



THE LONDON SCHOOL
OF ECONOMICS AND
POLITICAL SCIENCE ■

Social Policies and Distributional Outcomes

in a Changing Britain

The Conservatives' Record on Adult Social Care: spending, policies and outcomes in England, May 2015 to pre-COVID 2020

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Social Policies and Distributional Outcomes research programme

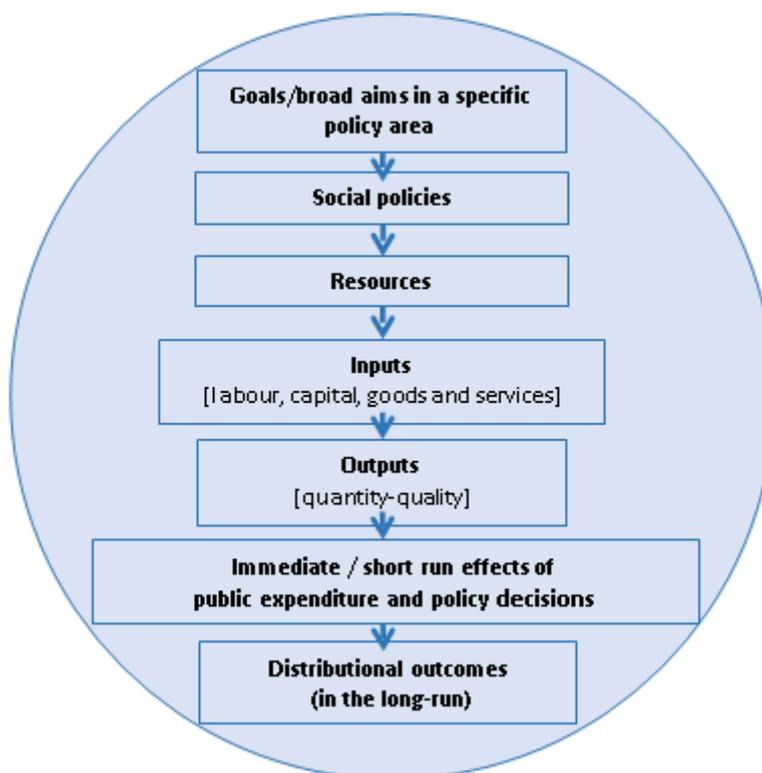
The central objective of the SPDO research programme is to provide an authoritative, independent, rigorous and in-depth evidence base on social policies and distributional outcomes in 21st century Britain. The central question to be addressed is: What progress has been made in addressing social inequalities through social policies? The research programme is ambitious and comprehensive in scope, combining in-depth quantitative analysis of trends in social inequalities and social divides with detailed and systematic public expenditure and social policy analysis across ten major social policy areas over the period 2015-2020, together with broader reflection on the changing nature of social policies and distributional outcomes over the 21st century.

The programme of research adds to (and will reflect on) the previous Social Policies in a Cold Climate (SPCC) research programme covering the period 1997-2015. The SPDO programme will update, extend and broaden our analysis of public expenditure, social policies and distributional outcomes using the most recent datasets available, resulting in a unique evidence base on trends in social inequalities and social policies going back to 1997. Innovative extensions included within the SPDO research programme include: coverage of additional areas of social policy (e.g. physical safety/security and complex needs/homelessness); emphasis on the new context for social policy making (e.g. devolution and BREXIT); assessment of a broader range of multidimensional outcomes within our quantitative analysis; and the inclusion of additional breakdowns (e.g. migration status). This programme will also have a

forward looking component, identifying the key challenges for social policy in the 2020s.

The current paper is part of work-package 3 of the broader programme, which is providing in-depth and cross-cutting analysis of trends in social policies over the period 2015 to pre-COVID 2020. The work-package will include analysis within and across ten major social policy areas (social security and general housing; health; social care; early years; compulsory school age education; higher education; employment; safety and security; social mobility; and homelessness / complex needs). The analytical schema for the social policy analysis undertaken within the programme is set out in Figure A below. The figure shows the structure of the analysis, which will address (1) broad policy goals for each policy area; (2) the actual policies and measures adopted in each area; (3) public expenditure trends (including where feasible and meaningful per capita and in relation to demand / need); (4) inputs and outputs (how resources were spent and what was produced from this); (5) overall outcomes achieved.

Figure A: Analytical schema for public expenditure and social policy analysis



Source: adapted from Lupton et al. (2013). Note: Arrows denote steps in the analytic chain but not causality through the chain. The background circle denotes the broader universe of other policies, the economy and society, which shape all stages.

More information and other publications in the series are available at the project webpage: http://sticerd.lse.ac.uk/case/_new/research/spdo/default.asp

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1 Introduction

Social care was referred to as the 'forgotten front line' during the COVID-19 crisis. Recognition of the role that care homes, and care home staff, played in looking after the vulnerable, sick and dying, lagged well behind the high-profile (and justified) recognition of hospitals and NHS staff. Understanding of the need for community-based care to continue was limited amongst policymakers and the general public, and the challenges that presented for people with needs and for the paid and unpaid carers trying to look after them, went largely unremarked. It was several weeks before coronavirus-related deaths in care homes and in the community were even reported as part of the regular updates on numbers of deaths.

When the statistics finally began to emerge, they made increasingly grim reading. At the time of writing, there have been 19,394 deaths of care home residents recorded as involving COVID-19 between 2 March and 12 June 2020 in England and Wales (ONS, 2020). Overall deaths (measured over a slightly longer period 28 December 2019 to 12 June 2020) were 45.9% higher than the same period in the previous year. In addition, there were 6,523 deaths of recipients of domiciliary care in England (10 April to 19 June 2020); this was more than twice as many as the three-year average for this time of year.

The second class status of social care within the health and social care system is unfortunately all too familiar to those who have worked in this area for some time. Chronic, long-term, lack of resources and investment in the sector and fragmentation of provision meant that adult social care was, according to many commentators, already in 'crisis' even before the pandemic hit. This meant that there was limited capacity and resilience to respond to the enormous additional burdens that suddenly arose in March 2020.

The focus of this paper is on reviewing the state of adult social care on the eve of the pandemic, and how we had arrived at that point. It concentrates on the period from the start of the Conservative majority government in May 2015 up to the arrival of COVID-19 in the UK at the start of March 2020, setting this period in longer historical perspective where helpful. It focuses on England, with comparisons to other parts of the UK where these are particularly instructive. A brief outline of the social care system in England is given in Figure 1. The paper follows the same structure as others in this series. It begins by setting out key issues in adult social care inherited by the incoming government in May 2015, before reviewing the goals and policies pursued in turn by the Cameron, May and Johnson administrations. We then analyse trends in public and private expenditure on social care, and the inputs and outputs these resources produced. Taking a step back, and recognising that there are influences on outcomes other than direct policy and spending, we review the overall outcomes achieved for social care users and for unpaid carers, and the vexed problem of unmet need. Finally, we draw this together in an assessment of the state of adult social care on the eve of the pandemic, and the challenges for the future.

Figure 1 Explainer: the organisation and funding of adult social care in England

Adult social care is help with daily living for elderly people and people of working age who need assistance for example as a result of physical disability, mental illness or learning disability. Formal care includes residential care (care homes, nursing homes) and non-residential care (domiciliary care, community services) and may be short- or long-term. Informal care is synonymous with unpaid care.

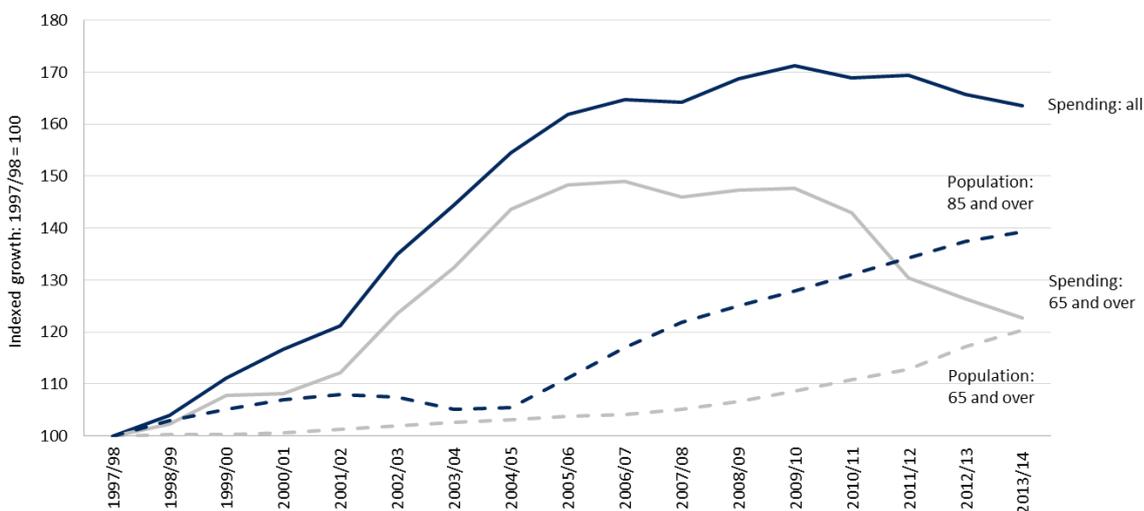
Informal care by family and friends	Formal care arranged and paid for through local authorities	Formal care arranged and paid for privately
<p>Unpaid care accounts for the largest share of all adult social care.</p> <p>Carers may receive advice and support from local authorities. Some are eligible for Carers Allowance.</p>	<p>Eligibility is determined by an assessment of need AND a means-test.</p> <p>The majority of care is commissioned by local authorities from independent (profit or non-profit) care homes and agencies. Some is provided by local authorities themselves, or provided in the form of a direct payment to the person with needs with which to make their own arrangements.</p> <p>Local authority-arranged care is funded through a combination of local revenue, central government revenue to local authorities, the NHS, and user charges.</p>	<p>Those who can afford it may arrange and pay for care themselves.</p> <p>In some cases families top-up the care funded by a local authority for the person with needs, in order to buy supplementary services or pay for a more expensive care home.</p>

2 Inheritance

Our previous review of policies, spending and outcomes in adult social care, in 2015, concluded that there were three key areas of concern: firstly, a widening gap between public funding and need; secondly, inequities arising from the highly restrictive means-test for social care and the lack of integration with health care; and thirdly, the prevalence of poor quality residential and community care and the abuse of vulnerable adults (Burchardt et al., 2015). However, there were signs of policy action at least on the second and third fronts, with the Care Act 2014 on the statute books, a raft of initiatives supporting health and social care integration, and a new Care Quality Commission inspection regime.

Firstly, in terms of the widening gap between public funding and need, Figure 2 shows that whilst the population aged 65 and over (dashed grey line) and the population aged 85 and over (dashed blue line) have been growing rapidly since 2004/05, spending on adult social care in real terms began to fall from 2009/10 onwards, and fell especially rapidly for the over-65s. This produced a fall of one-quarter in the number of people receiving publicly-commissioned social care services between 2009/10 and 2013/14, as services were increasingly concentrated on those with the most intense needs; the proportion of adults receiving non-residential social care who received more than 10 hours per week increased from 34% to 45% over this period (Burchardt et al., 2015). The cuts were implemented across all client groups with the exception of learning disabled people. At the time we were writing, the effects of these cuts in support were yet to be detected in increased demand for other services (for example, A&E admissions, emergency mental health services, drug and alcohol services and policing) but it seemed unlikely that the cuts could be absorbed without knock-on effects elsewhere.

Figure 2 Growth in real net current spending and population estimates by age group, England, 1997/98 to 2013/14



Source: Lupton et al. (2016 , Figure 9.1)

We argued (Burchardt et al., 2015) that the widening gap was leading to:

- an intensification of demands on unpaid carers (by 2012/13, 38% of individuals receiving unpaid care were receiving continuous care compared to 29% in a decade earlier, according to data from the Family Resources Survey (FRS));
- high levels of unmet need (in the 2011/12 FRS, nearly half of 60-74 year olds with four or more physical or mental health or cognitive difficulties, and over one-third of 75 plus year olds in the same category, reported receiving no help at all);
- downwards pressure on the pay and conditions of the care workforce (for example, 6 out of 10 domiciliary workers were estimated to be on zero-hours contracts (Bessa et al., 2013)).

There were no plans on the horizon in 2015 to address the gap between need and public funding. Austerity was firmly established in government rhetoric and in the public imagination. And the demographic projections looked set to exert yet further pressure, with continuing steady increases in the number of over-65s and over-85s until 2030, and more rapid increase in the over-85s after that. Whilst there is conflicting evidence on whether the *rates* of disability and need for services among older people are rising, falling or constant over time, there is no doubt that the *numbers* of older people are growing (ONS, 2018; The King's Fund, 2019a). Meanwhile, the more limited evidence on rates of disability and need among people of working age point towards increasing demand from this section of the population, for example the proportion of working age adults reporting disability rose from 15% to 18% between 2010/11 and 2017/18 (The King's Fund, 2019a).

The second area of concern identified in our 2015 review were the inequities arising from the nature of social care funding. Publicly-funded social care was (and is) concentrated on those with the lowest incomes and without assets, who received free care *if* assessed as needing care by increasingly stringent criteria. However above this low threshold, the means-tested basis of public social care resulted in those with modest income or wealth who had the bad luck to experience a long or intense period of care needs facing very high costs. This inequity had been recognised as far back as the 1999 Royal Commission on long-term care (Sutherland, 1999), but efforts to secure political agreement on reforms had repeatedly failed. The 2014 Care Act signalled new promise, however, partially implementing the Dilnot commission recommendations (Dilnot, 2011), and giving the government powers to raise the capital means test threshold and to introduce a lifetime cap on care costs. The incoming government in May 2015 was poised to implement these changes. As we shall see in the following sections, what materialised unfortunately gave many people a strong sense of *déjà vu*.

Alongside this reform, and also recognised by the Dilnot Commission and the direct focus of another commission (Barker and The King’s Fund, 2014), was the issue of health and social care integration. In England, if a person’s need is deemed to be healthcare, the service is provided free at the point of use regardless of means, whilst if it is deemed to be social care, it is subject to the means test. In Scotland, the boundary had already been shifted: *personal care* has been provided free at the point of use for over-65s, regardless of their means or the setting in which the care is provided, since 2002. The Westminster government was not proposing to follow suite, but had instead introduced a number of initiatives to promote more effective joint working between health and social care authorities, including the Better Care Fund and pioneer areas for health and social care integration. We review the progress on this agenda later in this paper.

The third troubling aspect of the social care inheritance in 2015 was on-going concerns about the prevalence of poor quality residential and home care, and concerns about abuse. One in five nursing home inspections and one in ten residential care home inspections produced serious concerns about the quality of care (CQC evidence reviewed in (Burchardt et al., 2015)); and across care home residents, domiciliary care users and non-service-users there were 37,685 substantiated cases of abuse of vulnerable adults in 2013/14 alone (*ibid*). More focused CQC inspections, and a stronger statutory basis for local authorities’ adult safeguarding work, were intended to address these problems; below we consider the extent to which these changes have been effective.

3 Goals

Notwithstanding the introductory remarks above about social care as the ‘forgotten front line’, social care has crept up the political agenda. The Department of Health was renamed the Department of Health and Social Care in 2018 and a new ministerial post was created. Social care was mentioned more often in parliamentary debates, and in broadsheet media, in the second part of the period, although this change was not reflected in the popular press (Table 1).

Table 1 Average number of mentions of “social care” in parliamentary debates and print news media, per month, by political administration

	Commons’ or Lords’ debates	Broadsheets	Leading tabloids
Cameron administration	135	218	63
May/Johnson administrations	164	239	64

Source: authors’ searches on Hansard (5 Jan 2020) and Nexis UK (6 Jan 2020). Notes: Cameron administration taken as 763 days, from 8 May 2015 to 8 Jun 2017. May/Johnson administrations taken as 917 days 9 Jun 2017 to 12 Dec 2019. Broadsheets included are: Times and Sunday Times, Daily and Sunday Telegraph, FT, Observer, Guardian. Leading tabloids included are: Sun, Mail and Mirror (both dailies and Sundays).

Turning to the Conservative Party manifestos to identify the stated goals of social care policy over this period reveals a sorry tale. In brief, the 2015 manifesto showcased implementation of the preceding administration's flagship legislation that was, in fact, never implemented; the 2017 manifesto gave a high profile to brand new social care funding proposals, which were withdrawn even before the election was even held; and the 2019 manifesto acknowledged that there was no policy but promised...another review!

Taking each of these now in turn: in David Cameron's 2015 manifesto, most of the emphasis was on implementation of the recently-passed 2014 Care Act. The opening commitments on page 3 included the promise that, "we will cap the amount you can be charged for residential care", and the commitment to ensure "no one is forced to sell their home to pay for care" was highlighted at the start of the chapter on 'Dignity in your retirement'. It conveyed the sense that social care had been sorted. The small number of new commitments were vague, and expressed in less than a full paragraph: to "increase support for full-time unpaid carers"; "support commissioners to combine better health and social care services for the terminally ill", and more generally still to, "continue to integrate health and social care systems" through pilots and use of the Better Care Fund.

Soon after being elected, however, the Conservative government got cold feet about the magnitude of the additional funding that local authorities would require to compensate for the more generous means-testing thresholds and the cap on lifetime care costs. The original intention to part-fund the provision through freezing Inheritance Tax thresholds was no longer deemed politically attractive. The Conservatives announced in July 2015, just two months after the election, that implementation of the relevant provisions in the Care Act 2014 would be delayed until at least 2020. Central commitments in the manifesto to fairer charging for social care, for which the legislation was already in place, were simply shelved.

In relation to the other manifesto pledges, a call for evidence on support for carers was launched in 2016, but a Carers Action Plan was not produced until June 2018, and Carers Allowance was not increased relative to other benefits. The health and social care integration agenda – predating the 2015 manifesto – did progress, and this is discussed in more detail below.

Nothing daunted, or perhaps in a bid to distract attention from the broken promise of the 2015 manifesto, the 2017 Conservative Party manifesto (Conservative Party, 2017), now under the leadership of Theresa May, gave social care an even higher profile. It was identified as one of five "giant challenges": "giving people security in old age and caring for those with long-term health conditions, whilst making sure we are fair to younger generations" (p7). The manifesto promised, "The first ever proper plan to pay for – and provide – social care" (p4), and dismissed the Dilnot review recommendations (lauded in the 2015 manifesto and enshrined in Coalition-government legislation). This new plan in fact shared one feature with the original Care Act 2014 provision, namely, a substantial increase in the capital threshold for the

means test. In the Theresa May version, this was to rise from £23,250 to £100,000 for both residential care and care provided at home, meaning that those with modest assets would for the first time be eligible for social care free at the point of use. Understanding, however, that this was a potentially expensive change for the public purse, the proposal was coupled with a new provision allowing the means-test for care provided at home to take into account the value of family home, with payments deferred until after death, in the same way as was already the case for residential care.

The proposals provoked a firestorm of criticism from political commentators and social care analysts, and quickly unravelled. Concerns centred on applying the means-test to the value of the family home, even when other members of the family might still be living there - deferred payments were not perceived to be an adequate solution; and on the lack of any overall cap on care costs, which would mean that an unlucky few would still face very high costs. Five days after the launch of the manifesto, Theresa May 'clarified' that there would be a lifetime cap on care costs - although an amount was not specified, and there was no mention of such a cap in the manifesto briefing. Reform of social care funding was not included in the subsequent Queen's Speech.

Whilst the social care funding reforms were given pole position in the manifesto, a number of other policies relevant to social care were also outlined. Interestingly, some of these included issues of particular importance to the working age population with disabilities, who have tended to be overlooked in recent social care debates, despite making up at least half the number of social care users:

- 1 million more people with disabilities into employment over next 10 years (a previous commitment on this was expressed as 'halving the disability employment gap'), including through the digital economy
- a review of disability access regulations in relation to parking, licensed premises and housing
- work with service and utility providers to reduce extra costs.
- improving standards of care for people with learning disabilities and autism; and implementing in full the Transforming Care Programme.

In addition, there were commitments to improve the quality of care and support for carers, including by:

- making greater use of digital technology to promote independent living, monitor long-term conditions, and to deploy carers more effectively
- reducing loneliness
- legislating for statutory carers leave.

Finally in 2019, Boris Johnson's manifesto announced that, "We need a long-term solution for social care" (Conservative Party, 2019, p. 12). This was not, of course, news to anyone, and the fact that one of the points in the three point plan then outlined was to "bring forward the necessary proposal and legislation for long-term reform" (Conservative Party, 2019, p. 12) did not acknowledge that relevant legislation was in fact already on the statute books, waiting to be implemented, and nor did it inspire confidence that the new administration *had* a plan or would succeed where the previous two had failed. The promised green paper had already been delayed 8 times in two years (Courea, 2019). A second point in the three point plan emphasised, "a guarantee that no-one needing care has to sell their home to pay for it" – a commitment that the furore following the 2017 manifesto had already revealed to be insufficient to calm people's fears, since it does not rule out deferred payments (Conservative Party, 2017).

The third point in the three point plan was however genuinely new: "£1 billion extra of funding every year for more social care staff and better infrastructure, technology and facilities" (Conservative Party, 2019, p. 12). Further notes clarified that this spending commitment was from April 2020 onwards, but did not specify what was meant by 'extra' or whether 'every year' meant the funding was to be recurrent rather than one-off, or whether £1bn would be added to each previous year's total. In practice of course, this commitment was overtaken by events, as the pandemic took hold.

A further specific spending commitment in the manifesto was £74m over 3 years for expanding community care capacity for people with learning disability and autism, continuing the work for the previous administration under the Transforming Care Programme.

Other policies relevant to social care mentioned in the 2019 manifesto included rolling forward from 2017 the commitment to legislating for one week of unpaid leave entitlement; and doubling of the funding for dementia research.

It is notable that the 2019 manifesto made some high profile spending commitments on social care, in a way which was not seen in either 2015 or 2017. However it was much less specific than its predecessors on how social care policy was to be carried forward or reformed.

4 Policies

Despite the focus of all three manifestos on major social care funding reform, policy action in the period 2015 to early 2020 was principally about the implementation of existing policies to improve services. We review three main themes – implementation of the Care Act 2014 provisions on the organisation and delivery (but not financing) of care, including support for carers; the release of ad hoc additional public funding for social care; and the progress of health and social care integration. In the last sub-sections we discuss some cross-

cutting themes and policies, including devolution, the impact of Brexit, and the interdependence of social care on other policy areas such as social security, physical security and housing.

4.1 Implementation of Care Act 2014 provisions on organisation and delivery of care

Aside from the ill-fated sections on the financing of adult social care, the Care Act 2014 introduced changes to the way in which assessments of need were carried out and gave the Secretary of State the power to define a national minimum standard for the level of needs that local authorities must meet, required local authorities to 'take steps' to prevent, reduce and delay the need for care, and extended the statutory entitlements of unpaid carers. Implementation of these provisions proceeded during all three Conservative administrations.

Prior assessment of the changes to national minimum eligibility criteria suggested that they would be roughly equivalent to the previous threshold of 'substantial needs' as defined by the *Fair Access to Care* criteria (critical / substantial / moderate / low). The majority of local authorities were already in practice using this threshold; a handful were expected to have to widen their provision; while a larger proportion (12%) who were providing for some clients with 'moderate needs' were given a green light to further restrict services (DoH, 2013). However early appraisal, based on interviews with care managers and statistical modelling soon after the new provisions came into force, estimated that there were small net increases in numbers of eligible older people, and of working age people with physical or sensory impairments, or mental health needs, and little change for working age people with learning disabilities (Fernandez et al., 2015). Newly eligible individuals were mainly those who had difficulties with household tasks such as housework and shopping, in addition to personal care such as bathing. However these averages concealed greater change within categories, with some of those previously classified as having 'substantial' needs now being deemed ineligible (including some younger adults with learning difficulties), whilst some of those previously classified as having 'moderate' needs became eligible (including some older people).

The main thrust of the changes to eligibility criteria were to provide a national minimum floor, and to change the nature of the assessment to focus on whether a person is unable to achieve two or more specified outcomes as a result of their physical or mental impairment or illness. Where the inability to achieve these outcomes without support is deemed likely to have a significant impact on their wellbeing, the person is eligible for support. The ten outcomes and nine aspects of well-being as defined in the act and associated regulations are shown in Table 2. Social work bodies and care organisations broadly welcomed these changes, seeing the ethos as better aligned with their professional aspirations to provide holistic and person-centred assessments, with a focus on promoting wellbeing, and opening up the opportunity for them to move away from the narrow care

and resource management role into which they had been increasingly squeezed by the previous regime (Whittington, 2016).

Table 2 National minimum eligibility criteria

1. Needs	2. Outcomes	3. Wellbeing
<p>The adult's needs arise from or are related to a physical or mental impairment or illness</p>	<p>As a result of the needs, the adult is unable to achieve two or more of the following:</p> <ul style="list-style-type: none"> • Managing and maintaining nutrition • Maintaining personal hygiene • Managing toilet needs • Being appropriately clothed • Being able to make use of the home safely • Maintaining a habitable home environment • Developing and maintaining family or other personal relationships • Accessing and engaging in work, training, education or volunteering • Making use of necessary facilities or services in the local community including public transport, and recreational facilities or services • Carrying out any caring responsibilities the adult has for a child 	<p>As a consequence, there is or is likely to be a significant impact on the adult's wellbeing, including the following:</p> <ul style="list-style-type: none"> • Personal dignity (including treatment of the individual with respect) • Physical and mental health and emotional wellbeing • Protection from abuse and neglect • Control by the individual over day-to-day life (including over care and support provided and the way it is provided) • Participation in work, education, training or recreation • Social and economic wellbeing • Domestic, family and personal relationships; suitability of living accommodation • The individual's contribution to society

Source: Department of Health (2014)

In practice, however, the Act came into force after several years of unprecedented cuts in local authority funding and during a period of continued austerity, whilst the level of need in the population continued to grow – as we explore in more detail in the following section. The potential, therefore, for social workers to engage in the holistic, person-centred assessments to which they aspire, to interpret the eligibility criteria in the spirit of the Act, and to commission packages of services that effectively meet the identified needs, was severely constrained. This contradiction led Whittington (2016) to observe, “the promise to promote people’s well-being looks like a false prospectus at the heart of the Care Act itself” (p.1958) – a challenge to which we return in the section on unmet need under ‘Outcomes’ below.

Evaluating the impact of the Act on delaying, preventing and reducing the need for care is challenging because there is no easy counterfactual, and because local

authorities have diverse understandings of, and approaches to pursuing, this aspect of the Act's provisions (Marczak et al., 2019). Prevention as a cost-saving strategy was a more dominant interpretation than prevention as a tool to promote well-being. Services being trialled (but not always effectively evaluated) included reablement, telecare, adaptations, falls prevention, befriending and timebanking. A study based on seven local authorities that have prioritised prevention found a range of activities underway including making greater use of social and community networks to support the person with needs (for example through peer support or Community Circles), and using personal budgets to support early intervention (Tew et al., 2019). However the same study reported a number of barriers to effective action, including the pressure to reduce costs, lack of staff and management time, and tension with other policy objectives such as minimising delayed transfers from hospital. Rapid discharges sometimes meant there was little opportunity to put support in place to reduce the need for on-going care, and this proved difficult to reverse engineer in some cases. More generally, lack of integration with public health and the health service on prevention and early intervention was seen as an impediment by social services managers (Marczak et al., 2019).

Evaluation of the effectiveness of Care Act 2014 provisions on support for carers is on-going (Fernandez et al., n.d.). In services for older carers, Lloyd et al identified ambiguity over whether services were provided for the carer or for the person with care needs, and this affected how the service was charged (Lloyd et al., 2019). For example, if an agency worker is tasked to sit with the person with care needs whilst the carer attends a healthcare appointment, for whom is this a service? The reality of course is that the needs of carers and cared-for are inter-dependent. The same study found that an increasing use of third sector organisations specialising in supporting carers to conduct assessments brought new expertise but widened the divide between local authority assessments of the person with needs and the assessment of the carer.

It is probably fair to say that policy developments subsequent to the Care Act to support carers have been stronger on words than action. The 2017 manifesto commitment to legislate for statutory carers leave has not been delivered, and the consultation launched (with unfortunate timing) in March 2020 was for the modest proposal of a right to 1 week of leave per year, unpaid. The Carers Action Plan 2018-2020 contained some useful initiatives on sharing best practice (for example in commissioning breaks for carers, and for employers in providing flexible working for carers) and the creation of Carer Passports (helping to identify and recognise unpaid carers in hospital, as patients and as carers) (Department of Health and Social Care, 2018). But there were few concrete commitments. For example, the Department for Work and Pensions were to "ensure that benefits for carers...meet the needs of carers and support employment for those carers who are able to work", but there was no promise to increase the rate of Carer's Allowance or to raise the earnings threshold. The one-year progress update on the Action Plan records this action as "ongoing", despite the fact that there were no changes or announced plans (Department of Health and Social Care, 2019). One exception was the creation of a Carers

Innovation Fund, initially £0.5m but later raised to £5m, to pilot and evaluate services beyond statutory provision that aim to connect carers, facilitate their (continuing) employment, and promote their own health and wellbeing.

4.2 Drip-feed of additional funding

Neither the March nor the July 2015 budgets contained any additional funding for adult social care. Indeed the July 2015 budget pulled the rug from under one potential source of additional funding for social care that had been proposed at the time of the 2014 Care Act reforms, to contribute to meeting the additional costs of the lifetime cap and more generous capital means-test, namely freezing Inheritance Tax (IHT) thresholds. Instead, the July 2015 budget implemented *relaxations* to IHT where a main residence was passed to a direct descendent.

The July 2015 budget also included the announcement of a 'National Living Wage' for people aged 25 and over, from April 2016, set at a rate significantly higher than, and rising faster than, its predecessor National Minimum Wage (NMW). The social care sector is heavily dependent on low-wage workers (see Inputs section below), so the increase was very welcome as a way of recognising the valuable work done by some of those at the bottom of the wage distribution. On the other hand, it was expected to have a major impact on social care costs, which without corresponding increases in the funding available to local authorities to commission services, would inevitably result in a further squeeze on their budgets. Indeed the Resolution Foundation estimated that 160,000 care workers were already (improperly) paid *below* the NMW in 2015, and ensuring all frontline care workers were paid at least the independently-calculated Living Wage (not to be confused with the government's National Living Wage) would have cost £1.4bn in public funding in 2013 (D'Arcy and Kelly, 2015). Modelling suggested that the wage increases in 2016 were absorbed by care homes not primarily through cutting jobs but by reducing quality, with homes most affected also most likely to have deteriorating CQC ratings, controlling for other differences (Giupponi and Machin, 2018).

The subsequent increases in the National Living Wage have continued to exert pressure on local authority social care budgets. The cost of the increase in 2019/20 alone was estimated to be £0.45bn, with a further 6.2% rise to be absorbed in 2020/21 (Bottery, 2020).

The Autumn Statement and Spending Review in November 2015, a few months after the National Living Wage announcement, heralded some welcome relief. Local authorities would be allowed to charge a 2% precept on Council Tax for adult social care, from 2016/17 (HM Treasury, 2015). This was subsequently extended to 3% in 2017/18 and in 2018/19, subject to a maximum of 6% in total for the three years taken together. According to (National Audit Office, 2018a), by 2018-19 nearly all (97%) local authorities had applied at least some of the precept available to them, with two-thirds applying the maximum in 2017-18 and half applying the maximum in 2018-19.

Table 3 shows the estimated potential revenue generated by the precept, which stood at £1.81bn in 2019-20, if local authorities had all applied the optimal revenue-raising profile across the years.

This has certainly helped to plug a gap for some authorities. However authorities with higher levels of local deprivation – and, correspondingly, fewer households paying full council tax – are, in general able to raise less through this means than authorities in wealthier areas (as shown in Figure 6 in Cromarty et al (2019)). The shift in the balance from centrally to locally raised revenue to support local spending is part of a broader trend, discussed in the section on Resources below. This has a dis-equalising effect across authorities, with important implications for their ability to meet local need – a subject to which we return in our discussion of unmet need for social care among older people in the Outcomes section below.

Moreover, the additional £1.8bn potentially available in aggregate in locally-raised funding for social care by 2019/20 has been more than offset by falls in the core spending power of local authorities as shown in the right-hand column of Table 3 which at the end of the period stood at £2.4bn lower than the start. A more positive story emerges from following the fortunes of the ring-fenced central government grants for social care, as shown in the middle three columns in Table 3. The additions have been ad hoc, frequently re-announced, renamed, and sometimes substituted for other funding streams, but nevertheless add up to a genuine increase in funding available for social care of something in the region of £2.5bn by 2019/20, with an additional £1bn announced in September 2019 for the following financial year.

Table 3 Policies on cash funding available to local authorities for adult social care, and for general purposes, England, 2015/16 to 2019/20

	Council Tax precept: estimated potential revenue	Improved Better Care Fund	Adult Social Care Support Grant / Social Care Support Grant	Other tied grants (Winter Pressures WP, Disabled Facilities Grant DFG)	General ⁱⁱⁱ
Apr 2015				£0.22bn DFG	£43.5bn
Nov 2015 (spending review)	announced <= 2%	announced £1.5bn by 2019/20		announced £0.5bn DFG by 2019/20	
Apr 2016	£0.38bn			£0.39bn DFG	£41.6bn
Dec 2016 (provisional LG settlement)			announced £0.24bn for 2017/18		
Feb 2017 (LG finance report)	announced <= 3% (max 6% in total 2017/18 to 2019/20)				
Mar 2017 (budget)		announced £2bn for 2017-18 to 2019-20			
Apr 2017	£1.04bn	£1.12bn	£0.24bn ⁱ	£0.47bn DFG	£40.5bn
Feb 2018 (LG finance statement)			announced £0.15bn in 2018/19		
Apr 2018	£1.74bn	£1.50bn	£0.15bn ⁱ	£0.24bn WP + £0.47bn DFG	£40.7bn
Oct 2018 (budget)			announced £0.41bn shared with children's services		
Apr 2019	£1.81bn ^{iv}	£1.81bn	£0.41bn ⁱⁱ	£0.24bn WP + £0.51bn DFG	£41.1bn
Sept 2019 (spending round)	announced 2%	announced will maintain same level	announced additional £1bn ⁱⁱ	announced WP will maintain same level but rolled into iBCF	

Sources: National Audit Office (2018a); MHCLG (2019); (Cromarty et al., 2019, p. 22); Wilson (2018)

Key: Yellow cells show announcements. Green cells show cash amounts.

Notes:

i: The Adult Social Care Support Grant was a reallocation of New Homes Bonus funding already destined for councils (Local Government Association, 2017).

ii: The Social Care Support Grant is shared between children's and adult's services.

iii: Settlement Funding Assessment, Compensation for under-indexing the business rates multiplier, and Council Tax (excluding social care precept); MHCLG (2019) Core Spending Power supporting information – detail.

iv: Assumes that 2% precept was implemented in 2016/17, 3% in each of the following two years, and 0% in 2019/20. House of Commons library modelling suggests this profile produces the maximum additional potential revenue, consistent with the maximum 6% rise allowable in the period 2017/18 to 2019/20 (Cromarty et al., 2019, p. 22).

The 2015 spending review announced the creation of £1.5bn in an Improved Better Care Fund (iBCF), which was re-announced and increased to £2bn in the Spring 2017 budget. However the fund did not start until 2017/18 and the £2bn figure referred to the total amount over three financial years. The 2015 spending review also announced a doubling of the Disabled Facilities Grant by 2019/20. Confusingly, these funding streams, together with the Winter Pressures grant (not to be confused with the NHS winter pressures funding), make up the local authority contribution to the Better Care Fund (BCF), which is the vehicle for pooled health and social care spending, and which is discussed further in the next section. Adding the iBCF to the BCF – easily done, since ministers separately announce and discuss both – is double-counting.

A new £0.24bn Adult Social Care Support Grant was announced as part of the local government finance settlement in December 2016, from 2017/18 onwards. This was widely welcomed; however it transpired that the first two years were a reallocation of funding already destined for councils in the form of the New Homes Bonus, rather than new money. The New Homes Bonus fell by £0.24bn in 2017-18, and a further £0.28bn in 2018-19 (Ministry of Housing, Communities and Local Government, 2019) Core Spending Power supporting information – detail). The October 2018 budget announced a larger Social Care Support Grant, at £0.41bn; however this was to be shared between adult's and children's services.

The September 2019 spending round rolled forward the council tax precept, the Improved Better Care Fund – now to incorporate the winter pressures grant – and added a further £1bn to the Social Care Support Grant. Nothing further was announced in the 11 March 2020 budget specifically for social care, other than a brief mention of support for local authorities through the £5bn COVID emergency response fund, which was also to cover 'pressures in the NHS' and other public services, and was not ring-fenced and with no priority given to supporting care homes. In hindsight, this seems a missed opportunity.

To sum up, policy on social care funding over the period can be seen as shifting the balance from centrally to locally-raised *general* revenue – with disadvantageous impacts on local authorities serving more deprived areas - combined with increasing hypothecation of central government grants. These ring-fenced grants have increased in real terms, particularly from 2017/18 onwards, and are now quite substantial. However the piecemeal way in which they have been announced and funded through various streams and diversions has limited the ability of social services departments to plan and obliged them to continue to operate 'hand to mouth'.

4.3 Health and social care integration

Health and social care integration has been described as a 'no-brainer': since many people have a combination of health and social care needs, and because the two sets of services are inter-dependent, it is difficult to argue against the idea that they should work together as seamlessly and as efficiently as possible.

However, achieving this in practice is considerably more demanding. Each service is itself complex and comprises many different commissioning and provider organisations (there are an estimated 18,300 independent social care providers in England, for example – see section 6.1 below). Funding streams are separate, and are defined at different levels of government: national for the NHS and local for social care. Eligibility for publicly funded services is on a universal basis for healthcare with national standards, and on a means-tested basis for social care with local variation in the packages of care triggered by a given needs assessment. In addition to these high-level challenges, one must add the nitty-gritty of information technology incompatibility, legal restrictions on data sharing, and divergent reporting and accountability requirements. All of this takes place against a background of different organisational cultures, working practices and pay structures, and in a context of constrained resources and increasing demand for both sectors.

The integration agenda predates the 2015 Conservative government, but has been pursued vigorously throughout the recent period. The renaming in 2018 of the Department of Health as the Department of Health and Social Care reflected this focus. Pre-existing initiatives included the Better Care Fund, the Integrated Care and Support Pioneers programme, New Care Model Vanguard, and Personal Budgeting. To this have been added Sustainability and Transformation Partnerships (STPs), devolved care (notably the Greater Manchester Health and Social Care Partnership), Integrated Care Systems, and Integration Accelerator Sites. By May 2020, NHS England claimed that around half of England's population was covered by an integrated care system (building on the 50 vanguard sites and the STPs) in which NHS organisations, local authorities and voluntary sector organisations "take collective responsibility for managing resources, delivering NHS standards and improving the health of the population they serve" (NHS, n.d. accessed 31/07/2020).

This is not the place to review these schemes in detail; both the National Audit Office and the Health Select Committee have held enquiries on progress on integrated care, and there is also a growing academic literature (Erens et al., 2019; Health and Social Care Committee, 2018; National Audit Office, 2017). But some key points can be drawn out. The first is that these initiatives have been backed by real increases in, and redirection of, funding. For example, the Better Care Fund, which is one of the main vehicles for pooled health and social care budgets, has grown from £1.1bn in its start-up phase in 2014/15, to £9.2bn in 2019/20. Whilst this is still a small fraction of the NHS budget, it is very significant in relation to the £15bn spending by local authorities on social care (excluding income from the NHS). Not all of this is new funding, and not all of it is spent on social care, but as we saw in the previous section, such new funding as has been made available for social care has in large part been channelled into the Better Care Fund, to support joint planning and budgeting with Clinical Commissioning Groups.

The second key point is that the energy and focus of many – but not all - of these initiatives has been on improving *health*, specifically, and on protecting

the NHS. This is reflected in the quote above from NHS England about the objectives of integrated care systems. It is also reflected in several of the metrics used for the Better Care Fund: reducing delayed transfers of care from hospitals, reducing non-elective admissions, and reducing re-admissions. (Other indicators include admissions to care homes per 1000 population and the effectiveness of reablement). Thus while the rhetoric of some initiatives is about person-centred care, in practice this has taken a back seat behind the imperative to reduce pressure on the NHS (Erens et al., 2019; National Audit Office, 2017). This has important implications for the impact on 'end users' – that is to say, patients and care recipients – and, as we reflect on in section 9.1 below, on how 'integration' operates in a crisis.

The third and final point, made in every review of progress on health and social care integration to date, is that bringing about institutional and structural change in a context of increasing demands on both sectors and historically low spending growth (see below for social care and Vizard et al. (2020) for health) is extremely difficult. To what extent the results are apparent in health and social care outcomes is summarised in section 8.3 below.

4.4 Interaction with other policy areas

4.4.1 Brexit

Brexit was an absorbing policy preoccupation for the Conservatives (and the whole of parliament) from the launch of the referendum campaign onwards. At times, it appeared that this was to the exclusion of all else. The potential consequences of the UK's departure from the EU for social care was a recurrent theme, in particular in relation to the impact on the supply of care workers of restricted immigration and any limits on the rights (to work and to access healthcare or other benefits) of EEA citizens currently resident in the UK. This is discussed in section 6.2.1 below, under 'Inputs'. Some of the other issues of concern in relation to healthcare, such as the continued recognition of European qualifications, the supply of medicines, goods and services, and access to research funding and collaboration, are also relevant to social care, although not as centrally. In terms of potential benefits of Brexit, greater flexibility over maximum working times (even though the UK already allowed opt outs from the European Working Time Directive) was cited by some submissions to the health committee inquiry (House of Commons Health Select Committee, 2017). Reduction of the pressure on the demand for social care services from fewer EEA migrants being in, or coming to, the UK was not anticipated to be significant, since need for social care is associated with older age and most EEA migrants are young (Migration Advisory Committee, 2018).

4.4.2 Devolved administrations

Social care policy is a devolved matter and as noted in the introduction, this paper concentrates on England. In England social care is determined, implemented and to a considerable extent funded by local authorities. This produces substantial variation between areas. But there are also some salient

policy differences in relation to charging for social care between England and the other nations of the UK. In England, social care is provided only on a means-tested basis, regardless of age or type of service. In Wales, social care is also means-tested, but there is a maximum weekly charge for non-residential services, currently £100 per week. In Northern Ireland, people aged 75 or over are not charged for social care in their own home. Health and Social Care Trusts have discretion over charging for younger people, and charges are usually applied only for home help and meals. Residential care is means-tested, as in England. Meanwhile, personal care at home in Scotland has been free at the point of use for people aged 65 or over since 2002, and in 2018/19 this was extended to people of all ages. Domestic costs at home (for example, meals) and accommodation costs in residential care are means-tested. A comparison of the English, Scottish and Welsh systems for someone with savings above the means-tested threshold concluded that the Scottish system was the most advantageous of the three for personal care at home and for people needing a short residential stay, and the Welsh was the most advantageous for domestic care; whilst the reforms proposed but not implemented in the English Care Act 2014 would have created a system more advantageous than the Scottish or Welsh systems for people needing an extended period of residential care (Adams, 2016).

Health and social care integration has been pursued in all the countries of the UK. Northern Ireland has had structurally integrated health and social care since 1973, although an academic review in 2013 concluded that it had not entirely fulfilled its potential: "Advantages include a single employing body, a single budget, and agreed strategies and plans on, for example, dementia care and mental health. Disadvantages include the continuing dominance of health care over social care, cultural differences between these areas, separate training systems, and GPs not being fully engaged in a whole system approach" (Heenan, 2013, p. 21). Heenan also noted a lack of data on which to compare outcomes internationally or across countries within the UK.

The structure of health and social care in Wales is broadly similar to that in England. A recent parliamentary review did not suggest structural changes but recommended that the Welsh government make a number of changes, with an emphasis on participation and accountability: "strengthening the power of citizens and users to make change; improving the local leadership and governance needed to implement change; [...] and at a national level designing the system to expedite and incentivise progress through increased transparency." (p6) (Parliamentary Review, 2018).

In Scotland, successive governments have advocated integration both within healthcare, and between health and social care. Commissioners and providers of healthcare have been under joint health boards since 2004. The Public Bodies (Joint Working) (Scotland) Act 2014 further required local authorities and healthcare boards to set up integration authorities, and these have been responsible for an increasing share of total spending. A ministerial strategic review in 2018/19 following a report by Audit Scotland in 2018 concluded that

good progress had been made but the pace, effectiveness and consistency of integration needed to improve (Community Health and Social Care Directorate, 2019). Proposals ranged from promoting cross-sectoral leadership and ensuring that budgets are agreed earlier in the financial year, through improved accountability and engagement of members of the general public, to changing inspection arrangements so that they better reflect the integration agenda.

As well as country-devolution, the period 2015-2020 also saw developments in city-region devolution. The Greater Manchester Health and Social Care Devolution Memorandum of Understanding, published by the Coalition government in February 2015, paved the way for a partnership board which would develop a strategy for integrated health and social care in the city-region and oversee a combined budget – about £6 billion by 2018/19. This is discussed in more detail in the SPDO paper on city devolution (Lupton et al., 2018).

London also has some devolved health and social care powers since December 2015, currently used to support a number of pilot programmes; the Surrey Heartlands area has an agreement between NHS England, three Clinical Commissioning Groups, and the county council and some limited devolved powers from April 2018; and a number of other regional devolution deals have been agreed without a specific focus on health and social care (Parkin, 2019). In these cases it is too early to say how effective devolved health and social care integration can be, but there is a clear direction of travel during this period.

4.4.3 Other policies

There are a range of further themes in social care outcomes which we do not have space to address but which are relevant to other papers in the SPDO series. Previous research has drawn a link between constraints in social care spending in the period of austerity and the slowdown in life expectancy gains since 2010. For example, some analysis has found that constraints in social care spending were associated with higher than expected deaths (compared to pre-2010 trends), particularly in relation to care home and home deaths, well before the pandemic struck (Watkins et al., 2017). The Health paper in the SPDO series examines recent mortality trends and their underlying causes in depth (Vizard et al., 2020).

The social care experience of prisoners relates to a number of themes that cut across the SPDO series, including physical security, suicide and mental illness, and health (Cooper and Lacey, 2019; Vizard et al., 2020; Vizard and Treebhohun, forthcoming). In a recent inspection of social care in prisons, growing demand for social care in prisons was identified as being driven by an increase in the number of older prisoners (HM Inspectorate of Prisons and CQC, 2018). The inspection also expressed concern in relation to the prevalence of dementia, mental illness and learning disabilities, the under-identification of social care needs, and the fragmentation of social care delivery across different prisons. In response to these concerns, the Inspectorate recommended a national plan for social care in prisons. The Scottish Government is considering options for integrating health and social care in prisons in response to similar

concerns (see Levy et al (2018) and Scottish Government (2019)). On the theme of prisons and mental illness, it is possible that constraints in social care spending for people with mental illness may be associated with an increase in the population of prisoners with mental illness, though this is difficult to prove with existing data limitations (see Chow and Priebe (2016)).

There is a two-way relationship between social care and housing policies, including homelessness (Cornes et al., 2018). Supported and sheltered housing is important for some groups; some social care needs can be met through suitably adapted housing, of which there is a chronic and acute shortage (Equality and Human Rights Commission, 2018), or housing with sufficient space to accommodate a live-in carer. Conversely, tenancies may be at risk if suitable social care support for people with mental health needs and/or drug and alcohol dependency are not addressed (see Fitzpatrick and Bramley (2020)). This has been recognised by many local authorities, with attempts to include housing and homelessness services in efforts to achieve greater integration of health and social care (for example ihub (2017)).

Labour market policy has important consequences for social care, through at least three mechanisms: the pay and conditions of the care workforce (including statutory minimum wages), flexibility in employment for workers with unpaid caring responsibilities, and the availability and quality of employment for disabled people of working age. Some of these issues are discussed in McKnight and Cooper (2020).

Finally, there is an interaction between support for disabled people (both older people and those of working age) and for unpaid carers through the social security system (especially Carers Allowance) and through social care. Indeed the distinction between benefits paid in recognition of the additional costs faced by disabled people (Personal Independence Payments, Attendance Allowance) and Direct Payments paid to a disabled person or carer following an assessment by social services in order for them to arrange and purchase goods and services to meet their needs, can seem arbitrary, although the basis on which eligibility is determined and the accountability for spending are quite different. The joint incidence of disability benefits and receipt of social care among older people is modelled in (Hancock et al., 2019), and broader issues of social security policy under the Conservative government are discussed in the SPDO social security paper (Cooper and Hills, 2020).

5 Resources

Funding of social care and support for adults comes from a combination of public sources, from individuals with care needs themselves, and from their family and friends. Provision of social care by local authorities is perhaps the most likely to come to mind. Local authorities commonly arrange and/or pay for care services, or provide financial assistance, such as direct payments or individual budgets

for users. Care arranged by local authorities is mainly funded through grants from central government (general and ring-fenced) and local taxation, but is also partly funded through charges paid by some of the users, and funding provided via joint arrangements with the NHS.

The total funding of local authority provided or commissioned services in 2018/19 amounted to around £22bn (NHS Digital, 2019a), inclusive of client charges, incomes from NHS and joint arrangements and core funding of councils.

In contrast, a resource on which social care is heavily reliant but which is less 'visible' in monetary terms comes from family, friends and neighbours: so called 'informal care'. The estimated value of informal care¹ by the NAO came to a staggering £100 billion in 2016-17 (National Audit Office, 2018a), while the estimated value of the economic contribution made by carers in the UK estimated by Carers UK stood at £132 billion per year in 2015 (Buckner and Yeandle, 2015). Carers UK previous estimate for 2001, was £68 billion (Buckner and Yeandle, 2015), suggesting it had almost doubled in 14 years.

Another source of social care funding is money spent by the individuals with social care needs themselves or their families on privately provided care and support. The estimated value of such spending in 2016/17 was £11 billion (National Audit Office, 2018a) – equating to around half the amount of publicly provided or arranged care for the same year. Pre-paid long-term care insurance was always a very small market in the UK and is no longer sold; a small volume of annuities are sold at the point of care. In total there were 24,000 policies in force in the UK in 2018 (Association of British Insurers, 2019).

Additionally, other adult social care related public spending, which is perhaps less commonly thought of as social care support, comes from the government's spending on social security benefits (Incapacity and Disability benefits) which increased in real terms from £35 billion in 2009-10 to £42 billion in 2019-20 (Cooper and Hills, 2020).

This paper is predominantly concerned with the reporting of social policies and outcomes in adult social care and so the resources section focuses on the expenditure trends mainly by local authorities (as well as other public expenditure directly on adult social care), followed by the evidence on private spending by individuals and their families. While we are not estimating the replacement cost of family and friends providing social care support, we highlight the importance they have in provision of care in the following sections on Outputs and Outcomes. Public spending on social security benefits, including disability-related benefits, is covered in a companion paper in this series (Cooper and Hills 2020), and is not considered in detail here.

¹ The estimates for the value of informal care include care not only for adults and older people but also children with social care needs. They do not include ordinary childcare.

5.1 Public spending on adult social care

To fully understand how spending on adult social care by local authorities has changed since 2015, which we discuss in Section 5.1.2 below, we first examine the changes to the various strands of local authority revenue.

5.1.1 Local authority revenue

Local authority sources of income for adult social care spending can usefully be divided into funding that is not ring-fenced (central grants, tax and business rates), and ring-fenced funding (Improved Better Care Fund, the uplift on Council Tax known as the social care precept, the social care support grant, and the winter pressures grant). Below we discuss each of the streams and assess how funding changed over time.

Non-ring-fenced funding

The majority of local authority income for adult social care spending is not ring-fenced, and is comprised of central grants, tax, and business rates. Each council decides how to spend these allocated income sources based on the various demands on their budget, including adult social care.

The Institute for Government shows that between 2009/10 and 2018/19 total Local Government revenue fell by 18% (to £50bn), which was largely due to the cuts in government grants, partially offset by rising revenue from council tax and retained business rates² from 2015/16³ (Atkins, 2020). This resulted in a substantial shift from central grant funding to locally-raised revenue: the share of total revenue from council tax had increased from just over one third of the total revenue amount in 2009/10 to 50% by 2018/19⁴. Since 2015/16, there was a 9% fall in the total central government funding and retained business rates amounts, and a 13% increase in real terms funding from council tax with a net effect being on the overall revenue being an almost flat real term profile of funding over the period (authors' calculations using underlined figures from Atkins (2020) via personal communication with the author).

The overall flat profile of Local Government revenue since 2015/16 translated into real terms cuts per head, as estimated by the IFS. Central grant funding per head of population fell by 41% between 2015/16 and 2018/19 with a further decline in 2019/20, resulting in the per head amount of revenue from central

² Until 2013, Business Rates were pulled on a national level and allocated by Central Government within the general grant funding. The Business Rates Retention Scheme was introduced in 2013 and its goal was to incentivise councils to grow local businesses, which in return would provide them with funding amounting to the real term growth in local business rates revenues. Thus councils were allowed to retain 50% of their revenues from Business Rates. Some of these amounts were then re-distributed to other councils with greater need and less ability to raise revenue (Harris et al., 2019).

³ These figures exclude revenue grants to education police and public health, and include some NHS Social Care Transfers.

⁴ Authors' calculations using underlined figures from Atkins (2020) via personal communication with the author in May 2020.

grants falling by almost a half between 2015/16 and 2019/20, from £328 per head to £171 per head in 2019-20 prices⁵ (Table 2.3 in Harris et al. (2019)). This was offset by the introduction of retained business rates and increases in Council Tax but the net result was a fall in the total revenue from all sources from £969 per head to £935 per head over the same period (3.5%) (Harris et al., 2019).

The cuts in revenue funding since 2015-16 are reflected in cuts to Local Government spending as well as per person spending, with more deprived councils, which are heavily dependent on grant funding, seeing higher cuts to both revenue and spending since 2009-10, although the relationship between deprivation and reductions in revenue is not apparent after 2015-16 (Harris et al., 2019, p. 26). This is because in the period between 2009 to 2015 central grant funding was cut relatively more compared to the four year period which followed (55% vs 48%, respectively⁶), inevitably cutting funding more for deprived areas which were more heavily reliant on them. While the general grants continued to be cut post 2015, their lower absolute amounts together with the changes in the way grants are allocated with factored in councils' grant-dependence, meant a smaller impact of cuts on more deprived areas. The introduction of the Retained Business rates scheme (which began in 2013-14) meant not only that councils were allowed to retain 50% of their business rates revenues but also that there was a redistribution of some of those revenues from councils that were able to raise them but needed them less, to councils that were less able to raise these but needed them more (Harris et al., 2019). Figures for 2019/20 by IFS show that while more deprived councils are in a worse position to raise revenue (such as from council tax), they are more reliant on grant funding (27% of revenue of the most deprived councils in 2019/20 came from grants compared to 17% for the least deprived) and are much more reliant on retained business rates which comprise 45% of most deprived councils' revenue compared to only 16% of the least deprived in 2019/20 (Harris et al., 2019). However, as Harris and colleagues point out, the earlier pattern of regressive redistribution has not been reversed, with per person funding as well as spending for the most deprived councils relative to least deprived falling overall between 2009/10 and 2019/20 (Harris et al., 2019, p. 27).

Ring-fenced funding

As outlined in the Policies section above, there is a bewildering array of specific revenue streams for local authority adult social care spending, some of which

⁵ In order to make the figures more comparable overtime, the IFS excludes money budgeted for education (as Academies funding does not go through Local Government making comparison of both LAs and trends overtime not comparable), but also national park services, police services, and fire and rescue services. The estimate thus focuses only on revenue and spending over which local government has control, covering just over 50% total Local Government Revenue in 2019/20. Additionally, the authors also exclude spending on, and revenues specifically for, public health and make adjustments to social care spending as the amount of money received from the NHS had increased (Harris et al., 2019).

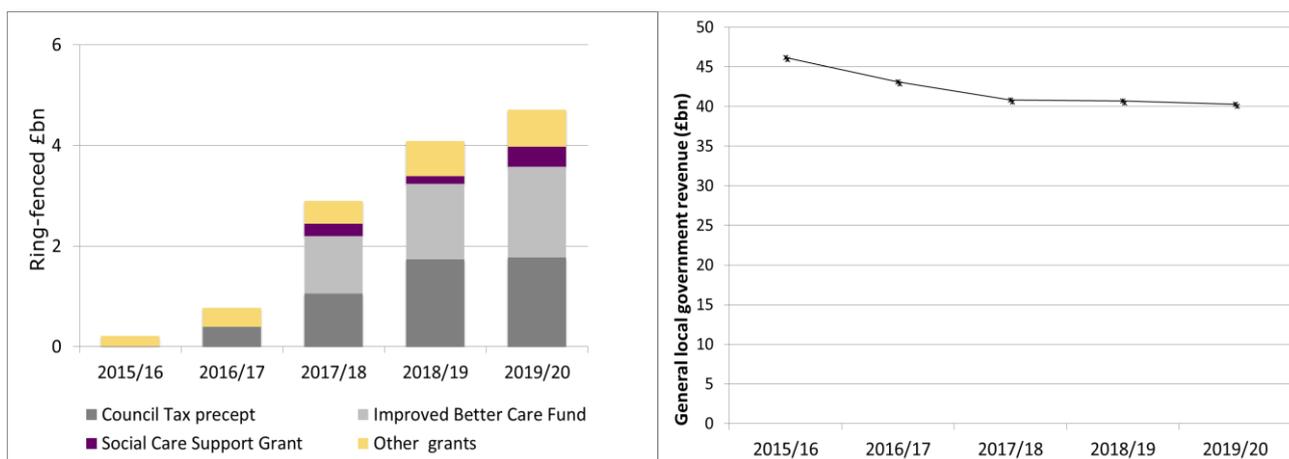
⁶ Authors' calculations based on the figures in Table 2.3 in Harris et al (2019).

are pooled with the NHS. The Better Care Fund is contributed to by the NHS budget (through the Clinical Commissioning Groups minimum contribution and voluntary contributions) and also through three specific streams in local authority budgets: the Disabled Facilities Grant (DFG), the adult social care Winter Pressures grant (distinct from NHS Winter Pressures payments for healthcare), and – confusingly – the Improved Better Care Fund, which pays for adaptations to assist with independent living and, increasingly, to facilitate discharge from hospital.

While general funding stream remains the dominant source of LA spending on social care, there has been a significant shift during the period since 2015 towards ring-fenced revenue.

Figure 3 shows that whilst there was £4.5bn of additional ring-fenced funding for adult social care in 2019-20 compared to 2015/16, general revenues (for all purposes, not just social care⁷) have fallen by £5.8bn⁸ (12.7%) over this period.

Figure 3 Ring-fenced grants for social care (left panel) and general local government revenue funding (right panel), 2015/16 to 2019/20 (2018/19 prices)



Source: Authors’ calculations using nominal figures from MHCLG (2019), NAO (2018a), Cromarty et al (2019) and GDP deflators from October 2019 (HM Treasury, 2019)

Notes: 1) We detail the elements and the time-line of ring-fenced funding between 2015/16 and 2019/20 in Table 3 of the policies section above. 2) The General local government revenue funding represents core funding available to local authority services, including Council Tax and locally retained business rates (Core Spending Power of Local Government), excluding social care precept.

Thus we see that the on-going cuts in general local authority revenues have been offset to some extent by a drip-feed of increases in revenue streams specific to adult social care. In the next section, we examine how these shifts have translated into changes in local authority spending on adult social care –

⁷ Including retained business rates and council tax, excluding social care precept

⁸ Authors’ calculations using amounts from the MHCLG (2019), adjusted using the GDP

taking into account the effect of inflation and local budgeting decisions – as well as setting these changes into longer-run historical perspective.

5.1.2 Local authority spending

A decade of cuts to local government revenue funding has had a varying impact on spending in different areas. Councils have, in general, protected spending on adult social care (and children’s services) relative to other service areas, despite the substantial falls in revenue funding described above. Spending per person on adult social care by councils fell by 7% between 2009/10 and 2019/20, a much lower relative amount compared to some other areas of local government spending such as housing, planning and culture where the reduction in spending was over 50% during this period (Harris et al., 2019). Moreover, nearly all councils protected adults’ and children’s social care services from cuts over this period, with the median council reducing their spending on adult social per person by less than 14 percentage points compared to reductions in their overall spending⁹ (Harris et al., 2019). One implication is that adult social care makes up an increasing share of total local authority spending, and now accounts for more than one-third of it (Directors of Adult Social Services, 2019).

The breakdown of the two periods, 2009/10 to 2015/16 and 2015/16 to 2019/20, shows contrasting trends in both absolute changes in adult social care spending per person and relative to changes in spending in other areas. After a fall in the per person spending on adult social care in the first period (along with all other areas of local government spending discussed above), in contrast to most other areas, spending on adult social care increased by 4% in the second period (Harris et al., 2019). Despite the absolute decline in spending on adult social care between 2009/10 and 2015/16, spending on it was relatively more protected, or prioritised over other spending (Harris et al., 2019).

The drip-feed of increases in revenue streams for adult social care, combined with local authority attempts to protect adult social care from the impact of on-going cuts in general revenues, have resulted in cash term increases in local authority expenditure on adult social care since 2015-16. The increases in real terms were less dramatic, as we shall see below, and did not reverse the major cuts in spending seen between 2009-10 and 2015-16.

There are many possible ways to define adult social care spending by local authorities because of the multitude of revenue streams that contribute to it.

Gross current expenditure by local authorities – a fiscal metric denoting local government spending - is defined as total local authority current expenditure, minus income from the NHS, joint arrangements and other (public) sources, and minus capital charges, but includes income from user charges. It is useful because it measures local authority spending on social care from its own

⁹ The authors estimate the percentage point difference in the cuts each council made to adult social care relative to the cuts it made overall. The councils are then ranked from the smallest difference (could be negative if a council made bigger cuts to adult social care than to overall budget) to largest difference and the middle council is the median council.

revenues, because it is available on a consistent basis over a long time series, and because breakdowns of gross current expenditure by client group and type of service are available. The Adult Social Care Finance Return (ASC-FR) collection contains social care activity and finance from the 152 Local Authorities with Adult Social Services Responsibilities (CASSRs) in England and shows that, using the gross current expenditure definition, local authorities spent £18.7bn in 2018/19 (see Box 1 for a worked example of what constitutes gross current expenditure).

The long-term trend in gross current expenditure since its peak in 2009-10 shows its *continuous* decline between 2009/10 and 2015/16, and an incremental annual increase after (Figure 4, a). While gross current expenditure increased by 2.8% in real terms over the period of Conservatives in government (2014/15 to 2018/19), when set against a 7% fall in spending in the previous, Coalition, period (2009-10 and 2014-15), it is clearly not sufficient to reverse the cuts. In fact, by 2018/19, gross current expenditure by local authorities had returned only to the level of 2013/14 (Figure 4, b and Figure 4, c). Even if one takes the overall fiscal envelope as fixed, for the sake of argument, this U-shape of substantial cuts followed by significant increases looks inefficient: it would have been better to cut less severely in the first place.

Box 1 Definitions and calculations of total, gross and net current expenditure by local authorities (LAs) and other public bodies on adult social care, using 2018-19 England figures for illustration

Total expenditure (by LAs) = £22.2bn.

This is the amount spent by LAs on adult social care, however financed.

Gross current expenditure (by LAs) = Total expenditure *minus* capital charges and *minus* all *income* (income from joint arrangements, income from NHS and any other income) **except income from client contributions (22.2 – 0.2 – 0.1 – 2.7 – 0.5 = **£18.7bn**).**

This is the amount spent by LAs on current adult social care, financed from their own revenue such as central government grants, local taxation and client contributions.

Net current expenditure (by LAs) = Gross current expenditure *minus* income from client contributions (18.7 – 2.9 = **£15.8bn).**

This is the amount spent by LAs on current adult social care financed from their own revenue that is not recouped through client contributions.

Total current public expenditure (all) = Net current expenditure (by LAs) plus all income except client contributions plus direct spending by NHS (15.8 + (0.1 + 2.7 + 0.5) + 0 = **£19.1bn).**

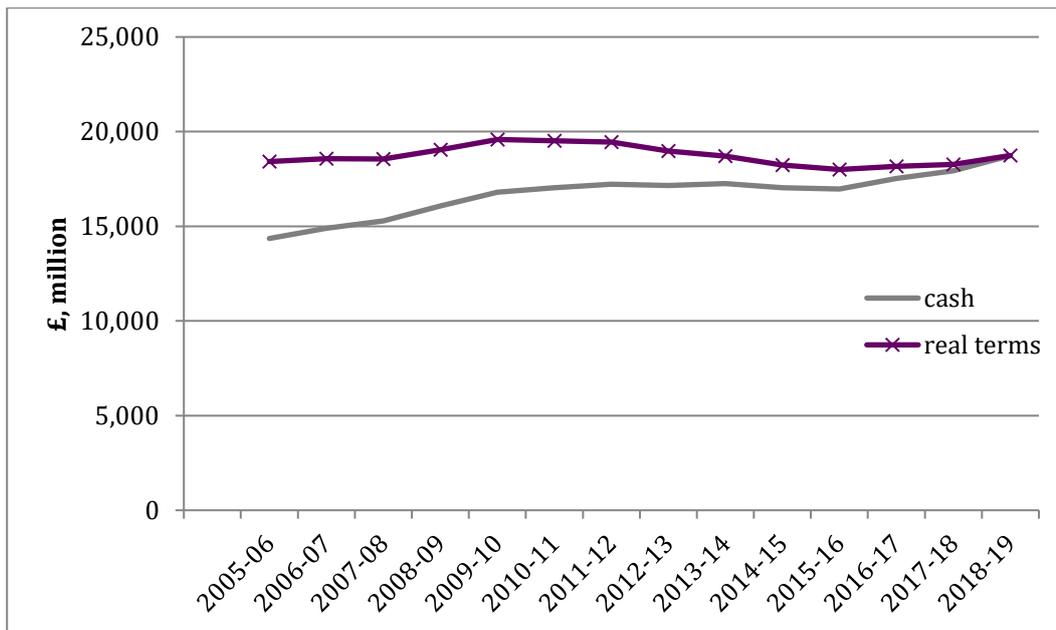
This is the most inclusive definition of publicly funded current spending on adult social care. It comprises the amount of current spending by local authorities and the NHS on adult social care, however financed (and without double-counting), excluding client contributions.

Sources: All the figures in the Box (with the exception of direct spending by the NHS) are from NHS Digital's main report; the figure for client contributions is from Table 6 in Reference Data Tables (NHS Digital, 2019a). Direct spending by the NHS, not counted as income by local authorities, is estimated by the authors to be zero in 2018/19, based on Better Care Fund (BCF)

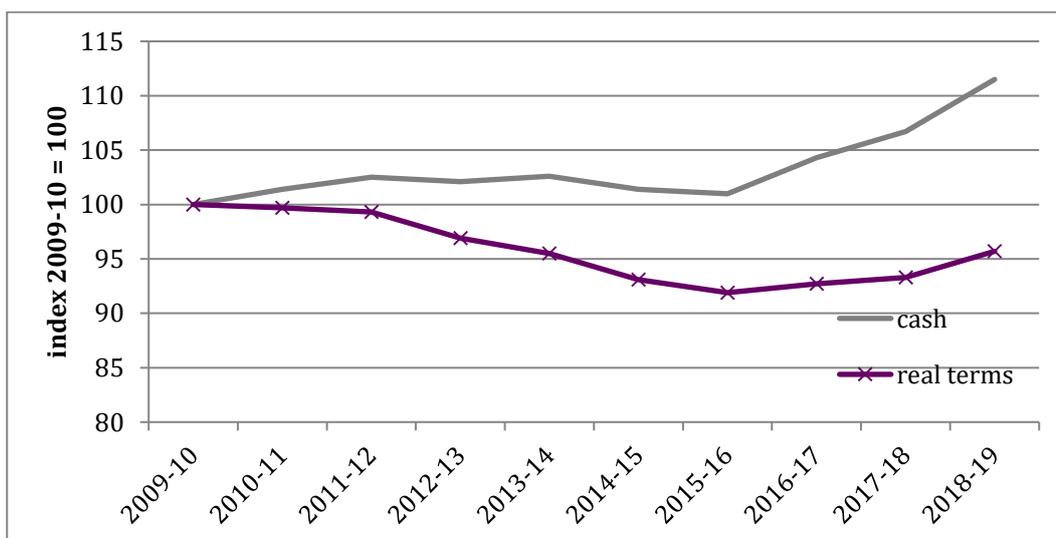
accounts and ASCFR and SALT reference tables sheet T7 for local authority income from BCF (NHS Digital, 2019a; NHS England, 2018).

Figure 4 Gross current expenditure by councils with Adult Social Care Responsibilities (CASSRs), 2005-06 to 2018-19, England, £million (2018/19 prices) and index numbers, 2009-10=100

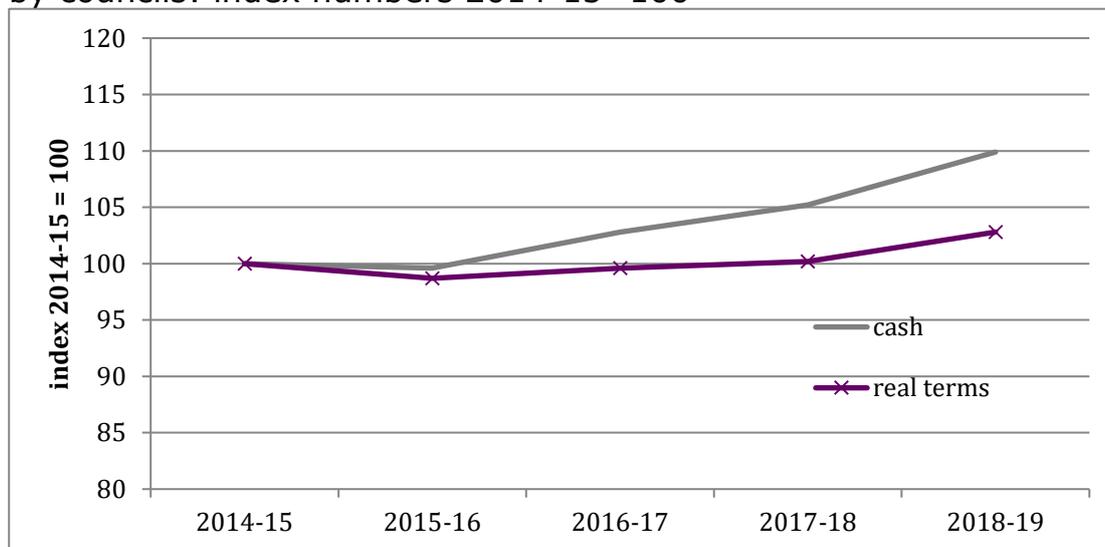
a) Nominal (cash) and real terms gross current expenditure by councils, £ million (2018/19 prices)



b) Nominal (cash) and real terms (2018/19 prices) gross current expenditure by councils: index numbers 2009-10=100



c) Nominal (cash) and real terms (2018/19 prices) gross current expenditure by councils: index numbers 2014-15=100

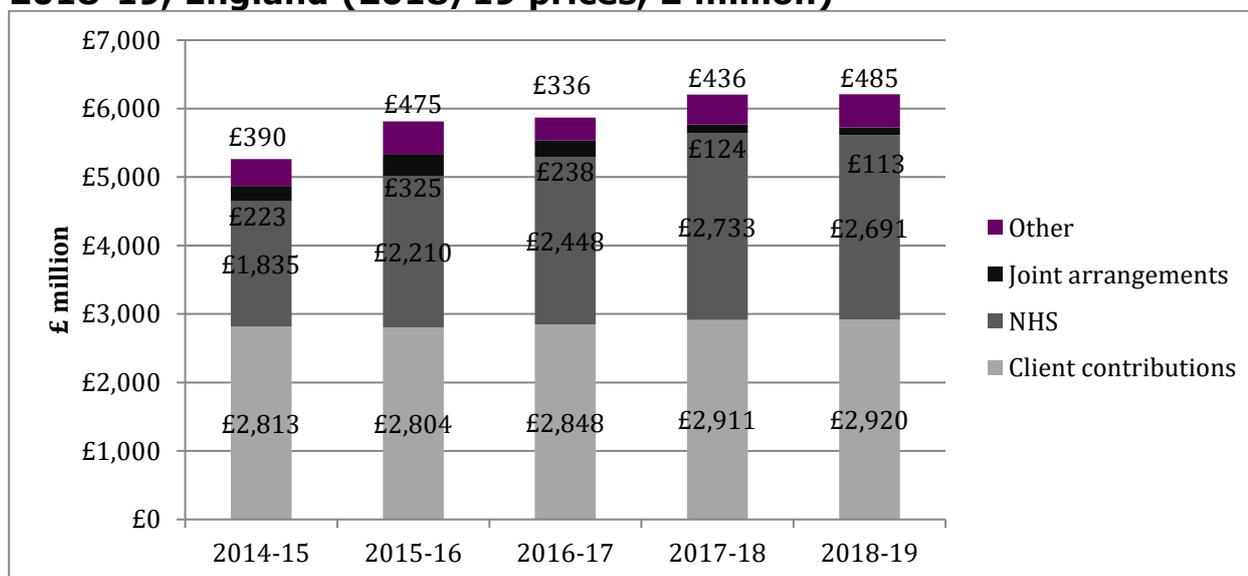


Source: Authors' calculations using NHS Digital expenditure figures within Reference Data Tables (NHS Digital, 2019a) and GDP deflators from October 2019 (HM Treasury, 2019)

In the period between 2014-15 and 2018-19, income from client contributions increased relatively less than that from other sources, such as the NHS (Figure 5), but their increase was greater than for gross current spending overall (3.8% vs 2.8%), indicating an increased burden on users. Given that the number of clients has declined (see section on inputs and outputs below), and the income from them grew faster than inflation, this suggests that the costs to users for adult social care have increased (Bottery et al., 2019).

Other income increased by 34% over the period 2014-15 to 2018-19, within it, income from the NHS, covering some of the funding for the Better Care Fund but also the costs of services which are the responsibility of the NHS rather than adult social care, increasing by 47% (authors' calculations using amounts in Figure 5).

Figure 5 Income sources of CASSRs by finance description, 2014-15 to 2018-19, England (2018/19 prices, £ million)



Source: 2014-15 figures from NHS Digital (2015); Figures for 2015-16 and 2016-17 are from NHS Digital (2017a), Reference data tables, table 4. Figures for 2017-18 and 2018-19 from NHS Digital (2019a), Reference data tables, Table 6 and GDP deflators from October 2019 (HM Treasury, 2019)

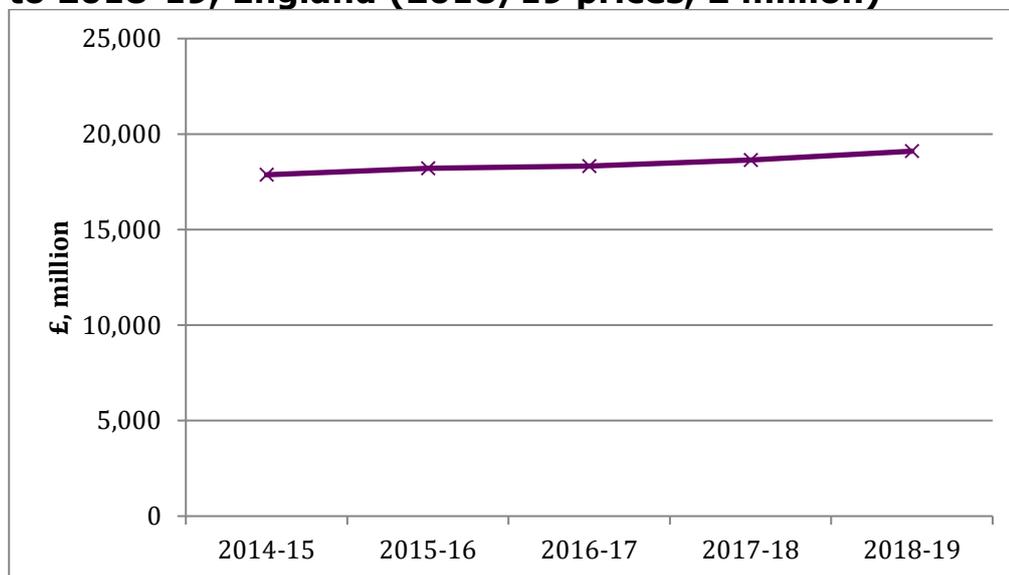
5.1.3 Total current public expenditure on adult social care

To arrive at the most comprehensive indication of *public* current spending on adult social care, client contributions should be excluded, since they are clearly spending by individuals, but spending by the NHS on social care should be included. Here we confront the fact that the boundary between healthcare and social care is blurred, and that what is defined as the responsibility of the NHS and what is defined as the responsibility of local authorities is not constant over time. This means that only a short time series is available on a reasonably consistent basis. The NHS pays for meeting some continuing healthcare needs of people in their own homes and for nursing care, including in nursing homes. This is treated as health rather than social care expenditure. However, sometimes care that meets identified health needs is arranged by local authorities, in which case the NHS may transfer the necessary funds to local authorities, and this shows up in local authority social care accounts as income. Furthermore, the NHS and local authorities increasingly make joint arrangements, as discussed above, through the Better Care Fund (pooled NHS and local authority funds) and other local agreements, and these too show up as income in the local authority social care accounts, but are not included in the gross expenditure figures shown in Figure 4.

In principle, NHS contributions to the Better Care Fund could be spent on social care over and above the amount recorded by local authorities as income but our calculations suggest that this was not the case for the years in which relevant data are available (2016/17 to 2018/19). We therefore treat NHS direct spending on *social* care as zero, but include all local authority spending financed by income

from NHS (including via the Better Care Fund), joint arrangements and other (non-client) income as part of total current public expenditure. Based on this definition, our estimate of total public current expenditure stood at £19.1bn in 2018-19¹⁰. This is an increase of 6.9% since 2014/15 in real terms (see Figure 6), more than twice the 2.8% increase in gross current expenditure by local authorities alone reported above. This reflects the growing emphasis on health and social care integration, but also reminds us that some of the much-heralded increase in spending on the NHS has in fact been diverted to social care. Between 2014/15 and 2018/19, the NHS budget increased by about £17bn in nominal terms (Vizard et al., 2020), of which nearly one-quarter was an increase in its contribution to pooled health and social care funding.

Figure 6 Total public current expenditure on Adult Social Care, 2014-15 to 2018-19, England (2018/19 prices, £ million)



Source: Authors' calculations using NHS Digital expenditure figures within Reference Data Tables (NHS Digital, 2019a), Better Care Fund accounts (NHS England, 2018), and GDP deflators from October 2019 (HM Treasury, 2019).

5.1.4 Expenditure on adult social care and population pressure

Trends in social care spending need to be understood in the context of the changing population it serves. For the longer time series and for breakdowns by sub-group on a consistent basis, we have to use the gross current expenditure by local authorities definition (i.e. spending by local authorities from their own revenues) but for the period since 2014/15 we can in addition examine total public spending (i.e. including income from the NHS, and excluding user charges).

Gross current expenditure fell sharply in the period between 2009-10 to 2015-16, while the ageing population grew (Figure 7, a). The period since 2015-16

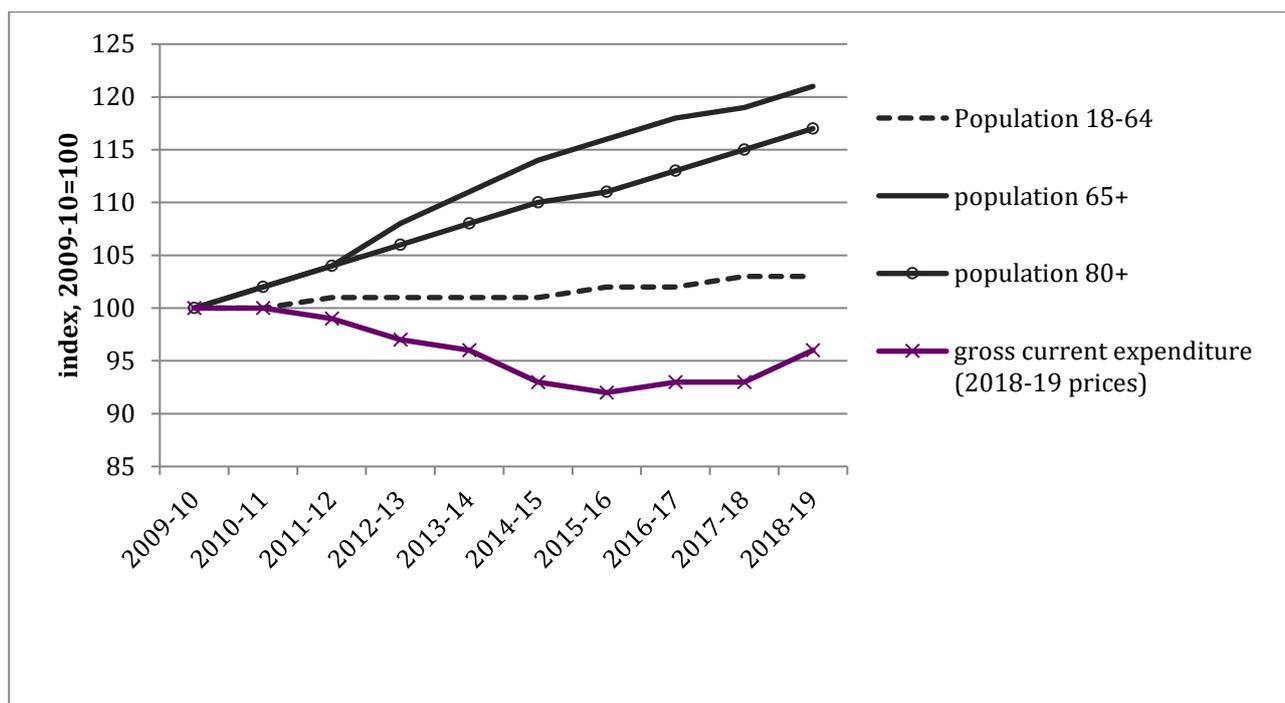
¹⁰ Authors' calculations using NHS Digital expenditure figures within Reference Data Tables (NHS Digital, 2019a) and Better Care Fund accounts (NHS England, 2018).

saw only a small incremental increase in spending, just about keeping up with the growing population (Figure 7, b). Since 2015-16¹¹ expenditure grew by 4.1%, while the number of 65 and over and 80 and over in the population grew by 4.7% and 5.7%, respectively. Split by age, expenditure on 18-64 year olds grew by 6.2% and on those aged 65 and over by 4.7%.

However the overall effect of the sharp falls in expenditure in the first part of the period, with only a relatively small increase in the second, meant that over the entire period between 2009-10 and 2018-19 adult social care gross current expenditure fell by 4%. Meanwhile, the number of people over 65 and over 80 grew during this time by 21% and 17%, respectively, while the number of adults aged between 18 and 64 grew by 3%. The growth in the older population over the entire period is striking, given a steep decline in real spending on those aged 65 and over in the period between 2009-10 and 2013-14 (see also Figure 1 in Burchardt, Obolenskaya and Vizard (2015)).

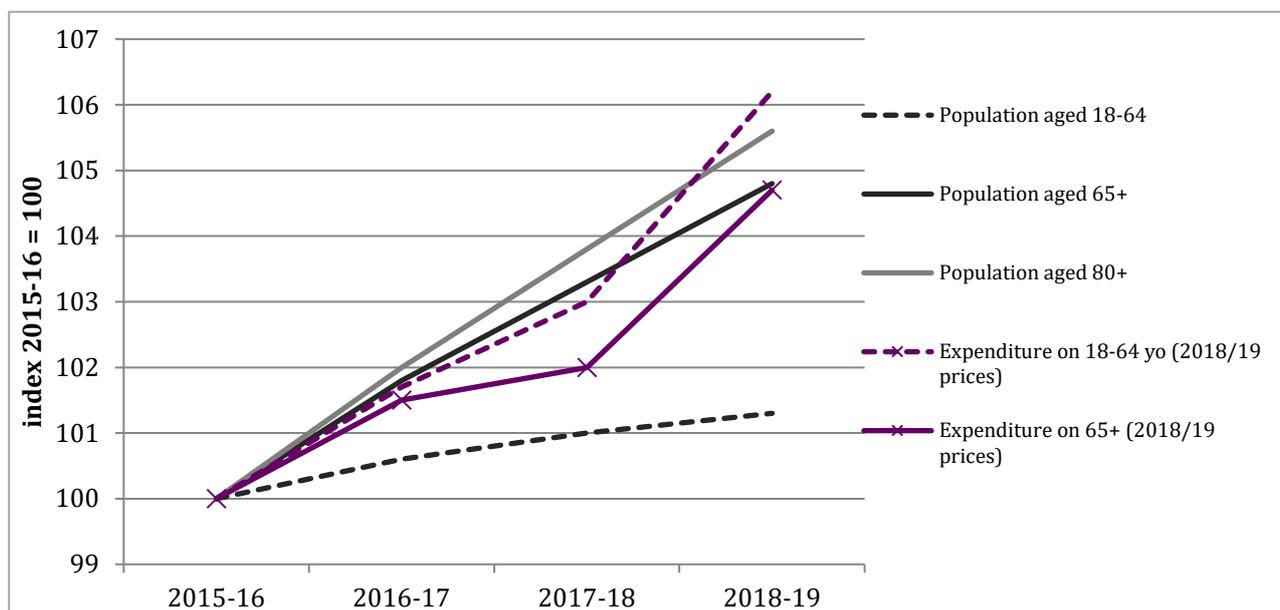
Figure 7 Gross current expenditure and population growth, England, index numbers

a) Gross current expenditure and population growth, 2009-10=100



¹¹ Please note, 2015-16 is the first year for which breakdown of gross current expenditure by age is possible on a consistent basis going forward.

b) Gross current expenditure by age group, and population growth by age group, 2015-16=100



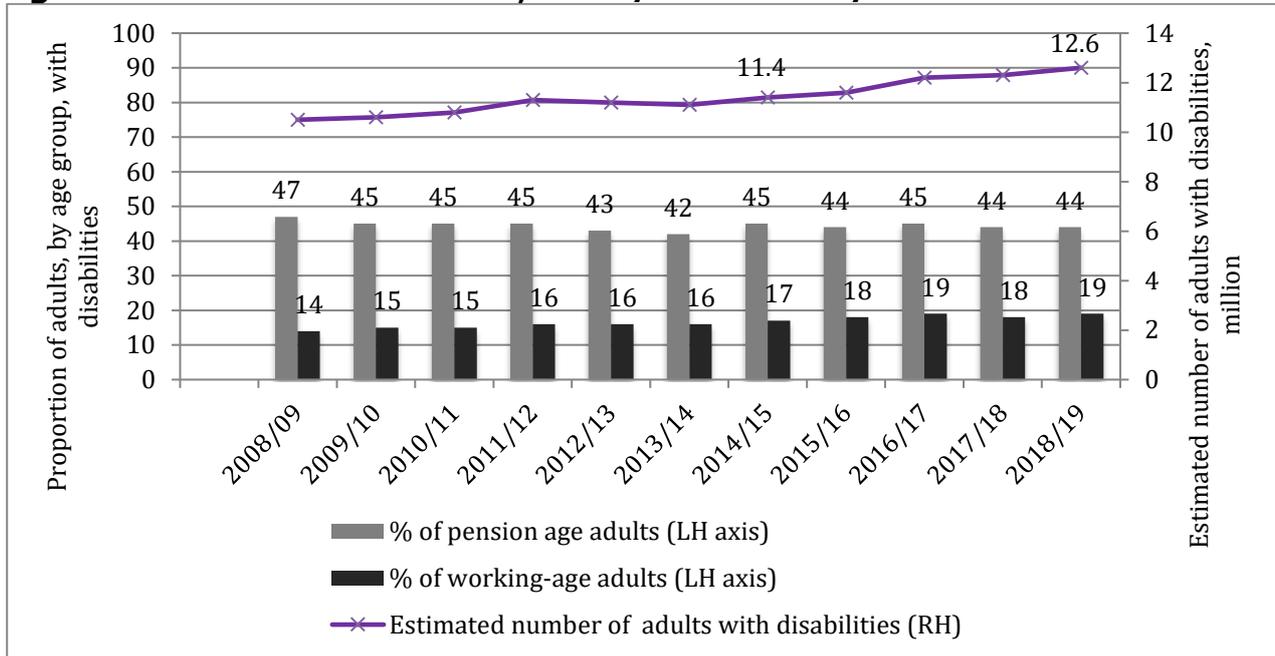
Source: Authors' analysis using nominal expenditure figures for gross current expenditure from NHS Digital and GDP deflators from October 2019 (HM Treasury, 2019). Figures for gross current expenditure is from NHS Digital (2019a). Nominal expenditure broken down by age for years 2017-18 and 2018-19 is from table T17 in NHS Digital (2019a); and for years 2015-16 and 2016-17 – from table T12 from NHS Digital (2017a). Population estimates are from ONS Population Estimates for the UK and constituent countries by sex and age; historical time series Notes: The spending by age groups includes spending for long-term and short-term care for each of the groups. Total gross current expenditure includes not only spending on the two age groups but also other gross current spending, which is not attributable to long-term or short-term care by age. Combined spending on each age group in 2017-18 and 2018-19 consists of around 81% of total spending for each year.

Growth in the number of adults in the population is one of the ways to assess potential increase in pressure on adult social care. Another is to look at the changes in the population who are disabled. UK household data only covers those living in private households, therefore omitting those living in care homes for example. The household data shows that in the UK between 2009/10 and 2018/19, prevalence of disability¹² among working age adults increased (from 15% to 19%), while among older adults it remained broadly stable (45% in 2009/10 and 44% in 2018/19) (Figure 8). The number of older age adults, however, increased dramatically over this period (by 21% in the UK overall¹³), resulting in an absolute increase in the number of adults with disabilities from 11.4m to 12.6m even though the prevalence appears to be relatively stable.

¹² While disability can be measured in different ways, in the text that follows we use the Family Resources Survey (FRS) definition for disability which is in line with the core definition of disability under the Equality Act 2010. According to this definition, a person is considered to have a disability if they have a long-standing illness, disability or impairment, which causes significant difficulties in carrying out day-to-day activities.

¹³ Authors' calculations using ONS (2019)

Figure 8 Prevalence of disability among working age and state pension age adults in UK households, 2007/08 to 2018/19



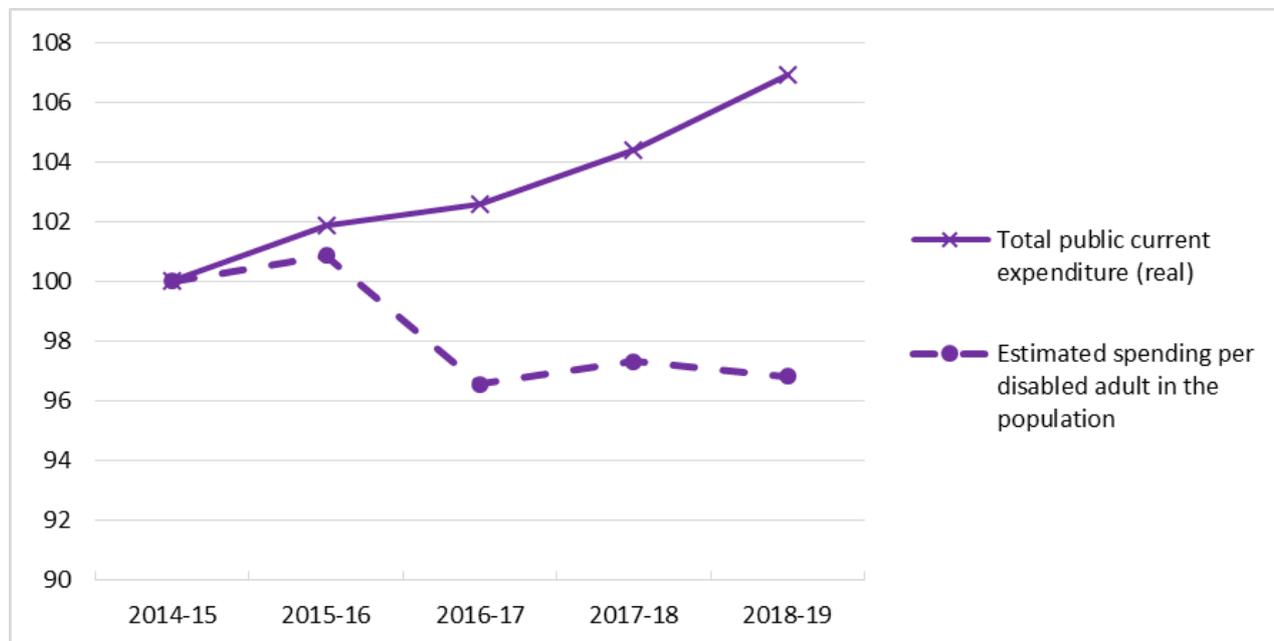
Source: Tables 4_1 and 4_2 in the Disability data tables excel document accompanying DWP (2020); DWP (2015, fig. 4.1) and Tables 4.3 in DWP (2020, 2019, 2018, 2017, 2016).

Notes: 1. The State Pension Age has been gradually increasing for women since 2010, at which point it was 60. By the year 2018/19 reported in this data, the State Pension age for women increased to 64 years 5 months. The time trend of the prevalence of disability for adults of state pension age therefore captures different age groups for women overtime. State pension age for men remained at 65 years in throughout the period. 2. Estimates of the number of adults with disabilities for 2014/15 to 2018-19 are from DWP (2020, 2019, 2018, 2017, 2016), table 4.3, and represent an estimated number of adults aged 20 and over with disabilities. The number of people with disabilities for these years are reported by DWP for three-year averages: e.g. an estimated number of people in 2018/19 is a three years average across 2016-17, 2017-18 and 2018-19. Estimated number of adults with disabilities for years 2008-09 to 2013-14 are estimated by DWP (2015, fig. 4.1) for single years and refer to 'working age and older' adults.

Homing in on the number of disabled adults (aged 20 or over) in England, we estimate a growth of just over 10.4% between 2014/15 and 2018/19, from 9.6 million to 10.6 million. This compares to a growth in real terms total public current spending on adult social care over the same period of 6.9%. Thus, on a per capita basis, real spending fell: from £1,861 per disabled adult in 2014/15, to £1,802 in 2018/19, a fall of 3.2%. This is shown in Figure 9.

Figure 9 Growth in total public current expenditure and in estimated spending per disabled adult in the population, in real terms, England, 2014/15 to 2018/19

Index 2014-15 = 100



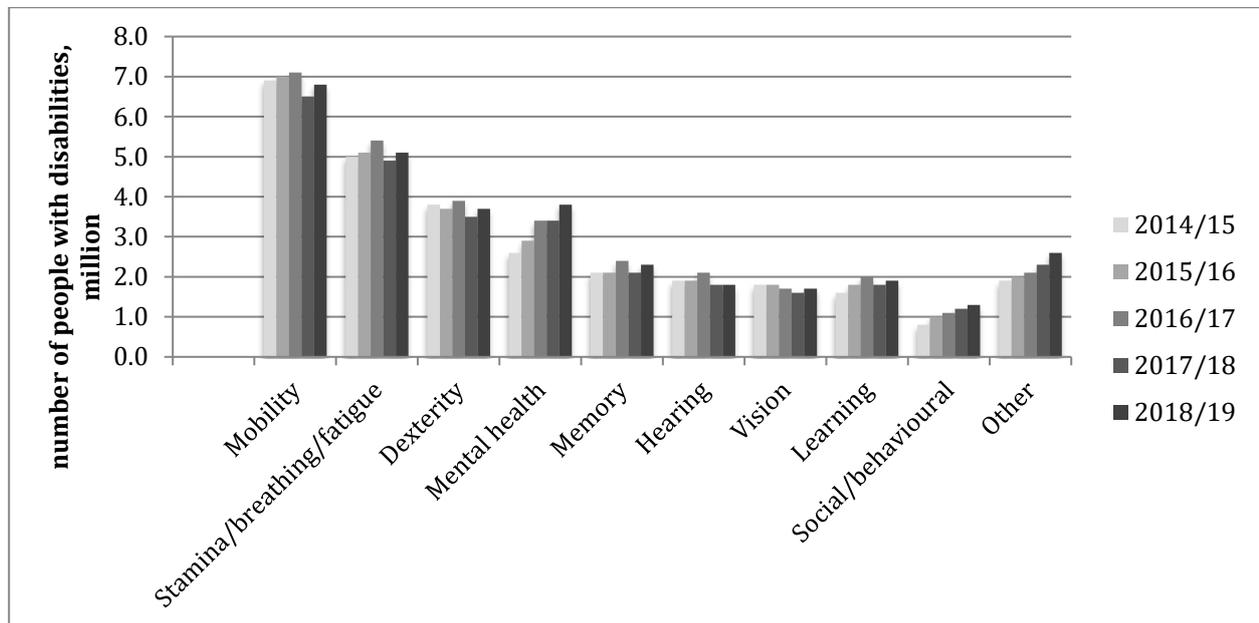
Source: Total public current expenditure (real): authors' calculations using NHS Digital expenditure figures within Reference Data Tables (NHS Digital, 2019a), Better Care Fund accounts (NHS England, 2018), and GDP deflators from October 2019 (HM Treasury, 2019).

Estimated spending per disabled adult in the population: authors' estimates using expenditure figures as described above, and DWP's estimates of the number of people with disabilities in the UK (see notes to Figure 8 above). The number of disabled people refers to adults aged 20. Figures for England were estimated by the authors using ONS population estimates (Office for National Statistics, 2020): UK population estimates, 1838 to 2019. Excel data file.

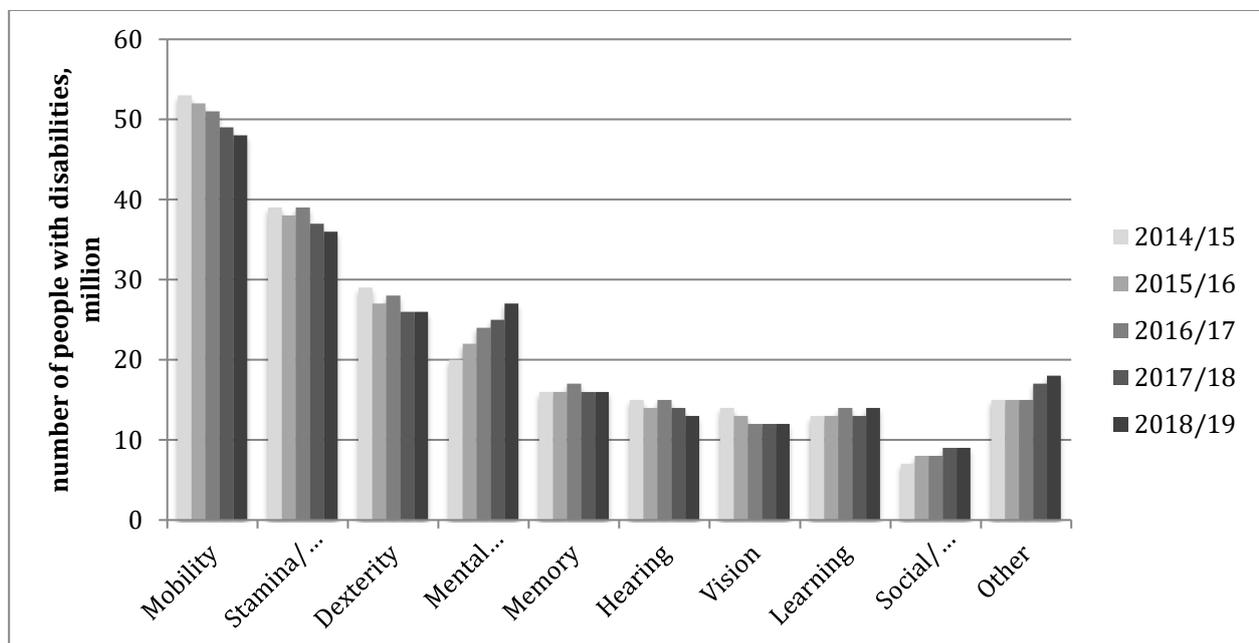
Looking at the type of disability, the number of people with mobility related disabilities, which is reported by the highest number of people in the UK, fell from 6.9 million people to 6.8 million between 2014/15 and 2018/19 whereas mental health-related, learning, memory, social/behavioural and 'other' disabilities increased (see Figure 10). An increase in the prevalence in mental health disability among working age adults between 2014/15 and 2018/19 stands out in particular, increasing from 30 to 39% over the period (Table 4). Some adults with learning and/or mental health impairments have complex needs and a higher number of such individuals in the population will exert an upwards pressure on social care costs.

Figure 10 Impairment types among all adults living in UK households, 2014/15 to 2018/19

a) Number



b) Percentage



Source: Tables 4_5 in the 'Disability data tables' excel documents accompanying DWP (2019, 2016) reports.

**Table 4 Percentage of adults with each impairment type, by age group¹
Adults living in UK households, 2014/15 and 2018/19**

a) working age adults

	Working-age adults	
	2014/15	2018/19
Mobility	45	40
Mental health	30	39
Stamina/breathing/fatigue	34	32
Dexterity	26	24
Other	17	20
Memory	16	15
Learning	14	14
Vision	11	14
Hearing	8	7
Social/behavioural	7	9

b) State Pension age adults

	State pension age	
	2014/15	2018/19
Mobility	69	67
Stamina/breathing/fatigue	46	44
Dexterity	36	34
Hearing	24	23
Vision	18	18
Memory	18	18
Other	12	16
Mental health	7	9
Learning	7	8
Social/behavioural	1	3

Source: These figures are taken from Tables 4_6 in the 'Disability data tables' excel documents accompanying DWP (2020, 2016) reports.

Notes: 1. The State Pension Age has been gradually increasing for women since 2010, at which point it was 60. In April 2018, the State Pension age was 64 years and 5 months for women, while it was still 65 year for me. On 6th of March 2019, the State Pension age increased to 65 years and 2 months for both men and women. The time trend of the prevalence of disability for adults of state pension age therefore captures slightly different age groups for men, but particularly for women overtime. 2 Figures do not add to 100% as people could report multiple disabilities. 3. The figures are ordered from highest to lowest in 2018/19.

To summarise, we have shown that gross expenditure by local authorities on adult social care grew in real terms from 2016-17 onwards, and that estimated total public expenditure on social care (including by the NHS) grew faster throughout the present administration. In the recent period, growth in local authority spending was just about in line with the growing older population, and growth in total public spending slightly exceeded it, but taking into account the growth in the working age disabled population, more than wipes out this

'surplus': total public spending per disabled person in the population has fallen by 3.2% since 2014-15.

In a longer term perspective, spending by local authorities in 2018/19 was only at the level of 2013/14 and had not reversed the sharp cuts observed between 2009/10 and 2015/16; and the increase in the number of both working age and older age adults with disabilities since 2009/10 points towards mounting pressure on adult social care services. We conclude that there was a wider gap between resources provided publicly and needs at the end of the period than in 2009/10 before the Coalition government took office.

5.2 Private spending on adult social care

With the pressure mounting on spending by Local Authorities, which until recently has been falling, has private spending been increasing to plug the gap?

Office for Statistics Regulation (2020) asserts that there are gaps in understanding how much people spend on social care privately and there are no comprehensive reliable estimates of such spending over time.

The spending on adult social care described up to now was in relation to local authority arranged care. We saw earlier that some private expenditure is being captured within the gross current expenditure by local authorities - recorded as income from client contributions. These amounts have increased in the period between 2014-15 and 2018-19 at a slightly higher rate than the overall increase in gross current expenditure by local authorities (3.8% vs 2.8%, respectively) and stood at £2.9 billion in 2018-19.

Other private expenditure on adult social care services takes place outside local authority activity and is purchased and provided privately, often because the individual is not eligible for local authority support as a result of having assets above the capital means-test threshold (currently £23,250), or because the services a local authority assesses a person as eligible for is regarded as inadequate in quality or quantity by the person concerned or his/her family. The receipt of and payments for care are often complex, reflecting different needs but also eligibility for and availability of services. In many cases, adults receive a combination of publicly and privately provided services, and the payment for these are also sometimes a combination of public and private resources.

5.2.1 Private spending on social care in residential homes

Cromarty and colleagues (2019) refer to figures by Laing and Buisson in their volume on Care Homes (Care Homes for Older People: UK Market Report, 29th edition), who estimated that almost half of older people in independent care homes in the UK (45% or around 176,000 people) paid for all of their care, and a smaller proportion being fully state-funded (35%, equating to 137,000 individuals). The rest, 11% (or 44,500 individuals) received some state-funded care but also contributed to the costs themselves (usually through their families).

Private payers comprise an even greater share of the care home market if we look at its value (rather than volume of care) – i.e. the amount of money from private payers. Private payers account for 51% of total value of care home market, due to the fact that they are subsidizing the market by paying on average 40% more for their care than Local Authorities do (Seymour, 2019). This is referred to as “cross-subsidisation” - allowing care homes to charge private clients more than those who are paid for completely or in part by LAs (Jarrett, 2018), not always with discernible differences in quality or quantity of care.

5.2.2 Private spending on social care in the community

The amount spent privately by those paying for their own care at home is even more uncertain. In the most recent reference to such estimates, the National Audit Office refers to their 2015 figures. The NAO anticipated that the number of people who pay for care support in their own homes is somewhere between 145,000 and 249,000 people (National Audit Office, 2018a). Estimates produced for Skills for Care suggested that 30% of total spending on non-residential care was by people paying for their own care (Kearney, 2018).

Using the LaingBuisson estimates for the total size of residential care, specialist care, and homecare/supported living, and for the proportion of self-payers in each of these services, and Competition and Markets Authority estimates for the mark-up in fees that self-payers are charged, a forthcoming paper by Burchardt and Reader (forthcoming) estimate that private spending in England was £11.2bn in 2018/19. This figure is similar, in real terms, to the equivalent estimate for 2013/14 (Burchardt and Obolenskaya, 2016), although changes in methodology and data collection make the comparison uncertain.

To obtain a figure for total private spending, one would need to add top-ups to local authority funded care paid by families (an unknown amount, but accounting for 11% of care home residents), and ‘client contributions’ (£2.9bn in 2018/19). Private spending in 2018/19 is therefore in the region of 75% of the magnitude of public spending ($11.2 + 2.9 = £14.1$ bn private, compared to £19.1bn public) on social care.

6 Inputs

6.1 Social care providers

Unlike healthcare, publicly-funded social care is almost entirely reliant on independent providers for both residential and non-residential care. For example, 95% of beds in care homes for the elderly are provided by for-profit and charitable providers (CMA, 2017). Skills for Care estimate that there were 7,800 organisations providing adult residential care in England in 2019/20, between them running 19,500 establishments (Skills for Care, 2020). A large majority

(80%) of providers run only one home, and 85% of all providers (residential and non-residential) employ fewer than 50 employees (CMA, 2017; Skills for Care, 2020). Care homes close down surprisingly often; the CQC identified 1,211 residential care homes that left the market over a two-year period to end of March 2018 – about 3 per cent per year – removing 18,206 beds and causing considerable disruption and distress to residents and families, as well as placing additional burdens on local authority commissioners (ADASS, 2019). Over the same period, 580 new residential homes opened, providing 11,168 beds, indicating a trend towards reduced overall capacity and a larger average size of home. This is particularly unfortunate since 23% of all large care homes were rated as inadequate or requiring improvement compared to just 9% of small care homes inspected by CQC (ADASS, 2019) – although whether the new homes opening follow this pattern is not known.

In addition to care home providers, there were 10,500 organisations providing non-residential care (domiciliary care, supported living, day care, support to carers and so on) in 2019/20, through 18,500 local units and approximately 70,000 individuals employing their own carers using Direct Payments and other arrangements (Skills for Care, 2020). The number of non-residential care units has been steadily increasing over time, whilst the number of direct payment recipients employing staff has been stable since 2014/15.

The picture that emerges for both the residential and non-residential care market is of highly fragmented provision, with a considerable degree of churn. In principle, local authorities have a duty under the Care Act 2014 to shape and maintain an effective market for meeting care needs, and the CQC have responsibility for market oversight (in particular with regard to sustainability) but in practice both of these functions are difficult to perform with limited resources and very little power to intervene.

6.2 Social care workforce

An estimated 1.65 million people worked in public and private adult social care in England in 2019, working over 1.16 million full-time equivalent jobs (Skills for Care, 2020). The majority of adult social care jobs are within the independent sector (79%), followed by employment by Direct Payment recipients (8 to 9%), local authority jobs (7%) and the NHS (6%). The distribution of type of employer shifted considerably over this period with the share of jobs in local authorities halving over the period from 14% of total number of jobs in 2009 to 7% in 2019.

Increases in the statutory minimum wage as a result of the introduction of the National Living Wage (NLW) in April 2016 have substantially improved the hourly pay of the lowest paid care workers (aged 25 or over), from £6.50 in 2014 to £8.72 per hour in April 2020. McKnight and Cooper (2020) report that the NLW compressed the bottom half of the hourly wage distribution in the labour market as a whole by bringing the 10th percentile closer to the median. However whilst in some sectors pay differentials above the NLW have been maintained, leading to increases for slightly higher paid workers as well, in social care the effect

seems to have been a further concentration of workers paid at the minimum. Skills for Care estimate that nearly 1 in 3 (28%) of independent-sector care workers were paid *at* the minimum wage in March 2019, compared to 1 in 6 (17%) three years earlier (Skills for Care, 2019a).

Statistics for local authority care workers are presented differently, but tend to confirm the conclusion that low pay is a sector-wide issue that has not been fully addressed by the NLW. The *median* whole time equivalent annual pay for a local authority care worker providing direct care was £19,200 in September 2019, an increase of just 2 per cent in real terms since before the NLW was introduced (Table T18 in NHS Digital (2020)). Clearly the substantial increases in the minimum wage have not fed through into improvements in average care worker wages.

Moreover, 40% of care workers are part-time and a further 11% have variable hours (Skills for Care, 2019b), so the £19,200 median annual pay quoted above for a whole time equivalent post overstates the annual earnings received by many carers. Indeed an estimated 1 in 3 care workers (all sectors including agency staff) were on zero hours contracts in 2018/19, a proportion that has not changed since 2012/13 when data were first collected. This employment practice is particularly prevalent in domiciliary care, with 58% of domiciliary care workers on zero-hours contracts.

Insecure contracts and low pay are associated with very high turnover rates among social care workers. Just under 1 in 3 staff (32%) either moved between jobs or left the adult social care sector in 2018/19, and this rate was even higher among those providing direct care (40%). Turnover has been on the increase, despite rises in hourly wages in real terms over this period. In 2014/15, before the Conservative administration took office and before the introduction of the National Living Wage, overall staff turnover was 6 percentage points lower (26%), and turnover among front line care staff was 8 percentage points lower (32%) (Skills for Care, 2019b). High rates of staff turnover add to cost pressures on providers and are difficult to reconcile with high-quality care, which depends on building good relationships between the carer and cared-for person (Lewis and West, 2014).

One of the ways to improve retention is to invest in staff and in particular in training and career development. However the National Audit Office found that local authorities were not in a position to require providers to train and develop their staff, whilst providers were struggling to deliver the services they were commissioned to provide given the fee levels set by local authorities (National Audit Office, 2018b). The organisation Skills for Care is charged by the Department for Health and Social Care to provide national training and development, but with an annual budget equivalent to £14 per worker, its impact is necessarily limited, and Coalition government commitments to promote skills development and recognition in the care sector have not been followed through (National Audit Office, 2018b).

Local authority budgets finance a substantial proportion of the overall care sector and, despite assurances from the government to the contrary, allocations to local authorities did not increase in proportion to rises in the minimum wage. Moreover, as we have seen the increases in funding that have been made available have been ad hoc and often short-term, which has made it difficult for local authorities to plan ahead or to invest in the workforce beyond the statutory minimum: pay rises and increases in fees paid to providers are risky if the funding stream to support them is fixed-term, because they are difficult to reverse. This squeeze has forced local authorities and care providers to find other economies, including through cross-subsidisation from self-payers as we noted in the previous section, and continued pressure on care workers' terms and conditions. Many local authorities and independent care providers were warning, even prior to the pandemic, that the settlement was unsustainable.

6.2.1 Brexit

Adding to the uncertainty about the future of the social care workforce is the impact of Brexit and changes to immigration rules. In 2018/19, 8% of the workforce were EU (non-British) nationals, and 9% were non-EU nationals. These proportions were lower among managers, social workers and occupational therapists, slightly higher among (senior) care workers ((7) 9% EU nationals and (10) 11% non-EU) and very much higher among registered nurses (18% EU nationals and 19% non-EU nationals). The likelihood that Brexit, whether with a deal or without, will reduce the willingness or ability of EU care workers currently in the UK to remain, and will restrict new immigration to the UK from EU countries, has caused concern among many commentators about a deterioration in the already high vacancy rate in social care jobs (House of Commons Health Select Committee, 2017; Independent Age, 2016; Stewart et al., 2019). However, whilst the Migration Advisory Committee was "seriously concerned" about social care in their report on EEA migration post-Brexit, they observed that "this sector needs a policy wider than just migration to fix its many problems" (Migration Advisory Committee, 2018, p. ii), and argued against making an exception for care workers to allow them access to the high-skilled worker migration pathway ('Tier 2') despite not meeting the minimum salary threshold.

The Conservative Party manifesto in 2019 proposed a fast-track visa system for EU nationals coming to work in the NHS post-Brexit but notably there was no mention of social care. A Health and Care Visa was subsequently announced in July 2020 as part of the government's points-based immigration system, but despite its name, regular care workers were not included in its remit: only social workers, therapists and nurses. This omission produced a strong reaction in the sector (for example ADASS (2020)) and at the time of writing the debate about how to square the demand for care workers with an increasingly restricted supply is still live.

6.3 Unpaid carers

The paid workforce is complemented and underpinned by an army of unpaid (or 'informal') carers. Indeed the vast majority of care overall is provided by unpaid carers. Estimating the number of informal carers is complicated by the fact that not all those providing care self-identify as carers. A survey carried out by Carers UK found that it took most carers more than a year to recognise that they were providing care and for 24% of carers it took more than five years (Carers UK, 2016). We should therefore treat estimates of care provision to family and friends as likely underestimates, recognising that there could be people who are do not realise or report their caring role.

A frequent source of estimates for the number of unpaid carers comes from England and Wales Census data. These figures show that there were 5.8m of unpaid adult carers in England and Wales in 2011, an increased of 600,000 since 2001 Census data collection. This growth was faster than the growth in the population overall and there was an intensification of the hours for which the care was provided: the largest growth in care provision was for 50 or more hours of care a week (Office for National Statistics, 2013). Using figures from two Censuses in England and Wales, Carers UK estimate that the total number of carers in the UK was 5.9 million in 2001, growing to 6.5 million by 2011 (Carers UK, 2019a).

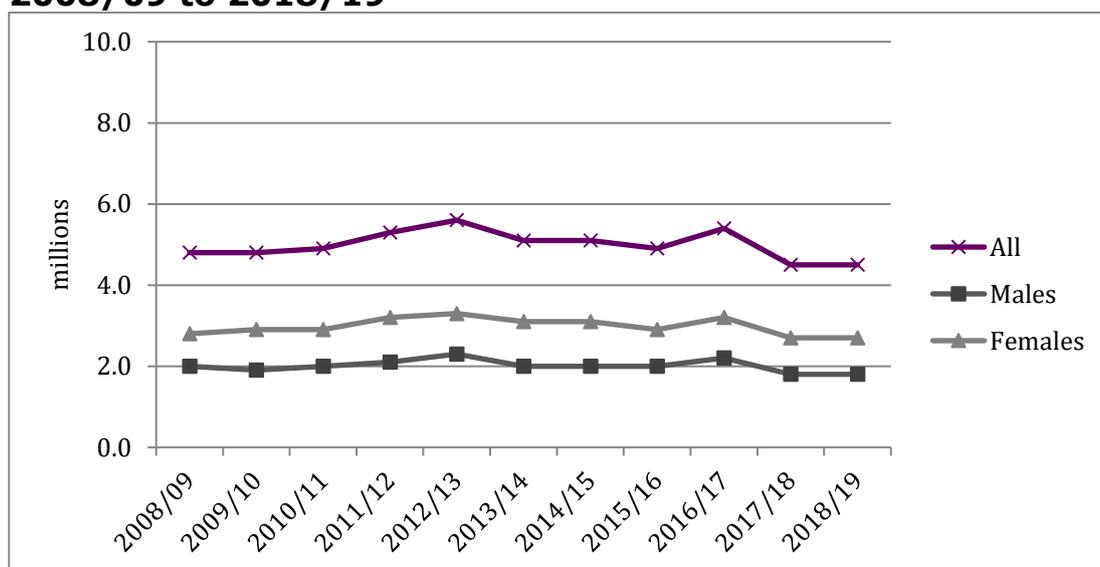
The Family Resources Survey (FRS), using a slightly different definition and question format, produces a somewhat lower estimate. The FRS shows that in 2018/19 there were 4.5 million adults in the UK providing unpaid care (both inside and outside their households), representing around 7% of the adult population. The number of carers has fluctuated over time, but was lower by 0.4 million in 2018/19 than in either 2015/16 or 2010/11 (Figure 11).

Meanwhile the intensity of care has risen. The proportion of carers who provide 35 hours of care or more a week increased from 27% to 32% between 2010/11 and 2018/19 (Figure 12).

Other data sources give higher estimates than FRS. For example, using data from the British Household Panel Survey and Understanding Society, the Social Market Foundation found that in 2015 14.5% of adult population in the UK (equivalent to 7.5 million people) were 'family carers' in the UK, representing an increase of half a million people from a decade earlier. Despite using a narrower definition of carers than the FRS (as it excludes providing care to friends and neighbours), these estimates are higher. This is partly because the FRS definition of adults are those aged 19 and over and 16-19 year olds who are not considered to be children (children are those who are unmarried/not-cohabiting and in full time or advanced education), while the findings from the Understanding Society data refer to all those aged 16 and over. The Social Market Foundation figures also show an increase in the proportion of adults providing more hours of care, 20 hours or more (from 24% to 28% between 2005 and 2015). When looking at care for parents specifically, the authors find

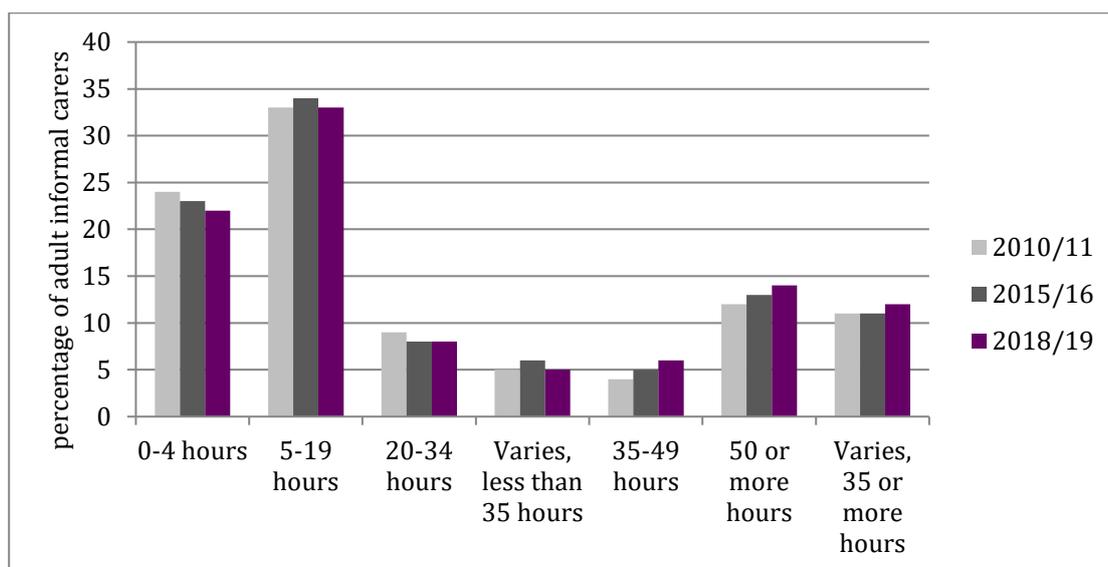
that carers are providing more care related to the Activities of Daily Living, or ADLs, which are absolutely necessary for individuals to function such as bathing, getting dressed and feeding. The proportion of adult children who provide such care to their parents increased from 16% in 2006 to 19% in 2015 (Petrie and Kirkup, 2018).

Figure 11 Estimated number of adults providing informal care in the UK, 2008/09 to 2018/19



Source: DWP (2020), Table 5.1, 'Carers data tables' excel document

Figure 12 Adult informal carers by hours of care provided per week, 2010/11, 2015/16 and 2018/19, UK



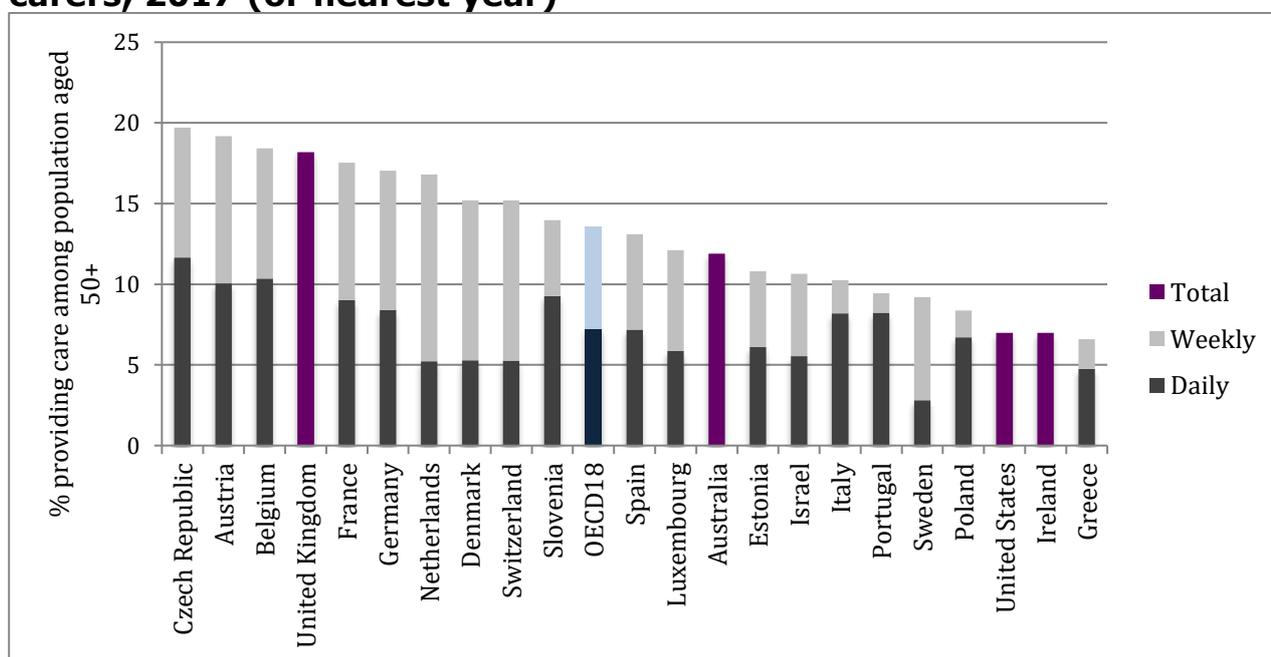
Source: Figures for 2010/11 are from Table 6.1 in DWP (2012); figures for 2015/16 and 2018/19 are from DWP (2020, 2017) Table 5.3 'Carers data tables' excel document.

The higher estimated number of adult carers from two household surveys points towards a high number of young people who we might not consider to be adults providing care (16 and 17 year olds). Moreover, it is not only adults who help look after those with social care needs, as Vizard, Obolenskaya and Burchardt (2019) show, over 1% of children aged 5 to 19 provided care in the UK in 2015/16.

Nonetheless, in the UK, most care provision falls on older adults, with 60% of adult carers being aged 50 or over (authors' analysis of FRS data). Internationally, the UK has maintained its place among as having one of the highest rates of care provision among people of that age across the OECD countries between 2010 and 2017 (OECD, 2013, 2019a).

Longer term trends in the OECD data show that the share of people over 50 who are carers has increased between 2007 and 2017 across OECD countries, including in the UK. In the UK the proportion of those aged 50s who were carers increased from 15.2% to 18.2% and the OECD average increase from 11.7% to 13.5% between 2007 and 2017. The figures remained broadly stable since 2010 (OECD, 2013, 2019a). This could partly be the result of changing patterns of male and female longevity (Emmerson et al., 2014).

Figure 13 Proportion of people aged 50 and over reporting to be informal carers, 2017 (or nearest year)



Source: OECD (2019a)

The other way to look at the pressure on family and friends to provide unpaid care is by looking at the data from care recipients – although this may also be under-reported, especially by men (Emmerson et al., 2014). Even those who do receive local authority provided care often still rely on support from family and friends as well. The vast majority of local authority service users also receive

regular practical help from family, friends or neighbours, with only 20% of all service users surveyed receiving no such help in 2018-19 (NHS Digital, 2019b). The majority of service users do not pay for their care or any top-up care, but almost 29% of service users have their family buy care / top-up care for them and 11% pay for it themselves (please note these proportions are not additive as a person could have both) (NHS Digital, 2019b). Looking at the older care recipients only, data from the Health Survey for England shows that a vast majority of older adults (65 and over) who receive care are receiving it from unpaid carers only: 65% and 70% of those receiving help with ADLs and IADLs received it from unpaid carers in 2018 (NHS Digital, 2019c).

The findings described above show strong evidence that the UK social care system as a whole continues to rely very heavily on inputs from unpaid care.

7 Outputs

7.1 Adults receiving social care support funded or arranged by local authorities

Approaching the current period, the total number of clients that received community and residential care services by councils with adult social care responsibilities (local authorities) was falling. The decline started in the last year of the Labour administration in 2009-10 and accelerated in the 5 years that followed (Burchardt et al., 2015). During that time the fall in the number of service users was particularly sharp for community-based services. The fall in the number of people receiving publicly-funded adult social care services coincided with a decline in spending on adult social care. As we saw earlier, there has been a continuous real terms increase in total gross current expenditure by local authorities since 2015-16. In this section we show that the increase in overall spending is not consistently reflected in the number of people receiving care (output). The picture of output that is being produced with the money spent is mixed, and NHS Digital attributes at least some of it to the increasing costs of care provision, including of course the higher wages of the lowest-paid care staff as a result of the National Living Wage (NHS Digital, 2019a).

NHS Digital provides adult social care activity figures mainly based on the number of adults receiving long-term care and the number of completed episodes of short-term support from local authorities, drawn from the Short and Long Term Services (SALT) collection by local authorities, which began in 2014-15. The process of care provision is described graphically in Appendix Figure A1. Prior to this date, activity data was collected via the Referrals, Assessments and Packages of Care return (RAP) and the Adult Social Care Combined Activity Return (ASC-CAR) which have now been discontinued. The changes in data collection in 2014-15 and incomplete data for 2014-15 meant that trends in activity data for the period we are interested in are not directly comparable to those prior to 2014-15. In this section we put together a trend for the number

of people who received care at any point during the year over the whole period, caveating some of the inconsistencies in the data and the way it might impact on the estimated number of clients.

The aim of Long-Term care (LT) is to provide on-going support in residential, nursing and community settings in order to maintain a person's quality of life. It ranges from high intensity support, such as nursing home care, to lower intensity support in the community, such as the provision of direct payments for regular home visits (NHS Digital 2019a). Short-term support is provided for a time-limited period, typically a few weeks, and aims to reduce or prevent long term need for social care, referred to as Short Term support to Maximise independence (ST-Max). It is the split of the activity data into these two categories and the units of the count (individuals vs episodes of care) that are the main difference from the figures reported prior to 2014-15.

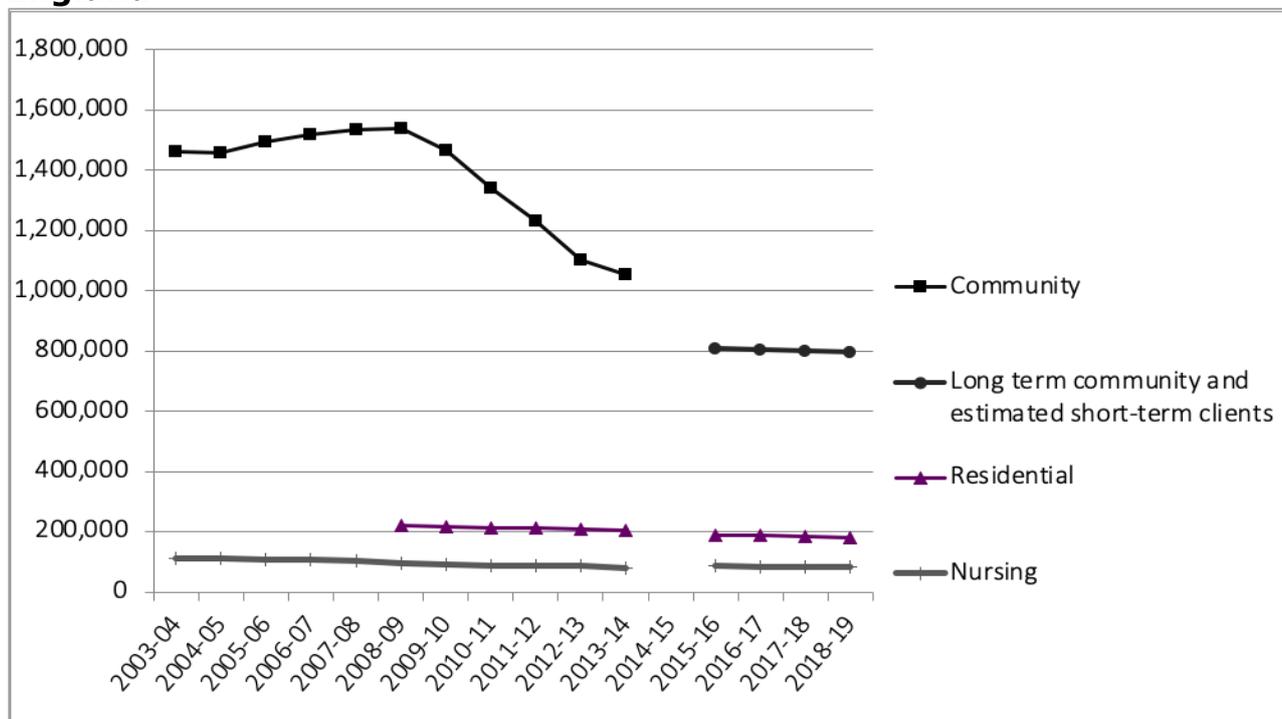
The 'old' recording concentrated on the number of people who received services in different settings: nursing, residential and community, with no distinction being made as to whether these services were long-term or short-term. The two main ways those figures were presented were either 'at the year end' or 'during the year'. The former was a simple snapshot of all those who were receiving adult social care services on the 31st of March each year. The reporting of the number of clients receiving social care services at any point 'during the year' meant that the same person could appear in any or all of the above mentioned settings depending on the services they received, potentially double counting across these service categories. However the total of all clients supported during the year was also reported, and excluded double-counting.

The comparison of the figures over time is thus not straightforward and few have attempted to do so. However given the dramatic decline in the number of people receiving non-residential services in the period up to 2013/14, it seems important to establish whether this trend has continued. The Institute for Government presents figures for the number of people receiving LT support at the end of the year and the number of new requests that resulted in ST support during the year, with a break between 2013-14 and 2014-15 (Institute for Government, 2019). We discuss some of the issues of comparability in their estimates across time in the Appendix. Instead, we calculate our own estimates of the number of LT and ST care clients who received support *during the year*, to produce the best approximation of a consistent series throughout the period (Figure 14). For ST care, this is based on using information about the average number of episodes of care per client (see Appendix for more details).

Our best estimate is that there has been a further 24% fall in the number of people receiving community-based services since 2013-14. Changes since 2015-16 have been slower, consistent with the stabilisation of spending, but still on a downward trajectory. The number of people receiving community based services (both long-term and short-term) fell from an estimated 808,000 people during 2015-16 to 796,000 during 2018-19, representing a 1.5% decline, whilst the

number of adults receiving care in residential and nursing homes fell by 5% (Figure 14).

Figure 14 Number of clients receiving adult social care support from local authorities within a year, by type of setting, 2003-04 to 2018-19, England



Source: Data for 2018-19 is from NHS Digital (2019a), Tables 10, Table 11 and Table 38. Data for 2017-18 is from NHS Digital (2018), Tables T10, T11, Table 38. Data for 2016-17 is from NHS Digital (2017a), Tables T8 and T9, Table T30. Data for 2015-16 is from NHS Digital (2016), Table STS001.a and Table LTS001a. Pre 2014-15 figures are from HSCIC (2014a), Annex M - Compendium 2000-01 to 2013-14.

Notes:

1. Number of clients completing ST episodes of care within a year and a total number of community and short-term care client are authors' estimates.
2. We exclude a small number of people who receive care in prisons. This was voluntary for LA to complete pre-2017-18.
3. NHS Digital provides the numbers for 'new' and 'existing' clients with completed ST-max episodes during the year for 2018-19 and 2017-18, but not for earlier years. We therefore take an average number of episodes per client from last available year's data - 2017-18 (1.17 episodes per client) and apply them to 2014-15, 2015-16 and 2016-17 figures on the total.
4. Figures are rounded to the nearest 1,000.

7.2 Volume of support received since 2015-16 by clients' age and need

In this section we look more closely at the recorded data on adult social care activity for the period between 2015-16 and 2018-19, broken down by age and type of need. We refer to the changes since 2015-16 as this is the most consistently recorded data. We report on the change in the number of adults who received LT care support and the number of completed ST episodes of care during the year funded or provided by councils. Unfortunately breakdowns of ST

care based on people rather than episodes of care as the unit of analysis are not available.

The large majority of people who receive adult social care support are aged 65 and over, and the majority of care provided can be classified as long-term care. Since the social care activity data by age and type of care received is reported on the basis of the number of people receiving LT support and the number of completed *care episodes* for ST support, figures for LT and ST support cannot be added up and are presented here separately.

There has been an increase in demand for adult social care support from those who are not already being supported on a long-term basis: the number of requests from new clients increased by 5.7% between 2015-16 and 2018-19 to 1,914,535. Broken down by age, the increase is higher among working age adults (9.9% increase in the number of requests) compared to older adults (4.1%) (authors' calculations using NHS digital figures¹⁴). Taking into account the number of people in these age groups, we still see an increase in the rate of requests among 18-64 year olds but a decline among older adults. The number of 18-64 year olds who requested support increased from 1,499 to 1,625 per 100,000 of the population of this age group, and the rate declined from 13,505 to 13,400 per 100,000 in the population among over 65s (authors' calculations using NHS digital figures¹⁵). This means that the increase in demand for adult social care among the younger age group was not purely due to an increase in the population of that age, while there was a decline in the number of requests made by those aged 65 and older despite a greater increase in the number of older people in the population as we showed earlier. It is unclear what lies behind the decline in the rate of requests for support among older people.

Despite the increase in requests for care, the total number of adults of any age receiving LT support during the year actually declined by 3.5% between 2015/16 and 2018-19, falling to 841,850 in 2018-19. This was driven by fewer clients aged 65 and over (a fall of 6.6%), while the number of clients aged 18 to 64 has increased by 2.9% over the period (Table 5). The decline in the number of older people receiving long-term support both within the community but also in residential and nursing homes is reflected in the falls in their numbers across two main categories of need: physical and sensory (7.2%) and memory and cognitive (5.2%), representing a fall of 32,290 and 3,875 people, respectively. Furthermore there was a decline in the number of older people receiving long-

¹⁴ Number of requests from new clients for 2015-16 are from Table STS001 in (NHS Digital, 2016) and for 2018-19 from Table T9 in (NHS Digital, 2019a).

¹⁵ Number of requests from new clients for per 100,000 in population for 2015-16 are authors' calculations using the number of requests from 'new' clients from Table STS001 in (NHS Digital, 2016) and mid-year ONS population estimates for 2015; and for 2018-19 the rates are from Table T12 in (NHS Digital, 2019a).

term support for mental health (8.8%) (Figure 15) despite increasing prevalence of mental health problems in the population.

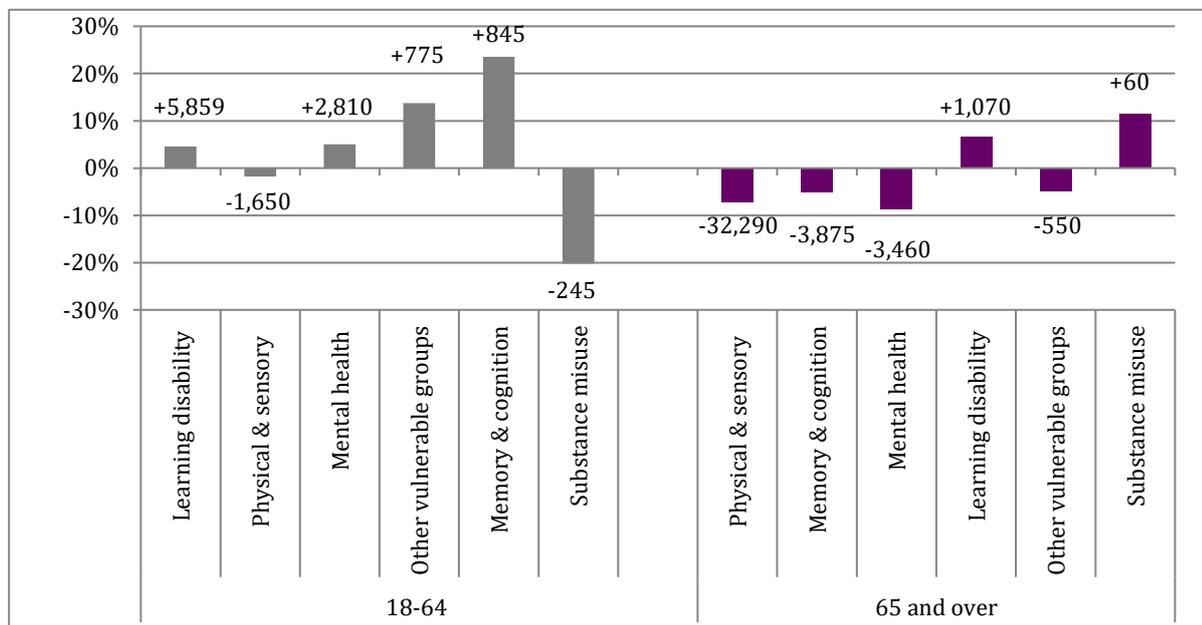
Table 5 Number of adults receiving long-term support during the year by primary support reason, 2015-16 and 2018-19, England

		2015-16	2018-19	Change	% Change
18-64	Physical & sensory	90,945	89,295	-1,650	-1.8%
	Memory & cognition	3,590	4,435	845	23.5%
	Learning disability	127,725	133,575	5,850	4.6%
	Mental health	55,935	58,745	2,810	5.0%
	Substance misuse	1,210	965	-245	-20.2%
	Other vulnerable groups	5,625	6,400	775	13.8%
Total 18-64		285,030	293,415	8,385	2.9%
65 and over	Physical & sensory	445,485	413,195	-32,290	-7.2%
	Memory & cognition	74,985	71,110	-3,875	-5.2%
	Learning disability	15,980	17,050	1,070	6.7%
	Mental health	39,240	35,780	-3,460	-8.8%
	Substance misuse	520	580	60	11.5%
	Other vulnerable groups	11,270	10,720	-550	-4.9%
Total 65+		587,480	548,435	-39,045	-6.6%
Total all ages		872,510	841,850	-30,660	-3.5%

Source: Number of long-term care clients during the year for 2015-16 are from Table LTS001a in NHS Digital (2016) and for 2018-19 are from Table T34 in NHS Digital (2019a).

Among people of working age, there were increases in the number of clients receiving long-term across most categories of need. In absolute terms, the large increases were for people with learning disability (+5,859 between 2015-16 and 2018-19) and people with mental health needs (+2,810). People with learning disability often have complex needs and these can be comparatively high-cost to meet. The increase in the number of people with mental health problems in need of support fits with the evidence on increasing prevalence among people of working age presented in section 5.1.4 above. In percentage terms, the striking increase is among working age people with need for support with memory and cognition (including early-onset dementia), albeit from a low base; whilst the striking decrease is in support for people with substance misuse.

Figure 15 Change in the number of adults receiving long-term support in the year by primary support reason, 2015-16 to 2018-19, England (percentage change shown by height of bars and absolute change shown as labels)



Source: Number of long-term care clients during the year for 2015-16 are from Table LTS001a in NHS Digital (2016) and for 2018-19 are from Table T34 in NHS Digital (2019a).

Notes: The reasons for support in this chart are ordered from the highest number of people receiving a certain type of support to the lowest: e.g. there were 413,195 older adults receiving physical & sensory support and 580 receiving substance misuse support in 2018-19. A left-right hierarchy on the original ordering of the reasons for support determines which support reason recorded when more than one reason applies. The original order (combined into fewer categories by the authors) is: 1) physical and sensory, 2) memory and cognition; 3) learning disability; 4) mental health; 5) substance misuse; 6) other vulnerable adults.

Looking at the ST-max care completed episodes for new clients during the year, the numbers show an overall increase, particularly prominent for working age rather than older adults (42.4% increase among the former and only 1.7% among the latter), resulting in the overall increase of the number of completed episodes for new clients of any age of just under 6% (Table 6, a). In the meantime, the number of existing clients (those who were already receiving LT support) fell over the period for both working age and older adults, resulting in the 17% fall in the overall numbers (Table 6, b).

Looking at the total completed episodes of short term care (whether by new or existing service users), between 2015-16 and 2018-19, there was an overall increase in the number of completed short term episodes of care among working age adults (27%) but a small decline among older adults (0.8%) (Table 6, c). The number of episodes supporting the 'physical and sensory' needs among older adults (the category with the largest share of episodes) fell by almost 2%.

Among support provided to working age adults between 2015-16 and 2018-19: the total number of completed episodes of care to both 'new' and 'existing' clients increase by 27%: from 28,220 to 35,890. The only category of need in which we see a fall in the number of episodes of care in this age group is for substance misuse (the smallest number of episodes are classified as such), falling from 550 to 205 during this period. There was a particularly noticeable relative increase in the number of episodes which were to support learning disabilities (increasing four-fold from 1020 to 4140) and 'other' vulnerabilities (such as social isolation, asylum seekers and other), which grew by 151% from 740 to 1,855. There was also an increase in short term episodes for support for mental health of working age adults, increasing by 16.4% since 2015-16 (Table 6, c). These trends are consistent with the picture for LT care.

By far the highest number of short-term episodes of care were for support with physical and sensory needs, both among working age and particularly among older adults (representing 67% and 93% of all short term episodes for these age groups, respectively). Short term support for these needs increased by 14.2% among the working age group, but fell by almost 2% among those aged 65 and over.

Table 6 Total number of completed episodes of short-term care to maximize independence during the year for 'new' and 'existing' clients, by primary support reason, 2015-16 and 2018-19, England

a) New clients		2015-16	2018-19	change	% change
18-64	Physical & sensory	17,840	21,075	3,235	18.1%
	Memory & cognition	175	300	125	71.4%
	Learning disability	510	3,140	2,630	515.7%
	Mental health	2,195	4,350	2,155	98.2%
	Substance misuse	275	195	-80	-29.1%
	Other vulnerable groups	625	1,725	1,100	176.0%
Total 18-64		21,620	30,785	9,165	42.4%
65 and over	Physical & sensory	178,960	179,825	865	0.5%
	Memory & cognition	4,815	4,430	-385	-8.0%
	Learning disability	160	160	0	0.0%
	Mental health	2,060	2,455	395	19.2%
	Substance misuse	110	110	0	0.0%
	Other vulnerable groups	3,415	5,835	2,420	70.9%
Total 65+		189,520	192,815	3,295	1.7%
Total all ages		211,140	223,600	12,460	5.9%

b) Existing clients		2015-16	2018-19	change	% change
18-64	Physical & sensory	3,330	3,100	-230	-6.9%
	Memory & cognition	175	105	-70	-40.0%
	Learning disability	510	1,000	490	96.1%
	Mental health	2,195	760	-1,435	-65.4%
	Substance misuse	275	10	-265	-96.4%
	Other vulnerable groups	115	130	15	13.0%
Total 18-64		6,600	5,105	-1,495	-22.7%
65 and over	Physical & sensory	28,720	23,865	-4,855	-16.9%
	Memory & cognition	1,470	1,295	-175	-11.9%
	Learning disability	150	145	-5	-3.3%
	Mental health	645	710	65	10.1%
	Substance misuse	10	20	10	100.0%
	Other vulnerable groups	570	535	-35	-6.1%
Total 65+		31,565	26,570	-4,995	-15.8%
Total all ages		38,165	31,675	-6,490	-17.0%

Table continues on next page...

Table 6 continued

c) Total new and existing clients		2015-16	2018-19	change	% change
18-64	Physical & sensory	21,170	24,175	3,005	14.2%
	Memory & cognition	350	405	55	15.7%
	Learning disability	1,020	4,140	3,120	305.9%
	Mental health	4,390	5,110	720	16.4%
	Substance misuse	550	205	-345	-62.7%
	Other vulnerable groups	740	1,855	1,115	150.7%
Total 18-64		28,220	35,890	7,670	27.2%
65 and over	Physical & sensory	207,680	203,690	-3,990	-1.9%
	Memory & cognition	6,285	5,725	-560	-8.9%
	Learning disability	310	305	-5	-1.6%
	Mental health	2,705	3,165	460	17.0%
	Substance misuse	120	130	10	8.3%
	Other vulnerable groups	3,985	6,370	2,385	59.8%
Total 65+		221,085	219,385	-1,700	-0.8%
Total all ages		249,305	255,275	5,970	2.4%

Source: Figures for 2015-16 are from Table STS002a and Table STS002b in NHS Digital (2016) and for 2018-19 are from Table 23, Table 25 and Table 26 in NHS Digital (2019a).

To summarise, since 2015-16 there has been overall increase in the number of working age adults receiving long term care and in the number of short term episodes of care completed among this age group. This is in stark contrast to a fall in the number of adults aged 65 and over receiving long term support, as well as the fall in the number of short term episodes of care completed among them, particularly those with physical and sensory needs. This is a worrying trend, as the decline in the number of older people receiving local authority funded social care has been now falling consistently for a decade (Burchardt et al., 2015).

7.3 Number of unpaid carers supported by local authorities

Local authorities also provide some support to informal (unpaid) carers. This area of responsibility was given particular emphasis in the Care Act 2014. However, comparing figures for 2015-16 and 2018-19 suggests a decline in the amount of support provided to carers over this period, and also – with less confidence in the comparability of the data – over a longer time-frame.

In 2018-19 in England, a total of 297,300 instances of support were provided to carers. The majority of support came in the form of information or advice or a direction to other universal services (187,320 instances), with the next largest category of support being direct payments (74,035 instances) with 6,725 as part direct payments. These numbers are a decline on the 2015-16 total figures, where a total of 314,240 instances of support to carers were recorded. Of these,

192,720 were for information/advice or signposting, 67,145 for direct payments and 14,805 part direct payments. These figures indicate that the number of direct payments to carers increased but other type of support declined.

Some support for carers, which is not counted within these figures, is directed towards the cared-for person, such as respite care. This category also appears to have fallen (57,440 in 2015-16 and 42,300 in 2018-19), despite Care Act promises. However, there is variation in recording practices across local authorities, and some replacement care may be entered under care-recipient services rather than support for carers.

Looking further back, to 2009/10, 387,180 carers were recorded as receiving services or information from social services in England, 30% more than in 2018/19 (NHS Digital, 2011 Annex Table C1.1). Although changes in reporting by local authorities over this period makes direct comparisons difficult, there is certainly no basis in these figures to conclude that the promise of improved support for carers in the Care Act 2014 has been delivered.

Carers UK conduct their own annual survey of carers. It is a large, though not necessarily representative, survey, achieving 7,525 responses from current carers in 2019 (Carers UK, 2019b). They found that 27% of carers had had an assessment or a review of their assessment in the last 12 months, compared to 31% in their previous survey in 2016. One fifth (20%) had been waiting more than 6 months for an assessment. Only a minority felt that the assessment fully considered their needs: 37% said it fully took into account their willingness and ability to provide care; 30% their need for support to look after their own physical and mental health; and 26% their need for regular breaks.

8 Outcomes

In this section, we review progress on social care outcomes in the context of constraints in social care spending and the reduction in services. The aim of social care, at its most fundamental level, is to enable people with care needs to live well (Quality matters, 2017). With this in mind, we review evidence on the quality of social care services and the experience of social care for service users, including satisfaction with care, quality of life and safety. Social care plays an important role in ensuring that people with care needs are healthy and that hospital admission is avoided where possible. We review evidence on the outcomes of policies which have sought to integrate health and social care. Given the crucial role of unpaid carers in the provision of care, we also review outcomes from the perspective of unpaid carers. Finally, we examine the evidence on the scale of unmet need, where neither formal nor informal care is providing what people need.

8.1 Social care service quality

Despite constraints in spending, the CQC report that the quality of social care services has improved in the recent period.

In addition, we need to remember that CQC inspections can only provide a 'snapshot' of service quality at the time of inspection and concerns have been raised in the media about the CQC's (BBC News, 2020).

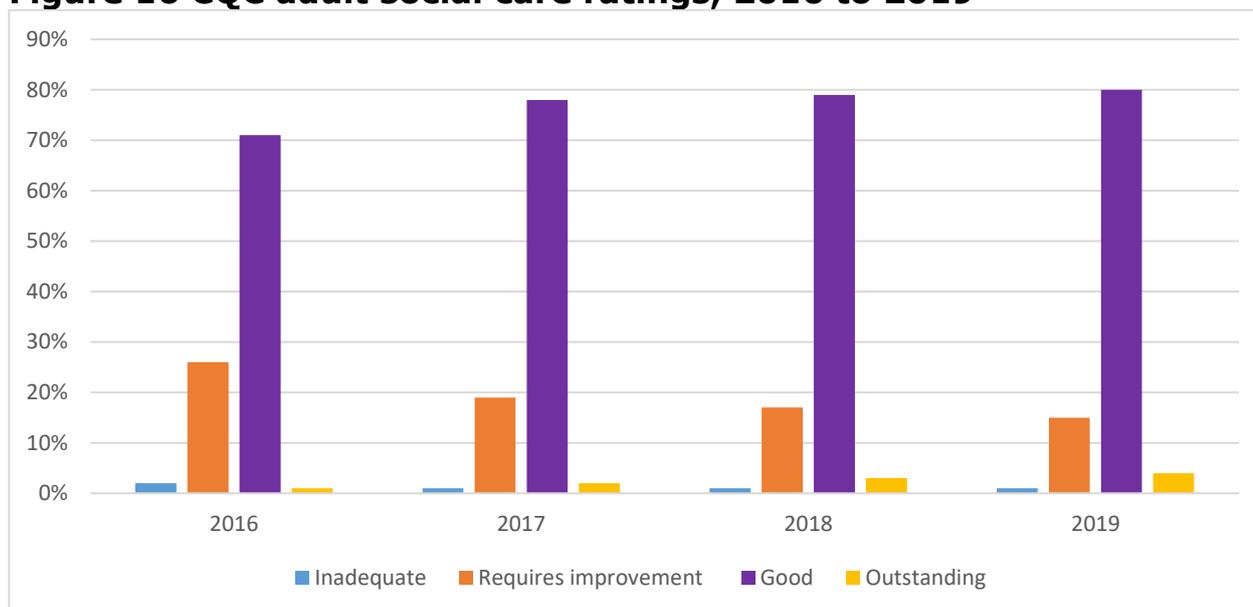
Figure 16 shows that the proportion of 'good' and 'outstanding' CQC ratings increased each year between 2016 and 2019 and the proportion of 'requires improvement' and 'inadequate' ratings declined. This is what we would expect, given the change in inspection methodology in 2014 that concentrated CQC effort on poorly performing services (CQC, 2019a). Services that are rated 'good' or better are inspected less frequently and services that are rated poorly are more likely to close (The King's Fund, 2019b).

In 2019, 16% (or 1 in 6) social care services were deemed to 'require improvement' or to be 'inadequate'. While this number has nearly halved since 2016, it remains high.¹⁶ Community services received the highest proportion of 'good' or 'outstanding' ratings (93%), followed by domiciliary care agencies (86%), residential homes (85%) and nursing homes (76%) (CQC, 2019b). The high ratings for domiciliary care agencies are difficult to reconcile with evidence from workforce consultations, however: three-quarters of home care workers survey by UNISON said that they did not have enough time to do their job 'without being rushed and without compromising the dignity or well-being' of the people they looked after, and three-fifths were still sometimes allocated 15 minutes or less for a visit (other than medication or a welfare check) (UNISON, 2017).

In addition, we need to remember that CQC inspections can only provide a 'snapshot' of service quality at the time of inspection and concerns have been raised in the media about the CQC's capacity to identify serious instances of abuse (BBC News, 2020).

¹⁶ This is a similar proportion to Ofsted's judgements of schools: 14% of schools in 2018 were classified as 'inadequate' or 'requires improvement'. Where the thresholds between categories should lie is a matter of institutional and individual judgement rather than an exact science.

Figure 16 CQC adult social care ratings, 2016 to 2019



Source: CQC (2016, 2017a, 2018a, 2019b)

8.2 Quality of experience for service users

The Adult Social Care Outcomes Framework (ASCOF) measures progress against a range of social care outcomes for social care recipients, carers, and the wider social care system (Appendix Table 1). ASCOF indicators relating to the quality of the social care experience for service users are derived from the Adult Social Care Survey (ASCS).¹⁷ ASCS data suggests that the quality of the social care experience has remained unchanged in the recent period. Between 2014-15 and 2018-19, approximately 2 out of 3 care recipients were 'extremely or very satisfied' with their care and support (indicator 3A) and fewer than 5% were

¹⁷ ASCOF indicators derived from ASCS are based on responses from all types of service user combined (NHS Digital, 2019b Annex Table 2a). The majority (70.5% in 2018/19) of service users whose primary need is identified as learning disability respond to an easy read version of the questionnaire, with slightly different response categories. Their responses are then merged with results from the main questionnaire, which inevitably introduces some distortion. Moreover, responses from learning disabled service users tend to be considerably more positive than other service users. For example, 75% of learning disabled respondents to the easy read questionnaire indicated, 'I am very happy with the way staff help me, it's really good', whereas only 60% of service users with physical support as a primary need indicated they were 'Extremely' or 'Very' satisfied with the care and support services received. Since learning disabled service users make up an increasing proportion of all care users over time, this also means that caution should be exercised in interpreting trends in the ASCS series and ASCOF indicators derived from it. Improvements may reflect compositional change as much as better quality services. A second methodological issue is the use of proxy responses. 10% of questionnaires overall were completed by someone else, without discussion with the service user. A further 70% of questionnaires were completed with assistance from someone else. In both cases, the 'someone else' could be a carer or service provider, which is likely to influence the way in which the quality of care and support services is evaluated. Despite these reservations, ASCS remains the best available quantitative source of detailed information on social care users experiences.

dissatisfied. In the same period, social care-related quality of life remained stable at 19.1 out of 24 (indicator 1A).

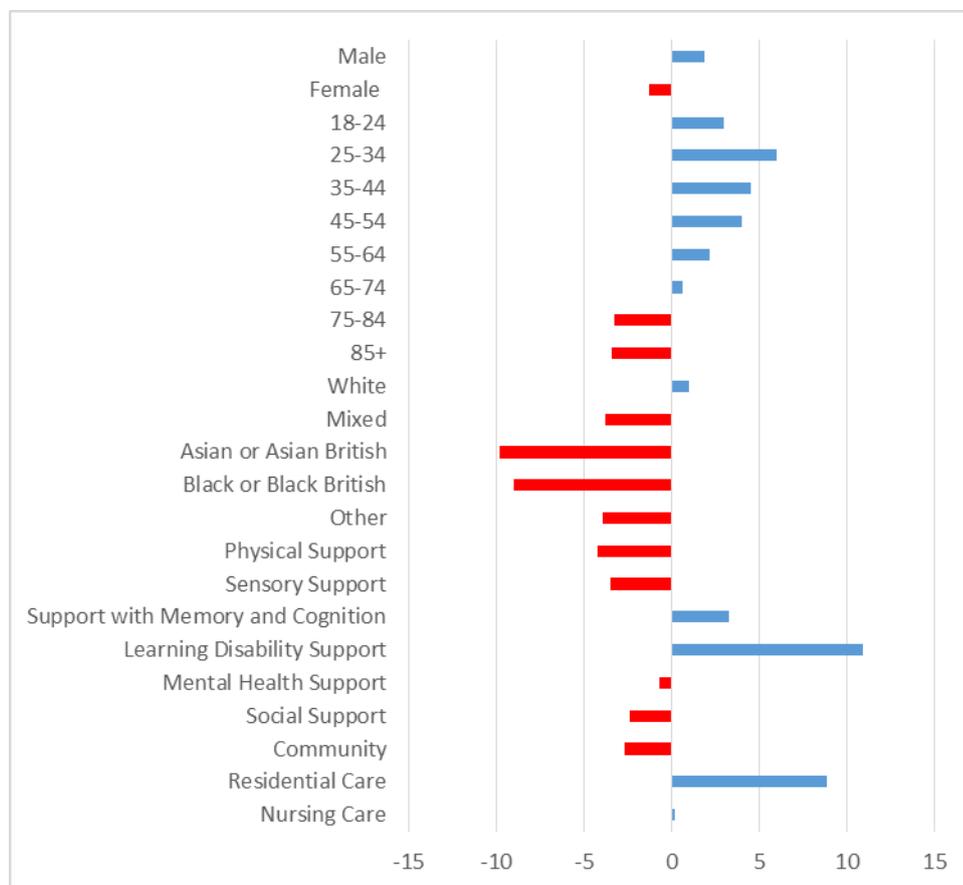
The ASCS results suggest that social care providers have managed to protect the quality of their services despite restrictions to social care budgets. Importantly, however, the ASCS only surveys adults who receive long-term support services funded or managed by social services. As a result, the ASCS only captures the experience of the declining number of people who are receiving care and not the increasing number who are not. Further, while it is positive that outcomes for service users have not declined in the context of funding constraints, it may be argued that there remains significant room for improvement across a number of ASCOF indicators.

The ASCS results also conceal considerable variation on the basis of demographics, care needs and care settings.

Figure 17 shows these variations in relation to overall satisfaction with care and support. Overall satisfaction is highest among males, people in middle age, people with a White ethnic background, people with a learning disability and residential care residents. Overall satisfaction is particularly low among people in older age, people with an Asian or Black ethnic background, people with physical or sensory support needs and people in receipt of community care. The lower reported satisfaction of older care recipients is particularly striking, because older adults are conventionally less demanding of services than younger people, and because as we saw in the previous section, services for older people have become increasingly restricted. It seems that it is not only declining access to receiving services that we need to be concerned about, but also the adequacy or quality of the services provided to those who do get it.

Figure 17 Overall satisfaction of care users with care and support: percentage point difference from England average for each sub-group, 2018-19

England average is 64.3%



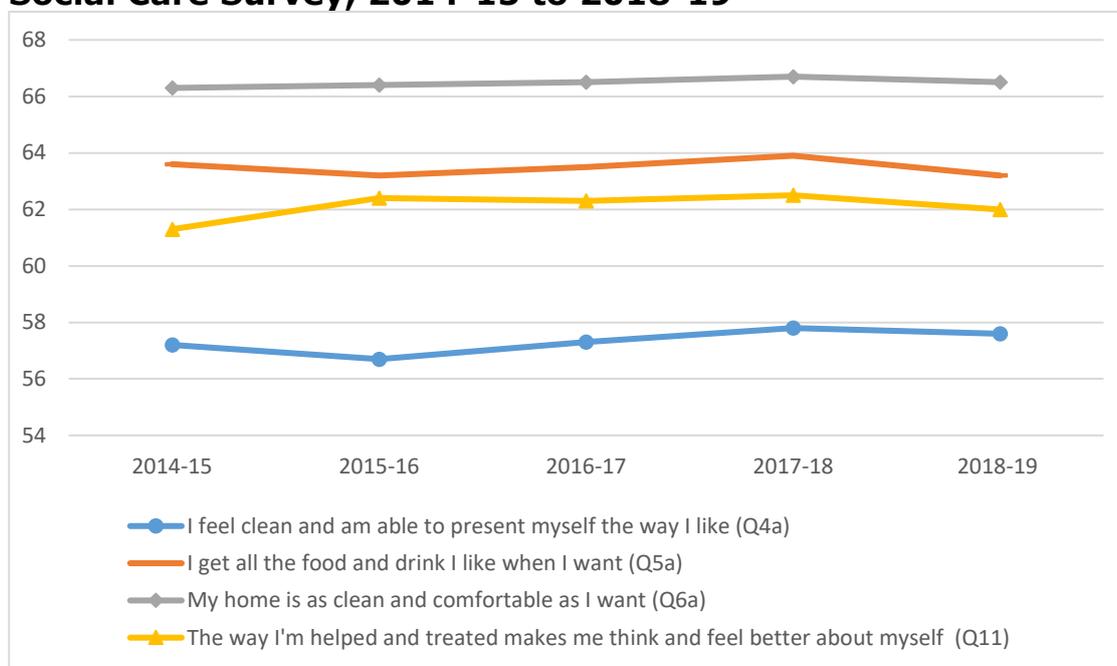
Source: Adult Social Care Survey 2018-19 (NHS Digital, 2019b)

Notes: There are different base values (sample sizes) for each group. Therefore, some figures are subject to more uncertainty than others. Also, the values shown are for each group compared to the average, without controls for the composition of the group. For example, the age profile of the White ethnic group differs from the age profile of the Black or Black British ethnic group. Since age also has an association with the outcome value, the effect of age is reflected in the ethnicity breakdown also.

The King’s Fund emphasise that the evaluation of social care quality should address compassion, respect and dignity in care (The King’s Fund, 2019c), particularly in the context of public concern about what can be achieved in 15-minute home care visits (Chirgwin, 2018), about abuse in care homes (Nelson, 2013), and through an under-trained care workforce. Figure 18 shows ASCS indicators relating to compassion, respect and dignity in care. Between 2014-15 and 2018-19, the proportion of care recipients who agreed that the way they were cared for made them think and feel better about themselves remained stable at around 62% (or 2 out of 3). During the same period, indicators relating to personal and domestic hygiene and food and drink consumption also remained largely unchanged. Again, while it is positive that these indicators have not declined in the context of funding constraints, there remains significant room for

improvement: a service which produces the result that more than two out of five recipients do not “feel clean and able to present myself the way I like” (blue line at the bottom of Figure 18), and one in three do not “get all the food and drink I like when I want” (orange line) is not one to celebrate.

Figure 18 Indicators of respect, dignity and compassion in the Adult Social Care Survey, 2014-15 to 2018-19



Source: Adult Social Care Survey (NHS Digital, 2019b). Note: In order for minor variations over time to be visible, the vertical axis in this Figure does not start at zero.

The ASCOF provides evidence of broader aspects of the social care experience for service users (Appendix Table 1). The proportion of service users who felt that they had control over their daily life remained stable at 77% (indicator 1B). While this is positive, the proportion of service users who received direct payments stalled at around 28% after a period of growth (indicator 1C (2A)). Direct payments allow service users to arrange and pay for their own services and provide a valuable measure of the ‘personalisation’ of care. Stalling direct payments may not simply be due to limited interest but may be explained by a shortage of services to choose from and a lack of support for people interested in taking up direct payments (The King’s Fund, 2019b).

According to ASCOF data, between 2014-15 and 2018-19, only around 45% of service users (or less than half) had as much social contact as they would have liked (indicator 1A (1)). During the same period, the proportion of service users who felt safe increased from 68.5% to 70% and less than 6% did not feel safe.

The increase in the proportion of service users who felt safe in ASCOF data is difficult to reconcile with the considerable increase in safeguarding activity in the recent period. Safeguarding duties are enshrined in the Care Act 2014 and require local authorities to protect adults with care needs (whether or not they are in receipt of care) who are experiencing or at risk of abuse or neglect (Age

UK, 2019a). Figure 19 shows adult safeguarding activity between 2015-16 and 2018-19. A safeguarding concern is a sign of suspected abuse or neglect identified by the local authority or reported to them. A section 42 enquiry occurs when a safeguarding concern meets the threshold for investigation under the Care Act 2014. Where a risk is identified following an enquiry a range of actions may be taken, from a referral to the police for a criminal investigation at the most serious end, through a change in service provision to better protect the individual concerned, to advice and support for both victim and perpetrator. While ASCOF data suggests that service users are feeling safer, the number of safeguarding concerns nearly doubled between 2015-16 and 2018-19. Not all safeguarding concerns are in relation to service users, but the majority are for people known to the council; for example 82% in 2014-15 (HSCIC, 2015).

Figure 19 Safeguarding activity, 2015-16 to 2018-19

	Count of safeguarding concerns ²	Count of s 42 enquiries (as % of safeguarding concerns) ³	Risk identified ⁴ (as % of concluded s42 enquiries)
2015-16 ¹	231,220	99,805 (43%)	
2016-17	364,605	133,265 (37%)	85,390 (64%)
2017-18	394,655	131,860 (33%)	89,005 (67%)
2018-19	415,050	143,390 (35%)	98,950 (69%)

Source: Safeguarding Adults, 2018-19 (NHS Digital, 2019d)

Notes:

1. Data collection was voluntary in 2015-16 so caution is advised when comparing this year's statistics with other years.
2. Safeguarding concern: a sign of suspected abuse or neglect that is reported to the local authority or identified by the local authority.
3. s42 enquiries: where a concern is raised about a risk of abuse and this instigates an investigation under safeguarding procedures in accordance with Section 42 of The Care Act 2014.
4. Risk identified: includes instances where a risk was identified whether or not action was then taken. It does not include instances where the risk assessment was inconclusive, even though in some of those cases action was taken.

Previous commentary has noted that increased safeguarding activity does not necessarily reflect an increase in underlying risk and may be attributable to improved data recording practices (HSCIC, 2014b), growing public awareness of complaint procedures (The King's Fund, 2019d) and of abuse in social care through media reporting (HSCIC, 2014b). However the number of section 42 enquiries as a percentage of safeguarding concerns has remained relatively stable and the number of cases in which a risk is identified as a percentage of section 42 enquiries has increased (Figure 19). This suggests that the increase in safeguarding concerns has not been driven by trivial claims.

On the other hand, there are a range of barriers to safeguarding concerns being raised (e.g. lack of awareness of complaint procedures, lack of willingness to raise a concern, unobserved abuse, etc.) which suggests that safeguarding statistics represent an *underestimate* of the prevalence of abuse and neglect. Even taken at face value, the number of enquiries where risk was identified – nearly 100,000 in 2018-19 - raises significant cause for concern. Shifting to a metric of individuals (adults) rather than enquiries (an individual may be the

subject of more than one enquiry), the safeguarding statistics indicate that approximately 1 in 400 adults in the population as a whole were the subject of an enquiry during 2018-19, but the rate was ten times higher - 1 in 40 – amongst adults aged 85 or over.

This high rate amongst the oldest age group partly relates to the high number, and rate, of enquiries relating to a safeguarding risk in a residential or nursing home: in 2018/19, 47,535 section 42 enquiries related to a safeguarding risk in a residential or nursing home (Table 7). Using the 2011 Census estimate of the English care home population (352,000) (Office for National Statistics, 2015), that equates to roughly 1 in 7 care home residents (ignoring the possibility of multiple enquiries for an individual).

Table 7 Concluded section 42 safeguarding enquiry¹ by type, location and source of risk, 2018-19

Type of risk	Concluded s 42 enquiry	% of concluded s 42 enquiries
Physical Abuse	37,630	22%
Sexual Abuse	6,920	4%
Psychological Abuse	23,480	14%
Financial or Material Abuse	24,625	14%
Discriminatory Abuse	980	1%
Organisational Abuse	7,040	4%
Neglect and Acts of Omission	54,050	31%
Domestic Abuse	7,990	5%
Sexual Exploitation	1,060	1%
Modern Slavery	340	0%
Self Neglect	7,790	5%
Total	171,905	100%
Location of risk		
Own Home	61,825	45%
In the community (excluding community services)	5,495	4%
In a community service	4,360	3%
Care Home - Nursing	14,195	10%
Care Home - Residential	33,340	24%
Hospital - Acute	4,095	3%
Hospital - Mental Health	3,300	2%
Hospital - Community	1,640	1%
Other	9,755	7%
Total	138,005	100%
Source of risk		
Service Provider	43,235	31%
Other - Known to Individual	69,475	50%
Other - Unknown to Individual	25,290	18%
Total	138,000	100%

Source: Safeguarding Adults, 2018-19 (NHS Digital, 2019d). Notes: Concluded Section 42 enquiries: when the safeguarding investigation is complete and the conclusions and actions have been decided. Only enquiries that concluded within this reporting year should be recorded. This can include cases that began in a previous reporting period.

However, safeguarding concerns are by no means restricted to care homes, nor to formal care providers. Table 7 shows 2018-19 concluded section 42 safeguarding enquiries by the type, location and source of risk. Whilst 31% of concluded section 42 enquiries related to the conduct of a service provider, the most common location was an individual's own home (45%) and the most common source was a person known to the individual other than the service provider (50%). The most common type of risk was neglect or acts of omission (51%).

8.3 Health and social care integration

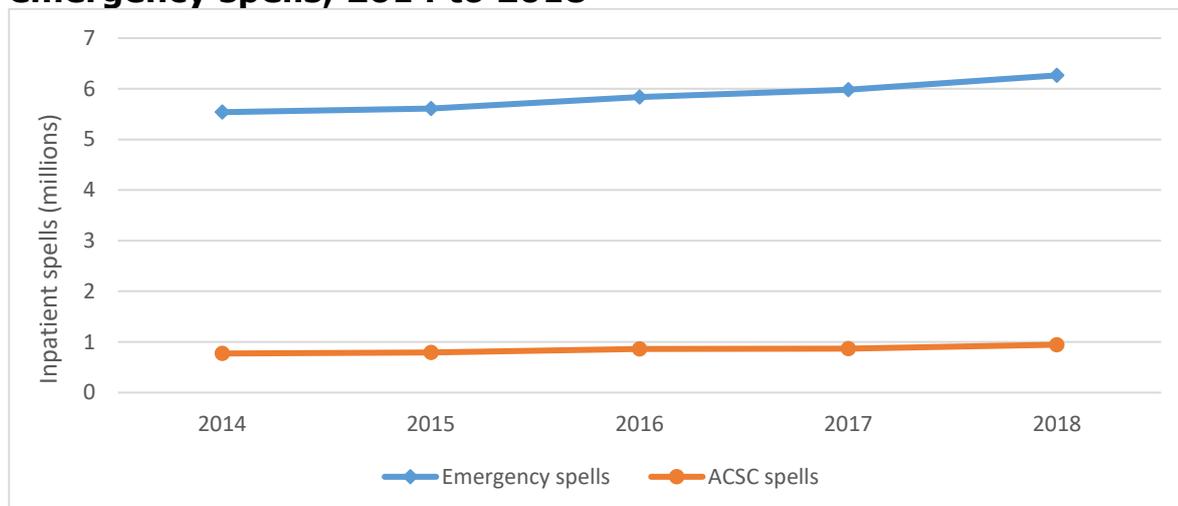
OECD health statistics allow for some limited international comparisons of social care outcomes. The rate of healthcare-associated infections (HAIs) such as urinary tract infections, lower respiratory tract infections, and skin and soft tissue infections, provides a marker of the quality of care and the extent of coordination between health and social care. In 2016/17, there was a higher proportion of long-term care facility residents with a healthcare-associated infection (HAI) in the UK (4.9% of residents) than the OECD19 average (3.8%). On the other hand, in the same period, there was a lower proportion of residents with a pressure ulcer in the UK (3.7%) than the OECD18 average (5.3%) (OECD, 2019b). Unfortunately the paucity of internationally comparable data makes it difficult to interpret these differences further.

Within England, however, a range of other indicators are available. Preventable emergency hospital admissions provide a useful measure of the effectiveness of social care in maintaining the health of care recipients and, at a wider level, the integration of health and social care services. Ambulatory care sensitive conditions (ACSCs) are conditions whereby the need for hospital admission can be prevented by effective community care. The NHS identifies 19 ACSCs and categorises them into three sub-sets: chronic (effective care can prevent a flare up); acute (early intervention can prevent progression); and vaccine-preventable (immunisation can prevent an onset) (NHS Digital, 2019e). Figure 20 shows the total number of hospital spells, defined as a continuous period of care in hospital¹⁸, for ACSCs and all emergency spells from 2014 to 2018. ACSC spells are a subset of emergency spells.

The interpretation of these statistics depends on whether one focuses on levels, proportions or trends. On the latter, the fact that the number of ACSC spells as a proportion of emergency spells has remained stable, increasing only slightly from 14% in 2014 to 15% in 2018, could be considered positive. However, in the context of rising pressure on NHS resources (Vizard et al., 2020), it appears unacceptable that 15% of emergency admissions (or 1 in 6) are for preventable conditions. Moreover, the total *number* of ACSC spells increased by 23% over this period, to just under 1 million.

¹⁸ <https://www.closer.ac.uk/wp-content/uploads/CLOSER-resource-Understanding-HES.pdf>

Figure 20 Ambulatory care sensitive condition (ACSC) spells and emergency spells, 2014 to 2018



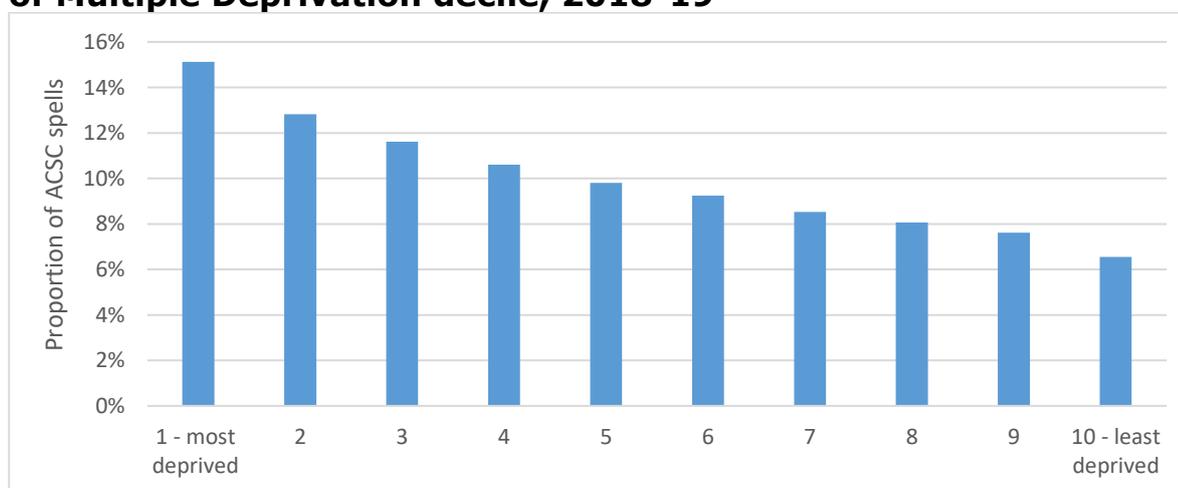
Source: Ambulatory care sensitive conditions (NHS Digital, 2019f)

Notes: Figures calculated using Microsoft Power BI tools. Years are calendar years.

Looking at patterns and trends in hospital admissions for ACSCs, Nuffield Trust analysis (2019) found that between 2007/08 and 2017/18, emergency admissions decreased or remained unchanged for those aged 0 to 15 and 35 to 84 but increased for those aged 16 to 34 and 85 or over. While the reason for the increase in admissions for the 16 to 34 age group is unclear, the increase for the 85 or over age group may be due to the reallocation of social care resources away from older adults.

ACSC spells also exhibit a strong social gradient, as shown by Figure 21. Patients who live in the most deprived tenth of areas according to the Index of Multiple Deprivation (IMD) are over-represented in ACSC spells by a factor of 1.5.

Figure 21 Ambulatory Care Sensitive Condition (ACSC) spells by Index of Multiple Deprivation decile, 2018-19



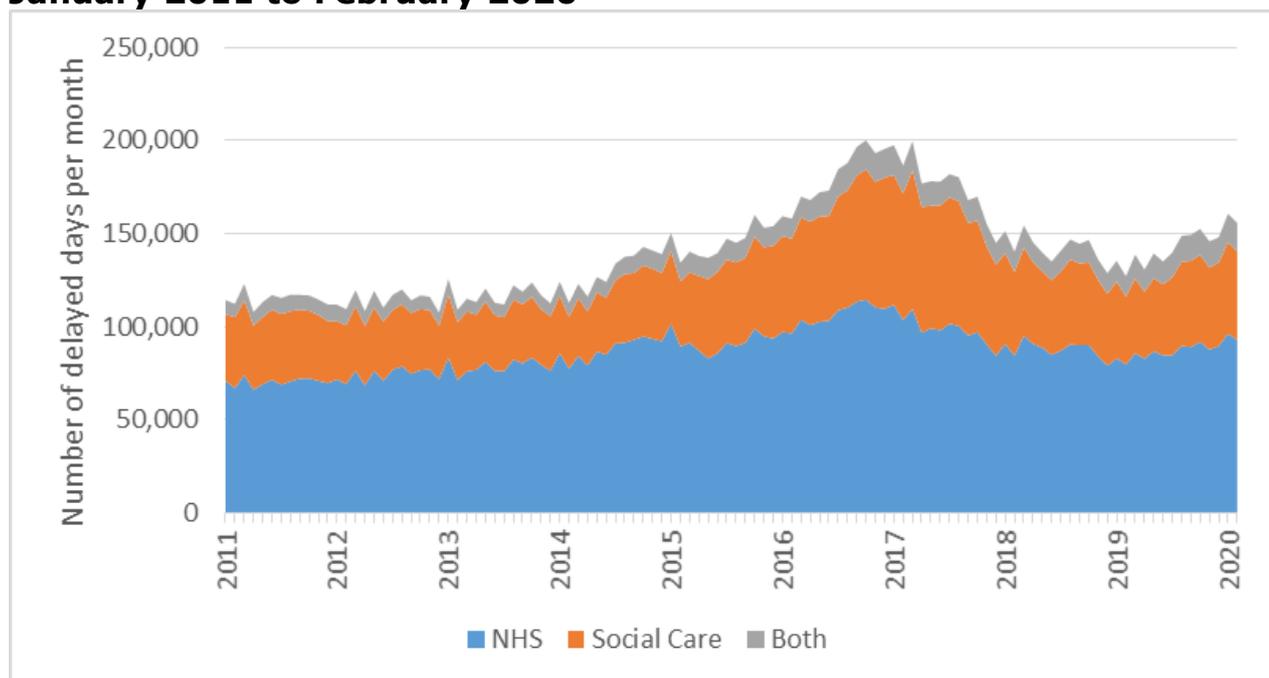
Source: Ambulatory care sensitive conditions (NHS Digital, 2019f)

Notes: Figures calculated using Microsoft Power BI tools

At the conclusion of a hospital spell, the integration of health and social care may be measured by delayed transfers of care. Delayed transfers occur when an inpatient is ready for discharge and continues to occupy a bed. Delayed transfers place strain on hospital staff and resources and are associated with adverse health outcomes, such as an increased risk of infection (The King’s Fund, 2018). Figure 22 shows the total number of delayed transfer days per month and the organisation deemed responsible between January 2011 and February 2020, on the eve of the pandemic. Delayed transfer peaked at 200,095 days in October 2016. The decline in delayed transfers which followed coincided with concerted government efforts to free up hospital beds (see Department of Health (2018), and NHS (2018)). However, delayed transfers began to creep up again in the last part of 2018 and throughout 2019. In February 2020, they stood at 155,717 days, a figure that was 21,364 higher than in February 2015, shortly before the Conservative government took office.

While delayed transfers provide a useful measure of care planning and integration, previous commentary has raised concerns about the recent intensive government focus on delayed transfers. A singular focus on delayed transfers may divert attention from other important areas of care integration which may be more effective in managing pressures, such as preventative care (CQC, 2017b), and the pressure to free up hospital beds may result in older adults being unnecessarily or hastily transferred to residential care rather than being set up with support in their own homes (ADASS, n.d.; Bolton, 2018). This issue came into sharp focus in the early stages of the pandemic, with serious consequences.

Figure 22 Delayed transfers of care by responsible organisation, January 2011 to February 2020



Source: Delayed transfers of care (NHS England, 2020)

Health and social care integration may also be evaluated with reference to the take up of reablement services. Reablement is aimed at people leaving hospital and is intended to support them to live independently and avoid readmission. According to ASCOF data, the proportion of older adults who received reablement services after discharge remained stable at around 3% between 2010-11 and 2018-19 (Table 8, indicator 2B(2)). Reablement services have been shown to be effective. In 2017, three quarters of people who used reablement services improved in their level of independence (NAIC, 2017). Despite this, reablement services lack capacity to meet demand (NAIC, 2017).

Evidence of the health and financial benefits of integration is limited and uncertain. The National Audit Office review in 2017 found no compelling evidence that integration had contributed to systemic or sustainable reductions in hospital activity or the cost of care (National Audit Office, 2017). However there are a range of challenges involved in evaluating the effects of integration. With the proliferation of integration initiatives in recent years, there are fewer control sites against which the effects of integration can be compared (Keeble, 2019). It is also difficult to isolate the effects of integration from other factors (National Audit Office, 2018c). Further, there are a range of data issues that hamper robust evaluation, including the lack of comparable cost data across care settings (National Audit Office, 2017), inconsistent boundaries between care organisations and target populations, and a lack of activity data for social care services and GPs (Keeble, 2019). While these challenges limit the extent to which research may claim the success – or otherwise – of integration, it may be expected that the effects of integration may take some years to materialise. Integration requires new relationships and ways of working to be embedded across sectors with different cultures and working practices (National Audit Office, 2017). NAO also note that local areas which have achieved better coordination of care have been working together for up to 20 years.

While there is limited robust evidence of the health or financial benefits of integration, there is some evidence that integration initiatives are contributing to positive health and social care outcomes. Qualitative evaluations of care integration at the local level have found that integration is perceived to improve the patient experience (see (QORU, 2018) and (CQC, 2018b)) and the Better Care Fund was found to incentivise local areas to work together (National Audit Office, 2017).

8.4 Unpaid carers

As discussed above, the provision of care by unpaid carers has intensified in the recent period, and this is partly related to the reduction in services for some of the people they care for. One in eight respondents (12%) to the Carers UK survey of unpaid carers in 2019 reported that they or the people they supported received less care or support services during the previous year due to a reduction in support from social services (Carers UK, 2019b). Half of these respondents were caring for over 90 hours a week, and 42% of them had been caring for 15 years or more. The Carers UK survey is unlikely to be fully representative of all

carers, but the picture they describe is consistent with the evidence presented in section 7 above on reductions in services for older people and for carers.

The increased policy focus on supporting carers has not – or not yet – been sufficient to offset this increased pressure, because outcomes for unpaid carers appear to have deteriorated. Some caution is needed in interpreting these results however, because of a change in methodology in the survey from which the ASCOF indicators relating to the experience of unpaid carers are derived – the biennial Survey of Adult Carers in England (SACE). The eligible population of carers was expanded in 2016-17 from those who had received a carer’s assessment or review from a local authority in the past 12 months to include those who had not (i.e. to all adult carers known to local authorities). The newly eligible sub-group report better outcomes on a number of questions in the survey than the original sub-group and the differences are statistically significant, so the effect on the overall pooled results will be to suggest an improvement (or less of a deterioration) between 2015-16 and 2016-17, where in fact there may not be in the carer population as originally defined by the survey (NHS Digital, 2017b). For this reason the ASCOF data also provide figures in parentheses for 2016-17 calculated for the originally eligible sample only.

Looking at ASCOF data (Appendix Table 1), in 2018-19, 38.6% of carers were satisfied with the support they and the person they cared for received from social services (indicator 3B). This was considerably lower than the 64.3% of care recipients who were satisfied with their care and support (indicator 3A). In 2012-13, carers’ satisfaction with services stood at 43.1%, and there is little indication that the change in sample eligibility substantially affected this time series (see figures in parentheses in Appendix Table 1). It is fair to conclude that between 2012-13 and 2018-19, satisfaction with services on the part of carers fell by 4.5 percentage points – from an already low base.

Similarly, carer-reported quality of life decreased, both in the most recent period and over the time series as a whole (indicator 1D). The quality of the social care experience for unpaid carers in the recent period is further illustrated by responses to SACE questions relating to carer health and financial stress. Table 8 shows that between 2016-17 and 2018-19, there was a statistically significant increase in the proportion of carers who experienced a range of health conditions caused by their caring role. Many of these conditions reveal the day to day strains of caring and the impact that caring can have on quality of life. It is concerning that only 8.6% of carers (or fewer than 1 in 10) *did not* experience a health condition affected by their caring role and that there was a statistically significant decline in this group. Table 9 shows that during the same period, there was a statistically significant increase in the proportion of carers who experienced a lot of financial difficulties due to their caring role. These results suggest that unpaid carers are increasingly bearing the social costs of constraints in social care spending.

Table 8 Carer health conditions affected by caring role in the last 12 months, 2016-17 to 2018-19

	2016-17	2018-19
Feeling tired	76.0	77.8 s
Feeling depressed	43.4	45.1 s
Loss of appetite	13.0	13.9 s
Disturbed sleep	64.0	66.0 s
General feeling of stress	58.7	60.6 s
Physical strain (i.e. back)	32.8	34.6 s
Short tempered/irritable	41.8	43.0 s
Had to see own GP	29.3	29.0
Developed my own health conditions	23.3	23.6
Made an existing condition worse	19.7	20.6 s
Other	3.3	3.4
No, none of these	9.7	8.6 s

Source: Survey of Adult Carers England (NHS Digital, 2019b)

Notes: 1. Question asked: 'In the last 12 months, has your health been affected by your caring role in any of the ways listed below?' 2. 's' denotes statistically significant change between 2016-17 and 2018-19

Table 9 Carer financial difficulties caused by caring, 2016-17 to 2018-19

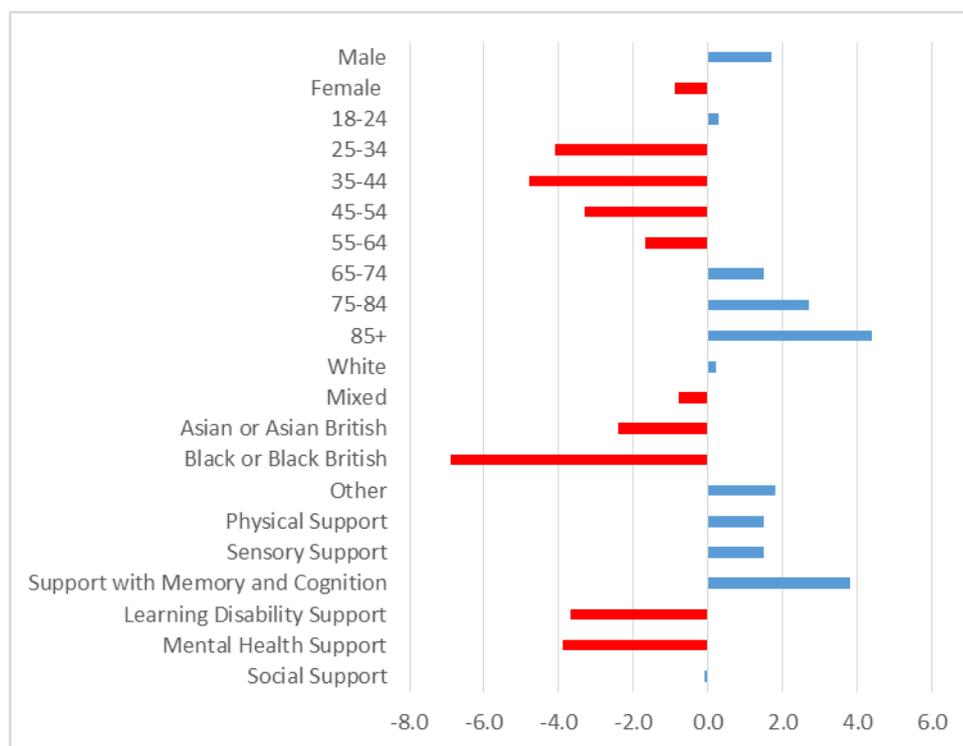
	2016-17	2018-19
No financial difficulties	54.4	53.4
Some financial difficulties	36.0	36.0
A lot of financial difficulties	9.6	10.6 s

Source: Survey of Adult Carers England (NHS Digital, 2019b)

Notes: 1. Question asked: 'In the last 12 months has caring caused you any financial difficulties?' 2. 's' denotes statistically significant change between 2018-19 and 2016-17

Outcomes for carers vary substantially according to the carer's demographic background and the primary support reason of the care recipient. Table 10 shows these variations in relation to carer satisfaction with social services. On average, male carers are more satisfied with social services than women. Carers in older age groups are more satisfied with social services than carers in middle-age, which is the opposite of the trend for care recipients (Figure 17). This could be related to the fact that older adults may be more likely to care for a partner and carers in middle-age may be more likely to carry additional responsibilities, such as paid work and other family duties. Carers with a White ethnic background are more satisfied with social services than carers from other ethnic groups and carers from a Black ethnic background are considerably less satisfied. Finally, carers who provide support to care recipients with memory and cognition issues are the most satisfied with social services while carers who provide support for people with learning disabilities and mental health issues are the least satisfied.

Table 10 Overall satisfaction of carers with social services: percentage point difference from England average, by sub-group, 2018-19
 England average is 38.6%



Source: Survey of Adult Carers England (NHS Digital, 2019b)

Notes: 1. Results are calculated for each sub-group in turn (bivariate not multivariate analysis). 2. There are different base values (sample sizes) for each sub-group. Therefore, some results are subject to more uncertainty than others.

8.5 Unmet need for care

The issue of unmet need for care gives rise to important conceptual, methodological and policy questions. Just as the social model of disability shifted the focus from individual impairments and functioning deficits, so recent discussions of 'care poverty' are seeking to shift the debate from individuals and families unable to meet their care needs to the social, economic and institutional structures that create this unmet need (Kroeger, 2019). Despite major changes in the composition and living and working arrangements of the population in recent decades (ageing, higher rates of working age disability, smaller and more geographically mobile families, higher rates of partnership dissolution, more women in employment), there has been little adaptation in the institutions of the welfare state or the labour market to accommodate the changing needs for care. However this institutional lens is not yet applied in the way that unmet need is measured or reported in regular survey data.

A range of methodological choices that must be made in measuring unmet need (Vlachantoni, 2019), starting with the definition of 'need'. This can be defined on the basis of the current service standards – in the English context, the minimum threshold for entitlement to social care as set out in the Care Act 2014

(Age UK, 2019b) - or a lower threshold, bearing in mind the arbitrariness of current standards and the fact that unmet needs below the service eligibility threshold can still significantly limit a person's quality of life. It must also be decided whether 'need' is based on self-evaluation, the opinion of a carer who knows the person well, or a third-party, such as a social worker's assessment. Evidence suggests that carers (at least carers who are also in paid work) perceive a higher unmet need for services for the cared-for person than the cared-for person him or herself (Brimblecombe et al., 2017).

Furthermore, whether a need is 'unmet' is open to interpretation. In many cases, a need is recorded as unmet only if care is entirely absent, but this ignores the possibility that some care is provided but not of a sufficient quality (including dignity and respect) or quantity or timeliness to address the need satisfactorily.

All of these challenges must be addressed in the context of significant data gaps and limitations. In particular, there is a paucity of evidence on unmet need among working age adults, because the main survey data sources on unmet need collect information on older adults only - a legacy, perhaps, of thinking about social care as predominantly an issue affecting older adults. Our previous analysis of one of the few sources on people of working age, the Family Resources Survey, indicated high levels of apparently unmet need in 2011/12. For example, 45% and 46% of 16-44 and 45-59 year olds in the UK reporting four or more areas of difficulty (for example, mobility, manual dexterity, communication, and memory or ability to concentrate)¹⁹ received no weekly (or more frequent) help from formal or informal carers (Burchardt et al., 2015). More recent estimates for people of working age are not available at the time of writing.

8.5.1 Unmet need among older adults

Unmet need among older adults is measured by the English Longitudinal Study of Ageing (ELSA) and the Health Survey for England (HSE). The ELSA measures needs by activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs refer to basic physical abilities and in ELSA include dressing, walking across a room, bathing, eating, getting in and out of bed, and using the toilet (NatCen, 2016). IADLs refer to tasks necessary for managing life and in ELSA include using a map, recognising physical danger, preparing a hot meal, shopping for groceries, making a telephone call, communication, taking medication, doing housework and managing money (NatCen, 2016). ELSA wave 8 (2016/17) asks respondents with ADL and IADL needs whether any help was received (from paid or unpaid carers) and, if so, whether it was sufficient to

¹⁹ Has a longstanding illness or disability and experiences 'substantial difficulties' in four 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.

meet their needs. ELSA thereby allows for both a minimalist and a more expansive approach to measuring unmet need among older adults, but without associating the help received with particular ADLs or IADLs. Table 11 shows AgeUK analysis of unmet need for care among older adults in ELSA wave 8 using population weights. According to this analysis, in 2016/17 approximately 1.4 million older adults with at least one ADL need had some level of unmet need for care. This increases to 1.5 million if IADLs are included. Using the mid-2017 England population estimate of older adults (10,030,511) (ONS, 2018), this implies that 14% of all older adults had unmet need based on at least one ADL need and 15% had unmet need based on at least one ADL/IADL need. While these figures are high, they reflect levels of unmet need where the bar for need is set low. In practice, the threshold for entitlement to social care services under the Care Act 2014 is approximately three ADLs (Age UK, 2019b). Using the same population estimate, 5% of older adults met the threshold of 3 ADLs or more, and 3% met the threshold and had some level of unmet need.

Table 11 Need and unmet need for help with ADLs and IADLs, people aged 65 or over, England 2016/17 (ELSA wave 8)

(a) Need for help with Activities of Daily Living (ADL)

	1 or more ADL	as % of need	as % of adults 65+	3 or more ADLs	as % of need	as % of adults 65+
Total number of people aged 65+ in need of help	1,944,585	100%	19%	534,858	100%	5%
...of which received insufficient help	262,582	14%		138,345	26%	
...of which received no help	1,140,937	59%		158,468	30%	
Total number of people aged 65+ with unmet needs	1,403,519	72%	14%	296,813	55%	3%

(b) Need for help with Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL)

	1 or more ADL/IADL	as % of need	as % of adults 65+	3 or more ADL/IADL	as % of need	as % of adults 65+
Total number of people aged 65+ in need of help	2,767,630	100%	28%	1,129,970	100%	11%
...of which received insufficient help	672,869	24%		374,178	33%	
...of which received no help	868,369	31%		139,036	12%	
Total number of people aged 65+ with unmet needs	1,541,238	56%	15%	513,201	45%	5%

Source: AgeUK analysis (Age UK, 2019b) of ELSA wave 8 (2016/17) using population weights, and authors' calculations

Using the older population with needs as the base, however, the proportions with unmet need are of course much higher. Table 11 shows that approximately 1 in 3 older adults with 3 or more ADL needs received no help at all, and a majority (55%) had some unmet needs.

HSE data presents a different picture of unmet need among older adults. HSE asks respondents about a broader list of ADLs and a different list of IADLs compared to ELSA. Additional ADLs in HSE include getting up and down stairs, taking medicine, preparing food, and washing face and hands. IADLs include shopping for food, doing routine housework, getting out of the house and doing paperwork or paying bills. HSE only records need as going unmet if no help

whatsoever is received in the last month, from formal services or unpaid care, with the ADL or IADL in question. There is no category of 'insufficient help received'. However it is possible in HSE for help to be received by a respondent with some ADLs or IADLs but no help to be received with other ADL or IADLs, in which case the respondent would still be recorded as having unmet need.

According to 2018 HSE data (Table 12), 27% of older adults needed help for ADLs (compared to 19% in ELSA) and 26% needed help for IADLs (compared to 28% in ELSA). By far the most common ADL need in HSE data is 'getting up and down the stairs' (22% of older adults), which is not included in ELSA, and this goes some way to explaining the higher rate of ADL need recorded in HSE.

Table 12 Need and unmet need for help with ADLs and IADLs, people aged 65 or over, England, 2018 (HSE)

	% of adults 65+
ADLs	
Needed help	27
Received some help last month	11
Unmet need in relation to at least one ADL	24
IADLs	
Needed help	26
Received some help last month	20
Unmet need in relation to at least one IADL	13

Source: Health Survey for England 2018, social care in older adults data tables (NHS Digital, 2019g)

Notes: 1. 'Needed help' includes those who said they could do an activity but with difficulty, those who could only do it with help, and those who were unable to do it. 2. IADLs: excludes help because of the way household responsibilities are divided. 3. It is possible to have received help with some ADLs or IADLs and still have unmet need for help with others, so 'Received help' and 'Unmet need' sum to more than 'Needed help'.

The wider base of ADL need in HSE, together with the linking of help to specific ADLs, feeds through into a higher proportion of the population recorded as having unmet need for help: 24% in HSE compared to 14% in ELSA. The estimates for unmet needs with IADLs are much closer: 13% in HSE and 15% in ELSA (Table 11).

HSE 2018 data provides evidence that unmet need follows a social gradient. Table 13 shows this gradient in relation to equivalised household income. The proportion of older adults in the lowest one-third of the equivalised household income distribution who needed help was almost twice the proportion than in the highest third of the income distribution. While a greater proportion of older adults in the lowest third received help, this was not sufficient to compensate

for higher levels of need. As a result, the prevalence of unmet need in the lowest third was considerably higher than the highest third.

Table 13 Need and unmet need for help by equivalised household income, people aged 65 or over, England, 2018 (HSE)

	% of adults aged 65 + in ...		
	highest third of income distribution	middle third of income distribution	lowest third of income distribution
...who:			
ADLs			
Needed help	18	25	32
Received some help last month	5	9	12
Had unmet need in relation to at least one ADL	16	22	28
IADLs			
Needed help	14	22	30
Received some help last month	13	17	23
Had unmet need in relation to at least one IADL	6	11	16

Source: Health Survey for England 2018, social care in older adults data tables (NHS Digital, 2019g)

Notes: 1. For information on equivalised income and how it is derived, see the HSE 2018 Methods report. 2. Data in this table have been age-standardised. For more information see the Introduction to the HSE 2018 Methods report. 3. See also notes to Table 12

This pattern is repeated in relation to the Index of Multiple Deprivation (Table 14). A higher proportion of older adults in the most deprived neighbourhoods receive help, but it is not sufficient to reduce the social gradient in needs between those in the most and least deprived areas. More than twice the proportion of adults aged 65 or over living the most deprived fifth of neighbourhoods had an unmet need for help with one or more activities of daily living, the the proportion in the least deprived fifth of neighbourhoods (41% compared to 19%). An even greater disproportionality is recorded in relation to unmet need for help with instrumental activities of daily living (22% compared to 9%).

The existence of a social gradient in health, and the importance of the social determinants of health, has become widely accepted but recognition of the social gradient in need for social care is in its infancy.

Table 14 Need and unmet need for help, by neighbourhood deprivation, people aged 65 or over, England, 2018 (HSE)

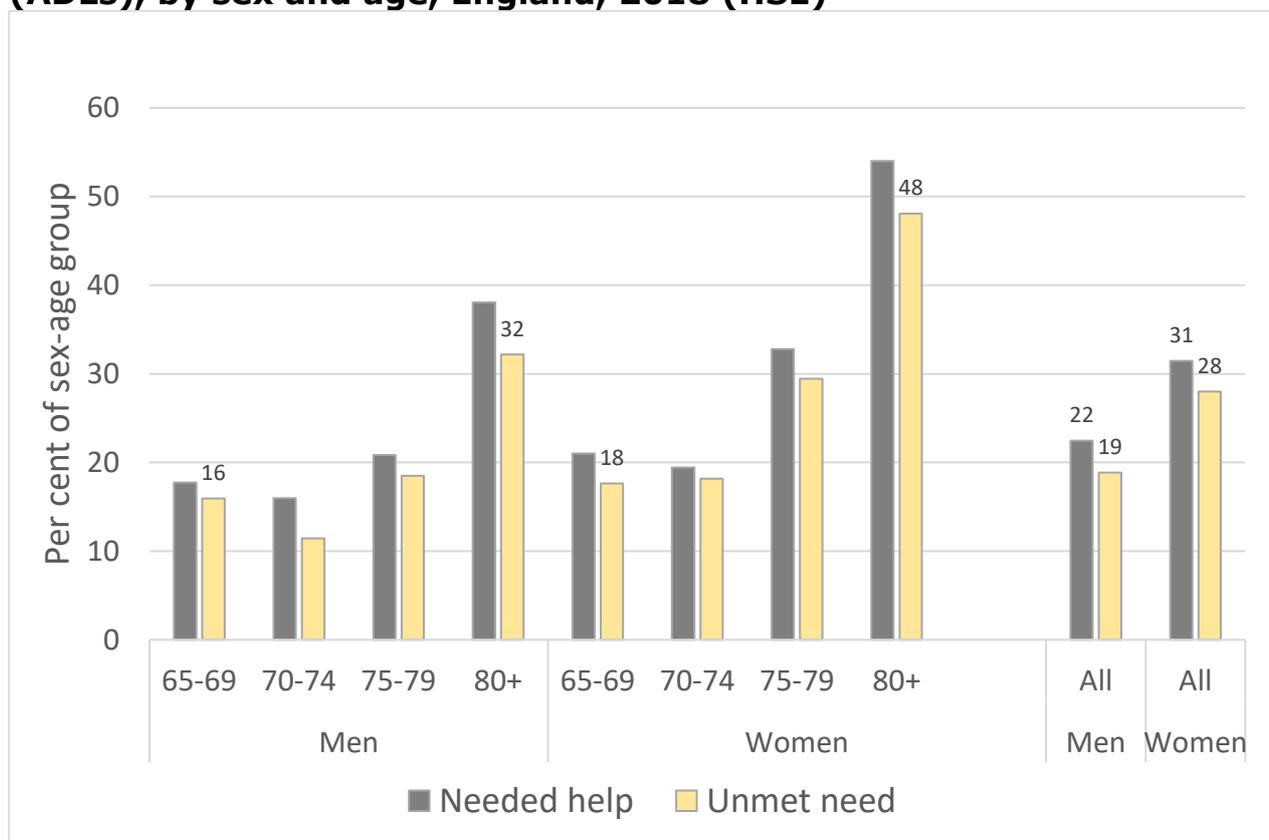
	% of adults aged 65 + living in				
	Least deprived fifth of neighbourhoods	2nd	3rd	4th	Most deprived fifth of neighbourhoods
...who:					
ADLs					
Needed help	21	21	26	33	47
Received some help last month	8	8	9	14	20
Had unmet need in relation to at least one ADL	19	18	23	27	41
IADLs					
Needed help	20	22	25	32	43
Received some help last month	15	14	20	25	32
Had unmet need in relation to at least one IADL	9	13	12	16	22

Source: Health Survey for England 2018, social care in older adults data tables (NHS Digital, 2019g)

Notes: 1. Neighbourhood deprivation as calculated by the Index of Multiple Deprivation 2015 for ONS Lower-layer Super Output Areas. For information on the Index of Multiple Deprivation and how it is derived, see the HSE 2018 Methods report. 2. Data in this table have been age-standardised. For more information see the HSE 2018 Methods report. 3. See also notes to Table 12.

Need for help and unmet need also vary by age and sex: women are more likely than men to need help with one or more ADL (31% compared to 22%), and are more likely to have unmet need (28% compared to 19%); and those aged 75 or over are more likely than 65-74 year olds to need help and to have unmet need, as shown in Figure 23. Putting these together, nearly half (48%) of women aged 80 or above have an unmet need for help with one or more ADL.

Figure 23 Need and unmet need for help with Activities of Daily Living (ADLs), by sex and age, England, 2018 (HSE)

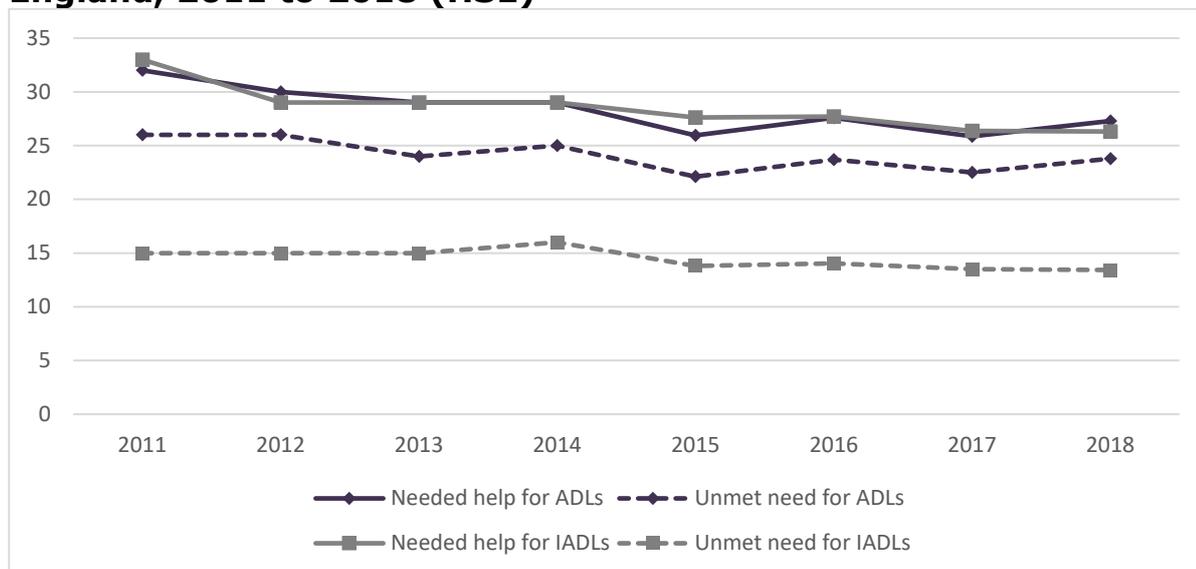


Source: Health Survey for England 2018, social care in older adults data tables (NHS Digital, 2019g)

Notes: See notes to Table 12

The HSE provides a time series of need and unmet need among older adults since 2011. Figure 24 indicates that the prevalence of unmet need for at least one ADL fell between 2011 and 2015, since when it has fluctuated. The most recent data point, in 2018, is one percentage point lower than the observation in 2014, before the Conservative administration took office. It appears that the increase in spending in real terms, but combined with the reduction in services provided to people aged 65 or over, has been broadly neutral over this period in terms of this measure of unmet need among older adults.

Figure 24 Need and unmet need for help, people aged 65 or over, England, 2011 to 2018 (HSE)



Source: Health Survey for England 2018, social care in older adults data tables (NHS Digital, 2019g)

Notes: 1. There was a change to the routing of these questions from 2013 onwards. Originally, all aged 65 and over were asked whether they needed help with each ADL and IADL, and then regardless of their answers they were asked whether they had received help for each. Many participants had neither needed nor received help, and found the repeated questions onerous. Therefore the change in 2013 meant that only those who said they needed help with at least one ADL or IADL were asked about whether they had received help. Analysis indicated that only a very small number of participants who said they did not need help for any ADL or IADL had actually received any help, and this change therefore has a negligible impact on results. 2. See also notes to Table 12.

Drawing together the findings on unmet need for care, we can identify three principle areas of concern. The first is the lack of up-to-date evidence for people of working age. Given that nearly half of gross current expenditure by local authorities on adult social care was devoted to people of working age in 2018/19, understanding the extent to which this spending succeeds in reducing unmet need is surely an important task.²⁰

The second area of concern is the very high *levels* of unmet need among adults aged 65 or over. Even using the higher threshold of people who need help with three or more activities of daily living, we find that just over half of this group (55%) do not receive sufficient help.

The third area of concern are the inequalities in unmet need. Women in their 80s are at particularly high risk. Moreover there is a steep social gradient in needs and in unmet needs for help with activities of daily living and instrumental

²⁰ Although working age clients make up a minority of people receiving adult social care (35% of long-term clients and 14% of short-term episodes), the unit costs are typically higher, such that 48.5% of gross current expenditure by local authorities that can be attributed to an age group is for people of working age. Author's calculations using (NHS Digital, 2019a).

activities of daily living. As we have seen, older adults living in the most deprived areas are more than twice as likely to have unmet needs as those in the least deprived areas. Social care is targeted on lower income (and low wealth) households, so the social gradient in unmet need would be even worse in its absence, but it remains very steep.

The consequences of not receiving basic help when needed can be severe. Ipsos MORI quote an interviewee in their study of people with unmet need for social care as saying: "You don't [cope], you exist. You just exist. It's an existence. I'll tell you what I think, I consider this house a coffin with a door. Do you understand that?" (female, age group 80-89) (Ipsos MORI, 2017, p. 51).

9 Conclusions

9.1 Strengths and weaknesses of adult social care on the eve of the pandemic

This paper began by observing that the crisis in social care provoked by the coronavirus pandemic had its roots in the development of social care policy, spending, and outcomes over the preceding decade. We turn now to summarise our assessment of the strengths and weaknesses of the sector on the eve of the pandemic.

9.1.1 Policies

Firstly, in terms of policies: a key strength has been the sustained emphasis on health and social care integration. As we saw in sections 4.3 and 5.1.1, this has been pursued both through a raft of policy initiatives nationally, regionally and locally, and through the channelling of funding to pooled NHS and local authority budgets. The development of mechanisms and institutional architecture to support joint planning, budgeting and accountability bodes well for the future, although there are still many barriers to overcome, not least the fragmentation within each sector in themselves, and progress is unlikely to be rapid.

However, we maintain that the principal driver of health and social care integration, at least at national level, has been the imperative to reduce pressure on the NHS. Lengthening waiting lists, cancelled operations and delays at accident and emergency feature prominently in news headlines, in a way that older people being left without assistance to dress or wash, or disabled people being treated with a lack of dignity in rushed 15-minute visits, typically do not. Whether for this reason or because the NHS is simply more visible and accessible to ministers, the emphasis in the centrally-directed integration agenda has been on reducing delayed transfers of care from hospitals, and reducing avoidable admissions. Arguably, this unbalanced approach to integration played out in the early stages of the response to COVID-19, when the drive to 'protect the NHS' led to patients being discharged into care homes without testing and without due regard either for their own well-being or for that of the residents and staff

in the receiving care home, especially in the context of inadequate PPE for staff (Hodgson et al., 2020); and in the policy of keeping care home residents who became ill *in situ* rather than transferring them to hospital – although clearly there are risks associated with hospital admission as well. Social care needs to be positioned as an important partner in achieving the overall objective of promoting life and quality of life, not as the handmaiden of the NHS (Daly, 2020).

Aside from integration, a second key policy focus during the Conservative administrations has been reforming the basis on which people are eligible for publicly-funded social care, specifically in relation to the capital means-test threshold, the treatment of the family home, and the existence or otherwise of a lifetime cap on costs. As we saw in section 3, this featured prominently in all three manifestos over a less-than-5-year period and absorbed a disproportionate amount of political capital, and yet we find ourselves further from a solution than we were in 2014, when the successful passage of the Care Act established the legislative framework for a higher capital means-test threshold and a lifetime cap, following much consultation and with cross-party support. Worrying about who will or won't be able to pass on their family home to their descendants seems like the wrong focus, when set alongside the scale of, and the steep social gradient in, unmet need (as evidenced in this paper). The gradient persists despite the already targeted nature of services. Raising the capital means-test threshold or placing a lifetime limit on costs will do nothing to address existing unmet needs among the most deprived older people. Of course, the 'horizontal' inequality generated by the means-test among people with modest (and higher) levels of capital between those who are lucky enough never to need long-term care, and those who have the misfortune to need a prolonged or intensive period of care, is important. But it is not the most pressing issue in the organisation or funding of social care today. The policy gaze has been mis-directed. That represents a missed opportunity to make faster progress on improving access and quality, which could have enhanced the resilience of social care ahead of facing one of the biggest challenges in its history.

9.1.2 Spending

There is no doubt that adult social care was better resourced on the eve of the pandemic than it had been in 2014/15 in the last year of the Coalition government. There had been an increase of 2.8% in real terms in gross spending by local authorities, and an estimated increase of 6.9% in real terms if pooled funding and spending by the NHS is taken into account. These are significant increases, and considering the 'what if' scenario had these increases not been in place or – worse still – had the preceding five years of cuts continued, is a salutary thought-experiment.

However the outcomes that could be expected from these increases are less impressive in four respects. Firstly, the funding was made available in an ad hoc manner and after a period of deep cuts. A smoother trajectory over the ten years as a whole would have been more efficient and aided planning and long-term investment. Secondly, the largest increases were available to local authorities

with the least deprived populations, as we saw in section 4.2. That is because local authority social care funding is increasingly dependent on locally-raised revenue (the social care precept) as opposed to central government grants, and authorities serving more deprived populations can raise less through these means. Thirdly, the substantial uplift to statutory minimum wages through the introduction of the National Living Wage, whilst a welcome boost for the army of low-paid care workers, added to service providers' costs. On some estimates, this has entirely offset the additional revenue from the social care precept. Fourthly, demand pressures in the working age population from both increased rates of mental illness and larger numbers of people with learning disabilities and complex needs, and a continuing increase in the number of people aged 80 or over in the population, have out-stripped funding increases over the longer term (section 5.1.4).

Thus whilst in terms of resources social care entered the pandemic in better shape than it would have done had the pandemic hit five years earlier, real-terms increases in funding were offset by higher input costs and rising demand, and the way in which some additional revenue has been raised generates equity concerns between more and less deprived areas. The government's recent 'levelling up' agenda has a lot of work to do, even just to reverse the dis-equalising effects of the Social Care Precept.

9.1.3 Inputs

As discussed in section 6.2, the lowest paid in the social care workforce benefitted significantly from increases in the statutory minimum wage from April 2016 onwards. However, the limited scope for budgetary manoeuvre on the part of local authority commissioners and care providers meant that these increases did not feed through into wage rises further up the distribution, instead increasing the concentration of care workers at the bottom. Nor was the higher wage floor sufficient to tackle high staff turnover or to induce employers to invest significantly in training and development. The social care sector arrived on the doorstep of the pandemic with a workforce described by a rule of threes: one in three independent sector care workers paid at the minimum wage, one in three of all social care workers changing job or leaving social care each year, and one in three care workers on zero-hours contracts. In fact, these proportions are even worse for some groups: 58% of domiciliary care workers are on zero-hours contracts, for example, and 40% of workers providing direct care leave their job each year.

One of the obstacles to improving the pay and job security of carers is the fragmented nature of provision. With an estimated 7,800 independent organisations providing residential care and 10,500 providing non-residential care in England in 2019/20, and a low rate of union membership (17% among employees in residential care, and 22% among employees in 'social work without accommodation', compared to 54% in healthcare, for example ²¹), the

²¹ Trade union membership by Standard Industrial Classification, UK, 2018 (ONS, 2019) Table A14

mechanisms for coordination and cooperation are lacking. Skills for Care, an independent charity, aims to plug some of the gap, including by providing training, but with funding from the Department for Health and Social Care to support this function equivalent to just £14 per worker per year, its impact is inevitably limited.

The long-standing reliance of social care on a dedicated but low paid, insecure, under-valued and under-trained workforce (perpetuated by chronic under-funding of public social care), distributed across a plethora of independent, competing organisations, had a direct and damaging impact on the sector's ability to respond effectively to the pandemic.

9.1.4 Outputs and outcomes

One of the weaknesses of the social care system on the eve of the pandemic has also affected the analysis in this paper, namely, the paucity of data. This relates to both outputs and outcomes. On outputs, because of the large number of providers, in many cases competing with one another, data on capacity, care provided, and equipment and costs are not centrally or publicly available. This proved to be an impediment to an effective response to the crisis and central data collection was belatedly instituted (although still not publicly available) (Hodgson et al., 2020). In addition, breakdowns of support received by age group and priority need are available only for gross current expenditure by local authorities, which means that the increasingly large share of total public spending on social care funded through income from the NHS via pooled budgets cannot be accounted for in the same way. This makes it difficult to track on a consistent basis who is and isn't receiving support.

On outcomes data, estimates of unmet needs among disabled people of working age is almost non-existent, despite the fact that they are an increasingly significant source of demand for social care: this could be remedied through extending the Health Survey for England module to the full sample. As we have seen, published data from the Adult Social Care Users Survey and the Carers Survey suggest inequalities in outcomes by ethnicity and age, but these cannot be investigated further – for example, to understand the extent to which these are linked to geographical variation - unless the microdata are made available to researchers.

Turning to what we do know about strengths and weaknesses of outputs on the eve of the pandemic: although breaks in the series make it difficult to be precise, our best estimate is that the number of people receiving publicly-funded non-residential care continued on its previous steep downwards trajectory to 2015/16, before stabilising from 2016/17 onwards (see Figure 14).

By 2018/19, the number of people receiving non-residential care arranged or funded by the local authority was an estimated 0.8 million, compared to 1.5 million at the peak volume of provision, in 2009/10. Since the number of people aged 80 or over in the population has continued to rise, as has the proportion of working age people with limiting long-standing illness or disability (including

mental illness and learning disability), the near-halving of publicly funded non-residential care provision over the last decade raises the question of whether - and if so how - those needs are now being met.

Surprisingly, perhaps, the answer does not appear to be that private spending on care has increased to fill the gap. Although the data are patchy, such evidence as there is does not support the interpretation of a significant expansion in privately funded care over this period. Also surprisingly, the proportion of the population reporting unpaid caring responsibilities had not risen pre-COVID, possibly because given the UK's already high dependence on unpaid carers, there were few further potential carers to be drawn in. Instead there appears to have been an increase in the intensity of the demands on those already providing unpaid care, as discussed in sections 6.3 and 8.4. The proportion of carers who provide 35 hours of care or more a week increased by five percentage points between 2010/11 and 2018/19; and there has been a deterioration in the impact of caring on carers' reported health and financial well-being. The warm words in the government's 2018-2020 Carers' Action Plan and consequent changes have not added up to effective support for carers.

The other part of the answer as to how needs are being met that were previously addressed by publicly-funded care services (for example, at the peak of provision in 2009/10) is that they are not. In section 8.5 we reviewed the evidence on unmet need among older people (because evidence on people of working age is lacking), and reported that over half (55%) of adults aged 65 or over who need help with three or more activities of daily living receive no help or insufficient help. This is a small proportion of the population as a whole but one that contains many individuals with high needs.

Social care on the eve of the pandemic was heavily dependent on unpaid carers who had already acted as 'shock absorbers' for cuts in formal service provision. There was also a large stock of unmet need for care, especially among women in the oldest age groups and those living on low incomes and in deprived neighbourhoods. COVID public health measures heaped yet further demands on already exhausted carers: some took on extra responsibilities in lieu of formal services that were either withdrawn or voluntarily cancelled for fear that the paid carers could bring the virus into the home. Lockdown policies carried forward the assumption, deeply embedded in social care policy thinking, that carers would 'just cope'. Evidence of the real impact on carers is only just beginning to emerge. The virus itself also disproportionately affected the most vulnerable in the community, sharply highlighting and exacerbating the pre-existing social gradients in unmet need.

9.2 Future challenges

The impact of the coronavirus pandemic on adult social care could – should – provide an opportunity to reset the policy debate. Flaws in the way social care is positioned and understood, in the level of public funding available, in the

fragmented institutional structures through which it is delivered, and in the outcomes it is able to achieve have been pitilessly exposed. Policy historians sometimes use the idea of a 'puncture' in the 'equilibrium': a moment in which long-established policy assumptions, embedded practices and vested interests can be overcome as a result of an abrupt change in external conditions, including in public opinion and awareness, producing the possibility of more radical reform (Pierson, 2004).

We argue that such reform needs to address four key challenges: recognition, coordination, adequacy and equity.

9.2.1 Recognition

As we noted at the start of this paper, a long-standing challenge for social care has been its low profile and status as the 'poor relation' of the welfare state. This is changing but recognition of the crucial role that social care plays in supporting disabled and older people needs to go far further and deeper than the creation of a 'CARE' lapel badge²². Specifically:

- Recognition of paid carers, including tackling the 'sticky floor' of the National Living Wage, reforming employment conditions to eliminate zero-hours contracts, providing consistent health and safety protection, more opportunities for training with qualifications, and easy access to visas (and associated benefits) where needed. This would also contribute to reducing staff turnover and improve the quality of care, discussed under the heading of 'Adequacy' below. However, for this recognition to occur, it needs to be accompanied by proportionate increases in funding for local authorities, to avoid reducing service levels or putting providers out of business. The Health Foundation estimated the cost of giving social care staff a similar pay uplift to planned increases for NHS workers from 2019 onwards to be £4.1bn per year by 2023/24, in 2019/20 prices (Gershlick et al., 2019) – a figure that illustrates the magnitude of the gap in recognition for carers and health workers.
- Recognition for unpaid carers, one-third of whom were providing full-time care even before the pandemic. Carers' satisfaction with the support they receive from services is low and declining, and the consequences of caring for their health and financial well-being are deteriorating. Recognition means improving and extending services for carers as well as services for the people they care for. It also means increasing the rate of Carers' Allowance, raising the earnings threshold, and ensuring that both are automatically updated, for example in line with the National Living Wage (see Cooper and Hills (2020)). The current proposal for one week's statutory *unpaid* leave for working carers would benefit only those who could afford to take it and even for them, would be a drop in the ocean.

²² <https://www.thecarebadge.org/>

UNISON are calling for the creation of a National Care Service (UNISON, 2020). Such an organisation would need to be carefully designed to avoid adding a layer of bureaucracy and sucking resources away from the frontline, and to ensure that local (community and local authority) expertise and working relationships were not undermined, but could serve a useful function in boosting the visibility of social care by giving it a stronger national voice and contribute to parity of esteem with the National Health Service. It could also explicitly embrace unpaid carers, recognising the dependence of formal services on their work and the value that they bring, and give their voice in national decision-making statutory protection, building on the advocacy work of voluntary sector carers' organisations.

9.2.2 Coordination

Good progress on integrating health and social care at national, regional and local levels needs to be built on. Integration at a national level has thus far been pursued mainly as a means to ensure that social care serves the NHS well. This needs rebalancing, and the positive innovations at regional and local level which take person-centred care more seriously should be extended. Accountability and reporting on pooled budgets needs to reflect this focus. Given the increasing proportion of total social care spending that is via these routes, data systems need to evolve to allow break-downs of total public social care spending by age and priority need (currently available only for gross local authority spending, which excludes pooled budgets). Ethnicity should be added as a key monitoring characteristic, given the indications of inequities as discussed in section 8.2 and below.

Integration *within* healthcare has begun to blur the boundaries between purchasers and providers in some cases (see Vizard et al. (2020)). This form of coordination is even more challenging in social care, where the large majority of providers are for-profit or not-for-profit independent organisations. However it is also very much needed, with a precarious settlement on fee levels, a high exit rate among providers and local authorities left to pick up the pieces.

Moreover, greater coordination among providers themselves would be beneficial. It is questionable whether attempting to deliver social care through 18,300 separate organisations in England is effective or efficient. Certainly it means that when it comes to shortages – of personal protective equipment or staff, for example – 18,300 organisations will be competing against one another rather than working together in a coordinated way to reach an optimal distribution. Smaller residential care homes are more likely to be rated 'Good' by CQC than larger homes, so increasing size of home is not likely to be the answer (ADASS, 2019), but the relationship between quality and the size of the organisation would be worth investigating, and the potential for better coordination and sharing of good practice between providers.

This fragmentation, together with the split between commissioners and providers, feeds back into the lack of recognition mentioned as the first key challenge, and makes it difficult to ensure consistency of standards. Thus a

second future challenge is to enhance three forms of coordination: internally among care providers, laterally between care commissioners and providers, and externally between health and social care – and other key services such as housing - with a genuinely person-centered focus. Better coordination should produce efficiencies, although it will also bring attention to gaps in services and poor standards. Levelling up will require greater investment of resources.

9.2.3 Adequacy

The challenge of adequacy has two key parts: resources and quality.

- **Resources:** real increases in public spending have begun to address the 'missing decade' of investment in social care since the cuts instituted from 2010/11 onwards (Glasby et al., 2020), but there is still a mountain to climb. The Health Foundation estimated that an additional £8.1bn per year (in 2019/20 prices) would be required by 2023/24 in order to restore 2010/11 levels of service provision (Gershlick et al., 2019)²³ – and 2010/11 was no paradise in terms of service adequacy. Looking further ahead, but taking the lower 2018 service standards as a baseline, Glasby et al (2020) project an additional 134,000 people needing long-term care and 43,000 needing short-term care by 2030 (the vast majority of them older people), corresponding to an additional £5.7bn per year in the absence of reform. Substantial increases in spending are also necessary to secure recognition for paid and unpaid carers, mentioned as the first key challenge, and easing financial pressures has been identified as an essential precursor to delivering the ambition of integrated health and social care included as part of the second key challenge above. Closing the gap of unmet need also means more spending. It is also necessary, but not sufficient, to bring about improvements in quality.
- **Quality:** with 1 in 6 services inspected by the CQC being rated as inadequate or in need of improvement, and nearly 100,000 cases of safeguarding risk confirmed in 2018/19 (about one-third relating to a service provider), the need to enhance the consistency of service quality is self-evident. This applies equally to residential and non-residential care. The implementation of training and standards, and the efficacy of the inspection regime, are hindered by the high degree of fragmentation in the sector, mentioned as part of the internal coordination challenge above; the high turnover of staff and low investment of employers in staff – part of the challenge of recognition - are also obstacles to raising quality. Partly because of chronic shortages of available places, the feedback from quality to commissioning is often also lacking: local authorities have to make use of whatever they can find that is available.

The ultimate measure of adequacy is the extent of needs for care which go unmet. As discussed in sections 8.5 and 9.1.4, recent evidence on unmet needs

²³ This is in addition to the pay uplift in line with planned increases for NHS staff, as mentioned in section 9.2.1, but is costed on the assumption that the pay uplift has been implemented.

among the working age population is lacking. For older adults, the scale of unmet need even prior to COVID was enormous: an estimated 300,000 adults aged 65 or over who need help with three or more activities of daily living received insufficient or no help in 2016/17 (Table 11) from formal services or unpaid carers, and service levels have fallen since then.

9.2.4 Equity

The final key challenge is to grasp the nettle of inequities in both the eligibility for, and provision of, publicly funded social care. Shelving the Care Act 2014 reform means we still fail to pool the risk of requiring long or intensive periods of care among people with modest wealth, and leave some unfairly exposed to hefty costs. While we have argued in this paper that this issue has been allowed to consume a disproportionate share of political capital and policy effort since 2015, it is nevertheless unfinished business. A fairer system, financed through tax or social insurance, is needed.

A more pressing aspect of inequity is the disparity in access to social care between people living in the most and least deprived areas of England. This could be exacerbated by the increasing shift towards locally-generated revenue for social care, through the council tax precept, which favours authorities serving less deprived populations, unless it is offset by other revenue redistribution in favour of deprived areas (a process begun post-2015). Already in 2018, twice the proportion of over-65s living the most deprived fifth of neighbourhoods had unmet needs for help with activities of daily living, compared to those living in the least deprived fifth of neighbourhoods.

In addition, there are troubling signs of inequalities by ethnicity and age, which should be vigorously investigated. Lower levels of satisfaction are reported by Asian and Asian British service recipients, and by Black and Black British recipients (10 and 9 percentage points lower, respectively, than the average of 64%), and by the same groups of unpaid carers (2 and 7 percentage points lower than the average of 39%); these differences have not received the attention they should. One in 40 adults in the population aged 85 or over were the subject of a safeguarding enquiry in 2018/19, a rate ten times higher than that for the adult population as a whole. It would appear that we are failing to treat our most senior citizens with the dignity and respect that they deserve.

Recognition, coordination, adequacy and equity are closely inter-linked challenges for the future of adult social care in England. The evidence reviewed in this paper suggests that they need to be tackled together, as a matter of urgency, to ensure that this long-neglected corner of the welfare state is fit for purpose in the 2020s and beyond.

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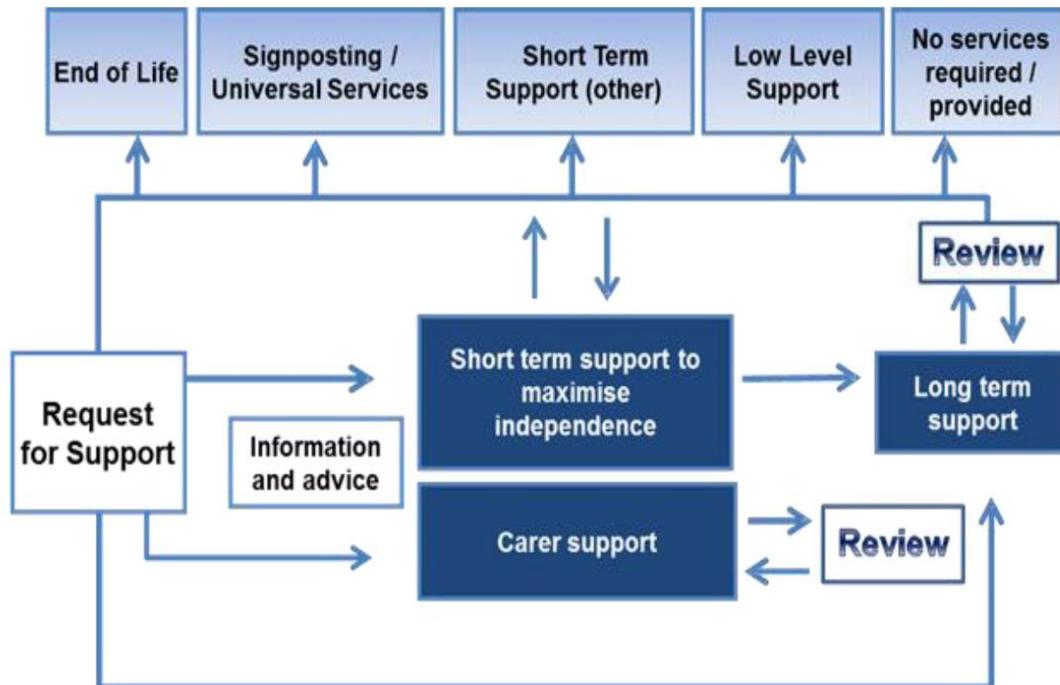
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APPENDICES

Figure A1 Flow of care provision by councils with adult social services responsibilities



Source: NHS Digital (2019a)

As mentioned in section 7.1, the new recording of the number of people who receive support from LAs distinguishes between the number of people who receive long-term care and the number of short term care episodes. The long-term care element consists of the number of people in nursing, residential, and community care during the year (each person is only counted in one setting during any one year and there is a hierarchy of the order specified above: e.g. if a person received both nursing and residential care in one year, they would only be recorded within nursing). Therefore people counted once, in one setting only in figures for both during the year and end of the year. Within the short term care element of recording, completed episodes of care are recorded within a year, which means the same person could have multiple episodes of care during a given year and only episodes that are finished count within this recording. These numbers are further broken down by whether these episodes are for the 'existing clients' (these would already be recorded within the LTC figures within a year) or 'new clients' (these clients would not be receiving any LT care but could have completed an episode of ST care earlier in the year). NHS Digital shows that the average reported for

all ST episodes in 2018-19 was 1.18 episodes per person, with slightly higher average for 18-64 year olds and slightly lower for 65 and over (Table T28 in NHS Digital (2019a)). Therefor the ST care episodes are double counting individuals in two ways: potentially counting multiple episodes for the same individual person during the year *and* potentially counting completed episodes for some adults who are also reported within LT support statistics.

The comparison of the figures overtime is thus not straightforward, and few had attempted to do so. The Institute for Government presents time trend figures for the number of people receiving LT support at the end of the year and the number of new requests that resulted in the ST support during the year, with a break between 2013-14 and 2014-15 (Institute for Government, 2019). By using the number of 'new' requests rather than the number of completed episodes the authors were able to bypass the issue of only counting the episodes that were completed, thus capturing a larger number of people who might have received ST support. They also include requests which resulted not only in ST care to maximize independence but 'other short term care', which maximizes the number of people who receive short term support during the year. There are, however a few issues with these estimates. Firstly, LT support and ST support figures are not additive not least as the former refers to end of the year numbers and the latter – throughout the year. Secondly, their figures only include 'new' requests²⁴ that resulted in ST care, which means they do not capture some of the people who may have been receiving LT support as well as ST support across different settings. For example, if a person is receiving a LT residential care in the new data they would only appear within that category even if they were also receiving a short term community support, therefore underestimating the number of people receiving services.

Our own estimates are also not without some caveats. Our estimated number of people receiving adult social care support services which we report on in Figure 14 provide us with a more consistent count between LT and ST care support compared to those presented by the Institute of Government described above, as both are measured within a year (as opposed to 'at the end of the year' for LT and within a year for ST as described above), and while still involving some of the comparability issues, we believe the figures to be more reflective of the actual numbers.

One of the issues which stands out as being slightly inconsistent with the old way of reporting, is that the number of people receiving LT support throughout the year only records a person against one of the

²⁴ There is no data available for requests from 'existing' clients (i.e. those receiving LT support already)

settings, even if that person experienced LT care across a number of settings. Therefore it is potentially underestimating the number of people receiving care within each setting, particularly affecting residential and community settings as the hierarchy of recording means that if a person received nursing care and another type of LT care during the year, they would only appear against a nursing setting within the new data. To estimate the number of people receiving ST support, we use the number of both 'existing' and 'new' *clients* who have completed ST episodes throughout the year. Thus we avoid double counting people with multiple episodes of ST care, and include 'existing clients' in order to attempt to overcome the issue of underestimation of community care support offered to those who are receiving LT nursing or residential care. However, by including the 'existing' clients within the ST care count, we are also potentially over-estimating the total number of people receiving community support when we add LT community care and ST clients. Furthermore, there is a caveat that the only ST clients counted here are those who had 'completed' their episode of care within rather than all short-term care received during the year (potentially undercounting the total number).

Appendix Table 1: Adult Social Care Outcomes Framework

	Indicator	Unit	2010-11	2011-12	2012-13	2013-14		2014-15	2015-16		2016-17		2017-18	2018-19
1A	Social care-related quality of life	/24	18.7	18.7	18.8	19	b	19.1	19.1		19.1		19.1	19.1
1B	Proportion of people who use services who have control over their daily life	%	75	75.1	76.1	76.8	b	77.3	76.6		77.7		77.7	77.6
1C (1A)	The proportion of people who use services who receive self-directed support	%						83.8	86.9		89.4		89.7	89
1C (1B)	The proportion of carers who receive self-directed support	%						76.9	77.7		83.1		83.4	83.3
1C (2A)	The proportion of people who use services who receive direct payments	%						26.3	28.1		28.3		28.5	28.3
1C (2B)	The proportion of carers who receive direct payments	%						67.6	67.4		74.3		74.1	73.4
1D	Carer-reported quality of life	/12			8.1			7.9		b	7.7 (7.6)			7.5
1E	Proportion of adults with learning disabilities in paid employment	%	6.6	7.1	7	6.7	b	6	5.8		5.7		6	5.9
1F	Proportion of adults in contact with secondary mental health services in paid employment	%	9.5	8.9	8.8	b	7	6.8	6.7			b	7	8
1G	Proportion of adults with learning disabilities who live in their own home or with their family	%	59	70	73.5	74.9	b	74	75.4		76.2		77.2	77.4
1H	Proportion of adults in contact with secondary mental health services who live independently, with or without support	%	66.8	54.6	58.5	b	60.8	59.7	58.6			b	57	58

Table continues...

Appendix Table 1 continued (2)

	Indicator	Unit	2010-11	2011-12	2012-13	2013-14		2014-15	2015-16		2016-17		2017-18	2018-19
1I (1)	Proportion of people who use services who reported that they had as much social contact as they would like	%	41.9	42.3	43.2	44.5	b	44.8	45.4		45.4		46	45.9
1I (2)	The proportion of carers who reported that they had as much social contact as they would like	%			41.4			38.5		b	35.5 (33.4)			32.5
1J	Adjusted Social care-related quality of life – impact of Adult Social Care services										0.404		0.405	0.403
2A (1)	Long-term support needs of younger adults (aged 18-64) met by admission to residential and nursing care homes, per 100,000 population							14.1	13.3		12.8		14	13.9
2A (2)	Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population							658.5	628.2		610.7		585.6	580
2B (1)	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	%	82	82.7	81.4	82.5		81.9	82.7		82.5		82.9	82.4

Table continues...

	Indicator	Unit	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17		2017-18	2018-19
2B (2)	The proportion of older people (aged 65 and over) who received reablement/rehabilitation services after discharge from hospital		3	3.2	3.2	3.3	3.1	2.9	2.7		2.9	2.8
2C (1)	Delayed transfers of care from hospital, per 100,000		10.6	9.7	9.4	9.6	11.1	12.1	14.9	b	12.3	10.3

Appendix Table 1 continued (3)

2C (2)	Delayed transfers of care from hospital that are attributable to adult social care, per 100,000 population		4.1	3.7	3.2	3.1	3.7	4.7	6.3	b	4.3	3.1	
2C (3)	Delayed transfers of care from hospital that are jointly attributable to NHS and Social Care, per 100,000 population										0.9	0.8	
2D	The outcome of short-term services: sequel to service	%					74.3	75.8	77.8		77.8	79.6	
3A	Overall satisfaction of people who use services with their care and support	%	62.1	62.8	64.1	64.8	b	64.7	64.4		64.7	65	64.3
3B	Overall satisfaction of carers with social services	%			43.1			41.2		b	39 (38.7)		38.6
3C	Proportion of carers who report that they have been included or consulted in discussion about the person they care for	%			73.3			72.3		b	70.6 (70.8)		69.7

Table continues...

3D (1)	The proportion of people who use services who find it easy to find information about support	%	74.2	73.8	74.1	74.5	b	74.5	73.5		73.5		73.3	69.7
3D (2)	The proportion of carers who find it easy to find information about support	%			68.9			65.5		b	64.2 (64.9)			62.3
4A	Proportion of people who use services who feel safe	%	62.4	63.8	65.1	66	b	68.5	69.2		70.1		69.9	70
4B	Proportion of people who use services who say that those services have made them feel safe and secure	%		75.5	78.1	79.1	b	84.5	85.4		86.4		86.3	86.9

Appendix Table 1 continued (4)

Source: Adult Social Care Outcomes Framework (NHS Digital, 2019h)

Notes:

1. 'b' denotes break in time series
2. Data in brackets for 2016-17 is review only
3. Caution should be taken when comparing data historically - please refer to the 'Comparability over time' worksheet
4. 1A, 1B, 1D, 1I, 1J, 3A, 3B, 3C, 3D, 4A and 4B are based on survey data. The base (i.e. the number of responses on which the outcome is based) should be taken into account when assessing the reliability of the outcome values. Outcomes based on a small base should be treated with caution.
5. 1A, 1B, 1I(1), 3A, 3D(1), 4A and 4B have been weighted to reflect that a stratified sample was taken (from 2011-12 onwards) and to account for non-response bias.
6. Prior to 2014-15, values less than six are suppressed for measures 1C(1A), 1C(1B), 1C(2A), 1C(2B), 2B(1) and 2B(2).
7. Base values less than three are suppressed for measures 1A, 1B, 1D, 1I(1), 1I(2), 1J 3A, 3B, 3C, 3D(1), 3D(2), 4A and 4B.
8. For measures 2C(1), 2C(2) and 2C(3) numerators are rounded to the nearest one.
9. For 2013-14 and 2014-15, measures 1F and 1H are based on averages of monthly outcomes, and suppression has been applied where the annual average numerator or denominator is less than 0.5 (6/12). For 2015-16, the measures are still based on averages of monthly outcomes and suppression has been applied where the annual average numerator or denominator is less than 0.75 (6/8).
10. Prior to 2014-15, values less than six were suppressed for measures 1E, 1G, 2A(1) and 2A(2).
11. For 2014-15 onwards, measures 2A(1), 2A(2), 2C(1), 2C(2) and 2D have no suppression applied.

12. For 2014-15 onwards, for measures 1D, 1I(2), 3B, 3C and 3D(2), a new weighting methodology was implemented for the Carers' Survey at regional and national level; the 2012-13 scores have been reweighted accordingly. Further detail are available in the 'Comparability over time' worksheet.
 13. For 2015-16 onwards, measures 1C(1A), 1C(1B), 1C(2A), 1C(2B), 2B(1) and 2B(2) have no rounding or suppression applied
 14. For 2016-17 onwards, suppression is applied where the denominator for 1E or 1G is less than five.
 15. The Carers' Survey is carried out biennially, and was first conducted in 2012-13; therefore there are no outcome scores for measures based on Carers' Survey data for 2013-14, 2015-16 or 2017-18.
 16. Councils were given the opportunity to resubmit their 2014-15 SALT data with their 2015-16 submission. The 2014-15 scores have been recalculated and scores in this annex have been calculated using the resubmitted data. The 2015-16 disclosure control rules have been applied to this data i.e. no rounding or suppression has been applied. The SALT ASCOF scores (1C, 1E, 1G, 2A, 2B and 2D) published in the 2014-15 publication should no longer be used.
- Measure 1J was introduced in 2016-17. Details of how the scores for 1J are calculated and a worked example are available in the IIASC Report Summary on the 2014-15 ASCOF publication page: http://content.digital.nhs.uk/media/23160/Identifying-the-Impact-of-Adult-Social-Care-report-summary/pdf/IIASC_Report_Summary_2014-15.pdf