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**The case for social care reform – the wider economic and
social benefits**

Final report

**Prof. Jon Glasby, Health Services Management Centre
(HSMC)**

Prof. Chris Ham, HSMC

**Rosemary Littlechild, Institute of Applied Social Studies
(IASS)**

Prof. Steve McKay, IASS

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About the Authors

Jon Glasby is Professor of Health and Social Care and Director of the Health Services Management Centre (HSMC), University of Birmingham.

Chris Ham CBE is Professor of Health Policy and Management at HSMC.

Rosemary Littlechild is a Senior Lecturer at the Institute of Applied Social Studies (IASS), University of Birmingham.

Steve McKay is Professor of Social Research at IASS.

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With such a broad review, individual sections of this report draw on material and more detailed arguments presented in:

- Glasby, J. and Littlechild, R. (2009) *Direct payments and personal budgets: putting personalisation into practice* (2nd ed.). Bristol, The Policy Press
- Glasby, J. and Dickinson, H. (2008) *Partnership working in health and social care*. Bristol, The Policy Press
- Glasby, J. (2007) *Understanding health and social care*. Bristol, The Policy Press

Data

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BHPS data used in this publication were made available through the ESRC Data Archive. The data were originally collected by the ESRC Research Centre on Micro-social Change at the University of Essex (now incorporated within the Institute for Social and Economic Research). Neither the original collectors of the data nor the Archive bear any responsibility for the analyses or interpretations presented here. Data from the LFS and the FRS were also made available through the ESRC Data Archive. Neither the original collectors of the data (ONS and DWP) nor the Archive bear any responsibility for the analyses or interpretations presented here.

as it takes time to show benefits and it is often difficult to attribute changes or improvements in people's situations to particular interventions (Department of Health, 2009e). A systematic review of nearly 100 studies identifying the benefits of telecare for frail older people and patients with chronic medical conditions (two thirds of which were from the United States) concluded that there is evidence of improved care and health outcomes for older people, but that evidence on cost effectiveness is not yet established (Barlow *et al.*, 2007). The Department of Health is awaiting results from the Whole System Demonstrator Programme which began in 2008 in Kent, Cornwall and Newham. These will evaluate the extent to which assistive technology has worked effectively with integrated health and social care services for people with long-term health conditions and/or people who are at risk of being admitted to hospital.

Meanwhile, there is *some* case study evidence to show that there are efficiencies to be made from assistive technology. For example:

- North Yorkshire County Council piloted a telecare approach in 2005/6 with 42 people with good results. In September 2008, all new telecare users were subject to evaluation. The cost of packages with telecare were compared to a calculation of costs without telecare. There was an overall reduction of home care hours with a net average annual efficiency saving per person, resulting in a 38% reduction in care package costs across the county (Department of Health, 2009a, p.39).
- Northamptonshire County Council compared the outcomes for a group of older people with dementia who received assistive technology in their Safe at Home scheme with a group of matched older people from Essex who did not. Over the 21 month period of the study, the Safe at Home group received fewer services, remained more independent and their carers reported greater confidence about the safety of the older person. Forty two per cent of the Safe at Home group left the community to enter residential or nursing home care, were admitted to hospital or died compared to 76% of the Essex group. The estimated saving over the whole of the period was £1.5 million (Woolham, 2006).
- Other new IT initiatives for accessing support and assistance 'online' are in the early stages of development. For example, Shop4Support is a social enterprise offering an online information service about, and a place to buy services from, local social care providers. Shop4Support was set up in September 2008 with 5 local authorities which are implementing in different ways the concept of online information and support for service users in receipt of individual budgets. Initial evaluations suggest high consumer support, enthusiasm by social care providers and efficiencies in administrative costs (Shop4Support, 2009).

Financial assumptions

Although greater use of IT should intuitively lead to a range of benefits for social care (given its impact on other aspects of life), the evidence base behind such assumptions

remains significantly underdeveloped. This section of the review is shorter than the others, with much fewer direct research findings on which to draw – albeit that case study evidence is emerging to suggest that there may be some scope for reduced use of services and/or fewer admissions to residential homes, nursing home or hospital. While this remains an area of great potential (Accenture, 2004), there is limited overall information about the effectiveness of past reforms. There are also concerns that the benefits of IT within the public sector have not always been realised in practice (Cats-Baril and Thompson, 1995), and that impacts have tended to be incremental overall, and not of the transformational kind (West, 2006). As a result, we have not built detailed financial assumptions about the potential impact of greater use of IT into the analysis in section 5 – as the evidence to date seems inconclusive.

Workforce development and reform

The adult social care workforce is a valuable resource in delivering effective social care services in the twenty-first century and, in recognition of this, the government has already put in place initiatives to both increase and develop the people who work within it. However, the close examination of the social work profession following concerns about safeguarding issues in children's services has revealed some social care services which are stretched beyond capacity with high levels of absenteeism, large numbers of vacancies and extensive use of agency staff (Department of Health and Department of Children, Schools and Families, 2009a). In order to realise some of the social and economic benefits of investment in adult social care, some of the costs associated with these issues across the whole of the adult social care workforce will need to be addressed and reduced.

There are estimated to be just over 1.5 million people working in adult social care in England, including social workers, care workers, allied health professionals, managers and administrative/ancillary staff who may work in residential, domiciliary or day care settings or within the community (Commission for Social Care Inspection, 2009, p.104). Approximately 71% of people are employed within the independent sector, 19% within local authorities or the NHS and the remaining 10% employed by people receiving direct payments who are recruiting their own staff. However, it is worth noting that this total estimate does not include workers who are employed by people holding personal budgets or by those funding their care privately. The actual number of people employed within adult social care is therefore more than 1.5 million.

The vacancy and turnover rates for staff are indicators of how stable a workforce might be and, in times of economic downturn, one might expect to see a low level of turnover as staff seek some financial stability. CSCI (2009, p.106) report that in June 2008 within *all* sectors, the vacancy rate was 3.8%, with care worker vacancy rates at 4.6%. The turnover rate for all jobs was 17.9%, with the highest rates of 23.6% amongst care workers in the private sector compared to 9.6% in the statutory sector. However, more recent data from the United Kingdom Homecare Association (UKHCA) suggest that the turnover rate for domiciliary workers may be higher at 24.9% (UKCHA, 2009, p.9). For 2007-8, councils reported overall vacancy rates of 8.4% and staff turnover of 10.3% in their adult social care workforce. There was considerable regional variation, with London reporting the highest vacancy rates of 11.1% and with the highest turnover rates in East Midlands (12.2%) and the South East (12%) (LGA, 2009).

The Local Government Association Workforce Survey identified a number of challenges facing local authorities in their employment of adult social care staff (LGA, 2009). Whilst the number of councils facing difficulties with recruitment and retention in general in 2009 has dropped to 52% from 83% in 2008, difficulties in the recruitment and retention of professionals working in adult social care have increased. Forty six per cent of those authorities reported difficulties in recruiting adult social workers, compared to 36% in the previous year, (surpassed only by difficulties in recruiting children's social workers in 72% of those authorities), 32% in recruiting mental health social workers and 25% in recruiting occupational therapists. Difficulties in retention of those same adult care professionals were reported by 28%, 17% and 11% of those local authorities respectively.

The interim report of the Social Work Task Force reported vacancy rates for social workers in England of 9.4% for adult field social workers with a turnover rate of 7.8%, comparing them to the relatively low vacancy rates in, for example, teaching, at 0.7% (Department of Health and Department of Children, Families and Schools, 2009a, p.16). UNISON (2009) has set the average UK vacancy rate for social workers as higher at 12%, with the top rate at 39%. The Social Work Taskforce commented on the lack of robust data on levels of staff vacancies, turnover and sickness levels in frontline social work but received evidence from managers and workers of a vicious cycle of staff shortages leading to work overload, additional stress, staff sickness and further staff shortages (Department of Health and Department of Children, Schools and Families, 2009a, p.17). According to the latest report by the Chartered Institute of Personnel and Development (see Boorman, 2009b, p.13), the average rate of absenteeism within the public sector is 9.6 days per year compared to a national average of 8 days per year, a rise from the previous year's average which has coincided with people feeling more stressed at work and experiencing a less satisfying life-work balance.

Of the total 1.5 million staff in adult social care, 1.41 million are directly employed and the remainder (6%) are made up of agency, bank or pool staff (CSCI, 2009, p.104). The government expects social care employers to reduce their reliance on temporary staff and, in *Options for Excellence*, has set an ambitious target that by 2020 employers will no longer need to employ agency staff to fill a role which a permanent social worker could fulfil (Department of Health, 2006). As part of the Social Care Workforce Research Initiative, the Department of Health commissioned a research study to assess what progress is being made to meet this target, and to identify what role, if any, employment businesses may have in the future for the adult social workforce (Cornes *et al.*, 2009a).

The study included a survey of 150 local councils in England which achieved a response rate of 37%. Of the responding councils, 92% said they had used agency workers in the financial year 2008-9. While nearly all of these had employed social workers, around two thirds had also employed administrative or care staff (Cornes *et al.*, 2009a, p.5). The average spend per council on agency staff was 8% of the adult social care workforce budget, but with large regional variations (with London Boroughs having the highest spend and authorities in the North East the lowest). The reasons given by councils for employing agency staff were difficulties in recruiting permanent staff, the chance to fill a post quickly or to cover for sickness and also to do specific identified tasks.

The evidence from Cornes *et al* (2009a) and other research (see, for example, Kirkpatrick *et al.*, 2009) concludes that, whilst the obvious benefits of agency workers are that they keep the service going, there are other drawbacks including higher employment costs of recruitment and support of workers and concerns about lack of continuity in service provision. A number of strategies to reduce the use of agency staff have had some limited effects - including some efficiency savings. However, it is not clear whether this is a result of addressing the underlying problems of recruitment and retention or of managing agency staff as a “*variable cost*” (that is, agency workers sometimes report that toward the end of a financial year, if budgets are tight they will be released from their contracts only to be brought back in the new

financial year to tackle the waiting lists that have built-up in their absence – see Cornes *et al.*, 2009a, p.46).

Based on a total workforce of 1.39 million in 2006, Skills for Care have predicted an additional 50%-80% growth in the size of the adult social care workforce by 2025 (Eborall and Griffiths, 2008). If this is the case, then employers in the future are unlikely to dispense entirely with agency staff. However, if employers are willing and able to adopt a framework for assessing and maintaining the ‘health’ of their organisations, including the development of national systems of support and supervision of workers as recommended in the final report of the Social Work Task Force (Department of Health and Department of Children, Families and Schools, 2009b), then one could expect the rate of sickness, absenteeism and therefore the use of agency workers to reduce.

The Department of Health has recently published an independent review of the NHS workforce (Boorman, 2009a) which put forward a strong case for investing in and promoting staff health and well-being (with evidence that low rates of sickness absence, staff turnover and use of agency staff positively correlates to patient satisfaction, quality of care and good use of resources - Boorman, 2009b, p.11). The review estimates that if the average absence rate of 10.7 days per year in the NHS were reduced by a third, the benefits would be (Boorman, 2009b, p.44):

- “ a gain of 3.4 million working days a year
- equivalent to 14, 900 WTEs
- with an estimated annual direct cost saving of £555 million.”

There would also be additional indirect savings – for example, some reduction of the £145 billion per year (representing 3.8% of the total wage bill) which the NHS currently spends on agency staff and temporary staff (Boorman, 2009b, p.46).

Financial assumptions

Using the evidence from the national survey conducted by Cornes *et al.* (2009a-b), councils are thought to spend an average of 8% of their adult social care workforce budget on agency staff – but reaching 17% in London boroughs. Clearly, if local authorities are going to positively address the difficulties of recruiting and retaining staff, and focus on the health and well-being of their staff, their spend on agency staff may well reduce. Indeed this is the picture found by Cornes *et al.* (2009a-b), with reductions anticipated, and with 60% participating authorities reporting a declining spending on agency workers in 2008-2009 compared with the previous year.

In a ‘solid progress’ scenario, we have assumed a potential saving of 2% of the workforce budget. In a ‘fully engaged’ scenario we have assumed a potential saving of 4% - halving the current spend, though allowing for a still significant level of spending, on agency workers. Such a level is already reflected in spending in the North East (Cornes *et al.*, 2009, p.55). Statistics for 30 September 2008 show that there were 202,200 Whole Time Equivalent (WTE) staff employed in Social Services Departments in England. At pro rata rates, 4% of the adult component of this workforce number gives a good idea of the magnitude of spending on agency staff.

Another perspective is provided by looking at sickness absence and how this may be managed. Evidence from the Labour Force Survey tends to suggest that those working in health and social care have slightly higher risks of having sickness absence in the week before being interviewed, with about 1 in 37 having done so compared with an overall average of around 1 in 50 – though the average length of leave was more typical.

Table 7 Sickness absence rates, LFS 2009, working age adults

<i>Industry division</i>	Had sick leave in reference week	Average number of days sick leave that week	Per cent in employment	
			Sample size (unweighted)	Grossed workforce numbers
Human health activities	2.4%	2.4	4,091	2m
Residential care activities	2.7%	2.0	1,462	750,000
Social work without accommodation	2.8%	2.4	1,921	975,000
All workers	1.9%	2.4	56,663	28m

Source: HSMC/IASS new analysis of the Labour Force Survey January – September 2009, removing rotating sample elements

Using the evidence from the recent review of the health and well-being of NHS staff (Boorman, 2009b), a ‘solid progress’ scenario might aim for a reduction of the average absence rate in the adult social care workforce of 10%. In a ‘fully engaged’ scenario, it might be possible to achieve a reduction of 30%. The latter change would be needed to bring down the results for those working within social work to the average across all employees.

At the same time, there are a number of caveats to bear in mind. If current trends for some support to be provided by the independent sector continue, then local authorities may have less direct control over absenteeism and spending on agency workers – making some of the potential savings above appear overly optimistic. Similarly, some of the data from the NHS may not necessarily be applicable to adult social care (where there is a very different workforce), and future policy will continue to need to focus on the specific nature of the social care workforce and measures to strengthen it.

5. Future scenarios

Building on this analysis, the next section of the paper sets out a number of potential scenarios for future reform in order to explore the policy, practice and financial implications of different options available. In the process, we draw heavily on the previous analysis of Derek Wanless (2002) from his review of NHS funding. In much greater depth than is possible in a very high level paper such as this, Wanless outlined three scenarios, using these to explore future costs and key policy/practice implications (p.35):

- ***Slow uptake*** – “*there is no change in the level of public engagement: life expectancy rises by the lowest amount in all three scenarios and the health status of the population is constant or deteriorates. The health service is relatively unresponsive with low rates of technology uptake and low productivity.*”
- ***Solid progress*** – “*people become more engaged in relation to their health: life expectancy rises considerably, health status improves and people have confidence in the primary care system and use it more appropriately. The health service is responsive with high rates of technology uptake and a more efficient use of resources.*”
- ***Fully engaged*** – “*levels of public engagement in relation to their health are high: life expectancy increases go beyond current forecasts, health status improves dramatically and people are confident in the health system and demand high quality care. The health service is responsive with high rates of technology uptake, particularly in relation to disease prevention. Use of resources is more efficient.*”

Building on this, our three scenarios are:

- ***Slow uptake***: under this approach, future policy and practice remain very much as they are now, with periodic attempts to more fully integrate health and social care, but without sustained and real change; little permanent reform of the adult social care workforce; some support for carers; ongoing preventative/rehabilitative pilots but a failure to really embed in mainstream services; and low rates of technology uptake. Using the five rationales for reform outlined above, this scenario is essentially about ‘meeting basic social expectations’ and providing a ‘basic safety net’, with some aspirations towards higher quality and more responsive rights-based services. Despite a stated commitment to partnerships, commissioning, personalisation, workforce reform and greater use of IT, action is limited and sporadic – with the commitment often rhetorical rather than reality.
- ***Solid progress***: while the stated aims of policy remain similar, there is a much more concerted effort to improve outcomes and deliver savings through integration; a greater understanding and embedding of the principles of personalisation; a genuine and sustained attempt to rebalance mainstream services towards a more preventative and rehabilitative approach; a sustained commitment to a commissioning-led system; greater support for carers;

significant workforce reform; and more innovative use of IT. In practice, the intended benefits are not fully realised to quite the extent that was envisaged (for example, integration does not deliver as much as expected and the impact of personalisation is reduced in practice by professional and cultural barriers). Over time, thinking retreats back towards meeting basic needs, extending some rights and trying to boost prevention/rehabilitation – but without fully realising the wider social and economic benefits.

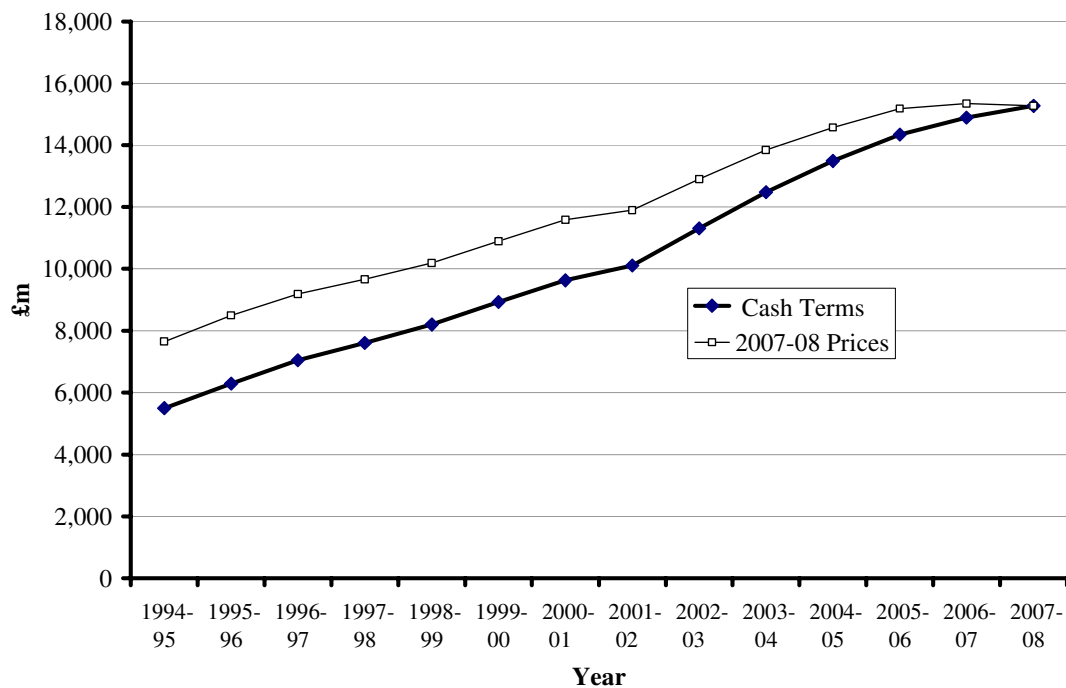
- *Fully engaged*: there is a sustained commitment to genuine change, motivated by a desire to realise in full the benefits for the health and social care system and for wider society. Where the evidence base is currently contested or unclear, the mechanisms used surpass expectations and start to really deliver. Thus, partnerships achieve the outcomes and the savings that intuition suggests they ought; commissioning proves an effective lever for reforming the system; personalisation is experienced as a lived reality by front-line staff and service users; there are high rates of technology take-up; and effective and ongoing workforce reform. This approach is underpinned by a genuine commitment to a rights-based approach, to mainstreaming prevention and rehabilitation, and to using social care funding in order to achieve a much broader range of social and economic benefits for users and carers.

Clearly, reducing the complexity of the adult social care system down to three basic scenarios is inevitably an oversimplification of a much more nuanced reality. However, for present purposes, we believe that such an approach can be a helpful way of highlighting the key issues, exploring the scale of the challenges ahead and providing a very high level overview of potential future costs.

The costs of adult social care

Gross spending on adult social care is on an upwards trajectory. In the recent past, spending has risen both in cash terms and in real terms. Spending was close to £16 billion in 2007-08, or almost double the figure of 1994 - even after allowing for inflation. The pace of increase grew considerably after 2001/02, though was considerably slower in the most recent data available. Over the period as a whole, spending grew by 5½% in real terms per annum.

Figure 11 Growth of social care spending on adult services (gross)



Source: NHS Information Centre, *Personal Social Services Expenditure and Unit Costs England, 2007-08*

The largest area of spending continues to be on older people, at over half the spending on adult social care. In the last four years, however, there have been faster rates of spending growth related to people with learning disabilities and physical disabilities – where spending has grown by about one-third in cash terms, against an overall budgetary increase of 22%. In real terms – after allowing for inflation – the total budget grew by a little over 10% over this four year period. The latter equates to real terms growth of 3.2% per annum.

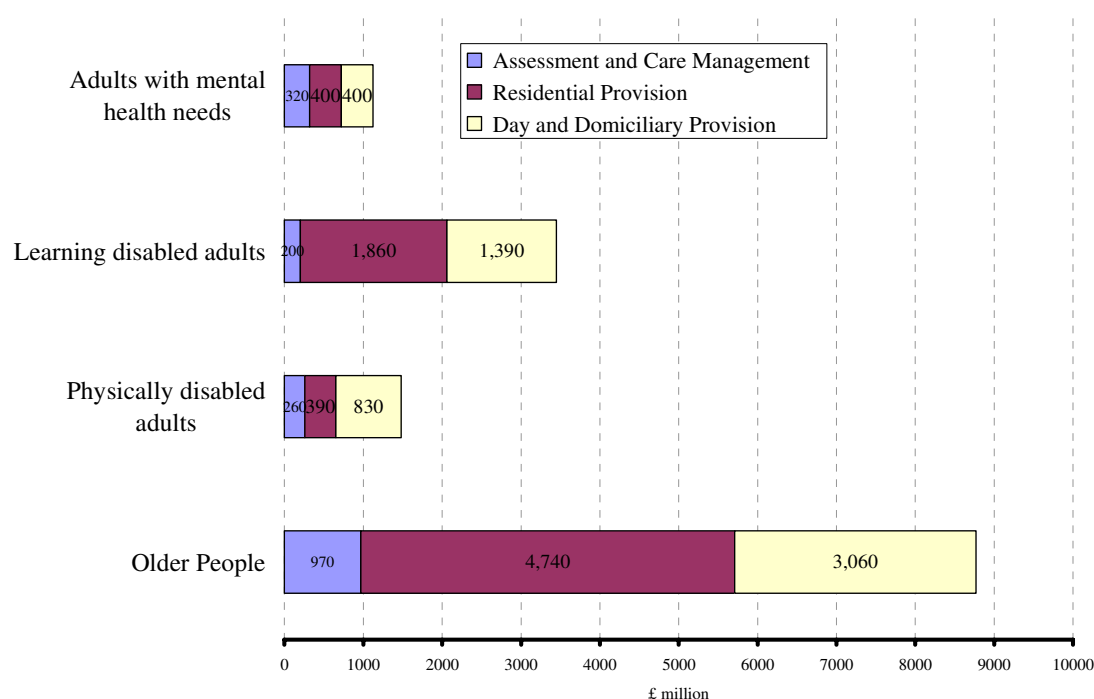
Table 8 Areas of spending and their recent growth

Major spending area	£ million in 2007-08	Rate of increase, 2003/04-2007/08	
		Cash terms	Real terms
Older people	£8,770	18.8%	7.2%
Physically disabled adults	£1,480	29.8%	16.5%
Learning disabled adults	£3,450	32.2%	19.4%
Adults with mental health needs	£1,120	19.2%	6.7%
Total	£15,270	22.4%	10.3%

Source: NHS Information Centre, *Personal Social Services Expenditure and Unit Costs England, 2007-08*

These areas of spending may also be broken down into the elements comprising residential and non-residential provision, and relating to assessing and managing cases. Overall residential provision represents 48% of spending, day and domiciliary provision a total of 39%, and assessment and care management the remaining 12%.

Figure 12 Areas of main social care spending on adult services (gross)

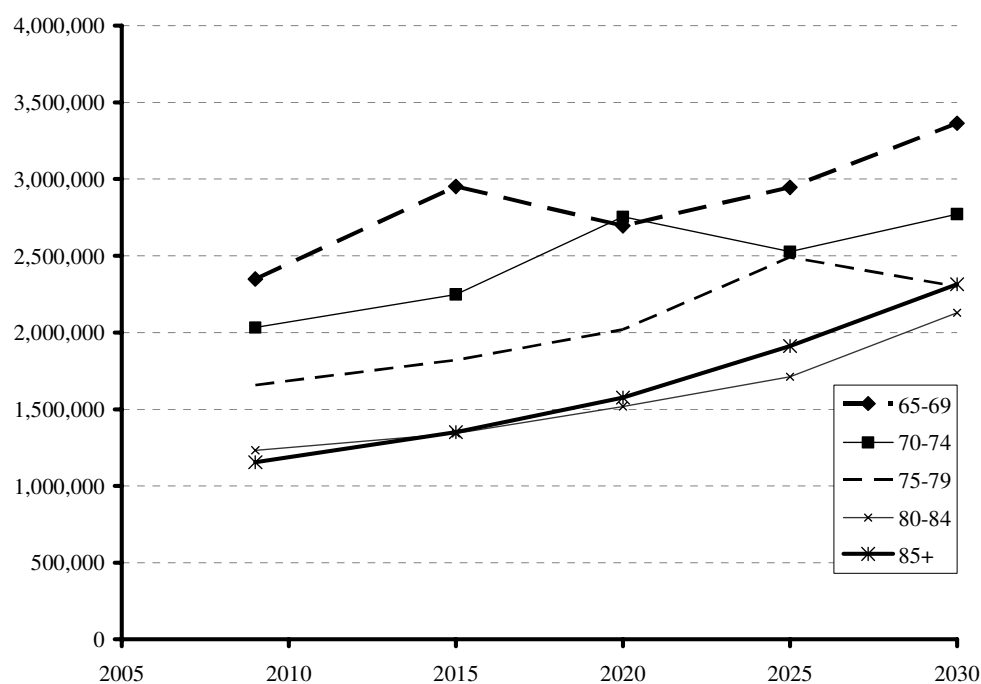


Source: NHS Information Centre, *Personal Social Services Expenditure and Unit Costs England, 2007-08*

Projecting the costs of adult social care

When we look to the future, however, there are two important sources of future spending growth. First is demographic. The numbers of older people are projected to increase, reflecting higher life expectancy of those who are already old, and the ageing of the ‘baby boom’ group born from around 1946-64. Higher life expectancies among older people are associated with more people living into their 80s and 90s (if not longer) where spending on adult services is concentrated. Between 2009 and 2030, the number of people aged 85 or older is projected to double from 1.15 million to 2.3 million – and this is the group most likely to be in residential care or receiving services of other kinds. The number aged 80-84 is also projected to increase by 75%. Conversely, the adult population aged under 65 will exhibit much less change in total growth, on ONS projections increasing by around 7% over this period, whilst the total population may grow by 16% with this growth concentrated among the older population.

Figure 13 Population projections for those aged 65+



Source: ONS population projections 2006 – Crown Copyright

Whilst the younger population is growing much less quickly than the older population, there are still important demographic influences among those of working age which may act to increase the groups likely to be receiving adult care services, in particular the group with learning disabilities. Emerson and Hatton (2008, p.i) note the declining rate of mortality (higher life expectancy) among this group, including those with the most severe needs. They also look to increased future needs of the baby boomer group, with a relatively high rate of learning disabilities. Overall they conclude that “*all scenarios suggest sustained growth in the need for social care services for adults with learning disabilities over the period 2009-2026. Average*

estimated annual increases varied from 1.04% (lower estimate of eligibility, services only provided to new entrants with critical or substantial needs) to 7.94% (upper estimate, services are provided to new entrants with critical, substantial or moderate needs)” (p.ii). These are somewhat above the estimates that have been previously used, of around 1.1% per year, based on past work by Emerson (see Wittenberg *et al.*, 2008b, and also Emerson, 2009). Instead they propose a minimum rate of growth of 3.2% in those likely to qualify for assistance, assuming services are not rationed only to those with the most critical needs.

The second source of increased spending on social care may well be increases in costs. Those projecting the future for social care have generally factored in cost growth of 2% ahead of inflation (see, for example, Wittenberg *et al.*, 2008a, p.3). Even this may be cautious, as the increased demand for social care services (from population ageing) will have to be supplied from a workforce that is not increasing at the same rate. Whilst 2% real growth sounds relatively small, the effect of compounding that rate over time can quickly increase the overall change. A 2% increase continued for twenty years would mean an overall increase of about half, and an overall doubling within 35 years. If we assume that costs are almost doubling in over thirty years, and that some groups (like the over-85s) are also doubling in number over that time, the scale of the overall increase quickly becomes very clear – potentially a four-fold increase in the spending on such a group. Forder (2008) has also suggested that the costs of tackling age discrimination within social care could be very high – in a multivariate analysis, controlling for disability and health, older people are less likely to be receiving home care or to have access to a social worker. His results are arguably also consistent with a strong element of gender discrimination.

We may take the demographic information (from ONS projections) and apply to it different rates of people receiving residential care for different groups, those receiving other kinds of adult social services (from Census and survey data), and cost data from the Department of Health, to project forward likely trends in spending.

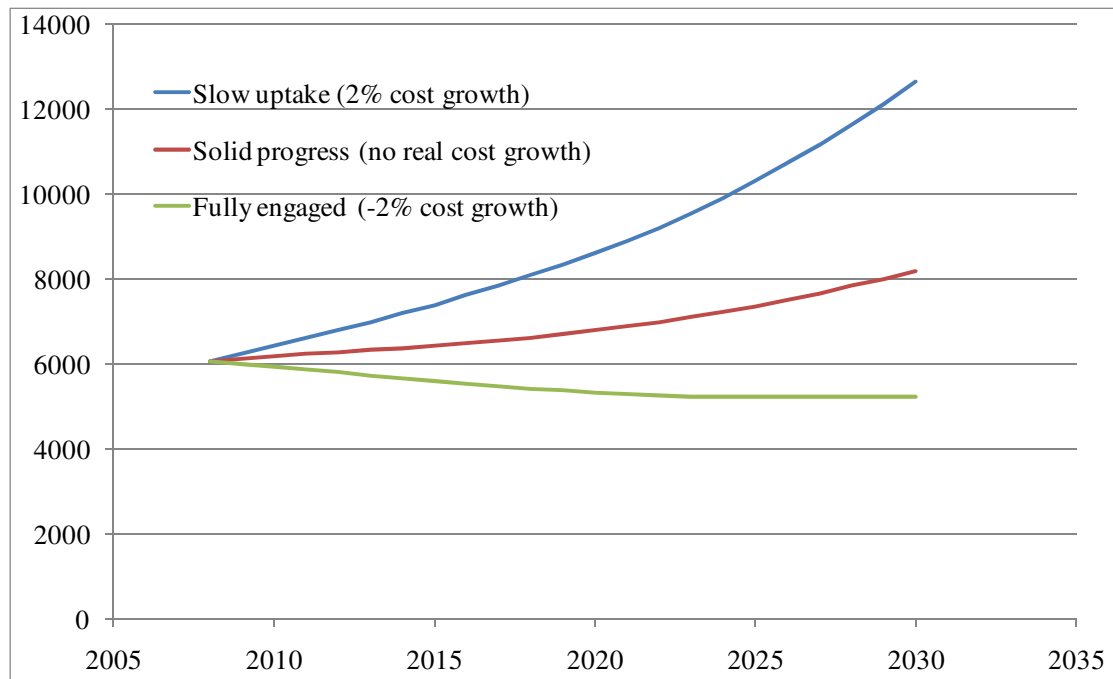
It is crucial to emphasise that these models produce *projections*, subject to a large number of assumptions, and not *predictions*. There are several reasons to be cautious. Most existing models do not take account of possible increased health at older ages, although projections of longer life expectancy tend to have more non-disability years. Instead we assume that rates of care are fixed by groups defined across gender, age and relationship status. In other words, a single woman aged 75 is regarded as having the same ‘risk’ of receiving care both in 2007/08 and in 2029/30. This assumption of constant rates over time (fixed by some combination of age, gender and marital status) is common to most approaches to projecting care needs for older people (see, for example, Wittenberg *et al.*, 2008a). It should also be added that the evidence base for estimates of the extent and severity of disability is mixed, with some data over ten years old. These models would not have predicted the recent rise in spending on social care, for instance (at least not without introducing assumptions additional to the ones generally used for forward projections).

We use Emerson (2009, Table 2) for estimates of the numbers of adults with learning disabilities. For the other adult groups (not the older group) we use population projections of total numbers, assuming similar levels of spend across those groups.

On current trends – 2% cost growth, and projected increases in numbers – the level of real spending on these groups could approximately double before 2030 – from £6 billion to £12 billion. This is a faster rate of growth than found by Wittenberg *et al* (2008b), but probably reflects the use of Emerson’s later figures with a faster rate of growth of those with learning disabilities.

If it was possible to keep costs fixed in real terms, then the demographic momentum would still take costs above £8 billion. It would only be possible to reduce real spending (which would still be a large increase in cash spending) if costs were able to be cut by 2%, year-on-year. That would be an extremely challenging outcome – and would make total costs slightly lower than at present in real terms.

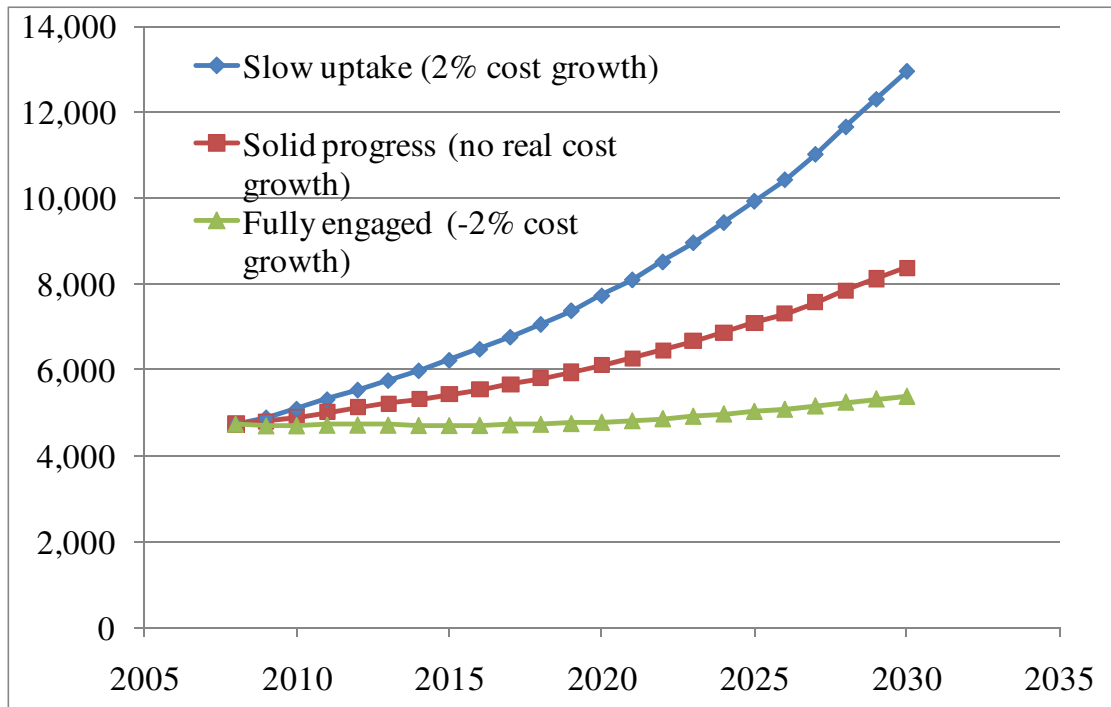
Figure 14 Gross spending on adults (£m in real term) who are physically disabled, learning disabled or with mental health needs



Source: HSMC/IASS projections

For older groups we use population numbers from the 2006 ONS projections, and take the size of the residential population from the 2001 Census for groups defined by age, gender and relationship status. The growth of the total older population, particularly those at the older ages with higher care needs, means that costs are projected to increase substantially – from around £4.7 billion in 2007/08, to reach closer to £13 billion by 2030. Gross spending would double even if unit costs were held constant in real terms, and indeed would still increase in the longer-term even if year-on-year reductions were made in costs.

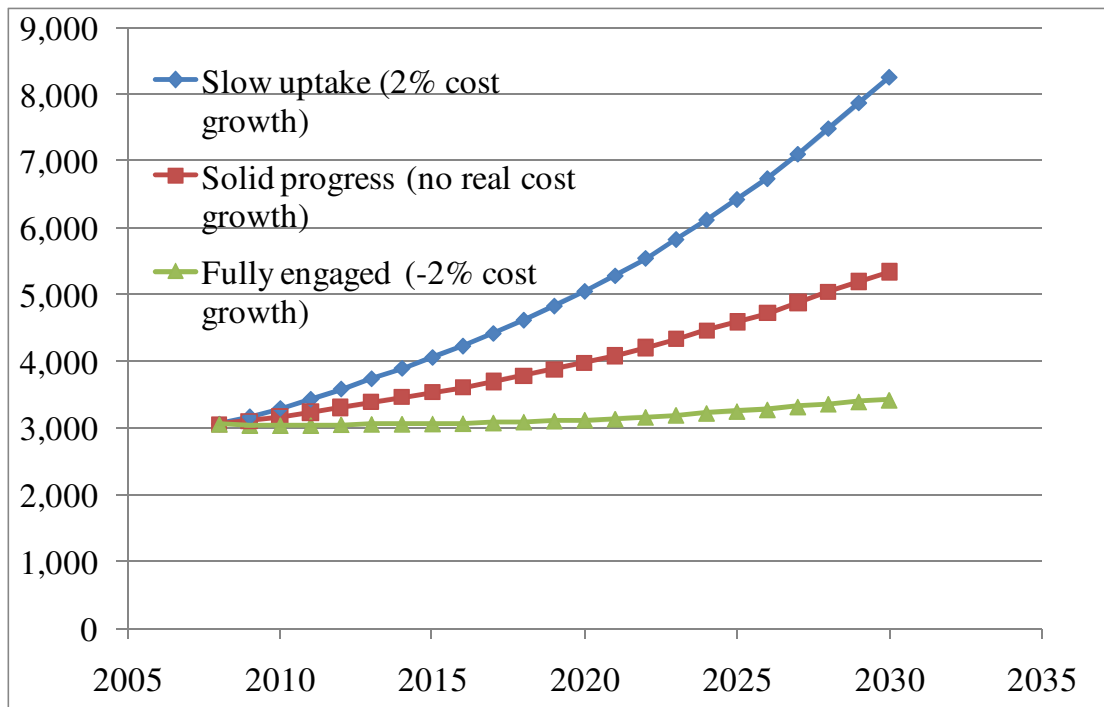
Figure 15 Spending on residential/nursing care for older people (£m in real terms)



Source: HSMC/IASS projections

The picture looks very similar when considering spending on community services for older people (domiciliary care, day care etc) – since both representations reflect to a large degree the demographic momentum built into an ageing population. It differs owing to the relative spending on different age groups within the older population. (This projection draws on an analysis of who receives social work assistance in the British Household Panel Survey – analysed by age group and marital status).

Figure 16 Spending on community services for older people (£m in real terms)



Source: HSMC/IASS projections

One of the main conclusions that may be drawn from this is the **high cost of inaction**. The real cost of adult social care is set to increase very rapidly, owing to increases in the number of older people, increases in those with learning disabilities, and the expectation that costs of provision will also rise in real terms.

6. Conclusion

Having briefly reviewed current calls for fundamental change within adult social care, this report has sought to explore the potential social and economic benefits of future reform. Rather than viewing spending on adult social care as essentially ‘dead money’, there is scope to re-conceptualise this as a form of social and economic investment – meeting basic needs and providing more of a rights-based approach, but also investing to save via greater prevention/rehabilitation and delivering significant wider benefits for society and the economy by providing better support to users and carers.

Future social care spending and reform

Using our three scenarios (‘slow uptake’, ‘solid progress’ and ‘fully engaged’), we conclude that ‘doing nothing’ is not a feasible option (see also Wanless, 2006; Forder and Fernandez, 2009 for similar analysis). The 2009 Green Paper and the 2008 *Case for Change* have already set out compelling evidence about the cost of inaction. To supplement this, our analysis suggests that our ‘slow uptake’ scenario could lead to continuing increases in the costs of the existing pattern of service provision. On existing demographic trends and with standard cost assumptions, the *real* costs of adult social care (that is, after allowing for inflation) could double within two decades – and this would be the case for current services and approaches (which have already been strongly criticised for failing to fully and appropriately meet need). Thus, this option would lead to real cost increases and do nothing further to tackle the quality of services – reform, after all, is about much more than just costs, and is more about improving services and hence people’s lives.

We have, in this report, listed a number of rationales for reform, and mechanisms for bringing about reform. Where possible, we have indicated the kinds of cost savings that each may be expected to generate, both in a ‘solid progress’ and a ‘fully engaged’ scenario. In some cases the evidence base has been too weak to sustain alternative assumptions. It is always difficult to generalise from a small number of specific areas to what might be possible with a national roll-out. It is also unclear how far the savings achievable in the short-term would be sustainable in the longer-term. Even so, for many of the mechanisms we have discussed, there is promising evidence emerging of the kinds of cost savings that may be practicable – if meaningful and sustained reform can be achieved in practice.

If ‘doing nothing’ is not an option, then neither is continuing with current policy priorities but failing to fully embed them in mainstream services or to deliver current aspirations. Under our ‘solid progress’ scenario, we project forward the implications of maintaining costs at their current level in real terms. This would be a strong achievement, compared with the expectation of rising real costs. Even with this scenario, the overall costs of the system continue to rise, given the momentum built into demographic change. They do, however, rise rather more slowly than for the baseline.

Given current financial, demographic and social pressures, the only credible option for adult social care appears to be our ‘fully engaged’ scenario - in which we seek to

develop a more rights-based approach, to mainstream prevention and rehabilitation, and to use social care funding in order to achieve a much broader range of social and economic benefits for users and carers. This is extremely challenging – it implies both a sustained commitment to significant change and an ability to deliver the potential benefits of such an approach in practice (in a way that has not always proved possible in past). If this were to be achieved, our analysis suggests that we would expect to see costs of adult social care contained at broadly their current level as well as significant benefits for other departments and services (for example, the NHS, social security and revenue from taxes). This is based on the very demanding premise that it would be possible to see year-on-year decreases in the unit costs of service provision, or similar reductions in the demands made on social services through earlier and smarter interventions. We have not assumed that all the various policies could be implemented simultaneously, leading to very large cost savings overnight. Instead we have projected forward a very demanding scenario that would only be achieved by systematic reform across a number of areas.

Of course, much of this report has focused on the potential for cost savings – either in current social care or in broader services (see below). Despite this, many of the approaches reviewed below are just as much about improvements in well-being, independence, choice and control than they are about the resources being expended – and it is crucial not to lose sight of this.

The broader impact on other services

In addition to the impact on future social care spending, this review argues that social care reform/investment also has the potential to reduce spending in other areas of the welfare state. While the evidence base is sometimes incomplete and fragmented, there is a clear suggestion that spending on adult social care can have a knock-on effect on spending in other areas. For example, our earlier analysis has suggested that:

- It may be possible to save £1.00 on emergency beds days for every £1 spent on prevention ('solid progress') and £1.20 saved for every £1 spent ('fully engaged').
- If some of the gains from high performing integrated sites could be achieved more generally, there may be scope to achieve 2.7 million fewer hospital admissions among the over-65s each year (a 22% reduction overall).
- Supporting social care service users to engage in paid employment could generate additional earnings of £400 million each year (of which over £50 million would be paid in tax and National Insurance) plus a reduction in benefits spending of £150 million ('solid progress'). This would double under a 'fully engaged' manner – reaching additional earnings of £800 million and reduced benefit spending of £300 million.
- Greater support for carers could lead to additional earnings of £750 million for working carers ('solid progress') or £1500 million ('fully engaged'), with extra revenue gained through tax and National Insurance. At present there

seems a key ‘tipping point’ of being outside the workforce at around 20 weekly hours of caring, for women. For both service users and carers, previous research has also indicated the important non-monetary benefits of remaining in work, rather than being out of the workforce.

Viewed from this angle, social care reform is necessary not just in response to pressures on the current system, but also as a form of **social and economic investment** that might impact positively on other areas of expenditure (producing better value for money as well as better outcomes for people using services).

Emerging messages for implementation

Over many years, policy has continued to promote values and more detailed models of care that emphasise:

- Independence and well-being
- Prevention and rehabilitation
- Care closer to home
- Choice and control
- Joint approaches between health and social care
- Greater collaboration between health/social care and broader, more universal services

In the words of previous policy initiatives, an ongoing aim has been to provide ‘the right care, in the right place, at the right time’, intervening early to keep people independent and well for longer. Although there has also been a strong emphasis on more joined-up approaches to service delivery, this is likely to acquire even greater significance in the current financial context, when scarce resources may force even greater collaboration than in the past. Against this background, there has been a degree of consistency over time in terms of the broader direction of travel and some of the outcomes that the system is trying to achieve. Despite this, there has been less clarity about how actually to do this in practice.

While not a formal aspect of our initial brief, the evidence above suggests a number of potential messages with regards to future policy implementation. Reviewers reading early drafts of our report have also asked us to comment in more detail on some of the underlying themes that emerge from our analysis for future policy and practice – helping to place the more detailed analysis above in a broader context.

Based on the evidence assembled here, and our analysis of options for the future, it is clear that there are many opportunities to use existing resources more efficiently. These opportunities need to be exploited in parallel with debate about more radical social care reform. The ‘postcode lottery’ in the use of current resources is arguably indefensible and unsustainable – particularly in the current financial context. The consequence is not only unacceptable variations of access to care services, but also poor value for the taxpayer. At a time when the resources available for public services are under huge pressure, it is imperative that concerted efforts are made to tackle variations in care and to spread best practice more effectively. More specifically, the evidence shows that:

- There is wide variation in levels of spending on adult social care and the composition of this spending (see, for example, Department of Health, 2009a).
- There is also wide variation in the use of hospital services by older people with much higher rates of emergency hospital admission and bed use in some areas than others (see our earlier discussion about the potential impact of health and social care integration).
- Analysis of routine data by the Care Quality Commission (unpublished, personal communication) and others (Department of Health, 2009a) shows that some areas appear to be using their resources more efficiently than others.
- Linked to this, our review of the evidence around scope for greater prevention, rehabilitation, personalisation and integration suggests that more efficient use of resources might mean lower than expected use of institutional forms of service provision; this is beneficial because such services are expensive and – in the case of hospitals - not especially safe places for older people to be.

In the face of this evidence, one of the policy challenges is how to generalise best practice, and particularly to free up resources that are spent in more institutional forms of support (for example, hospitals) for use on care closer to home, prevention, personalised support and independent living. In our view, this might best be tackled through greater transparency in existing variations in use of resources, with the Care Quality Commission and/or the Audit Commission publishing available data and raising further awareness of inequities in care. The regulators also have a major part to play in drawing attention to these issues and stimulating action at a local level to reduce the variations that exist. It is also essential that lessons are drawn from areas that have made most progress and are shared more systematically.

As this and other work (Ham, 2009b) suggests, there are different ways of making improvements in care and shifting resources away from institutional provision and into the community. It would therefore be unhelpful for government to prescribe a single pathway to reform and this should remain a matter for local choice making use of the legislative flexibilities already available. Instead, government should be prescriptive about the desired outcomes of care and hold local authorities/PCTs accountable for delivering these outcomes. Intervention by regulators and others should then follow from the consistent failure to deliver acceptable outcomes of care. It is likely that a basket of outcomes will be needed encompassing not only the use of health and social care services, but also outcomes that matter to service users themselves (see, for example, Glendinning *et al.*, 2006).

Final thoughts and next steps

Ultimately, this review suggests that doing ‘more of the same’ is unlikely to be successful – even if we do it a little more efficiently and effectively in future. Returning to the image in figure 1 at the start of this report, the challenges facing adult social care seem so significant that something equally radical seems to be required if the system as a whole is to be able to respond.

Woolham, J. (2006) *Safe at home: the effectiveness of assistive technology in supporting the independence of people with dementia*. Excerpt available online via www.tunstall.co.uk/assets/literature/512-Dementia%20-%20Safe%20at%20Home%202%20-%20%20Northamptonshire.pdf (accessed 23/11/09)

Yeandle, S. *et al* (2006) *Who care wins: the social and business benefits of supporting working carer*. London, ACE National

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Yeandle, S. *et al* (2007) *Diversity in caring: towards equality for carers* (CES Report No. 3). London, Carers UK/University of Leeds

Zarb, G. and Nadash, P. (1994) *Cashing in on independence: comparing the costs and benefits of cash and services*. London, British Council of Disabled People

Annex on cost projections

Sources of data

The cost projections discussed throughout the report are based on a number of simplifying assumptions, applied to data of various kinds. The data underlying the projections is drawn from:

- ONS population projections – for numbers of people of different ages, and of different living arrangements (couple versus single). Such data is crown copyright (ONS, 2001)
- Census 2001 – for proportions of older people living in residential settings.
- BHPS 2007-08 (wave 17) for receiving services among those living at their own residences (BHPS, 2009)
- PSS expenditure data of different kinds, from the DH Information Centre
- Estimates of the number of disabled people with learning disabilities (from Emerson and Hatton, 2008)
- Estimates of the work patterns of informal carers, from the Family Resources Surveys of 2003/04 and 2007/08 (the latest available) – DWP, 2009
- Analysis of the work participation rates of disabled and non-disabled people, from the quarterly Labour Force Surveys of Jul-Sep 2004 and Jul-Sep 2009 (ONS 2009)
- Analysis of sickness absence rates from the same source

Methods

Separate ad hoc approaches were used to estimate the potential cost savings from having more disabled people and carers back in the labour force. The main assumptions were of pay rates at the minimum wage (pessimistic) and full-time employment (optimistic).

The methodology used to analyse overall spending projections is that of cell-based simulation. This is a robust approach that has often been deployed to project future spending (see, for example, Wittenberg *et al.*, 1998, 2008a, 2008b). It is based on attributing outcomes to pre-specified groups in the population – such as the chances of being in residential care for groups defined by age, gender and marital status. The numbers of people in each group change each year, drawing on data from population projections. The product of the size of the group, and the associated incidence of care needs, multiplied by a cost factor, generates the components of the cost projections.

An alternative approach – micro-simulation – may be used to look at results at the level of individuals, but imposes greater requirements in terms of data and of programming the models (Wittenberg *et al.*, 1998). Developing new micro-simulation models was not possible given the short duration of this review. However it was possible to construct simple cell-based simulations to suggest how spending might develop in future *if a host of assumptions about the incidence of care and its costs continue to be met*. These are projections, not predictions.

Selecting the scenarios

In this report we have outlined a number of strategies that might generate cost savings, and improved outcomes. These have been quite substantial in some instances, but more limited in other areas. There are also strong and important differences in the robustness of the evidence, and the confidence that may be placed in different estimates of areas of saving.

Even given these factors, it is not possible to simply ‘add up’ the kinds of savings proposed to reach an overall figure. Some of the savings are in different areas of spending and so it would be double-counting to include both sets (for example, greater personalisation of care budgets, and the role of commissioning). There is also limited data on whether the cost savings achievable may be regarded as a ‘one-off’ reduction or instead may be treated as *dynamic factors* that continue to reduce future costs by similar proportions. In many cases the future savings may require upfront investment, in new procedures or infrastructure, that need to be included in the round.

For these reasons the *overall* scenarios modelled (equating to a 2% reduction on the baseline for steady progress, and a 4% reduction against the baseline for fully engaged) are based on the kinds of figures found within each strategy and are not attempts to naively sum up the sets of individual financial assumptions¹.

What the projections demonstrate is the large momentum built into the future costs of social care by population change. The overall costs in real terms continue to increase quite sharply even if there is no change in the real unit costs of care provision. Even if costs could be cut by two per cent annually in real terms - a demanding challenge - the effect is barely to constrain real levels of spending to their current level.

¹ For information, ten sets of 2% reductions would equate to an overall reduction of 18%, and ten sets of 4% reductions would amount to an overall reduction of close to 34%.