Feasibility Study: Data Collection for a Review of the Adult Social Care Relative Needs Formulae

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Executive Summary

A feasibility study has been undertaken to investigate options for a future review of the Relative Needs Formulae (RNF) for adult social care. This section sets out the key conclusions and recommendations.

1. Project objectives and methodology

1.1. The Relative Needs Formulae (RNF) for adult social care is used to ensure an equitable distribution of resources to and between local authorities with responsibility for providing such services. The project was established to identify the issues which would need to be taken into account in any future review of the adult social care RNF, drawing on experiences of past reviews, current data and delivery issues within adult social care and the impact of future developments. An additional objective was to consider issues relating to adults who fund all or part of their own care (self-funders).

1.2. In agreement with the Department of Health, the methodology for the feasibility study has involved a number of different elements including literature review, data review, stakeholder engagement, local authority survey and local authority fieldwork. The survey element invited responses from 25 local authorities and 10 authorities were included in the more detailed fieldwork. The draft report was also subject to external peer review; and this final report takes into account comments received from this process.

2. Key findings

2.1. The feasibility report has identified a number of key issues which will have significant implications for any future reviews of the adult social care RNF:

- There have been significant changes in the delivery of adult social care and the priorities for care which will need to be reflected in any future review of the RNF e.g. future care of older people with dementia, reablement projects, the use of intensive short-stay residential care, developments in home care;
- Data is unlikely to be available at individual or small area level through the data collections by the NHS Information Centre (NHS IC) or other national data collections, within the short to medium term. Therefore, undertaking a small area analysis as the basis for revising the RNF will require comprehensive data collections from local authorities;
- There are peaks and troughs in service provision throughout the year which may affect the data provided if a sample week or month was chosen for the full survey. Therefore consideration must be taken of appropriate timescales and accessibility issues;

- There have been significant improvements in data collection, for client and financial data at local authority level since 2004/05. The survey of local authorities found that, with sufficient lead time, data to support small area analysis would be available from local authority client and financial databases. Local authorities appear capable of providing data showing basic demographic, service and finance information for individual clients accessing each aspect of their service e.g. residential care, home care, reablement;

- However, there are data limitations which need to be reflected in any future data collection strategy e.g. pre-care postcodes for clients in residential care could be made available for most clients if additional resources were expended, although data relating to socio-economic characteristics of individuals is less reliable. Further, integration between client and finance data is improving but there are still significant gaps for some authorities;

- There are a range of other data sources available which could be used to supplement the local authority data collection. However, not all of this data is available at small area level and there are timing issues that would need to be taken into account, particularly in relation to data that will be derived from the forthcoming 2011 Census, although we expect 2011 Census data to be available in time to produce new formulae;

- There is a significant impact of self-funders on the services provided by local authorities, particularly in relation to assessments. However, local authorities do not appear to have a common understanding or definition of self-funders, nor is there comprehensive data available relating to the number and care needs of self-funders;

- There is a variety of self-funder information available, at a national and local level, from data collected by private providers of care. Private sector information could be used to inform a review of the RNF in the following ways: it could either complement the data routinely collected by some local authorities; it could inform a specific survey to support the development of future social care RNF; or be used to create a more representative sample by supplementing this data with data received from local authorities; and

- Our review of information relating to self-funders has shown that there are major limitations to the data which is currently available on self-funders, from local authorities and from national surveys. If a future review of the adult social care RNF needs to incorporate self-funders, therefore, it is likely that some additional and very specific data collection is required. A future specification to undertake the future review could therefore consider data collection via local authorities, working with private providers to access existing data or working with private providers to collect new data.

3. Recommendations

3.1. Based on our analysis of current and future data sources, it appears unlikely that national sources will provide detailed data which can be used to undertake small area analysis for the next review of the adult social care RNF. We believe that data will still be needed from local authorities to support the analysis and, therefore, a data collection exercise involving local authorities will be required. A proposed approach to obtaining data from individual local authorities is set out below:

- Initial sampling and engagement work should identify 60-75 authorities who could be included to produce a representative sample (representing approximately 50% of all local authorities with adult social care responsibilities);
- From this initial sample, agreement should be reached with a ‘working sample’ of 45-50 local authorities who are willing to work towards providing the required data with extensive support from the research team;
- From this working sample, it should be the intention of the study to collect data from as many of the participating authorities as possible with a minimum requirement of at least 30 returns; however
- The exact number of authorities required will need to be determined at the time of the research and reflect the most up-to-date information possible on population and the key drivers of care needs e.g. demographic, economic and health indicators.

3.2. It is recommended that the focus of any future data collection should be on increasing awareness of the adult social care RNF review from the project’s inception, and on encouraging participation amongst local authorities by offering them comprehensive and ongoing support to provide the required data, as follows:

- Extending the time allocated to collect data to up to 12 months from the start of the review, allowing researchers to work with local authorities and support them in providing the most difficult-to-access data, particularly pre-care addresses and individual financial data;
- Providing a clear framework for the data to be collected and ensure data requests are consistent with national data definitions and practice, allowing local data to be supplemented by national data; and
- Working with a more representative sample of local authorities to support small area analysis.

3.3. Implementing the above recommendations would have the following implications for any future commissioning of data collection and analysis:

- There would need to be a comprehensive communications strategy in place well in advance of the data collection phase, raising the profile of the review and encouraging local authorities to participate. This should be maintained throughout the course of the research. Participating authorities for this research have identified that the Association of Directors of Adult Social Services (ADASS) could be the centre point of any future communications strategy concerning a review of the adult social care RNF;
- The lead time for the project from start date to data collection should be up to one year – this would allow time for comprehensive engagement with local authorities to ensure a representative sample is achieved. The start of the project should also be timed to ensure that the main period of data collection does not overlap with the existing pressure period, currently faced by local authorities, for the preparation of social care statutory returns (generally April - June);
- Extensive resources will be required to support local authorities in the period prior to the submission of data and to review data snapshots to identify any significant data quality issues; and
- Organisations such as the NHS Information Centre (NHS IC) should be involved to support the data collection process, ensuring that any developments in social care data specification (e.g. application of the minimum data set) are taken into account.

3.4. In relation to self-funders, the feasibility study has identified that there are limitations to the data that is currently captured by local authorities for those residents who fund their own care. There may be improvements in the medium term, particularly as the NHS IC continues to look at data collection issues in relation to self-funders. However, there are three main options for the next review of the RNF if the Department of Health want to include data relating to self-funders:

- A specific survey could be conducted in the participating local authorities to collect data from self-funders directly (or from organisations who provide care to self-funders). Depending on the breadth of data required, this data could be collected from a sub-set of the participating authorities; or
- The research team could draw on existing surveys being conducted on self-funders e.g. working in partnership with private providers and agencies; or
- A specially commissioned survey could be undertaken with care home providers as part of the RNF review or wider data collection strategy i.e. a sampling strategy would be required to identify a sample of care homes and a mechanism for accessing data from the care homes.

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Introduction

A feasibility study has been undertaken to investigate options for a future review of the Relative Needs Formulae (RNF) for adult social care. This section sets out the background and the aims and objectives for the study.

1. Background

1.1. The Relative Needs Formulae (RNF) for adult social care is used to ensure an equitable distribution of resources to and between local authorities with responsibility for providing such services. The formulae take account of differences in population numbers, needs, resources and input costs (wages) between areas. There are two formulae for adult social care – for younger adults and for older people – and allocations are based upon a range of demographic and socio-economic indicators which profile the population of each local authority – see Annex 1.

1.2. The adult social care RNF formulae have been reviewed and updated periodically, most recently in 2006. The Department of Health (DH) is considering reviewing the formulae in time to make changes from 2015/16. By 2015/16 there will have been changes in patterns and provision of care since 2006 and the data on which the formulae are currently based will be dated, especially when information from the 2011 Census become available.

1.3. The future delivery and funding of adult social care is likely to be defined by the recently established Commission on the Funding of Care and Support, set up by the coalition government in July 2010. The Commission has responsibility for developing recommendations on how to achieve an affordable and sustainable funding system for care and support for all adults in England, both in the home and other settings. The introduction of the Equality Act 2010 may also influence the way that councils provide care.

1.4. This initial feasibility study was commissioned prior to the general election in May 2010. Three months were allowed for undertaking the research and fieldwork commenced in June 2010. The derivation of the funding formulae is widely scrutinised by many individual local authorities and local authority groupings, given the significant impact that it has on their funding levels. This study will contribute towards ensuring that, if change takes place, future funding formulae are as robust as possible, and that funding is distributed equitably to local authorities for the subsequent delivery of services to adult social care clients.

2. Aims and objectives

2.1. The primary research question to be addressed during this initial feasibility study was *"What issues would need to be taken into account in any future review of the adult social care RNF, given the difficulties experienced as part of the 2006 review?"* The initial aims of the feasibility study, as established in the tender documentation, were to:

- Investigate and advise on the availability of information on numbers of service users and costs by client group for small areas within local authorities for those supported by local authorities and those who are self funding;
- Investigate the feasibility of producing data on client numbers and costs for care home residents by their small area of residence prior to admission to a care home for those supported by local authorities and those who are self funding;
- Investigate and advise on the availability of socio demographic information on service users by client group for small areas within local authorities for those supported by local authorities and those who are self funded;
- Investigate and advise on the best means of data collection through consultation with stakeholders and the best means of validating the collected data;
- Advise on the structure of the data to be collected and the best way to fill data gaps, in consultation with the NHS IC;
- Investigate and advise on what constitutes an adequate and a representative sample in terms of the number of local authorities sampled, the sampling of self-funders and how we take account of deprivation and other socio economic factors in the sampling; and
- Advise on the likely cost of subsequent data collection and expert statistical analysis.

2.2. At the Department of Health's request, in addition to the original aims and objectives noted above, research has also been undertaken to provide an assessment of issues relating to self-funders i.e. those individuals who fund some or all of their own residential and/or home care.

3. Methodology

3.1. The methodology for this feasibility study involved a number of different work streams:

- Literature review – a review of the work undertaken in 2004/05 to produce the current adult social care relative needs formulae; a review of available data sources and information on the current state of self-funder populations, including definitions of self-funded care; and a review of relevant literature which may be useful in determining the scope of a full review of the adult social care RNF;

- Data review – an analysis of other data sources which may be relevant to a full review of the adult social care RNF;
- Stakeholder engagement – a series of stakeholder interviews to provide insight into the issues facing different sectors and to gain better intelligence on key factors which may prove important in a full review of the adult social care RNF (see Section 4 below for the list of stakeholders);
- Local authority survey – a sample of 25 local authorities were invited to take part in a survey designed to: explore the issues surrounding the availability of relevant data within local Client Information Systems (CIS) and financial systems; explore data quality issues and concerns regarding the ability to download data in a common format; discover whether there is local intelligence on self-funder populations; investigate the type of data fields available to inform a larger survey; and identify the potential problems associated with such an activity;
- Local authority fieldwork – a sub-set of the 25 local authorities (10 identified Councils) were invited to participate in a more detailed exploration of the data requirement issues and to check the feasibility of providing a sample data download in the timescales available for this report.

4. Stakeholder engagement

4.1. The research has engaged with a wide range of stakeholders from local authorities, provider organisations and national bodies:

Table 1: List of stakeholders consulted

Name of Stakeholder	Role/Job Title	Organisation
Prof. Julien Forder	Principal Research Fellow & Deputy Director of PSSRU at Kent and at LSE	Personal Social Services Research Unit (PSSRU)
Damon Palmer	Social Care Strategic Policy & Finance	Department of Health (DH)
José-Luis Fernández	Deputy Director and Principal Research Fellow	Personal Social Services Research Unit (PSSRU)/London School of Economics (LSE)
Alistair Rose	Economic Advisor	Department of Health (DH)
Robin Darton	Senior Research Fellow (Kent)	Personal Social Services Research Unit (PSSRU)/University of Kent
Simon Adams	Senior Consultant	Simon Adams Consultancy Ltd (Formerly with Tribal)
Paul Dixon	Senior Consultant	Tribal
Mike Charnley-Fisher	Care Services Efficiency Delivery Unit	Department of Health (DH)
Mike Heiser	Senior Policy Consultant	Local Government Association (LGA)
Kate Anderson	Programme Manager for Social Care	NHS Information Centre (NHSIC)

Name of Stakeholder	Role/Job Title	Organisation
Robert Lake	Director for Social Care Information Delivery	NHS Information Centre (NHSIC)
Caroline Highwood	Director of Adult Social Services, Kent County Council	CIPFA Social Care Panel
Clive Bowman	Medical Director, Bupa Care Homes	Bupa
William Laing	Director	Laing and Buisson
Anne Mackay	Policy Manager	English Community Care Association (ECCA)
Mrs Nadra Ahmed OBE	Chair	The National Care Association

4.2. The research was overseen by a 'Relative Needs Formulae Feasibility Study Advisory Group' comprising of the following individuals:

Table 2: Members of RNF Feasibility Study Advisory Group

Name	Organisation
Sarah Horne	Department of Health (DH)
Siobhain Mckeigue	Department of Health (DH)
Damon Palmer	Department of Health (DH)
Raphael Wittenberg	Department of Health (DH)
Mike Charnley-Fisher	Care Services Efficiency Delivery Unit (DH CSED)
Prof. Julien Forder	Personal Social Services Research Unit (PSSRU)/University of Kent
Linda Whalley	NHS Information Centre (NHSIC)
Kate Anderson	NHS Information Centre (NHSIC)
Mike Heiser	Local Government Association
Colin Kelsey	Social Services Research Group (SSRG)
John Jackson	Association of Directors of Adult Social Services (ADASS)
Dan Thomas	Department for Communities and Local Government (DCLG)
Mark Chandler	Department for Communities and Local Government (DCLG)
Emma Bentley	Department for Communities and Local Government (DCLG)

4.3. The LG Futures' research team would like to place on record our thanks to all participants in this research for their, sometimes considerable, time and effort spent in responding to our information requests and queries.

Engaging with Local Authorities – Research Fieldwork

This section highlights the process for engaging with a sample group of local authorities as part of the research and the key issues raised.

5. The method of engagement

5.1. The research team, in discussion with the Department of Health, agreed a proposed method for engaging with a representative sample of local authorities. The following paragraphs describe this process in more detail.

5.2. With an outcome required of at least 10 local authorities who would be willing to undertake a survey and follow up interview(s), a sample of 25 local authorities was selected based on the following criteria:

- There would be representative local authorities from each authority type e.g. Inner London, Outer London, Shire County, Metropolitan District and Unitary Authority;
- The current adult social care RNF allocations, identifying local authorities in receipt of 'high' and 'low' RNF allocations in 2010/11, in order to reflect differences in relative socio-economic factors;
- A mix of Client Information System software usage, as the ability to record, analyse and report on local client data was deemed to be a key consideration. The current range of providers was identified thus:

  i) CareFirst (OLM)

  ii) SWIFT (Northgate)

  iii) Frameworki (Corelogic)

  iv) PARIS (In4Tek)

  v) PROTOCOL eSAP (Liquidlogic)

  Note: It was also considered important to include local authorities who currently have an in-house developed system as a comparator.

- The total number of adult social care service users per head of population; and
- Net spending on adult social care per head of population.

5.3. Although considered, it was agreed, in consultation with the Department of Health, that geographical location of the authority was not a pre-requisite for the sample list of contacts.

5.4. Letters of invitation were sent to ADASS contacts at each of the 25 local authorities, with follow up telephone calls being made as required. The following 21 local authorities agreed to take part in this research (a positive response rate of 84%):

Table 3: Local authorities that agreed to take part in the research

Local Authority	Client Information System
London Borough of Tower Hamlets	Frameworki
London Borough of Hackney	CareFirst
Wandsworth Borough Council	Frameworki
Royal Borough of Kensington & Chelsea	In-house
Manchester City Council	Frameworki
Liverpool City Council	In-house
Dudley Metropolitan Borough Council	SWIFT
Solihull Metropolitan Borough Council	CareFirst
London Borough of Newham	CareFirst
London Borough of Haringey	Frameworki
London Borough of Sutton	PARIS (In4Tek)
Derbyshire County Council	Frameworki
Hertfordshire County Council	PROTOCOL eSAP
Hampshire County Council	SWIFT
Durham County Council	In-house (SSID)
Leicester City Council	CareFirst
Wokingham Borough Council	SWIFT
Devon County Council	CareFirst
East Sussex County Council	CareFirst
Buckinghamshire County Council	SWIFT
Leicestershire County Council	In-house

5.5. A survey was developed which encompassed all of the issues deemed important in considering data capture from local authorities. The survey was developed with a series of key research questions covering the following themes and categories:

i. Confirmation of Client Information System used and the financial system used to record the cost data and/or payments;

ii. The type of information input and stored within the local systems relating to client activity data;

iii. The type of information held, interfaced and reported within the Financial System;

iv. Information held at a local level on the self-funder population;

v. Information held within systems identifying client need, demographics, benefits received, household data and other indicators of potential care need e.g. limiting long term illness, educational attainment;

vi. Other issues such as data reported geographically or by postcode, and issues relating to data quality and the ease with which the local authority could provide information in standard formats e.g. Excel spreadsheet.

5.6. The survey was a mix of fixed response questions with the ability to provide additional free text and questions allowing qualitative responses, giving the respondents the opportunity to describe issues and problems. Annex 2 contains a list of the survey questions.

5.7. Of the 21 local authorities expressing a desire to be involved in the research, 18 provided a survey response by the required closing date, with one council informing the research team that it was not possible to complete due to timing issues but that they would be willing to be interviewed later in the process. In total, 30 survey responses were received, with different officers within some individual local authorities providing responses independently. Only 5 responses did not provide sufficient information to be included in the analysis or were blank returns. Overall, there were therefore 25 completed surveys relating to 18 local authorities, giving a positive response rate of 86% (18 from the 21 agreeing to take part). These authorities are listed in the table below:

Table 4: Survey responses received

London Borough of Tower Hamlets
London Borough of Hackney
Wandsworth Borough Council
Royal Borough of Kensington & Chelsea
Manchester City Council
Liverpool City Council
Solihull Metropolitan Borough Council
London Borough of Newham
London Borough of Haringey
London Borough of Sutton
Derbyshire County Council
Hampshire County Council
Durham County Council
Leicester City Council
Devon County Council
East Sussex County Council
Buckinghamshire County Council
Leicestershire County Council

Table 5: Survey responses by type of authority

Local Authority Contact - Survey Responses	
Inner London Boroughs	4
Outer London Boroughs	3
Metropolitan District Councils	3
Shire County Councils	6
Unitary Authorities	2
TOTAL	**18**

5.8 Data from the survey responses was analysed and a series of additional questions were formulated to explore further data availability and quality issues (see Annex 2). In addition, some of the contacts were questioned further on self-funder issues. Subsequent interviews were conducted with the following local authorities:

i) City of Liverpool

ii) Durham County Council

iii) London Borough of Tower Hamlets

iv) London Borough of Sutton

v) East Sussex County Council

vi) Hampshire County Council

vii) Solihull Metropolitan Borough Council

viii) Leicester City Council

ix) Royal Borough of Kensington and Chelsea

x) Dudley Metropolitan Borough Council

Table 6: Interviews undertaken by type of authority

Local Authority Contact - Interviews	
Inner London Boroughs	2
Outer London Boroughs	1
Metropolitan District Councils	3
Shire County Councils	2
Unitary Authorities	2
TOTAL	**10**

5.9 In addition to the follow-up interviews, the above authorities were also asked to provide a snapshot of data relating to specific elements of social care provision. The data elements were selected to replicate the likely data fields that would be required for a full review of the RNF. Authorities were asked to provide data relating to a one-week period, namely the week commencing 7 June 2010. Annex 2 contains a list of the data fields which were requested.

5.10 Following concerns raised on the security and protection of data to be provided, the research team sent each of the selected local authorities a letter from DH reassuring them that the data would only be used for this research project and then destroyed. Summary data only would be used to inform the report and this would be available for reference purposes in any future review of the RNF.

5.11 Within the timescales of approximately four weeks, 4 authorities were able to provide a completed return in relation to the data request. For the authorities who responded, there are a number of key issues in relation to the review:

- Postcode of pre-care addresses could not be provided in all cases within these timescales, although authorities suggested it would be possible with more time;
- One authority could not provide a specific client cost for reablement services at the present time, although it was working towards calculating this cost at client level for the future;
- Authorities adopted different mechanisms for classifying intensity of care and this data was missing for some clients;
- Authorities were generally able to classify client data into service type or care group;
- Personal details were generally available (age and ethnicity) and there were more detailed socio-economic data in the download from one of the authorities specifically related to self-funders accessing care through brokerage services; and
- Authorities were able to link finance and client data e.g. to give weekly costs of care for each client.

5.12 The remaining authorities all confirmed that the download would have been possible if more time had been given in providing it.

5.13 Annex 5 contains more detail about the data provided by the four authorities, including a table outlining the different data fields and variable definitions used by each authority and some data tables relating to the client and cost data. The analysis gives an indication of the data provided and the variations between authorities, both in terms of key definitions and service profile.

5.14 In conclusion, the research elicited a very positive response from the local authorities contacted. The following issues are worthy of note:

- The response rate from the initial contact was extremely favourable, with 21 of the 25 local authorities agreeing to take part in the research – the research team believe there is now an increased awareness amongst officers in local authorities concerning the need for an ‘accurate’ Relative Needs Formulae to distribute formula grant;
- The survey was responded to by 18 of the 21 local authorities, with another authority agreeing to take part in the later parts of the process;
- In several authorities, more than one individual was responsible for completing the survey, providing responses to the sections related to their main work areas;
- There were no specific issues identified in the survey affecting only one particular type of authority;
- 4 of the 10 local authorities asked to provide a sample data download managed to provide information, although the team acknowledged that these samples were incomplete due to issues of time and resource; and
- Given the time restraints placed on this research, it was confirmed by all local authorities that the data requirements could be met with more time.

5.15 Outcomes from the fieldwork are described in the following sections of this report.

Review of the Earlier Work

This section highlights our review of the approach taken to produce the current adult social care RNF, including discussions with stakeholders and those involved in the development of the formulae.

6. Background

6.1. During the summer of 2004 the Department of Health (DH) commissioned three research projects to produce options for improved and updated formulae for calculating the relative need to spend by local authorities on social services. The research projects considered:

- Children's Personal Social Services (PSS) – undertaken by the University of York;
- Younger adults' PSS – undertaken by Secta Consulting (subsequently Tribal/Secta);
- Older people's PSS – undertaken by the Personal Social Services Research Unit (PSSRU) based within the London School of Economics (LSE).

6.2. All three research projects examined the scope for using either individual-level or small area analysis – i.e. using data below the level of the local authority – in place of the more conventional modelling of the drivers of need at a local authority level. It was argued that individual/small area analysis would be superior to that at local authority level, because relationships between variables may differ depending on the level of analysis due to the influence of other unknown or unmeasured variables.

6.3. However, small area and individual level modelling have intensive data collection requirements compared with local authority level analysis – they both require a data collection with quite detailed data. By comparison, local authority level analysis can be undertaken using nationally available expenditure data.

6.4. The research projects had to work to a tight timescale, reporting in June 2005 as the government intended to issue a consultation paper on formula options in July 2005. The results of the research projects for adults and older people were included in exemplifications in the July 2005 Formula Grant Distribution consultation paper and in the provisional local government finance settlement announcement in December 2005, covering the financial years 2006/07 and 2007/08. The revised formulae were confirmed in the final local government finance settlement at the end of January 2006. In both cases, the final formulae were based on small area analysis at ward level rather than individual level analysis or small output area.

7. Data collection for the Younger Adults' RNF

7.1. In relation to the Younger Adults' RNF, our review suggests that the key issues which impacted on the development of the formula can be summarised as follows:

- **Engagement from local authorities:** 66 local authorities were approached to provide data and 35 initially agreed to participate, but a number later withdrew, leaving only 18. These consisted of 3 shire counties, 4 metropolitan districts, 5 unitary authorities, 3 inner and 3 outer London boroughs. This can be compared to the original targeted aim of obtaining data from a representative sample of approximately 30 local authorities.

- **Representative data from the participating authorities:** analysis was undertaken on information on 26,595 clients in about 800 census wards in 18 local authorities. However, only 7 of these 18 local authorities were able to provide client level information on costs and some of this was incomplete. There were also difficulties in obtaining pre-care addresses for clients currently in care, and only 7 of the 18 local authorities were able to provide post or ward codes for pre-care addresses. Initial modelling undertaken was based on data from 14 local authorities. Subsequently, a further 4 local authorities were added which, according to the researchers, considerably improved the representativeness of the sample.

- **Survey of social workers:** the individual level research was originally intended to include a survey of social workers. However, this aspect of the study was discontinued after low response rates from local authorities and social workers.

8. Data collection for the Older People's RNF

8.1. In relation to the Older People's RNF, the key issues which impacted the development of the formula can be summarised as follows:

- **Individual level data:** the data collection for the individual level analysis comprised a survey of admissions to care homes and a sample of people currently receiving home care. The final datasets included information relating to 826 admissions to care homes and 384 home care clients. This compared with the planned sample sizes of 1,200 and 600 respectively. Further difficulties with the data, including changes in the definitions for pensions and benefits, resulted in the exclusion of the individual level data.

- **Small area data:** data from 17 local authorities became available, covering 775 wards (10% of the England total) and 76,325 clients. Several problems were identified with the data and ultimately the modelling included a national average unit cost for the 5 main categories of care: day care; home care; direct payments; care homes - personal

care; and care homes - nursing care. The data used therefore did not distinguish between different intensities of care provision or between types of provider of care homes.

9. Overall approach to data collection

9.1. For both the younger adults' and older people's RNF research projects, there were several important issues which impacted on the development of the new formulae:

- The timescales for the research project were particularly constrained, meaning there was insufficient time to overcome many of the difficulties with data collection;
- Local authority engagement, in particular market researchers gaining access to the right people in local authorities to support data collection within the constraints of the timescales;
- Lack of accessible data from local authority information systems, particularly in terms of linking financial and activity data with socio-demographic and socio-economic characteristics at small area and individual level e.g. authorities found it difficult to provide postcodes or ward codes for clients currently in care or previous address details for clients living in residential care. It also proved difficult to collect data which could support a more detailed analysis of costs according to intensity of support (based on health and care needs);
- The overall volume of data obtained from local authorities to support the modelling was well below the original targets for obtaining representative samples for small area and individual level modelling. This resulted in the need to use some data from previous studies and re-weight it to provide useful information for the consultation options based on individual data; and
- The collection of individual-level data proved to be very difficult and costly and, as stated above, the final formulae were ultimately based on small area analysis.

10. Lessons learned – views of the steering group

10.1. The steering group set up to oversee the feasibility study also identified a number of key lessons, specifically in relation to the timing of any future research and the data collection process:

- Research projects for the formulae review need to be commissioned with sufficient time for data collection, modelling and discussion with local authorities;
- Preparation for the data collection needs to begin long before the work is commissioned;

- Sufficient time must be built into the timetable to thoroughly consider and discuss the findings;
- Data collection is to be separate from the analysis of data for formula purposes – giving a comprehensive, quality assured dataset for the modelling without the need for special collections;
- Pro-active approaches are needed to improve the achieved sample sizes for all future surveys;
- Guidance needs to be provided about the use and transfer of data collected for research purposes. The arrangements for transfer of data should be agreed at the outset of any future studies. This could draw on the good practice guidance on use and transfer of data that some councils already have;
- Guidance needs to be provided to local authorities on research governance. This should recommend to local authorities that when they collect data they should include a tick box to allow data to be shared for research purposes.

Stakeholder Views on the Future Development of the RNF

This section highlights the key issues raised by stakeholders interviewed as part of the research project and responses from local authorities who participated in the surveys and follow-up interviews.

11. Stakeholder issues

11.1. According to stakeholders, local authorities want to ensure that the relative needs formulae for social care are:

- technically robust i.e. based on good data and sound modelling;
- easy to understand i.e. local authorities can clearly determine how funding is derived based on their population/demography/geography;
- transparent i.e. any value judgements included in the modelling need to be understood and explained;
- related to service delivery i.e. providing funding to reflect how services are being delivered and keep up with how delivery is changing (e.g. how authorities now use care packages to organise care);
- using available data where possible i.e. lots of data is already collected by local authorities and national bodies; and
- reflective of how commissioning is changing.

11.2. In the following sections, these concerns are discussed in more detail, focusing on:

- changes in the way care is organised and delivered;
- variations in health and care needs;
- policy changes and developments;
- variability in provision between authorities;
- using nationally available data and existing data returns;
- developments with information systems; and
- working with local authorities to improve data collection.

12. Changes in service delivery

12.1. Interviews with stakeholders have identified a range of developments in adult social care over the last five years (since the previous formulae review) which may impact on service delivery in the future and therefore need to be considered in any future formulae review:

- Increased use of short-stay residential care – a number of stakeholders have identified a change in practice in relation to the use of short-stay residential care as a means of ensuring that residents can ultimately be supported in their own homes for longer. Short-stay residential care is more intensive and therefore more expensive and these differences may not be reflected in current data on average fees / average costs;

- Focus on home care for older people – many local authorities are working with residents (particularly older people) to maintain residents in their own home rather than moving into residential care. This means a greater requirement for home care services and this has cost implications for domiciliary and residential care services in the long-term;

- Reablement initiatives – projects involving intensive homecare interventions to prevent the need for residential care are being introduced in many local authorities to supplement existing domiciliary care services. Projects vary from authority to authority but the costs may be hidden in funding on general domiciliary care services. Access to many of these reablement projects is not means tested in the same way as other homecare services as they are driven by health needs; and

- Supported living for adults with learning difficulties – there are lots of changes happening for this group of people and debates about how care is best delivered, particularly managing all the care packages efficiently.

13. Understanding health and care needs

13.1. Stakeholders, particularly those involved in the provision of care services, identified the importance of understanding the implications of variations in health and care needs:

- Stakeholders identified that there has been a significant impact of clients in residential care whose primary health concern is dementia. In particular, clients with dementia may require different support than clients with other health and care needs, and care for dementia residents is potentially more expensive.

- Several stakeholders drew attention to the changing health needs of older people in particular as they enter residential care. For example, the current focus on home care for older people means entry into full residential care can be delayed. When clients enter residential care, they can have higher levels of health and care needs which have significant cost implications. This change could be intensified by the use of reablement projects; and

- Ageing population – there is a range of evidence which highlights the impact of an ageing population on health and care needs. For example, Forder and Fernandez (2009) estimates that the number of people aged 65+ with some need for care is forecast to rise from 2 million in 2010 to 2.88 million in 2026. Self-funders are projected to increase from 0.29 million to 0.43 million people by 2026.

14. Policy developments

14.1. There are a number of broader policy issues identified by stakeholders which are expected to impact on the delivery of care services and should be taken into account in any review of the funding formulae:

- Personalisation agenda and personal budgets – this has impacted on the delivery of services but also has impacted on data collection relating to cost data for local authorities. The PSSEX1 returns, for example, are currently being reviewed to ensure that the format better reflects the personalisation agenda;
- There are changes being brought about by the new programmes for regulation and inspection through the Care Quality Commission (CQC). This will change the way care homes are graded and inspected;
- Workforce development, training and availability, particularly to respond to expected increases in the elderly population and the number of people requiring care services; and
- Proposed changes to commissioning of health services, with more responsibilities being directed to GPs, as per the recently issued White Paper "Equity and excellence: Liberating the NHS".

15. Differences between local authorities

15.1. Local authorities have considerable freedom in how care services are provided and also in applying thresholds for different types of care. Differences in funding and costs in an authority, which can be identified from comparative data (e.g. PSSEX1 data), may be a reflection of different policies in relation to the delivery of care and not just differences in the population profile of authorities:

- Local authority spending on social care may be impacted by involvement with Extra Care Housing, use of personal budgets, specific projects to reduce residential care through more comprehensive domiciliary care, short-stay residential care use of reablement projects (short bursts of intensive interventions) and different thresholds for accessing funded care;
- Local authorities have adopted different policies about whether to continue to provide residential care in local authority run care homes or establish contracts with private providers. Some authorities have found it possible to deliver better value-for-money

through contracts with private providers; other authorities have retained more in-house provision to meet their needs;

- Some local authorities may run specialist care homes or may fund residents in specialist care homes operated by private sector organisations e.g. for residents with dementia and Parkinson's Disease. These specialist centres will have higher costs and fees;
- Changes in the case-mix of residential care residents and their health and care needs e.g. increases in the number of residents with dementia / mental illness (higher weekly costs for these residents) and reductions in numbers of frail elderly residents (who are being helped to live in their own homes for longer);
- Costs relating to self-funders who transition into local authority funding – weekly costs can be 2 to 3 times higher for self-funders compared with the rates that a local authority has in place with private providers for local authority funded clients; and
- Third party top-ups – additional fees being paid by families to top-up rates being paid by local authorities. There is significant variation between the number of families paying top-ups and/or the amounts being paid.

16. Use of nationally available data

16.1. Local authorities are required to contribute to a range of national data collections in relation to adult social care, most of which are now managed through the Social Care functions of the NHS IC, for example Referrals, Assessments and Packages of Care (RAPs) and Personal Social Services Expenditure (PSSEX1). A national minimum data set for adult social care will be expanded so that it includes the current data on the social care workforce and new data on social care services as part of a zero-based review. In terms of future reviews, stakeholders suggested:

- The research should be trying to make data collection associated with the formula part of generic data collections and make better use of existing national data collections. This would reduce the issues relating to poor response rates (which might skew the findings) and limited data samples;
- Using nationally available data could reduce the burden on local authorities to respond to individual data requests;
- Work is already being done to match local authorities into "families" i.e. groups of similar authorities (as developed and used by CIPFA, Audit Commission, NHS IC NASCIS tool); and
- If nationally collected data is used, it may need to be validated with each local authority in order to better understand any variations in the data.

16.2. The implications for using nationally available data in future Adult Social Care RNF are considered later in this report.

17. Information systems

17.1. Many of the local authorities included in the survey have made improvements to their information systems since the previous review and are more confident about accessing comprehensive data about individuals and for small areas. For example:

- A London borough has moved to using Frameworki as this system enables them to have greater control of what data can be extracted for further analysis and is also minimising errors in data entry by ensuring users follow a more logical step-by-step process;
- A shire county reported that it has developed an interface to link data from its client database to its financial database and client data is now much more integrated with financial data; and
- A metropolitan authority is in a position to analyse its data using postcode, ward code and other geographical indicators and already uses this information to investigate variations in provision across the city. They also have a system for easily extracting information from its core databases and creating reports from this data directly.

17.2. Additional information about developments in information systems from the survey respondents is included in Section 30 onwards.

17.3. There are also other information developments being piloted in the East Midlands – the TRIPS (Transforming Raw Information in Public Services) project is intended to improve the quality of data to enable local authorities to interrogate activity, cost and personal data from individual packages of care through to local authority comparisons. The elements of the TRIPS toolkit have been developed in partnership with local authorities in the East Midlands and further developments are being piloted up to March 2011, including the development of a data dictionary to ensure local authorities have consistent approaches to data collection and analysis. The widespread use of TRIPS, or other tools like it, could possibly assist in improving the quality of the data collected to support future reviews of the RNF. However, it is not clear whether sufficient progress will be made on TRIPS within the expected timescales for the next review of the RNF to inform any future funding formulae – a decision on the future for TRIPS will be taken at the end of the current phase of piloting, in March 2011.

18. Working with local authorities

18.1. Stakeholders, particularly those who have been involved with previous data collections linked to the RNF, identified a number of key issues which must be addressed to improve the process of data collection from local authorities:

- Establishing contact with local authorities at the right level and with the right people e.g. senior social services data manager as well as the director of adult social services;

- Build relationships with local authority contacts over time in order to understand the precise nature of the data collected by that local authority on its social care clients;

- Meet with local authority contacts on-site to further develop relationships with participating local authorities and address data concerns early in the process;

- Provide support to local authorities to help them respond to data requests and ensure that the data they are providing is of the highest quality;

- Consider financial or other incentives as this may improve the "top level buy-in";

- Consider the time period when any data collection will take place to minimise the impact on local authorities e.g. avoid periods when statutory returns are being collated; and

- Have a strategy in place for addressing some of the concerns with data protection and confidentiality e.g. working with local authority contacts on providing anonymised data.

18.2. The local authorities who participated in the survey and follow-up interviews concurred with many of these suggestions but also highlighted the following:

- Practitioner support via ADASS, and the finance side through CIPFA, could be complemented by specific communication with RAP & PSSEX1 contacts for activity and financial information, to ensure that those parts of the council that will likely be submitting the return are informed and can make preparations;

- Regional workshops, forums or focus groups were suggested as an effective way of sharing issues and perhaps good practice with neighbouring councils. There are further benefits of a regional approach, as it would minimise travel time and costs for participating authorities and enable a support network to be formed;

- Clear templates are needed that show the format of data required and explicit definitions for all data fields which are as consistent with other data sets and/or statutory returns as possible;

- A single point of contact from the research team is needed for all issues associated with data collection;

- Participating authorities need to be provided with feedback from any pilots / testing of the data collection, so that they are aware of the issues to be expected from a larger piece of work;

- Large providers of social care software also need to be made aware of the issues (and it was acknowledged that they usually are) because those local authorities who are tied into products through contractual arrangements will need time to work with suppliers should any changes to systems be required to support data collection;
- Working with existing regional groups to raise the profile of the data collection, e.g. the North West Performance Group, has been proactive in communicating issues in relation to information management for social care;
- On-site support is needed from the research team to particularly address issues relating to integration between financial and activity-based systems, as this is a perceived weakness in the information systems for some authorities;
- DH should work with local authorities to develop a comprehensive mailing list for relevant officers in each authority – this sometimes varies according to the type of information being sent;
- There is a need for a long lead-time between the initial notification about the data collection and the actual period when data is collected – a period of at least six months should enable this process to be completed; and
- Support from the research team should be focused on ensuring consistency of definitions across all participating authorities.

18.3. There were some variable responses to the use of financial or other incentives to encourage participation:

- One London borough and one metropolitan authority suggested that financial incentives would not be necessary and could cause further complications in terms of authorising the receipt of money for what would seem to be a normal work requirement for local authorities at a time of financial restraint;
- One shire county suggested it would be more important to demonstrate the data collection process and information being supplied would be useful in the long-term e.g. contributes to a well-defined national data set for social care;
- A metropolitan authority identified that a cash incentive could be used by local authorities to specifically fund the extra work that would be needed to extract data from the necessary databases (i.e. to fund replacement costs for the staff involved); and
- A shire county preferred incentives to be focused on resource support as a better mechanism than direct financial incentives, giving the local authority some extra capacity to prepare systems for data extraction.

19. Conclusions and implications for future reviews of the adult social care RNF

19.1. The discussions with stakeholders suggested that there are a number of issues which will need to be taken into account by DH and research teams in future reviews of the RNF, as follows:

- The review should reflect current rather than historic patterns of service delivery, relying on the most up-to-date data as far as possible for all elements;
- The review should reflect the range of services being delivered by local authorities for adult social care and take account of cost differences between different types of services;
- The review should reflect the future needs for social care by taking account of the current and future health and care needs for each client group e.g. future care of older people with dementia;
- The review should attempt to benefit from improvements in information systems at local authority level and planned improvements in data collection processes e.g. TRIPS;
- The review should use nationally available data rather than specific data collections where data is already available at national level and is of appropriate quality; and
- The review should focus on engagement with local authorities, ensuring there is a high level of engagement with local authorities and a willingness to support data collection.

Reviewing Alternative Data Sources

This section highlights some of the different data sources which may be relevant to the future reviews of the adult social care RNF.

20. Overview

20.1. As previously acknowledged, the current adult social care RNF are based upon a combination of survey data and socio-economic data, including Census data, which were modelled to provide the detailed formulae used for local authority allocations. Nationally available data was used to identify the representative sample, generate dependent and independent variables in the modelling and also included in the formula factors.

20.2. A number of data sources have been identified as part of this research project, which may be useful in providing data to support the review of RNF. In particular, data sources have been investigated to determine whether:

- Data can be accessed from national bodies without requiring additional input from local authorities;
- Data is available at small area level (see below), local authority level or above;
- Data is regularly updated and at the time periods to which its relates;
- Data is currently available and whether it will be available in its current format in the future; and
- Data is of the necessary quality.

20.3. Data from national sources is needed for future reviews for several different purposes:

- To support the development of a local authority based data collection process based on national frameworks for data collection e.g. using standard definitions from RAP returns;
- To identify the representative sample of local authorities from whom data should be collected e.g. using comparative data for local authorities on age profile, spending on social care and deprivation indices;
- To validate data collected from local authority surveys at small area level against national returns at local authority level for consistency and representativeness;
- To supplement data from local authorities which will support the identification and validation of potential dependent variables in the modelling for the formula e.g. unit costs for various aspects of social care could be the dependent variables obtained at local authority level from PSSEX1 returns; and

- To provide data which will identify independent variables (drivers of need) on which financial allocations could be based e.g. socio-economic and socio-demographic indicators, such as those included in the Census and data from the DWP, which show a strong relationship with the measures of need for social care. This data needs to be available at small area level.

20.4. The table below summarises the findings of the review of data sources and the detail is contained in the subsequent sections, following a brief discussion of small area analysis:

Table 7:

Data Sources	Small Area Availability	Availability	Relevance to RNF Review
NHS IC Social Care Data e.g. RAP, PSSEX1, ASC-CAR	- Data generally not collected at small area level and most reporting at local authority level - Some small area analysis for National Indicator Set - Some small area analysis through NASCIS portal	- Returns published annually within 6-12 months of end of previous financial year - Returns updated annually – may be minor changes to the data being collected - Zero-based review will impact on collections from 2012/13 onwards	- Definitions for data fields in survey of local authorities - Validation of small area data from local authorities - Calculation of dependent variable(s)
Census Indicators (health, demographic and socio-economic)	- Almost all census indicators reported down to super output area and ward level to support small area analysis	- All indicators used for previous review are included in Census 2011 - Timing of review needs to coincide with availability of data at small area level from Census 2011 (expected 2013 onwards)	- Indicators for creating representative sample - Independent variables for analysis - Drivers of need (independent variables) for overall analysis (including health status) - Inclusion in revised RNF
Integrated Household Survey	- Allows small area analysis for specific indicators being analysed each year	- Survey is currently experimental data set – could be subject revisions in the future - Updates produced annually	- Drivers of need (independent variables) for overall analysis
English Longitudinal Study of Aging	- Reporting currently at national or local authority level - Raw data can be mapped to small areas - Relates to Older People only (population 50+)	- Core data sets for Waves 1 to 4 can be accessed - Wave 4 data collection undertaken in 2008-09 -	- Proxy measures for health status / prevalence of need - Proxy measures for financial status - Drivers of need (independent variables) for overall analysis

Data Sources	Small Area Availability	Availability	Relevance to RNF Review
Economic Indicators from DWP	- Most DWP indicators reported Almost all census down to super output area and ward level to support small area analysis	- Statistics are updated at least annually (time lag of 6 – 12 months) - Any changes to the benefit system will impact on the availability and quality of data	- Indicators for creating representative sample - Drivers of need (independent variables) for overall analysis
Health data sources e.g. prevalence rates and life expectancy	- Most health data sources are reported at the level of PCTs - Some data is available for GP practices - Quality Outcomes Framework is available for GP practices and can be mapped to small areas - Boundary issues may impact on use of health data	- Statistics are generally updated at least annually (time lag of 6 – 12 months) - Life expectancy rates will be updated following Census 2011	- Indicators for creating representative sample - Drivers of need (independent variables) for overall analysis
Data from providers of care services e.g. residential care surveys	- Data is collected from individual residential care homes and reported at regional levels - Data may be available to map to small areas	- Statistics are not generally available for research purposes – may need to agree special access - Not all updated annually - Need to ensure data is representative of all private provision if it is to be included	- Proxy data for identifying self-funders

21. Small area analysis

21.1. Before discussing the review of data sources, this section contains a brief summary of the issues relating to the use of small area analysis for future reviews of the adult social care RNF. Darton et al (2006), for the previous review of the RNF, reported that small area data can offer *"greater precision than large area data, such as local authority level data, by reflecting variations within the larger area, and multiple regression analysis can be used with small area data to tackle the complexity of needs factors"*. Further, as noted by Carr-Hill et al. (1999), comparisons at local authority level can mask the relationships between expenditure and need that will be identified in small areas.

21.2. However, it is also important that the choice of small area, be it super output area, electoral ward or district for example, is carefully considered. If the areas chosen are too small, there may be insufficient activity within each small area (e.g. clients receiving home care services) to create a viable data set. If the area is too large, the benefits of the small area approach are lost.

21.3. In the previous research for the social care RNF, electoral wards were chosen as the small area for analysis. Census data and socio-economic indicators from the DWP are all reported at ward level and generally cover populations of between 5,000-15,000 people. Whilst these indicators are generally also available for super output areas, which are much smaller areas and relate to populations of 1,000-1,500, this level may not be large enough to generate sufficient levels of activity for a robust data set. It is therefore likely that ward level will be the appropriate choice for small area for future reviews.

21.4. For some aspects of the review, data at small area level may not be considered sufficiently robust and could be validated against data from a higher level. For example, unit cost data for different aspects of social care may be more robust if calculated at local authority level than at ward level. Alternatively, unit costs could be calculated at ward level (from small area data collected from local authorities) and validated against local authority level unit costs derived from national data returns to the NHS IC (see below).

22. Social care data from the NHS Information Centre (NHS IC)

22.1. The NHS Information Centre (NHS IC) is now responsible for the collection, validation and publication of the majority of data relating to local authority provision of adult social care services. The most extensive and relevant data sets include:

- Referrals, Assessments and Packages of Care (RAP) – information on the number of adults contacting social services and going through the community care assessment process, and the services that they receive;
- Grant-Funded Services (GFS1) – a collection recording how vulnerable people are being helped to live at home outside of a formal care package;
- Personal Social Services Expenditure (PSSEX1) – the current expenditure on personal social services for adults;
- Personal Social Services Staffing (SSDS001) – information on the staff directly employed by social services departments for adults and children;
- Adult Social Care Combined Activity Return (ASC-CAR) – information to support national indicators and data on the number of adults in residential and nursing placements funded by councils with adult social services responsibilities.

22.2. For the data collated nationally by the NHS IC:

- With the exception of small area data in the National Indicator set used to support the development of Joint Strategic Needs Assessments (JSNAs), social care data used to produce national data sets is collected and reported at local authority level;
- Data sets are collected according to nationally agreed definitions and data is subject to extensive validation prior to publication;

- Most data sets are published 6-12 months after collection e.g. data relating to 2010/11 would not be available until September to December 2011;
- Cost data for home and residential care does not necessarily reflect the case mix of the population e.g. higher costs for dementia care, higher costs of short-stay compared with long-stay residential care. However, further analysis of this type may be available from the new pilot items on PSSEX1; and
- There is very limited data in relation to self-funders e.g. there has been an additional element added to community care statistics on the number of assessments undertaken as part of care management.

22.3. In relation to the adult social care RNF, the primary use for data from the NHS IC social care collections will be to supplement or complement local authority data collection to create the dependent cost variables which will form the basis of the RNF. However, the data will also be useful in validating local authority data collection and in defining the variables to be collected from local authorities.

22.4. The NHS IC has an agreed process for introducing new data elements to the national data sets. The Strategic Improving Information Programme (SIIP) Board provides overall governance for social care collections, including recommending what information should be collected and how best to gather it. The Adult Review Group (involving the NHS IC and representatives from national bodies / social care services) is one of the groups which looks at changes to data collection and develops programmes for implementation of new data collection. The most up-to-date listings of social care data from the NHS IC can be found in Annex 3.

22.5. There are currently a number of ongoing projects which could impact on the data collection strategy for a future review of the RNF:

- There is a plan to commence a zero-based review of all social care returns within the next 12 months – this would ensure all data being collected in the future from local authorities has a specific purpose. It could result in some existing returns being discontinued;
- NASCIS, which is an online tool enabling detailed analysis at local authority level of a range of indicators, has been designed to enable “families” of similar local authorities to be compared. These “families” could be useful in developing a representative sample for future surveys to support the RNF; and
- There is ongoing work on the development of the National Minimum Dataset for Social Care (NMDS-C at http://www.nmds-sc-online.org.uk/). Whilst the focus of this data set is on the workforce element of social care, it may be a useful source of information to complement activity and cost data provided by local authorities.

22.6. In the longer term, there is a consideration to move towards real-time data collection at an individual level for social care services (comparable with the Hospital Episode Statistics which collate activity for individual admissions to healthcare services). This would significantly reduce the time lag in social care data collections and enable analysis of activity at small area level without the need for additional data collection from local authorities. This work would take at least 4-5 years for significant progress to be made and is therefore unlikely to have any impact on the next review of the RNF. However, it may have significant impact for reviews beyond 2014/15.

23. 2011 Census

23.1. In relation to any future adult social care RNF, the primary use for data from the Census will be as independent variables in the analysis i.e. the basis of variation in costs between local authorities. Both the Younger Adult and Older People's RNF include some Census data in their formulation, for example population aged 65+ living in one person households and population aged 65+ living in rented accommodation (see Annex 1 for a detailed list of components).

23.2. The Census also includes a range of indicators relating to health needs, which may also be relevant to the formulation of the RNF in integrating health and social care indicators of need e.g. long-term illnesses and disability, information relating to carers. The Census indicators could also be used to determine the requirements of a representative sample e.g. the Younger Adults formula work in 2004 used census type indicators relating to educational attainment, limiting long-term illness, deprivation and ethnicity in defining its sampling framework.

23.3. The new Census will be completed in 2011 and the proposed format of the Census questionnaire has been subject to extensive testing over the last two to three years. None of the questions which have been used in the formula allocations or were used to support the modelling have been excluded from the 2011 Census – Annex 3 includes a summary table confirming the proposed content for household and individual questions for England and Wales.

23.4. Almost all statistics are reported down to super output area to support a small area analysis for the RNF. Preliminary results will become available from 2012 onwards and full findings at small area levels from 2013/14.

23.5. The most significant issue in relation to the next review of the RNF will be the timeliness of access to the small area data. If the Census data is not available at small area level when the review takes place this would be a major limitation to the analysis, particularly as the collection of census-type indicators from local authorities is not comprehensive (see section 28). A further key issue with Census data is that, even if output from the 2011 Census were available for the next review of social care RNF, it is not possible in general to update the data until the following Census. For this reason, CLG has tried to find alternatives to census-based indicators for most RNF formulae.

24. Integrated Household Survey

24.1. In reviewing the younger adults' and older people's RNF, researchers drew on findings from the General Household Survey (GHS) for both individual and small area analyses. The GHS has become the General Lifestyle Survey (GLF) and is now a part of the Integrated Household Survey (IHS), which is a composite survey combining questions asked in a number of Office for National Statistics (ONS) social surveys to gather basic information for a very large number of households. In relation to futures reviews of the adult social care RNF, the primary use for this type of survey data will be as independent variables in the analysis i.e. those variables which show a strong relationship with the measures of need for social care.

24.2. The aim of the IHS is to produce estimates for particular themes to a higher level of precision and at a lower geographic level than is possible in individual ONS social surveys. The IHS includes two sections: a suite of approximately 100 core IHS questions (which have been developed to provide estimates for a number of themes, including economic activity, education, health and disability, identity and income) and individual survey modules 'bolted' onto the core. Particularly relevant questions include health status, educational attainments and employment. Current modules of the IHS include:

- General Lifestyle Survey (GLF)
- Living Cost and Food Survey (LCF)
- English Housing Survey (EHS)
- Labour Force Survey (LFS)
- Life Opportunities Survey (LOS)

24.3. The IHS is currently an experimental data set in that experimental statistics are those where the data is new and the data and statistics have not yet been assessed by the UK Statistics Authority. The most recent data relates to 2009-10 and it is regularly updated. The most significant issue in relation to the next review of the RNF will be whether the data provided from the experimental data set is of sufficient quality to be used within the statistical analysis.

25. English Longitudinal Study of Aging

25.1. The English Longitudinal Study of Ageing (ELSA) is an interdisciplinary data resource on the health, economic position and quality of life as people become older. It is being conducted by the National Centre for Social Research (NATCEN), University College London and the Institute for Fiscal Studies.

25.2. ELSA is the first study in the UK to connect the full range of issues necessary to understand the economic, social, psychological and health elements of the ageing process. The survey covers the broad set of topics relevant to a full understanding of the ageing process, including:

- Health, disability, healthy life expectancy;
- The relationship between economic position and both physical and cognitive health;
- The determinants of economic position in older age;
- The timing and circumstances of retirement and post-retirement labour market activity;
- The nature of social networks, support and participation;
- Household and family structure and the transfer of resources.

25.3. Individuals involved in ELSA were drawn from previous respondents to the Health Survey for England and almost 20,000 people were identified as eligible. Wave 1 included productive interviews with some 12,000 people. Data collection for wave 4 of ELSA has recently been completed, with the achieved sample likely to be slightly lower than wave 1. Findings from the survey are being used, for example, to consider prevalence of certain health and care needs, access to health and care services and post-retirement income. Data sets can be accessed by researchers through the Economic and Social Data Service. However, ELSA data are not available at a local authority or ward level; as such, this data source would be of limited use in a formula review.

26. Economic data

26.1. In relation to the RNF, the primary use for economic data will be as independent variables in the analysis i.e. the basis of variation in costs between local authorities e.g. in reviewing the RNFs for younger adults and older people, researchers also drew on economic data from the Department for Work and Pensions (DWP) including pension credit and attendance allowance data. The Census indicators could also be used to determine the requirements of a representative sample. The following data continues to be produced either quarterly or annually, is available at super output area and ward level as well as local authority level, and is also broken down by age group and gender:

- Attendance allowance;
- Disability living allowance;
- Incapacity Benefit/Severe Disablement Allowance;
- Income Support;
- Jobseekers Allowance; and

- Pension Credit Claimants.

26.2. There are ongoing developments to the data being collected and reported by the DWP and it is likely that the quality of this data will continue to improve with these developments. The most significant issue in relation to the next review of the RNF will be the impact of changes (if any) to policies relating to benefits for adults and older people brought about by the new coalition government. This may impact on the eligibility criteria and also on the timeliness of the data available following any changes. However, if there are no changes to the benefits system, the data will continue to be available for future reviews of the RNF.

26.3. Income deprivation data for older people has also been combined into the Income Deprivation Affecting Older People Index (IDAOPI); the most recent data relates to 2007, but this is likely to be updated as part of the planned developments to update the overall Index of Multiple Deprivation (IMD). There are mixed views amongst local authorities on the validity of this data and it is not currently used in other distribution formulae for local authority funding.

27. Health data

27.1. The previous reviews of the adult social care RNF have not explicitly incorporated any indicators which reflect variations in health status between residents of local authorities or prevalence of specific medical conditions that may impact on the need for health and social care. However, this data could be useful in identifying independent variables for the analysis. As outlined in section 22, there are a number of indicators included in the 2011 Census which will collect data relating to health needs. There are also a range of other sources of information about health needs for younger adults and older people which may be relevant to the formulation of future adult social care RNF. For example:

- Statistics on life expectancy and health life expectancy for all populations and older people aged 65+ are produced;
- Prevalence data for a range of long-term conditions and illnesses is currently collected as part of the Quality and Outcomes Framework for GPs. It is available for specific GP practices as well as collated to PCTs. The data includes dementia; and
- Hospital admission rates for a range of causes are also available at PCT level.

27.2. The most significant issue in relation to the use of any health-based data sources for the next review of the RNF may be accessing the data at small area level – data is often collated at a higher level e.g. PCT boundaries. Furthermore, boundaries may not be coterminous with local authority boundaries. Future changes to organisational structures for the delivery of health services may also exacerbate these difficulties with the creation of different boundaries e.g. establishment of GP commissioning consortia. However, local authorities may have mapped some health indicators to small areas as part of their Joint Strategic Needs Assessment (JSNA).

28. Social care data from private sector providers and agencies

28.1. Laing and Buisson undertake a regular market survey of residential care home provision in England and Wales – the focus of the survey is the current care home population and this does not include any linking to previous residences / post code.

28.2. The findings of the surveys are collated into a subscription-based product which is accessed by many other providers of care, particularly to review issues relating to fees for residential care and local comparisons. For example, the 2009 survey included findings on:

- overall capacity and occupancy levels in the care home sector;
- numbers of self-funders, local authority-funded residents and NHS-funded residents;
- regional variations in the number of local authority and private sector care homes;
- regional variations in fees and fee increases for residential care;
- fees paid by local authorities to private sector care homes;
- analysis of thresholds for assessments and funded care; and
- projections for future capacity requirements and occupancy levels.

28.3. In response to the feasibility study, Laing and Buisson stated that they are willing to work with the Department of Health on any future review of the RNF, particularly to support the collection of better quality data.

28.4. Bupa (in partnership with other care home groups) has conducted three large surveys of its care home population since 2003 (2003, 2006 and 2009). The survey covered over 30,000 residents in 2006 (55% were Bupa residents). Approximately 26,000 residents from Bupa care homes across the UK and internationally were included in the 2009 Census, plus residents from an increasing number of other care home groups in the UK. There are approximately 450,000 care home residents in England.

28.5. The Census is administered by care homes: each facility appoints a facilitator to oversee census activity, with colleagues involved in the day-to-day care of residents encouraged to participate in the study. Bupa work with an external agency to “read” the data once the Census forms have been completed (on paper). This ultimately provides Bupa with an electronic data set for analysis.

28.6. The Census form is kept deliberately simple to encourage completion. The detailed census questions are included in Annex 3 and the main sections cover:

- Resident characteristics – gender, age.
- Care type – residential / nursing.
- Basis of stay – permanent / temporary.

- Care category e.g. frail elderly, dementia, young physically disabled, learning difficulties etc.
- Funding stream – self-funders, health/social care funding.
- Health needs – mobility, mental state, senses, continence.
- Admission reason and diagnosis.

28.7. Findings from the Census are used internally by Bupa (and other participants) to develop care home services e.g. increasing number of residents with dementia.

28.8. The data is particularly rich in terms of diagnostics / reason for admission / health-related concerns (dementia, continence) as recorded in the admission reason and diagnosis categories. This could be particularly useful in understanding more the impact of different health issues on care needs and the overall cost of care. However, the survey does not link residents to their previous residence (i.e. home postcode).

28.9. In response to the feasibility study, Bupa stated that they are willing to work with the Department of Health on any future review of the RNF and this could include an extension of the existing survey of care homes.

28.10. For any data from private providers, the key implications for inclusion in the RNF will be to ensure the data is representative (not skewed by the inclusion/exclusion of particular providers or localities) and consistent (based on equivalent definitions and data collection principles).

29. Conclusions and implications for future reviews of the adult social care RNF

29.1. The review of national data sources and associated comments from stakeholders, therefore, have particular implications for the future reviews of the RNF:

- Data is unlikely to be available at individual or small area level through the data collections by the NHS IC within the short to medium term. Therefore, to undertake a small area analysis as the basis for revised RNF will require comprehensive data collection from local authorities;
- The new Census data will be of value in identifying representative samples and calculating independent variables for the modelling and allocation formulae. It should be available, at small area level, by the modelling phase of the formulae review in late 2013 or early 2014;
- Alternatives to the Census for socio-demographic indicators, in particular, are available from a number of different surveys and could be included as independent variables. However, data quality issues will need to be taken into account for those surveys still considered to be experimental by organisations such as ONS;

- Changes in policy, particularly in relation to the delivery of income-related benefits, could impact on the socio-economic data which is available; and
- If DH is able to draw on data collected by private providers or relating to private provision, there will need to be detailed work to ensure the data is representative and consistent.

29.2. There are also a number of areas requiring a "watch and see" approach from DH for future reviews of the RNF. The following could impact on the data which is available and the way in which data is collected and/or reported by local authorities e.g.

- The outcomes from the NHS IC's zero-based review of data returns and the SIIP more broadly;
- The possible impact of projects such as TRIPS (see para. 17.3) on local authority data collection; and
- The proposed changes to health and social care delivery as set out in documents such as "Equity and Excellence: Liberating the NHS" may result in different organisational structures for health and social care services.

Data Issues from the Research

This section highlights some of the key issues relating to the collection of data to support the calculation of the assumptions for the RNF and the application of the formula from the findings of the surveys of local authorities.

30. Overview and key findings

30.1. The survey of local authorities has enabled the availability of data relating to small areas to be investigated. In particular, as well as more general data on client numbers and client groups, the survey focused on the ability of authorities to provide the type of information that proved difficult in preparing the current formulae e.g. pre-care address details, integration between activity and finance data, client characteristics. The survey also investigated whether client data could be mapped to small areas to support a small area analysis. The responses to the survey has shown that:

- Data to support small area analysis is generally available from local authority client databases;
- Pre-care address information will be more difficult to obtain for some local authorities;
- There is comprehensive information about the types of services being provided to home care and residential care clients, although definitions of "intensive" home care are more variable;
- Data relating to day care provision is not as comprehensive as for residential care and home care;
- Local authorities do collect some data relating to demographic and socio-economic indicators, although the data is not widely used by local authorities and therefore may have quality issues;
- There is some integration between client and finance databases and local authorities are working to improve this integration;
- Local authorities can access the type of data that would be required for a review of the RNF, but would need clear definitions and time to enable the data to be extracted;
- Downloads of data in Excel formats can be achieved.

31. The availability of data to enable small area analysis

31.1. In order to undertake small area analysis, data from local authorities needs to be linked to postcode or pre-mapped to agreed small areas e.g. super output areas. The table below shows a summary of the data used by services linked to individuals within their client databases:

Table 8: Does your client information system use the following fields as core service user data?

	Yes	No	Response Count
Client ID	100.0% (22)	0.0% (0)	22
NHS Number	42.9% (9)	57.1% (12)	21
Client Group (Older/PD/LD/MH/Other)	100.0% (22)	0.0% (0)	22
If receiving home based services - current postcode	95.5% (21)	4.5% (1)	22
If in residential care - postcode of carehome	90.9% (20)	9.1% (2)	22
If in residential care - postcode of Pre-care Residence	86.4% (19)	13.6% (3)	22
Date of Initial Assessment	95.5% (21)	4.5% (1)	22
		Comments:	13
		answered question	22
		skipped question	8

31.2. As shown in Table 8 above, there is currently very limited linking of local authority clients with their NHS number; and only two respondents reported actually linking with health systems. However, on the key issue of postcode mapping, one local authority who responded to the survey suggested that current postcode for home care clients was unavailable, whilst two local authorities suggested postcode was unavailable for care home clients (for residential care) within client-level databases. Specific comments included:

- A county council using an in-house system can produce data to postcode level, although there would be a need for data processing and cleansing of some records to ensure postcode quality;
- A London borough using Frameworki reported that postcodes are recorded for most residential care homes but not all; and
- A metropolitan borough using an in-house system is already geared up to analyse data by postcode, ward and by geographical location.

31.3. Further, only three of the local authorities who responded to the survey suggested that pre-care postcode data was not available and could not be obtained. However, for those local authorities who identified that pre-care address data could be provided, there were a number of caveats:

- A shire county using CareFirst reported that their system shows the client's address history as long as the client was recorded on CareFirst prior to admission to a care home. Therefore, pre-care address data would only be available for those individuals who had received other care services prior to admission to residential care e.g. home care. Further, it is not simply a "push of the button" exercise to find this data, particularly because temporary addresses can build up over a period of time and the original address can be "buried" within these changes;
- A shire county using SWIFT reported that postcode level information is collected; however, the postcode of pre-residential care clients is not captured and instead the location of the care home is held. There may be situations where the previous postcode is held, e.g. if the client was previously receiving domiciliary care, but this is not the postcode held on the SWIFT system. In addition, there could be alternative potential postcodes prior to residential care e.g. a client could have moved from their own address to the address of their family, prior to moving into a home; and
- A shire county using CareFirst reported that the postcode of pre-care residence is recorded as long as the client is not in residential care at the point of referral. However, they identified potential data quality issues for clients who have been in residential care settings for some time.

32. The availability of data to enable analysis by type of care received

32.1. Identifying clients who are part of reablement support is considered an important element of any future review, as these projects are generally more intensive and higher cost. Local authorities who responded to the survey had a mixed response to this issue:

- In a unitary authority using CareFirst, reablement residential care is recorded as a separate service type and reablement home care is recorded as a sub-category ("service element") of home care; and
- In a shire county using CareFirst, reablement activities are not currently captured within the care management system. However, a reablement model/process is currently under development (due November 2010). Two other authorities also responded that information systems are currently being developed to capture reablement activities.

32.2. The table below shows a summary of the level of information recorded in relation to the type of care received, including reablement services.

Table 9: Does your client information system specify the type of care as follows?

	Yes	No	Response Count
Nursing	100.0% (22)	0.0% (0)	22
Residential	100.0% (22)	0.0% (0)	22
Home care	100.0% (22)	0.0% (0)	22
Day care	100.0% (22)	0.0% (0)	22
Meals	90.9% (20)	9.1% (2)	22
Carer Support Services	90.9% (20)	9.1% (2)	22
Professional Support	81.8% (18)	18.2% (4)	22
Equipment/adaptations	77.3% (17)	22.7% (5)	22
Direct payments	100.0% (22)	0.0% (0)	22
Reablement	76.2% (16)	23.8% (5)	21
		Comments:	11
		answered question	22
		skipped question	8

32.3. Detailed recording of activities supplied to home care clients is another area where availability of data will be important to future reviews. As shown in the table below, there is some variation between authorities in relation to this question. Some of the more detailed responses included:

- A London borough using Frameworki reported that the breakdown of types of home care is not consistently shown at present in their client system;
- A London borough using an in-house system responded that all homecare services are recorded as text not individual data fields, making it more difficult to access them for analysis;
- In a London borough using PARIS, there is a distinction between services provided by their independent brokerage home care service, for which details are recorded in PARIS, and the in-house provision, for which information is captured at a basic level in PARIS, is recorded comprehensively in an external client record application called Staffplan;

- A shire county using CareFirst is able to record which of the following home care services are received by each client: bathing service, escorted shopping, laundry, meals in the community, medication, personal care, practical support, shopping and special care; and

- An inner London borough and a unitary authority using CareFirst also make reference to the fact that their systems record commissioned hours and not actual hours for home care services.

32.4. The table below shows a summary of the level of information recorded in relation to home care.

Table 10: For home care services, do you identify the following within your client information system?

	Yes	No	Response Count
Number of hours per week	100.0% (22)	0.0% (0)	22
Whether services are provided by the local authority	100.0% (21)	0.0% (0)	21
Whether services are provided by the independent sector	100.0% (22)	0.0% (0)	22
Whether this is intensive home care or regular home care	63.6% (14)	36.4% (8)	22
Personal Care (e.g. help with washing, dressing)	72.7% (16)	27.3% (6)	22
Home Services (e.g. shopping, gardening)	63.6% (14)	36.4% (8)	22
Any other services (please specify below)	44.4% (8)	55.6% (10)	18
		Comments:	15
		answered question	22
		skipped question	8

32.5. For day care and community based provision, there were also a range of responses from local authorities in relation to the availability and quality of data:

- A unitary authority using CareFirst records the number of days of day care and not the sessions attended.

- A shire county using Frameworki currently has very limited data on day services but is working to add these services to its financial and activity modules;

- A London borough using CareFirst responded that some of its day services for clients with mental health issues are not recorded on CareFirst, instead the data is held on local systems; and
- A shire county using CareFirst has categorised 96% of recent day care agreements, allowing them to identify enabling support, work preparation, LD shared lives support and also split between in-house and external provision, and make the distinction between LD individualised support and institutional day care services.

33. The availability of data to enable analysis of demographic and socio-economic variables

33.1. In relation to the health status and demographic indicators, there was considerable variations in the level of detail recorded:

- Age, sex, ethnicity and first language were recorded by all local authorities who responded to the question;
- Approximately half of all respondents reported that their local authority recorded data on the involvement of informal carers, both living with the client and living elsewhere; and
- Recording of data relating to the detail of disability living allowance, limiting long-term illnesses and educational attainment was minimal.

33.2. In relation to the recording of benefit data, the survey showed that there were areas where there were considerable gaps in the detail of information recorded by authorities:

Table 11: Does your client information system record the following benefits received by service users?

	Yes	No	Response Count
Attendance Allowance	26.7% (4)	73.3% (11)	15
Pension Credit	33.3% (5)	66.7% (10)	15
Job-seekers Allowance	26.7% (4)	73.3% (11)	15
Income Support	33.3% (5)	66.7% (10)	15
Disability Living Allowance	33.3% (5)	66.7% (10)	15
		Comments:	6
		answered question	15
		skipped question	15

- A shire county reported that they record benefits information in a separate financial assessment system and that the data is very difficult to integrate with the social care index data;
- A London borough reported that benefits information is only captured anecdotally;
- A shire county reports that their client information system (Frameworki) has specific episodes and documents used by their Welfare Rights Service which capture such information, but only where Welfare Rights are involved with a person; and
- A shire county holds the benefits data in its client information system for all clients who are subject to a financial assessment.

33.3. With regard to data relating to households, again there is limited coverage in the recording of this information:

Table 12: Does your client information system record the following information regarding household data for service users?

	Yes	No	Response Count
Living alone	81.8% (18)	18.2% (4)	22
Tenure	63.6% (14)	36.4% (8)	22
Household size	18.2% (4)	81.8% (18)	22
Relationship of client to head of household	22.7% (5)	77.3% (17)	22
		Comments:	6
		answered question	22
		skipped question	8

34. Integration between financial and client data

34.1. Local authorities reported very different experiences in relation to the integration between client and finance data. For example, the table below shows that the majority of systems contain some mechanism for linking individual clients to financial data:

Table 13: Does your financial information system currently record the following service user information?

	Yes	No	Response Count
Client ID reference or NHS number	76.2% (16)	23.8% (5)	21
System interface reference	68.4% (13)	31.6% (6)	19
		Comments:	10
		answered question	21
		skipped question	9

34.2. Furthermore, looking at some of the more detailed information relating to the cost of residential care, a similar proportion of respondents reported that detailed cost information was available, including contributions from clients towards the cost of their care:

Table 14: For residential and nursing packages, does your financial system record the following?

	Yes	No	Response Count
Gross Cost of Package	71.4% (15)	28.6% (6)	21
Client Contribution	76.2% (16)	23.8% (5)	21
Other Contributions	76.2% (16)	23.8% (5)	21
Net Cost of Package to Local Authority	57.1% (12)	42.9% (9)	21
Nursing cost component (for nursing homes)	65.0% (13)	35.0% (7)	20
		Comments:	10
		answered question	21
		skipped question	9

34.3. A similar pattern to the responses shown above was found when looking at the costs of day care and home care.

34.4. Looking in more detail at the links between finance and client-based activity data, however, authorities have identified many differences between their systems:

- In a shire county, the majority of information at service-user level is held on the client information system, to which finance staff have access. This level of detail is not replicated on the financial system;

- In a shire county, the vast majority of financial details relating to a client are held within the client database. An interface has been developed where an agreed dataset is uploaded to the financial system on a 4 weekly basis;
- For a unitary authority, all of the information relating to costs of residential packages of care is recorded within the client information system (CareFirst) and fees can be calculated. It is not recorded within the finance system (SAGE/Oracle);
- The financial system (Agresso/Abacus) used by a London borough has the ability to record a full data set in relation to costs for residential, nursing, domiciliary and day care packages but the modules are not currently being used by the authority;
- A London borough reported that financial data (Agresso) is not directly integrated with client data (PARIS) and that this matching would need to be undertaken manually. The matching is not necessarily 100% accurate e.g. a recent matching exercise for a month snapshot resulted in 6-9% of missing data; and
- For a shire county, for the costs associated with nursing home placements, the residential element of a placement in nursing homes is identified in the financial system (Oracle). The nursing element is paid directly by the Health Authority. The net cost of packages is not shown on the financial system (Oracle) but can be calculated.

35. The most appropriate means of data collection and validation

35.1. The survey identified that local authorities are using a range of different information systems (commercial packages and in-house) for both financial data and client data. For client data systems:

- CareFirst was the most common commercial package being used for client data, with 6 of 18 authorities making use of the system; Frameworki is being used by 5 authorities; 4 authorities have locally developed systems; the remaining 3 authorities for whom this data was provided were using either SWIFT or PARIS;
- For financial data, a wider range of systems were being used including SAP, Masterpiece Net, SWIFT, JD Edwards One World, Finest from Software AG, Agresso, SAGE, Abacus, Frameworki and Oracle.

35.2. This multiplicity of systems has implications for the way data requests are structured and data can be supplied. For example, services using commercial packages may have less freedom to interrogate their databases than those with in-house systems. Local authorities included in the survey reported the following issues:

- A London borough reported that some of the PARIS data fields can be reported on very simply as they form part of the core client record. Some client data, however, may be stored in free text fields or non-standard sections of the PARIS database and would be much harder to extract;

- A shire county identified that some of the data outlined in this report (i.e. the data fields included in the survey) is already routinely reported from SWIFT, whilst other information would require new reports to be developed and quality assured;

- A London borough using Frameworki reported that information management reports can be produced from the system if requested. The ability of the authority to respond to data requests is dependent on the size and varying topic of what is requested;

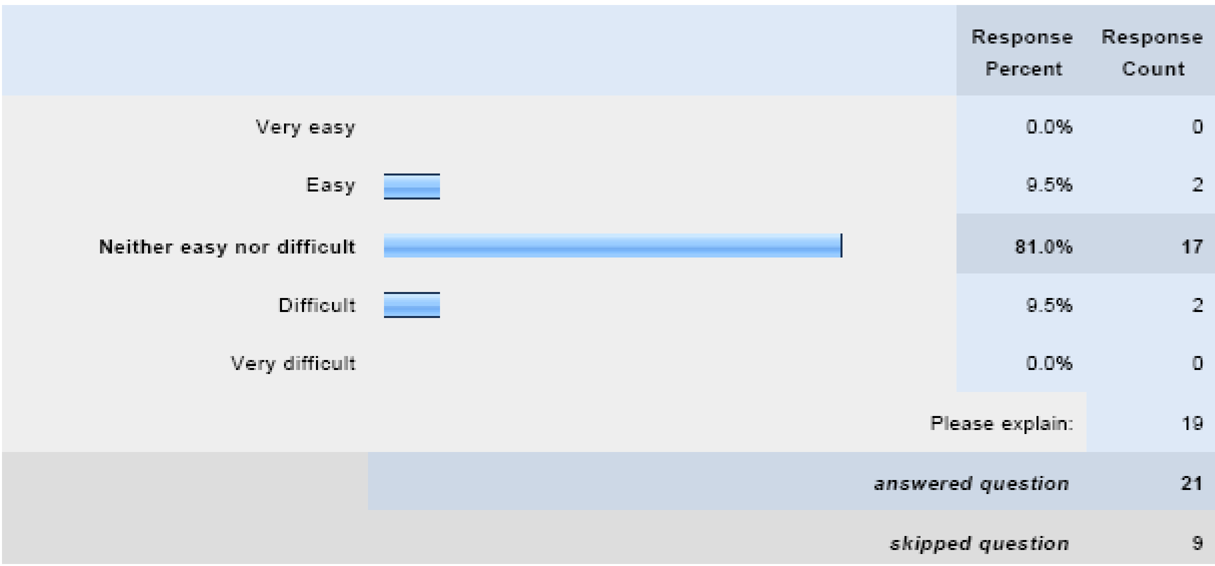
- A shire county using CareFirst reported that extracting individual data items from their care management system is fairly straightforward as they have identified a core client dataset which is regularly extracted and monitored to ensure good data quality. However, all data items are susceptible to potential data quality issues largely because it is difficult to make fields mandatory within the system. Overall data quality for individual data items is good, but there are more significant issues when linking records from across the system i.e. assessment episodes, service history and linking assessments to resulting care packages etc;

- A London borough responded that demographic data on service users is fairly straightforward. However, data relating to sequences of events is much harder. In preparing data for national data returns (e.g. RAP), it has taken time to get the process right and the authority has often had to make changes its CareFirst system to meet reporting requirements; and

- A shire county use an in-house adult social care index and so have to identify resources for data extraction projects. All data is held in a single, structured database and third party data extraction and manipulation tools are available.

35.3. However, all local authorities who responded to the survey reported that they would be able to supply a download of data in an Excel spreadsheet (or equivalent) provided that they had clear data specifications and sufficient time to respond. There do not appear to be any information systems that would make data collection impossible i.e. the vast majority of local authorities felt it would be possible to provide information and this would be “neither easy nor difficult”. Additional comments, obtained from the local authorities during the interview element of this research project, suggest that they responded with “neither easy nor difficult” to reflect that some aspects of the data request would be relatively straightforward; and, once a comprehensive data specification was received by them for any future review of the RNF, they would be able to work through the specification and provide the requested data, with sufficient levels of support and time.

Table 15: For all data held in your Client Information System, how difficult do you think this would be to collect for DH research purposes?



	Response Percent	Response Count
Very easy	0.0%	0
Easy	9.5%	2
Neither easy nor difficult	81.0%	17
Difficult	9.5%	2
Very difficult	0.0%	0
	Please explain:	19
	answered question	21
	skipped question	9

35.4. For the two authorities who responded that providing a data request would be "difficult", the main issues related to the breadth of the data request and more generic issues relating to data quality of data that is not regularly interrogated at a local level.

36. Conclusions and implications for future reviews of the adult social care RNF

36.1. Based on the findings of the survey therefore, the key issues in relation to data collection and specification for future reviews of the RNF are:

- Individual level data collection from authorities can be undertaken – local authorities are generally able to provide data showing basic demographic, service and finance information for individual clients accessing each aspect of their service e.g. residential care, home care, reablement;
- Data collection can support small area analysis – data could be collected at an individual level as local authorities generally have postcode information. Pre-care postcodes for clients in residential care are available for most clients with some time/effort;
- Reflect data limitations – whilst their databases may contain a broad array of data, local authorities have much more confidence in the data which is used by them regularly. Some of the data which may be included in the survey for the review of the RNF (e.g. socio-economic and socio-demographic indicators) is likely to be data which is not regularly reviewed. Therefore, local data should be supplemented by national

data sources such as Census and survey data to validate / supplement anything which is collected from local authorities;

- Use of agreed and standard definitions for all data fields – data collection will be simplified if the requested data fields are familiar to the local authorities who are participating in the research, particularly if they are consistent with data already supplied at a local authority level for national returns e.g. RAP and PSSEX1. Annex 2 Section 51 contains the template used for the data collection for the feasibility study and this should be considered a starting point for future reviews;

- Choice of sample week/month – there are peaks and troughs in service provision throughout the year which may affect the data provided if a sample week or month was chosen for the full survey. Therefore, two sample months may be the most appropriate e.g. June and September. Individual level data collected from Local Authorities should be validated against national data sources;

- Recognition that current data systems are not necessarily fully integrated – as the survey results have shown, many authorities do not have integrated financial and client systems. Therefore, providing data for a review of the RNF may require mapping to be undertaken manually. This is time consuming and also more likely to require additional validation to address any errors and/or missing data. However, local authorities responding to the survey have reported improvements in the interface between client and finance data and this may be less of an issue than for the previous review;

- Many stakeholders suggested that data should be obtained from existing data returns where possible. The current returns managed by the NHS IC are generally not available at small area level (see earlier sections) and so this may not be currently possible – however, this preference for use of data already supplied should be noted. Furthermore, national level data from the NHS IC will be useful in validating local authority data collection and ensuring financial data in particular is as robust as possible; and

- There is a much greater awareness at the local authority level of the importance of reconciling data for purposes such as the RNF, and all local authority contacts responded with enthusiasm even though resource and time constraints prevented them from issuing a snapshot data download.

36.2. Guidance to local authorities, as part of the review of the RNF and in general terms about improving access to data, should focus on areas where the data was shown to have the greatest limitations e.g. availability of pre-care addresses, integration of financial and client-based data systems, availability of demographic data at client level and collecting information relating to day care provision.

Self-Funders

A key part of the feasibility study has been to generate a better understanding of the issues relating to self-funders in relation to the future formulation of the relative needs formula and data collection to support this process. A literature review, stakeholder interviews and the local authority survey programme have been used to provide information about this issue.

37. Key issues

37.1. The Commission on the Funding of Care and Support is currently considering how care and support should be funded in future, including issues relating to those people whose social care is not currently supported by local authorities. The Commission is due to report in Summer 2011. If the Commission recommends an increase in state responsibility, there will be a requirement to incorporate information on these self-funders in order to produce adult social care funding formulae.

37.2. In reviewing the availability of information on self-funders, a number of key issues were identified and highlighted below.

37.3. There is a significant impact of self-funders on the work undertaken by local authorities, particularly in relation to assessments. However, there is also considerable variation between local authorities in relation to the support provided to self-funders. This is important in fully understanding the costs associated with adult social care.

37.4. Local authorities do not necessarily have a common understanding or definition of self-funders, particularly in relation to the different types of self-funders and those who are funding part of their care. This is significant, both in terms of collecting data from local authorities and in interpreting data provided by local authorities.

37.5. The availability of data relating to the numbers of self-funders in an authority is variable. Some authorities were able to provide detailed estimates of the number of self-funders within their authority, although this was not necessarily related to the entire population of self-funders. This is significant in terms of the representativeness of any future survey data.

37.6. The availability of detailed information about health and care needs of self-funders is variable. Some local authorities collect detailed information through their assessment process and continue to collect information post-assessment even where residents are funding their own care e.g. if they are using local authority brokerage services. Other authorities do not have a standardised process for collecting any information about residents who fund their own care directly. This is significant in terms of the completeness and usefulness of any future survey data.

37.7. There is a variety of information available about self-funders at a national and local level from data collected by private providers of care which could complement the data routinely collected by some local authorities or collected by specific surveys to support the RNF. This could be significant in complementing any future survey data to create a more representative sample.

38. Defining the self-funders market

38.1. The CSCI report on self-funded social care for older people (Forder, 2007) identified three main groups of self-funder, paying the full costs of care from their own pockets (with or without drawing on any disability-related benefits). For the purposes of this report, these three categories of residents will be defined as self-funders:

- People who choose not to approach public authorities;
- People who have assessed needs below the need-eligibility threshold; and
- People who choose to approach and are needs-eligible, but have savings above the relevant upper assets threshold.

38.2. There are also a proportion of those who are eligible for local authority support that pay something towards their care whilst being classified as "local authority supported". These will be designated as partial-funders:

- People needing residential care (unless their income is below the personal allowance, which should not happen if Pension Credit is claimed);
- People with sufficiently high income to face a charge for non-residential care in areas where councils make a charge;
- People who are eligible for council supported care but feel that the assessed care package is insufficient requiring them to top-up with privately purchased care.

38.3. There is generally more information about self-funders in residential care than accessing domiciliary services and a number of national estimates are available about the number of self-funders currently accessing services. From the three data sources, for example, approximately 40% of clients requiring care (residential and domiciliary) are self-funders:

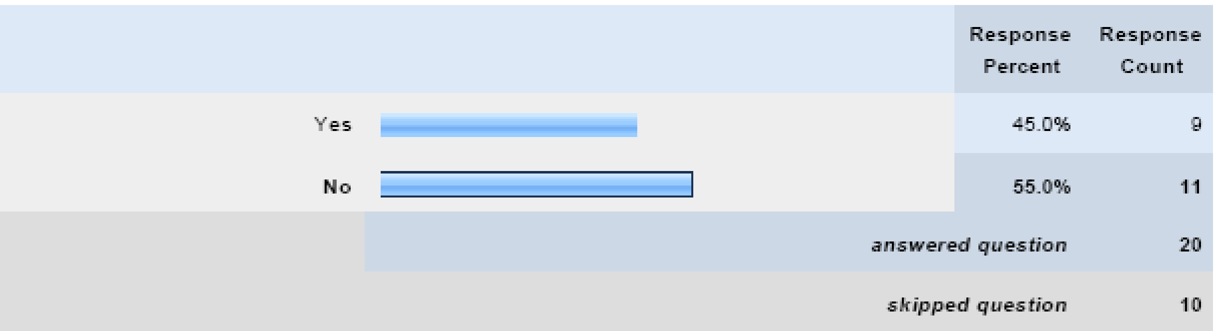
- According to the Laing and Buisson Annual Survey of the care home market for 2009, people funding their own care accounted for 41% of the market in 2009, up from 39% in 2008 and 31% in 2002, while councils' share fell to 52% in 2009 from 55% last year. Laing and Buisson said it expected self-funders' market share to keep on rising as the rate of home owner occupation among older people at risk of entering care homes continued to grow.
- A National Care Forum survey in January 2010 found that more than 40% of care home residents are self-funders, a rise of a third since 2002.

- The insurance and long-term care provider Partnership identified that there are 140 self-funders entering residential care each day and there are 130,000 people entering residential care homes in England each year, of which 41% or 53,000 people are wholly self funding.

39. Availability of data from local authorities

39.1. The research project has identified that there is considerable variation in the availability of information about self-funders and partial funders from local authorities. When asked whether they could provide the number of self-funders in their authority for example, more than half of all respondents were unable to provide any estimate at all:

Table 16: Is your Authority able to collect and report information regarding self-funders?



	Response Percent	Response Count
Yes	45.0%	9
No	55.0%	11
answered question		20
skipped question		10

39.2. Of those who could provide an estimate:

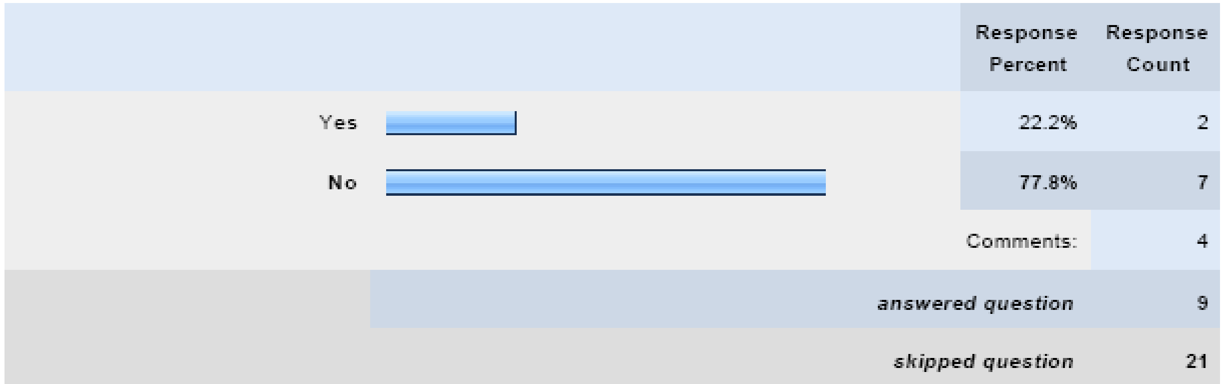
- Authorities were able to use their in-house information systems to identify the number of self-funders with whom they have had contact;
- Estimates were based on survey data of care home populations, for example, rather than actual data;
- Information is limited only to those self-funders who receive services directly provided by the local authority and are subsequently recharged for their services;
- The estimates provided for self-funders are actually for partial-funders only i.e. those residents who receive some funding from the local authority and self-fund elements of their care; and
- The data generally relates only to residential care and there is very little information about those who are self-funders for domiciliary services.

39.3. In relation to identifying postcode information for those authorities who record information about self-funders, 7 out of 10 respondents suggested that this information was available within their systems.

39.4. Furthermore, a similar level of response was received when asked for more detailed information about self-funders and most of the authorities who responded to the survey would have difficulties in providing information relating to fees being paid by self-funders, length of stay in residential care and detailed location information:

- Only 3 of the local authorities who responded to the survey were able to identify the average fee for self-funded residential care and the average length of stay;
- Postcode and fee information is limited to self-funders whose care is commissioned by the local authority and not available for all self-funders. Further, data is not routinely interrogated so there are concerns about the reliability of the data;
- Data about fees is only available for clients in residential care in local authority block contracted beds; and
- There was also a variable response in relation to the availability of data on residents who transition from self-funded and local authority funded care.

Table 17: Do you identify the number of self-funders needing local authority funding after transition?



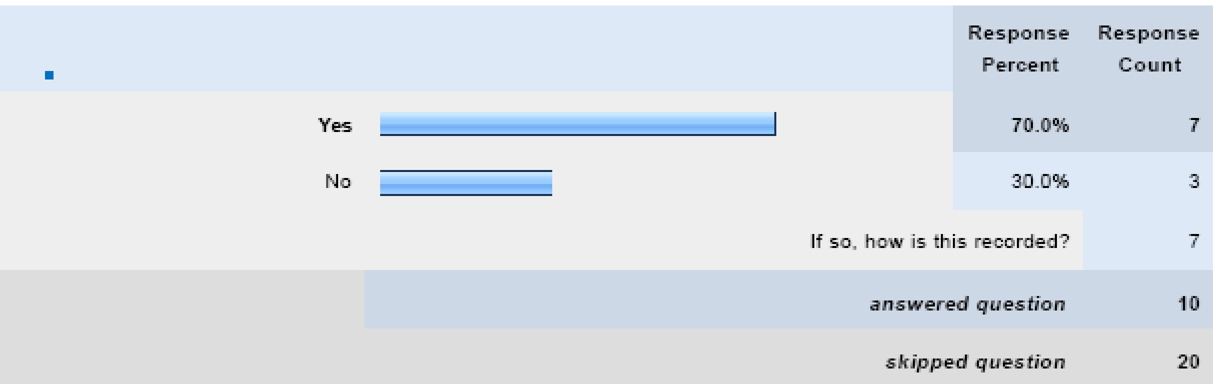
	Response Percent	Response Count
Yes	22.2%	2
No	77.8%	7
	Comments:	4
	answered question	9
	skipped question	21

- One authority reported that information about residents who transition from self-funded to local authority funded care is not routinely / specifically identified yet this may be possible by analysing service and financial history, but it would take a significant amount of work and may not be entirely reliable;
- Another, however, was able to specify that the total annual cost of these individuals is in excess of £1m per annum, with approximately 15% of self funded individuals becoming the Councils responsibility as their assets are reduced;
- Residents who transition are "the high risk group" for the local authority – they can consume high levels of resources, particularly if they have been living in residential care which is much more expensive than local authorities' maximum fee rates. The authority doesn't have a mechanism for collecting how much funding is allocated to self-funders who transition to local authority funded care but undertook an audit recently and found funding allocated for one year for transitioning residents was £3m.

39.5. The assessment process, however, does provide more detailed information about self-funders in a number of local authorities included in the survey.

- Assessments, in one authority interviewed, record the same details for self-funders and local authority funded clients – the process does not differentiate between clients until the final outcome data which identifies whether there is a need for care and whether the client is eligible for funding (or partial funding). The client data recorded within the assessment programme includes personal details and also a data field for primary client type (e.g. dementia, substance misuse, specific sensory impairments, physical disabilities).

Table 18: Do you identify the number of self-funders needing local authority funding after transition?



	Response Percent	Response Count
Yes	70.0%	7
No	30.0%	3
If so, how is this recorded?		7
answered question		10
skipped question		20

40. Services provided to self-funders

40.1. There is also significant variation in the services provided to self-funders and how this information is recorded, if at all. The local authority survey highlighted the following services:

- Telephone advice lines;
- Independent financial advice;
- Leaflets and internet-based information which act as signposting services to providers;
- Local authority run brokerage services which can be used to commission care by self-funders;
- Referrals to other commissioning agencies e.g. Age Concern;
- Referrals to service providers e.g. for domiciliary care;
- Provision of equipment and home adaptations; and
- Full assessments for new clients and reviews for self-funders who have previously been assessed.

41. Stakeholder views

41.1. In relation to self-funders, engagement with stakeholders also identified the following issues:

- There is very limited information on the top-up fees being paid by clients who are part funding their own care, either at home or in residential care, either in terms of the fees being paid and the services for which additional fees are being paid. Variations between authorities could reflect different policies by local authorities in terms of what is funded;
- Not all self-funders in residential care settings in an authority are residents of that authority – some authorities attract self-funders into an authority due to choice/ location/quality issues e.g. Kent's seaside settings draw residents from London; and
- The LGA has suggested that local authorities want the formula funding to include an accurate assessment of issues relating to self-funders, including the number of self-funders and self-funder assessments undertaken by local authorities. This should also include a much more detailed assessment of the cost implications of residents who transition from self-funder to local authority funded. Further, data from private providers could be used to supplement the data collection provided that it is comprehensive (i.e. relates to the range of services delivered to self-funders) and representative (i.e. the private providers who provide data are representative of the range of different types of providers across all local authorities).

42. Feasibility of gathering data

42.1. As the above information suggests, there are limitations to the data which is available from local authorities on self-funders. In particular:

- There is not necessarily a consistent understanding of who should be classified as self-funders;
- Where data is available, it is restricted to self-funders who have come through the local authority assessment process and/or have their self-funded services commissioned through brokerage services or provided by the local authority directly (for which they are charged);
- There is generally more information available about self-funders in residential care than self-funders accessing domiciliary services; and
- There is limited data available on the address details for self-funders.

42.2. A range of data sources relating to self-funders suggest that the proportion of self-funders within residential and home care is approximately 40%. However, there is limited information to link this data to the types of socio-economic and socio-demographic indicators on which the current RNF are predicated. The only national data collections relating to self-funders are undertaken in relation to private providers of care e.g. the Bupa Survey and the Laing & Buisson market analysis.

42.3. Therefore, if self-funders are to be included within the review of RNF, the information collected through this research project suggests that there would need to be a detailed data collection at local authority level, assuming issues relating to coverage, definitions and the availability of information can be addressed. Alternatively, data collected and analysed by the private sector providers of residential and home care could be utilised.

42.4. The data issues in defining self-funders are summarised in the diagram below, with the top row summarising the clients who are in need of care and the remaining three rows illustrating what is known about these four categories of clients. The particular difficulty in relation to self-funders that it illustrates is that there are variations between local authorities on the definitions for self-funders and part-funders, and what proportion of self-funders are actually known to local authorities and included in their data collection.

Figure 1: Defining Self-funders

<table>
<tr><th>Clients who are not accessing care services but who have need of care</th><th>Clients who fund all aspects of own care (estimated at 40% of total care population)</th><th>Clients who are part funded by the local authority but who make some contribution to their care costs (top-ups)</th><th>Local authority funded clients</th></tr>
<tr><td colspan="2">Unknown to local authorities</td><td colspan="2">Known to local authorities through assessment processes or brokerage services</td></tr>
<tr><td>Not counted</td><td>Designated as self-funders by some authorities</td><td colspan="2">Designated as local authority funded by some authorities</td></tr>
<tr><td>Not counted</td><td colspan="2">Designated as self-funders by some authorities</td><td>Designated as local authority funded by some authorities</td></tr>
</table>

43. Conclusions and implications for future reviews of the adult social care RNF

43.1. The review of data relating to self-funders has shown that there are major limitations to the data which is currently available on self-funders from local authorities and from national surveys. If DH want to include self-funders within future reviews of the RNF, therefore, it is likely that some additional and very specific data collection is required. The Department of Health could therefore consider data collection via local authorities, working with private providers to access existing data or working with private providers to collect new data. Due to time-constraints, and the lack of a clear definition for self-funders, we have been unable to obtain an indicative cost for data collection via private providers.

Recommendations for Future Data Collection

The feasibility study has identified a number of priorities for reviewing the RNF for younger adults and older people.

44. Adequate and representative sample size

44.1. The development of the current adult social care RNF was based on a comprehensive sampling strategy which focused on the achievement of a representative sample, establishing that an achieved sample size of 30 local authorities would be the basis for a representative sample for the area-based analysis. Criteria for determining representativeness included socio-economic and socio-demographic data. Strata for different types of authority were also included in the sampling strategy. As set out in Car-Hill et al (2007) for example, the final authorities included in the analysis for younger adults were intended to be nationally representative in the core characteristics of educational attainment, ill-health indices, deprivation indices and ethnicity.

44.2. Based on the analysis of current and future data sources, it is unlikely that national data sources will provide detailed data which can be used to undertake small area analysis for the next review of the RNF. It is likely that data will be needed from local authorities to support the analysis and, therefore, a data collection exercise involving local authorities will still be required. It is recommended that a similar sampling strategy to the previous research should be utilised, such that the authorities included in the data collection will provide a nationally representative sample based on the relevant socio-demographic and economic indicators (see paragraph above), as well as representing the different types of local authorities. It may also be useful to seek to obtain views from social care users during any future research.

44.3. Therefore in order to maximise response rates and ensure that a workable and representative sample size is achieved, the following sampling framework may be appropriate:

- Initial sampling and engagement work should identify 60-75 authorities who could be included to produce a representative sample (representing roughly half of all local authorities with adult social care responsibilities). This larger sample should also be identified to sufficient representatives from the different types of authorities e.g. shire, unitary, London boroughs;
- From this initial sample, agreement should be reached with 45-50 local authorities who are willing to work towards providing the required data with extensive support from the research team. These authorities will be selected through a stratified sampling approach such that there would be up to 10 authorities from each of the main 5 types (shire county, metropolitan, unitary, inner London, outer London) although there could be slightly fewer Inner London boroughs given the overall

number of these and their relative populations. The authorities within each strata would be selected to ensure the sample continues to be nationally representative;

- From this working sample, it should be the intention of the study to collect data from as many of the participating local authorities as possible. However, there would be some scope for non-participation or to reflect data quality issues, as a minimum sample of 30 authorities would still provide a representative sample (based on the findings of the previous research in 2004 and assuming coverage across the strata could be achieved); and
- The exact number of authorities which will be required should be determined at the time of the research and reflect the most up-to-date information possible on population and the key drivers of care needs e.g. demographic, economic and health indicators. However, the population from approximately 30 authorities included in the previous research and identified as the minimum requirement for future reviews is expected to be sufficient to give a representative sample once measures have been identified to test representativeness.

44.4. As stated, representativeness should again involve analysis of key demographic and socio-economic indicators as well as a stratified element to include the various types of local authority. The sampling, however, may also want to take into account the use of local authority families e.g. ONS area classification which gives clusters of local authorities (see http://www.statistics.gov.uk/about/methodology_by_theme/area_classification/la/cluster_summaries.asp for more information). The ONS methodology groups together geographic areas according to key characteristics common to the population in that grouping. These groupings are called clusters, and are derived using Census data. The clusters are used by government departments and for academic research. Using clusters could provide an alternative mechanism for developing a stratified sample.

44.5. In terms of criteria for assessing representativeness, those used previously continue to be relevant in terms of assessing relative need for care services. The data should be available from the Census and other surveys, assuming timing issues are addressed, and it is expected that these national data sources will be used to ensure the sample of local authorities is nationally representative against the key measures.

44.6. Based on the responses to the survey, local authorities are likely to require support to combine client-level and financial data systems; ensure the data they provide matches the definitions set out in any data specification; and address any issues related to missing data or data not collected by certain authorities. This will require specialist support from the research team, who will need to have knowledge of the information systems being used by LAs, in addition to an understanding of the data specification and how the data will be used in the research.

44.7. The strategy for any future data collection to review the adult social care RNF should instead focus on intensive engagement with local authorities to maximise the response rates for the data collection i.e. how to achieve a workable sample. To this end, it is recommended that:

- All authorities are notified of the RNF review up to 12 months before the planned period for data analysis and any authorities who wish to be considered for inclusion in the data collection could come forward at this stage. Communication relating to the review should be at several levels including representative bodies such as ADASS and CIPFA. Authorities should be made aware at this stage of the commitment that will be required from them (e.g. an estimate of days based on the findings of the feasibility study), the support that will be provided to them if they participate in the study, as well as the lessons learned from previous research including this feasibility study. Regional workshops and focus groups could be utilised to raise awareness and encourage participation.
- During the next 3 months, the agreed sample of authorities will be identified as “targets” for inclusion in the data collection (as per the sampling strategy) and an agreement reached with the target of 45 authorities. During the same period, the specifics of the data collection should be established, working in partnership with local authorities and national bodies such as the NHS IC, to create a workable data specification based on agreed data definitions (the suggested initial template for data collection as used for this feasibility study is included in Annex 2); and
- Over the next 6 months, detailed work will be undertaken at regional and local authority level to work with the agreed 45 authorities to obtain data from at least 30 authorities. The detailed work will include on-site support to local authorities and should help authorities realise many of the benefits involved in participation. Authorities could also submit a data snapshot, which could be reviewed and feedback provided on any identified data quality issues to be addressed before the full survey data is collected.

44.8. Specifically addressing the issue of local authority participation, it is recommended that many of the suggestions from the local authorities / stakeholders submitted in the feasibility study are adopted:

- All participating local authorities should have a key contact for the data collection who can respond directly and quickly to any data concerns and problems impacting on data collection. This could be organised on a regional basis; and
- Authorities are provided with clear templates showing the format of data required and explicit definitions for all data fields which are as consistent with other data sets and/or statutory returns as possible.

44.9. At the preliminary phase of the review of the adult social care RNF, time should be allowed to agree a comprehensive data confidentiality protocol with local authorities agreeing to take part in the work. Several stakeholders have raised this as a fundamental issue, in particular with reference to capturing data at an individual level. As well as anonymity, it is important to agree early on the method of data storage and retrieval, plus the parameters around data safety and security. It may be necessary to agree encryption rules and this will take time to develop.

44.10. Following all these recommendations would have the following implications for the commissioning of data collection and analysis:

- There would need to be a comprehensive communications strategy in place well in advance of the data collection phase, raising the profile of the review and encouraging local authorities to participate. This should be maintained throughout the course of the research. Participating authorities for this research have identified that ADASS could be the centre point of the communications strategy;
- The lead time for the project from start date to data collection should be up to one year – this would allow time for comprehensive engagement with local authorities to improve the response rate and ensure a representative sample is achieved. The start of the project should also be timed to ensure that the main period of data collection does not overlap with the existing pressure period for provision of social care information for statutory returns (generally April - June);
- Extensive resources will be required to support local authorities in the period prior to the submission of data and to review data snapshots to identify any significant data quality issues; and
- Organisations such as the NHS IC should be involved to support the data collection process, ensuring that any developments in social care data specification (e.g. application of the minimum data set) are taken into account.

44.11. The approach set out above, therefore, should address the major deficiencies of the previous review:

- It will increase awareness of the review from the earliest point and encourage participation by local authorities by offering them comprehensive and ongoing support to provide the required data;
- It extends the time allocated for data collection, allowing researchers to work with local authorities and help them provide the most difficult-to-access data, particularly pre-care addresses and individual financial data;
- It provides a clear framework for the data to be collected and ensures data requests are consistent with national data definitions and practice, allowing local data to be supplemented by national data; and

- It should enable researchers to work with a more representative sample of individual data.

45. Extending data collection to capture self-funders

45.1. In relation to self-funders, the feasibility study has identified that there are limitations to the data that is currently captured by local authorities for those local authority residents who fund their own care. There may be improvements in the medium term, particularly as the NHS IC continues to look at data collection issues in relation to self-funders. The outcome of the zero-based review will therefore also be important in relation to self-funders. However, there are three main options for the next review of the RNF if DH want to include data relating to self-funders, and there will be relative costs associated with undertaking this work depending on which option is taken forward;

- A specific survey could be conducted in the participating local authorities to collect data from self-funders directly (or from organisations who provide care to self-funders). Depending on the breadth of data required, this data collection could be collected from a sub-set of the participating authorities;

- The research team could draw on existing surveys being conducted on self-funders e.g. working in partnership with private providers and agencies; and

- A specially commissioned survey could be undertaken with care home providers as part of the RNF review or wider data collection strategy i.e. a sampling strategy would be required to identify a sample of care homes and a mechanism for accessing data from the care homes. For example, DH could draw on the Annual Census of Care Homes in Scotland, which enables the Scottish Office to collect information about the care home population, including the number of self-funders in each care home (details in Annex 4).

46. Resource requirements for future reviews of adult social care RNF

46.1. Further discussion would need to take place with DH for the gathering of data on self-funders, as referred to in earlier sections. For the work in capturing small area level data from local authorities, it is important to identify key milestone dates if any such review is to influence the RNF for the 2015/16 financial year.

46.2. Assumptions around resource requirements for this work assume that any final settlement needs to be laid in Parliament by early 2015 (probably January if the formulae are to be applied in April 2015). Working to this date, the Settlement Working Group (SWG) will probably need to have agreed and signed off any change proposals by early summer 2014 (possibly as early as May 2014). In order to feed reports and proposals into the SWG, the research team commissioned to undertake this work will need to have finished all fieldwork and data analysis by autumn 2013 at the very latest.

46.3. The timescales for the next review would also need to take account of the availability of key data sources, particularly from the next Census, which are likely to be part of the independent variables for any modelling. As discussed in section 23, the data from Census 2011 will not be released at small area level until 2013/14.

46.4. Therefore, we assess that the time needed to undertake this work with full and proper allowances for local authority engagement and support, anticipating some degree of delay due to data cleansing and matching issues, amounts to approximately 20 months from project commencement. Allowing for a reasonable period of time for communicating the work and to engage with all relevant stakeholders prior to starting the data capture would bring the total amount of time needed to approximately 23 months. Taking this into account, this would mean that the ideal start date for the work would be April 2012, allowing the project some element of flexibility while providing a robust timescale for completion. Clearly, the start date will depend on the procurement timescales, but the research evidence gathered in this feasibility project suggests that sufficient time is needed in key areas in order to achieve the outcomes required to influence a review of the RNF. The following table summarises the likely timeline:

Table 19: Indicative Timeline for Review of Adult Social Care RNF

Communication Strategy	3 months
Project Commencement to Data Capture	Minimum 14 months
Data Analysis	Minimum 3 months
Reporting of Findings and Amendments	3 months

46.5. The following table gives an indicative breakdown of resource days broken down by suggested work activities or themes, both for the fieldwork research element and the data analysis aspects:

Table 20: Suggested Resource Plan

Activity/Phase of Project	Field Research Team (Days)	Data Analysis Team (Days)
1. Project planning & initiation work	10	5
Data specifications, research design, sampling	10	10
Communication strategy, Stakeholder engagement	5	5
Events, Workshops, Focus Groups	20	10
Architecture including templates, systems	10	10
Pilot Work (5 local authorities)	15	5
2. Finalise Architecture	5	5

Finalise Sample Group including follow ups	25	10
3. Local authority on-site support:		
Assumes 5 days per local authority (45 estimated)	225	
Activity/Phase of Project	**Field Research Team (Days)**	**Data Analysis Team (Days)**
4. Data cleansing, validation, refining and input to templates	40	10
5. Data analysis - raw data to small area		30
Small Area Analysis		30
6. Reporting and stakeholder discussion	15	10
7. Project management	40	20
Total Resource Requirement	**420**	**160**

46.6. In proposing the number of resource days required for the full review, we have applied a 15% margin of error to the totals within the table. Taking 580 as the indicative number of days based on the activities highlighted in the table, the range will therefore be 493 to 667 and it is suggested that any future proposal to undertake a full review of the RNF takes this into account.

46.7. Taking a blended average daily rate of £760 inclusive of all costs, assuming a mix of direct resource from Director or Professor to senior Researcher or Consultant, the indicative cost would be between £374,680 and £506,920 using the range of days identified above. The research team consider this to be a reasonable indicative assessment of the likely cost for a wider piece of work to review the RNF. However, obviously, this estimate is entirely dependent, and subject to revision, on the Department of Health's actual requirements and resource constraints.

LG Futures
November 2010

Annex 1: Data Sources for Current Allocation Formula

The current data sources being used to distribute adult social care funding are detailed in the following two sections.

47. Younger Adults' RNF

Social Services for Younger Adults	Department	Source	Timeframe	Detail
Projected population aged 18-64	ONS	2004 (Revised) Sub-national Population Projection (2004R SNPP)	2004 Based Trend Data	
= Households with no family	ONS	Labour Force Survey; 2001 Census Univariate table 68	Average data - (Sept/Nov.) 2004 to (April/June) 2007	Survey of 60,000 Private Households in UK
= People aged 18-64 receiving Disability Living Allowance	DWP	Quarterly 100% Scans	Average -May 2004 to Feb 2007	The average number of persons, aged 18 to 64, in receipt of lower, middle or higher rates of disability living allowance
= People aged 18 to 64 who are long- term unemployed or never worked	ONS	2001 Census Theme Table 07	2001	
= People aged 18 to 64 who work in routine or semi routine occupations	ONS	2001 Census Theme Table 07	2001	

Social Services for Younger Adults	Department	Source	Timeframe	Detail
ACA for Children and Younger Adults PSS	DCLG	2004, 2005,2006 Annual Survey of Hours and Earnings; Resident Population 2006; 2005/06 Subjective Analysis Return; 2005/06 Trading Services Revenue Account; 1992-1993 Base Estimate Returns; HMRC Rateable values and hereditaments at 1 July 2007; DCLG Commercial and Industrial Floorspace Statistics 2006; gross NNDR rates and increases and reductions in rate yields from the NNDR Provisional Contributions Return 2007/08	Various	

48. Older People's RNF

Social Services for Older People	Department	Source	Timeframe	Detail	Comment
Household and Supported Residents aged 65 years and over	NHSIC and ONS	2001 Census Standard Table 1; Local Authority Form SR1	2001; 2006		Supported Residents Numbers derived from local authority returns
Older People PSS Age Top-Up					
= Household and Supported Residents aged 65 and over	NHSIC and ONS	2001 Census Standard Table 1; Local Authority Form SR1	2001; 2006		Supported Residents Numbers derived from local authority returns
= Household and Supported Residents aged 90 years and over	NHSIC and ONS	2001 Census Standard Table 1; Local Authority Form SR1	2001; 2006		Supported Residents Numbers derived from local authority returns
Older People PSS Deprivation Top-Up					
= Older People Receiving Attendance Allowance	DWP	100% Annual Scans	May 2004 and Feb 2007	The average number of persons, aged 65 and over, in receipt of attendance allowance	
= Older People in Rented Accommodation	ONS	Labour Force Survey; 2001 Census Theme Table 05		60,000 Private Households in UK	
= Older People Living in One Person Households	ONS	2001 Census Theme Table 05			
= Older People Receiving Pension Credit Guarantee/Income Based JSA	DWP	DWP quarterly scans between May 2004 and Feb 2007 (IS and GEPC); DWP Annual (August) Scans between 2004 and 2006 for IBJSA	2004-2007; 2004-2006		
Low Income Adjustment					
=Older People in Rented Accommodation	ONS	Labour Force Survey	Average 2004-2006	60,000 UK Private Households	
=ACA for Older People's PSS	DCLG	2004, 2005,2006 Annual Survey of Hours and Earnings; Resident Population 2006; 2005/06 Subjective Analysis Return; 2005/06 Trading Services Revenue Account; 1992-1993 Base Estimate Returns; HMRC Rateable values and hereditaments at 1 July 2007; DCLG Commercial and Industrial Floorspace Statistics 2006; gross NNDR rates and increases and reductions in rate yields from the NNDR Provisional Contributions Return 2007/08	Various		
Sparsity Adjustment for People Aged 65 and over	ONS	2001 Census Univariate Table 02 and 04	2001		
ACA for Older People's PSS	DCLG	2004, 2005,2006 Annual Survey of Hours and Earnings; Resident Population 2006; 2005/06 Subjective Analysis Return; 2005/06 Trading Services Revenue Account; 1992-1993 Base Estimate Returns; HMRC Rateable values and hereditaments at 1 July 2007; DCLG Commercial and Industrial Floorspace Statistics 2006; gross NNDR rates and increases and reductions in rate yields from the NNDR Provisional Contributions Return 2007/08	Various		

Annex 2: Survey Tools and Questions

This Annex contains details of all the survey tools used as part of the research.

49. Survey questions

49.1. The following is a copy of the survey used to gather information from 21 local authorities as part of the core research:

Department of Health RNF - Feasibility Study

1. Introduction

You have very kindly agreed to take part in this online survey. The Department of Health is considering reviewing the social care relative needs formulae (RNF), which are used to allocate part of each individual local authority's formula grant allocations. We are looking at the feasibility of collecting data on clients, their care packages and the cost of those care packages to inform a possible review of the RNF formulae. The survey results will be used by the Department to work out how best to collect data from councils.

The survey you are about to complete will form part of the core research for this work. The LG Futures research team would also like to interview, either by telephone or in person, a number of respondents to discuss in more detail some of the issues featured in the questionnaire. If you are amenable to being contacted in future, please can you indicate this on the next page.

This online survey should take no more than 30 minutes to complete, however if you feel you would like to expand on any of the issues raised please write in the free text areas at the end of each section. The deadline for all returns is 13th August 2010.

You may exit this survey and re-enter it before submitting and your previous data will be saved. Once submitted, the data cannot be changed.

The Department of Health and LG Futures are very grateful for your participation in this important research.

2. Personal Details

1. Please complete the following:

Name:

Company:

Address 1:

Address 2:

City/Town:

ZIP/Postal Code:

Email Address:

Phone Number:

2. Job Title:

3. I would be willing to be contacted by LG Futures:

Yes

No

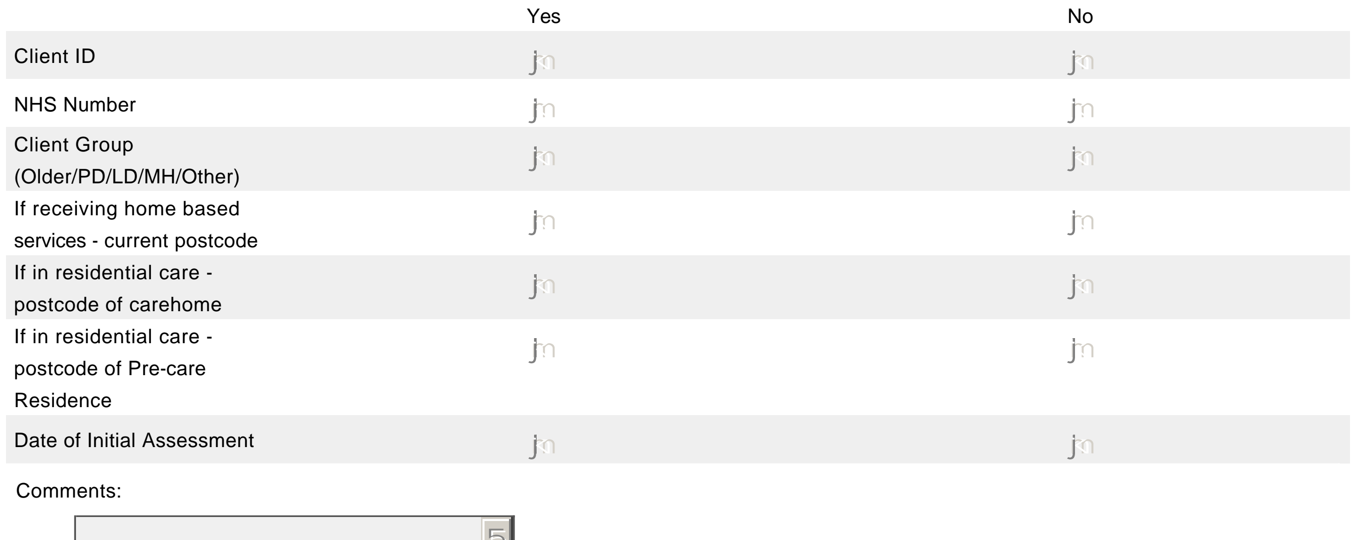
3. Introductory Questions

1. Please confirm the Client Information Systems you currently use:

2. If known, please confirm the current version used:

4. Information from Client Systems

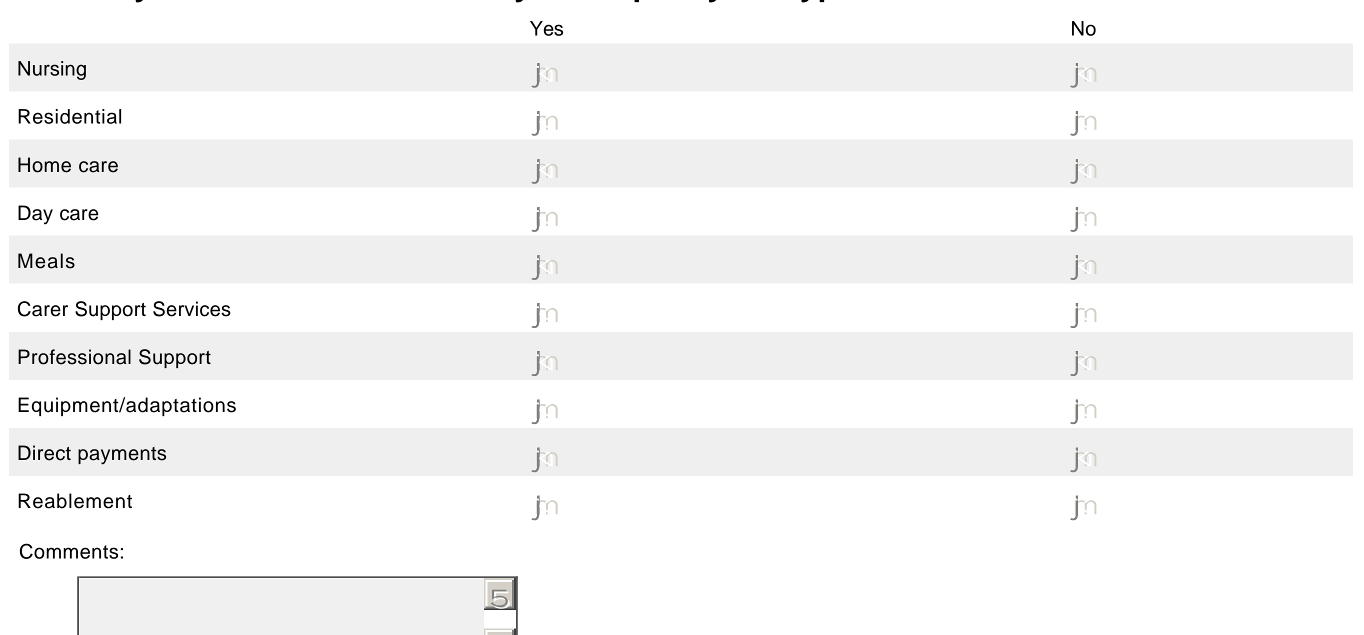
1. Does your Client Information System use the following fields as core service user data?



	Yes	No
Client ID		
NHS Number		
Client Group (Older/PD/LD/MH/Other)		
If receiving home based services - current postcode		
If in residential care - postcode of carehome		
If in residential care - postcode of Pre-care Residence		
Date of Initial Assessment		

Comments:

2. Does your Client Information System specify the type of care received as follows?



	Yes	No
Nursing		
Residential		
Home care		
Day care		
Meals		
Carer Support Services		
Professional Support		
Equipment/adaptations		
Direct payments		
Reablement		

Comments:

3. For Home Care Services, do you identify the following within your Client Information System?

	Yes	No
Number of hours per week		
Whether services are provided by the local authority		
Whether services are provided by the independent sector		
Whether this is intensive home care or regular home care		
Personal Care (e.g. help with washing, dressing)		
Home Services (e.g. shopping, gardening)		
Any other services (please specify below)		

Comments:

4. For Day Care Services, do you identify the following within your Client Information System?

	Yes	No
Number of sessions		
Whether services are provided by the local authority		
Whether services are provided by the independent sector		
Transportation		
Any other services (please specify below)		

Comments

5. For Reablement Services, do you identify the following within your Client Information System?

	Yes	No
Record of reablement assessment/care package		
Social worker details (if different from care manager)		
Occupational therapy		
Physiotherapy		
Any other services (please specify below)		

Comments:

5. Financial Systems Data

1. Can you please confirm what Financial System you currently use e.g. SAP, Agresso, IBM, Oracle?

2. Does your Financial System currently record the following service user information?

	Yes	No
Client ID reference or NHS number		
System interface reference		

Comments:

3. For Residential and Nursing packages, does your Financial System record the following?

	Yes	No
Gross Cost of Package		
Client Contribution		
Other Contributions		
Net Cost of Package to Local Authority		
Nursing cost component (for nursing homes)		

Comments:

4. For Domiciliary Care packages, does your Financial System record the following?

	Yes	No
Gross Cost of Package		
Client Contribution		
Other Contributions		
Net Cost of Package to Local Authority		
Current costs (in weekly amounts)		

Comments:

5. For Day Care packages, does your Financial System record the following?

	Yes	No
Number of Day Care Sessions		
Transportation		
Gross Costs of Day Care		
Client Contribution		
Other Contributions		
Net Cost of Package to Local Authority		

Comments:

6. For other Local Authority Services, does your Financial System record the following?

	Yes	No
Equipment/adaptations		
Direct Payments - amount		
Reablement - amount		

Comments:

6. Self-Funder Information

1. Is your Authority able to collect and report information regarding self-funders?

Yes

No

If yes, please complete the additional questions below as far as you are able to. If no, please move to the next page.

2. Can you please provide us with the number of self-funders in your Authority?

3. What is the source of your answer to Question 1 (e.g. IT system, care home sector)?

4. Please explain how self-funders are recorded in your Client Information System:

5. Please describe how you identify clients receiving self-funded care in Residential settings:

6. Please describe how you identify clients receiving non-residential self-funded services:

7. Are you able to identify the postcodes of self-funders?

- Yes
- No

If so, where is this recorded?

8. Do you identify the number of self-funders needing Local Authority funding after transition (e.g. level of capital falls below threshold)?

- Yes
- No

Comments:

9. Do you identify the average fee for self-funded residential care (per week)?

- Yes
- No

Comments:

10. Do you identify the average period of self-funded residential care?

- Yes
- No

Comments:

11. Do your systems allow you to identify how many self-funders have requested an assessment?

- Yes
- No

If so, how is this recorded?

12. What services and support have (assessed) self-funders received from the council (e.g. advice, other)?

7. Client Need Analysis

1. Do you identify clients based on the following?

	Yes	No
Free Access to Care (FAC) band		
Informal care from person living in the service user's home		
Informal care from a carer living elsewhere		
Date of admission into care home		

Comments:

2. Does your Client Information System record the following for service users?

	Yes	No
Sex		
Age		
Ethnicity		
First language		

Comments:

3. Does your Client Information System hold information on the characteristics of your social care clients e.g. on the state benefits they receive?

Yes No

If yes, please fill in the details below. If no, please move to Question 6 on this page.

4. Does your Client Information System record the following benefits received for service users?

	Yes	No
Attendance Allowance		
Pension Credit		
Job-seekers Allowance		
Income Support		
Disability Living Allowance		

Comments:

5. Does your Client Information System distinguish mobility and care components for Disability Living Allowance (DLA)?

Yes

No

Comments:

6. Does your Client Information System record the following information regarding household data for service users?

	Yes	No
Living alone		
Tenure		
Household size		
Relationship of client to head of household		

Comments:

7. Does your Client Information System record:

	Yes	No
Limiting long term illness		
Educational attainment		

Comments:

8. Is the service user information grouped geographically e.g. by area, patch, ward?

8. General Questions

1. For all data held in your Client Information System, how difficult do you think this would be to collect for DH research purposes?

Very easy · Easy · Neither easy nor difficult · Difficult · Very difficult

Please explain:

2. What data quality issues do you have when reporting information on service users from your Client Information System?

3. Are you able to download information from your Client Information System into a standard format e.g. Excel spreadsheet?

4. If the Department of Health were to request a sample of all your social care client data covering one week of a particular year, what problems or issues would you have in presenting this data effectively?

5. Can you confirm whether your organisation has a Resource Allocation System (RAS) in place (for personal budgets)?

- Yes
- No

Comments:

6. Do you currently link or interface your data with local Health Systems?

- Yes
- No

If yes, please identify the type of data linked or interfaced:

7. What progress has your Authority made on preparing a Joint Strategic Needs Assessment?

50. Follow-up questions for local authority interviews

50.1. The additional follow-up questions in relation to self-funders are detailed below:

- Data reporting issues – to identify any significant system issues which may prevent a straight-forward download into a standard format e.g. Excel.
- Data Cleansing – to identify how much lead-in time would be needed to do this. Would resource from the research team help to facilitate this? Would the local authority be amenable to this?
- To discuss the issue of matching activity data from the CIS with relevant cost data from the Finance system. What are the problems, if any, in achieving this? How would the local authority overcome any problems in matching data between systems?
- Does the local authority anticipate any system enhancements in order to produce this information if made a statutory requirement?
- What would be the most effective way for DH to communicate with the local authority about future survey requirements e.g. focus groups, existing NHSIC committees, other suggested routes?
- How long does the local authority need to prepare the data once communication, from DH, of survey requirements has taken place? Are there resource constraints on producing the data for DH?
- How easy is it for the local authority to anonymise the data prior to despatch?
- Does the local authority have any ideas on how we might be able to incentivise timely and accurate data collection? Do other bodies use incentives for non-statutory data collections?
- Any issues arising from the survey peculiar to that local authority will be referred to and further clarification made if required.

51. Follow-up questions for local authority interviews – Self-funders

51.1. The additional follow-up questions in relation to self-funders are detailed below:

- Identification of self-funders: clarification of how self-funders are identified by authority e.g. through assessments, routes by which self-funders are making themselves known to authority and engagement with private providers on identification of self-funders.
- Data collection: representative nature of the data and data about self-funders – what information is captured about self-funders and how reliable / comprehensive is this e.g. home postcode, care home postcode, costs of care for residential and domiciliary.

- Definitions of self-funders: clarification of how authorities define self-funders in their data (who is included and who is excluded) and clarification of policies relating to self-funders i.e. how authority has set its thresholds for need.
- Characteristics of self-funders: what information is used to define self-funder population (health needs, care needs, financial situation) and what differences are there between self-funders and local authority funded?
- Impact of self-funders on workload in authority: clarification of what activities are undertaken to support self-funders, services offered to self-funders and work with private providers to support self-funders.
- Details about self-funder assessments.
- Transition: clarification on what activities are undertaken to support self-funders in transition to local authority funded and policies relating to transition; the financial impact of transition i.e. costs to local authority; the service impact i.e. impact on individuals of transition; and data relating to transition i.e. what do authorities know about this population?
- Noticeable changes in self-funder population: have there been changes in recent years (e.g. number of self-funders, policies for self-funders)?

52. Data download request

52.1. The following data items were requested from local authorities in the follow-up interviews:

Older People Services and Younger Adult Services Data Requirements

Extract from Week commencing 7th June 2010 (one week of data) downloaded to Excel file

Data items from client information system/s:

Client ID
FAC Band
Sex
Age
Postcode/Ward code of current residence
Ethnicity
Whether client lives alone
Postcode/Ward code of pre-care residence (for those in care homes)
Primary client group
Any priority rating or other marker of absolute or relative need
Whether the client receives any of these services:
(In addition to whether they receive the services, we would be interested in any details on the volume or intensity of care that are recorded on the main client system)
Home care (and whether intensive)
Day care
Meals on wheels
Care home places (incl. respite)
Equipment and adaptations
Care home name /postcode
Type of care in care home *Nursing/personal only*
Date of admission to current care home
Whether client has been assessed
Responsible social worker (name or code)
Responsible team

Matched With:

Data items from client finance / payments and contributions systems

Client ID to link to data on main record system
Type of care *domiciliary, care home place*
Admission date to current care home
Type of care *nursing/personal care only*
Cost of current care home place *Gross weekly rate*
Funding of care home place *LA contribution, Client contribution, Top-up (families, charities etc) PCT (or other health contributions to nursing)*
Start date of domiciliary care
Cost of domiciliary care *Gross weekly or monthly cost*
Funding for domiciliary care *LA contribution, Client contribution, Top-up (families, charities etc)*
Combined costs of any other service elements *Gross weekly or monthly cost*
Funding for other services *LA contribution, Client contribution, Top-up (families, charities etc)*

Data to be presented anonymised and all data will be held by the Department of Health for this research only before being destroyed.

Annex 3: Data Options

This Annex contains supporting material for data collection and the review of data sources.

53. Social Care Collections 2010

53.1. The NHS IC included the following data sets in the Social Care Collections for 2010:

- Referrals, assessments and packages of care (RAP);
- Abuse of vulnerable adults (AVA);
- Adult social care combined activity return (ASC-CAR);
- Deaf or hard of hearing return (SSDA910);
- Expenditure and unit costs return (PSS EX1);
- Grant funded services return (GFS1);
- Social Services Staffing return (SSDS001) – continuation under consulted upon; and
- Two user experience surveys relating to carers and users of equipment.

54. Census 2011

54.1. The table below shows the proposed content for the household elements of the Census questionnaire for 2011.

Topic	2001	2011
Usual residence	✓	✓
Household and family relationships	✓	✓
Accommodation type	✓	✓
Dwellings and self-contained accommodation	✓	✓
Number of rooms	✓	✓
Household tenure	✓	✓
Type of landlord	✓	✓
Number of vehicles	✓	✓
Visitor information (new)	×	✓
Number of bedrooms (new)	×	✓
Type of central heating (new)	×	✓
Central heating	✓	×
Bath/shower and toilet access	✓	×

Topic	2001	2011
Lowest floor level	✓	×

54.2. The table below shows the proposed content for the individual elements of the Census questionnaire for 2011.

Topic	2001	2011
Name	✓	✓
Sex	✓	✓
Date of birth	✓	✓
Marital or civil partnership (new) status	✓	✓
Students in full-time education and term-time address	✓	✓
Country of birth	✓	✓
Address one year ago	✓	✓
Ethnic Group	✓	✓
Religion	✓	✓
Knowledge of Welsh (Wales only)	✓	✓
Health status	✓	✓
Long-term illness or disability	✓	✓
Carer information	✓	✓
Qualifications	✓	✓
Economic activity status	✓	✓
NS-SEC (self-employed, occupation, supervisor status, ever worked)	✓	✓
Industry / name of employer	✓	✓
Workplace address	✓	✓
Transport to place of work	✓	✓
Hours worked	✓	✓
Second residence (new)	×	✓
Main Language and English Language Proficiency (new)	×	✓
Month/year of entry into UK (new)	×	✓
Intended length of stay in UK (new)	×	✓
Passports held [as a proxy for Citizenship] (new)	×	✓
National identity (new)	×	✓
Number of employees at the workplace	✓	✓

55. Bupa Care Home Residents Census 2006

1. Postcode of the home

2. Resident age

3. Resident gender
    - Male
    - Female

4. Care type
    - Residential
    - Nursing

5. Basis of stay
    - Permanent
    - Temporary (e.g. respite)

6. Care category
    - Frail elderly (over 65)
    - Dementia
    - Learning difficulties
    - Mental disorder
    - Young physically disabled
    - Convalescent / intermediate care
    - Terminal / palliative care

7. Funding stream (England)
    - Residential
    - RNCC1
    - RNCC2
    - RNCC3
    - Fully Funded
    - Unknown

8. Mobility
    - Mobile
    - Mobile with assistance
    - Totally dependent

9. Mental State
    - Confused or forgetful
    - Challenging behaviour
    - Depressed or agitated

10. Senses
    - No sensory impairment
    - Moderate hearing and/or sight problems
    - Severe sight impairment
    - Severe hearing impairment
    - Severe hearing and sight impairment

11. Continence
    - Continent
    - Urinary incontinence only
    - Faecal incontinence only
    - Urinary and faecal incontinence
    - Does the resident wear pads, yes/no?
    - Does the resident have a catheter, yes/no?

12. Admission reason / diagnosis (medical diagnosis that led to their admission)

Neurological and mental illness
- Stroke
- Dementia including Alzheimer's
- Parkinson's
- Motor neurone disease
- Huntingdon's disease
- Multiple sclerosis
- Cerebral palsy
- Epilepsy
- Neurological trauma (head/spinal injuries)
- Schizophrenia
- Depression
- Manic depression
- Learning difficulties

Musculo-skeletal
- Arthritis
- Osteoporosis
- Fractures
- Missing limbs

Cardio-respiratory
- Heart disease
- Lung / chest disease

Sensory impairment
- Sight
- Hearing

Other medical conditions
- Diabetes and endocrine
- Cancer

Miscellaneous
- Frailty (unspecified)
- Housing
- Family / social reasons
- Unknown
- Other (please specify)

Annex 4: References

- Carr-Hill, R.A., Rice, N. and Smith, P.C. (1999): The determinants of expenditure on children's personal social services. British Journal of Social Work, 29, No. 5, 679-706 reported in Darton et al (2006).

- Carr-Hill, R.A, Dixon, P, Hennessey, S. and Spollen, M (2007) Resource Allocation Modelling for the Formula for Young Adults Social Services: Final Report, Tribal/Secta.

- Robin Darton, Julien Forder, Andrew Bebbington, Ann Netten, Ann-Marie Towers and Jacquetta Williams (2006): Analysis to Support the Development of the Relative Needs Formula for Older People: Final Report, PSSRU Discussion Paper: 2265/3 (http://www.pssru.ac.uk/pdf/dp2265_3.pdf).

- Julien Forder and José-Luis Fernández (2009): Analysing the costs and benefits of social care funding arrangements in England: technical report, PSSRU Discussion Paper 2644, July 2009 (http://www.pssru.ac.uk/pdf/dp2644.pdf).

- Julien Forder (2007): Self-funded social care for older people: an analysis of eligibility, variations and future projections, PSSRU Discussion Paper 2505 by Julian Forder, October 2007 (http://www.pssru.ac.uk/pdf/dp2505.pdf).

- Community Care: Care home decline at an end (17/09/2009) (http://www.communitycare.co.uk/Articles/2009/09/17/112607/Laing-and-Buisson-Care-home-decline-at-an-end.htm)

- Community Care: Solihull case raises questions over support for self-funders (08/06/2010) http://www.communitycare.co.uk/Articles/2010/06/08/114668/Solihull-case-raises-questions-over-support-for-self-funders.htm

- Long-term care 'will be funded by compulsory contributions', Health Insurance and Protection, 30/03/2010 (http://www.himag.com/healthinsurance/article.do;jsessionid=82F0A2F26102423F26721505ABEF510A.5d25bd3d240cca6cbbee6afc8c3b5655190f397f?articleid=20000176162&adname=his_breaking_news)

- Scottish Care Home Census (http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/ScottishCareHomeCensusB - a copy of the census form is available at http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/BlankSCHC2010)

Annex 5: Analysis of Data from Local Authorities

Section 1: Overview of Variables

The table below relates to the four data submissions and shows the data fields and descriptive categories provided by the four authorities.

Data Fields	Authority 1	Authority 2	Authority 3	Authority 4
Eligibility criteria (FACS)	Standard codes with four categories: • 1-Critical (A&OP) • 2-Substantial (A&OP) • Enhanced CPA (MH) • Standard CPA (MH)	Standard codes with seven categories: • 1 – Critical • 2 – Substantial • 3 – Moderate • 3 – Moderate Low • 3 – Moderate High • 4 – Low • No decision	Standard codes with four categories: • Critical • Substantial • Moderate • Low	Standard codes with four categories: • Critical • Substantial • Moderate • Unknown
Age / age categories	Actual ages and four age categories (18-64, 65-74, 75-84, 85+)	Actual ages	Two age categories (18-64, 65+)	Actual ages
Location codes	• Partial postcodes and ward code mapping • No pre-care addresses / postcodes	• Full postcodes • Pre-care postcodes provided	• Current address mapped to ward codes • Identifies out-of area placements • No pre-care addresses	• Full postcodes • Pre-care postcodes not provided for residential care clients

Data Fields	Authority 1	Authority 2	Authority 3	Authority 4
Ethnicity	• Standard codes in the format "White – British" • Codes not all consistent with other authorities	• Standard codes in the format "White British" • Codes not all consistent with other authorities	• Standard codes in the format "a. White British) • Codes not all consistent with other authorities	• Standard codes in the format "White British" • Codes not all consistent with other authorities
Living Alone	No flag / identifier	Flag for all care types	Flag for all care types	No flag / identifier
Care Group (Client Type)	Standard codes with four categories: • Physical / Sensory Disability • Learning Disability • Mental Health • Substance Misuse	Standard codes with six categories: • Learning Disability • Mental Health • Substance Misuse • Other Vulnerable Adult • Phys & Sens Disab (Frail) • Carer	Standard codes with five categories: • Physical Disability • Mental Health • Substance Misuse • Learning Disability • Vulnerable People	Standard codes with four categories: • Physical Disability • Learning Disability • Mental Health • Older People
Care Type	Standard codes with six categories: • Day Care • Direct Payment • Dom Care • Nursing Care • Residential Care • Other	Services matched to five categories: • Home Care • Day Care • Meals on Wheels • Care Home Placement • Equipment and Adaptations	Services matched to six categories: • Home Care • Day Care • Meals • Direct Payment • Care Home Placement • Equipment Adaptation	Services matched to five categories: • Care Homes • Domiciliary Care • Day Care • Equipment • Meals

Data Fields	Authority 1	Authority 2	Authority 3	Authority 4
Service Type	More detailed description of service being provided broken down by care group and care type	More detailed categories relating to care home placements in particular e.g. nursing care and personal care.	More detailed categories relating to care hour placements: • Nursing permanent • Residential permanent • Short term residential • Overnight respite	More detailed categories relating to care hour placements: • Permanent • Non permanent • PCT Transitional
Intensive Home Care	Flag to identify whether domiciliary care packages are "intensive"	Flag to identify whether domiciliary care packages are "intensive"	No flag	Flag to identify whether domiciliary care packages are "intensive"
Provider Sector	Standard codes with five categories: • Independent • OLA • SSD • Unknown • User purchased	Not provided	Not provided	Not provided
Provision Start Date	Data provided	Data provided	Data not provided	Data provided for care home admissions and domiciliary care start date

Data Fields	Authority 1	Authority 2	Authority 3	Authority 4
Cost Data	Able to map to individual clients to calculate weekly costs and client-based package costs	Not provided	Able to map to individual clients to calculate weekly costs and client-based package costs. Care costs broken into client, third party and LA contributions	Able to map to individual clients to calculate weekly costs and client-based package costs. Residential care costs broken include LA and client contributions

Section 2: Cross-Tab Analysis

The tables below provide some sample analyses from the data provided by the four authorities, looking at FACS banding, primary groupings, age profile, cost data and services provided. Data has not been combined as time did not permit detailed discussions with authorities to ensure consistency between categories used by the different authorities.

Table 1: FACS BAND by Age Profile

Authority 1

	AGE_BAND		
FACS_BAND	**18-64**	**65 Plus**	**Grand Total**
1-Critical (A&OP)	1771	3,354	5,125
2-Substantial (A&OP)	2671	7,283	9,954
Enhanced CPA (MH)	12	1	13
Standard CPA (MH)	6	3	9
Grand Total	4,460	10,641	15,101

Authority 2

	AGE_BAND		
FACS_BAND	**18-64**	**65 Plus**	**Grand Total**
1 - CRITICAL	340	880	1,220
2 - SUBSTANTIAL	682	1,240	1,922
3 - MODERATE	14	18	32
3 - MODERATE HIGH	187	411	598
3 - MODERATE LOW	23	50	73
4 - LOW	7	9	16
NO DECISION	10	10	20
Missing	271	323	594
Grand Total	1,534	2,941	4,475

Authority 3

	AGE_BAND		
FACS_BAND	**18-64**	**65 Plus**	**Grand Total**
Low	6	8	14
Moderate	16	25	41
Substantial	513	975	1,488
Critical	131	623	754
Missing	223	185	408
Grand Total	889	1,816	2,705

Authority 4

	AGE_BAND		
FACS_BAND	**18-64**	**65 Plus**	**Grand Total**
Low	0	0	0
Moderate	415	1,220	1,635
Substantial	1,133	4,118	5,251
Critical	90	356	446
Missing/unknown	242	496	738
Grand Total	1,880	6,190	8,070

Table 2: Primary Group by Age Profile

Authority 1

PRIMARY_GROUP	AGE_BAND		Grand Total
	18-64	65 Plus	
Learning Dis	2,327	95	2,422
Mental Health	613	42	655
Phys/Sens Dis	1,510	10,503	12,013
Subst Misuse	10	1	11
Grand Total	4,460	10,641	15,101

Authority 2

PRIMARY_GROUP	AGE_BAND		Grand Total
	18-64	65 Plus	
Missing	67	111	178
CARER	13	50	63
Learning Disability	580	80	660
Mental Health	265	268	533
Other Vulnerable Adult	8	8	16
Phys & Sens Disab (Frailty)	576	2,423	
Substance Misuse	25	1	26
Grand Total	1,534	2,941	4,475

Authority 3

PRIMARY_GROUP	AGE_BAND		Grand Total
	18-64	65 Plus	
Missing	2	22	24
Learning Disability	408	46	454
Mental Health	227	304	531
Physical Disability	246	1,320	1,566
Substance Misuse	1	3	4
Vulnerable People	5	121	126
Grand Total	889	1,816	2,705

Authority 4

PRIMARY_GROUP	AGE_BAND		Grand Total
	18-64	65 Plus	
Learning Disability	648		648
Mental Health	248	1	249
Older People	1	6,187	6,188
Physical Disability	983	2	985
Grand Total	1,880	6,190	8,070

Table 3: Primary Group by FACS Band

Authority 1

PRIMARY_GROUP	FACS_BAND					Grand Total
	Missing	Critical (A&OP)	Substantial (A&OP)	Enhanced CPA (MH)	Standard CPA (MH)	
Learning Dis		1,130	1,291		1	2,422
Mental Health		220	418	13	4	655
Phys/Sens Dis		3,775	8,234		4	12,013
Subst Misuse			11			11
Grand Total		5,125	9,954	13	9	15,101

Authority 2

PRIMARY_GROUP	FACS_BAND								Grand Total
	Missing	Critical	Substantial	Moderate	Moderate High	Moderate Low	Low	No Decision	
Missing	160	6	8		3		1		178
CARER	41	7	8		5	1		1	63
Learning Disability	22	58	441		119	13	2	5	660
Mental Health	99	307	96	3	17	5	2	4	533
Other Vulnerable Adult	1	5	7		2	1			16
Phys & Sens Disab	267	823	1,354	29	452	53	11	10	2,999
Substance Misuse	4	14	8						26
Grand Total	594	1,220	1,922	32	598	73	16	20	4,475

Authority 3

PRIMARY_GROUP	FACS_BAND					Grand Total
	Missing	Low	Moderate	Substanti	Critical	
Missing	10	2	1	9	2	24
Learning Disability	24	4	16	358	52	454
Mental Health	209	1		190	131	531
Physical Disability	149	7	18	850	542	1,566
Substance Misuse	2				2	4
Vulnerable People	14		6	81	25	126
Grand Total	408	14	41	1,488	754	2,705

Authority 4

PRIMARY_GROUP	FACS_BAND				Grand Total
	Missing	Moderate	Substantial	Critical	
Learning Disability	20	94	494	40	648
Mental Health	117	21	104	7	249
Older People	494	1220	4118	356	6188
Physical Disability	107	300	535	43	985
Grand Total	738	1635	5251	446	8070

Table 4: Service Type by Age Profile

For all authorities, there is not a 1-1 link between client numbers and service type. For authorities 1, 3 and 4, categories are not mutually exclusive and therefore the number of services is greater than the number of people. For authority 2, not all clients had a service type identified from the list of categories for this authority.

Authority 1

	AGE_BAND		
SERVICE TYPE	**18-64**	**65 Plus**	**Grand Total**
Home Care	2,356	6,236	8,592
Day Care	1747	1546	3,293
Direct Payments	919	348	1,267
Other	256	162	418
Nursing Care	110	1,698	1,808
Residential Care	1,016	2,305	3,321
Grand Total	6,404	12,295	18,699

Authority 2

	AGE_BAND		
SERVICE TYPE	**18-64**	**65 Plus**	**Grand Total**
Home Care	81	525	606
Intesive Home Care	35	207	242
Day Care	168	282	450
Meals	8	259	267
Equipment and Adaptation	196	587	783
Residential Care	238	464	702
No service type identified	890	1,114	2,004
Grand Total	1,616	3,438	5,054

Authority 3

	AGE_BAND		
SERVICE TYPE	**18-64**	**65 Plus**	**Grand Total**
Home Care	248	929	1,177
Day Care	465	443	908
Meals	0	1	1
Equipment Adaptations	11	21	32
Direct Payment	187	116	303
Residential Care	192	549	741
Grand Total	1,103	2,059	3,162

Authority 4

	AGE_BAND		
SERVICE TYPE	**18-64**	**65 Plus**	**Grand Total**
Home Care	183	1,242	1,425
Intensive Home Care	237	1623	1,860
Day Care	443	379	822
Equipment	566	1,134	1,700
Residential Care (Non-permanent)	60	62	122
Residential Care (PCT Transitional)	5	103	108
Residential Care (Permanent)	529	2,117	2,646
Grand Total	2,023	6,660	8,683

Table 5: Weekly Costs by Service Type and Age Profile

Local authorities 3 and 4 specified this was the LA element of the costs. Local authority 1 did not specify whether financial data was LA element only or total cost. Local authority 2 did not provide any financial data. Costs given relate to average weekly costs.

Authority 1

CARE_TYPE	Age_Band		Grand Total
	18-64	65 Plus	
Day Care	£130	£53	£94
Direct Payment	£245	£202	£233
Dom Care	£238	£139	£166
Nursing Care	£646	£501	£510
Other	£100	£21	£70
Residential Care	£1,012	£449	£622

Authority 3

CARE_TYPE	Age_Band		Grand Total
	18-64	65 Plus	
Care Home	£974	£309	£485
Day care	£163	£61	£102
Direct Payment	£181	£161	£174
Home Care	£257	£108	£142

Authority 4

CARE_TYPE	Age_Band		Grand Total
	18-64	65 Plus	
Care Home	£646	£277	£353
Day care	£325	£181	£258
Home Care	£231	£203	£207

Table 6: Weekly Costs by FACS Band, Service Type and Age Profile

Authority 1

CARE_TYPE	FACS_BAND	Age_Band		Grand Total
		18-64	65 Plus	
Residential Care	1-Critical (A&OP)	£1,089	£454	£685
	2-Substantial (A&OP)	£905	£446	£560
	Enhanced CPA (MH)	£646		£646
	Standard CPA (MH)	£507	£438	£472
Care Home Total		£1,012	£449	£622
Nursing Care	1-Critical (A&OP)	£627	£498	£507
	2-Substantial (A&OP)	£676	£505	£514
	Enhanced CPA (MH)	£717		£717
	Standard CPA (MH)			
Nursing Care Total				
Day care	1-Critical (A&OP)	£155	£60	£126
	2-Substantial (A&OP)	£113	£51	£80
	Enhanced CPA (MH)	£62		£62
	Standard CPA (MH)	£166		£166
Day care Total		£130	£53	£94
Home Care	1-Critical (A&OP)	£289	£186	£226
	2-Substantial (A&OP)	£208	£126	£145
	Enhanced CPA (MH)	£45	£13	£41
	Standard CPA (MH)	£36	£65	£47
Home Care Total		£238	£139	£166
Direct Payment	1-Critical (A&OP)	£303	£269	£295
	2-Substantial (A&OP)	£213	£176	£202
	Enhanced CPA (MH)			
	Standard CPA (MH)			
Direct Payment Total		£245	£202	£233
Other Payments	1-Critical (A&OP)	£118	£33	£99
	2-Substantial (A&OP)	£86	£18	£55
	Enhanced CPA (MH)			
	Standard CPA (MH)	£57		£57
Other Payment Total		£100	£21	£70

Authority 3

CARE_TYPE	FACS_BAND	Age_Band		Grand Total
		18-64	65 Plus	
Care Home	Missing	£940	£289	£576
	Low		£177	£177
	Moderate	£444		£444
	Substantial	£953	£346	£644
	Critical	£1,065	£296	£374
Care Home Total		£974	£309	£485
Day care	Missing	£161	£61	£74
	Low	£192	£26	£67
	Moderate	£146	£29	£114
	Substantial	£162	£59	£103
	Critical	£173	£79	£110
Day care Total		£163	£61	£102
Direct Payment	Missing	£83	£127	£94
	Moderate	£125		£125
	Substantial	£149	£142	£147
	Critical	£349	£203	£282
Direct Payment Total		£181	£161	£174
Home Care	Missing	£230	£87	£126
	Low	£83	£33	£49
	Moderate	£172	£64	£91
	Substantial	£246	£93	£129
	Critical	£328	£164	£197
Home Care Total		£257	£108	£142

Authority 4

CARE_TYPE	FACS_BAND	Age_Band		Grand Total
		18-64	65 Plus	
Care Home	Missing	£522	£250	£352
	Moderate	£450	£259	£299
	Substantial	£697	£279	£355
	Critical	£746	£295	£372
Care Home Total		£646	£277	£353
Day care	Missing	£289	£205	£240
	Moderate	£291	£173	£238
	Substantial	£331	£181	£262
	Critical	£384	£169	£306
Day care Total		£325	£181	£258
Home Care	Missing	£186	£210	£204
	Moderate	£209	£143	£152
	Substantial	£257	£214	£219
	Critical	£209	£282	£271
Home Care Total		£231	£203	£207