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Social care for older people
Home truths

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Key messages

- The social care system in its current form is struggling to meet the needs of older people. Six consecutive years of cuts to local authority budgets have seen 26 per cent fewer people get help. No one has a full picture of what has happened to older people who are no longer entitled to publicly funded care: the human and financial costs to them and those who care for them are mounting.

- Our assessment of national data and in-depth interviews in four unnamed local authority areas found that the past six years have also brought huge pressures on the social care market. Central government grant reductions to local authorities have been passed on to care providers in the form of reduced fees, or below inflation increases. Combined with shortages of nurses and care workers, higher regulatory standards and the introduction of the National Living Wage, this has put many social care providers under unprecedented pressure.

- Many social care providers are surviving by relying increasingly on people who can fund their own care, but those dependent on local authority contracts are in difficulty. Home care services face particularly acute workforce shortages and are now in a critical condition everywhere, threatening to undermine policies to support people at home. The possibility of large-scale provider failures is no longer of question of 'if' but 'when' and such a failure would jeopardise continuity of the care on which older people depend.

- Local authorities have sought to protect the most vulnerable older people with the highest needs, while at the same time encouraging others to be independent, drawing on the resources of their families and communities, and to reduce dependence on support from the state. For many people the experience of needing to find and pay for care comes as an unpleasant surprise for which, in general, they are unprepared. Unpaid carers will also be expected to do even more.

- Access to care depends increasingly on what people can afford – and where they live – rather than on what they need. This favours the relatively well off and well informed at the expense of the poorest people, who are reliant on an increasingly threadbare local authority safety net – especially if they live in areas where local authorities have been least able to sustain spending levels – and who are at a higher risk of declining quality and provider failure.

- The situation for older people has been compounded by pressures elsewhere in the NHS. Cuts to social care should not be viewed in isolation from overstretched general practice and community nursing and the uneven distribution of intermediate care beds; these are all factors identified by our interviewees. Under-investment in primary and community NHS services threatens to undermine the policy objective of keeping people independent and out of residential care.

- The most visible manifestation of pressures on health and social care budgets is the rapid growth in delayed discharges from hospital. While this is undoubtedly driven by funding pressures on both services and exacerbated by workforce shortages in social care, local authorities, NHS providers and commissioners must work more effectively together to address a problem that imposes a significant cost on the NHS and is taking an unacceptable toll on older people, their carers and families.

- The funding outlook for the next five years looks bleak. The measures announced by the government will not meet a widening gap between needs and resources set to reach at least £2.8 billion by 2019. Public spending on adult social care is set to fall to less than 1 per cent of GDP. The potential for most local authorities to achieve more within existing resources is very limited and they will struggle to meet basic statutory duties.

- Based on the national and local evidence we have considered in this report, there are three major strategic challenges facing policy-makers in shaping how the adult social care system could develop over the next five years.

  – **Achieving more with less** This could include continuing to work within the grain of existing policies such as personalisation, better commissioning and integrated care. But these efforts will not in themselves be sufficient to meet immediate funding needs. As the NHS England Chief Executive, Simon Stevens, has said, there is a strong argument that any extra funding should go to social care. As a minimum, the forthcoming Autumn Statement must recognise the scale of the immediate funding pressures facing the sector by bringing forward the additional Better Care Fund money planned from 2018/19, accelerating progress towards establishing a single pooled budget for health and social care in all areas by 2020 and developing a workforce strategy.

  – **A different offer** If the government is unwilling to provide adequate public funding to support the current system, it must be honest with the public about what they can expect from publicly funded services. This would mean establishing a fresh and more explicit policy framework, which makes it clear that primary responsibility for funding care sits with individuals and families, creating incentives for people to plan ahead for their care needs and revisiting some of the new duties and rights created by the Care Act 2014 so that expectations are aligned more realistically with what the government is prepared to fund and local authorities can afford. This will be an unpalatable future but it is one that is already upon us.

  – **Long-term reform** Because reliance on additional private funding will not be sufficient or equitable, a longer-term strategy is needed. England remains one of the few major advanced countries that has not reformed the way it funds long-term care in response to the needs of an ageing population. The Barker Commission – which called for a new settlement for health and social care – is the latest of a number of independent commissions and reviews to set out how this could be achieved. A frank and open debate is needed on how to fund health and social care on a sustainable basis into the future, recognising that a long-term strategy will exceed the lifetime of a single parliament. A mechanism is needed to secure cross-party consensus on some shared principles of reform.

1 Background and context

The adult social care system offers help, care and support to people with a wide range of needs arising from disability, illness or other life situations. It helps people to live as independently as possible, protects people from harm in vulnerable situations, balances risks with rights and offers essential help at times of crisis. Support is offered in people's own homes, residential and nursing homes or other community settings. Unlike NHS care, most of these services involve an assessment of the individual's 'eligible' needs and financial resources (means-testing). This report focuses on services for older people.

Local authorities have important statutory duties, but more than 90 per cent of actual support is provided by a diverse range of more than 19,000 independent organisations, ranging from big corporate chains to small family-run businesses, charities and social enterprises (**Skills for Care 2016b**). The withdrawal of local authorities and the NHS from the direct provision of long-term care has been a major strategic shift in adult social care policy over the past 30 years. The quality and sufficiency of these services are key indicators of a good society (**Association of Directors of Adult Social Services 2015**).

The success story of longer lifespans means there are many more people with care and support needs arising from a mixture of physical health and mental health conditions including dementia and frailty in old age. But the system is in trouble. Even before austerity gripped public spending in 2010, the state was able to meet only a proportion of older people's care needs; the remainder had to use their own resources, financial and family, to support themselves. Although 1.5 million people are employed in social care, another 6 million offer unpaid care as friends and family members. The gap between need and funding has grown wider since 2010. Over the past five years, local authority spending on the essential care and support needed by older and disabled people has fallen by 11 per cent in real terms and the number of people getting state-funded help has plummeted by at least 25 per cent. More people are paying for their own care, but the complexities of the system can be difficult for people to understand (**Independent Age 2016**; **Health and Social Care Information Centre 2015d**).

Older people generally have health as well as care needs. By the age of 65, most people will have at least one long-term condition and by the age of 75 most will have at least two (**Oliver *et al* 2014**). Older people account for 62 per cent of all hospital bed days and 52 per cent of admissions that involve hospital stays of more than seven days (**National Audit Office 2016**). The NHS, too, is under pressure even though its funding has been protected compared with funding for local authorities. Hospitals have struggled to meet the needs of the older age group in a timely way, in both emergency departments and inpatient admissions, and caring for older people in their communities has been hampered by shortages of non-acute beds, community nurses and overstretched general practices. Too often health and social care services are not joined up (**Care Quality Commission 2016a**). Most professionals and commentators believe that the cuts to social care services have contributed to the pressures on health services.

Low levels of pay, training and skills of care staff – 37 per cent have no recognised qualification – and increasing difficulties in recruitment raise worries about the quality of care, at a time when the acuity of people's needs in all care settings is rising. The former Chancellor's announcement in the 2015 Spending Review and Autumn Statement of a new National Living Wage has been welcomed but will add at least £2 billion to workforce costs by 2020. This has triggered fresh concerns about the financial viability of many care providers after several years in which fees from local authorities have been frozen. Already some of the largest providers of home care have withdrawn from the market (LaingBuisson 2016).

It is therefore not surprising that the National Audit Office has warned that 'national and local government do not know whether the care and health systems can continue to absorb these cumulative pressures, and how long they can carry on doing so' (**National Audit Office 2014a**).

The need for a better understanding of the current pressures facing care services and the implications for their future sustainability has never been greater. Yet evidence about the relationship between changes in public spending on social care, the quality and quantity of services and the impact on the health and wellbeing of people who use them is extremely limited. More older people are falling outside the social care system, either because their financial means are too high for publicly funded help or their care needs are not high enough, yet knowledge about what happens to them is limited (**Baxter and Glendinning 2014**; **Institute of Public Care 2012**).

2 The purpose of this report

The overall focus of this project is to better understand the impact of changes in local authority spending on social care for older people, through an analysis of national data and evidence and a snapshot of four local areas, taking account of the important relationship between the NHS and social care services in meeting the needs of older people.

This report concentrates on services for older people, defined here as people aged 65 years and over, noting that although pressures arising from other kinds of need, such as disabled people of working age, are considerable, they raise different policy and funding issues.

The project had four lines of inquiry that guided our conversations with local areas.

- How local authorities are dealing with current pressures, the implications for their financial sustainability and their ability to meet their statutory requirements.

- The implications for the social care market, including recruitment and retention issues, the impact of the new National Living Wage and the risks of provider failure.

- The impact on the NHS, with a particular focus on primary care, community nursing and acute services. How have changes in the availability of these services affected care needs and the ability of local authorities to meet them?

- The implications for older people's experience of social care and the quality of care they receive.

Figure 1 Our lines of inquiry

- Impact on provider market
- Local authorities' financial sustainability
- Older people and their carers
- Impact on NHS
- Quality of care
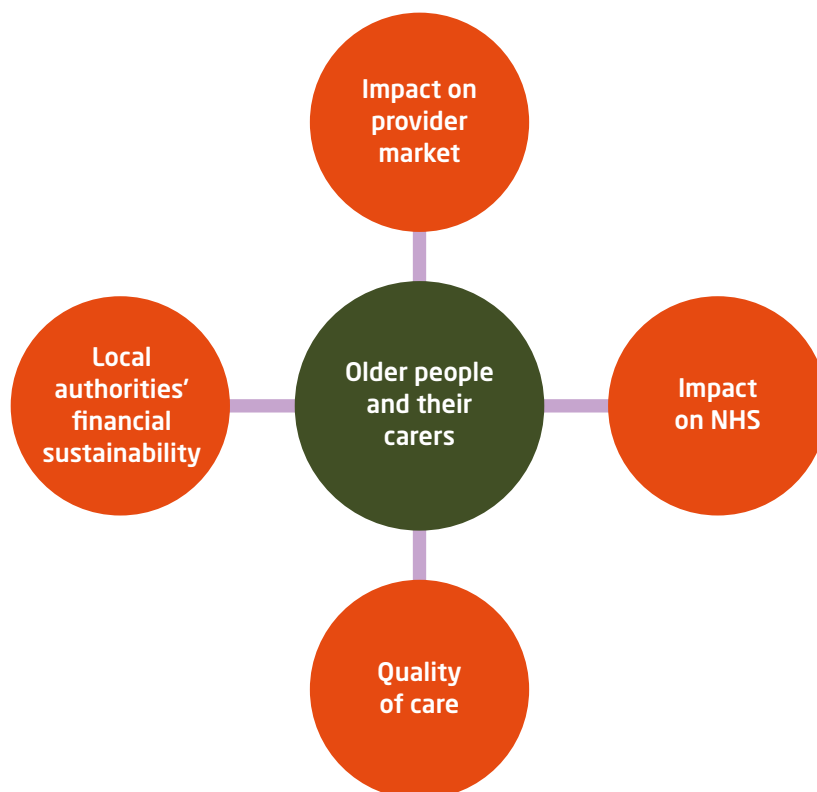
Methodology and approach

National data analysis

We conducted a comprehensive analysis of national trends in adult social care expenditure and activity for older people since 2009/10, and examined related NHS data and trends in independent sector care provision to form a view across the whole system of health and social care.

Case studies

Alongside this national data, we used a case study approach to describe what is happening at a local level. We conducted semi-structured interviews and focus groups in four local authority areas that varied in terms of size and type of council.

The authorities were in the North West, the West Midlands, the South East and London. We asked participants about changes to the funding of social care for older people in their area over the last five years; the impact this has had on social care providers, service users and other services; strategies that commissioners and providers are using to mitigate current pressures; and what they feel this means for the future of adult social care.

Participants included key representatives from local authorities (n=17); clinical commissioning groups (CCGs) (n=5); NHS providers (n=6); independent sector social care providers (n=25); voluntary organisations (n=8); and Healthwatch and other local groups representing people who use services (n=4).

Sites were selected to represent variations in local authority type; geographical area; rurality; and the deprivation and ethnic mix of the local population. The anonymity of sites is protected.

User interviews

Alongside this work we were commissioned by the Richmond Group of Charities to interview seven older people about their personal experiences of using social care services and/or about their experience as a carer of someone who uses these services. We draw on some of these stories in this report to illustrate the human dimension of our research findings. A full account of these interviews will be published by the Richmond Group (**Hall and Holder 2016**).

The structure of this report

In each section we provide a brief overview of the national data, followed by an analysis of themes from our interviews, which aimed to explore the experiences, perceptions and predictions from those involved in the care and health system for older people. The research findings are divided into five sections.

- The views of **local authorities** about the scale and nature of the savings made so far, the principles that have guided their decisions and their perceptions about the future (Section 3).

- The views of **social care providers**, including residential, home care and related voluntary sector players about the impact of local authority budget pressures (Section 4).

- The views of interviewees from all sectors about the impact on **older people, their families and carers** (Section 5).

- The view from **the NHS**, including commissioners and those within hospitals, on the experience of managing rising pressures from older patients, and the part played by local authorities (Section 6).

- An account of the various national and local **strategies to improve care and support for older people** and to mitigate the budget pressures (Section 7).

Finally, we consider the implications of our findings for the future of social care and assess the major strategic challenges facing policy-makers in shaping how the system could develop over the next five years.

❸ Local authorities: managing austerity

The national picture: what do we know?

Local authorities' spending on social care for older adults

Central government has reduced its funding to local government by 37 per cent in real terms between 2010/11 and 2015/16 (**National Audit Office 2014b**).

In 2014/15, local authorities spent £7.23 billion on social care for older people, £5.12 billion after user charges and other income is taken into account (*see* Figure 2). This accounts for 42 per cent of all council spending on adult social care (traditionally this has been closer to 52 per cent but has fallen because of definitional changes), the rest being spent on support for people aged 18–65 years. Since 2010, NHS money has been transferred to local authorities to support social care, currently through the Better Care Fund.

Although outside the local authority system, the government also spends a further £4.7 billion on attendance allowance, a cash benefit administered by the Department for Work and Pensions payable directly to older people with care needs. Knowledge of who receives this benefit and how it used is relatively limited. The government is proposing to consult on whether this spending should be transferred to local authorities.

To put this into perspective, the NHS budget in 2014/15 was £116.4 billion, and figures prepared by the Nuffield Trust for the *Guardian* (**Robineau 2016**) suggest that two-fifths was spent on older people. Given that total public expenditure of all kinds is £755 billion, the level of spending by local authorities on the care of older people seems a relatively modest sum (*see* Figure 3).

Figure 2 Local authority spending on social care for older people, 2014/15

NHS transfer

User charges

Net spend
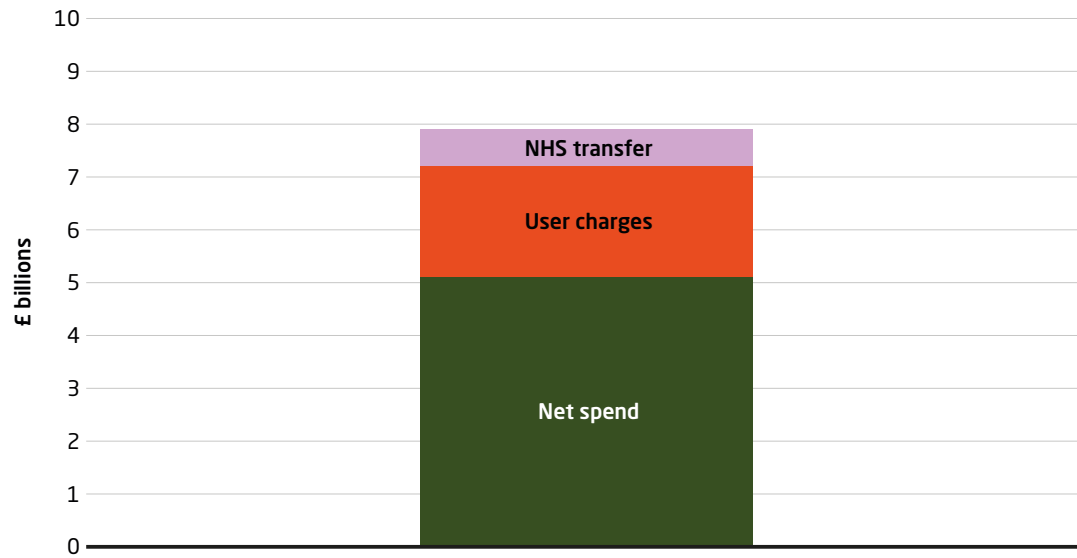
Source: Health and Social Care Information Centre 2015e

Figure 3 All health- and care-related spending on older people, 2014/15

Attendance allowance

Local authority social care

NHS
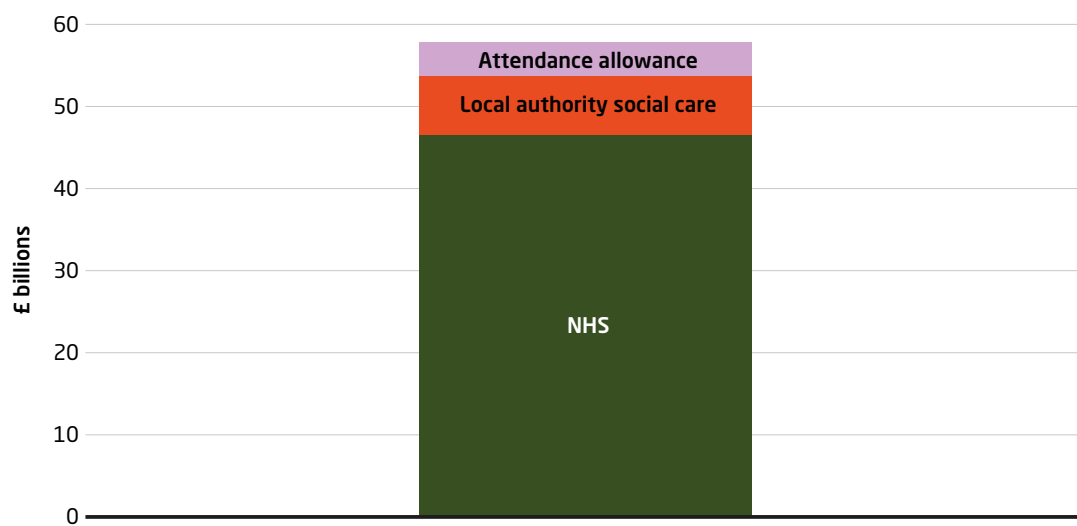
Source: Department for Work and Pensions 2016; Robineau 2016; Health and Social Care Information Centre 2015e

Against this relatively modest baseline, gross spending by local authorities on social care for older people has fallen by 9 per cent in real terms between 2009/10 and 2014/15. Without income from charges and money transferred from the NHS, it would have been 25 per cent. The NHS transfer, including the Better Care Fund, has made a real difference but has not fully compensated for cuts in local authority budgets. Of the £5 billion Better Care Fund, in 2015/16 just a third (£1.67 billion) was being used to protect social care services (**Association of Directors of Adult Social Services 2016**).

The national picture, on average, is one of reductions, especially taking into account increases in the older population over this period. Eighty-one per cent of local authorities cut their spending in real terms on social care for older people over the past five years. In more than half of local authorities the reduction was at least 10 per cent. However, the picture is not uniform – 18 per cent maintained or increased spending (*see* Figure 4).

Figure 4 Percentage change in gross total expenditure on older people's social care (per 100k population aged 65+) between 2009/10 and 2014/15, by local authority
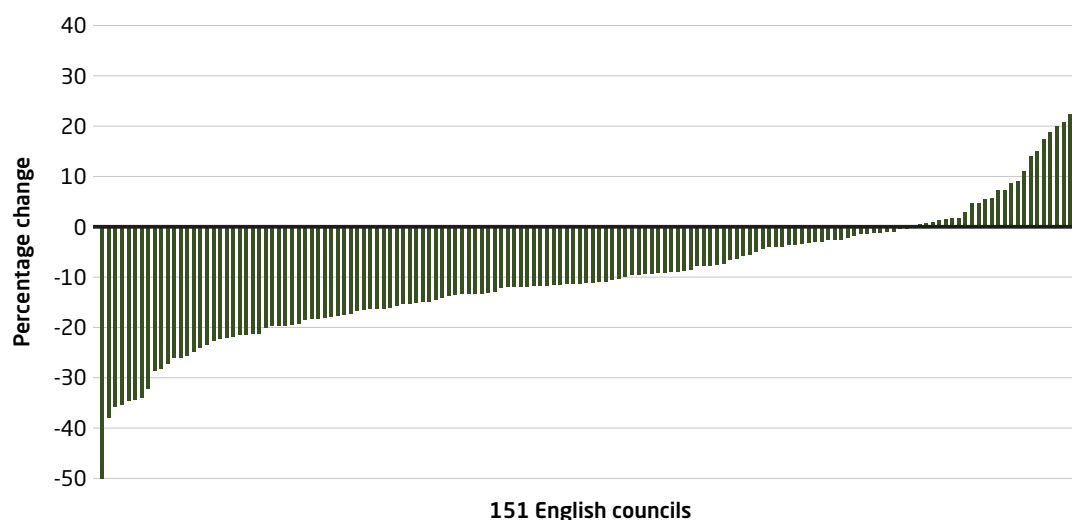

Source: **Health and Social Care Information Centre 2015e**

Reductions in numbers of people receiving publicly funded social care

There has been a big reduction in the numbers of older people receiving local authority-funded social care – from more than 1.1 million in 2009 to 853,615 in 2013/14 – a fall of 26 per cent (*see* Figure 5). It is likely that the trend will have continued in 2014/15 and beyond but changes to data collection unfortunately mean that there is no a longer a comparable figure. The fall has been especially steep since 2010, but this forms part of a longer-term trend that began in 2009. The number of people aged between 18 and 64 years getting help has also fallen, but not by as much.

Figure 5 **People receiving local authority-funded social care, 2005/06 to 2013/14**

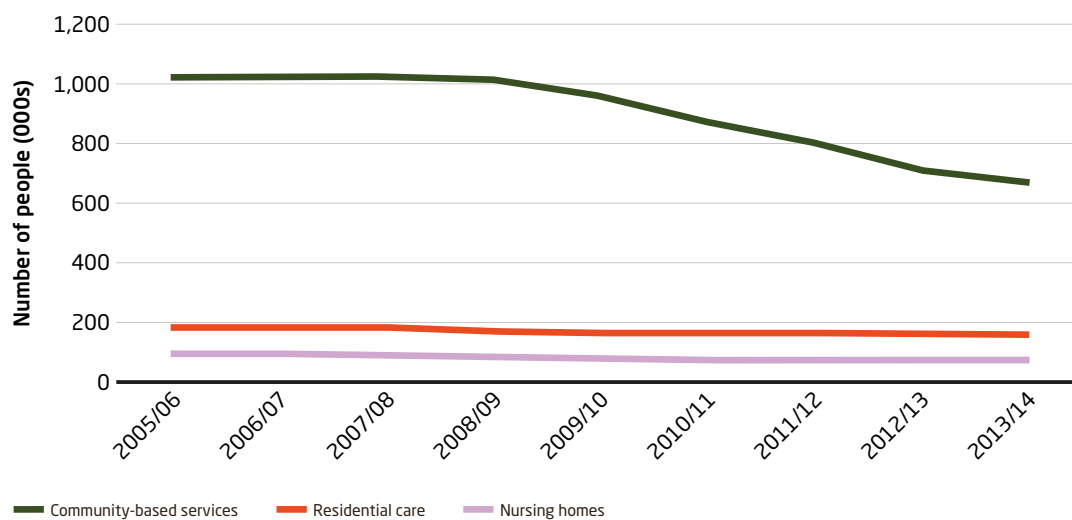Source: Health and Social Care Information Centre 2014
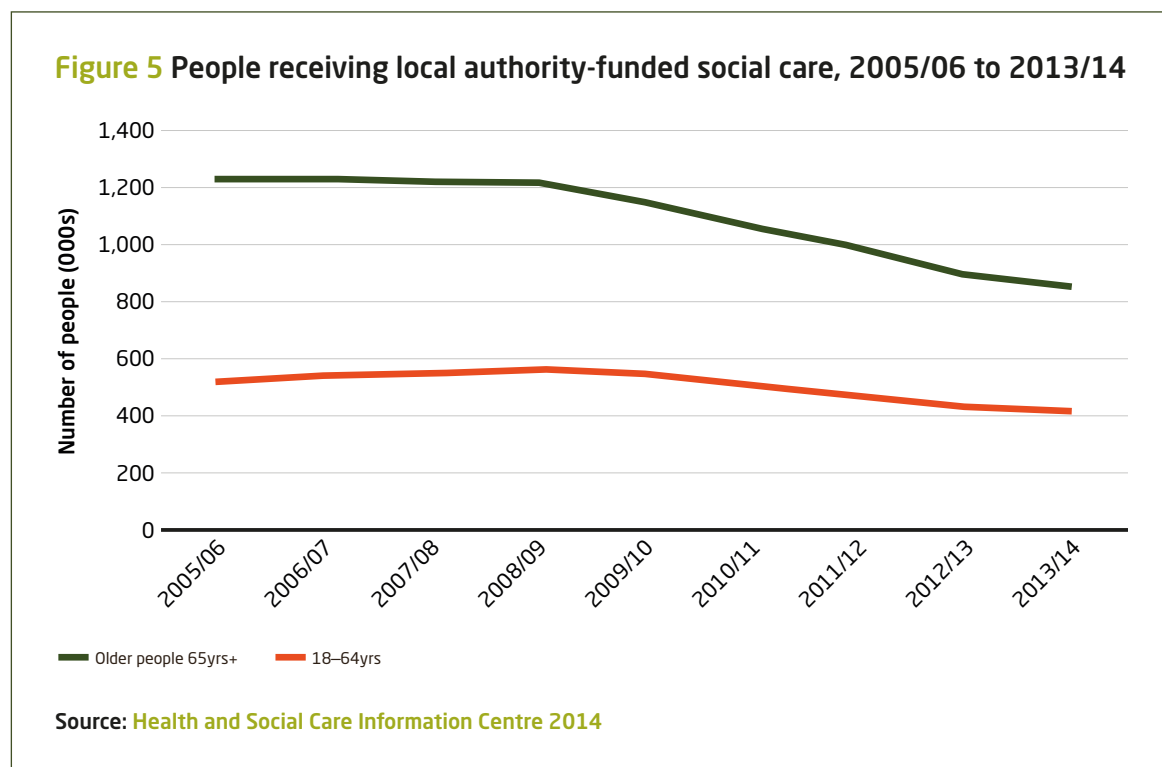
Despite the policy objective of supporting people to live at home, the steepest reduction has been in the number of people receiving local authority-funded community-based services – down 30 per cent since 2009 compared with just 4 per cent fewer for residential care and 6 per cent for nursing home care (*see* Figure 6).

Figure 6 Older people receiving community-based, residential or nursing home care, 2005/06 to 2013/14

Source: Health and Social Care Information Centre 2014

These national trends conceal wide variations in provision between different parts of the country and between individual councils. There is more than a six-fold variation between councils in their rates of people supported in care homes, and an eight-fold variation in their provision of home care (*see* Figure 7). The north-east and north-west tend to provide higher levels of both residential and community care (albeit with variations within those two regions). London stands out as having a low rate of residential provision, but high rates of home care. These differences arise from a variety of factors including historical patterns of provision, local property markets, levels of income, wealth and deprivation, the population age profile and different commissioning practices.

Figure 7 Rate of older people aged 65 and over receiving publicly funded care by local authority, at year end 2013/14
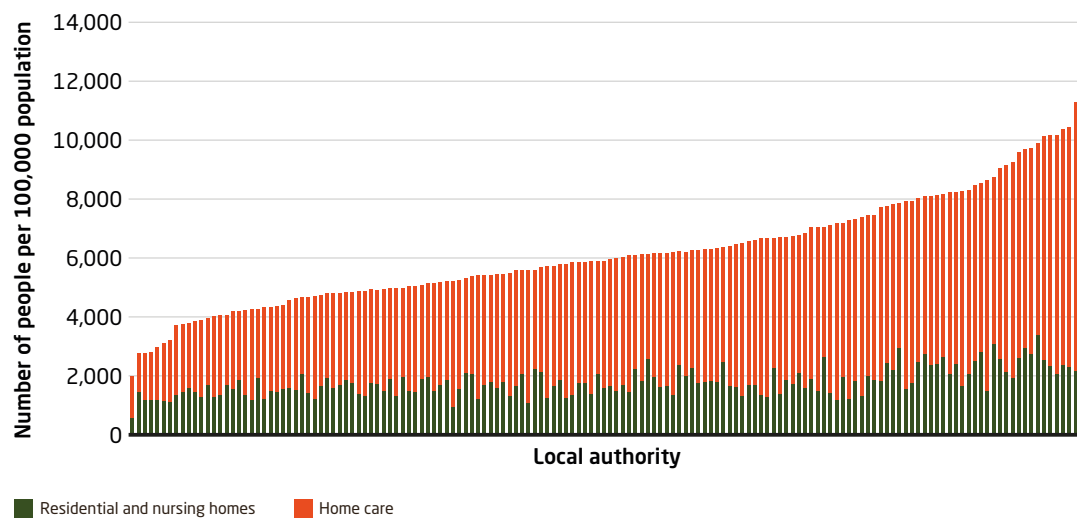
Source: Health and Social Care Information Centre 2014

The local picture: what we learned from our case studies

The scale of budget reductions

Interviewees in all local authority sites reported having had to generate millions of pounds of savings over the past five years and facing even more challenging savings targets until 2018. Even when an authority was achieving an overall net growth in spending on adult social care, the process over recent years was described as 'taking money out' because of the growth in demand over the same period. Interviewees described how savings in adult social care were made in the context of big savings across local government services as a whole. Because adult social care accounts for the largest proportion of local government spending, 'protecting' social care from cuts has not been a viable option for all local authorities:

> *We knew we had a council that had such huge cost savings to make across the years, you couldn't protect social care because of the width of its services from that scenario.*

(Local authority)

A theme common across all sites was the difficulty of this process, including painful conversations with elected council members and other departments. Interviewees from other organisational stakeholders in the area, even where budget cuts had directly affected their own viability, often expressed empathy with the unenviable position that the local authority found itself in:

> It's horrible… [A] lot of the directors started off as social workers, they didn't go in there to cut services or make a service work… but they've been put in this very difficult position.
>
> (Social care provider)

Where have the savings come from?

The approach taken to secure the millions of pounds' worth of savings in our case study sites is consistent with current knowledge in this area (**Association of Directors of Adult Social Services 2016**). Across the four case studies, interviewees from the local authorities reported having used a range of strategies, including:

- reductions in the number of people in residential placements

- reductions in domiciliary care placements

- reductions in the number of assessments carried out

- reductions in local authority staff

- reductions/no increases in payments to local authority funding to providers (homes and domiciliary care)

- reductions in grants to voluntary sector providers

- decommissioning local authority owned homes

- reductions in step-down beds

- reductions in additional services (for example, meals on wheels).

Although each of the local authorities we spoke to had challenges that were unique to them (for example, in relation to the labour market or the distribution of social care providers), a powerful theme common for nearly all of them was that there

was no easy route to further savings, as the obvious opportunities for savings had already been made.

> *We've pulled out anything that is, what we would almost say now is the nice stuff, the wrap-around stuff… we haven't got many places to go, is the answer.*
> (Local authority)

One local authority interviewee described how this financial year's savings target of just under £15 million could not be met without breaching the council's legal duties under the Care Act 2014 to assess and meet eligible needs. They had attempted to think innovatively – for example, charging users for telecare equipment already in use in their home, but had decided that the risk of people turning down the equipment and being more likely to have to turn to the NHS outweighed any savings they might have made. It would have been 'a silly thing to do'.

Another local authority felt that it hadn't 'quite reached the end of the road yet' but that things were extremely tough. In this case, the council's comparison of its own spending against that of others – suggesting that it was still a 'high spender' – had convinced the council that further savings must theoretically be possible. By contrast, an interviewee from another council felt that he had been pressured by the council leadership to reduce spending based on comparative performance. He felt that the figures underlying this comparison were 'misleading' because other councils had higher numbers of self-funders, making it possible for providers to survive on lower fees through cross-subsidy (whereby self-funding residents are charged more than the local authority rate).

The narrative from the local authorities was not all about reductions in spending. There were also examples of increasing investment where it could reinforce broader goals of reducing long-term admissions to care homes; for example, increasing investment in adaptations and re-ablement services to enable more people to be cared for at home.

What has been the approach guiding the savings?

A guiding principle common to all the case study sites – in addition to bringing spending in line with that of other comparable authorities – was a redefinition of the purpose of publicly funded social care for older people. Although different names were attached to this – a 'new vision', an 'asset-based approach' or 'promoting

independence' – interviewees described a set of ideas that involved thinking of publicly funded social care in a different way. This was framed slightly differently in different places, depending on the history of each local authority. For example, interviewees at one local authority felt that theirs had previously been an overly generous authority, which they described as having a 'gift-giving culture'. They said that in the past they had delivered too many services to people and undermined their independence:

> … *but what it did do was stop people going out, it stopped people socialising, stopped people's interaction with others, stopped people exercising. It was very patronising and wasn't very good.*
> (Local authority)

This authority looked to the example of a neighbouring council as something to follow: it provided a much more intensive information and signposting function, and diverted people to community groups and other non-statutory resources. They felt that people should be seen as citizens rather than potential service users, and should be willing to use whatever is available in their neighbourhood, however small, even 'one woman on a street' doing meals for some neighbours:

> *This is not about local authority interventions. This is about us shaping what happens with our communities.*
> (Local authority)

A similar approach was described in another case study site as 'asking questions back to people', rather than automatically deciding which services they could provide for them:

> *We ask individuals first of all what they can do for themselves, and then we turn to the family and say 'What can they do', then to the local community and say 'What can you do', then only after that do we think about what the council should do.*
> (Local authority)

The core idea of this approach – of facilitating a person's autonomy, preferably in their own home – also frames the provision of formal services when people do eventually need them. Our third case study site spoke about the challenges this brought, particularly in changing mind-sets in both the public and NHS clinicians, away from thinking about

care homes as a default option when older people reach a crossroads such as after an admission to hospital, to thinking about how that person can go home:

> *… we probably do find ourselves in greater debate, at times, with families about their views about whether their elderly relative can go home with support or not.*
> (Local authority)

The fourth case study site also described a similar shift in approach, which had successfully 'damped down demand' for long-term, bed-based care. This involved retargeting resources to services such as incontinence services, to address the more immediate triggers that often lead people into long-term care:

> *So we just said, 'Well we're not going to fund lunch clubs any more, we're not going to fund transport that trundles people round to get to lunch clubs, if you want to do it, the voluntary sector, that's up to you, but we're not funding it.'*
> (Local authority)

There was also agreement that the scale of the cuts that lie ahead would be even more challenging, even where councils planned to take advantage of the opportunity to raise Council Tax (the precept) granted in the 2016 Budget.

> *So much has come out of the rest of the council, it is going to come out of children and adult services, it is, because there's nowhere else for this to come from.*
> (Local authority)

> *Next year looks completely horrible.*
> (Local authority)

While local authorities described themselves as so far having been able to protect the most vulnerable service users, one area outlined that continued reductions in the adult social care budgets would start to reach 'diminishing returns', particularly if investment in prevention failed, leading more people at risk of needing long-term care.

There was also an awareness that some of the strategies that had been used until now, for example reducing fees to providers, could no longer be used, as it risked putting too many providers out of business or damaging quality. One local authority

had called a halt to further fee reductions for home care providers, and signalled that they would also meet the National Living Wage:

> *There was a commitment made to reduce the cost of home care to about £10.50 or something, wasn't it? So whatever we were paying was down to £10.50. Looked at it again, I said this is just ridiculous, you can't keep slicing the money. So what I said was we need sustainable services going into the future because they're our responsibility. Our issue is controlling demand, not salami slicing services.*
> (Local authority)

Concern about the impact of the National Living Wage on home care providers was also expressed in another of our case studies: even if the council could increase its fees to offset the National Living Wage, it might not be enough to reverse the recruitment problem facing home care:

> *Well, the home care has been proving very difficult and it is largely an issue of workforce and recruitment. It started off particularly in some of the rural areas… And then it spread a bit. So retail is our major competitor… Looking at some analysis of how retailers are responding to the National Living Wage, what we're able to do won't solve that problem.*
> (Local authority)

Prevention

Across all our case study sites, interviewees spoke about a 'gradual erosion' of preventive services as a result of the difficult process local authorities had undertaken to reduce budgets (Healthwatch). One interviewee felt that 'not enough' had been going into prevention, while an interviewee from another local authority said that investment was going to be reduced in this financial year (2016/17). Prevention was described by one interviewee as the 'poor relation' of health and care services, often not prioritised because the benefits may not be visible in the short term (Healthwatch). There was recognition that it was important to focus on the root causes of increases in demand and to support people so that they do not need to access services. However, as summarised by one interviewee, this is an example of an unintended consequence arising from operating in this financial environment without 'headroom': '[you] deal with one thing and, as you sort out that issue, something else pops up' (CCG).

1 2 3 **4** 5 6 7 8

4 The impact on social care providers

The national picture: what do we know?

Fee levels

Most local authorities have sought to manage financial pressures by freezing or even reducing annual fees to providers with whom they contract. Estimates suggest that average council fee rates have fallen by 6.2 per cent since 2011. However, this has begun to change. In 2015/16, the average increase for care homes for older people was 1.9 per cent, higher than previous years but still below a 'standstill' requirement of 2.5 per cent (Laing 2015).

This year has seen a sharp increase – 82 per cent of councils increased provider fees. Some 18 per cent increased fees by between 1 per cent and 1.9 per cent, and 46 per cent of councils increased fees by more than 3 per cent in 2016/17. Fees in home care in particular have risen quickly, with 5 per cent increases in a third of councils (**Association of Directors of Adult Social Services 2016**).

National Living Wage

Pressures are likely to intensify following the announcement in the 2015 Budget of a new National Living Wage of £7.20 per hour from 2016, rising to £9.15 per hour by 2020. Although any measures to raise wage levels in a notoriously poorly paid sector are to be welcomed, this will add substantially to the financial pressures faced by providers. It is estimated this will add £300 million to local authority costs in 2016/17, rising to £800 million by 2020 (**Local Government Association** *et al* **2015**). But the increase in total payroll costs of frontline staff is much higher – £2.3 billion by 2020, on top of £1.7 billion of costs already implied by above-inflation increases in the National Minimum Wage (**Gardiner 2015**). This has been seen as a new threat to the financial viability of providers (**Care England 2016**).

Workforce

Providers have also been struggling to recruit and retain staff. The care sector as a whole has a vacancy rate of 4.8 per cent (compared with a vacancy rate of 2.6 per cent across the economy). This rises significantly for qualified nurses, where the vacancy rate is 9 per cent; slightly more than a third of nurses (34 per cent) were estimated to have left their role within the past 12 months (**Skills for Care 2016a**). One estimate suggests that the sector could face a shortfall of more than 1 million care workers by 2037 (**Independent Age 2015**).

Given the sector's ongoing difficulty with recruitment and retention, migrant workers play a large role in the social care workforce. Around 266,000 care workers were born outside the UK, one in five of the total. This figure rises to three in five in London. Among this population of foreign-born workers, 28 per cent were born within the European Union (**Independent Age 2015**). The outcome of the UK's referendum vote to leave the EU has increased concerns about the sustainability of the care workforce.

Market developments

There has been a steady reduction in the number of residential care homes since 2010 and the number of places has fallen by 7 per cent (Care Quality Commission, unpublished). But the number of nursing homes increased over the same period and there were 9 per cent more places (*see* Figure 8). There are wide regional variations in these changes, with the loss of residential care home beds ranging from -18 per cent in London to -2 per cent in the East of England. Nursing home places have increased by as much as 16 per cent in the East of England but just 3 per cent in Yorkshire and the Humber.

Signs of provider distress are increasing. Seventy-seven local authorities reported that at least one care home provider has ceased trading in their area in the past six months (**Association of Directors of Adult Social Services 2016**). Recent analysis of care home company accounts for the BBC suggests that 28 per cent of care homes are at risk of financial failure (**BBC Radio 4 2016**). Homes of lower quality and where there is more competition between providers are at higher risk of closure (**Allan and Forder 2015**). The spectre of large-scale provider failure was raised by the collapse in 2011 of Southern Cross, the largest independent care home operator in the country,

which threatened the care of 17,000 people in some 750 homes (**National Audit Office 2011**). Some of the key factors behind this crisis – high levels of debt, separation of property ownership from care provision, under-occupancy and reliance on squeezed local authority fee levels – are still present in parts of the market (**Burns *et al* 2016**; **Institute of Public Care 2014**).

Figure 8 Number of care home places, 2010 to 2016
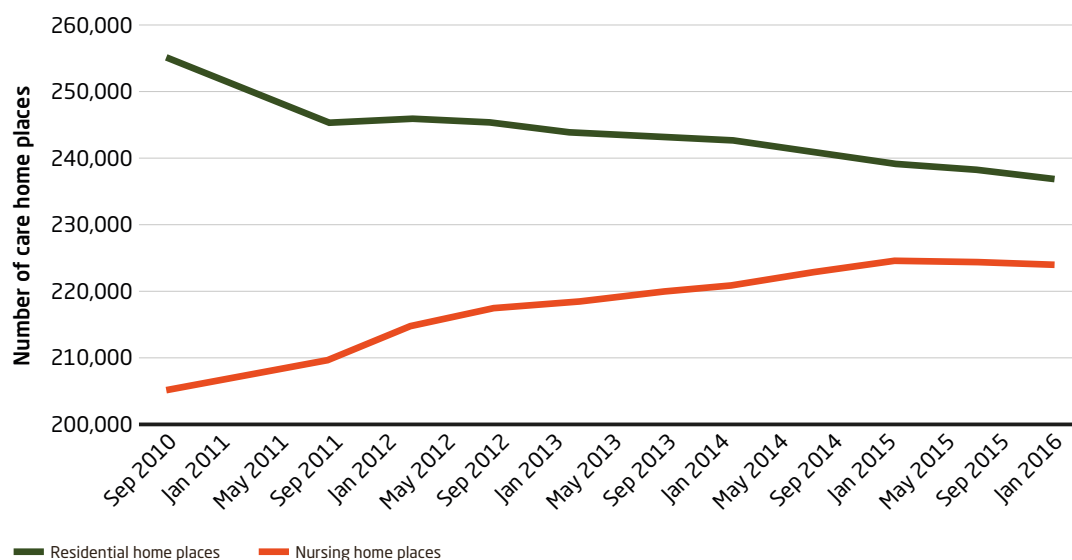
Source: Care Quality Commission registration data (unpublished)

Many providers have responded to the financial pressures by concentrating on people who pay for their own care ('self-funders'). Some 53 per cent of residential and nursing care funding now comes from private individuals, if 'top-ups' from relatives are included (though in part this increase arises from more older people having property and savings that place them above the £23,250 threshold for local authority financial support). The gap between local authority and private fee rates has widened over the past five years – one estimate is that average self-funded rates have risen by 40 per cent over this period (Laing 2015). There is now clear evidence that in many places self-funders are cross-subsiding local authority residents who receive generally the same care and accommodation at a much lower price (**County Councils Network and LaingBuisson 2015**).

These developments are leading to the polarisation of the market, with some providers in generally less affluent areas with low levels of self-funding very reliant on inadequate local authority fee levels. In contrast, in affluent areas with higher levels of self-funders the market is relatively buoyant. This is being reinforced by new scheme developments concentrating on the private market rather than local authority-funded residents (Laing 2015).

Financial pressures on providers of care in people's own homes (also known as domiciliary care) are also intense, with clear signs that a tipping point has been reached in a fragmented market. The minimum sustainable price for home care is estimated at £16.70 per hour, with one survey showing that last year just 14 per cent of local authorities paid the minimum price (United Kingdom Home Care Association 2015a, b). Two of the largest national home care providers have already left the publicly funded market and two others have posted operating losses in the past year (LaingBuisson 2016). In the past 16 months, home care providers have handed back contracts in 59 local authority areas, and in another 48 areas at least one home care provider has ceased trading (Association of Directors of Adult Social Services 2016).

The local picture: what we learned from our case studies

Although the landscape of social care providers looks different in different areas, our interviewees from residential, domiciliary and third sector care providers described how a combination of fee pressures and rising costs was creating a 'perfect storm', with implications for workforce, the shape of the provider market and the quality of care for older people.

Fee levels

The local authorities we interviewed were candid about how they had used fee reductions to providers as a key strategy to make the savings needed each year:

> *We made savings on hammering down provider prices, so we didn't pass on any inflation for five years. If I look back over five years, holding price, provider prices down, was quite a strong part of our overall savings.*
> (Local authority)

Sometimes these reductions were made as part of retendering contracts at lower fee rates. In one local authority, this had reduced the number of providers in the market, in this case home care, when the providers found they were unable to continue offering services on such low prices:

> *We did a tender about five years ago, we took considerable costs out of the market, again… We'd wanted eight providers across the borough, but we lost two, in quite quick succession, because the business model that they'd built their tenders on wasn't sustainable. So, and we're still unpicking from that, really, we're down to four providers.*
> (Local authority)

There was a common theme from interviews with both providers and local authorities that this process of reducing fees had reached its limits; in some cases, local authorities were starting to increase the amount paid:

> *I think it's clear that we can't strip any more costs out of the care providers.*
> (Local authority)

But in the view of many of the providers we spoke to, even small increases were not now going to be enough to offset rising costs:

> *All the fees that are being announced now for, I'll get my years right, 16/17, we've had as low as 0.2 per cent and the highest one we've had so far is 4 per cent. So is that going to cover the costs? No, there's real-world cuts happening, and unfortunately, where we stand, and I'm not saying as a provider, it's as an industry, it's a question of last man standing.*
> (Social care provider)

Care home providers expressed frustration with local authorities when it came to estimating the true costs of providing care. In one case study site, providers reported that the local authority had based its costs on the assumption that homes had 100 per cent occupancy, which they felt was unrealistic. In another, there was frustration that the council had spent money on external consultants to estimate costs, when in reality they knew what the real costs were:

I mean, how many times do I have to submit those cost of care calculations? We know what the cost of care is. If all these councils and the amount of millions they have spent, on trying to calculate fees, to fit their model, you know. They're just opinion shopping. I mean, we know that the cost of care is probably over £600 [a week]. If they can't afford that, let's recognise it and say, going forward, you know, this is what we expect.

(Social care provider)

There was equal frustration from our interviews with providers of home care, where prices had also been driven down. In one case study area, this had had a direct impact on their ability to retain staff, particularly because a neighbouring council was prepared to pay a higher hourly rate:

So the situation now across the board really with the exception of [council X] is reaching the untenable stage because it is now proving to be almost impossible to find the staff who are willing to work for the low pay which is made available by the councils.

(Home care provider)

In some areas, a trend towards increased transparency was emerging between commissioners and providers as financial pressures intensified. Two social care providers in one area spoke about how they had spent time with the local authority explaining their costs in detail as a way of justifying their fees. One of these providers explained that it was important to try to show that the organisation was not trying to make a profit in the way that others perceived private providers to do. Conversely, two providers in one area said that the transparency and 'frankness' shown by the local authority had worked in its favour and facilitated positive working relationships (social care provider).

The National Living Wage

All providers also mentioned the impact of the National Living Wage. Across the board, it was welcomed, but was also met with scepticism about its reach and worry about its affordability. One social care provider outlined that the costs for their organisation were going to be higher than originally modelled because they

were planning to apply the wage increase to all ages, to make it 'fair'. The cost of maintaining pay differentials was also stated as another resulting cost.

For home care providers, this worry was particularly amplified, given that a bigger proportion of their costs are made up by wages. One local authority commissioner described the potential worry for an already stretched home care market in his area:

> *I think in home care, it's not just National Minimum Wage, it's the rulings on paying travel time or sleep or pensions, there's all sorts of stuff, isn't there, that are combined together. I mean, they weren't making big margins anyway, the providers, I did quite a lot of work on it, so our worry is that we'll see; already we've had local providers who have sold up and said 'It's not worth doing any longer'.*
> (Local authority)

Despite these challenges, the National Living Wage was seen as a positive step in trying to improve the perception of care work as a rewarding career and was supported, in principle, by many of the interviewees. However, one interviewee pointed out, it did not solve the provider market's competition for staff with the retail sector.

Workforce

A theme common across our interviews in residential, nursing care and care in the home was the increasing difficulty in recruiting and retaining both care staff and nurses. Interviewees described intense competition with the retail and service industries as well as the NHS:

> *It's an incredibly difficult job, difficult profession, which doesn't pay very well, where you're being asked to do more and more on less ratios that will become less appealing.*
> (Social care provider)

Two providers discussed their reliance on migrant workers, but emphasised that they needed to be mindful of the needs of these workers if they wanted to retain them:

Bring in folk from Eastern Europe, but be clear about their ability to speak English and invest management time and resources into doing the cultural transition for those folk: it's a pretty, literally, foreign workplace for them.
(Social care provider)

A number of interviewees described real difficulty in recruiting and retaining nurses both in the context of the declining numbers of nurses, competition with the NHS and the lack of clear career paths in social care. Where competition from the NHS is strong, care homes are finding themselves having to pay more, under pressure from potential staff aware of the alternatives:

Two years ago, I was probably paying nurses £13–£14, now I'm paying up to £20… I now get nurses who say 'I'll only work for £17' and I think 'Who is interviewing who here?'.
(Social care provider)

In two of our fieldwork sites, interviewees suggested that in order to survive some providers were employing people on a 'cash-in-hand' basis; they hinted that many may be working without proper documentation and/or being paid less than the minimum wage. One provider was frank:

I expect there are quite a few who pay cash in hand and below the minimum wage… I get people knocking on my door looking for a job cash in hand.
(Social care provider)

This would be consistent with evidence of a wider problem of non-compliance with the National Minimum Wage in the social care sector (**HM Revenue and Customs 2013**).

Older people with more complex needs

Similarly, all sites reported an intensification of need in their client group, across the voluntary sector, domiciliary, residential and nursing care. For providers of nursing and residential homes, this was often seen as a result of the success of the policy agenda of keeping people at home longer. Although interviewees were split about the merits of this approach (some thought older people with care needs were often

staying in their own home too long), they all agreed that the average complexity of need had intensified:

> *We've seen an increase in dependency levels… There has been a huge government push for people to be cared for as long as they can in their own homes and this is the consequence of the success of that policy.*
> (Social care provider)

Another interviewee suggested that care workers were often being asked to carry out clinical tasks, or tasks which may have traditionally been carried out by a community nurse. Examples include stoma care or dressings. Care home providers also illustrated this intensification, describing a pressure from local authorities to accept inappropriate placements, putting people with dementia into residential care:

> *You end up having to move them because they're wrongly placed. The council are saying, 'Put them in a residential bed until they can't cope, then we'll move them'.*
> (Social care provider)

The same care home provider explained how far the situation had to deteriorate before additional payment was forthcoming to meet the older person's needs:

> *In order for you to get the dementia payment, the person has to be beating somebody up, or violent towards the staff, they have to be wrecking the home.*
> (Social care provider)

For providers of home care, the combination of low fees from local authorities, workforce shortages and the greater needs of older people was described as extremely challenging, putting enormous pressure on the remaining workforce. An example was given by a home care provider of what happens when meeting the complex needs of a person (needing two carers and described as 'particularly difficult' by the provider) exceed the time being paid for by the council for a morning visit:

> *We've not been able to do it for less than an hour and a half and because the council are yet to approve the extra time, the carer is now refusing to go back and we're literally almost out of carers, our supervisor had to go at 7am this morning*

because we couldn't find a carer to go to do the other half of the 'double up'. So the complex needs is certainly something which is very apparent.
(Social care provider)

Quality

The challenge of maintaining quality under these pressures was a strong thread running through all the interviews with providers, local authorities and the NHS. The CQC's role as regulator of quality was seen as powerful: examples were given of care homes that had closed as a result of not being able to meeting the minimum standards of care – 'the expectations of the standards, quite rightly, is going up' (NHS provider).

Many social care providers felt ambivalent about the role of the CQC and, unsurprisingly, there were negative views about the style and content of the inspections. The social care providers we interviewed recognised that the funding pressures were having an impact on quality. In one site, social care providers were sceptical that high-quality care could be provided on the fees that the local authority was prepared to pay:

I just don't understand how you can provide CQC compliant care for £400 and… I don't know how they do it and I suppose I don't want to know how they cover it up that they don't do it and unless you've got a really hot CQC inspector in there asking the right questions and looking in the right ways…
(Social care provider)

Interviewees mentioned that savings could be made by not investing in new furniture, or requiring staff to buy their own gloves and aprons. Concerns were mentioned by several participants about the quality of training being offered by social care providers and about the ratio of staff to residents. Inappropriate referrals could also have an impact on the balance of staff to older people in care homes.

What happens is CCGs, local authorities and the hospitals are under pressure and when everyone is pushed out of hospital you are under pressure to fill the beds. What happens then is you get a frail resident next to a dementia nursing patient and it upsets the whole balance of care.
(Social care provider)

Overall, where providers were under financial pressure, the view was that quality was going to be harder to maintain:

> *I think ultimately quality has to suffer. There is no maliciousness to it, most people working in care do it to the best of their ability. I think people came into it for the right reasons. But we're at the back of the bus queue when it comes to recruitment. If all the good young staff are going to Sainsbury's where you get £8.50 an hour, what is left for us when we pay the minimum wage and have to operate on a casual basis doing really difficult work?*
> (Social care provider)

Market developments

An interesting aspect of our interviews was the impact of fee reductions on providers' business strategy. Although participants did not agree on how exactly providers should respond to the operating environment, many providers discussed a change in their business models and described a shift (where possible) to offering more services to self-funders and the NHS (acute trusts and CCGs) as well as local authorities.

Care homes described making renewed offers to CCGs and acute trusts to assist with admission and delayed transfer of care pressures. They often saw themselves as offering a less intense environment than an acute inpatient ward, which could replace a shrinking NHS intermediate care offer, essentially acting as additional NHS capacity for older people. This contribution was typical:

> *If you've got someone going into hospital, it has a great impact on the hospital; it's easily managed within a care home because you've got the right person in there to support you. But then, what you need to do is up-skill all the rest of your staff and it's something that we're starting to look at: the business of starting around having a more senior carer role that then picks up – I suppose you could say – the bottom end of that nursing role.*
> (Social care provider)

Another way in which both care homes and home care agencies discussed changing their business model was shifting towards one that relies on self-funders. One of our local authority interviewees, in an area with more prosperity and more self-funders,

described the impact this was having: the income from self-funders was being used to subsidise local authority-funded users, leading some providers to abandon local authority-funded people altogether:

> *… unquestionably, there's cross-subsidisation in those homes that will do business with us. They afford our rates by what they charge self-funders. But, increasingly there are homes that, actually, don't need to, don't want to do business, again, particularly in the more affluent parts of the county.*
> (Local authority)

What this meant for the older people who were supported by the local authority in the wealthier areas was less choice, and the prospect of being placed in homes at some distance across the county, which was large. Choice could also be reduced by the decision of social care providers to close down their businesses altogether. The combination of higher standards being driven by the CQC and the challenges of finding staff had led to care home providers deciding to quit in parts of the same local authority area, leaving the local NHS hospital with a reduced number of homes to discharge people into:

> *And a number of care home owners have said, 'I can't recruit. It's getting harder and harder to maintain registration at the levels that I would want to in a safe and financially viable way. So, do you know what? I'll sell my massive, big, Victorian house overlooking the sea and turn it into flats and make an absolute killing.' It's not a difficult decision for someone to make and that's what they've done.*
> (NHS provider)

Another local authority in an area with plenty of self-funders described how nursing care providers were now in a strong negotiating position because they had alternatives to local authority funding. This had resulted in the local authority having to pay more for nursing home places. The interviewee understood why providers were shifting to a model built on self-funding but realised that this option was not available to providers elsewhere:

> *In our bit of [city] there's a very buoyant, self-paid market, so providers are on a strategy of just saying: 'We can just shift more and more towards self-pay and just get rid of these miserable local authorities who don't pay us enough.'*
> (Local authority)

A large care provider in the same area described how it was working to diversify its income streams, including investing in specialist rehabilitation care, as well as self-funders. This provider recognised that the instability in the provider market would eventually shift the balance of power, through a process of survival of the fittest, as providers both small and large dropped out:

> *I think what will happen is you will see a huge amount of 'ma and pa' type facilities going out, you'll see a number of corporates falling over, and actually the only thing that will change the dynamic will be less places available, and at that point those that have got through the difficult times will have leverage and actually say, 'We're not having £600 a week, it's now £800'.*
> (Social care provider)

This social care provider had calculated that it would be impossible to survive without at least 25 to 33 per cent of fees coming from self-funders to cross-subsidise the business as a whole. This level of cross-subsidy brought with it some ethical dilemmas, in the view of the provider in question, who felt uneasy raising self-funder fees at well above the rate of inflation:

> *We try and justify it, that unfortunately it's government legislation; however, on the softer side, you get a paper, WiFi and some flowers every now and then, ultimately it's the same service. I think what's becoming increasingly difficult is in many instances I'm the one stood up at the front in residents and relatives meetings and people are asking me to justify and people are saying, 'Can I have a breakdown of my fees?'. It's an unanswerable question, what do we say?*
> (Social care provider)

What was clear from our case study sites was that the decision to focus on self-funders was driven by the affluence (or lack of it) at a local level, and these sorts of strategies were very unevenly distributed.

In one of the case study sites with much lower levels of personal wealth, the problems for the provider sector were more apparent. The home care market was described by the local authority as having 'fallen over':

The number of providers in the market has reduced, except for some of the bigger ones. And the bigger ones are, some of them, are considering whether to stay in the market, [these are] some of the messages we're getting.
(Local authority)

For residential and nursing care in our case study areas with more dependence on local authority fees and fewer self-funders, social care providers described the situation as heading for a crisis, with five or six homes in the area having already closed:

And I think it's quite a tragedy, really, that we all know that's going to happen, it feels like we're heading to that brick wall. And it almost feels like there needs to be a wall to collapse, in order to get some government action.
(Social care provider)

A provider in a local authority-dominated market confirmed this view:

Most of our residents are publicly funded, there aren't many top-ups. So you know, you can't expect all the bells and whistles. We have to operate very economically here. That is the reality.
(Social care provider)

In this case study site, also heavily dependent on local authority-funded business, survival often hinged on whether the care home was willing to charge a 'top-up' above the local authority rate:

So those homes have really struggled, especially if they've been homes that have never requested or been able to get a third party top-up as well, they're really struggling and those have been the homes who have got into trouble really if I'm honest.
(Social care provider)

An NHS provider described how providers would try to maximise top-ups when a patient was ready to be discharged. In two of our sites, the local authority admitted it was aware that because it seeks out the lowest price, it means providers not only rely on cross-subsidisation to stay profitable, but maximise the amount they can make from top-up fees, often in an arbitrary way.

One home care operator, however, suggested that providing for (or deliberately reorienting towards) only private payers could be counterproductive, and would result in no access to local authority markets and problems when people 'run out of money'.

Reflecting the national data, all areas described the emergence of a 'two-tier' system as a result of the change in business strategy: one for those who can afford to pay for their own care, and one for those who rely on local authority-arranged care.

As a result of a reduction in public sector funding, interviewees felt that the social care provider market was likely to undergo a number of changes over the next five years. One interviewee predicted a 'large-scale collapse' of the market, particularly affecting small providers in old stock that are unable to make the investments needed to sustain their buildings (care home provider), and that, without an increase in local authority rates, providers would be without an 'adequate incentive' to continue their businesses. As a care home provider in a different area put it:

> *If all I could take was local authority we'd be bankrupt, yeah, we wouldn't survive.*
> (Social care provider)

Another interviewee agreed that the number of small providers would be reduced, alongside the possible failure of a number of large corporate providers. The suggestion was that there are some large providers, with 'deep pockets', taking a longer-term view about investing in this market (that is, waiting and strengthening their market share) that are therefore subsidising their activity in the social care market with other parts of their business (social care provider).

Voluntary and community sector

Interviewees from the voluntary and community sector also spoke about the pressures created by local authority cuts. At the same time, they recognised that their services were more in demand than ever, and that their role in any 'asset-based' vision of care was a crucial one.

In some areas, voluntary sector organisations had come together to work collaboratively, often in response to local authorities wanting to streamline and simplify their contracts. Several participants discussed how voluntary and

community sector organisations were coming together across local authorities to consolidate services, and look for grant funding at a national level. Others talked of diversifying income and fundraising streams, looking harder at national grants and charging. A few also talked about reorienting towards the NHS, which was perceived as having deeper pockets, offering preventive services and rapid response discharge assistance.

There was no doubt that the recent years have been painful, however. A common theme from the voluntary and community sector interviews was the determination to continue services even when contracts with the local authority had been curtailed:

> *We fund our own information and advice services now, having not successfully gained a tender. We fund it through our trading programme, through our own resources, and a couple of small grants, and we just find the demand is growing and growing. Because of the complexity of the system, and older people, and their families and their carers, the complication of being able to access the services which they have an entitlement to.*
> (Voluntary and community sector provider)

Where the voluntary sector delivered services to older people directly, reductions in local authority grants were particularly difficult to manage, especially if the voluntary and community sector provider did not want to introduce payments. In one case study, a provider described the experience of negotiating with its cash-strapped local authority:

> *We spent a long time putting a case forward to say we couldn't, because we're delivering services, we literally pay staff to go out and deliver services so what do you want anyone to do, if I deliver less hours I've got to keep the same number of staff on, I can't just sack the staff or pay them a lower salary, so I can't give them less, so I'm just delivering less hours which means our unit costs are going up… So they listened to that, came back and said, 'We don't care'.*
> (Voluntary and community sector provider)

Voluntary sector organisations were also looking to the NHS for funding, but in two case study areas voluntary and community sector providers observed that NHS funding could be even more short term, often funding pilots with no commitment

to continue funding. A number of interviewees felt that the public sector tended to assume that volunteers were cost free: 'They aren't free… they need training, support and supervision' (voluntary and community sector provider).

Descriptions of providers' relationships with CCGs echoed this sentiment. In one area, a voluntary and community sector provider described the CCG as 'faceless', stating that its approach is similar 'whether you're buying bins or lightbulbs, or people's services. It's really worrying'. Another provider commented on the difficulties of working across multiple CCGs, each with varying priorities; in a different area, a voluntary and community sector provider described the CCG as being indecisive even in the face of contracts that were near their end and, therefore, involved possible staff redundancies. However, one voluntary and community sector organisation explained that the local CCG was more open than the local authority to exploring new models of care and other provider innovation, because the latter had severe internal capacity issues.

There were a number of examples of how voluntary sector organisations worked hard to maximise their income, from renting out office space in buildings that they owned to more familiar charitable activities such as raffles and generating income from their shops. One common theme was the need to charge users for services that might once have been free, for example a small charge for cutting toenails, which was set significantly below what it would cost for an older person to buy it privately.

Other organisations had bitten the bullet and introduced charging for their core services. One example was a day centre that had lost its funding:

> *Our strategy is about selling services and people paying for them themselves on a full cost recovery basis. With effect from the 1st of April the people coming in downstairs pay £20 for half a day, £40 for a full day for day care.*
> (Voluntary and community sector provider)

But despite this perception of relative resilience in the sector, a few interviewees discussed the loss of a number of smaller organisations that had struggled to recruit good trustees or to adapt to a more flexible way of working which might ask service users to contribute more by way of volunteering and charging for services.

Governance has been a vital part of our ability to adapt in this environment. Without it and without flexible trustees and leadership, we may have been in a much more difficult situation.
(Voluntary and community sector provider)

Voluntary and community sector organisations were felt to be facing threats to their sustainability similar to those experienced by commercial providers:

A lot of good charities have been lost and will continue to be lost. And once you lose those, they never come back.
(Voluntary and community sector provider)

⑤ The impact on older people, their families and carers

The national picture: what do we know?

Access to care and unmet need

As we have seen, the most striking feature of social care for older people is the dramatic reduction of at least 26 per cent in the numbers of people receiving publicly funded services over the past five years. Some of this reduction may reflect positive developments that have reduced the need for care and other approaches based on promoting independence and alternative community support (**Bolton 2016a**). But the fact that there is an increasing number of older people with multiple health conditions and more acute levels of need suggests that more older people should be getting social care, not fewer. It should be noted also that access to care had been tightened considerably over the past decade, so that by 2010 90 per cent of local authorities were limiting help only to those with 'substantial' or 'critical' needs (Fernandez *et al* 2013).

Although defining, let alone measuring, the extent of unmet need is fraught with difficulty, by 2011 there was already strong evidence of significant levels of unmet need among older people (**Vlachantoni *et al* 2011**). A more recent assessment of official statistics and the English Longitudinal Study of Ageing for Age UK indicates that unmet need has grown. More than a million people who have difficulties with the basic activities of daily living, such as getting out of bed, washing and dressing, now receive no formal or informal help at all. That is an increase of 100,000 in one year alone (**Marmot *et al* 2015**).

The Care Act 2014 introduced a new requirement on local authorities to consider how they can identify unmet needs (**Department of Health 2016b**). Monitoring

arrangements are in place in 34 per cent of local authorities and in development in a further 31 per cent (**Association of Directors of Adult Social Services 2016**). As yet we do not have a clear and comprehensive national picture of what happens to people who are not eligible for publicly funded social care – those who are 'lost to the system' (**Henwood and Hudson 2008**).

Even if older people have needs that are high enough to be eligible for publicly funded care, they may have to pay for some or all of it themselves if they have resources that exceed £23,250. Some 41 per cent of care home funding is met by individuals from their own private resources and a further 12 per cent from 'third parties', usually relatives who top up the fees paid by local authorities in order to secure higher standards of accommodation (Laing 2015). The extent to which people pay for care in their own homes is much less understood but one estimate suggests it amounts to around £1 billion of private expenditure (LaingBuisson 2016). Some will be using their own resources to pay for care without necessarily getting good advice or information (**Institute of Public Care 2012**). A further source of confusion and inequity for older people is the continuing division between health care free at the point of use and means-tested social care, exemplified by the continuing health care assessment process. Older people are not well served by our complex and fragmented health and social care system that is difficult to understand and navigate (**Commission on the Future of Health and Social Care in England 2014**; **Independent Age 2016**).

Quality and experience of care

For those older people who get publicly funded social care, 90 per cent are satisfied with the care and support they receive, slightly higher than working-age people at 86 per cent. Only 4 per cent were dissatisfied (**Health and Social Care Information Centre 2015d**). Changes to the methodology of the national social care user survey means it is no longer possible to compare current satisfaction levels with those of previous years. But considering the 2014/15 survey took place in the fourth consecutive year of real-term cuts in local authority social care budgets, it is interesting that satisfaction levels have stood up so well, emphasising that the survey does not capture the experience of people who fall outside the publicly funded system. This contrasts with rising levels of complaints to the ombudsman about adult social care – up by 18 per cent since 2013; 55 per cent of claims were upheld. In 2014/15,

complaints about home care rose by 29 per cent (**Local Government Ombudsman 2016**). That a high proportion of these – 67 per cent – were upheld by the ombudsman is consistent with the concerns about the state of home care that have emerged from our research. The upward trend in complaints suggests that councils are finding it harder to meet people's needs and expectations

Another window into quality is the outcomes of inspections by the regulator. Changes in inspection regimes and standards make it hard to assess changes over the past five years, with a new approach introduced from 2014. Based on inspection up to May 2015, care in 1 per cent of locations was judged to be outstanding, in 59 per cent it was good, 33 per cent required improvement and 7 per cent were judged to be inadequate (**Care Quality Commission 2015**). By 4 April 2016, this had changed to 1 per cent, 67 per cent, 29 per cent and 3 per cent respectively (**Care Quality Commission 2016b**). In part, this reflects the prioritisation by the CQC of higher-risk locations for inspection; the overall picture is likely to improve further as more lower-risk locations are inspected.

There are differences between services, with nursing homes less likely to offer good care. Smaller homes of all kinds provide better care than larger ones. Just under half (46 per cent) of nursing homes inspected up to 31 May 2015 were rated good or outstanding and 10 per cent were rated inadequate. Home care, residential homes and community social care (which includes Shared Lives schemes) were rated as being good or outstanding (68 per cent, 65 per cent and 68 per cent respectively).

This does not suggest that there has been a collapse in the quality of care as a result of spending reductions but, as discussed earlier, our case studies indicate that providers are finding it harder to maintain standards. The CQC has warned that the impact of budget pressures and expectations created by the Care Act 2014 is likely to have significant implications for the ability of providers to improve or maintain their quality of care while trying to maintain financial viability (**Care Quality Commission 2015**).

The role of carers

The social care system is heavily reliant on unpaid informal carers, usually family members, whose numbers exceed the paid social care workforce by around two to one. There has been an increase in the number of unpaid carers, who have risen from 16.6 per cent of the population in 2011, peaking at 18.9 per cent in 2013, before falling slightly to 17.6 per cent by 2014. In 2014, 30.6 per cent of people providing care did so for 20 or more hours a week. Many older people are carers themselves (**Mortimer and Green 2016**).

The Care Act 2014 offers important new rights for carers, including taking into consideration the carer's health and wellbeing; their family relationships and the need to balance their home life with their education or work; their entitlement to support from their local authority, if eligible; and provision of advice and information to prevent their needs from getting worse. A year on, the potential benefits of the legislation appear to be outweighed by pressures in social care and changes in the benefits system. A recent assessment by the Carers Trust (**2016**) concluded that the Care Act had made 'little or no difference' to many carers.

In another survey of more than 6,000 carers, one in three carers (34 per cent) reported a change in the amount of care and support services they or the person they care for receive. Of these, more than half (59 per cent) saw a reduction in care and support services due to cost or availability; this includes 13 per cent who said a service was closed with no replacement offered (**Carers UK 2016**).

The annual national survey of more than 131,000 adult carers reveals much lower levels of satisfaction than expressed by older people who receive social care – 74 per cent of carers were satisfied with the support and services they received (3 per cent lower than the year before), compared with 90 per cent among older people. Some 38 per cent of carers reported that they spend 100 hours or more a week looking after or helping the person they care for, up from 36 per cent in 2012/13 (**Health and Social Care Information Centre 2015d**). Demographic projections suggest that the availability of intensive unpaid care to older people by their children is unlikely to keep pace with demand in future years (Pickard 2015).

The local picture: what we learned from our case studies

One of the main questions behind this research project was whether the reductions in services to older adults have had a negative impact on older people and their carers. This includes: people who might have received services of any sort when funding was more generous and who are now directed elsewhere, and those who still receive services but who might have fewer hours or experience a lower quality of service as fees have been reduced to providers. This section contains the views of the NHS, local authority officials, the voluntary and community sector and Healthwatch on what is happening to users. We present the experiences of users themselves in the boxes.

The local authority perspective

All the local authority staff we interviewed emphasised how savings had been designed with the aim of not harming service users and carers. All conceptualised their role as targeting scarce resources to support people with the highest and most complex needs, and all were confident that the savings they had implemented had not led directly to unmet need or harm among older people. The local authority officers backed up their views with reference to an array of sources, including hard data (from public health or user surveys) or soft data from the voluntary sector, Healthwatch, centres for independent living, elected council members and consultation exercises led by local government. One local authority felt that its close working arrangements with GPs, community nurses and locality social workers meant that it would know if someone had slipped through the net:

> … *because they just tell each other who they are worried about and get on with it, and I don't think, you know, they work so closely with GPs, I think that if there was somebody there who needed, we'd know.*
> (Local authority)

Another local authority put it more precisely: there was 'not an unmet, eligible need'. However, the same interviewees thought that some people who had had their care packages reduced were not happy. They cited an example brought to them by one of

their elected members who had been knocking on doors, and who had reported to them an example of a reduced care package that meant the user had had to pay for her own cleaner:

> *… they would interpret that as a decrease in quality, wouldn't they… I think we would say it's not an unmet eligible need. Of course, everyone's got needs, but we don't have the money to meet all needs, we just meet eligible needs in a very, very targeted way.*
> (Local authority)

A common theme across all the local authority interviews was that people with lower-level needs were not simply being turned away from services, but redirected towards other sources of support, such as voluntary organisations in the community. But it was striking that there were no obvious sources of information about what was happening to those no longer eligible for statutory services: 'We just don't have the resources to do follow-up studies on everyone that we signposted away'. Local authorities were relying instead on soft data from the voluntary sector and Healthwatch.

For those still eligible to receive social care from local authorities, the view from local authority interviewees was that continuing high levels of satisfaction recorded in user surveys suggested that the quality of care was holding up. But there was an awareness that recruitment and retention problems, coupled with the retendering of home care contracts, may have disrupted continuity between older people and carers.

The experience of an unstable home care market: Robert's story

I had different care workers nearly every day. Sometimes they didn't even... I mean, one day I was going to the hospital on the hospital patient transport and I had to be ready at nine o'clock and half past eight they hadn't even turned up. And they sent up a manager who just hadn't got a clue. They changed their names four times while I was with them.

And anyway, it then changed... the new firm were just impossible to deal with. The management changed every three, six months and... And the, pardon me, the field care supervisors were, well, I was going to say a jobsworth, they just couldn't care less, that was their attitude, because their jobs, I think, were on the line anyway and then all of a sudden, without any warning, they decided they wouldn't deal with disabled people. So they sent us back to the council, yeah, social services. They then moved me to [another] firm... I thought, great, the manageress was a very nice person, and she'd had her own care company, but she was having difficulty getting staff, so she sold her business... Now, she was very nice, a very nice person, but unfortunately, she started in the July or August, was it, something like that and then in the October she'd gone. Well then one Sunday morning I had a visit, the... they call them CEOs, from [the new firm] and he brought with him a, I suppose, yes, area manager and he stood in the bedroom and he said to me, I couldn't believe it, he said, 'Mr [...], you're not cost effective'. So I looked, I said, 'what do you mean?' He said, 'no, you're not cost effective', but I'm standing here doing nothing and I thought, well, my God, you are the chief executive, you should be leading by example. Within a week of him saying that, chop, out. That was 2013, [20]14.

The view from outside local authorities

There was less confidence about the impact on people among interviewees who worked outside the local authorities. When asked whether the system could still completely miss people with high levels of need, a social care provider reported that they got calls 'every now and again' to assess people in their own homes and sometimes found people living in 'appalling' conditions. In the same area, an interviewee from the voluntary sector claimed that there had been a significant increase in the numbers of people being found dead in their own homes, but did not attribute this directly to a reduction in services. A social care provider in another authority felt that the safety net worked well nearly all of the time, and that complete failures were rare.

In both cases, the source of the information was anecdotal and it was anecdotal evidence that was put forward in our interviews with members of Healthwatch and voluntary and community sector organisations across the case study sites. The following examples come from a focus group of voluntary sector providers in one local authority. It is striking that the shortcomings in care relate to both social care and health services.

> *I've got a man with dementia that's not eating or anything without being prompted. But that's not seen as a need. He can look after himself because he can make a sandwich. It doesn't matter that he doesn't want to make himself a sandwich and eat. And he will just sit there and starve. But he has got a daughter, but they have quite a strained relationship. So that's happened with a lot of them.*

> *There was a gentleman that had prostate cancer and he's been out of hospital for four months. But we're still waiting for the incontinence team to work with him. But he's been incontinent since coming out of hospital from his operation.*

> *We've got a woman in sheltered housing and she's set the flat on fire three times in the last three weeks. And there's no managers there or anything if there's an incident. Just the telecare.*

The absence of hard data on the impact of budget cuts was a concern for Healthwatch interviewees in all four case study sites. One Healthwatch organisation had conducted a consultation with service users to influence the local authority's decision-making on whether to raise Council Tax – 'it was actually talking to real people', which included views from a group of older people: '… and one of them said, "I'll just start practising to eat less from now". It's that sort of stuff'. Healthwatch planned to go back and follow up to generate 'evidence'. A Healthwatch officer in another authority was less confident about their ability to really understand what was happening in relation to older people in their homes, where more and more care is being delivered, because they have no right of entry. The third Healthwatch organisation felt that they had not had a particularly strong focus on adult social care, partly because the failing NHS trust had generated more pressing issues for patients. Their attempts to locate social care users had included outreach to supermarkets, market stalls, GP surgeries, community centres and outpatient departments, with limited success:

… although we've done quite a lot of outreach in areas where we would expect people to be in receipt of adult social care or to be a relative of somebody in receipt of adult social care, we get almost no feedback about it from people.
(Healthwatch)

It was widely suggested that the next five years were unlikely to bring a solution to the funding pressures facing the health and social care system. The consequence of this for users was felt by some to be extremely serious: 'People will be dying in their homes… alone. Or suffer' (voluntary and community provider).

Pressure on hospitals – the human cost to older people

The experience of discharge: Ann's story

They didn't tell me when I went in, I'd have to be non-weight-bearing for a month. Nobody mentioned that to me. So therefore, I'd have to hop. But they came to see me to say, 'well, we don't think you're ready to come home, so we're going to send you to a nursing home or county hospital'. I said, 'who's going to look after my husband? Are you sending him as well?' Oh no. They now wanted the bed, they wanted to get rid of me. I didn't want to be in the hospital, I wanted to be home, but they said I couldn't come home. So I said, 'I thought I was entitled to a week's care'. They said, 'there isn't any care at the moment'. They are in crisis. There is no care. They haven't got enough trained-up people. They did nothing. Now, I didn't know I could have asked for a social worker, nobody told me that. They said, 'well as you're refusing to go to a nursing home or to a community hospital, we'll have to consult your daughter'. Well I'm afraid that was the final straw, I blew my top and said, 'my daughter doesn't have power of attorney over me. I have all my faculties'. I said, 'I'm looking after two other people, I make my own decisions'. And they said, 'well we'll just discharge you then'. Just like that. And by this time I was so fed up with them, I just thought, get on with it. Get on with it.

So, ten o'clock, Saturday night, I'm sound asleep, the nurse comes in and wakes me up, she said, 'we're moving you'. I said, 'you're not, I'm going home tomorrow. There's all this equipment, all my things'. She said, 'oh we've got to move you, they're bringing someone down from the [X hospital]…' I said, 'then you'll have to drag me out of this bed, because I'm not moving. I'm going home tomorrow, that's that'. She said, 'well I better consult someone higher'. And off she went. She came back at half past eleven, and woke me up to tell me they'd decided not to move me. But the nurse was so… it wasn't the nurses, it's the people controlling the nurses, that is so sad.

The most directly visible element of the health and care crisis lies in the difficulty in getting people out of hospital. As discussed in the next section on the NHS, cuts in local authority budgets are only one dimension of an extremely complex problem. In our interviews, there was a common theme that, regardless of the underlying cause, it was older people and their families who bore the brunt of the problem:

> *It's upsetting from most patients' perspective… people are frustrated – the staff are frustrated for patients and patients are frustrated themselves if they are here when they know they could and should be elsewhere.*
> (NHS provider)

In three case study sites, interviews from the NHS brought evidence – albeit soft evidence – of delays caused by families, possibly attempting to delay having to fund their own care, or worried about the quality of care homes, or disputing whether a person should be going home at all. A similar view was expressed by a local authority director who said they had experienced conflict with families who wanted their relatives to be 'tucked up' in residential care rather than returned home.

While there was no consensus that social care cuts were causing pressure on A&E departments, interviewees across all the case study sites offered examples of 'something' having failed, leading to older people turning to emergency departments as a last option.

> *One of the GPs came to us and said, I have this elderly lady who lives by herself, I went to see her and she said, 'Can you put me in hospital over Christmas just so at least I've got someone to talk to?'*
> (Local authority)

Two interviewees raised concerns about the national policy/narrative to prioritise home care above bed-based care (residential, nursing or intermediate). Although the description of home care being a cheaper option for commissioners was not disputed for short-term goals, it was felt that the increasing acuity of older people's needs meant that this may not be suitable in the future, particularly for those social care users with 'very limited input' because of short visits from carers, who are at risk of isolation (voluntary and community sector provider).

The way we're going is not sustainable, I think we've closed so many homes and the emphasis has been on keeping people within their own home, and for me personally I'm not sure that that always works. There's people with very, very, very heavy need… some of them suffer terribly from loneliness.
(NHS provider)

Not addressing these issues was expected to lead to a 'repeating pattern' of pressure on the NHS, with more people in hospital and more episodes of delayed discharge.

Carers and families

If there was an area in which some of the local authorities felt standards had slipped, it was in relation to carers. Two of the local authorities reported this: one said it was a 'more negative picture' for carers, based on falling satisfaction levels in their carers' survey; another also reported that carer satisfaction had fallen, conceding that they had sometimes 'dropped the ball' in relation to carer assessments.

> ### The experience of organising carers through direct payments: a carer whose mother has MS
>
> We get all the admin to do. We're in such a big package and a big need for care, we then have to employ enough carers to cover the hours and then do a rota – which my sister does – which you'll see on the table up there. I'll make sure that there's carers here to come in when Mum needs them and that they can all cover… And then they're all on holiday because they're all then entitled to holidays and then we have to have… holiday sheets so they can write on when they're on holiday… because we're not experienced employers… I'm not experienced in employment law. And there isn't a lot of back-up for you. There is supposed to be a third party – I can't remember what they're called now – charity. They're a charitable institution that's supposed to help with taking people on at first. But they haven't helped us with any of that recently… And a few of them, we've taken on through word-of-mouth or 'Someone's got a carer that's really good and she's looking for some…' That sort of thing. But there isn't really… We've fallen lucky with our girls but it's a bit difficult to know whether these girls are trained to do what they're doing.

The experience of moving from self-funding to continuing care: Pat's story, as told by her partner

We didn't know anything about care or rights or anything like that. So, at the time the council provided the care and it was 40 hours per week. So, Pat had to put up... because Pat needed from the beginning 24-hour care, Pat had to put money from her pocket, to the point that she had to re-mortgage her house because there was no money to pay for the carers.

But, the breakthrough was probably about three years ago when... I just thought, you know, the money is not going to last Pat, and I started to approach the council again, and it was when the financial crisis happened, so they told us you're wasting your time, you know, what's given is what it is. But, I don't know why, I persevered, and I persevered for over a year... [and] managed to get the acknowledgement that she needed health care and not social care and that's what transformed Pat's life in terms of funding, suddenly she had money to pay the carers a good salary, there was money to pay for training, there was money to pay for holidays, for bank holidays. It is to do with the fact that they acknowledged Pat had health care needs.

The future

I think the bigger question that we've got to ask ourselves is what the general public want, what do we want, what does the government want… if we had a better plan… we wouldn't be at this point.
(Social care provider)

In all areas interviewees spoke of the need for better self-management by users and greater involvement from families and the wider community in the provision of care for those in need. This was often talked about as a remedy to what was viewed as an almost paternalistic state provision: one interviewee stated, 'We've made people dependent on services' (NHS provider), and another said, at present we are 'sucking people into the social care system' (local authority). Others described this as being a direct result of reductions in public funding – 'care will have to come from people's pockets' because services such as meals on wheels, which have recently been reduced, will not be replaced in the future (voluntary and community provider). In a different (more affluent) area, the local authority prediction was that, in the future, the role of the authority would be to provide information and guidance rather than support.

'Asset-based approaches' and increasing individuals' 'social capital' were frequently described as necessary solutions to the lack of capacity in social care. These were defined as building up local volunteering schemes, 'encouraging neighbourliness', community participation, 'revitalising' the VCS, more involvement from friends and family, and better self-management. However, it was recognised that this required a cultural shift in perceptions that would be difficult to achieve. One interviewee suggested: 'I'm not sure the population are ready'. Another commented that the local authority itself needed to 'articulate better our community offer' in order to make this new approach a success. A Healthwatch interviewee welcomed the introduction of an asset-based approach but thought that while this was 'accepted wisdom' in the council, they had not brought the public with them. It was also suggested that individuals will need to better prepare for the financial cost of their care in later life.

1 2 3 4 5 **6** 7 8

6 The NHS

The national picture: what do we know?

Hospitals: rising admissions and delayed transfers of care

Older people are the biggest users of hospital care, accounting for 62 per cent of total bed days in 2014/15; those with longer stays (of seven days or more) accounted for 52 per cent. As the bulk of ill health occurs at older ages, the presence of predominantly older people in hospital is unsurprising, but there is growing concern about the increase in delays over the past five years experienced by older people who are medically fit for discharge but unable to leave hospital ('delayed transfers of care'). It has been estimated that the NHS spends around £820 million a year keeping older patients in hospital who no longer need to be there (**National Audit Office 2016**).

It is not clear how far the cuts to publicly funded social care have driven this. The official dataset attributes delays to the NHS, social care or 'both'. Although the number of delayed days due to social care reasons has risen sharply over the past 12 months, over the past five years at least 60 per cent of delayed days every month have been attributable to the NHS (*see* Figure 9).

Figure 9 Who is responsible for delayed transfers of care? Delayed days by responsible organisation, 2010 to 2016
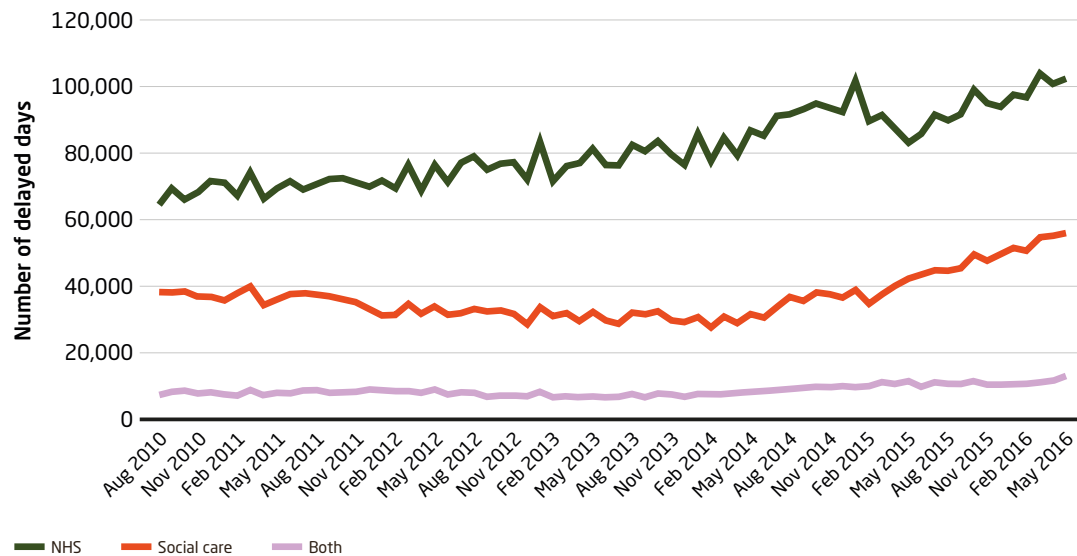
Source: NHS England 2016a

Looking beyond organisational responsibility to the underlying causes of delays, there has been a rapid rise in waits for care packages at home (*see* Figure 10), up 163 per cent over the past five years and by 40 per cent in the past year alone. In contrast, waits for public funding are now lower than they were five years ago and have never accounted for more than 4 per cent of all delayed days over the past two years. Escalating numbers of delayed transfers now appear to be symptoms not simply of insufficient money but also of problems of workforce and service capacity as well as poor co-ordination and information sharing between different parts of the system (National Audit Office 2016). They reinforce concerns about the fragile state of the home care provider market discussed earlier.

Figure 10 Delayed transfers of care from hospitals, 2010 to 2016 (number of delayed days by reason for delay)

Legend:
- Awaiting completion of assessment
- Awaiting public funding
- Awaiting further non-acute NHS care
- Awaiting residential home placement or availability
- Awaiting nursing home placement or availability
- Awaiting care package in own home
- Awaiting community equipment and adaptations
- Patient or family choice
- Disputes
- Housing – patients not covered by NHS and Community Care Act

Source: NHS England 2016a

There have also been concerns about the impact of social care budget pressures on the 'front door' of hospitals. In the past five years, emergency hospital admissions of older people have risen by 18 per cent (for the general population it was 12 per cent). Some 50 per cent of older people attending A&E were admitted to hospital, compared with 16 per cent for those aged under 65 (**Health and Social Care Information Centre 2015b**). There are wide variations between hospitals in the proportions of

older people they admit, how long they stay and how quickly they are discharged (**Public Health England** *et al* **2015**). Social care pressures could be a factor in rising rates of admissions of older people but so could shortfalls in primary and community health services, and the complex clinical needs of patients.

Primary care has also been under pressure. Recent research by The King's Fund found that the number of patient contacts taking place in general practice grew by more than 15 per cent between 2010/11 and 2014/15, with the greatest increase in activity seen among the oldest age groups. The total number of contacts with patients over 85 increased by 28 per cent over the same time period. (**Baird** *et al* **2016**). At the same time, primary care has been experiencing funding and workforce challenges. An overall increase in GP numbers has not kept pace with an ageing population, so the ratio of full-time equivalent GPs to the number of people in the general population aged over 85 has fallen steadily (*see* Figure 11).

Figure 11 Number of full-time equivalent GPs per person aged 85 and over
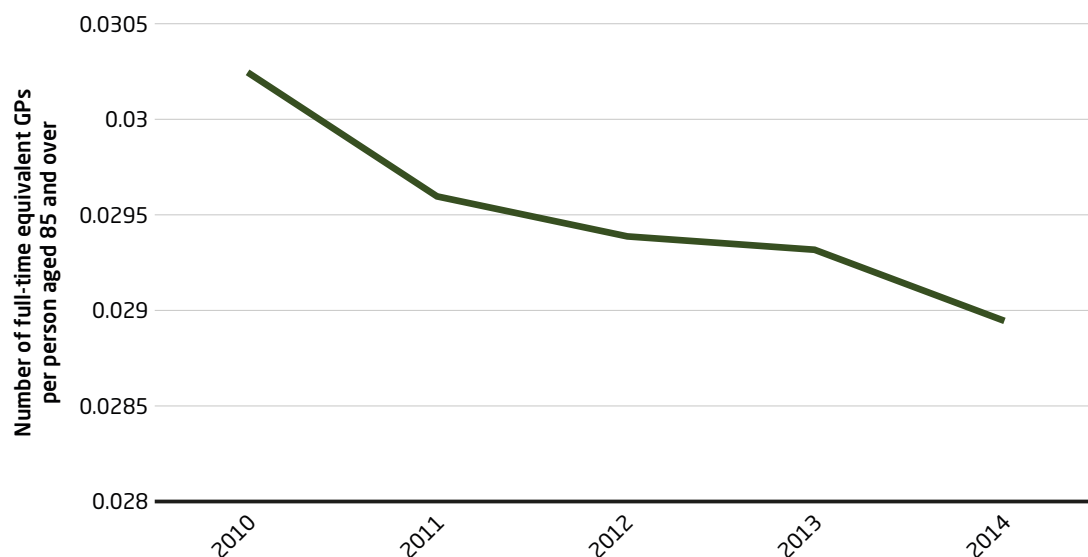
Source: **Health and Social Care Information Centre 2015a**

Over the same period, funding for primary care as a share of the overall NHS budget fell each year – from 8.3 per cent to just over 7.9 per cent (**Baird *et al* 2016**). In recognition of the pressures facing general practice, NHS England recently committed to increasing recurrent funding of primary care by an estimated £2.4 billion a year (**NHS England 2016b**).

There is a lack of clarity about activity and demand in other community-based health services that are essential to keeping people with chronic, complex conditions well enough to live independently and stay out of hospital (**Oliver *et al* 2014**). For example, there is no robust national data regarding the activity undertaken by district nursing services, but available evidence points to an increase in the volume and complexity of caseloads over recent years (**Maybin *et al* 2016**). Yet despite increasing demand, there was a 28 per cent reduction in the total number of full-time equivalent district nurses between 2009 and 2014 (*see* Figure 12). Some of this reduction is likely to

Figure 12 **Number of full-time equivalent district nurses, 2009 to 2014**
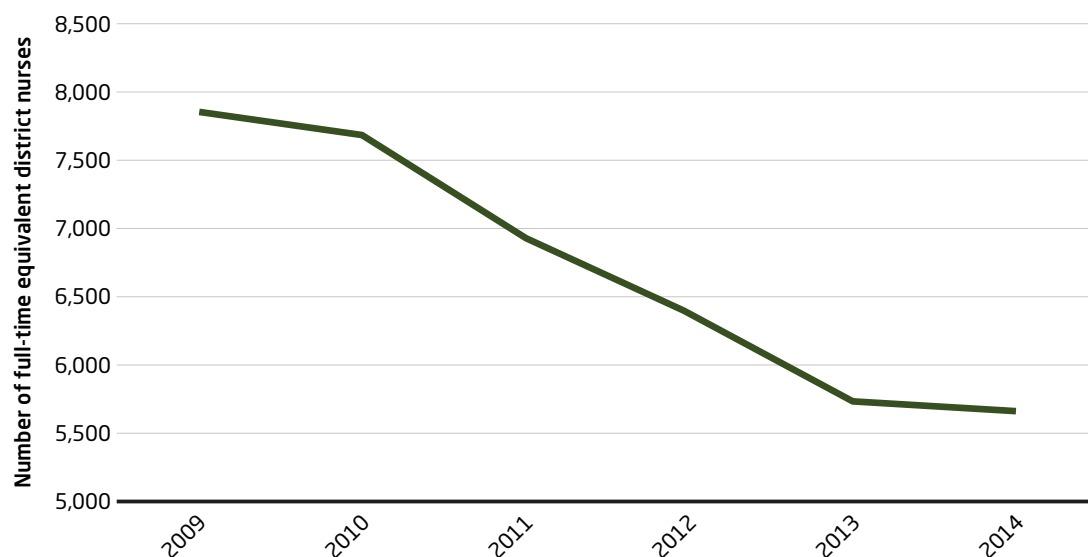
Source: **Health and Social Care Information Centre 2015c**

be accounted for by the transfer of staff to independent providers as part of the Transforming Community Services programme, but this is unlikely to be the sole cause as the decline pre-dates the implementation of the policy (**Addicott *et al* 2015**). Monthly workforce releases suggest this decline is continuing; the number of full-time equivalent district nurses fell by 13.6 per cent between March 2014 and March 2016 (**Health and Social Care Information Centre 2016**; **Maybin *et al* 2016**).

Intermediate care services are most often used by older people, and are designed to prevent unnecessary hospital admissions, support independence following a stay in hospital and prevent people having to move into a residential home where possible. Availability of these services varies widely across England, and has failed to keep pace with demand. The national audit of intermediate care suggests that the current level of spend on intermediate care is consistent with about a half of the capacity required to meet demand; and since 2013 it appears that capacity in health-based intermediate care has remained static while capacity in re-ablement services has reduced (**NHS Benchmarking *et al* 2015**).

The local picture: what we learned from our case studies

The picture painted in our case studies was of a health system under huge pressure, but one that was reluctant to attribute these pressures in any simplistic way to the budget reductions in social care. Factors contributing to this pressure, across all sites, as identified by those we interviewed were: the growing demand on NHS services in general, the lack of availability of temporary and permanent support packages and placements post-discharge (particularly in the home), and the reduction of NHS community services.

Discharge from hospital

At a national level, delayed transfers of care have become emblematic of problems in social care, and it was the same story in all our case study areas. Although the national data captures 'reasons' for delay, and ascribes causation to either the NHS, social care or 'both' (*see* Figure 9, page 55), most interviewees described a complex and interdependent set of causes behind delays in discharging older people.

Prominent among these factors was a lack of social care services, in particular nursing homes, beds for older people with social care and mental health needs,

re-ablement places and, particularly, home care packages. These services were described as having a mutual dependency, which ultimately had consequences for acute hospitals. For example, if increased demand for home care was not matched with availability, the lack of access to services would then cause a slowdown in the flow of people through re-ablement, which then results in delays in discharging patients from hospital.

As one local authority interviewee commented:

> *I think it is about… accessing home care… what has tended to happen is our enablement service has silted up: can't get people off the other end and that washes back into the hospital situation.*
> (Local authority)

Additionally, the complexity of need people had when leaving hospital or re-ablement-type services was described as an important part of the delays. Getting the right, specialist placement for those with high levels of need or behavioural problems was seen as difficult in two areas.

A few interviewees were reluctant to attribute these challenges solely to reductions in local authority funding. For example, a CCG interviewee suggested that it was too simplistic to argue for a direct causality: 'I don't think you can say local authority budgets have been absolutely plundered, ergo health is now completely on its knees'. This was in part because some of the difficulties in sourcing suitable community-based services were also felt to be in part the fault of NHS commissioners. One local authority interviewee criticised its local CCG for having focused too heavily on its acute trust and not on its community services. A CCG interviewee explained that, in district nurses alone, their local community nursing numbers were short of around 20 staff members. Two areas talked about poor-quality primary care or a lack of capacity development training as the source of much of the pressure facing their local acute and social care services (local authority).

NHS payment mechanisms were seen as compounding the problem by driving negative/unco-operative behaviour in acute trusts. One CCG interviewee, describing the local hospital trust, said: 'because they [the trust] are severely

challenged, it also drives a lot of behaviours that make them try to balance the books'. Another interviewee gave an example of their trust's behaviour – attempting to discharge patients without co-ordinating with the wider strategy:

> *We've got the hospital decanting people into a spot bed, which takes up a residential place that we could probably be better using… you do things because the person who's got the whip isn't interested in the knock-on impact.*
> (CCG)

A third area had commissioned an independent research report into the hospital's discharge of older people, which found that it was creating 'completely unnecessary' bed-based discharges. In the same area, a discharge to assess scheme was set up, whereby patients were automatically discharged into a short-term bed and comprehensively assessed once out of the hospital. This was criticised for having benefited the hospital by shortening the length of stay but using up residential home capacity, in some cases inappropriately. The interviewee noted that the gains for the hospital were only temporary, as the capacity issues in social care meant that they were soon back to having delayed discharge.

Another complicating factor in discharging patients, described by two interviewees, was the requirement of hospitals to consider the patient's choice of post-discharge plans. One interviewee suggested that patients' families feel as though their relative is 'safe in hospital, so there's no rush to find, you know, a home for their mum' (NHS provider). Patients are given the opportunity to wait for a placement that they think better suits their needs, 'And the issue drags on' (local authority). At a national level, delays caused by patient or family choice accounted for 11 per cent of all delays in May 2016 (**NHS England 2016a**).

From the patient perspective, there were concerns about people's independence when they left hospital after an extended period of admission: 'We have the effect of a lot of patients being here that don't need to be. And it isn't right for them to be here from a health perspective, let alone from an efficiency perspective' (NHS provider). The consequences of this were seen as self-defeating: people waiting in hospital could often become less robust and subsequently require more intense health and social care support when they were eventually discharged.

Increased demand for NHS services

The problems facing the social care sector were also implicated in the rising admissions and pressure on the front door of the hospital, albeit they are harder to quantify:

> *The most visible parts are the delayed transfers because it's easier to count, it's very obvious. But I would say the arrival of patients with a care package who, with an alternative set of options out in the community, never would need to come to the hospital is an equal problem, definitely.*
> (NHS provider)

The increased acuity of need of A&E attendees and those being admitted to hospital was noted by a number of interviewees. One commented that older people were arriving in 'genuine need of care and support' (Healthwatch). This was explained in part by the ageing population. Others, however, suggested that it was as a result of a lack of suitable care in the community and a reduced focus on preventative care. One interviewee outlined the position from her perspective in her area, stating that more older people were becoming unable to cope living at home by themselves, causing an increase in demand in primary care, community services and the acute hospital:

> *It is not necessarily that there are more people that are being admitted: it is that there are people being admitted more times… there's certain parts of the population that are just not getting the response that they need and, therefore, are knocking on many doors.*
> (CCG)

A Healthwatch interviewee summarised the situation as 'talking to GPs I get a feeling that they think people are coming to them because they have a social need rather than a health need'. A social care provider in the same area stated that local authorities' ambitions to care for people in their own homes had resulted in some older people becoming 'expensive', 'revolving door cases' in A&E. Another described the 'vicious circle' caused by focusing social care budgets on those most in need and not providing sufficient preventative, 'downstream' activities that could

minimise falls and other issues that result in admissions to hospital where people 'decompensate' and come out needing more nursing support.

Perceptions of the fragility of support for older people in the community, and the risks facing people with little or no support, were also seen as affecting the decisions of admitting doctors in acute hospitals in two of our case studies. One interviewee described some of the doctors as 'risk averse' and the other suggested that, in some instances, doctors were admitting patients in the absence of alternative available care options.

7 Strategies to improve care and support for older people

The national picture: what do we know?

Many aspects of the national policy framework through which social care for older people is delivered reflect long-standing policy objectives that pre-date the coalition government formed after the general election in 2010. This includes the policy of personalisation, based on the use of personal budgets and direct payments, renewed emphasis on promoting independence through prevention, re-ablement and the use technology, and the continuation of existing strategies for dementia, carers and the social care workforce. The most significant and substantial policy developments in the past five years have been major legislative reform and new initiatives to improve the co-ordination and integration of services.

The Care Act 2014

The Care Act 2014 came into force in in April 2015. The Act was the most significant reform of social care in more than 60 years, consolidating a complicated legal framework dating from the beginning of the welfare state and building in significant new rights and responsibilities. However, implementation of Part 2 of the Act – that would have introduced a cap on care costs and changes to means-testing – has been delayed until April 2020 (Hansard 2015).

The central change in the Act is a shift from defining social care as a set of interventions to the duty to promote wellbeing across a population.

Councils are charged with refocusing their activities from narrow service provision to paying attention to personal and community strengths and preventing care needs, rather than waiting until crises take place to address them. The Act introduces significant new rights for carers, widens access to advocacy and puts good practice

in information provision, co-operation, commissioning, adult safeguarding and integration into statute. It also introduces new national eligibility criteria, replacing the old, locally determined Fair Access to Care framework.

The Act was introduced through a relatively co-operative and cross-party political process, and broadly reflects the aspirations of the sector. But there are real and growing doubts about the feasibility of its ambition in the financially squeezed environment we are now in.

Integration of health and social care

Since 2010, the government has introduced a number of measures to achieve this long-standing policy objective. The Better Care Fund is a national initiative set up to encourage CCGs and local authority commissioners to work together using a pooled budget, worth £5.3 billion in 2016/17 (**Department of Health 2016a**). The money is intended to be spent on social care services that have a health benefit. Successive payments of funding are predicated on local areas being able to demonstrate success.

In 2013, the government selected 14 integration pioneer sites across England to trial different approaches to joint, integrated working. The process was then repeated when a further 11 pioneer sites joined the programme in January 2015. These 25 sites aim to draw on collective expertise, including from the voluntary and independent sector, to improve quality across health and social care (**NHS England 2016c**).

Social care is an important element of the new models of care announced in the *NHS five year forward view* published by NHS England and other national NHS bodies in 2014 (**NHS England** *et al* **2014**). A total of 50 'vanguard' sites have been chosen to take a lead on the development of new care models. They will act as blueprints for the rest of the NHS and can be adapted to meet the needs of different local populations. The three types of vanguard model in which social care is most relevant are:

- integrated primary and acute care systems – joining up GP, hospital, community and mental health services

- multi-specialty community providers – moving specialist care out of hospitals into the community

- enhanced health in care homes – offering older people better, joined-up health, care and rehabilitation services.

The November 2015 Spending Review and Autumn Statement announced that all areas would be required to submit plans for integration between social care and the NHS by 2017, to be implemented by 2020 (**HM Treasury 2015**).

The local picture: what we learned from our case studies

Improved relationships?

Solutions to the challenges facing the health and social care sectors were seen by our four case study areas as emerging from improved relationships between the health and social care sectors. Co-ordinated, joint working was described as a vital step towards creating a culture in which the pressures caused by increased demand, reduced budgets and inefficient processes were seen as a shared problem.

> *We're finding ways of working together between health and social care and across the providers… because there's no point the hospitals just going on and on about the fact that there isn't enough residential home care capacity… there isn't and you can't knit it any time soon.*
> (CCG)

One of the case study sites was moving towards creating a single integrated care organisation with a single commissioning function. In addition to improving processes and the flow of people between sectors, the scheme was also trying to change cultural differences and silo working. One interviewee commented that the 'crisis' situation had forced the services to work more closely together, more effectively, and others noted that the creation of the Better Care Fund had facilitated a new approach to tackling the issues that blurred traditional boundaries between sectors:

> *You had a whole range of offers from the practices, that started to blur… health and social care needs [… the Better Care Fund] has started to get GPs to think beyond the medical.*
> (CCG)

In one of the case study areas, nearly all of the interviewees mentioned the beneficial impact of their System Resilience Group as a way of improving communication between providers and commissioners.

Despite these strategies, some interviewees reported signs of frustration and a lack of understanding between the sectors. For example, one social care provider expressed resentment at local authority budgets being decreased more than NHS budgets, particularly when, in their view, the NHS was unable to manage its own budgets effectively. However, an NHS provider in a different area suggested that, for the local authority, 'money is the driving force' whereas in the NHS, money is important 'but less important compared to the quality in health'. One interviewee suggested that it was 'problematic' having different accountabilities between the NHS and local government, with the director of adult social services as a single point of accountability in the local authority with a great deal of pressure on them not to overspend (CCG). Another CCG interviewee echoed this sentiment by stating that local authorities are held to account by their councillors and public whereas accountabilities are much more diffused in the NHS, spread across CCGs, providers and NHS England.

Similarly, many interviewees outlined the intense demand and cost pressures facing their local acute trusts, summarised by one interviewee as: 'We are the only service around that still says yes to everything' (NHS provider). However, two providers suggested that their acute trust 'sucks' resources and services into it. This was seen to cause tensions between local providers and act as a barrier to new models of care, with commissioners needing to 'wrestle' money out of the trust to spend it on community-based services (social care provider).

Three interviewees described unco-operative and individualistic behaviours among health and social care commissioners. In one area, the local authority was accused of 'cost shunting' because it was reassessing its Continuing Health Care (CHC) files to see if the CCG could be retrospectively charged for some users (CCG). The local authority itself said it was supporting users who were 'obviously' eligible for CHC and that if the CCG tried to fund these additional cases as part of the Better Care Fund plans, it would be 'counterintuitive' and against the 'spirit' of the Better Care Fund. A local authority interviewee in a different area also said that they were supporting an increasing number of users with highly complex needs without receiving any additional funding from the NHS. One social care provider suggested that their care workers were filling the gap left by declining numbers of district nurses and were therefore performing tasks beyond their pay grade.

Integration and the Better Care Fund

Integration of services and funding was a continuing focal point and source of optimism across the four areas. Interviewees described integration as a way of redistributing resources between the sectors, creating more 'equitable funding'. As one CCG interviewee commented, when thinking about the individual in need of care: 'It goes back to the whole point of, "Who's paying?" and "Why does that matter?"'.

In addition to collaboration over commissioning budgets, examples were given of plans to integrate provision over the next five years. One area described its ambition to create a co-designed, integrated pathway for older people, mental health and children's services, to be commissioned through a pooled budget. Another was piloting a multidisciplinary, community care team.

Outside health and social care, one area referenced its collaboration with the local fire service to undertake preventive work and joint assessments. Another talked about the value of working with the breadth of the voluntary and community sector including, for example, harnessing the value of local faith groups.

The pooled budget created by the Better Care Fund was used in our case study sites in a number of different ways, including:

- discharge to assess services

- early multidisciplinary team assessments

- general funding for packages of social care, some specifically to meet unfunded increases in demand due to demographic growth

- seven-day working programmes

- community and district nurses

- hospital-based, salaried social workers

- case management

- therapies and re-ablement services

- investment in improved relationships/communication between the local authority and CCG.

Two areas described the Better Care Fund as being a useful mechanism for improving ways of working between the sectors and, in particular, for encouraging NHS colleagues to think about patient/user care in a more holistic way. Another described the process as being of benefit to the relationship between the commissioning bodies and that they were moving towards integrated commissioning rather than, for example, sharing the costs of salaries.

However, beyond that, opinions on the Better Care Fund were predominantly negative. The administrative process of submitting the plans was described as a 'disaster'; there were difficulties in getting it signed off from NHS England because the CCG's original suggestions were 'further ahead' than what the Fund was trying to achieve (CCG). In one area, a Healthwatch interviewee suggested that, rather than being a shared or joint process, the plans had been dictated by the CCG without much space for collaboration with the local authority.

Two areas made reference to the fact that collaborative working between their local authority and CCG pre-dated the Better Care Fund. In one area, the announcement of the Fund was perceived to have actually set integration plans back by a year and half while the CCG responded to the national policy. Another area echoed this sentiment, stating that their plans were not particularly innovative – 'Frankly, we just took all the budgets we currently shared and bundled them up' (CCG). The interviewee described the process as an 'unnecessary reworking of stuff we're already doing' and, consequently, felt much more confident in the Vanguard new models of care work as a mechanism for innovation (CCG).

There were also some wider concerns about integration. With reference to their local integration initiatives and the need to involve the private and voluntary and community sectors, one social care provider said: 'If we look at working together as a proper team then I think the future is looking quite good, but I'm not holding my breath to be honest'. Another interviewee expressed doubt about the vanguard programme's ability to deliver change at the scale and pace needed (NHS provider).

Improving community-based care to prevent admissions

Establishing better links between care homes and primary and secondary care, or up-skilling staff in care homes, were schemes that three of our areas had established in order to prevent unnecessary admissions to hospital. In two areas, social care

providers outlined their plans to set up NHS-funded support for people with complex health and care needs. One area talked about plans to create medically led rehabilitation or temporary beds with support that would be more intensive than is currently available in nursing homes; these would, therefore, require CQC registration. The ambition was two-fold: to create extra capacity in the care home sector and to support those who otherwise would be taken to A&E:

> *Our referrals ideally would come from GPs and paramedics, they're going to find people who otherwise would be blue-lighted to the acute sector but may be blue-lighted to our ones [homes].*
> (Social care provider)

The second example was that of a care home provider that had set up a re-ablement unit for patients being discharged from hospital. This pushed the provider beyond its normal nursing home provision into creating specific units with a gym and a physio to support people to return home.

Two areas had set up multidisciplinary community-based teams that were located in local GP centres. One of these involved a community navigator whose role was to promote social prescribing and other similar activities. The other included wider tasks to tackle social isolation such as befriending and home visits.

Assessment and discharge

All of the case study areas were refining their assessment and discharge models in acute hospitals. Interviewees outlined the complex process of discharging, particularly for hospitals dealing with multiple local authority areas, each with differing eligibility criteria and models of provision. One NHS acute provider was in the process of trying to get agreement among the local authorities in their area for a single, generic social work assessment that would, in their view, reduce length of stay. This would signal a return to when hospitals had an in-house social worker who did all the assessments, rather than waiting for a social worker from a local authority to do the assessment themselves. However, they were facing some resistance from the local authority, which was concerned about an 'impact on their resources' if someone other than its staff conducted the assessment (NHS provider).

In order to reduce the wait for social care funding, one hospital and local authority had changed the way in which funding assessments took place. Rather than having a set quota per week, with the funding board/panel meeting once a week, the local authority had agreed to accept individuals as needed. The result was: '[We are] not having any delays now for local authority funding, which is positive' (NHS provider).

One area had tried to stimulate more efficient ways of managing assessment and discharge by co-locating hospital and social care staff members in order to improve communication. What was previously described as 'quite fragmented and quite distant' was now 'much improved' because of this change (NHS provider).

As mentioned previously, one area set up a discharge-to-assess model. This was described as having improved the flow in hospitals temporarily but subsequently caused delays in accessing social care due to their reduced capacity. The local authority in this area outlined plans to create a single team of occupational therapists operating in local health and care services as well as, alongside that, designing an enablement service that was therapy-led.

Technology

Three areas suggested that the use of digital aids and technology was going to be an important part of improving care in the future. In one case study area, which has an affluent population, a social care provider interviewee described the investments they were making to increase capacity and make better use of technology. This company was building new homes aimed to be 'attractive propositions' to the self-funder market, though it also wanted to get a mix of publicly funded users and work collaboratively with local NHS providers. In this new development, the ambition was to give staff hand-held devices that would allow them to update care records instantaneously. Users and their families, where authorised, would also be able to view this information and be able to send messages via an online portal.

8 Discussion: the future of social care over the next five years

Somebody in government, or somewhere, needs to look at whether they care about their old people or not.
(Voluntary and community sector provider)

In our conversations with local authorities, social care providers, the voluntary sector and the NHS, we heard an amplification of messages that will be familiar to those who have watched the social care sector over the past five years: social care providers under pressure, struggling to retain staff, maintain quality and stay in business; local authorities making unenviable choices about where next to wield cuts; NHS providers scrambling to get older people out of hospital before they deteriorate; and the voluntary sector keeping services going on a shoestring. Collaboration and innovation are taking place despite the odds, but no one was very optimistic about the future.

We began our study with a question about what all this meant from the perspective of older people. Three things stand out from the interviews in our case studies.

First, no one has a full picture of what has been happening to older people and their carers as local authority-funded social care has taken a battering from austerity. Although it is clear that fewer people are now eligible for social care than in the past, we do not know how well they have managed to put in place support for themselves, or at what cost to their carers' and family members' health and wellbeing.

Second, the gap in experience between those people who happen to have their own resources, or live in an area with more social care, and those who do not has widened. As we have seen, the gap will be greatest in those places where local

authorities have been least able to sustain spending levels. In other words, an unfair situation has become worse.

Third, local authorities' vision of an enabled, independent older citizen, supported at home by family and community, turning to the state for care only in extremis, requires a vibrant voluntary and community sector, family members able and willing to play that role, and health and care services fully geared up to support people in their homes. We have not found evidence of these things being in place.

Below, we offer an assessment of the choices ahead, informed by our research and the voices we have heard.

The financial context

Looking ahead, spending on social care is likely to be broadly flat in real terms over this parliament, taking account of the additional Better Care Fund money that will be allocated directly to local authorities from next year, reaching £1.5 billion by 2019/20. The government's current spending plans are based on a reduction in public spending from 40 per cent of gross domestic product (GDP) to 36 per cent by 2021 (noting that these figures will change as a result of the referendum vote to leave the European Union). If the government's current assumptions about how much will be raised by the social care precept over the next five years are correct, spending would rise by an average of 0.6 per cent a year. Under an alternative, less optimistic estimate, spending would fall by an average of 0.4 per cent a year (*see* Figure 13). Local authorities in poorer areas with a low Council Tax base will be able to raise much less through the precept than richer areas – ranging from £5 per head of adult population to £13. These areas also happen to be places with relatively high levels of need for publicly funded social care (Humphries 2015).

These scenarios are an improvement on the past five years, when spending on social care fell by an average of 2.2 per cent a year, but it will not be enough to meet projected cost pressures of 4 per cent a year (**Wittenberg and Hu 2015**). The funding gap by 2019/20 will be £2 billion or £2.7 billion, depending on how much the precept raises. On a conservative assessment, implementing the National Living Wage will add another £800 million to these estimates (**Local Government Association *et al* 2015**). Overall, the social care funding gap is likely to

Figure 13 Social care spending 2009/10 to 2019/20, real annual changes
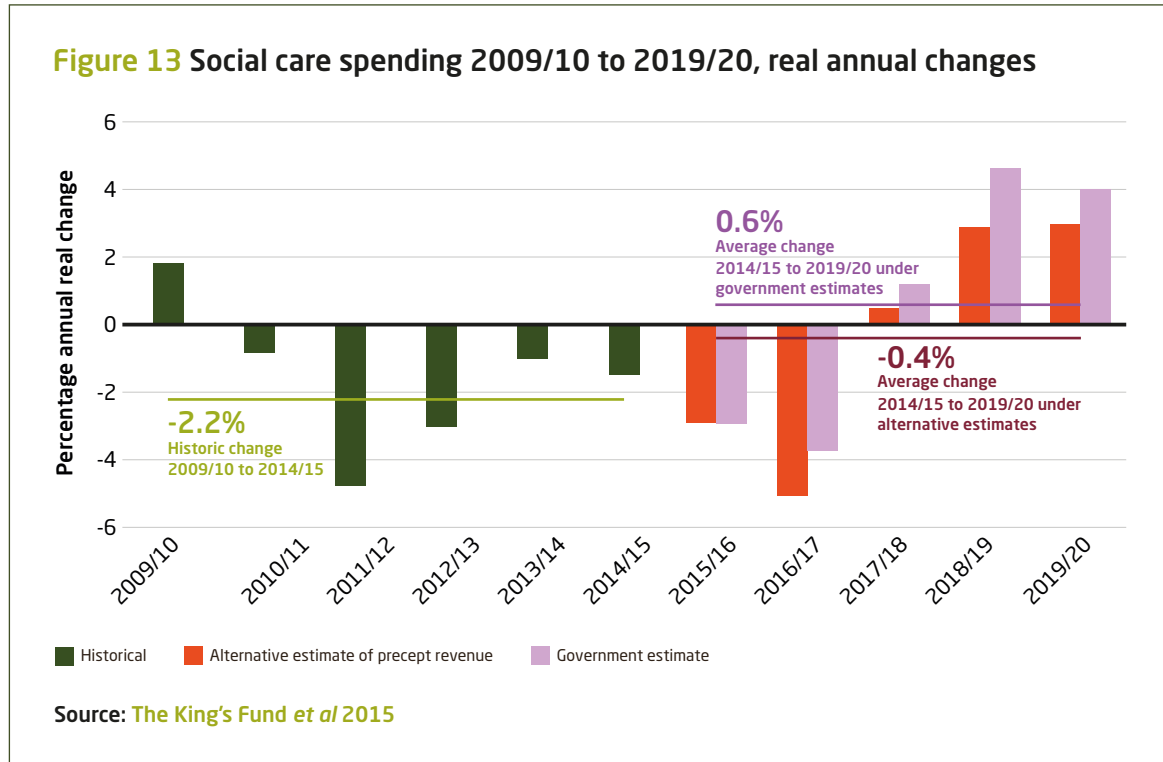
be somewhere between £2.8 billion and £3.5 billion by the end of the parliament. Public spending on social care is set to fall to less than 1 per cent of GDP by 2020 (**The King's Fund *et al* 2015**).

It is no wonder that with the Care Act 2014 placing new expectations on local authorities, just 36 per cent of directors of adult social services are fully confident that they can meet their statutory duties this year, and only 2 per cent are confident they can do so in 2019/20 (**Association of Directors of Adult Social Services 2016**).

The policy context

Efforts to place the funding of social care on a sustainable footing have eluded all governments since 1997, despite the work of four independent commissions (the Sutherland Royal Commission in 1999 (**Royal Commission on Long Term Care 1999**), Wanless in 2006, Dilnot in 2011 (**Commission on Funding of Care and Support 2011**) and Barker in 2014 (**Commission on the Future of Health and Social Care in England 2014**)). England remains one of the few major advanced countries that has not reformed

the way it funds long-term care in response to the needs of an ageing population – although it has introduced new legislation, the Care Act 2014, that has raised expectations of what the system should offer.

At the local authority level, the government proposes to replace the central government grant so that councils will become wholly reliant on locally raised revenue through council tax and the retention of business rates (**Department for Communities and Local Government 2016**). It is not clear how this will affect individual local authorities but making the funding of essential care services dependent on the level of local property wealth and economic activity introduces a new set of uncertainties. This could increase the risk that access to care will depend on where people live rather than what they need.

Uncertainty also arises on a far bigger scale from the referendum vote in favour of leaving the European Union (**McKenna 2016**). It seems inevitable that social care, along with many other domestic policy issues, may be sidelined while the government gives priority to negotiating the terms of the UK's departure from the EU and new trade arrangements. If there is an economic downturn, this will affect public finances. A further concern is the potential impact on the social care workforce, 5.2 per cent of whom come from EU countries (**Independent Age 2016**).

So the prospect of any substantial change in the fortunes of social care is remote and it is now even less likely that the current government's commitment to implement the postponed Part 2 of the Care Act (introducing the cap on care costs and improvements to means-testing) by 2020 will see the light of day (**Hansard 2015**).

The future of social care for older people

The conclusions we draw from national data and evidence, our work with the four local authorities and their partners with very different circumstances, and the messages from older people and their carers are unequivocal. The social care system is on the brink. Although local authorities have absorbed a reduction of more than £5 billion in social care budgets over the past five years, at least 26 per cent fewer older people are getting help, unmet need appears to be increasing and more is being expected of unpaid carers. The needs and circumstances of older people who are no longer eligible for publicly funded care are poorly understood.

Our case studies illustrate that the combined impact of under-investment in primary and community health services alongside inadequate social care will make it harder for older people to get the right care, in the right place, at the right time. This perpetuates a vicious cycle in which older people are more likely to end up in hospital or in long-term care, in turn creating further financial and service pressures. Future prospects for older people will depend as much on where they live and what they can afford as on what they need. Expectations on families and carers will continue to increase, and more people will find themselves paying for their care wholly or partly from their own financial resources. Although new money available to local authorities this year through the new social care precept has enabled them to increase fees to providers, it is unlikely to be sufficient to stabilise the market. The home care market in its current form is not sustainable.

It is clear also that the challenges facing social care are now as much about workforce as they are about money. The availability and quality of care is threatened by mounting problems in staff recruitment and retention, underpinned by a culture of low pay and under-investment in training, and by the reliance in many areas on migrant workers (**Kingsmill 2014**).

Policy challenges

Based on the national and local evidence we have considered in this report, there are three major strategic challenges facing policy-makers in shaping how the adult social care system could develop over the next five years.

Achieving more with less

If there are no fundamental changes to the level and adequacy of social care funding in the foreseeable future, statutory responsibility for managing the pressures and challenges we have described will rest on the shoulders of local authorities and their partners. This will mean working within the grain of the existing policy framework to achieve better outcomes with existing resources in some of the ways described in our case study sites. These include better management of demand, promoting independence, better commissioning and procurement and implementing models of integrated care that give best outcomes, rather than shunting costs between each other (**Bolton 2016b**; **Local Government Association 2016b**). The NHS has a key role,

too, avoiding commissioning practices such as poorly designed 'discharge to assess' schemes that increase costs. There is considerable scope for the NHS to achieve better value and release resources, but this will take time (**Alderwick** *et al* **2015**).

These efforts will be helped by recent attempts to bend national policies towards supporting systems of care rather than the funding and performance of individual organisations (**NHS England** *et al* **2015**). In our four case study sites we heard of the obstacles caused by organisational complexity, fragmented funding and transactional commissioner/provider relationships. A move towards a single pooled budget for the health and care needs of the whole local population will make it easier for local authorities and their NHS partners to agree on the best use of the public pound and to focus on services that can be shown to reduce the need for long-term health and social care, especially community-based services, and intermediate and asset-based approaches that promote independence and maximise the use of community resources. The creation of sustainability and transformation footprints, devolution deals and the emergence of combined authorities offer opportunities to develop approaches to the planning and funding of systems of care rather than individual organisations.

Many of the approaches to achieving savings through efficiency and transformation programmes described in our case study sites are being widely used by local authorities and have been assessed through the Local Government Association's Adult Social Care Efficiency Programme. This concluded that:

> *The challenges over the next few years are immense. Indeed, some councils are beginning to believe that they cannot make the level of savings required without putting their basic services for vulnerable people at risk. They would argue that a combination of increasing demographic pressures (which they can manage down no further) and rising costs (which have been held down for too long), added to the fact that they have undertaken all of the efficiency actions they believe possible, means they can cut no further. Some councils have already afforded a level of protection to social care services (adults' and children's) at the expense of other public services, such as buses, libraries and leisure centres.*
> (Local Government Association 2016a)

This encapsulates the experience and views of all our case study sites. Working within the grain of existing policies and best practice in the way we have described

to achieve 'more with less' is important and necessary but our conclusion is that these efforts will not in themselves be sufficient to meet immediate funding needs. In the words of NHS England Chief Executive, Simon Stevens, 'There is a strong argument that were extra funding to be available, frankly we should be arguing that it should be going to social care.' (**Stevens 2016**). The forthcoming Autumn Statement should recognise the likelihood of major provider failure over the next two years by bringing forward the additional Better Care Fund money planned from 2018/19 and accelerate progress towards establishing a single pooled budget for health and social care in all areas by 2020.

A major gap in the current policy framework is the lack of a coherent strategy to improve workforce capacity in the social care system. Quite apparent from the immediate pressures, modelling suggests that if the workforce grows in line with demographic trends, 275,000 additional jobs will be needed by 2025 – an increase of 18 per cent (**Skills for Care 2016b**). More multi-skilled staff will be needed to work across NHS and social care boundaries. The need to develop a fresh strategy for workforce development by the Department of Health, in partnership with independent sector organisations, local authorities and NHS England is now urgent.

Although this did not arise as a significant issue in our case study sites, there is good evidence about the importance of housing in reducing the need for health and social care services and offering care options that achieve better outcomes at lower cost. However, as with integrated care, housing-with-care schemes are not straightforward to design and take time to deliver (**Holland 2015**; **DEMOS 2014**). Moreover, proposed changes to how supported housing is funded through the benefits system have created uncertainty about the future of existing schemes and new developments (**Wilson 2016**).

A different offer

At a local level, our case study sites, like many local authorities, are redesigning their 'offer' to the public to reflect the limits of their resources; this involves greater reliance on individuals, families and communities. There has been little dialogue nationally – or, sometimes, locally – about this fundamental change.

At the national level, no government has ever made it clear to the public that responsibility for paying for care, and for arranging it, rests largely with individuals

and families, with public funding available only for those with the very highest needs and lowest means. Unless there is a major change to the upper means-tested threshold of £23,250, this is now the default trajectory of the adult social care system. Yet, while members of the general public are clear that NHS services are generally free at the point of use, their understanding of who pays for social care is much less clear (**IPSOS Mori 2011**). Lack of public awareness results in people having inappropriate expectations of the NHS and local authorities, and this creates distress for individuals and their families, distorts the efficiency and effectiveness of services and makes it harder for people to get the help they need. Unless the government is prepared to introduce a different system, it should establish a fresh policy framework that explicitly promotes a clearer public understanding of how the system works and encourages individuals to financially plan ahead for their care needs in the same way as they would for pensions.

This could see, for example, the creation of new financial incentives for individuals to make provision for care costs through the taxation, pension and benefits systems, such as 'care ISAs', and tax relief for spending on care costs; fresh discussions with the financial services industry to stimulate the development of better financial products, such as the promotion of immediate needs annuities; and the strengthening of advice, information and advocacy, possibly by linking it to pensions advice and planning (**Association of British Insurers 2014**).

An explicit re-casting of the social care system based on individual and family responsibility would have profound consequences for local authorities, the NHS and the social care market. For local authorities, it would confirm their role as operators of a basic safety net for the poorest people with the highest needs and as a system leader and market shaper working strategically with partners, rather than as a direct provider of services. For the NHS, and especially NHS providers, it raises some difficult issues about how care is co-ordinated with thousands of self-funding individuals rather than one local authority, for example at the point of hospital discharge. It will sharpen the division between health care that is free at the point of use and social care that is means-tested, with a risk of more conflict between individuals, professionals and organisations about who should pay. Social care providers, too, face similar challenges in understanding a market in which individuals – not local authorities – are their primary customers; in places with high levels of self-funding, independent providers may find collaborating with each other

in understanding market trends a more attractive proposition than competition. Providers in areas with low levels of self-funding, who are therefore reliant on local authority contracts, face an uncertain future.

While a new and clearer offer could lead to improvements for those who will have to pay for their own care, it will confirm beyond doubt the emergence of a two-tier system of care in which access to care will depend increasingly on where people live – and on their private wealth – not on what they need. As we have described earlier in this report, this is already being reflected in the polarisation of the social care provider market that will increasingly favour the relatively well off and well informed at the expense of the poorest people reliant on an increasingly threadbare local authority safety net and at a higher risk of declining quality and provider failure.

A more open and transparent approach to the respective responsibilities of the individual and the state may involve revisiting some of the new rights and duties created by the Care Act 2014 so that expectations are aligned more realistically with what the government is prepared to fund.

For many, this will be an unpalatable and unacceptable scenario but it is one that is already upon us. Without a coherent national policy framework to support it, social care will continue its unplanned drift by default into a poorly understood, dysfunctional and ineffective system.

Long-term reform of funding

International evidence shows that spending rises on health and social care as the population grows and ages has been reflected in the spending profiles of almost all advanced countries since the end of the Second World War (**Organisation for Economic Cooperation and Development 2014**). The question is not whether these costs will arise but to what extent they fall on the public purse or the private individual. As we have seen, efforts to achieve more with less and delivering better value will not release resources at the pace and scale required to close the widening funding gap.

The Barker Commission questioned whether additional private funding would be sufficient or equitable and recommended that public spending on health and social care should increase to between 11 and 12 per cent of GDP by 2025 (**Commission on the Future of Health and Social Care in England 2014**). Every independent review in the

last 18 years has recommended that the future funding of social care needs as well as health needs should come from public rather than private finance. It is impossible for individuals to predict whether they will need care, how much, for how long and how much it will cost. As the Dilnot Commission put it:

> *The system, conceived in 1948, is not fit for purpose. People are exposed to very high costs, which they are unable to protect themselves against. The system is confusing, unfair and unsustainable. People are unable to plan ahead to meet their care needs.*
> (Commission on Funding of Care and Support 2011)

As more of us develop a mixture of health and social care needs, this will expose further the dissonance between some kinds of care that are free at the point of need and others that are met wholly or in part by individuals and families.

A frank and open debate is needed on how to fund health and social care on a sustainable basis into the future, recognising that a long-term strategy will exceed the lifetime of a single parliament. A mechanism is needed to secure cross-party consensus on some shared principles of reform, building on the work of recent independent commissions including the Barker Commission and the House of Lords Select Committee on Public Service and Demographic Change (**House of Lords 2013**). In an earlier review commissioned by The King's Fund, the late Derek Wanless observed:

> *At the heart of the [funding] issue should be a debate about what social care will do in the future. How will it help people? What outcomes should it aim to achieve? Who should it help? Once its purpose is understood and specified, important decisions can then be made about the range and type of services, the size and composition of the workforce, the implications for housing, the use of technology to assist people to live with more control, and the extent of preventative action required to avoid or delay need.*
> (Wanless 2006)

Ten years on, the need for that debate has never been more necessary or urgent.

Appendix: Methodology

The research for this report took place between September 2015 and June 2016 and comprised a literature review; analysis of national data; semi-structured interviews with representatives from health and social care in four case study sites (including commissioners, providers and patient representatives); and narrative interviews with older people who have used social care services in recent years. The research was guided by an external reference group, which included members from ADASS, LGA, CQC, the Department of Health and representatives from health and social care provider organisations and patient advocacy groups.

National data analysis

We conducted a comprehensive analysis of national trends in adult social care expenditure and activity for older people since 2009/10 using two datasets:

1. *Personal social services: expenditure and unit costs, England* (**Health and Social Care Information Centre 2015e**)
    This provides information about the money spent on adult social care by the social services departments of councils with adult social services responsibilities (CASSRs) in England. Prior to 2014/15, this data was sourced from the *Personal social services: expenditure and unit costs return* (PSS-EX1). In 2014/15, this finance return was replaced with a new collection, the *Adult social care finance return* (ASC-FR). There are some differences between these datasets, but councils were also required to submit a limited amount of data on the previous form in 2014/15, enabling ongoing trend analysis.

2. *Community care statistics: social services activity, England* (**Health and Social Care Information Centre 2014**)
    This provides information about the social care activity of CASSRs in England. It contains information taken from council administrative systems used to record the process of assessing eligibility to state-funded social care and

providing services to eligible individuals. Prior to 2014/15, this data was sourced from the *Referrals, assessments and packages of care return* (RAP) and the *Adult social care combined activity return* (ASC-CAR). In 2014/15, these were replaced with the *Short and long term services collection* (SALT). It is therefore not possible to make direct comparisons between 2014/15 and previous years for most data items.

We also examined related NHS data and trends in independent sector care provision to form a view across the whole system of health and social care.

Case studies

We conducted semi-structured interviews and focus groups with stakeholders from four local authority areas. Sites were selected to represent variations in local authority type; geographical area; rurality; and the deprivation and ethnic mix of the local population. The anonymity of sites is protected.

We asked participants about changes to the funding of social care for older people in their area over the past five years; the impact these have had on social care providers, service users and other services; strategies that commissioners and providers are using to mitigate current pressures; and what they feel this means for the future of adult social care.

Participants included key representatives from local authorities (n=17); clinical commissioning groups (CCGs) (n=5); NHS providers (n=6); independent sector social care providers (n=25); voluntary organisations (n=8); and Healthwatch and other local groups representing people who use services (n=4).

Interviews were audio-recorded and transcribed for thematic analysis. Emerging findings were discussed and further developed in conversation with national stakeholders and the external reference group. The findings were supplemented with analysis of available local and national data for each case study area in order to contextualise our interview findings.

User interviews

Our researchers were commissioned by the Richmond Group of Charities to conduct a small number of narrative interviews to capture the experiences of older people who use social care services. Participants were identified and recruited by the Richmond Group according to agreed recruitment criteria, and interviews were conducted by researchers from The King's Fund and the Nuffield Trust. Audio-recordings of the interviews were transcribed and edited by the researchers. A full account of these interviews has been published by the Richmond Group (Hall and Holder 2016).

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The King's Fund is an independent charity working to improve health and care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

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The need for a clearer understanding of the care available for older people has never been greater. Years of financial constraint and increasing levels of demand mean that the social care system in England is under severe pressure, yet evidence about the relationship between changes in public spending on social care, the quality and quantity of services and the impact on the health and wellbeing of people who use them is extremely limited.

Social care for older people looks at the effect of changes in local authority spending on care for older people, based on an assessment of national data and interviews with representatives from local authorities, clinical commissioning groups, the NHS and independent sector providers, voluntary organisations, Healthwatch and other local groups. Alongside this work, we were commissioned by the Richmond Group of Charities to interview older people about their experiences of social care.

Based on the evidence in the report, the authors recommend that policy-makers address three major challenges in shaping the development of social care for older people over the next five years:

- achieving more with fewer resources – for example, through better commissioning and integrated care – recognising that these initiatives will not be enough to close the funding gap

- establishing a more explicit policy framework, which makes it clear that primary responsibility for funding care sits with individuals and families

- undertaking long-term reform of funding because reliance on additional private funding is unlikely to be sufficient or equitable.

The report concludes that the human and financial costs of social care for older people and their carers are mounting and warns that the potential for most local authorities to achieve more within existing resources is very limited.