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in a Changing Britain

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The Conservatives' Record on Adult Social Care England, May 2015 to pre-COVID 2020

Tania Burchardt, Polina Obolenskaya and Jarrod Hughes

Social care has been referred to as the 'forgotten front line' during the COVID-19 crisis. The second class status of social care is unfortunately all too familiar to those in the sector. Chronic under-resourcing meant that the gap between need and capacity to supply coordinated, comprehensive and high-quality care was already wide before coronavirus hit. The focus of this paper is on reviewing the state of adult social care in England on the eve of the pandemic, and how we had arrived at that point. It should be read in conjunction with the companion paper on health.

- An increasing proportion of revenue for social care is in **pooled budgets** with the NHS. This encourages joint arrangements and **total public spending** on adult social care grew 6.9% in real terms between 2014/15 and 2018/19. But because both health and social care continue to be under severe financial and organisational pressure, integration in practice falls well short of the ambition.
- Homing in on **gross current expenditure** by local authorities on adult social care: this grew by only 2.7% in real terms over the same period, and in 2018-19 it remained 4.3% below the previous peak in 2009-10. The population aged 80+ has grown by 17% since then.
- Just under 1 in 3 independent-sector **care workers** were paid at the minimum wage in March 2019 (compared to around 1 in 14 of all UK workers); 1 in 3 of all care workers were on zero hour contracts; and 1 in 3 staff either moved between jobs or left the adult social care sector in 2018/19.
- Our best estimate is that there has been a further 24% fall in the number of people receiving **community-based services** since 2013/14, although a change in recording practices in 2014/15 makes it difficult to be precise. This has particularly affected older people.
- The intensity of care by **unpaid carers** has increased. One third of the UK's 4.1 million adult carers provide 35 hours or more of care per week, with worsening consequences for their health and financial circumstances.
- Two out of five older people living in the most deprived fifth of areas did not receive any help when needed with at least one Activity of Daily Living such as washing or dressing, more than twice the rate of **unmet need** among those living in the least deprived areas.

What were the Conservatives' goals?

The Conservative majority government took over from the Conservative-LibDem Coalition in May 2015 after five years of cuts in real spending on adult social care. The Care Act 2014 gave the government new powers to raise the capital means-test threshold and introduce a lifetime cap on care costs, partially addressing long-standing inequities arising from the highly restrictive means-test for social care.

The three Conservative manifestos during this period chart a course of rowing backwards: from an assumption in 2015 that the problem of adult social care funding had been solved by the Care Act 2014 (never implemented), through a new proposal for reform in 2017 (quickly withdrawn), to an announcement in 2019 that, "We need a long-term solution for social care" – with no specific propositions attached.

What did the Conservatives do?

Despite the focus of all three manifestos on reform, policy action in the period 2015 to early 2020 was principally about the implementation of existing policies to improve services.

Organisation and delivery of care: National minimum need eligibility criteria were implemented. The potential for more person-centred and holistic assessments was welcomed by the social work and care professions but in the context of increasing needs and a continued squeeze on budgets, many felt it was a "false prospectus" (Whittington 2016, 1958). Part of the squeeze was produced by above-inflation increases in the wages of careworkers through the National Living Wage from April 2016 onwards – itself a welcome improvement – not being matched by increases in local authority budgets in a context of rising demand. Meanwhile improved support for unpaid carers was not delivered. Carers UK reported in 2019 that 27% of carers had had an assessment or a review in the last 12 months, compared to 31% in 2016. Statutory carers' leave was not enacted.

Drip feed of additional funding: Powers for local authorities to charge an additional 2% (later raised to 3%) on Council Tax to pay for adult social care were announced in November 2015. Announcements of 'extra' funding through a variety of ring-fenced grants (the Improved Better Care Fund, (Adult) Social Care Support Grant, Disabled Facilities Grant, and Winter Pressures) followed on an ad hoc basis, although the Adult Social Care Support Grant turned out to be a reallocation of New Homes Bonus funding already destined for councils.

Health and social care integration: £9.2bn of planned spending was pooled between the NHS and LAs by 2019/20 in the Better Care Fund, up from £5.6bn in 2015/16 in real terms. This was brought about through a combination of voluntary arrangements, increased minimum required contributions by Clinical Commissioning Groups, and nearly all of the increase in central government social care funding over the period being channelled through pooled budgets. Compared to estimated total public spending on social care of £19.1bn in 2019/20, the pooled budget is now substantial (not all spent on social care). However at a national level the integration agenda has been driven by the imperative to relieve pressure on the NHS rather than to deliver person-centred care. At a regional level, the Greater Manchester Health and Social Care Partnership is the largest of a range

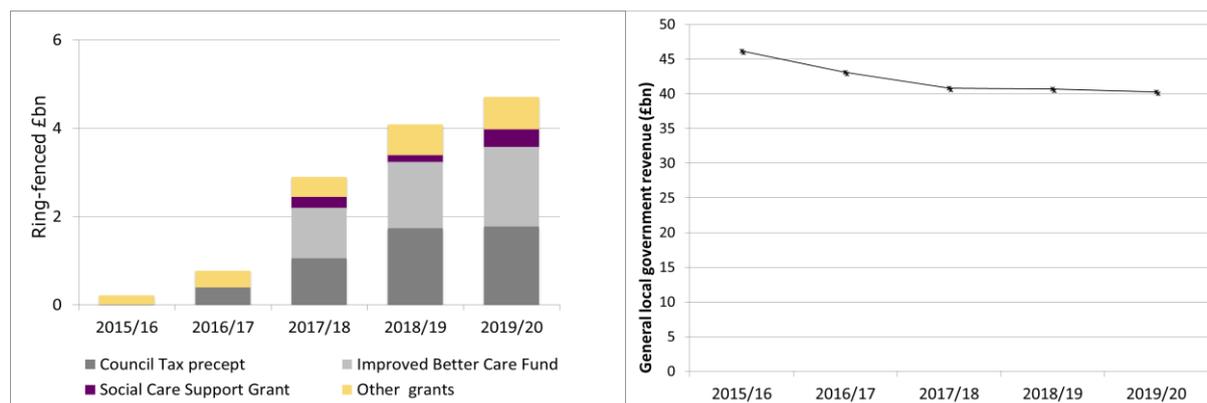
of initiatives underway. Both NAO and the Public Accounts Committee raised doubts about the national integration strategy, commenting on the difficulty of building and sustaining joint arrangements when both sectors are under significant financial pressure, an observation that is also relevant regionally and locally.

Brexit: Migration Advisory Committee (2020) modelling of the government’s proposed post-Brexit immigration system estimated it would produce a reduction in the social care workforce of 3% (with substantial regional variation), as a result of most care workers earning below the earnings threshold which would be newly applied to EEA migrants. However MAC argued against special exemption for care workers on the grounds that the underlying problem is one of low pay for skilled work, and under-resourcing of the sector, rather than immigration restrictions – advice the government appears to have accepted, without addressing the underlying problem identified.

How much did the Conservatives spend?

Local authority revenues: Public spending on social care is largely through local authorities (LAs). There has been a significant shift during this period towards ring-fenced revenue. Figure 1 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 care¹) have fallen by £5.8bn² (12.7%) over this period. Within general revenues, LAs serving more deprived populations are more dependent on central government grant funding because they have less scope to raise revenue through local taxation (including the social care precept). Central grant funding per head of population nearly halved between 2015/16 and 2019/20³.

Figure 1 Ring-fenced grants for Adult Social Care have increased (left panel), while general Local Government revenue has fallen (right panel) 2015/16 to 2019/20 (in 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)

¹ Including retained business rates and council tax, excluding social care precept.

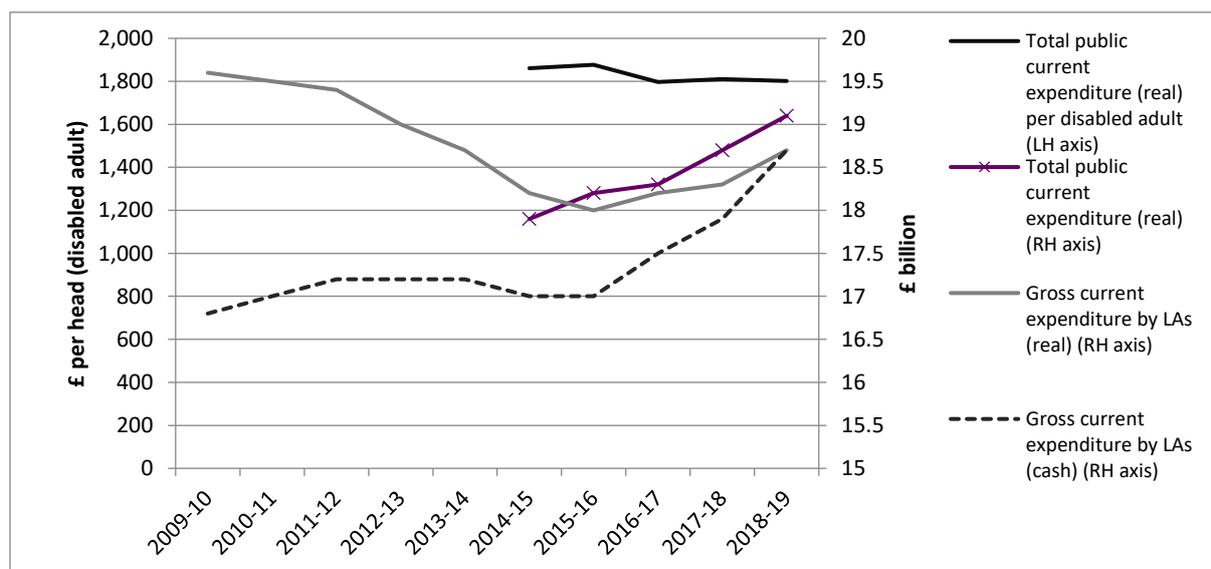
² Authors’ calculations using amounts from the MHCLG (2019), adjusted using the GDP

³ From Harris, Hodge and Phillips (2019). Figures exclude income for education, public health, police, fire and rescue, and national park services.

Local authority spending: Gross current expenditure on adult social care increased in nominal terms from 2016-17 onwards (Figure 2 grey line), but the corresponding increases in real terms (purple line) were less dramatic. Moreover these increases followed a prolonged period of spending cuts. Real spending in 2018/19 recovered only to 2013/14 levels, and remained 4.3% below the peak in 2009/10.

Estimated total public current expenditure: Public expenditure on adult social care is higher than indicated by gross current expenditure by LAs because some spending is funded by the NHS. On the other hand, user charges should not be counted as part of public spending, since this is clearly spending by individuals. Total public current expenditure stood at £19.1bn in 2018/19. This is an increase of 6.9% since 2014/15 in real terms, a larger increase than in gross current expenditure by LAs alone (solid grey line in Figure 2). This reflects the growing emphasis on health and social care integration, but also reminds us that around a quarter of the much-heralded increase in spending on the NHS has been diverted to pooled health and social care budgets, and it should not be counted twice.

Figure 2 Increases in total public spending on adult social care since 2014-15 are greater than increases in spending by local authorities alone, but spending per disabled adult in the population has not increased at all



Source: Authors' calculations using NHS Digital (2019), Better Care Fund accounts (NHS England 2018), GDP deflators are from October 2019 (HM Treasury 2019); Family Resources Survey; population estimates are from ONS (2020)

Trends in social care spending need to be understood in the context of the changing population it serves. The population aged 80 or over, the age group with the highest rate of need for social care, was 7% larger in 2018/19 than in 2014/15, and 17% larger than in 2009/10 (authors' calculations using ONS population estimates). Moreover, the working age disabled population was also growing over this period, especially people with mental illness. Estimated total public spending on adult social care per disabled adult (aged 20 and over) in the population fell by 3.2% between 2014/15 and 2018/19 (Figure 2 top line, left-hand axis).

What did the Conservatives achieve?

What were the inputs?

Care workers: An estimated 1.65 million people worked in public and private adult social care in England in 2019 (Skills for Care 2020), employed by local authorities and by the 7,800 independent organisations providing residential care and 10,500 organisations providing non-residential in England 2019/20. Real-terms increases in the statutory minimum wage since April 2016 have substantially improved the hourly pay of the lowest paid care workers (from £6.10 to £8.72 p/h in April 2020). However, according to Skills for Care workforce estimates:

- the wage distribution of care workers has become increasingly compressed at the bottom, with 1 in 3 (28%) of independent-sector care workers paid at the minimum wage in March 2019, compared to 1 in 6 three years earlier.
- staff turnover is high and increasing; just under 1 in 3 (32%) staff either moved between jobs or left the adult social care sector in 2018/19.
- an estimated 1 in 3 care workers (both local authority and independent-sector 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.

LA budgets finance a substantial proportion of the overall care sector and as we have seen these did not increase in accordance with increases in the minimum wage and in demand. This squeeze has forced care providers to find other economies, including through 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.

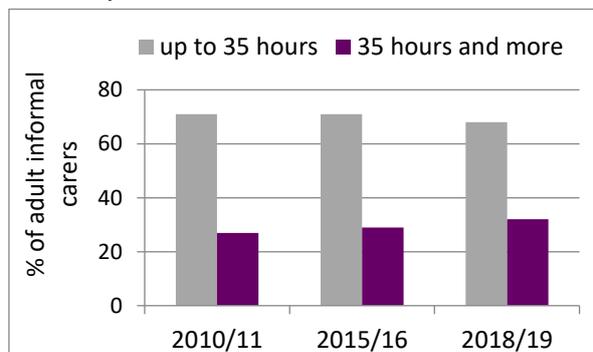
Unpaid carers: Estimates from the Family Resources Survey show that in 2018/19 there were 4.5 million adults in the UK providing unpaid care (both inside and outside their households), representing around 7% of the adult population. The number of carers fell by 0.4 million over the period since 2010/11, but 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 3).

Most adults who provide informal care are aged 50 or over (authors' analysis of FRS data) and the UK maintains its place among the OECD countries as having one of the highest rates of care provision among people of that age when comparing 2010 and 2017 figures (OECD 2013; 2019). These findings together with the fact that caring has intensified, means that the UK social care system as a whole continues to rely very heavily on inputs from unpaid care.

What were the outputs?

The decline in the total number of adults that received community and residential care services arranged or paid for by local authorities started in the last year of

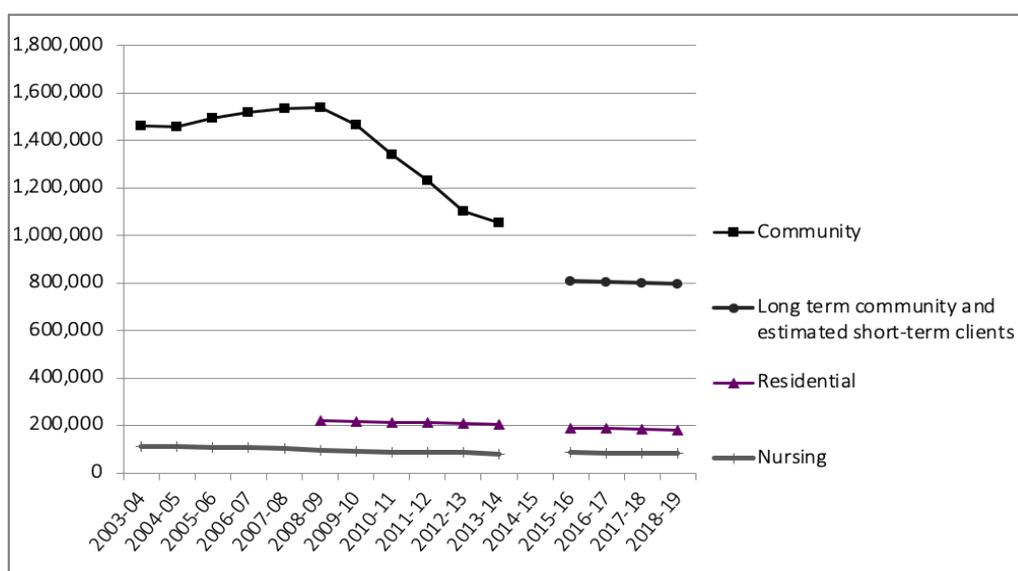
Figure 3 Intensity of care provided by informal carers is increasing.
Hours per week, UK.



Source: DWP (2020; 2017; 2012), Table 5.3, 'Carers data tables'

Labour administration, in 2009/10, and accelerated in the 5 years that followed (Figure 4). During that time the fall in the number of service users was particularly sharp for the community-based services. This trend has continued into the current period. Our best estimate is that there has been a further 24% fall in the number of people receiving community-based services since 2013/14, although a discontinuity in recording practices in 2014/15 make it difficult to be precise.⁴ 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 by 1.5%, whilst the number of adults receiving care in residential and nursing homes fell by 5%.

Figure 4 The number of people receiving adult social care support from local authorities within a year continued to fall, although at a slower rate from 2015/16 onwards. By type of setting, 2003/04 to 2018/19



Source: Authors' calculations using NHS Digital (NHS Digital 2019; 2018; 2017; 2016) and HSCIC (2014). Break in the series due to change in recording practices. 'Estimated short-term clients' is authors' estimate based on average duration of spells.

Support received by age group: Long-term care accounts for the majority of support provided by adult social care services. The overall fall of 3.5% between 2015/16 and 2018/19 in the number of adults receiving long-term (LT) support during the year conceals contrasting trends for the over-65s and working age adults (Figure 5): 6.6% fewer clients aged 65 and over received LT support by the end of the period, whilst 2.9% more 18-64 year olds did so.

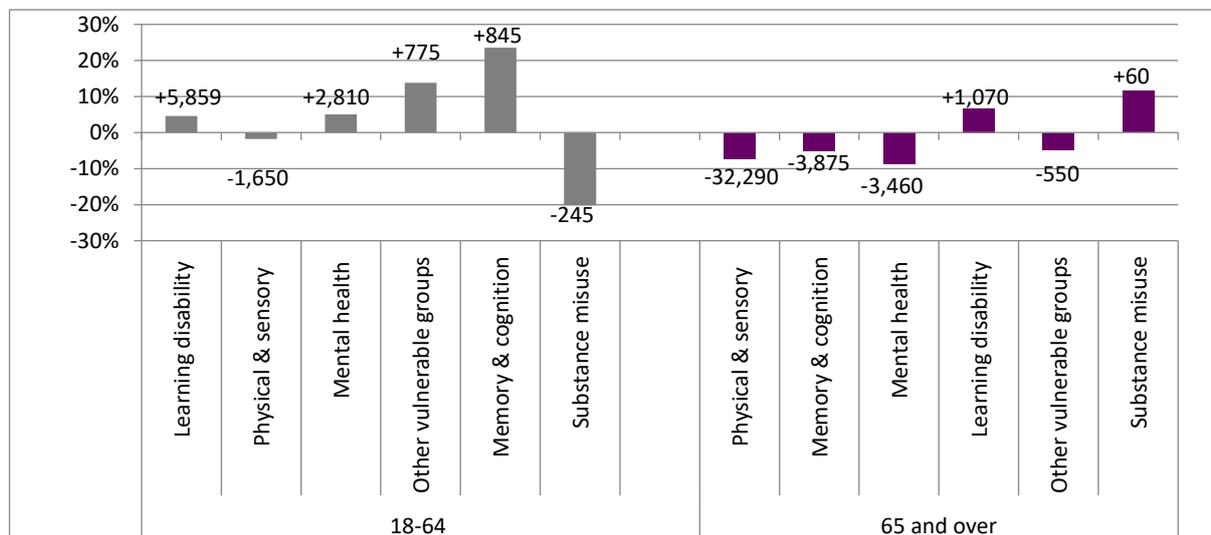
The 'physical and sensory' and 'memory and cognitive' need categories account for 88% of older people receiving LT support, and there were reductions of 7.2% and 5.2% respectively in the number of recipients in these categories. The number of older people receiving long-term support for mental health, the next largest

⁴ Following a break in the series of data, data collection is now focused on the number of people who receive Long-Term care (LT) - on-going support in residential, nursing and community settings in order to maintain person's quality of life; and Short-Term care - to maximise independence (ST-max), which in majority of cases takes place in the community.

group, also fell by 8.8%, representing 3,460 people. The high and increasing proportion of working age adults with mental health disabilities in the population have been met with a small increase in LT mental health support, but this does not restore the levels of support provided at the start of the decade.

Since 2015/16 there was an overall increase in LT care provided to working age adults and in the number of ST 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 LT support, particularly those with physical and sensory needs, and the fall in the number of ST episodes of care completed for this age group. This is a worrying trend, as the number of older people receiving LA funded social care has been now falling consistently for a decade (Burchardt, Obolenskaya, and Vizard 2015).

Figure 5 The largest absolute decline in the number of adults receiving long-term support was among over-65s with physical and sensory primary support needs, while the largest percentage decline was among working age adults with substance misuse. Change (percent and absolute) in the number of adults receiving long-term support in the year by primary support reason, 2015/16 to 2018/19.



Source: Authors' calculations using NHS Digital (2019; 2016). Notes: The primary support reasons are ordered from the highest number of people to the lowest in 2018-19, for each age group. A left-right hierarchy on the original ordering determines which support reason is 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.

What were the outcomes?

Safety and quality

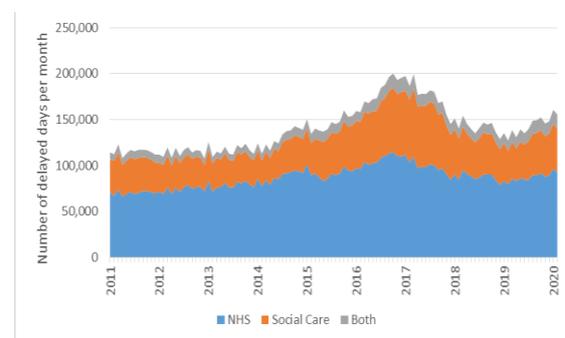
- Nearly 100,000 instances of safeguarding risk for vulnerable adults were confirmed in 2018/19. There was a strong age gradient in risk, with 1 in 40 adults aged 85 or over the subject of a safeguarding enquiry, ten times the rate for the adult population as a whole.
- 1 in 6 social care services inspected were deemed by Care Quality Commission to be 'inadequate' or to 'require improvement' in 2019.

- However, overall satisfaction of care users with care and support remained stable at around 64%, according to the Social Care Users Survey. (This reflects only the views of those able to access services).
- Satisfaction of care users aged 75-84, and for those aged 85 or over, was 3 percentage points lower than average for all care users.
- Satisfaction of Black or Black British, and Asian or Asian British care users, was 9 and 10 percentage points lower than average, respectively.

Effectiveness

- 15% of emergency admissions to hospital in 2018 were for conditions that could be prevented by effective community care (known as Ambulatory Care Sensitive Conditions, ACSCs). This was similar to the proportion of emergency admissions in 2014, but the total *number* of ACSC spells increased by 23% over this period.
- Patients who live in the most deprived tenth of areas have 1.5 times more ACSC spells than average.
- Delayed transfers from hospital peaked in October 2016 and began to rise again in the last part of 2018 (Figure 6). In February 2020, they stood at 155,717 days, 16% higher than February 2015 shortly before the Conservative majority government took office, and 39% higher than in February 2011 (earliest comparable data).

Figure 6 Delayed transfers of care began to rise again in the last part of 2018. Number of delayed days per month, by responsible organisation, January 2011 to February 2020.



Source: NHS England (2020)

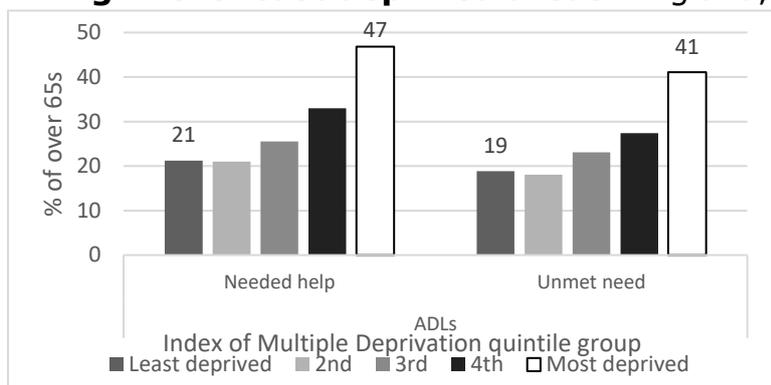
Outcomes for unpaid carers

- At 39%, carers' satisfaction with services (both for themselves and for the person they look after) in 2018/19 is much lower than care users' satisfaction. Moreover this indicator had fallen by 4.5 percentage points since 2012/13.
- Satisfaction among Black or Black British carers was 7 percentage points lower than average.
- Younger adult carers, and those caring for people with learning disability or mental health needs, expressed much lower levels of satisfaction than others.
- Carers were also increasingly likely to report financial difficulties and health problems affected by caring. In 2018/19 fewer than 1 in 10 carers *did not* experience a health condition affected by their caring role.

Unmet need

There is a paucity of evidence on unmet need among working age adults. Among older adults, rates of unmet need remain high and have a strong social gradient (Figure 7). Two out of five older people living in the most deprived fifth of areas did not receive any help with at least one Activity of Daily Living (ADL) with which they needed help, more than twice the rate of unmet need among those living in the least deprived areas. Nearly half (48%) of women aged 80 or above have an unmet need for help with one or more ADL.

Figure 7 People aged 65 or over living in the most deprived areas are twice as likely to need help and to have unmet need than those living in the least deprived areas. England, 2018.



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

Notes: 1. Data have been age-standardised. For more information see HSE 2018 Methods report. 2. Unmet need is defined as needing help but not receiving any help in relation to at least one ADL in the last month.

Conclusions and policy challenges looking forward

Strengths and weaknesses on the eve of the pandemic

Policies: Sustained emphasis on health and social care integration was a key strength, backed by increased funding channelled to pooled budgets. Institutional architecture to support joint planning and accountability bodes well for the future. However the emphasis in centrally-directed integration on reducing pressure on healthcare played out badly in the early stages of the response to COVID-19, when patients were discharged into care homes without testing (Hodgson et al. 2020). 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).

Significant policy effort was expended on efforts to reform the capital means-test for publicly-funded social care, despite a consensus on an alternative already having been established in 2014. Arguably this preoccupation distracted from making faster progress on improving models and quality of care, which could have enhanced the resilience of social care ahead of the COVID crisis.

Spending: Social care entered the pandemic with more resources than it would have done had the pandemic hit five years earlier – a salutary thought-experiment. But real-terms increases in funding (+6.9% if spending by the NHS is included) 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.

Inputs: 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. The low status of care workers may also have contributed to their high COVID mortality rate: twice that of other adults by June 2020.

Outputs and outcomes: Social care on the eve of the pandemic was also heavily dependent on unpaid carers who had already acted as ‘shock absorbers’ for cuts

in formal service provision. There was 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 - evidence of the impact on them is only just beginning to emerge – and lockdown policies carried forward the assumption that carers would 'just cope'.

Policy challenges for the 2020s

The continuing impact of the coronavirus pandemic on adult social care 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. We identify four interlinked challenges.

- 1. Recognition**, for paid carers, unpaid carers, and the contribution of the sector as a whole. This includes tackling the 'sticky floor' of the National Living Wage, reforming employment conditions to eliminate zero-hours contracts, providing consistent health and safety protection, and more opportunities for training with qualifications. For unpaid carers, one-third of whom were providing full-time care even before the pandemic: to make good on commitments to improve and extend services for them as well as for the people they care for, and to increase and index link both the rate of Carers' Allowance and the earnings threshold.
- 2. Coordination**, internally among the 18,000+ organisations providing care, laterally between care commissioners and providers (as has begun to occur within healthcare), and externally between health and social care, with a genuinely person-centred focus, and parity between the sectors.
- 3. Adequacy**, in terms of resources and quality. Recent increases in spending have not yet fully reversed austerity. The current government rhetoric of 'levelling up' could help to address shortfalls in deprived areas if translated into spending increases. But an additional £8.1bn per year would be required by 2023/24 to restore 2010/11 levels of service provision (Gershlick et al. 2019) – and 2010/11 was no paradise in terms of the reach or adequacy of services. Moreover, with 1 in 6 services being rated as inadequate or in need of improvement, and nearly 100,000 cases of safeguarding risk confirmed in 2018/19, the need to enhance service quality is self-evident.
- 4. Equity**, addressing inequalities by ethnicity and age among service recipients (substantially lower satisfaction among Asian and Asian British, and Black and Black British recipients); and by age, gender and socio-economic status among non-recipients (nearly half of women aged 80+ have an unmet need for help with one or more ADL; unmet need is twice as high among older people in the most deprived neighbourhoods). Recognition of the social gradient in need for care and in unmet need is in its infancy compared to the now-widespread acknowledgement of the social determinants of health.

Recognition, coordination, adequacy and equity are closely inter-linked challenges for the future of adult social care in England that 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.

Further information

The full version of this paper *The Conservative's Record on Adult Social Care: policies, spending, and outcomes in England, May 2015 to pre-COVID 2020* (including references) is available at (CASE website)

<http://sticerd.lse.ac.uk/dps/case/spdo/spdorp07.pdf>

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