Commission for Social Care Inspection

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Making Social Care Better for People

The state of **social care** in England 2007-08

January 2009

About CSCI

The Commission for Social Care Inspection (CSCI) was set up in April 2004. Its main purpose is to provide a clear, independent assessment of the state of social care services in England. CSCI brings together into one body the social care components of the work of the National Care Standards Commission, the Social Services Inspectorate and the SSI/ Audit Commission Joint Review Team. CSCI combines inspection, review, performance and regulatory functions across the range of adult social care services in the public and independent sectors.

CSCI exists to promote improvement in the quality of social care and to ensure public money is being well spent. It works alongside councils and service providers, supporting and informing efforts to deliver better outcomes for people who need and rely on services to enhance their lives. CSCI aims to acknowledge good practice but will also use its intervention powers where it finds unacceptable standards.

Reader Information

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The state of social care in England 2007-08

January 2009

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Foreword by the Chair and the Chief Inspector

This is the Commission for Social Care Inspection's fourth and final report on the state of social care in England. The first part of the report sets out detailed information on the range, quality and availability of social care services across the public, private and voluntary sectors. This information is based on CSCI's findings from inspections, regulatory activity and performance assessment of councils. The second part assesses the support available to people with multiple and complex needs, and the extent to which this group of people is benefiting from the 'personalised care' agenda outlined in *Putting People First*.

Last year's state of social care report focused on the situation for people who are not eligible for publicly funded social care, and who have to find and fund their own care. We highlighted the increasingly sharp divide between people who qualify for care that is funded and arranged by their local council and those who fall outside that system and become 'invisible' to it.

The Commission was pleased to be asked by the Care Services Minister in early 2008 to undertake a review of the current eligibility criteria that councils use to make decisions about how and where to allocate resources. We presented our findings to ministers in the autumn, together with recommendations on the way forward. It is our view that everyone looking for social care support should be entitled to information, advice and a proper opportunity to have their needs assessed. We also recommended a clearer, simpler framework for determining which individuals are a priority for publicly funded support.

This final report summarises the progress made over the last six years in improving the performance of councils and the quality of care services overall. For people who are entitled to receive services, the care they receive is, in general, better than it has ever been. However, the number of people who have to find and fund their own care is growing. And there is a significant gap between the aspiration that everyone should receive individualised advice and support to help them make decisions about their care and people's real experiences.

We are concerned that, while many councils are improving their performance in the context of what is currently required of them, it is not yet clear how they will go about delivering the transformation agenda of *Putting People First*. While there are some excellent examples of people receiving the support they need to enable them to live their lives as they wish, much remains to be done to make personalised support a reality for people with the most complex needs. A change of culture is needed in many councils, with stronger leadership from lead members on the real benefits and possibilities of personalised care, based on a commitment to promoting real equality and upholding human rights.

The next few years will be a crucial time for adult social care in England, with important decisions due to be made both about the future shape of the care and support system and about the way the system is funded. It is our clear view that social care in the future should be delivered within a single system, regardless of who is paying, so that no one is excluded from assistance in gaining access to the care and support they need to manage their lives.

Dame Denise Platt DBE
Chair
Commission for Social Care Inspection

Paul Snell
Chief Inspector
Commission for Social Care Inspection

Contents

The state of social care in England 2007-08: an overview

This fourth report from the Commission for Social Care Inspection:

- Describes trends in the range, quality and availability of social care services in 2007-08 across the public, voluntary and private sectors.
- Looks at support to people with multiple and complex needs to see whether these people are benefiting from the new personalised care agenda as described in *Putting People First.*

This overview offers a commentary and analysis of the contents of this report. A full executive summary is provided in a separate publication.

Context

During 2007-08, around 1.75 million people of working age and older people used different social care services, either provided by their local council or purchased on their behalf from private and voluntary organisations. Councils spent £16.5 billion on social care for all adults.[1] In addition many other people arranged and bought their own support. For example, in 2008 146,000 older and disabled people living in care homes were estimated to have paid fees privately.[2] It has been estimated that in 2006 £3.52 billion was spent by older people not eligible for council support, mostly on care homes and total private expenditure was £5.9 billion, if charges and top-up expenditure are added.[3]

- At the end of March 2008, 18,541 care homes, run by private and voluntary organisations and councils, provided nearly 450,000 places to adults of all ages.
- 4,897 home care agencies, the majority privately run, provided support to people to live at home.
- 73,540 people of working age, older people and carers used Direct Payments and 4,800 adults had Individual Budgets.
- 1.5 million people were estimated to be working in adult social care services in England in 2007-08.

1 This is gross expenditure by councils in 2006-07. Expenditure data from councils for 2007-08 will be published by the NHS Information Centre for Health and Social Care in February 2009

2 Laing and Buisson (2008) *Laing and Buisson care of elderly people market survey*

3 CSCI (2008) *The state of social care in England 2006-07*

People's views on social care

People are looking for timely and individualised support to help live their lives as they choose. In 2008, nearly 3,000 people responded to the CSCI survey as part of the review of eligibility criteria and many described the considerable cost to them in financial, emotional, personal and physical terms when they could not get the help they required.[4] This, and other evidence provided for the review, echoes the findings of last year's state of social care report which highlighted the problems for people unable to access social care.

Those people who have been able to design and direct their support, whatever their impairment and however complex their needs – whether they live at home or in a care home – have described the real difference it has made to their lives. As one person using Direct Payments commented:

"I would have been imprisoned with a care agency. Can't stress that too strongly. I live at home supported by people I recruit who I am very clear with who I am... Life has been a thousand times better on Direct Payments even with its challenges."[5]

Government policy

Acknowledging current demographic and other challenges and opportunities, the Government has been encouraging a wide debate on a future care and support system and development of a new settlement between individuals, families and the state that is "*fair, sustainable and unambiguous about the respective responsibilities".*[6]

This is at the same time as allocating £520 million for a programme to transform social care as set out in *Putting People First,* a cross-government concordat with local government, NHS, social care partners and CSCI. This aims for people to have choice and control over their support, confidence in the quality of services, to be safe and treated with dignity. Prevention, early intervention and enablement are also key elements of "*a high quality, personalised system".* The funding for three years from April 2008 is to ensure a strategic balance of investment between preventative services and the provision of intensive support and care for people with complex needs. It is also to ensure everyone eligible for statutory support has a personal budget and transparent allocation of resources.

Councils are being asked to make substantial progress on transforming their local services. From 2009, Comprehensive Area Assessments will be assessing the performance of local services in meeting outcomes for local citizens and what it is like to live in their local area.

Social care, in partnership with a wide range of organisations and agencies, is thus challenged to ensure there is personalised support for people with multiple and complex

4 CSCI (2008) *Cutting the cake fairly: CSCI review of eligibility criteria for social care*

5 CSCI (2008) *Putting People First: Equality and Diversity Matters 1. Providing appropriate services for lesbian, gay and bisexual and transgender people*

6 Department of Health, Social Care: Personalisation http://www.dh.gov.uk/en/SocialCare?Socialcarereform/Personalisation/index.htm

needs,[7] for people to maintain their independence and for people with emerging needs. This is in the context of considerable concerns about the adequacy of current resources.

This state of social care report considers how far policy on 'personalisation' has been realised in practice and whether progress has been the same for everyone seeking support. The report includes a special focus on support to people with multiple and complex needs, to follow up concerns raised by CSCI in an earlier state of social care report, and to assess whether these people are benefiting from new approaches.

Summary of the state of social care in England

- Over the last six years, there has been steady improvement in the overall performance of councils in addressing current policy requirements and in regulated care services meeting National Minimum Standards.
- There have been some tentative steps to address the new personalisation agenda which have meant more people are able to control and choose their support through, for example, Direct Payments, Individual Budgets and good person-centred assistance.
- There are some outstanding examples of people's lives being radically improved where they have been able to direct their own support, including those people with multiple and complex needs.
- However, councils are at an early stage in transforming social care and developments are patchy and vary between different groups of people. There are different understandings of and commitments to 'personalisation' by councils, partner agencies, people who use services and carers, as well as difficulties in extending pilot schemes.
- People, whether they pay for their care or are publicly funded, are not always getting the individualised help that they need to make decisions about their support which in the long term can be costly to individuals, family carers, councils and the NHS.
- People are not always getting quality personalised support, particularly those with multiple and complex needs, some of whom may have little, if any, choice about their care.
- Concerns remain about people who are 'lost to the system' because they are ineligible for publicly funded support or are 'self-funders'.
- In the current situation of resource pressures and increased demand, there continues to be a tension between resourcing support for those people with highest levels of need and investing in a raft of services, including universal, open access and rehabilitative services, which can maintain people's independence and improve their quality of life.

7 The different understandings of 'complex' needs are discussed in Part two of this report

Improvements in council services

This is the sixth successive year that social care services for adults, where councils have arranged their care, have improved. There are currently no councils with zero stars in addressing current policy requirements and 87% with two or three stars.

Over 73,500 people are now using Direct Payments, including carers, which represents a significant increase over six years and a substantial shift towards putting people in control of their own support. There are fewer people using Individual Budgets (4,800 recorded in March 2008) but examples, illustrated in Part two of this report, where these have been used very creatively to enable people with very complex needs to have independent lives.

There has been a significant rise in the numbers of people receiving 'reablement' services in their own home to help restore their independence. 225,000 people received these services in 2007-08, over 32,000 more people than the year before.

Councils are investing in a range of preventative services and those that promote social inclusion. Other organisations, including the NHS, are working with councils on many of these initiatives. It has been estimated that in 2007-08 each council spent, on average, £1.63 million on services to adults that people can access without a formal assessment or meeting eligibility criteria.

There has been a 25% increase in the numbers of carers receiving a service (or Direct Payment) in 2006-07. The number of breaks for carers also increased; councils reported in their 2007-08 self-assessment survey returns that over 4 million carers' breaks had been funded in the year.

Improvement in the quality of care services

The performance of care services against the National Minimum Standards (NMS) has also risen for the sixth consecutive year. More standards are being exceeded and fewer are failing with major shortfalls. The proportion of standards being exceeded by services has increased from 2% in 2003 to 7% in 2008. The proportion of standards not being met with major shortfalls has reduced from 8% in 2003 to 2% in 2008.

The NMS focus on processes rather than examining outcomes for people but judgements to provide quality ratings for services are based on a range of evidence, including the views of people who are using the service. In 2008, when quality ratings were first published, more than two-thirds (69%) of all care services were rated as 'good' or 'excellent'.

Progress since 2003

- Councils have improved their performance: in 2008 there are no councils with zero stars and 87% have two or three stars.
- Care services have improved their performance and more than two-thirds (69%) of all services were rated as 'good' or 'excellent' in May 2008.
- The proportion of National Minimum Standards not being met with major shortfalls has reduced from 8% in 2003 to 2% in 2008.
- Care homes meet almost a quarter (23%) more National Minimum Standards in 2008 than in 2003.
- Home care agencies are meeting 16% more National Minimum Standards than in 2005.

Patchy and inequitable developments to transform social care

However, these overall improvements do not show the whole picture. A more in-depth look shows some difficulties and challenges in shifting traditional patterns of services and ensuring everyone benefits from the new social care agenda. All councils have some way to go to meet the ambitions of *Putting People First,* building on their strengths.

Practical and conceptual challenges

There are both practical and conceptual problems in developing small Individual Budget pilots into mainstream approaches. Our special study (Part two) showed there are mixed views held by local councillors, staff and people using services and their families about the concept, feasibility and application of personal budgets. One the one hand there are fears held by councils about how they will manage limited resources; on the other there are the concerns of families that they might be left to cope alone with the realities of day-to-day support if traditional services are not replaced. Not everyone is convinced that Individual Budgets will work well for people with multiple and complex needs, although there are some outstanding examples where people's lives have been significantly improved through their use.

Addressing equality and human rights

Underlying these concerns about the personalisation agenda are challenges in shifting the culture of social care services to one that sees equality for disabled people (of all ages) as central. This means the focus is on the barriers that disabled people face in society, rather than disabled people's impairments. Choice and control are at the core of 'independent living'. An analysis of 2007 self-assessment data supplied by social care services showed only 33% reported they had taken specific action on disability equality.[8]

8 CSCI forthcoming publication (2009) *Putting People First: Equality and Diversity Matters. Achieving disability equality in social care services*

There are challenges, too, in ensuring services do not discriminate against older people and carers in the way resources are allocated, needs are assessed and services are delivered.

Commissioning challenges

Some councils are struggling to make the shift from reliance on specialist services out of their area, from buildings-based services, and from block contracts with traditional services, to encouraging and developing new types of local provision able to meet the needs of a wide range of people. This is hindered by a generally poor engagement with independent service providers who are still not brought into strategic planning in many areas.

Ensuring individualised help for everyone seeking support

Changes are needed to ensure everyone, whether they fund their care or not, gets the assessment, advice and information to which they are entitled. Recent CSCI studies and evidence gathered for the review of eligibility criteria continue to find people struggling to get the one-to-one help they need in deciding about the care and support that will suit them.

Those people who do get an assessment are generally satisfied, but there are others who are asked about their financial means before any discussion about their needs and are turned away; those who have inadequate discussions about their situation, often over the telephone, that fail to understand their needs; and those who find the information they are given does not lead to the help they need. This can mean individuals make ill-informed decisions that can result in unnecessary financial and emotional costs for themselves and their families or they can go without essential support. It can also be costly for the social care and health system, which may have to step into a crisis situation or pick up the funding of a residential placement at a later date.

Policy barriers

There are also national policy issues which need to be addressed to support the transformation of social care at local level and particularly to ensure coherent and coordinated support to people with multiple and complex needs. These include the loss of jointly funded care packages and Direct Payments where people move on to NHS Continuing Healthcare funding; restrictions in the way in which Independent Living Fund monies can be spent; and different definitions across parts of the health, education and social care system as to when adolescence ends and young adulthood begins and about eligibility for funding and support.

Variable quality of support

People are not always getting good quality, personalised support – whether they fund their own care or not. A number of important levers for improving quality are highlighted in this report.

Starting with people and their networks

Councils are still relying on specialist residential provision for people with very complex support needs which is at a distance from the person's home and not always offering the

best quality of care. Some councils have not developed sufficient alternative solutions and support to residential care for older people with multiple and complex needs. In contrast there are councils that have found innovative local solutions by starting with the person looking for support and their networks and using Direct Payments or an Individual Budget to tailor support accordingly. This is the exception for people with multiple and complex needs rather than the norm.

Ensuring quality is built into council contracts with services

There is new evidence from CSCI about the quality of care services purchased by councils that shows some councils are not ensuring quality is built into their contracts with care services. For example, one in five older people between April to September 2007 were moving permanently into a care home arranged by their council which had a rating of 'poor' or simply 'adequate'. This new CSCI data will assist councils to assess themselves against a national benchmark to help improve the quality of local services.

Achieving a wider understanding of personalisation

Quality support for many people, particularly those with high support needs, requires a coordinated response in planning, commissioning and service delivery from a number of services beyond social care – such as health, housing and transport services. However, partner agencies are not always signed up to the concept or full implications of personalisation. Steps such as personal health plans and piloting personal health budgets may help to secure wider understanding in health services.

Place-shaping role of local councils

Councils are working to enable disabled and older people to access universal services to increase the likelihood of people being able to exercise choice and control. However, more needs to be done to ensure universal access to transport, leisure and other mainstream services and for councils to meet their duty to *"promote disability equality"* as set out in the Disability Discrimination Act 2005. Comprehensive Area Assessments will be very important in showing how far local services are improving outcomes for people and what further actions are needed to improve the quality of life and social inclusion of older and disabled people.

A well supported and trained workforce

High quality, personalised support also depends on well supported and trained staff and excellent leadership. This is particularly important for support staff, care assistants and social workers working with people with multiple and complex needs. Whilst there has been a general improvement in the levels of qualifications of care assistants and home carers, in 2007 around one-third had not obtained a basic NVQ level 2 qualification. Importantly, the National Skills Academy for Social Care will be established as an independent organisation in March 2009 and target training and development support to the 1.5 million social care workers in England. There will be a particular emphasis on small and medium-sized organisations with limited training and development budgets.

New inspection methodologies

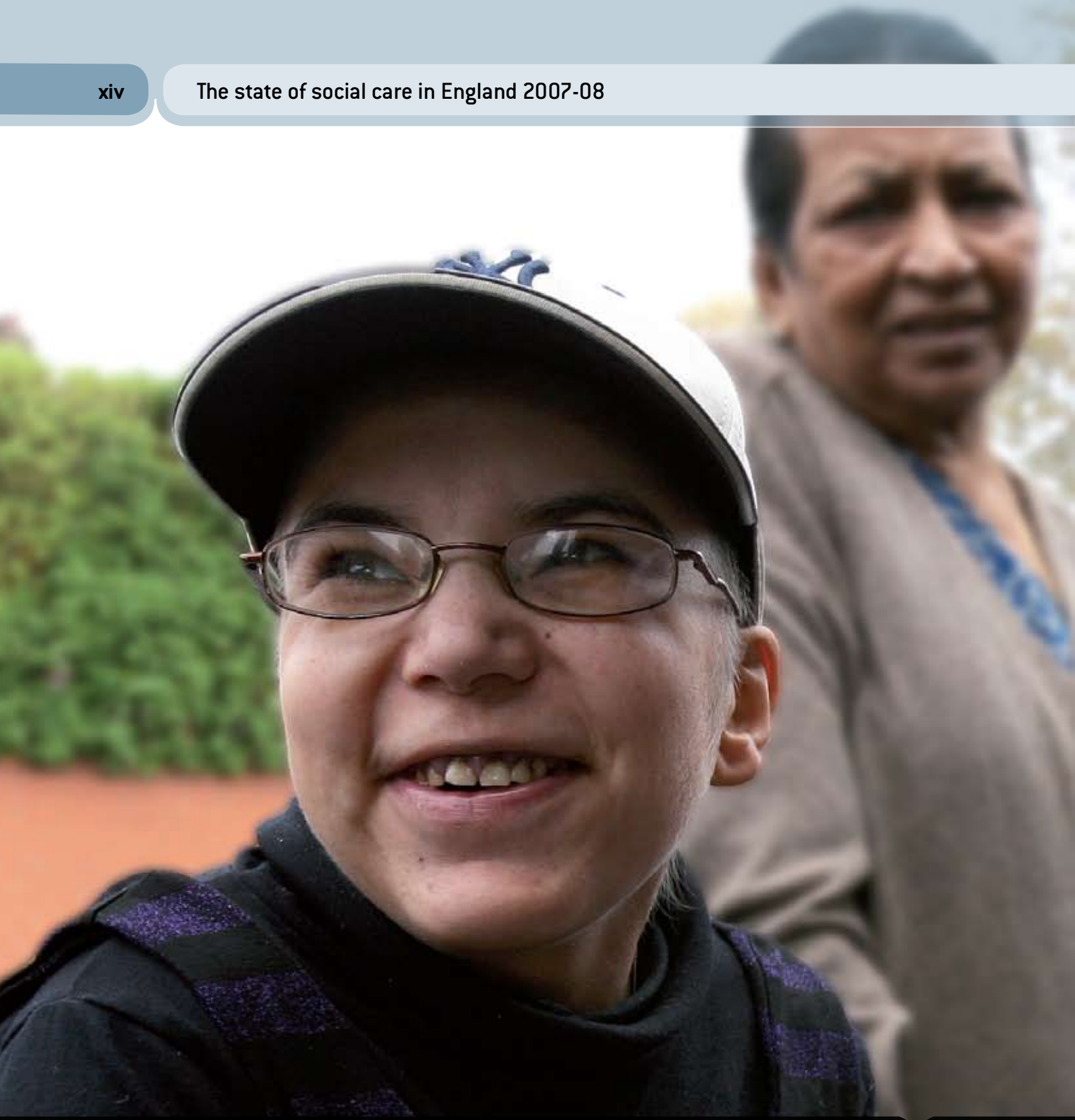
New ways of inspecting services that capture in a systematic way the experience of care of people who have great difficulties in communicating their feelings and views are getting beyond the surface of routine care practice. SOFI (Short Observational Framework for Inspection) is still under development but has shown its potential in helping to drive improvements in the quality of care.[9]

Resourcing personalised care

Many would argue that quality comes at a price. Government has acknowledged funding pressures on the social care sector and the risk of *"people going without services they need to live their lives fully and stay well"* or demands on families becoming too heavy. CSCI found many of the concerns about eligibility criteria and how they are applied relate to the amount of resources allocated for social care. The pressures are likely to exacerbate in the current economic situation – both for individuals who will have fewer of their own resources to fall back on and for public bodies who may face increased numbers of people seeking support as well as the rising costs of all services.

A decent quality of life where people are able to live with dignity is a basic human right. This report on the state of social care in England shows what can be achieved by personalised social care but also the challenges and distance to go before this is the experience of every person of working age and every older person seeking support to lead their lives.

9 CSCI (2008) *See me, not just the dementia: understanding people's experiences of living in a care home*



Context and focus

Chapter 1
Introduction

1.1 This is the fourth report from the Commission for Social Care Inspection providing an overview of the state of social care in England. Based on evidence from the Commission's performance assessment and regulatory activities and specially commissioned studies, this report:

- describes trends in the range, quality and availability of social care in 2007-08 across the public, voluntary and private sectors
- looks at support to people with multiple and complex needs to see whether they are benefiting from the new personalised care agenda as described in *Putting People First*.

1.2 Last year's report summarised the state of social care in England 2006-07 as one where:

"There is an increasingly sharp divide between those people who benefit from the formal system of social care and those who are outside it.

People qualifying for services arranged by their council are seeing improvements and, in some areas, early steps towards a redesigned system offering personalised care.

But the picture can be very different for those people who are not eligible for council-arranged care, and there is little consistency as to who is ineligible both within and between councils.

People 'lost to the system' because they are not eligible for council-arranged services and cannot purchase their care privately often struggle with fragile informal support arrangements and a poor quality of life.

People who fund their own care are also disadvantaged, lacking advice and information about their care options and often largely invisible to local councils.

Care services provided by councils, private and voluntary bodies are meeting more of the national minimum standards but improvement appears to have stalled.

The Government's proposed Green Paper on long-term care funding offers an important opportunity to establish a fair and sustainable social care system where people, whether they pay for their own care or not, as a minimum get good advice, an assessment of their situation, and access to high quality services."

1.3 In response to the report, the Government made it clear that there should be one system of care and support where people, regardless of who funds their care, should have proper advice and assistance about the support they need. The Government also asked CSCI to undertake a review of eligibility criteria for social care; and taking account of the *Putting People First* concordat to review the application of Fair Access to Care Services (FACS) by councils and their impact on people. The report of this review was presented to the

Government in September 2008. In this report CSCI highlights problems in the way that policy has been implemented in the context of increased demand and the unintended consequences it has had, particularly for the growing number of people who have found themselves excluded from the social care system as a result.[10] People who took part in the review and who could not get the support they required described the considerable cost to them in financial, emotional, personal and physical terms. For example, a respondent to the online survey said:

"My flat's a tip and I often spend days without washing or dressing as I'm not able to do it myself. I'm limited in when and where I can go out, and what I can eat as I struggle to prepare a meal, and often burn myself when using the oven."

Further details about the recommendations of the report are provided in Chapter 2 of this report.

1.6 In an earlier report on the state of social care in England[11] (2005-06), CSCI highlighted concerns about people with complex needs whose specialist needs in addition to their ordinary needs are not being met. This year's report focuses on those people to assess how far the steps to transform social care are including people with very complex needs so they can live their lives with dignity.

People using social care

1.7 During 2007-08, around 1.75 million people of working age and older people used different social care services either provided by their local council or commissioned on their behalf from private and voluntary organisations. As at March 2008, 73,540 people, including carers, used Direct Payments to buy the help they wanted. (Direct Payments are cash payments made in lieu of social services provisions to individuals who have been assessed as needing services and are eligible for publicly funded support.) In addition, many people arranged and paid for their own care and support. For example, in 2007-08 146,000 older and disabled people living in care homes were paying fees privately.[12] Many other people 'topped up' the help they received from their local council.

1.8 Disabled people, older people and people with mental health needs look for support to live independently and to be able to participate in and contribute to society throughout their lives. This is support that people can design and direct themselves, whatever their impairment, and whether they live in their own home or in a care home. For example, an inspector reported the preferences of a woman with dementia living in a care home were sensitively noted so her care was exactly as she wanted:

"I wear a light night dress. I like a cup of tea before bed and when in bed please close the door. I would prefer to be washed and dressed by a female carer".[13]

10 CSCI (2008) *Cutting the cake fairly: CSCI review of eligibility criteria for social care*
11 CSCI (2006) *The state of social care in England 2005-06*
12 Laing and Buisson (2008) *Laing and Buisson care of elderly people market survey*
13 CSCI (2008) *See me, not just the dementia: understanding people's experiences of living in a care home*

1.9 Partners, relatives or friends provide the majority of support for people, without payment and as part of their relationship. The 2001 national census estimated there are 5.2 million carers of whom 1.7 million care for 20 hours or more a week. Social care and other services are crucial to assist carers to care and to have a life of their own, and to ensure families are properly supported. But support varies and one mother looking after her disabled son commented in her response to the CSCI online survey for the review of eligibility criteria:

"Sometimes I have been made to feel that my son's needs are a mix of either not severe enough, too severe or a burden on services. I feel that unless a family is at crisis point then help is not available."[14]

14 CSCI (2008) *Cutting the cake fairly: CSCI review of eligibility criteria for social care*

1.10 People who use social care services are of all ages, from all backgrounds, ethnic and faith communities and of different sexual orientation. What every individual wants is *"based on a complex mix of experience, identity and preferences".*[15] Whilst the needs of people from different communities are often the same as others, their needs may be met in different ways. As one person using direct payments explains:

"I am a Direct Payments user. Yes, it has been a much better option for me as an LGB person, no question. I would have been imprisoned with a care agency. Can't stress that too strongly. I live at home supported by people I recruit who I am very clear with who I am. They don't change every week and they are not all straight or gay... Life has been a thousand times better on Direct Payments even with its challenges."[16]

1.11 People are looking for their cultures to be recognised, whilst avoiding assumptions based on stereotypes, and they want to feel safe and to be free from discrimination. An older person living in a care home for the South Asian community praised the support she had:

"Communication is good. I understand them and the staff speak my language. I have a choice to have staff support me in my culture."[17]

About this report

1.12 The following chapter sets the policy context for this review of the state of social care in England.

1.13 The report is in two parts.

Part one provides facts and figures on:

- expenditure by councils on social care for adults and council activity for people using services and carers
- trends in registered social care services for adults and the balance of residential and community services
- the performance of councils in delivering the outcomes people want
- the quality of care services
- the quality of care services purchased by councils
- the adult social care workforce.

Part two focuses on personalised support to people with multiple and complex needs.

1.14 An overview providing commentary and analysis of the state of social care based on all of this evidence is presented at the beginning of this report.

1.15 A full executive summary is published separately.

15 CSCI (2008) *Putting People First: Equality and Diversity Matters 2. Providing appropriate services for black and minority ethnic people*

16 CSCI (2008) *Putting People First: Equality and Diversity Matters 1. Providing appropriate services for lesbian, gay and bisexual and transgender people*

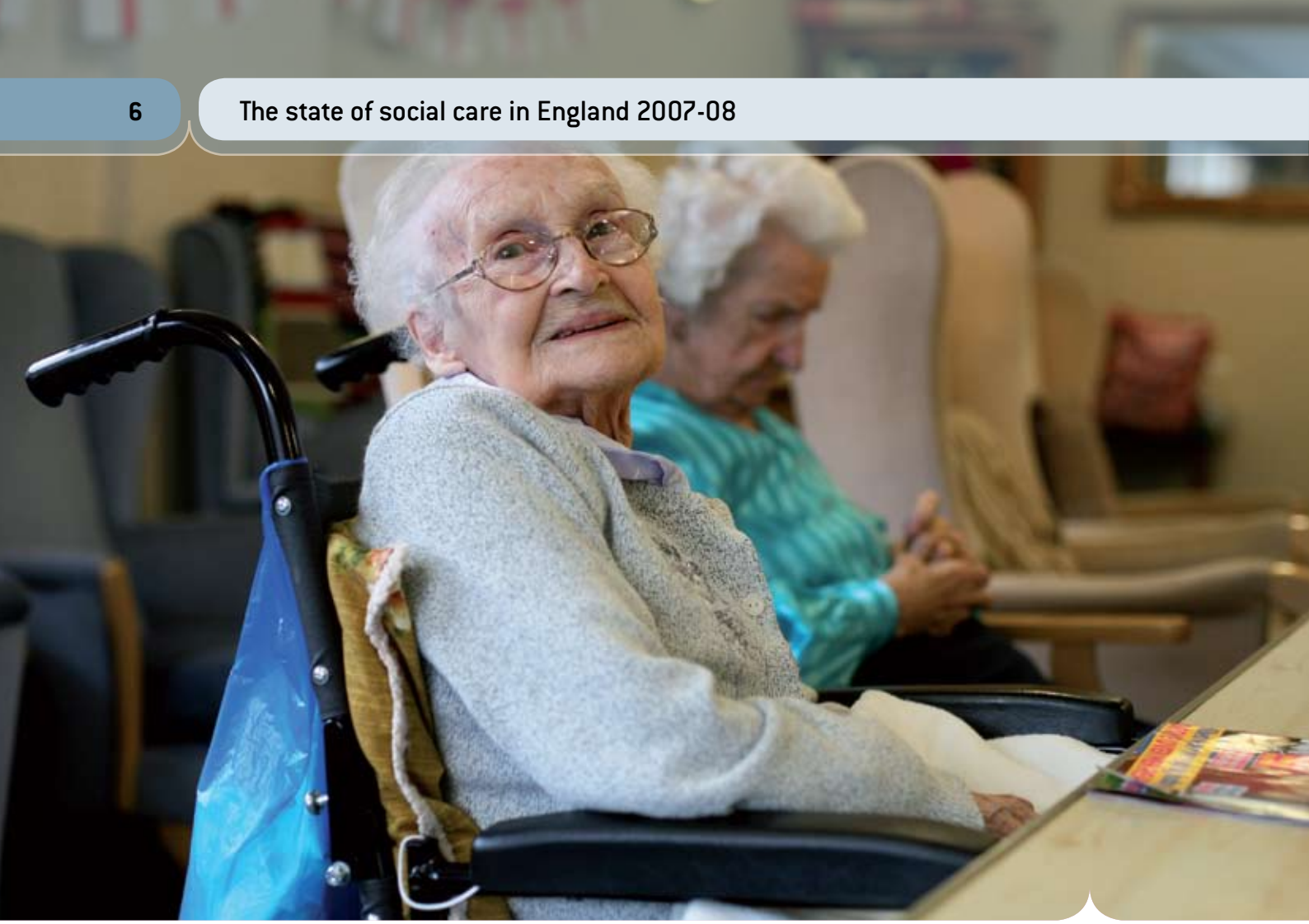
17 CSCI (2008) *Putting People First: Equality and Diversity Matters 2. Providing appropriate services for black and minority ethnic people*

About CSCI

The Commission for Social Care Inspection (CSCI), as England's single social care regulator for adults' services during 2007-08, has a unique perspective on the whole of social care provision whether this is by local councils or the private and voluntary sectors.

CSCI controls entry to the care market by licensing providers through its registration activity; monitors the quality of service provision by inspecting services and reporting on its findings; and reviews council social services to ensure they perform well and deliver value for money.

People who use services are at the heart of the work of CSCI, whose activities aim to ensure that wherever services are provided, they are safe, meet the needs of the people who use them, and are of good quality.



Chapter 2
Setting the scene: the policy context

Introduction

2.1 During 2008, the Government has been engaging people in a debate on a future care and support system and a new settlement between individuals, families and the state. This is a settlement that is "*fair, sustainable and unambiguous about the respective responsibilities*"[18] – as called for in previous reports on the state of social care in England. Government explains:

"A radical rethink of the care and support system is needed to address the challenges and meet the opportunities of the 21st century. Otherwise, we risk the demands on families becoming too heavy and people going without services they need to live their lives fully and stay well."[19]

18 Local Authority Circular: LAC (DH) (2008) 1, *Transforming Social Care*, London: Department of Health

19 Department of Health (2008) *The case for change – why England needs a new care and support system*

2.2 The Government has already set out a transformation programme promoting independence, choice and control for everyone who uses care and support services. The shared aims and framework for reform is detailed in *Putting People First,*[20] launched in December 2007. The emphasis is both on 'personalisation' – so that every person who receives support, whether provided by statutory services or funded by themselves, has choice and control over that support in all care settings – and on early intervention and prevention.

"Across Government, the shared ambition is to put people first through a radical reform of public services. It will mean that people are able to live their own lives as they wish; confident that services are of high quality, are safe and promote their own individual needs for independence, well-being, and dignity... Personalisation, including a strategic shift towards early intervention and prevention, will be the cornerstone of public services."[21]

2.3 There are different understandings of prevention, from avoiding dependency, targeted rehabilitation and recuperation to broader approaches to improving the quality of life. [22] The Government initiative of Partnerships for Older People Projects (POPPS) are testing out different ways of improving the health and wellbeing of older people by focusing on early intervention and prevention.

2.4 There is considerable synergy between *Putting People First* and the *NHS next stage review.* The final report published in June 2008 by Professor Sir Ara Darzi[23] aims for quality healthcare that is fair, personalised, effective and safe. Recommendations that particularly align with the social care transformation agenda include:

- those to help people stay healthy and for primary care trusts (PCTs) to commission comprehensive wellbeing and prevention services in partnership with councils
- more rights and control for people over their own health and care including personalised health plans and proposals to pilot personal health budgets, and
- high quality care, with new enforcement powers for the health and social care regulator, the Care Quality Commission, and where quality measures include people's own views on the success of their treatment and quality of their experiences.

2.5 Similarly, the NHS programme on commissioning[24] is seen as key to moving the emphasis from spending on services to investing in health and wellbeing. By strengthening relationships between key local partners, such as councils and PCTs, improved commissioning aims to facilitate better links between different aspects of a person's care, ensuring the care offered is personalised and effective.

20 Department of Health (2007) *Putting People First: a shared vision and commitment to the transformation of adult social care*

21 Department of Health, Social Care: Personalisation http://www.dh.gov.uk/en/SocialCare/Socialcarereform/Personalisation/index.htm

22 See background paper to CSCI review of eligibility criteria: Hudson B, Henwood M (2008) *Prevention, personalisation and prioritisation in social care: a review of the literature and development of an analytic framework,* London: CSCI

23 Department of Health, Professor the Lord Darzi of Denham (2008) *High quality care for all: NHS next stage review final report,* London: The Stationery Office

24 Department of Health (2007) *World class commissioning: vision*

2.6 However, the changes required are not just within health and social care services as "*reforming social care to achieve personalisation for all will require a huge cultural, transformational and transactional change in all parts of the system, not just in social care, but for all services across the whole of local government and the wider public sector.*"[25]

2.7 This chapter outlines these dominant policy themes and developments of 2007-08 that have centred, firstly, on transforming the care and support system and, secondly, on the debate about its future.

Transforming social care

(i) Putting People First

2.8 *Putting People First,* a cross-government concordat with local government, NHS and social care partners and CSCI, builds on previous white papers on local government[26] and community health and social care. [27] The protocol agrees a shared responsibility *"to create a high quality, personalised system which offers people the highest standards of professional expertise, care dignity, maximum control and self determination."*[28] This is an agenda that cannot be delivered by social care alone and requires partnerships with housing, benefits, transport, health, leisure and others. It also involves work between councils and independent, voluntary and community organisations that draws upon resources beyond those of adult social services. These approaches should be reflected in the joint strategic needs assessments agreed between councils and PCTs and in local area agreements.

2.9 Key elements of the transformation of social care as set out in *Putting People First* include:

- **joint approaches to commissioning and market development**
- **prevention, early intervention and enablement as the norm**
- **universal information, advice and advocacy service, irrespective of eligibility for public funds**
- **a common assessment process of individual needs with a greater emphasis on self-assessment**
- **person-centred planning and self-directed support**
- **personal budgets for everyone eligible for publicly funded adult social care so that there is a clear, upfront allocation of funding to enable people to make informed choices about how best to meet their needs**
- **Direct Payments for increasing numbers of people**
- **family members and carers to be treated as experts and care partners.**

25 Local Authority Circular: LAC (DH) (2008) 1, *Transforming social care*, London: Department of Health

26 Department for Communities and Local Government (2006) *Strong and prosperous communities* (the Local Government White Paper)

27 Department of Health (2006) *Our health, our care, our say: a new direction for community services*

28 Department of Health (2007) *Putting People First: a shared vision and commitment to the transformation of adult social care*

2.10 Reform of the system also requires actions to integrate working between adults' and children's services; to support organisations and networks of people using services; to have effective arrangements to safeguard adults and promote dignity in local care services; and to raise the skills of the workforce across all sectors.

2.11 A social care grant, of £520 million for three years from April 2008, has been awarded to facilitate the transformation and ensure:[29]

- everyone eligible for statutory support has a personal budget and transparent allocation of resources
- a strategic balance of investment between enablement, early intervention and prevention, providing intensive care and support for those with high-level complex needs
- a common assessment framework to deliver a more diverse range of services and support
- the views of people using services, carers and other stakeholders are central to every aspect of the reforms.

(ii) Other strategies to transform the care and support system

2.12 Other strategies to improve the care and support system include those that aim for:

- **All disabled people to live autonomous lives** and have the same control over their lives as non-disabled people. The *Independent living strategy*, published in March 2008, is a cross-departmental strategy that pulls together initiatives on employment and housing, as well as social care.[30] It also seeks to build the capacity of organisations of disabled people to help people negotiate and manage their way through the care system.
- **Sufficient appropriate housing available** to assist people to live in their homes for longer, healthier and more independently. The cross-government strategy for housing and communities, *Lifetime homes, lifetime neighbourhoods: a national strategy for housing in an ageing society*, aims for better home adaptations, repairs, advice and information.[31] Homes should be designed as lifetime homes – suitable for "*families with pushchairs right through to older people in wheelchairs*".[32] New funding of £35 million (up to 2011) has been provided to support the development of housing information and advice services for older people and increases in handyperson services and home improvement agencies.
- **People using housing-related support to be at the heart of the Supporting People programme** and local delivery of the service. *Independence and opportunity*[33] seeks to build on Supporting People's record of delivering personalised services and to work

29 Local Authority Circular: LAC (DH) (2008) 1, *Transforming social care*, London: Department of Health

30 Office for Disability Issues (2008) *Independent living – delivering on choice and control for disabled people*

31 Department for Communities and Local Government (2008) *Lifetime homes, lifetime neighbourhoods: a national strategy for housing in an ageing society*

32 The Rt Hon Hazel Blears MP, Secretary of State for Communities and Local Government, February 2008: http://nds.coi.gov.uk/Content/Detail.asp?ReleaseID=355088&NewsAreaID=2

33 Department for Communities and Local Government (2007) *Independence and opportunity: our strategy for Supporting People*

further with the third sector in encouraging smaller voluntary providers of housing support services.

- **Local people and local communities to have more influence and power to improve their lives**. *Communities in control: real people, real power* aims to shift power into the hands of communities and individual citizens and encourage the role of voluntary organisations and social enterprises.[34] The *Local Government and Public Involvement in Health Act 2007* requires councils to undertake joint strategic needs assessments in conjunction with PCTs and to establish Local Involvement Networks (LINks) to involve local people in shaping health and care services.
- **The third sector, including social enterprise, to contribute** to the design and delivery of public services and to provide advocacy services.[35]
- **Innovative technologies to be used to support the care of people with complex social care and health needs**. A £31 million Whole System Demonstrator Programme has been set up to test the use of telecare, telehealth and other technologies in three councils.
- **Improved quality of care at the end of life.** The *End of life care strategy*[36] seeks good integrated health and social care and specialist palliative care that involves people in identifying their preferences, coordinates care, provides high quality services whatever the setting, and supports family and carers.
- **A skilled workforce to deliver the personalisation agenda.**
  Work is under way on an adult workforce strategy. An interim statement was published in June 2008 which summarises work jointly undertaken by the Department of Health with partner organisations and identifies the key issues for the workforce as set out in *Putting People First* and develops these into broader, strategic priorities for the workforce. It is intended to provide all stakeholders, whether public service or private and voluntary sector, with a high-level overview of strategy development prior to finalisation of the full adult social care workforce strategy. Also, a Social Care Skills Academy is being set up to develop the leadership, management and commissioning skills key to the reform of social care. The Department of Health is also funding National Vocational Qualifications to ensure a better-trained and qualified workforce to raise the quality of social care services in both statutory and independent sectors. *Common core principles to support self care*,[37] developed with Skills for Health and Skills for Care, have been issued to help everyone working in social care and health to support people to live independently and have better control over their wellbeing and health.

34 Department for Communities and Local Government (2008) *Communities in control: real people, real power*

35 Third sector strategy http://www.justice.gov.uk/docs/third-sector-strategy.pdf

36 Department of Health (2008) *End of life care strategy: promoting high quality care for all adults at the end of life*

37 Skills for Care and Skills for Health (2008) *Common core principles to support self care: a guide to support implementation*

(iii) Transforming support for specific groups of people

2.13 There have been a number of new strategies aimed at improving support to specific groups of people, including people with dementia and people who have had a stroke, carers, people with a learning disability, and people with mental health needs. There has also been a policy emphasis on meeting the needs of the whole family, particularly those who experience multiple problems.

2.14 ***People with dementia***: From June to September 2008, the Government has been consulting on a National Dementia Strategy[38] that seeks to transform services for people with dementia. Improvements are sought in three key areas: raising awareness and understanding of dementia; early diagnosis and intervention; and high quality care and support. CSCI's findings about the quality of care for people with dementia living in care homes highlights the importance of leadership, support to staff, the culture of the home and staff training to provide truly personalised care for those living in care homes.[39]

2.15 ***People who have had a stroke***: The National Stroke Strategy[40] published in December 2007 aims to provide a quality framework to secure improvements to stroke services. This includes better information, advice and support for people who experience a stroke; specialised rehabilitation; improving people's discharge from hospital; and increasing the range of local services to support people with long-term needs.

38 Department of Health (2008) *Transforming the quality of dementia care: consultation on a national dementia strategy*

39 CSCI (2008) *See me, not just the dementia: understanding people's experiences of living in a care home*

40 Department of Health (2007) *National stroke strategy*

2.16 ***Carers***: A new carers' strategy, *Carers at the heart of 21st century families and communities*[41] was launched in June 2008, with aims that, by 2018, carers will:

- be treated with dignity and respect as expert care partners
- have access to the services they need to support them in their caring role
- be able to have a life of their own
- not be forced into financial hardship by their caring role
- be supported to stay mentally and physically well, and that
- children and young people will be protected from inappropriate caring roles.

2.17 £255 million has been committed to health and social care and employment initiatives, information for carers, support to young carers and short breaks for carers.

2.18 ***People with a learning disability***: Government has been consulting on a 'refresh' to the *Valuing people* policy with an emphasis on personalisation, what people do during the day, better health and access to housing.

2.19 ***People with mental health needs***: A range of new legislation has improved the rights of people with mental health needs. The Mental Capacity Act was implemented in two phases, in April and October 2007. The Act introduced a new offence of ill treatment or wilful neglect of a person who lacks mental capacity. It also introduced the Independent Mental Capacity Advocate service. A code of practice supports those who have to implement the deprivation of liberty safeguards and to inform those who may become subject to the safeguards, as well as providing guidance on other aspects of the Act.

2.20 The Mental Health Act 2007 was implemented in October 2008. This amended the Mental Health Act 1983 and changed the definition of mental disorder. The revised measures include amending detention criteria, expanding the scope of who can perform certain professional roles, and giving people with mental health needs rights over decisions on who acts in their best interests.

2.21 ***The family***: A £16 million Family Pathfinder programme involves 15 local areas testing and developing the Think Family approach developed by the Cabinet's Social Exclusion Task Force. One of the aims is to ensure that adults' and children's services work closely together to respond to the needs of families as a whole.

(iv) A Human Rights approach to transforming social care

2.22 Protecting and promoting people's human rights are at the heart of personalised services and enabling independent living. In May 2008 an amendment was passed to the Health and Social Care Act 2008 to close the loophole for publicly funded people in private and voluntary homes who do not fall within the scope of the Human Rights Act[42] and are unable to seek legal redress for any breach of their human rights. The relevant section came into

41 Department of Health (2008) *Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own*

42 *The Human Rights of Older People in Healthcare Eighteenth Report of Session 2006-07 Volume 1 – Report and Formal Minutes* House of Lords House of Commons (2007). London: The Stationery Office

force on 1 December 2008. However, people who fund their own care still remain outside the scope of the Human Rights Act.

2.23 A Government Dignity in Care Campaign is aiming to ensure that all people using care and health services are treated with dignity and respect at all times. A report published by the Healthcare Commission in September 2007 found that although the right systems are in place there is still considerable work to do to ensure all older people in hospitals are treated with dignity.

2.24 The Government responded to the Joint Committee on Human Rights report published in March 2008, *A life like any other? Human rights of adults with learning disabilities,* acknowledging the large gap between the aspirations in *Valuing people* and the actual experiences of people with learning disabilities.[43]

2.25 Abuse of adults is a violation of their human rights. Government is reviewing the national framework, *No secrets* (published in 2000), to help prevent and tackle abuse locally. CSCI has found uneven progress in the development of local arrangements to safeguard adults across the country and much more needs to be done to ensure people who direct their own support are able to benefit from appropriate and individually tailored safeguards.[44]

2.26 A guide entitled *The human rights framework as a tool for regulators and inspectorates* is being developed by the Ministry of Justice to secure better understanding of how to use the human rights framework as a tool for effective, efficient and objective regulation and inspection.

The future care and support system

(i) Proposals for new arrangements for eligibility

2.27 In the context of *Putting People First,* CSCI was asked to undertake a review of the current eligibility criteria for Fair Access to Care Services, their application by councils and their impact on people. CSCI presented its findings and recommendations to the Government in September 2008.[45] The evidence showed a number of flaws in the current system for determining eligibility but CSCI concluded that the key issue is not simply the criteria used to assess people's eligibility for publicly funded care and support, but the amount of resources currently allocated. The report highlights an urgency to address the role of care and support services in the future and how they will be funded.

2.28 CSCI also proposes immediate changes as the current system is so heavily criticised and as long-term reforms may be at least five years away. The recommendations seek to set eligibility criteria for access to support in a broader context that is more consistent with *Putting People First* and proposes some level of assistance and advice to everyone seeking support. CSCI also recommends that the current criteria be replaced with a revised

43 Government response to the Joint Committee on Human Rights (2008) *A life like any other? Human rights of adults with learning disabilities* London: The Stationery Office

44 CSCI (2008) *Safeguarding adults: a study of the effectiveness of arrangements to safeguard adults from abuse*

45 CSCI (2008) *Cutting the cake fairly: CSCI review of eligibility criteria for social care*

system based on 'priorities for intervention'. A national resource allocation formula is also proposed to underpin individual or personal budgets and to provide a common approach across the country. A range of measures recommended to support the implementation of new arrangements includes ways of improving the initial response from councils to people seeking support.

2.29 The report also provides a commentary on the longer-term funding of social care and support in the context of assessing eligibility for publicly funded support. It highlights the trade-offs that may have to be made between national entitlements to support or public funds and local discretion to assess individual needs; how far those responsible for assessing needs for support should also be expected to set and operate eligibility criteria; and the best ways of assessing needs for support.

(ii) Debate on the future care and support system

2.30 The Government has laid out *The case for change* in its discussion paper[46] to stimulate debate ahead of the publication of the Green Paper, expected early in 2009, which will consult on plans for the future of care and support. The debate centres on how to progress the transformation programme to make *"independence, choice and control a reality"*; the role people want the Government to play; and how best to allocate government funding and whether there should be one or more systems for different groups of people.

46 HM Government (2008) *The case for change – why England needs a new care and support system*

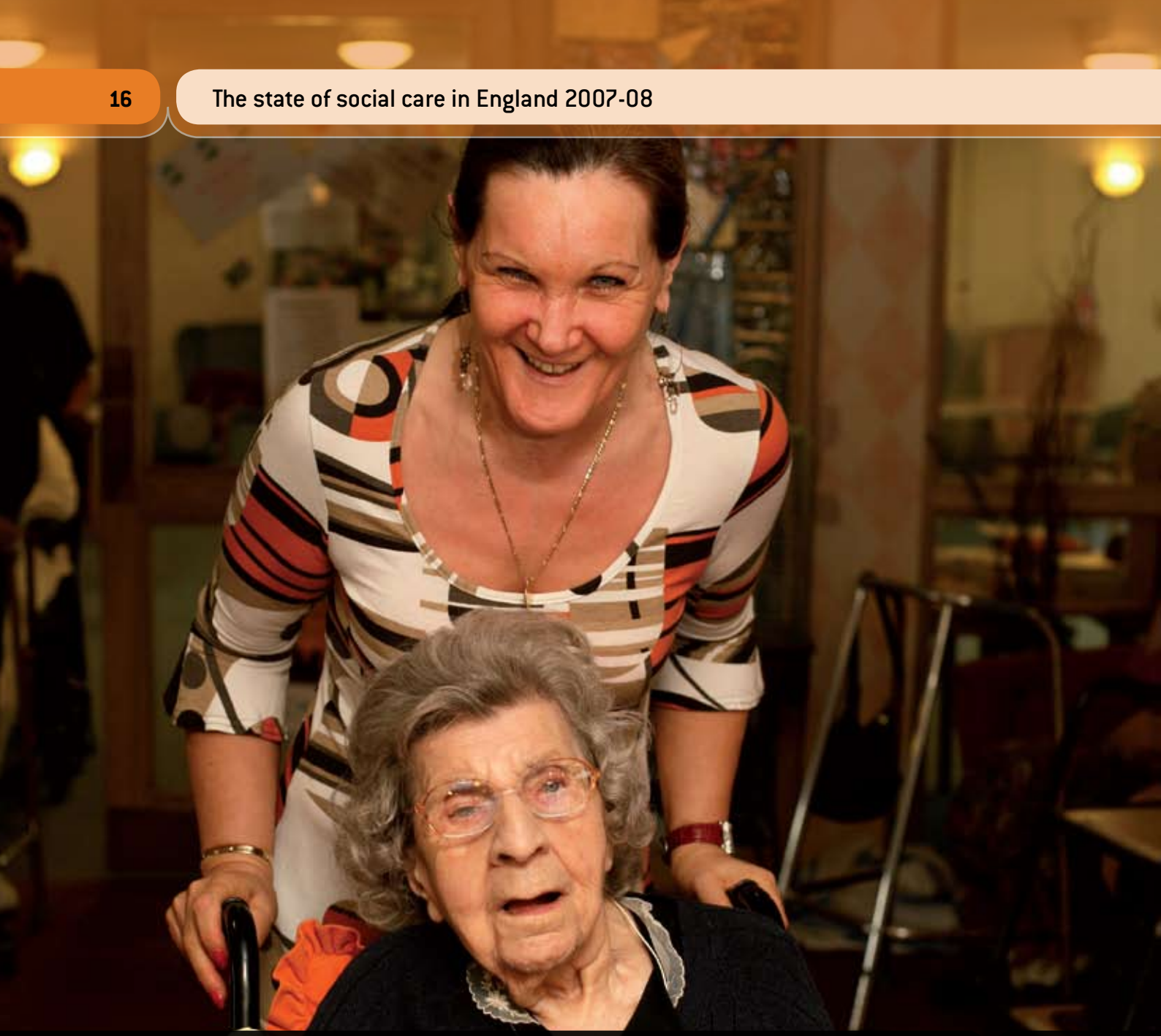
(iii) The new regulator and regulatory activities

2.31 The Health and Social Care Act received royal assent on 21 July 2008 and established the Care Quality Commission – a new health and adult social care regulator – to inspect, investigate and intervene where care providers are failing to meet safety and quality requirements. The Care Quality Commission brings together the Healthcare Commission, the Commission for Social Care inspection and the Mental Health Act Commission. The new Commission is required to report annually to Parliament on its activities and on the state of healthcare and social care.

2.32 Comprehensive Area Assessments will replace the Comprehensive Performance Assessment from April 2009, offering a new framework for assessing the performance of local services in meeting outcomes for local citizens. Previously local performance assessments looked primarily at how well individual organisations are serving local people and their prospects for improvement. The aim now is to assess what it is like to live in a 'place' and how far local services are contributing to improved outcomes for people, particularly those living in vulnerable circumstances and at risk of harm or social exclusion. A methodology is being developed between the Audit Commission (which is coordinating activities), CSCI, Healthcare Commission, HM Inspectorate of Constabulary, HM Inspectorate of Prisons, HM Inspectorate of Probation and Ofsted.

The context for this report on the state of social care

2.33 Personalisation and prevention continue to be key themes in national policy. Social care, working with a wide range of partner organisations and agencies, needs to ensure personalised support for people with very complex needs, for people to maintain their independence and for people with emerging needs. The finite resources available and how they are allocated to individuals are the subject of considerable debate as shown in the CSCI review of eligibility criteria. The following chapters provide evidence of how policy ambitions are being translated into services, support and practice in the context of current resources and share findings about the outcomes for people seeking support.



Part one: The picture of social care: data and trends

Chapter 3
Expenditure and activity

Key findings

This data focuses on public expenditure and does not provide the totality of expenditure on social care.

Expenditure

- Gross expenditure by councils in 2006-07 on social care for adults amounted to £16.5 billion; a rise of 1.2% in real terms from 2005-06, compared to annual rises in 2004-05 and 2005-06 of around 4% and 8% respectively.
- Of this expenditure, 59% was on services for older people (compared with 61% the year before) and 22% on adults aged 18-64 with learning disabilities (compared with 21%). There was an increase in expenditure of 17% in real terms between 2003-04 and 2006-07 on adults with learning disabilities and 15% on adults with physical and sensory impairments.
- Half of councils' net expenditure on services is used to purchase care in care homes, though there has been an annual shift of net expenditure from residential and nursing care to community services of around 1% over each of the last five years.
- In 2006-07 adult social care departments spent £291 million net on supported accommodation and £557 million net of Supporting People funds. Together this accounted for 24% and 32% of net council expenditure on community services for adults with learning disabilities and mental health needs respectively and represents a significant investment in providing care services to support people in 'ordinary' housing.
- Direct Payments accounted for nearly 7% of net expenditure on community services in 2006-07, amounting to £344 million. As a proportion of *total* gross costs of adult social care, £2.50 in every £100 was spent on Direct Payments. This compares with £2 in every £100 in 2005-06. 40,600 adults and older people used Direct Payments as at 31 March 2007 compared with 32,200 at the same point the year before. By 2008, the number had risen to 55,900.
- Nearly 4,800 people had an Individual Budget at March 2008, with just under half having a Direct Payment as part of the arrangement. The average annual gross value of an Individual Budget has been estimated as £11,450, most of which is social care funding.
- In 2006-07, £2.36 billion (net) was spent on home care and accounted for 46% of all community services expenditure. This is a 2% increase in expenditure in real terms from 2005-06, but represents a significant fall from an annual year-on-year increase of nearly 10% in the years from 2002-03.

- From 2001-02 to 2006-07 the percentage of (gross) expenditure with private and voluntary providers grew from 59% to 70%, amounting, with overheads, to £10.9 billion.
- Grants (not including contracts for services) made by social services to over 6,000 voluntary organisations providing services for adults amounted to £278 million, an increase of £26 million (7% in real terms) from the year before. A further £44 million was provided to fund carer organisations and £7 million for other groups of people.
- In 2006-07 the NHS contributed £1 billion to joint arrangements and pooled budgets with councils (6% of gross spend on adult care). Funding for learning disability services amounted to £645 million; and £171 million for services for older people (principally intermediate care).
- Councils recovered nearly £2.1 billion in fees and charges for social services in 2006-07 (13% of total gross adult care expenditure). Charges for care in care homes represent over three-quarters of these fees and charges.

Council activity

- Just over 1 million adults were supported at home with community services as at March 2007 (having increased by 1.3% from March 2006, and by 2.9% the previous year). A further 236,000 adults supported by councils were permanent residents in care homes; 8,600 (3.5%) fewer than in 2006.
- In the five years from March 2003 there has been a fall of 27,000 (13%) older people supported by councils and living in permanent care in care homes. The level of reduction has been similar for those under 65, though for those with learning disabilities it was 7%.
- The pattern and delivery of community services for adults under 65 per 10,000 population has changed over the last five years, 2003 to 2007, with an increase in Direct Payments and home care; an increase in day services for those with mental health needs and a decline for disabled people; a marked increase in professional support services for those with a mental health problem; and a growth in numbers provided with equipment and adaptations.
- In contrast, from March 2003 to March 2007, for older people there has been a significant reduction in the rate per 1000 population of recipients of home care, meals and day care services. However, there have been increases in Direct Payments, equipment provision and short-term/respite care.
- The number of older people using community and residential services dropped overall from 867,000 people in March 2003 to 827,000 in 2007; this is at a time when the population aged 75 and over increased by 5%.

- However (as reported above) councils increased their funding to voluntary organisations supporting people not eligible for social care services. It has been estimated that in 2007-08 each council spent, on average, £1.63 million on services to adults that people can access without a formal assessment or meeting eligibility criteria.*
- 198,000 carers aged 18-64 and 189,000 aged 65 and over were offered an assessment or review in 2006-07; 7,000 (2%) more, in total, than the year before. About 1 adult in 4 who received a community service in the year had a carer who was offered an assessment or review. 178,000 carers received a service following their assessment or review. Some 7,700 carers used a Direct Payment as at March 2007. Breaks for carers, reported by councils, increased by 15% from 2004-05 to an average of 20,520 per council in 2006-07.

* CSCI (2008) *Cutting the cake fairly: CSCI review of eligibility criteria for social care*

Introduction

3.1 The first half of this chapter provides a summary of expenditure by councils on social care for adults, how this money has been spent and how this has changed over recent years. The rest of the chapter provides information on care services provided through councils.

3.2 The latest detailed information on expenditure that is available is for the financial year 2006-07. Expenditure data from councils for 2007-08 will be published by the NHS Information Centre for Health and Social Care in February 2009.[47]

3.3 This chapter focuses on public funding and does not describe the totality of social care expenditure. As last year's report on the state of social care showed,[48] private expenditure is considerable; for example, charges and top-up expenditure amount to around half of all expenditure on personal social care for older people alone. In 2006 charges and top-ups were estimated to be nearly £5.9 billion. Recent calculations by Age Concern indicate older people and their families pay £0.5 billion top-ups and higher fees to meet the gap between market rates and those paid by councils.[49]

3.4 The majority of council activity data in this chapter from the NHS Information Centre for Health and Social Care also relates to 2006-07 but, where appropriate, information is included from Performance Assessment Framework Performance Indicators, 2007-08. The data collection for the future will need to reflect new patterns of service developments as increasing numbers of people use individual and personal budgets.

47 Provisional data as submitted by councils will be available on the IC website from October 2008 while data integrity checks are carried out in preparation for publication in February 2009

48 CSCI (2008) *The state of social care in England 2006-07,* Part two, Chapter 7

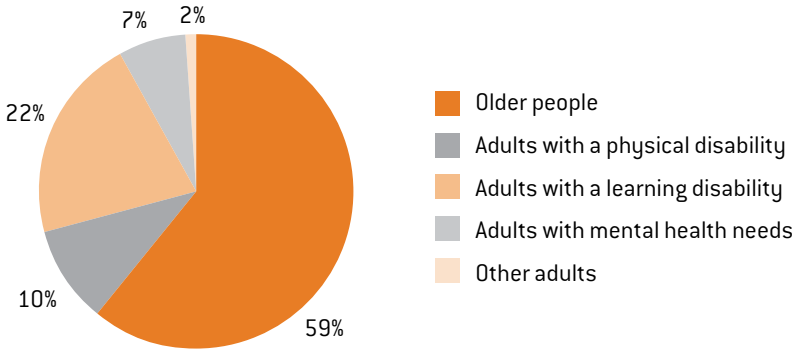
49 http://www.ageconcern.org.uk/AgeConcern/243025778B1A41EAB7B7FCE2A91BDB66.asp

Council expenditure on adult social care

3.5 Gross expenditure by councils in 2006-07 on adult personal social services amounted to £16.5 billion,[50] [51] an increase in cash terms of £0.6 billion (4%) from 2005-06.

3.6 Of this expenditure, 59% was on services for older people (compared to 61% in 2005-06) and 22% on adults aged 18-64 with learning disabilities (compared to 21% in 2005-06) (Figure 3.1). In total around 1.75 million adults received one or more services through councils in 2006-07[52] and councils responded to over 2 million new referrals from local people.[53] The total numbers of people being supported have not changed from the year before, but the distribution between those under and over 65 has altered.

Figure 3.1
Distribution of council expenditure on adult social services 2006-07[54]



3.7 Overall gross spending on adult social care rose by only 1.2% in real terms between 2005-06 and 2006-07,[55] compared to the increase from 2004-05 to 2005-06 of 4.3% (see Table 3.1). The growth between 2003-04 and 2004-05 was 7.8%.[56] The largest percentage increases were in Direct Payments and equipment and adaptations. Supporting People funding for housing and support fell by nearly 9% between 2005-06 and 2006-07. This

50 NHS Information Centre for Health and Social Care (February 2008) *Personal social services expenditure and unit costs, 2006-07*

51 'Gross' expenditure is all costs incurred by councils including overheads before any income from fees and charges or from other sources including partner agencies is 'netted' off

52 NHS Information Centre for Health and Social Care (March 2008) *Community care statistics: referrals, assessments and packages of care (RAP) report, 2006-07,* Table P1. Numbers of those aged 65 and over were unchanged while there was a 5% increase in numbers under 65 from 518,000 to 543,000

53 *ibid*, Table R3.1.

54 NHS Information Centre for Health and Social Care (February 2008) *Personal social services expenditure and unit costs, 2006-07*, Table 3.3

55 Source: NHS Information Centre for Health and Social Care website, PSS EX1 2006-07, 2005-06, 2004-05 and 2003-04 datasets. The GDP deflator (of around 3% each year for the period) has been applied, following the Annex to the PSS EX1 2006-07 report. The application of the deflator restates all prices as at 2006-07 values, taking into account general inflation in the domestic economy. Because employee costs constitute a high percentage of social care costs, the GDP deflator under-represents the degree to which *social care* costs have changed year on year. A personal social services pay and prices index calculated by the Department of Health suggests inflation on these costs is around 4% each year for the period (see CSCI (2007) *Social services performance assessment framework indicators, 2006-07*, page 120)

56 NHS Information Centre for Health and Social Care (February 2007) *Personal social services expenditure and unit costs, 2005-06*, Table 3.3

followed a similar fall between 2004-05 and 2005-06 after a real-terms increase of nearly 10% between 2003-04 and 2004-05.

Table 3.1
Growth in real terms, 2006-07 over 2005-06 and 2005-06 over 2004-05, by service

	2005-06 £000 gross	2006-07 £000 gross	Real growth: 2006-07 over 2005-06	Real growth: 2005-06 over 2004-05
Direct Payments	281,877	356,744	26.6%	39.7%
Supported and other accommodation	293,115	334,437	14.1%	7.9%
Other services*	677,736	722,540	6.6%	6.0%
Home care	2,555,604	2,642,512	3.4%	9.7%
Assessment and care management	1,733,167	1,767,589	2.0%	4.9%
Day care	1,221,573	1,225,149	0.3%	5.2%
Residential care home placements	5,126,039	5,116,830	-0.2%	1.7%
Equipment and adaptations	198,162	196,234	-1.0%	10.5%
Nursing home placements	1,819,852	1,785,887	-1.9%	3.3%
Meals	101,460	94,919	-6.4%	-2.8%
Sub-total	14,008,586	14,242,841	1.7%	5.0%
Supporting People	632,257	573,814	-9.2%	-8.6%
Grand total	14,640,843	14,816,655	1.2%	4.3%

***** Includes HIV, substance abuse, and other adult services such as community workers, support for carers, and grants not included elsewhere.

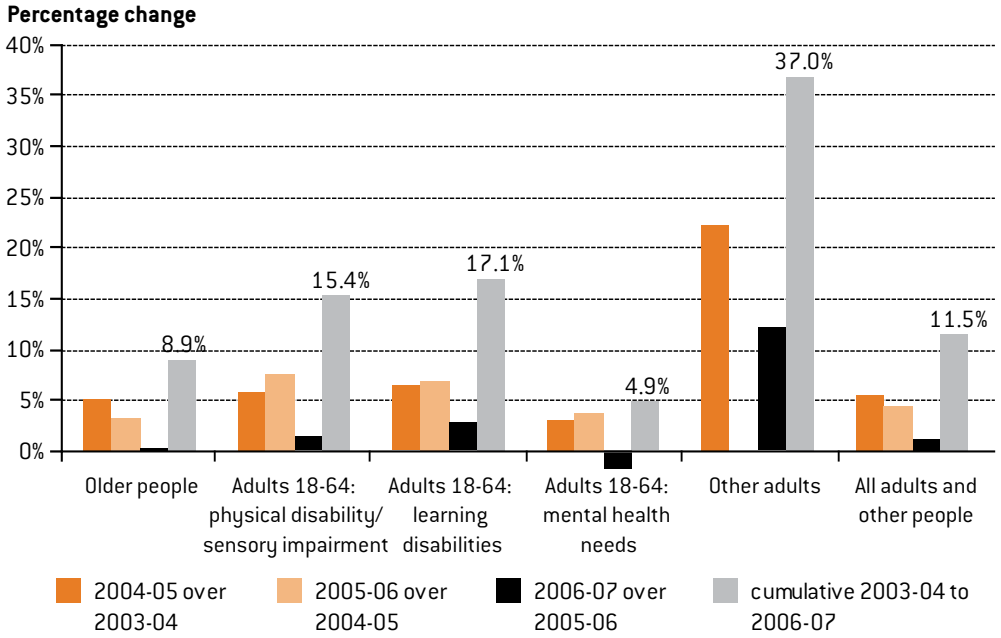
3.8 Figure 3.2 highlights the reduction in the real-term growth of gross expenditure between 2005-06 and 2006-07 for different groups. This needs to be seen in the light of overall growth from 2003-04 to 2006-07 in real terms of over 11%. For all adults the growth rate fell from 6% between 2003-04 and 2004-05 to 1% between 2005-06 and 2006-07. The group with the largest increase between 2005-06 and 2006-07 was adults with learning disabilities with an increase of £90 million (3%) though gross spend on 'other adults' increased by 12% (£40 million). Despite a growing population of older people this group saw real-terms growth of only £30 million (0.3%).[57] One significant contributory factor across all the groups was that Supporting People expenditure reported by councils fell by £58 million (9.2%) between 2005-06 and 2006-07.[58]

57 Analysis of comparable trends in net expenditure reveals a broadly similar pattern. Overall net expenditure on adult care increased by 1.3% between 2005-06 and 2006-07 in real terms. The largest increase was for adults with a learning disability (5%: £139m) with 'other adults' 12.7% (£22.7m). Older people saw a 0.3% increase (£23m). Net Supporting People expenditure fell by 9% (£56m)

58 Supporting People costs account for almost half of all gross expenditure for 'other adults'

Figure 3.2[59]

Percentage change in real-terms gross expenditure year-on-year for different groups of adults, 2003-04 to 2006-07

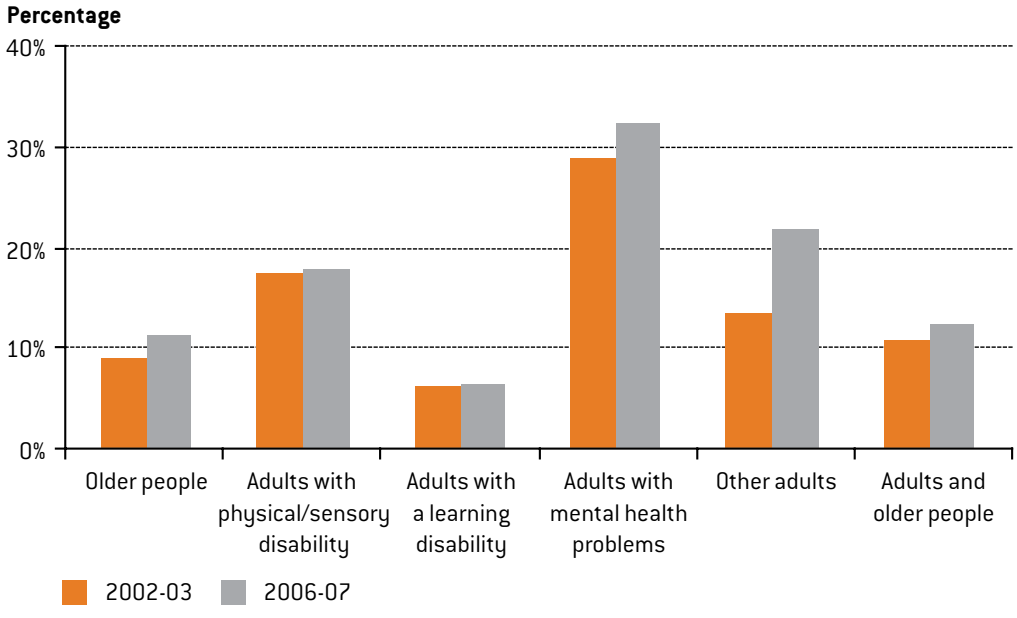


Costs of assessment and care management

3.9 The cost of social workers and occupational therapy staff, and support to these staff, such as offices and IT systems, constitutes on average about £1 in every £8 of what councils spend on adult social care. This cost has grown over the period from 2001-02 as a proportion of expenditure on services to adults.

Figure 3.3

Assessment and care management costs as a percentage of gross expenditure on adults, 2002-03 and 2006-07



59 NHS Information Centre for Health and Social Care (2008) *Personal social services expenditure and unit costs England, 2006-07,* Table 3.3 and net and gross spend Excel file on website, with GDP deflator applied

3.10 Assessment and care management costs constituted the largest proportion of gross care costs for adults aged 18-64 with mental health needs (32% in 2006-07).

3.11 There has been an increase in the proportion of the total costs of care for older people spent on assessment activity over the last four years. This is likely to reflect the 11% increase in recorded reviews of older people from 2004-05,[60] as well as an increase in the complexity of needs of people seeking help and those being supported to live at home rather than in care homes.[61] The workload from an increasing number of referrals about safeguarding issues is also reflected in this expenditure.[62]

3.12 Councils have been using IT and call centres to ensure that this area of expenditure is as efficient and cost effective as possible. However it should be noted that the recent CSCI review of eligibility criteria found problems with the way in which some councils responded to people at their first contact. People's needs and circumstances are often insufficiently explored. Of survey respondents for the review who did not meet eligibility thresholds, 62% stated they were not given any information about other help that might be available; and some people reported that their financial means were assessed before their needs.[63]

Changes in council expenditure on services

3.13 National policy over the last 15 years has been to shift care from hospitals and residential care homes to community-based services. In terms of net expenditure there has been a 1% shift of expenditure from residential to community services over each of the last five years (Figure 3.4).[64] There has been an increase in the percentage spent on community services since 2002-03 for all but mental health services. Trends in numbers of people receiving care home and community services are reviewed in paras 3.21 to 3.25 below.

60 See para 3.38. Numbers of older people receiving an assessment have decreased by 3% since 2003-04

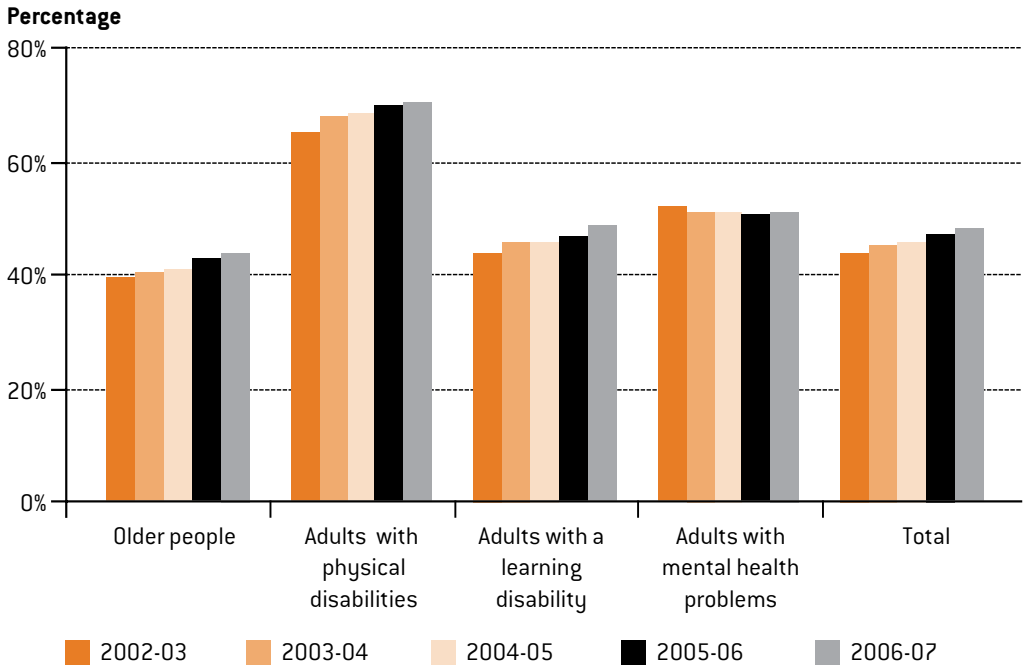
61 The percentage of older people with completed assessments and care delivered within 28 days increased at the same time as the percentage of all those using services with a review in the year

62 Self-assessment survey returns show an increase in 'vulnerable adult' referrals from 2006-07 (41,000) to 2007-08 (56,000). These data were not reported to a set of national standards of how such referrals should be classified and counted. Definitions are in place for 2009-10 (see http://www.ic.nhs.uk/our-services/improving-social-care-information/social-care-collections)

63 CSCI (2008) *Cutting the cake fairly: CSCI review of eligibility criteria for social care*

64 That is, excluding the impact of charges to those who use services and contributions from the NHS and others (see paras 3.27 and 3.29 below)

Figure 3.4
Changes in the percentage of total net expenditure on services committed to community services, 2002-03 to 2006-07[65]



3.14 The real level of change in the shift of expenditure to community services is likely to be greater than 1% a year in that the data on expenditure currently available do not allow identification of the:

- Increasing use of care home placements for intermediate care and respite care. Intermediate care admissions rose from 29,400 to 46,300 between 2003-03 and 2006-07 and totalled 50,800 in 2007-08. Carers' breaks, often involving respite stays in care homes for the person cared for, have also increased over the last four years, as councils have received significant levels of special grant.
- Improved quality of care home provision provided or purchased by councils.[66] Net costs to councils of care home places purchased for older people have increased by 6% in real terms between 2003-04 and 2006-07; by 21% for people with learning disabilities aged under 65; and by 13% for people with mental health problems.[67]
- Extra costs associated with councils taking over funding of provision in care homes for people with severe disabilities and dementia who would hitherto have used provision funded by the NHS.
- Added costs of providing residential care for those who can no longer be supported in the community. Average age on admission for older people and levels of dependency (including people with dementia and older people with a learning disability) have risen.

65 NHS Information Centre for Health and Social Care, *ibid.,* PSS EX1 data for England for relevant years

66 For example few admissions are now made to shared rooms. See also analysis in Chapters 6 and 7

67 From NHS Information Centre for Health and Social Care *Personal social services expenditure and unit costs England* net and gross spend Excel files on website, with GDP deflator applied

3.15 At the same time as residential care costs are increasing for fewer people living in care homes in total (numbers of permanent older residents supported by councils fell by 27,000 (13%) from March 2003 to 2007[68]), patterns of expenditure on community services are changing. People with lower levels of need are likely to receive fewer or no services; for example, there has been a 22% reduction in the numbers of households using home care services of five or fewer hours of care in a sample week from 2003 to 2007 (a reduction of some 42,000 households).[69] People with higher levels of need are being supported for longer in the community in settings that provide alternatives to care in a care home, such as extra care housing, supported housing and adult placement schemes.

3.16 Intensive rehabilitative programmes in the community to avoid hospitalisation or to ensure speedy rehabilitation after hospitalisation will entail extra costs on home care and occupational therapy services funded by councils. The numbers of people using non-residential intermediate care reported by councils rose from 98,000 in 2002-03 to 190,400 in 2006-07[70] and 225,000 in 2007-08.

Supporting People funding and supported accommodation

3.17 In 2006-07 adult social care departments reported that they spent £291 million net on supported accommodation for adults with social care needs and a further £557 million (net) of Supporting People funds. Together these accounted for 27% and 41% of net council expenditure on community services for adults with learning disabilities and mental health needs respectively. There continues to be a significant investment *within* community support arrangements in providing care services to support people in 'ordinary' housing.[71] It will be important to monitor this expenditure once Supporting People funding is no longer ringfenced (from 2009).

Expenditure on Direct Payments and Individual Budgets

3.18 In 2006-07 Direct Payments [72]accounted for nearly 7% of net expenditure on community services, amounting to £344 million. As a proportion of *total* gross costs of adult social care, £2.50 in every £100 was spent on Direct Payments in 2006-07. This compares with £2 in every £100 in 2005-06. However, in terms of *community* services for adults with a physical or sensory disability this represents almost £1 in every £4 (see Figure 3.5). A significantly lower proportion of expenditure on community services is used in provision of Direct Payments for other groups of people who use services.

68 NHS Information Centre for Health and Social Care (2007) *Community care statistics 2007*, 'supported residents', Table S5 – see para 3.46 below

69 NHS Information Centre for Health and Social Care (2007) *Community Care Statistics 2007*, 'home care services for adults', Tables 5 and 9. Some of these people will have received Direct Payments in place of home care

70 CSCI (2007) *What councils are saying about their progress in delivering services to adults with social care needs* (online SAS report)

71 See CSCI (2006) *Supporting People – promoting independence* for a review of evidence from joint inspections of Supporting People services

72 Direct Payments are cash payments made in lieu of social services provisions to individuals who have been assessed as needing services

3.19 40,600 adults and older people were receiving Direct Payments at March 2007, compared with 32,200 in March 2006 (an increase of 26%).[73] The increase has been sustained in 2007-08 – a total of 55,900 adults received a Direct Payment (an increase of 15,300 (38%) over 2007).[74] The average annual net expenditure per Direct Payment recipient increased in real terms from £5,100 in 2005-06 to £5,400 in 2006-07 for older people but reduced from £8,300 to £8,100 for recipients aged under 65.[75]

3.20 Following trials in 13 councils, Individual Budgets[76] are increasingly being implemented by councils. The average annual gross value of an Individual Budget has been calculated as around £11,450, with the majority of funding from social care.[77] The provisional data available for 2007-08 for the thirteen councils[78] show that nearly 4,800 adults had an Individual Budget at March 2008, with just under half having a Direct Payment as part of the arrangement. The NHS Information Centre for Health and Social Care has published proposals on how this key initiative will be monitored.[79]

73 NHS Information Centre for Health and Social Care (March 2008) *Community care statistics: referrals, assessments and packages of care (RAP) report, 2006-07,* Table P2f. Two-thirds of recipients were aged under 65. 5,160 carers with Direct Payments are not included in this total.

74 See CSCI (2008) *Social services performance assessment framework indicators: adults*, section on PAF PI C51.

75 NHS Information Centre for Health and Social Care (2008) *Personal social services expenditure and unit costs England, 2006-07,* unit costs Excel file on website, with GDP deflator applied

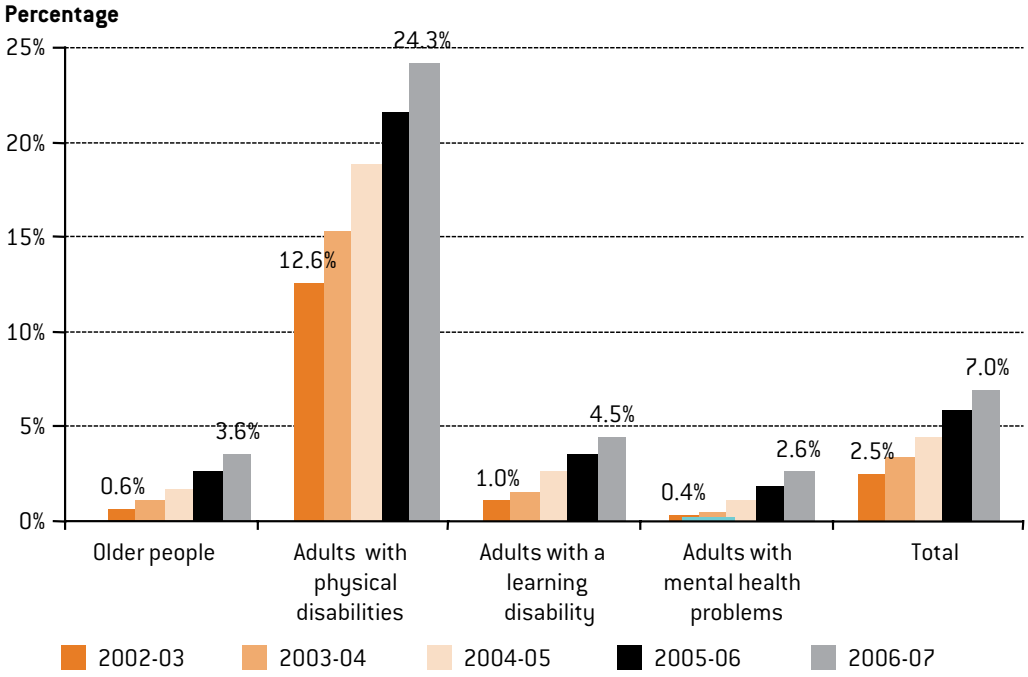
76 Individual Budgets include a transparent allocation of resources, giving individuals a clear cash or notional sum for them to use in a way that best suits their particular requirements

77 IBSEN (2008) *Evaluation of the individual budget pilot programme summary report,* York: SPRU

78 See 2007-08 provisional RAP return, Table P2s1.e at: http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information. One council reported over half of the total of the 4,795 adults with an individual budget

79 See Appendix 8 at: http://www.ic.nhs.uk/our-services/improving-social-care-information/social-care-collections/Collections-2009

Figure 3.5
Council net expenditure on community services which was spent on direct payments, 2002-03 – 2006-07



Trends in expenditure on community services

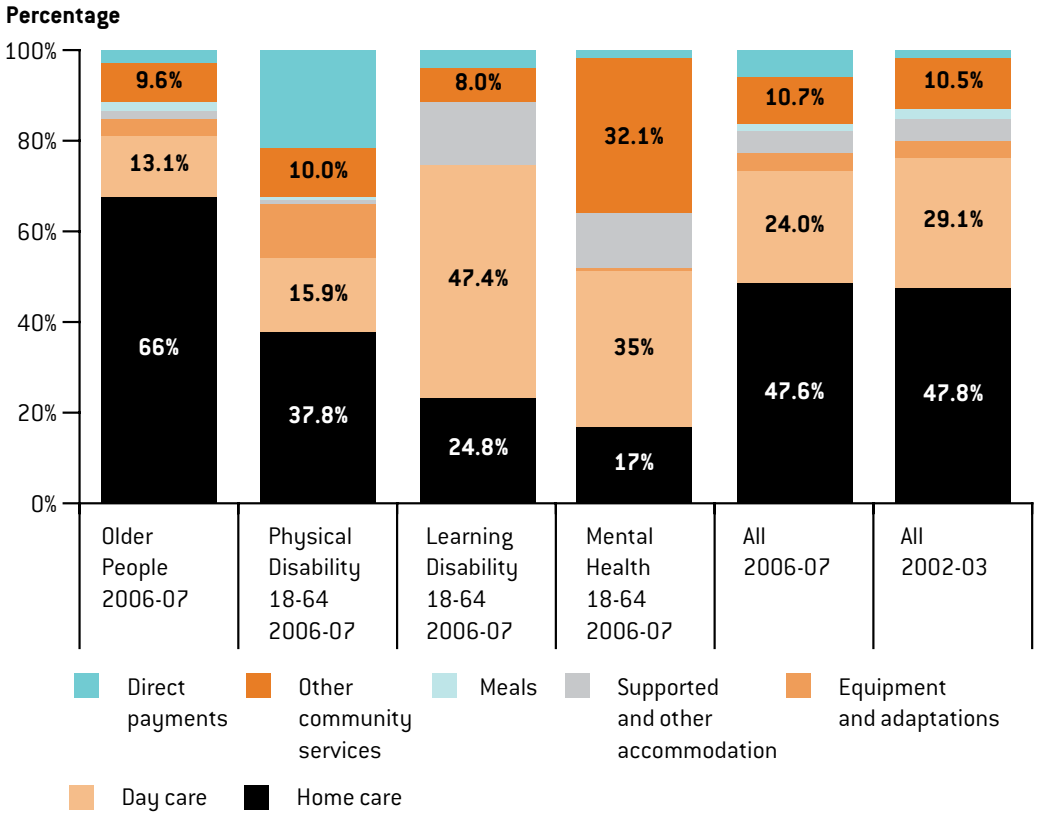
3.21 £2.36 billion (net) was spent on *home care* in 2006-07. There was a 2% increase in expenditure in real terms from 2005-06: this represents a significant fall from an annual year-on-year increase of nearly 10% in each of the years from 2002-03. In 2006-07 home care accounted for 47.6% of all net expenditure on community services, down from 48.5% in 2005-06. However, this is in part reflecting the proportion of net expenditure on community services spent on *Direct Payments* which increased from 5.8% to 7% between 2005-06 and 2006-07, having been at 2.5% in 2002-03.

3.22 Net spend on *day services* has fallen over the five years by five percentage points to 24%. Day services account for nearly half of total community services expenditure for adults with a learning disability, though this too has fallen from 63% in 2002-03 to 47%.

3.23 The percentage of expenditure on *equipment and adaptations* remained static over the five years at 4% of net expenditure on community services. Costs of *meals services* (meals on wheels and frozen meals delivered to people's homes), £54.6 million net in 2006-07, fell from 1.7% of all community expenditure in 2002-03 to 1.1%, reflecting the fall in numbers receiving meals services.

3.24 Figure 3.6 shows net expenditure on community services for different groups of people using services in 2006-07 and a comparison with 2002-03 for all people using services.

Figure 3.6
Distribution of net expenditure on community services, 2006-07 (and 2002-03)

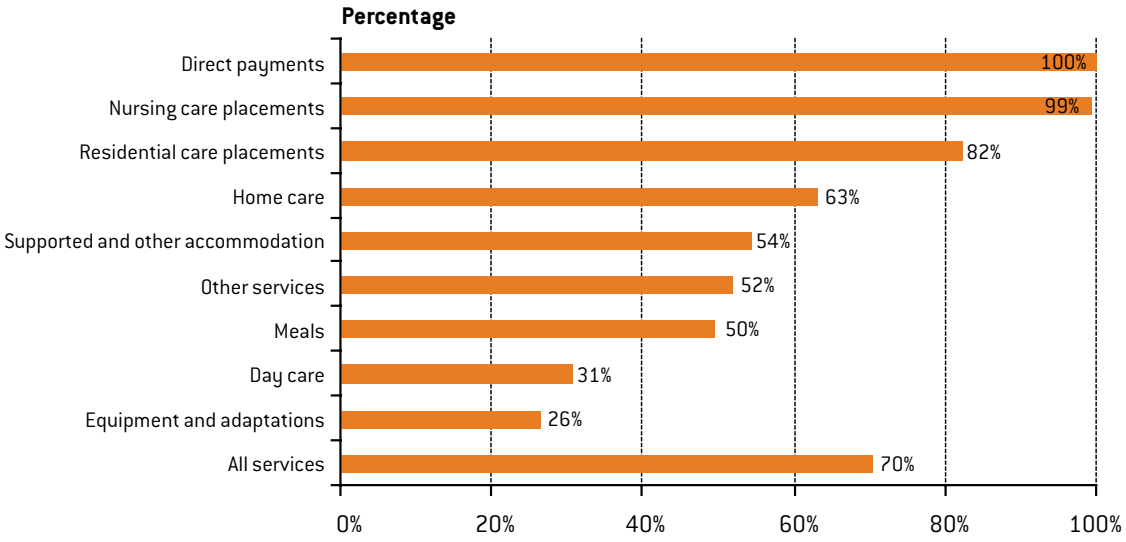


Development of services in the private and voluntary sectors

3.25 Councils are increasingly purchasing services from private and voluntary organisations. From 2001-02 to 2006-07 the percentage of (gross) expenditure on care services purchased from private and voluntary providers grew from 59% to 70%, amounting (with overheads) to £10.9 billion. Figure 3.7 shows the percentage of gross expenditure on different services in 2006-07 with private and voluntary providers.[80]

80 Direct Payments must be spent on externally provided services (though the same recipient can also receive services provided by the council itself) so 100% is spent on the independent sector. The equipment and adaptations figure probably reflects the joint commissioning of equipment stores and delivery from the private and voluntary sector; it may also cover some payments to the NHS for their provision of these services

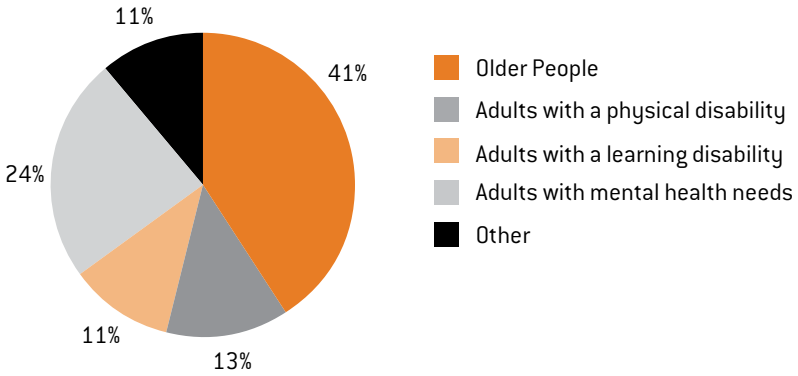
Figure 3.7
Percentage of gross expenditure on services for adults and older people spent with the private and voluntary sector, 2006-07[81]



Grants and service level agreements with voluntary organisations

3.26 In 2006-07, grants (not including contracts for services) made by councils to some 6,000 organisations providing services for adults amounted to £278 million (2.5% of gross council expenditure with non-council service providers).[82] This was an increase of £26 million (7% in real terms) from the year before. A further £44 million was provided to fund carer organisations and £7 million for other 'client groups'.[83] Organisations helping older people received the highest level of this funding support (41%), followed by adults with mental health needs (24%) (Figure 3.8).

Figure 3.8
Grants from adult social care budgets to voluntary organisations, 2006-07



81 NHS Information Centre for Health and Social Care website (February 2008) England summary sheet in Excel file Detailed PSS by council in *Personal social services expenditure and unit costs, 2006-07*

82 NHS Information Centre for Health and Social Care (February 2008) *Personal social services expenditure and unit costs, 2006-07*, Section 5. Thirty councils were not able to provide information so estimates have been included for them

83 *ibid*: only 102 councils provided information on grants to carers' organisations

Joint working with the NHS

3.27 In 2006-07, the NHS contributed £1 billion to joint arrangements and pooled budgets with councils (6% of gross spend on adult care).[84] The majority of this (£645 million) was for learning disability services, with a further £171 million for services for older people (including intermediate care). In some instances both council and PCT pool resources to fund the work of agencies such as drug and alcohol action teams. The NHS contribution in 2006-07 was principally towards provision of care home placements (55% of the £1 billion) and home care (10%), with nearly 10% towards assessment and care management (in contributions towards joint teams and posts).

Charges to people using services

3.28 Councils recovered nearly £2.1 billion in fees and charges from those using services in 2006-07 (12.7% of total gross adult care expenditure). The largest source of this income was for residential and nursing care: £1.6 billion (77% of total income from fees and charges). Home care was the other main source: £285 million (14% of total income from fees and charges).

3.29 Councils reported recovering 46% of gross care homes costs in charges, with 10% of home care costs and 41% of meals costs being recovered. The percentage of gross expenditure recovered has fallen over time from 20% in 2001-02 to 14% in 2005-06 and 13% in 2006-07. This reflects government policy as set out in *Fairer charging*[85] and subsequent changes to charging arrangements, such as provision of free nursing care in nursing homes, free rehabilitative services and free equipment and minor adaptations.

Council activity in social care provision for adults

Assessment and care management

3.30 In 2006-07, as the year before, councils received referrals from, or about, 2.04 million adults not already being provided with care from council social services. This was an increase of 4% over 2004-05.[86] Over half of the referrals in 2006-07 led on to a formal assessment by the council. In almost six councils in 10 at least half of those referred had their needs assessed by council staff.

3.31 Nearly half of all referrals (43%) are made by people on their own behalf or for family members or neighbours. Over a third (37%) of all referrals come from the NHS.[87] (Figure 3.9.)

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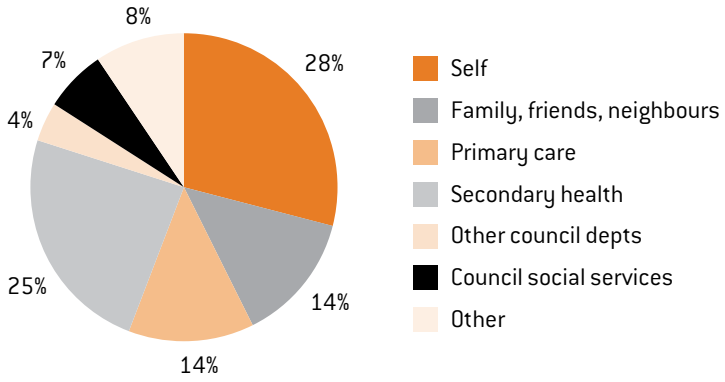
84 This figure, which is taken from the 2006-07 PSSEX1 returns, is significantly higher than that reported in 2005-06 (£650m) (see CSCI (2007) *The state of social care 2006-07*, page 28). The increase reflects a change to the PSS EX1 report to more clearly identify this item. Detailed analysis at council level suggests that reporting is not yet robust. The figure does not include extra funding awarded for NHS Continuing Care in 2007-08. Council payments *into* NHS-held pooled budgets are not identifiable from within PSS EX1

85 Department of Health (2003) *Fairer charging policies for home care and other non-residential social services*

86 NHS Information Centre for Health and Social Care (2007) *Community care statistics 2006-07: referrals, assessments and packages of care for adults: England,* Table R3.1

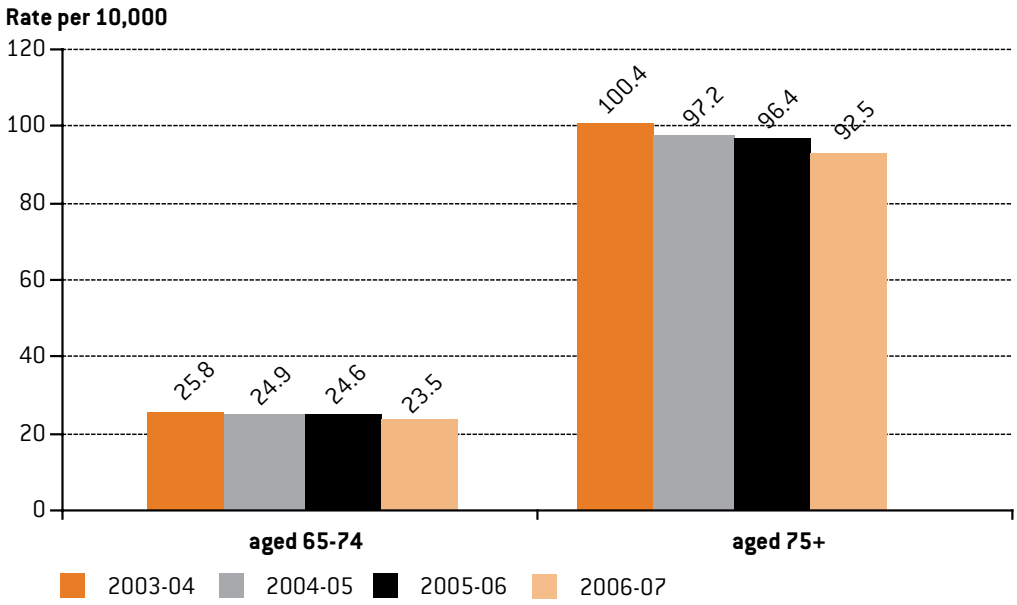
87 Some of those recorded as 'self referrals' and referrals by family and friends may also result from contact with the NHS

Figure 3.9
Sources of referrals, 2006-07



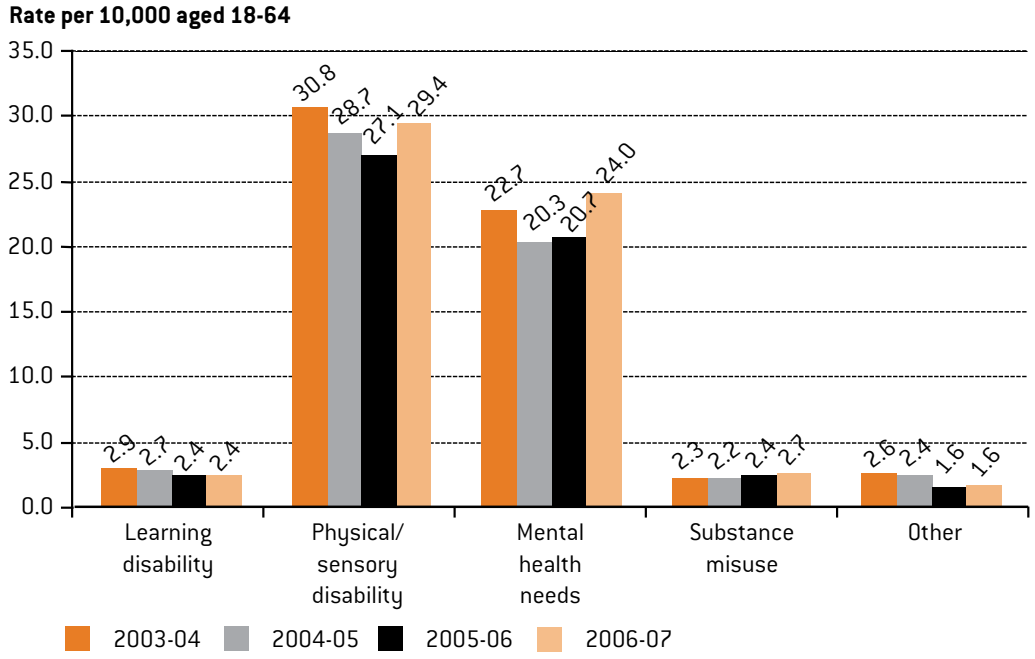
3.32 In 2006-07 460,000 older people not already in receipt of services had a completed assessment of their needs as did a further 190,000 people aged under 65. Of those under 65, 93,000 were adults with a physical disability and 76,000 adults with mental health needs. Figures 3.10 and 3.11 show trends over time taking into account changes in the population.[88]

Figure 3.10
New assessments of older people



88 NHS Information Centre for Health and Social Care, *ibid* for relevant years, Table A1.1a.

Figure 3.11
New assessments of younger adults



3.33 Allowing for population change, there has been a gradual reduction in the rates of completed new assessments for older people in the years to 2006-07 (Figure 3.10). After three years of rates having fallen, the rates increased in 2006-07 for adults with physical and sensory disabilities. They also rose for adults with mental health needs (Figure 3.11). The latter increase may reflect transfers of council mental health social work staff to NHS trusts in the early part of the period and consequent difficulties in consistent reporting of new assessments.

3.34 The proportion of assessments per 1000 population for older people from black and minority ethnic (BME) groups[89] is marginally higher than that for the 'white' population but this is likely to be a reflection of differences in relative affluence and health. This pattern is also evident in access for adults under 65 from black and minority ethnic groups.[90]

Activities arising from assessments

3.35 Eight in 10 new assessments of older people in 2006-07 were completed within four weeks of initial contact (compared with six in 10 in 2003-04). Nine in 10 older people received all the services which were agreed in their assessment within four weeks (compared with eight in 10 in 2003-04).[91]

89 PAF PIs E47 and E48. These are reviewed in detail in the CSCI PAF PI publication (CSCI (2007) *Performance assessment framework performance indicators: adults, 2006-07)*

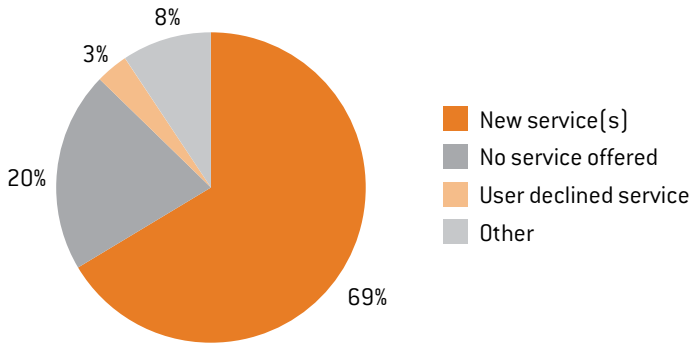
90 A further complicating factor is that there are no robust up-to-date figures for England on the numbers of white and BME residents by age group: the comments here are based on use of 2001 Census data to establish the percentage of different ethnic groups in the whole population. ONS have published experimental data for 2006 (ONS ,2008, PEEGC100, Ethnic group of adults by custom age bandings, mid-2006) which suggest that there may have been an increase of one-third in the proportion of BME groups over the five years from the 2001 Census (from 2.9% to 3.9% of the population aged 65 or above).

91 CSCI *ibid*: Performance Indicators D55 and D56.

3.36 The CSCI review of eligibility criteria found some people do not have their needs and circumstances properly explored at their first contact with their council.[92] In the survey for the review, one in five carers and one in eight of those people who said they could benefit from social care reported they failed to have an assessment of their needs. One-third of these respondents understood this was because they did not meet financial eligibility criteria for help (suggesting they were asked about their financial resources prior to any needs assessment, which contravenes policy).

3.37 Following an assessment, a person may be provided with a new service/s, may not be offered a service,[93] may themselves decline any service, or may have some other outcome. Some may be referred on to the NHS or housing agencies or to voluntary sector services (often funded by grants by councils). Figure 3.12 shows what happens to adults who had an assessment in 2006-07, with 69% of people receiving a service.[94] A more in-depth study of the outcomes for people who are not offered a service is provided in the CSCI review of eligibility criteria.

Figure 3.12
Action following completed assessments, 2006-07



Reviews

3.38 In 2006-07 councils reviewed[95] 71% of adults receiving a service in the year (up from 66% in 2005-06). Reviews are crucial to ensure people are getting the most appropriate service, to monitor the quality of service and outcomes for people, and to ensure the best use of resources. This rate of review has risen substantially for most councils over the last four years, as shown in Figure 3.13, although in 2006-07 one council in 10 failed to review the situation of 40% or more of people using services.

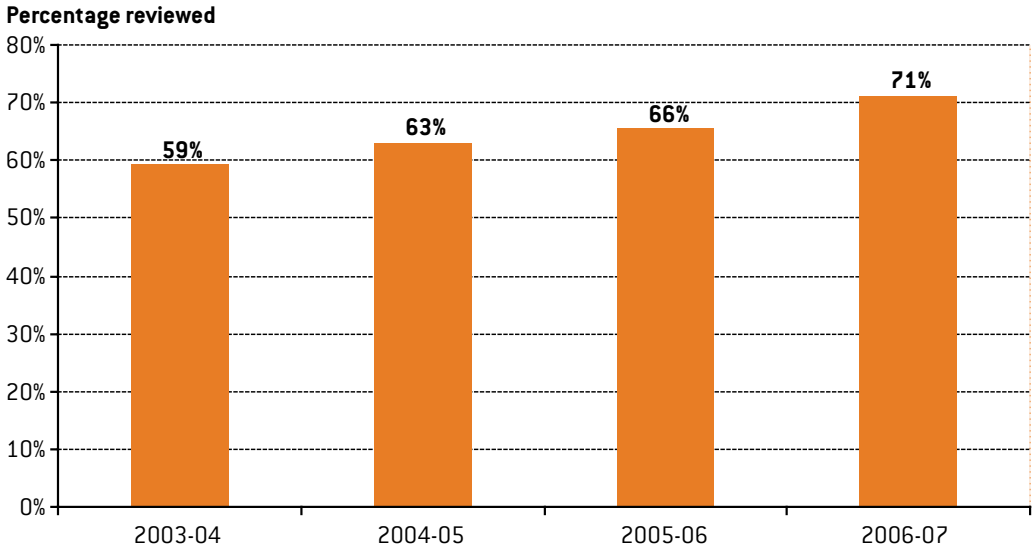
92 CSCI (2008) *Cutting the cake fairly: CSCI review of eligibility criteria for social care*

93 'No new service offered' does not imply no help was given – it may well have been appropriate to refer on to voluntary or self-help groups

94 NHS Information Centre for Health and Social Care (2007) *Community care statistics 2006-07: referrals, assessments and packages of care for adults: England,* Table A.1

95 Reviews can include an unplanned reassessment of existing needs and services following changes in a person's situation, or planned reviews to ensure services are achieving their planned outcomes. (NHS Information Centre for Health and Social Care (2006) *Information and guidance on the referrals, assessments and packages of care collection, 2006-07,* page 120)

Figure 3.13
Reviews of people using services



Numbers of people supported by councils

3.39 At March 2007, just over 1 million adults were supported at home with community services and 236,000 adults were permanent residents in a care home financially supported by councils. In the five years from March 2003 there has been a fall of 32,000 (12%) permanent residents supported by councils in care homes. This level of reduction has occurred in all groups of those who use services, other than those aged under 65 with learning disabilities where it was 7%. The numbers of people supported at home rose by 1.3% from March 2006 as compared with a growth of 2.9% in the previous year.

3.40 Figures 3.14 and 3.15 show the numbers of older people and adults aged under 65 who used services at March 2007 compared to March 2003:[96] 827,000 older people in 2007, compared to 867,000 in 2003; and 432,000 adults aged 18-64 in 2007, compared to 375,000 in 2003. The decline in numbers of older people of 5% needs to be related to the increase in the population aged 65 or above of 2.8% between mid-2003 and mid-2007 (with an increase of nearly 5% for those aged 75 or above). The 15% increase in those aged under 65 relates to a population increase of 3.6% for this age group over the five years.

96 Using data from *Supported residents* and *Referrals, assessments and packages of care* returns to the NHS Information Centre for Health and Social Care (SR1 permanent supported residents Tables S4 and S5 and RAP Table P2s 'on the books' totals)

Figure 3.14
Numbers of older people using services arranged by councils

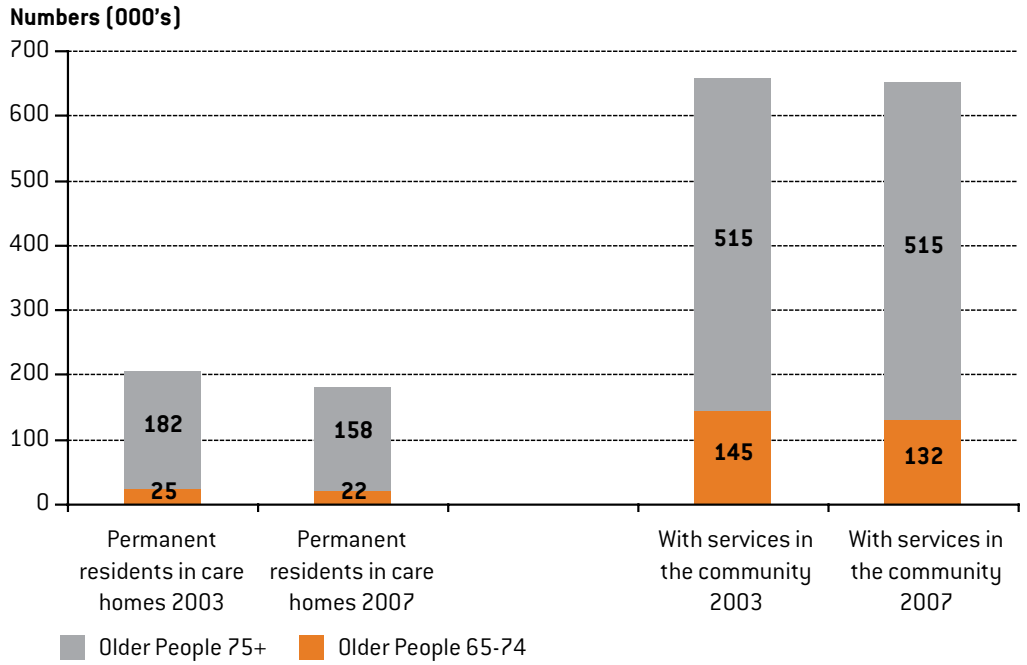
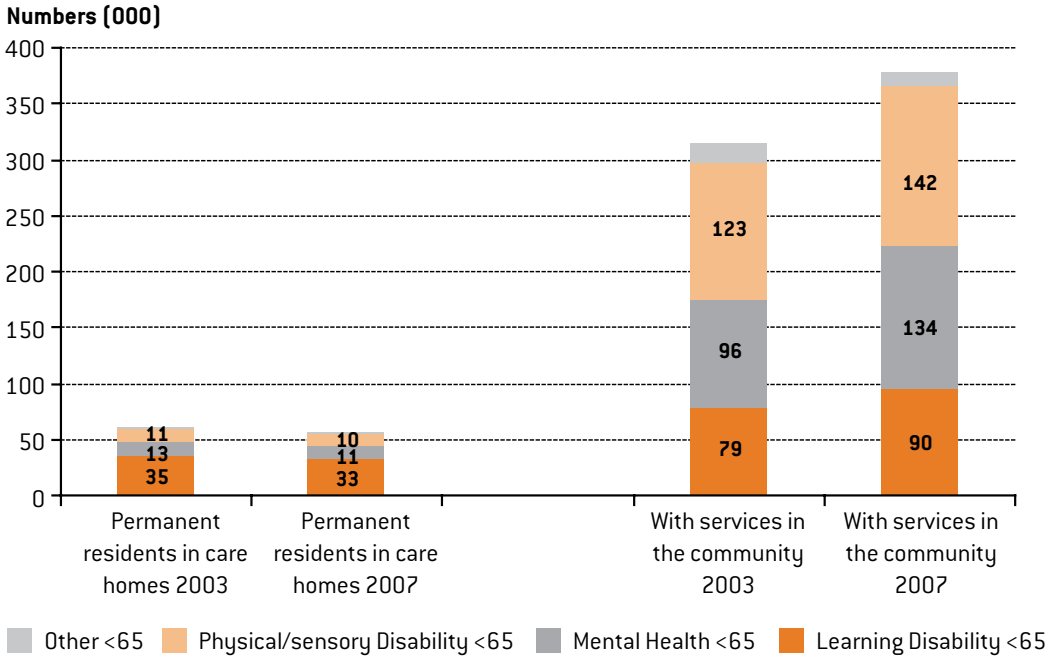


Figure 3.15
Numbers of people aged 18-64 using services arranged by councils[97]



3.41 There are a number of policy and practice shifts that may have affected the decreasing number of older people using services. Clearly the higher thresholds for access to services

97 The data in the right hand columns of Figure 3.15 form the numerators for 'helped to live at home' performance indicators C29-31 – see further CSCI 2007, *Performance assessment framework performance indicators: adults, 2006-07*. The PAF PI C32 (older people helped to live at home) is derived from summing the data in the right-hand columns of Figure 3.14 and relating them to the population aged 65 or above

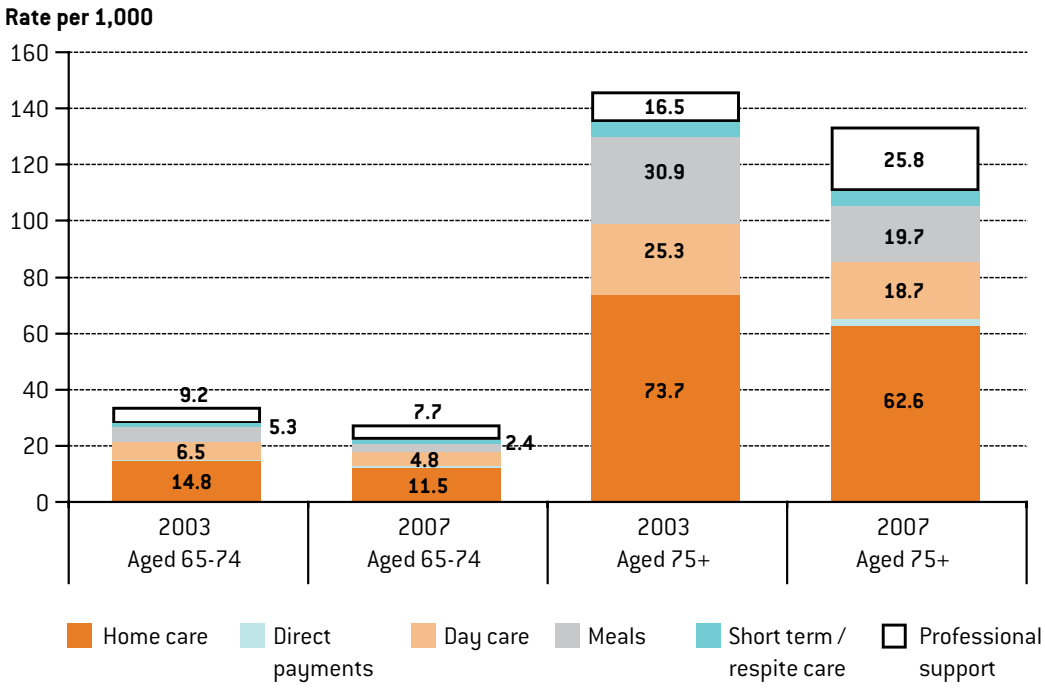
(eligibility criteria) have played an important part. It is difficult to assess how far the figures may also reflect an increase in people being funded through contracts with voluntary sector organisations as well as the impact of a range of preventative and wellbeing services, such as falls services, intermediate care, and new technology at home. The last state of social care report included estimates that in the current system (assuming the support of family carers) 450,000 older people have some shortfall in their care.[98]

Rates of provision of community services

3.42 From March 2003 to March 2007 there has been a significant reduction for older people in the rate per 1000 aged 65 or above of receipt of home care, meals and day care services. However, there have been increases in Direct Payments and short-term/respite care.[99]

Figure 3.16

Community services commissioned by councils for older people[100]



3.43 The pattern and delivery of selected key services for adults under 65 (rate per 10,000 18-64 as shown in Figure 3.17) has also changed in the five years to March 2007, including:

- an increase in Direct Payments, particularly for those with physical disabilities

98 CSCI (2008) *The state of social care in England 2006-07*

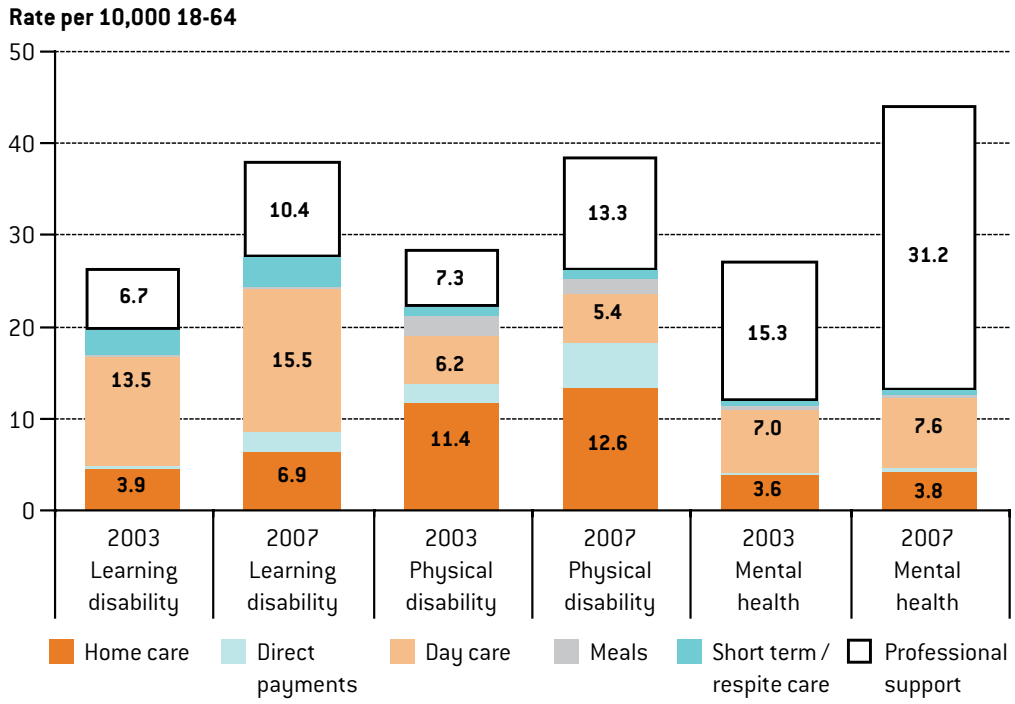
99 Changes in both the pattern of services and reporting make comparisons over time difficult. There has been a marked drop in numbers of households receiving low levels of home care but the service now includes substantial levels of 24-hour support, including to those in extra care housing. (21% of home care hours delivered in September 2007 were through overnight/live-in or 24-hour services and a further 16% were out of normal hours NHS Information Centre for Health and Social Care (2007) *Community care statistics 2007, home care services for adults*, Table 3). Day care and meals services provided through voluntary organisations may now be excluded from the RAP data because those using the services no longer receive a formal assessment. Older people may also be purchasing more care privately

100 Professional support is shown in a different format as it will generally be associated with other service provision and may include support from NHS staff where there is a Health Act 2006 s75 agreement between the council and NHS

- an increase in home care provision (especially if Direct Payments which are used to buy home care-type support are added in)
- an increase in day services for those with mental health needs and learning disabilities but a decline in these services for disabled people[101]
- a marked increase in 'professional support'[102] services for all groups, but especially for those with a mental health problem, likely to reflect the inclusion of support from community psychiatric nurses within joint community mental health teams.

Figure 3.17

Community services commissioned by councils for younger adults, 18-64[100]



3.44 Council provision of equipment and adaptations has increased: 49 older people per 1000 over 65 were helped in 2006-07, compared to 39 in 2002-03 (a 21% increase) and 48 in 2005-06. For younger adults with disabilities, the rate per 10,000 aged under 65 rose from 30 in 2002-03 to 34 (a 15% increase).[103]

Care homes

3.45 At March 2007 some 230,000 adults financially supported by councils were permanent residents in care homes. A further estimated 118,000 older people were permanently

101 Reductions in day care may reflect reshaping of services towards helping people into work and back to independence

102 'Professional support' does not include the process of care management (ie assessing or reviewing care needs), but typically occurs when the care manager goes on working with the person after the care management process has been completed (as part of the care plan/package), or another professional is involved to provide therapy, support or professional input, eg counselling.

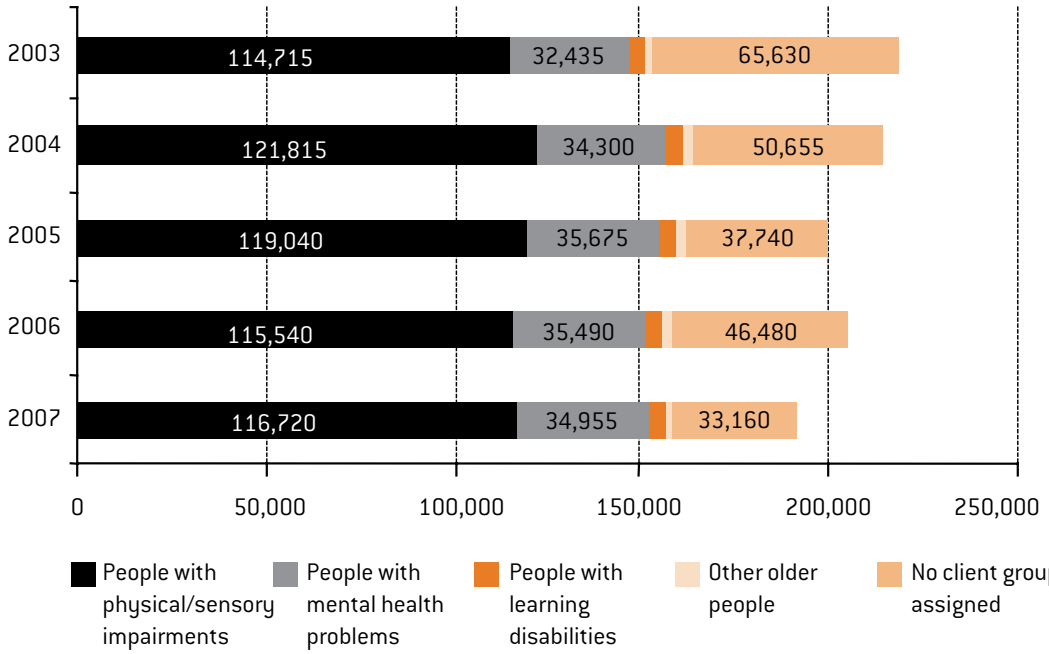
103 NHS Information Centre for Health and Social Care (2007) *Community care statistics 2006-07: Referrals, Assessments and packages of care for adults: England,* P2f tables for relevant years. The increase in 2006-07 will have included some of the initial work by councils on extending telecare services. The introduction of prescriptions for equipment will only start to be evident from 2007-08

resident and fund their own care.[104] The national overview of care home provision is set out in Chapter 4. In this section the focus is on those whom a council funds to a greater or lesser extent.

3.46 Trends over the last five years in older people permanently placed in care homes supported financially by councils are set out in Figure 3.18. Total numbers fell by nearly 27,000 (13%) between March 2003 and 2007 whilst the population is growing in those groups most likely to need care.[105] The rates per 1000 aged 75-84 and 85 or above fell by around a fifth (22% and 19% respectively). A reduction has also occurred in the rates aged under 65 supported in permanent and temporary care though this is less marked (a 9% reduction overall). Rates of new permanent admissions of older people arranged by councils have also been falling (19%),[106] while temporary admissions for older people increased by 4% over the five-year period. For adults aged 18-64 permanent admissions reduced by about a third to 5,470 in 2006-07: temporary admissions fell by 13% to 113,575.

Figure 3.18

Numbers of older residents in care homes financially supported by councils[107]



3.47 Numbers of people supported by councils and living in care homes, and numbers of supported permanent admissions to care homes, are falling, in part because councils are increasingly providing and commissioning services which provide an alternative to

104 see CSCI's report (2008), *The state of social care 2006-07,* Chapter 7

105 Figure 3.18 shows the numbers of older people with mental health problems and learning disabilities. While the proportions of these two groups are increasing, this may in part reflect more accurate reporting. See the reduction in numbers not assigned to a client group from 65,000 in 2003 to 33,000 in 2007

106 CSCI (2007) *Performance assessment framework performance indicators: adults, 2006-07*: C72 rate of older people permanently admitted per 10,000 65 or above from 86 to 80 from 2005-06 to 2006-07 (a fall of 7%) down to 75 for 2007-08 (a fall of 9%). C73 (adults 18-64) fell from a rate per 10, 000 of 1.9 in 2005-06 to 1.75 in 2006-07 and to 1.5 in 2007-08. Changes in counting arrangements preclude comparisons with earlier years

107 Source: special analysis for CSCI by NHS Information Centre for Health and Social Care (February 2008) from data in *Community Care Statistics 2007*, supported residents (adults) England 2006-07, Table 1

residential care. These include, for example, extra care housing, supported living, adult placement scheme placements ('shared lives'), and assisting people to live at home with intermittent care in residential settings for respite. This change is a slow process, partly because of the capital costs involved. Some of the fall in numbers of older people supported by councils and living in care homes also reflects the growth in numbers of people funding their own care.

Support to carers

3.48 Councils have a variety of duties towards carers – people who, unpaid, look after a partner, relative or friend who needs assistance because of physical or learning disability, illness or mental health needs. The 2001 Census reported that there were some 5.2 million people in England who provided care (1 in 10 of the population). 1.7 million provided care for 20 hours or more in a week. In 2004-05, the Family Resources Survey found that in Great Britain, more than half of carers were providing care to someone living outside of their own household (58%). The largest proportion (49%) of care given outside the household was provided by relatives. Care provided to partners within the household accounted for 16% of all help provided. Those in full-time employment (31%) made up the largest group of carers, regardless of whether care was provided inside or outside the household, followed by those in retirement (22%) and those who were otherwise inactive or in part-time employment (both 15%).[108]

3.49 Some carers seek help from the council in their own right and many approach local voluntary groups that support carers. In November 2006 some 790 carers' organisations in

108 Office for National Statistics (2008) *Social trends 2007*, page 105

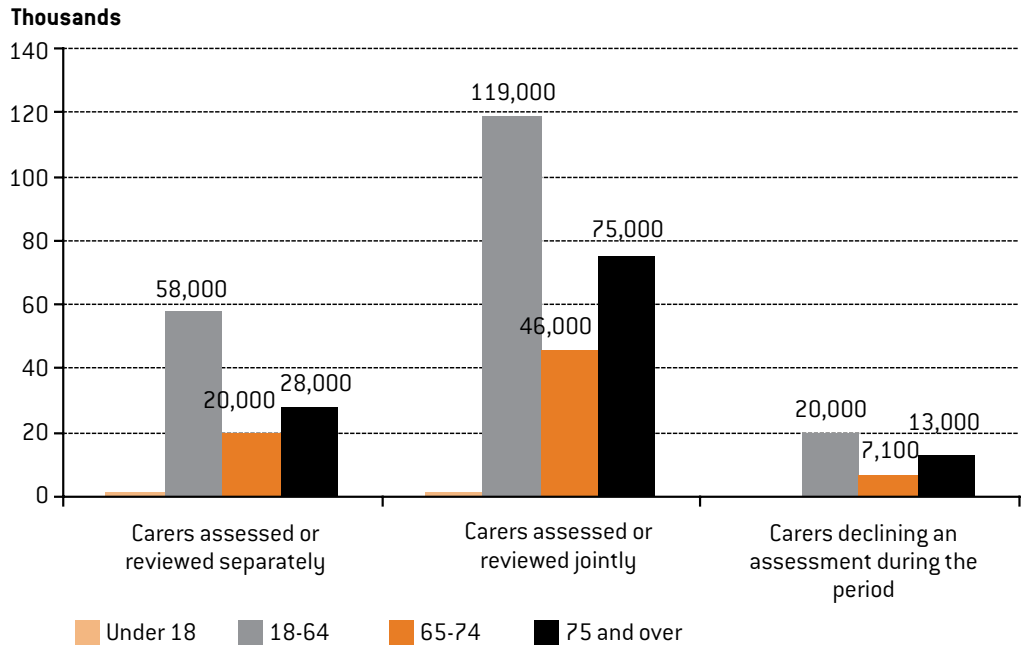
the voluntary sector received council financial support and reported helping around 35,000 carers in a sample week.[109]

Carer assessments

3.50 Councils with social services responsibilities have a statutory duty to assess the needs of carers as well as those of the person cared for. In 2006-07, 390,000 carers aged 18 and over were offered an assessment or review (Figure 3.19) (an increase of over 7,000 (2%) over 2005-06).[110] About one adult in four who received a community service in the year had a carer who was offered an assessment or review.[111] Other research has also shown the relatively low numbers of carers having an assessment, for example finding only 17% of 'new' carers had a carer assessment.[112]

Figure 3.19

Numbers of carers in contact with councils in 2006-07



109 NHS Information Centre for Health and Social Care (2007) *Community care statistics 2006-07: grant funded services for adults, England* pages 9 and 11. Note there may be some double counting in the estimate of 790 carers' organisations in that the same organisation may receive financial support from more than one council.

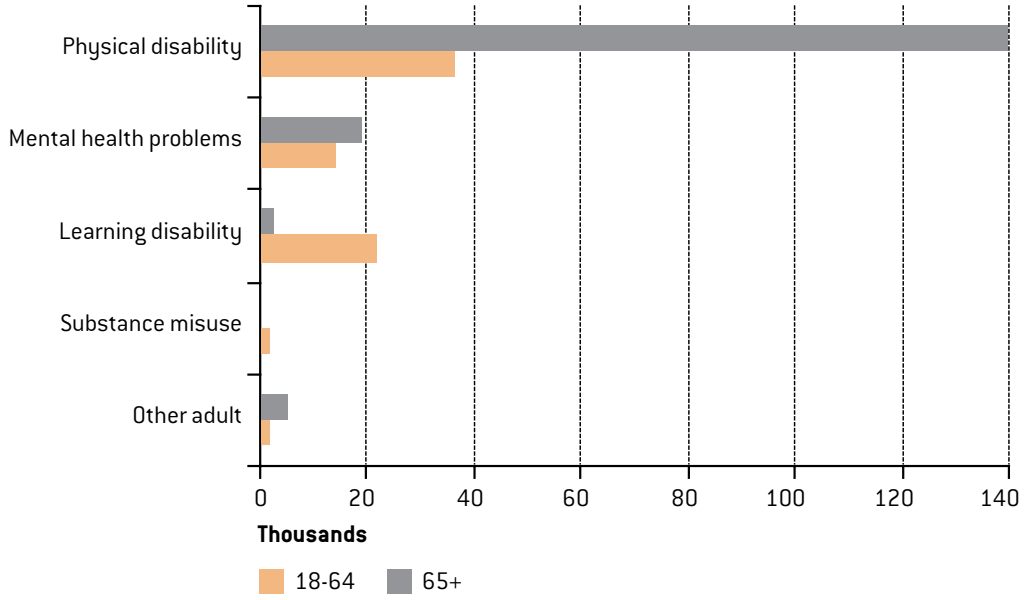
110 A further 3,100 carers under 18 were offered an assessment or review in 2006-07. NHS Information Centre for Health and Social Care (2007) *Community care statistics 2006-07: referrals, assessments and packages of care for adults: England,* Table C1

111 Calculated by relating data from NHS Information Centre for Health and Social Care (2007) *Community care statistics 2006-07: referrals, assessments and packages of care for adults: England,* Table C1 to data from Table P2f. There is little variation in who has a carer – people with a learning disability or substance misuse problem were marginally more likely to have a carer who was offered an assessment or review. There is, however, significant variation between councils in their reporting of support to carers: 32 councils reported they assessed or reviewed (or offered assessments/reviews to) carers of fewer than 15% of all community service recipients in 2006-07. 21 councils supported 40%+ of service recipients in this way. Data were not available for nine councils

112 Yeandle S, et al (2007) *Stages and transitions in the experience of caring,* Leeds: University of Leeds

3.51 Figure 3.20 shows the numbers of those cared for by those carers who were assessed or reviewed in 2006-07.[113] The majority of people assisted by carers were disabled and most were aged 65 or over.

Figure 3.20
Carers assessed or reviewed in 2006-07 by age and client group of the person cared for



3.52 Some 40,000 carers declined assessments or reviews in 2006-07. This is not necessarily a measure of dissatisfaction. It may in fact signal that carers are satisfied that the council will meet the needs of the person they care for and do not consider that they themselves need any further support. Some 660 complaints from carers were reported by councils in 2006-07.[114]

Services for carers

3.53 Carers' services provided or funded by councils are diverse. They include Direct Payments to carers, respite care and other breaks for the carer, carers' support groups, training and other support. In 2006-07, 178,000 carers received a carer's service following assessment or review by council care managers. (This includes some 7,700 carers who received a Direct Payment at March 2007[115]). The numbers increased by 25% from 142,000 in 2005-06.[116]

113 NHS Information Centre for Health and Social Care, *ibid*, Table C1.3

114 CSCI *Self assessment survey 2006-07*. The numbers of complaints from carers for 2007-08 totalled 530 (CSCI *Self assessment survey 2007-08*)

115 The 178,000 figure reflects those instances where CASSR staff determine that the carer rather than the person they care for derives the greater benefit from the service. This understates those instances where the carer benefits from the home care or day care or equipment provided for the person they care for. Direct Payments data are taken from CSCI's *Self assessment survey* data (4.7GN122).

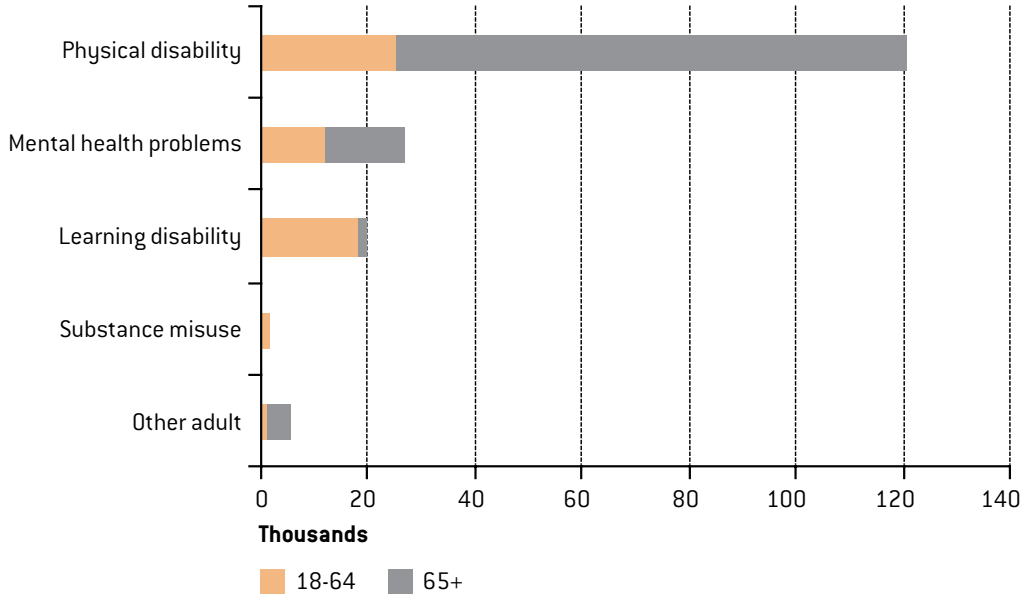
116 This increase may in part reflect more comprehensive reporting by councils, as well as the services developed with the Carers' Grant from the Department of Health.

3.54 About half of all carers assessed or reviewed in 2006-07 received a carer's service – others were provided with information and advice. Figure 3.21 shows the numbers of those cared for by those carers who were assessed or reviewed in 2006-07 where the carer received a carer's service in the year.[117] The majority of those cared for were physically disabled, including eight in 10 of those aged over 65.[118] 18,000 adults aged 18-64 with a learning disability and 12,000 adults with mental health needs had a carer who was assessed or reviewed in the year and received a carer's service. These latter groups were the groups most likely to have carers receiving a service in their own right.

117 NHS Information Centre for Health and Social Care (2007) *Community care statistics 2006-07: referrals, assessments and packages of care for sdults: England,* Table C1.2

118 96,000 of those aged 65 or above were physically disabled: 15,000 had mental health problems and 1,800 had a learning disability. NHS Information Centre for Health and Social Care *ibid,* Table C2.1.

Figure 3.21
Adults who received a carers service in 2006-07 by age and client group of the person cared for



3.55 The number of breaks for carers funded under the special Carers' Grant reported by councils increased by 15% between 2005-06 and 2006-07, to an average of around 20,520 per council. 40% of the breaks were for older people, amounting to 45% of the total cost. 13% of the breaks were for carers from black and minority ethnic groups, but breaks for these groups only involved 6% of the total spend.[119] Councils reported in their 2007-08 self-assessment survey returns that over four million carers' breaks had been funded in the year.

3.56 Some £44 million was committed in grants to voluntary organisations working with carers in 2006-07.[120] Other expenditure by councils to support carers is not available in national datasets.

119 CSCI *Self assessment survey 2006-07* report p19, www.csci.org.uk/professional

120 NHS Information Centre for Health and Social Care (February 2008) *Personal social services expenditure and unit costs, 2006-07* section 5. This will cover services such as helplines, carer support groups and training, deploying volunteers, provision of carers' breaks, etc

Chapter 4

Trends in the care market

Key findings

- The number of care homes and care home places has fallen slightly each year since 2004. At the end of March 2008, there were 18,541 registered care homes, a fall of 168 from the year before (0.9% fall). There were 448,065 care home places; 692 fewer care home places than in the previous year (0.15% fall).
- Within the care home sector, the number of residential homes and places has fallen, whilst the number of nursing homes and places rose slightly between 2004 and 2008. The main growth in nursing homes has been in the private sector.
- Overall though, changes in the capacity of the care market have been relatively small. At the end of March 2008 there were nearly 450,000 places in care homes of all types (compared to 454,463 in 2004).
- Around 83% of care home places were in care homes for older people and 17% in care homes for younger adults under 65.

- From a survey of 657 care homes for older people, over 40% of residents were identified by the homes as having particular needs as a result of dementia; and over 84% of homes in the survey had at least one resident with dementia.
- The number of registered home care agencies has risen each year since 2004 reflecting the trend towards providing care to people in their own homes. There were 4,897 registered home care agencies at the end of March 2008.
- The home care sector continues to be made up of many small home care providers with most having fewer than 100 people using their service. The prevalence of small agencies makes this sector particularly vulnerable at the present time.
- The private sector dominates the home care market with over three-quarters of home care agencies in private ownership.

Introduction

4.1 This chapter on trends in services to adults of all ages is based on the information the Commission holds on regulated services which are used both by people who fund their own care and those who are publicly funded.

4.2 There are some adult social care services that are not registered with the Commission; for example, those that offer supported living arrangements. However, requirements set out in the Care Standards Act 2000 and Health and Social Care (Community Health and Standards) Act 2003 mean that the majority of organisations providing social care to adults are registered with CSCI. This provides a comprehensive dataset of social care services and allows detailed analysis of trends in the sector.

4.3 On 31 March 2008 there were 24,289 care services. These services include care homes, home care agencies, nursing agencies, and Shared Lives (formerly adult placement) schemes, regulated by the Commission.

4.4 During the second half of 2007, and as part of its Inspecting for Better Lives programme to improve the regulation of adult social care, CSCI launched the Annual Quality Assurance Assessment (AQAA). This is a self-assessment survey for completion by all regulated services, providing more detailed information on their staff, people using their services and how their services are run. A sample of AQAAs from approximately 5% of services has been analysed to provide additional information on adult social care services reported in this chapter.

Care homes

Capacity in the care home market

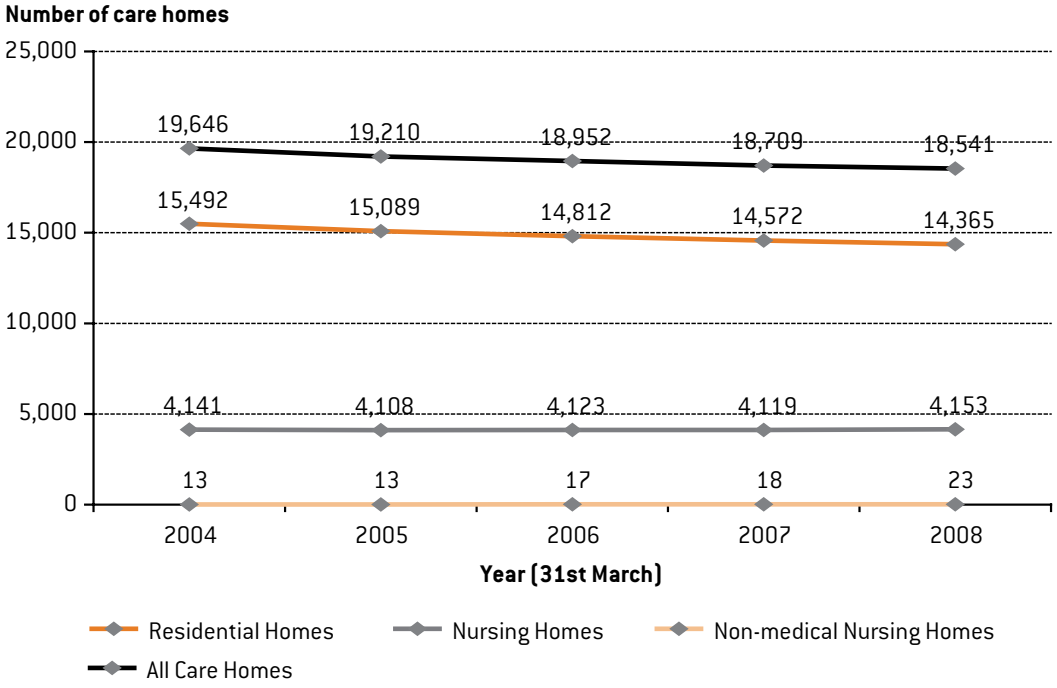
4.5 At the end of March 2008 there were 18,541 care homes[121] registered with the Commission: a fall of 168 since the same point in 2007. There were 692 fewer care home places in these homes between the two dates but, overall, the average size of homes increased.

4.6 Trends in the number of homes and places are illustrated in Figures 4.1 and 4.2 below and show:

- year-on-year falls in the number of residential homes and places
- the number of nursing homes has slightly increased and the number of places has risen each year.

Figure 4.1

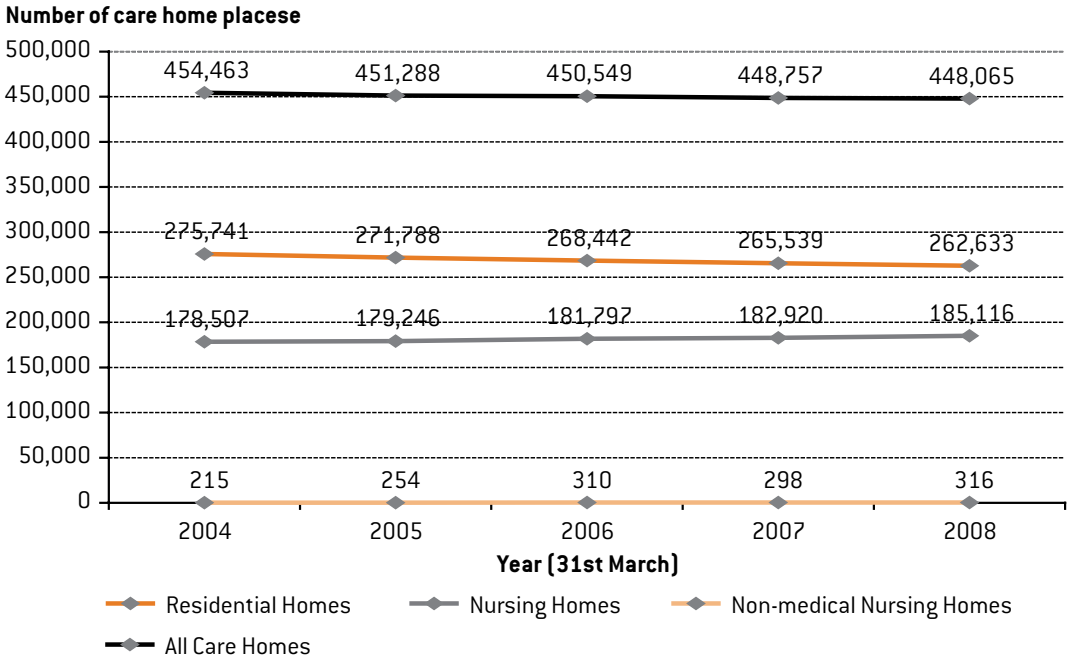
Number of care homes[122]



121 Throughout this section 'care homes' refers to all types of care homes. 'Nursing homes' refers to homes registered to offer nursing care to at least some residents. 'Non-medical' nursing homes are a small number of homes that include those for people who choose to rely upon religious methods of healing, such as Christian Scientists. 'Residential homes' refers to homes registered to provide non-nursing or personal care only to residents

122 Historical figures on the number of care homes and places have been re-stated in this edition of *The state of social care* to take into account improvements in data collection. As a result, there are some minor differences compared to the figures reported in 2006-07

Figure 4.2
Care home places



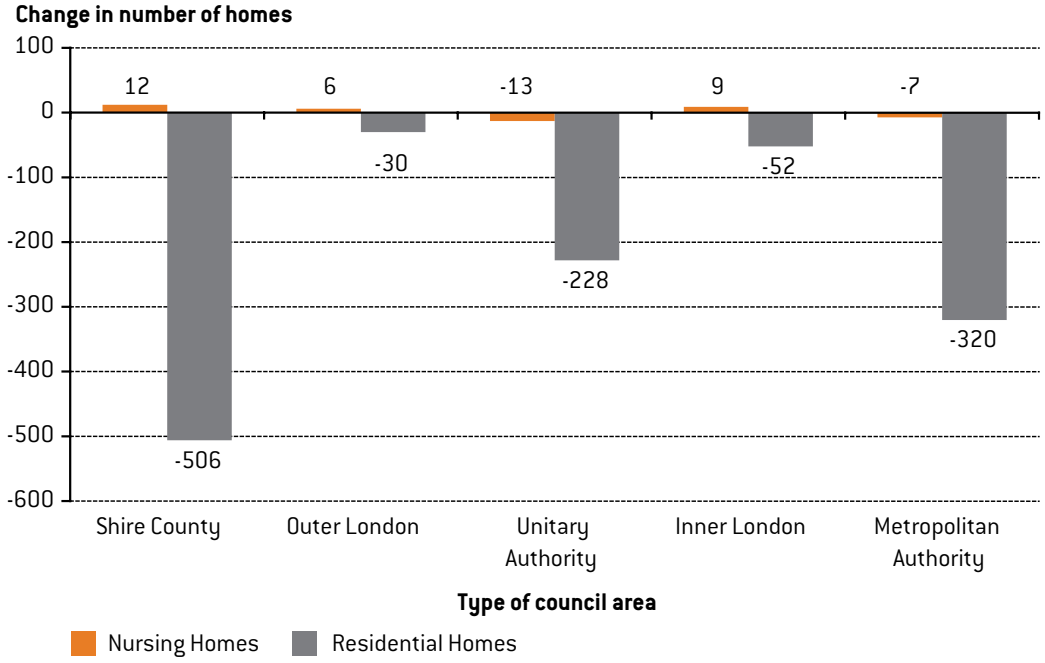
4.7 The fall in the number of places available in residential homes between 2004 and 2008 reflects government policy to support people to live in their own homes. At the same time, the small rise in nursing home places may be influenced by changes in the delivery of medical care. People who would formerly have been cared for in a hospital setting are now more likely to live in nursing homes, while others who may have entered residential care homes are more likely to remain at home supported by home care services. (See homecare trends described later in this chapter.)

4.8 Figure 4.3[123] below, shows the changes in the number of care homes by the type of council between 2004 and 2008.[124] There has been very little change in the number of nursing homes but falls in the number of residential care homes in all types of council.

123 Non-medical care homes have been excluded here due to the small number involved

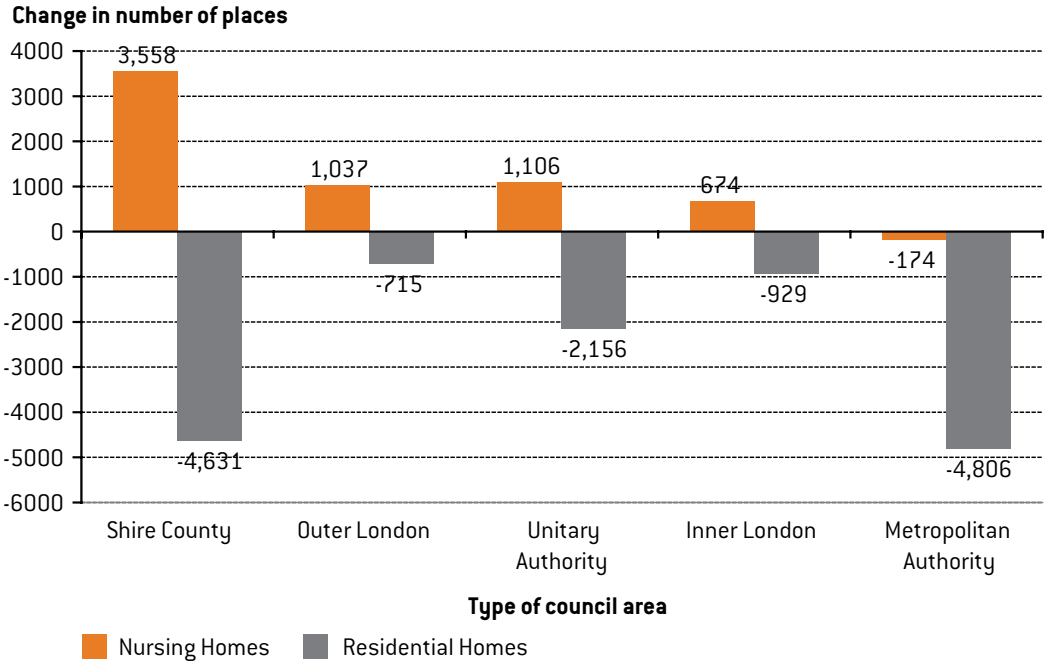
124 The council area of each service is calculated by mapping postcodes to council areas. In some cases, for instance if the service has a brand new postcode, it has not been possible to calculate the relevant council. In this small number of cases the figures have been excluded from the graphs

Figure 4.3
Changes in the number of care homes by type of council (March 31 2004 to March 31 2008)



4.9 Figure 4.4 shows changes in the number of registered places over the same period. In metropolitan council areas alone, there have been falls in the number of places in both residential homes and nursing homes. All other types of council show an increase in nursing places and a decrease in residential places, mirroring the picture for England as a whole.

Figure 4.4
Changes in care home places by type of council (March 31 2004 to March 31 2008)



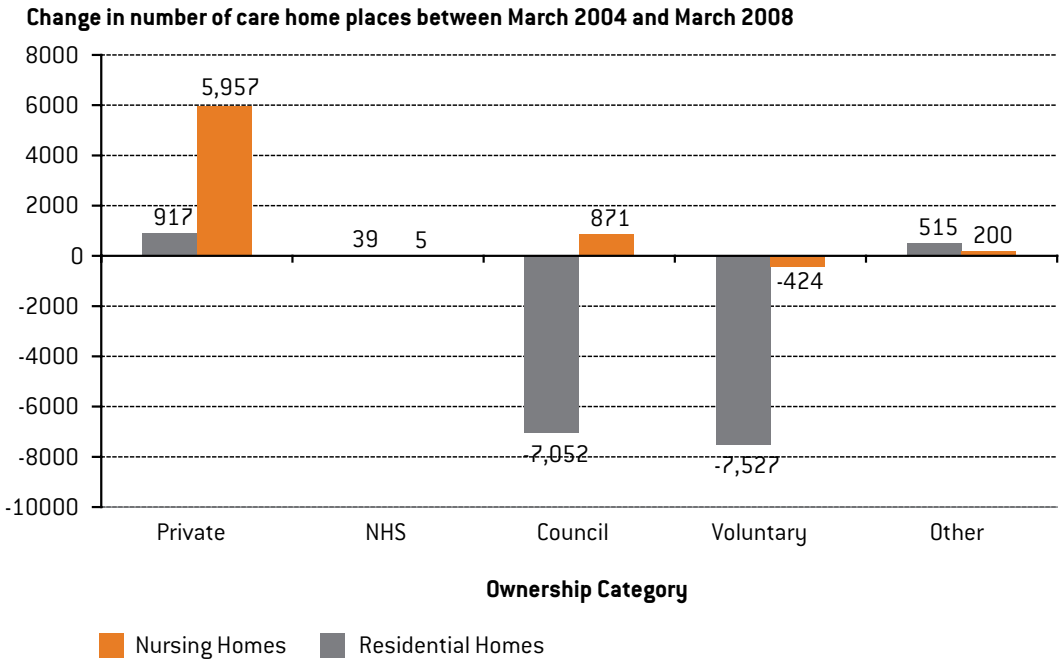
Ownership type

4.10 Care homes are run by councils, the private sector, voluntary organisations, and other groups. Figure 4.5 below shows the change in the number of places between 2004 and 2008 by the type of ownership and the type of care home. There has been an increase in the number of places in privately run homes over the four years in both residential homes and nursing homes. The number of places in both types of home has dropped in the voluntary sector, however. In the case of council-run homes there has been a significant drop in the number of places in residential homes but a rise in the number of places in nursing homes.[125]

There is also evidence of corporate and larger owners becoming more dominant in the market.[126] In April 2007, according to Laing and Buisson, care providers with three or more facilities owned or operated 212,000 of the 411,000 places in independent sector care homes for older people, representing a rise of 3% over the previous year to a 52% share of the market. Similar trends are shown for learning disability services with major providers holding a 52% market share.

Figure 4.5

Change in care home places by ownership type



4.11 The relative changes in the number of places show up clear differences between the types of ownership but it is important to note that there were nearly 450,000 places in care homes at the end of March 2008. Changes in the capacity of the market overall have been relatively small.

125 Councils can run nursing homes by way of a s75 agreement (under the NHS Act 2006) with the primary care trust

126 Philpot T (ed) (2008) *Residential care: a positive future,* Surrey: The Residential Forum

Occupancy rates

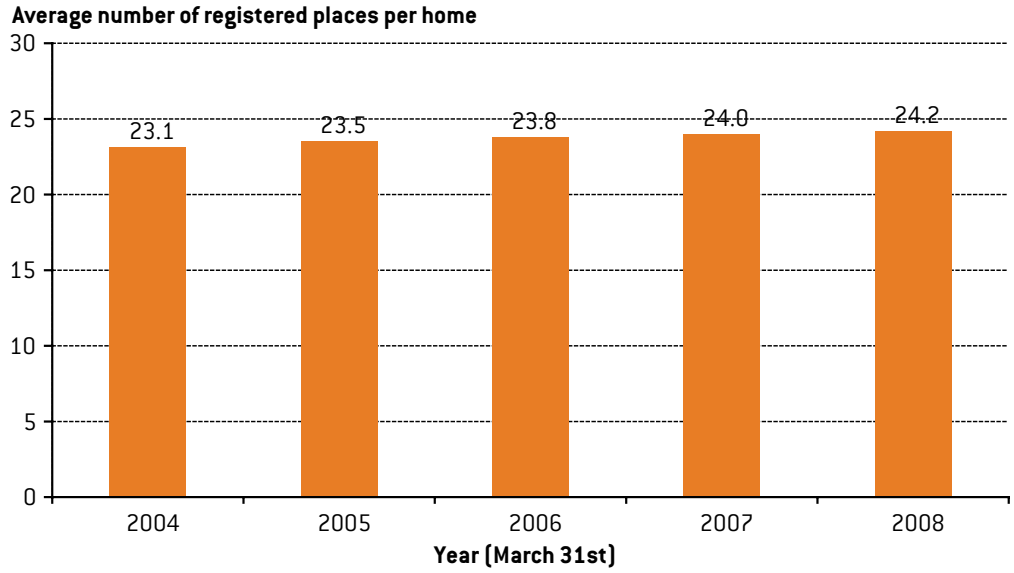
4.12 The sample of AQAA returns[127] shows that, at the time the service completed the questionnaire, 83% of care home places were occupied. The data must be treated with some caution but the indication is that at any one time there are a number of care home places that are not occupied.

Size of care homes

4.13 Figure 4.6 shows the change in the average size of all care homes between 2004 and 2008. The average size of care homes has steadily increased over the period even though the overall number of places has dropped due to the reduction in the number of homes.

Figure 4.6

Average number of registered places per care home

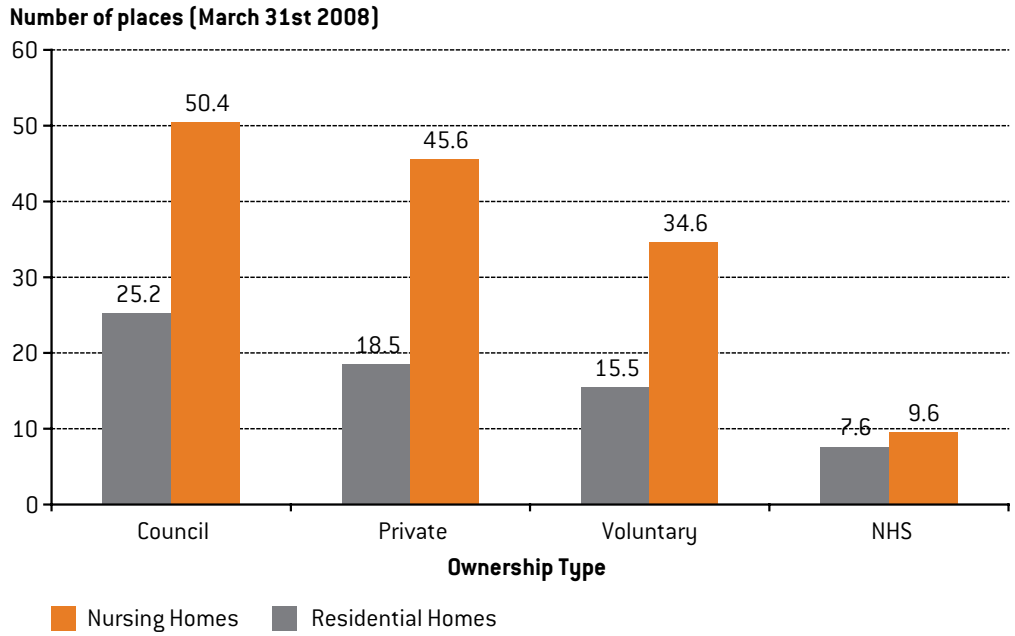


4.14 Care homes in the council and private sectors have the largest number of places, on average, as shown in Figure 4.7. Care homes run by the voluntary sector and the NHS are much smaller. For each ownership type, the average size of residential homes is smaller than for nursing homes.

127 All services regulated by the Commission are required to complete an Annual Quality Assurance Assessment questionnaire. A quota sample (taking into account type of service, quality of service and location) of the returns received relating to inspections between April and September 2007 was used to calculate occupancy rates. Returns where data was unreliable have been excluded from the analysis. In all, 852 returns were used in the calculation of occupancy rates

Figure 4.7

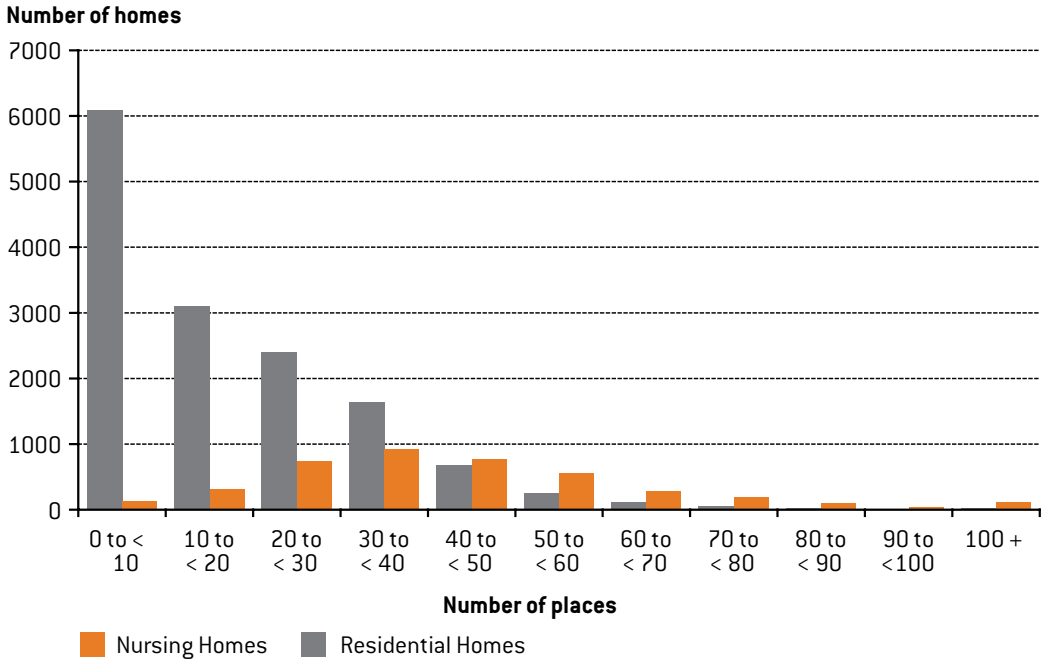
Average number of registered places in care homes by type of care home



4.15 There is a considerable range in the size of care homes and this is illustrated in Figure 4.8. Over 6,000 residential homes have fewer than 10 places. The majority of nursing homes, however, have 30 or more registered places.

Figure 4.8

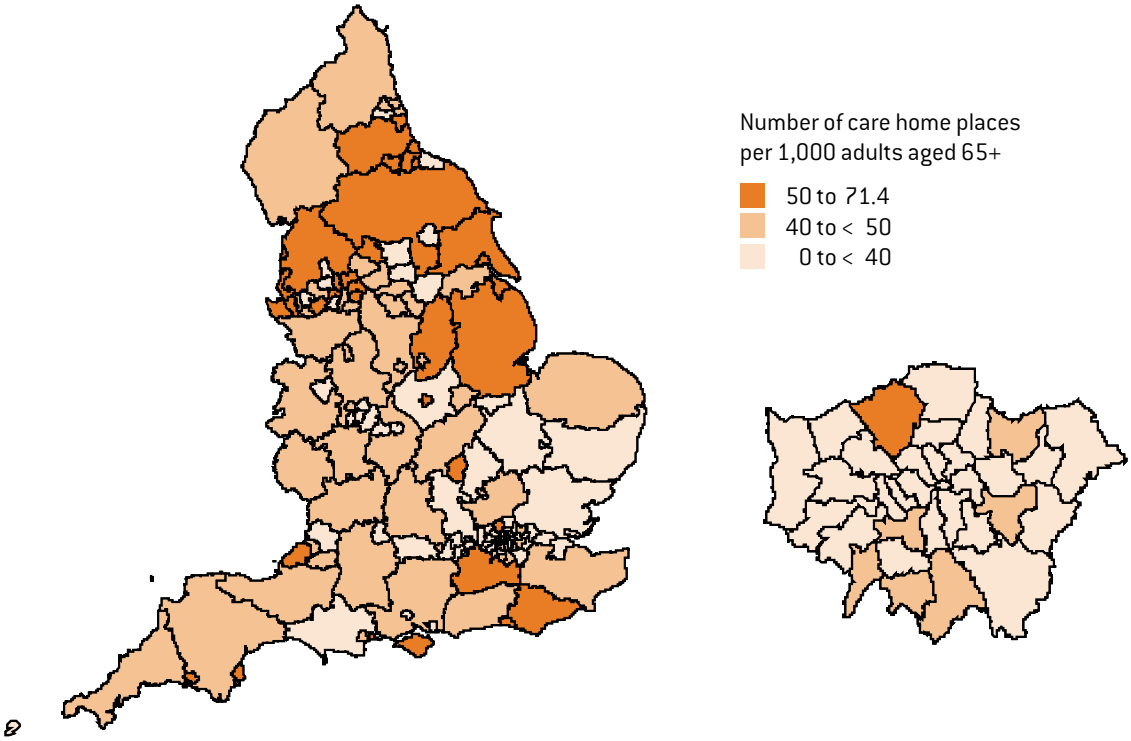
Number of places in care homes



Care homes for older people

4.16 Care homes are classified as homes for younger adults or for older people depending on the set of National Minimum Standards against which they are inspected. The decision about the set of standards used is based on the relative numbers of older people (aged 65 or above) or younger adults (aged 18-64) resident at the time of inspection. There were 10,383 care homes for older people with a total of 361,164 places at 31 March 2008.[128]

Figure 4.9
Care home places for older people per 1,000 adults aged 65 or above



4.17 Figure 4.9 shows the number of care home places for older people per 1,000 people aged 65 or above[129]. In London there are many fewer places available for older people in care homes. In parts of the North of England, there are particularly high numbers of places available relative to the population.

Care homes for younger adults

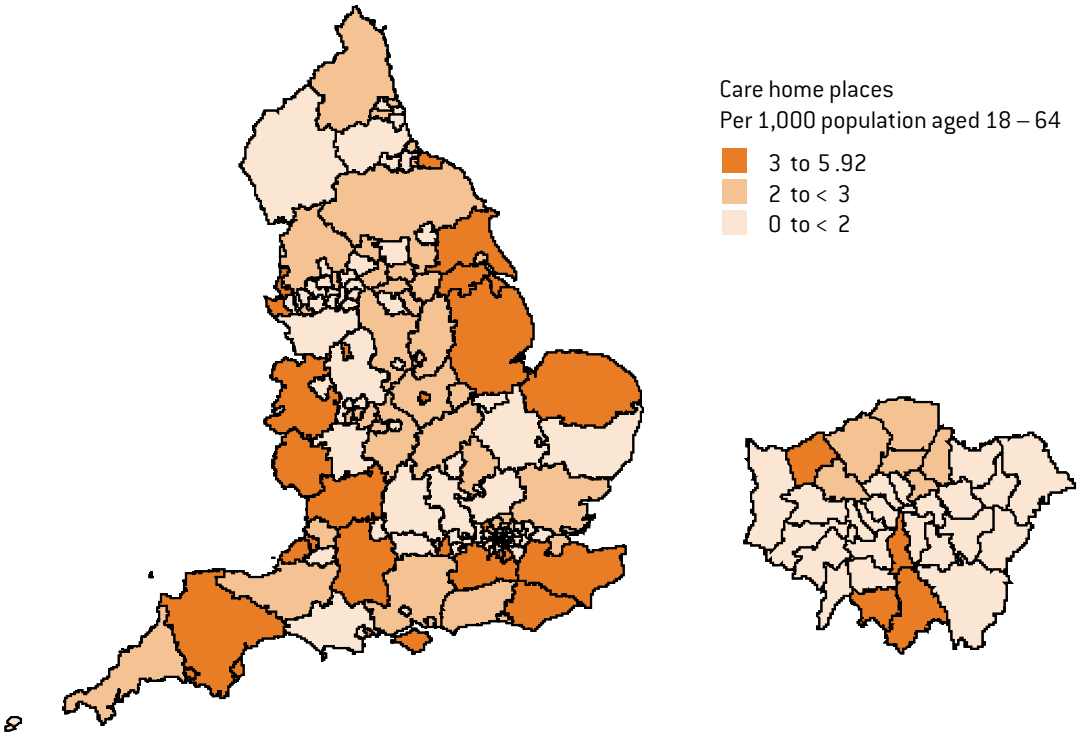
4.18 There were 7,538[130] care homes for younger adults at the end of March 2008, providing 72,472 places. The average number of places in a care home for younger adults is 9.6. This compares with an average number of places of 34.7 in care homes for older people.

128 These figures are an underestimate of the total number of homes and places. New services registered up to six months before 31 March 2008 may not have received their first inspection and so would not have been classified as either a home for older people or for younger adults. As a result, the sum of care homes for younger adults and older people is less than the total count of homes

129 Source for population figures: ONS 2006 mid-year estimates

130 These figures are an underestimate of the total number of homes and places. New services registered up to six months before 31 March 2008 may not have received their first inspection and so would not have been classified as either a home for older people or for younger adults. As a result, the sum of care homes for younger adults and older people is less than the total count of homes

Figure 4.10
Care home places for younger adults per 1,000 population aged 18-64



4.19 Figure 4.10 shows the number of care home places for younger adults per 1000 people aged 18-64[131] by council area. In general, it is the rural and coastal areas that provide more places.

131 Source for population figures: ONS 2006 mid-year estimates

Care home provision for people with specific needs

4.20 A summary of the percentage of older people with specific needs as reported in the AQAA survey[132] is given below in Figure 4.11. A single person may have more than one specific need and so the percentage values do not add up to 100%.

Figure 4.11
Specific needs of people living in care homes for older people

Specific need	Percentage of people living in care homes for older people with this need
Dementia	40.2%
Impaired vision	34.8%
Physical disability	27.7%
Impaired hearing	22.8%
Other mental health needs	10.0%
Learning disabilities	2.3%
Drug dependence	1.0%
Alcohol dependence	0.8%

4.21 Over 40% of people living in care homes for older people have been identified by the homes as having particular needs as a result of dementia and over 84% of homes in the survey had at least one resident with dementia.

Figure 4.12
Specific needs of people living in care homes for younger adults

Specific need	Percentage of people living in care homes for younger adults with this need
Learning disabilities	64.0%
Mental health needs	31.2%
Physical disability	26.3%
Impaired vision	15.7%
Impaired hearing	7.9%
Dementia	3.8%
Drug dependence	2.9%
Alcohol dependence	2.1%

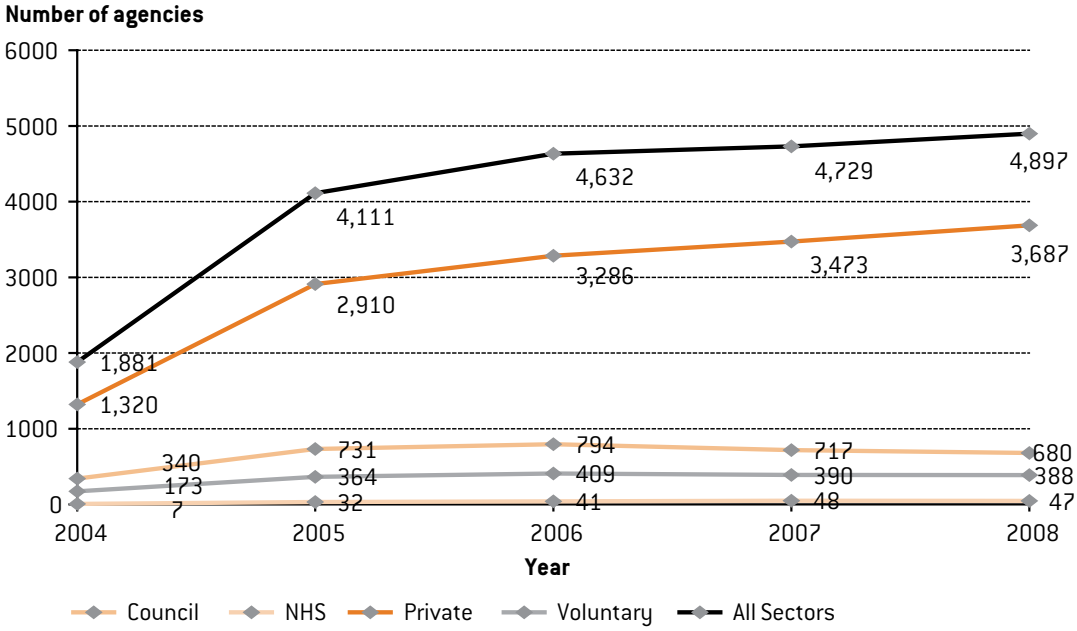
132 In all, 293 returns from care homes for younger adults and 657 returns from care homes for older people were used in the calculation of percentages of people with specific needs

4.22 Most people living in care homes for younger adults have learning disabilities. The proportion of people with mental health needs (not including dementia) in care homes for younger adults is much higher than in care homes for older people.

Home care agencies

4.23 On 31 March 2008 there were 4,897 home care agencies[133] registered with the Commission. The number of home care agencies has increased year on year since 2004 and this change is illustrated in Figure 4.13 below, by each type of ownership. The growth since 2006 has been concentrated within the private sector. Indeed, the number of home care agencies run by councils or the voluntary sector has fallen over this period.

Figure 4.13
Number of home care agencies by type of ownership

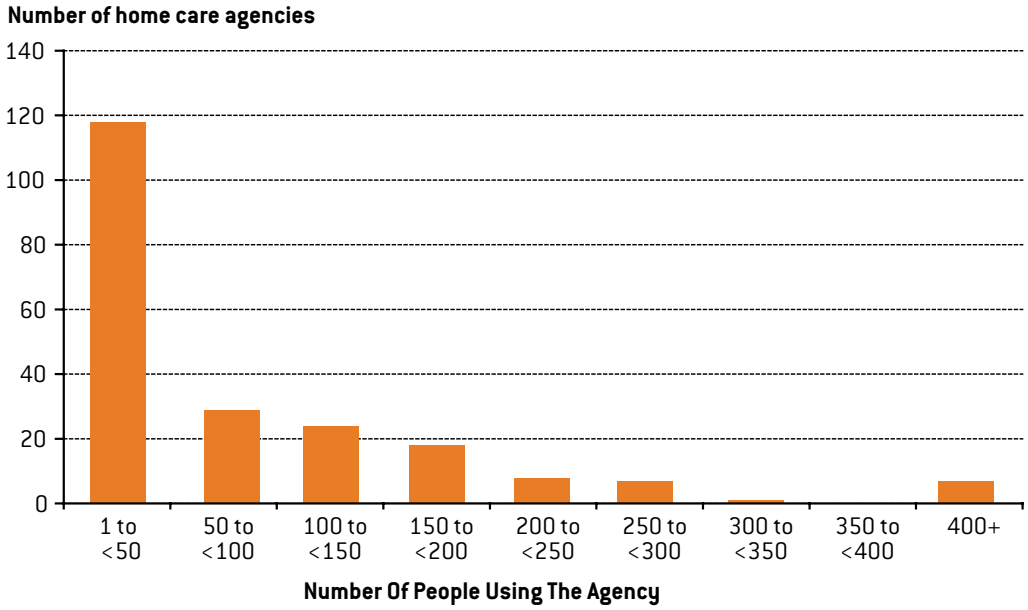


4.24 The AQAA sample of home care agencies[134] provides data on the numbers of people using a service at the point when the questionnaire was completed. This indicates an average of 88 people using each service. However there is a large variation in the actual number of people using each service as illustrated in Figure 4.14. There are fewer than 100 people on the books of most of the home care agencies in the sample but there are a small number that have over 400 people using their service.

133 Home care (or domiciliary care) agencies provide care staff who help people in their own homes with bathing, dressing, preparing meals and other tasks

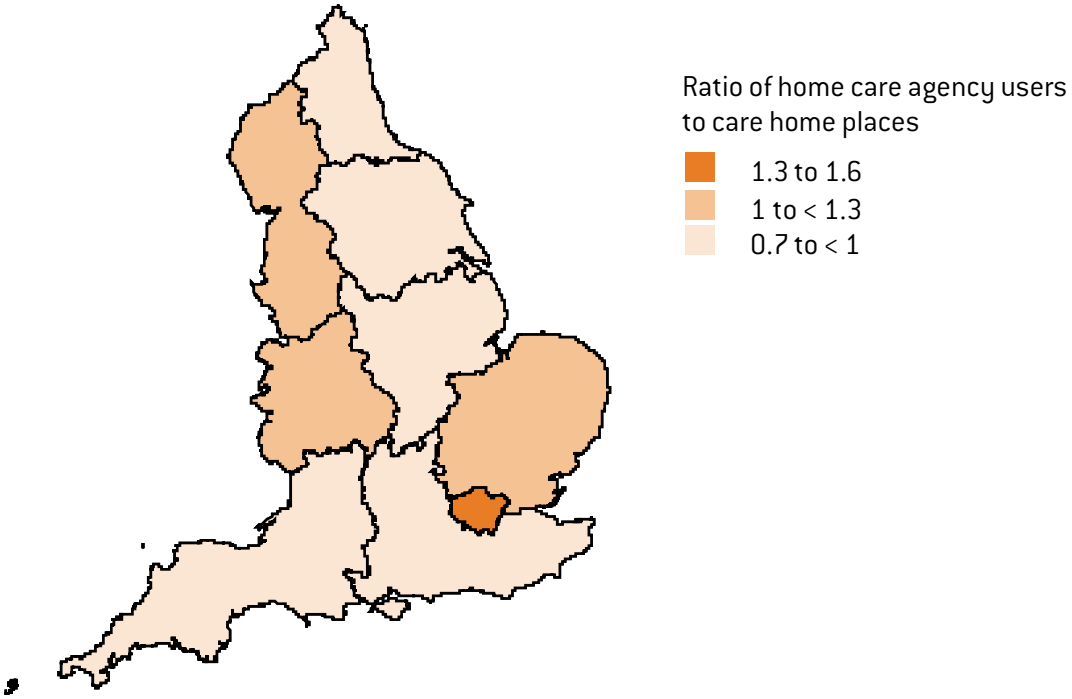
134 In all, 213 valid responses from home care agencies were used in calculating the number of users

Figure 4.14
Size of home care agencies



4.25 An estimate[135] of the number of people using home care agencies in each region (using AQAA data) has been compared with the numbers of people in care homes in those regions. A ratio of the two figures is given in Figure 4.15. For values below one there are more people using care homes than home care agencies and for values above one the reverse is true. The map illustrates the relative size of the home care market in London, which continues to be larger than in other parts of the country. This pattern tends to reflect the availability of resources, rather than need; so where there is a good supply of care homes these will be used rather than home care and where home care services have developed, often due to the high cost of land, these services rather than residential care will be used.

Figure 4.15
Comparison of numbers of people using home care agencies and available places in care homes



4.26 The ownership of home care agencies varies a little from that of care homes and the differences are summarised in Figure 4.16. Compared to care homes, there is a much higher percentage of home care agencies run by councils. At the same time, a smaller percentage of home care agencies are run by the voluntary sector. Over three-quarters of home care agencies are run by the private sector, a little more than for care homes.

135 The number of home care agency users was calculated by multiplying the average number of users (from AQAA data) by the number of home care agencies in each region. The number of care home places was obtained from the register of services. The ratio of the two figures was calculated for Figure 4.15

Figure 4.16
Percentage ownership of home care agencies and care homes

Type of ownership	Home care agencies	Care homes
Private	75.3%	73.6%
Council	13.9%	6.1%
Voluntary	7.9%	18.0%
NHS	1.0%	0.9%
Other	1.9%	1.4%

4.27 Information on the type of people using home care services is available from the AQAA survey[136] and a summary of this is given in Table 4.17.

Figure 4.17
People using home care agencies

People who use home care	Percentage of people using home care agencies
Older people	66.7%
People with physical disabilities	16.8%
People with a learning disability	7.5%
People with mental health problems	7.2%
People with multiple disability	6.3%
People with sensory loss including dual sensory impairment	6.2%
Personal or family carers	2.4%
Children and their families	1.5%

4.28 The results from the AQAA survey suggest that a higher percentage of people in care homes have specific health problems than those using home care agencies.

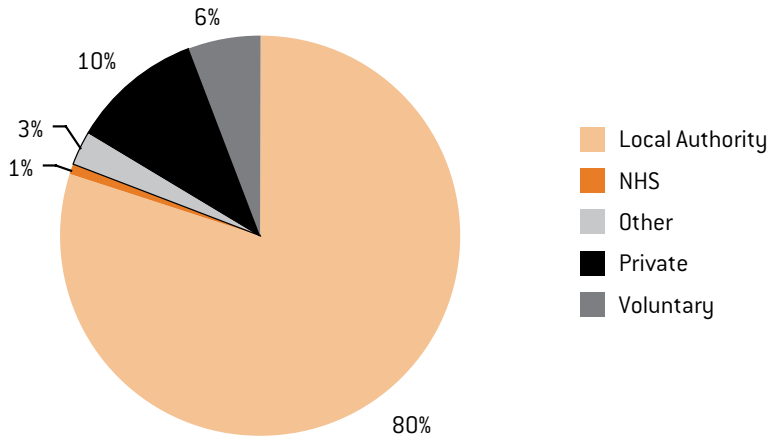
Shared Lives (formerly adult placement) schemes

4.29 Adult placements have recently been termed 'Shared Lives' as they involve the mutual sharing of everyday life experience between the carer and the individual who chooses to use this type of care. These schemes recruit individuals, couples or families who can offer people a family life, on either a short- or a long-term basis, or daytime support in their home or out in the community.

4.30 At the end of March 2008, 135 of these schemes were registered with the Commission. Since April 2006, 12 new Shared Lives schemes have been established. The majority of the schemes are run by local councils.

136 In all, 209 valid responses from home care agencies were used in calculating the figures on specific needs

Figure 4.18
Ownership of Shared Lives schemes

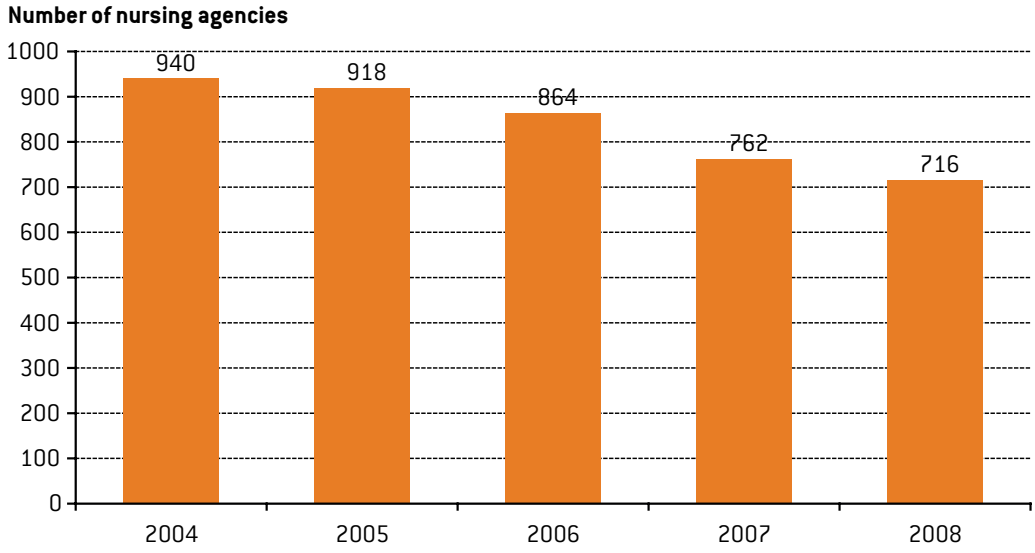


Nursing agencies

4.31 Nursing agencies provide a variety of staff to care homes and hospitals and introduce nurses to individuals purchasing their own care. Commonly, in the social care sector, nursing agencies provide cover for nurse shifts in care homes where there is a shortage of qualified staff.

4.32 The AQAA survey of nursing agencies[137] suggests the average number of nurses working for an agency was 20, although the range in the sample extends from 1 to 149 nurses working for a single agency.

Figure 4.19
Number of nursing agencies



137 The sample of nursing agencies consists of 29 valid returns

4.33 Since 2004 the number of nursing agencies regulated by the Commission has dropped each year, as illustrated in Figure 4.19. It is not clear from the available data whether this trend is matched by a similar fall in the number of people using nursing agencies.

4.34 Geographical analysis of the percentage of services that are nursing agencies has been limited to a high-level split of the type of council. The details are summarised in Figure 4.20 and show London has a higher percentage of nursing agencies than elsewhere.

Figure 4.20
Percentage of all services that are nursing agencies

Type of council	% of all services that are nursing agencies
Inner London	8.0%
Outer London	4.3%
Unitary authority	3.5%
Metropolitan authority	2.7%
Shire county	2.4%

Overview of trends

4.35 The social care market has changed steadily between 2004 and 2008. There has been a modest fall in the number of care homes and in the number of places that they provide and a shift within the care home market towards slightly more nursing homes and places. Over the same period, the number of registered home care agencies has risen, predominantly those run by the private sector. The home care market is potentially vulnerable at the present time as it continues to consist of a large number of small agencies.

Chapter 5

Council performance in meeting the outcomes people want

Key findings

Overall performance of councils

- Councils have improved their overall performance for the sixth consecutive year. In 2008, 27 councils (18%) were judged as delivering 'excellent' outcomes for people who use social care, 104 (69%) were judged as 'good', and 19 (13%) were judged as 'adequate'.

Exercising choice and control

- 32 councils (21%) were judged to be 'excellent' at increasing choice and control for people using social care through, for example, the provision of Direct Payments, good advice and advocacy and a broad range of local services. 35 councils (23%) delivered only 'adequate' outcomes in this area.

Health and emotional wellbeing

- Overall, over four-fifths of councils (87%) are delivering 'good' or 'excellent' health and emotional wellbeing outcomes for people using social care, generally reflecting good working relationships with health partners.

Personal dignity and respect

- 57% of councils are providing 'good' outcomes, compared with 63% last year. 11% are providing 'excellent' outcomes, the same as last year. 46 councils are classed as 'adequate' compared with 35 in 2007; and two councils are classed as 'poor', the only outcome with poor judgements. These figures partly reflect uneven progress in developing effective arrangements to safeguard adults from abuse.

Quality of life

- 35 councils (23%) were judged to be 'excellent' at improving the quality of life for people using social care, supporting people to live in the ways that they choose. A fifth of councils (20%) delivered only 'adequate' outcomes in this area.

Freedom from discrimination

- An 'excellent' judgement includes providing an initial assessment to determine people's needs, whether they fund their support or not. Two-thirds of councils were judged to be delivering 'good' outcomes whilst nearly a fifth of councils were 'adequate'. The CSCI review of eligibility criteria found that some people have their financial means assessed before their needs, contravening current policy.

Making a positive contribution

- Councils performed well in helping people using services to contribute to the wider community, develop their skills and qualifications, and be involved in the development of services, with 55% of councils providing 'good' outcomes and 39% providing 'excellent' outcomes. 6% of councils are 'adequate'.

Economic wellbeing

- Overall, councils performed relatively well in this outcome with 73% of councils providing 'good' outcomes and 21% providing 'excellent' outcomes. Ten councils are 'adequate'.

Introduction

5.1 This chapter presents information about the performance of councils. Performance assessment of councils for 2007-08 relates to the seven outcomes in *Our health, our care, our say,* derived from what people say they want:

- improved quality of life
- personal dignity and respect
- exercise of choice and control
- improved health and emotional wellbeing
- freedom from discrimination and harassment

- economic wellbeing
- making a positive contribution.

5.2 This chapter is based upon information from the judgements about councils. These judgements draw upon evidence from the self-assessment survey that every council completes; targeted service inspections, some of which are carried out jointly with the Healthcare Commission; and national performance indicators. The chapter also provides findings from special CSCI studies (which are not used in the process of making judgements about individual councils).

Summary of overall performance of councils

Council performance

5.3 Social care services for adults, where councils have arranged their care, have improved for the sixth successive year. In 2008, the star ratings improved for 28 councils (19%) and deteriorated for 11 councils (7%), indicating an increase in the rate of improvement to 2007.

5.4 There are currently no councils with zero stars, 19 councils (13%) with one star, 75 (50%) with two stars and 56 (37%) with three stars. This is the third year running when there are no councils with zero stars.

5.5 Fourteen councils improved their performance sufficiently in 2007-08 to be awarded three stars. The vast majority of these councils moved up to three stars because of their ability to deliver good social care outcomes for people and an excellent capacity to improve.

5.6 Overall 27 councils (18%) were judged as delivering 'excellent' outcomes for people who use social care, 104 (69%) were judged as 'good', and 19 (13%) were judged as 'adequate'.

Exercising choice and control

Where councils achieve an excellent judgement for this outcome people who use social care services can expect:

- all contact with social care to be respectful and timely
- accurate and accessible information about services and service standards, which is appropriate to culture, religion, sexuality, gender and age
- help to understand how to complain or comment, and support in doing so if needed
- for any complaint to be handled promptly and courteously, with action taken where appropriate; also to be kept informed throughout this process
- where needed, to be able to access help and support out of hours
- to tell their story only once, and with any planned outcomes clearly recorded in a care plan
- access to any information that is kept about them, and to be told how to do this
- a broad range of services, which offer choice and meet preferences
- access to advocacy service
- support to live where they choose and help to take control of the way in which they access services.

How well are councils increasing the choice and control of people using services?

5.7 Thirty-two councils (21%) were judged to be 'excellent' at increasing choice and control for people using social care, but 35 councils (23%) delivered only 'adequate' outcomes in this area.

Examples of progress

5.8 Councils continue to make increasing use of Direct Payments to enable people – disabled people, older people and carers to design and purchase their own support. The total number of Direct Payments reported by councils in the self-assessment survey has increased over the six-year period since 2002 by a factor of almost 10, from an average per council of 52.5 (national total 7,900) at 30 September 2002 to 490.0 (national total 73,540) at 31 March 2008.

5.9 The profile of people using Direct Payments has also changed, with higher proportions of Direct Payments now going to older people and carers in particular. The numbers of Direct Payments for people with mental health needs has increased by 61% in the past year, but remains the least represented group with just 4.6% of the total number of Direct Payments.

5.10 The use of Direct Payments has been judged a strength in just under two-thirds of councils. Individual Budgets were identified as a strength in 17 councils which arranged for individuals to direct their own support.

5.11 More than a third of councils demonstrated a strength in handling and responding to complaints and making information about complaining easily accessible. Councils who

are judged as being 'excellent' in this area demonstrate lower levels of complaints through proactive management of potential complaints, and take action to improve services and practice as a result of complaints.

5.12 Out-of-hours services were judged to be a strength in 40 councils where there was comprehensive support for people who require urgent help, and improved outcomes for their carers. Emergency duty teams or out-of-hours services were noted as areas for improvements in 11 councils. Councils judged as 'excellent' in this area are more likely to have developed out-of-hours services jointly with health partners and to have involved people who use services to make improvements.

5.13 The proportion of assessments of adults and older people leading to provision of a service increased from an average of 72.6 in 2006-07 to 75.0 in 2007-08.

5.14 The average amount spent by councils on advocacy services for people with learning disabilities has risen steadily from £74,000 in 2003-04 to £122,000 in 2007-08 (a 15% increase on the previous year, and in excess of the planned average of £114,100).

5.15 Advocacy and interpreter services were a strength in 53 councils where support was available to assist people to make personal decisions, life choices and to promote equality and inclusion. Advocacy services were identified as an area for improvement in 27 councils.

Examples of areas for improvement

5.16 People should not have to repeat their story to staff in different services, and although there has been progress in the provision of a single assessment summary, in 2008 less than a half of councils (46%) have a summary available to both professionals and individuals across their area. This compares with 33% in 2007.

5.17 Prompt assessments to ensure that people who use services maintain their independence was identified as a strength in only 12 councils.

5.18 The CSCI review of eligibility criteria[138] found problems for some people seeking support, where their needs and circumstances are insufficiently explored at their first contact with the council. Of survey respondents who did not meet eligibility thresholds, 62% stated that they were not given any information about other help that might be available. In addition, some people complained that their financial means were assessed before their needs.

5.19 Only four councils out of 15 inspected between November 2007 and 2008 were judged to be delivering good personalised care. Even amongst councils judged to be 'good', common areas for development included:

- assessments and care planning were not sufficiently person-centred and holistic
- single assessments were not operating effectively
- carers felt unsupported, lacked information and often did not know where to go for help
- limited advocacy support was available.

138 CSCI (2008) *Cutting the cake fairly: CSCI review of eligibility criteria for social care*

Improved health and emotional wellbeing

Where councils achieve an excellent judgement for this outcome people who use social care services can expect:

- help to understand how to stay healthy and maintain emotional wellbeing
- well developed and consistent joint working arrangements with health partners and other relevant agencies
- stays in hospital (or other units that administer medical care) to reflect medical need in almost all instances
- rehabilitation which prevents the need for further medical and social care intervention.

How well are councils improving the health and wellbeing of people using services?

5.20 Overall, over four-fifths of councils (87%) are delivering 'good' or 'excellent' health and emotional wellbeing outcomes for people using social care.

Examples of progress

5.21 The weekly average number of people whose discharge from acute hospital was delayed has again fallen slightly, from 27.7 in 2006-07 to 26.8 in 2007-08.

5.22 Intermediate care aims to restore people's independence and prevent avoidable admissions to hospital or residential care. The number of people receiving intermediate care at home in 2007-08 increased by over 32,000 compared to 2006-07, to a total of 225,000.

5.23 Joint working arrangements with health and other partner organisations are seen as a strength in one-third of councils but as an area for improvement only in three. In councils judged as 'excellent' or 'good' there is evidence that development of intermediate care services is helping prevent admissions to hospital and maintain low levels of delayed discharges.

5.24 People's needs change and should be regularly reviewed. In 2007-08 the average of the percentages of adult and older people receiving a service in the year who also had a review (or reassessment) has continued to rise, from 71.0% in 2006-07 to 75.6%.

5.25 Eleven councils are shown to have established a fully integrated single assessment process. This helps effective collaboration and planning between agencies to ensure good outcomes for individuals, and prevents unnecessary hospital admissions. Twenty-three councils have areas for improvement concerning the single assessment process.

5.26 The National Evaluation of Partnerships for Older People Projects[139] shows that 99,988 individuals had received, or were receiving, a service within the POPP programme across

139 PSSRU (2008) *National evaluation of Partnerships for Older People Projects: interim report of progress*

470 projects within 29 council-led partnership pilot areas. The results indicate that for every £1 spent on POPP, an average of £0.73 is saved on the per-month cost of emergency hospital bed-days (assuming the cost of a bed-day to be £120.) People using the services see their quality of life as improved. The POPP programme appears to be associated with a wider culture change within their localities, with greater recognition of the importance of including early intervention and preventative services focused toward wellbeing.

Examples of areas for improvement

5.27 The number of people with learning disabilities remaining inappropriately[140] in a hospital environment at 12 April 2008 has reduced over the year, from a total of 923 in 2007 to 220 in 2008. However there are an additional 1,662 adults with learning disabilities remaining in NHS campus accommodation.

5.28 Information about staying healthy and maintaining emotional wellbeing was identified as a strength in just under half of councils and as an area for improvement in only a few. Information targeted at black and minority ethnic communities is only identified in a few councils as a strength.

Personal dignity and respect

Where councils achieve an excellent judgement for maintaining dignity and respect people using social care services can expect:

- **safeguarding against abuse, neglect, embarrassment or poor treatment whilst using services**
- **access to single rooms, if they choose, in care homes or supported living settings**
- **help to form interpersonal relationships and express sexual preferences, in a safe and non-judgemental context.**

How well are councils helping people using services maintain dignity and respect?

5.29 Some 57% of councils are providing good outcomes, compared with 63% last year. Eleven per cent are providing 'excellent' outcomes, the same as last year. However, 46 councils are classed as 'adequate' compared with 35 in 2007; and two councils are classed as 'poor', the only outcome which has 'poor' judgements.

Examples of progress

5.30 The proportion of adult social care staff trained to identify and assess risks to adults whose circumstances make them vulnerable rose by 10 percentage points in 2007-08 to 82%, close to councils' plans. A further increase to 89% is planned for 2008-09. Improvements

140 That is who are medically fit for discharge and no longer in need of continuing hospitalisation

were achieved in all regions, but some individual councils are lagging behind. In 14 councils less than half of relevant staff had had the training.

5.31 The proportion of independent sector staff who had received training, funded or commissioned by councils, has gone up from just under a third (31%) to just under half (46%) in 2007-08. Improvements have been achieved in all regions but there is wide variation between individual councils, with 31 councils having trained less than a quarter of independent sector staff.

5.32 Over a third of councils had training on safeguarding adults noted as a strength. Councils judged as 'excellent' in this area demonstrate investment in training for the independent sector which has raised awareness in safeguarding people. However, nearly one-third of councils need to improve training for the protection and safety of adults.

5.33 More than a quarter of councils demonstrated a strong multi-agency commitment to the continued development of safeguarding adults. Councils who perform well in this area monitor the outcomes from investigations concerning safeguarding through the adult protection committees which influence improvements in the service.

5.34 Procedures for safeguarding adults were judged to be a strength in 44 councils where their policy on safeguarding is widely available to all stakeholders, including regulated providers.

5.35 In 2007-08, 135 councils, compared with 125 the year before, in at least 95% of situations, gave people (adults of all ages) a single room on moving permanently into a residential or nursing home.

Examples of areas for improvement

5.36 A recent CSCI study into the effectiveness of arrangements to safeguard adults from abuse found uneven progress[141]. In almost three-quarters of council inspections unacceptable variability was found in the standard of practice when supporting someone who has experienced abuse in at least two of the following: a clear chronology of events and core information; risk assessment; protection plans; and case recording.

5.37 Councils are beginning to provide options to help prevent abuse for people who direct their own support (under developments such as Individual Budgets) but evidence from the study on safeguarding indicates that no council yet has a systematic approach in place.

5.38 Of the 20 councils inspected between August 2007 and April 2008, four (20%) were judged to be 'poor' on safeguarding delivery, 10 (50%) were judged 'adequate', and six (30%) were judged to be 'good'. No councils were judged to be 'excellent' on safeguarding delivery.

5.39 Monitoring of safeguarding referrals was judged as a strength in only 6 of the 20 councils. The need to improve monitoring and analysis of safeguarding performance was identified as an area for development in 13 councils.

141 CSI (2008) *Safeguarding adults: a study of the effectiveness of arrangements to safeguard adults from abuse*

Quality of life

Where councils achieve an excellent judgement for this outcome people who use social care services can expect:

- **support to live life in the way that they choose**
- **easy access to a choice of services that meet needs and are high quality, reliable and appropriate to culture, religion, sexuality, gender and age**
- **help which prevents the need for more intensive medical and social care intervention in the future support to feel safe and secure in their own homes.**

How well are councils improving the quality of life of people using services?

5.40 Thirty-five councils (23%) were judged to be 'excellent' at improving the quality of life for people using social care (compared with 15% in 2007) but a fifth of councils (20%) delivered only 'adequate' outcomes in this area.

Examples of progress

5.41 The movement to support more people to continue to live in their own homes continues to be complemented by the growth in provision of extra care housing tenancies. The average increase in extra care housing tenancies in 2007-08 was 7.0 per 10,000 population aged 65 or above; this was 26% below the average planned value of 9.5 per 10,000.

5.42 Some councils are improving their ability to meet people's specialist needs – for example through an increase in specialist housing provision and better stimulation of the care market. This has been assessed as a particular strength in 25 councils. Supporting people to remain independent through extra care housing was noted as a strength in 44 councils.

5.43 Councils judged as 'excellent' at improving the quality of life for people who use services demonstrate that they are effective at delivering preventative services including telecare, helping people to remain independent and feel more secure, and reducing the anxieties of families and carers.

5.44 The White Paper, *Our health, our care, our say* set a target for the number of older people supported by the provision of telecare equipment to increase by 160,000 by 2007-08 from the level at 31 March 2006. Telecare is the combination of equipment,[142] monitoring and response that can help individuals to remain independent at home. In the event, there was a total of 149,700 new users recorded in 2006-07 and a further 158,300 in 2007-08. Almost half (44%) of the most recent provision was by councils alone, with a further 26% jointly between the council and other agencies.

5.45 The provision of equipment and adaptations can play an important role in enabling a person to manage in their own home and preventing or postponing the need for more

142 Refers specifically to electronic alarm and monitoring equipment, primarily to enable older people to remain safely in their own homes

intensive packages of care. The speed of delivery of equipment and minor adaptations has continued to show improvement, with all councils now achieving the two highest levels of performance, and 137 councils (91%) achieving the highest level, with 85% of items or more delivered within seven days.

5.46 The rate of adults with physical and sensory disabilities helped to live at home has shown a gradual increase over the past five years, from an average of 4.2 per 1000 population aged 18-64 in 2002-03 to 4.8 in 2007-08; the figure for people with a mental health problem has increased more rapidly over the same period, from an average of 3.5 per 1000 to 4.5 in 2007-08. The number of adults with learning disabilities helped to live at home has increased the most gradually, from an average of 2.6 per council in 2002-03 to just 2.9 in 2007-08 (the same level as in the previous year).

5.47 Support for carers is a high priority as increasing numbers of individuals and families have to find and fund their own care. This was the third year of collection of the performance indicator which gives the number of carers receiving a specific carer's service as a percentage of all clients receiving community-based services,[143] and once again showed a significant improvement in performance.

5.48 Support services for carers were seen as a strength in more than half of all councils, while improvements were needed in around a third of councils.

An example of new housing and support developments

One council is developing 2,400 extra care apartments to be complete by 2011. Features in the schemes include: a focus on offering affordable rented units; 'active ageing' facilities for residents and older people in the wider community; community alarms and telecare services designed in the provision of assisted bathing facilities available for access by the wider community; and provision of consulting rooms for use by healthcare professionals. A single care and support contract is integrating personal care, practical support and a range of supporting people tasks to offer people a seamless service.

Examples of areas for improvement

5.49 For major adaptations, the reduction in waiting time is less marked, but also reducing steadily, having fallen from an average value of 38.3 weeks in 2003-04 to 26.6 weeks in 2007-08 (slightly better than the average planned value of 27.1 weeks). However, this still represents an average waiting time of six months from agreement to the adaptation to start of work.

143 Note that C62 is predicated on the carer having been assessed or reviewed in the year by the council and being given specific carers' services. This excludes carers who are referred (or self-refer) to voluntary organisations supporting carers

Freedom from discrimination and harassment

Where councils achieve an excellent judgement for this outcome people who use social care services can expect:

- clear eligibility criteria for all services which are easy to understand and fair to all
- an initial assessment to determine need, regardless of whether they are eligible for council provision or plan to self-fund
- inclusive support and services regardless of culture, religion or belief, sexual orientation, gender or age
- a team or manager who will take them through from assessment to ensuring, where appropriate, individual need is met.

How well are councils ensuring that people using services are free from discrimination and harassment?

5.50 Councils' performance in this outcome has improved since 2007 with 124 councils now judged as 'excellent' or 'good' in ensuring freedom from discrimination and harassment.

Examples of progress

5.51 The publication of understandable and clearly available eligibility criteria was a strength in 66 councils. Better performing councils are more likely to publish their eligibility criteria in a variety of formats and languages.

5.52 Comprehensive ethnicity recording is a prerequisite for being able to monitor equality of access. This has continued to improve so that in 2007-08, on average, only 2% of assessed adults and adults receiving services did not have their ethnicity stated.

5.53 Nine out of 10 councils had implemented Commission for Race Equality Level 2 Equality Standards (assessment and consultation) and just over two-thirds had implemented Level 3 (setting quality objectives and targets) by March 2008. Only a minority of councils have reached Level 4 and none Level 5.

5.54 Older people from black and minority ethnic communities continue to be slightly more likely to receive an assessment than older people from the general population (average ratio 1.2).

5.55 Once assessed, older people from black and minority ethnic groups are as likely to receive a service as other older people in 24 councils (16%), more likely in 63 councils (42%) and less likely in 63 councils (43%).

5.56 On average, the proportion of clients with learning disabilities who are from black and minority ethnic groups continue to reflect the proportion of black and ethnic minorities in the adult population (ratio 1.0). However, the England average masks wide variations between councils: only about a quarter of councils (40) had a ratio within the expected range of 0.9-1.1; 39 % (58) reported a lower ratio than this and 35% (52) reported a higher ratio.

5.57 Nearly 40% of councils have run pilot schemes around self-assessment.

Examples of areas for improvement

5.58 Three councils have set their eligibility threshold for care-managed services at critical while 105 have their threshold set at substantial. One council is expected to lower the threshold in 2008-09 from moderate to low.

5.59 The CSCI review of eligibility criteria found that of survey respondents, almost one in five carers and one in eight of those who said they could benefit from social care reported that they had failed to have an assessment of their needs. One-third of these respondents understood this was because they did not meet financial eligibility criteria for help – suggesting they were asked about their financial resources prior to any needs assessment, which contravenes current policy.[144]

Making a positive contribution

Where councils achieve an excellent judgement for this outcome people who use social care services can expect:

- **support to say what they truly think and to contribute to the workings of the wider community**
- **support to develop abilities, skills and qualifications**
- **to be actively involved in the development and review of services and be able to see the impact of this involvement**
- **people in the community to be encouraged to volunteer in groups across social care and welfare services, with effective use made of these people locally.**

How well are councils helping people using services to make a positive contribution?

5.60 Councils continue to perform relatively well in this outcome with 39% of councils providing 'excellent' outcomes and 55% providing 'good' outcomes. Nearly one-third of councils are judged as delivering better outcomes for people who use services than in 2007, while seven councils are judged as having poorer performance since 2007.

Examples of progress

5.61 Around one-third of councils are engaging people who use services well. Councils that are judged as 'excellent' are more likely to ensure that people who use services and their carers are involved in many types of activity, including the production of guidance, consultations, tendering processes and training staff.

5.62 Over half of councils are good at promoting volunteering through initiatives such as volunteering events and forums to promote support such as befriending, assisted shopping, transport, and lunch clubs, among other activities.

144 CSCI (2008) *Cutting the cake fairly: CSCI review of eligibility criteria for social care*

Economic wellbeing

Where councils achieve an excellent judgement for this outcome people who use social care services can expect:

- well developed and consistent joint working arrangements for continuing care
- advice and guidance to help increase income and employment opportunities
- support to avoid financial difficulties
- support for carers to continue in employment or to return to work where they choose to do so
- preventative help which reduces the amount they may pay for care over time.

How well are councils helping people using services to achieve economic wellbeing?

5.63 Overall, councils performed relatively well in this outcome with 73% of councils providing 'good' outcomes and 21% providing 'excellent' outcomes. Ten councils are 'adequate'.

Examples of progress

5.64 On average 43 learning disabled people per council were helped into paid work[145] in the year, representing an average of 2.4 people with learning difficulties per 10,000 population aged 18-64. Eighteen councils achieved more than twice this rate and 50 councils less than half. Performance is lowest in the Eastern region, and highest in London and East Midlands.

5.65 Help for carers to continue in employment, or to return to work, was an area for improvement in 17% of councils and a strength in 23%. Councils who perform well in this area are more likely to ensure that carers' assessments address education, training and employment support and provide care services such as day, respite and home care services that fit in with carers' work patterns.

5.66 On average 53 learning disabled people per council were helped into voluntary work in the year. This was an increase of 7% over last year, though below the planned 10% increase.

Examples of areas for improvement

5.67 Early intervention and prevention services were noted as a strength in only 12 out of 150 councils.

145 It is important to note that this does not indicate the nature of the work and that according to the Office for Disability Issues Factsheet nearly 6 in 10 disabled people report that they possess higher personal skills than those required in their job

Leadership and management

To achieve an excellent judgement for leadership councils need to:

- have highly competent, ambitious and determined leadership skills of senior officers and elected members that champion the needs of people who need social care
- undertake comprehensive and coherent strategic planning
- have sufficient people, skills and capability at all levels, because of long-term systematic planning
- monitor and implement professional and occupational standards irrespective of whether the services are in-house or commissioned by the council
- have effective performance management, quality assurance and scrutiny arrangements
- demonstrate performance improvement is linked to management action.

Performance of councils

5.68 More than a third of councils (68) were judged as having 'excellent' leadership, with seven councils (5%) being judged as having uncertain capacity.

5.69 The great majority of councils have partnership agreements in mental health (81%), learning disabilities (85%) and integrated equipment services (94%). Just over half of councils (53%) have agreements for older people with mental health needs and delayed transfers of care. Councils with adult social services responsibilities are the predominant leads for learning

disabilities and equipment services, and NHS agencies for mental health. The lead on delayed transfers of care is more equally shared.

5.70 Fewer councils experienced recruitment and retention difficulties for particular groups and services. In particular there have been improvements in occupational therapy services. However, there remain difficulties in recruiting and retaining mental health social workers (31% of councils), social workers for other groups of people using services (20% of councils) and home carers for older people (22% of councils).

5.71 The relative spend of the National Training Strategy Grant on council and independent sector staff was 62% compared to 38%, similar to previous year but with a small rise in spend of this grant on independent sector staff.

5.72 Fifty councils (33%) are set to deliver the full Skills for Care's National Minimum Dataset for Social Care (NMDS-SC) by March 2009, and a further 75 (50%) will deliver a partial dataset by that date. Work has started in 10 of the remaining councils.

5.73 Strong and effective leadership teams were regarded as a strength in more than one-third of councils. 'Excellent' councils also demonstrate solid support from elected members, providing the platform for clear direction, good value for money, and people who are highly satisfied with services. Leadership was identified as an area for improvement in 10 councils to achieve service modernisation and personalisation.

5.74 Strategic plans with effective links to the local area agreement were highlighted as a strength in 24 councils. There were examples of targets for self-directed support and personalisation in some local area agreements. Only two councils had strategic planning noted as an area for improvement.

5.75 A workforce development strategy that demonstrated workforce engagement with service development and investment in training in all sectors was regarded as a strength in 17 councils. Councils performing well in this area have wide availability of practice-based learning, training in partnership with the independent sector and adult protection training.

5.76 Strong leadership underpinned by effective performance management was noted as a strength in well over a third of councils. 'Excellent' performing councils also demonstrate good reporting links with other strategic partners and a learning culture based on sound performance data.

Chapter 6

The quality of care services

Key Findings

- **Quality ratings for care services** are based on a wider range of evidence than simply their scores in relation to National Minimum Standards, including the views of people using the service. In May 2008, when quality ratings were first published, more than two-thirds (69%) of all services were rated as 'good' or 'excellent'.
- 80% of voluntary run services were rated as 'good' or 'excellent' compared to 79% of council-run services and 66% of privately run services.
- There are marked differences in terms of quality ratings between care homes for younger adults and those for older people. 76% of homes for younger adults were rated 'good' or 'excellent' compared with 67% of homes for older people.
- Shared Lives (formerly adult placement) schemes have the highest proportion of services rated either 'good' or 'excellent' (86%). Almost three-quarters (73%) of home care agencies and nursing agencies (73%) are rated 'good' or 'excellent'.

- **The performance of care services against the National Minimum Standards** has risen for the sixth consecutive year. Whilst the rate of improvement has slowed, more standards are being exceeded and fewer are failing with major shortfalls than last year. Common areas of improvement concern the handling of complaints, protection, information and quality assurance.
- Care homes have been regulated for longer than other types of service and show the largest improvement in meeting standards. On average, homes are now meeting just under a quarter more (23%) standards than they did in 2003.
- The average percentage of standards met by care homes for:
  - older people: 82%
  - younger adults: 85%
- Nursing agencies were the best performing service type in 2008 (87% of standards were met or exceeded).
- Shared Lives schemes have made the greatest improvement in the last 12 months (8% more standards met than in 2007) with 84% of standards met or exceeded in 2008.
- Services run by voluntary organisations still meet more standards on average than private and council-run services but council services are closing this gap. Privately run services are improving at a slightly slower rate than voluntary and council-run services.

Introduction

6.1 This chapter examines the quality of regulated care services by looking at quality ratings and performance against the National Minimum Standards (NMS). The NMS focus more on inputs and processes than on outcomes for people so CSCI has been concerned to make more rounded assessments and has introduced quality ratings that draw on more information than the NMS scores.

6.2 Quality ratings were first made available to the public in May 2008. They aim to provide a simple and clear indication of how services are performing. Services are classified as:

- 3 stars excellent service
- 2 stars good service
- 1 star adequate service
- 0 stars poor service

6.3 The Commission bases its quality rating judgement on the following range of evidence:

- interviews with staff and the people who are using the service
- information given to CSCI by the care service

- surveys filled in by people using the service, their relatives and other professionals involved in their care
- a key inspection by CSCI inspectors (the service does not usually know when inspectors are coming to visit)
- information CSCI holds about the history of the service.

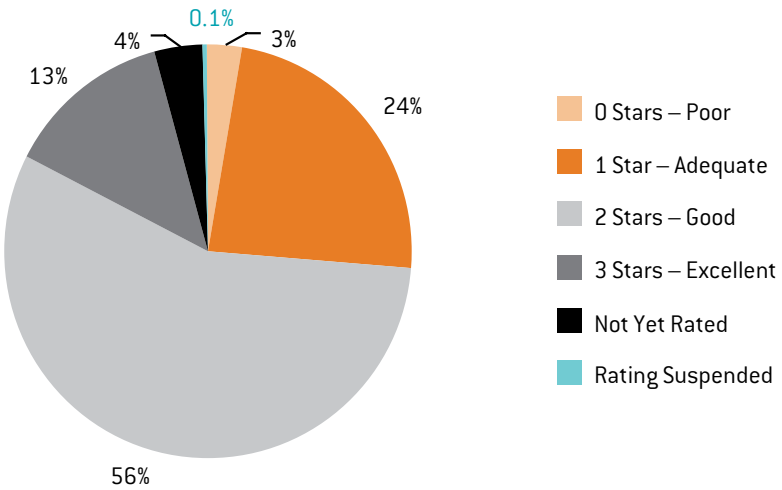
6.4 CSCI established enforcement teams in 2007-08 to help improve services. 1,205 requirement notices and 493 statutory notices were issued over the year on poorly performing services.

6.5 The Commission inspects all regulated care services against NMS. Each type of care service has its own set of standards, representing a level of good practice below which no service is expected to operate. For each standard, services receive a score of 1,2,3 or 4. The definition of these scores is:

- 1 – Not meeting standard with major shortfalls
- 2 – Not meeting standard with minor shortfalls
- 3 – Meeting standard
- 4 – Exceeding standard

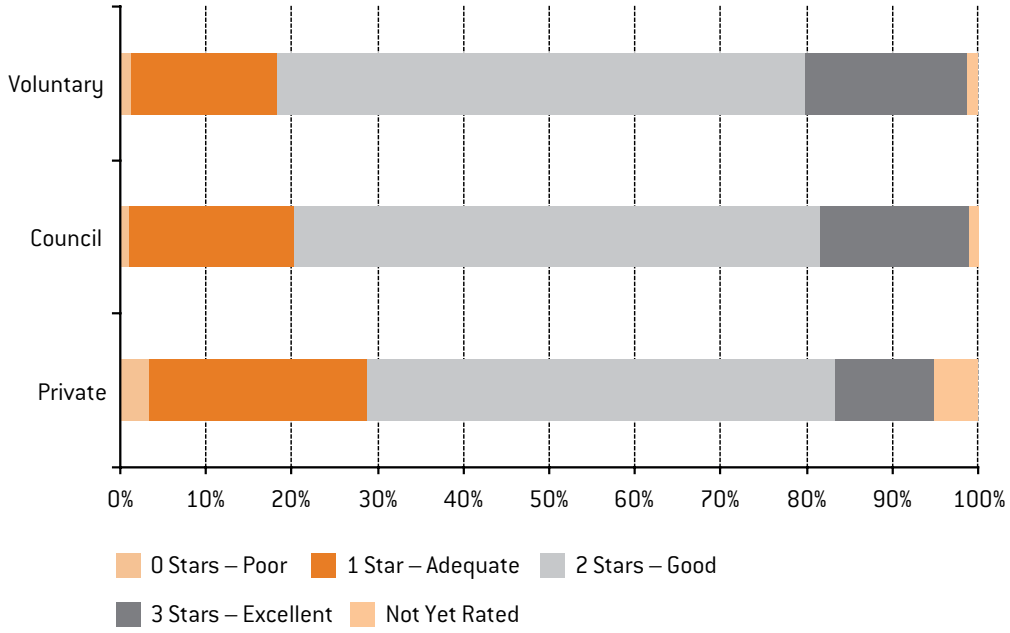
Quality ratings of regulated services

Figure 6.1
Distribution of quality ratings in May 2008



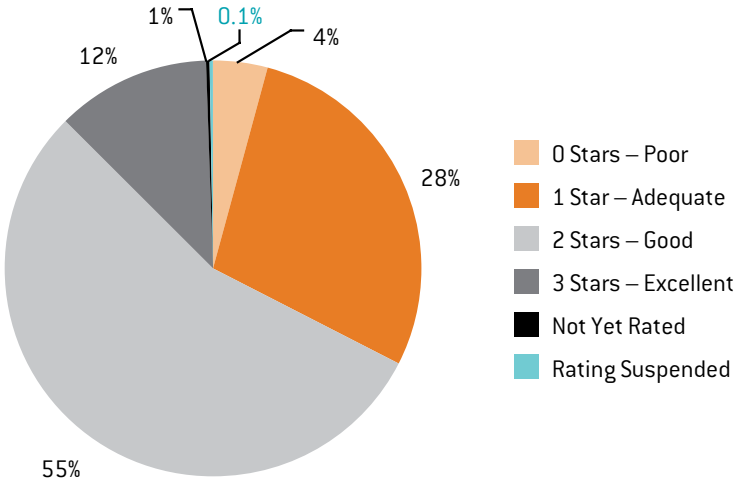
6.6 When quality ratings were first published, more than two-thirds (69%) of all services were rated as 'good' or 'excellent' (see Figure 6.1). Where a service is new and has not yet received its first key inspection, it is described as 'not yet rated'. ' Rating suspended' refers to services that are subject to enforcement proceedings. In May 2008 there were 34 services (0.1%) in this bracket.

Figure 6.2
Distribution of quality ratings by ownership type



6.7 80% of voluntary run services are rated as 'good' or 'excellent'. Council-run services have a slightly smaller proportion (79%) and private services perform least well with 66% being rated 'good' or 'excellent' (see Figure 6.2).[146]

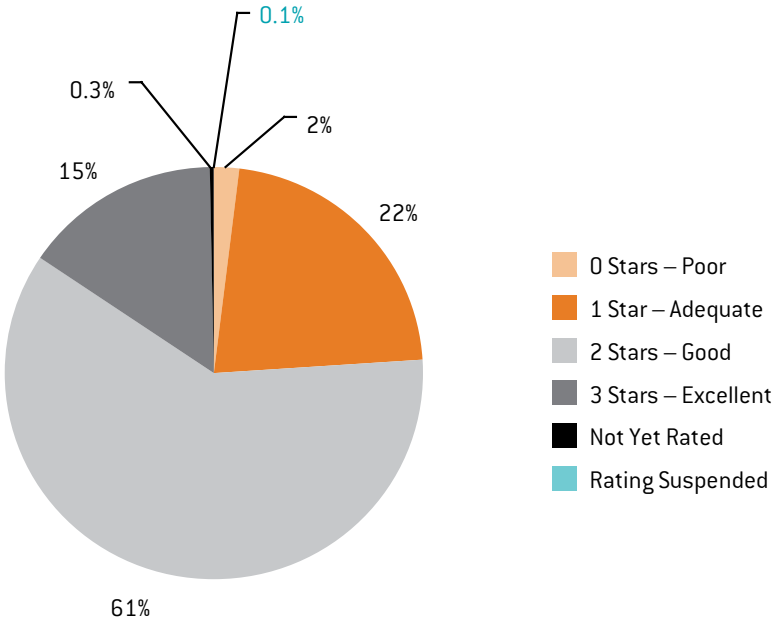
Figure 6.3
Quality ratings of care homes for older people



6.8 As at May 2008, more than two-thirds (67%) of care homes for older people were rated as 'good' or 'excellent' (see Figure 6.3). Over a quarter (28%) were rated as 'adequate' and 4% as 'poor'.

146 Due to the relatively small number of services run by the NHS and organisations denoted as 'other', these have not been included in this chart

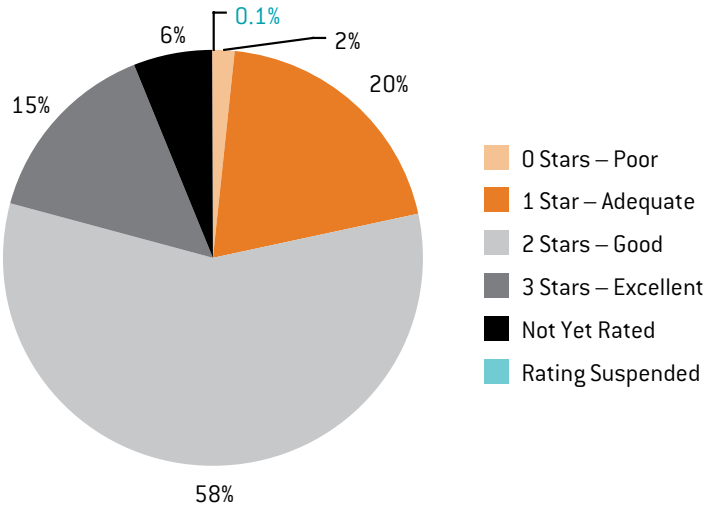
Figure 6.4
Quality ratings of care homes for younger adults



6.9 There are marked differences in terms of quality ratings between care homes for younger adults (see Figure 6.4) and those for older people. 76% of homes for younger adults are rated 'good' or 'excellent' compared with 67% of homes for older people.

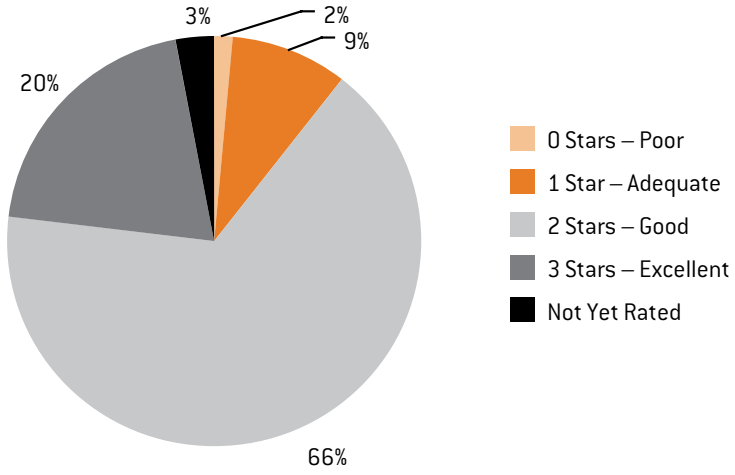
6.10 There are also differences in the proportion rated as 'poor'. Of care homes for younger adults, 2% have this rating compared with 4% of homes for older people.

Figure 6.5
Quality ratings of home care agencies



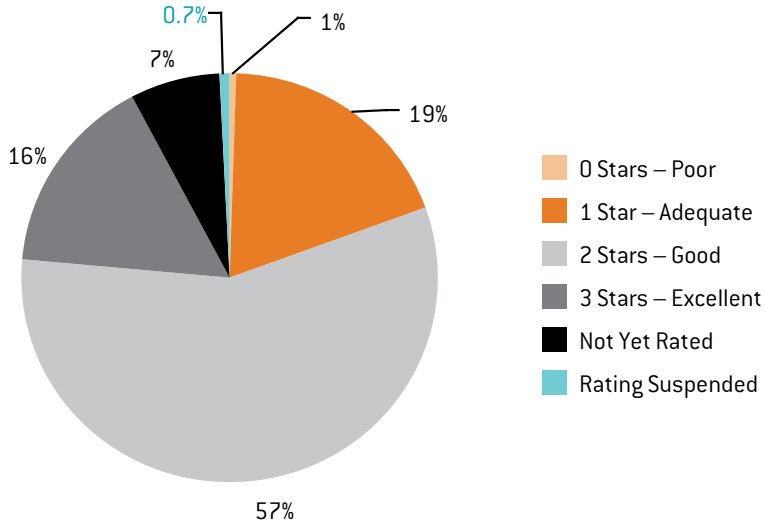
6.11 As at May 2008, almost three-quarters (73%) of home care agencies were rated as 'good' or 'excellent' (see Figure 6.5).

Figure 6.6
Quality ratings of Shared Lives schemes



6.12 Shared Lives schemes have the largest proportion of services rated 'good' or 'excellent' (86%), as shown in Figure 6.6, when compared with other service types.

Figure 6.7
Quality ratings of nursing agencies

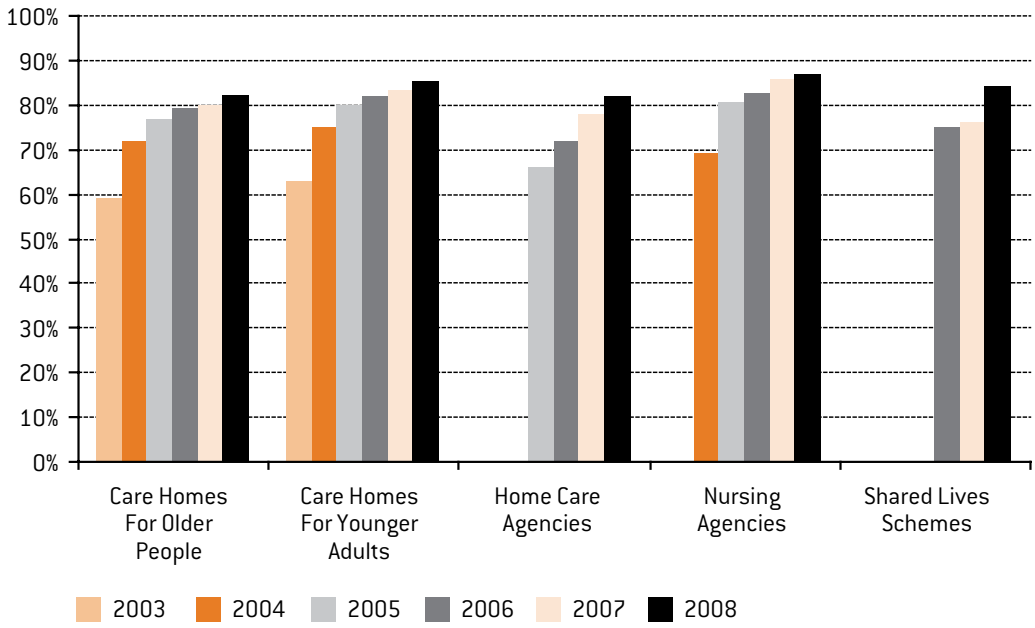


6.13 Just under three-quarters (73%) of nursing agencies are rated 'good' or 'excellent' (see Figure 6.7). Nursing agencies have the smallest proportion of services rated 'poor' (1%) of all the regulated service types.

Performance against the National Minimum Standards

Figure 6.8

Average percentage of NMS met/exceeded by type of service for each year

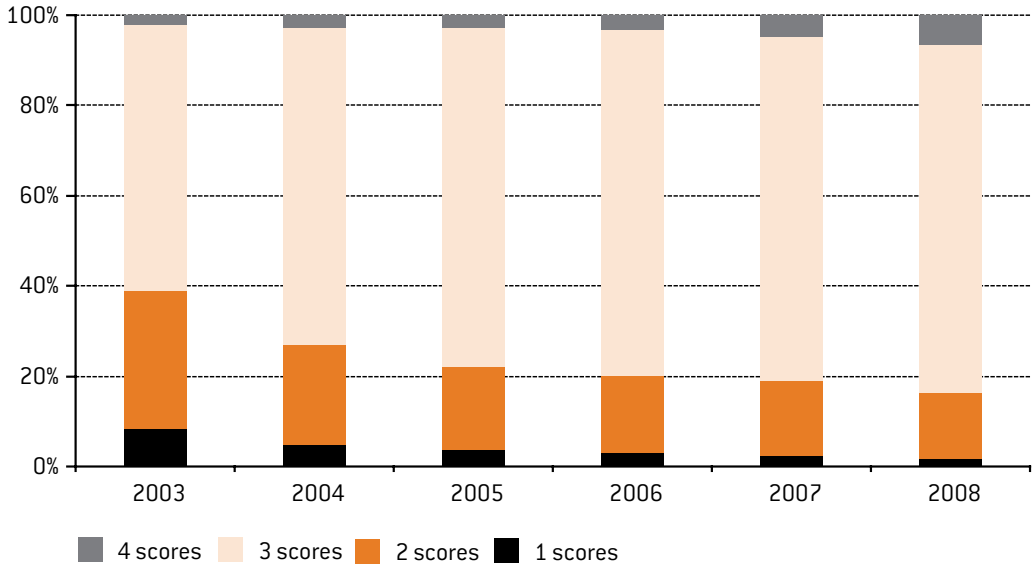


6.14 Performance against the National Minimum Standards has improved for the sixth consecutive year for all service types (see Figure 6.8).

6.15 As reported in *The state of social care in England 2006-07*, the rate of improvement has slowed since 2005 for most types of service. However, more standards are being exceeded in 2008 and fewer are being failed with major shortfalls. The proportion of standards being exceeded by services (achieving a score 4) has increased from 2% in 2003 to 7% in 2008 (See Figure 6.9). Standards not being met with major shortfalls (score 1) has reduced by the same approximate proportion from 8% in 2003 to 2% in 2008.

Figure 6.9

Distribution of NMS scores by year



6.16 Care homes for older people have made the greatest improvement since 2003, meeting almost a quarter (23%) more standards in 2008. Care homes for younger adults have made a similar improvement, meeting 22% more standards in 2008 than in 2003.

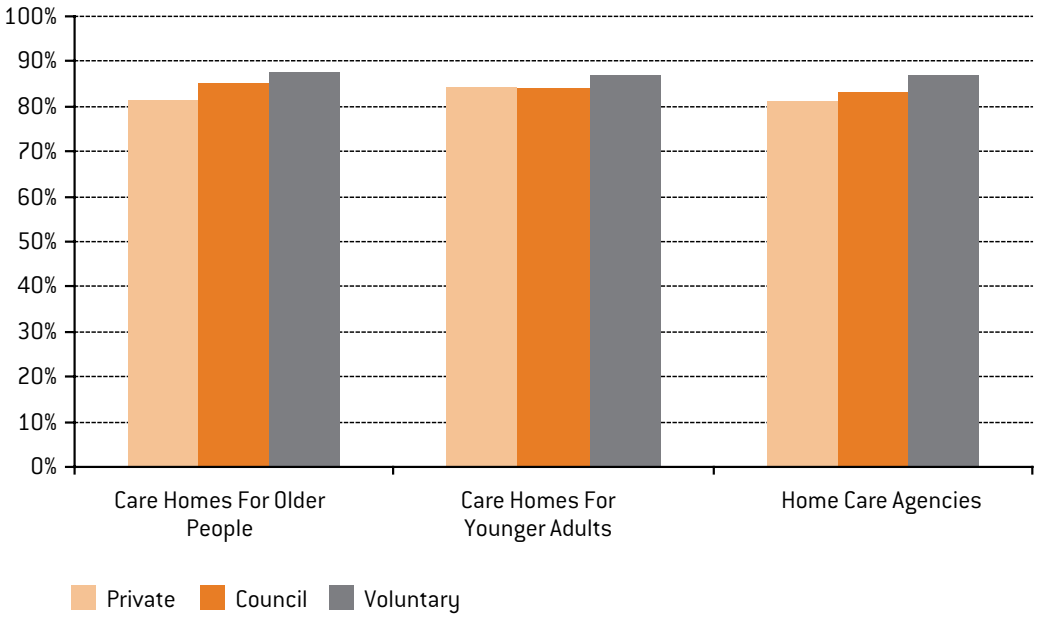
6.17 CSCI began regulating nursing agencies a year later than care homes. The improvement for these services is smaller than for care homes though still considerable with just under a fifth (18%) more standards now being met by nursing agencies. On average, nursing agencies meet the highest proportion of standards of all regulated care services (87%).

6.18 CSCI began inspecting home care agencies in 2005. Agencies are now meeting 16% more standards than in 2005.

6.19 Though only subject to inspection against NMS for three years, Shared Lives (formerly adult placement) schemes meet an average of 9% more standards in 2008 than in 2006.

Figure 6.10

Average percentage of NMS met by ownership type[147]



6.20 Services run by voluntary organisations continue to perform better in relation to National Minimum Standards than services run by different types of organisation (see Figure 6.10). The gap between voluntary run care homes and those run by private organisations has increased by 1% in the last 12 months.

6.21 The gap in performance between council and voluntary run services has been closing since 2005. For instance, in 2005 home care agencies run by voluntary organisations met 12% more of the standards than council-run agencies. This difference for care homes was 6%. In 2008 the difference between voluntary and council-run services dropped to 3% for care homes and 4% for home care agencies.

147 As the majority of Shared Lives schemes are run by councils and most nursing agencies are privately run, these are not included in Figure 6.10 as a comparison would not be meaningful

6.22 The difference in performance between voluntary and private care homes for younger adults remained fairly static at around 2% between 2005 and 2007 but this has increased to 3% in 2008. For care homes for older people, this difference is slightly greater at around 7% and this has also remained relatively unchanged in the last four years. The difference in performance between voluntary and private home care agencies has decreased from 10% in 2005 to 6% in 2008.

Care homes for older people

6.23 Care homes for older people[148] have been inspected against the NMS since April 2002. The first set of scores against the NMS were compiled in 2003. Since then, these services have shown significant improvement rising from an average of 59% of standards met in 2003 to 82% in 2008.

6.24 Figure 6.11 shows the rate of improvement in the percentage of homes meeting each of the standards. Performance against the information standard has improved the most, with 54% more homes meeting this standard in 2008 than in 2003.

6.25 Over one-third (37%) more homes are meeting the protection standard in 2008 than did so in 2003. This standard has also seen one of the largest improvements in the past year, rising by 5% to 83% in March 2008. A recent thematic inspection highlights where more needs to be done to improve the arrangements for safeguarding adults.[149] The thematic inspection showed that inadequate staff training, written documentation – such as safeguarding policies and procedures – and recruitment processes were the most common shortfalls. There were also a large number of recommendations about information to people on their rights to be safe and how to report any concerns.

6.26 Almost a third (31%) more homes are meeting the standard for recruitment in 2008 than did so in 2003. Performance against this standard has improved by 7% since 2007, a year after a special report was published that examined recruitment practices.[150]

6.27 Performance relating to NMS on medication handling has increased by 22% since 2003 and by 7% since 2007, following on from a report focused on this topic.[151] A third of homes are still not meeting these requirements in 2008.

6.28 Care homes for older people perform least well in relation to standards relating to care plans (62%). However, good care plans, that are drawn up with the person and that focus on their abilities and what they aspire to, are crucial to personalised care. Nevertheless there has been an improvement of just over a quarter (28% more homes) since 2003 meeting the relevant NMS.

148 Care homes are classified as homes for younger adults or for older people depending on the set of National Minimum Standards against which they are inspected. The decision about the set of standards used is based on the relative numbers of older people (aged 65 or above) or younger adults (aged 18-64) resident at the time of inspection

149 CSCI (2008) *Safeguarding adults: a study of the effectiveness of arrangements to safeguard adults from abuse*

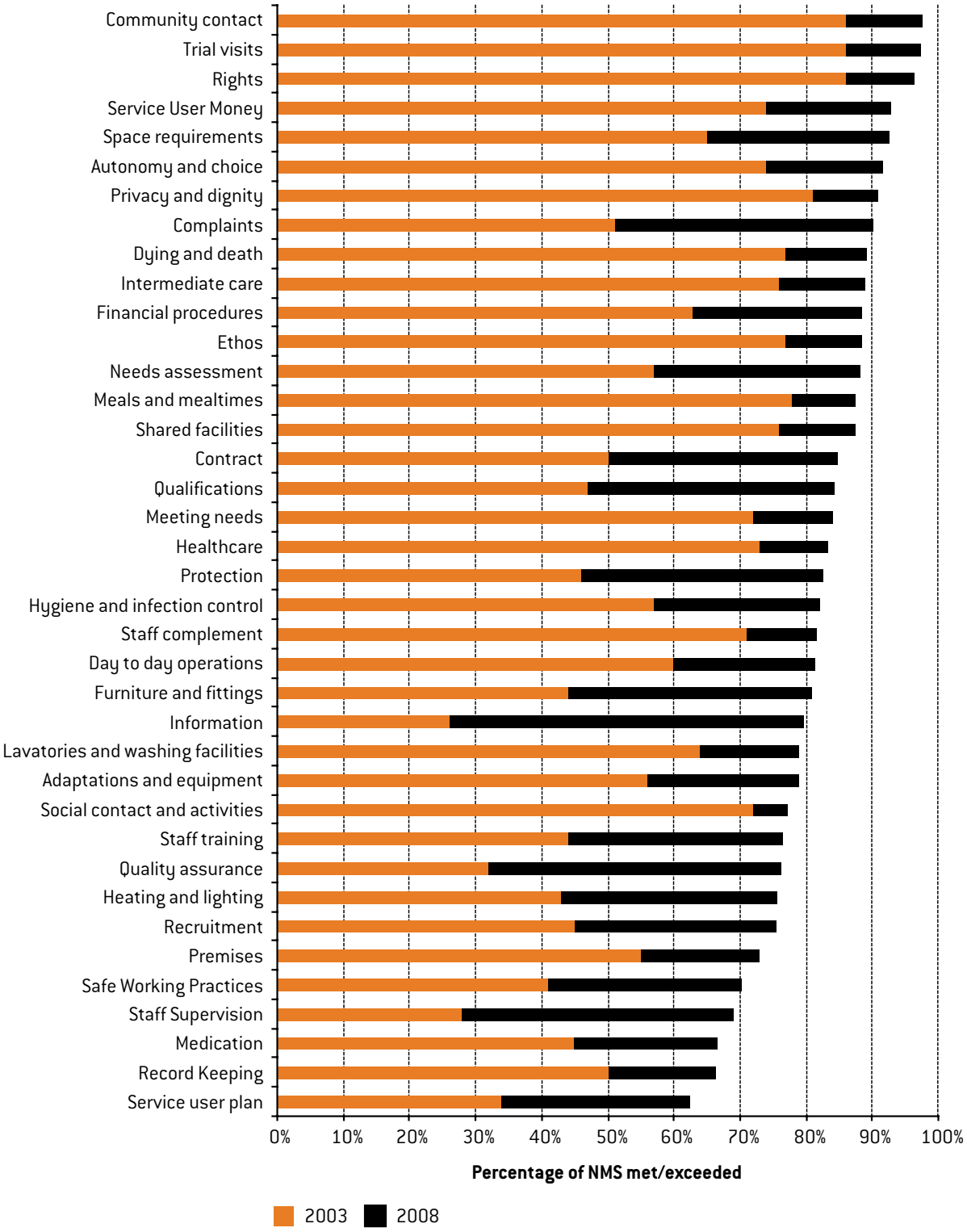
150 CSCI (2006) *Safe and sound*

151 CSCI (2006) *Handled with care?*

6.29 Performance against the record-keeping standard has dropped by 1% since 2007 and has only risen by 16% since 2003. Over a third (34%) of homes are still not meeting this standard in 2008.

Figure 6.11

Improvement in percentage of standards met by care homes for older people since the introduction of NMS



Care homes for younger adults

6.30 The average percentage of standards met by care homes for younger adults has risen by over a fifth from 63%, when regulation began in 2003, to 85% in 2008.

6.31 Figure 6.12 shows how many more homes are now meeting the individual standards than did so five years ago. As is the case for care homes for older people, the standard against which homes have shown the greatest improvement is information. 61% more homes meet this standard in 2008 than in 2003.

6.32 The proportion of homes meeting the concerns and complaints standard has risen by 42% since 2003. 90% of homes are now meeting this standard.

6.33 More than a quarter (27%) more homes are meeting the requirements of the medication standard than did so in 2003. Care homes for younger adults perform better in relation to this standard (73% meeting) than care homes for older people (67%). However, this is still one of the least often met standards.

6.34 Since March 2007, care homes for younger adults have made the largest improvements in standards relating to safe working practices (73%), recruitment (79%) and quality assurance (76%). Performance in these areas has improved by around 7% in the last 12 months.

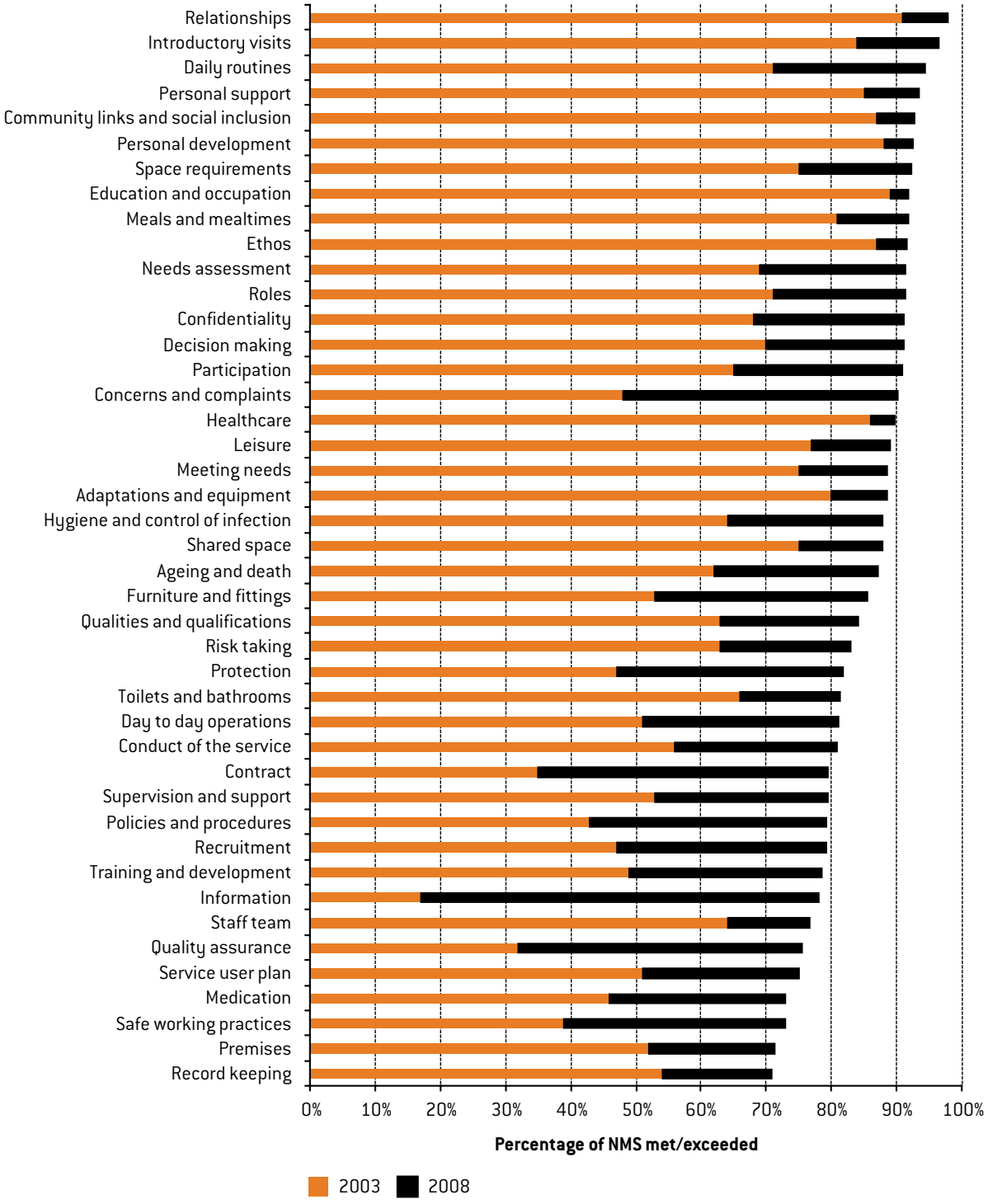
6.35 Care homes for younger adults perform least well in the areas of record keeping (71%), premises (71%), safe working practices (73%) and medication (73%).

6.36 Best performance for care homes for younger adults is in relation to relationships (98%), introductory visits (96%), daily routines (94%), personal support (93%), community links and social inclusion (93%) and personal development (93%).

6.37 Over a third (35%) more services are meeting the protection standard in 2008 than in 2003. 82% of care homes for younger adults are meeting this standard in 2008.

Figure 6.12

Improvement in the percentage of standards met by care homes for younger adults since the introduction of NMS



Home care agencies

6.38 CSCI began inspecting home care agencies against NMS in April 2004. In each of the first two years of inspection, the average percentage of standards met increased by 6%. Between March 2007 and March 2008, this slowed slightly to an increase of 4%, with agencies meeting on average 82% of standards.

6.39 The standards against which agencies have made the greatest improvement since inspection began are information (33% more agencies now meeting the standard), protection of the person (28% increase), supervision (26% increase) and recruitment and selection (25% increase). Figure 6.13 shows the percentage increase of home care agencies meeting each standard in March 2008 compared with March 2005.

6.40 Performance against the protection of the person standard (83%) improved by 11% for the first two years of inspection and by 6% between 2007 and 2008. More than a quarter (28%) more agencies are meeting this standard in 2008 than did in 2005.

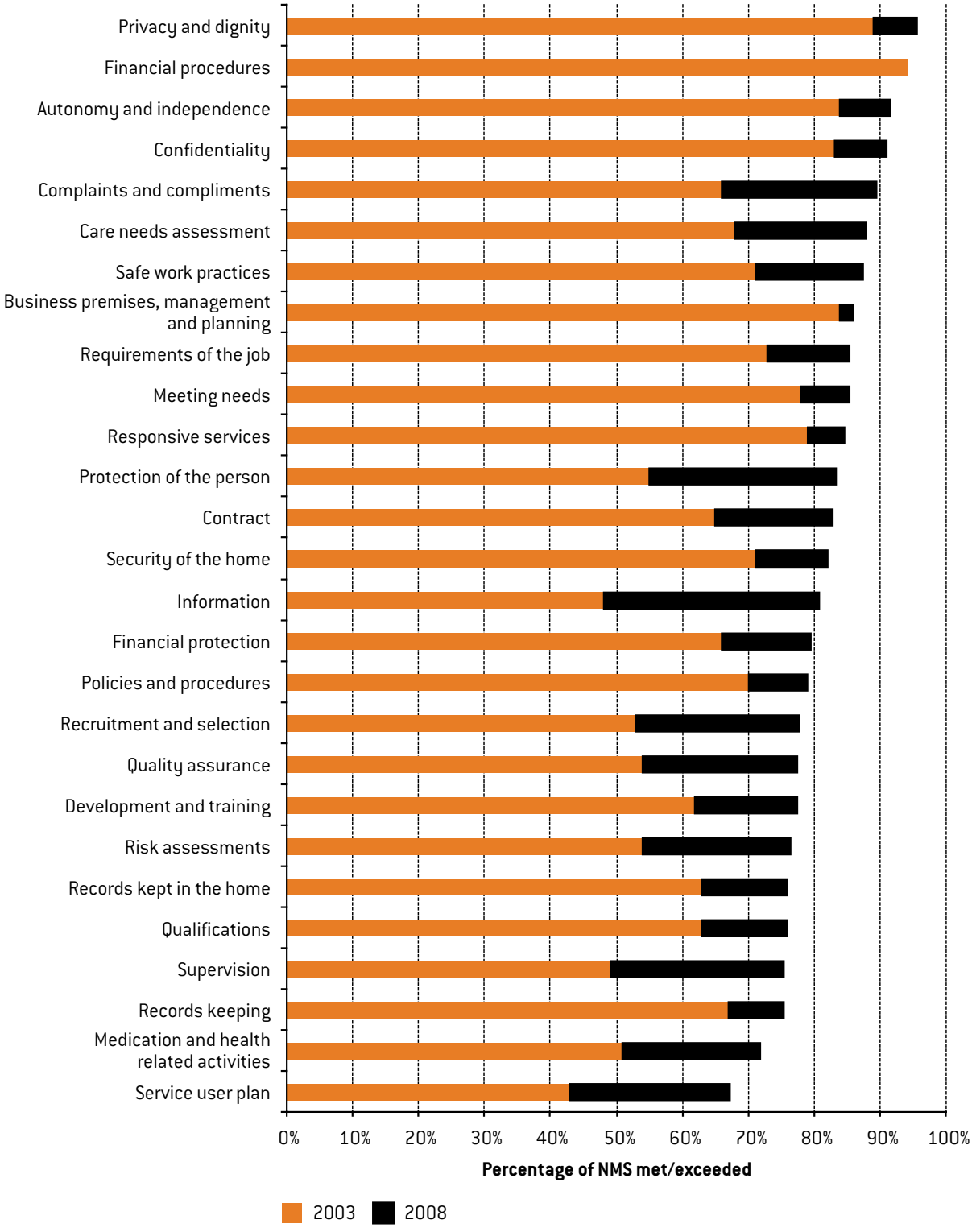
6.41 In October 2006, CSCI published a report[152] examining the performance of home care in England and identifying areas for improvement. These included the need to improve practices relating to the handling of medication and processes for the recruitment and supervision of staff. Performance in these areas has continued to improve since this report was published and the medication and supervision standards have seen the largest improvement of all the standards in the past 12 months. However, whilst this improvement is encouraging, these remain amongst the standards where home care agencies perform least well.

6.42 In 2008, 8% more agencies are meeting the risk assessments standard than in 2007. In 2006 CSCI published a report[153] which looked at the experiences of older people using care services and how they have been helped to minimise risk whilst retaining choice and control over their lifestyles.

152 CSCI (2006) *Time to care? An overview of home care services for older people in England*
153 CSCI (2006) *Making choices: taking risks*

Figure 6.13

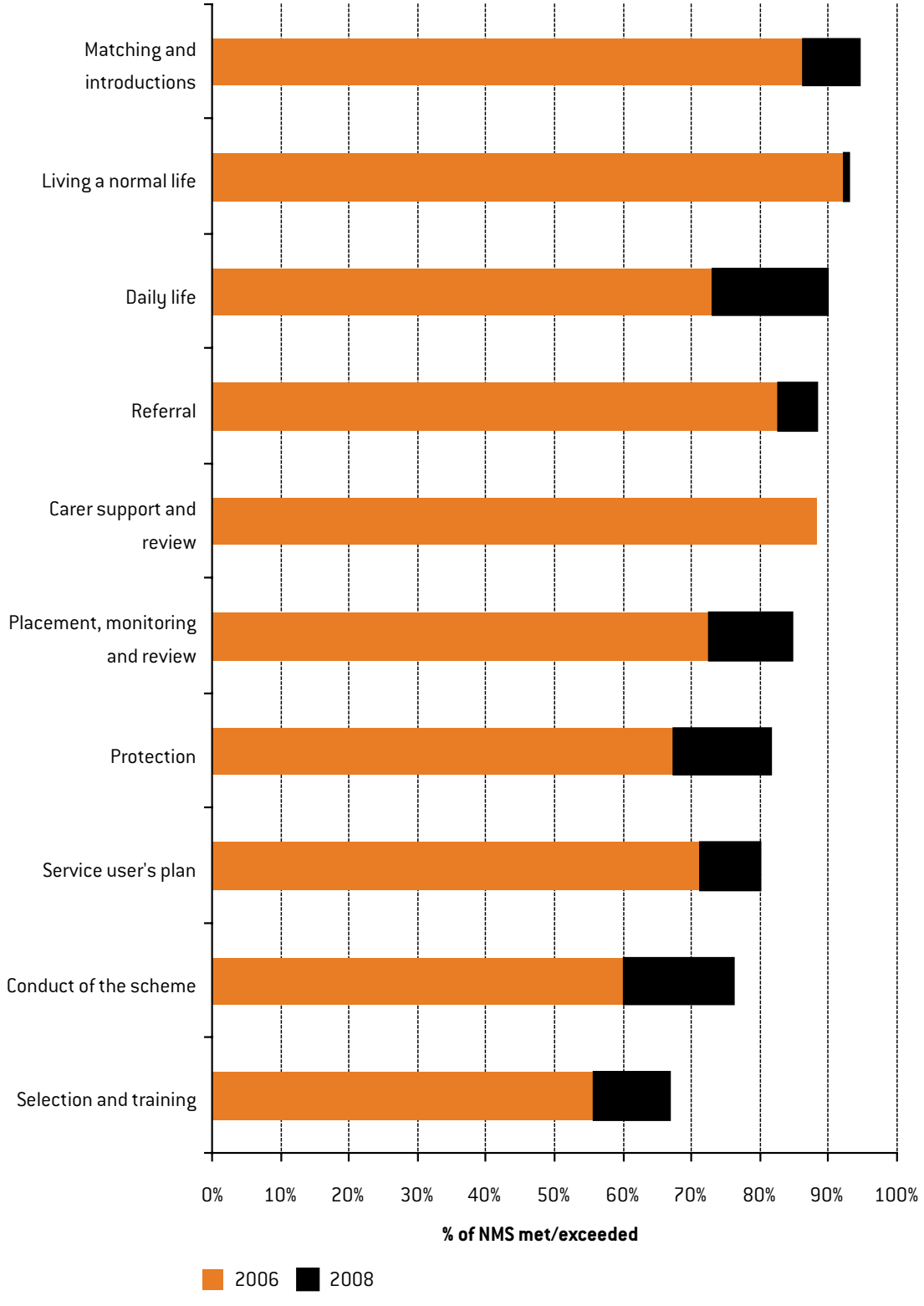
Improvement in the percentage of standards met by home care agencies since the introduction of NMS[154]



154 The proportion of home care agencies meeting the financial procedures standard is the same in 2008 as it was in 2005

Shared Lives schemes

Figure 6.14
Improvement in the percentage of standards met by Shared Lives schemes since the introduction of NMS[155]



155 The proportion of shared lives schemes meeting the carer support and review standard is the same in 2008 as it was in 2006

6.43 CSCI began inspecting Shared Lives schemes (formerly known as adult placement) against NMS in April 2005. Since then the average percentage of standards met by these services has risen by 9% to 84% in 2008.

6.44 Figure 6.14 shows the improvements in performance against the standards since 2005. The largest improvement is in relation to daily life (17% more services meeting this standard in 2008 than in 2006), conduct of the scheme (16% improvement) and protection (15% improvement).

6.45 Of all the regulated service types, Shared Lives schemes have made the greatest improvement in the past year with 8% more standards being met on average.

6.46 Shared Lives schemes perform best in relation to matching and introductions (95%), living a normal life (93%) and daily life (90%). However, 1% fewer Shared Lives schemes are meeting the living a normal life standard than did so last year.

Nursing agencies

6.47 On average, nursing agencies meet more standards than any other regulated service type (87%).

6.48 Since nursing agencies were first inspected against NMS in April 2003, the proportion of standards met or exceeded has risen by just under a fifth (18%).

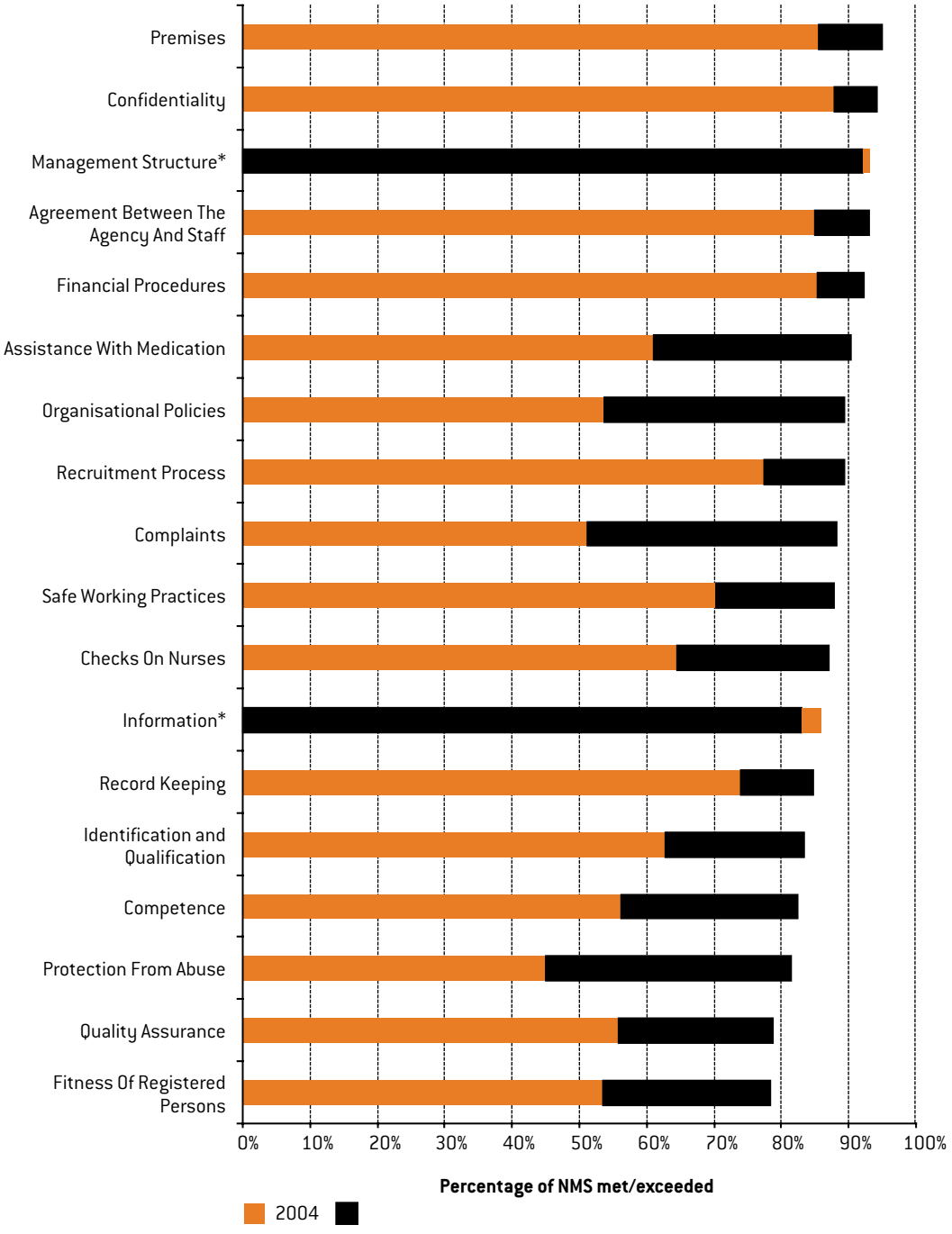
6.49 Figure 6.15 shows how performance against the standards in 2008 compares with 2004. The largest improvements have been in the areas of complaints, protection from abuse (both up 37%), organisational policies (up 35%), assistance with medication (29%) and competence (up 26%).

6.50 The percentage of nursing agencies meeting the information standard has dropped by 3% since 2004 and the proportion meeting the management structure standard has dropped by 1%.

6.51 Nursing agencies perform best in relation to premises (95%), confidentiality (94%), agreement between the agency and staff (93%), financial procedures (92%), management structure (92%) and assistance with medication (90%).

Figure 6.15

Improvement in the percentage of standards met by nursing agencies since the introduction of NMS



* The proportion of nursing agencies meeting the Management Structure and Information Standards has decreased since 2004

Overall picture

6.52 There is evidence that the quality ratings have encouraged performance. There was a net improvement in the quality ratings of almost 1,400 services between April 2007 to April 2008. In July 2008, two months after quality ratings were formally introduced, CSCI commissioned a two-stage research project to look at the impact of quality ratings on people who make decisions about care services: commissioners, people who use services and carers. The first stage reported in October 2008. Its findings suggested a very good awareness in and use by councils of quality ratings. For example, 81% of councils used quality ratings in the decision-making process for care homes and 69% for home care. In addition, the research revealed that 99% of councils used CSCI reports in decisions about care homes. As might be expected, awareness was lower amongst people in care homes or using home care services or their relatives. Even so, it was very encouraging to note that, at such an early stage after ratings were introduced, 45% of relatives of people in residential care were aware of the rating system. The second stage of the exercise will take place in early 2009, covering the same groups of decision-makers plus people in adult placement services. A full report will be available in March 2009.

6.53 CSCI has also sought to drive improvements in the quality of care through new inspection processes, particularly for the care of people with communication difficulties and dementia to ensure they are getting truly individualised care. The SOFI (Short Observational Framework for Inspection) is a unique tool for inspectors to capture in a systematic way the experiences of care. By looking in detail at people's emotional wellbeing, who they are engaged with during the day and how staff relate to them allows the inspector to get beyond the surface of routine care practice. It is a methodology under development but one that is helping to raise the bar in the quality of care.

Chapter 7

The quality of care services purchased by councils

Key findings

- A new CSCI initiative with councils in 2007 has provided evidence for the first time on the quality of services purchased by each council. This is early data and must be treated with some caution but does relate information from councils on the numbers of people for whom they purchased care at individual service level (April to September 2007) to the new CSCI quality ratings (published in 2008 but based on evidence prior to that date that was available). This offers a first baseline for the quality of services purchased. More detailed data being provided to councils will assist them in reviewing the care services they are purchasing to help improve the quality of the local care market.

- The data shows considerable variability in the quality of services purchased by councils. At September 2007 one place in five (21%) purchased by councils (that is some 7,700 places out of 36,500) was in care homes rated 'poor' or 'adequate'. The percentage was higher for nursing care in homes for older people (24%). The percentage of 'good' and 'excellent' places was highest for nursing care for younger adults (83%).
- 22% of older people moving permanently into a care home arranged by councils in the six months to September 2007 went into a home rated as 'poor' or 'adequate'. This was also the position for older people who had places purchased by the council outside of the council's area. By way of contrast, seven temporary admissions in eight (88%) of younger adults were into a home rated as 'good' or 'excellent'.
- Between April to September 2007, one in 10 of people whose care was purchased by the council received a service from a home care agency which was rated as 'adequate'; 88% received services from a home care agency rated as 'good' or 'excellent'. In all, 3,700 people were receiving home care from services rated as 'poor', and a further 24,000 receiving their care from services rated as 'adequate'. One person in seven received a home care service from an independent sector provider with a published rating of 'poor' or 'adequate', as compared with almost one in 20 with a service from a voluntary organisation.

Care home services purchased by councils

7.1 All 150 councils provided CSCI with data in April 2008 on the numbers of their residents for whom they purchased care in care homes in the period April to September 2007.[156],[157] The data supplied have been linked by CSCI to its data on quality ratings as at August 2008.[158]

7.2 In total, council data reported to CSCI shows that councils purchased just over half of all the registered places in care homes in England at September 2007 (Figure 7.1).[159] They purchased a lower proportion of all places in homes offering nursing care[160] and a higher

156 CSCI requested a minimum dataset of numbers of supported residents, permanent and temporary admissions to each registered care home from which the council purchased care and for the number of those provided with home care type services from home care agencies. Most councils provided further data but a small number of councils were only able to supply data for earlier or later periods

157 Councils matched their data on individual services to CSCI service identifiers in a small proportion of cases this matching was not possible or was incorrect

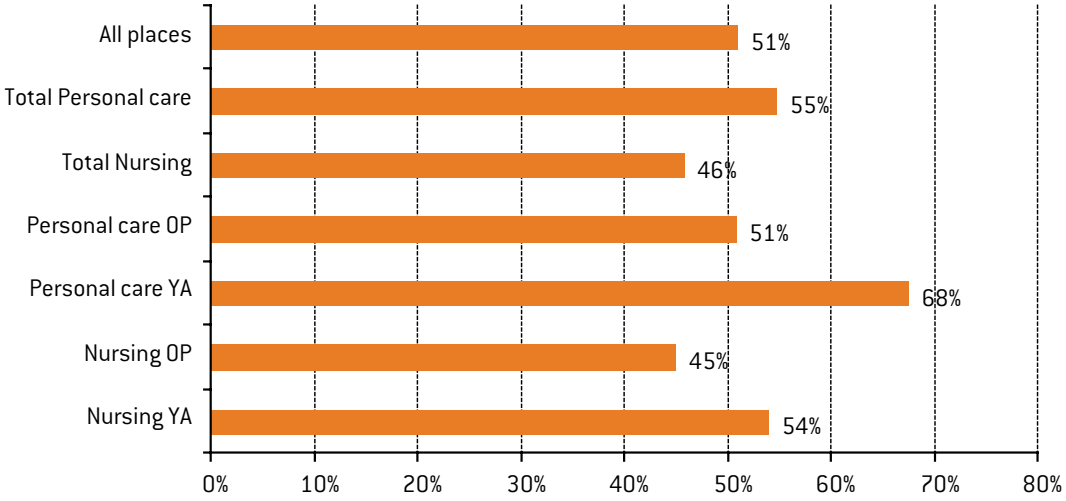
158 First published in May 2008. At that time some 27% of all registered services asked CSCI not to publish their ratings, pending a key inspection

159 This denominator for this percentage, 209,500, is lower than the total of 246,000 supported residents reported at March 2007 by the NHS Information Centre for Health and Social Care (in its *Community care statistics 2007, supported residents (adults) England* report (2007, Table S1)). Numbers of supported residents are falling and there are a small number of services where councils were not able to provide the correct identifier for homes from which they purchased care

160 The total registered places in any home offering nursing care in *any* of its beds are classified as nursing care beds. Comparisons of 'nursing care' and 'personal care' data cannot therefore be made directly between the data reported here on council purchasing against the data discussed in Chapter 3 from councils' returns to the NHS Information Centre for Health and Social Care (the Supported Residents return SR1)

proportion in homes only providing personal care. Councils purchased over two in every three places in homes registered to provide personal care for younger adults.

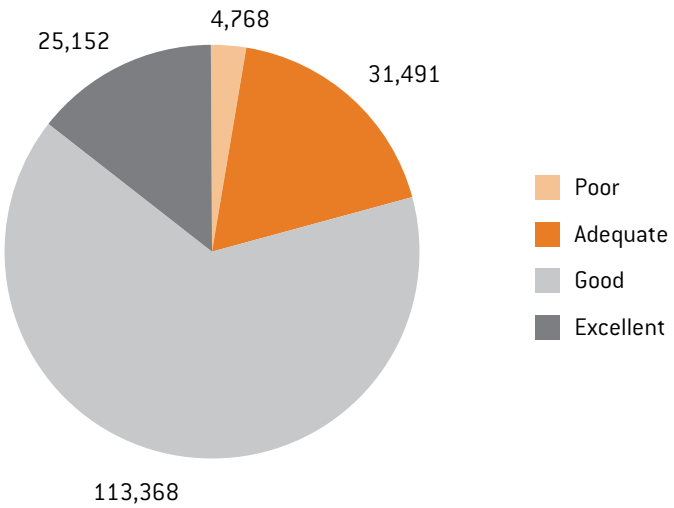
Figure 7.1
Percentage of registered places purchased by councils, 30/09/07



Note: YA = Younger Adults; OP = Older People

7.3 175,000 people had places arranged by their council in care homes at September 2007 which had a published rating by August 2008. Of these nearly 5,000 (3%) were in homes rated as 'poor', with a further 31,500 (18%) in homes rated as adequate (Figure 7.2).

Figure 7.2
Residents supported by councils in care homes, 30/09/07 (published Quality Ratings at August 2008)



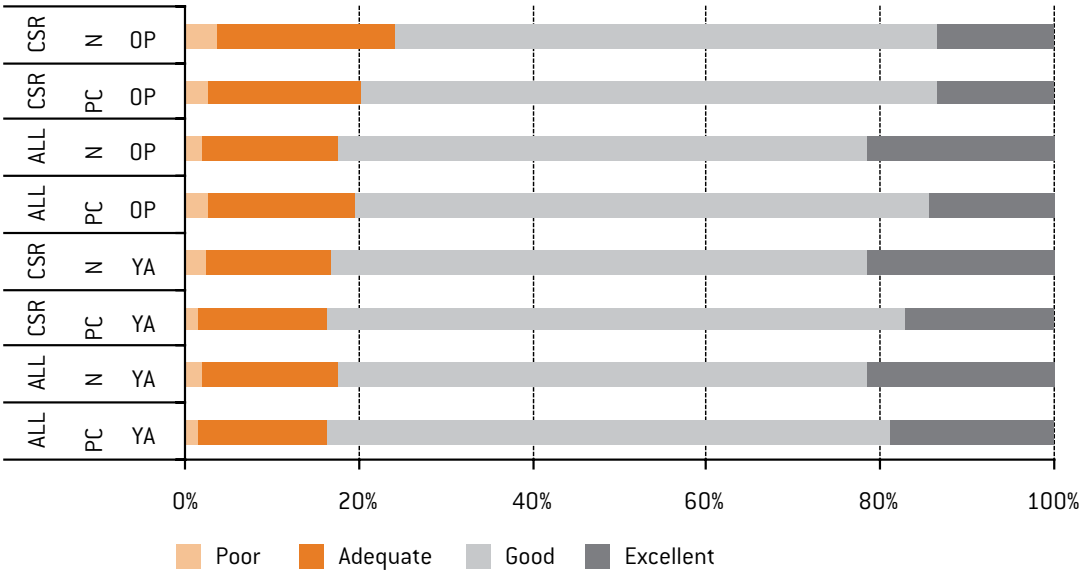
7.4 Figure 7.3 shows the distribution of published quality ratings of all registered places in England in homes for younger adults (YA) and older people (OP) respectively, split by personal care homes (PC) and those offering nursing care (NH), and the equivalent measures for all council-purchased places. Data reported exclude care homes where their

quality rating had not been made public by August 2008. The percentages shown of 'poor' and 'adequate' places to residents is likely to be higher once all ratings for each individual service are included.

7.5 For nursing care for older people 24% of 58,350 council-purchased places were rated 'poor' or 'adequate'; whilst 18% of all 129,000 registered places with a published rating were rated as 'poor' or 'adequate'. Councils purchased marginally better nursing care in homes for younger adults than that available in total (16.8% of 5,200 places purchased were rated 'poor' or 'adequate' as against 17.6% of the total of 9,200 places across England).

Figure 7.3

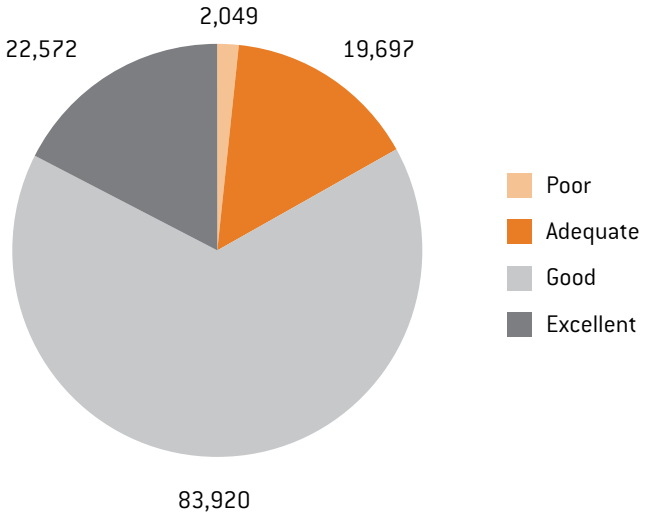
Percentage of places/council supported residents at 30/09/07 (published Quality Ratings at August 2008)



Note: ALL = All places in England; CSR = Council Supported Residents (September 2007); PC = Personal Care; N = Nursing Care; OP= Older People; YA = Younger Adults

7.6 Data from all councils also provide for the first time a view of the quality of council-purchased care for those *admitted* to registered homes in the six months to September 2007. Figure 7.4 shows the pattern by type of home where a published rating was available at August 2008.

Figure 7.4
Admissions to homes by councils in April – September 2007 (published Quality Ratings as at August 2008)



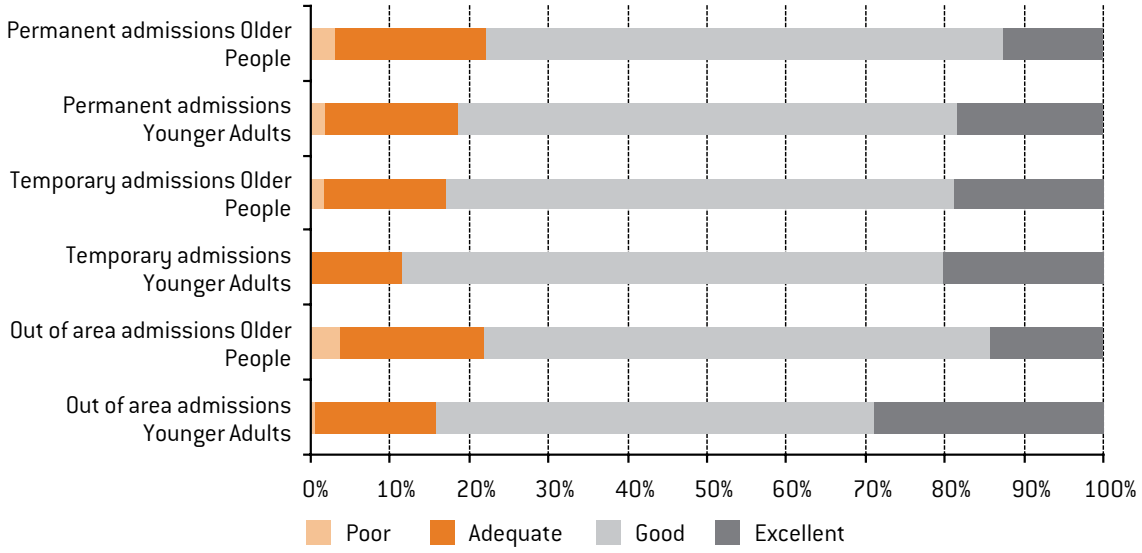
7.7 One permanent admission in five (22%) of people moving into homes for older people[161] was into a home rated as 'poor' or 'adequate' (Figure 7.5). This was also the position for placements in this category of home out of the council's area.[162] Care purchased for adults newly admitted to homes for younger adults was in general more often in homes rated as 'good' or 'excellent': for example, seven temporary admissions in eight (88%) of younger adults[163] were into a home rated as 'good' or 'excellent'.

161 Councils reported 31,500 admissions to such homes in the six months to September 2007. A small proportion of those admitted will be aged under 65 – the categorisation of the home by CSCI is based on the largest proportion of residents at the time of the inspection aged 65 and over (see Chapter 4, para 4.16)

162 7,360 admissions (permanent and temporary: residential and nursing care combined) in the six months to September 2007

163 Councils reported 34,200 such temporary admissions in the six months to September 2007

Figure 7.5
Percentage of council placements April-September 2007 x Quality Rating of home (August 2008)



Home care agencies

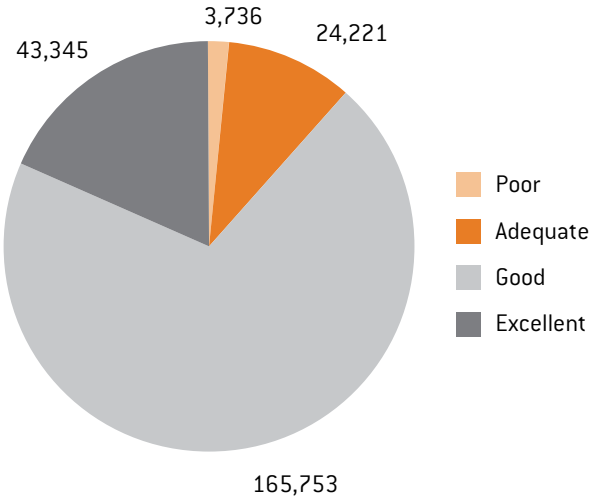
7.8 Councils also reported to CSCI in April 2008 the numbers of adults for whom they arranged home care with registered agencies in a week in the six months to September 2007. Although some councils did not provide a full dataset,[164] the overall picture for England can be assessed.

7.9 The numbers of people using services and the quality ratings of the agencies from which they received care are shown in Figure 7.6, with 88% receiving services from home care agencies with a published rating of 'good' or 'excellent'. 3,700 people were receiving care from 'poor' services (1.6% of all councils' clients) and a further 24,000 receiving their care from services rated as 'adequate'. One in 20 people with a service purchased by the council from a voluntary organisation received it from one with a published rating of 'poor' or 'adequate', as compared with almost one in seven with service from an independent sector provider.

164 Councils reported fewer people using services than the 345,000 reported in a sample week in September 2007. (NHS Information Centre for Health and Social Care (2008) *Community care statistics: home care services for adults*, Table 5). This arises from some councils not being able to provide data on the breakdown of people using internal home care agencies, and others reporting some agencies as care homes or nursing agencies

Figure 7.6[165]

Adults receiving care arranged by councils in 2007 by published Quality Rating of their home care agency (August 2008)



7.10 There are considerable differences between councils in the percentage of people that they fund who are using home care agencies with a published rating of 'poor' or 'adequate'. More than a third of the people 21 councils fund were receiving a service from 'poor' or 'adequate' home care agencies, while 65 further councils reported a figure of 5% or less.

The quality of procurement by councils

7.11 To help improve procurement and commissioning by councils and drive up the quality of services, CSCI has provided every council with an analysis of its own data and that for the overall totals for England. CSCI is also discussing the implications with senior council staff and making further analyses available to councils so they can explore the quality of the care they are purchasing.[166] The data provided to councils includes:

- the type of provider (independent, voluntary, council, etc)
- the length of time since the home or agency was first registered
- how far the home or agency was meeting specific National Minimum Standards at September 2007, and whether it had improved in meeting these standards since March 2006.

7.12 Using local data councils can also review quality in terms of:

- cost per placement or per hour of service
- complaints about care
- safeguarding referrals
- the ethnicity of people whose care was arranged by the council

165 Figure 7.6 excludes agencies where their quality rating had not been made public by August 2008.The percentages shown in Figure 7.6 as 'poor' and 'adequate' are likely to be higher once all ratings for each individual service are included

166 The data collection from councils is being repeated for April to September 2008: the results will be fed back to all councils in February 2009

- whether the home or agency was being used to provide intermediate care
- whether the council had a block contract arrangement with the service.

7.13 In the performance assessment of councils for 2007-08 account has been taken of councils' response to this new data. For 2008-09 greater emphasis will be placed on the evidence and councils' efforts to ensure good quality care for all those whom they support in care homes or with home care services.

Chapter 8

Adult social care workforce

Key findings

- Good personalised care and support is highly dependent on the availability of suitably skilled and trained staff: social workers and support staff. For many people who depend on ongoing support from care services, having the same care staff working with them over time is equally important.
- The adult social care workforce in England is estimated at 1.5 million workers, an overall increase of 8% since 2006-07.
- Numbers employed in adult social care by councils fell from an estimated 228,000 in 2006-07 to 221,000 in 2007-08.
- Numbers working in the independent sector increased from an estimated 988,000 to 1,070,000, and in personal assistant roles from 113,000 to 152,000.
- People using services should be engaged in the debate about the qualities needed in personal assistants and whether such roles should be regulated.

- The number of vacancies notified to JobCentres for care workers, social workers, occupational therapists and other care and support-related occupations exceeded 100,000 in the second of half of 2007 and has remained at these high levels during the first half of 2008. Over 80% of vacancies are for care workers.
- Council workforce vacancy and turnover rates were 8.6% and 10.0% respectively in 2007-08, little changed from 2006-07 when the corresponding rates were 8.4% and 10.3%.
- The independent sector has a turnover rate of 17.9% for all staff and a vacancy rate of 3.8%. These rates are higher in home care settings, with turnover rates of 20.7 % for all staff and vacancy rates of 5.2%.
- In 2007 just over 66% of care workers had obtained the equivalent of an NVQ level 2 or higher, while around one third had not obtained a level 2 qualification. This is an improvement on 2006 levels when fewer than 60% had an NVQ2 or equivalent.
- As at November 2008, there were 81,323 registered social workers in England; over 12,000 have a post-qualifying award.

Workforce for adult social care

8.1 Good personalised care and support is highly dependent on the availability of suitably skilled and trained staff, including both support staff and social workers. The latter are key to supporting self-assessments, understanding people's aspirations and ensuring they have access to personalised support whether it is through a Direct Payment, Individual Budget or a personally tailored package of services and support. For many people who depend on ongoing support from care services, having the same care staff working with them over time is also important.

8.2 Skills for Care has estimated the adult social care workforce in England in 2007-08 to be 1.5 million workers; of these 1.41 million are directly employed workers and 93,000 others not directly employed. The majority of the information in this chapter has been provided by Skills for Care.

8.3 This figure represents an overall increase of 8% since 2006-07 and, as can be seen in Table 8.1, is mainly attributable to:

- Increased numbers working in the independent sector (up from 988,000 to 1,070,000) and in the NHS (increase from 60,000 to 62,000).
- An estimated 152,000 personal assistant roles working for people using Direct Payments, compared with an estimated 113,000 in 2006-07. This reflects the continuing growth in numbers of people using Direct Payments for adult care services. There is an urgency to engage people using services and support in the debate about the qualities they see as important in personal assistants and whether such roles should be regulated.
- A fall in numbers employed in adult social care by councils from an estimated 228,000 in 2006-07 to 221,000.

Table 8.1

Estimated size of the adult social care workforce in England, 2007-08 (headcount in jobs) (derived from various sources[167])

Type of employer	Private sector	Voluntary sector	Sub-total: Independent sector	Councils*	NHS**	Recipients of direct payments employing own staff	Total	% of total directly employed	% of total work force
Area of work									
Residential care	456,000	129,000	585,000	50,000	-	-	635,000	45%	42%
Domiciliary care	271,000	35,000	307,000	44,000	-	152,000	503,000	36%	33%
Day care	8,000	32,000	40,000	27,000	-	-	67,000	5%	4%
Community including NHS and the organisation and management of care in local authorities and the community	22,000	35,000	57,000	90,000	62,000	-	208,000	15%	14%
Total directly employed	757,000	231,000	988,000	210,000	62,000	152,000	1,413,000	100%	94%
% of total directly employed	54%	16%	70%	15%	4%	11%	100%		
Agency workers and others not directly employed ***	48,000	34,000	82,000	11,000	n/a	n/a	93,000		6%
Total workforce	805,000	265,000	1,070,000	221,000	62,000	152,000	1,505,000		100%
% of total workforce	**53%**	**18%**	**71%**	**15%**	**4%**	**10%**	**100%**		

Note on calculations:

Because of rounding, individual components may not sum to totals.

* the allocation of the council-employed workforce between adults' and children's services is that employed by LAWIG/LGA in its 2006 Adult Social Care Workforce Survey and is likely to include some staff working wholly or mainly in children's services.

** the NHS estimate includes healthcare assistants but not support workers, nursing assistants/auxiliaries and helpers/assistants, except in social services and occupational therapy areas.

*** the independent sector estimate of not directly employed workers includes bank/pool staff and also small numbers of students, volunteers and voluntary workers and other workers, as well as agency staff; the corresponding council estimate is based on the findings of LAWIG 2006 Adult Social Care Workforce Survey because NMDS-SC does not as yet include sufficient representative returns from local authorities.

This estimate excludes the following:

- workers employed by individuals using Individual Budgets and privately purchasing care and support, which could be many more thousands of workers

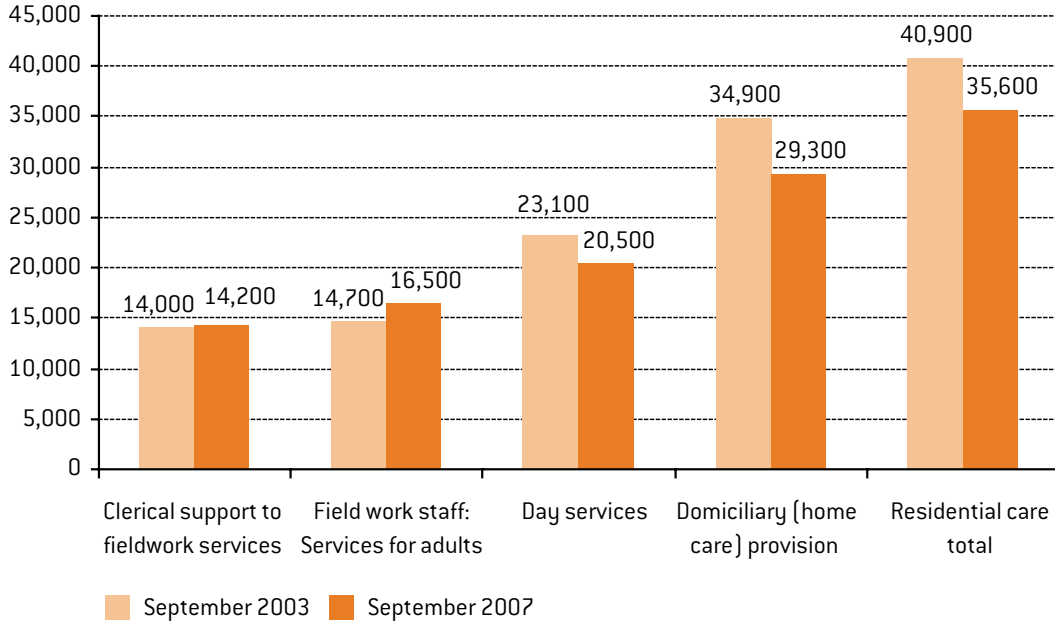
167 As well as the National Minimum Data Set – Social Care (NMDS-SC), the sources used to estimate these workforce numbers include the NHS Information Centre for Health and Social Care's analyses of council social services workforce from the September 2007 SSDS001 returns, the September 2007 NHS Non-medical Workforce Census, the LAWIG 2006 Adult Social Care Workforce Survey and CSCI's March 2008 Self Assessment Survey for councils.

- council care staff employed in organising, managing or employed in sheltered housing or assisted living establishments, which are currently outside the 'social services' footprint under which the source workforce data is collected
- NHS agency staff
- social workers and social care staff employed in government departments, agencies and executive bodies
- unpaid carers.

The estimates have been produced in a similar way to previous Skills for Care estimates and so are comparable. However, it is becoming apparent that they are closer to numbers of job roles than to numbers of individual workers, and that people working in more than one job in adult social care is quite common.

8.4 Figures from the NHS Information Centre for Health and Social Care are of whole-time equivalents and show as at September 2007 councils employed around 130,000 staff working with adults.[168] This total had fallen by about 8% over the five years from 2003 which reflects increasing number of services being contracted out to the independent and voluntary sector (Figure 8.1). The numbers of staff providing assessment and reviews increased by about 12% while the numbers of staff supporting them remained broadly static.

Figure 8.1
Staff in councils providing adult care services: 2003 and 2007 (from SSDS001 returns – whole time equivalents)



168 The annual SSDS001 return from councils to the NHS Information Centre for Health and Social Care does not fully separate staff employed by councils between those working with adults and those working with children. Some work with both groups. The data presented here exclude all those working solely with children but include all 'generic' staff

Turnover of staff and vacancies

(a) All social care employers

8.5 The number of vacancies notified to JobCentres for care assistants and home carers (the closest approximation to care workers), social workers, occupational therapists and other care and support-related occupations rose past the 100,000 mark in the second half of 2007 and have remained at these high levels during the first half of 2008. (These figures include those people working in children's services.) The sharp rise in the number of vacancies reported over those 18 months is mainly because of the increase in vacancies reported for care workers. Over 80% of vacancies (shown in the tables and figure below) are for care workers.

8.6 Fluctuations in the numbers are caused by various factors, including seasonality in employment and demand, and promotional activities by JobCentres.

Table 8.2

Vacancies for selected care occupations notified to JobCentres in England, from January 2008 to June 2008[169]

Occupation and SOC 2000 classification	Jan – Jun 2008	% of total
6115 : Care assistants and home carers	98,044	80.9
2442 : Social workers	5,658	4.7
6111 : Nursing auxiliaries and assistants	7,012	5.8
3231 : Youth and community workers	5,766	4.8
3232 : Housing and welfare officers	3,273	2.7
6114 : Houseparents and residential wardens	769	0.6
3222 : Occupational therapists	658	0.5
Total of these occupations	**121,180**	**100.0**

169 Source: ONS National On-Line Manpower Information System (NOMIS) website

Table 8.3

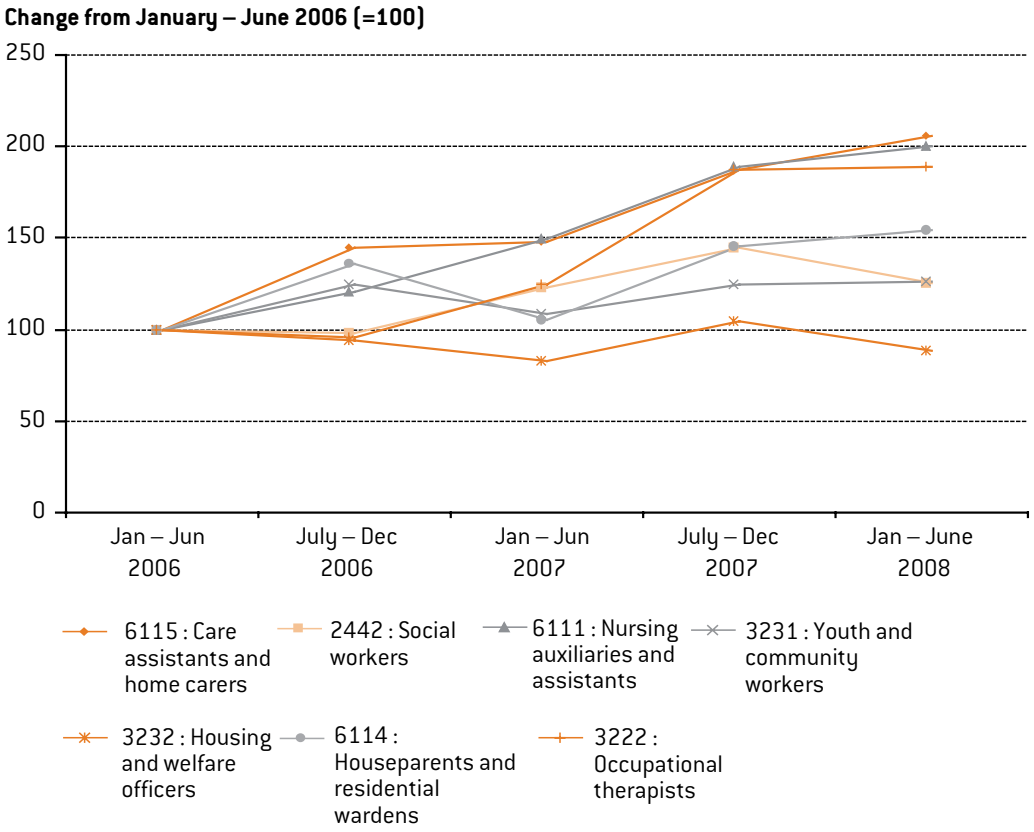
Vacancies for selected care occupations notified to JobCentres in England, from July 2003 to June 2008[170]

Occupation and SOC 2000 classification	July – Dec 2003	Jan – Jun 2004	July – Dec 2004	Jan – Jun 2005	July – Dec 2005	Jan – Jun 2006	July – Dec 2006	Jan – Jun 2007	July – Dec 2007	Jan – June 2008
6115 : Care assistants and home carers	52,599	52,955	52,904	45,776	51,481	47,736	68,885	70,576	89,403	98,044
2442 : Social workers	5,415	6,465	6,104	5,904	5,553	4,521	4,424	5,555	6,540	5,658
6111 : Nursing auxiliaries and assistants	14,484	9,559	11,021	9,493	4,461	3,499	4,218	5,221	6,602	7,012
3231 : Youth and community workers	5,057	4,952	5,688	5,162	5,788	4,583	5,720	4,988	5,728	5,766
3232 : Housing and welfare officers	3,953	4,004	5,071	3,931	4,377	3,713	3,478	3,083	3,892	3,273
6114 : Houseparents and residential wardens	1,209	746	772	726	696	497	677	524	724	769
3222 : Occupational therapists	632	725	894	813	671	349	335	435	654	658
Total of these occupations	**83,349**	**79,406**	**82,454**	**71,805**	**73,027**	**64,898**	**87,737**	**90,382**	**113,543**	**121,180**

170 Source: ONS National On-Line Manpower Information System (NOMIS) website

Figure 8.2

Changes in numbers of vacancies notified to JobCentres, 2006 to 2008



(b) Council workforce

8.7 As reported in the CSCI Self Assessment Survey by councils, there has been little change in figures from 2006-07 at a national level where vacancy and turnover rates were reported to be 8.4% and 10.3% respectively (See Table 8.4).

8.8 London had the highest vacancy rates in 2007-08 at 11.1% – one in nine posts. The North West had the lowest vacancy rates.

8.9 The highest turnover of staff was found in the East Midlands (12.2%), followed by the South East (12%).

Table 8.4
Regional vacancy and turnover rates for all directly employed staff in adult services in councils in England[171]

	Vacancy rate 2007-08 Outturn	Highest	Lowest	Turnover rate 2007-08 Outturn	Highest	Lowest
London	11.1	33.0	0.0	9.4	23.0	2.9
Inner London	11.6	n/a	n/a	10.2	n/a	n/a
Outer London	10.8	n/a	n/a	8.9	n/a	n/a
South East	11.3	34.7	1.8	12.0	20.0	3.0
Eastern	8.9	25.3	1.9	10.7	17.2	5.0
Yorkshire and Humber	8.8	17.0	0.9	9.6	12.4	6.0
East Midlands	7.1	17.0	0.0	12.2	29.0	3.8
West Midlands	7.2	24.1	0.3	9.7	15.0	6.0
North East	6.4	11.6	1.7	9.5	16.5	5.3
South West	6.7	16.2	0.3	10.6	21.6	3.3
North West	6.4	17.9	0.6	8.3	15.0	3.2
Metropolitan Districts	7.5	n/a	n/a	8.4	n/a	n/a
Shire Counties	8.0	n/a	n/a	11.7	n/a	n/a
Unitary Authorities	8.2	n/a	n/a	10.4	n/a	n/a
England	8.6	34.7	0.0	10.0	29.0	2.9

Indicators : Turnover – 8.3GN242, Vacancies 8.3GN243

(c) Independent sector

8.10 The two tables below have been produced using NMDS-SC data as at the end of April 2008.[172] Overall, the sector has a turnover rate of 17.9% for all staff and a vacancy rate of 3.8%. These rates are higher in home care settings, with turnover rates of 20.7% for all staff and vacancy rates of 5.2%.

8.11 Analysis of specific jobs shows lower turnover and vacancy rates for registered managers than for all other roles. Highest vacancy rates are for care workers in people's own homes (5.7%), while the highest turnover rates are for care workers in care homes with nursing (23.2%).

171 Source: CSCI Self Assessment Survey Analysis tool, spring 2008

172 Please note the data includes a small number of statutory sector employees

Table 8.5
Turnover and vacancy rates by main service provided (NMDS-SC, April 2008)

	Main service provided			
	All Services	Care home with nursing provision	Care home without nursing provision/ care only	Domiciliary care/ home care
All Job Roles	**491,716**	**125,838**	**154,143**	**111,095**
Vacancy Rate (%) for this job role	3.8%	2.4%	3.9%	5.2%
Turnover Rate (%) for this job role	17.9%	18.9%	18.4%	20.7%
Registered Manager	**13,355**	**2,270**	**7,015**	**1,807**
Vacancy Rate (%) for this job role	1.8%	1.9%	1.7%	2.3%
Turnover Rate (%) for this job role	11.3%	14.6%	10.4%	10.7%
Senior Care Worker	**42,125**	**7,993**	**20,884**	**6,043**
Vacancy Rate (%) for this job role	2.6%	2.0%	2.4%	2.8%
Turnover Rate (%) for this job role	10.1%	9.2%	10.4%	10.7%
Care Worker	**290,625**	**62,266**	**97,633**	**86,121**
Vacancy Rate (%) for this job role	4.6%	3.1%	4.4%	5.7%
Turnover Rate (%) for this job role	20.9%	23.2%	20.5%	22.0%

(d) All sectors

8.12 Vacancy rates for all jobs are fairly consistent across sectors at around the 3.6% mark. Turnover rates for all job roles show more variance, with the highest found in the private sector (18.6%).

8.13 Vacancy rates for registered managers are consistent at around 1.8%. Turnover rates for this job role are highest in the private sector (12.2%) and lowest in the statutory sector (8.4%).

8.14 For care workers, vacancy rates are generally around 4.6%, but lower in the statutory sector. Care worker turnover rates are highest in the private sector (23.6%) and considerably lower in the statutory sector (9.6%).

Table 8.6
Turnover and vacancy rates by sector (NMDS-SC, July 2008)

	All Sectors	Statutory Sector	Private sector	Voluntary sector
All Job Roles	**491,716**	**46,446**	**353,309**	**108,582**
Vacancy Rate (%) for this job role	3.8%	3.9%	3.4%	3.6%
Turnover Rate (%) for this job role	17.9%	7.9%	18.6%	13.4%
Registered Manager	**13,355**	**764**	**9,124**	**2,886**
Vacancy Rate (%) for this job role	1.8%	1.9%	1.9%	1.7%
Turnover Rate (%) for this job role	11.3%	8.4%	12.2%	9.6%
Senior Care Worker	**42,125**	**2,635**	**30,069**	**7,685**
Vacancy Rate (%) for this job role	2.6%	3.4%	2.3%	3.1%
Turnover Rate (%) for this job role	10.1%	6.7%	10.2%	10.7%
Care Worker	**290,625**	**23,171**	**199,239**	**55,675**
Vacancy Rate (%) for this job role	4.6%	4.4%	4.5%	4.8%
Turnover Rate (%) for this job role	20.9%	9.6%	23.6%	15.8%

Please note that columns do not sum to total because establishments falling in 'other' and 'unrecorded' sectors have been taken out.

Qualifications of staff

All sectors

8.15 Table 8.7 below shows levels of qualifications held by workers in selected social care occupations, according to the Labour Force Survey (a self-reporting survey). This includes some people working in children's services.

8.16 There has been some improvement in levels of qualifications of care workers. In 2007 just over 66% of care workers said they had obtained the equivalent of an NVQ level 2 or higher, while around one-third had not obtained a level 2 qualification. This compares with 2006 when fewer than 60% of care workers said they had obtained the equivalent of an NVQ level 2 or higher.

8.17 As at November 2008, there were 81,323 registered social workers in England.[173] All registered social workers have a social work degree or equivalent professional qualification. Over 12,000 qualified social workers have a post-qualifying award of some description. There are 14,185 social work students training in England.

173 Data provided by the General Social Care Council

Table 8.7
Highest level of qualification held by main occupation (source : 4 quarter average Labour Force Survey 2007, ONS)

SOC2000 occupation groupings	2442 Social workers	3222 Occupational therapists	6111 Nursing auxiliaries and assistants	6114 Houseparents and residential wardens	6115 Care assistants and home carers
Unweighted Base	*143*	*54*	*333*	*51*	*983*
Weighted Base	*73,881*	*27,364*	*173,384*	*25,817*	*501,876*
Percentages (%)					
NVQ Level 4 and above	78.8	89.5	27.9	26.3	11.5
NVQ Level 3	9.4	1.4	22.7	32.1	20.2
Trade Apprenticeships	0.4	0.0	1.9	1.7	2.1
NVQ Level 2	5.2	4.8	18.1	11.3	32.5
Sub-Total : Level 2 or above	93.7	95.6	70.6	71.5	66.2
Below NVQ Level 2	2.0	3.7	14.5	16.4	12.1
Other qualifications	3.4	0.7	7.8	7.3	12.9
No qualifications	0.9	0.0	7.1	4.8	8.8
Total	100.0	100.0	100.0	100.0	100.0

NB: In the Labour Force Survey occupation is assigned from the information which individual respondents provide about their job, without any check on qualifications, etc. A proportion of the respondents describing themselves as social workers are probably not registered social workers.

Regulated services

8.18 The following information is taken from the National Minimum Data Set Social Care as at September 30 2008 (please note the caveat on the qualifications data under the table):

- Just over a half of all registered managers for whom information is available are qualified to NVQ level 4 in a social care related qualification with the highest levels found in residential care homes (56%) and the lowest in home care (45%). No information is available for over a quarter of returns received for registered managers.
- Overall, just over 54% of senior care workers for whom information is available have obtained an NVQ level 2 or above or an equivalent in a social care related qualification. This figure rises to 57% in residential care homes and falls to 47% in home care. It should be noted that no qualifications data has yet been recorded in two-fifths of all records received from senior care workers.
- Just under a quarter (23%) of care workers for whom information is available have obtained an NVQ level 2 or above or an equivalent in a social care related qualification. This figure rises to 29% in residential care homes. It should be noted that no qualifications data have yet been recorded for over 70% of all records received from care workers.

Table 8.8

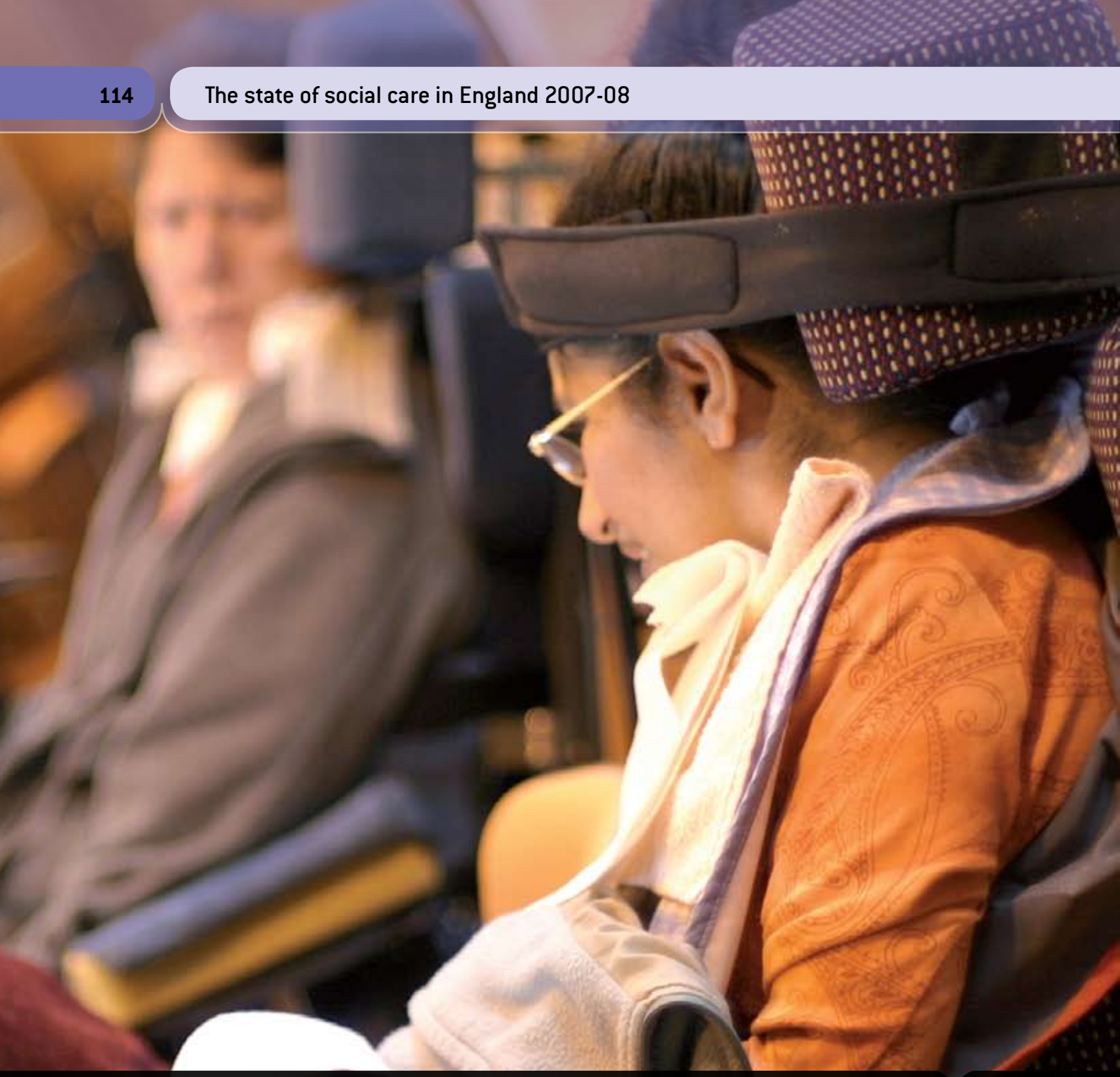
Highest qualification level held by main job role by service setting, NMDS-SC September 30, 2008

Highest Qualification level held	All Services	Care Home Only	Care home with Nursing	Domiciliary Care
All Job Roles (Base)	226,731	71,582	53,129	42,824
4 or 4+	4.0%	4.8%	2.8%	2.8%
3 or 3+	9.7%	10.3%	13.8%	6.3%
2 or 2+	13.0%	17.1%	9.6%	16.9%
Entry or 1	0.1%	0.1%	0.1%	0.1%
Other relevant qualifications	5.7%	7.4%	3.6%	5.8%
No relevant qualification or non-recorded	67.5%	60.3%	70.1%	68.0%
Registered Manager (Base)	4,880	2,542	754	527
4 or 4+	52.6%	55.5%	50.3%	45.4%
3 or 3+	16.0%	14.8%	21.4%	16.1%
2 or 2+	1.6%	1.5%	0.5%	3.0%
Entry or 1	0.0%	0.0%	0.0%	0.0%
Other relevant qualifications	2.3%	2.4%	0.4%	4.4%
No relevant qualification or non-recorded	27.6%	25.8%	27.5%	31.1%
Senior Care Worker (Base)	17,792	9,466	2,923	2,297
4 or 4+	3.6%	3.5%	2.6%	3.1%
3 or 3+	27.1%	27.5%	30.9%	18.5%
2 or 2+	23.7%	26.0%	22.3%	25.6%
Entry or 1	0.1%	0.1%	0.1%	0.0%
Other relevant qualifications	4.1%	4.4%	2.8%	3.4%
No relevant qualification or non-recorded	41.4%	38.5%	41.3%	49.5%
Care Worker (Base)	127,604	39,273	24,536	31,393
4 or 4+	1.1%	1.2%	1.0%	0.9%
3 or 3+	5.2%	6.0%	5.5%	3.9%
2 or 2+	17.1%	21.8%	16.2%	18.7%
Entry or 1	0.1%	0.1%	0.1%	0.1%
Other relevant qualifications	5.0%	6.7%	2.8%	5.7%
No relevant qualification or non-recorded	71.6%	64.2%	74.4%	70.7%

Note: NMDS-SC Qualification data caveat

Please note that the quality of information received to date on qualifications held within individual worker returns is variable. There are large volumes of returns with no information within the qualifications section; currently the NMDS-SC reports such workers as holding no relevant qualifications/no information.[174]

174 Work is ongoing to allow the NMDS-SC to differentiate between no information provided (for whatever reason) and genuine cases of no qualifications held. The implication for current reporting is that the NMDS-SC will underestimate the levels of qualifications held by the care workforce. Improving worker data is currently a priority of the work being carried out within the implementation stream of NMDS-SC



Part two: Personalised support for people with multiple and complex needs

Chapter 9

1. Background
2. Local strategies and policies to support people with multiple and complex needs
3. Delivering personalised support for people with multiple and complex needs
4. Conclusion

Introduction

Part two of this report focuses on people who have 'multiple and complex' needs. This follows up the concerns raised in an earlier report on the state of social care in England (2005-06) about how well social care services are meeting both their specialist and their ordinary needs. "It is often these small numbers of people who are not offered the special packages of services that mean they can live their lives with dignity."

Most importantly, this section looks at what the personalisation agenda is offering people with multiple and complex needs.

The evidence presented in this chapter is based on:

- **In-depth fieldwork**[175] in five anonymised English councils providing a range of geographical location; of authority types; of socio-demographic characteristics; of CSCI star-rating attainment, and of different points of engagement with the personalisation agenda. This involved analysis of policy and procedural documents; analysis of case records of people with complex needs; visits to services and consultation with people using them; semi-structured interviews with 76 respondents at policy, operational and front-line levels; and semi-structured interviews and focus groups with 35 people using services and carers.
- **Findings from recent local CSCI inspections of councils** into the independence, wellbeing and choice agendas.
- **Analysis of other documentary sources and research evidence**.
- **Data from the Individual Budgets Evaluation Network – IBSEN**, drawing on interviews with project leads for Individual Budgets, funding stream lead officers and front-line staff from the Individual Budgets pilot projects in 13 sites. The IB data provide a wider context for the fieldwork findings and similarities and differences of findings.
- **Work and studies by Professor Jim Mansell,** a leading expert in the field of learning disabilities and a CSCI Commissioner.

175 The full report is available on the CSCI website (www.csci.org.uk). Henwood M and Hudson B (2008) *Keeping it personal: supporting people with multiple and complex needs: A report to the Commission for Social Care Inspection*

Chapter 9

1. Background

Key points

- There are diverse understandings and definitions attached to the concept of 'multiple and complex' needs. The complexity relates to multiple needs associated with multiple impairments, the severity of need, and challenging behaviour. How complexity is defined can have a significant impact on how people's needs are perceived and how support is constructed.
- The typical diagnostic classifications and service structures adopted by service planners and providers tend to segregate people according to the reason for their impairments, as well as in relation to demographic factors such as age. This is poorly suited to supporting people whose needs fall into more than one category.

- Given the lack of consensus on what is meant by multiple and complex needs, the estimation of the numbers of people involved is a difficult task, and such figures as *are* available do tend to be classified by a person's condition. Recent estimates suggest in 2008 there are 12,567 children (under 18) in England with profound multiple learning disabilities and 50,896 with severe learning disabilities. Between 2009 and 2026 numbers of new entrants to adult social care services with profound multiple learning disabilities are likely to be between 559 and 763 per year. Numbers of older people unable to undertake several activities of daily living are likely to increase to 631,000 in 2012.
- Three key factors are highlighted in evidence to date that impede a flexible and individual response to people's needs: poor strategic commissioning that results in restricted choice and access both to mainstream and specialist services and a reliance on inappropriate out of area residential provision; a lack of person-centred care; and the marginalisation of human rights. Most importantly there is frequently a lack of ambition and a prevailing negativity as to what people with multiple and complex needs might achieve. This study explores how well these issues are being addressed to meet the aspirations of *Putting People First* for people with complex needs.

9.1 The response of councils and other agencies to people who are deemed to have 'complex' or 'multiple' needs is critical. Are these needs properly addressed, or do people risk falling between the boundaries of groups defined in terms of age, diagnosis, or by generic care group characteristics? Do local agencies work in partnership to ensure that needs that cross traditional organisational boundaries are met holistically and that people do not become stuck in service silos? Most importantly what does the emerging personalisation agenda (as set out in the concordat *Putting People First*[176]) have to offer people with multiple and complex needs?

9.2 These questions are explored in greater detail in this chapter, with a focus on 'multiple and complex needs' in terms of both 'breadth' and 'depth'. 'Breadth' refers to people having a range of different needs, often interrelated, and likely to require support from several different services, and 'depth' refers to needs being serious, intense, severe or profound. This includes people with multiple and complex needs who are in transition between children's and adult services; people of working age with multiple and complex needs and those of pensionable age. A full range of complex needs arising from learning disabilities, mental health, physical and sensory disabilities and older age are addressed.

What is meant by 'multiple and complex needs'?

9.3 There are diverse understandings and definitions attached to the concept of 'multiple and complex' needs. Both in the research literature and in the experience of the fieldwork, it is

176 HM Government (2007) *Putting People First: a shared vision and commitment to the transformation of adult social care*

apparent that complexity is a contested term, with no consensus of definition, that attracts what has been described as a 'surplus of meaning.'[177]

"We don't actually have a definition of complex need but we do tick a box to say someone has complex needs. I hate putting people into boxes, but basically it's someone who doesn't fit into our usual boxes (...) I would consider a complex need is somebody that I would struggle to find a good solution for."

(Learning disability, team manager)

"Someone might have needs that traditionally don't look complex but for a service they are hugely challenging, perhaps around criminal or sexual behaviour."

(Commissioning manager)

"...we call them maybe complex cases, but it is more that they have a chaotic lifestyle – usually because of drugs or alcohol."

(Social worker)

9.4 In addition to defining multiple and complex needs in terms of the breadth and depth of individuals' needs and their complex interaction, other definitions focus on the multiple problems that are presented to *services*, particularly when people have behaviour problems. In the UK the notion of '*challenging behaviour*' is frequently adopted as a means of describing people whose behaviour presents a significant challenge to services, whatever the presumed cause of the problem. The definition, coined over 20 years ago by Emerson et al,[178] is still used today:

"Severely challenging behaviour refers to behaviour of such an intensity, frequency or duration that the physical safety of the person or others is likely to seriously limit or delay access to, and use of, ordinary community facilities."

9.5 In the case of learning disability (the context in which this term is most frequently used), Mansell[179] has suggested this covers a diverse group that includes people with all levels of learning disability, many different sensory or physical impairments, and presenting some quite different kinds of challenges. It includes, for example, people with mild or borderline learning disability who have been diagnosed as mentally ill and who enter the criminal justice system for crimes such as arson or sexual offences, as well as people with profound learning disability, often with sensory impairments and other physical impairments or health conditions. It is also used to refer to people with more moderate learning disabilities in conjunction with a diagnosis of autistic spectrum disorder.

9.6 Mansell's conceptualisation is similar to that adopted by the joint CSCI and Healthcare Commission's current investigation of the commissioning of services and support for

177 Stalker K et al (2003), *Care and treatment? Supporting children with complex needs in health settings.* Brighton: Pavilion Publishing for the Rowntree Foundation

178 Emerson, E et al (1987) *Developing services for people with severe learning difficulties and challenging behaviours.* Canterbury: Institute of Social and Applied Psychology

179 Mansell, J (2007) *Services for people with learning disabilities and challenging behaviour or Mental Health Needs.* London: Department of Health.

people with learning disabilities and complex needs.[180] The definition includes people with difficulties because of:

- the extent of their intellectual impairment
- physical disabilities which severely affect the ability to be independent
- sensory disabilities which severely affect the ability to be independent
- a combination of physical and sensory disabilities
- any behaviour that can severely challenge services
- a form of autistic spectrum disorder
- complex health needs
- a forensic history.

9.7 In the case of 'challenging behaviour', Mansell has pointed to the way in which the original construction of a term can be corrupted over time to imply a different meaning. He notes that when the term was introduced, it was intended to emphasise that problems were often caused as much by the way in which a person was supported as by their own characteristics. He is critical of the drift in ensuing years to using it as a label for *people*, and he consistently uses the term in its original meaning in guidance commissioned by the Department of Health.[181]

9.8 The typical diagnostic classifications and service structures adopted by service planners and providers tend to segregate people according to the reason for their impairments, as well as in relation to demographic factors such as age. Not only does this approach highlight differences between groups (rather than similarities that are shared across boundaries), but it is poorly suited to supporting people whose needs fall into more than one category.

9.9 In this report the term '*multiple and complex needs*' has been the favoured term for two main reasons because:

- we are concerned with a wide range of people from young adults through to people of pensionable age, and we do not wish to use a term that is normally associated with a specific age or condition. As Clare and Cox[182] argue, the advantage of 'complex need' as a shorthand descriptor is that it does not reflect a diagnostic or classificatory approach, but at the same time it emphasises to service planners and providers that their focus should be on responding to need.
- we are exploring the use of a common policy and practice framework rooted in personalisation that is expected to be applied to everyone, whatever their condition or age.

9.10 The definitions explored above were echoed in the views from the field for this study, with three clear positions emerging – the dominant criterion, multiple criteria, and the challenge

180 CSCI, Healthcare Commission and Mental Health Act Commission (2008) *The commissioning of services and support for people with learning disabilities and complex needs: assessment framework.*

181 Mansell.(2007), Op Cit.

182 Clare, L and Cox, S (2003) 'Improving service approaches and outcomes for people with complex needs through consultation and involvement'. *Disability & Society,* 18(7), pp 935-53

to services. How complexity is defined is of more than semantic interest since it can have a significant impact on how people's needs are perceived and how support is constructed. This will be explored further in the course of the chapter.

Numbers of people with multiple and complex needs

9.11 Given the lack of consensus on what is meant by multiple and complex needs, the estimation of prevalence is a difficult task, and such figures as *are* available do tend to be diagnostically classified. There is a particular difficulty in tracing the 'care pathway' of people who have been in contact with several different services as a result of the complexity of their needs. Indeed, in their review, Rosengard et al conclude that the one key finding from the literature is that there is *no* clear picture, at either service or strategic planning level, of people's contacts with different services.[183] However, one study of shared populations of health and social care services in an English county by Keene and Li[184] found that 22% of people using services were in touch with at least two service 'clusters' defined as different delivery agencies.

9.12 Better information is available in the case of specific categories, especially where the problems are long-standing. In the case of learning disability, for example, Emerson has estimated that over the whole country it is likely that about 24 adults with a learning disability per 100,000 total population present a serious challenge at any one time.[185] If accurate, this would suggest that there are over 12,000 people with learning disabilities in England with challenging behaviour. Recent estimates indicate there are 12,567 children (under 18) with profound multiple learning disabilities and 50,896 with severe learning disabilities in England (in 2008). The estimated number of new entrants to adult social care services with profound learning disabilities between 2009 to 2019 ranges between 559 and 763 per year, with an average of 630.[186]

9.13 The position in relation to older people is harder to calculate, and the best estimates are probably those contained in the Wanless Report.[187] In attempting to estimate current and future levels of need, the figures most relevant are for what Wanless calls 'Group 4' – people who are unable to perform two or more core activities of daily living (ADLs). Using a combination of data from different sources it is calculated that the numbers of people in this category will increase from 551,000 in 2002 to 631,000 in 2012 and then to 847,000 by 2026 – an increase over the whole period of 54%.

9.14 Complex and multiple needs across the older population are also likely to reflect additional problems associated with dementia or other cognitive impairment. The combination of cognitive impairment *and* difficulties with daily living activities is particularly strongly

183 Rosengard, A et al (2007) *A literature review on multiple and complex needs.* The Scottish Government.

184 Keene, J and Li, X. (2005) 'A study of a total social services care population and its inter-agency shared care populations'. *British Journal of Social Work,* 35: 1145-1161

185 Emerson, E (2001) *Challenging behaviour: analysis and intervention in people with severe intellectual disabilities.* Cambridge: Cambridge University Press

186 Emerson E, Hatton C (2008) *Estimating future need for adult social care services for people with learning disabilities in England.* Centre for Disability Research, Mencap and Learning Disability Coalition

187 Wanless, D (2006) *Securing good care for older people.* London: King's Fund, p44

associated with the move into permanent residential care. Data cited by the Wanless inquiry suggested that as many as 85% of people with this combination of impairments live in care homes, compared with 25% of those with problems with activities of daily living only, and 12% with cognitive impairment only.[188]

Background evidence about the quality of support

9.15 Three factors are well documented in the research literature which have affected the scope for responding flexibly and individually to people's needs: poor commissioning which has resulted in restricted choice and access to mainstream and specialist services and inappropriate out-of-area residential provision; a lack of person-centred care; and the marginalisation of human rights.

(i) Poor strategic commissioning

9.16 The recent review of commissioning for people with learning disabilities by the Social Care Institute for Excellence[189] concluded that "*far too many localities appeared to be characterised by underdeveloped systems*" for:

- mapping current and future needs, especially at the point of transition
- evaluating the costs and outcomes of placements, especially out-of-area placements
- developing joint protocols, service specifications and other mechanisms for delivering more sophisticated commissioning.

9.17 Recent CSCI inspections have noted the weakness – or indeed the total absence – of a commissioning strategy in some councils as the following extracts indicate:

"Neither a strategy nor an action plan to guide learning disability priorities and deployment of resources existed for 2007-08."

"Commissioning activity was relatively under developed – only approximately 50% of people estimated to have a severe learning disability were known to the council."

"The joint commissioning strategy had no analyses of changing demographics, resources or risks on which to base commissioning for the coming three years."

"The lack of a proper commissioning strategy meant that principled commitments to altered patterns of service were unsecured by clear plans."

9.18 The Healthcare Commission investigation[190] also reported "*limited evidence*" of robust involvement by councils and primary care trusts (PCTs) in the commissioning process, describing this as "*a missed opportunity to influence the safety, quality and cost-effectiveness of service provision*". In these circumstances there can be little assurance about standards of service provision for senior managers, board members or elected

188 Ibid. P.166

189 Emerson, E and Robertson, J (2008), *Commissioning person-centred, cost-effective, local support for people with learning disabilities.* SCIE

190 Healthcare Commission (2007) *A life like no other. A national audit of specialist inpatient healthcare services for people with learning difficulties in England*

members. Most importantly people with multiple and complex needs require a range of services, including some specialist services, which calls for good joint strategic planning as well as effective arrangements to ensure coordinated commissioning and delivery of care.

9.19 A lack of planning for the whole community to ensure equality of access to mainstream services has been illustrated by the recent report from the Joint Committee on Human Rights[191] on the human rights of adults with learning disabilities which received evidence of inadequate access to further and continuing education, transport, healthcare, dentistry, welfare benefits and housing. Similar findings are evident in the Healthcare Commission audit of specialist inpatient healthcare services for people with learning disabilities (*op cit*) which explored the extent to which people were being supported to make everyday choices, and were being actively listened to in order to make them. The Commission reports only "*limited evidence*" that this is happening, with site visits frequently failing to support the claims made in questionnaires by providers.

9.20 Where there is limited choice and access to services and support, little progress on personalisation can be expected, regardless of the sophistication of a person-centred planning process. Robertson et al,[192] in a recently reported study of barriers to the implementation of person-centred planning, for example, found that once a plan had been developed, the limited choice and availability of services was identified as a significant barrier. This was especially the case with day services, housing and community activities. Mansell, too, has shown that commissioners are often failing to undertake the service development required for people with complex needs and are simply contracting with services that are already there.[193]

9.21 In its good practice guidance on specialist adult learning disability health services issued in 2007, the Department of Health[194] refers critically to the highly variable services available across the country, noting that:

- there are still up to 3,000 NHS campus beds in use despite government policy stating that these should be closed and replaced with ordinary housing and support run and managed outside the NHS[195]
- there is a growing use of independent sector hospitals and residential social care services that are often many miles from a person's home and community
- a significant proportion of NHS assessment and treatment centres are effectively 'blocked' as people have lived in them for years due to delayed discharge and a lack of investment in non-bed-based provision.

191 Joint Committee on Human Rights (2008) *A life like any other? Human rights of adults with learning disabilities.* Seventh Report of Session 2007-8. HL Paper 40-1. HC 73-1

192 Robertson, J et al (2007) 'Reported barriers to the implementation of person-centred planning for people with intellectual disabilities in the UK'. *Journal of Applied Research in Intellectual Disabilities,* 20, pp 297-307.

193 Mansell (2007) Op Cit

194 Department of Health (2007) *Commissioning specialist adult learning disability health services: good practice guidance*

195 Recent data from 2008 self-assessment surveys returned by councils to CSCI indicate there are 1,622 adults with learning disabilities remaining in NHS campus accommodation and a further 220 remaining inappropriately in a hospital environment

9.22 The Mansell Report (*op cit*) estimates that there are over 11,000 people with complex needs related to their learning disability who are supported 'out of area' by their local councils in England. This constitutes 31% of all people with learning disabilities supported by councils, and the increasing number of these placements has contributed to the dramatic rise in social services expenditure on such services. Moreover, there is evidence that the quality of support in these settings is often poor as highlighted in the recent national audit by the Healthcare Commission.[196]

9.23 The position in respect of children and young people is somewhat similar. It has been estimated that over 11,000 pupils with a statement of special educational needs are placed in out-of-authority schools, usually children with severe behavioural, emotional and social difficulties (BESD) and autistic spectrum disorders (ASD). Expenditure on these placements is high and has increased steeply in recent years.[197] Mansell (*op cit*) further notes that these placements are often disruptive of ties with family and community, so that families face particular problems getting local services that can provide the level of support needed when responsibility passes from children's to adult services.

(ii) Lack of person-centred care

9.24 People with complex and multiple needs require personalised solutions and very skilled staff, including support staff as well as managers of residential and home care services who can provide the necessary practice leadership.[198] There are good person-centred service models[199] but a limited number are evident in practice.[200] Again much of the evidence is from the field of learning disability, with the most recent data contained in the report of the Healthcare Commission (2007 *op cit*). It is clear from this investigation that although the rhetoric of a personalised approach to support is now widespread, there are some routine failings in much practice.

9.25 In a different field, a study from the Commission for Social Care Inspection on the experience of people with dementia living in care homes used a new observational process – the Short Observational Framework for Inspection (SOFI) – to look at the experience of 424 people with a diagnosis of moderate to advanced dementia.[201] This is a tool based on person-centred approaches that treats people as individuals with a unique history and personality, listens to their 'voice' and recognises that all human life is grounded in relationships.

196 Healthcare Commission (2007) *A life like no other: a national audit of specialist inpatient healthcare services for people with learning difficulties in England*

197 Audit Commission (2007) *Out-of-authority placements for special educational needs*

198 Beadle-Brown J, Hutchinson A, Whelton B, *A better life: the implementation and effect of person-centred active support in the Avenues Trust.* Tizard Centre, University of Kent and Avenues Trust, Kent

199 See for example Ashman B, Beadle-Brown J *A valued life: developing person-centred approaches so people can be more included.* United Response and Tizard Centre, University of Kent

200 Mansell J, McGill P, Emerson E (2001) '*Development and evaluation of innovative residential services for people with severe intellectual disability and serious challenging behaviour'* in International Review of Research in Mental Retardation (vol 24), New York: Academic Press

201 CSCI (2008), *See me, not just the dementia. Understanding people's experiences of living in a care home*

9.26 Earlier inspection work by CSCI has found that people with dementia do not always receive good person-centred care, while other research has also documented the poor quality of life for some people with dementia living in care homes,[202] [203] and inadequate services for all people with dementia.[204] Improving the quality of care for people with dementia is one of the three key themes of the draft National Dementia Strategy issued for consultation in June 2008.[205]

9.27 The CSCI report found that over one-third of homes inspected failed to meet statutory requirements on the quality of their care planning, and staff were sometimes not involved in the process and would have *"little background information on which to judge what someone's wishes or preferences might be."* The report also documented some poor practices around communication and observed that *"the quality of staff communications has a great bearing on how people with dementia feel".*

9.28 Other work has highlighted the importance of person-centred approaches and the techniques for support planning that are especially productive in working with older people. Helen Bowers and colleagues have emphasised that self-directed support is not just about money; for older people having increasing control and a 'different menu of support' are the biggest attractions.[206] Without person-centred support Bowers et al argue that older people's lives become fragmented into a 'service world' and 'ordinary life', with apparently poor connection between these two and with services playing little role in supporting or restarting ordinary life.

9.29 Recent work between the Centre for Policy on Ageing and the Older People's Programme to explore older people's experiences of living with high support needs, focusing on those moving to and living in care homes and using other kinds of supported accommodation, has highlighted the lack of a voice for these older people. This means that people cannot exercise choice and control over their support or any aspect of their life. The project identifies the need for significant cultural and structural changes taking an approach that is "*based on citizenship and a focus on personal identity, self expression, individual aspirations and fundamental human rights".*[207]

(iii) The marginalisation of human rights

9.30 Evidence of the marginalisation (or even denial) of human rights to people with multiple and complex needs is the most fundamental problem of all, for if these are denied then there can be no improvement in people's lives on any other dimension. People with multiple and complex needs are most at risk of not having their rights respected. There is considerable evidence

202 Help the Aged, National Care Forum and National Care Homes Research and Development Forum (2007) *My home life. Quality of life in care homes. A review of the literature*

203 Alzheimer's Society (2007) *Home from home. A report highlighting opportunities for improving standards of dementia care in care homes*

204 National Audit Office (2007) *Improving services and support for people with dementia*

205 Department of Health (2008) *Transforming the quality of dementia care: consultation on a national dementia strategy*

206 Bowers H, Bailey B, Sanderson H, Easterbrook L, Macadam A (2007), *Person centred planning with older people: Practicalities and Possibilities,* CSIP/In Control.

207 CPA briefings (2008) *Older people's vision for long term care* http://www.cpa.org.uk/policy/briefings/older_peoples_vision_long_term_care.pdf

that guarantees of such basic rights are not routinely in place. The Mencap Report, *Death by indifference*,[208] highlighted six examples of institutional discrimination against people with a learning disability, and drew attention to a number of contributory factors. One common factor across all of the cases was that the individuals had severe or profound learning disabilities, with little or no verbal communication. Subsequent investigations in Cornwall[209] and Sutton and Merton[210] NHS Trusts also highlighted a correlation between increased levels of impairment and abusive practices, including sexual abuse, physical abuse, deprivation of liberty and institutional practices.

Summary of context to this study

9.31 The wider literature and reports demonstrate the gap between the rhetoric of inclusion for people with multiple and complex needs and the reality of their circumstances. The dominant framework has been a disease-based model that focuses on individual pathology, and although there are many situations where medical skills and knowledge are invaluable, this model does not always provide the best foundation for responding to longer-term, non-acute conditions or for promoting social inclusion.

9.32 It is in this context that personalisation is seen as a way of introducing choice, control and flexibility into the lives of all people who use services, including those with multiple and complex needs. Individualised services may be achieved in a range of ways – well-coordinated services that transcend traditional boundaries, person-centred planning, Direct Payments, the ***In Control*** model, Individual Budgets, personal budgets and others. Although initially practical models have been developed primarily in the context of support for adults with learning disabilities, they are now seen as equally appropriate for people of every age and all types of circumstances that might be described as 'multiple and complex needs'.

9.33 It is important to acknowledge the severity of need for people with 'multiple and complex needs' and thus the implications for services. 'Multiple and complex needs' includes:

- ***multiple needs*** often due to multiple impairments and hence a number of agencies may have to be involved
- ***a severity of need*** that is likely to be an issue in itself for services (for example a person with profound and multiple learning disabilities who has difficulty swallowing will need skilled assistance to eat their meals)
- ***challenging behaviour*** that may require one-to-one support.

9.34 The following experiences of a young man illustrate a number of supports and dilemmas for people with complex needs and what can be achieved to personalise support. The next section of this chapter looks at the progress being made to personalise support for people with complex needs, focusing on local strategic developments and personalisation policies and the factors that are promoting or impeding developments across the country.

208 Mencap (2007), *Death by indifference*

209 Commission for Social Care Inspection/Healthcare Commission (2006) *Joint investigation into services for people with learning disabilities at Cornwall Partnership NHS Trust.*

210 Healthcare Commission (2007) *Investigation into the service for people with learning disabilities provided by Sutton and Merton Primary Care Trust*

Example 1
The experience of a person with complex needs

Roy Jones[211] is a young man in his mid-20s who has cerebral palsy, learning disability and epilepsy and is reliant upon other people for meeting all of his needs. His communication consists of gestures and his preferences can only be discerned by people who know him very well indeed.

After his schooling had ended, Roy was offered a place at a residential college but his parents were not convinced this would best meet his needs and opted for him to remain at home and attend the local day centre that adjoins the special school. Although the centre is not popular with his social worker, Roy's parents are appreciative of the specialist equipment and attention that Roy receives.

Although happy for Roy to remain living at home after the end of his education, Mr and Mrs Jones were keen for him to have a place of his own to live – *"like other young men"* – and this became his main goal. In the meantime he accessed a Direct Payment for support in getting out of bed in the morning and having a shower before going out. Roy's parents were less than satisfied with the quality of support, especially the high staff turnover and the absence of training and preparation for understanding Roy as an individual.

In Roy's locality the council was introducing the *In Control* model, and he was assessed under the Resource Allocation System (RAS) for an 'indicative amount' of £50,000 per annum. Although this was insufficient to fund his own housing, Roy had two friends at the day centre whose parents were also looking at the possibility of supported living. The three young people and the families all knew each other and agreed to pool all of the available funding to secure suitable accommodation and support. The council's calculations assumed that support through the Independent Living Fund (ILF) would be available on top of the combined indicative budgets.

It proved difficult to find an accessible four-bedroom bungalow, but in the meantime tenders for providing the support element were invited. Four providers expressed an interest, and were interviewed by the three families themselves in their own homes, with a social worker present. This process worked well and a provider was selected. Finding a housing provider proved to be more difficult but eventually (and after much complication) a specialist learning disability housing association agreed to undertake the task on the basis of a three-way shared ownership arrangement. In total it took three years to make these arrangements.

Roy's story has aspects of almost all of the various services, supports and dilemmas that can be found in the circumstances of people with complex needs – the problem of transition from adolescence to young adulthood, the role of traditional day centres, the use of Direct Payments and access to appropriate supported living. In Roy's case he has been well supported by committed and loving parents, and an experienced and creative social worker.

211 None of the names quoted in this study are the actual names of the people concerned

2. Local strategies and policies to support people with multiple and complex needs

Key Findings

Commissioning challenges

- Government policy on increasing the availability of appropriate local provision for people with multiple and complex needs is well established. Councils in our study had strategies to promote independence and choice and were concerned to address reliance on residential provision outside of their area.
- The cost of funding these placements was seen as unduly expensive and diverting resources that could be used to develop local services. There were frequently expressed concerns about the quality and cost-effectiveness of out-of-area provision; and the study found there was weak contracting and inadequate contract monitoring.
- It was rare for independent sector providers to be involved in strategic meetings about the implications of personalisation and development of new types of services.

Working in partnership and across boundaries

- Coordinating services and taking an effective 'whole-person' approach to support people with multiple and complex needs was challenging for all the councils in this study.
- Although there have been steps to improve the transition from children's to adult services for people with multiple and complex needs, some of the key agencies (particularly health) tend to take a very rigid approach at odds with the personalisation agenda.
- Relations between councils and Learning and Skills Councils have become more difficult in recent years as costs have come under greater scrutiny and are now the subject of dispute and negotiation, most commonly in the case of residential college placements.
- Moving from school to college (out-of-area or local) at the age of 18 or 19 is no longer something that can be taken for granted by young people with complex needs.

The health-social care interface

- Relationships between councils and PCTs are reported to have improved in many respects, and where these are robust then it is feasible to deliver coordinated and personalised support.
- The biggest reported area of contention remains Continuing Healthcare. The introduction of the National Framework had generally been felt to have led to some improvements, but basic problems of access remained.

- There is now an additional difficulty – the potential *consequences* of accessing Continuing Healthcare which can mean the loss of jointly funded care packages and Direct Payments. This is in direct conflict with policy on personalisation.

Boundaries between different income streams

- The evaluation of Individual Budget pilots indicated difficulties in bringing together funding streams and that often only broad alignment rather than integration was possible. Most difficulties reported in the councils for this study, and in the Individual Budget evaluation, were in respect of the Independent Living Fund (ILF) with concerns about incompatibility with personalisation objectives because of restrictions in the way that ILF monies must be spent.

Developing and implementing local personalisation policies

- Whilst the aims of prioritisation are widely shared and accepted, there is some scepticism and even opposition at local level about the implementation of policy on personalisation through Individual Budgets. Whilst the picture for council staff and professionals is mixed, the study found a generally negative stance to implementation taken by local politicians.
- None of the councils in the study had a settled approach to the self-assessment questionnaire and were all grappling with some of the practicalities of refining their Resource Allocation System so that it resulted in indicative personal budgets that were affordable to the council.

9.35 In this section we identify three key policy and strategic challenges affecting the development of personalised support to people with multiple and complex needs:

- changing traditional patterns of commissioning,[212] particularly a dependence on out-of-area provision
- working across several boundaries with partner organisations to ensure a 'whole-person' approach to supporting people
- developing personalisation policies.

Traditional patterns of commissioning and out-of-area placements

9.36 In all the councils in the study commissioning strategies for specific care groups had clear statements of the vision for future developments and an emphasis on promoting independence and choice. Joint strategic needs assessments informed commissioning intentions and deficits in service development were identified. Councils were aware of the need to address reliance on out-of-area placements which had developed for historical reasons, or because of a continued failure to commission sufficient specialist local services. However, it was rare for independent sector providers to be fully engaged in

212 The Commission for Social Care Inspection, Healthcare Commission, and Mental Health Act Commission are undertaking joint work to assess how councils and primary care trusts commission services and support for people with learning disabilities with complex needs. A report is to be published in 2009

strategic debates about the implications of personalisation and while some providers were enthusiastic about the opportunities that might exist for developing new services, most were either poorly informed about the potential of personalisation or struggled to see how it would affect their service provision.

9.37 Reliance on out-of-area residential provision (primarily for people with severe learning disabilities, particularly in conjunction with physical disabilities) was a concern in all the fieldwork sites, although none of the councils in our study was an extensive users of these.[213] Government policy on increasing the availability of appropriate local provision for people with multiple and complex needs was clearly understood. However, out-of-area placements continue to be made for predominantly negative reasons, such as placement breakdown and dissatisfaction with local services. Most such placements are in the independent sector, often in large settings, and tend to disrupt relationships with family and friends, as well as having other disadvantages for people using services. From the point of view of commissioners, an equally important problem was the cost of funding the placements, which were seen as unduly expensive and diverting resources that could be used to develop local services. As one of the elected member interviewees stated:

"We can't make any straightforward calculations about our budget. All we need is someone to come out of hospital needing a massive care package and that would hit us really hard."

9.38 All the councils taking part in this study were aiming to reduce dependence upon such costly placements. Leads in the Individual Budget pilot sites were anticipating that cost savings made with particular care groups (typically people with learning disabilities who were brought back into the authority from expensive out-of-area placements) could be used to offset the higher costs of introducing Individual Budgets among other groups of people (typically older people). It was too early to determine whether this proved to be the general experience of implementation. However, others were concerned that any savings made in the short term would be cancelled out by the impact of demographic changes, in particular the ageing population and the increase in older people with more complex needs requiring more complex and costly support.

9.39 Councils were also concerned about the *quality* of out-of-area provision, particularly that of specialist residential colleges for young people. One manager in adult care services found it difficult to comprehend the reasoning behind some such placements by children's services, suggesting poor strategic coherence between children's and adult service agendas despite the greater emphasis on improved transition:

"It feels like there is a disjuncture in culture between us and children's services in terms of out-of-area placements. They are not placements we would have. It has almost set up a culture that is counter to the culture we want to develop."

9.40 Other interviewees similarly highlighted the difficulties associated with out-of-area placements:

213 According to a classification by Emerson and Robertson (2008), (Op Cit.) Their data shows considerable variation, from one London borough externally placing around 90% of its supported residents, to a northern city only placing about 5%. In general the London boroughs use significant numbers of out-of-area placements, whilst the North East and Yorkshire and Humber use few

"They disappear off to residential college for two or three years and have a wonderful time and then they have got to be moved back. In theory, they are supposed to be getting prepared for supported independent living but the reality is quite different. They are learning a set of skills that aren't easily transferable."

(Transitions coordinator)

9.41 As the following comments illustrate, there were major concerns about the quality of the care provided at a distance, and about the disparity between the claims made by some providers and the reality of experience:

"Lots of places sell themselves saying they do A, B and C and then say 'oh we have difficulties, we have a staff shortage'. It's just one thing after another."

(Transitions coordinator)

"Certainly one place that we went to [look at] – the fabric of the place was fantastic (...) I met the manager, I talked to the staff, and it was (...) you know people are seduced by what they saw but not what they got (...) in this particular environment, the young people, one of whom has a disability the same as [my son], their needs are appallingly met. And yet, ostensibly, you walk through the door and you think 'wow, this looks very smart'."

(Mother of a young man with learning disabilities)

9.42 Some similar concerns were expressed about adult placements:

"Many of these specialist services out of county would claim to be doing a person-centred approach but the reality is that its containment...they haven't been delivering."

(Area manager, learning disability)

"Once they have got them at 19 they think they have got them for life. There is a complacent attitude of 'we are wonderful at what we do'. They might be good at some things like keeping the person safe, but how much do they access the community? I wouldn't want to be watching Fireman Sam DVDs back to back."

(Transitions coordinator)

9.43 However, some were critical about the narrow definition of what constitutes 'out of area' where services were literally 'a street away'.

"Every authority can't have provision for every type of complex need. Some people's needs will inevitably be better served with a placement that is not in this area."

(Senior manager)

The emphasis upon local provision may obscure the possibility that this may not always be the most appropriate setting for some individuals – partly because of their specialist needs, and partly because local provision may not be sufficiently well developed (a particular challenge in smaller councils). An acknowledgement that local provision may not necessarily be most appropriate was a prominent theme in our study, as the following comments illustrate:

"A lot of our business comes from people being moved out of hospital into badly supported settings. People are being moved, but not for the right reasons."

(Specialist independent provider)

"Bringing people home is a later piece of work. The first, and more difficult, piece of work is to improve the local choice for local people now so that it doesn't have to happen again. Very few people are doing that."

(Independent provider)

"Every authority can't have provision for every possible type of complex need. Some people's needs will inevitably be better served with a placement that is not in this area."

(Senior manager)

9.44 Some respondents acknowledged that it was sometimes inappropriate to contemplate bringing people back from out-of-area placements, particularly if they have lived there a long time and have few if any links with their original residence:

"It's been undertaken with a dogma that is really quite unsettling where people are being moved against their will into a local area that they don't wish to move to and have no interest in moving to. We have had a number of examples of this. If any of us were moved to where we grew up without involvement from ourselves it would be a national scandal."

(Independent provider)

"It's a directive that comes out and everybody has to follow it. The poor individual for whom it is meant to improve things is not considered in a lot of cases. It's a big frustration for us."

(Independent provider)

9.45 There was evidence in this study of poorly constructed and monitored contracts. Commissioners acknowledged that objectives are not always clear in contracts and hence reviews are not effective. Providers, too, reported highly variable experiences of contact and contract monitoring. In some cases even where there was regular contract monitoring they felt the focus was on the wrong issue.

"The difficult relationships are those commissioners who are looking entirely in terms of inputs – an occupational therapy report, a speech and language therapy report and so on – regardless of whether these are meaningful or helpful to the individual, and certainly regardless of whether they lead to a positive outcome for the individual. It's a very poor use of clinical time and makes everything too expensive."

(Independent provider)

Working in partnership to take a 'whole-person' approach

9.46 People with multiple and complex needs frequently have needs that cross established professional and organisational boundaries. A CSCI inspection report noted that 10 agencies and carers had been involved in one project for people with high support needs. Developing an effective 'whole-person' approach to support people with multiple and complex needs proved to be very challenging for all the councils in this study. Several key boundaries were

identified: at the transition from adolescence to young adulthood; between adult social care and the NHS; and between individual budget income streams.

9.47 **Transition from adolescence to young adulthood** is characterised by a plethora of guidance developed at national level, and many localities now seem to have appointed transition coordinators or created transition teams to address the issue. There was a widespread view in the fieldwork sites that the transition process had improved in recent years with councils now much more confident about the quality of their information on the number of young people coming through the system, and the nature of their needs. In most of the councils the transition period had also been used to pilot personal budgets and prepare the ground for the changes taking place in adult social care. But despite these efforts, the transition process continues to be affected by boundary issues of various types.

9.48 There is no consensus across the various agencies as to when adolescence ends and young adulthood begins. Some of the key agencies seem to take a rigid approach defined variously at age 16, 18 or 19 with different criteria followed by different parts of the health, education and social care system (as highlighted in an earlier CSCI study).[214] As one transitions coordinator noted:

"The problematic area is getting the involvement and commitment from health colleagues around anyone moving from children's services into adult services. They have different criteria that I'm still not clear about. It just all works so differently."

9.49 The Learning and Skills Council (LSC) has a specific duty to have regard to the education and training needs of learners with disabilities, and is aided by the local LSCs that have been established in England, each of which will have a designated contact person for disabilities and must consult local councils on their policies and priorities. A common view expressed in this study is that relations between councils and LSCs have become more difficult in recent years as costs have come under greater scrutiny, and new rules are being applied. Councils reported that costs that were previously met by the LSC are now the subject of dispute and negotiation, most commonly in the case of residential college placements.

"There is now an expectation that we will contribute. The standard formula is 30% from social care and 20% from health if the person has a significant health need. We pay but some authorities don't."

(Transition worker)

9.50 Additional issues were identified with LSC funding which relate to the restrictions on access to courses. Moving from school to college (out-of-area or local) at the age of 18 or 19 is no longer something that can be taken for granted by young people with complex needs. Part of the problem here is the LSC requirement that people in educational settings must be able to demonstrate evidence of 'progression' – something that can be difficult or impossible to achieve in the cases of some young people with multiple and complex needs. This in turn has a significant knock-on effect for adult social care with young people entering adult social care services rather than accessing educational support, as this service manager explained:

214 CSCI (2007) *Growing up matters: better transition planning for young people with complex needs*

"Colleges are saying 'we can't hit our targets with these people' so they now come to us at 18. They are the only people we actually support in day services – we have not taken any new referral from any other source for three years, only young people with complex needs because we can't support them elsewhere."

9.51 What all of these boundary disputes can result in is a game of budgetary 'pass the parcel' in which the people whose interests should be at the forefront find themselves marginalised as agencies argue over who will foot the bill.

9.52 **Adult social care and the NHS**: People with multiple and complex needs generally require support from both the NHS and social care. There is wider evidence that relationships have improved in many respects,[215] [216] and this was confirmed in some of the sites in our study, especially in those localities where the council and the PCT have coterminous boundaries.

9.53 Given the high cost of supporting people with multiple and complex needs, it is unsurprising that where disagreements arose they tended to be about funding. In some cases this involved alleged withdrawal from established agreements or perceived misuse of specific funding allocations.

9.54 By far the biggest reported area of contention, however, is Continuing Healthcare (CHC), though here too there was some limited evidence of fairly good working relationships in our study. More typically, Continuing Healthcare was reported as an area of ongoing contention:

"There is a real steer coming from the SHA [Strategic Health Authority] saying that people with learning disabilities probably generally won't be eligible under CHC. I find that bizarre and we will be resisting that manfully."

(Senior manager)

9.55 The introduction of the National Framework for CHC in October 2007[217] was generally believed to have led to some improvements, but some basic problems remained:

"Thankfully we now have a little more consistency since the National Framework was introduced. Prior to that it was a nightmare, an absolute nightmare. But a lot depends on each nurse assessor team. You can have very different types of people, sometimes leading to very different types of working relationships and different decisions."

(Team manager, physical disabilities)

"It has changed the balance – it was so narrow before. In terms of people with challenging behaviour we are getting more confident about putting an application in. We are getting a feel for it."

(Senior manager)

215 Henwood, M (2006) 'Effective partnership working: a case study of hospital discharge'. *Health and Social Care in the Community* 14 (5), 400-407

216 House of Commons Health Committee (2005), *NHS continuing care*, Sixth Report of Session 2004-05

217 Department of Health (2007), *National Framework for NHS Continuing Healthcare.*

"We've got criteria but in a way you can interpret them how you like. The PCT is good on obvious ones like high health needs, rapid deterioration and unstable conditions, but I don't think they understand intensity and complexity."

(Area manager, adult services)

9.56 In addition to all of these issues around *access* to CHC and ensuring that criteria are based on need and not diagnosis, there is now an additional difficulty in the context of the personalisation agenda – the potential *consequences* of accessing CHC. The main concern being expressed is the potential loss of personalised support. Once CHC funding has been agreed for an individual then the general understanding of the legal position is that Direct Payments and support from the Independent Living Fund are no longer possible, and this is likely to mean that existing personalised support arrangements will cease. Certainly this was the common experience across the sites in this study:

"At the moment there appears to be little flexibility. If someone is coming through transition with direct payments and ILF and are then continuing healthcare funded, they will lose the flexibility in their support."

(Learning disability team manager)

"People who are CHC funded gain financially but lose in terms of choice and control. The NHS is a very patriarchal, clinical-led organisation in which the professionals know best and people are 'done to' rather than being part of person-centred planning. These individuals are at risk of losing a package of support that works for them."

(Team manager, physical disabilities)

9.57 As this manager described, this has led to perverse incentives *not* to seek fully funded CHC:

"And it always used to be, 'let's hope this person gets 100% continuing care funding.' Now it tends to be, 'well, let's hope they get 95% or 90%' because then there's ability to commission and pay for that social care bit (...) at the moment it's very rigid. If somebody has 100% continuing care we have experienced difficulties in how you commission those (...) flexible services."

(Learning disability, team manager)

9.58 For some individuals with complex support arrangements founded upon long-serving and trusted personal assistants (many of whom are regarded as friends rather than employees) the transition to fully funded CHC was viewed as a potential disaster rather than a financial gain – and in some cases had led to a refusal to leave council-funded care. As this person facing the prospect of eligibility for CHC remarked:

"The social worker tries his best for me. I tell him what I need and he organises it. But once I go on this NHS care he won't be part of it and I don't know where I will go. Jean (PA) has got to stay with me. She has practically lived with us for four years, she's here every day."

9.59 Overall, although there is some evidence of good PCTcouncil relationships and of positive practice with individuals, there are still some major fault-lines. Funding pressures too easily result in unilateral actions that are perceived as a betrayal of trust, and this in turn bedevils future partnering. Attempts to clarify responsibilities through CHC have helped to some

extent but have also resulted in some perverse consequences for the support of vulnerable individuals. The possibility of including CHC funding within Direct Payments through NHS personal budgets was one that was seen by most interviewees as logical and welcome. This is explored in greater detail below.

9.60 **Individual Budget streams**: One of the key features of Individual Budgets is the proposed bringing together of a variety of streams of support and/or funding, from more than one agency. Evidence from the evaluation of the Individual Budget pilot sites indicates that integration of different streams has been hard to achieve and that the best that has been possible has been broad alignment. In our fieldwork sites the difficulties with different funding streams were identified most frequently in respect of the Independent Living Fund (ILF). Despite many positive views about the role of ILF assessors, there was widespread concern about apparently reducing flexibility and incompatibility with personalisation objectives because of restrictions in the way that ILF monies must be spent solely on 'personal care and domestic assistance', rather than on other support that may contribute to independent living outcomes.

9.61 The IBSEN evaluation similarly found that the constraints of the ILF Trust Deeds meant that integration with social care funding during the duration of the pilot was not possible. Instead, the ILF and the pilot sites attempted to align and fast-track some of their processes, but there remained frustration at the time taken for an ILF application to be turned around.

9.62 Taken together the problems of integrating income streams posed major question marks in the fieldwork sites over the notion of multi-stream Individual Budgets, as opposed to single-stream personal budgets consisting solely of council adult social care monies. This is a national policy issue that needs to be addressed.

Developing and implementing personalisation policies

9.63 Developing personalisation policies for people with all types of care and support needs, not just those with multiple and complex needs, is currently the biggest single challenge facing adult social care, and was certainly an issue that preoccupied all of the sites in this study. Across the councils there were clearly supporters, doubters and opponents of the implementation of policy on personalisation, including the mechanisms of Direct Payments and Individual Budgets.

9.64 Perhaps the most consistent constituency of opposition (in all but one council) – regardless of political party – was that of elected members. Here the concerns often went beyond matters of practicability and into issues of principle:

"The politicians were very resistant to Direct Payments. They have a real problem with the inequity of it and the impact on the workforce – that it could be the end of the in-house provider. They felt that if you got money through a DP [direct payment] then you could choose something that people without a DP couldn't choose, therefore nobody should get the choice."

(Service manager)

9.65 Another elected member, who felt he had drawn "*the short straw*" in becoming lead member for adult services, felt the policy had no financial reality:

"At what point do you want to start printing money? Forgive my cynicism but we are in the real world and having to make £22m of budget reductions over four years."

9.66 In none of our fieldwork sites were politicians driving the debate or advancing the case for personalisation. In the council where there *was* a more positive stance on the part of the executive member for adult care, this was expressed only in terms of generalised support for the concept of personal budgets, rather than through a specific vision for transformation. Officers were pursuing the personalisation agenda with varying degrees of enthusiasm in the face of conditional support, indifference and outright resistance from members.

9.67 All of the sites were still at an early stage of development of a Resource Allocation System (RAS). The first step had been to choose (or develop) one of the self-assessment questionnaires that have been developed by *In Control*, and to then use this as the initial basis of the RAS. Both of these tasks were preoccupying the councils. These issues are discussed further in the next section of the chapter that looks at delivering personalised support. Whatever approach is adopted there is no escaping the need to articulate a rationale for allocating resources between competing priorities, and the potential effect of the transparency of the Resource Allocation System was a major preoccupation of politicians and officers in this respect. The CSCI review of eligibility criteria highlighted the development costs of all councils working on local resource allocation systems and the need to consider a single, national resource allocation formula to increase clarity and transparency and reduce variations likely to emerge locally.[218]

218 CSCI (2008) *Cutting the cake fairly: CSCI review of eligibility criteria for social care*

3. Delivering personalised support for people with multiple and complex needs

Key Findings

Assessment and care management

- Examples of good practice in assessment and person-centred planning were identified (particularly in developing individual communication passports) but it was recognised that overall the quality is variable.
- In practice, and particularly for people with complex needs, self-assessment entailed intensive support from care managers, more demanding of staff time and skills than traditional professional assessment.
- Staff working with people with very complex needs knew of a range of sensitive ways to communicate with them but there was evidence that this was not always happening in practice.

Direct Payments and Individual Budgets

- While there was broad support for the principles of personalisation, this was qualified by certain reservations by some councils, including doubts about providing personal budgets for certain groups of people, particularly those with 'chaotic lifestyles' and people with severe learning disabilities.
- There is a significant minority of people using services, and of carers, who are hostile to the idea of direct payments or personal budgets. These objections were often based on a fear of being left to cope with inadequate support and a reluctance to take on what was seen as onerous demands.
- People with multiple and complex needs are using Direct Payments in a variety of ways – from simply fine-tuning conventional support packages to developing highly creative and individual support.
- A significant minority of council staff expressed scepticism about the Individual Budget model and the *In Control* approach which they did not believe had been adequately tested in supporting people with complex needs.
- The rules restricting Direct Payments to people who have capacity to consent have constrained developments for some people with complex needs. Some councils had found creative ways around these legal impediments (such as through user-controlled trusts) ahead of the relaxation of rules following the Health and Social Care Act 2008.
- Transparency of the Resource Allocation System has highlighted concerns about equity between different groups of people who use services and the more limited opportunities and financial support available to older people with complex needs.

Range of services

- CSCI inspections have identified concerns over limited, traditional and insufficiently flexible services. In the councils in this study these concerns were also identified in respect of support for people with complex needs. A significant proportion of people with complex needs, and of their carers, were conservative in their service preferences and resisted attempts to reconfigure support – particularly day opportunities. This reflects a number of experiences and viewpoints, partly about concerns of being left without sufficient help; and in some instances where people have become 'institutionalised' and fear moving on to use a range of different services.
- Typically councils were having to double-run traditional and new models of support and to approach the transition between the two with caution.
- Many of the success stories in using personal budgets featured new patterns of support often developed with the help of exceptional caring families and of visionary and committed care staff.

Support and advocacy

- The balance between choice and control on the one hand and increased risk on the other was identified as a concern in all the councils but there was little evidence of clear risk strategies.
- The interests of family members can conflict with those of the person with complex needs and highly skilled interventions may be required to help people find the support they need. But advocacy services were generally under-developed (with some notable exceptions) and there is considerable confusion about different types of advocacy and how it differs from brokerage.

Flexibility and accountability

- The balance between flexibility and accountability was continuing to evolve in all the councils. It was recognised that there are tensions between maximising flexibility for people using services while also ensuring accountability and appropriate use of public money and there were all shades of opinion on such matters.

9.68 This section considers the key components for delivering personalised services for people with complex needs – whatever the nature or origin of those needs:

- assessment and care management
- promoting independence and choice
- range of services
- support and advocacy
- flexibility and accountability.

Assessment and care management

9.69 The quality of practice was variable in the study sites, also reflected in recent CSCI inspections of assessment and care plans in other councils. In particular, care planning has been seen as unfocused and unambitious; service rather than needs-led; and heavily task focused. Across the fieldwork sites much assessment and care planning was focused on what people are unable to do rather than on individuals' strengths and qualities. This was vividly portrayed in one of the councils where a middle-aged adult with physical impairments was critical of the deficit approach of assessment:

"There is a feeling and you have to fight against it, but the only way that you are going to get the help us not by emphasising the positive points; you have to emphasise your negative points (...) it's not a question of saying 'I can do this but I need help to do it.' It's always – I can't do something."

Not only did this approach fail to recognise the richness and complexity of people's lives, but it failed to support or promote independence. Person-centred planning was not yet the norm, as this comment indicates:

"I think we have pockets of outstanding person-centred planning; and we have an amount of tokenistic person-centred planning if I was honest."

(Operations manager, independent provider)

9.70 It was acknowledged that it is easy to pay lip service to person-centred planning and assessment, but much harder to do it well. One of the tools employed in at least three of our sites was the development of 'communication passports'. These documents provide the essential information which says 'this is who I am'. Staff described the value of these documents:

"This is what I like and this is how I am communicating and this is what I am telling you. So when I do this, this is what I mean (...) I think it takes a long time to develop some of that, to get some of that information about some of the people we work with."

9.71 Such accounts as the following extracts are typical of the content of these good quality plans or passports:

"My name is...I have Down's syndrome. I'm allergic to penicillin; I've been diagnosed with dementia and paranoid schizophrenia. I may shout and cry, sometimes about things that I have imagined happened."

"My dementia has had an effect on my eating habits (...) sometimes I will say 'ham' or 'sandwich' (...) this does not necessarily mean that I want these specific foods, just that I want something to eat (...) it is important that staff keep offering me drinks throughout the day, as I am unlikely to pick them up myself."

9.72 Self-assessment was widely viewed as a misleading term, and in practice it was found that self-assessment entailed intensive support from care managers working with people needing support to identify their needs and aspirations jointly. Where this worked well it was viewed as a superior outcome to that attained by conventional assessment; however, it

was more demanding of staff time and skills than traditional professional assessment. This is an important consideration if everyone is to have the opportunity for self-assessment and personalisation is to be developed for everyone needing social care support.

9.73 Across the Individual Budget pilot sites there was also a range of practice and different ideological positions on the interpretation of self-assessment. An Individual Budget lead referred to a *"default position"* that *"people can do this for themselves"*, while recognising that particularly in older people's services:

"...there may need to be care manager involvement especially as increasingly families don't live near the older person, so there's thus nobody to help them; they're more isolated. Some older people prefer supported self-assessment. In mental health, people can self-assess but this can cause anxiety around paperwork and so the care coordinator follows it up to make sure they are okay with it."

Another care coordinator in an Individual Budget site observed that all sorts of options were possible:

"They could have a professional advocate or if they want to have a family member or carer do that [self-assessment], it's entirely up to them."

Promoting independence and choice

9.74 The degree of engagement of councils with Direct Payments provides a basic indicator of their approach to choice and independence. There was wide – virtually universal – support for the underlying principles of personalisation, but reservations were expressed about the applicability of the model, in terms of personal budgets, to people with so-called 'chaotic' lifestyles (particularly around the balance between choice and compulsion) or to people with severe learning disabilities. The Individual Budget sites revealed similar views about certain groups of people for whom Individual Budgets were seen as too difficult or inappropriate. Some argued that these included individuals at times of crisis, for example while a person is in hospital. This was on the grounds that individuals would not be in a position to undertake self-assessments, support planning and think about arranging their own support, and that support needs are likely to change as people move out of the crisis situation and matters begin to stabilise. Nevertheless, six of the 13 Individual Budget sites decided to offer Individual Budgets to people using mental health services. Some sites explicitly chose this because they thought that if they could make Individual Budgets work for people with complex and/or fluctuating mental health needs, then they could make them work with any and all other groups.

9.75 A further group identified as challenging in terms of providing Individual Budgets in the IBSEN study was that of older people, where it was argued that needs tend to change much faster, therefore a support plan may be out of date within a couple of months. An older person's situation is thus likely to need more frequent monitoring, and this may particularly be the case for older people with complex needs. However the study found that the most striking difference between Individual Budget sites was their different experiences of working with older people. Sites generally expected that older people would not want the

aggravation of managing a Direct Payment and would thus opt for a care-managed account. However, some sites found that, contrary to expectation, more older people ***had*** opted for a Direct Payment and thus to manage the money themselves. Lead officers in the Individual Budget sites believed that this development reflected a number of factors, but particularly the opportunity for people to use a Direct Payment without having to be an employer; and more active promotion of Direct Payments by care managers as they developed better understanding of the range of options available and the capacity to mix and match elements of Direct Payments with other support directly commissioned by a care manager.

9.76 Some interviewees in our study identified similar concerns about whether personal or Individual Budgets could work for people with severe learning disabilities, or for people whose behaviour challenges services. Nonetheless, there *were* also examples of people who on face value might be described as having 'chaotic lifestyles' who *were* managing with a Direct Payment. As this account illustrates:

"Y had a very, very dense stroke about six years ago. She lives on her own, no family, nobody. No family. No friends. Neighbours okay. She is a very feisty lady is Y, and she is very clear about what she does and doesn't want. She constantly falls, so she has broken her arm about eight times from falling. Because she drinks. She is an alcoholic (...) and she employs help with her DP, I think we have just upped it to about 25 hours a week, and that is all she has actually, it's all DP. And she has a carer who she employs herself."

9.77 Across the five councils it was acknowledged that developments with Direct Payments over the years had been variable. In part this was a reflection of the way in which staff had or had not encouraged take-up and supported people, as this comment from a team manager explains:

"I want people to be on Direct Payments. But my argument has always been that it is inadequate to send somebody a leaflet or to say to somebody at the point of first contact or the first point of assessment, 'do you fancy a Direct Payment?' (...) I think that potentially a lot of people are excluded from having Direct Payments, not because they shouldn't have them, but because of the manner in which it is portrayed to them and the manner in which it is explained."

9.78 In two of our five sites some carers objected to having the idea of Direct Payments *"pushed down our throats"*, fearing that far from offering greater choice or flexibility this merely signalled more paperwork and difficulty, despite attempts to offer reassurance that other people could manage the administration of Direct Payments on their behalf. As this carer remarked:

"For heaven's sake, County can't do it, and they've got hordes of paid people to do it. How are they going to expect us to do it just with a grant you know? There's something wrong here, and that's a real worry."

9.79 Take-up of Direct Payments is a crude indicator of engagement with personalisation or improved choice and control, not least because Direct Payments cover a range of possibilities. People – with or without complex needs – might use them very creatively to change the nature of support they receive and to fine-tune arrangements to suit their lives,

or to make relatively modest demands which might appear to make little difference but which may in practice be highly significant.

9.80 As described above, the five councils were at different stages of evolution in their approach to personalisation. Typically the move to Individual Budgets was approached on a limited or pilot basis in the first instance, most often for people with learning disabilities. In one of the councils, for example, young people in transition to adult services had been the focus of an *In Control* model for two years and this was increasingly viewed as the core system model. While the council was poised to move from this platform to '*In Control* Total', introducing Individual Budgets across the whole system, it was recognised by service managers that this transformation would be demanding:

"And the challenge has been how do we spread that across the whole directorate, across everybody rather than stick with transition? Because in a way it was the easiest group to work with because they are new people and often families and individuals are absolutely ready for an In Control type model."

9.81 How Direct Payments and Individual Budgets can be used was a matter of debate across all the sites. In many instances officers acknowledged that uncertainty about rules meant that people were operating on the margins of legality. The rules governing how Direct Payments can and cannot be used, particularly in not normally being paid to relatives within the same household, could be particularly restrictive. In a particular situation (see Example 2) the council explained their pragmatic approach to allowing money to be used in this way because it offered the best outcomes for the person concerned whose *"life has never been better than it is today".*

9.82 Despite the advantages of being able to use Direct Payments people also commented on the negative impact of restrictions in the way that money could be used only for certain help. For example, one carer who was looking after both his severely disabled wife and his disabled adult son commented that it would be helpful to be able to use the payment to help with fuel costs:

"It would be useful to spend the DP on other things as well. Even things like towards the electric bill, because you have the fire on all the time (...) and things like that for my wife (...) it's not your money sort of thing. You don't get the money, it's just in this pot and it's just going nowhere really. You don't get the benefit of it like that."

9.83 Moreover, not everyone using a Direct Payment had flexibility to change the support they received. Another person who has advanced multiple sclerosis and was using Direct Payments described a situation in which she had little control over what time people put her to bed, with obvious limitations on her lifestyle and dignity:

"If I want an evening out now, my children have to put me to bed, and that's on the odd occasion if they are doing something (...) you cannot get care calls when you need them. I mean, I have got a life; I have got children and there is the odd occasion when they are doing something in the evening and they want me to watch them, but the companies don't provide, you are in a routine and you can't change from that routine."

9.84 Recruiting people to work as personal assistants is a recurrent concern and affects people using Direct Payments just as it does council services and care providers. This was a particular challenge for people with complex needs for whom the choice of staff would be especially critical. However, some of the people using Direct Payments in the councils taking part in the study had found innovative solutions that involved looking beyond the traditional care sector and drawing on the wider social capital of the community. For example, one man who has a form of muscular dystrophy explained how he had recruited two of his PAs from bar staff at his local pub:

"...it means that I can go and have a night at the pub and stay until closing time – I haven't done that for a long time. Now I hope that is the sort of thing that could happen in In Control Total. But the landlord might say 'yeah well so and so said she would come back and help you, but I will have to pay her an hour extra.' Right, invoice me then."

Example 2

Carers' experience of using Direct Payments for their son's complex needs

Mr and Mrs Gordon are in their mid-40s and have one child – Niall aged 20. Niall is autistic and has been diagnosed with Fragile X, the most common inherited form of learning disability. He exhibits high levels of anxiety and when anxious turns to 'fight' rather than 'flight'. He went through a variety of unsuccessful educational experiences, and as he got older and bigger these included substantial amounts of physical restraint which only came to light when his mother did some teacher training practice in one of his schools. Other educational placements were tried without success – in his mother's view because her entreaties on the need for structure and routine were ignored. Despite the poor experiences of schooling, Niall's behaviour is managed much more successfully at home where he has been taught sign language and is able to communicate his anxiety, but there has always been a problem getting support staff who can use sign language. His mother is firmly of the view that the problem is not Niall's behaviour but the way it has been mismanaged by educational and other agencies.

After leaving school at 16 it was suggested Niall went into hospital as an in-patient for six months but his parents were unhappy with this and felt he needed support at home. Their request for home-based support from NHS psychology and psychiatry was rejected, with such support said to be conditional upon becoming an in-patient. In response to this situation Mrs Gordon gave up her own career aspirations and stayed at home to look after Niall despite the financial problems this created. By this time his behaviour was very difficult even at home – "*He was just so anxious and angry, he used to trash our house from top to bottom. He would sit under the stairs and say he was sorry. I would say it's alright. You just had to give him loads of love and then put all the things back".*

A package of support commissioned by adult social care was offered to the family, but Niall's parents worried that this was adversely affecting his behaviour. Both of his parents tracked his movements during the day and were horrified by what they saw – Niall was sitting alone, eating dirt and was subjected to verbal abuse from the support workers at the placement. At a subsequent meeting with the specialist behavioural analysis intervention team it was suggested that a Direct Payment be used and this has (unusually and creatively) been paid to Niall's parents to support him during the day. Full accounts of what activities are undertaken and how the money is spent are provided by Mr and Mrs Gordon, and Niall's behaviour has now improved beyond recognition.

9.85 Similarly, the parent of a young man with severe learning disabilities, non-verbal communication and some physical disabilities explained her approach to recruiting different people to help with her son's support:

"The word is beginning to seep out, and the marketing that we're doing differently is beginning to generate a different interest (...) and my aim really is to have a bank of people, and that's beginning to happen....one woman may be coming in and cooking, she's keen on cooking, and filling up the freezer once a month. That's with them – it's doing it with them, not for them or to them. And that's been the difference; it really has."

(Mother of son with learning disabilities)

9.86 The regulations surrounding the use of Direct Payments have restricted some groups of people who could potentially benefit from them. In particular, the issue of 'consent' has been crucial. However, the Health and Social Care Act 2008 extends the availability of Direct Payments to people who lack the capacity to consent to their receipt. Two of the councils in our study had already pushed the boundaries in interpreting guidance as permissively as possible in order to maximise the opportunities for people to make best use of Direct Payments. In addition to the exceptional situation where co-resident family members were being paid through a Direct Payment, other situations had led to the creation of a trust fund and appointing trustees to administer a Direct Payment on behalf of a person lacking capacity to consent. The story of one such family is presented in Example 3 below.

Example 3
Innovative use of a Direct Payment through a trust fund

Gary is 23 years old. He has complex learning disabilities and some physical disabilities; he has very limited verbal skills and has learned other ways of communicating. Gary attended a boarding school followed by a residential college and all his life he has been good friends with Max – another young man who also attended the same school and college. The families also know and live near each other. Gary's parents had been investigating residential homes for his future; because he had lived away from home at college they felt strongly that he should not then come back to being dependent on them but should be helped to live in a supportive environment. Despite looking at various options the family were unable to find anything that met their requirements or offered appropriate support.

The council proposed an alternative approach that would involve supporting Gary and Max to live in a housing association property close to their families. For the council this was consistent with their pursuit of personalised care and an opportunity for them to develop an individualised solution. The families as well as staff were involved in training about *In Control* and how to write a support plan. Gary and his family contributed almost all the information required for his support plan. The support package was put out to tender and five providers responded. The tender was awarded to a local Mencap service which saw this as an opportunity to personalise their support. Gary and Max moved into the house in January 2008, following a period of transition where they had overnight stays. The house is within walking distance of the family home and Gary knows the neighbourhood well. His mother describes the arrangements as *"far superior to anything that we have been able to research or find as an alternative".*

While the families remain involved with their sons they have been able to withdraw so that they are providing less direct care or support themselves. At the outset the families continued to provide a lot of the support while a team was being established. They have gradually built up a bank of staff and assistants who want to work with Gary and Max and who can bring a range of skills and interests to their lives. All prospective staff are observed interacting with Gary and Max and the young men have the final say on whether or not a person comes to support them. Recruiting staff has been difficult, partly because the parents have refused to make use of agency staff. Gaps in staffing have been met in the interim by the parents of both young men providing hands-on support. Gary has a personal budget worked out using the RAS model; on the first calculation this produced an indicative budget of £45K, and subsequent adjustments to take account of his complexity produced a total budget of around £62K (and a similar figure for Max). There is a trust established to manage the money on his behalf and Gary has a 'circle of support' of people who are working in his best interests. Both the young men have settled well into their new home and the local community.

It is still early days for Gary and Max in establishing their own home and living independent lives, but the success to date owes much to the combination of an enthusiastic council eager to push the boundaries of personalisation, and an ambitious and articulate parent unwilling to put up with residential containment for her son.

9.87 An important issue which was identified in all the councils was the question of equity between different groups of people using services. Whether some people are supported to achieve greater independence and to exercise more choice than others raises some profound ethical issues. These questions arose most frequently in relation to support for older people. It was recognised that cost ceilings had a differential impact on different groups of people using services and mean that older people generally have fewer options than other people. As this person remarked:

"So you could have an older person in the early stages of dementia or whatever it might be, who really wants to stay in their own home, but their package is going to be absolutely massive and you have got a spend ceiling for older people, so they can't have it. They have to go into residential care unless somebody tops them up, you know, their family. You could have a person with learning disability with dementia in their later stages of life being supported, and massively, to stay at home. Now that's the tension."

(Manager, learning disability services)

9.88 Some older people using services were only too aware of the inequity of services and the potential implications for their own support. One such person who had experienced life-long complex physical impairments and was now entering old age believed she had a 'reasonable package' of support and was a long-time user of Direct Payments, but was fearful of the future:

"I guess if I was getting a Direct Payment now I don't think I would be quite so lucky; I would be very worried (...) as a person who does have quite a lot of need I am a very active person; it is very hard then if they say well we have got to be fair and other people don't want to do a lot of those things (...) I think I could finish up with less."

9.89 Another older person who was using the Independent Living Fund also highlighted the inequity of people aged over 65 being unable to qualify for ILF support, and the implications of this for the opportunities in their daily lives:

"One of the things I have about ILF – and it doesn't affect me because I qualified for it before I was 65 (...) is that I could be next door to someone with the same level of impairment. I was diagnosed and got ILF before 65, [but if] they didn't apply – they have an existence; they get up in the morning and get fed, they get showered and they get put to bed again. But I can go to the cinema, I can go shopping. Yet it is just because of an age – that one person can't have a life."

These issues of equity are becoming more transparent under the RAS models whereby there may be different price points for different groups of people – an issue discussed in the CSCI review of eligibility criteria.[219]

Range of services

9.90 Establishing new systems to enable people to use Direct Payments or personal budgets is only part of the essential superstructure to support people in achieving greater

219 CSCI (2008) *Cutting the cake fairly: CSCI review of eligibility criteria for social care*

independence and choice. Another vital element is the range of services available and the reconfiguration of traditional service patterns. The CSCI service inspections on independence, wellbeing and choice have highlighted the difficulties where services are limited and insufficiently flexible, where day services are traditional and predominantly based in buildings, and where block contracting arrangements limit the range of services on offer. These features were also identified in the councils taking part in this study. The following comments highlight the difficulties of providing personalised support to people with complex needs within the constraints of traditional services:

"I think people at the extremely challenging end tended to go out of borough, or they didn't really fall into our services if you like (...) so that was the beginning for me of remodelling day services and how we did things very differently."

"...part of the problems, part of the challenges was the fact that they were in a building-based service and they couldn't tolerate the noise; they couldn't tolerate the amount of people in the building. And it just created a whole host of problems for them."

9.91 Block contracts posed difficulties both in terms of the practicalities of releasing resources from fixed overheads, but also in the 'mindset' in getting officers procuring services and care managers to think beyond a standard offer, and raise challenges for councils having to double-fund existing and new models of services:

"We are locked into these block contracts and it's about how you release the money in one block contract to pay for something which could potentially be a lot more costly (...) There is no new money in the service and we know that and it's hard to take out say £40,000 from our existing budget because where is that £40,000 going to come from? You know, when we are already paying for the staffing resource, the building resource."

"(...) just to get people to start thinking very differently, to hopefully get mindsets changing. For some people it is changing and it is changing really quickly, and they have got on board with the idea and they really embrace it – 'oh yeah, that is actually better for the person.' Let's do something differently than people being building-based for the rest of their lives."

9.92 A further factor in progressing the personalisation of support for people was a conservative tendency of many people using services, and more particularly of the parents and carers of people with learning disabilities who tended to emphasise the value of traditional and familiar services. The following comments were typical of many across the five councils:

"Parents like to see a building; they cannot really understand that, oh you can be here one day, you can be there one day. Who is looking after your son or daughter? They are really afraid of how much social interaction their sons and daughters can have."

"Some families are very up for it and some families aren't at all, and that's been very interesting (...) some want five days in the service and so many days respite care, and that's all they want. They're not interested in employment, they're not even interested in what happens during the day, as long as they're picked up by transport and taken to a day service five days a week. They want it to look like school."

9.93 Some carers also questioned whether new approaches to services really did offer an improved quality of life and described poor experiences of alternatives to day services, as this comment illustrates:

"...using his home as a base and taking him 'hither and yon'; I mean he has spent most of his life on the transport, which isn't particularly pleasant. It's hot [in summer] and it's cold in winter; he is clamped with a strap across his middle and he can't move. It's not very nice (...) it's not a life."

9.94 A few family carers challenged the entire idea that choice and control could be meaningful for their relative, particularly for people with learning disabilities, as this comment highlights:

"It sounds to me as if somebody has made that decision when they have no experience of disabled people at all, because you cannot say to a disabled person 'what would you like to do today, or where would you like to go?' They want to be told 'we are going on a theatre outing next Saturday', and it gives them something to look forward to, or the music room today, and a meeting at such and such a time, that sort of thing."

9.95 Even if families accept a person's right to independence and to access the community, supporting them to achieve that and to manage a personal budget can be extremely demanding, as this learning disability team manager acknowledged:

"...Parents, for example, would be responsible for sorting a lot of the stuff out for individuals that aren't so able. They're like the rest of us; they're short of money, they need to work full time, they have all the same pressures that the rest of us are under. And then they've being asked to actually coordinate that as well."

9.96 Social care staff fully recognised the difficulties for many parents, particularly if they had spent the past 18 years struggling with services and with the needs of a child or young person, and they have run out of energy to take on anything new. As this carer remarked:

"I don't want (...) I'm 65; I've looked after my daughter for 38 years. I don't want to take on more responsibility."

9.97 A manager remarked that the implications of personalisation for community access are *"almost like a second phase resettlement"*. People who used to live in long-stay hospitals have moved into the community, the challenge now is for people to be able to fully participate in that community:

"It will be a gradual thing; it's not going to happen overnight – but five, ten years down the road, it will be the norm."

(Area manager, community learning disability teams)

9.98 Despite frustrations with insufficient range of services from which to make choices, it was also clear across the five councils that there *were* examples of successful personalisation and innovation in support for people with complex needs. These were bold stories of people creating new patterns of support to suit their ambitions, often with the support

of exceptional caring families and visionary care staff. Some of the many stories had the following features:

- using Direct Payments for support that traditionally adult social care would not pay for, such as a ticket to go to watch the football rather than to use traditional day services
- people living in supported tenancies where previously their only option would have been residential care
- support to use local facilities and services in preference to using traditional day services
- people being brought back from out-of-area placements because new specialist services enable them to be supported locally
- supporting people to live more independently and to have the confidence to participate in community life.

Example 4
Personalisation without a Direct Payment

Danny and Steve are identical twins of almost 20 years old. They both have profound and multiple physical disabilities and severe learning disabilities. The young men cannot speak and have no other means of communication, beyond some basic sounds, but for skilled carers who know them well they are able to indicate preferences and discomfort. Both young men need a high level of support 24 hours a day and have no independent mobility. For most of their lives Danny and Steve have been cared for at home by their father (a sole parent and carer) with a package of home care. The family live in a council four-bedroom bungalow which has been adapted for their use.

Three years ago the father decided that when his sons left school at 19 they should be supported to live independently. This decision was partly based on wanting his sons to have the best life possible and looking to the long-term future, but he was also hoping that this would enable him to return to paid employment, since he had given up work to be a full-time carer to his sons. It was agreed with the council that the father would vacate the family home and be re-housed nearby, leaving his sons living in a home they were familiar with and which had already been adapted for their needs.

The young men have different personalities and preferences. They respond to people being around them and enjoy the stimulation of activity and going out. They become distressed if they are separated or out of sight of each other for more than a short period. The young men have constant support from a team of care staff. The house (on an ordinary estate) has been refurbished throughout and provides a high quality environment. Ceiling tracks are provided throughout the bungalow to allow hoisting Danny and Steve in and out of wheelchairs wherever necessary.

Danny and Steve have become more engaged and healthier since support has been taken on by the young adults team. It is believed they are benefiting from greater stimulation and attention from staff who constantly talk to Danny and Steve and involve them in everything that is happening. The young men left school in July 2008 and started a college programme in the autumn. In addition to personalised support at home they also have access to hydrotherapy and rebound exercise facilities.

Since they have left school, support for Danny and Steve is funded entirely through social services at an annual cost of almost £93,000 each (nearly £186,000 in total per annum). They do not qualify for support from the Independent Living Fund because of the high costs of their support package. They do not have a Direct Payment and their support is through council-arranged services. Their needs are complex but largely stable and they have a quality of life which reflects not only the nature of the one-to-one support they receive but the input of a highly committed and motivated staff team.

Safeguarding, support and advocacy

9.99 What support people need to use Direct Payments or personalised budgets, and the balance between choice, control and safety, were issues identified repeatedly across the councils. People drew attention to the risks that can arise when people using Direct Payments employ personal assistants who they may not know, who are currently unregulated, who may not have CRB checks, and who are accepted on face value. These issues arise for all people using Direct Payments, but they are amplified when those people have complex needs. The following comments are typical of many that were made:

"I think vulnerable people do need protection; little ladies down the road could take advantage financially. Not just financially, you know it's practically – how well do they know them?"

(Registered manager)

*"They need protection. I mean some people in an ideal world, your family **do** support you. But in the real world, they don't you know."*

(Registered manager)

9.100 There are particular concerns about the personalisation agenda for people with complex needs, especially when they may be unable to communicate or to indicate their distress. The following comment was typical of many that were voiced across the councils in this study:

"The people who are promoting that are very articulate, in control, forceful characters who wish to exert their choice – and good luck to them. But the people that I've been working with, many of them literally have no speech never mind no real voice, but even those who can speak are not often listened to seriously. And I think there's a very, very great risk."

9.101 Although the issue of risk was widely articulated across the councils, there was little evidence that clear risk strategies designed to address the move towards personalisation were available or in the process of development. This is consistent with the findings in several CSCI inspections and in a recent CSCI study:[220]

"Approaches to ensure appropriate consideration of additional risks associated with self-directed care were under-developed."

"Not enough thought had been given to protecting people using self-directed support. CRB checks on potential employees were not offered automatically to each vulnerable person, but only if they specifically asked. There had been no strategic consideration of the council's duty of care versus the less formal arrangements that self-directed support brings."

9.102 Advocacy services were under-developed or in the process of developing in most of the councils. Independent advocates are typically involved where people with complex needs have no one to support their interests or if there has been a dispute between the council

220 CSCI (2008) *Safeguarding adults: a study of the effectiveness of arrangements to safeguard adults from abuse*

and family members and a neutral perspective is required. There was a general recognition that more services are required to meet the range of people's needs. In one council the lack of adequate services was explained as:

"There's absolutely no interest locally at all. We have no strong advocacy groups or user groups; we're having to develop those all the time."

9.103 Without a strong tradition of user-led organisations there was nothing to build on and stimulate to develop advocacy or brokerage roles. It is also the case that there is considerable uncertainty about what these new roles actually entail, and particularly how they differ from care management or social work responsibilities. In councils where 'robust organisations' exist locally and have a long history there is a greater range of models of support, including instructed and non-instructed advocacy,[221] professional advocacy and citizen advocacy (the latter model of support uses trained volunteers to support people).

9.104 Other uncertainties concerned the place of advocacy in the future and how it might fit with the development of brokerage services, particularly where one of the core principles of advocacy is seen as *"it's free and freely accessible"*. If paid brokerage develops it may be that advocacy is seen as irrelevant, but arguably the two roles are different, albeit with some overlap. In one of the councils which had piloted *In Control* models, problems had arisen because a service that had been identified to provide support and brokerage was also a service provider, able to recommend that people buy their services. Not only were there conflicts of interest, but people using the brokerage service resented the amount of their money that was being deducted, as this comment illustrates:

"...we have done a lot of work with carers and individuals are brokering their own packages. The people in the pilot have realised they got very little for their money because they paid for their brokerage as well in the pilot. They have looked at it and thought, well I could do that; I paid you £2,500 and actually you did nothing that I couldn't already do!"

(Learning disability team manager)

9.105 In two of the councils in-house brokerage was operating for people using personal budgets. As a director of adult services explained, this was a pragmatic response that enabled best use to be made of staff skills:

"We've got a whole workforce of people who are trained in social care, who like doing it, who understand it and who'd quite like to work in this new way, please, if given half a chance (...) we can't have both – we can't have independent brokerage and a whole workforce."

9.106 Most people we spoke to who were using Direct Payments or personal budgets had assembled support for themselves, or with the support of strong families, with minimal support from any other parties. Advocacy or brokerage were rarely identified as central to people's plans. This does not mean that they are unimportant; rather it suggests that they are relatively unknown or simply unavailable. The contribution that could be made

221 Non-instructed advocacy supports the interests of people who do not have the capacity to 'instruct' their advocate or cannot articulate their preferences

by advocacy and brokerage support remains an unknown quantity at this stage, although across all the councils there was recognition that the interests of family members are not always consistent with the best interests of a person with complex needs, and independent advocacy may be required to distinguish these factors. As this advocate remarked:

"...we never work with the carer and the client with the same advocate (...) many carers just see themselves as speaking for a client, even though they clearly aren't, but they can't see that because of their close relationship with the client (...) we come across those conflicts all the time."

9.107 What *is* evident is that there is a clear role for highly skilled interventions in helping people with complex needs to navigate the support they need. There is also considerable scope for people to have greater knowledge of what might be possible, what exists, or how to judge the quality of their experience if they do access support.

Flexibility and accountability

9.108 The balance between flexibility and accountability was a recurrent theme in all the councils and was recognised as an area of tension in implementing policy on personalisation. It was acknowledged that public money needs to be used responsibly, but most people also favoured a light-touch audit process to ensure people could maximise flexible use of Direct Payments. These positions were not always easily compatible. The following comments epitomise the difficulties:

"There is always going to be one or two that are just going to take off with a Direct Payment and you don't see them again and you never get your money back. And there is always going to be families that maybe because the person could be vulnerable, who take the money. But it is going to have to be audited really isn't it?"

(Learning disability, team leader)

"I think the dilemma for services is (...) being able to move back and say right, let that person be in control you know. I still think there is an issue around well what's the money being spent on? What's the service definition?"

(Support worker, transitions)

9.109 It was recognised that spending Direct Payments on activities or support that bears little resemblance to what people would recognise as 'services' or even as 'social care' is at the heart of these dilemmas, but whether that spending achieves the desired outcomes for people is the most important question, for example:

"I think provided that we are as clear as we can be that we are meeting an assessed need, I would argue it doesn't matter so much how that assessed need is being met. And I would like to see a whole lot more flexibility and a lot more autonomy."

(Team manager, physical disabilities)

The Audit Commission has published guidance (October 2008) that sets out the approach it expects its appointed auditors to take when reviewing the arrangements that councils put in place to make individual and Direct Payments for adult care packages. It makes clear that

money can be spent on any product or service that achieves the outcomes specified in the individual's care plan.

9.110 The balance between flexibility and accountability was work in progress across all the councils in relation to all people using more personalised support, including people with complex needs. In the absence of any clear guidance beyond some general principles about how money could or could not be spent most councils were taking a pragmatic approach.[222] However, it was also evident that flexibility typically reflected the particular understanding and ideological approach of individual staff. The style and culture of each council that was set by the executive team either created the preconditions for personalisation to flourish or ensured that it would develop incrementally and cautiously.

4. Conclusion

9.111 The overall picture that emerges from this special study and other CSCI evidence is one of councils in the process of changing the culture, commissioning and delivery of support to people, including those with multiple and complex needs. While some councils are engaging with the agenda for people with complex needs, believing that if they can make it succeed in such situations it can work for everyone using social care, others are altogether more conservative and limited in their ambitions. Indeed, the findings of the study revealed a general suspicion that the personalisation model has, as yet, been insufficiently developed for people with complex needs and that the most widely showcased examples of success highlighted in the Individual Budget pilots and other schemes have addressed some rather 'easier wins'.

9.112 While all of the councils in the study were engaging with the challenges of personalisation to some degree, all were struggling with the requirements of moving from pilot developments to mainstream operating systems. The enormity of the challenge to skill up and scale up are apparent, and even the most enthusiastic and committed councils are finding it takes considerable time to realise their ambitions.

9.113 It is clear that it is essential that councils work with other agencies, professions, and providers to support people with multiple and complex needs, both in strategic planning for their local population and in delivering personalised support to the individual. However, many partners are not yet signed up to or fully understand or accept the core principles or objectives of personalisation.

9.114 Joint strategic needs assessments should have an explicit focus on people with multiple and complex needs to ensure a coordinated response across agencies. Councils must take

222 Guidance issued to auditors by the Audit Commission in October 2008 recognises the need for proper arrangements to ensure accountability for public money, but states that the responsibility is on councils to have such arrangements and therefore *"if payments are made under lawful powers and in accordance with relevant statutory and professional guidance and there are proper arrangements in place then how payments are spent is not a focus for audit work".*

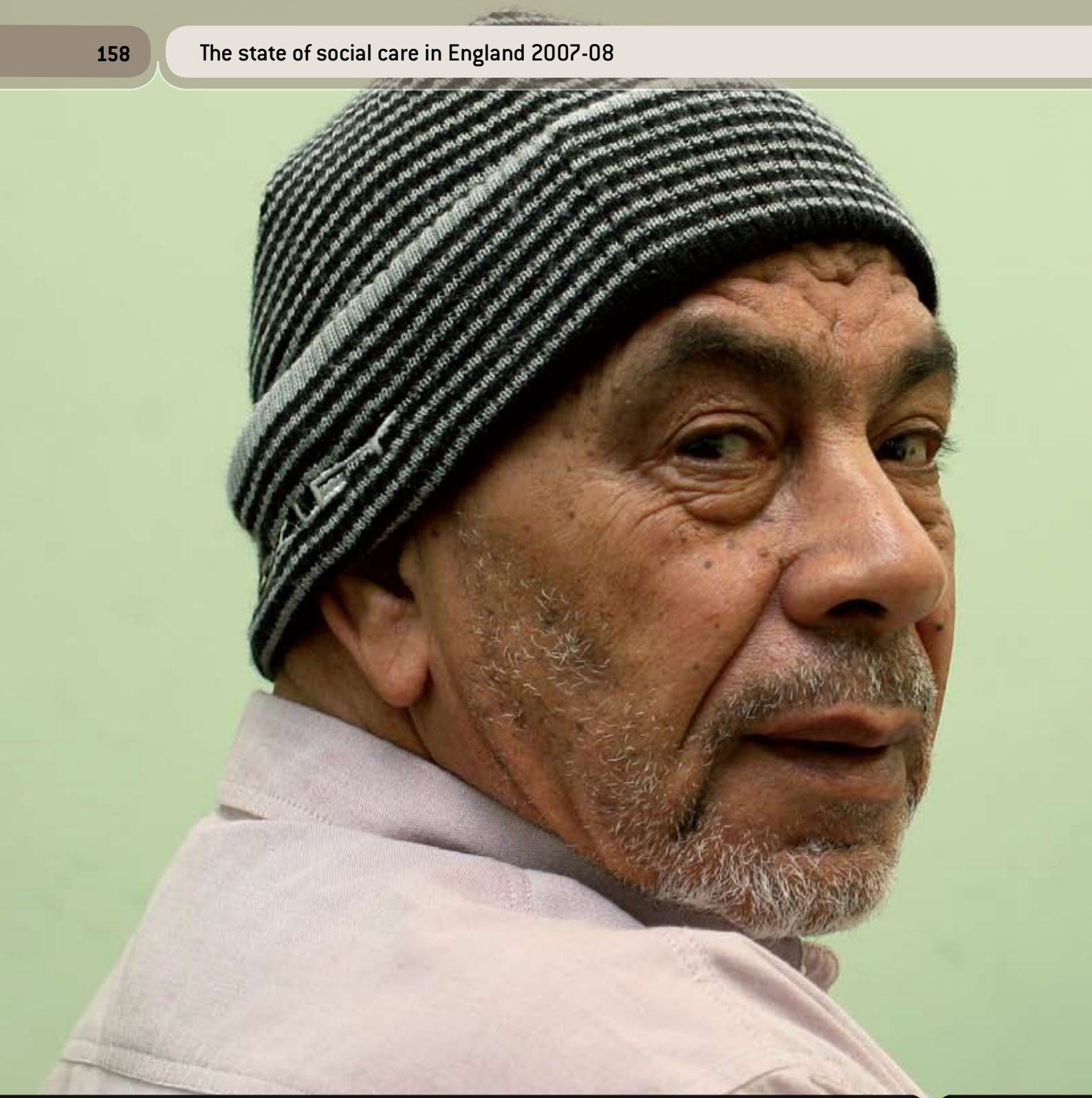
a lead in the work with partner agencies to develop local services that can meet people's highly individualised needs. Good services for people with multiple and complex needs will by definition be highly personalised and thus central to implementing personalisation policy.

9.115 The experience of the person receiving support must be one of coherence and integration, however many different services are required. In the forthcoming pilots of personal health budgets for people with long-term conditions it will be important to maximise the opportunities for people with multiple and complex needs to participate. This is likely to require some expansion of the eligibility criteria that have initially been proposed which on face value would exclude people with complex, unstable, or unpredictable needs.

9.116 Our study found many examples of people with multiple and complex needs being categorised inappropriately by one criterion or another – their learning disability, their mental health, their physical or sensory disabilities – and accordingly allocated to one section of a council's activity rather than another, or being labelled as a 'health' or a 'social' responsibility. In some cases agencies seek to pass the costs of support (which can be considerable) on to other agencies; in all cases it is individuals who are at risk of losing out. Examples from people's experiences where the use of personal budgets have been able to overcome bureaucracy and organisational boundaries and the focus has instead been on the outcomes for the person point to the potential for transforming the lives of people with complex needs.

9.117 This study has presented a snapshot of an unfolding story and the picture it reveals may well look very different in another year or two. Currently the situation is mixed and messy. In some councils there are some (albeit at this stage relatively few) individuals with complex and multiple needs who have been supported to achieve inspirational and life-enhancing outcomes through creative application of the personalisation agenda. In others there are individuals (often carers but sometimes also people using services in their own right) who have settled comfortably for traditional provision which takes little or no account of individual needs and circumstances. And in others again there are cases of people trapped in inappropriate services who are desperately seeking greater degrees of flexibility and control. The task must surely be to ensure that all of those people who want choice, flexibility and control are supported in their endeavours, even – or perhaps especially – when their needs are complex and their capacity to communicate their preferences is extremely limited.

9.118 This is a human rights issue and human rights principles and approaches should underpin every aspect of the steps to personalise support to people with multiple and complex needs. This includes commissioning, service delivery and ensuring person-centred practice. Public services cannot fulfil their obligations under the UN Convention, the Human Rights Act or the Disability Discrimination Act unless they attend to this. A human rights approach challenges a number of attitudes apparent in this study and should be at the core of personalising support to people, however complex their support needs.



Appendices

Appendix A

TABLE A1 OVERALL COUNCIL EXPENDITURE ON ADULT SOCIAL CARE

						% change	% change	% change in real terms (1)	
	2002-03	2003-04	2004-05	2005-06	2006-07	2006-07	2006-07	2006-07	2006-07
	£000 gross	£000 gross	£000 gross	£000 gross	£000 gross	over 2005-06	over 2002-03	over 2005-06	over 2002-03
ADULTS AND OLDER PEOPLE									
Older people over 65	6,860,472	7,179,710	7,795,388	8,238,453	8,521,287	3%	24%	1%	12%
Under 65 physical / sensory disability	1,047,228	1,117,876	1,222,542	1,342,773	1,406,733	5%	34%	2%	21%
Under 65 learning disability	2,253,481	2,370,541	2,641,158	2,913,618	3,121,100	7%	39%	4%	25%
Under 65 mental health	814,532	819,778	895,152	955,032	987,338	3%	21%	1%	9%
Other adults	133,411	147,127	158,724	179,217	206,384	15%	55%	12%	39%
Total Adults and older people	11,109,124	11,635,033	12,712,965	13,629,093	14,242,841	5%	28%	2%	16%
Supporting People		693,034	659,454	615,129	573,814	-7%		-9%	
TOTAL ADULTS AND OLDER PEOPLE INCL SUPPORTING PEOPLE		**12,220,247**	**13,372,419**	**14,244,222**	**14,816,655**	**4%**		**1%**	

ADULTS AND OLDER PEOPLE					
Older people over 65	62%	62%	61%	60%	60%
Under 65 physical / sensory disability	9%	10%	10%	10%	10%
Under 65 learning disability	20%	20%	21%	21%	22%
Under 65 mental health	7%	7%	7%	7%	7%
Other adults	1%	1%	1%	1%	1%
Total Adults and older people	100%	100%	100%	100%	100%
Supporting People as % of Total adults and Older People (incl Supporting People)		6%	5%	4%	4%

TABLE A2 COUNCIL EXPENDITURE SPLIT BETWEEN SERVICES

						% change	% change	% change in real terms (1)	
	2002-03	2003-04	2004-05	2005-06	2006-07	2006-07	2006-07	2006-07	2006-07
	£000 gross	£000 gross	£000 gross	£000 gross	£000 gross	over 2005-06	over 2002-03	over 2005-06	over 2002-03
OLDER PEOPLE (AGED 65 OR OVER) INCLUDING OLDER MENTALLY ILL									
Assessment and care management	622,471	736,990	863,395	912,458	962,288	5.5%	54.6%	2.6%	39.3%
Nursing home placements	1,479,751	1,334,647	1,420,399	1,490,802	1,507,077	1.1%	1.8%	-1.6%	-8.2%
Residential care home placements	2,741,712	2,901,216	3,041,558	3,107,716	3,161,766	1.7%	15.3%	-1.0%	3.9%
Supported and other accommodation	24,522	22,990	29,041	40,665	45,603	12.1%	86.0%	9.1%	67.6%
Direct payments	10,698	21,491	40,360	67,757	98,636	45.6%	822.0%	41.6%	730.9%
Home care	1,395,093	1,524,689	1,699,165	1,856,901	1,931,743	4.0%	38.5%	1.2%	24.8%
Day care	286,905	300,916	320,477	341,907	351,961	2.9%	22.7%	0.2%	10.6%
Equipment and adaptations	67,254	76,058	85,852	100,186	111,902	11.7%	66.4%	8.7%	49.9%
Meals	95,469	96,022	95,723	94,860	91,014	-4.1%	-4.7%	-6.7%	-14.1%
Other services	136,598	164,691	199,418	225,203	259,297	15.1%	89.8%	12.0%	71.1%
TOTAL OLDER PEOPLE	6,860,472	7,179,710	7,795,388	8,238,453	8,521,287	3.4%	24.2%	0.6%	11.9%
Supporting people[3]		196,128	175,704	154,482	137,677	-10.9%		-13.3%	
TOTAL OLDER PEOPLE (including Supporting People)		**7,375,839**	**7,971,092**	**8,392,935**	**8,658,964**	**3.2%**		**0.4%**	

For sources and notes see page 167.

						% change	% change	% change in real terms (1)	
	2002-03	2003-04	2004-05	2005-06	2006-07	2006-07	2006-07	2006-07	2006-07
	£000 gross	£000 gross	£000 gross	£000 gross	£000 gross	over 2005-06	over 2002-03	over 2005-06	over 2002-03
ADULTS AGED UNDER 65 WITH A PHYSICAL DISABILITY OR SENSORY IMPAIRMENT									
Assessment and care management	181,318	199,916	224,863	240,079	249,784	4.0%	37.8%	1.2%	24.1%
Nursing home placements	121,603	114,753	125,200	136,410	139,583	2.3%	14.8%	-0.4%	3.4%
Residential care home placements	213,506	207,610	211,408	218,211	224,405	2.8%	5.1%	0.1%	-5.3%
Supported and other accommodation	10,292	8,031	8,061	9,343	10,697	14.5%	3.9%	11.4%	-6.3%
Direct payments	64,519	89,052	121,341	158,860	189,003	19.0%	192.9%	15.8%	164.0%
Home care	220,891	237,521	257,777	287,800	305,865	6.3%	38.5%	3.4%	24.8%
Day care	109,412	118,986	118,256	120,042	123,825	3.2%	13.2%	0.4%	2.0%
Equipment and adaptations	65,305	76,314	83,823	91,504	82,664	-9.7%	26.6%	-12.1%	14.1%
Meals	2,571	2,559	2,434	2,264	2,529	11.7%	-1.6%	8.7%	-11.3%
Other services	57,812	63,133	69,378	78,261	78,377	0.1%	35.6%	-2.6%	22.2%
TOTAL ADULTS AGED UNDER 65 WITH A PHYSICAL DISABILITY	1,047,228	1,117,876	1,222,542	1,342,773	1,406,733	4.8%	34.3%	1.9%	21.1%
Supporting people[3]		25,968	17,144	19,079	17,753	-7.0%		-9.5%	
TOTAL ADULTS AGED UNDER 65 WITH A PHYSICAL DISABILITY ETC (inc. Supporting People)		1,143,844	1,239,687	1,361,853	1,424,486	4.6%		1.8%	

For sources and notes see page 167.

						% change	% change	% change in real terms (1)	
	2002-03	2003-04	2004-05	2005-06	2006-07	2006-07	2006-07	2006-07	2006-07
	£000 gross	£000 gross	£000 gross	£000 gross	£000 gross	over 2005-06	over 2002-03	over 2005-06	over 2002-03
ADULTS AGED UNDER 65 WITH LEARNING DISABILITIES									
Assessment and care management	136,821	152,659	176,183	205,392	201,293	-2.0%	47.1%	-4.7%	32.6%
Nursing home placements	69,362	63,167	74,216	77,098	72,506	-6.0%	4.5%	-8.5%	-5.8%
Residential care home placements	1,161,765	1,174,039	1,293,325	1,393,556	1,459,134	4.7%	25.6%	1.9%	13.2%
Supported and other accommodation	153,734	163,464	181,996	191,179	228,296	19.4%	48.5%	16.2%	33.8%
Direct payments	8,303	14,368	27,530	42,181	60,799	44.1%	632.2%	40.2%	559.9%
Home care	138,671	175,347	216,098	288,125	349,107	21.2%	151.8%	17.9%	126.9%
Day care	516,568	558,586	572,359	620,478	638,879	3.0%	23.7%	0.2%	11.5%
Equipment and adaptations	1,020	808	727	799	937	17.3%	-8.1%	14.1%	-17.2%
Meals	789	1,488	734	1,306	950	-27.3%	20.4%	-29.3%	8.5%
Other services	66,449	66,616	97,990	93,502	109,199	16.8%	64.3%	13.6%	48.1%
TOTAL ADULTS AGED UNDER 65 WITH LEARNING DISABILITIES	2,253,481	2,370,541	2,641,158	2,913,618	3,121,100	7.1%	38.5%	4.2%	24.8%
Supporting people[3]		238,899	209,066	196,708	171,182	-13.0%		-15.3%	
TOTAL ADULTS AGED UNDER 65 WITH LEARNING DISABILITIES (inc. Supporting People)		2,609,441	2,850,224	3,110,326	3,292,281	5.9%		3.0%	

For sources and notes see page 167.

						% change	% change	% change in real terms (1)	
	2002-03	2003-04	2004-05	2005-06	2006-07	2006-07	2006-07	2006-07	2006-07
	£000 gross	£000 gross	£000 gross	£000 gross	£000 gross	over 2005-06	over 2002-03	over 2005-06	over 2002-03
ADULTS AGED UNDER 65 WITH MENTAL HEALTH NEEDS									
Assessment and care management	234,903	254,847	281,402	304,060	319,184	5.0%	35.9%	2.1%	22.5%
Nursing home placements	60,009	51,821	59,076	66,242	66,721	0.7%	11.2%	-2.0%	0.2%
Residential care home placements	241,083	240,781	256,011	267,693	271,525	1.4%	12.6%	-1.3%	1.5%
Supported and other accommodation	37,024	31,375	39,777	43,989	49,842	13.3%	34.6%	10.2%	21.3%
Direct payments	1,010	1,388	3,089	5,443	8,306	52.6%	722.7%	48.5%	641.4%
Home care	41,143	44,529	46,913	53,547	55,798	4.2%	35.6%	1.4%	22.2%
Day care	90,237	92,642	95,893	106,054	110,483	4.2%	22.4%	1.4%	10.3%
Equipment and adaptations	597	832	475	304	730	140.1%	22.3%	133.6%	10.2%
Meals	269	431	534	282	427	51.2%	58.7%	47.1%	43.0%
Other services	108,257	101,132	111,981	107,418	104,322	-2.9%	-3.6%	-5.5%	-13.2%
TOTAL ADULTS AGED UNDER 65 WITH MENTAL HEALTH NEEDS	814,532	819,778	895,152	955,032	987,338	3.4%	21.2%	0.6%	9.2%
Supporting people[3]		124,219	105,467	102,346	87,180	-14.8%		-17.1%	
TOTAL ADULTS AGED UNDER 65 WITH MENTAL HEALTH NEEDS (inc. Supporting People)		943,997	1,000,619	1,057,378	1,074,518	1.6%		-1.1%	

For sources and notes see page 167.

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						% change	% change	% change in real terms (1)	
	2002-03	2003-04	2004-05	2005-06	2006-07	2006-07	2006-07	2006-07	2006-07
	£000 gross	£000 gross	£000 gross	£000 gross	£000 gross	over 2005-06	over 2002-03	over 2005-06	over 2002-03
OTHER ADULT SERVICES									
Assessment and care management	17,669	20,819	28,095	24,226	35,040	44.6%	98.3%	40.7%	78.7%
HIV/AIDS	15,334	15,897	16,246	16,229	18,299	12.8%	19.3%	9.7%	7.5%
Substance abuse (addictions)	51,774	71,103	73,342	93,646	81,343	-13.1%	57.1%	-15.5%	41.6%
Other services	48,633	39,307	41,042	45,116	71,701	58.9%	47.4%	54.6%	32.9%
TOTAL OTHER ADULT SERVICES	133,411	147,127	158,724	179,217	206,384	15.2%	54.7%	12.0%	39.4%
Supporting People		107,820	152,073	142,514	160,021	12.3%		9.2%	
TOTAL OTHER ADULT SERVICES (including Supporting People)		254,946	310,797	321,731	366,405	13.9%		10.8%	
ADULT SERVICES (excluding Supporting People)	**11,109,124**	**11,635,032**	**12,712,965**	**13,629,093**	**14,242,841**	**4.5%**	**28.2%**	**1.7%**	**15.5%**
Supporting People		693,034	659,454	615,129	573,814	-6.7%		-9.2%	
ADULT SERVICES (including Supporting People)		12,328,066	13,372,419	14,244,222	14,816,655	4.0%		1.2%	

TABLE A3: COUNCIL EXPENDITURE (GROSS AND NET) SPLIT BETWEEN SERVICES (% WITHIN EACH CLIENT GROUP)

	2002-03 gross	2003-04 gross	2004-05 gross	2005-06 gross	2006-07 gross	2002-03 net *	2006-07 net *
OLDER PEOPLE (AGED 65 OR OVER) INCLUDING OLDER MENTALLY ILL							
Assessment and care management	9%	10%	11%	11%	11%	12%	14%
Nursing home placements	22%	19%	18%	18%	18%	19%	15%
Residential care home placements	40%	40%	39%	38%	37%	34%	33%
Supported and other accommodation	0%	0%	0%	0%	1%	0%	1%
Direct payments	0%	0%	1%	1%	1%	0%	1%
Home care	20%	21%	22%	23%	23%	24%	25%
Day care	4%	4%	4%	4%	4%	5%	5%
Equipment and adaptations	1%	1%	1%	1%	1%	1%	2%
Meals	1%	1%	1%	1%	1%	1%	1%
Other services	2%	2%	3%	3%	3%	2%	4%
TOTAL OLDER PEOPLE	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
ADULTS AGED UNDER 65 WITH A PHYSICAL DISABILITY OR SENSORY IMPAIRMENT							
Assessment and care management	17%	18%	18%	18%	18%	19%	19%
Nursing home placements	12%	10%	10%	10%	10%	10%	9%
Residential care home placements	20%	19%	17%	16%	16%	18%	15%
Supported and other accommodation	1%	1%	1%	1%	1%	1%	1%
Direct payments	6%	8%	10%	12%	13%	7%	14%
Home care	21%	21%	21%	21%	22%	21%	22%
Day care	10%	11%	10%	9%	9%	11%	9%
Equipment and adaptations	6%	7%	7%	7%	6%	7%	6%
Meals	0%	0%	0%	0%	0%	0%	0%
Other services	6%	6%	6%	6%	6%	6%	6%
TOTAL ADULTS AGED UNDER 65 WITH A PHYSICAL DISABILITY	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

For sources and notes see page 167

	2002-03 gross	2003-04 gross	2004-05 gross	2005-06 gross	2006-07 gross	2002-03 net *	2006-07 net *
ADULTS AGED UNDER 65 WITH LEARNING DISABILITIES							
Assessment and care management	6%	6%	7%	7%	6%	7%	7%
Nursing home placements	3%	3%	3%	3%	2%	3%	2%
Residential care home placements	52%	50%	49%	48%	47%	49%	46%
Supported and other accommodation	7%	7%	7%	7%	7%	5%	7%
Direct payments	0%	1%	1%	1%	2%	0%	2%
Home care	6%	7%	8%	10%	11%	6%	11%
Day care	23%	24%	22%	21%	20%	26%	21%
Equipment and adaptations	0%	0%	0%	0%	0%	0%	0%
Meals	0%	0%	0%	0%	0%	0%	0%
Other services	3%	3%	4%	3%	3%	3%	4%
TOTAL ADULTS AGED UNDER 65 WITH LEARNING DISABILITIES	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
ADULTS AGED UNDER 65 WITH MENTAL HEALTH NEEDS							
Assessment and care management	29%	31%	31%	32%	32%	32%	34%
Nursing home placements	7%	6%	7%	7%	7%	7%	6%
Residential care home placements	30%	29%	29%	28%	28%	26%	26%
Supported and other accommodation	5%	4%	4%	5%	5%	3%	4%
Direct payments	0%	0%	0%	1%	1%	0%	1%
Home care	5%	5%	5%	6%	6%	5%	6%
Day care	11%	11%	11%	11%	11%	12%	12%
Equipment and adaptations	0%	0%	0%	0%	0%	0%	0%
Meals	0%	0%	0%	0%	0%	0%	0%
Other services	13%	12%	13%	11%	11%	15%	11%
TOTAL ADULTS AGED UNDER 65 WITH MENTAL HEALTH NEEDS	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

For sources and notes see page 167

	2002-03 gross	2003-04 gross	2004-05 gross	2005-06 gross	2006-07 gross	2002-03 net *	2006-07 net *
OTHER ADULT SERVICES							
Assessment and care management	13%	14%	18%	14%	17%	14%	17%
HIV/AIDS	11%	11%	10%	9%	9%	12%	9%
Substance abuse (addictions)	39%	48%	46%	52%	39%	38%	39%
Other services	36%	27%	26%	25%	35%	37%	35%
TOTAL OTHER ADULT SERVICES	100%	100%	100%	100%	100%	100%	100%

Notes

Sources : The NHS Information Centre for health and social care(2008) website http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information/personal-social-services-expenditure-and-unit-costs:-england-2006-07 : Gross Net 2006-07 (England) . GDP deflator from NHS IC 2006-07 PSSEX1 report on website, p 17

Strategy expenditure excluded throughout as not possible to split between adults and children: total spend for both was £61.7m in 2002-03 and £72.1m in 2006-07.

Asylum seekers expenditure excluded throughout: expenditure was primarily on families and unaccompanied asylum seeker children and young people. Of the total gross spend in 2006-07 of £216m, £20m was spent on lone adults. For 2002-03, gross spend was £548m and £146m respectively.

Supporting People expenditure shown separately: first reported 2003-04

1. Real terms – GDP deflator applied to allow comparison of previous years at 2006-07 prices (see PSSEX1 2006-07 report page 17)
2. (greyed cells): Other services and Supporting People expenditure estimated from PSSEX1 table data
3. (yellow shaded cells): Supporting People expenditure first reported 2003-04
4. Overhead costs for services such as information technology, finance functions, council premises, training and personnel services etc are distributed across each row in the table.
5. Please note that the data presented in this table are not continuous with those in Annexes of previous CSCI reports on State of Social Care. Comparisons should not be made with data in earlier reports.
6. Final outturn data for 2007-08 should be published on the NHS Information Centre for health and social care website in February 2009

Appendix B

B

TABLE B1 OLDER PEOPLE AND YOUNGER ADULTS RECEIVING SERVICES FROM COUNCILS (AS AT 31ST MARCH EACH YEAR) (ROUNDED)

	2002-03[1]	2003-04[2]	2004-05[2,3]	2005-06[2,3]	2006-07[2,3]
18-64 Physical/Sensory Disability					
Home Care[5]	44,000	42,000	42,000	42,000	40,000
Day Care[5]	24,000	21,000	19,000	18,000	17,000
Direct Payments	6,000	8,400	12,000	15,000	18,000
Residential and Nursing Care	11,500	11,000	10,500	10,000	10,000
18-64 Learning Disability					
Home Care[5]	15,000	18,000	19,000	20,000	22,000
Day Care[5]	52,000	51,000	49,000	50,000	49,000
Direct Payments	900	1,800	3,100	4,800	6,600
Residential and Nursing Care	36,000	36,000	35,000	35,000	35,500
18-64 Mental Illness					
Home Care[5]	14,000	12,000	14,000	13,000	14,000
Day Care[5]	27,000	26,000	25,000	25,000	24,000
Direct Payments	200	400	900	1,600	2,200
Residential and Nursing Care	13,000	12,500	12,000	12,000	11,500
65+ Older People					
Home Care[5]	338,000	318,000	319,000	309,000	293,000
Day Care[5]	122,000	114,000	100,000	99,000	93,000
Meals[5]	138,000	121,000	110,000	101,000	87,000
Direct Payments	1,500	3,200	6,100	10,200	13,700
Residential and Nursing Care	218,500	214,000	204,500	200,000	191,500
All Adults and Older People[4]					
Home Care[5]	412,000	392,000	395,000	386,000	370,000
Day Care[5]	226,000	214,000	195,000	192,000	183,000
Meals[5]	147,000	131,000	118,000	108,000	93,000
Direct Payments	8,600	14,000	22,000	32,000	41,000
Residential and Nursing Care	284,000	278,000	266,000	259,000	250,000

Notes

1. Data for residential care includes clients formerly in receipt of preserved rights
2. Data for residential care includes Boyd loophole residents and clients formally in receipt of preserved rights
3. Data for community services : RAP definitions were re-stated for 2004-05 – this may account for some decrease on prior years' data
4. Includes other adult groups including those with substance misuse problems and other vulnerable adults. Services specified as for carers (e.g. direct payments and respite care) are excluded.
5. Reductions over time in numbers receiving home care, day care and meals may reflect in part a move to provision of direct payments, which those using services may use to buy their own home care support etc.

Source: The NHS Information Centre for Health and Social Care feedback volumes : Supported Residents (SR1) Table 1: rows in this table for those using residential and nursing care
Referrals, Assessments and Packages of Care (RAP) Table P2s: rows in this table for those using home care, day care, meals and direct payments.

Appendix C

TABLE C1 NUMBERS AND CAPACITY OF SERVICES FOR ADULTS

		2004	2005	2006	2007	2008
Care Homes (All)	**Services**	19,646	19,210	18,952	18,709	18,541
	Places	454,463	451,288	450,549	448,757	448,065
Residential Homes	**Services**	15,492	15,089	14,812	14,572	14,365
	Places	275,741	271,788	268,442	265,539	262,633
Nursing Homes	**Services**	4,141	4,108	4,123	4,119	4,153
	Places	178,507	179,246	181,797	182,920	185,116
Non-Medical Care Homes	**Services**	13	13	17	18	23
	Places	215	254	310	298	316
Home Care Agencies	**Services**	1,881	4,111	4,632	4,729	4,897
	Places					
Nursing Agencies	**Services**	940	918	864	762	716
	Places					
Shared Lives	**Services**		47	123	133	135
	Places					

All figures as at 31st March in the given year

TABLE C2 ADULTS' SERVICES REGISTERED AT 31 MARCH 2008

	Private		Council		Voluntary		NHS		Other		TOTAL	
	Services	Places	Services	Places	Services	Places	Services	Places	Services	Places	Services	Places
Residential Homes	9,919	183,732	1,102	27,811	2,992	46,481	156	1,191	196	3,418	14,365	262,633
Nursing Homes	3,710	169,034	30	1,513	353	12,223	5	48	55	2,298	4,153	185,116
Non-Medical Care Homes	20	287			1	6	1	6	1	17	23	316
CARE HOMES TOTAL	**13,649**	**353,053**	**1,132**	**29,324**	**3,346**	**58,710**	**162**	**1,245**	**252**	**5,733**	**18,541**	**448,065**
Home Care Agencies	3,687		680		388		47		95		4,897	
Nursing Agencies	688		2		11		1		14		716	
Shared Lives	14		108		8		1		4		135	
ALL SERVICES TOTAL	**18,038**	**353,053**	**1,922**	**29,324**	**3,753**	**58,710**	**211**	**1,245**	**365**	**5,733**	**24,289**	**448,065**

TABLE C3 ADULTS' SERVICES REGISTERED AT 31 MARCH 2007

	Private		Council		Voluntary		NHS		Other		TOTAL	
	Services	Places	Services	Places	Services	Places	Services	Places	Services	Places	Services	Places
Residential Homes	9,886	182,664	1,171	29,608	3,136	48,471	178	1,393	201	3,403	14,572	265,539
Nursing Homes	3,670	166,830	30	1,517	354	12,207	6	68	59	2,298	4,119	182,920
Non-Medical Care Homes	16	275					1	6	1	17	18	298
CARE HOMES TOTAL	**13,572**	**349,769**	**1,201**	**31,125**	**3,490**	**60,678**	**185**	**1,467**	**261**	**5,718**	**18,709**	**448,757**
Home Care Agencies	3,473		717		390		48		101		4,729	
Nursing Agencies	733		2		10		1		16		762	
Shared Lives	11		109		7		2		4		133	
ALL SERVICES TOTAL	**17,789**	**349,769**	**2,029**	**31,125**	**3,897**	**60,678**	**236**	**1,467**	**382**	**5,718**	**24,333**	**448,757**

TABLE C4 ADULTS' SERVICES REGISTERED AT 31 MARCH 2006

	Private		Council		Voluntary		NHS		Other		TOTAL	
	Services	Places	Services	Places	Services	Places	Services	Places	Services	Places	Services	Places
Residential Homes	9,884	181,271	1,248	31,691	3,298	50,739	179	1,357	203	3,384	14,812	268,442
Nursing Homes	3,674	166,031	25	1,218	365	12,510	6	68	53	1,970	4,123	181,797
Non-Medical Care Homes	15	287					1	6	1	17	17	310
CARE HOMES TOTAL	**13,573**	**347,589**	**1,273**	**32,909**	**3,663**	**63,249**	**186**	**1,431**	**257**	**5,371**	**18,952**	**450,549**
Home Care Agencies	3,286		794		409		41		102		4,632	
Nursing Agencies	834		2		9		1		18		864	
Shared Lives	11		99		7		2		4		123	
ALL SERVICES TOTAL	**17,704**	**347,589**	**2,168**	**32,909**	**4,088**	**63,249**	**230**	**1,431**	**381**	**5,371**	**24,571**	**450,549**

TABLE C5 ADULTS' SERVICES REGISTERED AT 31 MARCH 2005

	Private		Council		Voluntary		NHS		Other		TOTAL	
	Services	Places	Services	Places	Services	Places	Services	Places	Services	Places	Services	Places
Residential Homes	9,992	181,834	1,297	33,333	3,455	52,345	156	1,295	189	2,981	15,089	271,788
Nursing Homes	3,659	163,586	19	910	371	12,581	3	43	56	2,126	4,108	179,246
Non-Medical Care Homes	10	207			1	24	1	6	1	17	13	254
CARE HOMES TOTAL	**13,661**	**345,627**	**1,316**	**34,243**	**3,827**	**64,950**	**160**	**1,344**	**246**	**5,124**	**19,210**	**451,288**
Home Care Agencies	2,910		731		364		32		74		4,111	
Nursing Agencies	899		2		7		1		9		918	
Shared Lives	8		38						1		47	
ALL SERVICES TOTAL	**17,478**	**345,627**	**2,087**	**34,243**	**4,198**	**64,950**	**193**	**1,344**	**330**	**5,124**	**24,286**	**451,288**

TABLE C6 ADULTS' SERVICES REGISTERED AT 31 MARCH 2004

	Private		Council		Voluntary		NHS		Other		TOTAL	
	Services	**Places**	**Services**	**Places**	**Services**	**Places**	**Services**	**Places**	**Services**	**Places**	**Services**	**Places**
Residential Homes	10,245	182,815	1,329	34,863	3,591	54,008	137	1,152	190	2,903	15,492	275,741
Nursing Homes	3,692	163,077	14	642	376	12,647	3	43	56	2,098	4,141	178,507
Non-Medical Care Homes	10	168			1	24	1	6	1	17	13	215
CARE HOMES TOTAL	**13,947**	**346,060**	**1,343**	**35,505**	**3,968**	**66,679**	**141**	**1,201**	**247**	**5,018**	**19,646**	**454,463**
Home Care Agencies	1,320		340		173		7		41		1,881	
Nursing Agencies	922		6		6		1		5		940	
ALL SERVICES TOTAL	**16,189**	**346,060**	**1,689**	**35,505**	**4,147**	**66,679**	**149**	**1,201**	**293**	**5,018**	**22,467**	**454,463**

Appendix D

TABLE D1 AVERAGE PERCENTAGE OF NMS MET BY ADULTS SERVICES AS AT 31 MARCH

	2003				2004				2005				2006				2007				2008			
	Private	Council	Voluntary	All*	Private	Council	Voluntary	All*	Private	Council	Voluntary	All*	Private	Council	Voluntary	All*	Private	Council	Voluntary	All*	Private	Council	Voluntary	All*
All Care Homes For Older People**	58%	61%	68%	59%	71%	72%	79%	72%	76%	78%	84%	77%	78%	81%	84%	79%	79%	82%	85%	80%	81%	85%	88%	82%
Residential Care Homes***	57%	61%	67%	58%	70%	72%	79%	72%	76%	78%	84%	77%	79%	80%	82%	79%	79%	82%	85%	80%	81%	85%	88%	83%
Nursing Homes	60%	-	69%	60%	71%	-	79%	71%	76%	-	84%	77%	77%	-	78%	77%	79%	-	83%	79%	81%	-	86%	82%
All Care Homes For Younger Adults**	61%	57%	67%	63%	73%	70%	78%	75%	80%	76%	82%	80%	81%	80%	83%	82%	83%	81%	85%	83%	84%	84%	87%	85%
Residential Care Homes***	60%	58%	67%	63%	74%	70%	77%	75%	80%	77%	82%	80%	81%	80%	83%	82%	83%	81%	85%	84%	84%	84%	87%	85%
Nursing Homes	63%	-	70%	66%	70%	-	78%	73%	77%	-	83%	80%	79%	-	84%	81%	80%	-	85%	81%	84%	-	86%	85%
Home Care Agencies	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	65%	63%	75%	66%	72%	72%	76%	72%	77%	78%	83%	78%	81%	83%	87%	82%
Nursing Agencies	n/a	n/a	n/a	n/a	-	-	-	69%	-	-	-	81%	-	-	-	83%	-	-	-	86%	-	-	-	87%
Shared Lives Schemes	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	-	-	-	75%	-	-	-	76%	-	-	-	84%

* Column ALL includes private, voluntary, council, NHS and other sectors

** Includes personal care homes, care homes with nursing and non-medical care homes

*** Includes personal care homes and non-medical care homes

" – " indicates no services or a very small number of services which make inclusion of a percentage not statistically meaningful

n/a indicates CSCI was not regulating this service type in this year

Appendix E

TABLE E1 PERCENTAGES OF SERVICES MEETING OR EXCEEDING INDIVIDUAL NMS – ALL CARE HOMES FOR YOUNGER ADULTS

	Private						Council						Voluntary						All Services					
	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
Information	18%	52%	69%	77%	76%	77%	14%	41%	64%	73%	74%	79%	16%	51%	69%	79%	79%	80%	17%	51%	69%	77%	77%	78%
Needs assessment	66%	82%	87%	88%	88%	91%	66%	76%	82%	83%	85%	91%	73%	86%	89%	90%	91%	93%	69%	83%	88%	88%	89%	91%
Meeting needs	72%	81%	84%	86%	87%	88%	62%	75%	79%	81%	81%	83%	78%	85%	89%	90%	91%	91%	75%	82%	85%	87%	88%	89%
Introductory visits	82%	91%	94%	95%	95%	96%	70%	90%	91%	94%	95%	96%	86%	94%	96%	96%	97%	97%	84%	92%	94%	95%	96%	96%
Contract	34%	60%	73%	78%	78%	80%	21%	49%	65%	75%	74%	79%	38%	58%	74%	80%	80%	80%	35%	59%	73%	78%	78%	80%
Service user plan	46%	61%	68%	71%	70%	74%	48%	53%	63%	66%	67%	73%	57%	67%	71%	71%	72%	77%	51%	63%	69%	70%	71%	75%
Decision making	66%	79%	84%	88%	88%	89%	63%	88%	89%	91%	90%	93%	77%	86%	89%	92%	93%	94%	70%	82%	86%	89%	90%	91%
Participation	62%	80%	88%	89%	89%	90%	55%	77%	83%	85%	86%	89%	70%	86%	91%	92%	93%	93%	65%	82%	89%	90%	90%	91%
Risk taking	57%	70%	77%	78%	79%	82%	62%	70%	74%	74%	78%	81%	72%	78%	79%	81%	83%	84%	63%	73%	77%	79%	80%	83%
Confidentiality	64%	82%	89%	91%	91%	91%	66%	82%	90%	92%	92%	91%	75%	87%	92%	92%	92%	91%	68%	84%	90%	91%	91%	91%
Personal development	85%	90%	92%	92%	91%	92%	87%	91%	92%	90%	88%	90%	91%	94%	95%	95%	95%	95%	88%	91%	93%	93%	93%	93%
Education and occupation	87%	90%	92%	91%	91%	91%	91%	92%	91%	90%	90%	91%	91%	95%	96%	94%	94%	94%	89%	92%	93%	92%	92%	92%
Community links and social inclusion	85%	90%	92%	93%	93%	92%	73%	89%	93%	92%	87%	90%	90%	94%	95%	94%	94%	94%	87%	91%	93%	93%	93%	93%
Leisure	76%	83%	86%	88%	88%	88%	59%	81%	84%	86%	82%	83%	81%	87%	88%	91%	91%	92%	77%	85%	87%	89%	88%	89%
Relationships	90%	95%	97%	97%	97%	97%	94%	95%	96%	96%	98%	98%	93%	96%	98%	99%	99%	99%	91%	95%	97%	98%	98%	98%
Daily routines	67%	81%	88%	91%	93%	93%	61%	79%	85%	93%	93%	94%	76%	88%	92%	95%	96%	96%	71%	84%	89%	92%	94%	94%
Meals and mealtimes	79%	84%	87%	89%	90%	91%	74%	82%	85%	89%	90%	91%	84%	88%	89%	90%	93%	94%	81%	86%	88%	90%	90%	92%
Personal support	83%	88%	91%	92%	92%	92%	80%	89%	91%	90%	90%	92%	87%	92%	93%	92%	94%	96%	85%	90%	92%	92%	93%	93%
Healthcare	84%	88%	89%	89%	88%	89%	86%	90%	86%	86%	88%	90%	87%	90%	90%	88%	89%	92%	86%	89%	89%	88%	88%	90%
Medication	43%	56%	62%	66%	67%	72%	42%	50%	56%	67%	68%	73%	50%	59%	63%	68%	69%	74%	46%	57%	62%	67%	68%	73%
Ageing and death	60%	74%	83%	85%	86%	87%	68%	75%	83%	84%	83%	85%	65%	78%	84%	86%	87%	88%	62%	76%	83%	85%	86%	87%
Concerns and complaints	45%	75%	83%	86%	87%	89%	38%	67%	81%	88%	89%	91%	52%	78%	84%	87%	89%	92%	48%	76%	83%	86%	88%	90%
Protection	41%	63%	71%	72%	75%	80%	66%	69%	74%	79%	78%	82%	55%	71%	76%	77%	80%	85%	47%	66%	73%	74%	77%	82%
Premises	53%	63%	67%	68%	69%	72%	41%	42%	50%	56%	60%	67%	52%	57%	61%	63%	65%	71%	52%	59%	63%	65%	66%	71%
Space requirements	75%	90%	94%	93%	93%	93%	51%	76%	84%	85%	86%	87%	75%	90%	94%	93%	94%	93%	75%	89%	93%	92%	92%	92%

	Private						Council						Voluntary						All Services					
	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
Furniture and fittings	50%	68%	78%	82%	84%	85%	42%	54%	71%	77%	76%	80%	58%	73%	80%	84%	86%	87%	53%	69%	78%	83%	84%	86%
Toilets and bathrooms	66%	77%	80%	83%	82%	83%	51%	64%	66%	74%	75%	75%	66%	73%	77%	80%	80%	79%	66%	75%	78%	81%	81%	81%
Shared space	76%	84%	86%	88%	88%	88%	61%	73%	79%	83%	82%	83%	75%	81%	85%	86%	87%	88%	75%	82%	85%	87%	87%	88%
Adaptations and equipment	81%	86%	88%	90%	88%	89%	63%	72%	77%	82%	80%	83%	80%	88%	89%	89%	89%	89%	80%	85%	88%	89%	88%	88%
Hygiene and control of infection	63%	74%	79%	84%	86%	87%	68%	69%	74%	83%	88%	91%	66%	76%	81%	83%	86%	88%	64%	74%	80%	83%	86%	88%
Roles	66%	80%	89%	90%	90%	90%	71%	88%	91%	92%	92%	92%	76%	87%	93%	93%	94%	94%	71%	84%	90%	91%	91%	91%
Qualities and qualifications	61%	70%	74%	74%	78%	83%	68%	69%	74%	76%	80%	84%	65%	75%	81%	80%	84%	87%	63%	72%	77%	77%	80%	84%
Staff team	62%	72%	77%	79%	78%	76%	47%	71%	74%	74%	73%	73%	66%	75%	77%	78%	78%	77%	64%	73%	76%	78%	78%	77%
Recruitment	45%	55%	63%	69%	72%	78%	29%	42%	55%	64%	70%	78%	50%	54%	63%	70%	78%	82%	47%	54%	62%	69%	73%	79%
Training and development	40%	56%	67%	70%	71%	76%	52%	63%	70%	70%	71%	79%	60%	72%	78%	78%	79%	83%	49%	63%	71%	73%	74%	79%
Supervision and support	43%	63%	73%	75%	75%	77%	61%	76%	80%	82%	80%	84%	66%	78%	83%	83%	82%	84%	53%	70%	77%	79%	78%	79%
Day to day operations	47%	55%	62%	71%	78%	80%	51%	59%	65%	73%	79%	84%	57%	61%	64%	74%	80%	83%	51%	58%	63%	72%	78%	81%
Ethos	85%	91%	93%	92%	91%	91%	83%	89%	93%	90%	89%	89%	90%	95%	95%	94%	93%	93%	87%	92%	94%	92%	92%	92%
Quality assurance	27%	47%	59%	63%	68%	74%	23%	47%	53%	59%	65%	70%	39%	55%	63%	68%	74%	79%	32%	50%	60%	65%	70%	76%
Policies and procedures	38%	64%	75%	78%	77%	78%	33%	58%	69%	74%	75%	75%	49%	69%	78%	80%	81%	81%	43%	66%	76%	79%	78%	79%
Record keeping	52%	64%	71%	72%	71%	71%	55%	54%	65%	67%	68%	68%	56%	66%	70%	73%	72%	72%	54%	65%	70%	72%	71%	71%
Safe working practices	36%	46%	55%	60%	64%	71%	33%	40%	50%	56%	65%	75%	44%	50%	56%	60%	67%	76%	39%	48%	55%	60%	65%	73%
Conduct of the service	54%	71%	79%	80%	79%	79%	39%	66%	75%	76%	79%	78%	60%	75%	82%	83%	83%	83%	56%	72%	80%	81%	80%	81%

E

TABLE E2 PERCENTAGES OF SERVICES MEETING OR EXCEEDING INDIVIDUAL NMS – RESIDENTIAL CARE HOMES FOR YOUNGER ADULTS*

	Private						Council						Voluntary						All Services					
	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
Information	17%	52%	69%	78%	77%	77%	14%	41%	64%	73%	74%	79%	16%	50%	69%	78%	79%	80%	17%	50%	68%	77%	77%	78%
Needs assessment	66%	82%	87%	88%	88%	91%	68%	76%	82%	83%	85%	91%	73%	86%	89%	90%	91%	93%	69%	84%	88%	88%	89%	91%
Meeting needs	72%	81%	84%	86%	87%	88%	61%	76%	79%	81%	81%	83%	78%	85%	89%	90%	91%	92%	75%	82%	86%	87%	88%	89%
Introductory visits	82%	91%	94%	95%	95%	96%	70%	90%	91%	94%	95%	96%	86%	94%	95%	96%	97%	97%	84%	92%	94%	95%	96%	96%
Contract	34%	60%	73%	78%	78%	80%	20%	48%	65%	75%	74%	79%	38%	58%	74%	79%	80%	80%	35%	58%	72%	78%	78%	79%
Service user plan	46%	61%	68%	71%	71%	74%	49%	53%	63%	66%	67%	73%	57%	67%	72%	71%	73%	78%	50%	63%	69%	71%	71%	75%
Decision making	65%	79%	84%	88%	89%	89%	66%	88%	89%	91%	91%	93%	77%	86%	89%	92%	93%	94%	70%	82%	86%	89%	90%	91%
Participation	62%	81%	88%	89%	89%	90%	55%	77%	83%	86%	86%	89%	70%	86%	91%	92%	93%	93%	65%	83%	89%	90%	90%	91%
Risk taking	56%	70%	76%	79%	79%	82%	63%	70%	74%	74%	79%	81%	71%	78%	79%	80%	83%	84%	63%	73%	77%	79%	80%	83%
Confidentiality	63%	82%	89%	91%	91%	91%	66%	82%	90%	92%	92%	91%	74%	87%	92%	92%	92%	91%	68%	84%	90%	92%	91%	91%
Personal development	86%	90%	92%	92%	92%	92%	87%	91%	92%	90%	88%	90%	91%	94%	95%	95%	95%	95%	88%	92%	93%	93%	93%	93%
Education and occupation	87%	91%	92%	92%	92%	91%	91%	93%	92%	90%	90%	91%	91%	95%	96%	94%	95%	95%	89%	93%	94%	92%	92%	92%
Community links and social inclusion	85%	90%	92%	93%	93%	92%	75%	89%	93%	92%	87%	90%	90%	94%	95%	94%	95%	94%	87%	91%	93%	93%	93%	93%
Leisure	76%	84%	87%	89%	88%	89%	61%	81%	85%	87%	83%	83%	81%	87%	88%	91%	91%	92%	78%	85%	87%	89%	88%	89%
Relationships	90%	95%	97%	97%	97%	97%	93%	95%	96%	97%	98%	98%	93%	96%	98%	98%	99%	99%	91%	95%	97%	98%	98%	98%
Daily routines	66%	82%	88%	91%	93%	93%	61%	79%	85%	93%	93%	94%	76%	88%	92%	95%	97%	97%	71%	84%	89%	93%	94%	95%
Meals and mealtimes	79%	85%	88%	89%	90%	91%	77%	82%	86%	89%	90%	91%	84%	88%	89%	90%	93%	94%	81%	86%	88%	90%	91%	92%
Personal support	83%	89%	92%	92%	92%	92%	80%	89%	91%	90%	90%	92%	87%	92%	93%	92%	94%	96%	85%	90%	92%	92%	93%	93%
Healthcare	84%	88%	89%	89%	89%	89%	85%	90%	86%	86%	88%	90%	87%	89%	90%	88%	89%	92%	86%	89%	89%	88%	89%	90%
Medication	42%	56%	62%	67%	68%	73%	41%	50%	56%	67%	69%	73%	49%	59%	63%	68%	70%	75%	45%	57%	62%	67%	68%	74%
Ageing and death	59%	74%	83%	84%	86%	87%	68%	76%	83%	84%	83%	85%	64%	77%	84%	86%	87%	88%	62%	75%	83%	85%	86%	87%
Concerns and complaints	44%	76%	83%	86%	87%	89%	37%	67%	80%	88%	89%	91%	51%	78%	85%	87%	89%	92%	47%	76%	83%	86%	88%	90%
Protection	40%	63%	70%	72%	75%	80%	64%	69%	73%	80%	78%	83%	54%	71%	76%	76%	80%	85%	47%	66%	73%	74%	77%	82%
Premises	53%	63%	67%	69%	69%	72%	41%	42%	50%	56%	60%	67%	51%	57%	60%	63%	65%	72%	52%	59%	63%	65%	67%	72%

E

	Private						Council						Voluntary						All Services					
	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
Space requirements	75%	90%	95%	93%	93%	93%	51%	76%	84%	86%	86%	87%	76%	90%	94%	93%	94%	94%	75%	89%	94%	93%	93%	92%
Furniture and fittings	51%	69%	78%	83%	84%	85%	42%	54%	71%	77%	76%	81%	58%	73%	80%	84%	86%	87%	53%	69%	78%	83%	84%	86%
Toilets and bathrooms	67%	78%	81%	83%	83%	84%	51%	64%	66%	74%	75%	75%	67%	72%	77%	79%	80%	79%	66%	75%	78%	81%	81%	81%
Shared space	77%	84%	86%	88%	88%	88%	62%	73%	79%	83%	82%	83%	74%	81%	84%	86%	87%	88%	76%	82%	85%	87%	87%	88%
Adaptations and equipment	81%	86%	89%	90%	89%	89%	63%	72%	77%	82%	80%	83%	80%	88%	89%	89%	89%	89%	80%	86%	88%	89%	88%	89%
Hygiene and control of infection	63%	74%	80%	84%	86%	88%	68%	69%	74%	83%	88%	91%	66%	76%	81%	83%	86%	88%	64%	75%	80%	84%	86%	88%
Roles	66%	80%	89%	90%	90%	90%	71%	88%	91%	92%	92%	92%	76%	87%	92%	93%	93%	94%	70%	83%	90%	91%	91%	91%
Qualities and qualifications	61%	70%	74%	74%	78%	82%	69%	69%	74%	77%	81%	84%	64%	75%	80%	80%	84%	87%	63%	72%	77%	77%	80%	84%
Staff team	62%	72%	76%	79%	78%	76%	47%	71%	74%	75%	74%	73%	66%	75%	77%	78%	78%	78%	63%	73%	76%	78%	77%	76%
Recruitment	45%	55%	63%	69%	72%	78%	29%	42%	55%	64%	70%	79%	49%	54%	63%	71%	78%	82%	47%	54%	62%	69%	74%	79%
Training and development	40%	56%	67%	70%	71%	76%	51%	63%	71%	70%	71%	79%	60%	72%	77%	78%	79%	83%	49%	63%	71%	73%	74%	78%
Supervision and support	43%	64%	74%	76%	75%	77%	61%	76%	81%	82%	81%	84%	67%	78%	83%	83%	82%	84%	54%	71%	78%	79%	78%	80%
Day to day operations	47%	55%	62%	71%	78%	80%	51%	59%	66%	74%	79%	84%	56%	60%	64%	74%	79%	82%	51%	57%	63%	72%	78%	81%
Ethos	85%	91%	93%	92%	91%	91%	84%	89%	93%	90%	89%	88%	90%	95%	95%	94%	93%	93%	87%	92%	94%	92%	92%	92%
Quality assurance	27%	47%	59%	64%	68%	73%	24%	47%	53%	60%	66%	70%	38%	55%	63%	67%	73%	79%	32%	50%	60%	65%	70%	75%
Policies and procedures	38%	64%	75%	78%	77%	78%	35%	58%	69%	74%	75%	74%	48%	69%	77%	80%	81%	82%	42%	65%	76%	78%	78%	79%
Record keeping	52%	64%	71%	72%	71%	71%	55%	54%	65%	67%	68%	68%	56%	66%	70%	72%	71%	72%	54%	65%	70%	72%	71%	71%
Safe working practices	36%	46%	55%	60%	64%	71%	35%	40%	50%	56%	65%	75%	43%	50%	55%	60%	67%	76%	39%	47%	55%	60%	65%	73%
Conduct of the service	54%	71%	79%	80%	79%	79%	41%	66%	75%	76%	79%	78%	59%	75%	82%	82%	82%	83%	56%	72%	80%	80%	80%	81%

E3

TABLE E3 PERCENTAGES OF SERVICES MEETING OR EXCEEDING INDIVIDUAL NMS – NURSING HOMES FOR YOUNGER ADULTS

	Private						Voluntary						All Services*					
	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
Information	27%	54%	71%	73%	73%	79%	23%	58%	79%	84%	75%	75%	25%	55%	73%	77%	74%	78%
Needs assessment	70%	76%	85%	86%	85%	90%	79%	81%	87%	86%	93%	95%	74%	79%	86%	85%	88%	92%
Meeting needs	74%	76%	81%	86%	85%	86%	80%	86%	87%	87%	84%	86%	77%	80%	83%	86%	85%	86%
Introductory visits	82%	88%	92%	95%	94%	96%	92%	97%	98%	97%	97%	98%	86%	92%	94%	96%	95%	97%
Contract	42%	61%	76%	81%	77%	81%	43%	63%	79%	87%	82%	82%	43%	62%	77%	82%	78%	81%
Service user plan	52%	58%	60%	66%	70%	74%	65%	65%	64%	68%	70%	73%	57%	60%	61%	66%	69%	73%
Decision making	70%	81%	85%	86%	84%	91%	76%	85%	88%	93%	90%	90%	72%	83%	85%	88%	86%	90%
Participation	59%	75%	84%	88%	82%	90%	67%	85%	89%	89%	88%	89%	62%	78%	86%	88%	85%	90%
Risk taking	66%	73%	81%	75%	80%	82%	75%	80%	81%	84%	88%	88%	70%	76%	81%	78%	82%	84%
Confidentiality	70%	82%	88%	88%	87%	90%	78%	87%	93%	93%	91%	91%	73%	85%	90%	90%	89%	91%
Personal development	81%	83%	85%	87%	89%	89%	92%	91%	94%	96%	96%	95%	86%	87%	88%	90%	91%	91%
Education and occupation	80%	80%	87%	86%	84%	87%	91%	93%	93%	90%	85%	88%	85%	85%	89%	87%	85%	87%
Community links and social inclusion	81%	83%	89%	89%	88%	92%	87%	90%	94%	93%	92%	93%	83%	86%	90%	90%	89%	92%
Leisure	64%	74%	78%	81%	80%	85%	81%	86%	87%	89%	86%	86%	71%	78%	81%	83%	82%	85%
Relationships	92%	95%	98%	95%	97%	98%	95%	96%	97%	99%	99%	99%	93%	95%	97%	97%	98%	98%
Daily routines	71%	74%	84%	85%	88%	90%	72%	84%	90%	90%	92%	93%	72%	78%	86%	87%	90%	91%
Meals and mealtimes	78%	81%	81%	84%	88%	90%	83%	85%	86%	86%	90%	91%	81%	82%	83%	85%	89%	91%
Personal support	80%	85%	85%	87%	90%	92%	86%	89%	91%	91%	93%	94%	83%	86%	87%	88%	91%	93%
Healthcare	87%	81%	85%	84%	82%	88%	88%	92%	90%	84%	88%	91%	87%	85%	87%	84%	84%	89%
Medication	61%	56%	60%	61%	63%	68%	62%	57%	71%	66%	61%	64%	61%	57%	63%	63%	62%	67%
Ageing and death	73%	79%	84%	86%	85%	89%	79%	84%	89%	90%	91%	90%	75%	81%	85%	88%	87%	89%
Concerns and complaints	55%	74%	83%	87%	88%	90%	58%	78%	80%	92%	90%	94%	56%	76%	82%	89%	88%	92%
Protection	55%	64%	73%	73%	74%	81%	65%	73%	80%	80%	77%	85%	59%	68%	76%	75%	75%	82%
Premises	44%	56%	60%	61%	62%	70%	53%	63%	62%	63%	63%	68%	48%	59%	61%	61%	63%	69%

	Private						Voluntary						All Services*					
	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
Space requirements	66%	82%	88%	88%	87%	89%	67%	84%	90%	95%	95%	92%	66%	83%	89%	89%	90%	90%
Furniture and fittings	46%	58%	70%	78%	78%	83%	57%	76%	81%	85%	88%	87%	51%	65%	74%	80%	82%	84%
Toilets and bathrooms	62%	70%	74%	80%	76%	79%	60%	77%	81%	81%	80%	80%	62%	73%	76%	80%	78%	80%
Shared space	71%	76%	83%	85%	84%	88%	77%	79%	88%	87%	89%	88%	73%	77%	85%	86%	86%	89%
Adaptations and equipment	75%	78%	83%	84%	80%	83%	79%	87%	87%	86%	86%	90%	77%	81%	84%	85%	83%	86%
Hygiene and control of infection	61%	66%	76%	81%	80%	85%	67%	73%	83%	81%	86%	88%	64%	69%	78%	80%	82%	86%
Roles	78%	83%	89%	90%	88%	89%	77%	87%	95%	95%	96%	95%	78%	85%	91%	92%	91%	91%
Qualities and qualifications	64%	69%	75%	75%	76%	83%	71%	77%	82%	81%	85%	89%	67%	72%	78%	77%	79%	86%
Staff team	63%	70%	80%	83%	79%	82%	71%	78%	79%	82%	79%	74%	67%	73%	80%	83%	79%	79%
Recruitment	48%	50%	63%	67%	66%	75%	59%	49%	61%	67%	75%	83%	51%	49%	63%	68%	69%	77%
Training and development	42%	60%	68%	70%	72%	76%	63%	73%	84%	79%	79%	87%	51%	64%	74%	74%	75%	80%
Supervision and support	34%	54%	65%	68%	67%	74%	60%	75%	76%	82%	81%	80%	44%	62%	70%	74%	72%	76%
Day to day operations	50%	56%	66%	73%	79%	81%	64%	73%	74%	81%	87%	87%	56%	62%	69%	76%	81%	83%
Ethos	84%	89%	94%	89%	91%	90%	92%	94%	96%	93%	93%	92%	87%	91%	95%	91%	91%	91%
Quality assurance	30%	51%	62%	60%	67%	79%	42%	57%	69%	73%	85%	83%	34%	53%	64%	66%	73%	81%
Policies and procedures	48%	68%	78%	82%	77%	78%	58%	76%	82%	85%	83%	79%	52%	71%	79%	83%	79%	79%
Record keeping	60%	64%	69%	70%	68%	70%	65%	67%	76%	79%	75%	76%	61%	65%	72%	73%	70%	72%
Safe working practices	43%	50%	55%	60%	64%	74%	56%	57%	63%	62%	64%	75%	48%	54%	58%	60%	63%	74%
Conduct of the service	59%	71%	82%	82%	79%	80%	66%	81%	89%	87%	86%	88%	62%	76%	85%	84%	82%	84%

*Includes a small number of homes run by councils and NHS homes

TABLE E4 PERCENTAGES OF SERVICES MEETING OR EXCEEDING INDIVIDUAL NMS – ALL CARE HOMES FOR OLDER PEOPLE

	Private						Council						Voluntary						All Services					
	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
Information	26%	58%	72%	78%	78%	79%	16%	53%	71%	76%	77%	78%	30%	60%	76%	84%	82%	85%	26%	58%	72%	78%	78%	80%
Contract	49%	72%	81%	85%	83%	85%	34%	62%	74%	78%	77%	78%	58%	79%	85%	89%	87%	88%	50%	72%	81%	85%	83%	85%
Needs assessment	55%	76%	82%	85%	84%	88%	75%	78%	84%	85%	84%	89%	65%	83%	88%	87%	86%	89%	57%	77%	83%	84%	84%	88%
Meeting needs	71%	79%	81%	83%	83%	83%	80%	80%	82%	84%	82%	84%	80%	86%	88%	90%	89%	90%	72%	79%	82%	84%	83%	84%
Trial visits	85%	93%	96%	97%	97%	97%	80%	93%	93%	94%	95%	95%	92%	97%	99%	99%	98%	99%	86%	94%	96%	97%	97%	97%
Intermediate care	75%	78%	80%	86%	87%	88%	81%	80%	81%	82%	87%	89%	81%	88%	90%	92%	95%	94%	76%	80%	82%	86%	88%	89%
Service user plan	33%	49%	56%	57%	56%	62%	44%	49%	58%	55%	58%	66%	43%	53%	57%	58%	56%	65%	34%	50%	56%	57%	56%	62%
Healthcare	73%	77%	77%	77%	79%	83%	84%	77%	80%	83%	80%	86%	77%	82%	83%	84%	83%	87%	73%	78%	78%	78%	79%	83%
Medication	45%	53%	56%	59%	60%	66%	35%	49%	60%	60%	60%	68%	50%	57%	58%	58%	60%	69%	45%	53%	56%	59%	60%	67%
Privacy and dignity	80%	85%	88%	89%	89%	90%	81%	91%	90%	92%	94%	95%	89%	93%	94%	94%	94%	95%	81%	87%	89%	89%	90%	91%
Dying and death	76%	83%	88%	89%	88%	89%	75%	83%	86%	87%	88%	89%	83%	90%	93%	92%	93%	92%	77%	84%	88%	89%	89%	89%
Social contact and activities	71%	77%	80%	78%	75%	76%	73%	80%	82%	79%	76%	78%	81%	87%	87%	86%	85%	86%	72%	79%	81%	79%	76%	77%
Community contact	85%	94%	97%	98%	97%	97%	91%	95%	97%	98%	98%	97%	91%	97%	98%	98%	99%	99%	86%	94%	97%	98%	97%	98%
Autonomy and choice	73%	85%	90%	90%	91%	91%	80%	90%	94%	93%	94%	95%	81%	90%	95%	95%	95%	95%	74%	86%	91%	91%	92%	92%
Meals and mealtimes	77%	81%	84%	84%	85%	87%	87%	85%	86%	89%	89%	92%	84%	88%	89%	91%	92%	92%	78%	82%	84%	85%	86%	88%
Complaints	50%	78%	85%	86%	87%	90%	51%	77%	86%	88%	89%	93%	58%	84%	91%	90%	90%	93%	51%	79%	85%	87%	88%	90%
Rights	85%	92%	96%	96%	96%	96%	91%	95%	97%	97%	96%	96%	92%	97%	98%	98%	98%	98%	86%	93%	96%	96%	96%	96%
Protection	45%	66%	73%	73%	76%	81%	63%	78%	82%	85%	86%	88%	56%	78%	82%	83%	84%	89%	46%	69%	75%	75%	78%	83%
Premises	55%	64%	68%	66%	67%	72%	38%	51%	57%	63%	69%	74%	63%	71%	76%	73%	75%	81%	55%	64%	68%	67%	68%	73%
Shared facilities	75%	86%	89%	87%	86%	87%	74%	82%	88%	88%	88%	88%	83%	89%	93%	92%	92%	93%	76%	86%	89%	88%	87%	87%
Lavatories and washing facilities	63%	74%	78%	79%	78%	78%	58%	70%	74%	79%	78%	80%	73%	82%	84%	86%	86%	87%	64%	74%	78%	80%	79%	79%
Adaptations and equipment	54%	66%	75%	77%	77%	77%	57%	69%	77%	81%	83%	82%	68%	80%	88%	89%	88%	89%	56%	68%	77%	79%	78%	79%

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	Private						Council						Voluntary						All Services					
	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
Space requirements	64%	88%	93%	93%	92%	93%	49%	83%	90%	90%	91%	90%	74%	91%	95%	95%	95%	95%	65%	88%	93%	93%	92%	93%
Furniture and fittings	42%	60%	70%	77%	77%	79%	40%	55%	70%	76%	78%	82%	59%	77%	84%	88%	89%	90%	44%	61%	72%	78%	79%	81%
Heating and lighting	42%	56%	67%	72%	73%	74%	42%	57%	70%	75%	77%	81%	55%	71%	78%	82%	83%	84%	43%	58%	68%	73%	74%	76%
Hygiene and infection control	55%	66%	72%	75%	77%	81%	61%	69%	74%	82%	83%	86%	67%	78%	83%	85%	85%	89%	57%	67%	73%	77%	78%	82%
Staff complement	71%	75%	79%	80%	81%	82%	46%	65%	73%	79%	78%	77%	77%	81%	84%	84%	84%	84%	71%	75%	79%	81%	81%	82%
Qualifications	46%	57%	61%	70%	76%	83%	56%	63%	72%	84%	90%	94%	58%	74%	77%	80%	84%	90%	47%	59%	64%	72%	78%	84%
Recruitment	43%	51%	59%	64%	68%	74%	47%	51%	60%	71%	78%	86%	53%	60%	67%	71%	75%	81%	45%	52%	60%	65%	69%	76%
Staff training	42%	60%	69%	70%	71%	75%	63%	72%	77%	79%	80%	81%	62%	76%	83%	82%	80%	83%	44%	63%	71%	72%	72%	76%
Day to day operations	58%	62%	67%	72%	76%	79%	74%	70%	74%	81%	87%	90%	74%	79%	82%	84%	87%	90%	60%	65%	69%	74%	78%	81%
Ethos	75%	85%	89%	88%	87%	87%	86%	91%	94%	94%	94%	93%	85%	91%	95%	94%	93%	93%	77%	86%	90%	89%	89%	88%
Quality assurance	30%	49%	60%	66%	68%	74%	41%	55%	66%	71%	76%	82%	43%	63%	71%	78%	81%	87%	32%	51%	61%	67%	70%	76%
Financial procedures	61%	77%	85%	87%	87%	87%	54%	77%	86%	89%	88%	89%	74%	86%	92%	94%	93%	94%	63%	78%	86%	88%	88%	88%
Service User Money	73%	83%	87%	87%	91%	92%	72%	82%	88%	90%	93%	95%	81%	87%	92%	93%	93%	96%	74%	83%	87%	88%	91%	93%
Staff Supervision	24%	50%	62%	65%	65%	67%	69%	73%	77%	81%	78%	79%	49%	68%	75%	75%	75%	76%	28%	54%	65%	67%	67%	69%
Record Keeping	49%	61%	67%	67%	66%	65%	54%	63%	65%	68%	69%	69%	53%	67%	73%	73%	72%	72%	50%	62%	67%	68%	67%	66%
Safe Working Practices	39%	46%	52%	53%	60%	69%	48%	48%	54%	59%	66%	77%	51%	54%	62%	62%	67%	78%	41%	47%	53%	54%	61%	70%

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TABLE E5 PERCENTAGES OF SERVICES MEETING OR EXCEEDING INDIVIDUAL NMS – RESIDENTIAL CARE HOMES FOR OLDER PEOPLE*

	Private						Council						Voluntary						All Services					
	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
Information	23%	57%	71%	78%	77%	79%	16%	53%	71%	76%	77%	77%	28%	62%	75%	84%	83%	86%	24%	57%	72%	78%	78%	79%
Contract	48%	73%	81%	85%	83%	84%	34%	62%	74%	78%	77%	78%	58%	80%	86%	89%	88%	88%	49%	72%	81%	85%	83%	84%
Needs assessment	52%	74%	81%	83%	83%	87%	74%	78%	84%	85%	84%	89%	63%	83%	87%	87%	85%	88%	54%	76%	82%	84%	83%	87%
Meeting needs	70%	78%	81%	84%	84%	84%	79%	80%	82%	84%	82%	84%	79%	86%	88%	91%	90%	91%	71%	80%	82%	85%	84%	85%
Trial visits	85%	93%	96%	97%	97%	97%	80%	92%	93%	94%	95%	95%	93%	98%	99%	99%	98%	99%	86%	93%	96%	97%	97%	97%
Intermediate care	81%	83%	85%	89%	91%	91%	80%	80%	81%	82%	87%	89%	82%	90%	91%	94%	94%	93%	81%	83%	84%	88%	90%	91%
Service user plan	32%	50%	57%	57%	57%	62%	44%	49%	58%	56%	59%	67%	42%	53%	58%	60%	57%	66%	34%	50%	57%	57%	57%	63%
Healthcare	74%	80%	79%	80%	81%	83%	83%	77%	80%	83%	80%	86%	77%	83%	83%	85%	85%	88%	74%	80%	80%	81%	81%	84%
Medication	41%	51%	56%	61%	61%	66%	35%	49%	60%	60%	60%	68%	49%	58%	59%	59%	62%	70%	42%	52%	57%	61%	61%	67%
Privacy and dignity	81%	87%	90%	90%	90%	92%	81%	91%	90%	92%	94%	95%	90%	94%	94%	94%	94%	95%	82%	89%	90%	91%	91%	92%
Dying and death	73%	83%	88%	89%	90%	90%	74%	83%	86%	87%	88%	89%	82%	90%	93%	92%	93%	93%	75%	84%	88%	89%	90%	91%
Social contact and activities	73%	80%	82%	79%	77%	78%	74%	80%	82%	79%	76%	79%	81%	87%	88%	88%	86%	87%	74%	81%	83%	81%	78%	79%
Community contact	84%	93%	96%	98%	97%	97%	91%	95%	97%	98%	98%	97%	91%	97%	98%	98%	99%	99%	85%	94%	97%	98%	97%	98%
Autonomy and choice	72%	85%	90%	91%	92%	92%	80%	90%	93%	93%	94%	95%	82%	90%	95%	96%	96%	95%	73%	86%	91%	92%	92%	93%
Meals and mealtimes	79%	83%	86%	87%	86%	89%	87%	85%	86%	89%	89%	92%	85%	89%	90%	92%	92%	92%	80%	84%	86%	88%	87%	90%
Complaints	47%	78%	85%	87%	87%	90%	51%	76%	87%	88%	90%	93%	58%	84%	91%	91%	91%	94%	48%	79%	86%	87%	88%	91%
Rights	85%	92%	96%	96%	96%	96%	91%	95%	97%	97%	96%	96%	92%	97%	98%	98%	98%	98%	86%	93%	96%	96%	97%	97%
Protection	41%	65%	72%	73%	75%	80%	63%	78%	82%	85%	86%	88%	55%	78%	81%	83%	84%	89%	44%	68%	74%	75%	78%	82%
Premises	55%	66%	69%	67%	67%	72%	38%	51%	57%	63%	69%	74%	63%	71%	75%	73%	75%	81%	56%	65%	68%	67%	68%	73%
Shared facilities	77%	88%	90%	89%	88%	88%	74%	82%	88%	88%	88%	89%	83%	89%	93%	92%	92%	93%	78%	88%	90%	89%	88%	89%
Lavatories and washing facilities	64%	76%	79%	80%	79%	78%	58%	70%	74%	79%	78%	81%	72%	82%	84%	87%	86%	88%	65%	76%	79%	81%	80%	80%

	Private						Council						Voluntary						All Services					
	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
Adaptations and equipment	54%	66%	75%	78%	77%	78%	56%	69%	77%	81%	83%	82%	67%	80%	88%	89%	88%	88%	56%	68%	77%	80%	79%	80%
Space requirements	64%	88%	93%	93%	93%	93%	49%	83%	90%	90%	91%	90%	73%	91%	95%	96%	96%	96%	65%	88%	93%	93%	93%	93%
Furniture and fittings	43%	63%	72%	79%	80%	82%	40%	55%	70%	76%	78%	83%	59%	78%	85%	89%	90%	91%	45%	64%	74%	80%	81%	83%
Heating and lighting	35%	51%	63%	69%	70%	72%	42%	57%	71%	75%	77%	81%	53%	70%	78%	82%	83%	84%	38%	54%	66%	72%	73%	74%
Hygiene and infection control	55%	66%	73%	77%	77%	81%	61%	69%	74%	82%	83%	86%	66%	77%	82%	86%	85%	89%	57%	68%	74%	79%	79%	82%
Staff complement	71%	75%	79%	82%	81%	83%	46%	65%	73%	79%	78%	76%	77%	81%	84%	84%	84%	83%	71%	75%	79%	81%	81%	82%
Qualifications	45%	57%	62%	70%	76%	84%	56%	63%	72%	84%	91%	94%	56%	72%	77%	81%	86%	91%	47%	60%	65%	73%	79%	86%
Recruitment	41%	50%	58%	63%	65%	72%	48%	51%	60%	71%	78%	86%	53%	59%	68%	71%	75%	81%	43%	51%	59%	65%	68%	75%
Staff training	39%	57%	67%	69%	69%	74%	62%	72%	77%	80%	80%	80%	62%	76%	83%	82%	81%	83%	42%	62%	70%	72%	72%	76%
Day to day operations	54%	61%	65%	72%	75%	79%	73%	70%	74%	82%	88%	90%	73%	78%	81%	84%	87%	91%	57%	64%	68%	74%	78%	81%
Ethos	75%	85%	89%	89%	88%	88%	86%	91%	94%	94%	94%	93%	85%	91%	95%	94%	93%	94%	76%	86%	91%	90%	89%	89%
Quality assurance	28%	47%	57%	64%	66%	72%	41%	55%	66%	71%	76%	82%	43%	61%	70%	78%	80%	86%	30%	50%	60%	66%	69%	75%
Financial procedures	59%	75%	83%	85%	85%	86%	54%	77%	86%	89%	88%	89%	74%	85%	92%	93%	93%	93%	61%	77%	85%	87%	87%	88%
Service User Money	76%	85%	87%	88%	91%	92%	72%	81%	88%	90%	93%	95%	81%	87%	91%	92%	93%	95%	76%	85%	88%	88%	91%	93%
Staff Supervision	25%	50%	63%	66%	66%	68%	69%	73%	77%	81%	78%	80%	50%	69%	75%	77%	76%	78%	30%	55%	66%	69%	69%	70%
Record Keeping	47%	59%	65%	66%	64%	63%	54%	63%	66%	69%	70%	70%	54%	67%	73%	72%	71%	71%	48%	61%	66%	67%	66%	65%
Safe Working Practices	37%	45%	50%	52%	59%	68%	48%	48%	54%	59%	66%	77%	51%	54%	62%	63%	66%	78%	39%	46%	52%	54%	60%	70%

* Includes personal care homes and non-medical care homes

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TABLE E6 PERCENTAGES OF SERVICES MEETING OR EXCEEDING INDIVIDUAL NMS – NURSING HOMES FOR OLDER PEOPLE

	Private						Voluntary						All Services*					
	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
Information	31%	59%	74%	78%	79%	80%	37%	54%	81%	80%	77%	81%	31%	59%	74%	78%	78%	80%
Contract	52%	72%	81%	85%	83%	86%	62%	77%	84%	86%	85%	92%	52%	73%	82%	85%	83%	86%
Needs assessment	62%	78%	84%	85%	85%	90%	71%	82%	93%	87%	87%	93%	63%	78%	84%	85%	85%	90%
Meeting needs	74%	79%	81%	82%	82%	82%	82%	84%	86%	86%	83%	87%	75%	79%	82%	82%	82%	82%
Trial visits	85%	94%	97%	98%	98%	98%	87%	94%	99%	99%	99%	99%	85%	94%	97%	98%	98%	98%
Intermediate care	67%	72%	74%	81%	82%	84%	77%	80%	88%	86%	98%	98%	68%	72%	75%	81%	83%	85%
Service user plan	35%	49%	53%	56%	55%	62%	46%	52%	52%	50%	50%	63%	36%	49%	53%	55%	55%	62%
Healthcare	71%	73%	74%	72%	76%	82%	78%	82%	80%	78%	77%	84%	71%	74%	74%	72%	76%	82%
Medication	53%	56%	55%	56%	59%	67%	55%	54%	52%	55%	49%	64%	53%	56%	55%	56%	58%	67%
Privacy and dignity	77%	82%	85%	86%	87%	88%	85%	89%	92%	91%	91%	92%	78%	82%	85%	86%	87%	88%
Dying and death	81%	83%	88%	87%	86%	86%	86%	90%	94%	92%	93%	90%	81%	83%	88%	88%	86%	86%
Social contact and activities	67%	73%	77%	76%	73%	73%	81%	88%	85%	78%	84%	81%	67%	74%	77%	76%	74%	74%
Community contact	86%	94%	97%	97%	97%	97%	93%	97%	98%	98%	100%	99%	87%	94%	97%	97%	97%	97%
Autonomy and choice	74%	86%	90%	88%	90%	89%	77%	91%	95%	90%	93%	92%	74%	86%	90%	89%	90%	89%
Meals and mealtimes	74%	77%	80%	80%	82%	83%	79%	84%	86%	87%	90%	89%	75%	78%	80%	80%	82%	84%
Complaints	57%	78%	84%	86%	87%	89%	58%	85%	89%	88%	86%	90%	57%	79%	84%	86%	87%	89%
Rights	86%	93%	96%	96%	96%	96%	91%	97%	97%	98%	97%	97%	86%	93%	96%	96%	96%	96%
Protection	52%	69%	75%	74%	78%	83%	60%	78%	86%	81%	81%	88%	52%	70%	75%	75%	78%	83%
Premises	54%	61%	66%	65%	67%	72%	64%	75%	79%	74%	78%	82%	55%	62%	67%	66%	68%	73%
Shared facilities	72%	82%	87%	84%	84%	85%	83%	89%	92%	91%	90%	92%	72%	83%	87%	85%	85%	85%
Lavatories and washing facilities	61%	71%	76%	77%	76%	76%	80%	82%	85%	83%	84%	83%	63%	72%	77%	78%	77%	77%
Adaptations and equipment	54%	67%	75%	76%	75%	76%	71%	82%	90%	92%	87%	90%	56%	68%	76%	77%	76%	77%
Space requirements	65%	87%	93%	92%	92%	91%	79%	93%	94%	93%	93%	91%	66%	87%	93%	93%	92%	91%
Furniture and fittings	38%	54%	66%	73%	74%	76%	59%	74%	83%	83%	85%	84%	39%	56%	67%	74%	74%	76%

	Private						Voluntary						All Services*					
	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
Heating and lighting	54%	65%	74%	76%	76%	78%	65%	77%	79%	83%	85%	87%	55%	66%	74%	76%	77%	78%
Hygiene and infection control	56%	65%	70%	73%	77%	81%	69%	85%	87%	81%	87%	89%	57%	66%	71%	73%	77%	82%
Staff complement	72%	75%	78%	79%	80%	80%	76%	81%	85%	82%	82%	87%	72%	76%	78%	79%	80%	80%
Qualifications	48%	56%	60%	68%	76%	81%	65%	81%	78%	78%	75%	87%	49%	58%	62%	69%	76%	82%
Recruitment	48%	53%	61%	65%	71%	77%	52%	63%	60%	69%	72%	80%	48%	54%	61%	66%	72%	77%
Staff training	47%	64%	72%	71%	73%	77%	62%	76%	85%	81%	75%	83%	48%	65%	73%	72%	73%	77%
Day to day operations	64%	65%	69%	73%	79%	80%	78%	86%	87%	87%	83%	87%	65%	66%	70%	74%	79%	81%
Ethos	77%	85%	88%	87%	86%	86%	86%	92%	95%	95%	91%	91%	77%	85%	89%	87%	87%	86%
Quality assurance	34%	54%	64%	69%	72%	77%	41%	70%	77%	75%	83%	90%	35%	55%	65%	69%	72%	78%
Financial procedures	65%	81%	88%	90%	90%	90%	76%	91%	96%	96%	95%	97%	66%	82%	88%	90%	90%	90%
Service User Money	69%	80%	86%	86%	90%	93%	81%	84%	93%	93%	92%	97%	70%	80%	87%	87%	90%	93%
Staff Supervision	22%	50%	62%	63%	63%	66%	43%	61%	74%	67%	70%	66%	24%	51%	63%	63%	64%	66%
Record Keeping	54%	63%	69%	69%	68%	68%	50%	65%	77%	75%	78%	76%	53%	63%	69%	69%	68%	68%
Safe Working Practices	44%	48%	54%	54%	63%	70%	53%	56%	63%	57%	67%	80%	45%	48%	55%	54%	63%	71%

*Includes a small number of homes run by councils and NHS homes

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TABLE E7 PERCENTAGES OF SERVICES MEETING OR EXCEEDING INDIVIDUAL NMS – HOME CARE AGENCIES

	Private				Council				Voluntary				All Services			
	2004-05	2005-06	2006-07	2007-08	2004-05	2005-06	2006-07	2007-08	2004-05	2005-06	2006-07	2007-08	2004-05	2005-06	2006-07	2007-08
Information	49%	66%	76%	80%	39%	64%	74%	79%	55%	71%	85%	87%	48%	66%	77%	81%
Care needs assessment	66%	77%	83%	87%	69%	75%	82%	89%	74%	80%	84%	92%	68%	77%	83%	88%
Meeting needs	76%	80%	82%	84%	79%	80%	85%	87%	89%	91%	89%	91%	78%	81%	83%	85%
Contract	65%	76%	80%	83%	65%	76%	78%	79%	69%	82%	86%	88%	65%	77%	80%	83%
Confidentiality	83%	88%	90%	91%	80%	88%	89%	91%	89%	90%	92%	94%	83%	88%	90%	91%
Responsive services	78%	77%	81%	84%	75%	76%	79%	85%	91%	87%	87%	90%	79%	78%	81%	85%
Service user plan	41%	51%	59%	67%	41%	49%	58%	67%	57%	62%	67%	74%	43%	52%	60%	67%
Privacy and dignity	88%	93%	94%	95%	90%	94%	94%	97%	94%	96%	95%	98%	89%	93%	94%	96%
Autonomy and independence	83%	89%	90%	91%	82%	88%	90%	91%	91%	94%	94%	94%	84%	89%	91%	92%
Medication and health related activities	50%	58%	63%	71%	43%	53%	63%	72%	65%	63%	72%	81%	51%	58%	63%	72%
Safe work practices	69%	76%	82%	86%	76%	80%	86%	91%	77%	81%	89%	95%	71%	78%	83%	87%
Risk assessments	52%	63%	68%	75%	51%	59%	71%	80%	68%	70%	74%	82%	54%	63%	69%	77%
Financial protection	64%	73%	76%	78%	68%	76%	80%	84%	72%	79%	82%	86%	66%	74%	77%	80%
Protection of the person	53%	64%	75%	82%	54%	70%	82%	88%	72%	76%	85%	89%	55%	66%	77%	83%
Security of the home	73%	78%	81%	83%	58%	69%	75%	79%	76%	78%	80%	81%	71%	76%	80%	82%
Records kept in the home	62%	69%	72%	76%	60%	65%	70%	75%	74%	77%	76%	78%	63%	69%	72%	76%
Recruitment and selection	52%	59%	71%	76%	50%	64%	77%	83%	63%	65%	80%	84%	53%	61%	72%	78%
Requirements of the job	71%	81%	83%	85%	76%	86%	87%	86%	85%	89%	90%	91%	73%	82%	85%	86%
Development and training	60%	65%	72%	76%	63%	68%	72%	80%	74%	75%	80%	85%	62%	67%	73%	77%
Qualifications	63%	68%	70%	74%	57%	67%	77%	82%	72%	79%	81%	81%	63%	69%	72%	76%
Supervision	45%	52%	65%	74%	51%	69%	75%	82%	68%	65%	74%	80%	49%	57%	67%	75%
Business premises, management and planning	85%	83%	83%	86%	76%	79%	82%	86%	85%	88%	86%	89%	84%	83%	83%	86%
Financial procedures	95%	95%	94%	94%	88%	91%	92%	93%	99%	97%	96%	97%	94%	94%	94%	94%
Records keeping	66%	70%	73%	75%	67%	72%	72%	74%	76%	76%	81%	83%	67%	71%	73%	75%

	Private				Council				Voluntary				All Services			
	2004-05	2005-06	2006-07	2007-08	2004-05	2005-06	2006-07	2007-08	2004-05	2005-06	2006-07	2007-08	2004-05	2005-06	2006-07	2007-08
Policies and procedures	69%	75%	76%	78%	67%	78%	80%	81%	80%	76%	82%	82%	70%	76%	77%	79%
Complaints and compliments	66%	75%	85%	89%	64%	78%	86%	93%	75%	82%	90%	92%	66%	76%	85%	89%
Quality assurance	54%	65%	72%	78%	46%	60%	68%	76%	64%	73%	77%	80%	54%	65%	72%	78%

TABLE E8 PERCENTAGES OF SERVICES MEETING OR EXCEEDING INDIVIDUAL NMS – NURSING AGENCIES

					All Services
	2003-04	2004-05	2005-06	2006-07	2007-08
Information	86%	93%	76%	82%	83%
Fitness Of Registered Persons	53%	66%	77%	76%	78%
Recruitment Process	77%	87%	86%	87%	89%
Checks On Nurses	64%	72%	81%	82%	87%
Identification and Qualification	63%	76%	85%	83%	83%
Competence	56%	73%	83%	81%	82%
Complaints	51%	74%	83%	86%	88%
Protection From Abuse	45%	63%	77%	78%	82%
Assistance With Medication	61%	80%	88%	89%	90%
Confidentiality	88%	94%	79%	94%	94%
Safe Working Practices	70%	83%	84%	86%	88%
Financial Procedures	85%	91%	91%	92%	92%
Premises	86%	91%	86%	93%	95%
Management Structure	93%	92%	86%	94%	92%
Organisational Policies	54%	73%	83%	87%	89%
Agreement Between The Agency And Staff	85%	92%	83%	94%	93%
Record Keeping	74%	83%	84%	85%	85%
Quality Assurance	56%	68%	72%	76%	79%

TABLE E9 PERCENTAGES OF SERVICES MEETING OR EXCEEDING INDIVIDUAL NMS – SHARED LIVES SCHEMES

			All Services
	2005-06	2006-07	2007-08
Living a normal life	92%	94%	93%
Referral	83%	82%	88%
Matching and introductions	86%	91%	95%
Daily life	73%	81%	90%
Service user's plan	71%	67%	80%
Placement monitoring and review	73%	74%	85%
Carer support and review	88%	79%	88%
Selection and training	56%	60%	67%
Conduct of the scheme	60%	63%	76%
Protection	67%	69%	82%

How to contact CSCI

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Helpline: 0845 015 0120 or 0191 233 3323
Email: enquiries@csci.gsi.gov.uk
www.csci.org.uk/professional

We want people to be able to access this information. If you would like a summary in a different format or language please contact our helpline or go to our website.

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From April 2009, the Care Quality Commission will take over the work of CSCI, the Healthcare Commission and the Mental Health Act Commission.

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