended by TC, his family and the current provider. The Assessing Officer had previously spoken to TC family and advised that we were looking to support TC to move into a property of his choice. Family initially ok with this but at the meeting, they expressed concerns they had. They were concerned that TC would be placed in a property alone where he received '4 visits a day' and be left alone for the rest of the time.

At the meeting, it was explained that it had been established that as TC has submitted several 'My Homes' forms, we needed to ensure that we are listening to him and actively

supporting him to look for the right placement, although acknowledging that TC may well request to move again as those who know him well felt that this is something he has always done. It was also reiterated that no decision had been made about future accommodation type as no evidence as to what TC could do and what he needed support with.

It was identified that more work needed to be done to support TC to have the potential to move on from his current placement. TC has been engaging well with the enablement team who have been carrying out kitchen skills. This has enabled the team to establish how TC problem solves, understands instructions and can execute a task with minimal instruction or prompting.

TC has now been offered a placement in the Lobley Hill area, in a bungalow, sharing with a friend who he knows from his work placement, which is exactly what he had requested on his 'My Homes' form. TC has identified that he would now like to live there. Meeting held with family who have requested to go and see the property and are happy that the service is staffed 24/7. Although cannot be confirmed until TC moves into new property, a significant saving is expected from this.

Next steps
The following enablement outcomes have been achieved:

- The use of Assistive Technology to promote service user's independence;
- The concentrated use of people's life history / biography to get the best out of service users;
- The emotional support given to family carers.
- Multi-disciplinary approaches to address individual needs.

This way of working is being adopted across adult social care so it is hoped that further savings and improved outcomes will be achieved.