

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

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

- The Government legislated to make more people with modest wealth eligible for publicly funded support, by raising the capital threshold used as a means test from £23,250 to £118,000 (from 2016) and introducing a lifetime cap on care costs. However, this cannot be expected to have much impact on continued under-funding for social care as a whole.
- Public spending on social care has failed to keep pace since the mid-2000s with demand for services from growing numbers of older people. Spending cuts imposed by the Coalition intensified the pressure on social services from 2010 onwards.
- Overall spending is projected to have fallen by 13.4 per cent over the Government's five years in office. Already by 2013/14, 17.4 per cent less was being spent on services for older people. By contrast, the number of people aged 65 and over increased by 10.1 per cent over the same period, including an 8.6 per cent increase in the population aged 85 or over.
- The number of people receiving publicly-commissioned adult social care services fell by one-quarter between 2009/10 and 2013/14 from 1.7 million to below 1.3 million. Care at home and other community-based services were hit especially hard, resulting in an average 8 per cent reduction in the number of users each year.
- The number of people with learning disabilities using community-based services grew slightly, but all other client groups experienced cuts. The number of service users among working-age adults with mental health problems dropped by 37 per cent and the number of physically disabled users aged 65 or over fell by 32 per cent.
- Local services were increasingly targeted on adults assessed as having the most complex needs. The proportion of social care clients being supported for five or fewer hours a week declined from 37 per cent to 28 per cent between 2009/10 and 2013/14. The proportion receiving care for more than ten hours a week increased from 34 per cent to 45 per cent. At the same time, nearly three-quarters of councils now arrange some social care visits as short as 15 minutes.
- Monitoring of care services based on users' perceptions suggests some quality of life outcomes have improved. Nevertheless, statistics on the abuse of vulnerable adults show 37,685 substantiated cases in 2013/14, while Care Quality Commission inspections revealed serious concerns about the quality of care in a fifth of nursing homes and a tenth of residential care homes.

## What were the Coalition's aims and goals?

There was little debate during the 2010 election campaign about social care issues. However, the Coalition Agreement provided for a commission to make recommendations about the future funding of long-term care. It also promised steps to improve the integration of health and social care, improve the uptake of personal budgets for care, and increase the availability of direct payments for carers.

## What did the Coalition do?

### *Future funding*

The promised Commission on Funding of Care and Support, chaired by Sir Andrew Dilnot, reported its findings in 2011. A modified version of its recommendations was implemented in the Care Act 2014. This set a 'lifetime cap' on the contribution that any individual will be required to make towards care costs, with effect from April 2016. This was set at £72,000 for pensioners and lower levels were promised for working-age adults. The cap does not apply to daily living expenses, so only part of the overall cost of a residential care placement will count towards it.

At the same time, the upper capital threshold to be used to means test publicly funded payments towards residential care was raised to £118,000 – a more than four-fold increase from £23,250. The Government also committed to keep the lower threshold at which care fees become fully funded, constant, in real terms, at £14,250. This means the wealth range over which individuals are eligible for at least some state support has become considerably wider. Together, the measures were designed to remove some of the more extreme financial consequences of needing long-term care under the existing system. Once implemented, they are primarily expected to benefit those with high intensity or prolonged care needs and modest wealth.

### *Eligibility*

The Care Act expanded the responsibilities of social services to take preventative steps to delay the need for care. It also sought to reduce the 'postcode lottery' of different eligibility criteria set for social care by local authorities by defining national minimum criteria for entitlement to services for those in need of care, and, for the first time, for carers. In practice, a decision was taken to fix the criteria at such a high threshold that it was expected only 3 authorities would be required to widen their provision, while 19 would be shown a 'green light' to further restrict existing eligibility. This gave statutory backing to a shift already underway locally from providing home care and other services for those with 'moderate' needs, to a higher threshold of having 'substantial' needs.

### *Integration of health and social care*

The Health and Social Care Act 2012 and the Care Act 2014 both sought to promote the integration of health and social care. A *Better Care Fund* was set up, pooling existing NHS and social care resources, with the aim of reducing emergency hospital admissions and other acute health care spending by improving care in the community. Although not 'new money' and less than 3 per cent of total NHS and social care spending, the fund was projected to be worth £3.8bn in 2015/16 and was set to deliver a significantly bigger funding pot for joint working than previously available.

### *Regulation, monitoring and inspection*

In response to a series of scandals about care quality, including undercover TV documentaries exposing the abuse of vulnerable care home residents and Serious Case Reviews by public bodies, the Coalition sought to strengthen the statutory basis of adult safeguarding and the regulation of care homes. In addition, following the collapse in 2011 of the UK's largest private care home provider, Southern Cross,

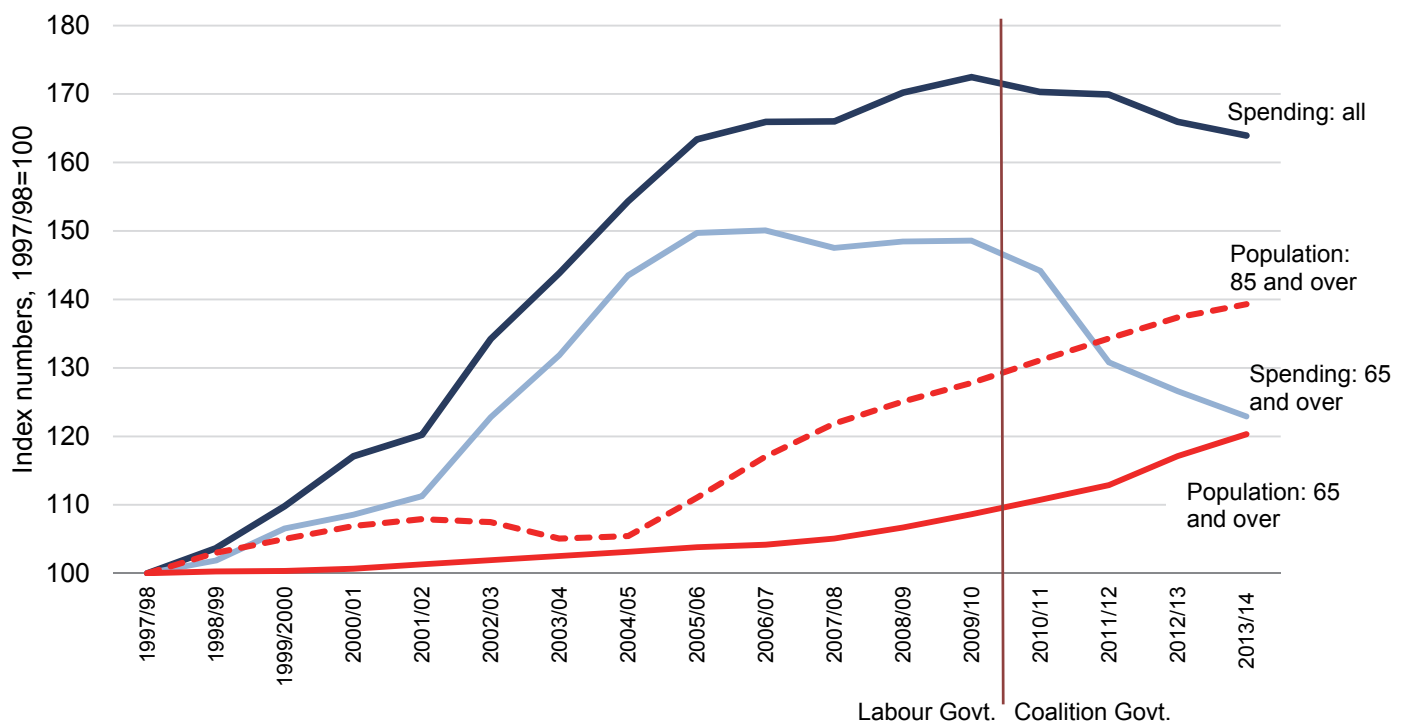
the Care Act 2014 placed a duty on local authorities to provide continuity of care when an independent residential care provider ceases to operate.

The Care Quality Commission’s inspection regime for social care providers was overhauled to include assessments of financial management and sustainability. The CQC also aimed to make more systematic use of users’ views in their care home inspections and improve the monitoring of complaints. Local Safeguarding Adults Boards, made up of social services, NHS and the police, were put on a statutory footing. The Government introduced a national Adult Social Care Outcomes Framework in 2011 with monitoring indicators relating to health and social care integration, quality of care, services for carers and choice and control for users (see below).

### How much did the Coalition spend?

Overall spending on adult social care had increased in real terms under Labour up to 2009/10, but spending on people aged 65 and over had declined from 2006/07.

**Figure 1: Growth in real net current spending on adult social care, and in the older population, England, 1997/98 to 2013/14**



Sources: Personal Social Services Expenditure and Unit Cost in England 2013-14, ONS population estimates.

Figure 1 shows that this was despite rapid and continuing growth in the number of older people – not least the ‘oldest of the old’ population aged 85 and above. This suggests there was a growing shortfall between expenditure and the need for adult care services.

Spending cuts made by the Coalition intensified the pressures on social care. By 2013/14, there had been a real terms reduction of between 7.1 per cent and 7.6 per cent (depending on expenditure definitions) with further cuts planned for 2014/15. This took place in the context of an 10.1% increase between 2009/10 and 2013/14 in the population aged 65 and over, including a 8.6% increase in the number aged 85 or over. Spending on older people fell faster than for adult social care as a whole: by 17.4 per cent between 2009/10 and 2013/14 (real net current spending).

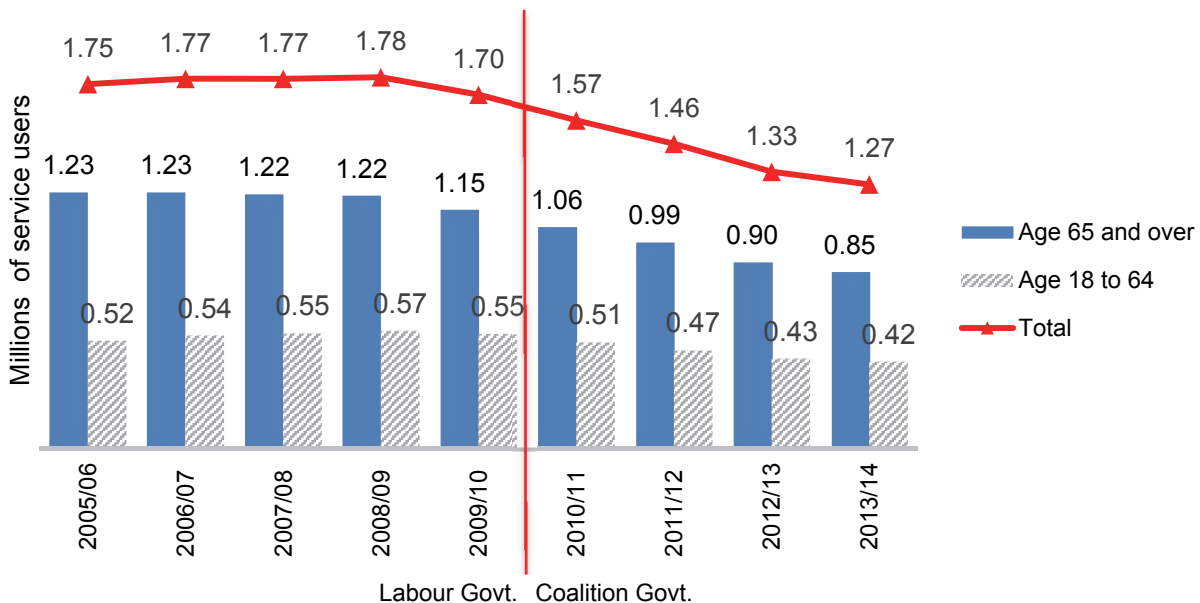
Publicly-funded care accounts for only part of the services being provided at any time. Unpaid, informal care makes an important contribution, as do services that disabled adults and older people purchase for themselves. Between 2009 and 2013, there was a 17 per cent increase in the number of people living in residential care homes who funded their own care entirely. This represented an increase in the proportion of self-funders from 40 per cent to 44 per cent. While pre-dating the Coalition, the trend suggests that an increasing number of disabled and older people were relying on self-funding to enter and remain in residential care as public funding was reduced.

### What was achieved?

*Despite rising demand for care services, the number of older people and other adults supported through local authorities declined dramatically*

The number of people receiving adult care services through English local authorities fell to 1.27 million in 2013/14 – a fall of 29 per cent in the total caseload since the peak in 2008/9, and a fall of 25 per cent since 2009/10. While the decline began under Labour, it accelerated under the Coalition (Figure 2).

**Figure 2: Falling number of people receiving community-based, residential or nursing care services through local authorities, by age group, 2005/6 to 2013/14, England**



Source: National Adult Social Care Intelligence Service (NASCIS)

The decrease in numbers of clients was especially steep for care arranged by local authorities for people in their own homes. Under the Coalition, the average annual rate of reduction in the number of people receiving this and other community based services was 8 per cent.

The number of community service users with learning disabilities grew slightly (as did the number of individuals in this population), but all other client groups experienced significant cuts. For physically disabled people aged 65 or over – by far the largest client group within adult social care – the reduction from 2009/10 was 32 per cent. The number of mental health service users of working age, who make up another large group, declined by 37 per cent.

*Community services became more targeted on individuals with the most complex needs*

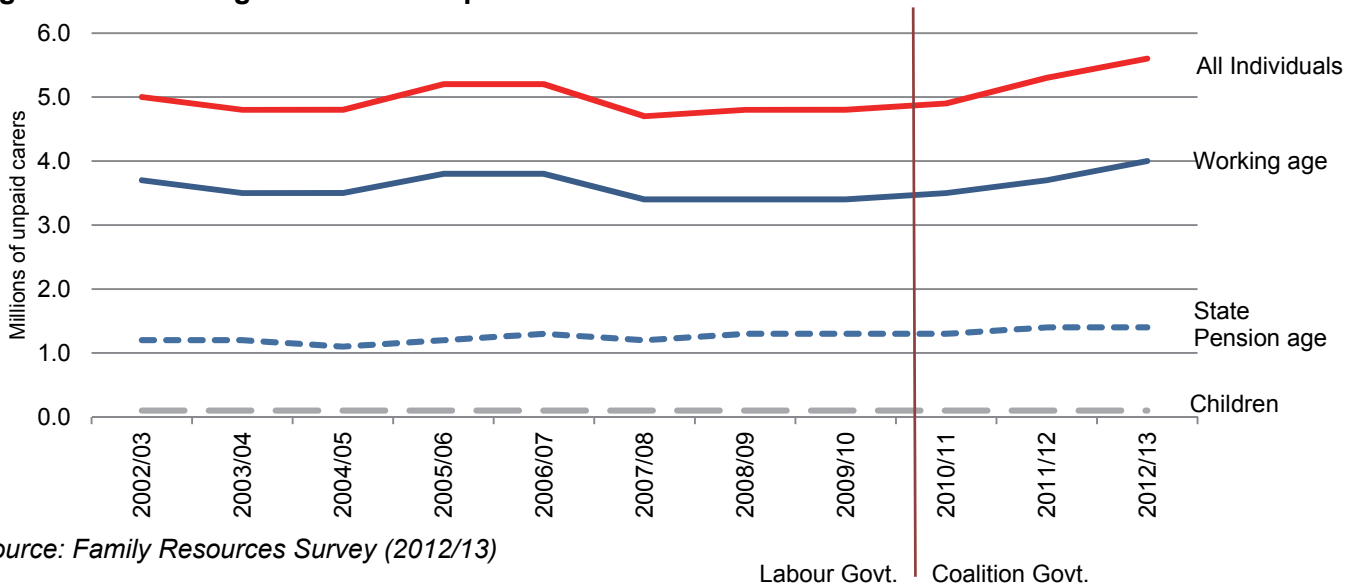
Activity (measured by the number of clients) showed a much faster decline than figures for real terms expenditure. This reflected changes in the types of service being commissioned and the way they were targeted. There was a notable shift away from low-intensity support to people in their homes towards higher-intensity services. For example, in 2009/10, 37 per cent of clients were receiving care packages of 5 hours per week or less, but by 2013/14, this had fallen to 28 per cent of clients. Conversely, the proportion of clients receiving support for more than 10 hours per week rose from 34 per cent to 45 per cent.

At the other end of the spectrum, there was an increase in the use of social care visits as brief as 15 minutes. By Autumn 2014, 110 out of 149 local authorities were commissioning visits as short as 15 minutes (for example, to provide a meal and help someone eat, or get someone up, washed and dressed), an increase of 5% on the previous year.

*The number of disabled and elderly adults receiving unpaid care grew – as did the number of informal carers*

Coinciding with the declining availability of publicly funded and commissioned care services, the provision of unpaid, informal care by family and friends increased. In 2009/10, 4.8 million individuals provided care on at least a weekly basis. By 2012/13, this figure had reached 5.6 million (Figure 3).

**Figure 3: Increasing numbers of unpaid carers in the UK since 2010/11**



Source: Family Resources Survey (2012/13)

The Family Resources Survey (FRS) suggests that 3.2 million people were receiving unpaid care in 2012/13, compared with 2.9 million in the two preceding years. Here, too, the data point to an intensification of support provided by family or friends, with 38 per cent receiving round-the-clock care in 2012/13, compared with 35 per cent in 2007/08 and 29 per cent in 2002/03. Among developed nations belonging to the OECD, the UK is one of the most heavily dependent on unpaid care for sick, disabled and older people.

#### *The proportion of adults with unmet care needs remained high under Labour and the Coalition*

FRS data also show high levels of unmet need, both in the last years of the Labour administration and under the Coalition. For example, the proportion of people aged 75 and over with less intensive needs (defined as one to three substantial difficulties) without any support from either paid or unpaid carers grew from 72 per cent to 74 per cent between 2007-8 and 2011-12. Notwithstanding the intensification of services that took place, unmet needs among 75 and overs with four or more substantial difficulties remained at over one-third (36 per cent in 2011-12).

#### *Quality of life indicators show improving outcomes among those who receive services...*

The Adult Social Care Outcomes Framework (ASCOF) was introduced to monitor a range of indicators relating to the quality of life experienced by care users, including their health, choice and control, personal safety, employment and satisfaction with services. More specific policy goals, such as promoting the integration of health and social care, and making greater use of reablement and rehabilitation services, are also included. Since 2010/11, trends for 11 of the 23 indicators or sub-indicators included have been positive, and negative for only one. The remaining 11 are unavailable or show no clear direction. All the measures obtained by surveying social care users (with one exception where there is no clear trend) suggest improvement.

These indicators suggest that the experience of the 'intensified' group of clients who receive publicly-funded care services is generally good. However, the indicators provide no account of the experiences of those who are not, or are no longer, eligible for services, including those whose needs do not meet the higher threshold of need now being set.

#### *...but there are continuing concerns about abuse and poor quality care in residential homes and community services*

Statistics indicate 37,685 substantiated cases of vulnerable adults suffering abuse in England during 2013/14. It is likely that these represent the tip of the iceberg, given the continuing barriers to abuse being reported and investigated. Inspections by the Care Quality Commission in the same year revealed safety concerns (such as failure to give out medicines safely) in one in five nursing homes, and serious concerns about the quality of care, staffing or safeguarding in one in ten residential homes. There were also concerns about staffing and quality monitoring in one in ten home care services inspected.

## Conclusions

Adult social care was already substantially underfunded when the Coalition came to power. The Government's spending cuts served to intensify the pressures on services. Councils endeavoured to protect adult social care from the deepest cuts, but nevertheless there has been a projected real terms cut of 13.4 per cent in expenditure on social care during the Coalition's term in office. This must be viewed against the background of a 9.1 per cent increase in the population aged 75 and over, whose care needs are especially intense. Given the squeeze on overall resources, it was rational to focus local service



provision on those with the most complex difficulties. But this left large numbers of people with substantial needs depending on unpaid care from family and friends or not receiving any kind of support whatever.

The Government's reforms, based on the Dilnot Report, were a significant milestone after decades of indecision and debate about the appropriate split between public and private individual funding for long-term care. The changes will primarily benefit those who would otherwise have faced very high care costs and who have modest wealth, but will do little to redress the chronic under-funding of social care as a whole.

Progress was made in introducing new regulatory and safeguarding measures to better monitor and protect adults against abuse. However, in spite of steps to promote joint working and budget pooling between the NHS and local authority social services, the year-on-year reductions in resources overall raise a formidable barrier to improving quality (for example by investing in a higher-skilled and more stable care workforce) and relieving pressure on services (for example by reducing caseloads). In addition, the Care Act 2014 contains an unresolved tension between the Government's declared commitment to improve preventative services and the endorsement it offered to local authorities setting a high threshold of need for access to care in the home and other support services. In reality, care needs are on a continuum, with appropriate support at each stage being likely to reduce, delay or prevent further needs developing.

Other major challenges that will face an incoming government after the 2015 election include:

- Relieving the pressure on unpaid carers, particularly those who have stepped in to fill the gap left by withdrawal of formal services, and are providing high-intensity care.
- Tackling unmet needs. Many disabled and elderly people receiving neither formal nor unpaid support are at risk of deteriorating health and social isolation as a consequence.
- Ensuring that residential and community-based services are of a consistently high quality. Given continuing evidence of market failure and both public and private service providers' inability to guarantee minimum standards of care, it could become increasingly necessary to question the structure of the social care sector as a whole, and in particular to address the composition, status, qualifications and workloads of the care workforce.

## Further information

The full version of this paper *The Coalition's Record on Adult Social Care: Policy, Spending and Outcomes 2010-2015* is available at <http://sticerd.lse.ac.uk/dps/case/spcc/WP17.pdf> This is one of a series of papers produced as part of CASE's research programme *Social Policy in a Cold Climate* (SPCC). The research, concluded in 2015, examines the effects of the major economic and political changes in the UK since 2007, focusing on the distribution of wealth, poverty, inequality and social mobility.

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