MANAGING SOCIAL SERVICES FOR THE ELDERLY MORE EFFECTIVELY
Managing Social Services for the Elderly
More Effectively

A Report by the Audit Commission

February 1985
The Audit Commission for Local Authorities in England and Wales (the Commission) is concerned with the economy, efficiency and effectiveness of local authorities' services. To this end over 1,600 value for money projects were undertaken by auditors and their local authority clients in 1984, concentrating on purchasing, refuse collection, further education and the police. In preparation for the current audit round, the Commission also published a number of reports last year setting out its views on good management practice in: vehicle fleet management, council house management, and non-teaching costs in secondary schools. These reports have demonstrated that there are worthwhile opportunities for local authorities to obtain better value for money.

This latest report summarises the findings of a study of local authority services for the elderly that has been in train for over two years - the work was started by the former Audit Inspectorate. Its tone is different from that of the earlier reports. It is less prescriptive, and more concerned with helping those involved with social services address such basic questions as:

- How much residential care and community services for the elderly should be provided locally, given likely demographic changes and the expansion of private services?
- Are clients receiving the care most appropriate to their needs; in particular, are clients in residential care when it would be better for them and the local ratepayers if they were supported in the community?
- Are existing services for the elderly being managed as effectively, economically and efficiently as possible?

As will be readily apparent, these are difficult questions to address. For all practical purposes, there is no limit to the potential demand for local authority services for the elderly; so the answer to the question "how much" is a matter of policy, not just management judgement. Moreover, social work professionals do not agree among themselves on the desirable outcomes for particular types of client. This is scarcely surprising in light of the often conflicting pressures from the client, friends and relations and those paying for the services.

But the questions cannot be ignored. Social services for the elderly now cost over £1 billion a year; and demands are certain to grow over the next decade, reflecting the steady increase in the number of people over 75 years old. If these services are to be managed effectively, directors of social services and members of social services committees, as well as chief executives and treasurers and the members of local authorities responsible for allocating resources, must reach informed judgements on them. The purpose of this report is to assist in this difficult but essential task.
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The number of elderly people in England and Wales is increasing. By 1991 there will be 15% more people aged 75 and older than there were in 1981 and 30% more people aged 85 and over. Against this background local authorities are already spending over £1 billion a year on residential care and community services directly for the elderly - mainly on home helps, day care, meals-on-wheels, sheltered housing.

In a typical authority, these services account for some 45% of total social services expenditure, but there are wide variations in the amounts spent by individual authorities even after taking into account differences in unit costs, local demography, the provision of National Health Service (NHS) long stay accommodation and other factors. Some local authorities only spend, on an adjusted basis, one third as much as is being spent by some other authorities.

The extent of the services to be provided for the elderly is very much, but not wholly, a matter determined by what it is felt locally can be afforded. This is a political choice. The Audit Commission offers no opinion on how much a local authority should spend, although it does have views on how money can be spent to better advantage.

At present residential care is provided for around 2% of those over 65 years old and support in the community for a further 13%. The number in residential care is very small; and although it seems unlikely that the NHS will increase its facilities, the level of private residential care is rising. Residential care costs an authority £3,000 a year, which can be from 30% to 50% more than intensive community care, depending on the type of support provided.

Any move for a substantial extension of residential care facilities would, of itself, create an enormous resource problem. But some of the pressure for more facilities is eased because of the belief of many engaged in the welfare of the elderly that the wellbeing of the old is best served by supporting them in the community for as long as possible. They take the view that unnecessary or premature admission to residential care can be avoided without exposing those concerned to undue risk. If this can be achieved, the result will be greater value for money for the elderly person and ratepayer alike.

By far the majority of elderly people fend for themselves or are looked after adequately by relatives, friends or the voluntary sector without turning to the local authority social services for support. If this situation changes materially, and considerably more elderly people seek assistance from their local authority, then the authorities would be unable to cope within the scope of their existing resources. Support for those caring for elderly relatives and friends is also, therefore, justifiable on economic as well as social grounds.

The lack of any realistic limit to potential demand for social services for the elderly and the pressure on budgets means that these services must be managed well if they are not to be overwhelmed. Many social services departments are well managed. But in some areas there are management
weaknesses in the running of the social services for the elderly which, if remedied, would alleviate some of the growing pressure on local authorities to devote greater resources for the care of the elderly. The report illustrates:

(i) Some people are inappropriately placed in residential care. Where there is pressure upon places some of those that need residential care cannot secure it, and remain at risk in the community. In three of the seven authorities studied in detail, about half of the residents in the authorities' homes might be expected to be able to be supported in the community, if the necessary resources were available; in each case, the number of severely physically disabled residents (who would be expected to justify a residential place) was well below average. This situation may reflect the nature of the local community and elderly population. Often, however, the underlying cause is lack of effective management:

- the lack of the necessary information about individuals' needs being analysed systematically for management purposes;
- admissions procedures that are not effective in ensuring that places are allocated to those who need them most;
- lack of community support for elderly people (and the relatives and friends often caring for them).

(ii) Community services not directed to those who need them most. In four of the sample authorities, half or more of the expenditure on community services for the elderly was allocated to those who do not obviously need it. In two of these four authorities, provision for those most dependent on the support of the public sector was below average.

(iii) Inadequate co-ordination of health, housing and social services. Arrangements for the provision of sheltered housing and the selection and training of wardens, as well as for the provision of community nursing support and medical treatment for disabled elderly clients of social services departments, are rarely as effective as they can, and should be.

(iv) Inadequate management of community services. The overall objectives of providing individual services are often unclear; management's policies and guidelines on how they should be used are often not well articulated; and procedures and systems for controlling their use are largely absent. These weaknesses were especially apparent within the management of the largest community service, the home help service.

(v) Waste, in the provision of services. In particular, in some of the authorities studied:

- average frequency of meals-on-wheels varied from two to five meals per week; the contribution of only two meals a week to the welfare of an elderly house-bound client was often not clear; little attention had been given to alternative methods of meal preparation;
- home help rosters were such that staff are spending too much time travelling at the expense of service levels;
- day-care transport costs were substantially higher than necessary;
- residential homes were incurring excessive staffing costs during the day, with unexplained overtime and the use of agency staff; at night, some authorities were continuing to pay staff to sleep-in, even when active night staff had been appointed.

As stated above, these weaknesses are not universal; many authorities are coping well with the difficult problems they face. This report describes
an approach, to diagnosing local management problems and tackling them, that draws on the experience of successful authorities in England and Wales. It does not offer a blueprint. There is no single 'right' answer to any of the questions discussed. Rather, the report sets out an approach to thinking about the questions, and thus to managing social services for the elderly more effectively.

The cost implications are not trivial. At present, a typical shire county might spend £9 million a year on services for the elderly and a metropolitan district £6 million. Managing these services well would result in better social services for the elderly, in some cases at lower costs to ratepayers. This study suggests that in a number of authorities the social services department could support 15% to 20% higher service levels (i.e. at least as much as the likely growth in demand) within existing resources at the same time as improving the quality of service given to clients.
Exhibit 1

PROJECTION OF THE ELDERLY POPULATION
England and Wales

Source: Government Actuary's Department in Consultation with OPCS, reprinted in Annual Abstract of Statistics, 1983 Edition Table 2.8
Introduction

1. The elderly population of England and Wales (i.e. those persons aged 65 and over) is approximately 7.5 million (15% of the total population) of whom some three million (40% of the elderly) are aged 75 or over. Exhibit 1 indicates that the number of elderly people, and especially the 'elderly elderly' (those over 85 years old), is going to increase considerably over the next decade. The age structure of the population differs considerably between individual authorities. The percentages of the total population who are aged 65 or over range from 10% to 25% in authorities in England and Wales. The percentages of the elderly who are aged 75 or over range from 33% to 45%.

2. The major factors influencing the dependency of elderly people on others are physical disability, mental state, degree of incontinence, and environmental circumstances (e.g. housing conditions, access to shops). As a rough approximation, the study team estimates that about 50% of the elderly population have no specific physical disability and are able to live independent of any support; and that a further 35% have relatively little physical disability but are unable to perform heavy household cleaning. However, at least 15% of the elderly population are likely to be dependent on others for the performance of at least some tasks which they would previously have performed independently. In many cases, especially where the degree of dependence is low, support from friends and relatives alone is sufficient. Where the degree of dependence is higher, however, or where support from friends and relatives is not available, services from a variety of organisations may be required.

3. The major public sector providers of services to the elderly are local authority social services departments and the National Health Service (NHS). Support is also available from a range of organisations in the private and voluntary sectors. The range of services provided from these four sources is wide.

(i) Local authority social services provide residential services - both long-stay accommodation and - to assist in the rehabilitation of elderly people or to provide relief for caring friends or relatives - short-stay accommodation. They also provide day care services (day centres and clubs) and domiciliary services (home help, meals-on-wheels).

In addition to their normal housing responsibilities, local authority housing departments provide sheltered housing for old people. Other departments, such as education and sports and leisure, may provide services (e.g. community centres) used mainly by the elderly.

In addition to these services, local authority social services departments may also make resources available to provide a range of aids to the elderly, to make adaptations to their homes, to provide telephones or to provide holidays. They also may provide funds to local private and voluntary groups and may 'purchase' care from the private and voluntary sectors.
ANALYSIS OF LOCAL AUTHORITY SERVICES FOR THE ELDERLY _ 1983

Estimated breakdown

Source: NHS, CIPFA (1982-83 Actuals)
Study Team Estimates (for degree of disability)
(ii) The National Health Service is responsible for in-patient services - acute, rehabilitation, long-term and short-stay relief/respite hospital beds for the elderly and mentally infirm as well as day treatment services (day hospital, out patients), and community and psychiatric nursing. In addition to these services, the NHS provides therapy services, chiropody, audiology and other services for the elderly as well as primary care through the family practitioner services.

(iii) The private and voluntary sectors provide similar services to those provided by local authorities and, in some cases, to those provided by the NHS: residential accommodation, nursing homes, day centres and clubs, home help, some meals-on-wheels, nursing, and some sheltered housing (through housing associations and private developments), as well as a variety of specialised services. A social services department may provide funds (e.g. through grants) for some of these services, and may also employ specialist co-ordinators of voluntary service.

4. Exhibit 2 provides the breakdown of social services department expenditure on the elderly, the levels of physical disability, and the extent to which the elderly are at present drawing on support from social services departments. As will be apparent approximately 2% of the elderly account for well over half social services’ expenditure on services for the elderly with a further 13% accounting for the balance. Over 80% of elderly people receive no social services support at all.

5. Even though services are concentrated on a small minority of the elderly, very large sums of public money are involved. It is estimated that, net, between £1,400 million and £1,700 million p.a. were spent on direct services for the elderly by local authority social services departments and the NHS in 1982-83 (excluding payments made to elderly people by the DHSS and also the cost of primary care provided by GPs). In this chapter, and elsewhere in this report, expenditure figures are quoted net of receipts (e.g. income from charges, payments from government or health authorities for specific purposes) as these are a measure of the true cost to the providing organisations. It should be noted that fees and charges for social services can be quite substantial. For residential care, income from residents is determined by statutory means-tested scales and authorities can do little to influence their eligibility for government grants or health authority payments. Most other fees and charges can be set within broad limits as the authority determines.

6. Without making any allowance for the allocation to the elderly client group of any of the £280 million spent by social services departments on fieldwork, or of the £320 million spent on administration in these departments, the net cost to social services departments of services for the elderly in 1982-83 was approximately £735 million. In addition the annual total payments to the voluntary sector by social services departments (a large part of which are for the elderly) exceed £170 million (ref 1)*. Thus, making some allowances for indirect expenditure, social services departments probably spend in excess of £1 billion annually on about one million people. This is the largest percentage allocation of social services expenditure to any client group.

7. Social services departments face complex challenges in providing appropriate levels and types of care for individual elderly people.

(a) Clients' needs vary and, furthermore, change over time. Each person

* The references are listed in Appendix A.
has to be individually assessed to determine the appropriate package of care given his or her characteristics and domestic circumstances. As Exhibit 1 showed, the number of elderly (and the older elderly in particular) will increase substantially over the next decade: there will be over 200,000 more people aged 75 or older in 1996 than there are now.

(b) *The availability of care varies* among authorities, by factors of two or more. The range of services available to the elderly is wide. For example, residential care provides 24 hour supervision for more dependent elderly people whereas lunch clubs provide a meal and company for the relatively active. Home help clients cover the spectrum of dependency and many receive very different levels of help. Within these services the level of local service provision varies.

- The 11th highest overall level of provision of services within an authority is just over twice the 11th lowest. Some of this variation reflects the demands of different age structures and different percentages of elderly people living alone. However, after standardising the populations of the authorities for these two factors, the highest is still as much as 90% greater that the 11th smallest.

- The mix of local service provision varies. For example, some authorities spend over twice as much on residential care as on community care; in others the position is reversed.

- Unit costs (i.e. cost per residential place or per home help full time equivalent) differ. The 11th highest overall unit costs are about 70% greater than the 11th lowest. The overall variation is as much as 40% after allowing for the 'London' effect associated with the higher price levels in London boroughs.

(c) *The requirement for services is not well-defined.* Unlike children in care, most social services to the elderly are not being provided under statutory obligation. In practice the level of provision and the recipients are largely at the discretion of the local authorities. Moreover, local authorities need to take account of the services provided by the NHS and the private and voluntary sectors:

- The NHS provides care to many elderly people both in hospital and in the community. The level of provision varies from region to region. The government has a declared policy of encouraging care in the community. The impact of this policy will vary in different parts of the country; but it will almost certainly mean that the level of NHS long term hospital care will not keep pace with demographic changes.

- The number of old people in private residential homes has grown very rapidly over the last decade and continues to expand but again varies from area to area. Most professionals interviewed during the study believed the rate of growth will continue or increase. Since the entry of people to private homes is largely outside the control of local authorities, private homes introduce a major uncertainty into the planning of public sector provision. At the same time local authorities' statutory duties to inspect and register such homes are being strengthened by new legislation.

(d) *New technology* is opening up new possibilities for sheltered accommodation and 'remote' monitoring of individuals' circumstances. A number of authorities are testing new approaches to providing packages of community care and to supporting carers - those people who, voluntary, are looking after elderly frail relatives or friends.
8. In addition to these challenges specific to caring for the elderly, there are more general difficulties in planning the provision and use of any social services. First, there is a general lack of reliable and comparable data. For some items of information (e.g. levels of residential care, details of the home help service), data from CIPFA and DHSS returns are available for all authorities although the reliability of some of this data is suspect. For other items of information (e.g. frequency of attendance at day centres, prevalence of particular characteristics of the client population), data is often limited and incomplete. Equally important, it is difficult to define desirable outcomes (or 'outputs') for clients. For example, residential care may provide greater security to an individual but otherwise a lower quality of life as compared with care in the community; the relative importance given to security and other aspects of quality of life will therefore affect an authority's provision of services.

9. The former Audit Inspectorate and, more recently, the Audit Commission decided that it would be worthwhile to examine how the problems inherent in meeting the needs of an increasing elderly population can best be managed. This report summarises the results of two related studies into the value for money of care of the elderly by local authority social services departments. It is directed towards a general audience of social services management, local authority members, and local authority auditors. The first of these studies was arranged by the former Audit Inspectorate of the DOE. The study covered two metropolitan boroughs and two inner London boroughs; and resulted in a report entitled Social Services: Provision of Care to the Elderly published in 1983 by HMSO (ref. 2). The second study was carried out on behalf of the Audit Commission. It was carried out by the same team and extended the coverage of the earlier study to include shire counties. In both studies, the project manager was John Hall, a member of the District Audit Service. The work was performed by Arthur Andersen & Co., Management Consultants. The inner London and metropolitan boroughs were selected to cover different approaches to care for elderly people, and different expenditures on the various types of service. The shire counties were selected to include both high and low spenders on community care and authorities making extensive use of potential alternatives to residential accommodation. A further ten authorities were surveyed to supplement the data from the seven authorities studied in detail.

10. Both studies sought to identify the factors underlying differences in the patterns of care provided to elderly people by social services departments in different local authorities, and to review the impact these factors have on the costs of care provided and the value for money obtained; they also sought to identify good practice and managing services for the elderly, whose adoption by other authorities might improve their value for money.

11. The study team would like to acknowledge the considerable help and support given to them by the officers and members of the local authorities involved in the study, the relevant auditors, the Association of Directors of Social Services, the Association of Metropolitan Authorities, the Association of County Councils, the Association of District Councils, the Department of Health and Social Security, the Volunteer Centre, and various researchers in the field for their many comments and suggestions. But, of course, responsibility for the conclusions set out in this report rests with the Commission.

12. The work was in three parts. First, national data was reviewed and analysed. This provided insights into the range of differences observed in practice and the extent to which factors outside the control of the social
services department might affect the level of services provided. Next, visits were undertaken to selected authorities:

- to conduct interviews with officers and staff of the social services department (and the housing and treasurer's departments where necessary) to understand the authority's policies with regard to the care of the elderly and to understand their objectives;
- to visit residential and day care establishments, and area social work offices, both to interview the relevant officers in charge and to collect detailed data concerning the characteristics of the clients in receipt of social services;
- to collect and analyse data on the provision of services and on the capital and revenue costs of the care provided to the elderly;
- to contact local health authority officers in order to collect any readily available health service data relevant to the care of the elderly.

13. This report was prepared using national data and the views and data from the authorities studied. Data from a questionnaire sent to another 25 authorities and from pilot-testing an Audit Guide was drawn on where appropriate.

14. This work suggests that in many cases a more systematic approach towards managing services for the elderly will result both in more appropriate care for individual clients and also in better value for money. Three main initiatives are discussed in turn:

(i) Reviewing the present strategy, to determine whether some shift in direction is required. This study indicates that authorities are pursuing very different strategies - or at least that different strategies are implied by the way their resources are now deployed. Chapter One provides a framework against which an authority's present provision and use of resources can be reviewed, and suggests how it might be applied to reach a soundly based answer to the question: how much residential accommodation for the elderly should the authorities be providing now?

(ii) Minimising the need for residential care. Given that care in the community is better for many less dependent clients and generally more economic on a per client basis, authorities will want to ensure that long-stay residential care is provided for those that cannot be sustained in the community, and only for those who would not benefit from other methods of support. Chapter Two describes the steps that authorities should consider to ensure that levels of community care provision are sufficient to prevent unnecessary admissions to residential care and that community services are well directed.

(iii) Improving value for money in existing services. There are often opportunities to secure better value - i.e. client benefits - from the services now provided for the elderly. Chapter Three identifies some initiatives that may be worth consideration at the local level in those authorities seeking answers to the question: are local services for the elderly well managed and are they being provided as economically and efficiently as is reasonable to expect?

Finally, Chapter Four sets out the Commission's views on the appropriate next steps by authorities, government and the Commission and its auditors to help meet the needs of the elderly more effectively in the years ahead.

15. There are, of course, matters relating to care of the elderly which are not fully covered in this report. These include the effectiveness of joint planning arrangements together with the NHS, housing and the private and
voluntary sector; referral procedures, client record systems, planning and reporting systems etc; provision and use of travel concessions, aids and adaptations, telephones and holidays; the role of social services community expenditure in encouraging the voluntary services (e.g. through grants); the effectiveness of certain innovatory methods of care of the elderly such as fostering and resource centres; working agreements between employer and employees.

16. Where it seems appropriate in the text of the report to draw a particular matter to the attention of officers and members, or to the attention of people at the national level, a 'suggestion for consideration' is identified. Reviewing these should allow an authority to focus quickly on matters where this report contains something of direct relevance.
17. Analysis of the way authorities now provide services for the elderly is summarised in the charts shown in Appendix B. It implies large differences in strategic approach.

(a) The total resources devoted to services for the elderly vary by a factor of two or more, even after standardisation to eliminate differences in unit costs and known effects of demography - i.e. variations in the proportion of elderly in different age groups and living alone. Appendix C describes how these adjustments have been made.

(b) The balance between community and residential expenditure varies considerably, again after taking account of differences in unit costs and adjusting for age structure and the proportion of elderly living alone. At one extreme, community expenditure is nearly four times as high as expenditure on residential care; and at the other, residential services account for a level of expenditure about twice as high as that of community care. Moreover, there is no evidence, at least on a regional basis, that the local authority residential provision varies with the availability of NHS geriatric beds.

(c) The mix of dependencies of elderly people accommodated in residential homes varies considerably, as Table 1 below indicates.

<table>
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<th>Table 1: CHARACTERISTICS OF ELDERLY PEOPLE IN RESIDENTIAL HOMES IN SAMPLE AUTHORITIES*</th>
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<td>Per 1000 elderly</td>
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<tr>
<td>--------------------------------------------------------------</td>
</tr>
<tr>
<td>Average</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Total in residential care***</td>
</tr>
<tr>
<td>Number of LA residents with severe or greater physical disability</td>
</tr>
<tr>
<td>Number of LA residents with moderate or less physical disability</td>
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<tr>
<td>Number supported by LA in private and voluntary sectors</td>
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*The seven authorities studied in detail plus ten others surveyed subsequently.
**If the authority at each end of the range is excluded, the ranges would become 12-24, 8-14, 2-10 and 0-7 respectively.
***Includes elderly people in private and voluntary residential homes supported by the local authority.
Source: study team estimates

18. The differences may, of course, reflect members' and officers' policies: they may have decided on the present allocation of resources between residential and community care, and among clients with differing levels of dependency on the public sector, based on their view of the local situation and their priorities.

19. On the other hand, the differences may have just 'happened'. The pattern of residential accommodation inherited on re-organisation in 1974, combined with the budgets of previous years could largely have determined the present pattern of care and may not reflect members' and officers' views on the appropriate balance of resources. The evidence available to the study team suggests that 'happenstance', rather than deliberate choice, is sometimes a major reason for differences in the way resources are deployed.
Exhibit 3

SOCIAL SERVICES EXPENDITURE ON THE ELDERLY - 1983
Breakdown by Service %; Direct Net Costs

100% = over £1 billion

Residential Care 55%

Day Care 4%

Sheltered Housing 31%

Meals On Wheels 4%

Home Help 3%

Other 4%

Source: CIPFA 1982-83 Actuals
20. This chapter therefore describes a method of analysis by which each authority's present strategy can be examined and suggests how it might be used. All statistics relating to the provision of residential care in individual authorities and the estimated numbers of different groups of elderly people have been standardised for the proportion of elderly who are aged 75 and over and the proportion of elderly living alone. The provision of residential care by each authority is taken to comprise its own residential places plus the number of old people in private and voluntary residential homes who are financially supported by the authority (there will, of course, be others in the authority in private and voluntary residential homes who are not financially supported by the authority).

DEFINING A FRAMEWORK

21. For most social services departments, as Exhibit 3 shows, residential accommodation is the most important item of expenditure on the elderly. Moreover, it is almost invariably more expensive on a per client basis than supporting an elderly person in the community. Table 2 below provides some illustrations (see paragraph 54 for an explanation of costing principles).

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost per Week - Net Estimates for a Typical Authority 1982-3, £</th>
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<tr>
<td>Residential LA accommodation</td>
<td>£60</td>
</tr>
<tr>
<td>Intensive community care*</td>
<td>45</td>
</tr>
<tr>
<td>Limited community care**</td>
<td>15</td>
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*9 home help hours, 5 meals-on-wheels and 2 day care attendances per week. (Note that more intensive packages could cost as much or more than residential care).

**4 home help hours, 2 meals-on-wheels per week.

Source: study team estimates.

22. The decision on how much residential accommodation to provide is therefore critical. The judgements of how much residential accommodation to provide and how it should be allocated to individuals are probably the most important and difficult resource decisions that social services departments and their committees face.

23. This decision cannot be made in isolation. It is necessary to consider the levels of NHS provision, as well as private residential accommodation and intensive community care. Several of the authorities studied believed that specific community-based packages of care can reduce the requirement for long-stay residential care, by allowing the authority to care for some of these elderly people in the community at lower cost.

24. Based on these observations it is clear that three fundamental questions have to be answered before the appropriate number of residential places can be assessed.

- First, what are the characteristics of those elderly people outside hospital who really need to be looked after in a residential home? In the rest of this report these people are said to represent the 'core' group requiring residential care.

- Second, what are the characteristics of those elderly outside hospital who can manage either in residential care or with alternatives which can be arranged in the community, and who cannot manage with anything less? In the rest of this report, these people are said to comprise the 'optional' group requiring residential care or its realistic alternatives.

- Third, how many people have these characteristics now; and how will the situation change over the next five years or so?

Given answers to these questions, and a view on how many of these people will be cared for in hospitals, private residential care and in the voluntary sector, it becomes possible to decide the number of residential places which should be provided by the local authority.
25. The 1948 *National Assistance Act* puts local authorities under a statutory obligation to provide residential accommodation for "persons who by reason of age, infirmity or any other circumstances are in need of care and attention which is not otherwise available to them". However the 1948 Act does not give guidance on how many people will require residential accommodation, nor does it help directly in estimating the numbers involved. But to review whether value for money is being provided, or could be improved, some yardstick is required. This chapter therefore describes a reference framework to help authorities address the question: how much residential care should be provided locally by the local authority?

26. A three-step approach is proposed.

(i) *Identify the major groups of the elderly.* This identification is based on previous research conducted by the DHSS (the 'Balance of Care' approach), adapted after discussions with professionals at the sample authorities. The factors considered in this grouping are degree of physical disability, level of support available from friends and relatives, mental state, incontinence and housing conditions. Level of physical disability and degree of support are used to identify some of the key issues which social services departments need to address when formulating and implementing policies on their provision and use of residential care. While other factors (particularly mental state) may affect an individual's requirement for services, their exclusion from the analysis does not affect the nature of the suggestions in this chapter.*

(ii) *Examine the care requirements for each major group* and the issues of care relating to that group. This examination is based on discussions with professionals at the sample authorities and on the collection and analysis of data concerning, for example, the numbers of elderly people from each of the major groups who were in long-stay residential care in each authority.

(iii) *Estimate from national data the approximate average size of each group.* Many of the suggestions in this chapter are independent of the prevalence of the different groups; for other suggestions the theme is that the local authority should ensure that it has adequate information on local situation with respect to particular issues. The national size estimates are used to put an order of magnitude on the different issues, however, the tentativeness of some of these estimates is recognised; where more than small changes in the numbers would affect the suggestions, this too is recognised in the text.

27. In the next three sections, three groups of the elderly often requiring residential care and intensive community care are discussed in turn. The three groups have very severe physical disability, severe physical disability and moderate physical disability. Key issues are identified for each. Table 3 summarises these groups, and the study team's approximate national estimates.

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*For example, someone with moderate physical disability and many other problems may have a definite requirement for residential care; someone else with moderate physical disability and very few other problems may only require a low level of community support. In defining their more detailed policies local authorities may want to distinguish more groups of the elderly. Work performed on the DHSS Balance of Care projects using about 30 groups (ref. 3) and/or the 17 groups used by the Personal Social Services Research Unit (at Kent University) could form a basis for more detailed work.*
Table 3: SUMMARY OF LEVELS OF PHYSICAL DISABILITY AMONGST THE ELDERLY

<table>
<thead>
<tr>
<th>Level of physical disability</th>
<th>Identifying characteristics</th>
<th>Approximate % of elderly population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very severe</td>
<td>bed-bound, chair-bound or unable to eat or drink unaided</td>
<td>2</td>
</tr>
<tr>
<td>Severe</td>
<td>unable to perform some important personal tasks unaided or unable to prepare a cup of tea without help</td>
<td>3</td>
</tr>
<tr>
<td>Moderate</td>
<td>unable to perform some important domestic tasks unaided or unable to wash all over without help</td>
<td>10</td>
</tr>
<tr>
<td>Less than moderate</td>
<td>able to do the above unaided</td>
<td>85</td>
</tr>
</tbody>
</table>

Source: study team estimates

Over 6% of the elderly population are often classified as 'mentally infirm' and about 13% have some degree of incontinence. Some, but not all of these, will also have physical disabilities.

28. This group comprises elderly people who are bedfast, chairfast or cannot feed themselves unaided. Most of the professionals contacted in the course of this study felt that the majority of elderly people with very severe physical disability require the type of 24-hour nursing care which is found in hospital; but that some could manage in the community with the support of friends or relatives and appropriate community services. In practice a small number will be found in residential homes (if only because they have become very severely physically disabled after entering the home). This section discusses two questions which should be addressed at the local level:

(i) Could more of this group be cared for in local authority residential homes, with appropriate levels of nursing support, rather than in hospital?

(ii) Are the very severely physically disabled who live in the community receiving an adequate level of care, and are their relatives receiving proper support?

29. More intensive residential care. Professionals contacted during the study felt old people whose physical disability deteriorated while in residential care should often remain in local authority residential care, rather than being transferred to hospital. However, standard residential homes cannot accommodate more than a few very severely physically disabled people without unduly disrupting the routine of the home. In practice few authorities can cater for more than a small number of such people (on average, in the authorities studied, 3/1000 elderly from this group were in residential care).

30. For effective use of both NHS and LA resources it is essential that these two organisations consider the likely care requirements for their local populations and make the necessary arrangements to ensure their common activities are co-ordinated to ensure maximum value for money. Together with the local district health authorities, some authorities are therefore considering using the recently revised financial arrangements with the NHS to provide residential care which includes sufficient nursing care to meet the needs of this group. These financial arrangements are described in the DHSS circular Care in the Community and Joint Finance (ref. 4) which sets out modifications to joint finance arrangements and the terms under which the NHS may offer lump sum payments or continuing grants to local authorities.

Suggestion for consideration:
Together with their district health authorities, social services departments should consider caring for more very severely physically
disabled elderly outside hospital by developing more intensive residential care. Such care may offer greater value to these old people at no additional cost to the local authorities if continuing finance and manpower from the NHS can be agreed under the recently revised arrangements; and at lower cost to the public sector as a whole.

31. In none of the authorities studied had such specialised residential care yet been implemented. However, two were considering "whether and in what manner selected and appropriate establishments might be adapted to provide more nursing care to supplement or replace long-term geriatric provision in hospitals. Such plans will involve negotiating new forms of collaboration with district health authorities". Possible options include 'leasing' places to district health authorities or using the recently amended joint finance arrangements. The respective roles of NHS community nurses and social services residential care staff in providing the necessary nursing care would need to be clearly defined and responsibilities distinguished. Matters relating to clinical responsibility would also need to be defined.

32. **Provision for the very severely physically disabled in the community.** A number of elderly people with very severe physical disability remain in the community. The study team estimates that at least 4 people with very severe physical disability per 1000 elderly appear to be living with support from friends and relatives in the community - or around 450 people in a typical county with a total population of 750,000. These people may need more services than are usually provided by social services in the community. Community services for this group also have the objective of providing relief for caring friends and relatives. Most of the professionals interviewed believed that many of these people require a co-ordinated package of care which includes nursing care (e.g. as provided by NHS community nurses or day hospitals) and community services provided by the social services department. Several authorities, but not all, have set up joint arrangements with local district health authorities and others, to develop policies on the appropriate packages of community care for different categories of very severely disabled elderly.

**Suggestion for consideration:**

Social services departments should co-operate with district health authorities to ensure that people with severe physical disability receive appropriate community services from both health and local authorities. Such co-operation should extend down to the 'grass roots' to agree appropriate care packages for individual clients.

33. The people in this group are more mobile than those with very severe disability but they cannot perform some important personal tasks (including one or more of bathing, combing hair, washing hands or face), or prepare light snacks. For those in this group who have little or no support from friends and relatives, the professional opinion at the sample authorities was that many required residential care.

34. On average, in the authorities studied, about 8/1000 elderly with severe physical disability were accommodated in residential homes*. The study team estimates that nationally, at least 9/1000 elderly and perhaps as many as 22/1000 (i.e. as many as 2,500 people in a shire county with population of 750,000) have severe physical disability and little or no support from friends or relatives. Thus, it appears that over half of those

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* This average is consistent with the data from 16 of the 17 authorities surveyed. In the exceptions, the survey of 100 residents indicated substantially more such people (16/1000 elderly) in residential care. This does not affect the nature of the suggestions in this chapter; it does, however, emphasise the need for local data collection exercises (see paragraph 50) prior to the local formulation of a longer-term strategy.
with severe physical disability and little or no support from friends or relatives may remain in the community. Three possible explanations for this observation were suggested to the study team:

(a) Some local authority residential homes have inadequate facilities (lifts etc.) to care for this group. If there are insufficient residential places which have adequate facilities to cater for those of severe physical dependency, there are two likely consequences. First, the elderly people in need may be receiving inadequate care in the community. Second, the authority may fill the home with people of lower dependency who could be better cared for with less intensive, less expensive community service. This appeared to be happening in one of the authorities studied.

Another of the authorities studied had carried out a review of the physical standards and facilities of its homes. The authority is planning to close some of its unsuitable homes and to use the money thereby released to upgrade some existing homes and build new homes which offer a higher level of facilities.

Suggestion for consideration:
Residential care can sometimes be upgraded by a relatively small extra investment in lifts, bathing facilities etc. Authorities should ensure that the absence of such investment is not a constraint on admissions of more dependent elderly.

(b) Some of the people concerned want to remain in their own homes. There is a need to ensure that an adequate package of community care is provided, and that this package includes an appropriate provision of personal care (e.g. from community nurses). New technology (e.g. alarm systems, mobility aids) can often make a useful contribution.

(c) The local authority may not know about individual cases. A survey carried out by one authority showed that disabled old people were more likely to receive services from the social services department if they were supported by friends and relatives than if they were alone. The authority believed that the friends and relatives drew attention to the old person’s needs. Thus social services departments must be concerned to identify people with severe physical disability living in the community with little or no support from friends and relatives.

Suggestion for consideration:
Authorities need to ensure that they have adequate information about the elderly people with severe physical disability who are living in the community with little or no support from friends and relatives.

35. Elderly people with severe physical disability and behaviour disorders or severe dementia pose particular difficulties for social services departments. People with these characteristics are sometimes termed ‘the elderly mentally ill’. These old people can be very difficult to accommodate and disruptive of normal routines; they can occasionally be a danger or nuisance to the community at large, to other residents in a home, and to the staff. The NHS provides services for this group through geriatric hospital care, psychiatric care and community services. Local authorities use different methods. These include social services department standard Part III accommodation, specialist residential accommodation for the elderly mentally ill and community services.

36. There does not appear to be a generally accepted professional view as to which is best for the old people concerned and their families. This point is given further emphasis by a DHSS policy document which states
that "a common complaint of referring general practitioners is to find that psychiatric, medical, geriatric and social services departments all believe the patient to be someone else's responsibility". It is therefore important that local health and social services have jointly defined policies for this group of people.

*Suggestion for consideration:*

Policies for the elderly mentally ill are often muddled or absent. There should be an explicit agreement with local district health authorities on how the needs of this group are to be met. These joint policies should include: specification of the respective roles and responsibilities of the local authority and NHS agreed with the district health authorities; specification of the amount of any particular types of residential accommodation to be provided (e.g. specialist homes for the elderly mentally ill or specialist units in standard homes). The defined policy needs to be communicated to residential management and staff, so that their co-operation with implementation of the policy is secured.

37. This group comprises people who need assistance with household tasks such as shopping and cleaning but who do not require personal care. It was generally agreed by professionals in the authorities studied that nearly all those in this group with support from friends or relatives do not require residential care, community care being cheaper and usually better for the elderly person. However, some of those who have little or no support from friends and relatives are candidates for residential care.

38. Some of the professionals interviewed felt that almost all of the people in this group could be adequately cared for in the community, given the provision of suitable alternatives. However, care in the community often involves potential additional risk to the old people; and housing conditions and design can limit the extent to which community care is practical.

39. Only a minority of this group should be in residential care in any local authority. In practice the numbers in residential care appears to vary considerably: in the authorities studied from 1/1000 to 15/1000. Those admitted to residential care may have particular combinations of other characteristics (e.g. dementia, incontinence, inadequate housing). Dementia in particular can require constant supervision; in the absence of support from friends and relatives, this may only be available in hospital or residential care. Or they may have an urgent need for residential care, caused by bereavement or illness. Decisions about which, if any, of these factors constitute a definite requirement for long-term residential care for this group have a major impact on the level of residential provision required. In any event, a few weeks after admission each client's case should be assessed in detail to confirm that long-stay residential care really is appropriate, since it is common for admissions to be due to particular crises even though the client might be better off in the longer term with a package of community care.

*Suggestion for consideration:*

As a basis both for planning target levels of residential care and for defining admissions policies, authorities should develop and maintain explicit statements of the factors which will normally warrant admission of a person with moderate disability only to residential care.

In one of the sample authorities the view had been taken that there were very few such factors and that nearly all this group could be cared for in the community, at lower cost. Thus, for this authority, very few of the moderately physically disabled would be placed in the core group who can only be adequately cared for in a residential home.
40. In summary, current professional opinion suggests that the core group of clients to be cared for in residential accommodation comprises: some very severely physically disabled clients who are not cared for by the NHS, and those severely physically disabled who cannot be supported adequately elsewhere (by friends and relatives or a package of community care) including those with behaviour disorders not cared for by the NHS. Table 4 summarises the core and optional groups as derived above.

Table 4: REQUIREMENTS FOR RESIDENTIAL ACCOMMODATION

<table>
<thead>
<tr>
<th>Level of physical disability</th>
<th>Hospital</th>
<th>Residential care only (core group)</th>
<th>Residential care or alternatives (optional group)</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very severe</td>
<td>some</td>
<td>limited</td>
<td>some</td>
<td>some</td>
</tr>
<tr>
<td>Severe (limited support or behaviour disorders)</td>
<td>some*</td>
<td>some</td>
<td>some</td>
<td>some</td>
</tr>
<tr>
<td>Moderate (limited support)</td>
<td>some</td>
<td>limited</td>
<td>some</td>
<td>most</td>
</tr>
</tbody>
</table>

* Hospital is an option for some of these people with behaviour disorders or severe dementia.

41. In assessing the provision and use of residential care by an individual authority, two questions need to be asked: is the authority providing an appropriate level of residential care for the core group and how should the optional group be cared for? The framework below suggests a way of thinking about an authority's present provision of residential accommodation.

Fig. 1:

FRAMEWORK TO IDENTIFY POLICY QUESTIONS: RESIDENTIAL CARE

Residents per 1000 elderly

42. Each box in the framework implies different questions for the management of social services, as follows:

Box 1: High provision to the core, low overall provision. These authorities appear to be catering adequately for the core group
CHARACTERISTICS OF ELDERLY RESIDENTS IN SAMPLE AUTHORITIES
Number of Residential Places/1,000 Elderly

Notes:

a) Surveys at 'A' and 'D' used different methods which may have underestimated the number in residential care having more than moderate physical disability

b) 'P & V' includes only those residents in private and voluntary residential care who are financially supported by the local authority

Source: Study Team Estimates (adjusted data)
but the authority would need to be satisfied that there are no
special local factors resulting in increased demand from the core
group now or in the near future. They would in any case need
to check the adequacy of their provision of alternatives for the
optional group.

Box 2: High provision to the core, high overall provision. These
authorities are providing above average residential care for both
the core and optional groups. In addition to the questions above,
some of the optional group may be more appropriately placed
outside residential care.

Box 3: Low provision to the core, low overall provision. These
authorities may not be providing sufficient residential care to the core
group; they would need to check the adequacy of their care to
elderly people with very severe or severe physical disability who
remain in the community.

Box 4: Low provision to the core, high overall provision. These
authorities may be excluding too many of the core group from
residential care and providing too much residential care to those
less dependent.

43. The next section of this chapter describes how this framework might
be applied in an individual authority, using the seven sample authorities for
illustrative purposes. Exhibit 4 shows the characteristics of the present
residents of the local authority residential accommodation in the authorities
in question and underlines the extent to which the situation varies from
authority to authority.

USING THE
FRAMEWORK

44. For an authority to assess its current provision to the core and
optional groups it is necessary to put a scale on the two axes presented in
the framework. In any particular authority, local socio-economic factors
and local judgements will influence what numbers should be used for the
scaling. In the absence of detailed local information a national 'reference
framework' can be used, at least as a start. This national reference
framework, based upon the discussion in the previous sections, is built up
according to the following table.

<table>
<thead>
<tr>
<th>Level of physical disability</th>
<th>Core in residential care</th>
<th>Optional in residential care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very severe</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Severe</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: study team estimates

The estimate of the core group in residential care reflects the average
numbers in residential care with these levels of physical disability in the
sample authorities; the optional group is derived from national average
numbers in residential care (17) less the number in the core group in
residential care (11) from Table 5. Many of the very severely physically
disabled (up to 10/1000 nationally) are likely to be in NHS long-stay
hospital care; the remainder are likely to have support from friends or
relatives, remaining in the community.

45. The national reference framework figures can now be used as a first
basis for labelling the quadrants. For the distinction between 'high' and
'low' on the provision of residential care to the core group, the average
estimated size of the core group in the sample authorities, 11/1000 elderly,
Many 'core' group clients are not receiving residential care

CORE GROUP RESIDENTS IN SAMPLE AUTHORITIES - 1984

Number per 1,000 Elderly

<table>
<thead>
<tr>
<th>Authority</th>
<th>Optional Residents</th>
<th>Financed Residents in Private and Voluntary</th>
</tr>
</thead>
<tbody>
<tr>
<td>G</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>F</td>
<td>11½</td>
<td>4½</td>
</tr>
<tr>
<td>B</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>E</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>A</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>C</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>D</td>
<td>6</td>
<td>13</td>
</tr>
</tbody>
</table>

Source: Study Team Estimates (adjusted data)
is used as an indicator. On the other axis the average provision of residential care, 17/1000 elderly, is used to distinguish between high and low overall provision. These numbers provide officers, members and auditors with a means of identifying the position of their authority on the framework - assuming that the information is available. The situation in the seven sample authorities illustrates the different strategic positions in which they find themselves as well as the questions which are prompted as a result. Figure 2 shows authorities' positions in respect of the overall number of elderly clients in residential accommodation and the number of the core group in residential care. The figures have been adjusted to take some account of variations in local demographic circumstances (using the methodology set out in Appendix C); but no account has been taken of local judgements about, for example, the best form of care for the elderly mentally ill. Hence the positions shown are for illustrative purposes only.

Fig. 2:

POLICY QUESTIONS SUGGESTED FOR SAMPLE AUTHORITIES

Residents per 1000 elderly

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46. It will be evident that the seven sample authorities cover, between them, all four quadrants in the framework. As Exhibit 5 suggests, in each case it prompts some important questions, of the type set out in paragraph 42:

(a) Authorities A, D with a low number of core group and a high overall number in residential care (Box 4) should consider reviewing and revising the use made of existing residential provision to ensure that sufficient care is given to the core group. The exact nature of this review will depend on the particular circumstances:

- it may be directed at the adequacy of the facilities in the homes if these appear not to be appropriate for elderly people with severe physical disability;

- alternatively the emphasis may be on the admission process and the control of admissions to ensure that priority is being given to the core group.
If, after the review, there was an increase in the numbers from the core group (i.e. the position of the authority begins to move from Box 4 to Box 2) the suggestions in (b) below would apply.

(b) Authority B (and to a lesser extent F and G) with a high overall number as well as a high proportion of the core group in residential care (Box 2), would appear to be giving priority to the core group. They need to consider whether value for money would not be improved by caring for more of the optional group in the community - particularly since demand for residential care from the core group is likely to increase substantially.

Table 6 below illustrates the kind of increases in demand which a county may have to manage over the next decade.

| Table 6: COUNTY POPULATION PROJECTIONS |
| Numbers |
| Age group | 1986 | 1996 | % change |
| 65-74     | 43,000 | 47,000 | + 9 |
| 75-84     | 22,000 | 24,000 | + 9 |
| 85 and over | 5,000 | 7,000 | + 40 |
| TOTAL     | 70,000 | 78,000 | + 11 |

Table 6: COUNTY POPULATION PROJECTIONS

After making adjustments for demography the study team estimates that the authorities providing a higher level of residential care than the national average of just over 17 places /1000 elderly (i.e. 1,200 places in the county above) spend, in total, at least £20 million a year more than if they were to provide the national average provision.

(c) Authority C, combines a low number of core group with a low overall number in residential care (Box 3). The authority may need to review the adequacy of the community care to the severely physically disabled in the community. (There is the distinct possibility that there are elderly individuals currently at risk in the community; and the potential for increased value by increasing levels of service to these people is high).

(d) Authority E combines a low overall number with a high proportion of the core group in residential care. Such authorities may need to review their long-term plans for residential care to assess whether the balance between residential care and potential community-based alternatives will be appropriate in the future, given the likely increase in local demand for services for the elderly.

47. It is always difficult and time consuming for an authority to increase or reduce the number of residential places it offers for elderly clients. Rationalisation is invariably painful; and capital expenditure is generally under pressure in local government at present. In the short-term, therefore, the emphasis needs to be on ensuring that available accommodation is used by clients who need it most.

48. Two of the authorities studied had embarked on a policy of building up their provision of community-based alternatives to residential care with a view to limiting, and possibly reducing, their residential provision. One of the first steps in implementing this policy was to tighten the criteria used for deciding whether to admit an elderly client to residential care. The authorities found that this step alone, taken prior to the establishment of specific alternatives to residential care, had had a noticeable effect on the demand for residential care places from social workers on behalf of their clients.

- In several of the sample authorities, senior management had found that strongly worded directives to social workers to
consider every alternative before resorting to long-stay residential care had had an immediate impact on the demand for places. In one authority the application form for residential care included a checklist of questions of the form 'have you (the social worker) tried this?', 'have you considered that?'

- In another of the authorities all applications were referred to a panel which included both residential and community officers. The adequacy of community care for applicants was considered by this group before a person was admitted to residential care. A few specialist home helps, controlled by these panels, were made available to ensure that people were not admitted to residential care simply because community services were inadequate.

**Suggestion for consideration:**
In the relatively short-term, authorities may be able to reduce the numbers of elderly with moderate physical disability admitted to residential care by clarifying and communicating their admissions policy to social workers.

49. Some old people are referred because they are ill and treatment of the illness could remove the need for residential care. Consultants/general practitioners are responsible for the medical assessment of applicants for residential care. In one authority, not one of those studied, inner city money was used to pay for an NHS-employed registrar to co-ordinate and provide medical services for a number of old people in the community.

50. The short-term measures described above may have the effect of allowing some of the less dependent elderly now in residential care to be cared for in the community. However, the type of more dependent moderately physically disabled now in residential care would require community-based alternatives to residential care if they are to be cared for without undue risk. This requires a longer-term strategy, since the provision of alternatives may take time to achieve. At the local level one approach to assessing the requirement for alternatives to residential care in an authority's particular circumstances would be to survey all admissions to residential accommodation for a period of time. The assessment should concentrate on the following question: can this person's needs only be met in a residential setting, or could they be met equally well or better in possible community-based alternatives? This assessment would be for the purpose of collecting data about the need for residential care and its alternatives. (If, as is the case in many authorities, the alternatives to residential care were insufficient, then the old person might still need to be admitted to a residential care establishment).

**Suggestion for consideration:**
Authorities should consider surveying the needs of the old people entering residential care to determine whether the provision of suitable alternatives could allow the authority to care for them in the community. If so, a plan should be made for the provision of community-based alternatives to residential care. This would improve the service to the client and also release substantial amounts of money in the medium to long term.

51. **Assessment procedures for elderly persons referred for local authority residential care**, published last year by the Social Work Service Development Group discusses how this suggestion might be carried forward. Sound assessments are central to the achievement of value for money, as several recent studies have observed. For example Winbow and Farguharson report that since 1979 they have examined 384 elderly people newly referred for local authority residential care in the Thurrock area. 126 required some form of medical treatment; and, after treatment, only half of
these subsequently entered residential care. Some 15% were admitted for
day care and 18% were transferred to sheltered accommodation or a
ground floor flat. This is not inconsistent with the findings of Brocklehurst
et al (1978) who examined a sample of elderly people judged by Manchester
Social Services Department to require residential accommodation. Many
were found to have undetected but treatable illnesses. After treatment,
16% remained at home or entered sheltered accommodation.

52. This section has suggested that providing community-based alterna-
tives for some of the elderly with moderate physical dependency in
residential care offers the prospect of increased value for money: the total
additional expenditure nationally of providing more than 12 residential
places /1000 elderly (sufficient to cover the core group with some allowance
for under-occupancy; a level provided in some authorities and two thirds of
current average provision) is of the order of £55 million p.a., after taking
account of the additional costs to the social services department of
providing the required alternatives for some people. Community-based
care is preferable for many clients; it is also more economic. Sufficient
residential places must be kept available for those elderly for whom there is
no realistic alternative to residential care; but this accommodation should,
so far as possible, be limited to those in the core group of elderly people
who cannot be supported in the community.

*    *    *

53. The next chapter discusses how the need for residential care can be
minimised. The extent to which authorities can move in this direction is not
clear and will not be until more experience of alternatives is available. But
this does not lessen the importance of increased emphasis on alternatives to
residential care, given the very large amounts of money involved.
2 Minimising the Need for Residential Care

54. Unless there is adequate support available in the community, the number of elderly people requiring residential accommodation is likely to increase, with serious financial consequences for local authorities. Table 7 below illustrates the impact of the annual cost implications of caring for different levels of the optional group in residential accommodation. The figures are purely illustrative, based on weekly costs quoted in Table 2 (paragraph 21) for a typical metropolitan district with an elderly population of 45,000 and a county with 112,000 people aged 65 or over; but they suggest the scale of the resource implications for a typical authority.

Table 7: COST IMPLICATIONS OF DIFFERENT PATTERNS OF CARE - £m/year - illustrative only.

<table>
<thead>
<tr>
<th>Assumed pattern of care for optional clients (number per 1000 elderly)</th>
<th>Residential care</th>
<th>Intensive community care</th>
<th>Met district</th>
<th>Shire county</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>15</td>
<td>19</td>
<td>4.5</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>10</td>
<td>2.3</td>
<td>5.3</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>5</td>
<td>2.6</td>
<td>6.1</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>–</td>
<td>2.9</td>
<td>6.9</td>
<td></td>
</tr>
</tbody>
</table>

Source: study team estimates

55. The cost of providing a service may be carried by an agency providing that service, Central Government, the client or a combination of the three. In addition, the cost may be revenue, capital or both. In this report, the quoted costs are the direct net revenue costs to the agency providing the service. Using gross costs (i.e. not deducting income) would generally increase the difference in unit cost between residential care and the other packages. The inclusion of revenue costs by other local authority departments is only applicable for very sheltered housing (VSH). The inclusion of capital costs (i.e. debt charges) would also generally increase the difference in unit costs between residential care and other forms of support to the elderly.

56. This chapter discusses in turn:

(i) The planning of total community expenditure on support to the elderly. Since there is no practical limit to potential demand for community services for the elderly, one of the most difficult questions facing social services departments is: how much community expenditure is appropriate?

(ii) The development of realistic community-based alternatives to residential care for the elderly. Many authorities have concluded that it is not sufficient simply to expect home helps and meals-on-wheels to provide an appropriate alternative to residential care, using the normal levels of service to elderly clients. More intensive support, in ‘packages’ specially designed to meet the particular needs of the moderately disabled elderly person with no local support from friends or relatives, will be needed.
57. More money, appropriately spent, can generally improve the standards of care offered to a particular elderly person in the community. So the decision on how much community support to provide is a matter of local political judgement. But this judgement should be based on consideration of the relevant facts. As in the discussion on residential care in the previous chapter, the approach taken is to identify the needs of different groups of elderly people for community support and to provide a framework to identify the questions for more detailed examination.

58. Table 8 identifies the two groups with differing needs for community support that will be discussed in this chapter: 9% of the elderly who are highly dependent on the public sector, and the rest.

Table 8: SUMMARY OF GROUPS OF THE ELDERLY USED TO DISCUSS COMMUNITY CARE REQUIREMENTS

<table>
<thead>
<tr>
<th>Group</th>
<th>Identifying characteristics</th>
<th>Approximate % of elderly population</th>
</tr>
</thead>
<tbody>
<tr>
<td>High public sector dependency (HPSD) group</td>
<td>very severe physical disability or severe physical disability or moderate physical disability but little or no support from friends or relatives</td>
<td>9% (includes those in NHS or residential care)</td>
</tr>
<tr>
<td>Low public sector dependency (LPSD) group</td>
<td>not as above</td>
<td>91%</td>
</tr>
</tbody>
</table>

Source: study team estimates

59. The study team’s estimate for the size of the HPSD group is about 65/1000 elderly (9% less the 2.5% in hospital or residential care) - around 7,300 people in a medium size county, or 2,900 in a typical metropolitan district. At least half of this group are likely to be elderly people with severe physical disabilities but with support from friends and relatives. The professionals interviewed generally felt that the combination of community health and social services and support from friends or relatives could enable such people to remain outside residential care. But the situation will, obviously, differ from place to place - depending on local traditions, employment patterns, housing developments, and the host of other factors that distinguish communities one from another. The remaining half of the group are elderly people with moderate physical disability who need assistance with household tasks such as cleaning or shopping but who have little or no support from friends and relatives.

60. Expenditure on community services to the HPSD group by the authorities studied varied widely. As Exhibit 6 indicates, substantial differences still remained after taking account of known differences in economy and efficiency (i.e. differences in unit costs), in local provision of hospital and residential care, and in demographic circumstances.

- Two of the authorities studied spent the equivalent of about £20 a year per elderly person in the authority on community services to the HPSD group after making adjustments for the factors listed above (the provision of community services in one of these authorities was in the lowest 10% of authorities in England and Wales; the other had a level of provision approximately equal to the national average but allocated a relatively small proportion to the more highly dependent). The value of this expenditure is not in question; the key question facing such authorities is:

  ’Is the authority satisfied that its services to the more highly dependent elderly are sufficient to avoid high-risk situations occurring?’

- Another two of the authorities studied spent the equivalent of about £40 a year per elderly person on community services to the HPSD group. The provision of community services in both authorities was in
the highest 10% of authorities in England and Wales. Given the fact that other authorities appear to be managing with much lower levels of expenditure, even after making allowance for known local factors, the question to be asked of such authorities is:

'Is the extra expenditure generating sufficient benefits, given the possible alternative uses for some of this money?'

The two situations, and the issues to be examined, are discussed below.

61. Authorities with relatively low levels of community expenditure on the HPSD group. In each of the three authorities studied who provided relatively low levels of community services there was a mechanism for assessing and managing the appropriate community services for highly dependent individuals, to help ensure that the overall needs of each individual are met by a combination of social services, the voluntary sector and friends and relatives. The adequacy of provision for the group as a whole depends on whether:

(a) the provision of social services to some elderly people has the effect of mobilising support from friends, relatives and the voluntary sector, thus keeping them in the low public sector dependency group - rather than persuading them that their efforts are no longer necessary.

(b) the resources are deployed so that those with moderate physical disability and without support from friends and relatives are given the necessary support.

(c) means exist to detect problems experienced by those without support from friends and relatives in time for action to be taken.

(d) most people who need personal care but have support from friends and relatives can manage without social service provision, (though they may be receiving nursing or other care from the NHS or support from elsewhere).

62. The study team's analysis suggests that the community services provided could be about sufficient to give at least some care (home help, day care, meals, sheltered housing) to all members of this group who would be expected to have little or no support from friends or relatives.

Suggestion for consideration:

Some authorities have relatively low levels of community care. They should review what steps are taken to avoid high-risk situations occurring in the community and, where appropriate, further develop local contacts with other organisations.

If it appeared that service levels to the highly dependent were not sufficient, the authority would need to consider an increase in the provision of community services and/or the development of mechanisms to direct more of the available services away from the LPSD group and towards the HPSD group.

63. Authorities with relatively high levels of community expenditure on the HPSD group. Provision to the HPSD group in authorities with relatively high levels of community expenditure can be separated into two parts. The first is on services which are worthwhile almost irrespective of the cost. The second is additional expenditure where the value for money is not so clear, and depends on the local views of what constitutes 'value'.

64. The community expenditure in two of the authorities studied was about £20 per elderly person more than the low reference point. Most of this expenditure was spent on providing home help to more people rather than more home help per recipient. This allowed these authorities to provide some home help to people who had support from friends and relatives. Therefore this figure is used by the study team as an indicator to
**COMMUNITY EXPENDITURE: HPSD**

Net expenditure per head elderly

Note: Authority 'E's adjusted community expenditure is subject to error because of the uncertain effect of the very high local level of private residential care.

Source: CIPFA 1982-83 Actuals and Surveys Carried out by the Study Team (adjusted data)
separate the expenditure into two. Exhibit 6 illustrated the sample authorities’ expenditure divided in this way.

65. The total amount spent by local authorities on community services to the HPSPD group over and above the low reference point - after allowing for differences in local demographic circumstances, unit costs and local levels of residential and hospital provision - is estimated to be about £25 million a year. By and large, the authorities spending more money on community support services will be providing more value to their clients. This does not lessen the need for rational judgements given the very large sums at stake and all the competing claims on local authority resources. At the authorities studied it was not clear that current levels of expenditure were always soundly based on such judgements.

*Suggestion for consideration:*

Some authorities have relatively high levels of community care. Have members in such authorities decided on higher levels of provision in the light of information about: the groups of people receiving services; the reason for providing these services; and their provision in comparison with other similar authorities?

66. If an authority decides it wishes to lower its level of community expenditure on those now dependent on the public sector, it needs to ensure it can mobilise support from friends and relatives and the voluntary sector to take on some of the tasks previously carried out by social services.

*Suggestion for consideration:*

Authorities wishing to lower their total level of community expenditure on the HPSPD group should consider a pilot project to assess the practicality, pace and direction of any changes in service provision. Such a project would aim to identify:

- the potential for focusing a reduced amount of community services so that additional support from friends and relatives can be mobilised,
- a clarification of the role of community services in providing care to elderly people or relief to their friends and relatives,
- the extent to which services are provided to individuals because there is currently no alternative way in which they can receive the necessary care,
- the extent to which services are provided to individuals merely because they are available,
- the possibilities for developing innovatory methods of care and schemes aimed at encouraging informal care.

67. The low dependency group comprises: moderately physically disabled old people living in the community who do not require personal care, but need assistance with household tasks, and who have support from friends and relatives; plus those elderly with little or no physical disability (although they may be generally frail), whether or not they have support from friends or relatives. The study team estimates that about 90% of the elderly fall into this group, and less than one in ten receive community services. However, this still represents a large number of people. In the authorities studied, about 50% of available home help hours were allocated to individuals from this group. This represents about 15% of total expenditure on the elderly.

68. All the authorities studied spent more than £12 per elderly person p.a. on this group. The authorities studied included three of the lowest spenders on community services in England and Wales. This was sufficient to provide home help to 4% of the LPSPD group. Other authorities spend much more on this group; in some of the authorities studied the figure was nearly £50 per elderly person.
Exhibit 7

COMMUNITY EXPENDITURE: LPSD

Net expenditure per head elderly

Note: authority 'E's adjusted community expenditure is subject to error because of the uncertain effect of the very high local level of private residential care

Source: CIPFA 1982-83 Actuals and Surveys Carried Out by the Study Team (adjusted data)
69. Exhibit 7 shows the three main differences in the level of community services between the authorities:

(a) The coverage of the LPSD group by home help was twice as high in some of the authorities as in others. In three authorities this difference in coverage amounts to about 5% of this large group and accounts for about £15 per elderly person in the authority.

(b) In one of the authorities home help was provided to collect pensions and to do the shopping for many people as well as to perform heavy cleaning. The effect of this was to raise the average level of home help per person from three hours per week to four hours per week and accounted for £15 per elderly person in the authority.

(c) In one authority about £20 per elderly person in the authority was spent on lunch clubs and day care for people who could make their own way to these establishments. The other authorities spent insignificant amounts in this way.

70. In the authorities studied, much of the expenditure on this group was justified on the grounds that it added to the quality of the elderly person's life. The wide differences in provision for this group of people suggest that all authorities need to be clear about their objectives in providing community support services for those elderly people less dependent on the public sector and thus (by definition) able to look after themselves unaided or with the help of friends and/or relatives. Large amounts of money are involved. The amount of community expenditure over and above the low reference point is of the order of £70 million in total. The study team estimates that up to £45 million of this is on the less dependent.

_Suggestion for consideration:_

In many authorities, substantial community expenditure is devoted to those apparently able to care for themselves with little help from the public sector. Authorities with relatively high levels of community expenditure on the less dependent should clarify their purpose in providing these services. If the preventative value of such care is a major factor, the authority should satisfy itself that community expenditure is preventing or delaying a sufficient number of people from needing more intensive services in the longer term.

71. If authorities are to be satisfied that community services are delaying the requirement for more intensive services (and thus reducing the authority's overall expenditure), it needs to be demonstrated that community care significantly delays the process of becoming more dependent. This was held to be true by many social service professionals, though no direct evidence was presented to the study team. If it were possible to demonstrate this effect, it would further be necessary to show that authorities were able to select, from the 90% of elderly in the LPSD group, those who were likely to become more highly dependent and were able to concentrate resources on this small group. This may be difficult for authorities to achieve.

72. The framework in Figure 3 is designed to help members and officers identify the relevant questions to be asked about overall expenditure on community services for the elderly. To provide a scale, figures which are 25% above the low community expenditure reference point for each group have been used to distinguish 'high' expenditure from 'low'. (25% is convenient because it separates those authorities who are above from those who are below the national average provision). Exhibit 8 shows the difference in the level and pattern of community provision for the elderly in the sample authorities. (The figures differ from those published by CIPFA because they have been adjusted to take account of unit cost differences, variations in local demography, residential and hospital provision).
Exhibit 8

PATTERNS OF COMMUNITY EXPENDITURE, 1984

£ (Net) per elderly person

Source: Study Team Analysis (adjusted data)
73. The position of an authority on the quadrant suggests the basic questions that need to be addressed. For example, in deciding possible directions for change, the sample authorities would need to satisfy themselves on questions such as the following:

- Authority D, with high provision to LPSD, low provision to HPSD (Box 4) should be satisfied that levels of expenditure on the less dependent are consistent with local political and professional views about value for money. The authority should consider a re-allocation of its resources towards the more highly dependent.

- Authorities A, C & F with high provision to both groups (Box 2) should confirm that these levels of expenditure are consistent with local political and professional priorities: do members intend to provide above average provision to the less dependent; and if so what are they seeking to achieve, and how will they know if they have succeeded?

- Authorities E and G with low provision to both groups (Box 3) should be concerned to ensure that the levels of community services to the highly dependent, and their control, are sufficient to avoid high-risk situations occurring. (They might also want to review their long-term plans for community expenditure and assess whether these are compatible with projected demographic changes.)

- Authority B with a high provision to HPSD and a low provision to LPSD (Box 1) should satisfy itself that sufficient effort is devoted to preventing premature admissions to residential care.

74. Clearly, decisions on the levels of community expenditure and residential care are related. Obvious as this may sound, there was little evidence from the sample authorities of the expected relationship between residential and community provision. Exhibit 9 illustrates this. Higher community provision is not, generally, associated with lower residential
Exhibit 9

Above average community provision is not associated with fewer residential places

SERVICE PROVISION IN SAMPLE AUTHORITIES
Per 1,000 Elderly

Source: Study Team Analysis
developing alternatives to local authority residential care

75. To provide adequate levels of care and security to members of the optional group living in the community, several different services need to be co-ordinated and tailored to the specific needs of individual clients; combinations of any or all of home care (often through the home help service), day care, meals-on-wheels, short-stay residential care, sheltered housing, aids and adaptation and occupational therapy may be required.

76. The sample authorities agreed that new approaches were needed. Six of the seven authorities had either developed or were planning to develop specialised community services for the elderly. This section discusses particular specialised methods of care which were observed in the sample authorities, viz 'very sheltered housing' and 'phased care'. They are relatively recent developments and their effectiveness in helping to avoid long-stay residential care is yet to be proven. The section then goes on to discuss the need for local authorities’ planning to take account of private sector developments. Three conclusions are discussed in turn:

(i) Access to very sheltered housing needs to be carefully controlled, if the additional costs involved are to provide the expected benefits.

(ii) Means must be found of providing support to friends and relatives often caring for elderly people in the community with little assistance from the formal sector (i.e. NHS or local authorities).

(iii) The availability of private residential care and the type of residents (e.g. their level of physical or mental disability) need to be taken into account in deciding how much residential care and community support the authority needs to provide.

77. 'Very sheltered' housing has been defined as "an extension of conventional warden-controlled (or sheltered) housing with enhanced welfare and care facilities . . . These schemes have been designed so that they are capable of accommodating residents as they become increasingly old and frail". In the local authorities where such developments are taking place, they are a joint venture between the social services departments and the local housing departments. No national statistics on provision levels are available; but schemes either exist or are being developed in at least ten authorities including one in the sample. The DOE is currently examining "the suitability of extra-care housing . . . for frail elderly people in need of significant extra support" (ref. 5). In sample authority F the level of very sheltered housing provision is 10 units per 1000 elderly (the equivalent of over 400 units in a typical metropolitan district and over 1000 units in a shire county with a total population of 750,000). This authority believes that, generally, elderly individuals prefer to be in very sheltered housing rather than in residential care.

78. Very sheltered housing costs much more than the community care typically provided to many old people. But costings carried out by the authority and reviewed by the study team suggest that very sheltered housing is less expensive (in revenue terms) than care in standard Part III accommodation for each of the three measures: net cost to social services, net cost to local authorities and gross cost to local authorities. After making an allowance for the additional requirements for home help and meals-on-wheels from more dependent very sheltered housing tenants, the study team estimates the average difference in the net revenue cost per place to social services at about £1,400 p.a. The capital cost of new very sheltered housing provision is broadly similar to the capital cost of new residential provision.
The process for funding very sheltered housing is complex.

ILLUSTRATION OF FUNDING RELATIONSHIPS BETWEEN AGENCIES INVOLVED IN VERY SHELTERED HOUSING

Note: 'Inner city money' is also provided to some social services departments directly by the DOE.
In practice the policy implemented in the sample authority appears to have resulted in an increase in the authority’s net costs because most of the very sheltered housing tenants are less dependent elderly people, few of whom would otherwise be in residential care. At least 30% of those in very sheltered housing would otherwise need to require residential care if even modest overall cost savings to the social services department are to be achieved. However, the proportion of very sheltered housing tenants in this authority who might otherwise require residential accommodation was somewhat less than 30%; and 50% of tenants had no specific physical disability. In these circumstances, the value for money of very sheltered housing in authority F thus depends on the view of the benefits to elderly tenants which are additional to those they would receive from other forms of community provision.

Authorities which decide to provide very sheltered housing will therefore need to ensure that arrangements are made to control access to the available places. In particular:

(a) The objectives of very sheltered housing provision and the types of people for whom it is appropriate should be agreed between the social services department and the relevant housing authorities. The roles of the wardens for these schemes need to be defined and working arrangements agreed.

(b) Before the decision to go ahead with very sheltered housing is made, the social services department should consider:
- the estimated reduction in the requirement for residential accommodation;
- the plans for changing the overall level of residential accommodation;
- the overall budgetary implications for the social services department.

(c) The social services department should be satisfied that vacancies will be allocated in line with the stated objectives. In authority F tenancies were allocated by the local district councils only to those clients who, at the time of entry, were able to look after themselves. At one time admissions were limited to those aged under 75. If a similar policy is followed in other authorities it will be at least five years before the dependency level of the tenants becomes comparable with clients in residential care.

Suggestion for consideration:
Very sheltered housing will only save money overall if a sufficient number of admissions are postponed or diverted from residential care. Tenancy allocations need to be controlled accordingly.

Very sheltered housing is usually, by its very nature, a co-operative venture between social services and housing, and it will often include an NHS component. This in itself introduces complexities which need to be overcome at a local level (these complexities may be increased in shire counties in which social services and housing are at different tiers in local government). Exhibit 10 illustrates the complex process involved in funding very sheltered housing. A streamlined system is clearly required if very sheltered housing initiatives are to be taken forward across the country. The DOE study referred to above is also examining ‘whether the existing boundaries between the responsibilities of housing departments/associations and those of social services over revenue expenditure in support of mixed housing/caring projects strike the right balance’.

The experience of authority F has been that this complexity was compounded by a number of other constraints related to use of joint finance, capital allocations and design standards. These constraints have
since been relaxed; but their existence at a time when the authority was wishing to develop very sheltered housing indicates the difficulties that new initiatives between different local organisations can encounter.

83. As will be apparent, the level of demand for local authority residential accommodation for the elderly is critically dependent on the level of support for elderly people available from family and friends. Table 9 sets out the team's approximate estimates of the numbers of elderly people in different types of environment, based on its analysis at the seven sample authorities.

Table 9: LIVING ENVIRONMENTS OF THE ELDERLY
Number per 1000 Elderly, 1983

<table>
<thead>
<tr>
<th>Degree of physical disability</th>
<th>NHS</th>
<th>LA-sponsored residential place</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very severe/severe</td>
<td>10</td>
<td>11</td>
<td>26</td>
</tr>
<tr>
<td>Moderate</td>
<td>–</td>
<td>6</td>
<td>89</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>17</td>
<td>115</td>
</tr>
</tbody>
</table>

84. It appears that more severely physically disabled people are supported in the community than are cared for in hospital or in local authority residential accommodation; and well over ten times as many people with moderate physical disability are supported in the community as are in LA-sponsored residential care - though a few of these are in private or voluntary residential care. The table illustrates the nature of the dilemma facing those responsible for caring for the elderly. There is no practical limit to the potential demand for the services; and if even a small proportion of those friends and relatives now providing support to elderly people were to 'hand over' their responsibilities to the formal sector, the consequences would be serious: insufficient residential accommodation to cope and costs increasing by, literally, hundreds of millions of pounds a year. Often the carers receive no help from the formal sector even though they may be saving their fellow citizens directly over £3,000 a year for every elderly person looked after, assuming that the alternative is local authority residential care. Quite apart from the equity considerations involved, it makes obvious sense for these carers to be supported so that they continue to carry out their current role.

85. The table also indicates the extent to which the nature of the local community may affect demand for local authority social services. Local economic or housing difficulties, or the lack of friends and relatives living near by and willing to help, can mean greatly increased calls on the resources of the formal sector. The figures in the national framework presented earlier are, therefore, only a starting point; detailed policy formulation at the local level will need to incorporate local data analysis.

86. Most local authority residential places are occupied on a long-stay basis; elderly people are admitted to residential homes with no plans for discharge at a later date. Most authorities also provide a few residential places for use on a short-stay basis, so that elderly people can be admitted for defined periods of time - usually between two and four weeks. National statistics on the number of short-stay places are not available, but professionals interviewed believed this number was growing and may be up to 3-4% of the total of local authority residential places (66% of admissions of elderly residents were for short-stay care in 1984). Short-stay residential care can be provided to an individual for several reasons: relief to carers, holiday relief, rehabilitation, at times of crisis, convalescence, assessment etc.
87. ‘Phased care’ is used by one of the sample authorities - with low community expenditure to both high and low public sector dependency groups, but national average residential provision. People come into residential care on a planned basis at regular intervals as part of the care package offered to them by the social services department. A residential place is, in effect, shared between three or four people in two week blocks. The purpose is 'to provide short-stay care . . . to help avoid or delay . . . admission for longer-term care'.

88. Detailed costings of phased care were not available. However, analysis suggests that phased care is generally likely to be less expensive per person to the social services department than long-stay residential care - though much more per person than the community care typically provided to many old people. Thus, the value for money of phased care depends on the extent to which it can provide a satisfactory alternative for some old people who would otherwise require long-stay residential care. The data available in the sample authority indicates that, whereas recipients can have a level of physical disability equal to that of many long-stay residents, most have some support available from friends and relatives for the periods (about 75% of the time) when they remain in their own homes.

89. Given the many different potential uses of short-stay residential care, authorities will need to evaluate the overall implications for social services of phased care and to develop the arrangements for controlling its use, prior to its development.

*Suggestion for consideration:*

Authorities wishing to effect a shift away from long-stay residential care by the development of phased care should undertake a pilot project to iron out the practical difficulties involved (e.g. in deciding how to control its use).

90. Phased care, as described above, is only one possible way of supporting the informal carers. Authorities interested in the experience of other authorities in providing support should examine the models described in *Fifty Styles of Caring* published in July 1984 by the Social Work Service Development Group of the DHSS. The main conclusions arising from the project include the following:

(a) Carers have needs and rights - since their work is important to the economy of the health and social services. These rights were listed as: time off for themselves, priority in receiving services and consultation in policy making, some training in caring and counselling, and choice over the type of support provided.

(b) The information needs of carers should be met more readily. Carers need information about the medical and other needs of their dependent relatives and about benefits and services available to help them, so that they can obtain all the support they need. More information should be given verbally to carers by professional workers (health service, social services voluntary agencies) and adequate written information should be made available from national and local bodies and displayed or distributed widely.

(c) Early identification of carers is necessary, and workers in the health and social services should pay more attention to this, referring potential or new carers to an appropriate organisation for support, or providing support themselves.

(d) Incontinence services are generally seen as being in need of improvement. These include information on prevention and treatment of incontinence, provision of aids and laundry services.

(e) More self-help groups need to be developed. Some groups are formed by voluntary organisations or by individual carers who see the need, and others are promoted by statutory authorities.
Sometimes such support groups are funded, at the outset if not continuously, by statutory agencies. Self-help groups benefit from a professional link with the supporting organisations.

91. The number of old people in private residential homes appears to have doubled between 1975 and 1982 (ref. 6); the number is currently around 15-20% of the accommodation available in local authorities, although the situation probably varies considerably from area to area. The professionals interviewed generally believed the rate of growth has increased since 1982. This rate of growth is likely to be further stimulated by the recent publication by the DHSS of revised rules guiding the payment of supplementary benefits to residents in private homes.

92. Professionals interviewed since these revised rules were published have been uncertain about the effect that the continuing growth in private residential care will have on the demand for local authority services. Most authorities have little or no data about the characteristics of people entering these homes. Some professionals believe that residents in many private homes in their authorities are less dependent than those in local authority residential care. If this is so, the question arises: will the present and likely future residents in private accommodation eventually need to be cared for by the local authority, when they become mentally infirm or physically disabled? Statutory inspections could be used to collect information on the dependency of residents in private nursing homes, so that the authority can plan its own provision.

**Suggestion for consideration:**

Before sanctioning any increase in local authority residential accommodation, social services committees should take account of the current and likely future availability of private accommodation as well as the level of dependency of current residents in private homes and the capability of these homes to cater for core clients.

93. This chapter has suggested how authorities might address the question: how much community care should be provided for the elderly, to minimise the need for residential care; and how should these resources be deployed? Very large sums of public money depend on the results. Table 10 below shows the cost implications of above average provision of different types of community services for a typical metropolitan district and shire county. Again the figures are only illustrative, to provide some indication of the scale involved - and thus of the need to reach judgements that are based on the relevant facts rather than simply on instinctive value judgements.

<table>
<thead>
<tr>
<th>Table 10: COST IMPLICATIONS OF DIFFERENT LEVELS OF COMMUNITY CARE IN TYPICAL AUTHORITIES £000/year - illustrative only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan district</td>
</tr>
<tr>
<td>Provision of residential places limited to 12/1000 elderly</td>
</tr>
<tr>
<td>Expenditure on LPSD group limited to low reference point.</td>
</tr>
<tr>
<td>20% of residential clients transferred to intensive packages of community care</td>
</tr>
<tr>
<td>10% of private carers 'hand over' to local authorities' average community care</td>
</tr>
</tbody>
</table>

*Net impact; assumes appropriate increase in community services.

Source: study team estimates

Of course, these figures are only illustrative; there is no such place as a typical metropolitan district or shire county. Moreover unit costs will vary considerably. The next chapter deals with the question of efficiency, and suggests how an authority might approach the question, is there avoidable waste in local residential and community services for the elderly?
3 Improving Value of Current Services

94. The two previous chapters have been concerned with strategic issues: does the authority provide the appropriate level of residential care, and is it being used in the best possible way with regard to clients and costs; could the need for residential care be reduced by a further development of community services or specific alternatives to residential accommodation? The whole emphasis of this report thus far has been on planning and implementing appropriate packages of care rather than focussing on any particular resource.

95. However, there are opportunities to secure better value from existing services by taking steps to improve their operational effectiveness. These can be taken independently of any strategic changes that may be indicated. This chapter describes opportunities that the Commission believes are worth examining in most authorities:
(i) making better use of available home help hours;
(ii) using day care more effectively;
(iii) ensuring that meals-on-wheels meet their real client service objectives;
(iv) improving co-ordination with housing authorities over sheltered housing;
(v) reviewing staffing in residential accommodation, in light of dependency and occupancy levels.

Each of these opportunities is discussed below, with the study team's evidence from the sample authorities and elsewhere that they are worth exploring at the local level.

96. From national statistics, 30% of total social services expenditure on the elderly is on home help and about 65% of the elderly in receipt of social services receive home help. The home help service accounts for about two thirds of social services net expenditure on community services. The tasks which home helps carry out include: shopping, collecting pensions, paying rent and bills, writing letters, heavy and light household cleaning, washing and ironing (including dealing with the results of incontinence), making beds, preparing meals, washing dishes, and monitoring a client's condition. A more effective use of available home help hours could therefore offer a considerable improvement in the value delivered to elderly clients.

97. Different groups of clients have different requirements for home help service. On average, in the sample authorities, something over 50% of home help hours are provided to members of the high public sector dependency group. In these cases home help may be one element in a package of care including support from friends and relatives and/or other services which together allow the elderly person to remain in the community. The remaining hours are provided to the low public sector dependency group. For these people, home help will often be the only
Exhibit 11

Patterns of Home Help Contact hours vary
BREAKDOWN OF HOME HELP CONTACT HOURS
BY LEVEL OF HELP PROVIDED

% Total

Weekly Hours Per Client

Over 6 hours
- Authority A: 10
- Authority B: 40
- Authority C: 50
- Authority D: 15
- Authority E: 10
- Authority F: 5
- Authority G: 10

3-6 hours
- Authority A: 50
- Authority B: 40
- Authority C: 50
- Authority D: 15
- Authority E: 30
- Authority F: 40
- Authority G: 56

Under 3 hours
- Authority A: 40
- Authority B: 20
- Authority C: 50
- Authority D: 30
- Authority E: 60
- Authority F: 55
- Authority G: 35

Source: Study Team Analysis
social service they receive. The level of home help support varies considerably: some clients receive one hour per week, others more than 20 hours per week.

98. Even for people of similar dependency, the tasks home helps carry out may be quite different. As Exhibit 11 shows, in the authorities studied there is a considerable difference in the distribution of home help contact hours across clients; there were also large differences between areas in some of the authorities. In some authorities 40 – 50% of the hours are being allocated to clients receiving more than six hours a week; in others the situation is very different, with 50 - 60% of the hours being allocated to clients receiving under three hours a week. These differences were not obviously related to differences in stated policies nor to different levels of provision. It seems that they may just have 'happened'.

99. A systematic process of planning and controlling the level and nature of home help to the different groups of the elderly is needed in every authority. This is not invariably the case now. A management services study in one of the authorities concluded that "the home help service is not effectively managed for a variety of reasons but principally because there is a high workload in some areas and there is a lack of: overall strategy and long-term planning, policy and operating guidelines, and information for management purposes".

_Suggestion for consideration:_

Authorities should ensure that appropriate systems are in place to support the most effective use of available home help hours. The systems should include:

(i) policies and guidelines within which individual organisers operate;

(ii) procedures for implementing planned policies;

(iii) reporting systems for monitoring actual use of hours.

100. Authorities will want to be satisfied that the following requirements for the effective management of the home help service are met:

- a clear statement of the aims of the service. For example, to what extent should the home help service provide personal care or shopping as well as basic cleaning?

- explicit criteria for service. For example, to what extent should the home help service provide heavy cleaning to less dependent elderly people? Particular target groups might include: families in crisis, those requiring personal care to remain in the community, people discharged to the community in need of rehabilitation or convalescence and temporary relief for carers.

- guidelines on the average levels of support for each main group of recipients. At what levels should the service be provided? For example, should the guidelines for standard cleaning be two or three hours home help per week? Note that these guidelines should not be used to determine individual allocations but, rather, as a guide to organisers.

- guidelines on the types of client for whom co-ordination of home help with other community services may be required. For example, in what circumstances should clients be referred for day care?

- policies on frequency and length of visits. For example, if three hours home help are to be provided, should this in general comprise one visit or two?

- policies on the allocation of clients to home helps. For example, should a home help visit clients all in the same geographical area to minimise travelling time; should specialist home helps be used to provide personal care?
Procedures for implementing planned policies

- procedures for allocating home helps to areas. To ensure that the level of home help in an area or district of the authority is consistent with that required to achieve authority policies and to ensure equity across areas.

101. Upon receipt of a referral or request for home help, a prospective client is usually visited by a home help organiser or assistant; the client's need for home help is assessed; and an allocation of a number of hours help is determined. All the authorities studied believed it important to follow this initial assessment by regular reassessment to try and ensure that the service is well matched to requirements. In these authorities the process of assessment and reassessment was gradually becoming more formalised. Specific good management practices observed during the study included the following:

- standard referral and allocation procedures
- standard but simple assessment forms
- guideline estimates on the time required to perform particular tasks
- organisers’ visit cards which include information on other services received
- panels and other mechanisms for co-ordinating community services to the highly dependent elderly
- monitoring of referral rates
- random reviews of assessments by other home help organisers
- minimum requirements for reassessment intervals
- monitoring of reassessments performed
- systems to prompt organisers when a client is due for review
- analyses of organisers’ workloads.

Suggestion for consideration:
Social services committees should ask for a report identifying whether the guidelines and practices set out above are part of the local routine; if they are not the directors should explain why they consider them unnecessary or what corrective is proposed.

102. The purpose of monitoring the use of available home help hours is to ensure that the service is reaching those that the authority intends to benefit, and at the desired levels.

103. The requirement for such monitoring is demonstrated by the situation in one of the authorities studied where very substantial differences in the levels of support to clients of similar dependency existed between areas. Senior management were surprised to find these differences. One authority analysed monthly statistics on the average hours received by area; these statistics were distributed to front-line management as part of a monthly status report and regularly reviewed by senior management. In this authority differences between areas were very small.

Suggestion for consideration:
Authorities should review their existing systems for monitoring the use of available home help hours; and they should also consider the adequacy of the distribution of this information.

104. Apart from differing workloads per person, one source of difference in contact hours per client is travelling time. This accounted for less than 2% of total home help time in one authority and about 10% in another. These differences were not obviously due to differences in the geographical size of the authorities concerned. For a typical authority with a population of 500,000, each 1% reduction in travelling time would result in a cost saving of about £25,000 p.a.. In one authority with very little recorded travelling time, home help routes were organised in relatively small patches. Another authority had identified potential for saving £100,000 p.a. (5% of its home help expenditure) by reorganising the

Monitoring the use of available hours

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workloads of different home helps to minimise distance between clients. In
a third authority travelling time was very small because relatively few visits
of short duration were provided.

**Suggestion for consideration:**
Authorities may be able to achieve worthwhile cost savings by
reviewing the travel routes of individual home helps.

105. Other matters concerning the home help service which may be of
importance to individual social services departments but which are not
covered in this report include: local agreements about working arrange-
ments (e.g. the guaranteed working week); methods for increasing the
flexibility of the home help service; and financial systems to support the
home help service.

**USING DAY CARE MORE EFFECTIVELY**

106. Day care accounts for about 4% of social services expenditure on
the elderly (£30 million). It can be provided to an individual for several
different reasons, for example: personal care, such as bathing, for more
dependent old people on an intensive four or five day a week basis; relief
for caring friends and relatives for one or two days a week; and as a social
facility - for old people to meet, eat and talk - especially for those living
alone. Day centres can be managed entirely by the social services
department or in association with voluntary groups. The health service may
provide some of the personal care to people attending the social service day
centres.

107. None of the authorities studied appeared to have a clear and agreed
statement of the objectives of providing day care. Yet as table 11 shows
provision varies by a factor of seven. Facilities varied considerably; and
frequency of attendance varied from a norm of one day a week to four or
more times a week.

<table>
<thead>
<tr>
<th>Authority</th>
<th>£/ elderly, at standard unit costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>28.9</td>
</tr>
<tr>
<td>B</td>
<td>6.2</td>
</tr>
<tr>
<td>C</td>
<td>2.6</td>
</tr>
<tr>
<td>D</td>
<td>4.9</td>
</tr>
<tr>
<td>E</td>
<td>4.4</td>
</tr>
<tr>
<td>F</td>
<td>5.1</td>
</tr>
<tr>
<td>G</td>
<td>6.4</td>
</tr>
</tbody>
</table>

* Includes lunch clubs
Source: study team estimates

108. Several of the authorities studied kept central information on
frequency of attendance; others did not. Such information, which is
relatively simple to collect, is essential if day care facilities are to be
managed effectively.

**Suggestion for consideration:**
Authorities should satisfy themselves that the purpose of providing
day care is widely understood and agreed throughout the depart-
ment, that the nature of the service given is in line with its stated
objectives, and that appropriate attention is given to effective
liaison with other organisations.

109. A major part (up to 75% in the authorities studied) of the cost of
day care is incurred in transporting clients to and from the centres. The
demand for such transport tends to be concentrated around a period in the
early morning and a period in the late afternoon. In addition, the task of
taking people home from centres does not usually finish before 6 p.m. and
may cause many drivers to work regular overtime. Reducing the cost of
transport in an average authority by 10% would result in cost savings of up to £10,000 p.a..

110. In several of the authorities the unavailability of transport was restricting the number of old people attending day care to below the capacity available. Particular methods used to reduce transport costs, and/or increase the level of transport available in the authorities studied were:

- using day centre transport to transport people to and from lunch clubs;
- employing drivers to work in the day centres during the middle of the day;
- using taxi services at peak time;
- sharing transport with other departments;
- more effective use of the potential contribution of volunteers.

**Suggestion for consideration:**
Authorities should review transport arrangements for day care to find out whether it is possible to make worthwhile cost savings and/or increase the utilisation of existing day care capacity at low marginal cost.*

111. Meals are provided to the elderly by social services departments mainly by meals-on-wheels services, lunch clubs, and day centres. Meals may also be provided by various voluntary organisations. About half the national total of meals provided come from the meals-on-wheels services. The meals-on-wheels service accounts for about 3% of social services expenditure on the elderly (£20 million). Table 12 below shows the level of meals-on-wheels and lunch club provision in the seven sample authorities at standard unit costs (so that the effect of London price levels, for example, is excluded).

**ENSURING MEALS-ON-WHEELS MEET SERVICE OBJECTIVES**

**Table 12:** MEALS PROVIDED TO THE ELDERLY - 1984
£/ elderly, at standard unit costs

<table>
<thead>
<tr>
<th>Authority</th>
<th>Lunch clubs</th>
<th>Meals-on-wheels</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>£8.3</td>
<td>£7.3</td>
</tr>
<tr>
<td>B</td>
<td>0.9</td>
<td>3.6</td>
</tr>
<tr>
<td>C</td>
<td>0.5</td>
<td>3.8</td>
</tr>
<tr>
<td>D</td>
<td>0.6</td>
<td>1.7</td>
</tr>
<tr>
<td>E</td>
<td>1.0</td>
<td>1.3</td>
</tr>
<tr>
<td>F</td>
<td>2.3</td>
<td>3.0</td>
</tr>
<tr>
<td>G</td>
<td>0.4</td>
<td>2.0</td>
</tr>
</tbody>
</table>

*Source: study team estimates*

112. In the authorities studied there appeared to be two very distinct types of meals-on-wheels service. In three of the authorities, meals were controlled by the home help organiser and were mainly provided on a five days a week basis; meals were seen as an integral element of a package of care to the highly dependent. In the other four authorities the meals were delivered by volunteers, most recipients received meals two or three times a week, and the social services department's involvement was small.

113. The value of providing two or three meals a week to many old people is not obvious unless it secures support from friends or relatives on the days when meals are not delivered or unless the 'value' of these meals is seen to be primarily in increased human contact. If the perceived value mainly relates to providing required nutrition for the frail housebound, the meals-on-wheels service must, obviously, provide more than occasional meals.

* See also the Commission's recent report on *Improving Vehicle Fleet Management in Local Government*, available from HMSO, price £4.50, which suggests steps to reduce the costs of operating and maintaining vehicles.
Suggestion for consideration:
Authorities with a low average number of meals-on-wheels per client per week need to satisfy themselves about the value of such a service and check to ensure that clients are receiving meals on the days when meals are not delivered.

114. The cost of providing meals-on-wheels is divided into two elements: a preparation cost (about two thirds of total cost) and a delivery cost. After taking account of differing price levels, preparation costs were similar in the authorities studied. However, one of the authorities is in the process of introducing a 'cook-chill' meals-on-wheels service whereby meals are cooked in advance and re-heated prior to delivery. Calculations performed in the authority suggest that revenue savings of about 15 pence per meal (£35,000 p.a. in a typical authority if all its meals were 'cook-chill') can be achieved by this service, for a capital cost of eight pence per meal. This authority was also planning to use the cook-chill service to provide meals for their residential establishments. One of the authorities studied was experimenting with the delivery of cold pre-cooked meals combined, in some cases, with the purchase of ovens and/or freezers for recipients. Such schemes offer the potential for increasing average intensity by allowing the delivery of more than one meal at a time.

Suggestion for consideration:
Authorities should investigate the value for money potential of alternative methods of meals preparation (including 'cook-chill' meals).

115. Conventional sheltered housing discussed in this chapter differs from 'very sheltered housing' discussed previously. It differs in intensity (conventional sheltered housing has a much lower level of warden cover) and purpose (conventional sheltered housing is primarily a type of housing designed specifically for old people, rather than a focus for social services provision). Sheltered housing is taken here to be purpose-built or suitably adapted property mainly for the elderly comprising a number of flats grouped together within a 'scheme'. Schemes range from purpose-built units with a resident warden, communal facilities and speech intercom to a group of flats which are visited by a peripatetic warden. Alarm systems, peripatetic wardens, 'granny' annexes and other potential alternatives to sheltered housing are not discussed in this report as they were not widely used in the departments reviewed; they are currently the subject of a government study (ref. 7).

116. Sheltered housing not only provides accommodation but also a place for meeting other old people (through the provision of communal facilities), regular visits (by the warden) and an emergency service (through the provision of alarm systems). There is substantial variation in the extent to which wardens provide assistance with everyday tasks.

117. The provision of sheltered housing is primarily a function of local authority housing departments, though social services departments often contribute towards running costs. In 1982-83, such contributions accounted for about 4% of social services expenditure on the elderly. In addition to providing for housing need, sheltered housing also helps to achieve some care objectives. The presence of these two types of objectives in providing sheltered housing to an individual client raises two questions of concern to social services departments:

(i) Who should be chosen for sheltered housing, why, and by whom?
(ii) What are the role(s) of sheltered housing wardens and how should they be managed in the performance of these roles?

Allocation of tenancies

118. In all the authorities studied, local housing departments made the
final decision on the allocation of tenancies. All agreed that the characteristics of elderly applicants (physical disability, support from friends or relatives etc.) can affect the value of providing sheltered housing to an individual and that social services department staff should have some role in the assessment of applicants. But research has suggested (ref. 8) that tenants in sheltered housing are relatively fit and active, often more so than their counterparts in the community. This raises questions about the extent of the social services department’s influence in selecting tenants for sheltered housing schemes.

(a) In one of the inner London boroughs (in which the housing department and the social services department are in the same tier of local government) there was a social services representative on each allocation panel. This presence ensured that information about the characteristics of applicants could always be taken into account by the panel. In the two metropolitan boroughs (again in which housing and social services are in the same tier) there was no formal process which guaranteed that such information would be provided to the housing department, although there were varying degrees of informal contact.

(b) In the three shire counties (in which housing and social services are in different tiers of local government) there was no formal relationship. In two of these authorities, however, senior social services management had recognised the need for collaboration at local level and were holding discussions with the district councils to see how the relationship could be strengthened. In one of these, monthly meetings were held between the director of social services and the district council housing directors.

_Suggestion for consideration:_

Local authorities should consider whether the system of collaboration between housing and social services is adequate to ensure that the allocation of tenancies is in line with local policies.

119. Most sheltered housing schemes have resident wardens. The role of these wardens is very wide and in practice often goes far beyond their job description, including the provision of a service which can help meet certain care objectives (collecting pensions, answering alarms etc.).

120. In three of the authorities the resident wardens were managed by the social services department; in the other four they were managed by local housing departments (including all three shire counties).

_Suggestion for consideration:_

Local authorities in which resident wardens are managed by local housing departments should consider whether the degree of involvement by social services in recruiting and training wardens is sufficient.

121. Payroll accounts for roughly three quarters of total residential revenue expenditure, and is the major contributor to variations in unit costs. It is the only contributor which is discussed in this section. (Other major contributors to reported differences in gross unit costs are non-recurring maintenance and differences in accounting). Within each type of authority in England and Wales (inner London, outer London, metropolitan boroughs, shire counties), in which similar price levels for labour and supplies would be expected to operate, the net staffing cost per person in residential care varies almost by a factor of two.

122. Staffing policies, once set for a particular home, remain relatively fixed despite varying levels of occupancy. Thus gross cost per place is a more appropriate measure than gross costs per resident week for reviewing...
the overall economy and efficiency of a department's residential care. By using this measure, issues of the economy and efficiency of the provision of the residential care can be kept separate from issues relating to its use (e.g. occupancy level).

123. Two factors which may affect payroll costs are: the level of care given to clients having a particular degree of dependence; and the extent to which clients have relatively high or low dependence. No direct evidence on the importance of these factors was obtained from the authorities studied. However, research carried out by the Personal Social Services Unit at the University of Kent (ref. 9) suggests that as much as three quarters of payroll cost difference in a cluster of similar authorities are accounted for by differences in quality of care and in dependence levels, and only one quarter is accounted for by differences in efficiency. Payroll costs in residential homes should be compared and an attempt made to identify the extent to which any variations are explained by differences in the dependency levels of their residents.

_Suggestion for consideration:_

Authorities should receive monthly reports on average occupancy levels and on staffing cost per place. The reasons for differences between homes in staffing cost per place should be explained, as should any shortfall in occupancy.

124. A number of other factors contribute to the variation in payroll costs and to efficiency. These include: overtime, agency staff, and home size. It was not possible to evaluate the overall effects of these factors in detail. In a previous comparative study carried out in 1981-82 by the study team in a number of London boroughs, it was observed that the average weekly payroll cost per bed declined as home size increased: by about £1.50 per extra bed provided (24% of average weekly payroll costs). This mainly reflected economies of scale in the costs of salaried staff whose numbers showed only a small tendency to rise as home size increased. The mix of home sizes is clearly a factor to bear in mind when comparing residential costs. Other factors are unexpected overtime and the use of agency staff (offset by unfilled staff vacancies); in one authority their combined effect was to raise the unit cost by £200 per place p.a. compared to the other authorities. This additional cost was equivalent to about £250,000 p.a. for an authority with a population of 500,000.

_Suggestion for consideration:_

Authorities should review the combined expenditure effect of unexpected overtime and use of agency staff.

125. To avoid confusion in case of fire, many authorities have had for some years staff sleeping in overnight at some homes for which they receive an allowance. Due to the increasing dependency of residents, some of these authorities now have active night staff. In at least two authorities (not from the sample studied in depth) however, the practice of having sleeping night staff continues alongside the introduction of active night staff without any review as to whether this is appropriate. For an authority with a population of 500,000, the cost of sleeping-in allowances can be up to £75,000 p.a..

_Suggestion for consideration:_

Authorities with both sleeping and active night staff should consider whether these two roles could not be combined.

* * *

126. This chapter has drawn attention to a number of possible opportunities to improve the economy and efficiency with which services for the elderly are provided. Once again, the cost implications for a 'typical'
authority are not trivial. Table 13 illustrates the effect of particular changes in the costs incurred by social services in the typical metropolitan district or shire county cited earlier.

**Table 13: COST IMPLICATIONS OF EFFICIENCY GAINS**  
£000/year - Illustrative only

<table>
<thead>
<tr>
<th>Cost Implication</th>
<th>Metropolitan district</th>
<th>Shire county</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home help's productivity improved by 5%</td>
<td>100</td>
<td>165</td>
</tr>
<tr>
<td>10% drop in day care costs (due to transport cost reductions)</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>10% reduction in cost per meal through 'cook-chill'; meals transport economies</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>5% reduction in staffing costs per residential place, through</td>
<td>220</td>
<td>400</td>
</tr>
<tr>
<td>- less unplanned overtime</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- less use of agency personnel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- improved organisation of night care</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>365</strong></td>
<td><strong>615</strong></td>
</tr>
</tbody>
</table>

Source: study team estimates  
* Costings based on the assumption that income is maintained.

While illustrative only, the scale of the cost implications is instructive: the typical shire county able to make the improvements shown above might be able to provide residential care for an additional 200 elderly people (an increase of around 10-15%) at no extra cost to ratepayers.
4 Next Steps

127. The main theme of this report is that services for the elderly can and must be managed properly. 'Happenstance' is no longer acceptable - if ever it was. The costs are too high in human and financial terms; and they can only increase as demographic, social and economic pressures combine to place greater strain on local authorities' limited resources. Since the problem is already pressing, action is urgently required. This chapter suggests the immediate next steps to manage services for the elderly more effectively that need to be taken by:

(i) Local authorities.
(ii) Central Government.
(iii) The Commission and its auditors

ACTION BY LOCAL AUTHORITIES

128. Exhibit 12 shows the key questions which this report suggests should be considered at the local level, and indicates their relationship to each other as well as the strategic implications. The first step at the local level should be for the social services committee to receive from the director a report addressing these questions:

(a) Is the present level of residential care provided by the authority appropriate, given local NHS and private provision; and are most of those in residential accommodation in the core group, and thus not able to be supported in the community to their own advantage? Where the authority fits on the framework for residential services shown in Figure 2 (paragraph 45) will suggest whether there are problems to be faced. The present position of the authority may not reflect where it would like to be; and if this is the case, the committee should know what action is proposed to correct the situation. The evaluation will need to deal with the position as it will be in five years time, given the lead time necessary to change capacity, as well as what can be done in the short term.

(b) Is the level of community expenditure adequate to prevent unnecessary (or premature) admission of clients to residential care; and is the expenditure directed to the people the authority considers should have a priority call on its resources? The position of the authority in the framework in Figure 3 (paragraph 72) should at least provide a starting point for answering this question.

(c) Are services well managed? In particular, are systems in place to plan, control and monitor the home help service (by far the largest community service)? Are the overall objectives of each service clear? Is the level of management effort sufficient?

(d) Are existing services run efficiently? In particular, can differences in residential staffing costs per place be explained by the levels of dependence of residents? Are there overnight 'sleepers' as well as active night staff in the local authorities' homes? Are rosters such that home helps are spending as much time as possible in clients homes, rather than travelling? Are meals-on-wheels to the less dependent making a worthwhile contribution to their quality of life,

55
ILLUSTRATIVE

No strategic change indicated?

Opportunities to improve service productivity?

Productivity gains sufficient to fill the gap?

Expand community care provision?

Adequate community care provision?

Generous local provision of residential places for "optional" clients
- LA
- Private

Adequate community support for "carers"?

Waiting list for "core" clients excessive?

Adequate Improve community productivity for current services?

Opportunities to improve service productivity?

Adequate Improve community productivity for current services?

Expand residential services?

Change admission arrangements?
or should these services be more focussed on those more dependent on the public sector?

129. One approach to tackling these questions would be for the social services committee to receive a report from its director, identifying which of the suggestions for consideration is relevant to the local situation and explaining why those suggestions that have been ignored do not warrant further investigation. With his report the director could be invited to submit a work programme for evaluating the suggestions in appropriate detail and initiating the necessary action.

130. Once the staffwork has been completed, authorities should ensure that they have in place an up-to-date strategy for meeting the anticipated growth in demand for services to the elderly over the next decade. This strategy should be agreed with the local district health authorities and should address the following:

- anticipated local changes in need and demand due to likely demographic, social and economic developments;
- likely maximum and minimum resource availability over the next five years including NHS funds;
- the effects of expected changes in NHS provision on demand for local residential care and community services;
- the possible effects on the need for local authority services of the growth in private provision;
- the expected contribution of the various voluntary bodies in the locality;
- possible measures to improve the value for money of existing provision;
- measures for ensuring that the residential and community care available is given to elderly people most in need.

This strategy, once agreed, should provide the basis against which the performance of the director of social services and his staff is assessed. It should be reviewed and updated periodically - at least once every four years.

131. The response of several of the sample authorities to this need for an up-to-date strategy has been to consider ways of improving the flexibility of their provision. For example, one of the authorities was consulting other local organisations (social services, health, housing, the voluntary sector and private homes) "to develop comprehensive local arrangements that will identify the part to be played by each".

SUGGESTIONS FOR CONSIDERATION AT NATIONAL LEVEL.

132. Some important aspects of providing effective care for the elderly are outside local authorities' control. Specifically:

(i) information on needs is unreliable;
(ii) there appears to be less than general agreement on the appropriate means of providing care to the elderly mentally ill;
(iii) the interaction of community and residential care with the formal and informal (family, friends and volunteers) sectors is poorly understood;
(iv) the future role of the private sector needs to be taken into account in national as well as local policy.

This section sets out the Commission's views and the action required under each of these headings.

Information on needs.

133. At times throughout the report, estimates of the sizes of different groups of the elderly are quoted. These estimates are only the best estimates from the limited amount of information available. They undoubtedly contain errors. Furthermore, regional variation in demographic
factors is known to affect the size of the groups in different parts of the country. The estimates are used in the arguments of this report only to give them quantitative perspective, and to provide signposts to authorities as to the questions on value for money which it is suggested they should be considering.

134. Nevertheless, greater accuracy in some of the group size estimates (e.g. the size of the group of elderly with moderate physical disability and little or no support from friends or relatives) would strengthen the quantitative analysis of some of the major issues (e.g. how much residential care to provide) and provide useful guidance to authorities.

**Suggestion for consideration:**

A national study should be carried out to estimate the relative sizes of different groups of elderly people nationally and to identify the factors which can lead to significant variations between different areas of the country. This study would need to define the groups of the elderly according to their differing requirements for service as has been done in the group definitions used in this report.

135. Most of the professions interviewed during the study agreed that providing care for the elderly mentally ill in general, and those with behaviour disorders in particular, is an increasingly important aspect of social services planning. Yet there seemed to be little consensus of view amongst these professionals about which forms of care provide the best value for money for this group. A policy document setting out good practice, the major issues to be resolved, and the major alternatives to be considered would help provide a framework for local planning.

**Suggestion for consideration:**

National guidelines about the appropriate forms of care for behaviour disordered and other elderly mentally ill people and the roles of social services departments in implementing the policies should be prepared jointly by some or all of the professional bodies, local authority associations and the DHSS.

A recently published report from the Health Advisory Service (ref. 10) which sets out some observations and conclusions resulting from its work since 1970 might provide useful input to such guidelines. In addition, the DHSS has made some money available for pilot schemes in social services.

136. The discussion about alternatives to residential care concluded that they provide a major opportunity for improvements in value for money; yet there was little consensus of view about the extent to which the effectiveness of different alternatives is proven. Many authorities are beginning to develop explicit alternatives to residential care, and are carrying out internal research into their effectiveness.

**Suggestion for consideration:**

A central body* should be made responsible for sharing information between social services professionals about alternatives to residential care. This could allow authorities to capitalise on the experience of others and hence respond more quickly to the opportunity to improve value for money.

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* The Commission has been informed that the National Institute of Social Work is preparing to set up a 'good practice forum' to monitor and disseminate information about innovative schemes for the care of elderly people.
137. This report has also suggested that authorities wishing to reduce their level of community care to the highly dependent would need to mobilise additional support from friends, relatives and the voluntary sector. If increased levels of support were following, and if an increased burden on friends and relatives were consistent with the authority's policies, the reduction in the authority's costs could be considerable. For example, a 10% reduction in provision to the 'high public sector dependency' group could save £150,000 p.a. for a typical authority, or £17 million p.a. nationally. It would therefore be worthwhile investing resources in a research study to investigate the possibilities for mobilising increased support for the elderly from the community.

138. The Commission is aware that the DHSS is encouraging activity in this area and that several research studies concerning the nature and extent of the support available from friends, relatives and the voluntary sector for highly dependent elderly people and means of increasing that support have, or are being carried out. Given the large numbers above, it would seem worthwhile investing resources to quantify the possible changes in service levels and resulting cost implications.

**Suggestion for consideration:**

A research study should be carried out to analyse and quantify the extent to which social services departments can encourage support from friends, relatives and the voluntary sector and thus reduce the requirement for services. For people who live with friends and relatives, the study should investigate the extent to which the provision of social services can allow the caring relatives to continue in that role. For people who live alone, the study should examine the scope for social services to encourage friends, relatives and volunteers to contribute to the care of the old people. This study should identify the actions which authorities should take to encourage support and should quantify any net cost savings to be gained.

139. This report suggests that over a third of the expenditure on community care, £100 million p.a. nationally, is spent on services for the less dependent. In several authorities the preventative value of this expenditure was cited as a major reason for their current, relatively high levels of community provision. It would be useful to have the case proved.

**Suggestion for consideration:**

A research study should be carried out to investigate the extent to which the provision of care to less dependent old people delays or eliminates the need for subsequent, more intensive services; to estimate the likely impact on the requirement for more intensive services of an increase or reduction in such care, and hence to quantify the net cost consequences of providing these less intensive services.

140. The number of elderly people in private residential care is increasing rapidly as capacity expands. From the point of view of the local authority two problems arise. First, it is important to understand how far private accommodation will increase, so that this can be taken into account in planning local authority provision. Second, authorities will need to make contingency plans to care for those 'elderly elderly' whom private homes can no longer support.

141. From the viewpoint of public policy, value for money considerations arise since some residents are entirely supported by supplementary benefit. Research shows that the cost of private residential accommodation is not significantly lower than that of local authorities and weekly fees of the order of £100 per week are not uncommon.
142. If, as seems likely, many of the residents could be cared for in the community, the growth of private accommodation will make increasing demands on public resources. As this report has shown, there is no practical limit to the potential demand for residential accommodation. Government may limit the extent to which public funds can be used to support elderly residents in private homes. This in turn could inhibit the growth of private accommodation and throw a greater than expected burden on to local authority social services departments. The sooner, therefore, that government policy toward the reimbursement charges for private homes is clarified, the better.

143. Finally, the Commission has asked its auditors to examine services for both children in care and the elderly in the audit round beginning in 1985. In each authority, a project will be undertaken designed to:

(a) Apply the frameworks for considering levels of provision of LA residential community support for the elderly, to ensure that relevant questions are being systematically addressed by members and officers.

(b) Establish which of the suggestions in this report is relevant to the local situation; and to confirm that the necessary action is in hand.

(c) Determine whether a longer term strategy is in place and the necessary resources to implement it are being made available.

(d) Identify examples of good practice which might be brought to the attention of other authorities.

A summary of auditors' study findings arising from the value for money projects about to begin will be published during the next 12 months.

144. The Commission well recognises the difficulties confronting directors of social services and their committees as they face unfavourable demographic trends and changing patterns of social behaviour with limited resources. This report and the local projects that will follow are designed to help manage this situation more effectively - without trespassing on local decisions about social standards or priorities or on professional judgements which are not the concern of the Commission or its auditors.

ACTION BY THE COMMISSION AND ITS AUDITORS.
A - REFERENCES

3. 'Balance of Care'
4. 'Care in the Community and Joint Finance', DHSS circular, HC(83)6, LAC(83)5.
5. 'An Evaluation of Very Sheltered Housing', programme item form, PIF NO:2G/109/84 (DHSS note).
Appendix B

This appendix analyses the wide variation of expenditure between individual authorities to indicate how this variation is reduced but not fully explained by taking account of certain factors. The appendix focuses on the provision made by authorities in terms of both total net expenditure on the elderly (excluding fieldwork and administration costs and certain items of expenditure not incurred exclusively on the elderly, e.g. telephones) and the major resources provided: residential care and home help. The sections in this appendix are as follows:

(i) overall variations in net expenditure;
(ii) variations in provision;
(iii) variations in unit costs.

Data on the net expenditure and provision made by local authorities in England and Wales, presented in this appendix, has been extracted from CIPFA Personal Social Services statistics (1982-83 actuals); the analysis includes all authorities for which the relevant data was available.

The measure of variation used in this appendix, and in the main body of the report, is the difference between the 11th highest and 11th lowest authorities as a percentage of the 11th lowest for the statistic in question. This measure represents the difference between the 90th and 10th percentiles for the 116 authorities. It has been chosen because it gives an indication of range without being distorted by the one or two exceptions at either end. It is calculated as follows:

Let $x =$ statistic for 11th highest authority
$y =$ statistic for 11th lowest authority.

Then measure of variation $= 100 \frac{(x - y)}{(y)} \%$.

For example:
the 11th highest and 11th lowest net residential expenditure p.a./1000 elderly are £88,000 and £38,000 respectively.
therefore, measure of variation $= 100 \frac{(88 - 38)}{(38)} \%$.

= 130%.

Exhibit B-1 illustrates the considerable differences between individual authorities in provision of resources, percentages of total expenditure spent on each service, and net unit costs of individual services.
Exhibit B-2 shows the net expenditure on residential care p.a./1000 elderly for each of the 116 authorities England and Wales. The 11th highest is 130% greater than the 11th lowest.
Exhibit B-3 shows the net expenditure on community care p.a./1000 elderly for each authority in England and Wales. The 11th highest is 280% greater than the 11th lowest.
Exhibit B-4 shows the total net expenditure p.a./1000 elderly for each authority in England and Wales. The 11th highest expenditure is 180% greater than the 11th lowest.
Total net expenditure is made up of two elements: provision levels and net cost per unit of provision. Therefore variations in total net expenditure can be caused by variations in provision levels and/or variations in net unit costs. Each of these is discussed below.

In order to examine variations in provision levels between authorities, Exhibit B-5 presents a histogram of the total standardised net expenditure...
p.a./1000 elderly calculated, using national average unit costs instead of the actual unit costs in each authority for the two largest services, residential care and home help (the requisite data is not available for the other services). The particular calculation used is:

\[
\text{total standardised net expenditure} = \text{SSD residential places} \times \text{national average unit cost} \\
+ \text{home help f.t.e.s} \times \text{national average unit cost} \\
+ \text{actual net expenditure on day care, meals and sheltered housing.}
\]

The measure of variation on this basis is 100%.

**Variations in provision after taking account of differences in age structure and the proportion of pensioners living alone.**

**Age structure.** Many elderly people aged 65-74 (who constitute 62% of the elderly) do not require or receive any local authority social services. The needs of the elderly change with age, however, and there is a significant increase in the requirement for services amongst elderly aged 75 and over. The proportions of elderly aged 65-74 and 75 and over in an authority will therefore affect the requirement for services.

**Proportion of pensioners living alone.** A higher proportion of elderly people living alone is likely to result in a higher proportion of elderly with little or no support from friends and relatives, other factors being equal. The proportion of elderly people living alone in an authority is therefore assumed to affect the requirement for services.

Exhibit B-6 presents the total net expenditures p.a./1000 elderly standardised for both these factors and for differences in unit costs. The measure of variation between authorities on this basis is reduced to 90%.

**Other factors affecting overall provision.**

**Local level of NHS provision.** A factor which might be expected to contribute to variation in the level of residential accommodation is variation in the level of NHS hospital bed provision for the elderly. Exhibit B-7 plots the available number of geriatric beds in each NHS region against the number of elderly in local authority residential care in that region. Although the available number of geriatric beds is not that accurate a measure of the number of elderly in long-stay hospital beds, the graph does not indicate that residential places increase as hospital places decrease, (if anything the graph indicates the opposite). Hence, overall, hospital place provision does not appear to contribute significantly to explaining residential variation. (The figures are not corrected for differences in age structure or proportions living alone. Making such adjustments, however, would affect both provisions similarly, and hence would not alter the conclusion).

**The method of funding for sheltered housing.** A further factor which might be expected to contribute to explaining variation in the overall levels of expenditure is differences in the methods of funding sheltered housing (i.e. between social services and housing departments). Exhibit B-8 presents the total net expenditure using standard unit costs, and adjusted for the demographic factors above, less expenditure on sheltered housing p.a./1000 elderly. The measure of variation on this basis is 90% which is the same as the measure of variation before this factor is taken into account. Hence, variation in the method of funding sheltered housing does not appear to be a major factor explaining the observed variation in total net expenditure at standard unit costs.

**The extent to which high levels of residential provision correspond to low levels of community provision.** The level of residential care varies between authorities. It might be expected that substitution between residential care and community care might account for some of the variation in total community expenditure. Exhibit B-9 plots the net expenditure on residential care against net expenditure on community care both at standard unit costs.
costs and adjusted for the demographic factors above. This graph does not indicate that community expenditure increases as residential expenditure decreases. Therefore substitution between residential and community expenditure does not appear to be a major factor explaining variations in standard net expenditure.

**Variations in unit costs.**

In order to examine variations in unit costs between authorities, Exhibit B-10 presents a histogram of the total net expenditure p.a./1000 elderly. This is calculated using national average provision levels instead of the actual provision levels in each authority for the two largest services, residential care and home help (the requisite data is not available for the other services). The particular calculation used is:

\[
\text{total standardised net expenditure} = \text{SSD cost per person in residential care} \times \text{national average residential provision} \\
\quad + \text{SSD cost per home help f.t.e.} \times \text{national average provision} \\
\quad + \text{national average expenditure on day care, meals and sheltered housing.}
\]

The measure of variation on this basis is 70%.

**Variation in unit costs after taking account of differences in price levels between types of authorities.**

Both inner and outer London authorities incur additional employee costs in terms of London weighting and allowances to compensate employees for the generally higher levels of cost in these types of authorities. In order to remove this effect the variation in unit costs within type of authority (inner London, outer London, metropolitan borough, shire county) was examined. The measure of variation between authorities on this basis is reduced to 40%.

**Remaining factors influencing unit costs.**

There are many possible factors underlying this remaining variation of 40% including:
- efficiency (e.g. the amount of home help time spent travelling)
- dependency of recipients (e.g. high intensity residential care for very disabled elderly)
- quality of service (e.g. superior facilities in residential homes)
- charging policy (e.g. the policy on charging for home help hours)
- affluence of population (e.g. residents in homes)
- services provided (e.g. residential staff have sheltered housing duties)
- accounting method (e.g. inclusion or exclusion of laundry in residential home costs)
- economies of scale (e.g. residential home size)
- economy (e.g. price of food supplies).

Analysis of the relative importance of these factors is not possible from national statistics. However, research (ref. 9) suggests that differences in the quality of residential provision, the dependency of residential clients, staff unit costs, home size and accounting method together account for about three quarters of the total variation in the unit costs of residential care. As residential care accounts for over half the total social services expenditure on the elderly, these factors may account for a substantial part of the remaining variation.
Exhibit B-1

Variations in Provision between different authorities in England and Wales.
(Source: CIPFA 1982-83 Actuals)
Total net expenditure on residential care p.a./1000 elderly for each authority in England and Wales.
(Source: CIPFA 1982-83 Actuals)
Exhibit B-2

Total net community care expenditure p.a./1000 elderly for each authority in England and Wales.
(Source: CIPFA 1982-83 Actuals).
Exhibit B-3
Total net expenditure p.a./1000 elderly for each authority in England and Wales. 
(Source: CIPFA 1982-83 Actuals).
Exhibit B-4

Total standardised net expenditure p.a./1000 elderly calculated using national average unit costs rather than actual unit costs in each authority. 
(Source: CIPFA 1982-83 Actuals).
Exhibit B-5
Total net expenditure p.a./1000 elderly standardised for age structure, proportion of pensioners living alone and differences in unit costs.

(Sources: CIPFA 1982-83 Actuals and 1981 Census).

Exhibit B-6

Available number of geriatric beds plotted against the number of elderly in local authority residential care in each NHS region.

(Sources: CIPFA 1978-79 Actuals and Hospital and Health Service Year Book, 1978 summary of available beds.)

Note: NW Region excluded as insufficient LA information available.

Exhibit B-7
Total net expenditure p.a./1000 elderly using standard unit costs, adjusting for age structure and number of elderly living alone (see Exhibit B-6) and excluding expenditure on sheltered housing.
(Source: CIPFA 1982-83 Actuals.)
Exhibit B-8

Total net expenditure on residential care plotted against total net expenditure on community care.
(Source: CIPFA 1982-83 Actuals.)
Note: Both expenditure figures are calculated using standard unit costs and adjusted for age structure and number of elderly living alone.
Exhibit B-9
Total net expenditure p.a./1000 elderly calculated using national average provision levels for each service rather than actual provision levels in each authority.
(Source: CIPFA 1982-83 Actuals.)

Exhibit B-10
The purposes of this appendix are to set out some notes on the approach used in this report; to describe the various groups of the elderly used in the main text; to derive national average estimates for the sizes of these groups and to summarise the important uncertainties in these estimates; and to set out the method for calculating the possible effects on the requirements for services of differing demographic characteristics in individual authorities (for example, the requirement for residential care/1000 elderly in any particular authority will clearly be higher if the authority has a higher proportion of older elderly in the population; this appendix sets out the method for quantifying this effect). The method used in this report to distinguish groups of the elderly is based on work done previously by Arthur Andersen & Co. and others under the auspices of the DHSS ('Balance of Care', ref. 3).

The sections in this appendix are as follows:
(i) principles of the approach used in the report;
(ii) factors used to classify the elderly;
(iii) the development of groups comprising elderly people with particular combinations of these factors;
(iv) the estimation of the national average sizes of the groups used in the main text of this report and the important uncertainties in these estimates;
(v) the estimation of the differences in the requirement for services in any particular authority (as compared to the national average) due to its particular proportion of elderly living alone and the age structure of the elderly population.

This report aims to help local authorities to define their policies on the overall provision and use of social services for the elderly and to find ways of improving the value obtained from the money spent in the context of wide variations in both practice and provision. The report does not try to prescribe the overall provision and use of services in any particular local authority; such decisions depend on local needs, local priorities and other factors of the local situation. Nor does it try to prompt decisions on individual cases; such decisions are quite properly the responsibility of professionals in the field. The approach of this report is designed with these objectives in mind.

(a) A framework is developed to help a review of the overall effectiveness of social services departments in managing their resources. This framework is designed to prompt constructive questioning and to identify issues for senior management to consider. The underlying methodology is based on the 'Balance of Care' approach used by the DHSS over many years. Inevitably the development of the framework requires simplifying assumptions and extrapolations based on limited and incomplete data (a particular problem in social services). The use to which it has been put reflects this: it is used as a reference to prompt the examination of relative need (rather than as a measure of absolute need) and thus to enable the formulation of challenges and questions for authorities to consider. Where appropriate particular assumptions and extrapolations have been identified in the text of this report.

(b) An underlying theme of this report is the need for clear and explicit policies at the local level to help accommodate increasing demand in a period of financial constraints. A second underlying theme is the
need for these policies to be based on improved information about
the local situation. The approach aims to provide a stimulus, where
it is needed, for authorities to undertake the work which is
necessary for adequate planning and implementation of change; it is
not the purpose of the approach to preempt the conclusions of the
planning.

(c) The approach concentrates on the overall provision and use of
services and the identification of major factors underlying the wide
variations. Observed differences in quality of service are outside the
scope of this report, which is not to minimise their importance. The
approach taken is, in effect, to assume that quality of service for a
given input level of resources is constant; and therefore to use the
intermediate outputs of 'levels of resources provided' as a major
indicator of the value for money that is achievable. In order to
examine the extent to which resource levels vary because of
differing professional and political views, certain statistics have been
'standardised' for known socio-economic differences. The approach
taken is to make the maximum allowance for the effect of these
differences in each authority.

(d) This report is more concerned with the formulation of policy than
the implementation of policy. Given the large amounts of expendi-
ture and the long lead times involved, the timing and impetus of any
planned changes in the level of, say, residential care are critical. The
mechanisms required for planning such issues as planned opening/
closing dates, cash flows and staff training are not addressed in this
report.

The factors considered in the classification of the elderly were:

(a) Physical disability. The level of ability to perform particular tasks
gives the following levels of physical disability:
- very severe: chairfast, bedfast or unable to eat and drink without
  help. The very severely physically disabled are not mobile at all
  without help; they require help both with the personal tasks which
can be undertaken at pre-determined times (getting up, washing,
dressing, eating, going to bed), and with the frequent but regular
necessary daily tasks (getting a drink, going to the toilet).
- severe: not 'very severe'; but unable to undertake certain
  personal care tasks (e.g. unable to do one or more of dressing,
  washing hands and face, preparing light snacks or combining hair)
  and some household tasks. The severely physically disabled have
  some mobility but not much; they require help with at least some
  of the personal tasks which can be undertaken at pre-determined
times, but they can cope with the necessary daily tasks.
- moderate: not 'severe'; but unable to undertake some household
  tasks (e.g. unable to do one or more of cooking main meals,
  washing all over, shopping or light household cleaning). The
  elderly with moderate physical disability are generally mobile
  within the home. They can perform personal tasks (apart perhaps
  from washing all over).
- little: able to undertake personal care and household tasks.

(b) Mental state i.e. dementia, with or without behaviour disorders.

(c) Incontinence.

(d) Social circumstances i.e. level of support from friends or relatives.

(e) Housing conditions.
For the analysis and discussion of the service provided to the elderly, the study team has found it convenient to divide the elderly population first into two broad groups:

(i) the 'high public sector dependency' (HPSD) group: this group comprises all old people of very severe or severe physical disability, together with old people of moderate physical disability who have little or no support from friends or relatives.

(ii) the 'low public sector dependency' (LPSD) group: this group comprises all other elderly people.

Within the broad HPSD group it is useful to distinguish five groups which differ in disability and the amount of support friends and relatives are able and willing to give.

A summary of the groups is shown in tables C-1 and C-2.

### Table C-1: HIGH PUBLIC SECTOR DEPENDENCY GROUPS

<table>
<thead>
<tr>
<th>Degree of physical disability</th>
<th>Group</th>
<th>Identifying characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very severe (bedfast or chairfast)</td>
<td>A</td>
<td>Any</td>
</tr>
<tr>
<td>Severe (not as above, but unable to undertake at least one of the following personal tasks: dressing, washing hands and face, preparing light snacks and combing hair)</td>
<td>B</td>
<td>Behaviour disorders</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>No behaviour disorders, but little or no support from friends or relatives</td>
</tr>
<tr>
<td></td>
<td>D</td>
<td>No behaviour disorders, substantial support from friends or relatives</td>
</tr>
<tr>
<td>Moderate (not as above, but unable to undertake at least one of the following domestic tasks: cooking main meals, washing all over, shopping and light household cleaning)</td>
<td>E</td>
<td>Little or no support from friends or relatives</td>
</tr>
</tbody>
</table>

### Table C-2: LOW PUBLIC SECTOR DEPENDENCY GROUP

<table>
<thead>
<tr>
<th>Degree of physical disability</th>
<th>Group</th>
<th>Identifying characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Moderate</td>
<td>L</td>
<td>(a) Substantial support from friends and relatives.</td>
</tr>
<tr>
<td>(b) No specific disability (i.e. not very severe, severe or moderate)</td>
<td></td>
<td>(b) Able to perform all of the above domestic tasks, either able or unable to perform heavy household cleaning.</td>
</tr>
</tbody>
</table>

The majority of elderly people do not receive regular services from social services departments. When estimating group sizes, it is necessary to distinguish between the demand for services, expressed in the group of elderly clients known to a social services department, and the potential requirement for services. This involves obtaining estimates for the group sizes which are independent of the current provision of services in the selected authorities.

Three data sources have been used to provide information for this exercise: Audrey Hunt's survey (ref. 11); the 'Balance of Care' projects in two authorities 1981 (ref. 3); and data collected by the study team. The Hunt study is a DHSS survey concerning the capabilities and difficulties of elderly people in the community. The Hunt data is used to derive estimates for the proportion of the elderly in the community with particular characteristics; which are in turn translated into estimates for the elderly as a whole (for example: if 20% of the elderly in the community are estimated to have characteristic C and 97.3% of the elderly are in the community then 0.2 times 0.973 percent of the elderly are estimated to have characteristic C and to be in the community). The 'Balance of Care' surveys were analyses of the characteristics of the elderly clients receiving either health or social services care. In each of the two authorities, approximately 8000 elderly people were surveyed; because these surveys were much larger than those
conducted by the study team and included recipients of health services as well, they (rather than the study team's) have been used to estimate the sizes of the individual groups. The data collected by the study team comprised surveys of the characteristics of elderly residents in local authority homes in each of the seven sample authorities and in a further ten selected authorities. In each of the 17 authorities about 100 residents were chosen at random to be surveyed. The size estimates obtained from both sources are intended only as very approximate guides to assist the analysis in the main text; more precise figures are not required for this analysis.

The estimated answer is used in the report to estimate the numbers of very severely physically disabled who remain in the community. The observation drawn is that this number is small but significant. This observation provides context for the report's suggestions regarding specialised residential care and the need to ensure that the community care provided to these people is adequate. The estimate was developed as follows:

(i) From the two 'Balance of Care' surveys the estimated number of very severely physically disabled elderly in hospital is on average 5/1000 elderly.

(ii) From surveys conducted in the seven sample authorities and using a similar questionnaire in a subsequent data collection exercise in ten other authorities, the estimated number of very severely physically disabled elderly in residential care is on average 3½/1000 elderly.

(iii) Assume that the proportion of elderly in the community with very severe physical disability is about equal to the proportion who cannot move around the house unaided. Given that the definition of very severe physical disability is 'bedfast, chairfast or unable to eat and drink without help' this assumption appears reasonable. From Audrey Hunt this is about 1% of the elderly in the community (9½/1000 elderly in total).

(iv) Therefore a total estimate for the number of very severely disabled elderly is given by 5 + 3½ + 9½ = 18/1000 elderly.

Some indication that this total estimate of 18/1000 elderly is of the right order of magnitude is given by the two 'Balance of Care' surveys which suggested that 14/1000 elderly and 15/1000 elderly in the two authorities were of very severe physical disability and were in receipt of either health or social services.

The estimated answer is used in the report to help build up national estimates for the numbers of elderly in the community with severe physical disability and little or no support from friends or relatives (see 3. below); and the numbers of elderly in the community who are of 'high public sector dependency' (see 5. below). The estimate was developed as follows:

(i) Using the same data sources as in 1. above, the estimated numbers of severely physically disabled elderly in hospital and residential care are 3½/1000 and 8/1000 elderly respectively.

(ii) Assume that the proportion of elderly in the community with severe or greater physical disability is about equal to the proportion who cannot make a cup of tea (2.6% from Audrey Hunt). Removing the estimated 1% with severe physical disability (see 1. iii) leaves 1.6% of the elderly in the community having severe physical disability (15½/1000 elderly in total).

1. How many elderly people have very severe physical disability?

2. How many elderly people have severe physical disability?
(iii) Therefore an estimate of the total number of severely disabled elderly is given by \( \frac{34 + 8 + 15}{1000} = \frac{27}{1000} \) elderly.

The major quantitative uncertainty about this estimate concerns the number of such elderly people in the community (from ii above). Reference to other data from the Audrey Hunt survey suggests that a more lenient definition of severe physical disability could imply a much larger total estimate. For example, if 'cannot use a frying pan' (5.4%) was used as an indicator rather than 'cannot make a cup of tea' (2.6%), the resulting total estimate would be 54/1000 elderly \((54 - 10) \times 0.973 + 34 + 8\) rather than 27/1000 elderly. The implications of this possible under-estimation are discussed in the relevant sections below. The two 'Balance of Care' surveys gave similar estimates as those derived above for the proportion of elderly with severe physical disability and receipt of either health or social services (27/1000 and 31/1000 elderly respectively).

3. **How many elderly people in the community have severe physical disability and little or no support from friends or relatives?**

An estimate of the numbers of severely physically disabled who remain in the community with little or no support from friends or relatives is given below. The observation drawn in the report from this estimation is that the number of such people is uncertain and that their identification should be an issue of concern to social services departments. The estimation was performed as follows:

(i) From 2. above, an estimate for the number of elderly with severe physical disability is 27/1000 elderly.

(ii) From the two 'Balance of Care' surveys the estimated proportion of elderly with severe physical disability who had little or no support was 32%. 32% of 27/1000 elderly is 9/1000 elderly.

(iii) From the surveys conducted in the seven sample authorities and in a further ten authorities, an average of 8/1000 elderly with severe physical disability are in residential care.

(iv) A minimum estimate can be obtained by assuming that all the 8/1000 in residential care had little or no support from friends and relatives prior to admission. Then it may be that very few people with severe physical disability and little or no support remain in the community.

However, there are several reasons for believing that the actual numbers of such elderly people in the community in any particular authority could be substantially greater than this estimate:

- Not all those admitted to residential care will have previously had little or no support.
- The level of support varies substantially between regions of the country. Data from Audrey Hunt on frequency of visits from relatives indicated regional variation of ±25% about the national average. This variation is even greater at a local level.
- As stated in step 2. the number of elderly people with severe physical disability used above may be a substantial under-estimate.

Taking these three factors together suggests that the numbers of elderly in the community with severe physical disability and little or no support in a particular authority may be, at the extreme, as high as 18/1000 elderly. This is calculated on the following assumptions: the total number of elderly with severe physical disability is 54/1000 (compared to the estimate in step 3. of 27/1000); the proportion with little or no support is 40% (compared to the estimate of 32% from the 'Balance of Care' surveys); and only half the elderly is residential care in the authority previously had little or no support. The calculation is then \( 54 \times 40\% - 4 = 18 \).

The conclusion is that the numbers of elderly people in the community
with severe physical disability and little or no support may range from very few to 18/1000 elderly. The uncertainty of this number reinforces the need for social services departments to have adequate information about the local situation.

The estimated answer is used in the report to help build up a national estimate for the number of elderly who are of 'high public sector dependency' (see 5. below). In addition, the observation is drawn that only a minority of this group will be in residential care in any local authority.

The estimate was developed as follows:

(i) From the two 'Balance of Care' surveys the estimated number of moderately physically disabled elderly in hospital is about 1½/1000 elderly.

(ii) From the surveys conducted in the seven sample authorities and in a further ten other authorities, an average of 5½/1000 elderly with moderate physical disability are in residential care.

(iii) Assume that the proportion of elderly in the community with at least moderate physical disability is about equal to the proportion who cannot go out unaided (12.4% from Audrey Hunt). Removing the estimated 2.6% with at least severe physical disability (see 2. ii) leaves 9.8% in the community with moderate physical disability or 95/1000 elderly in total.

(iv) Therefore a total estimate for the number with moderate physical disability is given by 1½ + 5½ + 95 = 102/1000 elderly.

(v) Assume that the proportion of the group with little or no support is about equal to the proportion of the elderly in the community who receive less than one visit a week (46% from Audrey Hunt).

(vi) Therefore a total estimate for the number with moderate physical disability and little or no support is given by 102 × 0.46 = 47/1000 elderly.

The two major uncertainties about this estimate are discussed below:

Proportion in the community who are of moderate physical disability. Given that 'an inability to go shopping' implies that the individual is of at least moderate physical disability (see definition at beginning of appendix), then using the indicator of 'cannot go out unaided' is very unlikely to over-estimate prevalence of moderate or greater physical disability (i.e. at least 12.4% of elderly in the community are likely to be of moderate or greater physical disability. Given, in addition, that the proportion of severe or greater disability in the community is very unlikely to exceed 5.4% (see step 2.), it follows that at least 7% of elderly in the community are likely to be of moderate physical disability.

Proportion of these with little or no support. There are several reasons for believing that this proportion is unlikely to be less than 30% on average nationally. First, Audrey Hunt data suggests that over 30% of old people in the community are visited by relatives less than once a month; second, of those severely physically disabled who were surveyed in the 'Balance of Care' surveys (who might be expected to be less well supported given their greater dependency) over 30% were classified as having little or no support.

Taking these two conservative assumptions together it seems extremely unlikely that less than 7% × 0.3 = 2.1% of those in the community (20/1000 elderly in total) are of moderate physical disability with little or no support.

The estimated answer is used in the report to provide context for the discussion of different levels of community expenditure to this group and, in particular, in the discussion of the suggestion in the report that "the adequacy of the level of care (provided by authorities with relatively low levels of community expenditure on the HPSD group) rests upon a number
of assumptions which, although plausible in themselves, need to be tested in practice. The statistic is calculated as follows:

(i) The HPSD group comprises those with moderate or greater physical disability less those with moderate physical disability and substantial support from friends or relatives (viz 18 + 27 + 47 = 92/1000 elderly).

(ii) The estimated size of the HPSD group in the community nationally is equal to the total estimated size of the HSPD group (from above) less the national average numbers in hospital and residential care (viz 92 - 10 - 17 = 65/1000 elderly).

As with the other size estimates, the major uncertainties about this number are the prevalence of support and of different levels of physical disability. Taking the most conservative estimates from the previous steps gives an estimate group size of 48/1000 elderly.

Many elderly people aged 65 - 74 (who constitute 62% of the elderly) do not require or receive any local authority social services. The needs of the elderly change with age, however, and there is a significant increase in the requirement of services amongst elderly aged 75 and over. The proportions of the elderly aged 65 - 74 and 75 and over in an authority will therefore affect the requirement for services.

Other factors being equal, a higher proportion of elderly people living alone is likely to indicate a higher proportion of elderly people with little or no support from friends and relatives. The proportion of elderly people living alone in an authority will therefore affect its requirements for service.

This section sets out the method used in the report to make adjustments for each of residential care and community expenditure in the sample authorities for the age structure of the elderly population and the proportion of elderly living alone in each authority.

For residential care the adjustment is made as follows:

(i) Let \( P_{65} = \% \) elderly aged 65 - 74 who are in residential care nationally

\[ P_{65} = 0.464\% \] (from "Community Care", ref. 12)

\( P_{75} = \% \) elderly aged 75 and over who are in residential care nationally

\[ P_{75} = 3.737\% \] (ref. 12)

\( M = \) proportion of elderly who are aged 75 and over nationally

\[ M = 0.378 \] (from 1981 census)

\( m = \) proportion of elderly who are aged 75 and over in the authority

\( m = \) proportion of elderly who are aged 75 and over in the authority

\( N = \% \) elderly who are in residential care nationally.

(ii) Define,

\[ n = \% \] elderly who would be in residential care in the authority if the authority provided a level of residential care equivalent to the national average.

(iii) The value of \( N \), the \% of elderly who are in residential care nationally, is given by,

\[ N = P_{65} .(1-M) + P_{75} .M \]

A similar calculation gives \( n \), the \% elderly who would be in residential care in the authority, if the authority provided a level of residential care equivalent to the national average; namely,

\[ n = P_{65} .(1-m) + P_{75} .m \]

(iv) Then the adjustment factor for the requirement for residential care is given by

\[ \text{adjustment factor} = \frac{n}{N} = \frac{P_{65} .(1-m) + P_{75} .m}{P_{65} .(1-M) + P_{75} .M} \]
For community expenditure the adjustment is made as follows:

(i) Let $P_{65} = \%$ elderly aged 65 - 74 who receive home help nationally
    $= 4.78\%$ (from "Community Care", ref. 12)

$P_{75} = \%$ elderly aged 75 and over who receive home help nationally
    $= 17.53\%$ (ref. 12)

$M = \text{proportion of elderly who are aged 75 and over nationally}$
    $= 0.378$ (from 1981 census)

$m = \text{proportion of elderly who are aged 75 and over in the authority}$

$N = \%$ elderly who receive home help nationally

(ii) Define,

$n = \%$ elderly who would receive home help in the authority if
    the authority provided a level of home help equivalent to
    the national average.

(iii) The value of $N$, the $\%$ of elderly who receive home help nationally, is given by,

$$N = P_{65} \cdot (1 - M) + P_{75} \cdot M$$

A similar calculation gives $n$, the $\%$ elderly who would receive home help in the authority, if the authority provided a level of residential care equivalent to the national average; namely,

$$n = P_{65} \cdot (1 - m) + P_{75} \cdot m$$

(iv) Then the adjustment factor for the requirement for home help is given by

$$\text{adjustment factor} = \frac{n}{N} = \frac{P_{65} \cdot (1 - m) + P_{75} \cdot m}{P_{65} \cdot (1 - M) + P_{75} \cdot M}$$

(v) Assume the change in the requirement for other community services changes is approximately in proportion to the changing requirement for home help.

(vi) Then the adjustment factor for the overall requirement for community services is given by the formula in (iv) above.

Adjustment for proportion of elderly living alone

The effect on the requirement for services of differing proportion of elderly living alone is not clear. The approach taken in this section is to calculate a minimum and a maximum adjustment for each of residential and community care; and hence to obtain upper and lower limits for the standardised level of service.

For residential care a maximum adjustment is as follows:

(i) Let $M = \text{proportion of pensioners living alone nationally}$ (excludes married couples)
    $= 0.29$ (from 1981 census)

$S = \text{proportion of elderly in the community with little or no}$
    $\text{support from friends and/or relatives nationally}$.
    $= 0.46$ (Audrey Hunt)

$m = \text{proportion of pensioners living alone in the authority}$
    (excludes married couples)

$s = \text{proportion of elderly in the community with little or no}$
    $\text{support from friends and/or relatives in the authority}$

$N = \%$ elderly who are in residential care nationally.

(ii) Define,

$n = \%$ elderly who would be in residential care in the authority if the authority provided a level of residential care equivalent to the national average.
(iii) A maximum adjustment is obtained by the following assumptions. First, that the proportion of elderly in the community with little or no support changes to the same extent as the proportion of pensioners living alone. Second, that all those in residential care would have little or no support if they were in the community.

(iv) Then the maximum adjustment factor for the requirement for residential care is given by:

\[
\text{adjustment factor} = \frac{\bar{N}}{\bar{S}} = \frac{\bar{M}}{\bar{S}}
\]

For residential care a minimum adjustment is given by assuming that a higher proportion of elderly people living alone does not indicate a higher requirement for residential care.

i.e. adjustment factor = 1

For community services, the maximum and minimum adjustments are calculated in the same way.
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