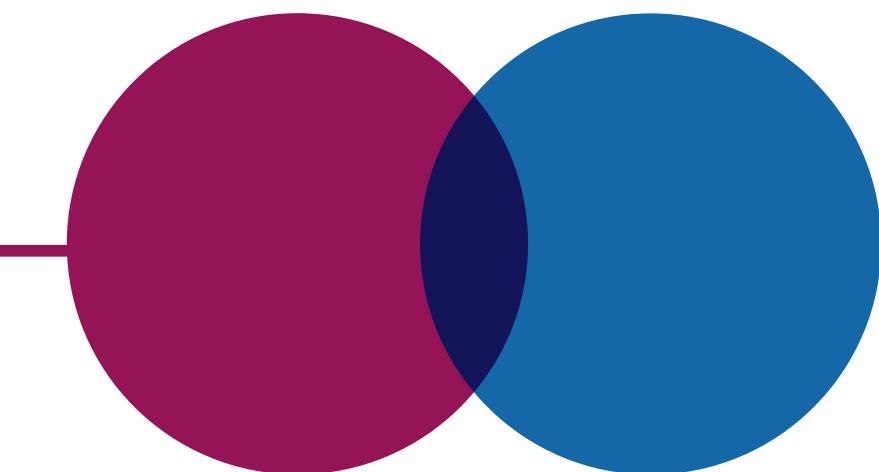




National Audit Office



The adult social care market in England

Department of Health & Social Care

REPORT
by the Comptroller
and Auditor General

SESSION 2019–2021
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HC 1244



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The adult social care market in England

Department of Health & Social Care

Report by the Comptroller and Auditor General

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Gareth Davies
Comptroller and Auditor General
National Audit Office

22 March 2021

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Key facts

839,000

number of adults receiving long-term support at some point during 2019-20, arranged by local authorities

£16.5bn

net local authority expenditure on adult social care in 2019-20

25,800

estimated number of regulated adult social care locations as at March 2020

- | | |
|--|--|
| <p>30%</p> <p>1.5 million</p> <p>29%</p> <p>90%</p> <p>57%</p> <p>106%</p> | <p>of the overall care market by number of beds, subject to Care Quality Commission (CQC) market oversight of the financial sustainability of most difficult-to-replace care providers</p> <p>estimated number of people working in adult social care in 2019-20</p> <p>projected forecast increase in adults aged 18 to 64 requiring care by 2038 compared with 2018</p> <p>projected forecast increase in costs of care for adults aged 18 to 64 by 2038 compared with 2018</p> <p>projected forecast increase in adults aged 65 and over requiring care by 2038 compared with 2018</p> <p>projected forecast increase in total costs of care for adults aged 65 and over by 2038 compared with 2018</p> |
|--|--|

Summary

- 1** Adult social care (care) covers social work, personal care and practical support for adults with a physical disability, a learning disability, or physical or mental illness, as well as support for their carers. Family or friends provide most care unpaid. The amount of unpaid care provided affects the extent of formal care required, funded through local authorities, or adults buying their care privately (self-funders). Eligibility criteria for accessing publicly funded care are set out in the Care Act 2014.
- 2** Care is delivered through local authorities, which are accountable to their local populations. The Department of Health & Social Care (the Department) is responsible for setting national policy and the legal framework. It is accountable to Parliament and the public for the performance of the care system as a whole. The Ministry of Housing, Communities & Local Government (the Ministry) oversees the distribution of funding to local government and the financial framework within which local authorities operate. As set out in the Care Act 2014, local authorities are responsible for commissioning care, mostly from independent providers which are autonomous enterprises. Around 14,800 registered organisations across 25,800 locations provide care. The Care Quality Commission (CQC) regulates care providers for quality and also provides oversight of the financial resilience of the largest and potentially most difficult-to-replace care providers.
- 3** Under the Care Act 2014, the Department does not have legal powers to intervene or hold individual local authorities to account for their performance. In February 2021, the Department published its legislative proposals for a Health and Care Bill, which include plans for gathering more information on social care and would give CQC new duties to review and assess local authority performance.
- 4** In 2019-20, local authorities spent a net £16.5 billion on care. Current demographic trends suggest a greater demand for care and increasingly complex care needs in the future, resulting in care forming an ever-increasing proportion of public expenditure. Future reforms, promised for several years, will need to tackle these growing challenges.

Our report

5 This report examines the current care market and the Department's role in overseeing the market now and in the future, with the aim of offering insights and recommendations ahead of future social care reforms. It builds on a significant body of past National Audit Office (NAO) work on care, including on the care workforce; personalised commissioning; and the interface between health and care. In Part One, we provide an overview of the market. In Part Two, we assess market oversight. In Part Three, we assess plans for future demand and reform.

6 Our main methods were analysis of available data; interviews with central and local government, provider organisations and other stakeholders; and review of published research and relevant departmental documents. Most data refer to the market as at 31 March 2020, the latest point for comprehensive data. Appendices One and Two set out our audit approach and methods in more detail.

7 We do not examine care delivery or policy in the devolved nations (Northern Ireland, Scotland, Wales) or internationally. The report does not assess care commissioned by health bodies, the interface between health and care systems in detail, or user experience. We therefore do not assess the impact of or issues arising from NHS continuing healthcare or NHS-funded nursing care.

Key findings

Overview of the market

8 Local authorities, who arrange most formal care, were facing significant financial pressures before COVID-19. Government funding for local authorities in aggregate fell by 55% in 2019-20 compared with 2010-11, resulting in a 29% real-terms reduction in local government spending power (government funding plus council tax revenue). Our report on *Local Government finance in the pandemic* highlighted how local authority finances will continue to be under significant financial pressure in 2021-22 (paragraph 1.7).

9 Local authority spending on care is lower than in 2010-11 but has begun to rise compared with previous years, with most spend going on long-term support. Local authority net spending (funded by council tax, government grants and business rates) in 2019-20 was £16.5 billion; 4% lower in real terms than in 2010-11, but at its highest level since 2012-13. Of this local authority net spend plus £3.1 billion in user contributions (amounts paid to local authorities by some care users towards their care costs), £15.4 billion was spent on providing long-term support, of which £6.4 billion was for physical support and £6.0 billion was for learning disability support (paragraphs 1.8 to 1.10).

10 Since 2015-16, the number of adults aged 65 and over receiving long-term support arranged by local authorities has fallen. Between 2015-16 and 2019-20, the total number of adults receiving long-term support arranged by local authorities fell from 873,000 to 839,000, within which those aged 65 and over fell 6.6% from 587,000 to 548,000. The Department does not have adequate data to assess how much of this decrease is due to reduced support offered by local authorities, more self-funders or the impact of preventative action meaning adults require less support and is planning research into this (paragraphs 1.13 and 1.14).

11 Estimates suggest high levels of unpaid care and unmet need. Pre COVID-19, the charity Carers UK estimated there were around 7.3 million carers in England, most of whom are unpaid family, friends and neighbours who provide care informally. In the Health Survey of England 2019, 17% of people aged 16 and over reported providing unpaid care. Levels of unmet care need in adults aged 65 and over has remained relatively stable at around 24% (paragraphs 1.17 to 1.20).

12 Most care is good quality, but 16% of CQC-registered care providers require improvement or are inadequate. As at May 2020, CQC found that four out of five registered adult social care services in England provided good care overall, with one in twenty providers rated outstanding. However, 15% of services require improvement and 1% of services were inadequate. The best-performing region was the North East (where 89% of locations provide good or outstanding care) while the worst-performing region was West Midlands (where 80% of locations provide good or outstanding care) (paragraph 1.23).

13 COVID-19 could have short- to medium-term consequences for the market's financial sustainability. Financial data pre-COVID-19 shows provider earnings varied. Some 55% of large for-profit care homes and 39% of large for-profit care at home providers reported a return on investment of less than 5% in 2019. Significant numbers of large providers are not financially resilient. We previously reported how the COVID-19 pandemic could negatively impact profitability as care home providers rebuild occupancy, which could take at least 18 months. CQC's latest analysis found that, despite COVID-19, revenue and profitability among large providers had remained relatively stable due to government support. However, it warns that ongoing support could be required in 2021 if care home admissions remain low or costs inflated. Occupancy in care homes fell from around 90% at the start of the pandemic to around 80% in February 2021. CQC found that large home care and specialist providers have been financially less affected by COVID-19 (paragraphs 1.24 to 1.27 and 2.31).

Oversight and accountability

14 Short-term funding settlements have hampered long-term planning, innovation and investment in care. The sector has long called for a sustainable, long-term funding solution for care. We have previously emphasised the importance of long-term planning and clarity beyond the end of a spending review period. Short-term and one-off funding initiatives for local government and successive one-year spending reviews have hampered local authorities' ability to plan for care costs beyond the current financial year, constraining much-needed innovation and investment. Government's increasing emphasis on raising permanent funds via increases in council tax through the precept could disadvantage those areas with a lower tax base and a greater demand for local authority-funded provision (paragraphs 2.4, 2.6 and 2.7).

15 Current accountability and oversight arrangements are ineffective for overseeing a disaggregated market. While the Department is responsible for securing funding for care, the Ministry distributes most grant funding to local authorities based partially on an out-of-date adult social care funding formula. In recent years ad-hoc funding increases have been required. Despite its high-level objectives for care, the Department lacks visibility of the effectiveness of local authority commissioning. The Department told us that because of its lack of legal powers under the Care Act, it has had limited oversight of local authority performance in a system which commissions services largely based on care home placements, staff time and tasks rather than outcomes. Instead, the Department relies upon insights from CQC's inspection and market oversight roles, as well as the Adult Social Care Outcomes Framework (the framework) to assess outcomes achieved. Yet the framework does not currently cover all local authority responsibilities for care, nor does it focus sufficiently on well-being and user perspective. These limitations mean the Department cannot evaluate spending, assess return on investment, or the extent of additional funding needed. In February 2021, the Department outlined proposals which include increasing its oversight of local authority delivery of social care and improving the data it has to assess capacity and risk in the system (paragraphs 2.2, 2.3, 2.7, 2.9, 2.13 to 2.18 and 2.30).

16 The Department acknowledges that most local authorities pay care providers below a sustainable rate but does not use this analysis to challenge local authorities directly. The Department uses an internally developed cost model to assess how many local authorities pay care providers below what it considers are benchmark costs. For 2019-20 the Department assessed that the majority of local authorities paid below the sustainable rate for care home placements for adults aged 65 and over and below the sustainable rate for home care. The Department does not challenge local authorities who pay low rates (paragraph 2.5).

17 The Department increased its focus on care and its oversight of the market in response to COVID-19. The Department outlined how, under the current Care Act 2014, its oversight of the market had been limited. Stakeholders reported the Department's limited engagement with, and understanding of, the sector going into the pandemic. Prior to COVID-19 there was no process in place to collect a wide range of data from providers regularly. There were also significant data gaps on self-funders, levels of unpaid care and unmet need and a lack of visibility of funding flowing through to providers, which remain. In response to COVID-19, the Department has increased the data it obtains on care providers and it intends to legislate for new powers to collect further data. For example, as part of its adult social care winter plan, the Department carried out a review of risks to local care markets and service continuity issues, offering targeted support. It also re-established a director-general post with sole responsibility for social care, increased its policy team three-fold and set up specific teams to provide support and challenge to local government on the COVID-19 response (paragraphs 2.10 to 2.12, 2.18, 2.19, 2.21, 2.25, 2.26 and 2.34).

18 Despite the introduction of CQC's market oversight function, stakeholders lack visibility of provider finances across the care market. The collapse of Southern Cross in 2011 highlighted the need for government to develop a system to address serious provider failure. Since 2015, CQC has overseen the financial sustainability of around 65 difficult-to-replace care providers, representing around 30% of the overall care market by number of beds. Currently local authorities do not benefit from CQC's analysis and monitoring until it notifies them that a provider is likely to fail, and service cessation is likely. Under the Care Act 2014, the scheme was only designed to give local authorities advanced notice of potential failure and service cessation so they can enact contingency plans in line with their legal duties to ensure continuity of care, if necessary. Some providers with a sizeable regional or local presence may not be subject to CQC's oversight but their failure would be significant. In 2020, consultants commissioned to analyse provider viability advised the Department to improve the quality of financial data and its internal processes to track provider finances in real-time. In view of local authority responsibilities for commissioning care and CQC's market oversight role, the Department does not collect additional information on provider finances or their sustainability and therefore did not have processes in place to assess if providers received enough support at the start of COVID-19. Stakeholders raised concerns over the lack of transparency of provider costs and their financial structures, and that increases in fees may result in higher profits rather than increasing care quality (paragraphs 2.18, 2.22 to 2.26 and 2.30).

19 Local authorities understand their duties to shape the market, but say they lack the levers to do this effectively. The Care Act 2014 requires local authorities to ensure a diverse market with enough high-quality services for adults to choose from. Nearly all local authorities and stakeholders we spoke to told us that these market-shaping responsibilities were clear but their ability to do so varied. Local authority market position statements should signal how a local authority would like their local market to develop. From our sample review of 38 statements, less than half of local authorities had updated these since 2016 (paragraphs 2.27 to 2.30).

Understanding future demand and costs

20 Based on long-term forecasts there will be large increases in future demand for care and therefore cost. Demand and cost projections are highly uncertain. The Department projects that if current patterns of care continue, around 29% more adults aged 18 to 64 and 57% more adults aged 65 and over will require care in 2038 compared with 2018. Between 2018 and 2038, the total costs of care are projected to rise by 90% for adults aged 18 to 64, from £9.6 billion to £18.1 billion, and 106% for adults aged 65 and over from £18.3 billion to £37.7 billion. The Department has performed sensitivity analysis on these projections (paragraphs 3.2 to 3.9).

21 The Department is unable to demonstrate that it has adapted demand and cost projections for potential changes in care delivery. The Department does not adequately model the impact of a range of relevant issues. These include changing the mix of care provided, for example a greater use of care at home, the potential impact of breakthroughs in medical treatment or preventative initiatives and the potential impact of cross-government or societal changes such as tax changes or increased flexible working. The Department has commissioned research into some of these issues (paragraphs 3.10 and 3.11).

22 Significant workforce challenges remain, yet the Department has no current plans to produce a workforce strategy. Around 1.5 million people work in care. We have not seen any evidence which has persuaded us to change the main conclusions we reached in our 2018 report *The adult social care workforce in England*. We found the Department had not followed through on key commitments it had made to enhance training and career development and to tackle recruitment and retention challenges. Stakeholders identified the need for central leadership to improve pay and conditions for care workers and to incentivise improved training and development. Despite NAO and Committee of Public Accounts recommendations that the Department produce a workforce strategy and its commitment to do so in 2018, the Department has not had a social care workforce strategy since 2009. The Department told us that a workforce strategy would be dependent on the next spending review settlement and wider system reforms to funding and accountability committed to in the recent white paper (paragraphs 3.16 and 3.17).

23 The Department does not have a clear strategy to develop accommodation for adults with care needs. The Department does not monitor the condition of current accommodation for adults with care needs itself. Business intelligence estimates suggest at current rates it will take several decades to fully modernise care homes. The Competition & Markets Authority warned in 2017 that the current funding situation combined with uncertainty about future funding and care policy means providers are reluctant to invest in the additional capacity needed. Current funding for new investment in accommodation for adults with care needs is ad-hoc, with no coordinated, long-term vision across government about how to fund or incentivise the market through mechanisms such as fee rates, housing benefit, grant funding or loans. The Ministry's calculation of future housing need does not consider the extent of older adult or specialist housing required. The Ministry expects local authorities to consider housing for different groups, including for older and disabled people, within their Local Plans for housing, but as we reported in *Planning for new homes in 2019*, only 44% of local authorities have an up to date Local Plan (paragraphs 3.18 to 3.21).

24 The Department will be responsible for leading cross-government efforts to deliver long-awaited reforms which address long-standing problems in the sector. Despite many years of government papers, consultations and reviews, the Department has not yet brought forward a reform plan. The COVID-19 pandemic has underlined the need to address some of the long-standing issues, such as limited data; workforce investment; and the visibility of provider finances. However, it has also delayed promised reforms as government prioritises the COVID-19 response. The Number 10 Health and Social Care Taskforce, which was focused on Spending Review 2020, concluded its work in October 2020. The Department is leading reform plans and has committed to bringing forward proposals in 2021 (paragraphs 3.11 and 3.12).

25 Reforms will be a significant challenge and will need a whole system, cross-government approach. Care policy cuts across many other policy areas. We have previously expressed concerns about the impact of planning and managing delivery in siloes on value for money and local services if multiple departments take separate, individual views of their policy areas. While the Department routinely meets with other departments to discuss various issues, future policy decisions will need to consider the interconnectedness of these areas to avoid creating tension and perverse incentives which negatively affect choices about care. For example, tax or benefit changes which could affect subsequent spend on social care. Better integration at a local level will be essential for delivering the person-centred, preventative care model the sector is calling for (paragraphs 3.14, 3.15, 3.22 and 3.23).

Conclusion on value for money

26 High-quality care is critical to the well-being of some of the most vulnerable adults in society. Yet levels of unpaid care remain high, too many adults have unmet needs and forecasts predict growing demand for care. The lack of a long-term vision for care and short-term funding has hampered local authorities' ability to innovate and plan for the long term, and constrained investment in accommodation and much-needed workforce development. In a vast and diverse social care market, the current accountability and oversight arrangements do not work. The Department currently lacks visibility of the effectiveness of care commissioned and significant data gaps remain. As such, it cannot assess the outcomes achieved across the system and whether these are value for money.

27 COVID-19 has focused attention on social care as never before. It has highlighted existing problems with social care and emphasised significant gaps in the Department's understanding of the market. However, we have also seen substantial efforts from those across the sector to deliver these essential services in such challenging circumstances. The Department has recently taken steps to increase the capacity of its teams; address data gaps, with local government and care providers; and strengthen system accountability and assurance. This renewed focus, impetus and collaborative approach must be capitalised upon when government finally focuses on the long-awaited social care reforms.

Recommendations

28 The Department should:

- a** as a priority, **set out a cross-government, long-term, funded vision for care**. It should collaborate with the Ministry and local government in particular; factoring in sector and user perspectives, such as people with lived experience;
- b** **develop a workforce strategy**, in line with its previous commitments, to recruit, retain and develop staff, aligned with the NHS People plan where appropriate;
- c** in conjunction with the Ministry, Department for Work & Pensions and local government, **develop a cross-government strategy for the range of accommodation and housing needed for people with care needs**, and how to fund it;
- d** **assess the performance and cost data it needs to gain assurance over the system's performance as a whole** and the potential costs to the sector of providing these data, bearing in mind its current proposals for enhanced accountability and oversight;

- e address significant gaps in the performance and cost data it collects on care, particularly on self-funders and unmet need. In doing so, it should be mindful of, and assess, the potential burden on local authorities and care providers;
- f consult on options for enhancing support for local commissioners which promotes an integrated approach and incentivises commissioning for outcomes; and
- g explore with CQC how best to increase visibility of and transparency over providers' financial sustainability and costs, bearing in mind operational and legal practicalities.

Part One

The adult social care market

1.1 This section outlines what adult social care (care) is, how it is funded and how much it costs. It also sets out how many adults receive care and provides data on providers of care. Later parts of the report on oversight and future demand build on this overview. Unless otherwise stated, data reflect the position for the year ending 31 March 2020. While the impact of COVID-19 had begun, the following data largely reflect the market pre-COVID-19.

About adult social care

1.2 Care covers social work, personal care and practical support for adults with a physical disability, a learning disability, or physical or mental illness, as well as support for their carers. Adults with care needs may need support with or cannot perform some activities of daily living such as washing, dressing, cooking or shopping without support.

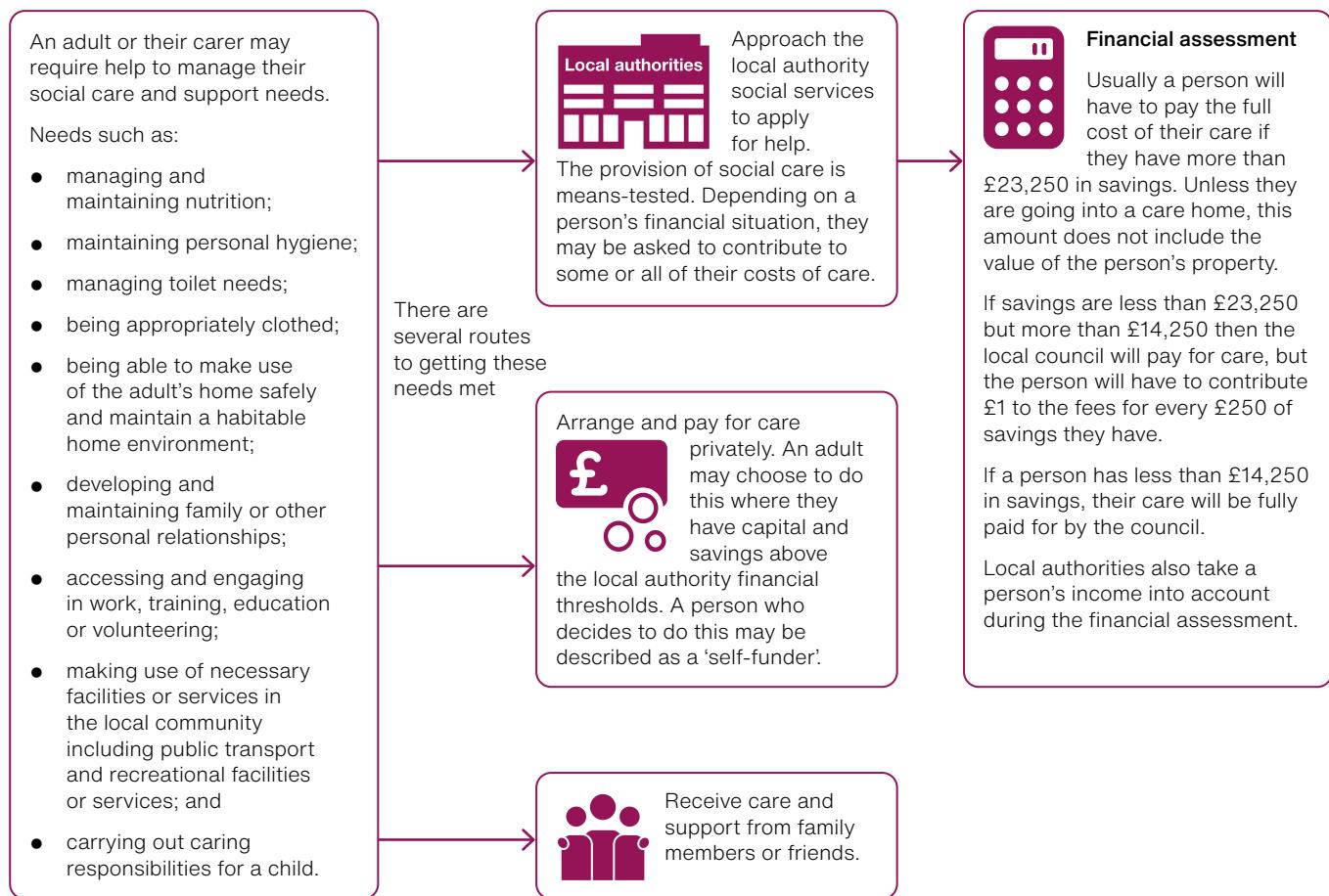
1.3 Family or friends provide most unpaid care. The amount of unpaid care provided affects the extent of formal care required, which local authorities or individuals fund. Adults who fund their own care are known as 'self-funders'. Some adults pay partial contributions to their cost of care, with some local variation over this. Eligibility criteria for accessing publicly funded care are set out in the Care Act 2014. Policy choices on eligibility change the number of adults who might need to buy their own care (**Figure 1**). The savings threshold of £23,250 has remained flat in cash terms since the Care Act 2014 was introduced, meaning an increasing number of adults may have to pay for their own care.

Figure 1

Access to and types of care in England

Access to care varies

The Care Act (2014) requires local authorities to ensure the provision or arrangement of services, facilities or resources to help prevent, delay or reduce the development of needs for care and support.

**Note**

1 Means testing does not apply for an eligibility assessment, information and advice and safeguarding.

Source: National Audit Office analysis of Department of Health & Social Care documents

1.4 Care is delivered through local authorities, which are accountable to their local populations. The Department of Health & Social Care (the Department) is responsible for setting the national policy and the legal framework for care in England and is responsible for accounting to Parliament and the public for the performance of the care system as a whole.¹ The Ministry of Housing, Communities & Local Government (the Ministry) oversees the distribution of funding to local government and the financial framework within which local authorities operate. The Care Act 2014 places a range of duties relating to care and support for adults on local authorities. Local authorities, of which there are 151 with care responsibilities, commission care, mostly from independent providers which are autonomous enterprises. The Department does not have the legal powers to intervene or hold individual local authorities to account for their performance.

1.5 Care is part of a complex system of interrelated public services and forms of support. The number of bodies directly involved in care, or with related policy responsibilities, highlights the challenge of coordinating policy across government, as shown in **Figure 2**.

Care funding and costs

1.6 As shown in Figure 1, care can be paid for by local authorities, self-funded by individuals or provided unpaid. Although local authorities pay for most formal care provided, the business intelligence provider, LaingBuisson, estimates that spend on self-funded care amounts to around £8.3 billion across England.² Estimates as to the value of unpaid care can be more than £100 billion a year.

1.7 As reported in *Local government finance in the pandemic*, local authorities providing care face significant financial pressures.³ Many authorities set budgets for 2021-22 in which they have limited confidence, and which are balanced through cuts to service budgets and the use of reserves. Government funding for local authorities in aggregate (including those local authorities which do not provide care) fell by 55% in 2019-20 compared with 2010-11. This resulted in a 29% real-terms reduction in local government spending power (government funding plus council tax revenue) over the period (**Figure 3** on page 18). Among councils with social care responsibilities (single tier and county councils) service spending is increasingly concentrated on statutory services, meaning these authorities have less headroom to find savings.

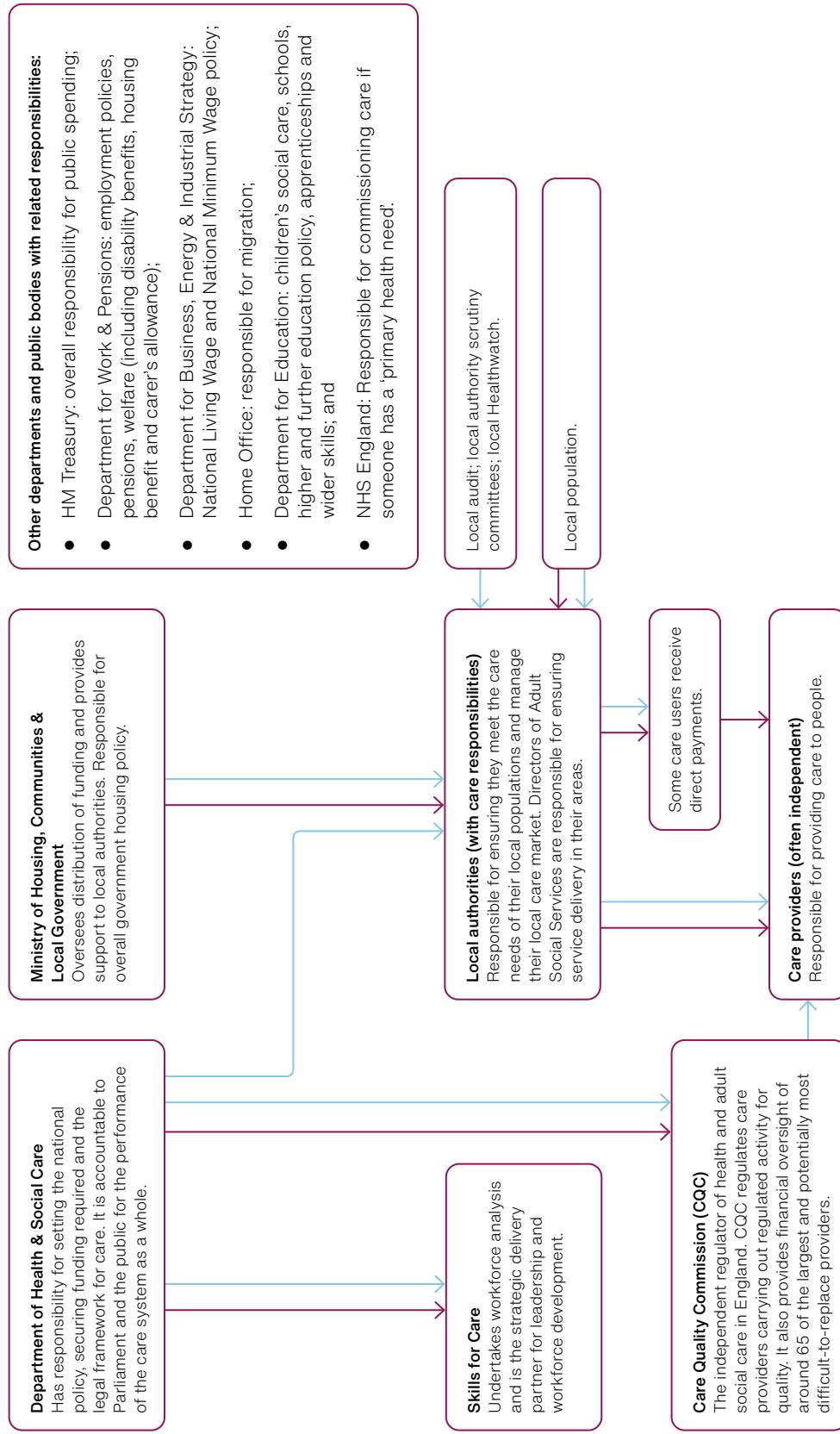
1 Department of Health & Social Care, *Accounting Officer System Statement*, July 2018.

2 This includes an estimated £1,518 million spent on home care and supported living in England in 2018-19 and an estimated £6,801 million on care homes for older adults and people with dementia aged 65 and over, in England, based on market share annualised as at March 2020.

3 Comptroller and Auditor General, *Local government finance in the pandemic*, Session 2019-2021, HC 1240, National Audit Office, March 2021.

Figure 2
Accountability for care arranged by local authorities in England

Roles and responsibilities for care are complex

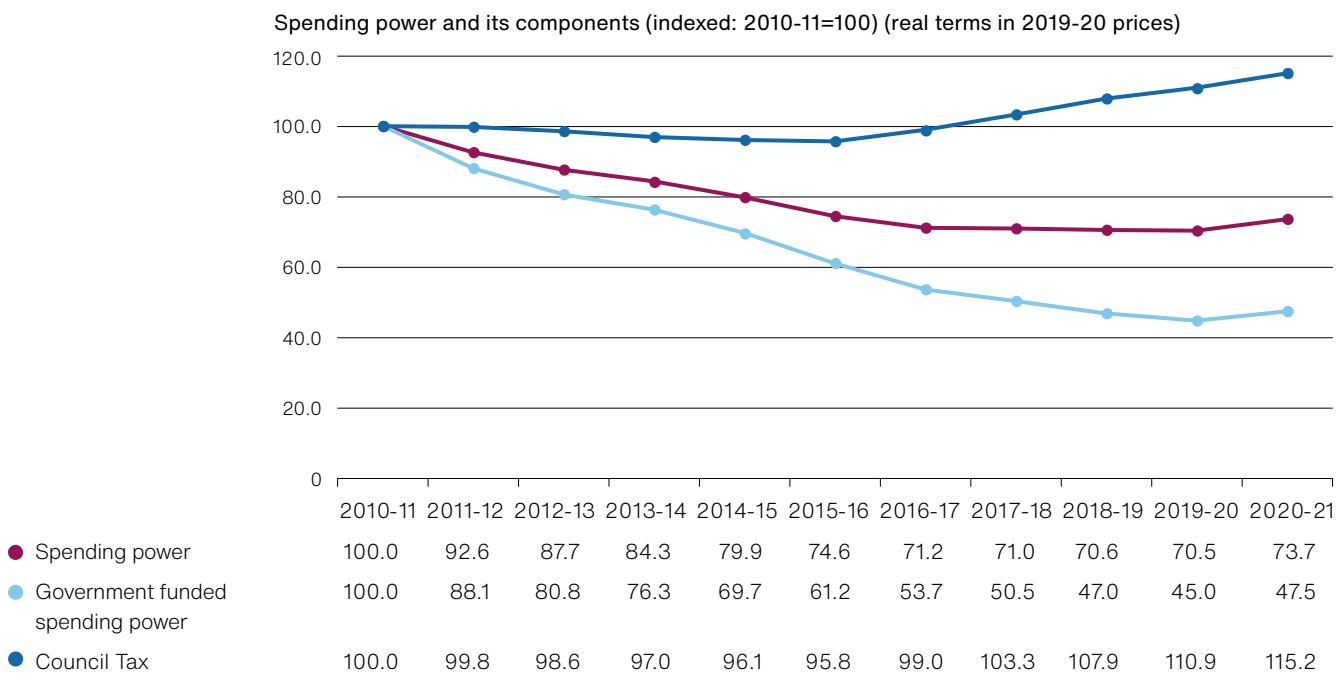


Source: National Audit Office analysis of cross-government documents

Figure 3

Change in spending power in English local authorities 2010-11 to 2020-21

Spending power fell rapidly from 2010-11 to 2016-17 but has been relatively stable since then with growth in 2020-21

**Notes**

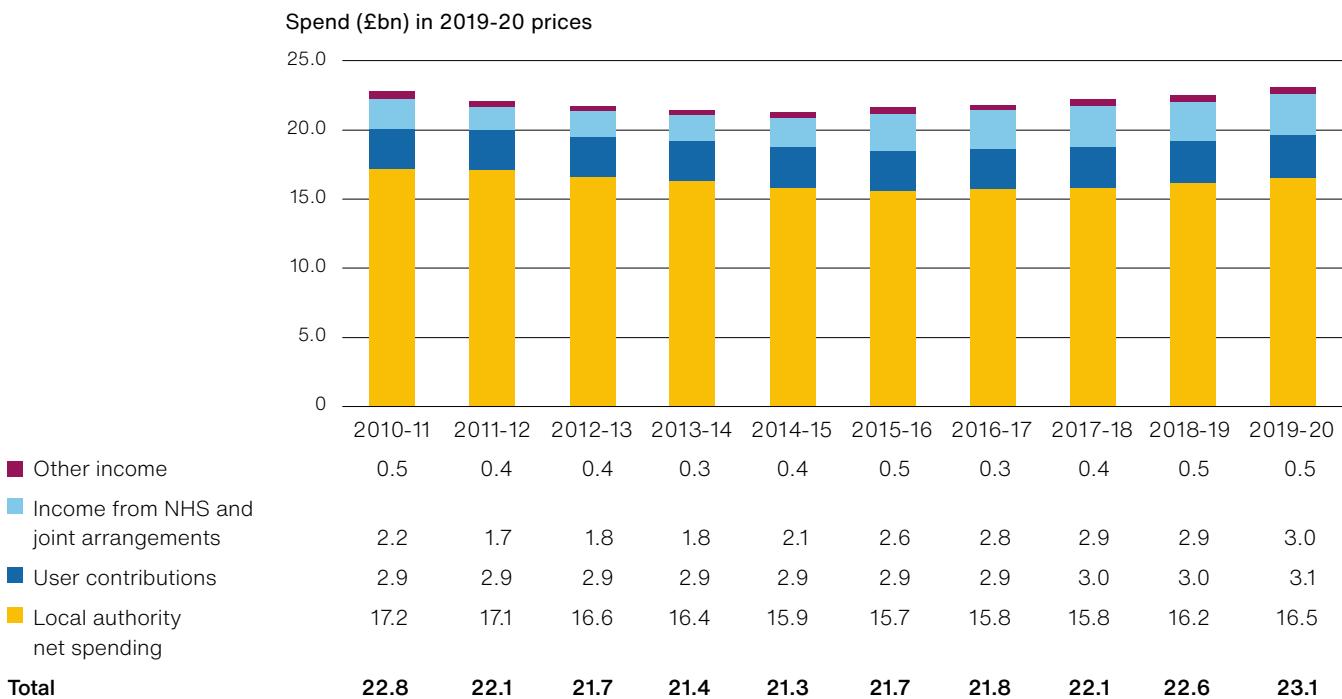
- 1 Spending power is an indicator that captures the main streams of government funding to local authorities alongside council tax. There have been significant changes in the duties placed on local authorities and the way financial data were reported in this period. To allow for a like-for-like comparison over time we adjust the data to account for these changes using a chain-linked index approach. This means that the results from our time series analysis show percentage change in a weighted index. This provides a good estimate of change over the period that is not skewed by changes in duties and reporting approaches. However, because the data are weighted it will not match spending power and council tax data published by the Ministry of Housing, Communities & Local Government precisely. Our full methodology is available with our report Financial sustainability of local authorities 2018 (Comptroller and Auditor General, Financial sustainability of local authorities 2018, Session 2017-2019, HC 834, National Audit Office, March 2018).
- 2 The values of the three data series are indexed against their 2010-11 values to enable comparison from a common starting point.
- 3 Funding received by local authorities through the Better Care Fund is excluded from this analysis.

Source: National Audit Office analysis of Ministry of Housing, Communities & Local Government data

1.8 The amount of local authority net spending (which is spending funded by council tax, government grants and business rates) on care remained lower in 2019-20 at £16.5 billion; 4% lower in real terms than in 2010-11 but at its highest level since 2012-13 (**Figure 4**). Overall spend on local authority arranged care was higher in 2019-20 than 2010-11.

Figure 4

Spending on local authority arranged care, 2010-11 to 2019-20, in 2019-20 prices

Most spend on local authority arranged care is funded by local authorities themselves**Notes**

- 1 Local authority net spending is funded through council tax, government grants and business rates. Excludes capital charges.
- 2 User contributions are amounts paid by some users towards the cost of their care.
- 3 Income from NHS and joint arrangements includes income received from NHS bodies which has been spent on the provision of adult social care. Income received by the local authority as part of the Better Care Fund should also be recorded under Income from the NHS. Local authorities cannot lawfully commission services that are clearly the responsibility of the NHS, except under pooled budget arrangements (Section 75 of the Care Act 2014) where the local authority acts as the lead commissioner.
- 4 Income received from other councils for services provided to them should be netted off gross expenditure. Where it is not possible for councils to exclude other council's clients from activity figures, the associated income is recorded as 'Other income'.
- 5 We have used published data for 2010-11 and 2011-12. Due to changes in how some elements of funding were provided to local authorities between 2010-11 and 2011-12, as well as variation in how these were recorded, these data points may not be fully comparable.
- 6 Some data may not sum due to rounding.

Source: Adult Social Care Activity and Finance Report, England 2016-17 to 2019-20

Spending by type of support

1.9 Most spend on care goes on providing long-term support. **Figure 5** outlines the 2019-20 gross spend (local authority net spending plus user contributions) by type of support provided. In our definition of care at home we include home care, supported living, supported accommodation, direct payments and other long-term community care. A much higher proportion of adults aged 18 to 64 receive support in their own home compared with adults aged 65 and over. In 2019-20, around 84% of adults aged 18 to 64 who received long-term care services at some point in the year received support in their own home compared with 60% of adults aged 65 and over.

1.10 Most care spend was on learning disability and physical needs support. In 2019-20, spend on local authority arranged care for adults needing long-term physical support was around £6.4 billion. Spend on long-term services for adults with a learning disability was around £6.0 billion. Together they made up around 81% of total spend on long-term care services (**Figure 6** on page 22). Around 88% of spend on long-term learning disability services was for adults aged 18–64, whereas around 79% of the spend on adults needing long-term physical support was for adults aged 65 and over.

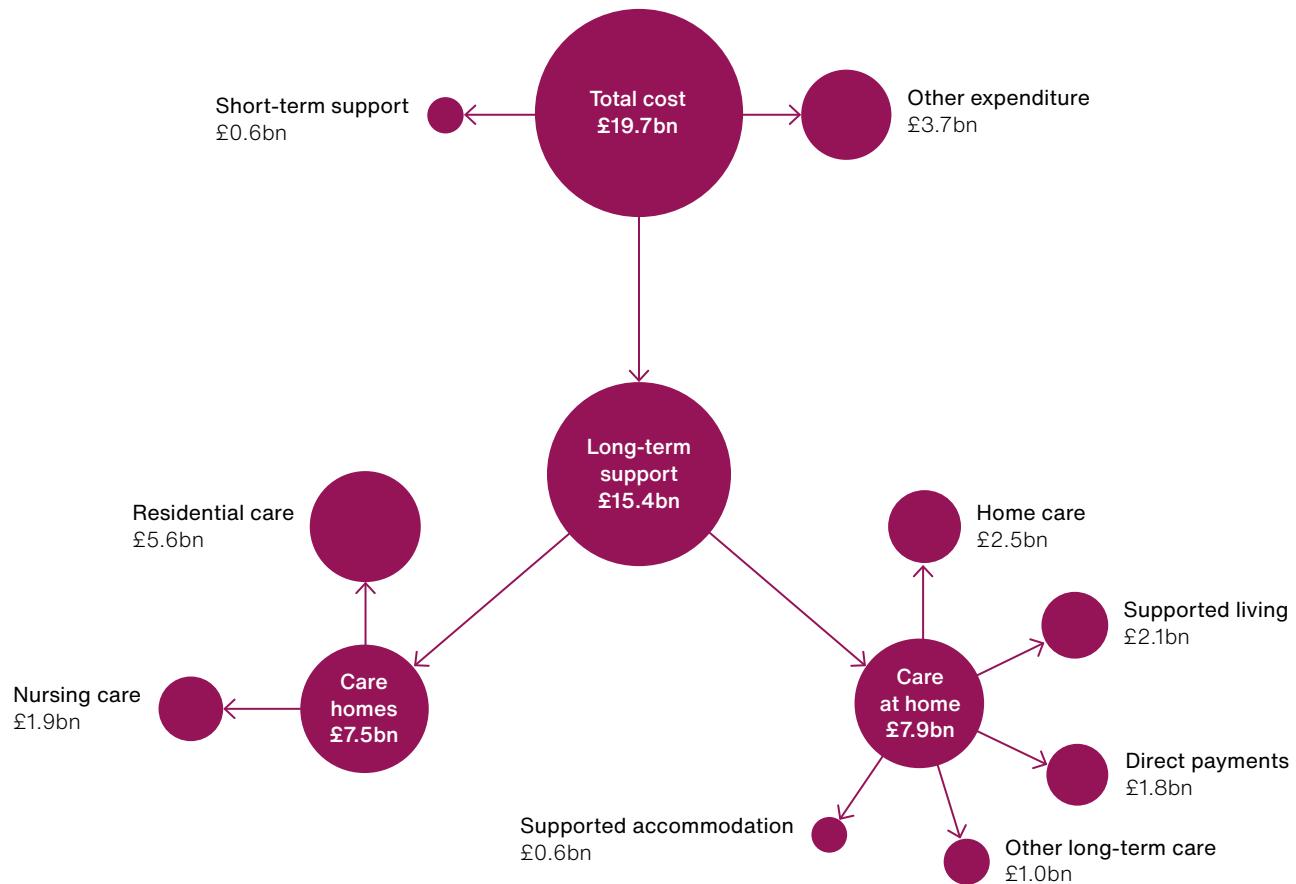
Variation in cost of care

1.11 Typical care home costs for adults aged 18 to 64 are higher than for adults aged 65 and over. In 2019-20, the average unit cost of care paid by local authorities for an adult aged 18 to 64 per week was £1,373 for a residential care home placement and £996 per week for a nursing care home placement. For adults aged 65 and over the average cost of a residential care home placement was £662 per week and £715 per week for a nursing care home placement. The average cost of care per hour paid by local authorities to an external provider for home care was £17.48 per hour.

1.12 Regionally there is wide variation in the costs of care paid by local authorities to providers. For example, the average cost per week of a residential care home placement for adults aged 18 to 64 ranged from £1,148 in the North East to £1,508 in the South West. Hourly home care rates paid by local authorities to external providers ranged by region from £15.40 in the North East to £19.94 in the South West, and within the South West average costs range from £16.08 to £25.56 between constituent local authorities. Local authorities cannot reasonably control many of the factors that affect the costs of care. These include the number of high-need individuals, the wider care market, staff costs, the local economy, levels of rurality and some of the accommodation costs borne by providers.

Figure 5

Costs by type of short- and long-term support arranged by local authorities during 2019-20

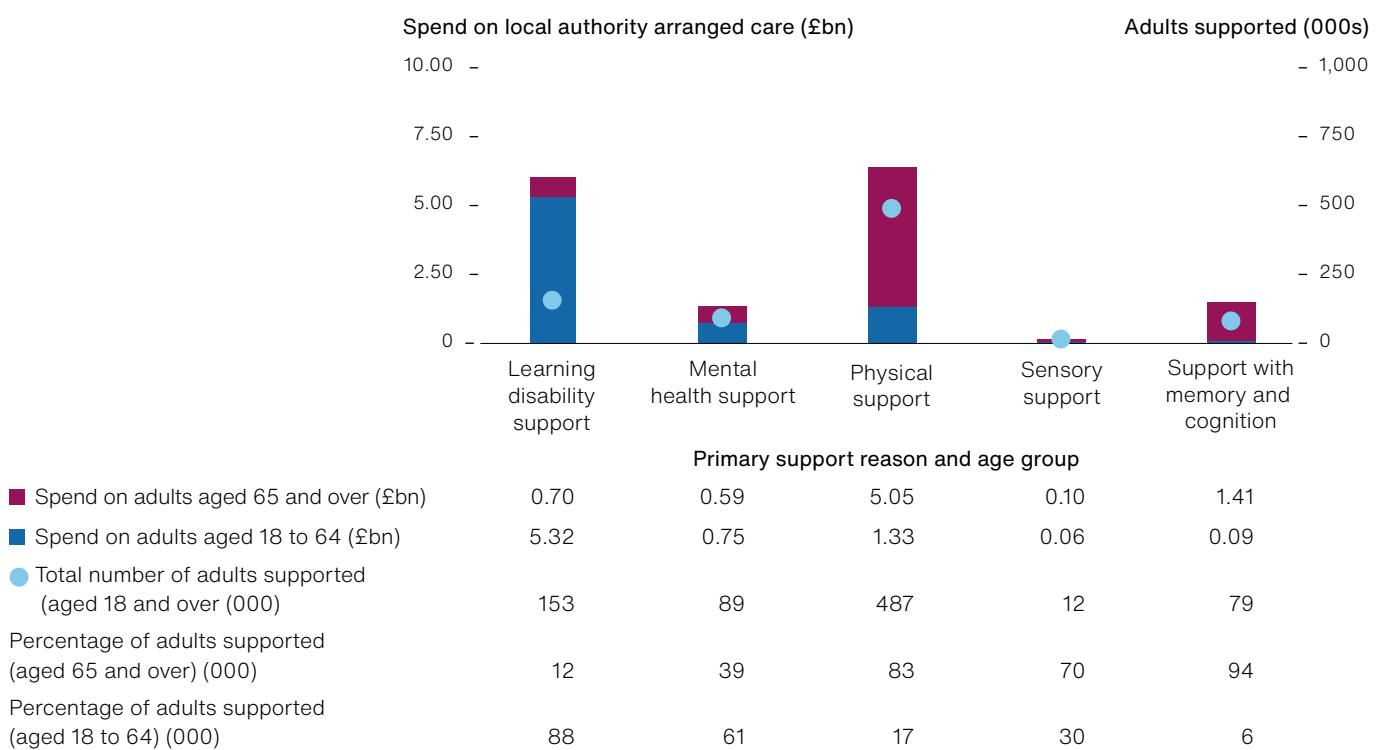
The majority of local authority care expenditure is on long-term support**Notes**

- 1 Includes local authority net expenditure on care plus user contributions. Excludes capital charges.
- 2 Long-term support can encompass any ongoing service or support provided to help maintain someone's quality of life, allocated based on eligibility criteria/policies.
- 3 Residential homes offer care and support in a residential setting throughout the day and night. Nursing homes offer the same type of care as residential homes but with care from qualified nurses.
- 4 Home care provides support with personal care and/or domestic tasks in the person's own home. Direct payments are payments either via a bank account or prepaid cards, for adults to buy their own care and support, often by employing personal assistants. Supported living comprises schemes that support younger adults to live independently in their own homes. Supported accommodation includes long-term placements in adult placement schemes, hostels and unstaffed or partially staffed homes. Other long-term care includes day care and meals services.
- 5 Short-term support is typically intensive periods of support aimed at regaining skills, confidence and independence lost as a result of illness, injury or disability, normally provided in someone's own home. Support should be time-limited and provided free of charge by local authorities for up to six weeks, ending with a formal assessment or review to determine what support will follow.
- 6 Other expenditure refers to other costs, such as the costs of commissioning services.
- 7 Some data may not sum due to rounding.

Figure 6

Local authority long-term support, spend and number of adults supported in England by primary support reason, 2019-20

Most care spend was on physical support and learning disability support

**Notes**

- 1 Includes local authority net expenditure on care plus user contributions. Excludes capital charges.
- 2 Number of adults supported excludes adults receiving short-term support and 17,810 adults receiving long-term 'social support'.
- 3 Data on spend and the number of adults supported should not be directly compared. Some adults will only receive care for part of the year.
- 4 Some data may not sum due to rounding.

Source: National Audit Office analysis of data from NHS Digital, Adult Social Care Activity and Finance Report, England 2019-20

Users of care

Numbers receiving care

1.13 The Department has not evaluated the extent of or the impact arising from local authorities reducing the number of adults they support. The total number of older adults receiving local authority-funded care at some point during the year fell 26% from more than 1.1 million in 2009 to around 850,000 in 2013-14 (the last year for which comparable data are available).

1.14 Since 2015-16, the number of adults receiving long-term care arranged by local authorities has fallen due to a decrease in adults aged 65 and over receiving care. Between 2015-16 and 2019-20, the number of adults receiving long-term support arranged by local authorities fell from 873,000 to 839,000. The number of adults aged 18 to 64 receiving long-term support each year remained steady at around 290,000. By comparison, adults aged 65 and over receiving long-term support arranged by local authorities fell 6.6% between 2015-16 and 2019-20 from 587,000 to 548,000 (**Figure 7** overleaf). The Department does not know how much of this decrease is due to reduced support offered by local authorities, more self-funders or the impact of preventative action meaning adults require less support for as long. It told us this was because the data for making this assessment are inadequate but that the National Institute for Health Research has planned research into this.

1.15 At year end, a smaller number of adults are supported than the total during the year, as some adults only receive support during part of the year. At 31 March 2020, local authorities supported 254,480 (0.75%) of the overall 18 to 64 population. This ranged by local authority, from 0.5% to 1.4%. At 31 March 2020, local authorities supported 375,775 (3.6%) of the overall 65 and over population. This ranged by local authority, from 2.0% to 9.0%.

Self-funders

1.16 The Department does not collect data on the number of self-funders. LaingBuisson estimates that, as at 31 March 2020, there were 11,000 self-funders aged 18 to 64 in England and 137,000 self-funders aged 65 and over in England living in independent sector care homes. LaingBuisson further estimates the number of self-funders in independent sector care homes for adults aged 65 and over in England increased from 40% in 2010 to 44% in 2020. In November 2017, the Competition & Markets Authority (CMA) published a report into the care home market for those aged 65 and over.⁴ It found self-funders pay around a 41% premium on top of what local authorities pay for a care home placement. With regard to home care, LaingBuisson estimates the private home care market is growing strongly, and that providers in an area can typically charge around £3 more per hour for care than the prevailing local authority rate.

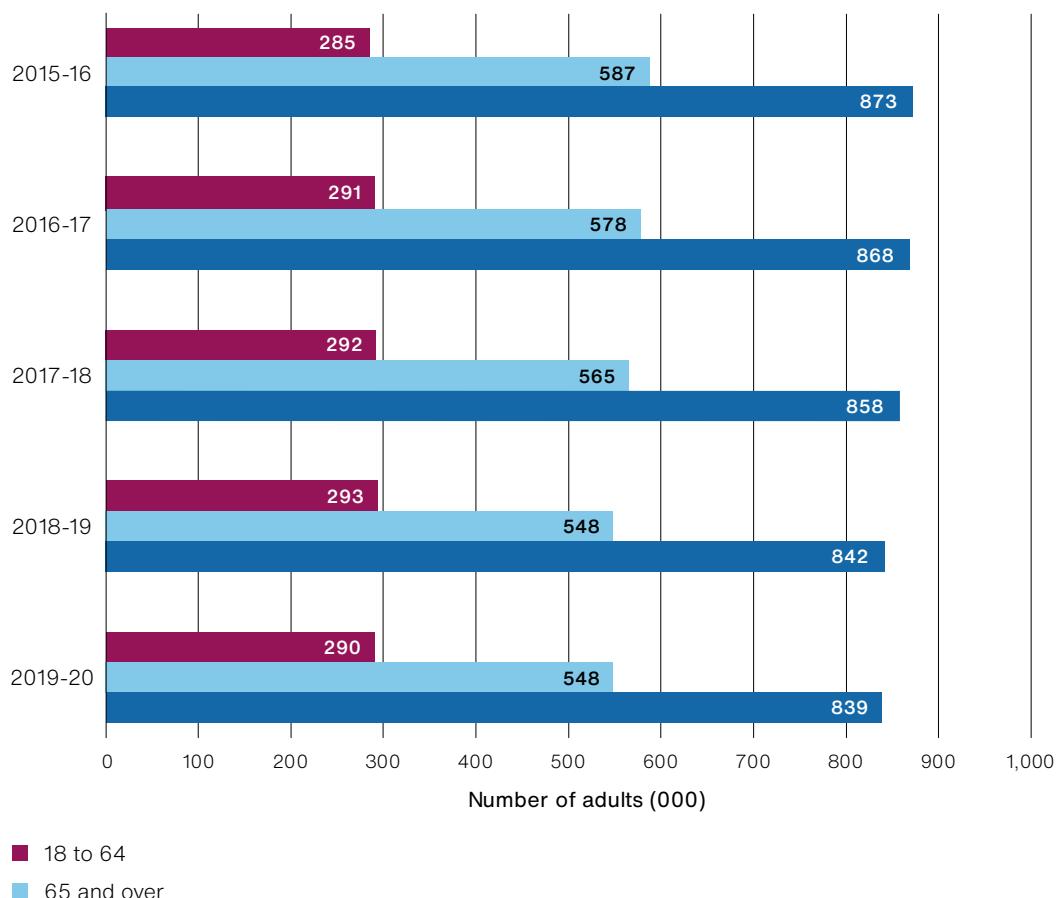
⁴ Competition & Markets Authority, *Care homes market study*, November 2017. Available at: <https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf>

Figure 7

The number of adults accessing long-term local authority arranged care support in England, 2015-16 to 2019-20

The number of adults receiving long-term care has fallen slightly, caused by a reduction in the number of adults aged 65 and over receiving long-term care

Financial year



Notes

- 1 Includes all long-term service users aged 18 and over.
- 2 The number of adults includes adults who may pay some user contributions towards the costs of their care.

Source: NHS Digital, *Personal Social Services: Expenditure and Unit Costs, England 2015-16* and *Adult Social Care Activity and Finance Report, England 2016-17 to 2019-20*

Unpaid care

1.17 A precise estimate of the extent of unpaid care is unknown. The Health Survey England 2019 estimated that 17% of people aged 16 and over reported providing unpaid help or support. In the 2011 Census there were 5.4 million carers in England (10.2% of the population in England). The charity Carers UK estimates that pre-COVID-19 there could have been around 7.3 million carers in England. Research published by academics in 2018 by the London School of Economics (LSE) found that by 2035 there could be a shortfall of 2.3 million carers for adults aged 65 and over.

1.18 Some carers are entitled to Carer's Allowance. In May 2020 around 1.1 million people in England were entitled to Carer's Allowance, of which 780,000 people were being paid it. The estimated total cost of Carer's Allowance in England in 2019-20 was £2.74 billion.

1.19 The Care Act 2014 placed a duty on local authorities to assess carers' needs, regardless of how much care they provide, and meet carers' needs on a similar basis to those for whom they care. In 2019-20, gross expenditure by local authorities on support for carers was £167 million. In 2019-20 316,000 carers received direct support from local authorities. Of these:

- 66% of carers received information, advice and signposting to other services rather than money; and
- 34% of carers received support in the form of direct or part-direct payments, local authority-commissioned support, or a local authority-managed personal budget.

1.20 In carrying out its duties under the Care Act, a local authority must identify adults in their locality who have unmet care and support needs. Local authorities are accountable to their local populations for care delivery. The Department does not have legal powers to intervene if local authorities are not complying with their duties under the Care Act. The Health Survey England asks adults aged 65 and over if they have limits around activities required for daily living, such as personal hygiene, personal movement and eating. In 2018, the latest year for which there are published data, 24% of adults aged 65 and over surveyed said they had some unmet need for an activity of daily living for which they did not receive support. The Department is working with academics at the LSE to explore a methodology that will better estimate unmet need, linked to eligibility under the Care Act.

Care providers

1.21 Around 14,800 registered organisations provide care across 25,800 locations. (**Figure 8**). In addition to these there are an estimated 3,800 non-Care Quality Commission (non-CQC) registered locations which offer residential services and 8,500 non-CQC registered locations which offer non-residential services.⁵ The top 10 providers of care homes and care at home have small market shares. Based on revenue, LaingBuisson estimates the market share of the 10 largest care home providers for older adults is 22% and the market share of the 10 largest care at home providers is just 16%. There are large numbers of small providers. Overall, 75% of care home providers run just one home, accounting for 38% of total beds; 90% of care at home providers operate from one location.

1.22 Independent providers run most care homes; based on market value, 76% of care homes for older adults and adults with dementia are for-profit. Of the remaining 24%, 14% are not-for-profit and 10% are run by a local authority or the NHS.

1.23 CQC regulates care providers for quality and provides oversight of the financial sustainability of the largest and potentially most difficult-to-replace care providers. Overall, CQC rates most care as being ‘good’. Across all services in England, 5% of providers were outstanding, 80% good, 15% require improvement and 1% were inadequate.⁶ The best-performing region was the North East (where 89% of locations provide good or outstanding care) while the worst-performing region was West Midlands (where 80% of locations provide good or outstanding care). Ratings for community social care services (such as supported living and shared lives) were higher than other services.⁷ CQC found nursing homes to be their biggest concern – with 21% rated as ‘requires improvement’ and 2% as inadequate (**Figure 9** on page 28). CQC found providers performed better on measures around caring, effectiveness and responsiveness, but less well on measures around safety and leadership. CQC also expressed concern that some services struggle to improve. For example, 3% of care homes and 3% of community social care providers have always received an ‘inadequate’ or ‘requires improvement’ rating.

⁵ The non-CQC regulated locations which offer residential services include homeless shelters, women's refuges, drug and alcohol support centres and a diverse range of other residential services. The non-CQC regulated locations which offer non-residential services include day care, carers' support services and a wide range of community support and outreach services for vulnerable adults.

⁶ Percentages do not sum to 100 due to rounding.

⁷ Supported living are schemes that provide personal care to people as part of the support that they need to live in their own homes. Shared Lives schemes match someone who needs care with an approved carer, who shares their family and community life, and gives care and support to the person with care needs.

Figure 8

Number of care home and care at home providers in England, March 2020

Although numbers of Care Quality Commission-registered providers in both the care home and care at home sectors are similar, care at home supports almost twice as many adults as there are typically occupied care home beds

	Care home providers	Care at home providers
Care Quality Commission-registered providers	7,522	7,263
Care Quality Commission-registered locations	15,537	10,288
Provision	457,000 registered Care Quality Commission beds across health and care sectors (average occupancy around 90% as at 31 March 2020)	An estimated 814,000 adults receive home care or supported living services across the health and care sectors

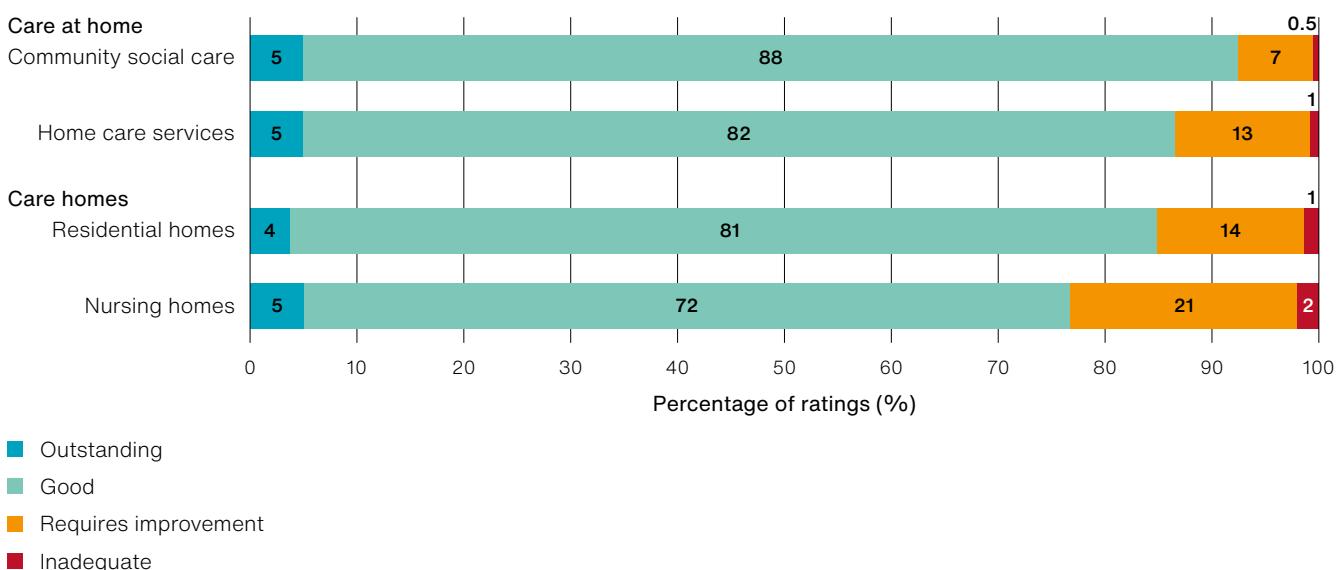
Notes

- 1 A provider may manage one or several registered locations.
- 2 Occupancy levels can depend on the calculation made. An average of around 90% occupancy based on the proportion of available beds which are occupied. Includes some adults in receipt of NHS continuing healthcare.
- 3 Estimate of provision of care at home in England made by LaingBuisson. Its estimate of home care includes NHS-funded complex care at home. It estimates 100,000 adults are in receipt of long-term supported living services funded by local authorities in England.

Source: National Audit Office analysis of Care Quality Commission care directory and LaingBuisson data for occupancy and care at home provision

Figure 9

Care Quality Commission (CQC) ratings by service type in England, May 2020

Most care in England is rated good**Service type****Notes**

- 1 Community social care includes supported living services, Shared Lives and Extra Care housing services.
- 2 Home care services refer to domiciliary care services only.
- 3 Ratings are taken from the CQC directory as presented in May 2020. These ratings represent the most recent inspection undertaken by CQC. This may have been prior to May 2020.
- 4 Percentages may not sum to 100 due to rounding.

Source: National Audit Office analysis of Care Quality Commission care directory

Financial health of care providers

1.24 The care market depends on the financial resilience of care providers operating within it. Using data from LaingBuisson, we analysed financial data on 92 of the largest care home providers (72 for-profit and 20 not-for-profit) and 64 of the largest care at home providers (38 for-profit and 26 not-for-profit) in England across a range of metrics (**Figure 10** on pages 29 and 30). Our analysis shows that there is significant variation in the level of earnings reported by care home and care at home providers, with care at home providers typically having lower earnings than those running care homes, but higher returns on their investment. The ability of providers to meet their obligations and to service their debt is similarly variable.

Figure 10

Analysis of large care home and care at home providers

Reported profits and overall financial health vary significantly among providers

Metric	Large care home providers		Large care at home providers	
	for-profit (%)	not-for profit (%)	for-profit (%)	not-for profit (%)
Proportion of spend on personnel				
Spend on personnel (%) (Personnel costs/revenue)	Below 50%	13	5	18
	50%-60%	40	35	5
	60%-70%	39	35	24
	70%-80%	4	20	18
	> 80%	4	5	34
Revenue and profitability				
EBITDAR (%) ((Earnings before interest, tax, depreciation, amortisation and rental costs)/revenue)	Below 0%	7	35	16
	0%-5%	8	0	32
	5%-10%	14	35	24
	10%-15%	24	25	8
	>15%	47	5	21
Return on capital employed ((Earnings before interest and tax/(Total equity and reserves + Total long term liabilities))	Below 0%	13	50	18
	0%-5%	42	50	21
	5%-10%	23	0	16
	10%-15%	10	0	5
	>15%	13	0	39
Liquidity and working capital				
Current ratio (Total current assets/ Current liabilities)	Below 1	39	20	34
	1-1.5	23	35	26
	1.5-5	28	25	39
	>5	10	20	0
Interest cover (Earnings before interest and tax/ Interest expense)	Below 1	13	30	34
	1-1.5	1	5	5
	1.5-5	45	20	13
	>5	30	30	26
	No interest	11	15	21
Financial risk				
Debt to asset ratio (Total liabilities/ Total assets)	0%-33%	28	50	16
	33%-66%	41	40	16
	66%-100%	23	5	37
	>100%	8	5	32

Figure 10 continued

Analysis of large care home and care at home providers

Notes

- 1 Using data from LaingBuisson, we have analysed data from 92 of the largest care home providers in England (72 for-profit and 20 not-for-profit) that reported data for 2019. All these providers had revenue of at least £5 million in 2019.
- 2 Using data from LaingBuisson, we have analysed data from 64 of the largest care at home providers in England (38 for-profit and 26 not-for-profit) that reported data in 2019. All these providers had revenue of at least £3 million per year.
- 3 For all providers accounting bases, terms, definitions and periods vary.
- 4 Five of the largest private equity backed providers could not be included in our analysis due to difficulty in accessing their accounts.
- 5 The data are a sample of the market. They do not reflect the whole market, and small and medium providers are not represented in this dataset.
- 6 Some data may not sum due to rounding.

Source: National Audit Office analysis of LaingBuisson Care Homes for Older People, thirty-first edition, January 2021; and LaingBuisson Home Care and Supported Living, third edition, April 2020

Care provider earnings and returns

1.25 Across large for-profit care homes, earnings before interest, tax, depreciation, amortisation and rent costs (EBITDAR) as a percentage of revenue have been stable over the past four years, with the average (median) ranging from 18% in 2017 to 14% in 2019. In 2019, 47% of large for-profit care homes had an EBITDAR as a percentage of revenue of more than 15%, but for 29% this was less than 10%. The average (median) EBITDAR as a percentage of revenue of for-profit care at home providers has fallen steadily from 7.2% in 2016 to 5.1% in 2019.

1.26 The percentage return on capital employed varies. Some 55% of for-profit care home providers and 39% of for-profit care at home providers reported a return of under 5%. By comparison, 23% of for-profit care home providers and 44% of for-profit care at home providers reported a return of more than 10%.

Liquidity and financial risk

1.27 Significant numbers of large providers are not financially resilient. Around 39% of for-profit care home providers and 34% of for-profit care at home providers have current liabilities which exceed their current assets. This means that they owe other organisations more money over the next 12 months than they currently have or are due to receive from past events. In addition:

- some 13% of for-profit care home providers and 34% of for-profit care at home providers have annual interest charges which are higher than their earnings before interest and tax;
- overall, most for-profit care home providers have total debt, which is less than their total assets, but 31% have total debt levels equivalent to two-thirds or more of their total assets; and
- of for-profit care at home providers, 32% have total debt which is higher than their assets.

Part Two

Adult social care market oversight

2.1 This section sets out the oversight and monitoring arrangements for adult social care (care), how these have changed in response to COVID-19 and the short-to medium-term market outlook.

The Department's oversight

Monitoring arrangements

2.2 Care delivery is complex and involves many bodies (paragraphs 1.4 and 1.5). It is delivered through local authorities, which are accountable to their local populations. There are 151 local authorities with responsibilities for providing or arranging care services as set out in the Care Act, 2014. They commission most care from around 14,800 registered providers in the independent (private and voluntary) sector across 25,800 locations. Care providers must follow statutory quality regulations monitored by the Care Quality Commission (CQC). The Department of Health & Social Care (the Department) is responsible for setting the national policy and legal framework for care. It is accountable to Parliament and the public for the performance of the care system as a whole. It has had overall policy responsibility for care since 1948. Under the Care Act 2014, which the Department brought forward, it does not have legal powers to intervene or hold individual local authorities to account for their performance.

2.3 For accountability arrangements to be effective, our report on *Accountability to Parliament for taxpayers' money* set out four essentials:⁸

- a clear expression of spending commitments and objectives;
- a mechanism or forum to hold to account;
- clear roles and someone to hold to account; and
- robust performance and cost data.

⁸ Comptroller and Auditor General, *Accountability to Parliament for taxpayers' money*, Session 2015-2016, HC 849, National Audit Office, February 2016.

Spending commitments and levels of funding

2.4 Local authority finances have been under significant financial pressure since 2010-11 (paragraph 1.7). Against a backdrop of tight funding settlements, local authorities expressed concerns that funding announced in the 2020 Spending Review falls short of what is needed and that government's increasing reliance on the care precept to raise permanent funding – first introduced in 2015 – is likely to disadvantage those areas with a lower tax base and greater demand for local authority-funded provision.⁹ The government has distributed some non-permanent grant funding, such as the Improved Better Care Fund and the social care grant, in such a way as to offset this.¹⁰ Our report on *Local government finance in the pandemic* highlighted how local authority finances will continue to be under significant financial pressure in 2021-22.¹¹ CQC has warned that the continuing lack of a long-term sustainable solution was having a damaging impact on the quality and quantity of available care.¹² The Competition & Markets Authority (CMA) reported in 2017 that the current model of care home provision could not be sustained without additional public funding and many care homes were relying on higher charges for self-funders to remain viable.¹³ It estimated that if local authorities were to pay the full cost of care for all care home residents they fund, it would cost around £1 billion extra per year.¹⁴

2.5 In addition to other benchmarks, the Department uses its own internally developed cost model to assess the extent to which local authorities pay care providers below benchmark costs, based on current policies. The model primarily assesses rates for local authority clients, so the benchmark costs are conservative in value. For 2019-20 the Department assessed that the majority of local authorities paid below the sustainable rate per week for care home placements for adults aged 65 and over and below the sustainable rate per contact hour for home care. The Department does not challenge those local authorities who pay low rates or provide support for local authorities who appear to be overpaying for care to reduce their rates.

9 The Spending Review 2020 confirmed that councils with social care responsibilities would be able to levy a further 3% precept for adult social care. If all local authorities implement this in full, it will raise around £1 billion for 2020-21. However, some local authorities may not raise the precept by the full 3%.

10 For 2020-21 and for 2021-22, the Ministry of Housing, Communities & Local Government expects that all local authorities will receive 94% of their total Adult Social Care Relative Needs formula-based share of the resources available through the Social Care Grant and the precept.

11 Comptroller and Auditor General, *Local government finance in the pandemic*, Session 2019-2021, HC 1240, National Audit Office, March 2021.

12 Care Quality Commission, *The state of health care and adult social care in England 2019-20*, HC 799, October 2020.

13 Competition & Markets Authority, *Care homes market study*, November 2017. Available at: <https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf>

14 This is a UK-wide estimate.

2.6 Since 2019, there have been successive one-year spending reviews. Our previous work has emphasised the importance of long-term planning and clarity beyond the end of a spending review period. In our report on *Financial sustainability of local authorities 2018*, we recommended that the Ministry of Housing, Communities & Local Government (the Ministry) develop a long-term, financially sustainable plan for local government that addresses current financial and demand pressures.¹⁵ The sector has long called for a more generous, long-term funding solution for care. Uncertainty over the long-term sustainability of funding has made it difficult for local authorities to plan how much care, and at what price, they will be able to purchase beyond the current financial year, constraining innovation and investment.

2.7 There are varying views from stakeholders and local authorities as to how care should be funded, but a common concern was the way funding is determined and allocated. The Department is responsible for securing the funding required for care, but the Ministry is responsible for most of its distribution to local authorities, through the annual local government finance settlement. As part of its overall funding formula for local government, the Ministry uses an adult social care relative needs formula, which has not been updated since 2013-14. Local authorities then determine their budgets and commission providers. In recent years the government has regularly had to announce ad-hoc funding increases.

2.8 For its 2020 Spending Review submission, the Department used its modelling around future demand and costs (outlined in Part Three) as a baseline and then adjusted this to:

- take account of the updated National Living Wage;
- maintain pay differentials between care workers and more senior workers;
- adjust for excess deaths that occurred during the COVID-19 pandemic; and
- adjust for provider viability.

High-level objectives for care

2.9 For many years the Department has had high-level objectives for care. These have tended to focus on ensuring better care for all and enabling adults to live independent lives for longer. However, the underpinning performance measures and the Department's performance reporting have focused on action taken and money spent rather than outcomes achieved. Spending Review 2020 announced that the Department would in future report progress against its priority outcome to improve social care outcomes through an affordable, high-quality and sustainable adult social care system, but this outcome and the underpinning performance metrics are currently provisional.

¹⁵ Comptroller and Auditor General, *Financial sustainability of local authorities 2018*, Session 2017-2019, HC 834, National Audit Office, March 2018.

2.10 In January 2018, the Department of Health became the Department of Health & Social Care and a specific ministerial position for care was created. Yet, between 2016 and 2020, the Department did not have a director-general with sole responsibility for care.

2.11 The Department recognises that it has historically taken a light-touch approach because it does not have legal powers to intervene or hold individual local authorities to account for their performance. It noted it did have frequent contact with the sector through engagement with local authorities, commissioners and providers as well as Association of Directors of Adult Social Services (ADASS) representatives and through the research it commissions from organisations such as the King's Fund and the Social Care Institute for Excellence. The Department also highlighted its recent engagement with a range of stakeholders to discuss reform priorities ahead of the 2020 Spending Review. Yet local authorities and a range of stakeholders in the sector expressed concern at the limited contact they had with the Department over long-term reforms and its lack of understanding of the range of care provision.

2.12 The Department reintroduced a director-general with sole responsibility for care in June 2020, following the Department's increased focus on care in the wake of the COVID-19 pandemic. The Department has increased its care team by around three-fold between April 2020 and January 2021. It has also set up teams to work with the local government regions in England to provide support and challenge the COVID-19 response, focusing on support and local delivery of the Department's adult social care winter plan. The aim is for teams to work closely with local authorities, providing feedback to the Department on any further policy response required.

Holding to account

2.13 Despite its high-level objectives, for example, to ensure accountability of the health and care system to Parliament and the taxpayer, the Department does not oversee commissioning by local authorities nor evaluate the effectiveness of it. The Department has historically left local government to lead and be responsible for delivery with limited national oversight of performance. It told us this was because, under the Care Act 2014, local authorities are accountable to their local population for the management and delivery of care services and it has no legal powers to intervene or hold individual authorities to account for their performance. As such, there is a misalignment between the Department's formal accountability and how the care system is organised. For several years, the Committee of Public Accounts has recommended the Department improve its understanding of how well local authorities commission care.

2.14 On 11 February 2021, the Department published its white paper, *Integration and Innovation: working together to improve health and social care for all*.¹⁶ In the paper, the Department recognises the need for an enhanced assurance framework that allows greater oversight of local authority delivery of care and improved data for the Department's understanding of capacity and risk in the system. It sets out legislative proposals for a Health and Care Bill which would give CQC new duties to review and assess local authority performance. The paper also emphasises the intention to identify best practice across the system, building on existing sector-led support and improvement programmes.

2.15 In 2014 the Department developed an efficiency tool to allow local authorities to assess their performance against similar areas (or 'statistical neighbours') in terms of care delivery for older adults and working-age adults with learning disabilities. Comparable indicators include spending per head, quality of services and access to services. The online tool was last updated in June 2015. Since 2019, the Care and Health Improvement Programme, working with the Local Government Association and ADASS has produced, among other things, a use-of-resources tool to support local authorities in comparing their spend on care.

2.16 The Department carries out high-level analysis of commissioning to assess the extent to which local authorities could make efficiency savings. After adjusting for certain costs, the Department found differences in the costs of purchasing care between similar local authorities, with greater variation in costs for adults aged 18 to 64. In July 2019, at an aggregate level, factoring in that local authorities should pay above the benchmark costs of care, the Department believed that local authorities could be 0.9% more efficient through their commissioning between 2020-21 and 2022-23. The Department accepts there were limitations with its approach, mainly due to a lack of data. The Department has not updated this estimate since. During a spending review, the Ministry factors this aggregate estimate into funding calculations. The subsequent distribution of grant funding by the Ministry does not factor in the Department's analysis of the efficiency of individual local authorities due to the complexities involved, and the need for a robust understanding of its potential impacts. The Department does not challenge those local authorities that appear to be less efficient. It notes that without improved national oversight and further investment, unlocking future efficiencies will be challenging.

16 Department of Health & Social Care, *Integration and Innovation: working together to improve health and social care for all*, CP 381, February 2021.

Performance and cost data

2.17 To measure system performance, the Department relies mainly on the Adult Social Care Outcomes Framework (the framework) and CQC inspection reports of care settings on the quality of care delivered. The Department commissioned ADASS to explore potential revisions to the framework in late 2019. In 2020, the Institute of Public Care (IPC), Oxford Brookes University was appointed to undertake this work in partnership with ADASS. Their review of the framework, which included a consultation exercise with senior care officers and sector stakeholders, found that the framework was limited in what it can report about care and that it does not cover large parts of local authority responsibilities under the Care Act 2014. An internal review by the Department also found that the framework does not focus sufficiently on well-being (a primary duty for local authorities under the Care Act) and user perspective. We previously reported how the framework does not enable the Department to assess how personal budgets improve outcomes.¹⁷ We understand the Department is currently revising the framework.

2.18 The Committee of Public Accounts has previously stressed the importance of a clear process for measuring outcomes, evaluating performance and demonstrating value for money, which allows organisations to be held to public account and which enables proper comparisons to be made across organisations delivering the same or similar services.¹⁸ Yet as well as a lack of data on outcomes, there is insufficient information on funding flowing from the spending review settlement through to providers. This means the Department cannot evaluate spending, assess the return on investment nor identify the extent of additional funding needed. Stakeholders raised concerns over the lack of transparency with provider costs and their financial structures, and that increases in funding may increase providers' profits rather than increase the quality of care.

2.19 We have previously highlighted limitations with care data.¹⁹ There is limited data on numbers of people cared for at home, levels of unpaid care or how many self-funders individual providers serve, making it hard to model future need (**Figure 11**). In January 2020, the Office for Statistics Regulation made recommendations for improving care statistics, highlighting gaps in understanding of privately funded care, unmet need, future demand, unpaid care and outcomes.²⁰ Prior to the COVID-19 pandemic, there was no process in place to collect a wide range of regular data from providers.

¹⁷ Comptroller and Auditor General, *Personalised commissioning in adult social care*, Session 2015–2016, HC 883, National Audit Office, March 2016.

¹⁸ HC Committee of Public Accounts, *Accountability for public money*, Twenty-eighth Report of Session 2010-11, HC 740, April 2011, page 5.

¹⁹ Comptroller and Auditor General, *Readyng the NHS and adult social care in England for COVID-19*, Session 2019–2021, HC 367, National Audit Office, June 2020.

²⁰ Office for Statistics Regulation, *Adult Social Care Statistics in England*, January 2020.

Figure 11

Data collected by government on care in England as at March 2020

Government-collected data are patchy on those service users who are local authority-funded, and poor on self-funders and unpaid care

Areas	Government-collected data			
	Formal care: Local authority-funded		Formal care: Self-funded	Unpaid care ²
	Care home	Care at home		
Total costs	✓	✓	✗	✗
Fees	Average ³	Average ³	✗	-
Requests for support	✓	✓	✗	✗
Number of people supported	✓	✗	✗	Estimate ⁵
Total workforce/carers	Estimate ⁴	Estimate ⁴	✗	Estimate ⁵
Number of providers ¹	✓	✓	✓	-
Quality of care	✓	✓	✓	✗
Types of support	✓	✓	✗	✗
Outcomes	Inconsistent ⁶	Inconsistent ⁶	✗	✗
User experience	Inconsistent ⁶	Inconsistent ⁶	✗	✗

Notes

- 1 Number of providers refers to those that are Care Quality Commission (CQC)-registered. CQC is included as 'government-collected data' here. Estimates are collected for non-CQC registered providers; this includes homeless shelters, women's refuges, drug and alcohol support centres, and day and outreach services.
- 2 The dataset sources here are updated at least annually. The table therefore excludes Census data which are collected on a 10-year cycle (next data collection in 2021) and includes questions on unpaid care.
- 3 Estimates for unit costs are calculated in the NHS Adult Social Care Activity and Finance data returns provided by local authorities. Average fee rates also reported for the Improved Better Care Fund.
- 4 Workforce data refer to that collected and analysed by Skills for Care. Skills for Care is included as 'government-collected data' here.
- 5 Estimates for unpaid care are derived from the NHS Digital Health Survey for England, and the Department for Work & Pensions Family Resources Survey, which extrapolate based on a representative sample. The English Longitudinal Survey of Ageing (ELSA) and UK Household Survey (UKHLS) provide estimates for provision of receipt of unpaid care in a similar way.
- 6 'Inconsistent' reflects data that are collected but are not comprehensive enough to reflect the total.
- 7 The table excludes established third-party data sets, such as LaingBuisson.

Source: National Audit Office analysis of publicly available adult social care datasets

2.20 While good performance data is fundamental to effective accountability, the cost effectiveness of providing good data needs to be balanced against the benefits of the information. During COVID-19 the Department led a significant amount of work with the sector to address longstanding gaps in care data and provide a near real-time view of the impact of the pandemic. A tool previously used to capture and share information between local authorities and the NHS on care home capacity, such as vacant beds, was adapted and then expanded. This capacity tracker covered care home outbreaks, COVID-19 cases, bed occupancy, workforce absence and Personal Protective Equipment (PPE) supply. As we reported in *Readyng the NHS and adult social care in England for COVID-19*, at the early stages of implementation in spring 2020, response rates were low at between 41% and 61% for care homes and 73% and 77% for home care.²¹ Coverage has increased, with around 92% of care homes and 73% of home care providers submitting data in February 2021, mainly as a result of the Department linking eligibility for infection control funding to consistent completion of the tracker.

2.21 There are concerns that increased data-gathering could lead to significant burdens for local authorities and providers. As part of its proposals for an enhanced assurance framework, the Department will focus initially on improving the quality, timeliness and accessibility of care data (paragraph 2.14). It plans to build on tools such as the capacity tracker and the experience of gathering data from care providers to collect data such as care hours provided, cost per person and how money flows to providers and workforce, as well as client-level data. The Department aims to reduce reporting burdens by using existing data sets. Local government supports the intention to gather high-quality data under these proposals if data collection is proportionate, supports effective local commissioning and the data flow back to local authorities. The Department has not yet consulted on these plans or assessed the impact that additional data collection would have on local authorities and providers.

²¹ Comptroller and Auditor General, *Readyng the NHS and adult social care in England for COVID-19*, Session 2019–2021, HC 367, National Audit Office, June 2020.

Oversight of providers' financial sustainability

CQC's market oversight

2.22 In 2011, Southern Cross – then the UK's largest care home provider – collapsed. Our report on *Oversight of user choice and provider competition in care markets* stressed the importance of further arrangements at a national and local level to address serious provider failure and protect users.²² In addition to its inspection role, since April 2015 CQC has undertaken market oversight of 'difficult-to-replace' care providers in England. It is a statutory scheme, as set out in the Care Act 2014. Its oversight team focuses on around 65 of the largest and most significant care providers across England, representing around 30% of the overall market by number of beds. To be in the market oversight scheme, care home providers must have either 2,000 beds or more nationally or have more than 1,000 beds and a significant regional presence. On this basis, some smaller, but regionally significant, providers may be excluded. Scheme entry criteria for care at home providers is based on number of care hours provided, number of service users and/or the intensity of care provided but does not factor in regional or local concentration.

2.23 CQC has a six-stage process for oversight, and it has a statutory duty to notify relevant local authorities (a stage 6 notification) if it believes that a provider is likely to fail and service cessation is likely. Despite CQC's oversight function, there is insufficient visibility of providers' financial sustainability across the care market. CQC issues a stage 6 notification under section 56 of the Care Act 2014 only after it has carried out a more detailed assessment of financial sustainability risks with the provider and potentially requested the provider produces a risk mitigation plan. Until CQC issues a stage 6 notification, local authorities have no additional information on the providers in their area from CQC. This is because the scheme is only designed to give local authorities advanced notice of likely failure and service cessation so they can enact contingency plans in line with their legal duties to ensure continuity of care. In five years, CQC has issued two stage 6 notifications. The level of providers at stage 4 (where CQC is engaging on risks identified through its regular monitoring) or stage 5 (where CQC is taking regulatory action and increasing engagement with providers) is unchanged in recent years.

2.24 In recognition that the market has evolved since its oversight role began more than five years ago, CQC has recently reviewed its market oversight and provider guidance, gathering public and stakeholder views on proposals between August and October 2020. As a result, the market oversight provider guidance could give local authorities more time to plan in the event of likely provider failure and service cessation.

22 Comptroller & Auditor General, *Oversight of user choice and provider competition in care markets*, Session 2010–2012, HC 1458, National Audit Office, September 2011.

Departmental knowledge of provider sustainability

2.25 In view of the local authority responsibilities for commissioning care from providers under the Care Act 2014 and CQC's market oversight role, the Department does not collect additional information on provider finances or their sustainability. Aside from analysis on a selection of large providers possible through a business intelligence provider's data (paragraphs 1.24 to 1.27), the Department has limited knowledge of small or medium-sized providers. In June 2020, the Department commissioned a consultancy firm to advise them about provider viability. The firm undertook limited analysis as there was up-to-date financial information only on less than a quarter of the total market. The consultancy firm advised that if the Department were to design an impactful early warning system, it must urgently improve the quality of the financial data it receives. It advised the Department that it should obtain access to relevant financial databases to improve its ongoing monitoring of the market and to develop internal capability to track the financial resilience of companies and individual care homes in real-time. The Department noted, however, that to do so could cut across local authorities' duties to shape and manage markets, as well as CQC's statutory market oversight role.

2.26 From April 2020, the Ministry began to monitor the financial pressures local authorities faced from the impact of COVID-19.²³ By the end of April, government had allocated £3.2 billion to local government to respond to COVID-19 pressures across local services, including care. Yet the Department did not have robust processes in place to oversee whether care providers were receiving enough financial support from local authorities at the start of the pandemic. Initially, the Department did not factor in extra funding required for additional costs – such as PPE or to implement infection control measures – or to compensate for shortfalls in income. In May 2020, to improve local transparency, the Department told local authorities to publish their initial support offered to providers. All local authorities published some information, but less than half of local authorities completed the optional template to provide details of the financial support given. In aggregate, less than £300 million could be identified from these returns so it was not possible to use them to analyse in detail the different support approaches taken. From mid-May, the Department controlled the allocations and the attached conditions of some COVID-19-related specific grants more than it had done so previously.²⁴ Local authorities told us they appreciated the flexibility to tailor support, but it was challenging to know the extent of support required. By the end of 2020-21, local authorities estimate they will have spent £3.1 billion on COVID-19-related spend for care, with 87% going to external providers.

²³ See footnote 21.

²⁴ For example, the Infection Control Fund One and Two instructed local authorities to pass most funding to providers based on a methodology.

Local authorities' oversight

2.27 The Care Act 2014 sets out minimum standards of care that local authorities must offer. It places a duty on local authorities to ensure there is a diverse market with enough high-quality services for adults to choose from. Local authorities must also ensure that no vulnerable person is without the care they need if their service closes due to business failure.

Market-shaping

2.28 Market-shaping is about understanding the local care market and stimulating a diverse range of care and support services to give adults choice about how their needs are met. It is also about ensuring that the care market remains vibrant and stable. Stakeholders told us that local authorities' responsibilities under the Care Act to shape their local markets are clear, but local authorities highlighted their limited levers to influence the market. There is significant variation in an area's ability to shape its market. For example, local authorities may be forced to pay high market rates if there are few state-funded users within parts of their borough while other local authorities have a more dominant market share.

2.29 The Department encourages local authorities to describe their market-shaping activities through published market position statements. Despite plans to do so in 2016 and a Committee of Public Accounts recommendation, the Department has not published a National Market Position Statement.²⁵ In its response to the Committee, the Department noted that while it had intended to develop this statement, it decided instead, in consultation with stakeholders, to focus on supporting local authorities by identifying, analysing and sharing best practice. Guidance on this was last updated four years ago. In June 2015, the Department published a market-shaping toolkit and advised local authorities to publish, review and regularly update their market position statements. From our sample review of 38 current market position statements (representing 25% of all local authorities with adult social care responsibilities), less than half of local authorities had updated these since 2016. The Department does not exercise any oversight over the quality of market position statements, instead relying on local processes, such as local authority scrutiny committees. Most statements we reviewed had data on the number of publicly funded adults, but only 32% provided detailed information about the self-funder market and only 18% contained detailed information on unmet need and unpaid care.

²⁵ HC Committee of Public Accounts, *Personal budgets in social care*, Second Report of Session 2016-2017, HC 74, June 2016.

2.30 Local authorities must put in place contract management arrangements with providers. Local authorities usually commission providers on the number of care home placements or on task and time for home care, rather than outcomes achieved. Local authorities are confident in challenging providers who offer unacceptable care quality, and they are happy to see low-quality small providers exit the market. However, local authorities are reticent to challenge providers about their workforce development, accepting that lower fees are a trade-off. Local authorities find it difficult to assess which local providers may expand, and note discussing succession planning with small providers may be sensitive.

The short- to medium-term outlook

2.31 Many providers run on tight margins and need high occupancy levels in care homes or high levels of home care hours to remain viable (paragraphs 1.24 to 1.27). In 2017, the CMA cautioned that providers focusing on local authority-funded residents might exit the market due to much lower profit margins and recent investment in care homes had focused on the private self-funder market.²⁶ We previously reported how the COVID-19 pandemic could negatively impact the profitability of care home providers as they seek to rebuild occupancy, which could take at least 18 months to return to former levels.²⁷ CQC's latest analysis found that among large providers, revenue and profitability within the period had remained relatively stable due to government support.²⁸ However, it warns that ongoing support is likely to be required in 2021 if care home admissions remain low or costs inflated. In February 2021, average occupancy levels in care homes were around 80%, compared with around 90% at the start of the pandemic. Around 15% of homes reported being closed or partially closed to new residents to manage infection control at the end of February 2021. CQC found that large home care and specialist providers have been financially less affected by the COVID-19 pandemic.

²⁶ See footnote 13.

²⁷ See footnote 21.

²⁸ Relates to quarterly data received from large providers as part of market oversight scheme, mainly ending 30 September.

2.32 Stakeholders told us that costs for care providers have also risen, but that government interventions such as the £1.1 billion Infection Control Fund and provision of free PPE had helped. Some stakeholders have reported concerns about rising insurance costs for care providers due to COVID-19. The 2020 Spending Review announced a further £1.55 billion in unringfenced funding to help local authorities address ongoing cost pressures from the pandemic. In January 2021, the Department wrote to directors of adult social services of local authorities to indicate what the £1.55 billion could be used for and this explicitly included insurance costs. In addition, in January 2021, the government announced a state-backed insurance indemnity scheme targeted at care homes who are or will become a ‘designated setting’ (a care location which can admit COVID-19-positive patients discharged from hospital) and cannot get sufficient insurance cover to do so. The scheme will run until the end of March 2021. While the scheme is not designed to address insurance premiums for the rest of the sector, the Department has committed to working closely with care providers and insurance representatives on these issues.

2.33 The pandemic has also affected care workforce levels. Skills for Care estimates the percentage of days lost due to sickness in care was 3% before the pandemic and 6% during the pandemic (April 2020 to January 2021).²⁹ In addition to its Infection Control Fund, the government has announced £120 million funding for social care to strengthen care staff capacity. The Department ran a national recruitment campaign from spring 2020 to recruit 20,000 people into social care. The Department is unable to record progress against this target and the overall campaign impact is not yet known, but its monitoring shows 94,000 people went on to search for a job on the campaign website. It has since launched the next phase of the national recruitment campaign, which will run until early April, as well as another campaign which aims to recruit short-term additional capacity during February and March by targeting volunteers, jobseekers and furloughed staff. The UK leaving the European Union could impact on the future care workforce. Currently around 7% of care workers are EU nationals, with a higher proportion working in certain roles such as nursing (16%) and areas of the country like London (13%). Staff in post before 1 January 2021 can apply for status under the EU Settlement Scheme and those granted settlement status will have the right to work in the UK. Workers outside the UK will not be able to apply for most care jobs under the new points-based immigration system, however.

²⁹ Skills for Care, *Days lost due to sickness – monthly tracking*. Available at: www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/Topics/COVID-19/days-lost-due-to-sickness.aspx

2.34 In October 2020, the Department, in partnership with ADASS and the LGA, undertook a service continuity and care market review, which was an action in the Adult Social Care Winter Plan 2020-21. The review asked local authorities to assess risks to their local care markets and service continuity issues through to the end of March 2021 and consider their contingency plans and any targeted and intensive support which may be needed. It found:

- 57% of local authorities were “slightly concerned” about their ability to ensure continuity of care between now and end of March for any care service;
- 43% of local authorities said they were at, or expect to reach, a critical point in their ability to ensure continuity of care provision across at least one service;
- local authorities were most concerned about services supporting older people;
- local authorities reported the impact of COVID-19, particularly on staffing but also on bed occupancy (primarily in nursing and residential care for older people) and increased insurance premiums, as primary causes for concern; and
- local authorities were using a wide range of measures to mitigate risks, although there was variation in the extent of mitigating measures being applied.

The Department has followed up on the review results and is providing targeted support to a small number of local authorities based on their response to the review and follow-up discussions. The review also identified areas for national action, including increasing regional and national market oversight; a long-term funding settlement; national workforce planning and support for EU transition impact on workforce; and support with insurance. The Department told us that many of these actions were already a high priority and were being implemented as part of its winter plan and wider work.

Part Three

Understanding future demand and costs

3.1 This section examines the Department of Health & Social Care's (the Department's) understanding of future demand and costs, and outlines issues to consider when reforming adult social care (care). The main projections within this Part relate to current patterns of care and the current funding system and were produced before the COVID-19 pandemic.

Forecasting demand and costs

Increasing demand

3.2 The Department commissions the Care Policy and Evaluation Centre (CPEC) at the London School of Economics (LSE) to produce projections of the long-term demand and cost of adult social care services in England. Their latest model projects that around 29% more adults aged 18 to 64 will need care in 2038 compared with 2018. For adults aged 18 to 64 the model projects a faster increase in demand for adults with learning disabilities (49%) compared with physical support (13%) and mental health support (2%) (**Figure 12** overleaf). This demand for care is much larger than the expected population growth for 18- to 64-year-olds (2.6% over this period). The extent to which adults with learning disabilities will live and require care for longer is uncertain. The presumption is that adults aged 18 to 64 with care needs will not self-fund their own care.

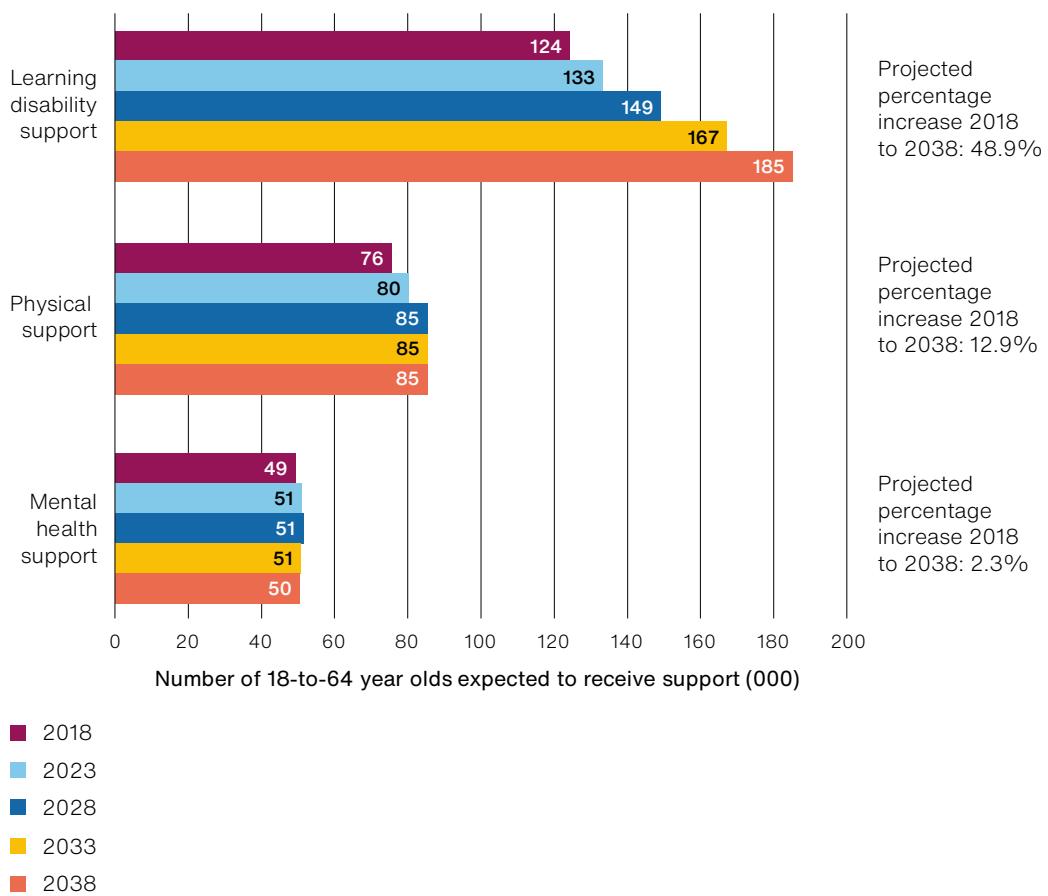
3.3 For adults aged 65 and over, the model projects that around 57% more adults will need care in 2038 compared with 2018 (**Figure 13** on page 47). The projected increase in demand for care at home (59%) is like that for care homes (55%). Demand is projected to increase faster for privately funded care homes (67%), due to a projected increase in the proportion of adults aged 65 and over who own their own home so are unlikely to be eligible for local authority support towards their care home fees. Overall, for adults aged 65 and over, the main driver for these increases is an ageing population, with a 41% increase in the number of adults aged over 65 between 2018 and 2038 projected.

Figure 12

Projected increases in demand for care for adults aged 18 to 64 years in England, 2018–2038

The number of adults aged 18 to 64 years requiring social care support is projected to increase, with the largest increase in learning disability support

Primary support reason



Notes

- 1 The model outputs are estimates and should therefore be treated as indicative.
- 2 Projections are based on projected population changes, adjusted by research on some matters, such as prevalence of learning disability among younger adults.
- 3 The model uses current policy assumptions on issues including unmet need, eligibility criteria and levels of unpaid care.
- 4 Physical support includes physical support and sensory support.
- 5 Mental health support includes mental health support and support with memory and cognition.
- 6 The model does not account for the impacts of the COVID-19 pandemic.
- 7 Data presented have been rounded.

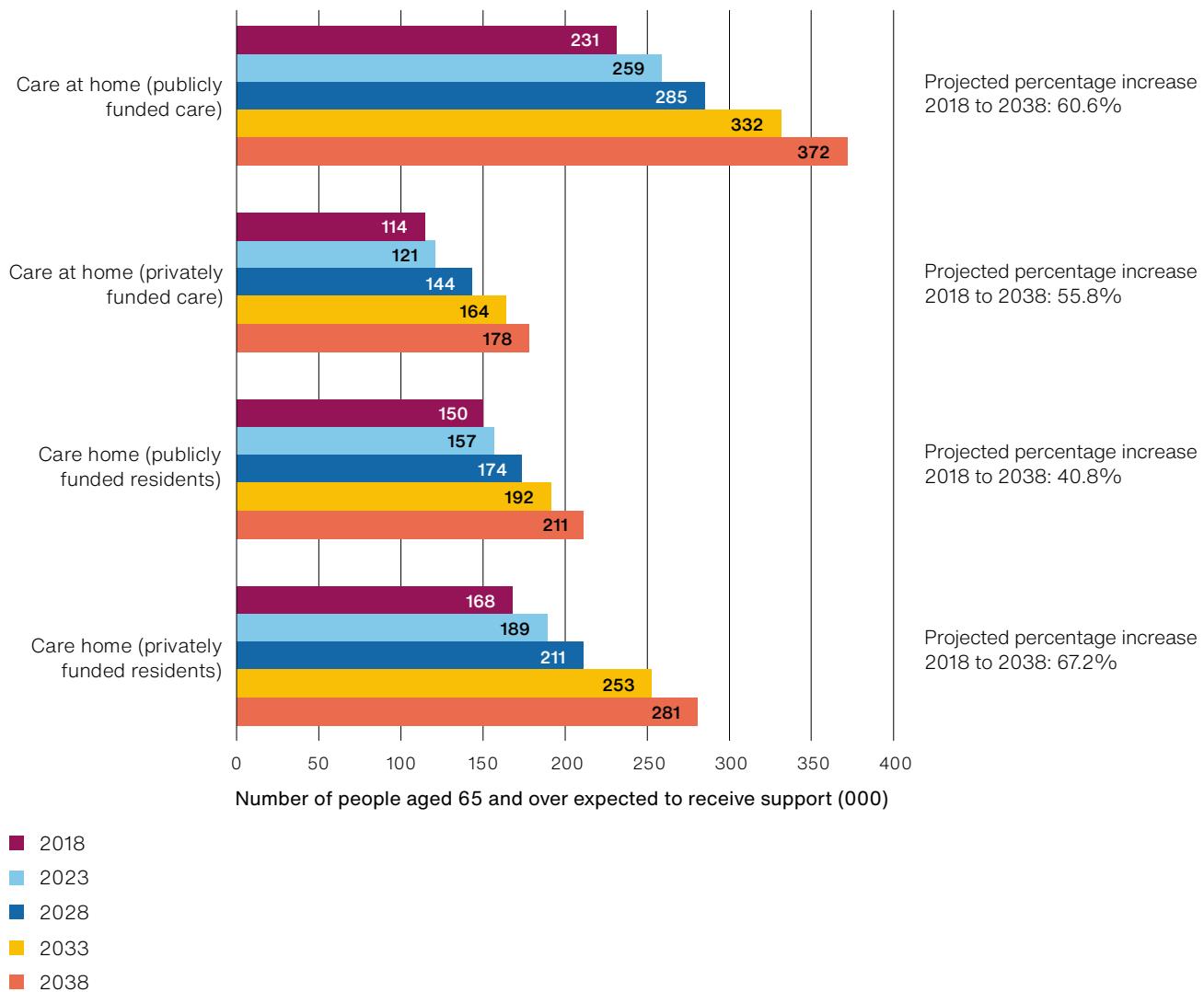
Source: National Audit Office analysis of Care Policy and Evaluation Centre, *Projections of Demand and Expenditure on Adult Social Care 2018 to 2038*

Figure 13

Projected increases in demand for care for adults aged 65 and over in England, 2018–2038

The number of adults aged 65 and over requiring social care support is projected to increase, with the largest increases in publicly funded care at home (61%) and privately funded care homes (67%)

Service type

**Notes**

- 1 The model outputs are estimates and should therefore be treated as indicative.
- 2 Care at home refers to adults receiving community care. Publicly funded care includes direct payments.
- 3 Care home refers to residential and nursing homes.
- 4 Projections are based on projected population changes, adjusted by research on some matters, such as prevalence of learning disability among younger adults.
- 5 The model uses current policy assumptions on issues including unmet need, eligibility criteria and levels of unpaid care.
- 6 The model does not account for the impacts of the COVID-19 pandemic.
- 7 Data presented have been rounded.

Increasing cost

3.4 Based on projected demand, CPEC produces a long-term model which projects the costs of care. These costs assume that current patterns of care and the current funding system continue. They do not allow for the potential impact of rising expectations or other behavioural changes that may occur. The modelling undertaken supports the Department's spending review bid, as outlined in Part Two, and feeds into the Office for Budget Responsibility's (OBR's) economic and fiscal outlook. The long-term projected increase in care spend contributes to the OBR's overall projection of growing public debt. It projects that social care expenditure will increasingly take up a greater proportion of GDP.

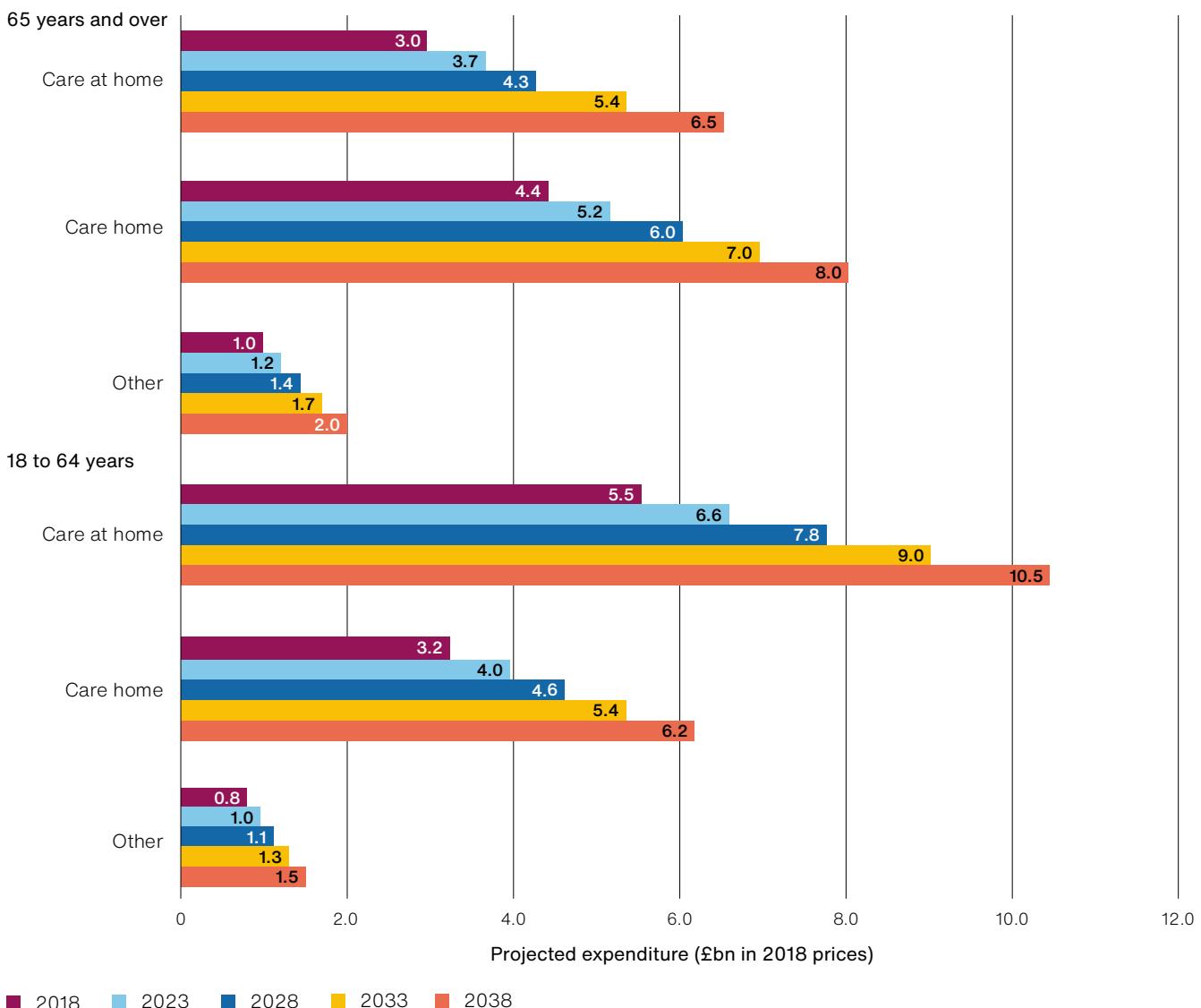
3.5 The model projects the publicly funded cost of providing care for adults aged 18 to 64 will rise by 90% between 2018 and 2038, from £9.6 billion to £18.1 billion. The percentage rise is almost identical between care at home, care homes and other expenditure. The cost is higher than the projected increase in demand as the expectation is that the unit costs of providing care will increase. For adults aged 65 and over the model projects the publicly funded cost of providing care will increase by 98% between 2018 and 2038. The percentage rise is higher for care at home (121%) than care homes (82%) (**Figure 14**).

3.6 Due to the small number of adults aged 18 to 64 who self-fund, there are no projections for increases in private care for adults aged 18 to 64. The model projects the total system cost of providing care for adults aged 65 and over will rise 106% between 2018 and 2038, from £18.3 billion to £37.7 billion. The largest percentage increase will be in private expenditure, rising 113% in the period (**Figure 15** on page 50). A key reason behind the projected rise in private expenditure is the projected increase in the proportion of adults aged 65 and over who own their own home. Therefore, they are unlikely to be eligible for local authority support towards their care home fees.

Figure 14

Projected cost of publicly funded care for adults in England, 2018–2038

Large increases in publicly funded costs of care for adults are expected between 2018 and 2038

Age group and support type**Notes**

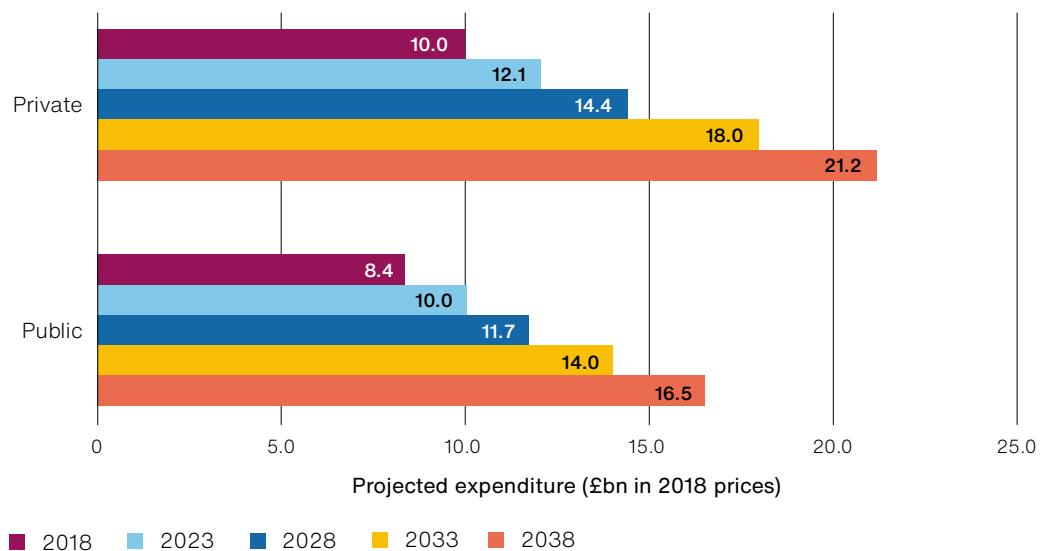
- 1 The model outputs are estimates and should therefore be treated as indicative.
- 2 Future costs for adult social care are based on the projected level of need and projected entitlements to publicly funded care. It is assumed that increases in unit costs will remain constant, in line with March 2020 forecasts by the Office for Budget Responsibility, with an uplift for the years to 2024 to take account of the planned rises in the National Living Wage.
- 3 Care at home refers to adults receiving community care.
- 4 Care home refers to residential and nursing homes.
- 5 'Other' includes expenditure on services not attributable as community or residential care, as well as expenditure on commissioning, strategy and administration activities.

Figure 15

Projected expenditure on care for those aged 65 and over in England, 2018-2038

Increases in private expenditure on care for adults aged over 65 will grow at a faster rate than social service spend

Expenditure type



Notes

- 1 The model outputs are projections and should therefore be treated as indicative.
- 2 Private expenditure is private expenditure plus user contributions.
- 3 Public expenditure projections are Care Policy and Evaluation Centre's projections for local authority net current expenditure on adult social care services and Better care fund expenditure.
- 4 Future costs for adult social care are based on the projected level of need and projected entitlements to publicly funded care. It is assumed that increases in unit costs will remain constant, in line with March 2020 forecasts by the Office for Budget Responsibility, with an uplift for the years to 2024 to take account of the planned rises in the National Living Wage.

Source: National Audit Office analysis of Care Policy and Evaluation Centre, *Projections of Demand and Expenditure on Adult Social Care 2018 to 2038*

Inherent uncertainty in the model and caveats

3.7 Our review of the model found that CPEC's approach is appropriate, but we agree with CPEC that caution should be exercised over the projections. This is because the projections:

- are constrained by data gaps outlined in Part Two;
- are partly dependent on wider research which may be out of date;
- are based on a set of assumptions about future socioeconomic and demographic trends;
- relate to current patterns of care and the current funding system;
- assume the current proportion of people providing unpaid care will continue;
- do not allow for the potential impact of rising expectations or other behavioural changes; and
- were made before the COVID-19 pandemic.

3.8 The Department asked CPEC to carry out sensitivity analysis around the National Living Wage and the extent of increase in the unit cost of care. If there are no real increases in the unit costs of providing care, CPEC projects that the combined cost of publicly funded care for all adults will rise by 39% from £17.9 billion to £25.0 billion between 2018 and 2038. This compares to their base projection of a 93% rise from £17.9 billion to £34.7 billion.

3.9 The Department has recently carried out sensitivity analysis on:

- disability rates;
- unit costs;
- demographics;
- net migration in the context of EU Exit;
- trends in home ownership;
- trends in learning disability prevalence;
- the future availability of unpaid care supply due to lower birth rates; and
- eligibility criteria.

From the above, changing eligibility criteria were the only major driver which caused more than a 12% difference in projected cost. The Department projects extending eligibility to care for those with moderate needs will increase costs by around one-quarter.

3.10 However, the Department is unable to demonstrate that it has adapted the CPEC projections of future demand and costs for potential changes in care delivery. The Department funds research, including through the National Institute for Health Research, into a range of topics, such as unpaid care; joint working with health; and drivers for demand. The Department and researchers are limited by a lack of data, as noted in Part Two.

3.11 While the Department undertakes some discrete pieces of modelling and research, overall, it does not adequately model the impact of:

- **changing the mix of care.** For example, whether a greater use of care at home could reduce costs while also improving outcomes. While the Department at a high level has looked at the potential impact of some interventions such as increasing reablement (temporary care at home after illness or hospital discharge) over the short term, it has not fully modelled the long-term impact of changing how care is delivered;
- **potential breakthroughs in medical treatment.** The Department commissions research into topics such as dementia, but the research is discrete. Improvements in treatment might reduce or increase the demand for care. We did not see any evidence that the Department uses this research to build on projections made by CPEC on future demand and costs;
- **initiatives around prevention and the extent to which these could change the intensity of care needed.** The Department has analysed some initiatives, such as encouraging the take-up of grants to support people in their own homes (Disabled Facilities Grants), but we have not seen evidence that it has assessed more widely the potential impact from improving the social determinants of poor health or a greater use of early intervention;
- **cross-government or societal changes.** For example, the impact of tax and benefit changes on the levels of personal savings, affecting user contributions and benefits administered across government. Societal changes, such as increases in flexible working, could impact on the provision of unpaid care; and
- **scope for future efficiencies.** The Department believes effective demand management and promoting independence could unlock savings but has not modelled which interventions could be scaled up.

Future reform

Preparing for reform

3.12 Governments, regardless of political party, have been promising care reform for the past 20 years. There have been repeated delays in reforms despite numerous government white papers, green papers, consultations, independent reviews and commissions over the years.³⁰

3.13 On 30 October 2020, the Number 10 Health and Social Care Taskforce, which was focused on health and social care priorities for Spending Review 2020 rather than on long-term reform, concluded its work. The Department confirmed it is responsible for reform and, in its recent white paper, proposed changes to data and assurance and set out legislative proposals for a Health and Care Bill to encourage better local working (paragraph 2.14). While the Department has committed to bringing forward proposals in 2021, a full reform plan for social care is not expected until late in the year as the government prioritises its COVID-19 response. The Department told us that the sequencing of reforms would need to be considered in the context of funding to be determined at a multi-year spending review.

3.14 A robust reform plan will need a broad cross-government perspective, including local government, that considers interrelated policy areas and cross-government objectives. For example, making sure that benefits, pensions and taxation policies are aligned with care policy to avoid creating perverse incentives which negatively affect choices about care. We have expressed concern before that planning and managing delivery in departmental siloes can undermine value for money and negatively affect local services if multiple departments take separate, narrow views.³¹ Our report on *Financial sustainability of local authorities 2018* stressed how the interdependent and connected nature of service delivery in local authorities is not reflected at the level of government departments.³²

3.15 The Department routinely holds meetings with other government departments at which various policy teams will discuss issues ranging from workforce and housing to funding reform (**Figure 16** on pages 54 and 55). Stakeholders told us that improving the workforce and providing future accommodation suitable to meet care needs are two of the most pressing issues within reform.

30 White papers are issued by government as statements of policy. Green papers set out for discussion proposals which are still at a formative stage.

31 Comptroller and Auditor General, *Improving government's planning and spending framework*, Session 2017–2019, HC1679, National Audit Office, November 2018.

32 Comptroller and Auditor General, *Financial sustainability of local authorities 2018*, Session 2017–2019, HC 834, National Audit Office, March 2018.

Figure 16

Meetings between the Department of Health & Social Care (the Department) and other government departments in relation to care

The Department meets with a range of other government departments on a variety of care issues

Government department	Regularity	Department of Health & Social Care team and the scope of discussions
Department for Business, Energy & Industrial Strategy	Ad hoc	Workforce – pay issues and other employment policy issues
	Ad hoc	Provider – issues that may impact provider markets
	Fortnightly	Housing – discuss Home of 2030 initiatives
Department for Education	Ad hoc	Workforce – skills and training for example, apprenticeships and the social work bursary
	Ad hoc	Accountability and oversight – Department of Health & Social Care developing assurance policy regarding Department for Education models; queries on easements that address children and adult social care
	Ad hoc	Provider-issues that may impact provider markets
	Semi-regular	Wider data and analysis – broader economic assumptions, and approach to modelling demand and spend
Department for Education/Department for Work & Pensions	Monthly	Funding reform – interaction between social care charging and the benefits system
Department for Work & Pensions	Ad hoc	Workforce- clarifying how the benefits regime applies to care workers
	Ad hoc	Housing- matters relating to supported housing
HM Treasury	Ad hoc	Funding reform – Spending review
	Weekly	Funding reform – charging reform policy discussions
	Low	Workforce – mainly on issues concerning funding for example, Spending review and COVID-19 issues
	Ad hoc	Health and social care integration-mainly discussions with regard to Department of Health & Social Care Spending review proposals
	Ad hoc	Provider – issues that may impact provider markets, including the impact of COVID-19 on insurance cover for adult social care providers
	Ad hoc	Housing – mainly discussions with regard to Department of Health & Social Care Spending review proposals
	Multiple per week	Adult social care funding – new policies (or changes to policies) which may have cost implications for adult social care/local government; fiscal moments (Spending review/budgets) and funding requirements for adult social care for COVID-19 needs
Home Office	Ad hoc	Workforce – issues relating to the Immigration Bill, to understand how the new points-based immigration system will impact the adult social care workforce

Figure 16 *continued*

Meetings between the Department of Health & Social Care (the Department) and other government departments in relation to care

Government department	Regularity	Department of Health & Social Care team and the scope of discussions
Ministry of Housing, Communities & Local Government	Fortnightly	Funding reform – charging reform policy discussions and interaction with local government
	Ad hoc	Funding reform – developing the Local Government Outcomes Framework in relation to the Department of Health & Social Care's assurance framework
	Ad hoc	Workforce – proposed new regulations to stop staff movement between health and care settings
	Ad hoc	Accountability and oversight- assist Ministry of Housing, Communities & Local Government on an outcomes based approach with local government, developing assurance proposals and to discuss potential adult social care metrics that might inform a local authority assessment programme
	High	Health and social care integration- various policy areas relating to integration, COVID-19 response and the Better Care Fund
	Regular	Provider – issues that may impact provider markets
	Multiple per week	Housing- various policy areas relating to housing and health, including housing adaptations (Disabled Facilities Grant), supported housing for older people and disabled adults, and future design and standards of mainstream housing
	Multiple per week	Adult social care funding – new policies (or changes to policies) which may have cost implications for adult social care/local government; fiscal moments (Spending review/budgets) and funding requirements for adult social care for COVID-19 needs
	Weekly	Wider data and analysis – adult social care policy, demand, the interaction of local government funding and spend on adult social care; broader economic assumptions and their interaction with adult social care demand and funding
Cross cutting	Monthly	Funding – interaction between adult social care charging and the benefits system
	Ad hoc	Provider – contingency planning for possible outcomes to the Supreme Court sleep-ins case/ongoing assessment of state of adult social care market

Notes

- 1 A summary of meetings held between July 2020 and December 2020. Some meetings may have since discontinued. For example, meetings with the Department for Business, Energy & Industrial Strategy over Homes 2030 ended in December 2020.
- 2 Other meetings in addition to those above may have occurred.

Source: Department of Health & Social Care internal documents

Workforce

3.16 Around 1.5 million people work in care. We have not seen any evidence which persuades us to change the main conclusions reached in our 2018 report, *The adult social care workforce in England*.³³ We found the Department had not followed through on key commitments it had made to enhance training and career development and to tackle recruitment and retention challenges. We concluded the Department had not achieved value for money as through its oversight role it had not demonstrably improved the sustainability of the workforce. We and the Committee of Public Accounts recommended that the Department produce a workforce strategy. Despite telling the Committee in 2018 that it was developing a health and care workforce strategy, the Department has not had a social care workforce strategy since 2009. The Department has not met previous commitments around tackling recruitment and retention challenges or on enhancing training and career development. The care workforce is one of the key principles for reform identified by the Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS) and multiple stakeholders. The Department told us that a workforce strategy would be dependent on the next spending review settlement and wider system reforms to funding and accountability committed to in the recent white paper.

3.17 Stakeholders identified the need for central leadership to improve pay and conditions for care workers, and to incentivise improved training and development. Skills for Care (an independent charity and company limited by guarantee) is the Department's delivery partner for leadership and workforce development in care. We reported in our *The adult social care workforce in England* report, that Skills for Care runs several small-scale initiatives. Pre-COVID-19, Skills for Care's total budget for workforce development equates to around £15 per worker, which reduces the coverage and potential impact it can have.

Future investment in accommodation

3.18 The Department does not monitor the condition of current care accommodation itself. LaingBuisson estimates that purpose-built accommodation makes up less than half of the care home market estate for older adults and adults with dementia. Only 72% of bed spaces in these homes have en-suite facilities. At current rates, it will take several decades to modernise the care home estate. Local authorities do not have a duty to collect data on the adequacy of current accommodation. The Department has not assessed the extent to which private homes could be adapted for greater use of care at home, and the costs these changes may result in for owner-occupiers or landlords.

³³ Comptroller and Auditor General, *The adult social care workforce in England*, Session 2017-2019, HC 714, National Audit Office, February 2018.

3.19 The Department does not have a coordinated, cross-government strategic vision for the delivery of housing with care. In **Figure 17** on pages 58 and 59, we outline the issues arising from the funding of new or improved accommodation for adults with care needs. The Department has not evaluated what mix of capital and revenue funding provides the best long-term value for money. Currently care home providers usually lease property or borrow privately to expand or modernise and recoup this investment through fees. The Department has not assessed whether it would be more cost-effective to offer providers loans or grants for new accommodation, in lieu of lower fees in future years. In 2017, the Competition & Markets Authority warned that the current funding situation combined with uncertainty about future funding and social care policy means providers are reluctant to invest in additional capacity for local authority-funded care home residents.³⁴

3.20 The Ministry of Housing, Communities & Local Government (the Ministry) has a standard method for local authorities to calculate the future numbers of new homes needed in their area, but the method does not consider the extent of housing for older adults or specialist housing required. The Ministry expects local authorities to consider housing for different groups within their Local Plans for housing, including for older and disabled people, but as we reported in *Planning for new homes in 2019*, only 44% of local authorities have an up-to-date Local Plan.³⁵

3.21 There are clear links between care and spend by the Department for Work & Pensions (DWP) on housing benefit. In November 2016 the Department jointly published with DWP a review into supported housing. It found there were around 554,000 supported housing units in England, owned mostly by social landlords. The review found that across Great Britain almost all adults aged 18 to 64 and 79% of adults aged 65 and over living in supported housing received housing benefit. In England, DWP spends around £3.5 billion a year on housing benefit for those living in supported housing accommodation.

³⁴ Competition & Markets Authority, Care homes market study, November 2017. Available at: <https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf>

³⁵ Comptroller and Auditor General, *Planning for new homes*, Session 2017–2019, HC1923, National Audit Office, February 2019.

Figure 17

Funding for new or improved accommodation for adults with care needs in England

Funding for new investment is ad hoc

Source of new capital funding	Current capital investment levels	Revenue implications	Issues arising
Private sector investment into care homes	Unknown.	<p>Self-funders or local authorities pay for this investment through future fees.</p> <p>Fee levels have implications for the level of investment that can be afforded. The Competition & Markets Authority has raised concerns that low fee rates mean that future investment is not viable for care homes with a large number of publicly funded residents.</p>	<p>The market may develop accommodation that is in the interests of investors, rather than service users.</p> <p>The Department of Health & Social Care has not investigated the extent to which care providers lease or rent property and whether this is more costly longer-term than providers developing their own accommodation.</p> <p>The government has not assessed whether providers are cost effectively delivering accommodation for the long-term.</p>
Private sector investment into sheltered housing, Extra Care or supported housing	Unknown.	This investment is paid for through future rents: adults renting the properties are liable to pay rent. Residents in supported housing who qualify for housing benefit are eligible for 100% of rent including service charges.	<p>The cost to a local authority (if a person qualifies for local authority support) is typically lower in supported accommodation than in a care home. This is partly because the local authority only pays for the costs of care in relation to supported accommodation; in relation to care homes authorities also pay for accommodation (the equivalent of rent).</p> <p>The government has not assessed whether providers are cost effectively delivering accommodation for the long-term.</p>
Grants or loans provided by central government	<p>There is a commitment that 10% of units built under Affordable Homes Programme run by Homes England and Greater London Authority between 2021 and 2026 will be for supported housing. This should support up to 18,000 new units over the period of the programme, which equates to an average of 3,600 new units a year across the period.</p> <p>In 2021-22 the Department of Health & Social Care intends to allocate £71 million of investment through Homes England via the Care and Support Specialised Housing (CASSH) fund.</p>	<p>Grant funding or the provision of a loan will be made by a government body such as Homes England which is part of the Ministry of Housing, Communities & Local Government.</p> <p>Grant funding may not cover all the costs of investment so adults or local authorities may have to pay future fees or rental charges in addition.</p>	<p>If government or a government body provides grant funding this is a spending commitment.</p> <p>There is a risk that an investor may default on a loan.</p> <p>If the government provides grant funding or a loan, the government will take on greater risks associated with development.</p>

Figure 17 continued

Funding for new or improved accommodation for adults with care needs in England

Source of new capital funding	Current capital investment levels	Revenue implications	Issues arising
Grants or loans provided by a local authority	Unknown.	<p>Grant funding may not cover all the costs of investment so adults or local authorities may have to pay future fees or rental charges in addition.</p> <p>Loan repayments and interest costs will be met through future fees or rental charges.</p> <p>The local authority will need to meet the net costs of any associated borrowing from revenue resources.</p>	<p>The ability of local authorities to fund capital investment varies. While local authorities can fund capital spending (such as making grants or loans to third parties) through the sale of capital assets, there are generally a range of calls on these resources. While local authorities can borrow to support capital spend, servicing the debt from revenue, financial pressures mean their ability to do this is often limited.</p>
Disabled Facilities Grants	In 2021-22, central government intend to allocate £573 million of Disabled Facilities Grants.	None.	<p>To be eligible for support a person must own the property or be a tenant, and intend to live in the property during the grant period (which is currently five years). A local authority needs to be happy that the work is necessary and appropriate to meet the disabled person's needs and is reasonable.</p> <p>The costs of providing Disabled Facilities Grants is a spending commitment.</p>
Adaptions made by private landlords	Unknown.	Potential that some landlords may increase rent, which could mean higher rental payments.	This may become more common in the future with an expected increase in the number of people requiring care living in private accommodation.

Note

1 The time periods covered for spending commitments are based on latest government announcements, as at February 2021.

Source: National Audit Office analysis of cross-government documents

Other reform considerations

Integrated approach focused on prevention

3.22 One of the key principles underpinning reform that stakeholders have called for is better integration across services, focusing on a person-centred, preventative approach to health and well-being. Joining up services can support a greater focus on preventative services and the wider determinants of health, particularly as adults live longer with multiple long-term conditions.³⁶ The LGA estimated that for every £1 invested in prevention, more than £7 of benefits, of which £1.90 are financial savings, could be generated.³⁷ Further advances in technology and research will also shape the demand for and type of care needed, for example around dementia. The government spent £344 million on dementia research between March 2015 and 2019, exceeding its pledge to spend £300 million on dementia research between 2015 and 2020. The government has not set out how it intends to deliver on further doubling of research funding into dementia in future years. Stakeholders have voiced concerns that care reforms could focus too much on care home funding for adults aged 65 and over, and that a broader range of community-based support, including for working-age adults, needs to be considered.

3.23 A whole-system approach to care centred on the individual's needs will require long-standing challenges around accountability, finances, culture and structure to be addressed as previously highlighted in our 2018 report on *The Health and social care interface*. The NHS Long Term Plan set out that from April 2021 all parts of the health and care system will be required to work together as Integrated Care Systems (ICSs), involving stronger partnerships in local places between the NHS, local government and others; developing strategic commissioning; and using digital and data to drive system working, connect providers and improve outcomes. Currently, the guidance on ICSs has little detail on care. However, the proposals include a greater role for local authorities in ICSs than previously. The Department told us that it plans to create a health and care partnership in each ICS area, bringing together local authority and NHS partners as the strategic planning body for health, social care and public health. As part of future reforms, the Department will need to consider the interrelation between NHS continuing healthcare and NHS-funded nursing care and the impact this has upon the costs and sustainability of local markets.

³⁶ Comptroller and Auditor General, *The health and social care interface*, Session 2017–2019, HC950, National Audit Office, July 2018.

³⁷ Local Government Association, *Prevention: A Shared Commitment*, September 2015.

Establishing an outcomes-based approach to monitoring and reporting

3.24 To support the reforms, government will require a refreshed outcomes framework which allows it to monitor system performance and effective delivery of its social care objectives and to identify any mitigating action needed. Given the move to better health and social care integration, there is a case for aligning the Adult Social Care Outcomes Framework with the NHS and Public Health Outcomes frameworks.

3.25 Going forward, it will be important to determine how to better align outcomes and funding, particularly if the reforms bring about increases in state funding for care. This will include deciding how providers' financial health will be assessed and reported upon and incentivising providers to increase transparency.

Appendix One

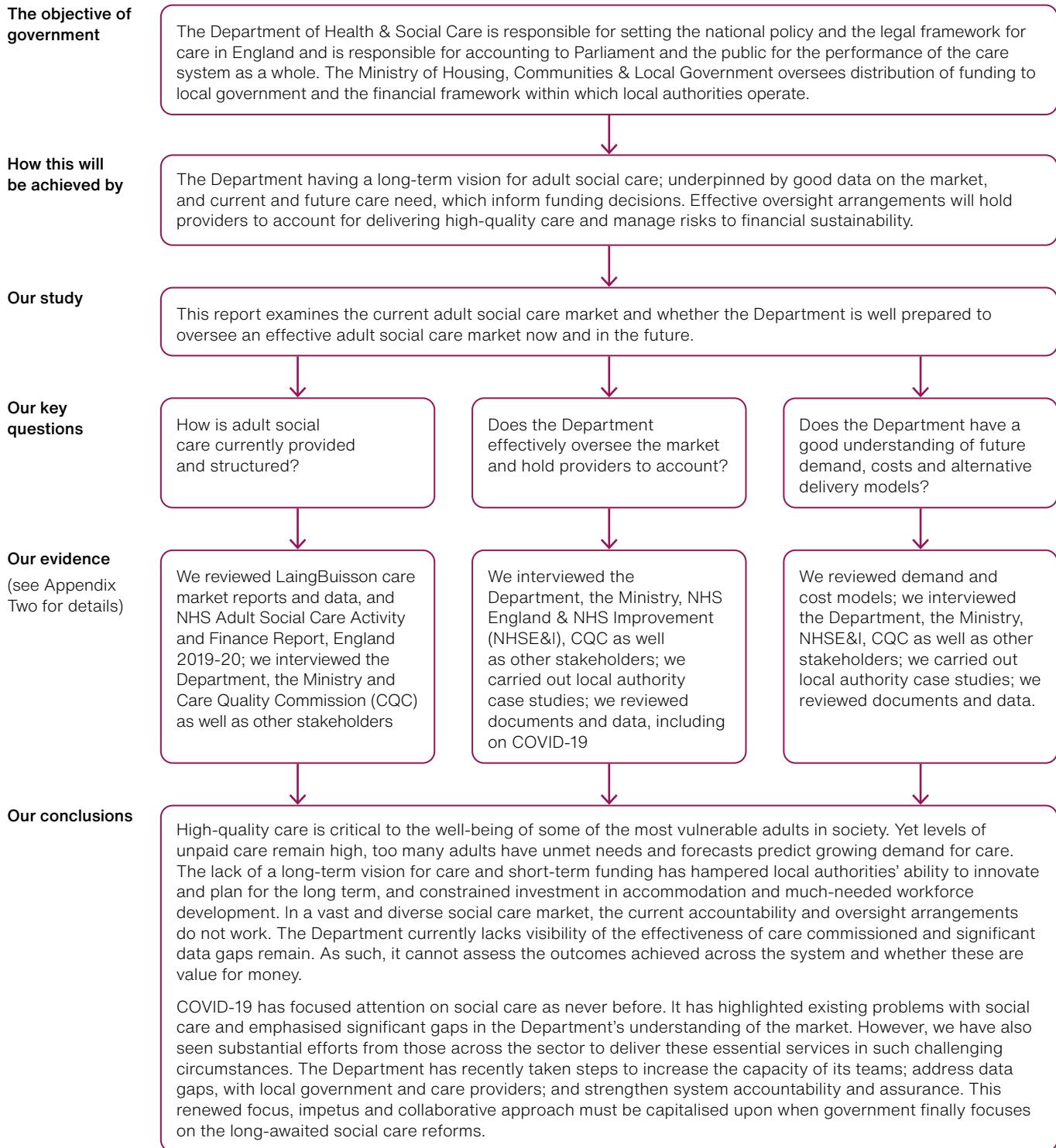
Our audit approach

1 This report examines the current adult social care market and the Department of Health & Social Care's (the Department's) role in overseeing the market now and in the future.

- We provide an overview of the adult social care market (Part One).
 - We assess the oversight and monitoring arrangements for adult social care, how these have changed in response to COVID-19 and the short- and medium-term market outlook (Part Two).
 - We examine the Department's understanding of future demand and costs, and outline issues to consider when reforming adult social care (Part Three).
- 2** Our audit approach is summarised in **Figure 18**. Our evidence base is summarised in Appendix Two.

Figure 18

Our audit approach



Appendix Two

Our evidence base

1 We reached our conclusion on whether the Department of Health & Social Care (the Department) has overseen the adult social care sector effectively by analysing evidence collected between July 2020 and February 2021. A separate methodology document setting out the principles behind our approach to our quantitative analysis of local government is available on our website: www.nao.org.uk/report/financial-sustainability-of-local-authorities-2018/

2 We applied an analytical framework with evaluative criteria that considers the Department's role in overseeing the adult social care market. Our audit approach is set out in Appendix One.

Interviews

3 We interviewed staff from the Department with responsibilities relating to the oversight of the care market. These meetings covered accountability; the monitoring and oversight of commissioning; the provider market; workforce; capital investment; data; the impact of COVID-19; and modelling for future demand. We also spoke to staff at the Care Quality Commission, the Ministry of Housing, Communities & Local Government and the Department for Work & Pensions about matters in which they are the lead body or have some responsibility.

4 We also interviewed a range of other organisations involved in, or with an interest in, adult social care. The organisations included: the Association of Directors of Adult Social Services, Age UK, Care England, Care Provider Alliance, , Carers UK, the Centre for Health and Public Interest, the Chartered Institute of Public Finance & Accountancy, the Competition & Markets Authority, the Health Foundation, the King's Fund, the Local Government Association, Mencap, Nuffield Trust, the Office for Budget Responsibility, Skills for Care, the Social Care Institute for Excellence, and the United Kingdom Homecare Association. We spoke to a wide range of individuals in addition, representing various stakeholder interests.

Case studies

5 We interviewed six local authorities in England, where we conducted semi-structured interviews with local authority employees. Our selection was based on a random sample, which ensured we had a representative group of the regions of England and four types of local authority with adult social care responsibilities. We also reviewed several documents from each local authority area to supplement our understanding from the interviews. In each location topic areas included: COVID-19, workforce, market shaping, commissioning, quality of providers, data and future delivery models. We spoke with the following local authorities: Bournemouth, Christchurch and Poole, Northamptonshire, Redcar and Cleveland, Rotherham, Suffolk, Waltham Forest. In addition, we spoke to directors of adult social services at other local authorities.

Data analysis and document review

6 We purchased data from LaingBuisson to undertake financial analysis of large care providers. We also purchased three market reports: on care homes, home care and specialist care. We supplemented this with a review of the Competition & Markets Authority's 2017 *Care homes market study*.³⁸

7 Throughout the report we reviewed departmental documents. This included a review of the Department's responsibilities, as well as a wide range of documentation relating to reviews or work undertaken on social care. We reviewed documentation relating to workforce and capital investment.

8 We carried out a review of our own work as well as external literature. We focused on our recent work covering adult social care as well as evidence from a range of external literature, including select committee and Committee of Public Accounts reports.

9 The main data sources we used in Part One were data from the Adult Social Care Activity and Finance Report, England 2019-20; Health Survey for England 2018 and 2019; the Care Quality Commission; and LaingBuisson.

10 For Part Two, in addition to interviews, we reviewed a wide range of documentation from the Department and the Care Quality Commission, including on COVID-19 impact. We reviewed a random sample of 38 market position statements, representing a quarter of the total market.

11 For Part Three, we interviewed and reviewed models prepared for the Department by the Care Policy and Evaluation Centre (CPEC) at the London School of Economics.

³⁸ Competition & Markets Authority, *Care homes market study*, November 2017. Available at <https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf>

CORRECTION SLIP

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Correction One:

Paragraph 9 (page 6) of the report was produced in error, the third sentence referred to net spend plus £3.1 million in user contributions whereas this should be billion.

The paragraph currently reads:

9 Local authority spending on care is lower than in 2010-11 but has begun to rise compared with previous years, with most spend going on long-term support.

Local authority net spending (funded by council tax, government grants and business rates) in 2019-20 was £16.5 billion; 4% lower in real terms than in 2010-11, but at its highest level since 2012-13. Of this local authority net spend plus £3.1 million in user contributions (amounts paid to local authorities by some care users towards their care costs), £15.4 billion was spent on providing long-term support, of which £6.4 billion was for physical support and £6.0 billion was for learning disability support (paragraphs 1.8 to 1.10).

The paragraph should read:

9 Local authority spending on care is lower than in 2010-11 but has begun to rise compared with previous years, with most spend going on long-term support.

Local authority net spending (funded by council tax, government grants and business rates) in 2019-20 was £16.5 billion; 4% lower in real terms than in 2010-11, but at its highest level since 2012-13. Of this local authority net spend plus £3.1 billion in user contributions (amounts paid to local authorities by some care users towards their care costs), £15.4 billion was spent on providing long-term support, of which £6.4 billion was for physical support and £6.0 billion was for learning disability support (paragraphs 1.8 to 1.10).

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