# Care & Health Improvement Programme

# Use of Resources in Adult Social Care

# Explanation of the 13-step approach

## Update as at December 2019

*This paper outlines the approach as developed as at October 2019. The latest information on the Use of Resources work is now available on the LGA website. This paper explains an approach to evaluating the use of resources in Adult Social Care which has been developed through the Care and Health Improvement Programme (CHIP) by the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS).*

*All numbers – apart from population data – quoted in this report are taken from the Finance and Activity information published by NHS Digital in October 2018 based on the SALT and ASC-FR returns for 2017/18. Later data for 2018-19 is used in the LA level reports which are available on LG Inform.*

*When this approach was first discussed, there was a strong view that the description of the approach as focusing on "value for money" was over-ambitious because the existing "outcome" measures need to be defined. In response, we have redefined this approach as "use of resources" in reflection of this.*

# Purpose of this Paper

This paper explains an approach to evaluating the use of resources in Adult Social Care which has been developed through the Care and Health Improvement Programme (CHIP) by the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS). The results of this approach are now available for those working within local authorities to use.

Trying to evaluate how much is spent on adult social care compared to need is not possible in a completely quantitative way as this paper explains. However, it is crucial that local authorities have the best possible advice and mechanisms available to them in trying to manage the financial pressures facing adult social care and local government.

This approach uses a 13 step methodology which we believe will ensure that all aspects of the use of resources are considered. It does not lead to a definitive statement that one authority is more efficient than another because we believe that this is impossible, at least in terms of the data currently available. It should encourage all local authorities, those advising them and those to whom they are accountable to continue to look carefully at how resources are used and to seek to improve value for money wherever possible.

The 13 step methodology is set out on pages 3 - 5 of this paper. The rest of the paper explains how we have come up with that approach. The methodology starts with the traditional approach to value for money as set out by the National Audit Office, then sets that in the context of what happens in practice. We then set out some key principles before looking at comparative spending against comparative need and why spending may be higher than elsewhere. It is important to note that there are some technical issues set out on pages 14 and 15 which will impact on this work which must be considered further (they will impact on any approach).

Iain MacBeath, Director Hertfordshire County Council and ADASS Treasurer and Trustee[1]

John Jackson, National Care & Health Improvement Adviser, Finance & Risks, CHIP and ADASS Resources Policy Co-Lead

Simon Williams, Director of Social Care Improvement, LGA

October 2019

[1] Iain was the other ADASS Resources Policy Co-lead at the time that this approach was developed.

# 13 steps to looking at value for money in Adult Social Care

**Step 1: Compare spending on adult social care with relevant populations to see if this is significantly higher than other authorities:**

**a) Total spending on adult social care with total number of adults;**
**b) Total spending on people aged 65 and over with the total number or people aged 65 or over;**
**c) Total spending on younger adults with the total number of people aged 18 – 64**
**d) Total spending on non-age specific spending with total number of adults**

Total gross current expenditure from NHS Digital Table 1

Gross Current Expenditure on long and short term care, by care type and age band, year on year comparison, Table 17

Population data from ONS.

**Step 2: Is there a genuine local reason why spending would be higher reflecting local needs which are clearly higher than other authorities? Consider both deprivation and the number of people aged 75 or over.**

Deprivation data is available on LG Inform; population data available from ONS.

**Step 3: Is spending higher because you are supporting more people than other authorities?**

Long Term support during the year by age band compared with relevant population age groups from ONS, NHS Digital Table 1

**Step 4: Do you know why you are supporting more people than other authorities? What does the information about what happens to people who ask for support tell you about your processes and practices?**

Number of requests for support received from new clients; Table 1 for Long Term Support during the year, NHS Digital Table 1.

“What happened next”, NHS Digital Tables 10 (Younger Adults) and 11 (Older Adults)

**Step 5: How does your performance compare with the performance measures suggested by IPC in their "Six Steps to Managing Demand in Adult Social Care – A Performance Management Approach"[2]**

Compare performance with measures suggested by IPC – see Appendix 1 of this note

If there is regional data, compare your performance on the different measures with the best performing authorities in the region. This could be combined with looking at data for other authorities outside the region if this is available.

**Step 6: Is spending higher because the average cost of supporting an older person or a younger adult is higher than other local authorities?**

Gross current expenditure by care type and age band, short and long term care, NHS Digital Table 17

Long term support during the year, NHS Digital Table 1

**Step 7: Is spending higher because you are making much greater use of more expensive care settings (such as care homes)?**

Adult Social Care Outcomes Framework (ASCOF) measures:

1C(2A) The proportion of people who use services who receive direct payments

1G The proportion of adults with a learning disability who live in their own home or with their family

2A(1) Long-term support needs of younger adults (aged 18-64) met by admission to residential and nursing care homes, per 100,000 population

2A(2) Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population

**Step 8: What are you are planning to do to use less expensive methods of care (where this still meets care needs)?**

Long term strategy (i.e. for the next 10 years) should be set out by the Council and reflected in the Market Position Statement

[2] See footnote 11.

**Step 9: Is spending higher because the costs locally for any particular setting are more expensive?**

Limited national data available:

Average weighted standard hourly rate for provision of home care, NHS Digital Table 49

Unit costs, by support setting and age band, for long term care, NHS Digital Table 50

[Note: this does not include care in the community so excludes what should be the most important ways of supporting service users].

**Step 10: If care costs are generally higher than elsewhere for specific local reasons (such as the local labour market) what are you going to do about looking at alternative ways of meeting care needs?**

This should be set out in the Market Position Statement

**Step 11: Is your work with the NHS (including the use of the Better Care Fund) achieving value for money for the local authority?**

Local judgement. Potentially culminating in a report to the Health and Wellbeing Board

**Step 12: Is your spending other than on care packages, effective? Could its efficiency be improved?**

It is important that all activities such as staffing are reviewed regularly to see whether they are effective and to see if they could be more efficient

**Step 13: What impact might the technical issues (set out on pages 12 and 13 of this note) have on your conclusions about value for money within adult social care in your authority?**

Gross current expenditure compared with revised gross current expenditure including income from the National Health Service, NHS Digital Tables 1 and 3

Income by finance description, NHS Digital Table 6 and 7

What spending is funded by the income from Joint Arrangements, Income from NHS and Other Income?

Have you discussed within your regional Finance group whether your use of these income sources is consistent with other authorities in the region?

## Value for Money as defined by those responsible for assessing value for money

This is to distinguish between the following:

- **"Economy**: minimising the cost of resources used or required (inputs) – **spending less**;
- **Efficiency**: the relationship between the output from goods or services and the resources to produce them – **spending well**; and
- **Effectiveness**: the relationship between the intended and actual results of public spending (outcomes) – **spending wisely."**[3]

In practice, the current debate is about the extent to which local authorities can save money from their spending on adult social care. All three elements above can deliver this:

1. Reducing the cost of a care package by finding an alternative provider who can deliver the same care package at the same standard but at less cost is an example of "economy". Alternatively, working with a provider to support productivity improvements (such as using assistive technology) is an alternative approach to "economy".
2. Improving the number of people who are supported by a reablement service (by minimising non-contact time) is an example of efficiency. Equally, reducing the amount of time that a home carer spends travelling through helping providers to implement a route planning system is also an example of efficiency.
3. Many authorities are looking carefully at whether their approaches support people to live independently and avoid over prescriptive care which leads to more dependency than is necessary. These are often referred to as "asset based" or "strengths based approaches" and were cited by Directors as the most common way of making savings in recent ADASS Budget Surveys. This is an example of effectiveness – outcomes are improved by focusing spending on what is most effective (for example a person with a learning disability being supported in supported living which provides more independence compared to a care home).

When this approach was first discussed, there was a strong view that the description of the approach as focusing on "value for money" was over-ambitious because the existing "outcome" measures need to be defined. In response, we have redefined this approach as "use of resources" in reflection of this.

## Use of resources in the context of increasing resource pressures

Local authorities need to make judgements on what is feasible, in order to arrive at robust Medium Term Financial Strategies. It is clear from discussions with the

[3] https://www.nao.org.uk/successful-commissioning/general-principles/value-for-money/assessing-value-for-money/. This approach is essentially the same as that articulated by the Audit Commission when it was in existence.

Department of Health and Social Care that they want to understand the extent to which local authorities could reduce spending through improved use of resources for adult social care. That is a reasonable expectation. However, it must be seen in the context that the need for adult social care is increasing due to an ageing population which impacts not just on the number of older people who need care but also an increasing number of younger adults who have care needs and the complexity of their care needs are increasing. Local authorities will need more resources. Use of resources improvements have the potential to reduce (slightly) the amount of extra money that will be required.

In his work with individual authorities who face particular financial pressures with adult social care, John Jackson emphasises the following:

"Ultimately, a saving will only be delivered if spending is reduced. For most adult social care savings, this means either reducing the number of people who receive care or reducing the cost of providing care compared with the assumptions made at the time that the budget was set."

## Principles for any approach

We believe that the following principles must underpin any approach to examining either value for money or the use of resources:

- It must use data which is collected consistently on national systems.
- No one metric can tell the whole story.
- Metrics can be used to come to the wrong conclusions if used crudely: they should really be a starting point for a further investigation and conversation.
- We see the outcome of this work as developing an approach that authorities and others can use as the starting point for further work or analysis.
- The approach needs to be simple enough that the narrative is clear.
- The approach must acknowledge that there are a range of stakeholders with different needs and lenses: social care directors, councils corporately both members and officers, local people who want to know if their council offers value for money, central government departments who make judgements about the priority of social care for central investment.

## A starting point – a simple comparison of spending against the population

We should start with looking at total gross current spending on adult social care by each authority. Potential technical issues which should be born in mind when using these measures are discussed on pages 14 and 15 below. However, the use of gross expenditure measures allows spending to be compared with total local authority population or more sensibly with total adult population. In addition, information is available from the ASC-FR returns which shows spending on those

aged 18 – 64 and those aged 65 and older. Thus, we can understand spending compared with those population groups[4].

A straightforward comparison ignores different levels of need from one area to another, so some account must be made of **need**. This is not straightforward especially in the case of spending on younger adults.

### Spending on younger adults

Most of this spending on younger adults will be on people with learning disabilities. However, there appears to be no useful information of the likely levels of need. Emerson and Hatton identify several factors which will influence the "incidence and prevalence of learning disabilities"[5]. However, there is no reliable information at a local authority level.

Actual spending on learning disabilities varies between authorities and there is no obvious pattern which explains why, other than some authorities appear to have approaches that make better use of resources than others. This suggests that the variation in gross current expenditure on younger adults with learning disabilities is unlikely to reflect need and is more likely to reflect either good use of resources or possibly an inadequate response to need by the authority concerned.

Spending on other younger adults may be more likely to reflect the combined impact of relative deprivation and poor health. However, the evidence again is not overwhelming.

It is important to remember that spending on those other adults is relatively low compared to spending on people with learning disabilities and that on older people with care needs, so is unlikely to have a significant impact on total spending on younger adults.

On the other hand, because adult social care has inevitably focused on the largest budgets (those for older people and those for people with learning disabilities) in its efforts to make savings, spending on those with physical disabilities or with mental health care needs has received less attention. This means that it does make sense to ensure that spending on those two smaller service user groups is reviewed carefully. In practice it may makes sense to apply good practice developed within learning disabilities to the support of other younger adults.

### Spending on older adults

The need to spend on older people however should reflect two key factors. Firstly, the number of older people. There is a tendency to look at spend per person aged over 65. However, we would argue that we should be focusing on the proportion of the population aged over 75 (and possibly those aged over 85) because this is the age when care needs start to become more significant. There are very big variations nationally in the local population aged 75 and over. The 10th highest proportion is

[4] This information is easily available from the ONS Midyear estimates

[5] "People with Learning Disabilities in England" Eric Emerson & Chris Hatton, CeDR Research Report 2008:1 May 2008

11.02% of the total population compared with the 10th lowest proportion (4.33%) of the total population[6]. [All numbers – apart from population data - in this report are taken from the Finance and Activity information published by NHS Digital in October 2018 based on the SALT and ASC-FR returns for 2017/18].

On the surface, this would imply that adult social care needs for older people in the first authority are two and a half times as high as they are in the second. However, this ignores the impact of deprivation. Using **gross** spending rather than **net** takes some account of this because it ignores the extra income that more prosperous areas should get from service users. However, our expectation is that in those more prosperous areas, more people will make their own arrangements for care and not approach the local authority (other than possibly for information and advice). Gross spending should be lower (and so should placements in care homes[7]). Using gross spending also ensures that the impact of higher house prices on the amount of income that can be collected does not distort the figures.

In deprived areas, we know that morbidity – the length of time that the average person spends living with a life-limiting illness – is twice as long in the most deprived areas compared with the least deprived (potentially 20 years compared with 10 at the extremes). This means that the likelihood of someone needing personal care is much higher in more deprived areas.

The greatest need will be in those local authorities which combine many older people aged over 75 and a relatively high level of deprivation. Blackpool – the most deprived authority in the country but with a relatively high number of people aged 75 or over[8] – is the best example of this.

## Comparing Gross Spending against Need

We are not aware of an easy way to come up with an objective measure for this. The approach that John Jackson has taken in his work with individual authorities is as follows:

1. If gross spending on younger adults appears unusually high, are there any local factors which might account for this? Examples that have been put forward include deprivation (increasing the numbers of adults of younger adults who may have need care due to their physical disability or mental health) and the pattern of long stay hospitals in the past.
2. Even if there are local factors, then this may not explain all the additional spending.
3. If gross spending on older people appears high, is there an unusually high number of older people aged 75 or over or is there a high level of deprivation or do both coexist? Even if one is absent and the other present this may not explain why spending is high. For example, many Inner London Boroughs had a high

[6] The full range is from 13.38% to 2.76%. We have used a narrower range throughout this note to ensure that the analysis is not distorted by outliers or incorrect data. In that respect we are copying the approach taken by DHSC in their efficiency tool.
[7] ASCOF measure 2A(2)
[8] 9.29% compared with the England proportion of 8.15%

level of spending on older people (per person aged over 65) in 2017/18. Whilst deprivation is relatively high in a number of those boroughs, the numbers of people aged 75 or over is low. We are unconvinced that deprivation is the sole reason to explain this.

## Why is spending relatively high compared to need? What does this mean for the scope to make savings?

These questions are linked. They also apply ultimately to all authorities. Even low spending authorities will want to see if they can improve the use of resources given the financial pressures on adult social care.

Most authorities will spend over 80% of the gross adult social care budget on care packages with most of the rest spent on assessment and review functions (including the front door) and early intervention including short term care (such as reablement).

This means that if spending is higher than might be expected, it will be because the spend on care packages is higher than in other authorities. However, it is also the case that reviewing what is spent on care packages is the principal way that all local authorities can make savings from adult social care[9].

This amount is a combination of the number of people supported and the average cost of supporting each person. Consequently, explaining higher levels of spending (after consideration of need), must be due to more people being supported or the cost of care packages being higher or both applying.

## Spending can vary because there are variations in the number of people being supported

NHS Digital publish information annually on the numbers of people receiving long term support and the numbers of requests for support from new clients. Both show significant variation when compared with the adult population of the local authority.

### Numbers receiving long term support

The numbers of people receiving long term support as a percentage of the adult population varies between the tenth highest at 2.82% and the tenth lowest at 1.47%[10]. It is not clear from the ranking that this reflects need.

Those supporting the most people, with some exceptions, have relatively high levels of deprivation. However, there are authorities with high levels of deprivation which support relatively few adults.

[9] We are ignoring for the purposes of this note the scope to reduce spending on back office/support functions. That is because those services are normally reviewed separately by local authorities being regarded as the responsibility of the relevant central Director. It is also important to note that the recharges to adult social care are relatively small compared with the gross spending on adult social care – typically no more than 10% (and sometimes less). This approach does not mean that those costs should not be reviewed and challenged.

[10] The full range is 3.68% to 1.27%.

In addition, it is not clear that this is driven by the numbers of people aged 75 and over. Several areas with high numbers of older people have low levels of support.

**What happens next when people ask for support**

There is also data on NHS Digital about the number of people who approach each local authority and what happens to them next. Most local authorities are looking to help respond to people's needs through providing information and advice to them so that they can either support themselves or be supported in a way that does not require a formal care package. This approach has been supported by the work of the Institute of Public Care in their publication "Six Steps to Managing Demand in Adult Social Care – A Performance Management Approach"[11].

The data for 2017/18 suggests that there are very significant variations both in terms of the number of people who ask for help and what happens next. Analysis shows that the number of new requests varies from 7.53% (10th highest) to 1.91% (10th lowest)[12]. There is no obvious explanation to this variation based on either deprivation or the age profile of the population.

All councils have different 'front-door' delivery models (with potentially different recording arrangements) including council wide team, integrated with the NHS, integrated with the police as a MASH, outsourced to the voluntary sector and private sector – and integrated with Children's Services. All of this could skew their activity results hugely – and thus could skew the number of people receiving on-going services hugely.

NHS Digital also shows what happens next to those who ask for support. This analysis is split between those aged 18 – 64 and those aged 65+. The percentage of those who ask for help and then receive **long term support** varies from 17.69% (10th highest) and 1.99% (10th lowest) for younger adults[13]. Nationally, most requests result in either support through universal services (34.68%) or no services (31.48%).

In the case of older people receiving long term support, the variation is from 21.50% (10th highest) to 3.88% (10th lowest)[14]. Nationally, most requests result in either support through universal services (26.49%) or no services (22.62%). 17.21% result in ongoing low level support, or short term care to maximise independence (15.53%).

The scale of this variation suggests that there is considerable scope for local authorities to look at their performance against the performance measures set out in the IPC report which should include reviewing their "front door arrangements". We have set out the most important measures in our opinion, in Appendix 1. John Jackson is suggesting to all the authorities that he works with to review their

[11] Institute of Public Care, March 2017
[12] The full range is 22.46% to 0.73%. The highest figure looks unusually high (the next highest is 9.93%) which justifies not using the most extreme figures.
[13] The full range is 36.08% to 0.75%. Where the numbers are less than 5, we have included in the calculation as a 4 value.
[14] The full range is 25.71% to 1.26%.

performance in this way. In addition, several regions are doing this as well to allow comparison within the region.

This suggests that there is scope to make savings through providing an alternative response to requests for help. There is a risk that this approach might lead to eligible care needs not being met. This is clearly a concern of Age UK who have highlighted the numbers of people who need help with activities of daily living and do not get any help.

We haven't seen any evidence that local authorities are systematically not supporting people who have eligible care needs. Indeed, it is unlikely that this would happen. Social care and health professionals would almost certainly speak out. Furthermore, it is likely that some service users/informal carers would raise this formally, potentially through a judicial review.

Our presumption is that some people are reluctant to come forward to ask for help either because they do not think it is appropriate, or because they are unaware that they could be helped or because they are dissuaded to do so because of the possible financial consequences. This reinforces the importance of local authorities providing good quality information and advice including signposting to community services that will help people. It is clear from the information held by NHS Digital that good use is being made of this although the extent clearly varies from authority to authority.

## Spending can vary due to variations in the cost of people being supported

This is the second reason why the spending on adult social care will vary. There is sometimes a tendency to look at the costs of individual types of care (such as residential care, nursing care or home care). However, this approach ignores the fact that the wrong sort of care may be used. It is important to look at both how people are supported and then when the right method of support is chosen, getting value for money from that method of care.

### How people are supported

Moving someone from an expensive setting such as a care home and supporting them in the community can often reduce the cost of the care whilst giving them the opportunity to have more independence and live a more normal life. However, ironically this can also mean that the unit costs of the types of care can increase. Only those with the most complex care needs are supported in care homes so the unit cost for each care home resident will be higher. Similarly, community care packages may be bigger than they used to be although they are still less expensive than supporting someone in a care home.

NHS Digital provide unit cost information based on the cost of supporting people in care homes and the hourly cost of home care but there is no information directly available on the unit cost of the numbers of older people/younger adults currently supported with long term care. It would help local authorities and those advising and

scrutinising them if this information was directly available either on NHS Digital or elsewhere such as LG Inform.

**Unit cost of supporting each older person or younger adult**

If unit costs are higher then this may reflect over-prescription of care packages. The IPC report suggests some measures which should help local authorities to review their practices. For example, home care packages should normally be between 7 and 14 hours a week for the service user. All local authorities should be reviewing the pattern of home care provision to see how many service users receive relatively few hours or a significant number of hours. It is also important to review the use of very short visits which may be very inefficient.

It is also possible that there may be local factors which put up the cost of providing social care. Examples include very little unemployment which means that wages are generally higher. Equally, tourist areas experience problems with labour availability during the busiest periods. The cost of home care will vary depending on the sparsity of an area. Typically, the costs of providing care in a more rural area is at least £2/hour more expensive than in urban areas[15]. Property costs vary considerably across the country. Prices in an area can be forced up if there is very strong self-funder demand or NHS activity which is not co-ordinated with the local authority.

However, local difficulties like this should prompt alternative approaches to meeting care needs. High labour costs may be addressed through looking at productivity improvements such as the use of better route planning and the use of assistive technology and potentially robotics. High property prices should be addressed by trying to reduce the use of care homes still further. Local authorities should be ensuring that there are local housing strategies that will provide sufficient extra care housing[16] or assisted living for younger adults.

All of this should be considered when the authority is reviewing its Market Position Statement. Continuous dialogue with providers, service users and carers is crucial if the Market Position Statement is to be genuinely co-produced.

**Spending on Assessment and Review, Early intervention and Commissioning functions**

Typically spending on these activities is up to 20% of the gross adult social care budget. Some authorities have sought to minimise spending on these functions partly because they are seen to be “non-statutory” and partly because the authorities want to protect the amount available to spend on care packages. This is understandable. However, there are also risks here too.

Having an adequate number of social care professionals who work to consistently high professional standards is crucial if assessments and reviews are to be undertaken timely to a high standard.

[15] This is not just a distinction between local authorities. Costs will vary within an authority if they contain both towns and rural areas.
[16] Advice on numbers is available from the Housing LIN and should be used.

Those professionals can only make the right decisions if the right services have been commissioned. Improving the quality of adult social care commissioning is a priority across local government.

The quality and impact of early intervention is crucial in managing demand. Most commentators believe that reablement is probably the most effective method of reducing the demand for long term care. It is less clear that spending on other methods of early intervention (such as day services) is as effective. Local authorities should be reviewing the impact of all investment in prevention and early intervention services.

In addition, they should be reviewing the efficiency and economy of their spending. The amount of time that social workers and occupational therapists can spend with service users can be increased by simplifying processes, simplifying bureaucracy and using mobile technology. Similarly, there is scope to reduce non-contact time for reablement workers so that they can work with more service users each day[17].

There is also scope to look at the skill mix within the frontline – should more use be made of occupational therapists, what is the role of support staff with frontline teams, what scope is there to work with health professionals to provide a more seamless service and reduce duplication of effort?

Integrated working with the NHS can help addresses these issues. If handled badly it can make them worse.

# Potential Technical Problems

This paper started with looking at gross current spending on adult social care as reported by local authorities to NHS Digital. There are several technical issues that must be borne in mind.

Firstly, the gross current spending excludes spending funded from the Better Care Fund. This is material. NHS Digital's Reference Data Tables for 2017/18 includes Table 7 which shows the income from Better Care Fund (BCF) for each local authority[18]. Gross current spending for 2017/18 is £17.9 billion. However, separately, the Better Care Fund allocated by local authority for funding adult social care activities is reported as £1.8 billion for 2017/18. Some BCF funding will be spent by the NHS directly but most of it will have been paid to local authorities. In addition, local authorities have received other funding from the NHS which will have been used to pay for adult social care. This is not included in the gross current expenditure figures either.

[17] Swindon have worked with Newton Europe on this issue and made significant progress.
[18] "Adult Social Care Activity and Finance Report: Reference Data Tables, Table 7. This reference to the Better Care Fund is to the **Original** Better Care Fund. The resources made available through the Improved Better Care Fund are distributed directly to local authorities so should be included in the "gross current spending" figure.

Excluding this spending will impact on the figures especially the spending on older people (much of the **Original** Better Care Funding was used to support services for older people).

Secondly, the financial breakdown used by NHS Digital is not used within local authorities. The returns distinguish between spending on long and short term care and "other". Looking at the "other figures" suggest that local authorities have applied very different approaches to what they have included in that category of spending. The gross current spending broken down over age groups exclude all spending on "other".

It is also worth pointing out the financial analysis is then broken down over primary support reasons. ADASS did not support this when it was first introduced and discussions in more recent regional workshops confirms that very few authorities are using this approach. The previous approach which focused on the four traditional service user groups (older people, people with learning disabilities, people with physical disabilities, people with mental health care needs) allowed much more effective comparisons. Most local authorities that we have worked with are still using this methodology. There is a need to find a standard approach which is widely accepted.

There is evidence that there is inconsistency in the way that some local authorities record their data. This means that the information for a minority of local authorities is not consistent with that provided by the majority of local authorities.

These technical reservations should not stop the application of the approach set out in this paper. However, they reinforce the importance to using this methodology as an approach rather than coming to definitive conclusions.

It is possible to compare total gross spending on adult social care including that funded from income from the NHS. The approach sets out how this can be done as part of Step 13. Interestingly, this does not appear to have a huge impact on the relative position between (most) authorities. However, it may have a more general impact on the relative position for younger and older adults.

The other technical issue relates to the extent that spending by local authorities is attributed to an age group (either younger adults or older adults) or not. A significant amount of spending is non-age specific: £3.403 billion.

This is made up as follows £301m social support; £203m Assistive Equipment and Technology; £1,609m Social Care Activities; £212m Information and Early Intervention; £1,078m Commissioning and Service Delivery[19].

There is considerable variation in the spending per adult on Other Expenditure. The variation is so great (especially in terms of the outlier authorities) that this must reflect recording issues as well as decisions about how much to spend on the different services.

[19] Table 44, Adult Social Care Activity and Finance Report, England 2017-18 Reference Data Tables, NHS Digital.

# Appendix 1

## Performance Measures suggested by the Institute of Public Care[20]

We suggest that the measures to focus on include:

- 1.1 The proportion of people who approach the council for help who go on to receive a full assessment (IPC suggest that it should be about 25%)
- 2.4 The proportion of acute patients who are discharged to a permanent residential care bed without any opportunity for short-term recovery (Close to zero)
- 2.5 The proportion of acute patients who return home after a short-term period (no more than six weeks) in a residential care bed. (Close to 75%)
- 2.6 The proportion of people who receive long-term care after a period of short-term/reablement based care (this could be either a therapy led programme or domiciliary care based reablement). (Close to 25%)
- 3.1 The proportion of older people who receive less than 10 hours of domiciliary care (as a proportion of all older people receiving domiciliary care). (No more than 15%)
- 3.2 The proportion of older people who are assessed as having care needs, who were offered a re-ablement based service. (More than 70%)
- 3.6 The proportion of those who are assessed as needing domiciliary care who receive their care within 48 hours of the assessment being completed (Over 90%)
- 4.1 The proportion of older people receiving longer term care whose care needs have decreased from their initial assessment/latest review. (Around 15%)
- 4.2 The proportion of younger adults receiving longer-term care who care needs may have decreased from their last review. (Around 66%)
- 4.3 The proportion of older people receiving longer term care whose needs have increased since their initial assessment or latest review? (No more than 25%)
- 4.4/4.5[21] The proportion of older people (with or without a diagnosis of dementia) who enter residential care after receiving domiciliary care. (No more than 20%)
- 4.6 The proportion of older people with a requirement for palliative care who died at home. (At least 75% of those who stated that they wanted to die at home).
- 4.7 The proportion of younger adults receiving longer-term services who are living in registered residential care. (Less than 10%)
- 4.8 Total spend by a council on all adult residential care. (No more than 30% of the gross adult social care budget).
- 4.9 The proportion of older people living in extra-care housing who are receiving more than 14 hours of care. (No more than 10% of those living in an extra-care facility at any one time).

[20] "Six Steps to Managing Demand in Adult Social Care - A Performance Management Approach", March 2017. See Appendix 1 for the full list of measures. Individual measures are listed 1.1, etc.
[21] IPC have separate measures for those who do not have a diagnosis of dementia and those who do. However, their suggested standard is the same. This means that local authorities can focus on all older people.