The Coalition’s Record on Adult Social Care: Policy, Spending and Outcomes 2010-2015

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Contents

Summary .................................................................................................................................................... 5

1. Introduction ........................................................................................................................................... 6
   Why social care matters .......................................................................................................................... 6
   Scope ..................................................................................................................................................... 7
   Inheritance and current context .............................................................................................................. 7
   Goals ...................................................................................................................................................... 9

2. Policies ................................................................................................................................................ 11
   Future funding ....................................................................................................................................... 11
   Eligibility criteria .................................................................................................................................... 12
   Integration of health and social care ..................................................................................................... 13
   Support for carers .................................................................................................................................. 14
   Regulation, monitoring and inspection ................................................................................................. 15

3. Resources ............................................................................................................................................. 17
   Expenditure by local authorities and other public expenditure ............................................................. 17
   Planned expenditure ............................................................................................................................. 19
   Expenditure and demand ...................................................................................................................... 20
   Public expenditure on adult social care for over 65s in England, Scotland and Wales ...................... 23
   Private expenditure on adult social care ............................................................................................... 25
   Summary of trends in resources ........................................................................................................... 26

4. Outputs .................................................................................................................................................. 28
   Receipt of unpaid care .......................................................................................................................... 35

5. Outcomes ............................................................................................................................................... 38
   Unmet need .......................................................................................................................................... 44

6. Conclusions ........................................................................................................................................... 52

References .................................................................................................................................................. 65

List of Tables

Table 1: Expenditure by Councils with Adult Social Services Responsibilities (CASSRs) by accounting category, 2007/08 to 2013/14, England, £m in 2009-10 prices ........................................................................... 18
Table 2: Net current expenditure\(^{(1)}\) on adult social care services including planned expenditure: by source of funding, England, 2007-08 to 2014-15 (in 2009-10 prices, £bn) .......................................................... 20
Table 3: Annual change in number of clients receiving services, 2006/07 to 2013/14, England .......... 29
WP17 The Coalition’s Record on Adult Social Care: Policy, Spending and Outcomes 2010-2015

Table 4: Percentage changes in the number of community service users, by client type, in Labour and Coalition periods ....................................................................................................................................... 34
Table 5: Summary of ASCOF outcome measure values: by measure and year, England ....................... 40
Table 6: Abuse of Vulnerable Adults, 2010/11 – 2013/14, England ......................................................... 43
Table 6: Levels of unmet need and numbers of people with unmet need – Millions of hours p.a. and millions of people, England (from Forder and Fernandez (2010)) ............................................................................................................................... 45
Table 7: Unmet need for help with Activities of Daily Living among people aged 65 or over, 2001/2 and 2008, England, from Vlachantoni et al (2011) ................................................................................................................................. 46

List of Figures

Figure 1: Growth in real net current spending and population estimates by age group, England, 1997/98 to 2013/14 ................................................................................................................................................. 22
Figure 2: Real terms growth in observed and demand-adjusted net current spending plus non-client contributions for the whole population and aged 65 plus, England, 2005/06 to 2012/13 ....................... 23
Figure 3: Growth in real total gross expenditure on Adult Social Care: England, Wales and Scotland (including capital charges and residual expenditure on supporting people and excluding expenditure on Service Strategy) and demographic pressure, 2007-08 to 2012-13 (index numbers, 2007-08=100)............ 24
Figure 4: Source of finance for independent care home residents, older and physically disabled people, UK .......................................................................................................................................................... 26
Figure 5: Number of clients receiving services (community based services, residential care or nursing care) provided or commissioned by local authorities with social services responsibilities, by age group, 2005/6 to 2013/14, England ........................................................................................................................................ 28
Figure 6: Number of service users receiving community-based services each year, by age group, 2005/6 to 2013/14, England ................................................................................................................................. 30
Figure 7: Number of supported residents in residential or nursing care at 31 March each year, by age group, England ........................................................................................................................................ 31
Figure 8: Number of community-based service users aged 18 to 64, by primary client group, 2005/06 to 2013/14, England ........................................................................................................................................ 32
Figure 9: Number of community-based service users aged 65 and over, by primary client group, 2005/06 to 2013/14, England .................................................................................................................................................. 33
Figure 10: Distribution of community-based services clients by planned contact hours per week at 31 March each year, England ........................................................................................................................................ 35
Figure 11: Number of unpaid carers, by age group, 2002/03 to 2012/13, UK ................................................................................................................................................................................................................................. 36
Figure 12: Population aged 50 and over reporting to be informal carers, around 2007, OECD ................. 37
Figure 13: Receipt of formal care by age group and year, UK (FRS) ............................................................... 48
Figure 14: Receipt of formal care by number of difficulties, age group and year, UK (FRS) ...................... 49
Figure 15: Receipt of informal care by number of difficulties, age group and year, UK (FRS) ......... 50
Figure 16: Unmet need for care, by number of difficulties, age group and year, UK (FRS) ............... 51
Figure 17: Projections of total local authority funding and population aged 75 or over, England, 2010 to 2019 ......................................................................................................................................................... 54
Summary

Approaching 1.3 million older people and younger disabled and mentally ill adults use social care services in England, and 3.2 million are cared for informally, by their families and friends. How did the Coalition respond to long-term pressures that are putting care services and carers under growing stress?

- The Government legislated to make more people with modest wealth eligible for publicly funded support, by raising the capital threshold used as a means test from £23,250 to £118,000 (from 2016) and introducing a lifetime cap on care costs. However, this cannot be expected to have much impact on continued under-funding for social care as a whole.

- Public spending on social care has failed to keep pace since the mid-2000s with demand for services from growing numbers of older people. Spending cuts imposed by the Coalition intensified the pressure on social services from 2010 onwards.

- Overall spending is projected to have fallen by 13.4 per cent over the Government’s five years in office. Already by 2013/14, 17.4 per cent less was being spent on services for older people. By contrast, the number of people aged 65 and over increased by 10.1 per cent over the same period, including an 8.6 per cent increase in the population aged 85 or over.

- The number of people receiving publicly-commissioned adult social care services fell by one-quarter between 2009/10 and 2013/14 from 1.7 million to below 1.3 million. Care at home and other community-based services were hit especially hard, resulting in an average 8 per cent reduction in the number of users each year.

- The number of people with learning disabilities using community-based services grew slightly, but all other client groups experienced cuts. The number of service users among working-age adults with mental health problems dropped by 37 per cent and the number of physically disabled users aged 65 or over fell by 32 per cent.

- Local services were increasingly targeted on adults assessed as having the most complex needs. The proportion of social care clients being supported for five or fewer hours a week declined from 37 per cent to 28 per cent between 2009/10 and 2013/14. The proportion receiving care for more than ten hours a week increased from 34 per cent to 45 per cent. At the same time, nearly three-quarters of councils now arrange some social care visits as short as 15 minutes.

- Monitoring of care services based on users’ perceptions suggests some quality of life outcomes have improved. Nevertheless, statistics on the abuse of vulnerable adults show 37,685 substantiated cases in 2013/14, while Care Quality Commission inspections revealed serious concerns about the quality of care in a fifth of nursing homes and a tenth of residential care homes.
1. Introduction

The ‘Social Policy in a Cold Climate’ programme

This is one of a series of papers examining aspects of the social policy record of the Conservative/Liberal Democrat Coalition in England from 2010-2015, with a particular focus on poverty, inequality and the distribution of social and economic outcomes. The papers follow a similar set covering Labour’s record from 1997-2010, published in 2013, although social care was not one of the areas of focus in the earlier set of papers. This set of papers start with a brief assessment of the situation the Coalition inherited from Labour, they move to a description of the Coalition’s aims (as discerned from manifestos, the Coalition Agreement and subsequent policy statements) and the policies enacted. They then describe trends in spending on the area under consideration, and give an account of what was bought with the money expended (inputs and outputs). Finally, they turn to outcomes, and a discussion of the relationship between policies, spending and outcomes, so far as this can be discerned.

The papers focus on UK policy where policy is not devolved (for example taxes and benefits) and English policy for areas like social care which are devolved. In the case of devolved policy areas, key points of similarity and difference between England and the other UK nations are highlighted, but a full four country comparison is beyond the scope of the study.

Why social care matters

There are 1.3 million adults receiving publicly-funded social care services in England, and they include some of the people with the most complex needs in our society: the oldest of the old, younger physically disabled people, people with mental illness or cognitive impairments, and people with drug and alcohol problems. The social care workforce is estimated at about 1.5 million people in England, employed by over 17,000 organisations (Skills for Care, 2014). These are large numbers, but service users and paid carers represent only the tip of an iceberg: added to them are a large group of people who have significant needs and are being cared for exclusively by family members and friends, and a further group of unknown size who are in need but are receiving no support at all – formal or informal. Moreover, these numbers are set to increase over the next years and decades, as life expectancy continues to rise, and as more young people with severe physical and mental impairments survive into adulthood. These are welcome developments but exert an upwards force on the demand for social care.

The scale and significance of social care as a policy area is therefore undisputed, and yet it receives comparatively little attention in everyday public and political debate. This may be due to social care being the responsibility of local rather than national government, delivered by a large number of organisations without a unifying ‘brand’ (unlike the NHS), and the fact that entitlement is means-tested (in England, Wales and Northern Ireland but not wholly so in Scotland). This combination deprives social care of a natural lobby. Only those who come into contact with the service – directly or through family members - are likely to become aware of its limitations and inadequacies, and they may be more concerned with dealing with their immediate situation than raising wider issues for debate. Moreover the
This paper aims to contribute to stimulating debate on the provision of social care – not just in the future, but in the here and now – by providing evidence on changes in adult social care under the Coalition government from 2010 to 2015. Following this Introduction, section 2 gives an account of the social care context, outlines the policies pursued by the Coalition, and considers the extent to which these mark a continuation or a break with policies under the previous administration. Section 3 provides analysis of spending on adult social care, with and without adjusting for changes in ‘demand’ or need over the period. Section 4 considers changes in what the spending has produced - outputs such as numbers of residential care places, hours of home care provided, and so on. Section 5 assembles evidence on a range of social care outcomes and attempts to estimate changes in the level of unmet need, and Section 6 concludes.

Scope

Social care is treated in this paper as a description of a type of support that is required, whether that is provided by unpaid friends and family members, through publicly-funded services, by assistance paid for privately by individuals, or offered on a charitable basis by organisations. These distinctions are discussed further below.

This paper is about adult social care; children’s services are touched on in the companion paper on ‘early years’ policy, although they are not the main focus of the paper. Policy and spending on children’s services are distinct from adult social care, despite the fact that they are both considered social services.

Social care is a devolved policy area, and there are significant differences of approach between the jurisdictions. For reasons of space and resources, this paper focuses mainly on England, but where relevant highlights important differences in policies.

The paper concentrates on the period of Coalition government, but in order to understand the significance of this period it is necessary to contextualise it with what went before. (Unlike for some of the other policy areas in the Social Policy in a Cold Climate programme, a separate paper on Labour’s record was not produced). In most cases, the data are not available on a consistent basis further back than the early 2000s, so this provides a limit on the length of the time trend considered. Start dates are based on data availability and have not been selected in order to emphasise a particular perspective.

Inheritance and current context

‘Demand’ for social care – or rather the need for social care, since needs are often unidentified and unexpressed - is rising as a result of increasing life expectancy and increasing numbers of physically and cognitively impaired young people surviving into adulthood. Using the Labour Force Survey definition of ‘long-term disabled’, there were 6.7 million disabled adults of working age in the UK in 2000, rising to 7.6 million in 2012 (ONS, 2013, Table 3.2), a 13% increase in just over a decade. The population in England aged 65 or over grew by 17.1% between 1997 and 2012, a faster rate of growth than for under 65s (11.1%). For social care, the ‘older old’ age group is particularly relevant, and there
has been an 18.3% growth in the population aged 75 or over since 1997, and a 37% growth in the population aged 85 or over (ONS, 2013z). Of course it is not simply age, but levels of ill health and impairment that drive demand for social care. Unhealthy life expectancy at age 65 has been growing less fast than life expectancy overall – which is good news – but it is nevertheless growing: from 6.4 to 7.3 years for men between 2000-02 and 2009-11, and for women from 8.2 to 8.6 years (ONS, 2014z).

Both the financing and provision of social care is complex. Care is provided by a range of sources, access to which is dependent on individuals’ circumstances: partners and families – sometimes called ‘unpaid care’ or ‘informal care’; local authorities’ social services through residential care and care in the community (mainly domiciliary or home care); the NHS in nursing homes and hospitals; private residential care homes and private agency workers going to people’s homes; and voluntary sector provision, including for example day centres and lunch clubs. Funding arrangements cut across these different forms of provision. Since the establishment of the post-war welfare state, NHS care has been free at the point of use, whilst care arranged or provided by local authorities has been means-tested. In fact, entitlements to residential and home-based social services are based on a double test – firstly a care assessment conducted by local authorities to determine the level of need, and secondly an income and wealth means-test. Services required according to the care assessment may be provided directly by the local authority, commissioned by them from a private or voluntary sector provider, or translated into a direct payment over which the client him/herself (or someone on their behalf) has control. Individuals and/or their carers may receive means-tested benefits and/or categorical benefits based on their needs, and these benefits may – in some circumstances - themselves be taken into account in the local authority means-test, or withdrawn altogether if the recipient goes into NHS or residential care for an extended period. Finally, individuals and their families may contribute to the costs of care directly: as a user charge for services commissioned or provided by local authorities, as a top-up to local-authority funded services (as is common with residential care, for example, to secure a place in a more expensive home), or as a purely private arrangement between the individual and a provider.

The complexity of arrangements for the financing and provision of care produces numerous boundaries, each of which can be a site of disputes and perceived or actual injustice: between the NHS and local authorities; between individuals, their families and the state; between public and private providers; and between residential and home care. Recognition of the complexity and inadequacy of the current system, especially in the face of increasing demographic pressures, has resulted in a series of major official investigations into the provision and financing of social care, especially social care for older people: Griffiths (1988), Sutherland (1999), Wanless (2006) and most recently Dilnot (2011), which is described in more detail in the next section. Griffiths noted that particular rules in the social security system acted as an incentive to place people in private residential care, and away from local authority homes or domiciliary care, and recommended a paradigm shift away from residential care to ‘care in the community’ – a shift that did indeed occur to some extent following the 1990 NHS and Community Care Act. Nevertheless more than a decade later, the Royal Commission on Long Term Care concluded that the system was “...too complex and provides no clarity as to what people can expect. ... There is a degree of fear about the system which is of concern in a modern welfare state. It is riddled with inefficiencies. The time has come for it to be properly modernised” (Sutherland, 1999, Executive Summary and Summary of Recommendations). The Commission recommended retaining means-testing for housing and living costs in social care, but funding personal care costs from direct taxation – a split adopted in Scotland in 2002 for people aged 65 or over, but not implemented in England or Wales.
Alongside recently implemented and proposed changes in the funding regime, there has been a long-running trend away from direct provision by local authorities and increasing use of private and not-for-profit providers (HSCIC, 2014d, Figures 4.5 and 5.1), which has itself been controversial. Concern over the suitability and sustainability of private residential care providers intensified in 2011 when Southern Cross – with 750 homes, the largest private provider of care homes in the UK at the time - went bust, leaving thousands of elderly and vulnerable residents at risk of having to relocate at short notice, and local authorities in many cases picking up the tab. The challenges of regulating providers are discussed later in the ‘Outcomes’ section of this paper.

Disabled people’s organisations have long campaigned for users to have greater ‘choice and control’ over the support they receive. Since the Community Care (Direct Payments) Act in 1996, there has been a gradual increase in the number of people receiving payments from local authorities with which to arrange their own care (“direct payments”), rather than the local authority providing or commissioning services on their behalf. This idea was extended to personal budgets, pooling the funds associated with entitlements disabled or older people may have to services from a range of sources, including for example community health as well as social care. Between 2000/01 and 2008/09, there was more than a 10-fold increase in the number of working-age people using direct payments, and an even faster increase among the over-65s (from a much lower base), so that by the end of this period there were more than 86,000 recipients of direct payments in England (HSCIC, 2014d, Annex M).

In addition to on-going debates about the provision and financing of care, major concerns about the quality of both residential and domiciliary care have come to light during the period of the Coalition government. These had an important influence on the development of policy and will be discussed in the sections on ‘Policies’ and ‘Outcomes’ below.

Goals

Disagreement between the parties during the election campaign in relation to social care focused on proposals for future funding. The Labour Party had a radical set of proposals including the establishment of a National Care Service, with the eventual aim of providing free residential care and care at home. The initial steps towards this goal were to be funded by savings from local government and the health service, as well as freezing the Inheritance Tax threshold. Conservatives dubbed the latter a ‘death tax’, and proposed instead to rely on voluntary private long-term care insurance. The LibDems hedged their bets with the proposal to establish a commission to investigate the options – a proposal that became a convenient compromise when the Conservative-LibDem Coalition was formed.

Social care does not feature in the overview provided at the start of the ‘Programme for Government’ document (HM Government, 2010) – although some of the general statements of purpose there could have application to social care: “Wherever possible, we want people to call the shots over the decisions that affect their lives” (p7), might be understood to support extending the ‘choice and control’ of social care users, for example through direct payments to arrange their own care, while the intention to, “completely recast the relationship between people and the state: citizens empowered; individual opportunity extended; communities coming together to make lives better” (p8) might imply greater use of unpaid care, although, “a much stronger society: one where those who can, do; and those who cannot,
we always help” suggests there was a commitment to continue to provide public support to those in need.

Social care was not a contentious area in the Coalition agreement (Box 1), since there was a broad alignment between Lib Dem and Conservative manifesto commitments (HM Government, 2010), and differences of opinion about future funding were glossed over by the agreement to establish a commission. Otherwise the Coalition agreement committed the government to improving the integration of health and social care, increasing uptake of personal budgets, and increasing the availability of direct payments for carers (a proposal from the Conservative manifesto; the Lib Dems wanted guaranteed respite provision for carers).

Box 1: The Coalition Agreement and party manifestos

Social care received little attention in the Coalition Agreement. Shared policies are underlined below; clauses in bold type stem entirely from the Lib Dems, while those in italics are solely from the Conservatives.

- **We will establish a commission on long-term care**, to report within a year. The commission will consider a range of ideas, including both a *voluntary insurance scheme to protect the assets of those who go into residential care*, and a partnership scheme as proposed by Derek Wanless.

- **We will break down barriers between health and social care funding** to *incentivise preventative action*.

- **We will extend the greater roll-out of personal budgets to give people and their carers more control and purchasing power**.

- **We will use direct payments to carers** and better community-based provision to *improve access to respite care*.

There were no specific Conservative manifesto commitments that did not make it into the Coalition Agreement, although they had wanted voluntary insurance rather than a commission on future funding. In two areas, Lib Dem manifesto commitments were included but in a weaker form than originally expressed: to ‘*Integrate health and social care to create a seamless service’*, and ‘*provide guaranteed respite care for the one million carers who work the longest hours’*.
2. Policies

Future funding

The Commission on Funding of Care and Support started work in July 2010 under Sir Andrew Dilnot and reported a year later (Dilnot, 2011). Its recommendations were taken up in a modified form in a subsequent White Paper, *Caring for our future: reforming care and support* (DH, 2012b), and in the Care Act 2014. The Act represents a significant milestone in the long-running debate about the balance between individual and public responsibility for social care funding. In particular, the Act establishes a lifetime cap on the care costs an individual can be required to make, which is to be implemented from April 2016 (and applied to costs accrued from then on). The cap does not include costs of daily living (including housing), so only part of the cost of a residential care placement would count towards the cap. The level of the cap will be set by regulations, and the government announced its intention in the March 2013 budget to set it at £72,000 for people of pension age (DH, 2013a). The Act also makes allowance for the cap to vary by age, and the government has likewise indicated its intention that the cap will be lower for people whose needs arise while they are of working age, and will be set at zero for those who have eligible care and support needs when they turn 18 (in line with Dilnot).

The government also accepted the Dilnot Commission’s recommendation that the capital means test threshold for residential care should be raised. Presently, people must spend down their assets (including the value of their house, unless a close relative continues to live there) to £23,250 before qualifying for any state funding. Those who have assets less than £14,250 qualify for full state funding. The March 2013 budget announced that the upper threshold would be increased to £118,000 for residential care - more than a four-fold increase - whilst keeping the lower threshold constant in real terms, thus extending the wealth range over which individuals will be eligible for some state support. This was a significant move at a time when eligibility for social security benefits (and, as we shall see later, access to social care services) were being restricted elsewhere, although it will affect only a small proportion of the population. Together with the lifetime care cap, Hancock et al (2013) estimate that there will be an additional 115,000 people receiving some public funding for social care by 2030, around a 9% increase.

The lifetime cap and more relaxed capital means test remove some of the most extreme potential financial consequences of needing care and thereby reduce uncertainty. At the moment, the amount people pay depends both on whether or not they are unfortunate enough to need significant periods of high-intensity care, and on their income and wealth. In future, the relative importance of the first of these elements will be reduced and the reforms can therefore be seen as going some way towards pooling the risk of high care needs. This is certainly welcome, but since low income and asset-poor individuals are already entitled to free care, the reforms are strictly regressive in terms of income and wealth distribution (Hancock et al, 2013) – although this will be offset to some extent by the government’s intention to pay for these reforms through a freeze on inheritance tax thresholds and changes to national insurance contributions (Humphries, 2013), both of which are progressive.
The Dilnot reforms implemented by the government will primarily benefit those with high intensity or prolonged care needs and modest assets, and for this group the reforms represent a shift from individual to public funding. But the reforms will do little to address the chronic under-funding of social care as a whole. As we shall see in the following sections, current spending is not meeting existing needs, and as needs will continue to grow over the coming decade, so will the funding gap.

Box 2: Summary of Coalition policies

**Future funding**
- Commission on Funding of Care and Support (Dilnot Commission), 2010-2011
- Significant relaxation of capital means test for residential care (announced in March 2013 budget)
- Lifetime cap on care costs (Care Act 2014, following Dilnot)

**Eligibility criteria**
- New national criteria for social care eligibility based on levels of need (regulations following Care Act 2014)

**Integration of health and social care**
- Health and Well-Being Boards (Health and Social Care Act 2012)
- More pooling of existing NHS and social care resources (Care Act 2014; Better Care Fund)

**Support for carers**
- Extension of statutory rights of carers to support from social services (Care Act 2014)
- Changes to right to request flexible working (July 2014)

**Regulation, monitoring and inspection**
- Stronger statutory basis for Adult Safeguarding Boards (Care Act 2014)
- Local authorities responsible for continuity of care (Care Act 2014)
- Adult Social Care Outcomes Framework (from 2011)
- New inspection regime by Care Quality Commission (from 2013)

**Eligibility criteria**

Other provisions in the Care Act 2014 are more significant for social care provision and outcomes in the short-term. The Act introduces for the first time a duty on local authorities to ‘take steps’ to prevent, reduce or delay the need for care, including by providing services. It also gives the Secretary of State power to introduce regulations to define the minimum level of needs local authorities must meet, including, for the first time, a minimum for carers. These provisions expand the statutory responsibilities of social services to include preventative work and support for carers, and have the potential to reduce
the ‘postcode lottery’ of care eligibility, with different local authorities conducting care assessments in
different ways and adopting different thresholds of entitlement. But in practice, the national minimum
eligibility criteria are being drafted, according to the Department of Health, so as to be equivalent to the
current threshold of ‘substantial needs’ as defined by the existing Fair Access to Care criteria. This
implies that only a handful of authorities (2%) will have to widen their provision, while a much larger
proportion (12%) will be given the ‘green light’ to further restrict their eligibility (DH, 2013b, para 3.3). In
effect they give statutory backing to the de facto shift in many local authorities from including those with
‘moderate’ needs in service provision, to only supporting those with the higher threshold of ‘substantial’
needs (AgeUK, 2014, Figure 5). The new draft criteria will come into force in April 2015, subject to
revisions through consultation and parliamentary processes.

It is difficult to see how setting the minimum eligibility threshold at the level of there being a ‘significant
risk to any aspect of the adult’s well-being’ is consistent with the new statutory requirement to offer
preventative services. Indeed the Act appears to promote a bizarre situation in which an individual may
be offered services to delay the need for care (perhaps the installation of some assistive equipment), but
when he or she actually needs care (for example, someone to help with a weekly bath), he or she will
not be entitled to assistance until there is deemed to be a significant risk to his or her well-being.1 It is
hard to see the logic of this hollowing out of care and support, concentrating resources on prevention
and on high-intensity needs, when in reality care needs are on a continuum, with appropriate support at
each stage being likely to reduce, delay or prevent further needs developing.

Integration of health and social care

The Health and Social Care Act 2012 and the Care Act 2014 both contain provisions to promote the
integration of health and social care, including through the work of Health and Well-Being Boards. The
June 2013 spending review announced what became the Better Care Fund, pooling existing NHS and
social care resources to create a joint fund for services intended to reduce acute health care expenditure
by improving care in the community (for example, services that avoid emergency admissions, or
rehabilitation and support services that make earlier discharge from hospital possible). The fund will be
worth £3.8bn in 2015/16, which is less than 3% of total NHS and social care spending, and not additional
money, but is still a significantly bigger pot than has previously been available for joint working. Pioneer
areas have been established to develop and share good practice, and The King’s Fund produced a
briefing outlining a plethora of forms of integrated care, some with strong evidence supporting their
effectiveness (Bennett and Humphries, 2014), although this may be more apparent in terms of improved
client experience rather than cost savings. The government appeared to get cold feet about the fund
after doubts were raised about the plausibility of the savings in acute health spending that were
supposed to be delivered, and revised conditions were announced in July 2014 (DoH and DCLG, 2014).
The King’s Fund (2014) have cautioned that the revised guidelines mean local authorities will have to
bear significant risks in investing up front in services, without being sure whether they will deliver the
reductions in emergency admissions that would trigger the release of performance-related payments.

1 There was some evidence of this tension already in the London boroughs studied as part of the SPCC
programme (Fitzgerald et al, 2013; 2014). In Redbridge, an adult social care officer reported that they were being
less restrictive about giving out small pieces of equipment to help people help themselves (eg a handrail or
microwave), following the preventative logic, while in Brent, an officer reported that eligibility criteria for assistive
equipment were being applied more strictly, as a means of making savings.
King’s Fund are also concerned that the speed with which the Better Care Fund has been introduced – and then altered – mitigates against the establishment of genuinely innovative and collaborative work at a local level, especially in the context of exceptional pressures on both NHS and social care budgets, and the NAO (2014a) cast further doubt on the likelihood of achieving even the much more modest savings from reduced emergency admissions the Fund is now forecast to produce.

Joining up the NHS and social services is notoriously difficult, and previous attempts at fostering greater integration have had limited success. It seems unlikely that the current initiatives will be significantly more effective, but they may contribute to a realisation, firstly, that forging links between existing structures is not sufficient, and, secondly, that the overall level of resources for social care needs to be addressed at the same time, rather than trying to squeeze more out of the same, inadequate, pot. This is the conclusion of the Barker Commission, run by The King’s Fund, which reported in September 2014. It recommends all health and social care should be jointly funded and commissioned, and that it should be free at the point of use for all those assessed as having ‘critical’ care needs, expanding to include those with ‘substantial’ care needs in due course. This implies a significant increase in resources, but Barker (2014) argues that the increase is both necessary and affordable by international comparison. Integration of NHS and social care is also reflected in recent policy announcements by The Labour Party, emphasising ‘whole person care’, although details have yet to emerge (Burnham, 2014).

Support for carers

As mentioned above, the Care Act 2014 expands the statutory responsibilities of social services to support carers and national minimum eligibility criteria for carers will for the first time be defined. Eligibility for carers assessments has also been broadened to include those with less intensive caring roles. The LibDems have reiterated their commitment to guaranteeing respite breaks for carers in the next Parliament but it has not been delivered through the Coalition government.

The right to request flexible working was extended from carers and parents to all employees with more than 26 weeks service with an employer in July 2014. However, at the same time, the requirements for employers were relaxed in a number of ways. Research on the previous period of flexible working requests suggests that up to one-fifth of requests may be turned down, and a similar proportion accepted only in part (Hegewisch, 2009).

Some individuals and families who employ a carer will benefit from the announcement in the 2014 Autumn Statement of a reduction in the employer National Insurance Contributions payable by them (rather confusingly referred to as an Employment Allowance) (Carers UK, 2014).

These developments appear modest in comparison to the range of strategies being pursued in other countries to help unpaid carers, according to the OECD: “These include paid care leave (e.g. Belgium), allowing flexible work schedules (e.g. Australia and the United States), providing respite care (e.g. Austria, Denmark and Germany) as well as counselling/training services (e.g. Sweden). Moreover, a number of OECD countries provide cash benefits to informal care givers or cash-for-care allowances for recipients which can be used to pay informal care givers” (OECD, 2011, p170). At present in the UK, care leave is unpaid, flexible working is a right to request not a right in itself, respite care is not
guaranteed, Carers Allowance has restricted eligibility, and direct payments cannot be used to pay family and friends as carers.

**Regulation, monitoring and inspection**

Another area of policy development has been in relation to the regulation of social care. In response to the collapse of Southern Cross in 2011, the Care Act 2014 includes a duty on local authorities to provide continuity of care if a private provider ceases to operate. This offers welcome security to residents and their families but does not of course address the underlying issue of the public sector having to carry a large share of the downside risk of private investment in social care.\(^2\) To reduce this risk, financial management and sustainability has been incorporated into the Care Quality Commission’s inspection regime for social care providers.

There have also been other changes to the inspection regime in response to a series of scandals about, and inquiries into, abuse and poor quality care. The Equality and Human Rights Commission conducted an inquiry into domiciliary care for older people (EHRC, 2011), gathering qualitative evidence from older people and their families, and carrying out surveys of local authorities and providers of home care. It found many instances of older people not being given adequate support with eating and drinking, neglect of basic care (often as a result of carers being too short of time), disregard of older people’s dignity and privacy, lack of choice and control, financial abuse, and even some physical abuse through rough handling and use of force. Older people spoke of the impact on them, including feeling depressed, frustrated, stripped of their self-worth and wanting to die. Yet many were reluctant to make complaints: “They did not want to get their care workers into trouble, feared being put into residential care, and did not want to ‘make a fuss’” (EHRC, 2011, Executive Summary p7). The Inquiry identified some good practice among local authorities in commissioning services placing an emphasis on quality and involving older people in decisions, while other authorities were driven primarily by price. It recommended a clearer focus on older people’s human rights in commissioning services, including removing barriers to older people raising concerns about their care.

Standards in residential care have also been a cause of concern. A Panorama programme in May 2011 revealed serious, systematic and long-running abuse of learning disabled adults at a home called Winterbourne View owned by Castlebeck Care. Following the revelations, the home was closed, 11 members of staff were prosecuted and convicted, the Care Quality Commission reviewed all services run by Castlebeck Care and inspected nearly 150 learning disability homes and hospitals, the South Gloucestershire Safeguarding Adults Board conducted a Serious Case Review, and the Department of Health published a national response. But as the government’s own report acknowledges, the fact that it took a television documentary to bring the abuse to light was itself an indictment of the commissioning and regulatory systems (DH, 2012a).

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\(^2\) Commissioning of services by local authorities provides a substantial proportion of the income of private and voluntary sector providers, so the level of fees paid by local authorities is a significant determinant of whether a provider remains in business. Making local authorities responsible for continuity of care for all clients if a provider ceases to operate therefore puts local authorities in a weak position in their negotiations with providers over fee levels – a weakness that is likely to be exacerbated by the trend towards fewer, larger, providers (Frost and Sullivan, 2013).
Also in 2011, a nursing home in West Sussex called Orchid View owned by Southern Cross was closed. The home had been subject to a series of serious safeguarding alerts and concerns raised by residents, families and other professionals who came into contact with the home, from within a few months of its opening in 2009 to the time of its closure, including maladministration of medication, delays in attending to serious injury, dehydration and malnutrition, physical, emotional and financial abuse, neglect, and falsification and destruction of records (West Sussex Adults Safeguarding Board, 2014). Nineteen deaths during the period 2009-2011 were referred to the coroner for an inquest, and the coroner concluded that 5 residents had ‘died from natural causes attributed to by neglect’, with inconclusive evidence about several other deaths in the home. A Serious Case Review commissioned by West Sussex County Council followed in 2013-14, making 34 recommendations covering governance, inspection, workforce, information provision to relatives and other issues (West Sussex Adults Safeguarding Board, 2014). The Review found that Orchid View management had put financial sustainability before quality of patient care – a strategy which ultimately failed even in its own terms, but not before it had cost the lives of at least 5 residents, and generated unnecessary suffering for scores of others.

The mounting and very high-profile evidence of the inadequacy of existing mechanisms for regulating and monitoring social care in both residential and domiciliary settings led the government and CQC to introduce new statutory powers and to revise their procedures. CQC’s new regime aims to incorporate users’ views more systematically into their inspections, both by monitoring complaints and through bespoke interviews, and they are also developing a new ‘ratings’ system, which could be used by people in making a choice between providers and hence incentivise providers to improve, as well as guiding the frequency with which CQC will re-inspect a given service (CQC, 2013a). Meanwhile the government gave Safeguarding Adults Boards, which comprise social services, health and the police, and are the first line of investigation for reports of adults at risk of abuse, a statutory basis in the Care Act 2014, helping to embed them in local practice.

Alongside these changes, the government introduced a national Adult Social Care Outcomes Framework in March 2011, with indicators reflecting a number of current policy concerns, including health and social care integration, quality of care, services for carers, and choice and control for users. This will be explored in more detail in as part of the analysis of social care outcomes in section 5 below, but before that we need to understand what has been happening to the inputs to social care, especially public spending.
3. Resources

Public expenditure on adult social care services is largely through local authorities: by provision or commissioning of services, through direct payments or individual budgets for users, through joint arrangements with the NHS, or through charges levied on users. Other formal care services may be paid for directly by individuals and their families, and this in turn may be funded (in part) through social security benefits such as Personal Independence Payment/Disability Living Allowance, and Attendance Allowance (estimated to be a ). In addition, a huge volume of care is provided by unpaid carers (friends and family), some of whom are also in receipt of Carers Allowance. This section starts by reporting trends in local authority and other public expenditure on adult social care, before going on to examine the evidence on private spending by individuals and their families. Consideration of unpaid care is held over the following sections on Outputs and Outcomes. Public spending on social security benefits is covered in a companion paper in this series (Hills, 2015).

Expenditure by local authorities and other public expenditure

Local government spending overall in England will have fallen by around 30 per cent between 2008 and 2015 (Hastings et al, 2013), and since social care spending is not ring-fenced, it has been among the services exposed to cuts. However, unlike some other areas of local authority activity, some social care provision is statutory, which reduces the room for manoeuvre in implementing cuts, and many authorities have in any case sought to protect frontline services in general and social services in particular (LGA, 2014a; ADASS, 2014). Indeed, adult social care is second only to children’s services in the degree of protection that has been afforded to its budget within non-ring-fenced local authority spending (DfE, 2014). The reductions in spending reported in this section are therefore not as great as the overall fall in local authority spending, although as we shall see, once increasing need is taken into account, the real reductions are substantial.

The Health and Social Care Information Centre (HSCIC) publishes data on social care in England, including social care activity and expenditure by Councils with Adult Social Services Responsibilities (CASSRs). The time series for the most comprehensive expenditure definition, Gross Total Cost, is available on a consistent basis back to 2007/08 (Table 1). Data on other types of expenditure are available on a consistent basis for longer time series (see Figure 1 below).

Most social care activity is financed by local authorities but some of it is financed by client contributions or by joint arrangements with other public bodies, including the NHS. This distinction is reflected in the accounting categories used in Table 1. Gross total cost (Table 1 row A) reflects all expenditure relating to local authority social care activity, however financed. It includes capital charges (row F) and spending funded through client contributions, the NHS and joint arrangements with the NHS (rows B and C) (see below for further discussion of these joint arrangements). Gross total cost is therefore of interest as an indicator of the amount of resources going into adult social care via local authorities altogether.

But we might also be interested in what social services are themselves financing; this is reflected in Net total cost (row E), which excludes client contributions and funding via joint arrangements and the NHS. Finally, Net current expenditure (row G) is the most minimal definition of expenditure, excluding capital charges as well as client contributions and any other funding from the NHS and joint arrangements.
Whichever definition one adopts, Table 1 shows that the peak in adult social care spending was in 2009/10 (in real terms), the final year of the Labour Government. Since then, there has been a consistent drop in real annual spending. By 2013/14, there had been a 7.2% fall in gross total cost (row A), a 7.6% fall in net total cost (row E: what local authorities themselves are financing), and a 7.1% fall in net current expenditure (row G, the most minimal definition of expenditure).

Table 1: Expenditure by Councils with Adult Social Services Responsibilities (CASSRs) by accounting category, 2007/08 to 2013/14, England, £m in 2009-10 prices

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<tr>
<td>A. Gross total cost</td>
<td>18,109</td>
<td>18,601</td>
<td>19,175</td>
<td>19,153</td>
<td>18,395</td>
<td>18,053</td>
<td>17,791</td>
<td>-7.2</td>
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<td>minus</td>
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<tr>
<td>B. Income from client contributions</td>
<td>2,266</td>
<td>2,285</td>
<td>2,343</td>
<td>2,373</td>
<td>2,363</td>
<td>2,368</td>
<td>2,388</td>
<td>+1.9</td>
</tr>
<tr>
<td>C. Income from NHS &amp; joint arrangements</td>
<td>1,410</td>
<td>1,454</td>
<td>1,642</td>
<td>1,833</td>
<td>1,385</td>
<td>1,498</td>
<td>1,478</td>
<td>-10.0</td>
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<tr>
<td>D. Total Income (including other income)</td>
<td>4,020</td>
<td>4,088</td>
<td>4,397</td>
<td>4,642</td>
<td>4,070</td>
<td>4,158</td>
<td>4,126</td>
<td>-6.2</td>
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<td>equals</td>
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<tr>
<td>E. Net total cost</td>
<td>14,089</td>
<td>14,513</td>
<td>14,778</td>
<td>14,512</td>
<td>14,325</td>
<td>13,895</td>
<td>13,665</td>
<td>-7.6</td>
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<td>minus</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>F. Capital charges</td>
<td>219</td>
<td>278</td>
<td>314</td>
<td>278</td>
<td>274</td>
<td>201</td>
<td>223</td>
<td>-29.2</td>
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<tr>
<td>G. Net current expenditure</td>
<td>13,870</td>
<td>14,235</td>
<td>14,463</td>
<td>14,233</td>
<td>14,051</td>
<td>13,695</td>
<td>13,443</td>
<td>-7.1</td>
</tr>
</tbody>
</table>

Source: Authors’ calculations using data from National Adult Social Care Intelligence Service (NASCIS) online analytical tool, Health and Social Care Information Centre (online) and GDP deflators from HM Treasury (2013) with reference year changed to 2009-10. Original data source: PSS-EX1.

Notes:
1. Definitions of accounting categories:
   A. Gross total cost = net current expenditure + capital charges + total income (i.e. the most comprehensive definition, including spending funded by non-CASSR sources)
   B. Income from client contributions (i.e. user charges)
   C. Income from NHS and joint arrangements (i.e. funding from these sources for CASSR activity)
   D. Total income = income from client contributions (B), NHS & joint arrangements (C), and other income
   E. Net total cost = A – D = net current expenditure + capital charges – total income (i.e. spending by CASSRs themselves)
   F. Capital charges
   G. Net current expenditure = E – F = expenditure excluding capital charges – total income (i.e. spending by CASSRs themselves excluding capital)

2. For a detailed explanation of accounting categories and changes in recording practices, see HSCIC (2014c)

Figures for net current expenditure reported by HSCIC (online) go back consistently3 to 1994-95 and show that the 1.3% fall in real terms in net current expenditure between 2009/10 and 2010/11 was the first year-on-year real terms fall since 1994-954.

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3 This is ensured by removing funding for Supporting People funding. Prior to 2003/04, Supporting People funding was classified as housing expenditure and not Social Services expenditure by the councils. The longer term time-series therefore exclude this grant altogether to be more consistent over time.
Despite cuts in social care spending, the costs were not mainly passed onto the users in the form of charges. Income from client contributions (which include sales, fees and charges) remained broadly constant (in real terms) over the period when social care expenditure declined (2009/10 to 2013/14). However it is worth noting that since the number of users also declined over this period (see section 4), user charges per head have in fact increased.

Table 1 shows that total income was increasing up to 2010/11 and then decreased by 12% in 2011/12 with a slight increase the following year. The large fall in total income between 2010/11 and 2011/12 is mainly accounted for by the fall in income from the NHS. This is due to changes in the way the Valuing People Now initiative, which focuses primarily on adults with learning difficulties, was recorded. Prior to 2011/12 it was recorded as income from NHS but after that the Valuing People Now initiative funding has been allocated directly to local authorities.

Separately, there is new NHS funding for social care from 2011-12. This includes a non-recurrent Primary Care Trust allocation to local authorities which is for the provision of social care that would also benefit NHS, for the years 2011-12 and 2012-13 (Department of Health, 2010), and subsequently the Better Care Fund. The examples of such allocations are telecare, maintaining eligibility criteria for social care, early supported hospital discharge schemes, re-ablement services, and bed-based intermediate care services. In 2010-11 to 2012-13, additional funding was transferred from NHS to local authorities under the Winter Pressures transfer, which is also part of the income to local authorities. These sums are included in Gross total cost but not in Net current expenditure in Table 1.

**Planned expenditure**

Table 2 shows net current expenditure on adult social care services by Local Authorities and includes a forecast for the final year of the Coalition government, 2014/15. Using HSCIC (2014b: table C1, p46) for methodology and some of the data, we calculate total net expenditure which is net current spending financed by local authorities themselves plus some of the main additional sources of financing of adult social care from the NHS. The Table includes budgeted figures for 2014/15 reported by local authorities (DCLG, 2014a,b,c), and to ensure consistency with these budgeted figures, the net current expenditure figures use a slightly different definition from row G of Table 1. If we only look at net current spending on adult social care by local authorities (first line in Table 2), the decrease in spending between 2009/10 and 2014/15 is 11.4%. However, taking into account some of the

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4 Authors’ calculations using nominal expenditure figures for gross and net current adult social care expenditure (HSCIC 2013a, National Gross Current Expenditure and National Net Current Expenditure (excel file) and GDP deflators HM Treasury (2013) – table not included here.

5 Table 2 comes from the Local Authorities returns (called RO3) to Department for Communities and Local Government (DCLG), including budgeted figures for 2014-15. The RO3 return is one of a suite of data returns and it covers all local government expenditure on social care. The total for social care in these returns matches those in the Revenue Account (RA) return. There are some minor differences between the accounting procedures between the RO3 Return and the PSS EX1 (the returns from CASSRs to HSCIC we refer to above) as well as difference in timing of collection of these returns, but the figures for Adult Social Services Net Current Expenditure are broadly comparable (HSCIC 2013a). In 2012-13 the Adult Social Services Net Current Expenditure on the RO3 return was £14.52 billion compared to £14.63 billion in the PSS-EX1, the difference of £106 million is less than one per cent of the RO3 figure (HSCIC 2013a).
main additional sources of social care funding, the decrease in total net current expenditure over the period of the Coalition government is expected to be 13.4%.

Table 2: Net current expenditure⁽¹⁾ on adult social care services including planned expenditure: by source of funding, England, 2007-08 to 2014-15 (in 2009-10 prices, £bn)

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<tbody>
<tr>
<td>Net current expenditure⁽²⁾</td>
<td>14,567</td>
<td>14,041</td>
<td>14,040</td>
<td>13,596</td>
<td>13,367</td>
<td>12,911</td>
<td>-11.4</td>
</tr>
<tr>
<td>Valuing People Now⁽³⁾</td>
<td>1,280</td>
<td>1,277</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>NHS transfer to local</td>
<td></td>
<td></td>
<td>619</td>
<td>580</td>
<td>788</td>
<td>809</td>
<td></td>
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<tr>
<td>authorities⁽⁴⁾</td>
<td></td>
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<tr>
<td>Winter pressures transfer⁽⁵⁾</td>
<td>156</td>
<td>143</td>
<td>94</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total net expenditure</td>
<td>15,847</td>
<td>15,474</td>
<td>14,803</td>
<td>14,270</td>
<td>14,155</td>
<td>13,720</td>
<td>-13.4</td>
</tr>
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</table>

Nominal figures: 2009-10 to 2012-13 are Local Authorities social care returns (adult component) to DCLG (2014a: Table 3); 2013-14 figures are from DCLG (2014b) and 2014-15 net current expenditure figure is budgeted figure from DCLG (2014c); 2009-10 to 2013-14 figures for VPN, NHS transfer to Local Authorities, Winter pressure transfer from HSCIC (2014); NHS transfer for 2014-15 is from DH (2014a).

Sources: Author’s calculations using nominal figures from various sources and GDP deflators (HM Treasury 2013). Nominal figures sources:
- net current expenditure for years 2009-10 to 2012-13 from Local Authorities social care returns (adult component) to DCLG (2014a: Table 3); 2013-14 figure from DCLG (2014b) and budgeted expenditure for 2014-15 from DCLG (2014c: Table 1);
- Valuing People Now initiative spending; NHS transfer to Local Authorities, and Winter pressure transfer for years 2009-10 to 2013-14 from HSCIC (2014b: p.46);
- NHS transfer figures for 2009-10 to 2013-14 from HSCIC (2014b), for 2014-15 from DH (2014a);

Notes (mostly from HSCIC 2013a: 40):
(1). Net current expenditure is total expenditure excluding capital charges and less all income.
(2). Expenditure as reported by Local Authorities to DCLG, includes Supporting People expenditure, and inclusive of expenditure on assessment, care management and other overheads.
(3). The Valuing People Now initiative aimed to give greater independence to young adults with learning disabilities.
(4). Responsibility for providing services to this group lay with the NHS before being transferred to CASSRs in 2008-09. Until 2011-12 funding continued to be provided through the NHS and so was not included in the net expenditure by social services departments. From 2011-12 funding for this initiative was allocated directly to CASSRs and therefore is included in the net expenditure of social services departments. The actual value of the transfer is known for 2010-11 only and has been assumed to be flat in real terms to provide a figure for previous years (HSCIC 2013a).
(4). These monies are transferred from the NHS to CASSRs for the provision of social care services that also benefit health, including for example the Better Care Fund. As they are considered to be income, the sums are not included in the net expenditure reported by social services departments.
(5). These monies are transferred from the NHS to CASSRs for the provision of social care services that also benefit health, specifically over the winter period. As they are considered to be income, the sums are not included in the net expenditure reported by social services departments.

Expenditure and demand

Pressure on publicly funded social care predates the budget reductions that we showed began in 2009/10. More people have been surviving into old age due to improvements in medical care and standards of living. And while the growth in population aged 65-84 and 85 plus has been accelerating,
resources for social care for this section of population have been cut along with the number of people for whom social care services were provided (see section 4).

Figure 1 (overleaf) shows the growth in net current expenditure on adult social care for the over 65s and overall, alongside an indication of demographic pressure from the ageing population expressed as growth in population of 65 and older as well as population of 85 and older. While we can see that the overall spending on adult social care had been increasing up to 2009/10, spending on over 65s began to decline from 2005/06 despite the accelerating growth in population of this age. This indicates that there is an increasing shortfall in expenditure compared to need.

The shortfall between spending and need is also shown by Fernandez and colleagues (2013) in their calculations of demand-adjusted expenditure. They estimated net current expenditure (total and by client type) adjusted to need for the period between 2005/06 to 2012/13. These need-adjusted, or standardised, figures were derived by applying multivariate regression techniques in order to control for changes across the time period in the council-level socio-demographic factors such as population age and gender profiles, Standardised Mortality Ratios, rates of limiting longstanding illness, population density among others were used (Fernandez et al 2013: p. 9). Their findings suggest that the need-standardised gap in levels of net social care expenditure in 2012/13, relative to the levels of expenditure in 2005/06 is approximately £1.5 billion. The reduction in the level of local authority investment per unit of need (demand-adjusted expenditure) accelerated significantly from 2010/11 (Fernandez et al 2013: 17). Fernandez et al (2013) showed that standardised net current expenditure including non-client income (i.e. including expenditure financed from the NHS and joint arrangements) peaked in 2009/10 and by 2012/13 had fallen by 12.2% (authors’ calculations using Fernandez et al (2013) Tables 4 and 5).

The over-65s have been particularly hard-hit, relative to demand. Figure 2 compares the real growth in net current spending plus non-client income by local authorities with the demand-adjusted estimates, for the population as a whole and for the over 65s in particular (authors’ calculations using figures from Fernandez et al 2013, Tables 4 and 5). It covers the period from 2005/06, when the spending on over 65s began to decline, up to 2012/13. Between 2005/06 and 2012/13 the fall in observed spending on older adults was 10.6%, while demand-adjusted net current spending on this age group was estimated to be 19.1%. The gap between observed and demand-adjusted spending on older people has widened significantly since 2009/10: in that year it stood at 1.3 percentage points (using an index based on 2005/06 = 100), while by 2012/13, it was 8.5 percentage points.

In addition to pressure from the growth in the numbers of older people, there have been changes in the working age population that are less well documented or understood, but which have also been increasing the strain on local authority budgets. More children with complex needs, including learning disabilities, are surviving into adulthood and their life expectancy is increasing, which implies greater and longer need for adult social care. This is reflected in the number of people receiving services shown in Figure 8 below.

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6 Both growth in net current expenditure on adult social care and net current expenditure on older people excludes Supporting People grant for consistency over time. Figures for total cost, i.e. including spending funded by NHS and joint arrangements, are not available consistently over this longer time period.
Figure 1: Growth in real net current spending and population estimates by age group, England, 1997/98 to 2013/14

Sources:
Public expenditure on adult social care for over 65s in England, Scotland and Wales

In Wales, Scotland and England, local authorities are primarily responsible for delivering care for older people, liaising with relevant health boards. Expenditure figures are drawn from different sources and may not be wholly comparable but give a broad basis for comparison.\(^7\)

Figure 3 shows that the peak in spending on adult social care in England was in 2010-11\(^8\), and in both Scotland and Wales it was in 2009-10, after which time expenditure in all three countries has fallen. While total gross expenditure in England carried on falling after its peak in 2010-11, expenditure in Wales and Scotland grew between 2011-12 and 2012-13. So over the period from 2007-08 to 2012-13 adult social care spending in England experienced a real fall of 1.4% while in Scotland and Wales experienced a real growth of 1.1% and 2.1% respectively. Over the period between 2007-08 and 2012-13, pressure from ageing population grew at similar rates in the three countries. In England population aged 65 and over increased by 12.7%, in Scotland by 13.0% and in Wales by 11.7% in the period from 2007-08 to 2012-13. During the same period, population aged 85 and over grew slightly faster in

\(^7\) Connolly et al (2011) compare health service expenditure, output and outcomes across the four countries of the United Kingdom and between English regions on a consistent basis, but the analysis does not cover social care.

\(^8\) Note: earlier in the report we demonstrated the peak of spending on adult social care being in 2009/10. This inconsistency is due to different use of the data. CIPFA excluded spending on Service Strategy for each country, which is included in earlier figures for England.
England than in Scotland and Wales: 11.5% in England, 9.4% is Scotland and 10.4% in Wales. Similar growth in older population in the three countries with a real cut in spending on over 65s in England compared to an increase (albeit small) in spending on older adults in Scotland and Wales indicates a greater funding deficit in England.

During the period of the Coalition Government the fall in adult social care spending in England was greater than in Scotland and more than double that of Wales. Between 2009-10 and 2012-13, total gross expenditure on adult social care in England fell by 5.5% compared to 3.4% in Scotland and 2.1% in Wales.

Figure 3: Growth in real total gross expenditure on Adult Social Care: England, Wales and Scotland (including capital charges and residual expenditure on supporting people and excluding expenditure on Service Strategy) and demographic pressure, 2007-08 to 2012-13 (index numbers, 2007-08=100)

Source: CIPFAstats (online), Social Care Actuals for each year between 2007-08 and 2012-13. CIPFA’s figures come from the following original sources: The data for England is from PSS EX1 return, a joint return between the Health and Social Care Information Centre and CIPFA; The data for Wales were obtained from the RO3: Revenue Outturn return supplied by Welsh Government; The data for Scotland were obtained from the LFR3: Social Work return supplied by Scottish Government

Notes:
Gross total expenditure (comprises of net current and capital spending as well as total income), includes residual expenditure on supporting people. The authors excluded Service Strategy spending from these figures as Service Strategy for Adult Services in Scotland is included with Service Strategy for Children’s Services and there is no way of disaggregating it.
Private expenditure on adult social care

Publicly funded care makes up only one part of the total value of care with some of it being also provided by family and friends (unpaid, informal care), as well as adults paying for some or all of their formal care services themselves (privately funded care). We have shown earlier that the amount of adult care funded publicly by local authorities has been decreasing with the reductions in real spending post 2009/10. Self-funding is particularly prevalent among older and physically disabled people in independent care homes, while almost all care homes for adults with learning difficulties and mental health problems are funded by either local authorities or the NHS (Laing and Buisson 2014a). There are less reliable data on privately funded homecare provision, but this too is estimated to be taking place mainly among older and physically disabled adults (Laing and Buisson 2014a). The NAO (2014b) estimate that the value of privately purchased care (residential and at home) is around £10.2 billion compared to £19.1 billion for services arranged by the local authority. Has private spending been increasing to plug the gap left by falls in public spending?

The vast majority (94%) of residential care home places for older and physically disabled people in the UK are in the independent sector, of which over half (56%) are publicly funded at least in part. Only 6% of residential care is publicly provided and publicly funded (Laing and Buisson 2014a: Figure 1.3.2, p.44)\(^9\).

There is evidence that the proportion of self-funded care has been increasing in the UK. Estimates by Laing and Buisson (2014a: p.42) show that number of self-funded older and physically disabled residents in independent care homes\(^{10}\) increased from 132,000 individuals in 2003 to 177,000 in 2013 (see Figure 4). This represents an increase from 34% to 44% of all those older and physically disabled people in the independent care homes. At the same time, local authorities reduced the number of people they were financially supporting from 239,000 in 2003 to 197,000 by 2013, which represents a reduction from 58% to 49% of all older and physically disabled residents in the independent care homes. A large proportion of local authority funded residents also receive a top-up from family or friends. If these part self-payers are added to those who entirely self-fund, they make up the majority nationally, accounting for 58% of all older and physically disabled residents in private and voluntary care homes in 2013. The number of older and physically disabled people who supplemented their local authority funded care with top-up funding has, however, been decreasing over the years, according to Laing & Buisson, although the CQC find an increase in the number of people topping up care home costs between 2010/11 and 2011/12 (CQC, 2013b, Technical Annex 2).

The number of older and physically disabled people whose independent care home place was funded by the NHS almost doubled between 2003 and 2013, but this still represents only a very small proportion of residents overall (6.7% in 2013, up from 3.6% in 2003).

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\(^9\) A small (unknown) proportion of places are fully privately funded in publicly operated care homes.

\(^{10}\) Independent care homes are operated by private and voluntary providers and in 2013 made up over 92% of care homes in the UK (Laing and Buisson 2014a: p.40)
There is very little reliable evidence on privately funded homecare. Using occasional surveys of independent sector homecare agencies (the latest of which was in 2011), Laing and Buisson (2014a: Table 1.5.2, p. 53) estimated that more than three-quarters of it is publicly funded and provided by either independent sector (67.8%) or the public sector (10.9%), while 21.3% of homecare is privately funded and provided by the independent sector. No private payers were known to receive homecare provided by the public sector (Laing and Buisson 2014a, Table 1.5.2, p. 54). These estimates include the entire homecare and supported living sector which includes provision for older and physically disabled people but also those with learning disabilities and mental health issues. Similarly, an industry body, the HealthTech and Medicines Knowledge Transfer Network (Frost and Sullivan, 2013, Table 2.6, p13) estimate that in the UK in 2011, 86% of revenue for independent sector homecare providers was from public funding.

Focusing on homecare provision for older and physically disabled people\textsuperscript{11}, both hourly and sessional, Laing and Buisson estimate that in 2013 in England, total spending was £3.29bn and 31.6% of it was privately purchased. Moreover, half of all purchased homecare for older and physically disabled people in the independent sector that required longer support (such as live-in, sleeper support or supported living) as opposed to support provided on hourly basis (or short units of time), came from private funds.

**Summary of trends in resources**

\textsuperscript{11} Laing and Buisson’s (2014a) estimated value of the independent sector supply of homecare and supported living services for older and physically disabled people in the UK in 2013 is £3.93bn (Table 1.5.2., p. 53).
The cuts in real expenditure on adult social care in England during the whole period of the Coalition Government (including budgeted expenditure) between 2009-10 and 2014-15 are expected to be 11.4% if we only look at net current expenditure by local authorities, or 13.4% if we take into account transfers from the NHS to social care (Table 2). Spending on older people declined slightly less fast than for adult social care as a whole, but in the context of a rising older and very old population, funding relative to demand fell faster. Net current expenditure including transfers from the NHS on people aged 65 or over fell by 9.2% between 2009-10 and 2012-13; the ‘demand-adjusted’ figures for the same period estimate the real fall to be 16.7% (Figure 2) (note that these figures are available only up to 2012-13; the final figure for the whole of the Coalition period will be higher given budgeted expenditure and demographic trends).

Public spending on adult social care had been increasing up to 2009/10, and indeed the fall the following year was the first real-terms decrease since 1994/95\textsuperscript{12}. However, pressure on publicly funded social care predates austerity. Spending on over 65s began to decline from 2005/06 despite the accelerating growth in population of this age. Between 2005/06 and 2013/14, net current expenditure by local authorities on older people declined by 25% in real terms while the numbers of over 65s in England grew by 16% and over 85s by 26%, indicating an increasing gap between funding and need. So the squeeze pre-dates austerity but has been intensified by it: Fernandez et al (2013) find that the reduction in the level of local authority investment per 'unit of need' accelerated significantly from 2010/11 onwards.

There was a 17% increase in the number of residents wholly self-funding their independent residential care between 2009 and 2013, which also represented an increase in the proportion of self-funders (up from 39.5% to 44.1%) (Figure 4) – and these statistics do not include those co-paying with the local authority. This suggests some substitution of self-funding as public funding was tightened – although again the trend predates the start of public spending cuts. As we shall see in the next section, the big reductions in publicly-funded services have been in homecare rather than residential care, but unfortunately evidence on self-funding of homecare is patchy. Public funding continues to account for a large majority of homecare spending overall.

\textsuperscript{12} Authors’ calculations using nominal expenditure figures for gross and net current adult social care expenditure (HSCIC 2013a, National Gross Current Expenditure and National Net Current Expenditure (excel file) and GDP deflators HM Treasury (2013)
4. Outputs

Figure 5 shows the total number of people receiving residential or nursing care, or community services (for example, care in their own home) provided or commissioned by ‘CASSR’ – that is, local authorities with adult social services responsibilities. The line shows the total number, while the bars give a breakdown by age group. The total number of clients rose to a peak of 1.78 million in 2008/9 before falling in each consecutive year to 1.27 million in 2013/14 (provisional figures). This is a fall of 29%, or nearly one-third of the total caseload. For the period 2006/07 to 2009/10 – the longest run of data we have on a consistent basis for the Labour administration - the average annual change since the previous year was -0.7%, whereas for the period 2009/10 to 2013/14, the average change was -7.0% (Table 3). So whilst the decline in numbers of clients had certainly begun in the Labour period, it has accelerated under the Coalition. There is some evidence of a slowing in the rate of decline in number of clients in the latest year, but figures are provisional.

Both the working age and older populations have been affected by the cuts, as shown by the red and blue bars in Figure 5. However, the working age population has fared slightly less badly, seeing a fall of 26% from 2008/09 in the number of clients, compared to 30% in the same period for the population aged 65 and over. The older population accounts for around twice the number of clients as the working age population overall (0.8 million clients in 2013/14 compared to 0.4 million).

Figure 5: Number of clients receiving services (community based services, residential care or nursing care) provided or commissioned by local authorities with social services responsibilities, by age group, 2005/6 to 2013/14, England

Source: National Adult Social Care Intelligence Service (NASCIS) online analytical tool, Health and Social Care Information Centre (online). Original source: RAP proforma P1
Notes:
1. Data for 2013/14 are provisional.
2. Values are rounded to the nearest 5.
3. Total includes those with no known age, therefore number of those in groups of under 65 and over might not add up to the total displayed
Table 3: Annual change in number of clients receiving services, 2006/07 to 2013/14, England

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual change since previous year (%)</th>
<th>Average annual change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006/07</td>
<td>+1.49</td>
<td></td>
</tr>
<tr>
<td>2007/08</td>
<td>-0.04</td>
<td>-0.70</td>
</tr>
<tr>
<td>2008/09</td>
<td>+0.44</td>
<td></td>
</tr>
<tr>
<td>2009/10</td>
<td>-4.69</td>
<td></td>
</tr>
<tr>
<td>2010/11</td>
<td>-7.27</td>
<td></td>
</tr>
<tr>
<td>2011/12</td>
<td>-7.13</td>
<td>-7.04</td>
</tr>
<tr>
<td>2012/13</td>
<td>-9.18</td>
<td></td>
</tr>
<tr>
<td>2013/14 (p)</td>
<td>-4.59</td>
<td></td>
</tr>
</tbody>
</table>

Source: authors’ calculations based on Figure 5

These figures include people receiving direct payments with which to arrange their own care. Inconsistencies in the time series on receipt of direct payments make comparisons between the period immediately before and after the Coalition came to power tricky, but it is clear that the trend towards a higher proportion of users receiving direct payments continued. The number of working age recipients rose from 72,525 in 2010/11 to 92,335 in 2013/14 and among the over-65s from 52,255 to 63,065, a 24.5% increase overall (HSCIC, 2014d, Annex M).

The decrease in numbers of clients overall – whether receiving services or a direct payment - has been especially pronounced in community based services, although there has also been a continuing decline in the number of supported residents in residential and nursing care, as shown in Figure 6 and Figure 7 respectively. The fall in community based services since the peak in 2008/09 has been 32% (34% for the 65 and over age group and 27% for age 18-64). These average annual rates of change were -0.4% over the period of data we have for the Labour administration, and -8.0% for the period since 2009/10: a very substantial shift, albeit in a direction that had already begun under Labour. The cut in one year alone (2011/12 to 2012/13) was 10.5%.

The decline in residential care has been continuous since this data series began in 2005/06, and has fallen by a total of 17% since that time – 16% amongst working age clients and 17% amongst the much larger population of older service users. Annual rates of change actually slowed under the Coalition government, from an average of -3.1% up to 2009/10 and 1.4% thereafter.

Direct payments have been expanded from Direct payments to Existing / New Direct payments and Personal Budgets in 2009-10. Therefore the 2009-10 data is not directly comparable to previous years. However the downwards trend continues after 2009/10.
Figure 6: Number of service users receiving community-based services each year, by age group, 2005/6 to 2013/14, England

Source: National Adult Social Care Intelligence Service (NASCIS) online analytical tool, Health and Social Care Information Centre (online). Original source: RAP proforma P2f

Notes:
1. Figures for the number of clients receiving different services do not necessarily sum to the 'Total of clients' as a client may receive services of more than one type.
2. Values are rounded to the nearest 5.
3. For 2007-08 this definition only covers "home help/ home care", in previous years "overnight respite - clients home" has also been included within Home Care.
4. Direct payments have been expanded from Direct payments to Existing / New Direct payments and Personal Budgets in 2009-10. Therefore the 2009-10 data is not comparable to previous years.
5. Data for 2013/14 are provisional.
Figure 7: Number of supported residents in residential or nursing care at 31 March each year, by age group, England

Source: National Adult Social Care Intelligence Service (NASCiS) online analytical tool, Health and Social Care Information Centre (online). Original source: ASC-CAR S1

Notes:
1. Excludes adult placements.
2. In 2012, 1,840 learning disabled clients were recorded as being permanent admissions to care homes as a result of their funding transferring from the NHS to CASSRs. These clients would not have been recorded in table S1 in previous years.
3. Values are rounded to the nearest 5.
4. Data for 2013/14 are provisional.

These falls in the numbers of people receiving services, especially community-based services, are all the more striking when put in the context of increasing need for services over this period as a result of the increase in the number of older people and especially very old people in the population, as described in section 0.

Community-based service users are classified by primary client group, that is, whether the main reason they are in need of support is because of physical disability, mental health, learning disability, substance misuse or another vulnerability. Figure 8 and Figure 9 show that the only client group for whom services have increased over the period is people with learning disability (whether working age or older), although this has to be set against an increase in the numbers of people in this group in the population (Emerson and Hatton, 2008). All the other large client groups have seen significant decreases in services since 2008/9, continuing and in some cases accelerating under the Coalition government. The percentage changes in numbers of service users in the last four years of the Labour period and the first four of the Coalition are shown in Table 4. Community based services for working age people with mental health
problems have been cut by 37% since 2009/10, more than reversing the widening of the service in the preceding period. Physically disabled older people have experienced a cut of one-third and their working age counterparts have seen a cut of more than a quarter. Some of the smaller client groups, whilst contributing less to the overall retrenchment in absolute terms, have experienced even larger proportional cuts in services: for example, the number of 18-64 year olds with substance misuse receiving services has almost halved – a trend that presumably increases pressure elsewhere, such as in the health service and/or the voluntary sector.

**Figure 8: Number of community-based service users aged 18 to 64, by primary client group, 2005/06 to 2013/14, England**

Source: see figure 9.
Figure 9: Number of community-based service users aged 65 and over, by primary client group, 2005/06 to 2013/14, England

Source: National Adult Social Care Intelligence Service (NASCIS) online analytical tool, Health and Social Care Information Centre (online). Original source: RAP proforma P2f

Notes:
1. The figures for the number of clients receiving the different services do not necessarily sum to the 'Total of clients' as a client may receive services of more than one type.
2. For 2007-08 this definition only covers "home help/ home care", in previous years "overnight respite - clients home" has also been included within Home Care.
3. Values are rounded to the nearest 5
4. Direct payments have been expanded from Direct payments to Existing / New Direct payments and Personal Budgets in 2009-10. Therefore the 2009-10 data is not comparable to previous years.
5. Data for 2013/14 are provisional.
Table 4: Percentage changes in the number of community service users, by client type, in Labour and Coalition periods

<table>
<thead>
<tr>
<th></th>
<th>% change</th>
<th>% change</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2005/06 to</td>
<td>2009/10 to</td>
<td>2013/14</td>
</tr>
<tr>
<td><strong>Age 18-64</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical disability</td>
<td>-1.1</td>
<td>-27.8</td>
<td></td>
</tr>
<tr>
<td>Mental health</td>
<td>19.0</td>
<td>-36.9</td>
<td></td>
</tr>
<tr>
<td>Learning disability</td>
<td>7.0</td>
<td>3.8</td>
<td></td>
</tr>
<tr>
<td>Substance misuse</td>
<td>-0.9</td>
<td>-47.8</td>
<td></td>
</tr>
<tr>
<td>Other vulnerable people</td>
<td>3.8</td>
<td>-37.4</td>
<td></td>
</tr>
<tr>
<td><strong>Age 65 plus</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical disability</td>
<td>-8.0</td>
<td>-31.5</td>
<td></td>
</tr>
<tr>
<td>Mental health</td>
<td>26.7</td>
<td>-19.1</td>
<td></td>
</tr>
<tr>
<td>Learning disability</td>
<td>18.3</td>
<td>22.5</td>
<td></td>
</tr>
<tr>
<td>Substance misuse</td>
<td>-1.4</td>
<td>-20.1</td>
<td></td>
</tr>
<tr>
<td>Other vulnerable people</td>
<td>-39.5</td>
<td>-39.3</td>
<td></td>
</tr>
</tbody>
</table>

Source: National Adult Social Care Intelligence Service (NASCIS) online analytical tool, Health and Social Care Information Centre (online). Original source: RAP proforma P2f.

A comparison between the trends in expenditure presented in section 3 above and the trends in social care activity in this section indicate that activity measured by numbers of clients has been falling much faster than expenditure in real terms. This suggests a shift in the types of service being provided. As we have already seen, community-based services have been cut faster than residential and nursing care placements, although both have fallen. But within community-based services there has also been a significant shift: away from low-intensity towards high-intensity provision (Figure 10). In 2008/09, 39% of clients were receiving care packages of up to and including 5 hours per week, but by 2013/14, this has fallen to 28% of clients. Conversely, the percentage of clients receiving care packages of more than 10 hours per week, including overnight care and/or live-in care, has risen from 34% to 45%. This concentration of services on those assessed as having the greatest need is sometime referred to as ‘intensification’, and has been noted by other commentators (Humphries, 2013).
The rate of change has been fairly constant since this time series began, with no apparent acceleration after the Coalition came to power and spending cuts were announced. A separate time series produced by HSCIC which incorporate number of clients receiving homecare and total number of homecare hours provided per year shows that average hours per client were already falling as far back as 2007/08 (HSCIC 2013b, Figure 4.6). Intensification seems likely to have been a response by social services departments to a chronic shortage of resources in the context of increasing demand, presumably in the belief that those with less high levels of need may be able to meet them by other means, for example, by relying on informal care or self-funding of private care. However, as we shall see in the following section on outcomes, such alternatives are not always available.

At the opposite end of the spectrum, concerns have also been expressed about the brevity of some home care visits. 110 out of 149 local authorities commissioned care visits as short as 15 minutes (for example, to provide a meal, or get someone up, washed and dressed) in Autumn 2014, an increase of 5% on last year (based on a UNISON Freedom of Information request). 15 minute visits make up one in seven of all the homecare visits commissioned by these councils. Commentators have argued that visits as short as these are unlikely to be compatible with treating the client with dignity and consideration (Leonard Cheshire, 2013), and also place considerable strain on the care workers.

Receipt of unpaid care

This section has so far reported on significant falls in the number of people receiving formal care services, commissioned and/or provided by local authorities, despite a growing older and very old population. Has there been a corresponding increase in privately paid-for care, or unpaid care provided
by friends and family? Unfortunately the data on privately paid-for care are scarce (see section 0 above), but we can a little further in charting changes in the receipt of unpaid care.

The Family Resources Survey has collected data on unpaid care of people who are disabled, ill or elderly since 2002/03. In the most recent year for which data are available, 2012/13, 3.2 million people were receiving unpaid care at least weekly, which accounts for 5% of the population as a whole. This is a slight increase on each of the previous two years, when 2.9 million people reported receiving unpaid care (DWP, 2014 and previous years). Published results for previous years do not give an estimate of the overall numbers, but looking at the distribution of the frequency of help received, there does appear to be a long-term trend towards receipt of more intensive care: in 2002/03, 29% of all individuals receiving unpaid care received continuous care; by 2007/08 this figure had risen to 35%, and in 2012/13 it was 38%. The percentage of individuals receiving care who received help only weekly has fallen from 12% to 9% to 8% over the same period.

Some carers look after more than one person, and some people receive care from more than one unpaid carer, so there is not a one-to-one correspondence between the numbers of people receiving and providing unpaid care. Nevertheless, examining the trend in the number of unpaid carers can give an indication of the volume of care being provided. Figure 11 shows that although the total number of individuals providing care has fluctuated somewhat over the years, it does appear that there has been

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14 FRS underestimates receipt and provision of unpaid care compared to other, more specialist, surveys. However, it is the only source with a long-running and reasonably consistent time series.
an increase in the most recent period: 4.8 million individuals were providing care at least weekly in 2009/10, and this had risen to 5.6 million by 2012/13 – a 17% increase. Most of the additional carers are people of working age (up from 3.4 million to 4.0 million).\(^{15}\)

Even before the recent increase, the UK already depended heavily on unpaid care, by international standards (Figure 12). According to OECD figures, only around 8 or 9 per cent of people aged 50 or over were providing unpaid care in Sweden and Denmark in the mid-2000s, compared to 15% in the UK. Moreover, while in Sweden and Denmark only 13 and 15% respectively of these carers were providing 20 hours per week of care or more, in the UK the corresponding figure was 27% (OECD, 2011).

**Figure 12: Population aged 50 and over reporting to be informal carers, around 2007, OECD**


\(^{15}\) The number of carers who are children may also be increasing: a comparison of the 2001 and 2011 Census data for England suggested a 20% increase in the number of carers aged 5 to 17, up to 166,363 (ONS, 2013e).
5. Outcomes

Local authorities have responded to increasing need and decreasing funds for social care in a range of ways. According to the Local Government Association and SPCC research on London boroughs, genuine efficiencies have been found, for example in procurement and in different ways of organising services, as well as diverting some people away from social care towards unpaid care or voluntary support, or by providing effective support for re-ablement and rehabilitation services following a crisis such as a fall (in line with the Care Act emphasis on prevention), thereby the need for on-going services (LGA, 2014b; Fitzgerald et al, 2013). In this section, we attempt to evaluate the extent to which these strategies have been succeeded in achieving good outcomes for people in need, despite the cuts in funding and services. The government has adopted a set of ‘actions and impact indicators’ to monitor its performance in policy delivery, and these are reported in Appendix 1. Here we take a broader view.16

At the most fundamental level, the aim of social care is to enable people with additional needs to lead full and fulfilling lives, and in this sense a wide range of outcomes are relevant for assessing the effectiveness of social care. This breadth is reflected in the Adult Social Care Outcomes Framework (ASCOF), developed under the previous administration and published for the first time in 2010/11. It includes, for example, indicators on ‘social care-related quality of life’, choice and control, employment rates, independent living, social contact and service users’ perceptions of their safety. More specific policy goals, such as promoting the integration of health and social care, and making greater use of re-ablement and rehabilitation services, are also included in the Outcomes Framework. Of the 23 indicators or sub-indicators included in the ASCOF, the trends since 2010/11 are positive for 11 (shaded green), negative for 1 (shaded red), and are unavailable or show no clear direction for the remaining 11 (shaded grey) ( ).

The one negative trend is in employment rates for people in contact with secondary mental health services, which has fallen from an already very low rate of 9.5% in 2010/11 to 7.1% in 2013/14 (provisional data). Employment rates in the general population aged 16 plus were relatively steady over this period (58.2% in the Apr-Jun quarter of 2010 and 58.5% in the equivalent quarter in 2013: ONS (2014b) series MGSR), so general economic conditions can not be held responsible for this outcome17. We noted in the previous section (Figure 8) that working age adults with mental health problems was one of the client groups that had contracted the most as a result of cuts to social care services, but this also cannot in itself explain the negative trend in the ASCOF indicator, since the ASCOF indicator specifically refers to “people in contact with secondary mental health services” – i.e. to service users rather than non-users. Rather it seems likely that cuts have meant concentrating resources on more needy individuals, who are further from the labour market, and perhaps also meaning less staff time is available to facilitate (re-)entry into employment.

Two indicators of transitions and joint working between health and social care are positive (2Bii offer of re-ablement services and 2Cii delayed transfers from hospital), and the other two have fluctuated but are

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16 Estimates of productivity are in principle a way of summarising the effectiveness of the translation of resources into valuable outcomes. Unfortunately, estimates of adult social care productivity are at an early stage of development and do not take account of changes in the quality or type of output (ONS, 2013d), so are not considered further here.

17 This rate includes people aged 65 and over, as does the ASCOF indicator.
lower in the most recent year than in 2010/11 (2Bi and 2Ci). Since integration of health and social care has been a specific policy priority, this is encouraging. On the other hand, some indicators not included in the ASCOF set are more worrying: whilst the number of delayed transfers from hospital attributed to social care has fallen, the aggregate number of days delayed for any reason has been rising (NHS England, 2014, Chart 2). The 12-month rolling average stood at a total of 115,000 delayed days in September 2011 (the earliest comparable period), compared to 124,000 in September 2014.

Another possible marker of the (lack of) joining up between health and social care is Accident and Emergency attendances for ‘avoidable’ causes among the older population, such as falls, pneumonia and urinary tract infections. Ismail and colleagues (2014) for the Nuffield Trust report that A&E attendance has been increasing among all age groups, but that for the over-65s attendance is much more likely to result in admission. CQC (2013b) found that between 2007/08 and 2012/13 admissions for ‘avoidable’ conditions had increased as a proportion of all emergency admissions, although they did not find a direct link with social care spending at a local level. (See also Blunt, 2013). In January 2015, concerns were raised by a council in North West England that life expectancy for over-85s was no longer rising in the region, a possibility reported in the media as being linked by some public health experts to pressure on the NHS and social care\(^\text{18}\). Public Health England are investigating but the significance of these findings is unclear at the time of going to print.

## Table 5: Summary of ASCOF outcome measure values: by measure and year, England

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>Units 2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14p</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A Social care-related quality of life¹</td>
<td>/ 24</td>
<td>18.7</td>
<td>18.7</td>
<td>18.8</td>
</tr>
<tr>
<td>1B Proportion of people who use services who have control over their daily life²</td>
<td>%</td>
<td>75.0</td>
<td>75.1</td>
<td>76.1</td>
</tr>
<tr>
<td>1Ci Proportion of people using social care who receive self-directed support</td>
<td>%</td>
<td>29.2</td>
<td>43.0</td>
<td>56.2</td>
</tr>
<tr>
<td>1Cii Proportion of people using social care who receive direct payments</td>
<td>%</td>
<td>11.7</td>
<td>13.7</td>
<td>16.8</td>
</tr>
<tr>
<td>1D Carer-reported quality of life²</td>
<td>/ 12</td>
<td>..</td>
<td>..</td>
<td>8.1</td>
</tr>
<tr>
<td>1E Proportion of adults with learning disabilities in paid employment³</td>
<td>%</td>
<td>6.6</td>
<td>7.1</td>
<td>7.0</td>
</tr>
<tr>
<td>1F Proportion of adults in contact with secondary mental health services, in paid employment⁴</td>
<td>%</td>
<td>9.5</td>
<td>8.9</td>
<td>8.8</td>
</tr>
<tr>
<td>1G Proportion of adults with learning disabilities who live in their own home or with their family³</td>
<td>%</td>
<td>59.0</td>
<td>70.0</td>
<td>73.5</td>
</tr>
<tr>
<td>1H Proportion of adults in contact with secondary mental health services, who live independently, with or without support⁶</td>
<td>%</td>
<td>66.8</td>
<td>54.6</td>
<td>58.5</td>
</tr>
<tr>
<td>1I(1) Proportion of people who use services who reported that they have as much social contact as they would like¹,⁹</td>
<td>%</td>
<td>41.9</td>
<td>42.3</td>
<td>43.2</td>
</tr>
<tr>
<td>1I(2) Proportion of carers who reported that they have as much social contact as they would like²,⁹</td>
<td>%</td>
<td>..</td>
<td>..</td>
<td>41.3</td>
</tr>
<tr>
<td>2Ai Permanent admissions to residential and nursing care homes for younger adults, per 100,000 population⁵,⁶</td>
<td>%</td>
<td>15.0</td>
<td>19.1</td>
<td>15.0</td>
</tr>
<tr>
<td>2Aii Permanent admissions to residential and nursing care homes for older adults, per 100,000 population⁵,⁶</td>
<td>%</td>
<td>686.6</td>
<td>695.9</td>
<td>697.2</td>
</tr>
<tr>
<td>2Bi Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (effectiveness of the service)⁷</td>
<td>%</td>
<td>82.0</td>
<td>82.7</td>
<td>81.4</td>
</tr>
<tr>
<td>2Bii Proportion of older people (65 and over) who were offered reablement services following discharge from hospital⁷</td>
<td>%</td>
<td>3.0</td>
<td>3.2</td>
<td>3.2</td>
</tr>
<tr>
<td>2C Delayed transfers of care from hospital per 100,000 population⁸</td>
<td>%</td>
<td>10.6</td>
<td>9.7</td>
<td>9.4</td>
</tr>
<tr>
<td>2Ci Delayed transfers of care from hospital, and those which are attributable to adult social care per 100,000 population⁶</td>
<td>%</td>
<td>4.1</td>
<td>3.7</td>
<td>3.2</td>
</tr>
<tr>
<td>3A Overall satisfaction of people who use services with their care and support¹</td>
<td>%</td>
<td>62.1</td>
<td>62.8</td>
<td>64.1</td>
</tr>
<tr>
<td>3B Overall satisfaction of carers with social services²</td>
<td>%</td>
<td>..</td>
<td>..</td>
<td>42.7</td>
</tr>
<tr>
<td>3C Proportion of carers who report that they have been included or consulted in discussion about the person they care for²</td>
<td>%</td>
<td>..</td>
<td>..</td>
<td>72.9</td>
</tr>
<tr>
<td>3D Proportion of people who use services and carers who find it easy to find information about services, ¹</td>
<td>%</td>
<td>..</td>
<td>..</td>
<td>75.5</td>
</tr>
<tr>
<td>ASCS component only¹</td>
<td>%</td>
<td>74.2</td>
<td>73.8</td>
<td>74.1</td>
</tr>
<tr>
<td>Carers’ Survey component only²</td>
<td>%</td>
<td>..</td>
<td>..</td>
<td>68.7</td>
</tr>
<tr>
<td>Total</td>
<td>%</td>
<td>74.2</td>
<td>73.8</td>
<td>71.4</td>
</tr>
<tr>
<td>4A Proportion of people who use services who feel safe¹</td>
<td>%</td>
<td>62.4</td>
<td>63.8</td>
<td>65.1</td>
</tr>
<tr>
<td>4B Proportion of people who use services who say that those services have made them feel safe and secure¹</td>
<td>%</td>
<td>..</td>
<td>75.5</td>
<td>78.1</td>
</tr>
</tbody>
</table>


Notes
- These data are not available.
- Measures 1A, 1B, 1I(1), 3A, 3D(1), 4A and 4B are based on the Adult Social Care Survey. When making comparisons over time it should be kept in mind that stratified sampling was introduced for 2011-12 and there was
also a change to the way in which councils checked if a service user had the capacity to consent to take part in the survey. The impact of these changes is not thought to be significant (based on the size of the confidence intervals of the survey estimates).

2. Measures 1D, 1I(2), 3B, 3C and 3D(2) are based solely on the Carer’s survey. This is a biennial survey which took place for the first time in 2012-13. Therefore no data are available for these measures for 2013-14, 2011-12 and 2010-11.

3. When making comparisons over time for Measures 1E and 1G, it should be borne in mind that there have been changes to the definitions. The restriction to capture employment and accommodation status at assessment or review was removed for 2011-12 onwards. Instead, service users could be included irrespective of whether they had had a review during the year, but these data did need to have been captured or confirmed within the yearly reporting period 1 April to 31 March.

4. Measures 1F and 1H are based on the Mental Health Minimum Dataset. In April 2011 a new version of the dataset (MHMDS V 4.0) was implemented and associated changes to the way these data are processed have had an impact on overall record volumes. For 2013-14 there has been a change to the calculation of these measures which are now derived from an average of the monthly outcomes using the latest dataset (MHMDS V 4.1); data for the provisional report are based on 11 months (April 13 to February 14), the final report will be based on 12 months. These changes should be borne in mind when comparing figures over time.

5. When making comparisons over time for outcome measure 2A(1) it should be kept in mind that in 2011-12 there was a transfer of funding of service users with a learning disability from the NHS to councils. These service users were classed as new admissions in 2011-12 as the source of funding had changed even though they had been receiving a service previously. Had no such transfer taken place, it is estimated that the national outcome measure for 2011-12 would have been 14.0 (see Chapter 3 in Measures from the Adult Social Care Outcomes Framework - England, 2011-12, Final available at: www.hscic.gov.uk/catalogue/PUB10284).

6. The mid-year population estimates used to calculate the provisional ASCOF figures for 2013-14 are for 2012 from the Office of National Statistics.

7. In 2011-12 there was a small change to the data collection behind Measures 2B(1) and 2B(2). Service users who were discharged from hospital and provided with a rehabilitation service following an assessment from social care services only, resulting in an individual support plan that involved active therapy, treatment or opportunity for recovery could be included. Previously, only those where a joint health and social care assessment had taken place could be included. Although this is not thought to have had a large impact on these data, comparisons over time should be made with this in mind.

8. Measure 3D was based only on ASCS data for 2010-11 and 2011-12. For 2012-13 it was based on a combination of ASCS data and Carers’ Survey data. For 2013-14 this measure has been replaced by 3D(1) and 3D(2) which provide separate measures for users and carers. Comparisons over time should be made with this in mind.

9. Measure 1I has been included for the first time in 2013-14, time series data have been based on historical releases of the Personal Social Services Adult Social Care Survey and Personal Social Services Survey of Adult Carers.
The ASCOF includes indicators for carers, but a time series is not yet available since the biennial Carers Survey was carried out for the first time in 2012/13. However, other sources suggest that the pressure on carers may be mounting. The proportion of adult carers providing 35 hours a week or more of care has risen from 22 per cent in 2002/03, to 28 per cent in 2012/13, according to the Family Resources Survey (DWP, 2014a and previous years).

A higher proportion of social care users were directing their own support or receiving direct payments (indicators 1Ci and 1Cii) by the end of the period than at the beginning. This has long been a demand of the disabled people’s movement and was one of the objectives mentioned in the Coalition agreement.19 At the same time, the Independent Living Fund (ILF), a small but important source of support for disabled people of working age with complex needs to remain in their own homes, was closed to new applicants in 2010 and is to be abolished in 2015 (despite an intervening High Court challenge)20. Responsibility and some funding for existing ILF recipients will be transferred to local authorities, but the government acknowledges that the level of funding will be reduced (DWP, 2014b), and, since these individuals require expensive packages to remain at home, it is likely that new assessments will in some cases result in disabled people having to move into residential care (Morris, 2014).

Many of the other ASCOF indicators show a positive trend. In fact, all the measures derived from the social care users survey bar one (1A, 1B, 1I(1), 3A, 4A and 4B, but not 3D) indicate improvement. Social care-related quality of life is up slightly, and there has been a 2.8 percentage point increase in users’ satisfaction with the care and support they receive. A higher proportion of users say they have control over their daily life, that they have enough social contact, and that they feel safe. These are all important outcomes and it is very welcome to see them moving in the right direction.

These results are hard to square with evidence presented in the previous two sections - the 16% cut in social care expenditure in real terms since 2010/11 and the 20% fall in the number of clients, in a context of rising demographic demand – until we note that the social care users survey does not, of course, include ex-users, non-users or would-be users. In so far as the cuts have been implemented through withdrawing low-intensity services, reducing the number of people who receive services overall and concentrating resources on the remaining high-need groups, it is not perhaps surprising to find that those lucky enough to retain services are pleased with the services they receive. An adult social care officer in Brent interviewed as part of the SPCC London borough case studies, stated explicitly that an older person receiving services now would be getting a better service than in 2009/10 (Fitzgerald et al, 2013) – quality has been protected or even enhanced, while the range and reach of services has been reduced. Even those who have experienced a reduction in service may be resigned to it, or indeed relieved to be continuing to receive any support at all. A user interviewed for the SPCC case studies who had had her care package cut was not embittered by it, despite acknowledging that she and her family

19 Of course, being in charge of an inadequate personal budget or direct payment does not afford the same ‘choice and control’ as being in charge of a generous package. Interviews carried out for the SPCC London borough case studies revealed some concerns from local managers that pressure was being applied to increase take up of direct payments that were not always in the best interests of older people, for example because they were too much hassle, or because recipients treated the payment as their money, which they were reluctant to spend on services that appeared to them too expensive (Fitzgerald et al, 2014). Similarly, Morris (2014) reports that personal budgets are not being implemented consistently across local authorities, with the result that some are not promoting choice and control as originally intended.

20 The ILF currently supports around 18,000 disabled people in the UK (DWP, 2014b).
were really struggling now; and other interviewees expressed empathy for the challenges faced by frontline staff (Fitzgerald et al, 2014).

Table 6: Abuse of Vulnerable Adults, 2010/11 – 2013/14, England

<table>
<thead>
<tr>
<th>Year</th>
<th>Alerts¹</th>
<th>Referrals²</th>
<th>Substantiated or partially substantiated (as % of completed investigations)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>92,865</td>
<td>95,065</td>
<td>30,365 (41%)</td>
</tr>
<tr>
<td>2011/12</td>
<td>133,395</td>
<td>106,165</td>
<td>34,670 (41%)</td>
</tr>
<tr>
<td>2012/13</td>
<td>172,130</td>
<td>107,650</td>
<td>37,410 (43%)</td>
</tr>
<tr>
<td>2013/14³</td>
<td>n/a</td>
<td>104,050 individual</td>
<td>37,685 (43%)</td>
</tr>
</tbody>
</table>

Notes:

1. Alerts are usually the first contact about a concern that a vulnerable adult has been, is, or might be the victim of abuse. Not all councils record information on alerts and referrals separately and some councils do not include alerts as part of the safeguarding process. Councils who do not collect alert data were instructed to submit blanks for this section of the table.
2. An alert/concern is progressed to referral status when it is assessed to meet the local safeguarding threshold and an investigation is opened. Referrals for which age, gender and client type are known are reported here.
3. Data for 2013/14 are calculated on a different basis and are not directly comparable. Data on alerts are no longer centrally collected. ‘Referrals’ is the number of unique individuals for whom safeguarding referrals were opened, while in previous years one individual with multiple referrals would could have been counted multiple times.

For example, measures 4A and 4B indicate that user survey respondents are feeling increasingly safe – up from 62.4% in 2010/11 to 66.0% in 2013/14 – and that the services they receive have contributed to making them feel safe and secure – up from 75.5% in 2011/12 to 79.2% in 2013/14. But if we set this alongside emerging evidence on the level and seriousness of adult ‘safeguarding alerts’ over this period, a rather different picture emerges. A safeguarding alert is usually the first point at which someone concerned about abuse contacts the local authority safeguarding team – whether this is the victim or someone else. A referral is where the local authority considers the allegation to meet the safeguarding threshold, and the case is then investigated. Referrals are not restricted to service users, but two-thirds of referrals for suspected abuse in 2012/13 were for service users (HSCIC, 2014a) – i.e. individuals in principle covered by the social care users survey – so one would expect trends and patterns observed in the safeguarding statistics to be reflected in the users survey. Yet the trends in the Abuse of Vulnerable Adults series – compiled from statutory returns made by all local authorities with adult social services responsibilities - are in exactly the opposite direction (Table 6).

The Health and Social Care Information Centre (HSCIC) note that the upwards trend in the number of alerts and referrals could reflect changes in local authority recording and reporting practices, as well as more widespread awareness of safeguarding procedures, and do not necessarily indicate an increase in underlying levels of abuse. Certainly, the higher public profile of abuse of older and vulnerable adults
may encourage more people to come forward. The fact that the proportion of completed cases that have been substantiated or partially substantiated has been sustained at a high level, suggests that the increases in the numbers of alerts and referrals is genuine and not due to an increase in frivolous complaints or to a purely administrative change.

The number of cases is a cause for concern. In the first place, there are multiple barriers to abuse being referred (the victim him/herself may be unwilling, unable or not know how to make a complaint; the abuse may not be observed by anyone; a complaint may not be recorded or taken forward, and so on), so these figures must be the tip of the iceberg. Even taking the figures at face value, the levels are high. For example, 21,240 of the 110,000 alleged perpetrators cited in referrals for abuse in 2012/13 were residential care staff (HSCIC, 2014a, Table 6a). There are roughly 350,000 residents in residential or nursing care at any one time in England (Census 2011 communal establishments table). So one can think of that as roughly 1 in 16 residents being the subject of a referral for abuse by a member of staff during the course of the year. A further 10,835 referrals related to alleged abuse by other members of social care staff, mainly domiciliary staff; and this can be compared – again, very roughly – to just over 1 million community care service users at one point in time during the year: a ratio of about 1 in 100.

Overall, the alleged perpetrator was a member of social care or health staff in 37% of all referrals, and was a friend or family member in 29% of cases. Given the concerns raised in Care Quality Commission (CQC) investigations and councils' serious case reviews about the role financial pressures played in undermining care quality in some cases, as described in section 2 above, it would be interesting to see a breakdown of safeguarding statistics for residential care and domiciliary care by type of provider – private, non-profit, or local authority – but unfortunately these data are not currently collected.

A summary of CQC’s inspections in adult social care in 2012/13 revealed that there had been concerns about staffing and quality monitoring in 1 in 10 home care services inspected, as well as safety concerns (such as failure to give out medicines safely) in one in five nursing homes inspected, and serious concerns about the quality of care, staffing or safeguarding in 1 in 10 residential homes inspected (CQC, 2013b). A separate investigation indicated a link between high staff turnover and the number of deaths in residential care homes (CQC, 2013b Annex 4). The following year, CQC (2014) highlighted a lack of trained nurses, failure to have a registered manager in place, and the size as risk factors for poor standards, with large, corporate, institutions in general and nursing homes in particular performing worse than other smaller settings and residential care.

Results from the ASCOF in general and the social care users survey in particular therefore need to be interpreted with caution. And since their focus is, sensibly and necessarily, on service users, they cannot tell us about how those who are in need but who are not receiving services are faring. We therefore need to look to other sources to gauge levels of unmet need and the extent to which the gaps left by formal services are being met by unpaid, informal care.

Unmet need

Forder and Fernandez (2010) used the PSSRU dynamic micro-simulation model to predict levels of unmet need from 2008/9 to 2012/13, given expected budget cuts to adult social care. Unmet need is defined as the difference between the predicted levels of support received and the current average
social services care packages for people with different needs. In the ‘reduced budget’ scenario, they model the effect of the tightening of eligibility thresholds that would be required by a 6.7% pa reduction in the social care budget in 2011/12 and 2012/13. This is compared to the ‘demand led’ scenario, in which the eligibility threshold (and means test) is held constant and expenditure is accordingly assumed to increase in line with predicted increases in need.

As Table 7 shows, under the reduced budget scenario, unmet need was expected to rise to just over one-quarter of a million people with high dependency by 2012/13 (column 2), equivalent to a shortfall of 119 million hours per year overall (column 1). This is based on the assumption that informal care will meet some needs not met by state-funded care; without informal care the gap is even greater, at 231 million hours (column 4).

Table 7: Levels of unmet need and numbers of people with unmet need – Millions of hours p.a. and millions of people, England (from Forder and Fernandez (2010))

<table>
<thead>
<tr>
<th>Year</th>
<th>1 Unmet need inc informal care (Millions of hours p.a.)</th>
<th>2 Number of high dependency people with unmet need (Millions of people)</th>
<th>3 Average unmet need - high need (Millions of hours p.a.)</th>
<th>4 Unmet need (no informal care) (Millions of hours p.a.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demand-led scenario</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007/8</td>
<td>78.06</td>
<td>0.13</td>
<td>5.89</td>
<td>155.99</td>
</tr>
<tr>
<td>2008/9</td>
<td>83.80</td>
<td>0.13</td>
<td>5.91</td>
<td>163.64</td>
</tr>
<tr>
<td>2009/10</td>
<td>81.45</td>
<td>0.12</td>
<td>5.77</td>
<td>160.90</td>
</tr>
<tr>
<td>2010/11</td>
<td>88.14</td>
<td>0.14</td>
<td>5.79</td>
<td>172.15</td>
</tr>
<tr>
<td>2011/12</td>
<td>61.62</td>
<td>0.08</td>
<td>4.39</td>
<td>135.92</td>
</tr>
<tr>
<td>2012/13</td>
<td>62.56</td>
<td>0.09</td>
<td>4.32</td>
<td>142.77</td>
</tr>
<tr>
<td>Reduced budget scenario</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007/8</td>
<td>78.06</td>
<td>0.13</td>
<td>5.89</td>
<td>155.99</td>
</tr>
<tr>
<td>2008/9</td>
<td>83.80</td>
<td>0.13</td>
<td>5.91</td>
<td>163.64</td>
</tr>
<tr>
<td>2009/10</td>
<td>81.45</td>
<td>0.12</td>
<td>5.77</td>
<td>160.90</td>
</tr>
<tr>
<td>2010/11</td>
<td>88.14</td>
<td>0.14</td>
<td>5.79</td>
<td>172.15</td>
</tr>
<tr>
<td>2011/12</td>
<td>96.31</td>
<td>0.21</td>
<td>4.29</td>
<td>189.54</td>
</tr>
<tr>
<td>2012/13</td>
<td>118.76</td>
<td>0.26</td>
<td>5.08</td>
<td>231.34</td>
</tr>
<tr>
<td>Difference b/w scenarios</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011/12</td>
<td>34.69</td>
<td>0.13</td>
<td>-0.10</td>
<td>53.62</td>
</tr>
<tr>
<td>2012/13</td>
<td>56.20</td>
<td>0.17</td>
<td>0.76</td>
<td>88.57</td>
</tr>
</tbody>
</table>

Source: Forder and Fernandez (2010) Table 5
Note: Unmet need falls under the ‘demand led’ scenario from 2011/12 as a result of the assumed introduction of free personal care at home – a reform which is not in fact being implemented.

Other sources offer direct survey evidence of changes in levels of unmet need amongst the household population, although there is of course a time lag in data availability. Vlachantoni et al (2011) use the 2001/2 General Household Survey (GHS) and 2008 English Longitudinal Survey of Ageing (ELSA) to estimate unmet need among people aged 65 or over (Table 8). They find that 39% to 61% of those needing help with bathing, dressing and/or getting in or out bed received no help in 2001/2, and that 32% to 62% of those needing help with bathing and/or dressing receive no help in 2008. (‘Help’ here is defined as state support, privately paid care or informal care). The survey definitions are not identical,
so comparisons between the two are difficult, but overall this suggests that the combined efforts of
public, private and informal care were more or less keeping pace with increasing numbers of people in
need over this period. Looking at formal state support alone, it would appear that help for those with
lower levels of need (such as help with dressing) fell over this period, while help for those with more
intense needs (bathing and dressing/getting in and out of bed) rose substantially.

Table 8: Unmet need for help with Activities of Daily Living among people aged 65 or over, 2001/2

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>% of those</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>reporting</td>
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<td></td>
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<td></td>
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<td></td>
<td></td>
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<td></td>
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<td>who receive..</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>..formal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>state support</td>
<td>6.0</td>
<td>1.6</td>
<td>8.2</td>
<td>7.3</td>
<td>6.5</td>
<td>19.8</td>
</tr>
<tr>
<td>..formal paid</td>
<td>1.6</td>
<td>(3.0)</td>
<td>2.7</td>
<td>2.2</td>
<td>(3.0)</td>
<td>3.3</td>
</tr>
<tr>
<td>support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>..informal</td>
<td>29.7</td>
<td>31.7</td>
<td>37.5</td>
<td>27.4</td>
<td>25.7</td>
<td>50.5</td>
</tr>
<tr>
<td>support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>..no support</td>
<td>61.2</td>
<td>66.0</td>
<td>49.9</td>
<td>61.4</td>
<td>38.9</td>
<td>31.6</td>
</tr>
</tbody>
</table>

Source: Vlachantoni et al (2011) Tables 1 and 2
Notes: 1. Survey definitions not exactly comparable.
2. GHS includes an “other support” category not shown in the table, but excluded from the “no support” estimate, so columns do not sum to 100.
3. Brackets indicate unweighted frequencies of cell counts below 5

Vlachantoni and colleagues are updating their analysis with more recent ELSA data and we await their
findings with interest. Other published evidence giving recent estimates of unmet need for people aged
65 or over (but no time series) comes from the Health Survey for England (HSE), combining data for
2011 and 2012 (Whalley, 2012). This analysis finds that 22% of men and 30% of women who needed
help with at least one ‘activity of daily living’ received none in the last month, while 14% of men and 15%
of women who needed help with at least one ‘instrumental activity of daily living’ received none.21 These
are lower estimates than those provided by Vlachantoni et al, despite using a broad definition of need.
The difference may be due to the fact that HSE asks whether people have received any help in the last
month with the activity in question, while GHS asks whether people usually receive help, and ELSA
asks who provides help, if anyone. The results are nevertheless instructive in revealing that levels of
unmet need as measured in HSE rise substantially with age among the older population: of those who
needed help with at least one ADL, 15% of men and of women aged 65-69 had received no help in the

21 ADLs: stairs, bath/shower, dressing/undressing, in/out bed, getting around indoors, taking medicine, using toilet,
eating incl cutting up food, washing face & hands. IADLs: shopping for food, routine housework/laundry, getting out
of the house, paperwork/paying bills. Need is defined as the respondent being able to manage the activity on their
own with difficulty, only being able to do the activity with help, or not being able to do it at all. ‘Help’ is either formal
(state or paid) or informal care.
last month, compared to 44% of men and 55% of women aged 85 or over. There is also a suggestion that rates of unmet need may be higher amongst low income households and those living in areas with a high Index of Multiple Deprivation, although the published findings are not conclusive on this point.\textsuperscript{22}

The final source of data on formal and informal care received and levels of unmet need over time is the Family Resources Survey. The FRS has the advantage of providing a consistent time series from 2002/03 through to 2011/12 for the whole adult household population in the UK, not just the over-65s, and a sufficient sample size to give at least 8000 respondents with ‘substantial difficulties’ in each year.\textsuperscript{23} However, unlike ELSA or HSE, it is not a specialist survey, so the questions on need and care received are less specific. Need can be defined in FRS as having a longstanding illness or disability and experiencing ‘substantial difficulties’ in one or more areas of life as a result of health problems or disability. The areas of life listed are: mobility; lifting, carrying or moving objects; manual dexterity; continence; communication (speech, hearing or eyesight); memory or ability to concentrate, learn or understand; recognising when you are in physical danger; physical coordination (eg balance); and other health problem or disability.\textsuperscript{24} Help received is identified by a series of questions about who within the household is receiving help or support because of physical or mental ill-health or disability or old age, the frequency of help provided, and, for those who receive help once a week or more often, by whom the help is provided (including a list of both formal and informal sources). Receipt of both formal and informal care are likely to be underestimated in FRS because the household respondent answers these questions on behalf of all household members, rather than each person responding for themselves. However, the magnitude of the underestimate is not thought to be large.\textsuperscript{25} Unmet need in FRS can therefore be defined in broad terms as having one or more substantial difficulties and receiving no weekly (or more frequent) help or support from formal or informal sources.

The next three figures show the FRS estimates of receipt of formal and informal care, which are then compared to levels of need in the final figure to produce estimates of unmet need. Figure 13 shows the trend in receipt of formal care by age group, taking four time points: 2002/03, 2007/08 and 2009/10 showing the trend during the Labour period, and 2011/12 being the latest year for which these data are available in the Coalition period. It shows that a much higher proportion of the 75+ age group with substantial difficulties in at least one area of life receive formal services than younger age groups. This is probably because the older age group are more likely to have multiple and more severe impairments. However, while working age people with substantial difficulties have become increasingly likely to receive services over this period as a whole, people age 65 or over, and especially those aged 75+, have become less likely to receive services. The changes appear to be particularly pronounced in the early part of the 2000s (though note this is a five-year gap rather than the two-year gaps shown thereafter).

\textsuperscript{22} Whalley (2012) Tables 8.11 and 8.12 report percentages who needed help with ADLs and IADLs, and percentages who received help in the last month, by household income quintiles and IMD quintiles respectively. But the author notes that those who received help in the last month may not be the same as the people who need help, so rates of unmet need cannot be directly inferred from these data.

\textsuperscript{23} Unfortunately, the question wordings on disability were changed in the 2012/13 FRS in a way that affects the number of people reporting health difficulties, so 2011/12 is the final year of this series that can be compared with previous years on a consistent basis.

\textsuperscript{24} The ‘other’ category was not included in the 2002/03 survey. This does not affect the proportion saying that they have any difficulties, but it does affect the number of difficulties reported. Therefore breakdowns by number of difficulties are shown only for 2007 onwards.

\textsuperscript{25} For example, the FRS estimate in 2009/10 was that 9% of adults were providing unpaid care, compared to 12% in the Department of Health survey of carers in the same year (DWP, 2013, p77).
We have noted above that need for social care was outstripping supply throughout the 2000s and that one of the responses has been ‘intensification’ – a concentration of services on those with highest levels of need. Figure 14 therefore presents a breakdown of service receipt by the number of areas of substantial difficulty respondents report, as a proxy for intensity of need. In 2011/12, 25% of those who have any substantial difficulties report difficulties in 4 or more areas of life. (2002/03 is omitted from the Figure due to inconsistency in the ‘number of difficulties’ variable).
Figure 14 confirms that those with more difficulties are more likely to receive services, across age groups and across years, as one would expect. Looking at all those with 4+ difficulties (right-hand bars) we can see that the proportion receiving formal care has increased over time, while the proportion of all those with 1-3 difficulties receiving difficulties has fallen – consistent with the increasing concentration of services. This trend pre-dates the Coalition period. The trends differ by age group, however. An increasing proportion of the 16-44 age group receive formal services, whether they have lower or higher level needs, with a particularly big increase in the proportion of those with higher needs receiving services. While for the 75 plus age group, although the levels of service receipt are higher than for other age groups, the trend has been downwards among both lower and higher level need groups.

Changes in formal service provision may be expected to have a knock-on effect on informal care, although the availability of unpaid care is neither inexhaustible nor evenly distributed across those in need (Pickard, 2013). Figure 15 therefore shows changes in receipt of unpaid care on the same basis as for formal care in Figure 14.
The first thing to note about Figure 15 is the scale of informal care. While only one in six (16%) of all those with 4 or more difficulties were receiving formal services in 2007/08 (Figure 14), one half (50%) were receiving some informal support at least weekly (Figure 15). However, the trends in the proportion of individuals receiving informal care, for both high and lower need intensity sub-groups, are basically flat, and even slightly downwards for the 75 age group with high need intensity, suggesting that informal care is not easily able to expand to meet increasing demographic demand and fill the gaps left by formal services – despite the increase in the number of carers identified earlier in Figure 11.

It is important to understand changes in the receipt of each of formal and informal care separately but we are also interested in the extent to which these changes have affected the extent and distribution of unmet need. This is shown in Error! Reference source not found., with unmet need being defined as having one or more substantial difficulties and receiving no weekly (or more frequent) help or support from formal or informal sources. This is in one sense a broad definition (the population group with one or more substantial difficulties is a large one), and in another sense a narrow one (the receipt of any help is treated as meeting need in full, whereas it is of course possible that the help provided meets some but not all of the individuals’ need for support).

Figure 16 indicates high levels of unmet need among all age groups, and if anything increasing slightly over time for those with low-intensity needs, and for the 75+ age group with high or low intensity needs. The lower-intensity need sub-group appear to have greater levels of unmet need than the high intensity need sub-group, but this is due in part to the assumption that the receipt of any formal or informal support counts as need being met. If we were able to measure unmet need as a matter of degree, it is likely that the picture would be rather different. Nevertheless, given the concentration of social services...
provision on higher intensity need groups, it is important to note the very high levels of unmet need among those with less intense needs: by 2011/12, 85% of those with substantial difficulties in 1-3 areas of life reported receiving no help at all.

**Figure 16: Unmet need for care, by number of difficulties, age group and year, UK (FRS)**

![Bar chart showing unmet need for care by number of difficulties, age group and year](image)

Source: author’s calculations using FRS 2007/08, 2009/10, and 2011/12

For the higher-intensity need sub-group, there are also high levels of unmet need – nearly half of 60-74 year olds with high intensity needs, for example, report no receipt of help, as do over one-third of 75 plus year olds.
6. Conclusions

Social care did not feature prominently in the Coalition’s stated aims but it could be seen as fitting within their general commitment to create “a much stronger society: one where those who can, do; and those who cannot, we always help” (HM Government, 2010, p8). In so far as a greater mobilization of unpaid care by family and friends is consistent with this idea of ‘big society, not big government’, the Coalition could be seen as having had some success – the number of carers and the intensity of their caring has risen (Figure 11), but the increase has not been sufficient to fill the gap created by the continuing rise in the number of people in need along with cuts in social services. The result is that many older people and people of working age with substantial difficulties in daily living are receiving support from neither formal nor informal sources (Figure 16). The commitment to ‘always help’ those who cannot help themselves therefore rings somewhat hollow.

To be fair, the gap between the need for social care and the public resources devoted to it predates the Coalition’s period in office. Although adult social care spending rose faster than the growth in the older population in the first half of the 2000s, it then flattened off at just the time when there was an acceleration in the numbers of older people (Figure 1). Social care was therefore already substantially under-funded when the Coalition came to power. Far from reversing this trend, the Coalition introduced cuts of around 40% to local authority core funding (LGA, 2014a), with substantial knock-on effects on social care budgets as discussed above in the section on ‘Resources’.

Addressing the shortfall in social care expenditure would of course have run counter to the priority afforded by the Coalition to reducing public spending. Instead, the Coalition’s policy agenda focused on establishing a new basis for the division of responsibility between the state and individuals for paying for care in the future – a question that has repeatedly been shelved by previous administrations. The Dilnot Commission and the subsequent Care Act 2014 mark a significant milestone in recognising the importance of bearing the risk of needing intensive and/or long-term care collectively, thereby reducing the uncertainty and potentially very high costs faced by individuals. Once introduced, the lifetime cap on care costs is unlikely to be reversed, although of course the level at which it is set and the costs that are deemed eligible may be varied, and it may therefore prove a major part of the Coalition’s legacy in social care. It is a policy for which the Lib Dems can claim some credit: by advocating a Commission on the future funding of care, they prevented the Conservatives from pressing ahead with their manifesto commitment to promoting voluntary private insurance. Modelling suggests that together with the relaxation of the capital means test, it will result in an increase of around 9% in the number of people receiving at least some state funding for their care by the year 2030 (Hancock et al, 2013), with the principal beneficiaries being those with modest wealth.

More significant in the short term, and also with longer-term consequences, has been the formalisation of national eligibility criteria – in effect giving statutory backing to the move many local authorities had already in practice made to restrict services to those with the highest levels of need – and the cuts to local authority funding. Although policy rhetoric (and some clauses in the Care Act 2014) promote preventative services and the integration of health and social care, and good examples are emerging in places, in practice both these goals have been subsumed under the drive to reduce costs.

Local authorities have endeavoured to protect adult social care within their budgets so the cuts in expenditure on adult social care during the whole period of the Coalition in government are expected to
be around 13.4% (Table 2), much lower than the reductions in local authority funding in general. Nevertheless, the cut is still substantial, especially when seen in the context of a 9% increase in the population aged 75 and over in the same period, and continuing rising need among the working age population as well (Figure 2). Various strategies have been adopted by local authorities to minimise the impact of cuts on users, including changing procurement practices and shifting provision to less costly settings (ADASS, 2014). Results from the Adult Social Care Users Survey, as reflected in the Outcomes Framework (Table 5), support the view that people who are ‘inside the system’ are generally pleased with the services they receive, although other indicators of quality of care and levels of abuse are not so encouraging (Table 6). People with higher-intensity needs, people with learning difficulties and residential care have been comparatively protected.

A serious area of concern, however, is the withdrawal of services from those with anything less than the most substantial needs. Given inadequate overall resources, concentrating on provision for those with the most complex needs is a rational response within the statutory framework, but one which leaves large numbers of people without the help they require. It is also likely to lead ultimately to increased demand for services – exactly the opposite mechanism to that envisaged in the Care Act emphasis on prevention. ‘Service intensification’, as it is sometimes called, pre-dates the Coalition, but has been reinforced and accelerated. The fall of 0.7% per year in the last four years of the Labour administration in the total number of social care users became a fall of 7% per year during the Coalition period to 2013/14 (Table 3). Community based services for working age people with mental health problems have been cut by over a third since 2009/10, more than reversing the development of the service in the preceding period, and the number of 18-64 year olds with substance misuse receiving services has almost halved (Table 4). One-third fewer physically disabled older people now receive services than was the case in 2009/10 – despite an 8% rise in the size of the population - and their working age counterparts have seen a cut of more than a quarter.

The knock-on effects of these cuts in other parts of the public and voluntary sectors - in the form of increased demand for other services such as Accident and Emergency or crisis support - may not yet be apparent. More immediate is the impact on the individuals themselves and their families. An increasing number of people, some of whom would previously have been eligible for social services, are relying on the support of family and friends – with potential consequences for the well-being and opportunities of the carers, especially for those taking on more intensive caring roles. Both Conservatives and Liberal Democrats mentioned support for carers in their manifestos, but relatively little has materialised; Britain could usefully learn from the range of strategies adopted in other European countries (Allen et al, 2011). Those who do not have access to alternative sources of support must lead more restricted lives. Analysis of the Family Resources Survey suggests that one half of 60-74 year olds with four or more areas of substantial difficulty, and one third of 75 plus year olds in that category, report receiving no support from either formal or informal sources (Figure 16).

**Challenges**

The incoming administration therefore faces a number of major challenges in social care. First and foremost is the growing gap between demographic demand and public funding for social care. This is illustrated in Figure 17, which shows the (projected) growth in the population aged 75 or over from 2010 to 2019 (a key determinant of the need for social care), alongside the Local Government Association's
While local authorities have thus far been successful in affording social care some protection from the worst of the budget cuts, there is a limit to how much further they can go: “Some councils are beginning to believe that they cannot make the level of savings required without putting their basic services for vulnerable people at risk. They would argue that a combination of increasing demographic pressures (which they can manage down no further) and rising costs (which have been held down for too long), added to the fact that they have undertaken all of the efficiency actions they believe possible, means they can cut no further” (LGA, 2014b, p44).

Figure 17: Projections of total local authority funding and population aged 75 or over, England, 2010 to 2019

Sources: ONS (2013c) and ONS (2013y) for population projections, and LGA (2014a) for local government funding

Note: Population is for mid-year 2010, 2014 and 2019, funding is for financial years 2010/11, 2014/15 and 2019/20. LGA forecast is based on their model for total funding including grants, council tax, business rates and other sources of income, in real terms.

Troubling as the prospect presented by Figure 17 is, there are reasons to think the scale of the challenge is even larger. Even were the downward trend in social care spending to be reversed and keep pace with new demographic demand over the next five years, it would not address existing levels of unmet need. Fernandez et al (2013) estimate that the need-standardised gap in levels of net social care expenditure in 2012/13, relative to the levels in 2005/06, was approximately £1.5 billion. The need for substantial increases in tax funding for social care - in line with those that were achieved for health care under the Labour administration when the economy was buoyant – is real and urgent.

A second major challenge is getting to grips with the integration of health and social care. Few doubt that this is a desirable objective: for the convenience and well-being of patients and users, for promoting better health and independence, for the efficiency of the service, and – possibly - to achieve cost
savings. But putting the cost savings first can itself become a barrier, as the Coalition have found with their Better Care Fund experiment. Making integration happen in practice is extremely difficult – NAO (2014a) list some of the challenges – but nevertheless there are some emerging examples of good practice (Ham et al, 2012; LGA, 2014b), and the Barker Commission (2014) sets out a roadmap for achieving a fully joined up care service.

The third and fourth challenges for the incoming government are closely related: tackling the high prevalence of poor standards and abuse in social care, and investing in the social care workforce. It is encouraging that these issues are gaining more attention in public debate – albeit largely as a result of TV documentaries rather than the work of the authorities - and safeguarding mechanisms, monitoring of social care outcomes, and inspection have all been taken forward under the Coalition, resulting in notable improvements in the information and guidance available. Nevertheless, the fact that in 2013/14, there were 37,685 confirmed cases of vulnerable adults being abused (Table 6) – a figure that we must assume represents the tip of the iceberg - and that the CQC finds cause for concern in 1 in 5 nursing homes it inspects, as well as 1 in 10 residential care homes and 1 in 10 domiciliary care providers, indicates there is great deal more to do.

Safeguarding and inspection bodies perform a crucial role but they are facing an uphill struggle, as local authority budget cuts apply downward pressure on costs among all providers, which in turn militates against raising standards for example through improved staff training, staff retention, and staff: client ratios. In child protection, it is now widely accepted that preventative services are at least as important as a reactive approach in reducing abuse and neglect (see Stewart, 2015 WP 12). While the issues are clearly different in relation to older people, there may nevertheless be lessons that can be read across from best practice in child protection, with greater emphasis on early intervention and changing the nature of settings within which people are cared for, rather than waiting to respond to whistle-blowers or referrals. The CQC’s new risk-based inspection regime is a step in this direction.

Changing the nature of the settings within which people are cared for may call for reconsideration of the structure of the care sector as a whole. CQC (2014) draws attention to the higher risk of poor quality care associated with corporate providers of large care homes – a type of provider that operates a growing share of beds overall (Frost and Sullivan, 2013). The UK is an outlier within Europe in depending so heavily on private for-profit companies to provide care (Allen et al, 2011, Table 3.7). There is both theory and evidence of market failure – public sector carrying the downside risk of private provider failure, high costs of exit for individuals, asymmetric information on quality and lack of repeat purchases – but there is also evidence of failure to maintain standards in publicly-provided and voluntary sector services, so there is no easy solution. The incoming administration may want to ask whether the institutional structure of the care sector needs a more radical overhaul, moving away from the commodification of care into 15-minute packages and aiming to create instead conditions in which relationships of care can flourish (Lewis and West, 2014). Creating such conditions undoubtedly requires attention to be given to the composition of the social care workforce. The care sector is heavily reliant on low-paid, often migrant, workers. 2.5% of domiciliary workers are actually paid below the National Minimum Wage, and a further large proportion at the minimum wage (Bessa et al, 2013), and as many as 6 in 10 are estimated to be on zero-hour contracts (Skills for Care, 2012). Care workers’ wages have been kept low during the recession along with other low-skilled workers (McKnight, 2015, WP15), and this is arguably not sustainable. Were the value of the
National Minimum Wage to increase in real terms – a move for which all political parties have expressed support - the costs of care would rise substantially (albeit with an off-setting decrease in the tax-credit bill), adding to the funding challenge identified above. Over and above that, it seems clear that investing in the skills and status of carers, as well as reducing caseloads and ensuring workers are given ‘time to care’ , could make an important contribution to improving the standards of care. CQC (2014) identify having trained and specialist staff, including nurses, a registered manager, and lower staff turnover as important factors in reducing risk.

In 1962, Peter Townsend remarked in his ground-breaking study of old people's homes, *The Last Refuge*, that society can be judged by how it treats its most vulnerable members. More than half a century on, we are still failing this test of civilisation, and it is a challenge to which the incoming administration must rise.
Appendix 1: Government ‘transparency’ input and impact indicators for social care


Coalition priority 1: To enable better health and well-being for all
[All actions and indicators are health-related under this heading]

Coalition priority 2: To enable better care for all

Actions

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<tr>
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<tbody>
<tr>
<td>2.3.i. Introduce primary legislation that will ensure the provision of personal budgets as part of the person's care and support plan, and clarify entitlements for direct payments for everyone eligible for ongoing care and support, including the disabled and older people</td>
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_Scheduled start date: Started, Scheduled end date: Apr 2015_

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<tr>
<td>2.4.i. Publish a framework document on integrated care and support, jointly with national partners, to help drive improvements in the quality and efficiency of services</td>
<td>May 2013</td>
<td>Complete</td>
<td>'Integrated Care: Our Shared Commitment' was published on 13 May 2013 [accessed 5 January 2015]</td>
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_Scheduled start date: Started, Scheduled end date: Jun 2013_
2.4.i. Launch scheme to identify and support pioneer areas to implement integrated health and care at pace and scale, as exemplars for improvement everywhere

**Scheduled start date:** Started, **Scheduled end date:** Oct 2013

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<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Complete</strong></td>
<td>Details have been announced of the fourteen areas leading the way in delivering better joined up care. <a href="https://www.gov.uk/government/news/integration-pioneers-leading-the-way-for-health-and-care-reform--2">https://www.gov.uk/government/news/integration-pioneers-leading-the-way-for-health-and-care-reform--2</a></td>
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2.4.ii. Launch the Better Care Fund allocations for 2015/16

**Scheduled start date:** Started, **Scheduled end date:** Mar 2015

|          |                     |                   | **In progress** |

2.4.iii. Perform a full independent evaluation of the Integrated Care Pioneers and their Better Care fund plans

**Scheduled start date:** Started, **Scheduled end date:** Jun 2015

|          |                     |                   | **In progress** |

2.5 Reform the care and support system

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<tr>
<td>2.5.i. Reform and modernise the care and support legal framework, placing individuals and their well-being at the heart of the law, and extending new rights to support for carers, on the same basis as those they care for, through the Care Bill</td>
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| Scheduled start date: Started, **Scheduled end date:** Apr |

|          |                     |                   | **In progress** |

58
### 2.5.ii. Allocate funding through the Homes and Communities Agency and the Greater London Authority to deliver 3,500 affordable homes for older and disabled people through the Care and Support Specialised Housing Fund by 2018

**Scheduled start date:** Started, **Scheduled end date:** Mar 2015

- **Status:** In progress

### 2.5.iii. Introduce new national eligibility criteria to set a minimum threshold for social care eligibility

**Scheduled start date:** Started, **Scheduled end date:** Apr 2015

- **Status:** In progress

### 2.5.iv. Lay minimum eligibility regulations before Parliament

**Scheduled start date:** Oct 2014, **Scheduled end date:** Oct 2014

- **Start date:** Oct 2014
- **End date:** Overdue in completing
- **Status:** Overdue
- **Notes:** Regulations providing for the national eligibility threshold were published in October 2014. The regulations are subject to debate in Parliament, expected to be later in 2014. [Link](https://www.gov.uk/government/news/final-care-act-guidance-published)

### 2.9 Implement the commitments of the Winterbourne View review, delivering through the NHS England and local government transformed services for people with challenging behaviour which eliminate excessive reliance on hospital care

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<tr>
<td>2.9.i. Review the care of all people in learning disability or autism inpatient beds and agree a personal care plan for each individual based around their and their families’ needs and agreed outcomes, supported by the joint NHS England/LGA Improvement programme and through NHS England, local health and care commissioners</td>
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<tr>
<td>Jul 2013</td>
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2.9.ii. Ensure each individual has an agreed personalised care plan that enables, in all cases where it is appropriate, for them to move into a community setting where they can receive care and support, with as many people as possible having moved by March 2015 through NHSE and local commissioners and supported by the Joint Improvement Programme

**Scheduled start date**: Started,  **Scheduled end date**: Mar 2015

2.9.iii. Consult on proposals to strengthen accountability and corporate responsibility for the quality of care

**Scheduled start date**: Jun 2013,  **Scheduled end date**: Jun 2013

2.9.iv. Publish a report following up progress in delivering all agreed actions one year on, including the work on strengthening corporate accountability

**Scheduled start date**: Dec 2013,  **Scheduled end date**: Dec 2013

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<tr>
<td>2.9.i.</td>
<td>Jul 2013</td>
<td>Complete</td>
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<tr>
<td>2.9.ii.</td>
<td>In progress</td>
<td>Progress with the Transforming Care programme has been slower than expected. The Department of Health is working with NHS England and other delivery partners to identify and address challenges and barriers to progress.</td>
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<tr>
<td>2.9.iii.</td>
<td>Jun 2013</td>
<td>Jun 2013</td>
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<td>2.9.iv.</td>
<td>Dec 2013</td>
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The completed report was published on 12
### Impact indicators:

| Quality of life for adults receiving social care | 19.0 (2013-14 Prov) | 18.8 (2012-13) | Data series shows slight improvement over each of the last 4 years from 18.7 in 2010-11 to 19.0 in 2013-14 |
| Satisfaction with adult social care services | 64.9 (2013-14 Prov) | 64.1 (2012-13) | Data series shows continued improvement over each of the last 4 years from 62.1% in 2010-11 to 64.9% in 2013-14 |

### Coalition priority 3: To enable better value for all

#### Actions

3.6 Reform funding of the Care and Support system

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<tr>
<td>3.6.i. Introduce universal deferred payments through the Care Bill</td>
<td>Started</td>
<td>Apr 2015</td>
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3.6.ii. Introduce the capped cost system and extended means test through the Care Bill

**Scheduled start date:** Started, **Scheduled end date:** Apr 2016

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<td><strong>Breakdown of adult social care spend (£ billion)</strong></td>
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<tr>
<td><strong>Unit cost of receiving community care (£)</strong></td>
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<td><strong>Unit costs: older people residential and nursing care (£)</strong></td>
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<td><strong>Unit costs: older people home help (£)</strong></td>
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<td><strong>Unit costs: older people day care (£)</strong></td>
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### Coalition priority 4: To deliver successful change

#### 4.1 Strengthen the role of the Care Quality Commission

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<tr>
<td>4.1.ii. Introduce a new offence for providers of health and social care that provide misleading information</td>
<td></td>
<td>May 2014</td>
<td>Complete</td>
<td>The offence was introduced through the Care Act 2014 on May 15th. DH is currently consulting on proposals for setting the scope of the offence through regulations. The consultation can be found online and closes on 5th June. <a href="https://www.gov.uk/government/consultations/healthcare-providers-supplying-misleading-information">https://www.gov.uk/government/consultations/healthcare-providers-supplying-misleading-information</a></td>
</tr>
<tr>
<td><strong>Scheduled start date</strong>: Started, <strong>Scheduled end date</strong>: May 2014</td>
<td></td>
<td></td>
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<tr>
<td><strong>Scheduled start date</strong>: June 2013, <strong>Scheduled end date</strong>: Oct 2014</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4.1.iv. Working with the Care Quality Commission, Monitor and partners, develop and implement a single failure regime for quality and finance</td>
<td></td>
<td>Sept 2014</td>
<td>Complete</td>
<td>Provisions for a Single Failure Regime, developed and enacted under the Care Act 2014, have now commenced.</td>
</tr>
<tr>
<td><strong>Scheduled start date</strong>: Started, <strong>Scheduled end date</strong>: Sep</td>
<td></td>
<td></td>
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<tr>
<td>Title</td>
<td>Start date achieved</td>
<td>End date achieved</td>
<td>Status</td>
<td>Notes</td>
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<tr>
<td>4.1.v. Amend a loophole in Section 19 of the Health and Social Care Act 2008 that allows some providers to voluntarily close services in order to avoid enforcement action by the Care Quality Commission</td>
<td>May 2014</td>
<td>Complete</td>
<td>The change will take effect on commencement of the relevant section of the Care Act 2014.</td>
<td></td>
</tr>
<tr>
<td>4.2 Work with HM Treasury and Cabinet Office to develop firm plans and milestones for ensuring robust and clear arrangements are in place to manage the continuity of essential services in the event of provider failure</td>
<td></td>
<td></td>
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<tr>
<td>4.2.i. Introduce new powers for CQC to oversee financial sustainability of care providers, to protect continuity of care through the Care Bill</td>
<td></td>
<td>May 2014</td>
<td>Complete</td>
<td>The Care Bill received Royal Assent in May 2014.</td>
</tr>
</tbody>
</table>

(No input or impact indicators)
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65


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