The underfunding of social care and its consequences for older people

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The government is taking major steps to modernise the health and care system. However, while substantial new investment is promised for the NHS, there has been no comparable review of social care funding. Social care for older people, like the NHS, has suffered from long term underfunding and shows signs of major strain.

For older people and their carers, health and social care are part of the same system. The underfunding of social care leads to back-ups and bottlenecks in the NHS which jeopardise the realisation of the Government’s objectives for the health service. Piecemeal measures to tackle aspects of the problem, such as delayed discharge from hospital, are not enough – they merely displace the pressures from one part of the system to another. Without new investment in social care, neither older people’s needs nor the Government’s modernisation objectives for the NHS can be met.

The Government should undertake a comprehensive review of social care funding for older people in parallel with, and in support of, its new investment in the NHS.

1. The need for social care

Just over a million older people receive formal social care, nearly half in their own homes, the rest in care homes. The great majority are in their 80s and older; all are frail, many are disabled and a high proportion suffer from dementia or other mental health conditions. They experience huge difficulties in trying to access the care system – this paper includes many real life examples.

Social care is not a luxury or an added extra. People seek help from the social services only when they can no longer manage their daily lives or when they are at serious risk of harm. Social care involves helping people to get in and out of bed, get dressed, keep clean, eat a reasonably balanced diet, have their nails cut, use the toilet, have clean laundry and live in a decent environment. Increasingly it involves additional help which would once have been seen as nursing care: changing catheters and dressings, preventing or treating pressure sores, managing medication and so on. Ideally social care also involves enhancing the quality of life of older people, enabling them to keep in touch with friends and family, to get out from time to time, to pursue interests and remain part of society – but with social care in such short supply, these aspects are very often neglected.
2. **The impact of underfunding on older people**

Underfunding results in ever tighter rationing of care for people who need it, and impacts on the quality of the support they receive. Moreover, older people are charged for the very basic care that enables them to survive day to day.

- Underfunding of social care leads to back-ups and bottlenecks in the health care system which jeopardise the realisation of NHS plan and NSF objectives.
- Underfunding of social care leads to waiting lists for care for those in the greatest need, little or no support for others, and lack of preventive services.
- Low cost ceilings on individual care packages for older people result in inadequate levels of care, poor quality, inflexible services and restricted choice.
- Charities, families and older people themselves are subsidising shortfalls in local authority funding for services for themselves and others.
- Charging for care is discriminatory in its effect and promotes pensioner poverty and social exclusion. It is administratively clumsy and militates against person-centred care.

**Social care for older people is rationed in four ways:**

- it is rationed by denying help to those with moderate care needs or with live-in carers;
- it is rationed by making those with high care needs wait for the help they need, either visibly in hospital or unseen in their own homes;
- it is rationed by limiting the amount of money allocated to each person, which denies people choice;
- it is rationed by strict limits on the amount and quality of the care they receive.

All these forms of rationing severely impact on the quality of life of some of the most vulnerable people in our society.

3. **Social care services are showing signs of major strain.**

The residential and nursing home sector is in difficulty. Local authority fee levels are insufficient to meet the costs of quality care. Families and charities are unlawfully pressured to top up fees and residents who pay their own fees subsidise shortfalls in local authority funding.

Home care is providing support to people who need greater and greater amounts of care but this change has not been recognised in funding levels. Consequently home care for the frailest people is too thinly stretched to offer high quality care.
Resources to develop preventive support and promote the independence of older people are too limited to make more than a superficial impact.

New resources are available for Intermediate care, but their adequacy in relation to need is unknown, and so is the proportion of those resources allocated to social care. Moreover, Intermediate care is intended to meet short-term needs only. Many of those coming out of hospital, or at risk of admission, will need long term support to avoid further crises. It is not clear where this money is to come from.

Support for the additional ‘50,000 older people enabled to live independently’ promised in the NHS Plan will require additional resources, as will the increase in demand for care resulting from growing numbers of very old people.

4. Financial pressures on social care

Increases in government funding for social services are well below those for the NHS - a comprehensive and integrated service for older people will require equal investment on both sides. New money for intermediate care addresses the most visible tip of the iceberg (i.e. the 700,000 delayed discharges from hospital each year), but there is no extra money to make good existing shortfalls in care, finance longer term support or meet Government objectives to promote the independence for older people on the scale that is required.

Social services funding has not kept pace with increased demand. Cash limits have been inadequately related to demand for more intensive services, greater numbers of people requiring support, or obligations to improve quality. Waiting list pressures have cut across whole systems developments and distorted priorities.

New policy and performance obligations have major cost implications for social services authorities and other providers. The requirement to ‘root out age discrimination’ will itself require significant new investment in older people’s services to bring them into line with those for younger people.

There are acute difficulties in the recruitment and retention of social care staff, whose numbers are broadly equivalent to those in the NHS. There is also a huge training deficit.

Social services departments routinely budget more than 10% (almost £1 billion) above government guidelines for social services, and even so they overspend. Older people’s services accounted for 47% of spending on 1999/2000 and are overspent by 21% on those budgets.

5. Conclusions

- The Government’s laudable aims of promoting the independence and inclusion of older people and ensuring quality care for those that need it cannot be achieved
without new investment. Resources for social care for older people need to be substantially increased if these aims are not to be hollow promises.

• Equally, aspirations for the NHS cannot be met while social care for older people (who make up two thirds of hospital patients) is so severely rationed.

• Sticking plaster solutions for visible problems like delayed discharge from hospital are not the answer: they merely serve to displace the problem from one part of the ‘health and care’ system to another. There needs to be a ‘whole systems’ review of funding for social care for older people, to ensure that the appropriate balance of services exist and are sufficient with regard to both quantity and quality.

• Current shortfalls in the funding of social care for older people need to be made good, and long term, consistent growth planned for, based on a realistic assessment of the costs of providing social care to the level and quality required to meet Government objectives and older people’s needs.

• A National Care Commission (as recommended by the Royal Commission on Long Term Care) should be established to monitor trends in demand and spending, to ensure transparency, and to plan for future needs.
The underfunding of social care and its consequences for older people

1. Introduction

The government has taken major steps to modernise the health and care system. Older people and organisations that represent their interests warmly welcome the Government’s commitment to improve services through the NHS Plan, the National Service Framework for Older People, the setting of minimum standards, improved joint working and the modernisation of social services. We also welcome the commitment to substantial new investment in the NHS.

For older people and their carers, however, health and social care are part of the same system; while one part of that system is being refuelled and re-tooled, the other part struggles and fails to keep up. Like the NHS, social care for older people has suffered from long term underfunding. Consequently, we now have a failing system in social care for older people which is no longer capable of sustaining acceptable levels of service.

The consequences of this failure are serious for older people and their families. They are also serious for the Government’s targets for the NHS and for social care. These targets cannot be met, and the major new investment in the NHS will not bring the desired results, without a comparable boost in resources for social care.

We urge the Government to act decisively to bring social care for older people into line with the ambitious programme for the NHS. The good intentions are there, the resources to carry them through are not.

Piecemeal measures are not enough - they merely serve to divert the pressures from one part of the system to another. What is needed is a fundamental review of funding for older people across the whole spectrum of social care. Without such a boost, neither older people’s needs nor the Government’s modernisation objectives for the NHS can be met.

2. The impact on older people

We attach to this paper real life examples of the experience of older people trying to access the care system. These very recent case studies are drawn from the Help lines of several members of the SPAIN group of voluntary organisations (see App. 3), including Counsel and Care, Help the Aged, the Association of Charity Officers and the Alzheimers’ Society. They illustrate powerfully the plight of those seeking help with their daily lives and of their families, and the difficulty of accessing such care.
Just over a million older people receive formal social care, nearly half in their own homes, the rest in care homes. The great majority are in their 80s and older. Most care is however provided by friends and families. The General Household Survey revealed that around six million people provide unpaid care to adult family members – a parent, a spouse or an adult child or other close relative. One third of such carers are themselves older people, and a third of older carers are providing high levels of personal care with little support, day in and day out, usually to a spouse with whom they live. A high proportion of those who require care have mental disabilities, with or without accompanying physical disabilities.

Social care is not a luxury or an added extra. People seek help from the social services only when they can no longer manage their daily lives or when they are at serious risk of harm. Social care involves helping people to get in and out of bed, get dressed, keep clean, eat a reasonably balanced diet, have their nails cut, use the toilet, have clean laundry and live in a decent environment. Increasingly it involves additional help which would once undoubtedly have been seen as nursing care: changing catheters and dressings, preventing or treating pressure sores, managing medication and so on. Ideally social care also involves enhancing the quality of life of older people, enabling them to keep in touch with friends and family, to get out from time to time, to pursue interests and remain part of society – but with social care in such short supply, these are often the aspects which are neglected.

The consequences of the lack of social care for older people are stark. They are illustrated by the real life case studies in section 5 of this paper.

**Underfunding of social care leads to back-ups and bottlenecks in the health care system which jeopardise the realisation of NHS plan and NSF objectives.**

- People are stuck in hospital awaiting social care funding – an inappropriate place for them to be. Consequently, there is increased pressure on hospital beds and longer waiting times for other patients.
- Older people in hospital are pressured into taking up inappropriate residential or nursing homes beds in order to free a bed, and thereby denied choice in what could be a decision affecting the rest of their lives.
- Lack of an adequate level of social care in people’s own homes results in unnecessary admission or readmission to hospital.
- Short term ‘solutions’ are found to meet a crisis with no long-term back up. Intermediate Care cannot be effective without adequate social care to back it up once the intermediate care period is over.
- NSF for Older People standards on age discrimination, person-centred care, hospital discharge and promotion of health and active life require investment in social care as well as NHS services.

**Underfunding of social care leads to ever tighter rationing of care for people who need it.**
There are waiting lists for older people even in the highest need categories – people may have to wait for weeks or months without help for residential or nursing home care or for support in their own homes.

There is limited support for those older people assessed as being in moderate categories of need, as those in the highest categories have first call on resources, resulting in unmet care needs and reduced quality of life and a need for more expensive care later on.

Local authorities, perhaps understandably, give priority to older people living alone. However, too little help is available for carers, including older carers living with their sick husband/wife, who may themselves be of a similar age and in a poor state of health; research demonstrates that older co-resident carers receive little help from health or social services

Although provision for respite care is rising nationally, there is not enough to give carers a break and those needing care a change in routine, whether in their own home or in another location. Many carers have been caring for years without a break.

Day care lacks focus and clear purpose. It may not be available to those who could benefit and doesn’t deliver what people want.

Ethnic minority community organisations - the only gateway to health care and support for many ethnic elders - are poorly and insecurely funded and have to restrict access, resulting in isolation for many elders.

There is little or no scope for innovation and development of preventive services or for investment in community-based services to support the continued independence of older people, severely impacting on Standard 8 of the NSF. The merging of prevention and partnership grants has exacerbated this situation.

Underfunded social care results in low cost ceilings on individual care packages for older people and restricted choice, as local authorities try to make the money stretch.

Cost ceilings for older people are customarily lower than those for younger people, a clear case of age discrimination and contrary to Standard 1 of the NSF.

There is less flexibility to adjust the cost of community care packages for older people to take account of individual needs – impacting on Standard 2 of the NSF.

Home care hours are tightly rationed for those who do meet the eligibility criteria; short task-orientated visits are commonplace, and there is little or no scope to promote quality of life.

Tasks undertaken by home care workers are strictly limited and tightly defined, resulting in little or no choice for the user and lack of person-centred care.

Home care is rarely able to adapt or be responsive to changing needs or personal circumstances. It tends to be fixed in the mould of the original assessment, and unable to adapt without ponderous reassessment procedures.

Older people are denied the choice to stay at home because local authorities have already paid for beds in residential and nursing homes and have an incentive to fill them.

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1 Milne et al: Caring in Later Life: reviewing the role of older carers. Help the Aged/University of Kent 2001
• The quality of life and quality of care in residential and nursing homes is restricted due to lack of staff time, skills and resources.
• There are two-tier charging systems for services. People who pay privately for residential and domiciliary care are subsidising shortfalls in local authority funding for others.
• Low fees are resulting in business failures and the closure of residential and nursing homes, resulting in severe disruption for residents, loss of security and broken friendships.
• Poorly managed moves almost certainly result in premature deaths. While the Department of Health has produced guidance, survival rates following unplanned moves have not been a priority for research.
• Untrained and poorly paid staff across the social care sector do not make for high quality personal care. Staff who change frequently disrupt older people’s lives and the support on which they depend.

Local authorities are required to means-test those who are eligible for residential or nursing home care and to impose a charge, and most local authorities do the same for home care.

• Charging for personal care impacts most on the oldest and frailest pensioners – it is discriminatory in its effect, increases pensioner poverty, promotes social exclusion and adds to the likelihood of needing long term care.
• The public does not recognise the distinction between personal and nursing care, resulting in widespread confusion and a sense of injustice amongst older people and their families when they are required to pay for care.
• Older people are denied the choice of staying in their own home when the cost ceiling for home care is reached. Local authorities have a financial incentive to require people to move into residential or nursing homes when their needs are high, since they can insist that someone’s home is sold to pay for care once someone is no longer living there.
• Some people who meet the local authority’s eligibility criteria for home care refuse it because of the cost, others because they consider their financial affairs to be a private matter.
• Charging regimes are discretionary with regard to home care, day care and respite care, resulting in widely variable charges in different areas, inequity and a postcode lottery.
• There is little help and support available for self-payers in most areas at a point where they are having to make critical life-changing decisions. Some local authorities refuse assessments to those with savings over the capital limit, leaving them to find their own way through the care system (the Fair Access to Care initiative should deal with this when it comes into force).
• The single assessment process is complicated by the need to undertake a financial assessment as well, and financial assessments are difficult to carry out when people are very ill, very frail or in a hospital bed – the very times when they are most likely to need care.

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2 Audit Commission: Charging with care 2000
Despite Government guidance that all Intermediate care should be free to the user, some local authorities appear to be charging for personal care aspects. A person-centred approach to assessment is more difficult to put into effect when it also requires disclosure of financial circumstances. The additional assessment process for people in nursing homes using the Registered Nursing Assessment Tool requires yet another process which distracts from person centred care and creates confusion and delay.

The case studies of older people presented in section 5 below tell their own story.

3. The impact on services

Social services underfunding has a direct and immediate impact on frontline services.

- Social care for older people is severely rationed:
  - it is rationed by denying help to those with moderate care needs or with live-in carers;
  - it is rationed by making those with high care needs wait for the help they need, either visibly in hospital or unseen in their own homes;
  - it is rationed by limiting the cost of the community care package for each person, which denies people choice;
  - it is rationed by strict limits on the amount and quality of the care they receive.

- Residential and nursing home care. The care home sector is in difficulty. Independent providers report that they are unable to provide quality care at the fee levels given, and their difficulties are fast becoming a major crisis. Fee increases paid by local authorities to providers have not kept pace with costs such as the introduction of the minimum wage and new standards, leading to a funding gap. Nursing home and residential care beds continue to be lost as a resource, down 5% between 1999 and 2000, and 35 000 beds over the last three years. Occupancy rates are rising, to worrying levels in some parts of the country. New care home registrations have dropped off dramatically. Meanwhile, private payers are subsidising shortfalls in local authority fees. Charities are called upon to meet the gap, thereby acting outwith their legal duties, and charities that run homes are using their own funds to subsidise inadequate local authority fees. Families too are unlawfully pressured to top up fees because local authority rates do not meet the standard local costs. In some cases, even residents’ Personal Expenses Allowance is absorbed into fees, leaving them nothing for their personal use, and such items as phone calls and clothing.

- Home care. The numbers of older people being supported in their own homes has actually been declining in spite of the rise in the numbers of people in the highest age brackets (see App 2). A decline in the residential and nursing home sector

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3 Laing and Buisson: Supply of care: presentation to the Continuing Care Conference Sept 2001
might be a welcome sign of the success of the Government’s policy to enable older people to remain at home, if it were accompanied by purposeful and significant growth in the numbers of older people receiving high quality domiciliary care and day care services. But this is not the case – the numbers of people receiving such care have been declining, while the number of hours allocated to each person each week has been rising. Only in respite care is there a rise in numbers, relieving some pressure on carers. The domiciliary care service is supporting people in their own homes who need greater and greater amounts of care. Funding levels need to be adjusted to take account of this greater intensity of support required.

- **Rationing impacts on quality.** Clearly good social care for older people exists. But while local authorities are required to ration care so comprehensively, concerns about basic safety and making the money stretch take priority, and the potential for developing flexible, person-centred care takes a back seat. The quality of care that most older people currently receive does not match the ideals of the Government’s policy intentions. A focus on basic survival tasks leaves little scope for ensuring that the oldest and frailest people are helped to have an acceptable quality of life.

- **Potential for developing preventive services and promoting independence is very limited.** The promotion of independent living is a Government objective that is very warmly welcomed by older people. However, Promoting Independence grants are the main source of available funding for such developments and resource pressures are such that the Social Services Inspectorate has expressed concern about the ability of many Councils to find the money to deliver preventive services⁴.

- **Intermediate care.** £900 million funding was allocated in the NHS Plan for Intermediate care, and the development of active recovery and rehabilitation services and rapid response teams to prevent admission to hospital. An additional £300 million over 2 years has recently been announced. The adequacy of this level of funding in relation to the level of need is unknown. There are, however, concerns about the distribution of the money between health and social services; evidence from the Social Services Inspectorate indicates that there has been ‘a diversion of intermediate care resources into acute services’⁵. Social care is an essential element in intermediate care, not an added extra. A substantial proportion of Intermediate care resources will need to be transferred to social services if older people are to receive the balance of care they need. Both the adequacy and the distribution of Intermediate care resources will need to be closely monitored.

- **Avoiding the ‘revolving door’.** Intermediate care is only intended to meet the short-term needs of older people discharged more quickly from hospital or avoiding admission. The guidance indicates that six weeks is the maximum period envisaged during which such care will be provided and the norm is expected to be as little as one to two weeks. Many of those who are helped to return home or to stay at home will need much longer term support from social care services in order to live

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⁴ Department of Health *Modern Social Services: a commitment to deliver* 2001
⁵ Ibid
independently, in many cases life-long. It is far from clear where these extra funds are going to come from.

Without long term support, Intermediate care will result only in a short delay before intensive services are again called upon. There is therefore a clear need for substantial additional resources for longer-term social care to prevent a ‘revolving door’ cycle of hospital admission or emergency care.

- **Longer term care.** The NHS Plan\(^6\) envisages 50,000 more people enabled to live independently at home with additional home care and other support, 50% more people benefiting from community equipment services, and 75,000 more older people and their carers benefiting from respite care (NHS Plan 15.14). Clearly this will substantially increase demand on social services which are already overstretched. It is not clear where this money will come from.

The prospects for independent living for older people and reduced demand for hospital and other high intensity services need to be sustained by realistic, planned long term funding for their support.

- **New projections** from the Personal Social Services Research Unit \(^7\) illustrate the likely steep rise in demand for social care resulting from population changes over the next thirty years. To put off dealing with today’s underfunding problem is only store up greater problems for the future, while getting the balance of social care right now could have a significant impact on future costs.

While a comprehensive re-evaluation of NHS funding has been undertaken and new substantial resources promised, no comparable assessment has taken place with regard to the resources needed for social services authorities to fulfil their side of the equation. Without that reassessment and enhanced investment, they will be unable to meet enhanced obligations, NHS objectives cannot be met, independent providers of home and residential and nursing home care will struggle against the odds to keep their businesses afloat and services running, and older people will continue to lack essential care.

4. **The reasons behind financial pressures**

What then are the financial realities behind this situation? Older people make up approximately 62% of social services clients (according to Department of Health estimates\(^8\)), but account for 47% of current social services spending\(^9\). Gross expenditure by social services on older people for 1999/2000 was £5,640 million and net expenditure, following fees and charges, was £4,160 million.

\(^6\) Department of Health: *The NHS Plan: a plan for investment, a plan for reform* July 2001
\(^7\) PSSRU: *Demand for long term care for older people in England to 2031* LSE and U of Kent 2001
\(^8\) This figure is a rough estimate for 1999/2000, since total client numbers are not routinely collected.
\(^9\) Department of Health *Personal Social Services – current expenditure in England* 2001
**Increased funding for social services has not kept pace with Government objectives.**

- The Government has provided a genuine ‘real terms’ increase in funding levels for social services departments through the Standard Spending Assessment (SSA) and Special Grants. However, the average increase of 3.5% over the next three years falls well short of the 5.9% average being invested in the NHS.¹⁰

- This differential increase is not consistent with the Government’s intention that health and social care should work together seamlessly to provide a comprehensive and integrated service to older people. Nor is it consistent with the NHS Plan’s objectives to enhance preventive care and promote the independence of older people.

- The Government has recognised the crisis in relation to delayed discharges from hospital. 6.2 million older people have a stay in hospital each year, and it is estimated that 11% of hospital stays suffer from delayed discharge – there are nearly 700,000 older people each year, whose discharge is delayed.

- The Government has promised new money for Intermediate care and an extra £300 million over two years (October 2001) to help resolve problems with delayed hospital discharge. It is not clear how far this money will go to resolve this problem, nor what proportion of it is likely to be spent on social care.

- The new money is geared to tackle only the most visible tip of the iceberg – older people occupying a hospital bed who need alternative care. Others are waiting out of sight in their own homes and many of those who are helped to leave hospital will need long term support.

- The underfunding of social care is a much wider problem and needs to be tackled comprehensively, so that we get the right levels of funding throughout the social care system and older people’s needs can be met in the right way at the right time.

**The increase in resources promised to the social services has not kept pace with increased service provision costs and increased demand.**

- Data from the Performance Assessment Framework returns (see App 1) show that the costs of providing home care, day care and residential care are rising more quickly than the increases in the Standard Spending Assessment allows for.

- Increasing numbers of people are seeking help from social services departments. The escalating financial pressures are apparent. Social care has suffered continually from being subject to cash limits which are inadequately related to the changing demand for services and to the Government’s desire to improve quality.

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¹⁰ Department of Health: *Modern Social Services: a commitment to deliver* 2001
With ever tighter eligibility criteria for access to social care, those being looked after by Social Services are frailer and more dependent each year. The intensity of services has therefore increased, with fewer people receiving more hours of home care, as reflected in Department of Health statistics and the attached chart (App 2).

While the Fair Access to Care initiative is attempting to ensure comparability in access to care across local authorities, few local authorities believe that their resources will enable them to fund more than those in the highest categories of need.

Ringfenced grants to promote independence may enable some new low level provision to develop, but for those who need a medium level of support to ensure their safety and comfort and to prevent deterioration in their circumstances, there will be nothing.

Cash limits are now being explicitly extended to health care services: the Department of Health’s guidance on assessment states that ‘When determining priorities and the services they provide, health authorities and PCTs are entitled to take their resources into account. When setting eligibility criteria, councils should take account of their resources’ (p17 Guidance on the Single Assessment Process, Aug 2001).

Waiting list pressures tend to cut across the ‘whole systems’ development of intermediate care facilities; Councils report a diversion of intermediate care resources into acute services in the NHS.

New policy and performance obligations have major financial implications for social services authorities and other providers.

The raised standards and expectations resulting from the implementation of the National Service Framework for Older People, the Quality Strategy for Social Care Services, the Care Homes for Older People-National Minimum Standards, new standards for domiciliary care, the introduction of the Carers and Disabled Children’s Act and the overall focus on improved responsiveness and service standards (and attendant increases in numbers of referrals) will have significant cost implications.

The National Service Framework requires social services, like the NHS, to ‘root out age discrimination’. Social services authorities customarily place lower cash limits on social care packages for older people than those for younger people, irrespective of the level of need. For example unit costs of residential and nursing care in 2000/01 were £342 for older people, £512 for those with physical disabilities, £423 for adults with mental health problems, and £669 for adults with learning disabilities. If local authorities are to equalise levels and quality of care between older people and younger adults, a major new injection of resources is going to be

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needed to bring older people’s services up to those routinely expected by other groups.

- Budget pressures will be increased by:
  - The introduction of statutory guidance to reduce the variation in domiciliary care charges from April 2001
  - The introduction of a three month disregard for those going into residential/nursing care
  - The charging delay brought about by the restoration of capital savings limits to 1996 levels, for which there is no funding provision
  - The pending introduction of free nursing care for those supported by local authorities, which raises the prospect of increased transactional costs for both health and social services.
  - The attendant systems’ reorganisation and a loss of income will exacerbate this cost pressure in 2001/02.

There are existing acute difficulties in the recruitment and retention of social care staff.

- The Training Organisation for Personal Social Services (TOPSS) estimates that there are some 1.1 million social services staff – more or less equivalent to the one million people employed by the NHS in England.

- A large percentage are untrained and it will take years before improvements in training show significant results, especially amongst front line staff in direct contact with older people.

- It is difficult to recruit and retain staff of the necessary calibre and with the right approach, because of poor pay and conditions and poor job satisfaction.

- *Future Imperfect*, the Kings Fund Care and Support Inquiry\(^\text{12}\), detailed many of the problems currently affecting social services staffing and the delivery of home care, including lack of training, hurried service delivery and recruitment problems due to poor pay and conditions.

- UNISON has pointed out that a high proportion of home care workers are currently in their fifties and not far off retirement.

- New standards are due to be introduced for domiciliary care this year. The demand for radical strategies has inevitable cost implications. With vacancy rates in excess of 20% and turnover rates of 16.9 % for homecare workers, local authorities’ ability

\(^{12}\) Kings Fund: *Future Imperfect* – the Care and Support Inquiry June 2001
to achieve national targets for social care services is seriously undermined. These difficulties in turn impact on the NHS’s ability to achieve many of the targets in the NHS Plan and threaten the quality of services being delivered to older people.

**Social services departments routinely spend more on social care for older people than the amount allocated for this purpose by central Government.**

- Local authorities spend significantly above their Standard Spending Assessment for social services, on average around 8.9% for 2000/01. This is set to rise to 9.7% in 2001/02. This clearly impacts on other council departments which they are subsidising their own social services departments from other budgets.

- Even so, social services overspend. The Local Government Association, Association of Directors of Social Services and Societies of County and Municipal Treasurers Financial Survey 2001 indicates that social services departments were typically starting the 2001/2002 financial year with overspends (App 1). This is clearly likely to affect their ability to keep pace with NHS partnership plans.

- The growing gap between central government allocations and local government spending means that most local authorities will not be able to sustain or improve their social services for 2001/02.

- With continuing policy and public pressures to improve child care services, older people’s services are often not the top priority for social services authorities. Older people’s services ‘tend to take a lower priority since the penalties for neglecting children are far worse’¹³. It is estimated by the Local Government Association that 64% of overspending by social services authorities is on children’s services and 21% on older people’s services.

- In spite of the general picture of overspending on older people budgets, a few local authorities, mostly in the South of England, actually underspend their SSA for older people, with a consequent impact on older people’s services in those areas.

**There is an urgent need for a ‘whole systems’ review of funding levels for social care for older people.**

- Social services budgets are already almost £1 billion above government provision, even without the additional overspend pressures of around £200 million this year. Budget returns for 2001-2002 suggest that Councils are planning to spend £9.87 billion on social services, more than 10% above government guidelines and almost 6% over last year’s budget plans. CIPFA data suggests an overspend of £210 million above Government grant and for older people, £42 million above locally set budgets. The Chair of the Local Government Association notes that the pressures are those of need, demand, statutory duty, workforce availability, market capacity and cost increases in excess of inflation.

¹³ Guardian Society 2.5.2001
• The Government has increased social care resources, with the announcement in October of an additional £300 million over two years to relieve delayed discharge from hospital. But the funding pressures on local authorities are far more far-reaching than that. Sticking plaster solutions for one part of the system are not the answer. They merely serve to displace the problem from one part of the system to another. Older people will be removed from hospital beds and out of the public eye, without there being any assurance that their long term needs can be met elsewhere. Those with less acute needs drop off the end of the queue, and the vicious cycle of lack of support for independence, increasing dependency and demand on high intensity services starts all over again.

• The Royal Commission on Long Term Care\textsuperscript{14} recommended the establishment of a National Care Commission, which would ‘monitor longitudinal trends, including demography and spending, ensure transparency and accountability in the system, represent the interests of consumers, and set national benchmarks, now and in the future’ (recommendation 2). We suggest that such a commission would be of great value to the Government, to those charged with managing services and to the public, and is long overdue.

• In the meantime, social care for older people is in crisis and there is an overwhelming case for an urgent across-the-board review of social care funding.

• \textit{What is needed is long term, consistent, planned growth based on a realistic assessment of the costs of providing social care to the level and quality required to meet Government objectives.}

5. Case studies

• Delayed discharge

\textsuperscript{14} Royal Commission on Long Term Care: \textit{With Respect to Old Age}. February 1999
Mrs K has been in hospital for 25 weeks, awaiting discharge to her home. She has been assessed as needing two care workers four times a day but due to understaffing she has been placed on a waiting list. The Social Services department will not consider other options, such as paying private carers or offering direct payments. She is extremely depressed in hospital. August 01

Mrs. B’s mother-in-law was assessed as needing residential care while in hospital in November 2000. The financial assessment has yet to be carried out. She has remained in hospital the whole time. The caller has been told that funding can only be arranged when a currently funded resident “no longer requires help” or extra resources are allocated by the government. July 2001

Mr. M’s mother is 93 and has been in hospital since February. She has been assessed as needing residential care, has no property to sell and has savings of below £11,500. Mr. M has been told by the Social Services Department that there is a 6 month wait for residential care funding and it has suggested the “benefits loophole” as an interim way to pay the fees. July 2001

Mrs Z is in hospital and has been assessed as needing a further night call once she returns home. The Social Services department has said that there are insufficient resources to provide this extra call and advised her of her right to use the formal complaints procedure. September 01

Mr. T’s mother has been in hospital for six months awaiting Social Services funding for a care home. The Social Services Department has informed the caller that funds are not available for this at present. He has made a formal complaint, contacted the MP and press and sent letters from a solicitor but to no avail. June 2001

Mrs. R has dementia and needs a hoist. Her husband was told by Social Services that it would have taken a minimum of 9 months to get a hoist. This would have resulted in his wife remaining in hospital for that length of time. Mr. R approached us for help with purchasing the hoist. June 2001

Mr. C was in hospital and assessed as needing a nursing home. The consultant said that only a few homes were capable of providing the level of care needed. The family were told the social services limit, £346, which was substantially lower than the cost of suitable homes. The family were looking at a top up of over £100 per week in order to get Mr. C into a suitable home. All other homes had turned him down. The family complained. The complaints officer told them that they couldn’t use the complaints procedure to complain about funding levels. The family have now made a stage two complaint.

Mrs P is in hospital awaiting an assessment. The Social Services Department has advised her daughter that if her mother returns home, it can no longer afford to provide her with her previous domiciliary care package or any additional care she now needs. They have also said that they ’will not be able to afford to pay any residential care fees’, although Mrs P has less than £11,500 in savings. July 01
• Mr A is in hospital following a stroke. The Social Services Department has assessed him as needing grab rails to help him with bathing when he returns home, but has said they no longer provide such items. June 01

• Mrs. H had been in hospital for over 6 months and had been assessed as needing a nursing home. The family identified a suitable, local home but the council said that it was above their funding level.

**Delivery of appropriate care**

• Mr. L has Alzheimer’s disease and is doubly incontinent. He is totally dependent on his wife to meet his needs. He needs a flat shower urgently to ensure that his personal care needs can be met safely and the risk of falls and injury to Mr. L and his wife are reduced. His assessment states that the current facility is unsafe and a new shower is needed urgently. Mrs. L has been told that she will have to wait a year. Mrs. L approached us for help. July 2001

• Mrs S is 83 and finding it hard to get in and out of the bath. The Social Services Department said that she wasn’t a priority and had not offered an assessment. August 01

• Mr. M's wife has dementia and has been assessed as needing to move into a nursing home. Social Services refused to pay for Mrs. M's nursing care because Mr. M was paid some compensation money following an industrial injury. Social Services viewed this money as if Mrs. M owned half of it, and consequently decided that she had too much money to qualify for help under Social Services' means-test. Mr. M's wife was therefore left without funding for her care home fees. We advocated on Mr. M's behalf, made a formal complaint to Social Services about their decision, and also involved the monitoring officer, a local councilor and the ombudsman. Social Services have now written to say they agree that Mrs. M did not in fact own the disputed money. This means Mrs. M should now get funding for her care home fees.

• Mrs. T has dementia and was being cared for at home by her husband. Mr. T suffered from cancer and was not expected to live long. He was admitted to hospital and was unlikely to return home. Mrs. T went into a local home for respite until her long term future could be decided. Social services carried out an assessment on Mrs. T and assessed her as needing to stay in the care home. Mrs. T's daughter contacted us as she and her mother were very distressed. We were told that Mrs. T was very agitated and clearly wanted to go home, but social services had told the family that they were not prepared to put in the hours of care that were needed to allow Mrs. T to go home, in effect forcing her into a care home. We wrote on the family’s behalf pointing out that the assessment should not just look at Mrs. T’s physical care needs. Mrs. T was having to come to terms with the loss of her husband and her main carer. If she was forced to move she would also be dealing
with the loss of her home and its familiar surroundings, and for someone with dementia this would be disastrous. Social services revised its decision and agreed a care package that keeps Mrs. T in her own home.

- Mrs. R is in her 90s and a resident of a care home. Social services refused to pay the full costs of the home and instead entered a "third party agreement" in which her three children, all retired and living on income support or disability benefits, agreed to pay a weekly sum towards the cost of the home. The three siblings had no choice as they were unable to find a home in the area which would take Mrs. R at the fee level set by social services. We were contacted by Mrs. R's daughter. The family had borrowed money in order to pay their contribution, were now in debt and unable to pay their share on the fees. We helped the family complain to social services and to the local government ombudsman. The ombudsman ordered social services to pay the full fees from the date Mrs. R moved into the home, and pay compensation to her family.

- Mrs. M was in respite care and assessed as needing a place in a residential care home near to her family. Mrs. M's family found a place in the only care home in the area with a vacancy but the social services funding limit was insufficient to secure a place without £20 per week top-up from the family. The department are refusing to increase its limit and the case is due to go to a review panel.

- Miss K has been in a care home for three years. Her savings fell to £15,000. The homeowner contacted the social services who told him to ask the family to get in touch. The only relative, a nephew, was told that the social service limit was £275. The home's fees, after a reduction, are £308. (Social services are paying this figure for another resident). The home owner informed us that a social worker called to see Miss K and suggested she move. The social worker contacted us and said that Miss K wanted to move and the home owner was putting pressure on her to stay. We spoke to Miss K on the phone. She said that she was alone. She said that the social worker suggested that she move. Miss K said that she told the social worker that she wanted to stay but "if there isn't enough money then I suppose I will have to move." We asked the social worker for a copy of the care plan. It states "Miss K felt bored at XXX House and liked the idea of a new bed and the opportunity to have a fresh start with new residents." We have contacted an advocate to attend a review of the assessment.

- Miss P is 90 years old and has mental health problems, a chest infection and MRSA. She wanted help with fees in a Home. Local authority funding was inadequate to cover the fees. She had been in the home for many years (but not in receipt of Income Support, having moved in later that 1993 but without local authority funding due to her own resources). Her own capital was now reduced and she did not wish to move to another, cheaper home (if one could be found in the area) and this is all the Local authority was offering. There is no question that she needs the care offered or that the home is suitable, money is the issue.
Mrs L has had a stroke, is paralysed on one side, incontinent, without speech and registered blind. She wanted help with a fees top-up. Local authority funding was inadequate to cover the fees and she did not wish to move to another, cheaper home, were one to become available in the area, now that her funds had depleted.

A 60 year old disabled man needs a stairlift. This is not disputed by the social services department which sent staff to visit and assess. However, Social Services has 'run out of money' and can do nothing further on his case for 6 months. Thereafter there will still be a delay before work can be planned and undertaken if the required sum were to be available. The client is desperate and needs the work done now. On social services advice he approached us for help.

An elderly lady, who was widowed in January 2000 and has since lived alone, can no longer cope and constantly falls. She is increasingly frail and the social services department has assessed her as needing residential care. Social services suggested a period of respite initially and the family was asked to pay the full cost of this. They agreed. They found a suitable home in consultation with the social services department who agreed to the placement. Social services discussed this at an allocation meeting where it was agreed that the family must find £60 per week towards the fees. However no 'funded rate room' was available and social services suggested to them that they approach charities. The room at £60 more is agreed to be best for her in that it is more spacious to allow her to move safely with her walking frame and it avoids the need for her to use a lift. In this room there is no need for her to change levels as all facilities are on the same floor along with the entrance. Using a lift she finds impossible as she is confused. Social services have explained to the family that if a charitable funder cannot be found by the family the resident will have to move to another home or a different room if one becomes available - unlikely in the time - despite agreeing to the placement in this home and the specific room due to her confusion.

Miss P requested a community care assessment for her 75 year old aunt in September 2000. The assessment had yet to happen in July 2001.

Mrs V was visited by her care manager and another person at less than 24 hours notice. The other person was not properly introduced but partially undressed Mrs V in order to ‘assess her ability to dress’. Mrs V felt frightened and upset by the experience. As a result of the visit, her care package was reduced, although her family feels that her needs have increased. July 01

The caller’s mother came to live with her eight years ago. She has juggled a full time job with caring for her mother without support throughout this time. She requested a community care assessment as she was finding it increasingly difficult to cope with her mother’s mobility problems and personal care needs. She was told her mother would not be assessed as she had too much capital, and in any case, the Social Services Department had no money to provide services or equipment at present. June 01
Financial sources

A. Extracts from Association of Directors of Social Services Resources Committee Data.

Personal Social Services Standard Spending Assessment
Real terms spending increases:
00/01  8693.4m
01/02  8845.9m +2.2%
02/03  9320.9 +2.8%
03/04  9938.9 +2.4%
Assumption of inflation at 2.5% and cost efficiency savings of 2% built in.

Risks
distribution formula
demographic pressures
inflation
additional duties

Promoting Independence Grant (formerly Partnership and prevention Grants).
00/01  216m (+ 30m)
01/02  296m (-100m for Winter pressures)
02/03  862m (-528m for DSS preserved rights and residential allowance [93m])
03/04  873m (-474m for DSS preserved rights and residential allowance)

NB Workload increases may make cost ceilings rise.

Carers Grant
00/01  50m
01/02  70m
02/03  85m
03/04  100m

Other Grants.
Placing more charges on homes.
01/02  15m
02/03  30m
03/04  40m

Community equipment and adaptations = £ unknown
Could provide real relief to capital budget
Disabled Facilities Grant 2001-2004 £39m
Information Management (‘Information for Social Care’)
01/02   3m – demonstration projects
02/03   25m
03/04   25m

**Performance Fund**

02/03   50m (based on 01/02 performance in first instance & focussing on intermediate care – will require joint work with health)
03/04   100m

**Funding In Partnership With Other Agencies.**

NHS Plan Funding – Intermediate care, 00/01 107m identified for such projects (from 660m). 900m funding to 03/04.

Intermediate/transitional care - 01/02 £52m, winter pressures money.

Additional capacity for winter – £40 million in November 2000 to address lack of capacity in residential and nursing homes.

One stop primary care centres (to include social workers) – £16 Billion capital by 2004

Supporting People – £138m over three years
01/02: £15m

**B. Performance Assessment Framework Indicator Data.**

**Indicators.**

B12 – Cost of intensive social care for adults and older people, with 98/99 base-line, risen by 3.6% in 99/2000.

B13 - Unit cost of residential/nursing care for older people, with 97/98 base-line, risen by 6.1% in 98/99 and 5% in 99/2000.

B17 - Unit cost of home care for adults and older people, with 97/98 base-line, risen by 10.2% in 98/99 and 4.1% in 99/2000.

C32 – Older People Helped to live at home, with 97/98 base-line, risen by 1.2% in 98/99 and 2.4% in 99/2000.

**C. National Statistics Bulletin 2001 (DOH).**

Older people account for 47% of gross expenditure (1999-2000)

Residential care provision gross costs up 9% from 98/99 to 99/2000
Day domiciliary provision spend risen from £1,600m in 98/99 to £1,720m in 99/2000, a rise of 7.5%.

D. CIPFA Data, older people, for England and Wales

<table>
<thead>
<tr>
<th>1999/00</th>
<th>2000/01</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Net Expenditure (£000’s)</td>
<td>£3,236,749</td>
</tr>
</tbody>
</table>

Total Net Expenditure = All expenditure, minus Income.

<table>
<thead>
<tr>
<th>Population over 65</th>
<th>8,426,799</th>
<th>8,331,581 (decrease is correct)</th>
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<tbody>
<tr>
<td>So Net Cost per head of population, 65+</td>
<td>£384</td>
<td>£405</td>
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% Overspend on Older People’s services = 21% of total overspend (Guardian), so Councils are forced to spend in 2000/01, £210 million above government grant levels (the £1 Billion in LGA survey text) and have also overspent their locally set budgets by around £42 million in 2000/01 (the £200 million in LGA Survey text).

The number of older people supported - This is a best guess from 99/2000 PAF indicator C32 – ‘Number of older people helped to live at home’. Added onto this is ‘5% of 65+ population are in residential/nursing care’ statement much used.

This equals 646,390 + 421,340 (CIPFA fig’s) = 1,067,730 clients supported.


Average Standard Purchasing Costs (to Local Authorities).

<table>
<thead>
<tr>
<th>Home Care per Hour</th>
<th>1999/2000(actuals)</th>
<th>2000/2001(estimate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Own</td>
<td>12.30</td>
<td>11.55</td>
</tr>
<tr>
<td>Other</td>
<td>8.89</td>
<td>9.02</td>
</tr>
<tr>
<td>Meals</td>
<td>Own</td>
<td>=3.58</td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Nursing Home per week</td>
<td>=356</td>
<td>=349</td>
</tr>
<tr>
<td>Other Residential, per Week</td>
<td>Own</td>
<td>=389</td>
</tr>
<tr>
<td>Day Care, per Day</td>
<td>Own</td>
<td>=19.76</td>
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<tr>
<td>Number of resident weeks being purchased</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Homes</td>
<td>=4,246720</td>
<td>=4,261496</td>
</tr>
<tr>
<td>Other Residential:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own</td>
<td>=2,668068</td>
<td>=2,841147</td>
</tr>
<tr>
<td>Other</td>
<td>=5,819318</td>
<td>=6,132323</td>
</tr>
</tbody>
</table>
Appendix 2: Care of People Aged 85 and Over

Population aged 85+ (000s) 1991 - 2000 (1) (trendline)
People Receiving SSD-Funded Home Care Services (all ages) 1992-1998, 2000 (2)
Net SSD Funding for Elderly (£000s) 1991-2000 (3) (trendline)
People aged 65+ Receiving SSD-Funded Home Care Services 1994-1998, 2000 (4)
People aged 65+ Receiving SSD-Funded Residential and Nursing Care 1991-2000 (5)
People aged 85+ Receiving SSD-Funded Home Care Services 1994-1998, 2000 (6)
People aged 85+ Receiving SSD-Funded Residential and Nursing Care 1991-2000 (7)

Sources: Office of National Statistics Population Estimates; Department of Health (various); Laing and Buisson Care of the elderly market survey 2000.
## Members of the Social Policy Ageing Information Network

<table>
<thead>
<tr>
<th>Organization</th>
<th>Contact Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbeyfield Society</td>
<td>Montelle Neufville</td>
</tr>
<tr>
<td>Action on Elder Abuse</td>
<td>Ginny Jenkins</td>
</tr>
<tr>
<td>Age Concern England *</td>
<td>Stephen Lowe</td>
</tr>
<tr>
<td>Age Concern Scotland</td>
<td>Maureen O'Neill</td>
</tr>
<tr>
<td>Alzheimers Society *</td>
<td>Julia Cream</td>
</tr>
<tr>
<td>Anchor Trust</td>
<td>Debbie Smith</td>
</tr>
<tr>
<td>Arthritis Care</td>
<td>Neil Betteridge</td>
</tr>
<tr>
<td>Association of Charity Officers</td>
<td>Valerie Barrow</td>
</tr>
<tr>
<td>Association of Retired Persons</td>
<td>Don Steele</td>
</tr>
<tr>
<td>Beth Johnson Foundation</td>
<td>Andrew Dunning</td>
</tr>
<tr>
<td>Carers UK</td>
<td>Vicky Pearlman</td>
</tr>
<tr>
<td>Centre for Policy on Ageing *</td>
<td>Keith Sumner</td>
</tr>
<tr>
<td>Counsel and Care</td>
<td>Les Bright</td>
</tr>
<tr>
<td>Fawcett Society</td>
<td>Geethika Jayatilaka</td>
</tr>
<tr>
<td>Greater London Forum for the Elderly</td>
<td>Carlie Newman</td>
</tr>
<tr>
<td>Hanover Housing Association</td>
<td>Sue Garwood</td>
</tr>
<tr>
<td>Health and Older People</td>
<td>Stan Davison</td>
</tr>
<tr>
<td>Help the Aged *</td>
<td>Tessa Harding</td>
</tr>
<tr>
<td></td>
<td>Gail Elkington</td>
</tr>
<tr>
<td>Hill Homes</td>
<td>Ann Ivis-Shaw</td>
</tr>
<tr>
<td>Housing 21</td>
<td>Nigel Walker</td>
</tr>
<tr>
<td>Joseph Rowntree Foundation</td>
<td>Sue Collins</td>
</tr>
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</table>
Methodist Homes for the Aged
National Association of Citizen Advice Bureaux
National Pensioners Convention Parkinsons Disease Society
Race Equality Unit
RADAR
Relatives and Residents Association
Senior Citizens Forums Network
Stroke Association
The Foundation of Lady Katherine Leveson
UNISON

Robert Parkinson
Liz Phelps
Dr Mary Parkinson
Rachel Haynes
Ratna Dutt
Agnes Fletcher
Sue Adams
Tony Carter
Sheila Dane
Alison Johnson
Celia Dignan

Secretary to the group: Alison Giordimaina, Help the Aged
Press advice: Hilary Carter, Help the Aged

Starred members of the group were principally responsible for compiling this report. Other members of the group contributed information, case studies and comments. Acknowledgement is also made to Gill Heath of Help the Aged who compiled the chart in Appendix 2.

November 2001