Client Level Data in Practice webinar, Thursday 5th December

On the 5th of December Partners in Care and Health (PCH) hosted a webinar aimed at Directors of Adult Social Services (DASSs) and other senior operational staff to provide an opportunity to find out more the Client Level Data (CLD) collection and derived metrics.

Thank you to everyone who joined us – at its peak we were just short of 100 attendees. And a big thank you to:

- Pete Sidgwick, Director of Social Care & Support (DASS) at Warwickshire and chair of the National Strategic Data & Intelligence Network for chairing the webinar.
- Colleagues from the Department for Health and Social Care (DHSC) for a thorough coverage of the development of CLD, its benefits and how it is being used nationally and locally including publication plans.
- Louise Ford from Dorset Council, and Jonathan Cox from the London Borough of Newham for sharing their experience of drawing insights from local analysis and use of the Client Level Data.
- All participants for engaging in the webinar and sharing their comments and experience!

Useful links

- The slides from the webinar can be accessed here (https://www.local.gov.uk/events/past-event-presentations/client-level-data-practice-5-december-2024)
- Adult Social Care Client Level Data (ASC CLD) communication and information page
- CLD Dashboard for councils to access their own data: https://athena.ardengemcsu.nhs.uk/home. Access to the CLD dashboard is granted via AGEM, for anyone who requires access please email: agem.apps@england.nhs.uk
- DHSC are keen to hear councils' ideas about how the CLD data is being used and what insights are being drawn from it. If you are doing things with CLD on its own or through linking to other data sets, please do get in touch so that DHSC can look at opportunities to share or scale that across the country. So please do get in touch with us by emailing socialcaredata@dhsc.gov.uk
- Home - Operating Model Toolkit - Knowledge Hub – local authority operating model to improve assessments.
- In his presentation on CLD and data linking in Newham, Jonathan Cox said that he is keen to join up with other places in the country that are a little bit further down the road to share ideas on working with the CLD data. If you have any thoughts / ideas please get in touch Jonathan.Cox@newham.gov.uk
- For any further information about the topics covered at the webinar please contact the PCH Research and Data Team at PCHdata@local.gov.uk

The following is an edited transcript of the webinar which can be read alongside the slidepack.

DHSC: The changing landscape of adult social care data: from aggregate to Client Level Data

This part of the session was introduced by Mark Browne, Deputy Director for Data, Assurance & Sector Support, Social Care Group. DHSC brought along a team of analysts and policy colleagues to provide an overview. The aim of the session is to talk a bit about the building blocks of CLD, but more importantly focus on the exciting uses that we can put this to help decision making nationally and locally, and ultimately opportunities to deliver better and more responsive care to people.

Introduction to the 'mechanics' of CLD (Jenny Neuburger)

From the ADASS survey it appears that most DASSs are aware of CLD, but may not know exactly what it is. In summary:

- This is a project that's been developed by DHSC with NHS England, who have that legal responsibility to operate the collection and AGEM, the commissioning support unit that runs the data platform, to which 153 local authorities upload their returns every quarter.
- It's the first national collection of adult social care records from local authorities. And when we say records, what we mean is that there are rows of data for each of four types of events.
    - A request for support.
    - An assessment of someone's care needs.
    - A service that's delivered by the local authority or arranged by them.
    - And a review of people's care and support plans.
- It became mandatory on the 1st of April 2023 with six quarterly submissions since July 2023. Because it is at event level, there are also start and end dates for events which mean you can analyse it. It also includes the NHS number and other characteristics of the people supported and their care.
- CLD has now replaced the SALT (Short- and Long-Term support) collection and is now the primary source of data on adult social care activity.
- The intention is that it's a minimum core data set designed to meet local reporting requirements.
- 153 local authorities are now submitting data, which is fantastic.
- The database now has more than 10 million records of unique events directly involving people requesting or receiving care. The quality of the data has improved quarter on quarter.

What are the benefits?

- More frequent data opens up new possibilities for using it in monitoring and testing, whether that's policy evaluation at the national level or locally.
- Individual event data enables more flexible analyses and insights – for example individual year of birth in place of simple grouping of 18 to 64 and 65+.
- The big one that DHSC are starting to explore – using the NHS number to link social care and health records to understand how people use both areas of care.

Using the data nationally: ASCOF and BCF

ASCOF measures using CLD have been tested on the dashboard and feedback has helped to define the definition. The ASCOF handbook will be coming out shortly, setting out principles and

definitions. The exact details and the code we plan to share early in 2025 with finalised methodologies by April. We are working on the principle of 'no surprises', being transparent, and allowing time to adapt the methods given data quality and various issues highlighted by councils. Some of the ASCOF metrics will feed into the Better Care Fund - admissions to long term residential and nursing care is expected to be a headline measure, and potentially a measure on outcomes of reablement support as another.

Using the data nationally: CLD and CQC's local authority assessments (Naomi Knight)

CQC is in the process of rolling out their local authority assessments to all councils and delivering all their site visits by the end of December 2025. Existing metrics are mapped against the CQC assessment themes on their website. Beyond the baseline period we expect to start to wrap in CLD based metrics into the assessments as we phase out SALT.

This will be really positive for assessment as many of the metrics used will be more timely because it's published every quarter, there will be fewer gaps in the in the data landscape, and CQC will be able to base their assessments on more detailed data.

We are also hoping that over time it will slightly reduce the amount of additional information that is required from councils ahead of assessment.

A key principle here is that the data will need to be published before CQC will use it. DHSC will continue to work with local authorities as this develops.

Supporting local authorities to use the data: the CLD Dashboard (Jenny Neuburger)

The CLD dashboard is mainly accessed by lead analysts with a few DASSs, such as Pete Sidgwick, also looking at it. It has been primarily used as a tool to play back the data for individual councils in a variety of formats, and for analysts to use it to check data quality, to improve data quality and also to test methodologies like the ASCOF measures. For example "do your figures look roughly right based on the 23/24 data" and mostly the answer has been no, they don't. So then DHSC look at what data quality issues need to be resolved and review the methodology.

DHSC are really keen over 2025 to move in the space of sharing data with DASSs and other colleagues for operational insight. So please look at the dashboard and give us your views.

Supporting local authorities to use the data: digitising assessments (Jen Goodall)

This section was presented by Jen Goodall from the Digitising and Streamlining Assessments team. Jen joined the webinar to share how the programme is supporting councils through aiming to improve and streamline the assessments process for people, and supporting local authorities (LAs) to increase assessment capacity, helping to reduce delays and backlogs. Here also to talk about how we're using CLD and including this in the tools and information and support we're providing to local authorities. There are four projects in the programme@

- supporting local authorities to increase the uptake of digital tools for care and financial assessments.

- developing and sharing this best practice on streamlined or proportional assessments, looking at the best way we can work with our sector partners and use existing networks to promote and share this learning and enable that peer-to-peer support and sharing of how they have implemented or used data or tools to make improvements.
- Progressing & scaling central government data sharing agreements on centrally held data.
- To support a future strategy for adult social care case management systems that supports these new approaches to assessments.

CLD will provide a better way to understand what's happening across the system at a national and a regional level, and help the team look at the different patterns and identify and share digital tools and guidance to support councils to make the changes that you identify to help streamline and digitise your assessment processes. Use of Client Level Data has been included in the interim Local Authority Operating Model Toolkit, and includes really helpful case studies. For example in Liverpool, how CLD was used to test when planning strategies; and some of the guidance published by one of our partners, SCIE about how the data can support better outcomes for people. CLD will provide that greater understanding of people's care journeys throughout the assessment process and afterwards. And it will just help with the better management and oversight of the system.

The Local Authority Operating Model Toolkit launched 2 weeks ago. DHSC are currently supporting targeted support with PCH and SCIE, alongside a series of Community of Practice events for all local authorities to access which launches on the 17th of December. *Information about the events will be available on the toolkit.* Please do click on the link on the slide when you get a chance to find out more about the toolkit and Community of Practice.

Publication Plans (Uma Moorthy)

What we've talked about so far is how we are making the data available to you in local authorities as DASSs and analysts for direct use. But we are also thinking about CLD data as official statistics now. We are now able to publish CLD directly as official statistics in the first social care official statistics publication that comes out on a monthly basis.
It is key to point out that everything is being done through co-production. There is a reference group that assesses the metrics, assesses the statistics that we are proposing to publish, and all of this is being done within the requirement on DHSC for transparency around statistics, around the data that we collect and making it available within certain information governance requirements to the wider public as well.

There will be announcements prior to publication, but the key thing I want to point out is the text on the slide highlighted in grey around the process for generating these statistics. Because the key thing that we want to make sure is that when we put anything out into the public domain, is

that it is correct and that councils are happy with what is being published.

Collaborative approach for developing and testing new CLD metrics and insights with the sector

1. Identify metrics

2. Develop at working level with LGA, CLD reference group and other experts

3. Share with all local authorities via CLD dashboard

4. Test and iterate with the wider sector

5. Finalise and publish as appropriate

So it is about a collaborative approach, and as Mark said, right at the beginning, co-production is absolutely the name of the game. So we work with you in local authorities to identify the metrics that are of best use. Then we develop these metrics at working level, working with Philippa and Dave in PCH and the reference group and other experts. And everything is run past colleagues in local authorities via the dashboard, which is why it's really important that everyone has access to the dashboard and is comfortable using it. And then we test and iterate with the wider sector and only when everyone is happy that the quality and the timeliness and the appropriateness of the data are all right do we finalise and publish. So we will keep you in the loop as things get published, with the next planned for January 2025. It is also worth councils checking that your data quality looks okay so that you can correct any issues in your submission in January.

Progress and challenges: your role as a leader (JN and UM)

We have said a lot of positive things, and it is an absolutely fantastic achievement. So in particular, you know the coverage - over 600,000 people receiving long term support at any point in time and closer to 850,000 in a financial year. We feel quite confident that we've got quite good data when it comes to counting numbers of people receiving long term support, their types of support and their characteristics. That quite closely matches your historic returns from SALT, but nevertheless we're also very acutely aware of the challenges that remain, and I think particularly two I'd highlight where I think we've had lots of discussions with the reference group and we're having a very detailed process as we update the specification and guidance, which is around definitions and principles. And that's where we really need your involvement.
DHSC analysts working primarily with local authority analysts isn't really enough. So it's sort of agreeing those principles that this is a person-centred collection, and that it reflects activity as people experience it. So we have lots of discussions for example about what is a request or an assessment given the fluidity and ongoing nature of many of these assessment and care processes. We don't think there is a strict and right answer. We think that the sort of principle should be that the activity that's recorded best reflects the purpose and intention of that interaction at the time of the event.
And so that kind of mapping is not something where we can say A always maps to B. We need

your professional judgement to say no, this is the intention. This is what conversation one in a three-conversation model means in our local authority. It is an assessment, it is a proportional assessment, and it should be recorded as that, and we will submit it that way. So we need that kind of input from you to make sure that we are getting meaningful data.
In the wider sense, the reason we have got this far with CLD in that we have data that we can use and publish is because of the help that you've all given us to champion CLD within the organisations and that is something that we absolutely can't do without. It is really about understanding, using, championing, and supporting, and in the wider sense that real leadership. Thank you for all of the input that you've made so far, but it's not time to rest on laurels. We need you to please carry on giving us that into the longer term.

We know there are challenges and gaps, particularly support for unpaid carers, which is often provided by external voluntary sector organisations and also reablement short-term support to maximise independence where there's often partnership arrangements with the NHS.

Wider progress in improving adult social care data (Raj Malhi)

This section is to set the context of the great work on CLD within other work that you may or may not be aware of. We had the Care Data Matters strategy that was part of the last administration. A lot of the work from that strategy is continuing to take place - the work on CLD is continuing, work on the Capacity Tracker, as well as the focus on a new digital product to provide insights.

Now that we are establishing adult social care data sets and are improving national data that we have on social care, the focus for DHSC has really been on *how do we make that data available* and *how do we improve the way in which we can generate insights from that data*, including through linking data. We are really keen to ensure a focus on how do we make the data available to you? And how do we ensure that we can provide access to linked data that may just be publicly available linked data or may be other sources of linked data. But those are the real focuses for us in the department to see how we can really generate the insights that helps you as DASSs, us at national level and also care providers for direct care purposes. So those are really the areas of focus for us in the short term and there is a lot of work underway that helps us to do that.
A request from DHSC: we certainly don't have a monopoly on ideas about how this data is being used and what insights that are being drawn from it. If you are doing things with CLD or other data sets linking data already, please do get in touch to tell us more about how you're doing that because we want to ensure that we can either amplify that or look at ways in which we can share or scale that so that others across the across the country can also access the same level of interrogation of data that you can. So please do get in touch with us via socialcaredata@dhsc.gov.uk.

Examples of how councils are using Client Level Data

Louise Ford, Strategic Health and Adult Social Care Integration Lead, Dorset Council

In my role I am working to join up adult social care and health across our wider system. Previously with my hat on in a performance and data role I was the business intelligence and performance lead for adults in housing at Dorset Council and prior to that for another local

authority in the South West. I'm coming to talk to you today about our data journey at Dorset Council.
Our approach in Dorset is about how we make data real. So how do we make it meaningful? We know that our operational colleagues across adult social care are really heavily focused on delivering activity at the frontline, supporting people, getting better outcomes for people. Our business intelligence and our performance teams take a much more analytical and technical approach to the reporting of the data and the provision of data to those colleagues.
So we used Client Level Data as a way to rethink our approach around how we use data and how we make it more usable. And we've started to be much more visual with our insight and the information that we present to colleagues as it as it really helps to show what a difference the data, and understanding the data, makes to the lives of people.
So we started with this visual as part of our preparations for an LGA peer review last year. And we've ended up using it quite a lot because it's landed really well across Dorset Council. We took Dorset in context and said if it was a village of 100 people, what would it look like in terms of numbers of people, average ages, where people live, what's the average house price identifying all of those kind of challenges and the things that make up Dorset.
So as I said, we use this in the peer review to really demonstrate how we started to use data differently and how by delivering something much more visually to our frontline operational colleagues, they really get to understand the importance of the data and how the information that they put into our case management system which feeds this becomes ever more important.
The Client Level Data story in Dorset started as a bit of a bumpy ride when I joined in November 2022, and we didn't really have much of a focus on planning and implementing Client Level Data. So we started with a really targeted piece of work in January 23 with our Business Intelligence teams really getting to grips with the draft specifications for each of the areas within Client Level Data.
Key to us being able to implement the changes that we needed around system reconfiguration to support those new reporting requirements was the extensive engagement that we undertook with our operational colleagues. So we worked really closely with our Corporate Director for Operations and Heads of Service across the localities, mental health, commissioning and safeguarding to really upskill them in understanding what Client Level Data means, why it's different and how we use it to understand more about the people that we support.
And this was a real step change for us. It was 'selling' Client Level Data as something which was not a statistical piece of work, but something that really enabled us to get to the heart of understanding more about the people that we support, the services that we provide and where we needed to make a difference to the work that we were doing to improve outcomes for people.
So we had quite some extensive work that took place, project based work to embed Client Level Data to make sure our systems were ready to support Client Level Data to be ready to go live from the 1st of April 23. So we successfully managed to run Client Level Data through 2023 in our draft reports. We initially ran our reports monthly to understand whether or not there were areas that we needed to reconfigure in terms of the reporting to check on the robustness of the data, and also to use the outturns as a way to check the quality of our data and to identify where we may need to improve recording in the system.

Our BI analyst went out across our various localities in Dorset - we have 5 localities - and talked to the operational staff within those areas about the data that they were seeing on a day-to-day

basis and the importance of the accuracy of the data that they were entering into the system. One of the key outputs that we saw from Client Level Data was an opportunity to really focus in on our waiting lists, but it enabled us to really make the changes that we needed to support the robustness of the data.
We've since moved to the quarterly submissions in line with the Client Level Data requirements and each time we do a submission, we update our analysis. So we're developing a really strong history and trend of how we're performing in this area. And we have those conversations with operational staff at sign off meetings to ensure that they really understand and grip and own the data.
So making it real, this is key for us. So as I've said within our localities, we piloted 1 area around waiting lists and looking at how we could use the data that we were providing as a business intelligence team to frontline staff to support them in their decision making. So our Head of Locality within that area took on a different approach to managing their waiting list, and really started to work more closely with her team in terms of engaging them with data, then about the decision making. So they changed their process, they moved away from spreadsheets and they moved to a harmonised approach of using the case management system to make sure that we were recording things in the right way. We were actively using the system for reporting, and we were getting it towards that single version of the truth in respect of our waiting lists. So she implemented this with regular team meetings, check ins by e-mail, supervisions, use of Teams channels and it was really about enhancing that communication and that team building ethos across the locality to really start to drive some of the improvements that we saw within the data. In terms of the work that we have done and the output that it has shown, now we're seeing within that particular area over 90% of people who come to us have their case allocated on the same day as the referral reaches the team. There's been a real strengthening of work allocation based on the use of the data. We are ensuring that our service users are not having to wait as long as they previously were for reviews and making sure that their cases are up to date on the system and the work morale across the teams we're seeing is significantly better now for operational staff, because we've managed to address some of the challenges and the blockers in the workload and our process and streamline.

So overall, we've managed to reduce our waiting list at Dorset Council for a Care Act Assessment by 25% and we started that piece of work earlier this year. We started in the financial year, so we've reached the 25% by the beginning of December and we've done that through optimising how we work, so we try to ensure that today's work when it comes in is done today. We've reconfigured some of the teams around our adult social care front door to ensure that we've got an occupational therapist in place. What we've seen in terms of that is a 63% reduction in the referrals that come from the front door into the locality offices and that's because our occupational therapists have been able to undertake an assessment at the front door and run equipment clinics. So addressing unnecessary referrals to our locality teams, reducing the burden on them has been one output. We've also implemented social worker capability at our front door. And again, what we're seeing because some of those conversations around social care are happening at the front door, referrals that ended up with our locality teams for onward resolution have reduced by almost 50%.

And I think the only last bit that I'd want to say just in terms of the Client Level Data is that we are also starting to think now about how we can use some of the outputs from our Client Level Data more widely across our integrated care system. We're embarking on quite a significant

transformation programme around our urgent and emergency care pathway, and one of the outputs of that will be enhanced use of reablement. So linking back to I think something Jenny, you mentioned at the start around reablement and external providers, we're really starting to use our data around reablement to feed into that wider programme across the integrated care system.

So just to conclude, I think you know we've really changed our approach in Dorset in terms of how we use data, and Client Level Data was the kind of impetus that we needed to be able to do that.

Jonathan Cox, Public Health Consultant, London Borough of Newham

Newham has had a long interest in data and informatics, which is why I've been involved in this work. Some of the key aims include all the usual ones about better preventative care, improving health and well-being, but also better understanding of our health and care system, and how it interacts. Some of the things we're trying to focus on just in these early days are people here on the cusp of needing social care and early needs, and what can we do around preventative approaches that we're not yet doing? And how can we start to move from descriptive into predictive about use of social care?

And just a word on some of the enablers we've got in our region, we have a long history of sharing primary care data going back to the 1980s. Some very engaged GPs had a very early interest in that, which led them to form the Clinical Effectiveness group and then Discovery Data programme. So we do have this very established trusted data sharing which I think has been a key part of why we've moved forward locally and the regional IG framework that all parties are signed up to that helps create a supportive environment. And our ICB now is picking up the CLD extracts from all of the boroughs across NE London, bringing them into a SQL database. So we have now got all the data linked, but at the individual level on NHS number.

So for our analytical approach, in our linked data set we've got the CLD data (it doesn't include carers at the moment) and a wide range of all of our services. We know our demography and equalities information and then it's linked to primary care data sets. So we've got all of the long-term conditions anyone has ever been diagnosed with and it's recorded in primary care, we have that, and we know when it happened. We have multi morbidity, we've got hospital admissions data set, medicines managed in primary care and then a whole load of other data. We've got a full data set for our team, measures of behaviour, all sorts of things and the mental health and community service, MDSS are shortly to be added to that too. So that's all linked at the individual level. So a really big, very, very rich database now.

In terms of hospital admissions we've got a history of five years and as I said primary care has all diagnosis, whatever happened. So how are we trying to use this? So there's two things we're thinking about: the cross-sectional association. So look at say, use of services, social care services, by people who smoke or don't smoke, frail or not frail, healthy weight or unhealthy weights, things like this so we can sort of dichotomize it in that way. Because it's a full population data set, we can compare people who use social care to those who don't use social care. And we could case match now, so we can actually control for all of those confounders, different populations and just look at where the only difference then is in using social care or not using social care. And we can think about longitudinal analysis, so every piece of data has essentially a timestamp, so we can construct chronological pathways for every person and look at their pathway of use of health and care resources for a system.

So that's potentially very powerful and we can think about different starting points. So we can start with looking at a health or a social care service cohort and then look at say use of social care after a health event or the other way round health event, and then used of a different service. So that's different ways that we're thinking about that.

So just a few high-level findings. So Newham, it's around 400,000 people. It's the most diverse borough in the country, has the highest number of people in temporary accommodation in the country. It's sort of deprived, but increasing affluence, so it's not a typical borough. One of the least typical boroughs in the country.
Not a lot of self-funding, but about 6,000 individuals using services and about 15,000 services at the minute. Some just initial findings, say two and a half times more likely to have an emergency admission when age, sex and ethnicity adjusted.
And very, very strong positive correlations with long term conditions and using social care. So almost 100 times more likely to use social care for people that have three or more conditions compared to someone without any long-term conditions. So very, very strong as we know long-term conditions are a very strong predictor of use of services.
I'm just going to now take you through a few examples of things we've done. So this is history of GP appointments in just looking at people who are aged 60 plus years. As I said, we can compare people who don't use social care against all the different use of packages. On the right there, these are expressed as relative risk. So on the right, you've got people aged 60 plus not using social care. They have about nearly nine appointments a year and you'll see on the left, we've got our nursing care, short-term long-term nursing care, people using those services having double the number of appointments of similar people not using social care services. And a range there, and what's interesting, we have Shared Lives. That's a service, a live in service for people with a learning disability or needs, and they actually use GP appointments less than the average person. So that's kind of an interesting finding there.
The next slide is another cross-sectional analysis looking at frailty. So on the top left there you will see this is the proportion of people with moderate or severe frailty aged 60 plus years. So we've got about 50 people who don't use social care, who are 60 plus years, 15% have recorded frailty and obviously up to really high levels of 3/4 of people using nursing and residential care, having frailty in the same age. So kind of frailty potentially being a big driver there.
And on the bottom right, a male female split of frailty as recorded by primary care across our services. So we'll see considerable differences there. Higher in females but some really big, important differences there. So just an example of frailty.

The next slide looks at Urinary Tract Infections (UTIs) admissions. So here we looked at bed days, hospital bed days for UTIs is on the top left. There again, we've got service, social care users and people not using social care services with age in the orange, we've got that people not using social care services and a rapid increase in UTI bed days. People who do use social care services have more UTI bed days across all ages. But what's really interesting, when you look at the bottom right one, we've got in the dark blue the people not using social care, they actually have more UTI bed days in our oldest groups than people using our services. So our nursing and residential care service users in 90 plus have either no or extremely few UTI bed days, much fewer than 90 plus people not in social care. So that's kind of really interesting. Perhaps endorsing the quality of some of our nursing and residential care there, but bearing in mind you know they had a lot more GP admissions, GP appointments and a lot more frailty for

example. So we're starting to see some different patterns in terms of health status now from this across different service types. So they're just a few examples.

And then this is a cross section analysis and then a longitudinal example. So as I said, everything has a timestamp of time point that we can use to construct a chronology for a patient and look at these temporal effects. So these are two examples. First a 75-year-old Asian male with a personal care need. And here we just looked at hospital admissions, contact with social care, receiving the service, having assessment and reablement. And the blue bars are scalar, so the sizes of them is sort of indicative of the length of time. And on the top line, you'll see now this particular person had a series of admissions and then received some reablement and then really quite a different pattern of hospital admission subsequently.
And the bottom example is an 80+ year old female. You can see a really different pattern of hospital admissions, and a long period of social care service of about a year and some reablement. So these are just examples of how we're trying to sort of visualise and explore the data and think what's a helpful way to cover this sort of longitudinal analysis. We pulled this together when we were questioning effectiveness of reablement and what's happening on subsequent health and care following a period of reablement. So just really testing the viability. We certainly don't have all the answers yet, but are exploring methods. So just another example there of a longitudinal analysis.
It's also worth saying we did some analysis looking at numbers of long-term conditions, and service use compared to people who don't use social care services. And that's quite interesting as we've seen that we see about a 20-year gap between delay of development of long-term conditions. So if you take people who use social care services, perhaps they have two conditions by the age of 40 in Newham. But if they are people who don't use social care, our population tends to reach two long term conditions at 60 years, so 20 years later. So we're seeing about a 20-year gap between use and not use of social care.
So really this is all just very early days for us. We're just really trying to figure out how to use this linked data set. These are just some examples that we pulled together to just explore and try and generate some discussion. But something we are particularly keen on is pathways into residential care - do we have young early use of residential care? What are all those individual journeys into residential care? Looking at that hospital discharge and social care interface particularly, and is our reablement working?

So we've just got a brief plan to do some high level descriptives: look at the relation between long term conditions and multi morbidity; hospital use - why are people for the different packages being admitted? There's a lot of methodological development to think about. We can do case mix adjustment and control for health status across all of these sorts of analysis using things like Cambridge morbidity score, and regression analysis, think about enablers, and trying to pull together a Community of Practice around all of this work. We can share our code now that generates all this stuff, and we are developing the access to the data platform that holds all the data. So it's trying to develop all of these things simultaneously to push it forward.
And just some of our key questions that I really would like thoughts and comments around is:

- what are the outcomes of interest for this? A lot the things we're pulling together seem to be outcomes that fall to the NHS and defining outcomes that we can explore that are more relevant to the council itself is probably a little bit more challenging.

- And then trying to work out what the actionable insight is? How do we identify prevention opportunities and move beyond ‘this is all really interesting information’, but what difference is it going to make?

As I said, it's really much at the start and we would very much like to explore those ideas with any other areas or anyone that has had any ideas and thoughts around that stuff. Really keen to join up with other places in the country that are a little bit further down the road - I know there's a few of them that have been doing this a bit longer than us. I'm just really doing this single handedly at the minute so it's on top of a busy job so it's difficult to try and progress.

So that's the story of where we've got to in Newham so far. I would love to hear from you to share ideas on this.

Questions

- What are our outcomes of interest for ASC and NHS?
- What are our prevention opportunities?
- How do we make greater use of the linked data generally?

If you have any thoughts / ideas please get in touch Jonathan.Cox@newham.gov.uk

Summary points from discussion and questions

- Examples from Newham and Dorset and other comments raised show that there is lot of good work going on in councils using data. There has been a perception that the sector does not use data as well as we could do, but there are clear examples of where and how it is used effectively - how we link in our local data, how we're using it to improve our performance and deliver better outcomes for people. We need to harness this more and collaborate – CLD provides a good opportunity to share and build on this learning.
- Reinforced the message that Client Level Data is very much an operational toolkit. It's a reflection of your Case Management System on a day-to-day basis, of which you just happen to take a cut once a quarter to submit. It should be your business as usual. There should be no burden or impact on your local business because it should be the core foundation for your local intelligence.
- Current focus for CLD is contacts, assessment, services and reviews, but there is nothing to stop councils adding in their own data on safeguarding, DoLs, Court of Protection, hospital discharge information and a whole myriad of other bits of information that will be dotted about your systems. That becomes a rich source of local business intelligence, which services the national requirement for CLD, but more importantly becomes business as usual with a focus on local intelligence, and feeding national intelligence from local operational input. So there's a synergy between the two.
- Future vision is an adult social care system where CLD is one of the core datasets that we use locally to demonstrate what we're doing and that CQC will be looking at that same data set. It is key that we work towards having one version of the truth, which is a national version of the truth. There will be challenges, but many benefits along the way.
- It is likely that some councils may have to adapt how they count or record events, in order to maximise the benefit of a core CLD dataset and associated insights and metrics. But there

are benefits in being able to compare with and learn from others, and for residents to have that transparency of their council's performance.
- CLD is here to stay. We have the opportunity now to collectively make it the best possible product it can be.

Response to questions

Access to benchmark data to compare with regional and statistical neighbours, for published and unpublished data.

Noted that whilst the secure dashboard for councils to review their own data, it does not offer any opportunity for benchmarking or comparison with others. Would be good to know what councils can share privately with other colleagues to understand if their performance is the same operationally.

Response from DHSC (JN)

The published data is available in LG inform so has support and functionality for benchmarking. For DHSC, if we can continue to publish stuff at the right rate, working with councils to make sure it looks good, then it can go into LG inform and that's the really good way to get some of those nicely presented benchmarking.
I think the DAP, the Data Access Project, might be another way to sort of bring in many more sources of data and to support that as well. We are still thinking about where we take the CLD dashboard. We are quite keen that it enables councils to share a lot more if it's limiting being just able to see your own data for operational and local use instead of looking over at trends over time. But we are open to suggestions on that as well.

Is there any additional funding for any software changes that are needed from April 25 to address any changes to the specification?

Response from DHSC (JN)

We have worked really closely with the reference group on the changes to the specification. We're not planning anything that would involve a recording change, or anything that would involve a change to the information you collect locally. Changes are more in the realm of very small reporting changes.
SALT has ended, so funding that local authorities historically received for SALT can go towards CLD. We're not planning any new data burdens. Any changes that are made are small. Safeguarding was mentioned - if there was there going to be any big change to scope then we'd have to think again about additional burdens.

Within DHSC there is also work ongoing to support local authorities with the procurement of case management systems. So there's some guidance around procurement and we're feeding closely into that to try and help with getting a good service from your IT suppliers as well.

Closing remarks, Pete Sidgwick

Big thank you to those who have taken part and contributed. It's really good to see so many people who are interested in this, and contributing to the development of CLD. We will review comments to see if there is support for follow up sessions and if so what their focus should be.

If there are any future CLD related topics you would like to see discussed in a webinar please email us at PCHdata@local.gov.uk.