UNVEILING THE TRUTH ABOUT SOCIAL CARE IN ENGLAND

PART THREE

The scale of misuse of public funds

Campaign For Real Care
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CONTENTS

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CONTEXT

There are two requirements if the best use of public money in social care is to be secured, which are:

- For people in need of care and support, to have accurate matching of resources to their unique individual needs, so their independence and wellbeing are maximised;
- the minimisation of needs for care and support through effective prevention.

Official policy recognises this and provides for both by:

- Eligibility for care and support determined through needs based on national criteria that are independent of resources to address impact on wellbeing. This enables the subsequent accurate matching of resource to unique individual need;
- Local budget setting to ensure there is sufficient resources to meet all eligible needs;
- All non-eligible needs being prevented from escalating to become eligible needs through advice, information and signposting to preventive services.

However, *Parts One and Two of Unveiling the Truth* show that this is not remotely what happens, as:

- Budgets cannot, and are not, set to meet all needs under the national criteria or any other criteria. Budgets are driven by historical patterns, which in turn bear no relation to known need;
- Eligibility expands - and contracts - to whatever the available resource happens to be. This requires practices that are resource-led and standardising, the opposite of capturing the uniqueness of the individual.

The result is misuse of public resources and poor value for money.

This part of *Unveiling the Truth* explores its scale. Part Four will then explore the implications for prevention.

It is possible to judge value for money by examining two elements:

- comparative spending pattern;
- if there are differences, the implications for impact on lives.

COMPARATIVE SPENDING PATTERNS

The Local Government Association (LGA), in conjunction with the Association of Directors of Adult Social Services (ADASS), provides confidential annual reports to councils[1] to assist them to compare their levels of spend and service levels with other councils. The most recent report, for 2021/22, notes major differences between the highest and lowest centiles for both ***spend per population***, and ***annual spend per service user*** - **£585** against **£403** for *spend per population*, and **£26.7K** against **£15.8K** for *spend per service user*. On the face of it, these differences – **45%** and **69%** - respectively are enormous. They raise questions. However, the LGA report says that evaluating *'how much is spent compared to need'* is not possible. A number of factors make each council's situation different.

However, the following sets out how those factors can be controlled for in order to come to a confident view about the relationship of spend to need.

Choosing the right measure

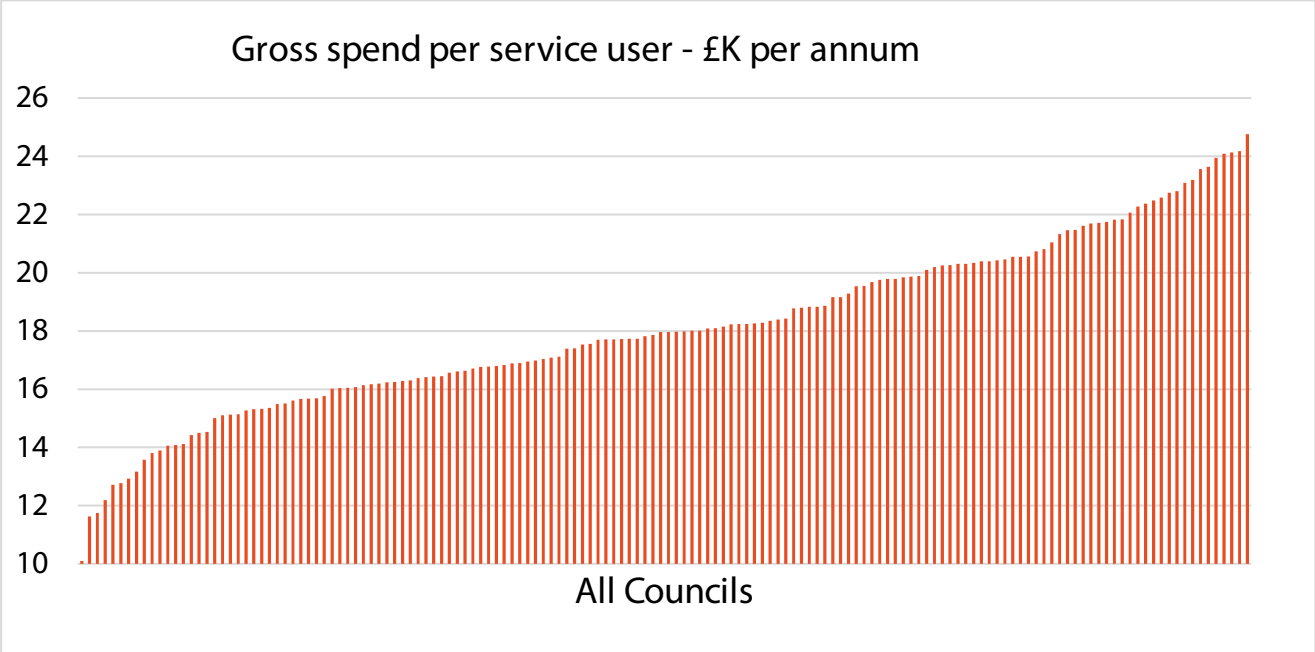
It is first important to choose the right measure. The LGA takes as its base measure *spend per head of population*. The LGA says, quite correctly, that differences in the needs of populations served will mean legitimate differences in demand.

But if the purpose is to understand level of spend relative to individual need, the most appropriate measure is ***spend per service user***. The overall level of demand within a community should make no difference to the level of support any particular individual requires. *Spend per service user* can measure the extent to which individuals with broadly comparable needs can expect a similar level of support, wherever in the country they live.

1 *Adult Social Care Use of Resources. Obtained through Freedom of Information request.*

Methodology

- The year 2019/20 was studied. This is because the Covid pandemic changed demand and spend in haphazard ways across the country making comparison more difficult.
- Only long term care was considered, both for spend and numbers of service users. *Long term* care accounts for approximately **80%** of spend.
- All figures are gross as it is the better measure of service levels.
- Long term spend comprises mostly spend from local authorities' own budgets. However, this is supplemented by income from the NHS, some of which councils use for long term care. Income from the NHS is published by NHS Digital, but not how much is spent on long term care. The figure for each council was obtained under Freedom of Information.
- The 10 highest and the 10 lowest spending councils per service user were compared. The LGA prefers to use highest and lowest *centiles* to exclude error from the influence of outliers. However, the figure below shows that none of these councils could be described as outliers. They are merely at either ends of the spectrum. Comparing the highest and lowest allows for the sharpest comparison to demonstrate what is happening across the spectrum as a whole.
- The 10 lowest spending councils were Barnsley, Bolton, County Durham, Hartlepool, North Tyneside, Redbridge, Salford, Sheffield, Southend-on- Sea, St.Helens.
- The 10 highest spending councils were Bath and North East Somerset, Bracknell Forest, Gloucestershire, Lewisham, Oxfordshire, Richmond-on-Thames, Surrey, Wiltshire, Wokingham, York.



For comparison to be meaningful, it is necessary to strip away the factors that are beyond councils' control that may be contributing to the difference. The LGA identify the following;

- Level of deprivation. The LGA notes that the more deprived areas have higher demand. Primarily this is the impact of the means test, with a higher percentage of more affluent populations being excluded and required to fund their own care. However, while this impacts on overall demand and therefore the ***spend per population***, it does not affect the required ***spend per service user***. What follows will show that while level of deprivation need have no *direct* impact on *spend per service user*, it has a powerful *indirect* impact.
- The age profile of the population – the LGA note that a higher percentage of older people in the population results in a higher number of service users and hence higher ***spend per population***. However, the reverse is the case with regard to ***spend per service user***. That is because the average spend per older service user is substantially less than working age people - **£26.1K** against **£14.1K** nationally in 2019/20. However, while the higher spending group have a higher percentage of older people in their populations, the two groups of councils had an identical proportion of service users who were older – **66%**. Therefore age profile did not impact on the overall spend per service user.
- Regional price differences – land and wage costs affect the price of delivery. This can be adjusted for. NHS Digital publishes unit costs by region for *residential care, nursing care* and *home care*. It does for services to older people and working age people separately. By dividing the relevant part of each council's spend by the unit cost for their region and multiplying by the national average unit cost, the spending of each of the 20 councils can be adjusted to the national average.

$$\text{Adjusted spend} = \frac{\text{Actual spend} \times \text{National average unit cost}}{\text{Regional average unit cost}}$$

This will allow for the impact of regional price pressures.

- The effect of rurality. The LGA note that delivery of home care is **£2** per hour more expensive in rural areas. The highest spending councils predominantly serve rural areas and the lowest spending councils urban. For the removal of any doubt, it is assumed that all ten highest spending councils operate entirely in a rural environment and all of the lowest spending councils in entirely urban environments. The spend on home care amongst all of the 10 highest spenders was reduced by **10%** given the national average hourly unit cost of home care is in the region of **£20** an hour.
- Strength of local community supports. The more support a community can provide informally means the less support is required from the council. This is addressed further on.

	Long term service users[2]	Gross spend on long term care – adjusted for regional price differences and rurality			Spend per service user
		Councils' own budgets	NHS Funded	Total	
Lowest spending councils	**58,473**	£761,204K	£134,816K	**£896,020K**	**£15.3K**
Highest spending councils	**47,499**	£1,045,594K	£92,339K	**£1,137,932K**	**£23.9K**

NHS funding accounted for **18%** of the spending by the lowest spending councils and just *8.8%* for the highest spending councils. This significantly reduced the disparity. Despite this, the highest spending councils spent **56%** more per service user than the lowest spending councils.

2 *This figure excludes service users classified as Social Support as the LGA report notes this group of service users are not included in the spend on long term care. They amount to 1.8% of all service users amongst the lowest spending councils and 2% amongst the highest spending.*

Accounting for the disparity

The relationship of the two variables at play – the *level of spend* and the *number of service users* – need to be understood. To make that meaningful, both must be pegged to *population*.

	Spend	Number of service users	Population 18+	Spend per head of population	Number of services users per 100,000
Lowest spending councils	**£896,020K**	**58,437**	**2,267,825**	**£395**	**2,576**
Highest spending councils	**£1,137,932K**	**47,499**	**3,325,450**	**£342**	**1,428**

The lower spending councils spent **15.5%** more per head of population than the highest spending councils, but had **80%** greater demand.

One explanation might be that service users of the highest spending councils came into the system later in their care pathway as their personal funds run out. They will therefore have greater needs upon entry to the system, most certainly in the case of older people. If that were the case, it can be expected to show in terms of their longevity within the system. If people are coming into the system later in life, people in the higher spending councils would be in the system for less time.

NHS Digital provides the data that enables a measure. It reports the number of service users at the end of the year who had been in the system for more than 12 months.

	% service users at end of year in for 12 months or more		
	Working age	Older people	All ages
Lowest spending councils	**83.7%**	**69.6%**	**75,3%**
Highest spending councils	**87.3%**	**68.5%**	**76.4%**

There is, in fact, very little difference overall. There is some of the expected difference in relation to older people, but scarcely of an order to suggest coming into the system later in life and with greater needs can account for the disparity in spend per service user.

Confidence in the data

A further reason the LGA urges caution in using the publicly available data to draw comparisons is data error. Councils cannot be relied upon to consistently follow the reporting rules. Can the above be a quirk of data returns?

There can be a high level of confidence in the financial returns. They are heavily audited.

A source of confidence in the data re: number of service users would be if it triangulated with other known correlations. This happens to be the case. As the LGA note, there is a correlation between deprivation and number of service users per population. The naked eye can see that the highest spenders tend to serve more affluent communities (with the exception Lewisham) and the lowest spenders more deprived.

The *Index of Multiple Deprivation* (IMD) is the key measure. It goes from 5.6 being the most affluent council (Wokingham) to 41.9 (Blackpool). The table below shows the average IMD score for the two groups of councils.

	Average Index of Multiple Deprivation score
Lowest spending councils	**27.3**
Highest spending councils	**12.8**

Clearly the highest spenders serve amongst the most affluent communities and so have the fewest service users. The lowest spenders serve the most deprived and have the most service users. There can, therefore, be sufficient confidence in the accuracy of the data returns.

Level of community supports

This above analysis allows us to return to the remaining factor the LGA notes that can account for differences in spend - the level of community supports. If community supports were capable of reducing the size of individual packages for the lowest spending councils, why were they not also able to prevent such large numbers of people needing support? And the converse applies equally. If community supports were responsible for keeping large numbers of people out of the system for the highest spending councils, why are they not capable of minimising the support required of those who do enter the system?

It is therefore safe to conclude that the level of community supports is not a factor that accounts for the disparities.

Summary

In 2011, the Dilnot Commission studying the resourcing of social care identified how people with similar needs received 'very different' levels of support depending on where they lived. This analysis puts a figure on it – **56%** difference between the highest and lowest spending councils with all stops in between.

The strategic allocation of resources, through central grants and local budget setting, is providing councils serving the most deprived communities more money to address the greater demand. But it is nowhere near enough to address the scale of demand.

THE IMPACT

Taken together with other known facts, the following two conclusions can be drawn in relation to the impact.

First two conclusions

The following three matters of fact provide critical context to the gross disparity in levels of spend;

1. **The only needs that councils meet are needs they deem 'eligible'.** Parts One and Two of *Unveiling the Truth* show that the *power* to meet need under the Care Act is never used to meet long term needs. The disparity is, therefore, *not* explained by some councils meeting a greater range of need beyond needs they have deemed 'eligible'.
2. **No eligible needs are ever left unmet.** The LGA says *'We haven't seen any evidence that local authorities are systematically not supporting people who have eligible care needs. Indeed, it is unlikely that this would happen. Social care and health professionals would almost certainly speak out. Furthermore, it is likely that some service users/informal carers would raise this formally, potentially through a judicial review'.*
3. **Nationally, spending is always to budget with only very small variations, both up and down.** This is shown to be the case year in year out by the ADASS Annual Budget Surveys.

	2017/18	2018/19	2019/20	2020/21	2021/22
Net budget	**£14.5bn**	**£14.8bn**	**£15.1bn**	**£15.6bn**	**£16.5bn**
Out-turn	**£14.5bn**	**£14.6bn**	**£15.3bn**	**£15.6bn**	**£16.4bn**
Variance	**0**	**-1.4%**	**+1.3%**	**0**	**-0.6%**

Conclusion One

Parts One and Two showed how operationally, on a day-to-day basis, the system's front lines ensure need is calibrated to the available resource. This Part shows the extraordinary scale of the system's capacity to do so and the extraordinary range and variability in what 'eligibility' means.

At the same time, the LGA and ADASS are able to sustain the public perception that 'eligibility' is determined through national criteria that are fair, reasonable and consistently delivered.

Conclusion Two

No less extraordinary is the ability of the system to cover up the reality.

Third conclusion

No less extraordinary is that the service user experience is scarcely different between the two groups of councils. The accompanying Raw Data document shows user experience, as measured by the annual service user survey all councils carry out, is virtually the same.

How can that be the case? A telling clue can be found in the case of one council. Wokingham serves the most affluent community in the country.

In 2015, when the national eligibility criteria moved from councils being able to choose how many of four bands - *critical, moderate, substantial* and *low* - they would treat as 'eligible', all but three councils operated at *critical* and *substantial* only.

Wokingham was one of the three councils that said they were not and were able to meet *critical* only.

Wokingham threatened government with judicial review if it didn't provide it with the extra money it believed it needed to get up to meeting the level of needs the rest of the country was managing in readiness for the new, single national eligibility criteria. Government had said it expected the new national criteria to result in the same level of need as critical and substantial.

Government responded by appointing a consultant to examine the case. The consultant examined a number of case files. He came to the conclusion that Wokingham, as well as the other two councils, was not providing any less - and in some cases actually more - than other councils.

Wokingham did not get extra money.

The consultant did not explore the publicly available data on comparative spend and demand as used in this report. Had he done so he would have seen that Wokingham spent **£22K** per service user in 2014/15 against a national average of **£14.9K**, fully **50%** more.

The question is whether Wokingham was knowingly gaming the system, or genuinely believed it was so much worse off than all other councils. The former is improbable - it would require all members of staff to be in on the game. The greatest likelihood is that Wokingham was sincere in its sense of injustice.

The question then arises – how could this be the case? Data still available shows that Wokingham back then was spending so much more per service user than almost all other councils just as it did in 2019/20.

The most credible answer lies in the way 'eligibility' is determined. The system recognises only high dependency needs and crises. At a point in time in a person's life when they need to be the most optimistic they can in order to make the best of their lives, the system requires them to be as pessimistic as they can and to assume the worst of their lives. Unwittingly perhaps, the system generates high dependency and crises.

For older people in particular, any dependency thus generated is both very real and unlikely to be reversed.

Evidence from research

In 2017, Ipsos Mori reported a study commissioned by the National Institute for Health Research into unmet need amongst older people.[3] The research expected to see a direct link. A large scale desk top analysis of national survey data, including the annual NHS survey of the health of older people, came to the

3 *Predicting unmet social care needs and links with well-being, 2017*

surprising conclusion that whether the system met or did not meet individuals' needs made no difference to their wellbeing.

> ***'Taken together, these (quantitative) results suggest, contrary to our hypothesis, that unmet need does not affect well-being.'***

A small qualitative study alongside it provided clues to the puzzle. The researchers spoke to people who were in receipt of support to meet needs that had been deemed 'eligible', such as personal care, but did not receive support for needs deemed 'ineligible' such as for social contact. This was despite:

- the person themselves placing greater value on their 'ineligible' needs which, if met, would add more to their wellbeing than the meeting of 'eligible' needs;
- meeting the needs deemed 'ineligible' would have cost less than meeting the 'eligible' needs.

> ***'Older people were much more likely to report on unmet need for social contact, being unable to participate in hobbies and interests and being unable to get out of the house. These were regarded as more important issues by older people.'***

> ***'Older people were also concerned that by accessing support too soon they could become dependent on it.'***

Thus the eligibility process was shown to result in irrational, not to say perverse, decision making. The irrationality works in both directions – spending on needs regardless of impact on wellbeing, simply because they are 'eligible', and failing to spend on other needs that may promote wellbeing simply because they were not eligible. This phenomenon can also be seen in some of the case studies on our website.

Conclusion Three

A system that allocates resources to crises and high dependency generates crises and high dependency

SUMMARY

It is not the case that all service users are made dependent. People with the strength to self-advocate, or have skilled advocacy on their side, are often able to impose their own view of their needs to secure the support they require. In particular people able to employ their own support staff have a 25 year track record of success.

However, their numbers are small, less than 10% of the service user population. For the great majority it is in the lap of the gods whether the council's determination of what they need happens to match what they actually need.

But for the great majority, there is a profound irony in how the system works. ***A system expressly designed to suppress demand actually creates demand.*** The people who suffer are those in need of care and support for whom the gap between what they need and what they receive grows ever larger.

It is a system that simply does not know how to use the resources it already has.