Balancing the Care Equation: Progress with Community Care

The Audit Commission is continuing to monitor the implementation of community care in England, focusing on local authorities as lead agencies and on financial issues.

Progress continues, but financial issues dominate the agenda...

♦ most authorities are having to take action to keep control of expenditure
♦ controlling expenditure is a complex balancing act

...and authorities need to keep financial commitments within the funds available.

♦ authorities are giving priority to community care
♦ spending on community care is 7 per cent more than proposed by the Government

Financial commitments depend on a number of factors...

♦ the number of people receiving care
♦ arrangements for meeting people's needs
♦ the cost of each episode of care

...and the number of people receiving care depends on the numbers seeking help and on eligibility criteria.

♦ there is wide variation between authorities
♦ criteria are often complex and difficult to understand

Arrangements for meeting needs require increasing flexibility...

♦ through devolution to care managers
♦ by merging the special transitional grant with the base budget
♦ through a better contracting framework – saving £130,000 a year in one authority

...and most authorities are improving the mix of services.

♦ by increasing home care
♦ by increasing targeting with more hours per household

The net cost of each episode of care needs to be contained by controlling gross costs...

♦ many independent providers’ prices are consistently below the cost of local authority services
♦ authorities should calculate the full gross cost of their own services

...by reviewing charges and monitoring how long care is needed.

♦ most authorities are increasing charges and there are wide variations between authorities
♦ perverse incentives favour residential rather than home care
♦ authorities need better information to help them keep within budget
The Audit Commission

...promotes proper stewardship

of public finances and helps those

responsible for public services

to achieve economy, efficiency

and effectiveness.
Introduction

1. The community care arrangements introduced by the NHS and Community Care Act 1990 came into force on 1 April 1993. This is the Audit Commission’s third bulletin charting progress with their implementation in England. As before, it focuses on local authorities as the lead agencies, and on financial issues.

2. If authorities are to continue to make progress, they must manage their resources with care and use their finances to best effect. Currently, financial issues dominate the agenda, not least because of continuing tight constraints on public expenditure. Few local authorities are actually overspending, but most report that they are under considerable financial pressure and are having to take action to keep control of expenditure. This action varies from authority to authority but most need to adjust one or more variables in a complex financial equation (Exhibit 1).

Exhibit 1
Balancing the care equation

Most authorities are having to adjust one or more variables in a complex financial equation.
Balancing the Care Equation
Progress with Community Care

'Some people - particularly younger people with a disability or a mental health problem - may need help for many years or indeed for most of their lives'

Balancing this equation is the subject of this report.

3. If the equation is to balance, financial commitments must not exceed the funds available. This bulletin starts in section 1 with a review of these funds. Subsequent sections then look at the main components of authorities' financial commitments, namely:
   - the number of people receiving care (section 2);
   - arrangements for meeting their needs (section 3); and
   - the cost of each episode of care (section 4).

4. The community care changes were introduced to improve care and provide greater choice for people who need help over a prolonged period to live at home or in 'homely settings' (Ref. 1). Many elderly people depend on such help, as do many younger people who have mental health problems, a learning disability or a physical disability. At any one time nearly 900,000 people are supported by local authorities in England (Exhibit 2) and many more are supported by the National Health Service (NHS) both in hospital and in community settings. The quality of life for these vulnerable people depends on the success of the changes underway.

5. Some people require support for relatively short periods while they re-establish their lives after an illness or some other trauma. Many elderly people receive services to help them stay at home as long as possible or to move to a homely environment where they can receive the care they need. The duration of such help varies enormously. Some people - particularly younger people with a disability or a mental health problem - may need help for many years or indeed for most of their lives.

6. Unlike last time (Ref. 3) it has not been possible to undertake an extensive review of users' and carers' views of progress during 1995 but comments are made throughout the bulletin where there are clear implications for them.

Exhibit 2
The number of people receiving help from local authorities in England 1995/96

At any one time, nearly 900,000 people are supported by local authorities.

Note:
Some double counting - some people will get daycare and care at home.

Source: CIPFA statistics (Ref. 2)
1. The Funds Available

7. Central government makes funds available to local authorities mainly through the revenue support grant (RSG). The amount each authority receives is based on a standard spending assessment (SSA) which takes into account the number of people in each area likely to require care. The SSA also provides funds for children’s services. Over the last three years these funds have been augmented by the special transitional grant (STG) which has transferred finance previously channelled through the social security budget for individuals receiving residential and nursing home care. Authorities have in turn assumed extra responsibilities for meeting the care needs of these individuals and further legislative change has added to these responsibilities. At the end of each year, the majority of this STG has then been subsumed within the SSA as part of an authority’s general funding. A new STG is then added on top for the following year (Exhibit 3).

8. The SSA merely provides guidance to authorities on the level of expenditure that the Government considers appropriate. It is up to authorities to decide how much they are actually going to spend. In practice, most are spending more than the SSA with the average across the Country being 7 per cent above SSA in 1995/96 (Exhibit 4a, overleaf). Most have increased the extent to which they are above SSA since 1 April 1993 (Exhibit 4b, overleaf) although a few have made relative reductions. In some cases, authorities have benefited or suffered from a change in their SSA, as a result of a change in formula or in their population (Exhibit 4c, overleaf); and last year the Commission reported on the impact of changes to the

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**Exhibit 3**

The main resources made available to authorities by central government

Over the last three years funds have been increased by the special transitional grant (STG) which has transferred finance previously channelled through the social security budget.

Note:
Figures represent actual expenditure not adjusted for inflation.

Source: Department of Health
Most are spending more than the SSA...

Source: Department of Health

9. Additional funds are available from central government through other grants (such as the mental illness specific grant) and through health authorities in the form of joint finance and payments for the care of people discharged from hospital; but these sums are relatively small compared with the RSG and STG (typically a few per cent) and often cease after a time.

10. Within social services departments, further adjustments have been made between client groups, with some changing the balance between adults' services and children's services.

11. Overall, most authorities have given priority to community care with steadily increasing sums made available to deal with the increased responsibilities. But whatever the framework set by central government or the budgets set by local government, financial commitments must be kept within these budgets. This calls for a number of measures starting with the careful management of the numbers receiving care.
2. The Numbers of People Receiving Care

12. The numbers receiving care depend on the number who seek help in the first place, and the criteria each authority uses to decide which of these people is eligible for care.

The numbers seeking help

13. Last year (1994/95) many authorities reported increasing demand for community care both for patients discharged from hospital and for those still living in the community, but few were able to demonstrate this with figures (Ref. 3). Of the 17 authorities surveyed this year, only 6 were able to provide comparable numbers of referrals for both 1993/94 and 1994/95. This sample shows that the change in the number of people referred and then given thorough assessments varies widely (Exhibit 5). The sample is small because in many cases the data either were not available, were not in the form required, or were not comparable over time (because of a change in definitions between years, for example). In part this is because of difficulties in defining what should be counted as a referral. All except one (authority 3) have reported a considerable increase in workload either as a result of a sizeable increase in the number given a complex assessment, or in the case of one authority (authority 6), as a result of a sizeable increase in the number of referrals.

14. A larger survey by the Association of Directors of Social Services (ADSS) shows a similarly wide variation (Table 1, overleaf). Authorities were asked to return their 'best guess' where data were not available, so reducing reliability.

15. The proportion of people receiving a thorough assessment also varied from 20 per cent to over 70 per cent suggesting

Exhibit 5
Changes in referrals and thorough assessments between 1993/94 and 1994/95

The change in the number of people referred and then given thorough assessments varies widely.
Table 1
Growth in referral and assessment rates (1993 to 1994)

<table>
<thead>
<tr>
<th>Sample size</th>
<th>Counties</th>
<th>London boroughs</th>
<th>Metropolitan authorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>% change in referrals</td>
<td>17.5</td>
<td>8.7</td>
<td>3.8</td>
</tr>
<tr>
<td>% change in assessments</td>
<td>12.5</td>
<td>8.5</td>
<td>6.4</td>
</tr>
</tbody>
</table>

A survey by the Association of Directors of Social Services (ADSS) showed wide variations.

either that authorities are defining ‘a thorough assessment’ in different ways or that practice in applying the definitions is varying markedly (Exhibit 6). Given the amount of work involved in carrying out assessments, local authorities need to assure themselves that each one is necessary. Authorities should screen referrals before deciding which should go forward for more thorough assessments. Somerset provides three levels of response (Case Study 1). Such screening ensures that everyone receives advice but that invasive and time-consuming assessments are restricted to those who need them. Authorities should set priorities for assessment and publish them in community care plans.

16. Data about the source of referral are even more limited than data about overall numbers of referrals. Of the 17 authorities reviewed, only 4 were able to supply figures showing how the source of referrals varied over time – so no conclusions can be drawn about whether the health service or some other source is increasing or decreasing in importance. Health authorities are having to define their role more precisely and identify their responsibilities for people who require ‘continuing health care’. Setting out those responsibilities in eligibility criteria should help to clarify the boundaries between health and social services.

17. Expectations from users and their carers are likely to grow as organisations representing their interests press for improvements to community care; and numbers will increase as demographic changes increase the number of those aged over 85. Implementation of the Carers’ Recognition and Services Act in April

Exhibit 6
Thorough assessments as a proportion of referrals in 1994/95

The proportion of people receiving a thorough assessment varied from 20 per cent to over 70 per cent.

Source: Audit Commission survey of 17 SSDs
Case Study 1
Somerset Social Services Department – providing three levels of response to referrals

Screening ensures that everyone receives advice but that invasive and time-consuming assessments are restricted to those who need them.

1996 will give carers a statutory right to have their needs assessed, further boosting the need for thorough assessments. And arrangements which allow local authorities to provide cash to users for the purchase of their own care could generate further interest. But at present it is impossible to assess the scale of activity given the paucity of information.

18. Local authorities must improve the quality of their information, preferably agreeing definitions among themselves, possibly with central co-ordination by the Department of Health, so that comparisons can be made. Without such key information, it is difficult to assess whether resources are sufficient. A programme of investment in information and information technology should be planned in each authority.

Recommendation:
Local authorities must improve their recording of numbers and source of referrals. They must also record numbers of assessments. They should agree common definitions so that the figures are comparable, possibly with central co-ordination by the Department of Health.
'Authorities should set out their criteria in their community care plans'

**Eligibility criteria**

19. However many people seek help, they are likely to exhaust the resources available unless authorities devise ways of setting priorities. Authorities set these out in the form of ‘eligibility criteria’, which define who qualifies for care. They should be set at a level such that authorities can meet the needs of those who qualify and still keep within budget. Setting criteria requires the close involvement of elected members. To work effectively, criteria need to be:

- simple to understand;
- easy to apply in practice;
- flexible (as no set of criteria can encompass all eventualities);
- precise (so that financial commitments can be estimated with some confidence); and
- widely publicised.

20. Unfortunately, these qualities are not easily achieved and may be mutually exclusive. Criteria that define those needing care with sufficient precision to limit expenditure in a predictable way may well be too complicated for people to understand or to operate on a day-to-day basis. Conversely, highly flexible criteria which enable diverse needs to be accommodated may make it difficult to estimate financial commitments with any certainty. A compromise is needed between simplicity and flexibility on one hand and complexity and precision on the other. A number of authorities acknowledge that early attempts at drafting new assessment documentation made things too complicated, producing forms and instructions which were often littered with boxes and computer codes. Many have simplified their early versions (Case Study 2).

21. Wide publicity is essential if people – both local authority staff and potential users and their carers – are to understand the process. Authorities should set out their criteria in their community care plans; they are being encouraged by the Department of Health to produce and publish local community care charters (in conjunction with health and housing authorities and others) by 1 April 1996.

**Case Study 2**

**Simplifying assessment documentation**

Newcastle upon Tyne Social Services Department has developed new assessment documentation to:

- prompt assessors to consider each of 12 possible areas in which community care needs may arise;
- allow the assessor with the user to give whatever information they feel appropriate to help determine the level of need;
- enable a more thorough assessment of need for a limited number of people in ‘high need’; and
- summarise each person’s overall level of need using a combination of dependency and risk scores.

Newcastle is also considering providing a minimum guaranteed standard of care based around key activities of daily living (eg, ability to look after self, safety, health, mobility, etc). The approach ensures a minimum standard of care for individuals, but at the same time allows each practitioner leeway in the use of resources to achieve this.
2. The Numbers of People Receiving Care

which should include ‘clear precise criteria for eligibility for assistance’. They should also produce clear, easy-to-read leaflets explaining the criteria and how they work. And they should have in place clear appeals systems with access to advocacy services for those who feel that they have not been properly assessed. Authorities should provide training for all staff who carry out assessments to make everyone thoroughly conversant with the process.

22. Many authorities are finding the whole process of setting criteria difficult – particularly those under financial pressure. A report by the Association of Metropolitan Authorities (AMA) on eligibility criteria concluded that most authorities were spreading their resources thinly, finding it difficult to refuse services even to the lower priority cases (Ref. 4). The AMA asked authorities to apply their criteria to typical case histories of people with high, medium and low needs and found that most were considered eligible for services. Many authorities considered themselves to be ‘providers of the last resort because of the consequences for the individual if they do not accept responsibility’. But if the finite resources are to go to those whom the authority considers most in need, some sort of priority system is needed.

23. Authorities are tackling the need to devise a priority system in several ways. All involve grouping people into categories that are ranked in order of need. Some take into account dependency and risk, sometimes using complex scoring systems.

24. Authorities use the terms ‘dependency’ and ‘risk’ in varying ways (often interchangeably with ‘need’). But by and large, ‘dependency’ refers to the ability of people to undertake certain tasks; and ‘risk’ refers to the likelihood of a situation deteriorating if nothing is done. Many authorities now assess both risk and dependency to place individuals typically into high, medium or low categories.

25. Whatever the mechanism used to determine the level of dependency and/or risk, authorities must apply the results to determine each person’s priority for services. The criteria should help care managers be consistent. Again, authorities approach this task in a number of ways, reflecting different local traditions and political decision-making processes.

26. One approach is to set priority levels and meet all the needs of people in the top priority group and then - where resources allow – the needs of people within priority groups 2, 3, 4, etc, until resources run out. A number of authorities faced with major financial difficulties have adopted this approach. But it can limit local flexibility. Authorities have found that people in lower priority groups may get no services at all and care managers cannot act to prevent predictable deterioration. In effect, the priority system does not recognise that those in ‘lower’ groups are at risk even though care managers do. This may be because it is more difficult to predict risk in a precise way.

27. To avoid these difficulties, other authorities allow local discretion in the allocation of resources between priorities. They take an explicit decision to allocate some resources to meet ‘lower priority’ needs, allowing local intervention to prevent deterioration and to counter risk. But it is difficult to apportion resources between priorities in a consistent way.

'Many authorities are finding the whole process of setting criteria difficult'
28. In a refinement to this approach, some authorities specify an amount that can be spent on each person in each category, setting ‘ceilings’ to the cost of each package of care for each priority level (Case Study 3). Under this approach, the cost ceilings for each band can be varied up or down according to the funding available, without the need to re-negotiate or implement new criteria. Provided they can estimate the numbers of people expected in each band with some degree of certainty, authorities can make a start on the complex process of estimating total expenditure (Case Study 4). Individual care packages can then be assembled or adjusted on the basis of a sum of money rather than a fixed range of services. And the approach makes more explicit and visible the level of need and provides a framework for recording the numbers and needs of those who do not meet the criteria. The main disadvantage of the approach is that it may not always be possible to support somebody adequately for the prescribed sum.

29. A number of authorities appear to apply ‘ceilings’ to the amount that can be spent on each person expressed as a percentage of the cost of residential care, either in terms of cash or amounts of services (eg, home care hours). In a few authorities no ceiling is set, or the ceiling is set at a level beyond the costs of residential care, to allow substantial community alternatives (Exhibit 7).

30. A number of local authorities are finding that tight criteria are not sufficient to keep the level of expenditure within budget and that they need to take additional action to restrict commitments. Some enforce criteria through the use of

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**Case Study 3**

Assigning costs to eligibility criteria

Buckinghamshire Social Services Department is adopting a risk/dependency approach, as part of a ‘banding’ system, around high, medium and low levels, attaching cost ceilings for care within each band. The authority has carried out an option appraisal of banding methods. A dependency/risk model has been tested by staff. Feedback has been very positive and encouraging, with staff finding the method straightforward to use. It provides an effective way of placing people into high, medium and low categories. Each band is assigned a maximum spend per case, as follows:

- **High priority** – the average net cost of residential care plus 20 per cent premium if spent on community services, enabling people to stay in their own homes;
- **Medium priority** – 60 per cent of the average net cost of residential care; and
- **Low priority** – 30 per cent of the average net cost of residential care.

The authority considers the advantages of the approach to be:

- providing assessment of need independent of costs and the availability of services;
- capping expenditure until any re-assessment assigns the person to a new priority band;
- providing a financial framework within which the care manager can negotiate the package of care required in a flexible way; and
- providing an opportunity for users and carers to say which needs they would like met and how they would like them to be met.
Buckinghamshire Social Services Department has reviewed past assessments to estimate the likely pattern of demand and cost of introducing a three-tier priority scale. The authority found:

- The numbers of people given services in the past were spread evenly between the three groups: high (32 per cent) medium (35 per cent) and low (33 per cent);
- Costs of packages of care provided to high dependency clients were known with some degree of accuracy (nursing and residential care, and intensive community packages) but were less well known for services provided to medium and low priority clients;
- Information on length of stay or care duration was available for nursing, residential and high dependency community packages but not for medium and low dependency clients. This made it impossible to calculate the costs of lower priority episodes of care; and
- While the size of care packages was limited by the criteria, reductions in the amount of services used did not produce any savings because the services were paid for directly from a central budget.

Work is continuing, and the problems identified are now being addressed.

31. Some authorities are having to tighten criteria, making them ever more prescriptive. One authority, under financial pressure, had to revise its eligibility criteria in January 1995 to restrict services to those in the highest category for the remainder of the financial year. Help was provided only to people with an inability to remain in or return to the community. It was not provided to those people considered to be medium priority who relied on others for maintenance of critical personal needs to keep them within the community. This...
authority was therefore unable to help maintain people in the community for this period in accordance with the community care policy.

32. The effect of all of this is to produce a maze of different criteria which are complex and difficult for people to understand. People who qualify for care in one authority may not qualify in another. The price of freedom of local decision-making is considerable variation in access to services between areas. Authorities may be able to reduce the worst effects of the inequities that result by comparing approaches and, here again, guidance may be useful.

**Recommendation:**

Authorities should review with other authorities how they set eligibility criteria to help spread good ideas and to reduce some of the inequity that inevitably results from local decision-making, while recognising different local traditions and political decision-making processes.

'The effect of all of this is to produce a maze of different criteria which are complex and difficult for people to understand.'
3. Arrangements for Meeting Needs

33. After assessments have been made and the criteria applied, a package of care is put together for those needing support. To do this cost-effectively, authorities must:

- **increase flexibility** to allow local staff to put together cost-effective packages that meet needs as precisely as possible; and

- adjust the range of services to ensure that they offer choice.

**Flexibility to deploy services**

34. Authorities have now put in place networks of care managers whose responsibility it is to set up and manage the more complex packages of care. Many authorities are experimenting with devolved budgets which allow their care managers flexibility and freedom. But this flexibility and freedom must be underpinned by effective financial controls.

35. The Audit Commission has already set out the principles for good control in a management paper (Ref. 5). Four principles were identified:

- financial responsibility must be aligned with management responsibility;

- responsibilities should be clarified, with managers operating within clear rules;

- financial information systems should be in place; and

- good financial support and advice is needed for managers.

**Financial responsibility** is aligned with management responsibility by devolving budgets to care managers responsible for assembling packages of care. This is only partially achieved at present. Most local authorities devolve the Special Transitional Grant monies to some extent and, while many devolve the management of services funded by the base budget, few devolve the base budget itself (Exhibit 8). Sometimes only the portion of the STG that must be spent in the independent sector (under the 85 per cent rule) is devolved.

37. Most authorities account separately for the STG and base budget monies. While this distinction was understandable immediately following the implementation of the community care reforms, it makes less sense as the transfer of the STG to...
local authorities draws to an end. Instead, resources need to be managed in an integrated way and merged into a single commissioning budget. The current arrangements are leading to two sets of services, with the bulk being provided by local authorities and funded directly from the centre and the remainder being provided by the independent sector and purchased individually by care managers through the STG.

38. Direct funding of core services continues in most authorities. The danger is that this may limit these service providers' ability and incentive to respond to care managers' requests. The independent sector may potentially become the main source of innovation, leaving local authority services behind. For example, in some authorities, the independent sector provides intensive packages of home help and home care while the local authority provides less intensive packages with fewer hours – as in the past (Exhibit 9). While some authorities no doubt provide a wide range of care, including some intensive packages, those responsible for local authority home care must ensure that their services are flexible enough to respond to all needs. Otherwise care managers may look elsewhere to meet needs.

39. Managing the STG separately can also lead to distortions. For example, where authorities apply maximum cost limits to packages of care for people, local authority services are sometimes excluded from the cost and in effect are treated as a 'free good'. As a result, care managers can construct very different packages of care within the same limit by using 'free' local authority services to supplement those purchased elsewhere. One authority even had different charging arrangements for services funded through the STG from those funded through the base budget. Under such arrangements, a care manager can manipulate the system to maintain someone at home at a cost considerably in excess of the limit set for a care package purchased externally. While it is understandable that care managers should try to work such systems to the benefit of their clients, this practice distorts priorities and results in widely differing levels of services for people with identical levels of need.
3. Arrangements for Meeting Needs

**The most common way for local authorities to pay for their own services is to fund them directly from the base budget.**

40. Authorities continue to fund their own services directly in order to ensure that they are available as a safety net for the most vulnerable. This also prevents double funding should users and care managers prefer other services. Double funding occurs where authorities have to meet both the cost of these other services and the cost of their own services, whether they are being used or not (see the last point in Case Study 4). While it is necessary to avoid such costs, there are better ways of doing so, as described below.

41. Responsibilities should be clarified with managers operating within clear rules. This is best done by treating local authority services in a similar fashion to independent sector services, using service agreements and contracts. This approach does not mean creating a free-for-all that destabilises services: instead, a more mature contracting framework is required for both types of service.

42. The most common way for local authorities to pay for their own services is to fund them directly from the base budget. The most common way for them to pay for services provided by the independent sector is to spot-purchase care for each individual separately through the STG or transferred grant. But other possibilities exist: block contracts, which purchase a given amount of service in advance at a fixed price; and cost and volume contracts, which provide a guaranteed minimum income, while requiring service providers to win extra revenue by innovating and competing with others (Exhibit 10).

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**Exhibit 10**
The contracting spectrum

A range of possibilities exist.
In their role as purchasers, authorities should act to provide greater regulation.

43. In moving local authority services on to more flexible contracts, authorities begin to identify where they are not meeting some needs as well as others, encouraging them to innovate and improve their performance. Transfer should be gradual, allowing services sufficient time to respond. In the past some authorities have floated off their own services – especially residential care services. While this remains an option, authorities can continue providing whatever services they think appropriate, provided they ensure that their own services meet needs as effectively and efficiently as those provided by the independent sector. Better contracting arrangements should help.

44. Conversely, by moving some independent providers on to more secure contracts, authorities find that they are able to reduce costs. Already, care managers and users in many local authorities prefer particular independent providers. One authority has begun to move from spot purchasing to the use of block contracts for residential and nursing homes. By placing nearly half of all money spent on residential homes on block contracts it has generated annual savings of nearly £130,000 – equivalent to nearly £20 a week per bed. This considerable cost benefit offsets the increased risk to the purchaser of unused beds. In fact, the risk is small because after nearly three years of the new arrangements for community care, the authority has a good understanding of the pattern of demand for places and knows that those purchased with the block contract are in popular homes and are almost certain to be chosen by people seeking a place. In another authority, out of a list of 20 approved providers of home care services, one supplied over a quarter of all independent sector services (at a price less than two-thirds the cost of the local authority services). Such a provider is a natural candidate for a closer working relationship within a sound contracting framework.

45. Better contracts should also allow authorities to specify the quality they require. Independent providers are being used to supply an increasingly significant proportion of home care and home help, although to varying degrees in different authorities (Exhibit 11). Many authorities

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**Exhibit 11**

Contact hours of home help and home care services provided by different sectors

Independent providers are used to supply a significant proportion of care, although to varying degrees in different authorities.

*Source: Department of Health statistics (Ref. 6) for Audit Commission surveyed SSDs*
argue that they are concerned about the quality of unregistered, unregulated domiciliary providers – and increasing numbers are introducing voluntary accreditation schemes. But they spot-purchase domiciliary services as required on an hour-by-hour basis, expecting independent providers to match the quality of local authority providers which have guaranteed direct funding. It is unlikely that independent providers will be able to do so unless given greater security through a more suitable contracting framework. And many 'not for profit' agencies complain about the uncertainty they face, with staff on 12-month contracts. In some cases, longer contracts guaranteeing a minimum income provide improved security, allowing better terms for staff and increased ability to raise capital. The cost to the local authority should reduce as a result, and the quality rise.

46. In their role as purchasers, authorities should act to provide greater regulation. Some are beginning to do so, developing extensive quality-based specifications for all providers, whether independent or local authority. They also need to develop closer partnerships with some of their service providers. In the commercial world a number of companies have shown that the right kind of co-operation can yield cost savings and quality improvements both to purchaser and supplier alike (Ref. 7).

Spot-purchasing is continually needed to ensure flexibility and choice, to encourage new providers into the market, and to provide purchasers with market intelligence. But a core of reliable providers ensures a stable supply of good quality, cost-effective services. Instead of restricting this role to their own services, leaving independent sector services to provide the flexibility and choice, some authorities are now adopting a more balanced approach with both sectors providing core services and flexible additional services (Exhibit 12).

Exhibit 12
Moving to a more balanced contracting framework

Instead of authorities providing their own core services exclusively, leaving independent sector services to provide flexibility and choice, a more balanced approach could be adopted.
Balancing the Care Equation

Progress with Community Care

"Resources need to be managed in an integrated way and merged into a single commissioning budget."

47. More mature contracting arrangements call for more sophisticated support, in terms of:

♦ better financial information systems; and

♦ good financial support and advice.

48. Budget holders need to know not only how much they have spent, but also how much of the budget that is outstanding is already committed in the future if care continues at the current levels. Without this information, they have no way of telling whether they are over-committing their budgets. The same systems must also inform people at the centre responsible for controlling overall expenditure about amounts spent and committed. Arrangements in place in authorities surveyed varied from elaborate, fully networked computer systems providing information on commitments locally and centrally, to separate spreadsheet systems managed locally and subsequently collated at the centre. Separate systems must regularly be reconciled with the main financial accounting systems, and if there is no direct link with the centre, delays are inevitable.

49. In one authority, financial staff prepare a one-page monthly summary which allows social services staff to follow progress. This summary sets out the number of people receiving care, the way they are using services and how these patterns of provision differ from those expected. It also summarises expenditure, both in terms of commitments and in a form that is compatible with the main local authority financial information system. The commitment expenditure shows the current position, how this compares with the expected position for the month and the full annual cost if expenditure continues at the same rate.

50. This sort of information allows managers who are not financially trained to understand the effects of their decisions on the budget. By making relatively complex information readily accessible to staff, authorities enable them to make sensible decisions which help keep commitments within budget.

Recommendations:

Resources need to be managed in an integrated way and merged into a single commissioning budget.

Authorities should treat their services in a similar fashion to independent sector services, through the use of service agreements and contracts within a mature contracting framework.

They should make information readily accessible to staff, to enable them to make sensible decisions which help keep commitments within budget.

Adjustments to the mix of services

51. Greater flexibility should initiate adjustments in the mix of services provided by authorities. Early indications suggest that this is happening in most authorities with increasingly flexible use of the STG for home care services, and greater targeting of these services to provide more intensive packages of care.

52. Prior to April 1993, the funds subsequently transferred to local authorities via the STG all went to individuals in residential and nursing homes through the social security system. One purpose of the transfer was to allow the funds to be used to keep people in their own homes wherever possible. The extent to which these funds have been diverted to promote home care is therefore one measure of the policy's success.
53. Over the first year of operation, authorities expanded their services in various ways using the additional resources made available through the STG. Overall, residential and nursing home care still took a bigger proportion of the total budget in 1993/94 than in 1992/93 with nearly all authorities expanding residential and nursing home care as expected. But most also diverted some of the funds to increasing home care (Exhibit 13) usually by increasing the amount of care provided to each household (Exhibit 14). Eleven authorities increased home care and actually reduced residential care; but ten increased residential care while reducing home care, and one reduced both.

54. Authorities vary in the amount of care provided to each household (Exhibit 15, overleaf), with some providing high numbers of hours of care to a few
households, while others provide a few hours to a high number of households (with most in between). About half are increasing both the hours of care and the numbers supported (Exhibit 16), although many are increasing targeting by increasing hours of care while reducing the numbers of households supported. But 12 are doing the opposite, and one is reducing both hours of care and numbers of households supported.

55. It is for each authority to determine the appropriate service response but authorities which currently provide a low number of hours per household and high coverage may need to increase their targeting to balance growing need with tight resources. Authorities should review their position within the range and possibly reassess existing users to ensure that the response is appropriate and in line with eligibility criteria. They should then set the direction.
'Each authority needs to review its pattern of provision and possibly reassess existing users to ensure that the response is appropriate and in line with eligibility criteria.'

of any changes required in their community care plans. Many authorities now specify actions to be achieved at agreed costs within specific timescales and monitor progress against the plans. In addition, many authorities are bridging the gap between strategy and action with 'purchasing' or 'commissioning' plans that set out the services required for a specified number of clients within particular categories, allowing them to indicate to those providing services the sorts of services required to meet care needs in the future.

56. Authorities also need to know the nature of help given to users and carers. Very few record this information in a regular way. For example, there is very little about out-of-hours and weekend use and the type of care given.

57. The level of service given in one authority measured by number of contacts (rather than hours) shows that housework still dominated for those receiving a weekly visit, while personal care – such as 'personal hygiene' – was important for those receiving daily or twice-daily help (Exhibit 17). This use of resources may not be inappropriate if the authority has a clear policy of early intervention and preventative work, but the information is needed to check that practice is following policy. The authority at least knew which services were being given and had the basis on which to review their appropriateness.

**Recommendations:**
Each authority needs to review its pattern of provision and possibly reassess existing users to ensure that the response is appropriate and in line with eligibility criteria.

Authorities need to set the direction of any changes required in joint community care plans.

They need to record in more detail the nature of help given to users and carers.

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**Exhibit 17**
Home help and home care activity analysis

At one authority housework still dominated for those receiving a weekly visit compared to a higher delivery of personal care for those receiving intensive help.

**Source:** Audit Commission survey of 1 SSDs

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![Chart](chart.png)
4. The Cost of Each Episode of Care

58. A network of care managers provided with greater flexibility through devolved budgets and an increasingly mature contracting framework will be unable to assemble suitable packages of care unless they can access cost-effective services. The total cost to the local authority of each episode of care depends on three things:

♦ the gross cost of care;
♦ the arrangements for charging for services which allow authorities to recoup some of their costs, releasing resources for more care; and
♦ the duration of care.

The gross cost of each service

59. In previous bulletins, the Audit Commission reported that the costs of local authority residential homes fell mostly between the costs of independent residential and nursing homes (Refs 3 and 10). These cost differences may reflect the relative dependency of individuals, the quality of care or the costs of providing extra care. But they may also be the result of inefficient services. Local authorities were advised by the Audit Commission to check the situation thoroughly to ensure that they were getting value for money. With limited resources, it makes no sense to protect services that are considerably more expensive than others unless they provide extra benefits.

60. In practice, many authorities are responding by reducing their direct provision. Nationally, statistics from the Department of Health show a fall in the number of available local authority home beds, with increasing numbers provided by the independent sector (Exhibit 18).

Exhibit 18
Changes in numbers of places in residential homes 1987-1995

There has been a fall in the number of available local authority beds, with increasing numbers provided by the independent sector.

Source: Department of Health statistics (Ref. 11)
4. The Cost of Each Episode of Care

A few are still considering their options while some continue to maintain relatively high cost residential provision. Authorities should continue to review costs rigorously to assure themselves that they are getting value for money.

61. As the independent sector increases its capacity, the balance of in-house and independent provision for domiciliary services also needs to be considered, taking into account quality and cost. Many independent sector domiciliary services are consistently priced below the costs of local authority services (Exhibit 19). In addition, the independent sector is particularly competitive outside normal working hours and at weekends. In one authority, the local authority home care provider sub-contracts weekend home care to the independent sector to keep costs down.

62. Local authority home care services often have high costs because of national pay and conditions for staff. While such an approach may ensure that they retain good quality people, authorities must always check that they are getting best value for money. Each pound extra paid to staff is a pound less for users and their carers.

63. In making commissioning decisions, local authorities calculate unit costs for home help and home care in a number of different ways. Some incorporate a full range of management and other overheads. Others exclude these costs or quote marginal costs, or even the hourly costs of staff alone (for example, authority A in Exhibit 19). Authorities must ensure, when comparing with prices quoted by independent providers, that they calculate the cost of their own services fully. They should be establishing their own services as ‘cost centres’ with all costs – including overheads and capital at market rates – recharged to them, so that decisions can always be taken on the basis of full costs.

64. The range of prices charged by independent providers is broad, possibly reflecting a wide variation in the type and quality of care provided. This should allow care managers to be selective, choosing the most appropriate care for each individual. But authorities need to provide care managers with the security of an

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**Exhibit 19**
Local authority costs and independent sector prices for home help and home care

Many independent sector services are consistently priced below the estimated costs of local authority services.

Note:
* This cost figure only includes the hourly cost of staff - see paragraph 63.

*Source: Audit Commission survey (3 SSDs)*
The discretionary framework for non-residential services has led to confusion with as many charging systems as there are local authorities.\(^1\)

### Recommendations:

Authorities must ensure when comparing the cost of their own services with prices quoted by independent providers that they calculate the full gross cost and take into account overheads. All services should operate as ‘cost centres’ with all costs – including overheads and capital at market rates – recharged to them so that decisions can always be taken on the basis of full costs.

They need to provide care managers with the security of an appropriate contracting framework with appropriate specifications and checks on quality.

### Income from charges

65. Authorities need to decide how much to charge users for services – particularly non-residential services – in order to keep the net costs of services as low as possible. Until recently, most local authorities’ charges for domiciliary and day services were low and nowhere near their full cost. This is now changing.

66. Local authorities have long been charging for residential care. Their powers derive from the 1948 National Assistance Act and allow only for limited local discretion. Powers to charge for domiciliary and daycare services are permissive and derive largely from the 1983 Health and Social Services and Social Security Adjudications Act (HASSASSA Act) and allow local authorities considerable discretion.

67. But central government monitors the income raised from charges (9 per cent of the gross cost of services in 1992/93). It has also issued guidance which states (Ref. 12):

> The Government’s view, confirmed in the Community Care White Paper, ‘Caring for People’ of 1989 and in subsequent policy guidance, has consistently been that users who can pay for such services should be expected to do so, taking account of their ability to pay. The White Paper and Policy Guidance also make it clear that ability to pay should not influence decisions on the services to be provided, and the assessment of financial means should therefore follow the care assessment.’

68. The discretionary framework for non-residential services has led to confusion with as many charging systems as there are local authorities. Individuals in similar circumstances can find themselves facing charges which vary from area to area according to each authority’s policy (Table 2, opposite and Appendix).

69. In some cases, users on income support in one authority will pay more for care than someone with substantial income or savings in a different authority. A number of authorities are further revising their charging schemes, increasing charges for community packages in 1996/97.

70. The financial incentive for authorities to use residential care remains strong. In nearly all situations it is substantially cheaper for local authorities to place people in residential care, even where there is no difference between the gross cost of residential care and care at home. There is an even bigger cost advantage to the local authority to place people who qualify for the residential allowance in independent sector homes. This allowance provides an additional £51 (£58 in London) per week. Where authorities impose cost ceilings expressed as a proportion of the average net residential cost (see Exhibit 7 and Case
4. The Cost of Each Episode of Care

Table 2
Costs to users and to the authority of care costing £197 per week in different social services departments

<table>
<thead>
<tr>
<th>User's circumstances (five examples – see appendix for details)</th>
<th>Residential Care</th>
<th>Community Care Package</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Gross cost £197 per week)</td>
<td>(Gross cost £197 per week)</td>
<td></td>
</tr>
<tr>
<td>In-house</td>
<td>Independent</td>
<td>SSD 1</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Charge to the user £s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income support</td>
<td>46</td>
<td>103</td>
</tr>
<tr>
<td>Income support and attendance allowance</td>
<td>46</td>
<td>103</td>
</tr>
<tr>
<td>‘Middle’ income and savings</td>
<td>169</td>
<td>169</td>
</tr>
<tr>
<td>High income</td>
<td>197</td>
<td>197</td>
</tr>
<tr>
<td>High savings</td>
<td>197</td>
<td>197</td>
</tr>
<tr>
<td>Net cost to local authority £s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income support</td>
<td>151</td>
<td>94</td>
</tr>
<tr>
<td>Income support and attendance allowance</td>
<td>151</td>
<td>94</td>
</tr>
<tr>
<td>‘Middle’ income and savings</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td>High income</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>High savings</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Study 3), this can restrict significantly the scope of community care packages.

71. Neither the legal framework nor subsequent guidance gives local authorities advice about how or whether to take users' savings and property into account when setting charges for non-residential services. Again, a range of systems is being developed and applied by authorities. The effect of income and capital on the charges levied is shown in Table 2 above and Appendix.

72. Some authorities implement 'full cost' schemes where individuals with high disposable incomes and sometimes with savings above certain thresholds meet the full costs of non-residential care. The income and the capital taken into account in the calculations varies between authorities. Some take account of capital above the income support threshold of £8,000 while others use the housing benefit threshold of £16,000.

73. Taking capital into account potentially equalises the charging regimes for residential and domiciliary care and reduces perverse incentives that make it cheaper for local authorities to provide residential care. It also equalises the treatment of individuals who have high incomes but low capital with those who have high capital and low incomes. However, those with low incomes could find it very difficult to meet charges imposed if their capital is in the form of their own home. There is uncertainty about whether authorities have the powers to impose charges in this way.

74. Some authorities deliberately charge people living at home less (and therefore have to pay more themselves). The White Paper, Caring for People, promotes the development of domiciliary, day and respite services to enable people to live in their own homes wherever feasible and sensible'. One authority explicitly acknowledged this by charging only up to half price for non-residential services to ensure that there was still a clear bias for users in favour of community services. But the authority clearly loses considerable potential income by adopting this approach. It is to many authorities' credit that they are increasing home care in line with the Government's policy, even though it is cheaper for them to make more use of residential care.

75. The costs of collecting charges vary with the complexity of the scheme. Different approaches have different costs. Flat-rate systems that charge everyone the same are cheaper to administer than ones that adjust charges according to means, but they are not so fair and raise less revenue – although not always significantly less. One authority with a flat-rate system estimated that an individual billing system would cost between £500,000 and £800,000 more to run (Case Study 5) and would only raise a maximum of £1,500,000. It would also take 98 per cent of clients' disposable income in some circumstances, which would clearly be unreasonable, and make the £1,500,000 appear difficult to achieve in full. The authority decided to increase its flat-rate charge to raise an estimated additional £700,000. But this approach is meeting some resistance, and the authority is still concerned about whether it is acting 'reasonably'. Section 17 of HASSASSA stipulates that:

'...an authority providing a service may recover such charge (if any) for it as they consider reasonable. In addition the charge levied has to be no more than it appears to them that it is reasonably practicable for him to pay.'
Case Study 5
Review of charging policy and costs of change

Work in the authority reviewed:

♦ **Estimates of income generation** – using financial modelling – to estimate how much could be raised;

♦ **Collection systems** – to explore alternative ways to collect and monitor income;

♦ **Implementation** – to review how, in what way, with what resources, and to what timescale;

♦ **Consultation** – with partner voluntary agencies on the effect of implementation;

♦ **Bad debt provision** – to estimate the risk on moving from ‘pay as you receive’ to alternative methods; and

♦ **Comparisons** – with schemes in neighbouring local authorities.

The benefits and drawbacks of changing or not changing the charging policy were examined.

The **costs** of a new individualised system were estimated as:

<table>
<thead>
<tr>
<th>Running costs:</th>
<th>£ (000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial assessment, calculating/notifying changes</td>
<td>110 – 250</td>
</tr>
<tr>
<td>Doubling additional local administration staff</td>
<td>30 – 30</td>
</tr>
<tr>
<td>Collection</td>
<td>180 – 230</td>
</tr>
<tr>
<td>Cash office staff</td>
<td>30 – 30</td>
</tr>
<tr>
<td>IT systems/maintenance/postage</td>
<td>20 – 30</td>
</tr>
<tr>
<td>Bad debt provision</td>
<td>250 – 375</td>
</tr>
<tr>
<td>Less current collection costs</td>
<td>(100) – (100)</td>
</tr>
<tr>
<td>Additional running costs</td>
<td>520 – 835</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Set-up costs:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporary staff (12 – 20)</td>
<td>180 – 300</td>
</tr>
<tr>
<td>IT set-up/promotion/publicity</td>
<td>50 – 50</td>
</tr>
<tr>
<td>Total set-up costs</td>
<td>230 – 350</td>
</tr>
</tbody>
</table>

76. The extent and limits to ‘reasonableness’ are not known:

♦ Are flat-rate charges reasonable?

♦ If not, is replacing a flat-rate scheme with an assessed scheme necessary or sufficient?

♦ If so, how complex does it need to be to be reasonable, given that administration costs rise with complexity?

77. The impact charging systems have on users also needs to be carefully evaluated. Data from one authority show a large number of people withdrawing from a home care scheme when the old flat-rate charge for all home care clients was replaced with a potentially more expensive system based on the ability to pay through an assessed income system (Exhibit 20, overleaf).
Exhibit 20

Effect of new charging arrangements on home care services

A large number of people withdrew from the home care scheme when new charges were introduced.

But there was no significant drop in the number of people seeking care for the first time at the point of change, and numbers quickly returned to their former rates. At another authority, the effects of change upon existing users were less (Case Study 6).

78. Authorities can minimise the effect of increased charges on users by offering welfare benefits checks where appropriate. One authority found that, as a result of running such checks, many users receive a net increase in income despite paying charges for community services (Case Study 7).

79. The net effect of different rules interpreted in different ways, together with differing collection systems and costs, is a variation in the percentage of income recovered. A recent review of charging arrangements by the National Consumer Council (Ref. 13) expressed concern that trying to develop a system which takes account of affordability may be incompatible with administrative simplicity and the ability of users – and staff – to understand its workings.

Case Study 6

Introducing a new charging policy

At Kent Social Services Department a system of charging based on ‘banded charges’ is being changed to an ‘assessable income scheme’. The cost of implementing the new system is estimated at £250,000 per annum. Full implementation should increase income by £1.85m. Implementation requires 9,000 financial re-assessments (taking an average time of two hours each). Only 20 people have withdrawn from the service so far. The authority provides advice on social security benefits while carrying out the financial assessments. The full picture will not be known for some time, as the new policy is being phased in and many users will not feel the full effects until 1996/97.
4. The Cost of Each Episode of Care

**Case Study 7**

**Providing welfare benefits advice**

At Sheffield Social Services Department a welfare benefits check is offered to all home care users. Over 3 years, 2,136 clients have opted for a welfare benefits check. This had the following results:

- 70 per cent of clients assessed were advised that they were eligible for one or more benefits that they were not getting;
- the advice given to date is estimated to generate over £4.4 million annually in total for users;
- on an average income of £100 per week, the extent of under-claiming was found to be £37; and
- from the extra £37 per week income generated by the welfare benefits check, clients pay £5 extra in home care charges.

**80.** Local authorities need to ensure that their charging policies have clear objectives which reflect and do not impede the implementation of community care (Box A).

**81.** Some consensus is needed on ways to reduce the variation in the way local authorities apply discretionary charging policies, possibly within a clear framework similar to the one for residential charges. Consensus is also needed on the legal boundaries of reasonableness and the extent to which capital should be taken into account in order to avoid current perverse incentives which favour residential care. The costs of various systems need measuring, and the impact on often vulnerable and needy individuals who are trying to sustain themselves in the community should also be assessed.

**Box A Charging policies**

Local authorities charging policies should:

- maximise income at minimal cost to the authority. They should take account of the individual's ability to pay and be as equitable as possible;
- be rigorously costed. Start-up costs should be included along with the effect on take-up, the costs of administration and collection and likely level of bad debts;
- be fully explained to users and communicated formally to them in a form best suited to their needs (eg, in Braille). Welfare benefits advice should be offered where appropriate;
- include a clear method for users to challenge charges where they feel them to be inappropriate, or incorrectly assessed; and
- be monitored, and adjusted in the light of results.
Recommendations:
The extent and limits to 'reasonableness' should be clarified.

The impact on users of charging systems needs to be carefully evaluated.

Authorities should offer benefits checks where appropriate.

They should ensure that their charging policies have clear objectives which reflect and do not impede the implementation of community care.

Consensus is needed on ways local authorities apply discretionary charging policies to avoid wide variations between them and perverse incentives in favour of residential and nursing home care.

Duration of care
82. Lastly, information on how long people need care is required by authorities if they are to estimate their financial commitments. As the transfer of the STG nears completion, care packages for new clients will need to be financed from resources released from individuals who no longer require care (either due to a change in care needs or death). If resources are released at rates significantly below planned expectations, funds for new packages of care will be in short supply.

83. In social services, the pattern of duration of care across different client groups and types of care is likely to be a complex one. Previous research (Ref. 14) on models of lengths of stay on hospital wards for the care of elderly people has found complex patterns similar to those observed in residential and nursing homes. A better understanding of these patterns should allow more accurate financial projections and controls. Authorities are currently using three different methods for monitoring duration of care:

- Length of stay – monitoring and tracking the stay of each individual;
- Turnover – monitoring the numbers entering and leaving care; and
- Monitoring cumulative 'spend' – eg. days of residential care purchased – showing the cumulative build up of spending commitments.

84. The emphasis so far has been on monitoring length of stay for residential and nursing home placements, although some authorities are now collecting information on the duration of community-based packages. As community packages increase in importance, authorities will need to monitor both. The implications are particularly significant for younger people who may need care for a whole lifetime.

85. Many authorities have made a good start but the issues faced and the data required are complex. This may be an area that could benefit from centrally directed research aimed at providing a methodology for authorities to use locally.

Recommendations:
Authorities should monitor how long people need care.

Centrally directed research should be considered to provide a methodology for authorities to use locally.
5. Conclusion

86. Progress with the implementation of the community care changes continues but varies widely. Authorities differ significantly in the proportion of people they assess, the eligibility criteria they apply, and the local arrangements they put in place to implement the changes, with different mechanisms used for devolving budgets and contracting for services. The pattern of use of services also varies widely, and authorities are charging users widely different sums. Some of this variation is to be welcomed as authorities experiment to find the best approach. It also reflects historic and local differences. But it is less satisfactory where it produces inequity between areas for users and their carers. Authorities should share ideas and compare their approaches to winnow out the less successful and promote those which benefit users and carers most, including those that lead to greater equity.

87. Many authorities are working hard to improve arrangements for users and their carers – often acting against perverse incentives. These perverse incentives, which could discourage many initiatives, should be addressed, so that the best interests of users, their carers and authorities coincide.

88. This bulletin has stressed the key role played by good information. It allows authorities to take control of the care equation, shaping and directing resources to best effect. Without it, they are at risk of drifting, unsure both of whether they are going to overspend or not, and of whether they are using resources to best effect. They need to bring all the information described in this bulletin together to get an accurate picture of what is happening (Exhibit 21, overleaf) and plan a programme of investment in information and information technology to provide it on a routine basis.

89. Authorities must start with a clear idea of the pattern of demand for help they are facing. Most are already putting in place a banding system based on degree of disability or risk. Statistics on referrals and assessments need to be strengthened to show the numbers of people seeking help who fall within each band. These figures need to be checked against the characteristics of the population in each area to make sure that they are consistent and that any anomalies are understood. The resulting information provides the starting point for planning a response.

90. Authorities then need to estimate the financial consequences of providing help. Information is required on the typical amount of care required by people in each band, the weekly cost of providing that care and the likely duration of care. It is best to start by examining past patterns of care to provide the information. Expenditure profiles can then be set up showing how much money is needed week by week to continue these patterns of care. Authorities should then review their eligibility criteria, using the expenditure profiles to model the financial consequences of giving priority to different groups.

91. Information systems are also needed at the operational level to monitor progress as care managers and others make day-to-day
decisions. Actual patterns of expenditure can be compared to the expected spending profiles. Any divergence can be spotted and addressed. If care managers change the types of service preferred, the trends can be spotted and changes made to central plans and purchasing strategies to reflect these preferences. Managers centrally can provide support by stimulating extra provision where it is needed and putting in place contracts which encourage providers to meet the changing needs.

92. Information on costs also needs to be monitored centrally to make sure that authorities are getting good value for money. And the impact of charges needs to be monitored to check that they are fair.

93. The review also needs to take place in the context of a wider debate about the future of the State in providing care. Many authorities are making explicit the limits to this source of care by tightening eligibility criteria, increasing charges and introducing 'cost per case ceilings' to care packages. This is necessary and prudent management, but what are the limits? In a rationing environment how are the relatively low level needs of some carers to be balanced against the high costs of some users? What is the role of prevention in social care? The White Paper, Caring for People, states that services should concentrate on those in greatest need. However, the White Paper, Health of the Nation, stressed the desirability of prevention. Critically, how are future and growing expectations and needs, in the context of demographic change, to be met from limited resources?

94. The difficulties have been most visible in relation to individuals assessed by local authorities as needing nursing home care. They are being charged for care which many thought would be provided by the NHS. The Government has issued guidance to health authorities requiring them to provide and make explicit the eligibility criteria for continuing health care (Ref. 15). With demographic trends, more and more individuals will require long-term care, whether to meet continuing health care needs or social care needs, wherever the line is drawn.

95. A wider debate is becoming essential; it should judge the balance between tax, rationing and insurance-based (ie, funded) or self-financing mechanisms of paying for care. This debate can take place effectively only if information is improved. Continuing improvements to community care depend on better information for local authorities, users and carers, and the general public alike.

'Continuing improvements to community care depend on better information for local authorities, users and carers, and the general public alike.'
5. Conclusion

Exhibit 21

Information requirements

Information will need to be improved across the board.

- **Numbers seeking help**: Information is required on referrals, their source, type of assessment and care packages by client groups. If such information is to contribute to the debate about resource adequacy, agreed definitions will also be necessary so that comparisons can be made across authorities.

- **Eligibility criteria**: If the financial consequences of eligibility criteria are to be estimated, information is required on:
  - the numbers in each category (e.g., high / medium / low);
  - the costs of packages of care by category;
  - and the duration of all types of package.

- **Flexibility to deploy services**: Financial information systems should be in place to monitor both spending and commitments for devolved budgets.

- **Range of options available**: Information systems need to better capture which services are deployed, for whom, to what extent, and in what way (e.g., home care at evenings / weekends).

- **Gross cost of each service**: Information on 'costs' of in-house services needs to represent a true and realistic cost to the purchaser - i.e., be adequate to compensate providers if they had to cover all of their costs.

- **Income from charges**: Charging schemes need to be rigorously costed, be fully explained to users, monitored and adjusted in the light of results.

- **Duration of care**: Information is required on 'length of stay' for residential and nursing home placements and the duration of community-based packages of care.
References

1. Caring for People: Community Care in the Next Decade and Beyond, Cmnd 849, HMSO, 1995.


10. Audit Commission, Taking Care: Progress with Care in the Community, HMSO, 1993.


12. Department of Health, Local Authority Circular LAC(94)1, January 1994


Appendix

The net cost to local authorities of different options of care

Table 2 in the main text shows the cost to local authorities of supporting people in either residential care or in their own homes for a total gross cost of £197 per week. This appendix provides supporting detail for this table.

Three options have been costed:

♦ Option 1: residential care in a local authority home (£197 per week);

♦ Option 2: residential care in a home provided by the independent sector (£197 per week); and

♦ Option 3: care at home (£197 per week) consisting of:
  - 20 hours of home care at £6 per hour
  - 4 days at a day centre including mid-day meal at £17 per day
  - 3 days of meals-on-wheels at home at £3 per day

The charges for people in five different sets of financial circumstances have been worked out for each of the three options for eleven authorities as shown overleaf. To simplify matters, accommodation costs at home have been ignored and in all five sets of circumstances, the person receives state retirement pension. In the first set the person is not in receipt of attendance allowance whilst at home, but is for the other four. Once in residential care the person cannot receive attendance allowance if funded by the local authority. In the last two circumstances the individuals can receive attendance allowance in independent sector residential care because they are funding themselves. In all sets the person’s contribution to residential care excludes the £13.35 per week personal expenses allowance.

A national set of guidelines provides local authorities with a consistent framework for calculating each person’s contribution to the cost of residential care, so that the net cost to all eleven authorities is the same for residential care. In some circumstances, the net cost for their own local authority homes exceeds the net cost for independent homes largely due to the residential allowance which currently amounts to £51 per week (£58 in London).

No equivalent national set of guidelines exists for charges for non-residential services and each local authority must decide for itself how much to charge for each service. As a result people in similar circumstances pay widely differing amounts, depending on where they live. Furthermore, the net cost to authorities of care for people in their own homes is often considerably higher than the net cost of care in residential homes, even though the gross cost of care is the same in all cases. This sets up a perverse financial incentive for authorities to place people in residential care wherever possible, even though the community care policy favours care at home where appropriate.
The net cost to local authorities of residential care for people in five different sets of financial circumstances

<table>
<thead>
<tr>
<th>Income and Benefits</th>
<th>Local authority residential care</th>
<th>Independent sector residential care</th>
<th>Own home with community care package</th>
</tr>
</thead>
<tbody>
<tr>
<td>State retirement pension</td>
<td>£58.85</td>
<td>£58.85</td>
<td>£58.85</td>
</tr>
<tr>
<td>Occupational pension</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tariff income from savings*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attendance allowance</td>
<td>6.25</td>
<td>6.25</td>
<td></td>
</tr>
<tr>
<td>Income support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential allowance</td>
<td>51.00</td>
<td>51.00</td>
<td></td>
</tr>
<tr>
<td><strong>Total weekly means</strong></td>
<td><strong>£58.85</strong></td>
<td><strong>£116.10</strong></td>
<td><strong>£65.10</strong></td>
</tr>
</tbody>
</table>

*For home care packages tariff income from savings varies according to local authority - the above figure is similar to that used for residential care - many SSDs adopt similar tariff income assumptions for home care packages.*
The net cost to local authorities of home care for people in five different sets of financial circumstances

Each of the 11 local authorities below operate charging policies that affect people in different ways. Authorities are shown in the same order in each of the charts below.

1. **The net cost to the local authorities of a home care package for someone on basic income support is higher than the cost of residential care in all circumstances except for one authority where it is less than the cost of local authority residential care (although the charges account for the majority of the person’s income).**

2. **The net cost to authorities does not change much for someone in receipt of attendance allowance although the person’s income has more than doubled.**

3. **In spite of substantial extra income, the net cost of home care is virtually unchanged in some authorities. However, the net cost of residential care has reduced significantly.**

4. **The net cost to local authorities of a home care package for someone with a ‘higher’ income is less again for most authorities and zero for one; but residential care now costs authorities nothing at all. For a few authorities the net cost is not substantially different from that for people on basic income support.**

5. **The net cost to local authorities of a home care package for someone with ‘high’ levels of savings (£16,000+ from April 1996) varies from zero in two authorities to 95% in three. Residential care continues to cost all authorities nothing so that while some have removed the perverse incentive, it remains strong in others.**