

Briefing

September 2018

Key challenges facing the adult social care sector in England

This briefing was originally commissioned by the Labour Party as an independent contribution to policy development.

Introduction

In the past 20 years there have been 12 White Papers, Green Papers and other consultations about social care in England (Wenzel et al 2018), as well as five independent reviews and commissions. Yet little has changed. Doing nothing – or doing very little – has proved a judicious option for policy-makers.

However, the scale of the difficulties facing social care means that doing nothing is no longer an option. Demographic pressures, growing public concern and a system at 'tipping point' all mean that action is essential. As we argue in *A fork in the road: next steps for social care funding reform* (Bottery et al 2018), full reform may be better value than trying to maintain the current, flawed system. If so, the key choice – the fork in the road – is between a better, fairer, means-tested system and one that is more like the NHS: free at the point of use for those who need it most.

As a first step in decision-making, *A fork in the road* argues that policy-makers need to identify which of the problems facing social care they most want to tackle. This briefing paper is intended to aid that process by identifying and exploring those key challenges. It was originally requested by the Labour Party and has been researched and written independently by The King's Fund, which retained full editorial control.

The document breaks down the social care sector into interlinked issues:

- need and demand
- eligibility
- funding
- market sustainability and fairness
- workforce and carers
- quality and efficiency
- integration with housing, health and the benefits system.

Each section features a short analysis of key trends in that area, followed by a summary of the challenges arising from that analysis. The document does not make specific policy recommendations but rather identifies and explores the issues that policy might need to address.

1 Need and demand

Unmet need/demand

Levels of unmet need for adult social care are disputed, at least partly because of definitions. The Department of Health and Social Care classifies unmet need in strict terms:

For there to be a significant unmet need out there, either one of two things must be happening. Local authorities are not implementing the Care Act in the way that it was intended or expected to be, or the criteria in the Care Act are wrong, such that there would therefore be a lot of people who are not picked up in it. I do not think there is any evidence that either of those two things is in place.

(Mowat 2017)

This definition essentially assumes that all people who need care will come forward for assessment and unmet need is defined only as individuals who are assessed as eligible but who do not in fact receive services.

Alternative and more widely accepted definitions of unmet need are based on the estimated numbers of people who have difficulty with activities of daily living and do not receive all the help they need. Age UK estimates that there are 1.4 million people in this category, of whom more than 300,000 need help with three or more activities (Age UK 2018). This includes more than 160,000 people who receive no help at all, either from formal or informal care. The Local Government Association (LGA) estimates that it would cost £2.4 billion to meet the needs of these 160,000 people and a further £1.2 billion to meet the unmet needs of working-age adults (if, as it assumes, the level of unmet need in this group is the same as that in the Age UK survey) (LGA 2018a).

The National Audit Office (NAO) notes that there is conflicting evidence as to whether unmet need has increased or not in recent years (NAO 2018a).

Numbers of people receiving services

The way in which the number of service users is measured was changed in 2014/15 and it is not possible to compare directly the current number of care

users with the number of users prior to 2014/15. However, between 2009/10 and 2013/14, the total number of adults receiving publicly funded care fell by around 400,000 (Nuffield Trust *et al* 2017).

The number of service users also fell between 2015/16 and 2016/17: the number of clients receiving long-term care in 2016/17 decreased by 4,080 to 868,440, and the total number of completed episodes of short-term care was 241,810 – a decrease of just over 2 per cent in 2015/16 (NHS Digital 2017a). Overall, therefore, it seems likely that there has been a continuing year-on-year reduction in the numbers who receive publicly funded care since 2010/11, which is likely to have contributed to unmet need.

There is wide regional variation in the extent to which people access publicly funded care, but the reasons for these differences are not clear. There is significant subjectivity in the needs test for social care services and this may explain some of the variation. However, there are also indications that reductions in individual council budgets (see 'Funding' section) have fed through into more systemic approaches to reducing service provision. In the Association of Directors of Adult Social Services (ADASS) budget survey 2018, 75 per cent of adult social services directors said that reducing the number of people in receipt of care was 'important' or 'very important' to their planned savings in 2018/19 (ADASS 2018).

The Local Government and Social Care Ombudsman told *Community Care* magazine in May 2018 that 'Increasingly the faults we see are much more structural and systemic because the local authorities are being forced to adopt the approaches (as to how) they deliver care and ration care, which – sometimes – are on the margins of what is acceptable' (Haynes 2018).

Preventing demand

Preventing, reducing or delaying the need for care, where feasible, was a key element of the 2014 Care Act, which stated that 'effective interventions at the right time can stop needs from escalating, and help people maintain their independence for longer' (Department of Health and Social Care 2018a). Councils say that increasing prevention and early intervention are important in realising the planned savings in adult social care, and there are also impacts on health services. For example, the NAO has estimated that one-fifth of emergency hospital admissions are for existing conditions that could be managed effectively by primary, community or social care and could be avoided (Department of Health 2013).

However, expenditure categorised as being on services intended to reduce or delay the need for social care has stayed at a low level since 2014/15 and, in the case of assistive technology and information/early intervention, has fallen in cash terms (Table 1). Together, they account for only around 3 per cent of gross council expenditure on adult social care.

Table 1 Spending on services to reduce the need for social care, 2014/15 to 2016/17

Financial year	Support for isolation (£ million, cash terms)	Assistive equipment and technology (£ million, cash terms)	Information and early intervention (£ million, cash terms)	Gross social care expenditure (£ billion)
2014/15	81	214	253	17.0
2015/16	78	207	234	17.0
2016/17	89	196	213	17.5

Sources: NHS Digital (2016; 2017a).

Managing demand – asset-based approaches

Significant numbers of councils now say they are adopting demand management approaches to social care, which focus on designing assessments and services to promote independence rather than necessarily providing formal, ongoing services. These approaches typically seek to reduce the requirement for formal services by assessing need accurately – avoiding, for example, assessment in hospital, when people are at their most dependent – and then identifying resources within the family, community and voluntary sector that can be used instead of, or as well as, formal services. When used sensitively, this involves an asset-based approach to supporting people’s independence and wellbeing that has wide support. Four in five councils now say the adoption of asset-based and self-help approaches is a very important part of their plans for making savings in 2018/19 (ADASS 2018). However, a 2016 report by The King’s Fund on social care for older people noted that this vision requires ‘a vibrant voluntary and community sector, family members able and willing [to take on a wider role], and health and care services fully geared up to support people in their homes’ (Humphries *et al* 2016). It noted at the time that it had not found evidence of these things being consistently in place.

Future demand

Two complementary trends in ageing are likely to drive a significant amount of future extra demand for care services:

- the demographic 'bulge' of people – the baby boomer generation – born in the 20 or so years after the second world war, who are now reaching retirement in the first decades of the 21st century
- the increased longevity of that population, with life expectancy at birth now 79.2 years for men and 82.9 years for women (Office for National Statistics (ONS) 2018a). Despite the recent slowdown in improvements in mortality rates, the ONS predicts that life expectancy will continue to rise, though at a slower rate than previously.

Overall predictions mask significant differences in life expectancy – for example, men and women born in the most deprived areas of England are expected to live 9.4 years and 7.4 years less respectively than those in the least deprived areas.

By 2066, the ONS estimates that there will be a further 8.6 million UK residents aged 65 years and over, taking the total to 20.4 million and making up over a quarter of the total population (ONS 2018a). The fastest increase is forecast in the 85 years and over age group.

As a consequence, as the population ages, it has been predicted that by 2030 there will be:

- 45 per cent more people living with diabetes
- 50 per cent more people living with arthritis, coronary heart disease or stroke
- 80 per cent more people (nearly 2 million in total) living with dementia (Select Committee on Public Service and Demographic Change 2013).

These population trends have important, well-reported impacts on health and care demand. A very recent study forecasts that the number of people over the age of 85 with high care needs will almost double in the next 20 years (Kingston *et al* 2018). Those trends have been exacerbated by related trends in working-age disability, as more people with disabilities are surviving longer and the costs of their support are increasing.

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The NAO (2018a) cites projections by the Personal Social Services Research Unit (PSSRU) that the number of people with disabilities will increase by 67 per cent between 2015 and 2040.

Summary of key challenges

- There are high levels of unmet need.
- There is a lack of investment in prevention and demand.
- There will be increasing future demand from both older people and working-age adults.

2 Eligibility

Means testing

The most fundamental difference between the NHS and social care remains means testing. The social care means test is extremely complex and poorly understood by the public, but its effect is that only those with low financial resources are eligible for publicly funded social care services. Currently, people with assets below £14,250 are not required to use these assets to contribute to their care, while those with assets of between £14,250 and £23,250 are required to contribute towards their care. Above £23,250, people are not eligible for publicly funded care.

The type of assets held by an individual and the type of care needed significantly affect eligibility. If an individual needs care at home, the value of their house is not counted towards their assets. If they need care in a care home, the value of the home is included (unless, for example, a spouse is living in that home).

The means test has also become less generous, because since 2010/11, the upper and lower thresholds in the financial means test (£14,250 and £23,250) have not been increased. Accounting for inflation, these thresholds are now 12 per cent lower than they were in 2010/11 (Thorlby et al 2018).

Those ineligible to receive publicly funded services are required to rely on informal care from their family (see 'Workforce and carers' section), go without care, or pay for it privately. Due to differences in factors such as disability prevalence and asset values, the extent of self-funding varies across England, from 61.9 per cent in the south east to 21.9 per cent in the north east (NAO 2018a).

Even if they qualify because their assets are sufficiently low, individuals are typically still required to contribute towards the costs of their care from their income. This has been called a 'disability tax' by one council, which abolished these charges for care at home (Hammersmith & Fulham Council 2014).

Needs testing

In addition to a means test, social care services are also subject to a 'needs test', which only confers eligibility on those with sufficiently high care needs.

Eligibility for publicly funded social care in England has been falling since at least 2006 because of changes to the needs test. In 2005/6, 40 per cent of councils provided care to those with moderate needs (graded under the previous Fair Access to Care system) but by 2011/12, this had reduced to 18 per cent (Age UK no date).

Catastrophic cost

People who do not qualify for publicly funded care must pay all their care costs themselves, with no cap on their total liability. The Commission on Funding of Care and Support (2011) estimated that one in ten people faced lifetime care costs of £100,000. There are no firm estimates of how many people need to sell their homes to pay for care, though the 2010–15 coalition government estimated this at 30,000–40,000 people a year (Full Fact 2013). Using homes to pay for care is unpopular in research into attitudes to social care funding (Cameron and Balfour 2018). Despite encouragement from government at the time of the Dilnot Commission on Funding of Care and Support, no new insurance products emerged that would allow people to protect themselves against catastrophic costs.

Alternative models of eligibility in the United Kingdom

The four home nations have diverged significantly in their approach to eligibility for social care, as summarised in Table 2 (Thorlby *et al* 2018).

A key difference is in Scotland, which in 2002 removed the means test for personal care services (including help with washing and dressing) for people over 65, though a needs test still applies. The Scottish government has committed to extending free personal care to those under 65 by 2019.

Table 2 Differences in social care means test in United Kingdom

	England	Northern Ireland	Scotland	Wales
Number of responsible organisations	152 LAs	5 HSCTs	32 LAs	22 LAs
Needs test?	Yes	Yes	Yes	Yes
Income test?	Yes	Yes	Yes	Yes
Asset test?	Yes	Yes	Yes	Yes
Lower asset test threshold (£)	14,250	14,250	16,500	
Upper asset test threshold (£)	23,250	23,250	26,500	40,000
Services covered by the means test				
Personal care	Yes	Yes	No	Yes
Nursing care	Yes	Yes	No	Yes
Accommodation costs	Yes	No	Yes	Yes

Source: Health Foundation

Note: LA = Local authority; HSCT = Health and social care trust

Summary of key challenges

- There is a fundamental, poorly understood distinction between social care means test and NHS.
- Few people qualify for publicly funded support.
- The low eligibility and no cap means some people pay catastrophic costs.

3 Funding

Sources of public funding for social care

Council funding for social care is derived from the revenue support grant received from central government, from locally generated incomes such as council tax and business rates, and from user charges. The current policy intent is to end the revenue support grant by 2020 and for local authorities to retain 100 per cent of business rates raised. The Institute for Fiscal Studies (IFS) has argued that under these reforms, different councils could find themselves with revenues that differ significantly from their social care spending needs (Amin-Smith *et al* 2018).

Additional funding in recent years has come from the NHS via the Better Care Fund (NHS England website), an Improved Better Care Fund grant paid directly to councils, the ability to supplement council tax with a social care precept, and an adult social care support grant from central government.

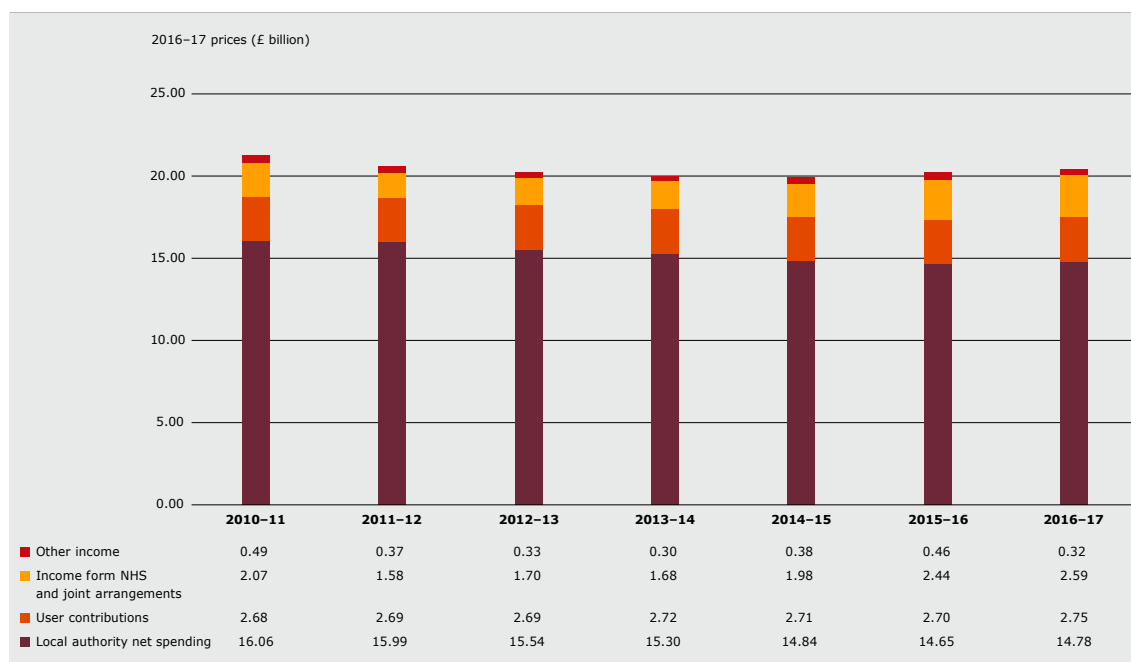
Trends in public spending on social care

The NAO found that in 2016/17, 43 per cent of local authority net current expenditure on main services was used to fund adult social care (NAO 2018a). It is the largest single area of council expenditure – double that of children’s social care and more than 10 times the level of spend on housing services (4 per cent). The split between older people and working-age adults is now virtually even, at 51 per cent to 49 per cent. Most councils say they are equally concerned about the cost pressures of the two groups but a third (32 per cent) are more worried about cost pressures of working-age adults (ADASS 2018), compared to 12 per cent who say they are more concerned about the cost pressures of older people.

The NAO estimated that between 2010/11 and 2016/17, local authority spending on adult social care reduced by 3.3 per cent in real terms. While net local authority spending on adult social care fell by 8 per cent, this was offset by income from the NHS, now channelled through the Better Care Fund (see Figure 1). Though this reduction came despite increasing numbers of older people and people with disabilities (Department for Work and Pensions 2018b), it was a relatively small reduction in comparison to long-term spending reductions for other services, such as 45.6 per cent for housing and

37.1 per cent for highways and transport. However, real terms spending on children’s social care increased by 3.2 per cent (NAO 2018a).

Figure 1 Sources of local authority spending on adult social care



Source: National Audit Office analysis of data from NHS Digital, *Personal Social Services: Expenditure and Unit Costs, England – 2010-11 to 2015-16* and *Adult Social Care Activity and Finance Report 2016-1*

These national figures mask significant local variation. Analysis by the IFS finds that **cuts to social care between 2009/10 and 2017/18 have varied across local authorities and tended to be larger in more deprived areas** (Phillips and Simpson 2018). It finds that the 30 councils with the highest levels of deprivation made cuts to adult social care of 17 per cent per person, while the 30 with the lowest levels of deprivation made cuts of 3 per cent per person.

In 2018, ADASS estimated that since 2010, adult social care savings had amounted (cumulatively) to £7.0 billion (ADASS 2018).

Private spending on social care

There is limited and often inconsistent data on the extent of private spending on social care in England. The NAO estimates the total size of the self-funder market at £10.9 billion in 2016/17 (NAO 2018a). The UK Homecare Association (UKHCA) estimates that in 2014/15, expenditure by self-funders on home care was £623 million in England (£713 million across the UK) (UKHCA 2016). The Competition & Markets Authority (CMA) (2017) estimates that 41 per cent of care home residents fund themselves fully, with 49 per cent receiving council funding, of which around a quarter have friends or relatives who pay 'top-up' fees to supplement the amount they receive from councils. The NHS funds the remaining 10 per cent.

There is very limited take-up of insurance to pay for future social care costs. Less than 1 per cent of the UK population has long-term care insurance according to the Financial Conduct Authority (FCA)'s financial lives survey 2017, which involved nearly 13,000 adults (FCA 2018). This figure also includes a very small number of immediate needs annuities currently sold to people entering care homes.

Funding gap

While there is broad consensus on the need for more money to be invested in adult social care, there is no consensus on the size of the funding gap. Estimates depend on which elements of potential additional spending are factored in – for example, whether one includes the funds required to widen eligibility or increase provider fees.

In its *The lives we want to lead* adult social care Green Paper, the LGA (2018) estimates that adult social care faces an 'immediate and annually recurring' gap of £1.44 billion between the cost of care and what councils pay. It estimates that demographic changes (ie, more older people and more people with disabilities), together with inflation, will increase that gap to £3.56 billion by 2025. This gap is to maintain the current level of services rather than increase access or improve quality.

The Health Foundation and The King's Fund estimate that meeting projected demand – again without improving access or quality – would cost £1.5 billion by 2020/21 and £6 billion by 2030/31 (Bottery *et al* 2018). To restore funding to the levels of quality and access achieved in 2009/10 would cost £8 billion by 2020/21 and £15 billion by 2030/31.

This also models the cost of reforming the current system significantly. Introduction of a 'cap and floor' model, which makes more people eligible and introduces a cap on the total lifetime amount they could pay for care, would cost £5 billion by 2020/21 and £12 billion by 2030/31. Introducing free personal care, based on the model applied in Scotland, would cost £7 billion by 2020/21 and £14 billion by 2030/31.

Public attitudes to funding social care

There is low public awareness of how social care is funded (Bottery *et al* 2018). Qualitative research suggests people are often surprised at what they see as low asset thresholds for accessing social care and feel it is very unfair for government to take into account the value of their homes. When the current funding system is outlined to them, people feel it needs to change. They find options such as the 'cap and floor' model difficult to understand and – though an improvement on the current system – do not view it positively. The option of free personal care is well received, though with wariness about its cost. The idea of a hypothecated tax to pay for social care is strongly supported.

Summary of key challenges

- There is wide agreement on need for greater expenditure on social care...
- ...but no agreement on appropriate public/private split or how to raise it.
- There is uncertainty about future size and structure of local government funding.
- There is lack of public awareness about current system and its limitations.

4 Market sustainability and fairness

Providers

In both residential care and domiciliary care, the great majority of providers are in the independent (voluntary or for-profit) sector.

The Care Quality Commission (CQC) (2017a) says there are:

- around 16,000 residential care homes, nursing homes and specialist colleges providing accommodation and personal care for adults of working age and older in England
- around 8,500 services providing domiciliary care services, in addition to extra care housing, Shared Lives schemes and supported living services.

The CMA (2017) review of the care home industry for older people estimates that there are around 5,500 providers in the UK operating 11,300 care homes for the elderly. The vast majority (80 per cent) of care home providers only operate one home.

According to the CMA (drawing on data from industry analysts Laing and Buisson):

- for-profit providers account for 83 per cent of care home beds and the voluntary sector accounts for a further 13 per cent. The remaining 4 per cent of care home beds are run by local government or the NHS
- the largest 30 care home providers supply 30 per cent of the overall capacity, and the 80 per cent of providers running one home supply 29 per cent of care home beds
- care homes have 40 beds on average. The average size of a care home has been gradually increasing, with the optimum size in terms of operational effectiveness considered to be around 60–70 beds (though this contrasts with the CQC finding that smaller care homes are of higher quality – see 'Quality' section).

The UKHCA (2016) says 92.1 per cent of domiciliary care funded by local authorities in 2013/14 was delivered by the independent or voluntary sectors (but does not distinguish between the two). The remainder was delivered by the statutory sector. There is very high turnover of domiciliary care providers, with around 500 new entrants every quarter offsetting 400 cancelled CQC registrations (CQC 2017a).

Market shaping, provider failure and sustainability

Local authorities have a statutory duty under the Care Act to 'shape the market' for care and support in their areas. However, the CMA said this market shaping was 'very variable' when it came to care home provision and that there was little evidence from council market position statements of a proactive approach to the sector (CMA 2017). The UKHCA has also criticised councils for in most cases failing to pay what it regards as a minimum sustainable price for home care services of £18.01 per hour (UKHCA 2016). In the past two years, several of the biggest national providers of home care have withdrawn from the publicly funded home care market. The ADASS budget survey 2018 reports that 'there is continued evidence... of failure within the provider market in the last six months, affecting at least 66% of councils and thousands of individuals as a consequence'. Almost a third (48) of councils said that home care providers in their area had closed or ceased trading within the past six months and 43 had had contracts handed back; 58 councils reported closure or ceasing to trade in residential/nursing care and 17 had had contracts handed back.

Concern about provider failure, particularly following the 2011 collapse of care home provider Southern Cross, underpins efforts to shape markets and ensure their sustainability. Among the government fiscal risks identified recently by the Office for Budget Responsibility (OBR) was 'potential pressure to bail out a private social care provider if in financial difficulty' (OBR 2017). Since 2015, the CQC has had a statutory responsibility to monitor and assess the financial sustainability of those care organisations in England that councils would find difficult to replace should they fail (CQC 2018b). Collectively, these providers represent around 30 per cent of the adult social care market in England. Following concerns about the financial health of the Four Seasons care home group, in December 2017, the CQC said it did not believe services were likely to be disrupted as a result of business failure (CQC 2017b).

The impacts of, and reasons for, care home closures are likely to be complex, with some natural turnover to be expected as owners retire (for example). A Knight Frank survey of care home registrations in the 12 months to April 2018 found a small net loss in number of beds over the period, driven by smaller care homes closing and larger schemes opening. The loss of beds was greatest in the north west, while beds were in fact gained in three areas – West Midlands, east of England and the north east, as well as Scotland and Wales. It said it was 'safe to say that financial stress was one of the key drivers to home closures' (Knight Frank 2018).

The average size of new care homes was 60 beds compared with 30 for those closing. Knight Frank found that of the top 12 places it regards as 'hotspots' for care home development potential, eight are in the south of England and only one is in the north. It suggests that this is triggered by lower gross domestic product (GDP) forecasts for northern counties, coupled with lower average weekly fees. The Knight Frank model also takes into account factors such as land values, staff costs, forecast 65+ population growth, local economic growth, local wealth, and current and expected future supply.

The CMA, in its review of the UK care home markets, found that:

... the current model of service provision cannot be sustained without additional public funding; the parts of the industry that supply primarily local authority-funded residents are unlikely to be sustainable at the current rates local authorities pay. Significant reforms are needed to enable the sector to grow to meet the expected substantial increase in care needs.

(CMA 2017)

Among other reforms, the CMA recommended oversight of local authority commissioning practices.

Price differentials

The CMA estimated that the average cost of self-funders in 2016 was on average 41 per cent higher, at £846 a week, compared to an average paid by local authorities of £621 a week. It estimated that around 25 per cent of care homes have more than 75 per cent of residents funded by the local authority, and that local authority fees are currently (on average) as much as 10 per cent below total cost for these homes, equivalent to a shortfall of between

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£200 million and £300 million. If all local authorities were to pay the full fees, the additional cost would be between £0.9 billion and £1.1 billion.

Summary of key challenges

- There is a risk of provider failure.
- There is wide local variation in supply of care.
- Substantial premiums are paid by self-funders in care homes.

5 Workforce and carers

Market size

Skills for Care estimates that in 2016, the adult social care sector – both publicly funded and self-funded – had around 20,300 organisations providing care from around 40,400 ‘establishments’ and a workforce of around 1.58 million jobs (1.45 million people and 1.11 million full-time equivalents (FTE)) (Skills for Care 2018b).

The number of jobs has increased by 19 per cent since 2009 (by 255,000 jobs), and by around 1.5 per cent (20,000 jobs) between 2015 and 2016. This rate of increase was slower than in previous years.

The sector accounts for around 6 per cent of total employment in the UK and contributes £46.2 billion to the economy (Skills for Care 2018a).

Four in five social care workers are female and the average age is 43. A fifth of social care workers (305,000) are over 55. This age distribution has been static over time. The vast majority (83 per cent) of the workforce is British, with 7 per cent (95,000 jobs) filled by a person with a European Union (EU) nationality and 9 per cent (127,000 jobs) non-EU. These figures vary across the country, with London having the lowest proportion of British care workers.

The sector has high levels of turnover (28 per cent) and vacancies. Turnover has increased steadily by nearly 5 per cent since 2012/13. Turnover is not uniform, with a quarter of employers having rates below 10 per cent. The vacancy rate is 6.6 per cent and equates to around 90,000 posts vacant at any one time. The vacancy rate fell slightly in 2016/17 after rising consistently from 2012/13. Skills for Care will begin a national campaign to promote the sector as a place to work in autumn 2018.

Workforce pay and conditions

Around a quarter of the workforce (24 per cent) was on zero hours contracts (325,000 jobs), with nearly half of domiciliary care jobs (47 per cent) employed on this basis. However, the overall percentage of workers on zero hours contracts has fallen by 2 per cent since 2012/13.

Payment for home care workers in particular is complex, with employers able to pay different rates for contact time and non-contact time provided that these average out above the national living wage. However, there are concerns that this complexity offers the potential to pay below statutory minimums, and a 2011 study estimated that between 9 per cent and 13 per cent of direct care workers might be affected (Hussein 2011). The average pay for independent sector care workers recorded by Skills for Care in 2016/17 was £7.76 per hour (compared to the then national living wage of £7.20), equivalent to an annual FTE rate of £15,000.

Following the introduction of the national living wage on 1 April 2016, care workers' pay has increased at a higher rate than in previous years, rising 3.8 per cent between 2015/16 and 2016/17. This £0.28 increase compares to an average of £0.12 since 2011/12.

However, a report by the NAO into the adult social care workforce in February 2018 said that rates of pay, along with tough working conditions and a poor image, are preventing workers from joining and remaining in the sector (NAO 2018b). It said that while many people working in the sector find it rewarding, there was widespread agreement that workers feel undervalued and there were limited opportunities for career progression.

In July 2018, the Court of Appeal overturned a ruling which would have meant that care workers received the full national living wage for 'sleep-in' shifts supporting people with learning disabilities. The LGA had estimated that this would have involved £400 million in back pay (LGA 2018b). The ruling has, however, been appealed (Public Sector Executive 2018).

A consultation by Skills for Care (2018c) found that social care providers faced the following recruitment challenges:

- perception of low pay (80 per cent)
- not enough people applying for vacancies (70 per cent)
- perception of poor terms and conditions of employment (69 per cent)
- poor public perception of adult social care locally (61 per cent)
- lack of awareness of different roles (56 per cent)
- candidates' expectations did not match the reality of the work (40 per cent)

- applicants did not have genuine interest in the roles (33 per cent) or lacked the right values (27 per cent).

Training and registration

The basic training requirement in social care is completion of the Care Certificate, which is employer-led. Almost two-thirds of direct care staff who had started work since January 2015 had achieved, partly achieved or were working towards completion of the Care Certificate.

Just under half of the social care workforce (46 per cent) held a relevant social care qualification (not including the Care Certificate). Only 5 per cent of the workforce is in regulated professions (for example, social work, nursing or occupational therapy).

England is the only one of the four UK countries where formal registration of care workers is not currently required or planned (Carter 2015).

Future demand

Skills for Care projections suggest that the number of additional social care workers required by 2030 will be up to 700,000, with a central projection of 500,000. This figure is based on the workforce growing proportionately to the number of people aged 65 and over (Skills for Care 2018b).

However, the NAO says that growth in the number of jobs has already fallen behind growth in demand for care (NAO 2018b). It cites Department of Health and Social Care modelling based on 2014 data suggesting that FTE care jobs would need to increase by around 2.6 per cent per year until 2035. However, annual growth has in fact been less than 2 per cent or lower. There are concerns that this gap could be exacerbated by any restriction on free movement of European care workers in the United Kingdom (Independent Age 2016).

A combined health and social care workforce strategy has been promised though not yet delivered; it is expected in late autumn 2018.

Numbers of carers and care provided

According to data from the 2011 census, there were approximately 5.8 million people (5.4 million in England alone) providing unpaid care in England and Wales – around one-tenth of the population (and therefore around twice as many people as are employed in the NHS and social care) (ONS 2011). This was an increase of 600,000 since 2001.

The charity Carers UK estimated that there will be a 40 per cent increase in the number of carers needed by 2037 – an extra 2.6 million (Carers UK 2015). Informal care is expected to increase as ageing and levels of disability increase. One estimate suggests that the number of adults with disabilities aged over 65 receiving informal care will increase from around 2.2 million in 2015 to around 3.5 million in 2035 (Wittenberg and Hu 2015).

A Carers UK/University of Sheffield/University of Leeds report estimated the value of unpaid care in the United Kingdom to be £132 billion a year (Buckner and Yeandle 2015).

The government published a cross-departmental carers action plan in June 2018, which recognised that ‘not only do carers face emotional challenges but they sometimes navigate through complex systems with little formal guidance and direction’ (Department of Health and Social Care 2018b).

The main benefit for carers – Carer’s Allowance (£64.60) – was claimed by 1.22 million people between July 2016 and June 2017, and its eligibility is limited to those caring for a minimum of 35 hours per week (Department for Work and Pensions 2018a).

Support to carers

Despite the projected increase in the number of carers, expenditure by local authorities on carers has decreased in the past three years (see Table 3).

Table 3 Carer expenditure and support

	2014/15	2015/16	2016/17
Gross expenditure on support for carers (real terms) (£ billion)	£0.21	£0.18	£0.18
Number of carers supported or assessed	n/a	386,600	368,990

Sources: NHS Digital (2016; 2017a).

This is consistent with data which shows that there has been an increase in the percentage of carers saying they have *not* received support or services from their local authority in the previous 12 months from 15.1 per cent in 2012/13 to 22.4 per cent in 2016/17 (NHS Digital 2017b).

In a sample of more than 7,000 carers polled by Carers UK in 2018, 40 per cent said they had not had a break in over a year. One in four said they had not received a single day away from caring in five years (Carers UK 2018).

In June 2018, the government published its carers action plan. It sets out cross-governmental actions intended to achieve outcomes such as improved identification of carers and improved access to support (Department of Health and Social Care 2018b).

Public attitudes to caring

Qualitative research suggests that providing care within the family is seen as a natural thing to do but that there are limits on what should be expected of families. People recognise that social changes such as physical distance of families, women working, longer life expectancy and more complex health conditions make it harder for families to care for relatives, and there is a strong sense that the state has a duty to provide support.

Summary of key challenges

- There are high vacancy rates in a sector that needs to recruit increasing numbers of workers to meet demand.
- There are low pay and levels of training.
- There are rising demands on family carers because of reductions in formal services.
- There is a lack of support for carers.

6 Quality and efficiency

Overall quality trends

There are differing, sometimes contradictory perspectives on quality in social care. Over 90 per cent of people receiving social care say their care is satisfactory (NHS Digital 2017c). Indeed, the social care-related quality of life score (a measure covering issues like safety, social participation, dignity and control) rose consistently between 2010/11 and 2016/17 (Carnall Farrar 2018).

However, carers are increasingly dissatisfied with the support or services that they or the person they care for have received (see Table 4).

Table 4 Carer satisfaction with social care services

	2012/13	2014/15	2016/17
Quite to very satisfied	77.3%	74.4%	71.0%
Quite to very dissatisfied	9.7%	11.1%	13.3%

Source: NHS Digital 2017b

In 2016/17, the Local Government and Social Care Ombudsman received more than 3,000 complaints and enquiries across the whole adult social care sector (up 3 per cent on the previous year), with the highest number concerning assessment and care planning (Local Government and Social Care Ombudsman 2017).

Around four in five social care services are judged 'good' by the CQC, though only a small number (around 2 per cent) are rated 'outstanding' (CQC 2017a). Quality ratings are derived from several factors; services score best for 'caring' (92 per cent rated 'good' or 'outstanding') and worse for 'safe' and 'well led', whereas 24 per cent are rated 'requires improvement' or 'inadequate'.

Factors associated with good services include the presence of a registered manager (in care homes) and size, with smaller care homes (1–10 beds) typically rated better than larger ones (more than 49 beds). This may be because many smaller homes are for people with learning disabilities and

these homes tend to perform better overall, though in domiciliary care, services catering for smaller numbers of people were also performing better, with 84 per cent of small services (up to 50 people) rated 'good' compared to 73 per cent of larger services (more than 100 people). The CQC suggests, however, that larger corporate providers may be better at improving when needed.

Public perception of quality – which, since it samples those who have not necessarily used services themselves, might best be thought of as a measure of public attitudes rather than of quality of services – appears to be weakening. The British Social Attitudes survey found that in 2017, satisfaction with social care services was 23 per cent (7 percentage points lower than in 2012), and dissatisfaction with social care services increased by 6 percentage points in 2017 to 41 per cent (Robertson *et al* 2018). There are also widespread public concerns about quality, particularly neglect and abuse, which have led to campaigns such as the Care Campaign for the Vulnerable, which calls for closed-circuit television (CCTV) systems to be installed in all care homes.

Regional variation

The CQC reports significant variation between regions and individual local authorities in the quality of care services (CQC 2017a). For care homes specifically, analysis from the charity Independent Age reports that seven local authorities – Tameside, Portsmouth, Kensington and Chelsea, Manchester, Bradford, Stockport and Trafford – have more than two in five homes rated 'inadequate' or 'requiring improvement' (Independent Age 2018). In contrast, eight local authority areas have less than 5 per cent of homes rated 'inadequate' or 'requires improvement'.

Neither the CQC nor Independent Age has research to explain the reasons for this variation.

Models of care

There is wide agreement that care should be focused on the needs and wishes of individual service users, helping them achieve the outcomes they seek and offering the widest possible choice and control (Think Local Act Personal no date). However, there are no agreed definitions of which models of delivering social care result in the best outcomes for a given level of investment. This is partly because social care services are traditionally commissioned on the basis of payment for delivery of specific tasks (in home care, for example, helping

someone get dressed or washed), rather than on the basis of the outcomes achieved for the individual.

One exception to this is the delivery of reablement services, typically delivered after an older adult has left hospital. These services are measured by the number of individuals receiving rehabilitation or reablement who have *not* been readmitted to hospital within 91 days. There is wide variation between local authorities, both in the number of people who receive services and in the number who are subsequently readmitted (NHS Digital 2017d) (see Table 5).

Table 5 Variation in reablement: receipt of services and readmission rate

2016/17	'Best' score	'Worst' score
Number of people receiving services (% of 65+ leaving hospital)	9.4%	0.6%
Non-readmission rate (% not readmitted within 91 days)	97.2%	62.1%

Source: NHS Digital

Productivity

The ONS says that the productivity of publicly funded adult social care fell by an average of 0.7 per cent per year between 1997 and 2016 (slightly less since 2010, when the figure was adjusted for quality) (ONS 2018b). From 1997 to 2011, it suggests smaller falls in the productivity of services for adults aged over 65 years than for services for adults aged under 65 years. The productivity of services for both client groups is relatively stable between financial year ending 2011 and financial year ending 2017.

These measures have not been widely explored or discussed, so it is hard to evaluate their relevance. Explanations for them include increased complexity/need of people receiving social care services, although the ONS says there is little evidence of this complexity based on the number of activities of daily living with which social care users need help.

Technology

Implementation of new technology has been cited as a potential route to improve the quality and efficiency of care in older age. The 2018 Industrial Strategy states that 'Innovation in age-related products and services can make a significant difference to UK productivity and individuals' wellbeing, and will find a growing global market' (HM Government 2017).

The government has also announced a £98 million 'healthy ageing programme' to 'drive the development of new products and services which will help people to live in their homes for longer, tackle loneliness, and increase independence and wellbeing' (HM Government 2018).

Despite this opportunity, and the role that technology now plays in many aspects of our lives, new technology currently plays a limited role in the delivery of social care services. Its main uses are telecare services at home – for example, 'pendant alarm' services, which a White Paper by the Telecare Services Association (TSA) says 'may have seen little or no service transformation and development over the past 10 / 15 years' (TSA 2016).

A forthcoming report by The King's Fund argues that one of the main problems in harnessing the potential of technology is whether there is sufficient demand for new technological approaches from commissioners whose focus has been on driving down the price they pay providers.

Summary of key challenges

- There is public concern about poor quality of care.
- There is unexplained variation in quality of care.
- There is limited consensus on most efficient models of care and productivity.
- There are unexplained local variations in care delivery.
- There is low investment in technology and new models of working.

7 Integration with housing, health and the benefits system

Housing

Most older people and those with disability live in mainstream housing: for example, according to the English Housing Survey 2014–15, a quarter of people aged 75–84 and a third of those aged 85 and over live in homes built before 1945 (Centre for Ageing Better 2017). Yet a study for Age UK found that only 740,000 (3.4 per cent) of homes have the four recommended features for someone with mobility problems (level access, flush threshold, toilet at entry level, and circulation space) (Oldman 2014).

Nearly half a million households containing at least one adult aged 65 years or over with a long-term illness or disability self-report the need for installation of at least one adaptation (Centre for Ageing Better 2017).

The Building Research Establishment (BRE) Trust estimated the cost to the NHS (there is no equivalent figure for social care) of poor housing – particularly from excess cold and falls – at £1.4 billion (Nicol *et al* 2015).

There is also a significant undersupply of housing designed specifically for older people. In the United Kingdom, less than 1 per cent of retirees live in housing with care, which is one tenth of that in the United States and Australia (JLL 2015). There is a potential requirement for an additional 725,000 housing with care units by 2025, which would equate to nearly half of all new homes being built.

Health and social care integration

Joining up services around the needs of the individual has become a consistent goal of policy in social care and health. Recent policies to promote integration have included the creation of health and wellbeing boards, local strategic planning forums with representatives from health and social care services, and the Better Care Fund (a pooled budget between the NHS and local authorities) (see below). There have also been a number of pilot projects

to improve integration, including integrated care 'pioneers' (established in 2013), while health and social care powers have also been devolved to some local areas in England, including Greater Manchester. In May 2013, national partners including the Department of Health and Social Care, NHS England, ADASS, the CQC and the Social Care Institute for Excellence signed up to a 'shared commitment' on delivering integrated care and support (National Collaboration for Integrated Care and Support 2013).

In its 2015 spending review and autumn statement, the government delayed until 2020 its target date for health and social care to be integrated across England, with local areas required to produce a plan by April 2017 for how they would achieve this (Department of Health and Social Care 2015).

The CQC review of 20 local health and care systems found that some areas of the country were working more effectively together than others and that none had 'matured into joined-up, integrated systems' (CQC 2018a).

A recent NAO report concluded that 'nearly 20 years of initiatives to join up health and social care by successive governments has not led to system-wide integrated services' (NAO 2017). Its July 2018 report, *The health and social care interface*, stated that 'more joined-up health and social care offers the prospect of saving money across the whole system, in the longer term' (NAO 2018c). It cites a 2016 LGA review, and concludes that efficiency savings of £1 billion each year could be realised through better integration of health and social care. However, it says that while there is a 'lot of good work being done nationally and locally to overcome the barriers to joint working', this is often 'not happening at the scale and pace needed' (NAO 2018c). The report highlights financial, cultural, structural and strategic issues that hinder progress.

National approaches to integration of health and social care have been focused around 44 sustainability and transformation partnerships (STPs), 14 of which are earmarked to develop into integrated care systems (ICSs). The Commons Health and Social Care Committee observes that STPs 'got off to a difficult start', with limited time to build relationships and develop plans. It says: 'Some areas have made considerable progress in light of [systematic funding and workforce] pressures, but those furthest behind are struggling with rising day-to-day pressures let alone transforming care'. It goes on to say that ICSs 'have made good progress in difficult circumstances, [but] they are still nascent and fragile' (Department of Health and Social Care 2018c).

NHS Continuing Healthcare

In some areas, there is tension between the NHS and local authorities over NHS Continuing Healthcare, which provides free care (including social care) to around 160,000 people who have significant ongoing health care needs. For those eligible, this is funded by local CCGs rather than local authorities. The House of Commons Public Accounts Committee says the system is 'hugely complex' and difficult for people to navigate (House of Commons Select Committee of Public Accounts 2018). As a result, some patients do not receive the care they are entitled to, with likelihood of receiving funding too dependent on local interpretation of assessment criteria. CCGs have been told to make the £855 million efficiency savings required of them by NHS England by 2020/21 (from a projected expenditure of £5.25 billion) but the NAO says it is not clear how they can do this without restricting access to care.

Better Care Fund and delayed transfer of care

The Better Care Fund is one key mechanism intended to encourage health and social care systems to work together more effectively. In 2016/17, £5.9 billion of health and care expenditure was pooled in this fund (though this is less than 5 per cent of the total NHS and social care spend) (NHS England website). However, it has been the subject of national and local disagreement about spending priorities, with NHS England keen to prioritise reducing delayed transfers of care (DTOCs) and, in 2017, the government threatening to withdraw funding from 32 local authorities deemed to have made insufficient progress in doing so.

While the proportion of delayed transfers attributable to social care increased substantially from 29 per cent at the beginning of 2015/16 to 38 per cent at the beginning of 2017/18, they had fallen to 30 per cent by May 2018 (Maguire 2018; NHS England 2018). The NHS, rather than social care, continues to be responsible for most of the delays. Nonetheless, in May 2018, awaiting a care package at home was still the single biggest reason for delayed discharge from hospital, having risen from 12,777 delayed days in August 2010 to 27,459 in May 2018, with a peak of 42,215 in December 2016.

Attendance Allowance

Attendance Allowance helps older people with the extra costs of long-term illness or disability, including care costs. At £5.7 billion in 2016/17, expenditure on Attendance Allowance is nearly three-quarters of the amount that local councils spend on care for older people but the benefit is administered entirely separately (and is not means-tested) (Department for Work and Pensions 2018a). It was paid to 1.62 million claimants in 2010/11 but, despite increasing numbers of older people and people with disabilities, the number has since fallen to 1.45 million. The reasons for this fall are not clear.

Summary of key challenges

- There is poor-quality general housing stock and limited availability of supported housing.
- There are challenges over priorities for Better Care Fund.
- There are tensions and inequalities over access to NHS Continuing Healthcare.
- There is no integration of Attendance Allowance with council social care system.

8 Key challenges

A summary of the key challenges for each area are provided below.

Need and demand

The key challenges for need and demand are:

- high levels of unmet need
- lack of investment in prevention and demand
- increasing future demand from both older people and working-age adults.

Eligibility

The key challenges for eligibility are:

- fundamental, poorly understood distinction between social care means test and NHS
- few people qualify for publicly funded support
- low eligibility and no cap means some people pay catastrophic costs.

Funding

The key challenges for funding are:

- wide agreement on need for greater expenditure on social care...
- ...but no agreement on appropriate public/private split or how to raise it
- uncertainty about future size and structure of local government funding
- lack of public awareness about current system and its limitations.

Market sustainability and fairness

The key challenges for market sustainability and fairness are:

- risks of provider failure
- wide local variation in supply of care
- substantial premiums paid by self-funders in care homes.

Workforce and carers

The key challenges for workforce and carers are:

- high vacancy rates in sector needing to recruit increasing numbers of workers to meet demand
- low pay and levels of training in sector
- rising demands on family carers because of reductions in formal services
- lack of support for carers.

Quality and efficiency

The key challenges for quality and efficiency are:

- public concern about poor quality of care
- unexplained variation in quality of care
- limited consensus on most efficient models of care and productivity
- unexplained local variations in care delivery
- low investment in technology and new models of working.

Integration with health, housing and the benefits system

The key challenges for integration with health, housing and the benefits system are:

- poor-quality general housing stock and limited availability of supported housing
- challenges over priorities for Better Care Fund
- tensions and inequalities over access to NHS Continuing Healthcare
- no integration of Attendance Allowance with council social care system.

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