

# Focus On: Social care for older people

Reductions in adult social services for older people in England

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# About QualityWatch

QualityWatch is a major research programme providing independent scrutiny into how the quality of health and social care is changing over time. Developed in partnership by the Nuffield Trust and the Health Foundation, the programme provides in-depth analysis of key topics through 'Focus On' reports and tracks an extensive range of quality indicators. It aims to provide an independent picture of the quality of care, and is designed to help those working in health and social care to identify priority areas for improvement. The programme is primarily focused on the NHS and social care in England, but will draw on evidence from other UK and international health systems.

 QualityWatch Focus On reports are regular, in-depth analysis of key topics. This Focus On report examines the scope and scale of cuts to spending on social services for older people in England from 2009/10 to 2012/13. Using the 2009/10 financial year as a baseline, the report tracks a period of real-terms reductions in revenue allocations from central government to local authorities, which are responsible for providing publicly funded social care.

This report and related outputs are available on the QualityWatch website: [www.qualitywatch.org.uk](http://www.qualitywatch.org.uk). The website presents key indicators by area of quality and sector of care, together with analysis of the data. This free online resource also provides research reports, interactive charts and expert commentary.

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# List of abbreviations

<b>ADASS</b>	Association of Directors of Adult Social Services
<b>ADLs</b>	Activities of daily living
<b>ASCOF</b>	Adult Social Care Outcomes Framework
<b>CQC</b>	Care Quality Commission
<b>ELSA</b>	English Longitudinal Study of Ageing
<b>FACS</b>	Fair Access to Care Services
<b>GDP</b>	Gross Domestic Product
<b>NASCIS</b>	National Adult Social Care Intelligence Service
<b>PSSEX</b>	Personal Social Services Expenditure
<b>RAP</b>	Referrals, Assessments and Packages of Care
<b>SSMSS</b>	Social Services Management and Support Service
<b>UTI</b>	Urinary tract infection

# Executive summary

## Context

This report describes the scale and nature of reductions in publicly funded social care for older adults<sup>1</sup> in England that have occurred in part as a result of the Coalition Government's efforts to reduce public sector spending following the financial crisis of 2008. In 2010, the government published spending plans that reduced central government grants to local authorities (who are responsible for funding social care) by 26 per cent in real terms between 2011/12 and 2014/15. Local government spending overall, which includes income from Council Tax and other charges, was projected to fall by 14 per cent in real terms. In June 2013, the government followed this with a further 10 per cent reduction in grants for 2015/16.

## Key points

- The majority of local authorities have responded by cutting spending on most categories of local government-funded activities, including social care for older adults. In 2009/10, local authorities in England spent £10.6 billion (in 2009/10 prices) in gross terms on social care for older adults, compared with £9.8 billion in 2012/13,<sup>2</sup> a reduction of 7 per cent. Real-terms net current spending (that is, excluding income) fell by 15 per cent, from £7.8 billion in 2009/10 to £6.6 billion in 2012/13.<sup>3</sup>
- These cuts to social care budgets for older adults have been implemented in a number of ways, including tightening eligibility for publicly funded support to concentrate resources on those with the greatest needs, increasing the fees payable by users, reducing the fees to providers of care, and generating savings from service redesign and reduced administrative costs.
- Spending on residential care for older adults was reduced by £331 million between 2009/10 and 2012/13, equating to a 13 per cent reduction. Real-terms net expenditure on nursing homes for older adults was reduced by £160 million over the same period (a 15 per cent reduction).
- Services in the community for older adults have seen the biggest reductions, with £539 million taken out of home and day care alone – a 23 per cent reduction in expenditure. Other community-based services have also contracted, with spending on meals reduced by 46 per cent between 2009/10 and 2012/13. Some of this reduction may have been offset by a 36 per cent rise in spending on direct payments; however, this rise consists of a relatively modest £90 million of additional expenditure in cash terms.
- Cuts in spending have been accompanied by reductions in the number of older people receiving publicly funded services, particularly in the community, which fell by 26 per cent in 2012/13 compared with 2009/10 (245,855 fewer older adults received services in 2012/13 compared with 2009/10). Some of

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1 'Older adults' refers to those aged 65 and over.

2 All figures in this report are presented in real terms. All figures are net current expenditure unless otherwise stated.

3 Net figures exclude expenditure on the Supporting People programme.



the most significant falls were in meals (59 per cent reduction or 54,795 fewer individuals) and day care (35 per cent reduction or 36,480 individuals). Only the number of older people receiving direct payments appeared to increase and even then only by 10,250 (an increase of 20 per cent in the two years between 2010/11 and 2012/13<sup>1</sup>).

- These reductions in spending and volume of social care services for older adults have occurred against a backdrop of growing demand for social care among the over-65s, as the population ages. According to the last national Census (2011), 29 per cent of respondents aged over 65 reported that they were limited 'a little' from a disability or illness expected to last more than 12 months, while a further 28 per cent reported that they were limited 'a lot'. There was also a 2 per cent rise between 2001 and 2011 in the number of respondents reporting that they cared for people for more than 20 hours a week.
- The combined effect of cuts in net spending and in the number of people supported is that a growing number of older people are having to use their own resources to support themselves or go without care. Research suggests that the level of unmet need varies widely across different types of help needed, but overall a third of women and a fifth of men over the age of 65 report having unmet needs for some activities of daily living (ADLs) (Whalley, 2012).

The impact of these budget reductions on the health and wellbeing of older people (and their carers) is not clear. Comprehensive measurement of older users' and carers' perceptions of social care services has recently been put in place as part of the Adult Social Care Outcomes Framework. However, the framework only covers those who receive publicly funded care and so the growing numbers of those who are not eligible for services will not be identified. It may be possible to trace the impact on users who have had their package of care reduced by the local authority, but a larger issue may be those who are reliant on their own funds, and the impact on complementary services such as the NHS.

Some of the recent reductions in adult social care budgets could have been even more drastic if not for recent transfers from the NHS to social care, and more significant sums (£2.0 billion) being transferred from the NHS to form part of the Better Care Fund (worth £3.8 billion in total), which is being made available to joint projects between local government and the NHS from 2015/16 (NHS England, 2013). These projects must be used to support adult social care services that also demonstrate a 'health benefit'. However, it is not clear what the relationship is between public spending on social care for older adults and the demand for health services, particularly hospital care (see, for example, Bardsley and others, 2012; Forster, 2009).

It is highly likely that reduced spending on social care for older adults is having a negative effect on the health and wellbeing of users and carers, but poor linkage between health and social care data at a national level means that it is currently difficult to quantify the impact. For example, although there is evidence of increased rates of emergency admissions for older age groups, it is difficult to directly attribute these to social care budget cuts, or other factors such as poor access to primary or community health services. Furthermore, there is no way of comprehensively identifying self-funders, or informal or formal carers, in NHS or social care data, so the overall impact of reduced publicly funded support for carers or more general reductions in household income among older people is unknown.

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<sup>1</sup> Data are not available for 2009/10, as presented with other service areas.

Given the future trends in population growth and the visible constraints to local government, which is facing further budget cuts in the coming years, it is imperative that we develop better information systems that span care providers for older people. Policy-makers need a clear understanding of the relationship between social care and the wellbeing and health of older people, and the impact of cuts to social services on other public services. At present, the difficulties faced by older people with social care needs can only be partially described and the levels of unmet need – which we expect are growing – are unknown.

# 1

## Introduction

This report describes the scale and nature of reductions in publicly funded social care budgets and services for older adults in England between 2010/11 and 2012/13. The report takes the 2009/10 financial year as a baseline, as the following year (2010/11) marks the beginning of a five-year period of planned real-terms reductions in revenue allocations from central government to local authorities, which are responsible for providing publicly funded social care. These budget reductions are now likely to last beyond 2015/16. Prior to 2010, local authorities were already managing a long-term mismatch between demand for adult social care and public resources (Commission on Funding of Care and Support, 2011; Humphries, 2013).

The report forms part of our QualityWatch programme, which is tracking the quality of health and social care services in England between 2010 and 2015, in the context of increasing demand and constrained budgets across the public sector.

Our ambition in this report is to describe how local government has responded to these reductions, from analysis of publicly available data. It is the first in a series of reports that will use a range of methodologies to track the impact of these reductions on service users and carers in terms of their health and wellbeing, as well as the impact on the wider health and social care system including the providers of health and social care. This report focuses on the provision of care and experiences of those aged 65 and over, referred to in the report as 'older adults'.

### What is social care?

Definitions of social care are potentially broad. The government's review of social care, published in 2011, defined social care as support for:

people of all ages with certain physical, cognitive or age-related conditions in carrying out personal care or domestic routines. It helps people to sustain employment in paid or unpaid work, education, learning, leisure and other social support systems. It supports people in building social relationships and participating fully in society.

(Commission on Funding of Care and Support, 2011, p. 4)

This support can come from public sources (including benefits such as Attendance Allowance and social care services) as well as private sources (including unpaid support from family or other informal carers, and paid-for support from the private or voluntary sector).

Social care supports children, working-age adults and older adults. As mentioned above, this report focuses on the publicly funded support given to older adults (aged over 65), via care services or financial support supplied by local authorities. The report does not explore the financial benefits supplied to older people in the form of pensions or other financial benefits derived from taxation and delivered by central government.

## The challenge of monitoring the impact of changes in social care funding

Reductions in publicly funded social care for older adults in England may have had a negative impact on the health and wellbeing of users and their carers. However, analysis of any potentially negative impact is hampered in two important respects.

First, data are only available for the volume and cost of publicly funded social care services, which capture only a partial picture of all older adults who use social care to assist them with ADLs. State-funded adult social care is organised by local government and the bulk of services are rationed on the basis of need and income.<sup>1</sup> Individuals who do not qualify for state-funded help are required to provide social care for themselves (and many individuals also supplement publicly funded care from their own resources). Data are sparse in relation to these fully or partially self-funded groups, either about the quality of services being used, or their ability to organise or pay for the right amount of care to meet their needs. Comprehensive measurement of older users' and carers' perceptions of local authority social care services is now in place as part of the Adult Social Care Outcomes Framework, but it is too early to see any trends over time and it only covers those who are financially supported by local authorities.

Second, poor linkage of data between the health and social care systems means that researchers only have a limited picture of the impact that any potential deterioration in the volume and quality of publicly funded social care services might have on users' wellbeing and their use of health services. Previous research studies have suggested that there is a close relationship between access to (some kinds of) social care services and health service use. For example, users of care homes are less likely to experience emergency hospital admissions than people using home-based social care or no social care (Bardsley and others, 2012; Forster, 2009). These studies were based on access to local datasets that have linked users of social care with hospital data, but these are not currently available at a national level. It is difficult to see what is happening to the quality of care services using only the lens that administrative data provide. Supplementing this analysis with survey data or regulatory inspection results brings us closer to an understanding of the impact of receiving or giving care on individuals, but these approaches are limited in scope and sensitivity. And, as mentioned above, the majority of these data only include those who are in receipt of publicly funded care and do not include those who are self-funded or those who have unmet needs.

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<sup>1</sup> Some services, for example the provision of information, equipment and time-limited 'reablement' support following hospital discharge, are available as universal services in many local government areas.

## Structure of this report

- The report will first give a brief description of the current social care system and the demographic pressures facing the service, to provide some context to our analysis of budget reductions since 2010.
- We then describe the magnitude of the cuts to local government budgets since 2010 and summarise what is known about how local authorities are responding to and implementing these reductions.
- The report then describes how different kinds of social care services are being affected, in terms of the amount being spent on them and the numbers of older adults receiving them, based on analysis of routine national datasets provided by local authorities across England. We explore both the aggregate national trends and the variations in responses at local authority level.
- Finally, we discuss the potential impact of these reductions in spending and services on the wellbeing of older adults and the possible effects on health services.

# 2

## Context: social care provision before 2010

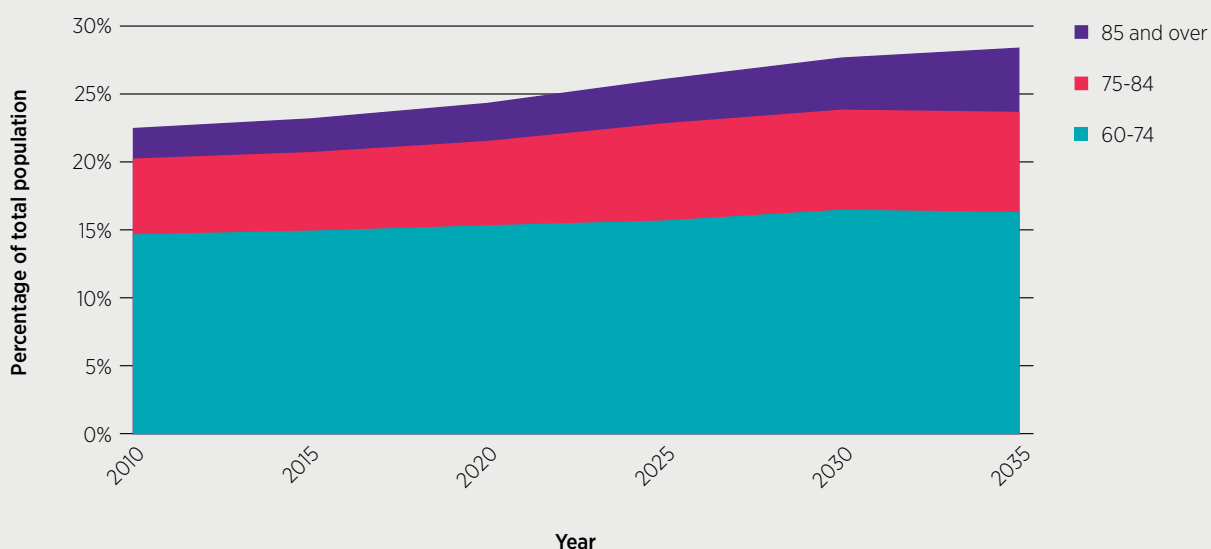
### The growing demand for social care

Pressure on publicly funded social care predates the budget reductions that began in 2010. Long-term improvements in the standard of living and medical care in the last century have led to an increase in the numbers of people surviving into old age. The growth of this section of the population has been at a faster rate than public resources for social care for older adults, leading to a growing mismatch between demand and public funding from at least 2005/06 (Commission on Funding of Care and Support, 2011).

This section gives an outline of the pattern of demand for social care among older adults. Robust estimation of demand for social care is complex, as it goes beyond projections of trends in mortality and morbidity, and depends on assumptions about the future development of family structure, patterns of wealth and income, as well as wider assumptions about taxation, welfare spending and economic growth (see, for example, Wanless, 2006; Wittenberg and others, 2012). Nevertheless, we present various proxies for demand, to paint a picture of the context for this report.

There has been a strong upward trend in the numbers of older people in England in recent decades, a trend that is expected to continue (Office for National Statistics (ONS), 2011). However, growth within this age group is not expected to

**Figure 2.1: Projected change in the percentage of the population aged 60 and over by age band, England**

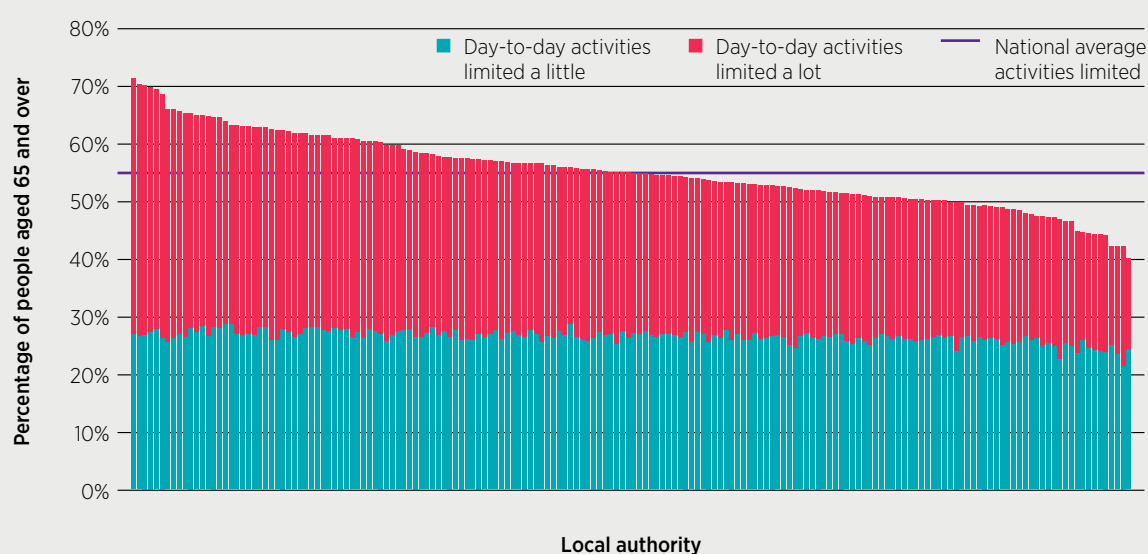


Source: ONS, 2011

be uniform (Figure 2.1). The proportion of the population aged over 85 is expected to double by 2035, to almost 5 per cent of the total population.

According to recent evidence, the proportion of the population aged over 65 who feel they need some support with daily activities is high. The 2011 national Census asked respondents whether their 'day-to-day activities' were limited, due to a disability or illness that was expected to last at least 12 months. The Census found that 26 per cent of respondents aged over 65 reported that they were limited 'a little', while a further 29 per cent reported that they were limited 'a lot', with an uneven distribution at local authority level (Figure 2.2).

**Figure 2.2: The percentage of people aged 65 and over with self-reported day-to-day activities limited 'a little' or 'a lot', by local authority (county/unitary), England**



Source: ONS Census 2011

The proportion of the population needing help with ADLs (including, for example, bathing, eating and going to the toilet) is likely to rise in line with the pattern of population growth, based on evidence from successive waves of the English Longitudinal Study of Ageing (ELSA). The survey suggests that the reported need for help with ADLs increases with age for both men and women – with a particularly marked rise in the over-80 age group, in which, on average, 36 per cent of men and 44 per cent of women reported needing some degree of assistance (Zaninotto and Steptoe, 2012).

### Who meets these needs?

Support with ADLs for older people comes from a wide range of sources, which can include private sources (support from spouses, other family members, friends and so on; and/or privately funded help from professional carers or institutions) and public sources, primarily local government (in the form of directly supplied services, fees to support people's care in care homes or direct payments for people to purchase their own care). Recipients of publicly funded care also contribute a varying proportion of the costs in the form of co-payments, which we describe below.

On average, only about 10 per cent of the population aged 65 and over receive local authority funded support, either fully or partially funded (author calculation based on Referrals, Assessments and Packages of Care – RAP – data 2012/13 accessed through the National Adult Social Care Intelligence Service (NASCIS; see ‘References and data sources’) and population estimates from the 2011 Census (see ‘References and data sources’)). Even those who receive support from the local authority may privately purchase additional care to ‘top up’ what they receive from the council. Estimates suggest that a significant number of people over the age of 80 receive additional care paid for by their family (approximately 35 per cent) or are fully self-funded (approximately 12 per cent) (CQC, 2013a). The result of a lack of publicly funded support is that the vast majority of those who need help with ADLs receive support from informal carers, the majority of which is provided by a spouse/partner or son/daughter (Whalley, 2012) (Table 2.1).

According to combined data from the 2011 and 2012 Health Survey for England, of those who received formal help, the majority reported paying for the total cost (49 per cent of men, 61 per cent of women), while only 11 per cent of men and 8 per cent of women reported co-paying, and 29 per cent reported paying for none of it (with 5 per cent not sure) (Whalley, 2012). It can be assumed that some of those not paying for their formal care themselves will be funded by local government.

**Table 2.1: Of those who received help in the last month, the proportions of those who provided the support, for those aged 65 and over**

Sex	Type of support needed	Informal helpers only	Formal helpers only	Both	None	Total
Men	ADLs	75	8	8	9	100 %
	IADLs	78	11	9	2	100 %
Women	ADLs	71	13	11	5	100 %
	IADLs	74	9	14	3	100 %

Notes: IADLs = instrumental ADLs (those ADLs that support independent living, though are not necessary for fundamental daily functioning) – see Table 2.2.

Sources: Health and Social Care Information Centre (HSCIS), 2012a; Whalley, 2012

## Unmet need

In general terms, available research evidence shows that, while available services are increasingly targeted at those with the highest need, the proportion of people who have needs that are met is low (Wanless Review Team, 2005). For example, as Table 2.2 indicates, the level of unmet need varies widely across different types of care need, but overall a third of women and a fifth of men over the age of 65 reported in the Health Survey for England having unmet needs for some ADLs.



**Table 2.2: Percentage of people who needed help but did not receive any in the last month, for those aged 65 and over**

Type of support needed	Men	Women
<b>ADLs</b>		
Getting up and down stairs	16	23
Having a bath or shower	7	9
Dressing or undressing	7	7
Getting in and out of bed	6	8
Getting around indoors	6	8
Taking medicine	2	2
Using the toilet	3	4
Eating, including cutting up food	3	3
Washing face and hands	3	3
Needed help with at least one ADL but received help with none	22%	30%
<b>IADLS</b>		
Shopping for food	7	7
Doing routine housework or laundry	8	8
Getting out of the house	7	7
Doing paperwork or paying bills	4	4
Needed help with at least one IADL but received help with none	14%	15%
Note: This Table illustrates those who needed help – whether formal or informal – but did not receive any. Source: Whalley (2012)		

## Trends in informal care before 2010

It is not clear how much of this unmet need is filled by informal care. An assessment based on General Health Survey (GHS) and ELSA data in 2001/02 and 2008, found unmet need rates of 50 to 66 per cent in older people needing assistance with bathing, and around 10 per cent in those needing help with shopping (Vlachantoni and others, 2011). The vast majority of those respondents reporting need for ADL support in these two survey waves received the support from informal carers, with formal state and paid support covering between 2 and 8 per cent. An earlier quantitative modelling exercise found that 18 per cent of older people in England experienced ADL support needs that were unmet, even after taking account of informal care (Forder, 2007).

Further indications of changing pressures within the social care system may be gleaned from data on provision of unpaid care from the 2001 and 2011 Censuses. Although there was a reduction in the number of informal carers providing between one and 19 hours of care a week from 2001 to 2011, the number providing higher-burden care of either 20–49 hours a week or 50 or more hours a week rose by around 2 per cent.

There may also be health and wellbeing implications for informal carers: in the 2011 Census, over 40 per cent of men and women providing 50 or more hours of care a week felt that their own health was 'not good'. However, the nature of the link between informal care provision and poor health outcomes is contested, and recent research suggests that type and intensity of care given may have more significant implications for carer health than care provision *per se* (Vlachantoni and others, 2013).

## What is publicly funded care and who gets it?

Although a considerable (and growing) proportion of older people in England at any one time are likely to need assistance with ADLs, publicly funded social care is rationed first on the basis of a needs assessment and second on people's income and assets.

Local authorities fund a range of services, which they either provide themselves or, more commonly, purchase from independent or third sector providers. These services include:

- institutional care:
  - residential care (care for people unable to live in their own homes)
  - nursing care (as above, with additional nursing support)
- community-based services in/around the home:
  - meals
  - home care (for example help with washing and dressing)
  - appliances, such as grab rails and hoists
  - access to day care
  - direct payments for users to purchase their own support.

Local councils also provide supported housing to eligible adults, which can range from support in a person's own home to living in a supported communal setting.

Under the current system (which will be reformed from 2016; see Nuffield Trust, 2013), individuals looking for support have to undergo a two-step process to qualify for state-funded support. First, they are given a needs assessment by the local authority, which uses a nationally specified scale of four levels of need – low, moderate, critical or substantial – based on the amount of help they require with bathing, eating, shopping and so on. These levels are known as the Fair Access to Care Services (FACS) criteria (see the Appendix).

Although these categories of need are nationally determined, local authorities have had the freedom to decide which level will act as a threshold for eligibility for public support. As we explain more fully below, even before the 2010 funding crisis, the trend in recent years has been for an increasing number of local authorities to restrict eligibility to those with 'substantial' or 'critical' needs.

Under the second, means-based step, local authorities assess an individual's income and assets to determine whether they qualify for full state support or have to pay for a proportion of the services themselves. These co-payments vary by local authority. The current thresholds target the bulk of resources on the poorest. Full state support for home-based (domiciliary) care with minimal contribution is only available for individuals who have less than £14,250 in assets, excluding housing assets. For anyone needing residential care, the value of a person's home is taken into account. Anyone who has housing assets worth more than £23,250 is liable to pay for their residential care in full. This threshold is well below the average price of a house (£250,000 across the UK as of December 2013; ONS, 2014).

The system described above results in three broad groups:

- a minority of people receiving the maximum level of local authority funding
- those who receive partial funding from the local authority but contribute a proportion of the costs themselves (either directly to care providers or via reimbursements to the local authority)
- those with social care needs but who are not financially eligible, and are fully self-supporting or self-funding as a result.

This report focuses primarily on the first two groups – that is, those fully or partially supported by local authority funding – because data are collected by local authorities only for these groups. Much less is known about the third, fully self-funding group, despite the fact that it is growing continuously, partly as a result of reductions to local authority budgets, as will be discussed in the following chapters.

## Summary

The picture for social care for older adults prior to 2010 was one of rising need for support, met – to varying degrees – by publicly funded, privately funded and informal care. On average, only around 10 per cent of the population aged 65 and over received publicly funded social care support of some sort,<sup>1</sup> although evidence from the 2011 Census indicates that nearly 28 per cent of the older population felt that their day-to-day activities were limited ‘a lot’.

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<sup>1</sup> Author calculation based on RAP data 2012/13, accessed through NASCIS and population estimates from the 2011 Census (see ‘References and data sources’).

# 3

## Impact of budget cuts on spending on adult social services from 2010

### Local government: reductions in overall income

In October 2010, the first significant cuts to local government were announced by the newly elected Coalition Government, when it published its spending plans for the public sector – the Comprehensive Spending Review – with the explicit aim of reducing the UK’s public sector deficit. The 2010 Spending Review reduced central government allocations to local government by 26 per cent in real terms between 2011/12 and 2014/15 (Table 3.1), which the Treasury estimated to be equivalent to a 14 per cent reduction once forecasts for Council Tax receipts were added in (HM Treasury, 2010). This followed an earlier modest reduction in central government allocations to local government of 1 per cent, announced in the 2010 Budget. In 2013, the government announced a further 10 per cent real-terms reduction to cover the period 2015/16.

**Table 3.1: Summary of central government budget reductions to local government**

	Percentage reduction (net)	Years covered
Budget 2010	1%	2010/11
Comprehensive Spending Review 2010	26%	2011/12–2014/15
Budget 2013	1%	2014/15
Spending Round 2013	10%	2015/16

Source: Audit Commission (2013)

The National Audit Office (NAO) (2013), which reviewed the progress of the Spending Review reductions over the first two years, noted that local governments had ‘absorbed’ only about half of the overall Spending Review reductions by 2013 (about £4.6 billion) and about half the overall Spending Review reductions still had to be made by March 2015.

The reductions in central government allocations have had an uneven impact at local authority level. According to the NAO (2013), this overall reduction of funding from central government from 2011/12 had a variable impact on the spending power of individual local authorities, ranging from 1.1 to 8.8 per cent in cash terms (NAO, 2013).

### How have local authorities responded to funding reductions?

Local government funds social care (and other local services) from a combination of a grant from central government, revenues from Council Tax and user charges. Providing social care for adults and children represents the largest category of spending for local councils. In 2012/13, councils spent £14.8 billion on adult social care, and a further £6.7 billion on children’s social care, representing 57 per cent of spending between them (the percentage includes non-education services

only) (Audit Commission, 2013). Spending on social care is not ringfenced, so local authorities can choose how they divide the bulk of their resources locally. This has led to substantial variation in terms of how local governments have distributed the budget cuts between and within departments.

The Audit Commission's (2013) analysis of councils' past spending and future spending plans shows that between 2010/11 and 2013/14, local authorities had cut budgets in all areas, with the exception of budgets in children's social care, which had increased slightly (by 1.2 per cent). Last year, the reductions made to adult social care budgets accounted for over 52 per cent of the total reductions in local government spending (Audit Commission, 2013).

### Implementing cuts within adult social care budgets

Some insights into the decisions made by local authorities about social care budgets can be derived from an annual survey of local authority directors by the Association of Directors of Adult Social Services (ADASS), known as the ADASS budget survey (see 'References and data sources'). In the three years prior to the latest 2013/14 budget survey, ADASS estimated that £2.68 billion in 'savings' had been made from adult social care departments, representing 20 per cent of net spending. Its survey suggested that most (82 per cent) of the savings had been implemented through the use of 'efficiencies', with most of the rest accounted for by 'service reductions'. However, councils acknowledged differences in what is classified as an 'efficiency', ranging from back-office reductions to service redesign and reduced levels of care provision. Similarly, a third of respondents to the ADASS survey reported that reducing the number of people receiving services was an important area of saving. It is impossible to know from these figures the extent to which savings have been made through genuine efficiencies or by service reductions.

As well as reducing budgets, councils managed costs by increasing fees to service users. There is some evidence for this (Figure 3.1), although it appears that client contributions have been steadily climbing for some time. As well as managing the income received, local authorities are thinking about the fees they pay to service providers. In 2012/13, 45 per cent of councils did not account for inflation in setting their fees to older people's care homes, and 65 per cent did not account for inflation in setting their fees to homecare providers (ADASS, 2013). Consequently, more than half of respondents acknowledged that providers were facing financial difficulties and 40 per cent thought that shifting activity to cheaper settings was likely to be highly important as an aid to saving resources in the coming year (ADASS, 2013).

Figure 3.1: Real-terms income, by source, older people's services, England



Notes: 'NHS' and 'joint arrangements' cover reimbursements for services provided to the NHS and other organisations. Note that in 2011/12, Valuing People Now funding (focused primarily on people with learning disabilities) was no longer recorded as 'income from the NHS' and, as such, this could result in a reduction in trend. Source: NASCIS Personal Social Services Expenditure (PSSEX) including Social Services Management and Support Service (SSMSS) data<sup>1</sup>

In addition to the cost-reduction measures, Figure 3.1 shows how transfers from the NHS have become an increasingly important element of local authority income. The drop in expenditure over recent years is significantly reduced when non-client income is included (as highlighted in Fernandez and others, 2013). These transfers are taken from NHS budgets and given to councils to spend on adult social care services that also have a health benefit. For 2013/14, £803 million was transferred (ADASS, 2013). Councils report that the funds have been allocated in the following ways:

- 32 per cent to avoid cuts to service provision
- 18 per cent for investment in new services
- 14 per cent to cover demographic pressures.

Thirty-six per cent is yet to be allocated (ADASS, 2013). In 2012/13, 46 per cent of the £622 million transfer was spent on off-setting pressure and cuts to services. Of the NHS transfer allocation for 2014/15, £200 million will be rolled into the Better Care Fund, which will make £3.8 billion available to local NHS and social care integration projects from 2015/16 (NHS England, 2013).

Despite these transfers to date, some directors of adult social services note that their budgets will be overspent this year (almost a third of the 58 councils who participated in a survey by The King's Fund, 2013). And although local governments have attempted to absorb the budget reductions through service cuts as well as efficiencies, there is a general consensus that the need for and impact of cuts are likely to rise. Half of the respondents to the ADASS (2013) survey felt that fewer people would be able to access services in the following two years and the results showed a growing uncertainty around the impact on the NHS, the quality of life for service users and the quality of care being provided (although the majority remained optimistic) (ADASS, 2013). This may in part be due to the fact that even councils that have been effective at delivering efficiency

<sup>1</sup> All expenditure data analysis over time in this report has been calculated with the use of a Gross Domestic Product (GDP) deflator.

savings with relatively straightforward gains suggest that making further savings is already becoming much harder (The King's Fund, 2013).

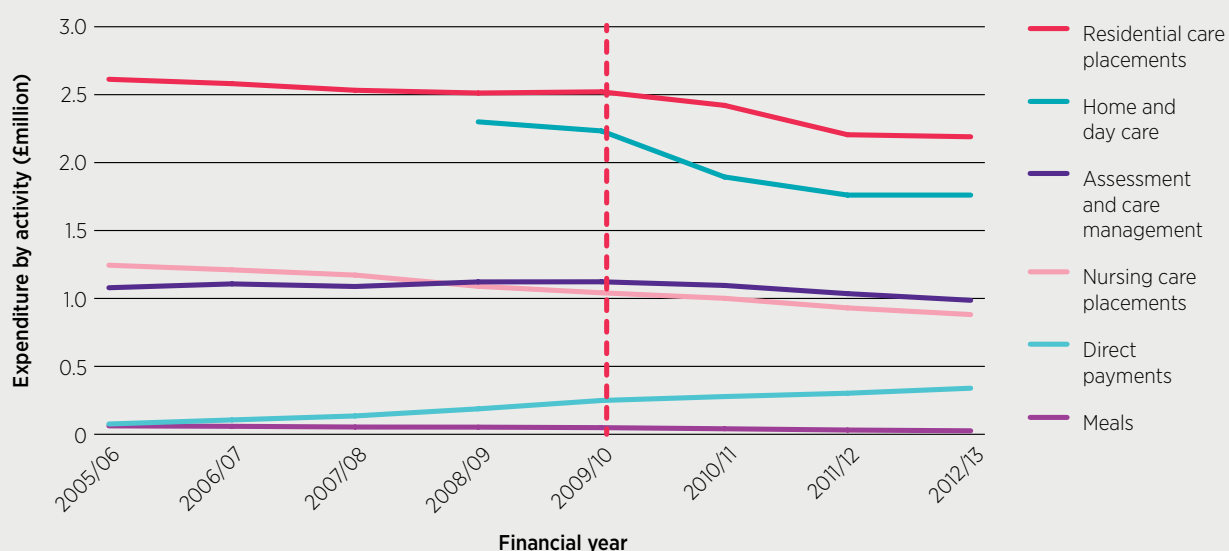
## Spending on adult social care services since 2010

National-level spending data show a combination of reductions in global expenditure and rising costs of service delivery at a local level. In 2009/10, England spent £10.6 billion (all figures presented here are in 2012/13 prices, using the HM Treasury GDP deflators as at June 2013) in gross terms on social care for older adults, compared with £9.8 billion in 2012/13, a reduction of 7 per cent. Real-terms net spending (that is, excluding charge income) fell by 15 per cent, from £7.8 billion in 2009/10 to £6.6 billion in 2012/13. The three largest areas of expenditure all faced reductions:

- home and day care services by 23 per cent (£539 million reduction)
- nursing placements by 15 per cent (£160 million reduction)
- residential care by 12 per cent (£331 million reduction) (Figure 3.2).

Spending on meals was the largest reduction (46 per cent), although the nominal amount was far smaller than the three service areas just listed. Some of this reduction may have been offset by a 36 per cent rise in spending on direct payments. However, this rise only accounted for an additional £90 million of expenditure (real-terms net current expenditure). Other service areas also increased.

**Figure 3.2: Change in real-terms net current expenditure, by service area, older people's services, England**



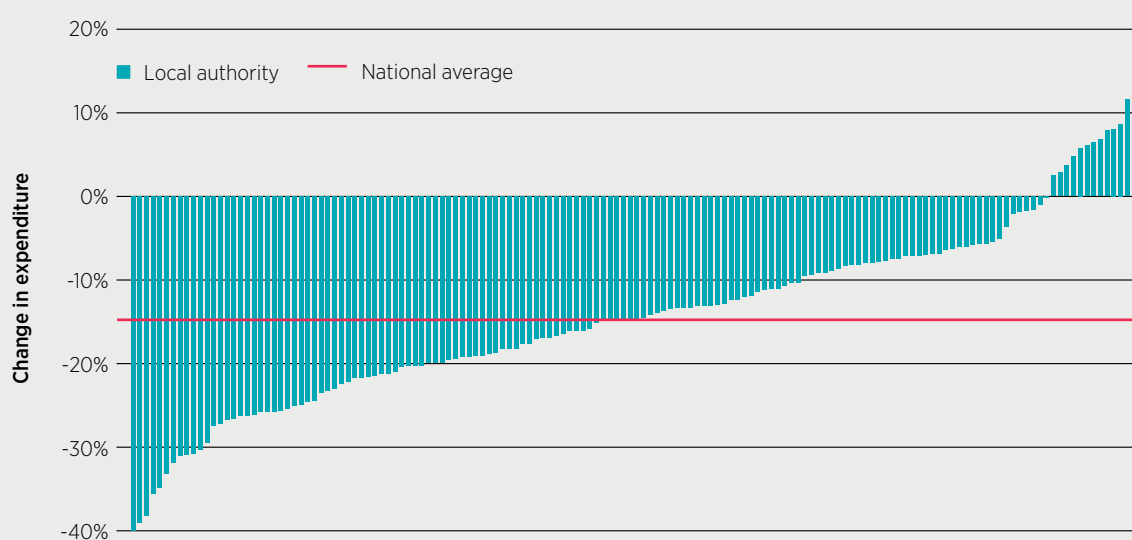
Notes: The red dotted line marks the 'baseline year' for this study. Home and day care is categorised in the data as to 'Fairer charging – community services'. Source: NASCIS PSSEX including SSMSS data

Unit cost data are difficult to interpret on a national level both because of gaps in the data series that are publicly available and because of local variations in costs. The Care Quality Commission's (CQC's) analysis of unit costs for all adults over the age of 18, published in its annual *State of Health Care and Adult Care* (CQC, 2013a), shows that weekly costs for local authorities of supporting people in residential homes, nursing homes or intensively in their own home had reduced by 2 per cent

in cash terms or 5 per cent in real terms between 2010/11 and 2011/12 (from £623 to £609 a week). The CQC noted that ‘there is concern around the ability of the sector to maintain quality standards if there are further funding reductions’ (CQC, 2013a).

It is also clear that individual local authorities have responded to the worsening economic climate in different ways (Figure 3.3). On average, local authorities reduced their net current expenditure on social care for older adults by 15 per cent between 2009/10 and 2012/13. But while around a third of local authorities reduced their net current expenditure by 20 per cent or more between 2009/10 and 2012/13, 12 local authorities saw increases (excluding the Isles of Scilly and the City of London as atypical).

**Figure 3.3: Percentage change in real-terms net current expenditure by local authority, between 2009/10 and 2012/13, England**



Note: excludes Isles of Scilly and the City of London. Source: NASCIS PSSEX including SSMS data

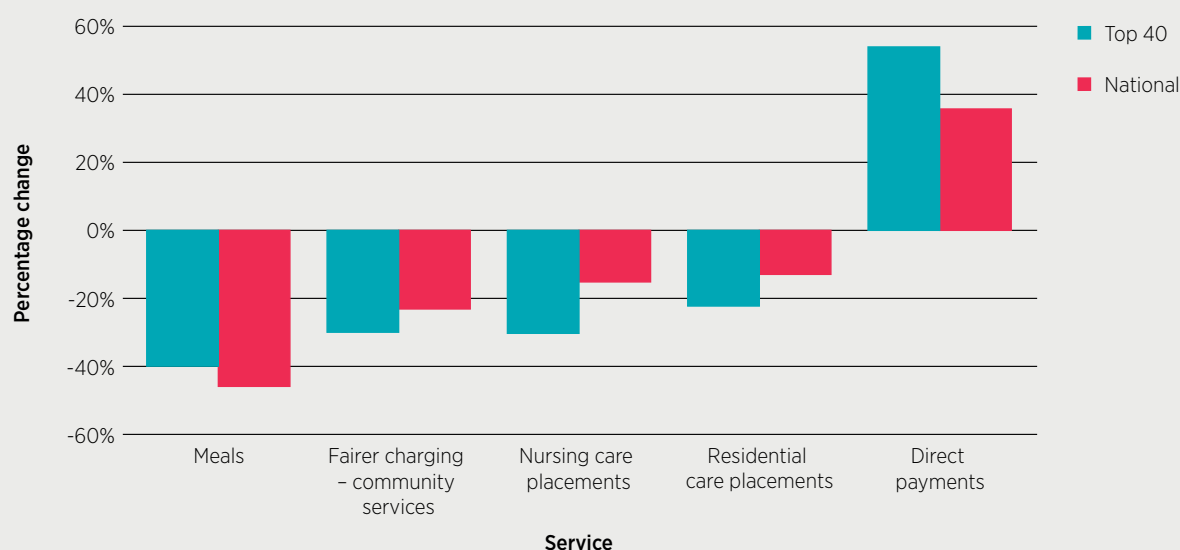
We looked in more detail at a subgroup of local authorities – roughly 25 per cent of all local authorities – that reduced net current expenditure the most between 2009/10 and 2012/13.

The 40 authorities that reduced net current expenditure on services for older people the most (that is, by anywhere between 21 and 40 per cent in real terms) were a heterogeneous group. They included authorities in inner-city urban areas with a significantly lower proportion of the population over the age of 65 than the national average, as well as those in more rural areas with a higher proportion. The percentage reduction in spending over the period was weakly correlated with relative need, showing that authorities with higher need were marginally less likely to have cut net current spending – although there was little difference from the national picture within this group.

Looking at specific areas of expenditure, we found that these 40 local authorities had reduced net current expenditure over and above the national average reduction (across all local authorities) for home and day care, residential care and nursing care, but had increased spending on direct payments above the national average (Figure 3.4). These figures should be treated with caution since there



**Figure 3.4: Percentage change in real-terms net current expenditure by service area, for the 'top 40' local authorities who have reduced their budgets, and all local authorities in England, between 2009/10 and 2012/13**



Source: NASCIS PSSEX including SSMSS data

was some spread in the distribution of reductions in spending on each service area according to the local authority, and it is also unclear as to what extent a substitution effect was observed – with savings generated in some service domains being transferred to support spending in others.

## Summary

Under the terms of the 2010 Comprehensive Spending Review, reductions in central government allocations to local government amount to a 14 per cent fall in real terms between 2011/12 and 2014/15, with an additional 10 per cent cut announced in 2013 for 2015/16. Local authority spending power has fallen by anywhere between 1.1 and 8.8 per cent in cash terms as a result (NAO, 2013). The way in which this has translated into actual expenditure has varied across local authorities, however. While real-terms net current spending on social care for older adults across England fell by 15 per cent overall between 2009/10 and 2012/13, our analysis shows that a very small number of councils increased their net current spend over the same period. There is no discernible relationship between net current spending and local estimates of need.

Further analysis of the 25 per cent of local authorities that reduced their net current spending the most over this time period again had no discernible relationship with local need. On average, this heterogeneous group of councils reduced spending on meals, day care, nursing care and residential care more than others, but increased spending more than others on direct payments.

The reductions in central government allocation implemented thus far represent about half of the total envisaged by 2014/15 (NAO, 2013), and it is likely that a clearer picture of the pattern by which councils are managing their changing financial circumstances will emerge in the coming years.

## 4

## Impact of budget cuts on access to and volume of adult social services

### Changes in eligibility for publicly funded social care

Local authorities have taken a range of actions in order to reduce the amount of money they spend on adult social services. One of the most common is to shift the needs-based eligibility threshold, under the Fair Access to Care Services (FACS) national criteria, so that public funds go only to those with more 'substantial' or 'critical' needs. It should be pointed out that although researchers have found some variability in the way in which FACS criteria are interpreted and applied locally (Fernandez and Snell 2012), the underlying trend has been to direct resources towards those deemed more needy.

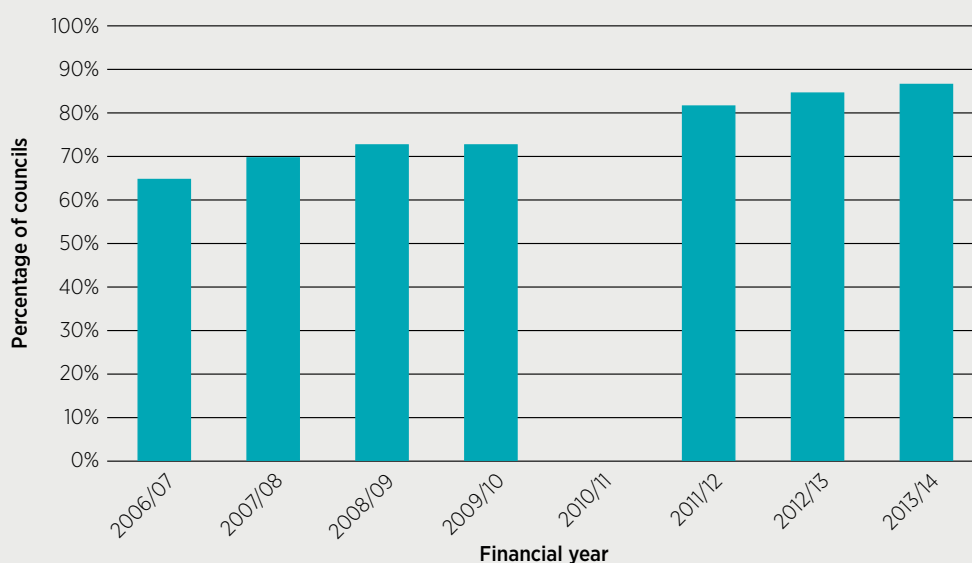
Results from annual surveys of directors of adult social services show that this trend to move public funding away from those with more moderate needs predates the financial crisis. The proportion of councils restricting public funding to those people with needs that are judged to be 'substantial' or above has grown steadily from 65 per cent of councils in 2006/07 to 87 per cent of councils in 2013/14 (Table 4.1, Figure 4.1).

**Table 4.1: Percentage of councils using each individual eligibility threshold as the minimum band for allocation of social care support**

	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Low	4	5	2	3		3	1	
Moderate	31	25	24	24		15	13	
Substantial	63	70	72	72	70	78	83	87
Critical	2	0	1	1		4	2	

Note: Gaps for 2010/11 and 2013/14 are due to a lack of published data.  
Source: ADASS surveys

**Figure 4.1: Percentage of councils using substantial or critical as a minimum band for allocation of social care support, England**

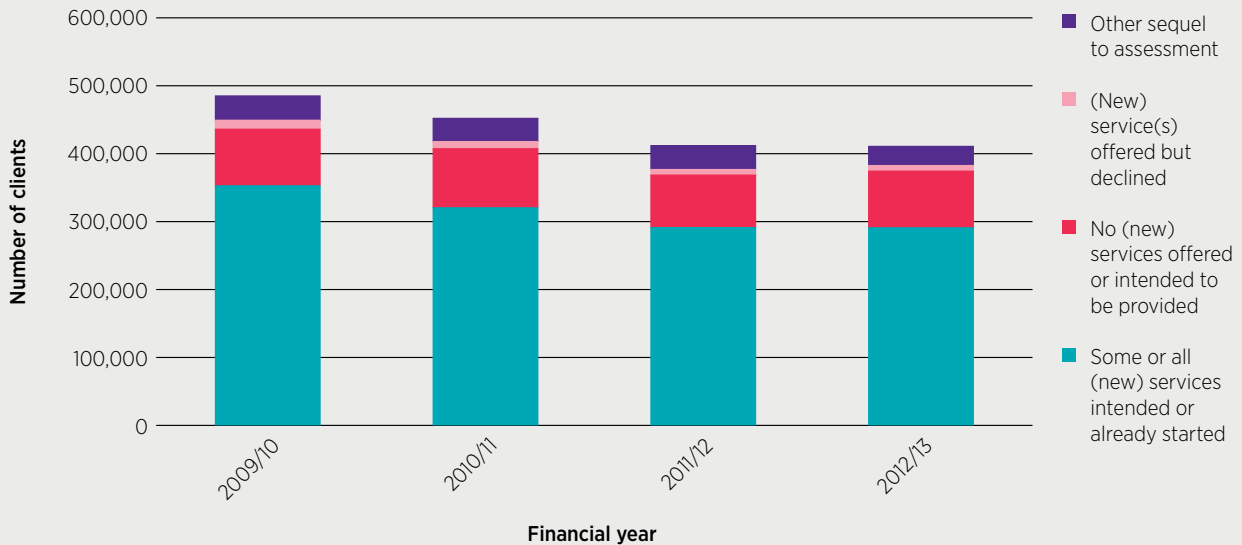


Note: The gap for 2010/11 data is due to a lack of published data. Source: ADASS surveys

## Declining numbers of recipients of publicly funded social care

Nationally, a picture is emerging of significant reductions in public provision of social care for older adults in the wake of the 2010 Comprehensive Spending Review, in terms of both the amount of money spent as already illustrated and the numbers of people receiving support. Accurately calculating the number of people who contact local authorities to request social care is difficult, the main reason being that councils may screen calls for suitability before recording it as a contact made with the council (HSCIC, 2012b). However, it is possible to trace the number of people who are put forward for an assessment and what the anticipated outcome is (Figure 4.2). The total number of assessments decreased by 15 per cent between 2009/10 and 2012/13, which means that 74,800 fewer people received an assessment in 2012/13 than in 2009/10. The proportion of people who were assessed but not expected to receive any services increased from 17 to 20 per cent over the same period.

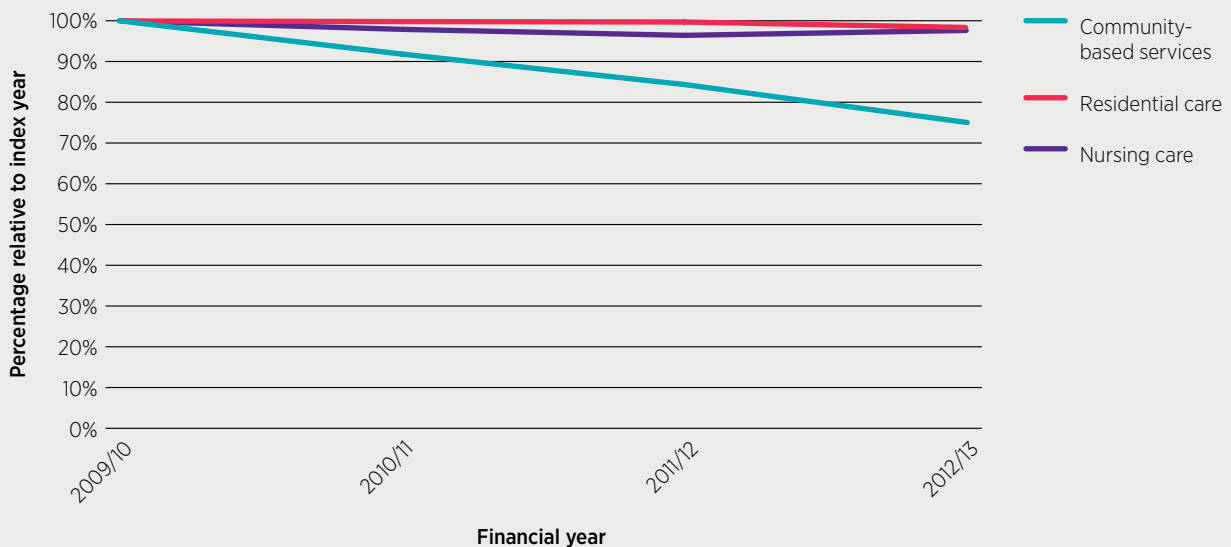
**Figure 4.2: Number of new clients who were assessed, by expected outcome of their assessment (all adults)**



Source: NASCIS RAP data

In terms of numbers of service users, residential care and nursing care saw relatively small overall reductions from 2009/10 to 2012/13 (Figure 4.3). A review of the data on the total number of service users alongside area relative need estimates was also conducted. However, the data did not show a strong correlation, again suggesting that areas with higher need were just as likely to have reduced service user numbers as those with lower need.

**Figure 4.3: Changes in service user numbers for community-based, residential care and nursing care services since the baseline year (where 2009/10 = 100)**



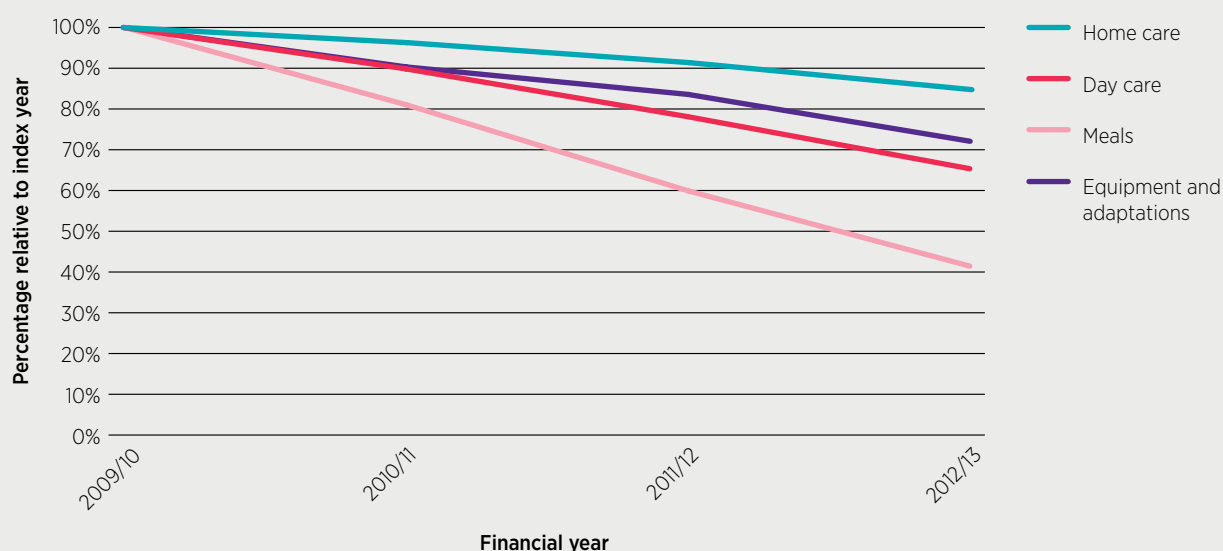
Source: NASCIS RAP data

The picture for older people receiving community-based services, by contrast, was stark. The number of publicly supported older people declined by 26 per cent between 2009/10 and 2012/13 (245,855 older adults). Some of the largest falls over this time period were in the following areas (Figure 4.4):

- meals – a reduction of 54,795 individuals or 59 per cent
- day care – a reduction of 36,480 individuals or 35 per cent
- equipment and adaptations – a reduction of 109,460 individuals or 28 per cent
- home care – a reduction of 68,010 individuals or 15 per cent.

Of course, some of these people may have been offered alternative services provided by the local council, but in terms of what is included in the administrative returns, only the numbers receiving direct payments appeared to increase and even then only by 10,250 older people (an increase of 20 per cent in the two years between 2010/11 and 2012/13).<sup>1</sup> Given what we know about rising demand for support, it is reasonable to assume that local authorities direct their limited resources to those in greatest need, by changing eligibility thresholds for access to care. Nevertheless, our review also found variations between local authorities in terms of growth or decline in community services. Again, though, there was no clear relationship between local changes in service user numbers and relative need; reductions in user numbers were just as likely to be seen in councils with older people with relatively high levels of need, as those without.

**Figure 4.4: Changes in user numbers for different forms of community-based care since the baseline year (where 2009/10 = 100)**



Source: NASCIS RAP data

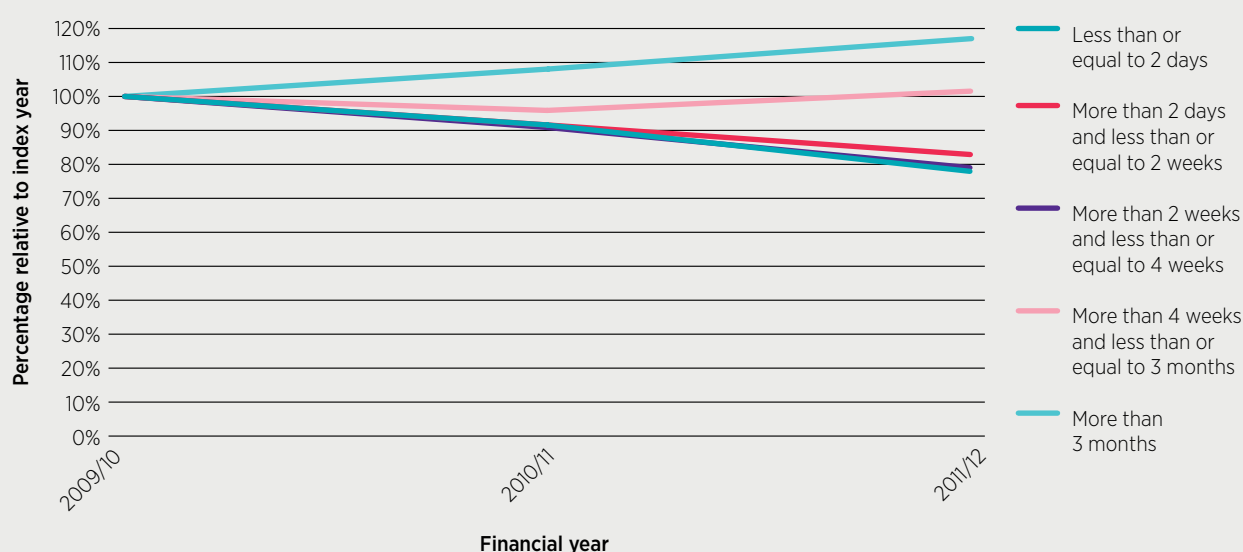
## Waiting times

Changes in waiting times for assessments and service provision potentially offer an early indicator of the impact of expenditure reductions, since they are often the first to show strain in times of difficulty. Unfortunately, national social care

<sup>1</sup> Data not available for 2009/10.

data capturing waiting times for initial assessments for new service users and delivery of services after initial assessment were removed from the RAP collection in 2012/13 and 2011/12 respectively. As the HSCIC (2013a, p. 13) itself points out, this means that 'the RAP return no longer collects any information on timeliness'. However, data for the period up to 2011/12 show a gradual increase in users waiting the longest measurement periods for assessments after first contact, along with a reduction in those waiting for the shortest time periods (Figure 4.5). For example, from 2009/10 to 2011/12 there was an 18 per cent increase in the number of new clients who waited for more than three months from first contact to their assessment.

**Figure 4.5: Change in length of time from first contact to completed assessment for new clients, by financial year (where 2009/10 = 100)**



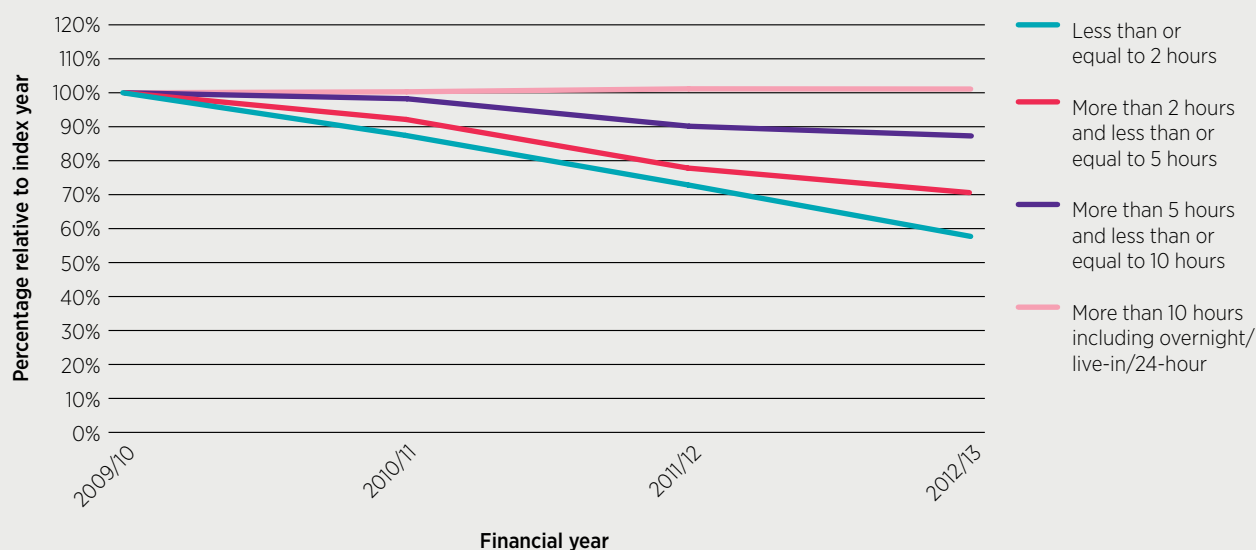
Source: NASCIS RAP data

## Contact time

Another measure of service activity is weekly contact time for community-based services. In general terms, given the demographic patterns described in earlier chapters and particularly the higher ADL support needs of older people, we might expect the volume of high-intensity care to be increasing over time.

Available data show that the number of service users receiving high-intensity care (10 hours a day including overnight care or live-in care) has remained constant but there are marked reductions in the number receiving lower-intensity care, with a reduction of 42 per cent between 2009/10 and 2012/13 (Figure 4.6, note that these data are only available for all adults, not just older people). This suggests that local authorities are attempting to focus their resources on those with the highest levels of need. It may also be the consequence of policy initiatives that try to keep people living at home rather than in an institution.

**Figure 4.6: Change in the number of service users in receipt of high-, intermediate- and low-intensity social care support since 2009/10 for all adults (where 2009/10 = 100)**



Source: NASCIS RAP data

## Identifying potential indicators of quality: data deficits and ways ahead

The evidence presented in this chapter shows that while publicly available data sources on social care performance exist, they predominantly gather information on process and activity. These sources are unlikely to offer information suitable for use as quality indicators over the long term, although – when taken together – they provide an indicative picture of how local authorities are changing the services they deliver to users over time. Newer sources of information – including, for example, the annual Adult Social Care Survey and the Adult Social Care Outcomes Framework (ASCOF) – will be a significant aid once a longer time series is possible.

Our understanding of local authority activity would be improved by:

- strengthening data collection on waiting times gathered by NASCIS – unfortunately, the removal of data on waiting times from the NASCIS RAP collection means that it is currently not possible to say anything about the timeliness of social service provision using publicly available data
- gathering information on the number of individuals falling within each eligibility band, by local authority, over time.

# 5

## Impact of budget cuts on outcomes: wellbeing and health services

### Information collection on outcomes from social care for older adults

Understanding the impact of reductions in spending on social care for older adults is essential. First it is important to understand the impact of the reductions on the wellbeing of individuals (and their carers) who are receiving services that might have been reduced in quantity or quality. And second it is necessary to understand the indirect effects of the reductions on other services, particularly health services.

Since the publication of the government's initial reform plans for the NHS and social care in 2010 (Department of Health, 2010), there has been a renewed emphasis on identifying and evaluating measures that capture the quality and effectiveness of social care services. In 2011, the government published the first iteration of the ASCOF, which will be used to improve services and allow for benchmarking between areas (Department of Health, 2011). In April 2013, the National Institute for Health and Clinical Excellence (NICE) assumed responsibility for developing advice and guidance for social care services in addition to health, reflected in its name change to the National Institute for Health and Care Excellence.

The current framework captures data across four domains:

- enhancing quality of life for people with care and support needs
- delaying and reducing the need for care and support
- ensuring that people have a positive experience of care and support
- safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm.

In the following sections, we assess available evidence in three areas:

- user and carer perceptions of their quality of life
- impact on health services
- impact on the quality of social care services.

### Perceptions of quality of life

#### Perceptions of quality of life: users of local authority social services

Quality of life is routinely measured as part of the ASCOF.<sup>1</sup> Perceptions of service users aged 65 and over have been relatively consistent over the past three years.

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<sup>1</sup> See <http://ascof.hscic.gov.uk>



However, there are wide ranges between local authorities:

- The average score for social care-related quality of life was 18.8 in 2012/13. (The maximum possible score for those who have a high quality of life is 24; these range by local authority from 17.4 to 20.4).
- 74.9 per cent of people who used services felt that they have control over their daily life (range by local authority from 60.8 to 89.1 per cent).
- 77.6 per cent of people who used services said that the services made them feel safe and secure (range by local authority from 55.4 to 83.6 per cent), up from 75.0 per cent in 2011/12.

This data collection can also be used to benchmark satisfaction with services. Of people who used services in 2012/13, 62.5 per cent were satisfied with their care and support (range by local authority from 45.1 to 75.4 per cent) (ASCOF). It will be important to track changes over time, to see whether the wellbeing and satisfaction of users change as budgets are reduced.

### Perceptions of quality of life: carers

It is also important to consider the impact on people who are providing informal care.<sup>1</sup> The 2011 and 2012 Health Survey for England found that the majority of people who received help for ADLs or IADLs were supported by an informal carer rather than a formal one (Whalley, 2012). Those who were cared for by their spouse or partner were receiving a substantial number of hours of care: 50 per cent of men and 45 per cent of women received 10 or more hours in the previous week, including 35 per cent of men and women who were receiving 20 or more hours (Whalley, 2012).

The same survey reported that a third of male carers and half of female carers felt that their own health had been affected by caring for others (Doyle, 2012). Most commonly this included feeling stressed and tired. Additionally, 15 per cent of male and 20 per cent of female working-age carers reported negative consequences for their ability to take-up or stay in employment. The biennial Personal Social Services Survey of Adult Carers in England 2012/13 (which does not include self-funders of social care) found that 59 per cent of carers felt that they had some control over their daily life but not enough, with 12 per cent stating that they had no control (HSCIC, 2013b). Two thirds of carers were satisfied with the support and services they and the person they cared for received from social services in the last 12 months (extremely, very or quite satisfied), compared to nine per cent who were unsatisfied (extremely, very or quite dissatisfied), with an additional 15 per cent stating that they had not received any support. The survey also found a negative correlation between how long carers spend per week in their caring role and their quality of life.

### Impact on health services

Concern has been mounting among policy-makers, users and service providers that the recent reductions in the quality and quantity of social care available to older adults will lead to harm, which might result in health service use that in some sense could have been 'avoidable'. The current and planned transfer of resources from NHS budgets to social care departments is based on the assumption that timely and appropriate investment in adult social care has a protective effect on individuals and prevents subsequent use of health services.

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1 The figures in this section relate to all carers, not just those who provide support for people aged 65 and over.

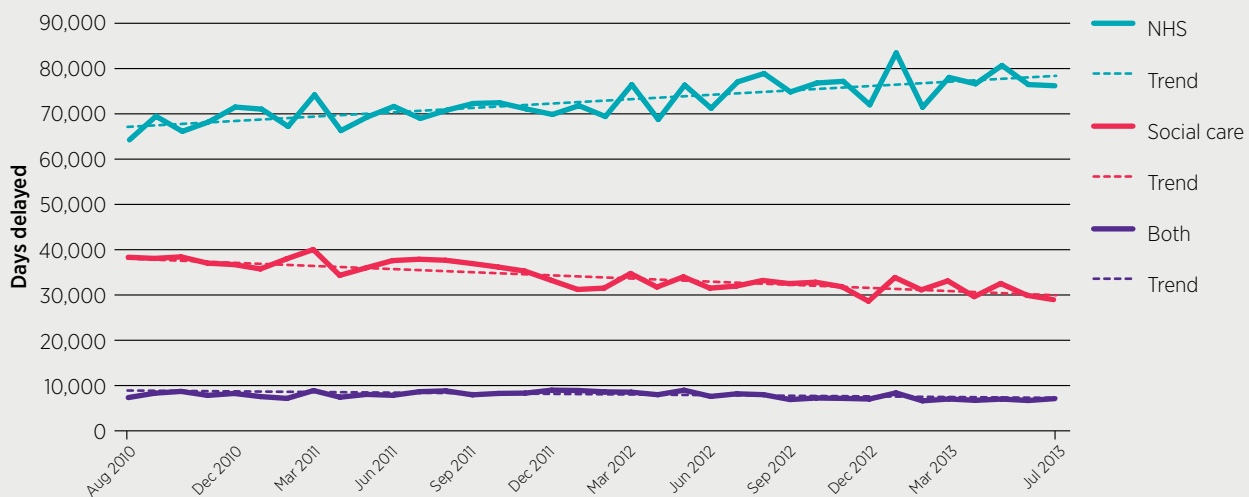
### Health impact: delayed transfers from hospital

One of the direct potential impacts of reduced spending on social care might be delays in accessing social care on discharge from hospital, when older people have experienced some sort of acute event that necessitates additional social care support.

The government collects and publishes data on the numbers of people waiting to be discharged and how many days of delay they experience, as a result of non-clinical reasons, including putting social care (and other out-of-hospital) services in place to support them either at home or in a residential or nursing home. Data on these 'delayed transfers of care' are presented at national level and attribute the cause of delays to either social care or the NHS.

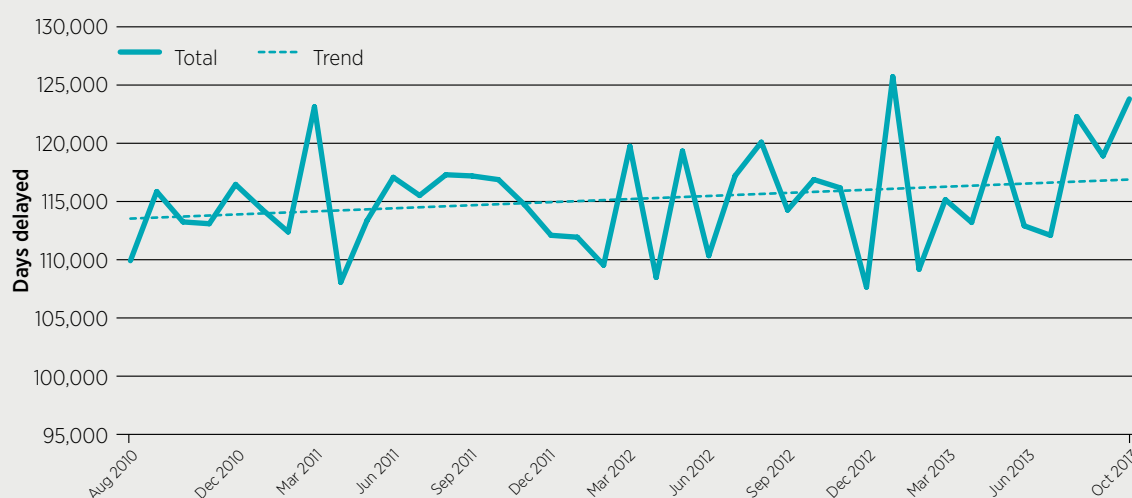
The data show that delays attributable to social care have declined slightly during the period from 2010/11 to 2012/13, while delays attributable to the NHS have increased since 2010 (Figure 5.1).

**Figure 5.1: Transfer of care: number of days delayed, by organisation responsible for the delay (August 2010 to July 2013)**



Source: NHS England, 2013 Delayed Transfers of Care: monthly situation reports

The data in Figure 5.1 suggest that any funding pressures affecting social services' capacity to assist with the discharge of patients have yet to be felt. Nevertheless, the total number of delayed days in NHS organisations (acute and non-acute) has crept up since August 2010 (109,908) and was 123,108 in October 2013 (Figure 5.2).

**Figure 5.2: Transfer of care: number of days delayed (August 2010 to October 2013)**

Source: NHS England, 2013 Delayed Transfers of Care: monthly situation reports

## Health service utilisation

Attendances at the Accident & Emergency departments of hospitals have been increasing among all age groups, including older age groups (HSCIC, 2013c). Older people are much more likely to be admitted to hospital as a result of an attendance, however, as the most recent figures from the NHS show.

**Table 5.1: Percentage of attendances, by disposal method and age group, 2012/13, all department types**

	Aged under 10	Aged 10 to 64	Aged 65+
Admitted	13.6%	14.9%	46.9%
Discharge – general practitioner	20.1%	21.7%	15.4%
Discharge – no follow-up	50.0%	40.5%	23.0%
Other	6.9%	9.1%	4.6%
Referred	9.4%	13.9%	10.1%

Note: 'disposal method' refers to the way in which A+E attendance has ended.  
Source: HSCIC (2013d, Table 21)

It is not possible to deduce from these figures what proportion of admissions might be the result of reduced access to, or quality of, social care services, because hospital data do not record whether a person was a social care user. However, poor-quality social care for older adults and their carers could potentially be behind some of these admissions, as reduced access to care or a reduction in the quality of services might potentially leave older people more susceptible to falls or infections resulting from inadequate (or poorly supervised) eating and drinking.

In its recent *State of Health Care and Adult Social Care* report, the CQC looked at a selection of admission causes that it deemed to be 'avoidable' through preventive care from either social care or primary care (CQC, 2013b). It noted that between 2007/08 and 2012/13, some conditions had increased as a proportion of all emergency admissions, for example pneumonia (64 per cent increase), food/liquid pneumonitis (52 per cent increase) and urinary tract infection (UTI) (45 per cent increase) (CQC, 2013b). However, additional analysis of the data at local

authority level by the CQC did not establish any link between the gross amount of money spent by local areas on social care and the rate of admissions for these causes.

The Nuffield Trust and the Health Foundation have conducted more detailed analysis of 'ambulatory care sensitive conditions' (ACSCs), which are potentially avoidable through better non-hospital-based care (Blunt, 2013). These include, for example, UTIs, which are common among older people. UTIs are often associated with, or exacerbated by, inadequate fluid intake, which could be a symptom of poor self-care or care from others. They can be successfully treated with antibiotics but prolonged or severe UTIs can result in hospital admission. Although it is important to note that in many of these cases the UTI is just one factor of the patient's complex health and social care needs, which are the underlying reasons for rises in admissions, UTIs remain an interesting, suggestive measure of care.

Data on emergency admission rates for UTIs are collected by NHS organisations as one of a set of conditions for which hospital admissions are potentially avoidable, through prompt primary care. They might also potentially be a marker for inadequate social care. It is not possible to track users of social care across the NHS hospital system at a national level, nevertheless it is possible to analyse rates of admissions against the proportion of people in an area living in care homes and the proportion of people aged over 65 living alone, who might have social care needs.

Our analysis found that there was no correlation between the standardised admission ratio for UTIs among the over 65s and the proportion of people living in care homes, but a weak correlation between UTI admissions and the proportion of people living alone, suggesting (possibly) that some cases might be due to inadequate levels of care in the home. Further research would be needed to establish whether this was connected to reductions in publicly funded social care available to people in their homes (Blunt, 2013).

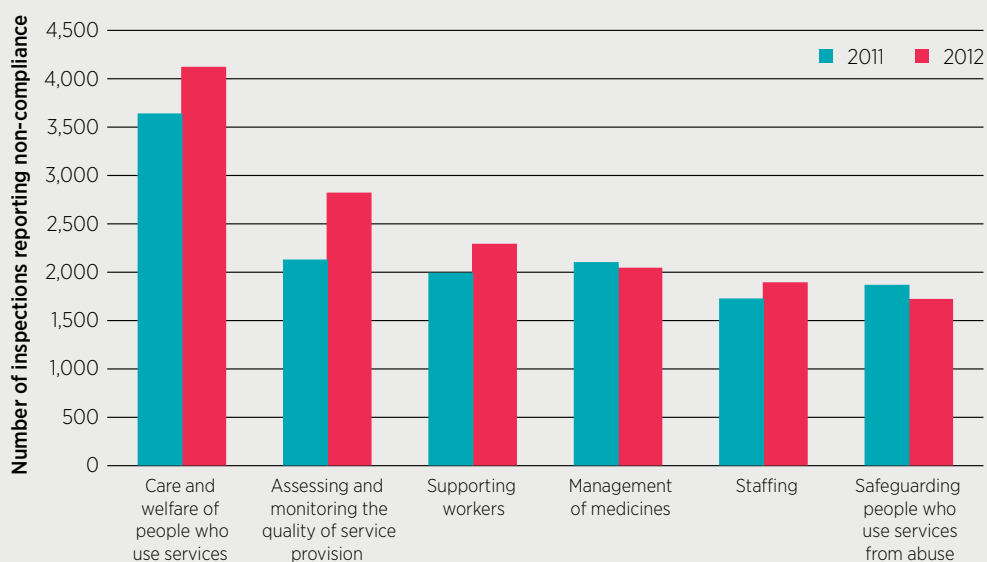
## **Impact on the quality of social care services: residential and nursing homes**

One potential area in which the impact of funding reductions might be seen is in the quality of care provided in the residential and nursing home sector, particularly those homes that are very reliant on local authority-funded clients for the bulk of their funding. Quality of care in this sector has historically been extremely difficult to capture robustly, and there is little formal analysis in this area. However, as part of the research for this report, we conducted a crude analysis of inspection data gathered by the CQC during care home visits between 2010 and 2013.

We focused our analysis on inspection data from institutions serving older people and those with dementia (the majority of whom we took to be aged 65 or over), and examined data on inspection judgements and the areas of operation found to be non-compliant in each case. Unfortunately, a change in the classification of inspection judgements in 2011 makes it difficult to build a time series of numbers of different inspection judgements over time. However, analysis of specific areas of concern for the two years for which data are most complete (2011 and 2012) demonstrated that, of the 21 standards, the most common standard was the 'care and welfare of people who use services' (Figure 5.3), but there was no clear pattern of change over time suggestive of a link to the broader funding

environment. The data do not distinguish between those homes that were reliant on funding from local authorities and those that had much higher proportions of self-funding residents.

**Figure 5.3: Number of CQC inspections reporting non-compliance, by the most frequently cited inspection standards**



Note: This figure presents aggregate figures at national level. Source: CQC inspection data provided to authors

The CQC's *State of Health Care and Adult Social Care* report for 2013 (CQC, 2013c) summarises the results of inspection data for all types of social care providers. There were small increases in the percentage of providers meeting the various standards between 2011/12 and 2012/13. However, the CQC also conducted more detailed analysis on the relationship between the performance of care homes in terms of death notifications and the characteristics of care homes, such as the skills of staff, staffing levels and turnover (CQC, 2013a). It found that high staff turnover was positively correlated to higher death notifications. This might be an indication that cuts in local authority funding have put pressure on providers' ability to retain staff. However, the CQC noted that other factors that were not possible to include in the analysis, such as the availability of GP and district nurse services, could also be important.

# 6

## Conclusion

The Coalition Government's reductions to local government grants between 2010/11 and 2015/16 have so far had a clear impact in terms of the amount of money being spent on social care for older adults and the numbers of those receiving services. While the number of people receiving publicly funded care in residential and nursing homes declined slightly between 2010 and 2013, there were more marked falls in the numbers receiving community-based services, particularly meals and home care. This is despite policy initiatives that have actively sought to support people in their own homes as an alternative to institutionalisation. While a small proportion of the declines to community-based services may have been offset by the introduction of more direct payments to older people, it seems likely that they also reflect an acceleration of an underlying trend towards limiting publicly funded social care to those with the highest levels of need.

We know that services have been reduced and the numbers in receipt of publicly funded care have also reduced but it is not clear what impact this is having on the wellbeing of those who receive social care services, or on the health and wellbeing of their carers. It is therefore vital that the NHS and social care system finds ways of understanding what is happening to all social care users and carers, regardless of their funding source. There are three main groups that need to be tracked through the system:

1. The first is the group of individuals whose care needs are fully funded by the state. These people have high needs and very low income and assets. This group could be experiencing reductions in the quality of their home or institutional care due to reduced fees paid to providers, staff shortages, high staff turnover or reduced contact hours. The health impact could be increases in avoidable harms such as pressure sores and infections from poor hydration, or an increase in falls.
2. The second is the group of individuals whose care needs are partially funded by the state. These people have high needs but modest means. They may also be experiencing poorer-quality care, and paying higher user contributions that could be having unknown impacts on their household spending (that is, reduced income for heating, food, transport and so on). There may also be a greater burden on informal carers.
3. The third is the group of individuals who self-fund their care – those who have never been eligible for state support and those who have recently been excluded because of changes to the eligibility thresholds in some local authorities. The main concern for this group is unmet need – those who cannot afford (or are possibly unwilling to provide) an adequate level of care to meet their needs. These individuals may also be more susceptible to falls, infections and other health problems that arise from a lack of care. They may also have difficulties accessing primary care. There will also be pressure on informal carers, which could affect their health and employment status.

It is not possible to get a definitive picture with regard to what is happening to all three groups. The first two groups could be tracked using available data if social care and NHS data were linked, but those who are self-funding and their carers are not recorded and are invisible in the system. Only household surveys provide an exploration of the social impact or quality of life indicators for all groups (where questions about the providers of care are also included), measuring, for example, social isolation and depression.

We would encourage the development of 'social care sensitive' indicators of the use of health services, which might serve to flag up when older people access health services as a result of inadequate or poor-quality social care services, regardless of whether they are publicly or privately funded. Given the future trends in population growth and the continuing constraints to local government funding, it is imperative that we develop better information systems that track older people across services, so that policy-makers have a clear understanding of the relationship between social care and the wellbeing and health of older people.

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## Appendix: Fair Access to Care Services (FACS) framework to assess eligibility for need

### **Critical** – when:

- life is, or will be, threatened; and/or
- significant health problems have developed or will develop; and/or
- there is, or will be, little or no choice and control over vital aspects of the immediate environment; and/or
- serious abuse or neglect has occurred or will occur; and/or
- there is, or will be, an inability to carry out vital personal care or domestic routines; and/or
- vital involvement in work, education or learning cannot or will not be sustained; and/or
- vital social support systems and relationships cannot or will not be sustained; and/or
- vital family and other social roles and responsibilities cannot or will not be undertaken.

### **Substantial** – when:

- there is, or will be, only partial choice and control over the immediate environment; and/or
- abuse or neglect has occurred or will occur; and/or
- there is, or will be, an inability to carry out the majority of personal care or domestic routines; and/or
- involvement in many aspects of work, education or learning cannot or will not be sustained; and/or
- the majority of social support systems and relationships cannot or will not be sustained; and/or
- the majority of family and other social roles and responsibilities cannot or will not be undertaken.

### **Moderate** – when:

- there is, or will be, an inability to carry out several personal care or domestic routines; and/or
- involvement in several aspects of work, education or learning cannot or will not be sustained; and/or
- several social support systems and relationships cannot or will not be sustained; and/or
- several family and other social roles and responsibilities cannot or will not be undertaken.

**Low** – when:

- there is, or will be, an inability to carry out one or two personal care or domestic routines; and/or
- involvement in one or two aspects of work, education or learning cannot or will not be sustained; and/or
- one or two social support systems and relationships cannot or will not be sustained; and/or
- one or two family and other social roles and responsibilities cannot or will not be undertaken.

Source: Social Care Institute for Excellence (undated, p. 4)

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Before this, Holly worked as a researcher for a social housing management consultancy. She has an MSc in Social Policy and Planning from the London School of Economics.

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