Institute for Fiscal Studies

National standards, local risks: the geography of local authority funded social care, 2009–10 to 2015–16

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The Health Foundation

E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL

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Preface

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Executive Summary

A significant number of adults with mental or physical ill-health or disability require support with the routine activities of daily living – such as cooking, cleaning and dressing themselves – or to ensure their safety and welfare (and the safety and welfare of others). That is, they require some form of 'social care'.

This report considers variations in the amount different local authorities (LAs) spend on social care for such adults, and how changes in spending, since recent cuts to LA budgets began in 2009–10, differ across England.

LA-organised care and the local government finance system

LAs organise and (partially) fund a range of adult social care services for their local populations, including short- and long-term residential, community and day care, and support for carers

Use of this funding is rationed using both care-needs assessments and eligibility criteria, and a financial means-test. Since April 2014, the needs assessment process has been set nationally, and all LAs must use eligibility criteria that are at least as generous as a national minimum standard. By excluding the value of the primary residence of the care-receiver, the means-test for home-based and day care is more generous than that for residential care.

Conditional upon meeting national minimum assessment standards, and eligibility criteria, LAs decide how much of their overall revenues to allocate to adult social care services

A number of factors will affect how much different LAs allocate to social care. Most obvious are the local population's need for social care, and the costs different LAs face in providing care. However, spending will also be affected by whether the LA goes beyond the minimum national eligibility standards, the quality of care it provides and the level of co-payment fees it charges. Different LAs will make different trade-offs between social care, other services and council tax rates.

LA revenues include council tax, business rates, grants from central government and financial transfers from the NHS to LAs to support social care services via the Better Care Fund

Historically, central government grants to LAs were based, at least notionally, on an assessment of local spending needs (including for adult social care) and the amount each LA could raise via council tax. Recent years have seen moves away from this system: the annual updating of needs assessments was ended and, more generally, recent cuts to LA budgets have fallen much heavier on those relatively poorer, more needy areas that depend more on central government grants. These changes will have affected funding available for social care.

In addition to care provided by LAs, formal social care services are paid for and organised by the NHS and by individuals and their families

The NHS organises and funds care for those individuals with the highest medical and care needs through its Continuing Healthcare programme. Individuals requiring care, but who are ineligible for support from their LA or the NHS (or their friends, families or charities), can purchase formal care services from private providers. Data issues prevent in-depth analysis of these expenditures, and how they vary across LA areas.

Adult social care spending in 2015–16

Net adult social care expenditure by LAs in England in 2015–16 amounted to £16.4 billion in 2016–17 prices, including £1.84 billion of NHS funding via the Better Care Fund

This is equivalent to £381 per adult (aged 18 or over) resident of England. However, there is significant variation in social care spending across the country: 10% of LAs spend less than £325 per adult resident, while 10% spend more than £445 per adult resident. At a regional level, spending per adult resident is over £390 in the East, North East and South West of England, and around £360 or lower in Yorkshire and The Humber and East Midlands.

Income from fees and charges amounted to £2.7 billion in the same year, on an average of £63 per resident adult

There is also significant variation in the amount LAs raise from fees and charges on users of adult social care services: 10% raise less than £35, while 10% raise £96 or more. There is little correlation between the amount LAs raise in fees and charges, and the amount they themselves spend on adult social care.

There is a positive correlation between levels of spending on adult social care services, and overall levels of spending on services by LAs

However, there is also significant variation in the proportion of service budgets (excluding education and public health) that is allocated to adult social care: less than 29% in a tenth of LAs, but more than 45% in another tenth, compared with an average of 38% across England.

The raw correlation between spending on social care per adult resident and the proportion of the population that is aged 65 or over is virtually zero

This seems to reflect the fact that many older people live in areas that have other characteristics – such as low levels of deprivation or earnings – associated with relatively low spending. This masks the underlying positive, although modest, correlation between social care spending and the proportion of the population that is aged 65 or over. There are also modest positive correlations between social care spending and the proportion of the population that is entitled to means-tested benefits or aged 18–65 and claiming a disability benefit.

There is some positive correlation between the assessed levels of relative social care spending needs per adult (as of 2013–14, when the last official assessment was undertaken) and actual spending on social care per adult

However, only 13% of the variation in actual spending can be explained by this needs assessment. This could reflect several factors: the official needs assessment may not capture true relative needs; relative needs may have changed significantly between 2013–14 and 2015–16; and/or factors other than differences in needs (such as differences in the priority placed on social care, or differences in the cost-efficiency of service delivery) could play a significant role in determining spending levels.

Changes to adult social care spending since 2009–10

Changes in social care spending per adult between 2009–10 and 2015–16 varied widely across England, with around one-in-ten LAs cutting spending by more than 25%, while another one-in-seven increased spending

Cuts have been far larger, on average, in London (18%) and the metropolitan districts (16%) covering other urban areas such as Greater Manchester, Tyneside and Greater Birmingham, than in the rest of the country. Outside these areas, cuts have been larger in the north of England than the south, on average.

Over this period, the distribution of spending across the country has narrowed

The gap between the 90th and 10th percentiles of the social care spending distribution fell from £158 to £121 per adult, or in percentage terms from 43% to 37%.

Cuts to social care spending have been greater in areas that initially had high levels of spending

Every £10 increase in social care spending per adult in 2009–10 is associated with an increase in subsequent cuts of around 1 percentage point, on average. Cuts have also been larger in LAs that were more reliant on grants for their overall revenues in 2009–10. Both likely reflect the fact that high-spending and more grant-reliant LAs have seen larger cuts to their overall budgets.

Cuts have been greater in areas that seem to have relatively high levels of spending needs

LAs that had higher levels of deprivation, more working age disability benefit claimants and more adults on pension credit, and therefore were assessed to have relatively high levels of spending need in 2009–10, made larger cuts to adult social care spending, on average, over the subsequent six years.

1. Introduction

A significant number of adults with mental or physical ill-health or disability require support with the routine activities of daily living – such as cooking, cleaning and dressing themselves – or to ensure their safety and welfare (and the safety and welfare of others). That is, they require some form of 'social care'.

The majority of care for these people is provided informally, by friends and family.[1] Other individuals, especially those with more substantial needs, and perhaps without a relative or friend with sufficient time or ability to care for them, are in receipt of formal care by paid carers. Some of these individuals will have purchased formal care privately.[2] However, public funding in England is available for those above a threshold level of care need and with assets below a certain level.

This publicly funded social care is organised largely by the approximately 150 LAs with social care responsibilities (the metropolitan and London boroughs, unitary authorities and counties). Historically, while all LAs were required to satisfy a number of statutory duties in relation to adult social care, there was substantial variation in assessment and eligibility criteria around the country (at least in terms of care needs). Following the Care Act 2014 though, we now have nationally defined criteria and processes for assessment of 'care needs' and national minimum eligibility criteria, to go alongside a set of common financial means-test thresholds.

However, LAs are able to use more generous eligibility criteria than the national minima if they so wish. They also have some flexibility over the quality of care provided to those who meet their eligibility criteria, and the level of co-payment fees they charge. Alongside differences in the local need for and cost of providing social care, and differences in the cost-effectiveness with which care is organised and provided, these factors mean that there can be significant differences in the amounts different LAs are spending on adult social care.

In this report, we examine the extent to which the level of LA social care spending per adult varied around England in 2015–16, and the extent to which these spending differences correlated with local demographic and socio-economic characteristics, and assessed local relative spending needs for adult social care as of the last official assessment in 2013–14. We also consider how social care spending changed between 2009–10 and 2015–16: a six-year period during which LAs saw an average real-terms cut to their overall budget for local services of 20%. Previous work by Institute for Fiscal Studies (IFS) researchers (Luchinskaya, Simpson and Stoye, 2017) has already shown that at a national level, social care spending was relatively protected, falling by 6.4% in real terms

[1] Comprehensive and consistent data on the prevalence and type of social care receipt among the full adult population are relatively sparse, with the survey data available focusing on the older population (King and Wittenberg, 2015). For instance, among English Longitudinal Study of Ageing (ELSA) survey respondents aged 65 or over, 26% report receiving some support with the routine activities of daily living: 17% report receiving only informal support from friends and family; 6% report receiving both informal support and formal support by paid professionals; and 3% report receiving only formal support by paid professionals (see Crawford and Stoye, 2017).

[2] Among the over 65s, for instance, around a quarter of those receiving formal support report paying for that support themselves. The remaining three-quarters report receiving formal care paid for by the state, charity or other individual (see Crawford and Stoye, 2017).

(after accounting for financial transfers from the NHS to support social care services). However, big differences in cuts to overall service budgets in different LAs (Amin Smith et al., 2016), and the different choices made by LAs on how to allocate these cuts across service areas, mean that changes in spending on social care also vary significantly across England. We again examine the correlation between these changes in spending and local demographic and socio-economic characteristics.

The rest of the paper proceeds as follows. In Chapter 2, we describe how social care is organised and funded in England. Then, in Chapter 3, we examine how spending on social care organised by LAs varied across England in 2015–16, and in Chapter 4 we show how this had changed since 2009–10. We conclude in Chapter 5. Further information is provided in five appendices: in Appendix A, we explain how we construct our measure of LA social care spending; in Appendix B, we discuss the role of the NHS in organising and funding the care of some of those with the highest medical needs, through its Continuing Healthcare programme; in Appendix C, we provide information on recent changes to local government finance in England, which will have affected the amounts different LAs have to spend on social care; in Appendix D, we provide information on variation in unit costs paid for adult social care services around the country; and in Appendix E, we provide further statistical analysis of the spending and spending change correlations discussed in Chapters 3 and 4.

Readers should note that this report provides descriptive evidence on how LA-organised social care spending (and changes in this spending) varies across England, and how this correlates with local demographic and socio-economic characteristics, and a *proxy* for local needs. We do not know how true need for social care spending varies across the country, nor do we examine how these differences in funding translate into differences in service quality or access. Furthermore, we do not make any judgement on whether differences in the levels or changes in social care spending are ‘fair’ or not.

2. Local authority organised care and the local government finance system

2.1 Local authority organised social care

As discussed previously, this report looks at how the amount spent on adult social care by LAs varies across England, and how this has changed over time. Our main definition of spending is an adjusted measure of *net* expenditure that includes spending funded by LAs' own revenues (from council tax, retained business rates and central government grants), and an estimate of funding transfers from the NHS to LAs for the purpose of social care through the Better Care Fund, based on national-level analysis by the NHS. Appendix A provides further detail on this approach.

We also use a wider measure of *gross* expenditure that includes income received by LAs in fees and charges levied on some social care users (for instance, payments for subsidised services such as Meals on Wheels, or payments by those ineligible for council-funded support but who ask to use – and pay for – support *organised* by the LA on their behalf).

Our definitions of spending therefore exclude the following two major components of spending on formal (paid-for) social care services.

- Privately funded care that is not organised or coordinated by LAs (such as that paid for directly by private clients of private nursing homes or private home-care providers). Data on expenditure on and the number of recipients of such care are sparse, especially at a local level (King and Wittenberg, 2015).

- Public spending on the care of some of those with the highest medical and care needs, funded and organised by the NHS as part of the Continuing Healthcare programme. In total, spending on this programme was £3.1 billion in 2015–16, although the fraction of this that relates to support for 'care' as opposed to 'health' needs is unclear.[3] The rules governing eligibility for Continuing Healthcare and the amount the NHS will pay differ significantly from those governing general adult social care provision by LAs. Appendix B provides further details.

The LA spending we examine funds a range of adult social care (and related) services including: long-term day, community or residential care for those with physical, cognitive or mental disabilities or health issues; short-term support for those requiring care following, or as a result of, illness; and services for friends or relatives acting as informal carers, such as respite. Funding for these services is rationed in two main ways.

First, individuals are subject to an assessment of their social care needs. Historically, there was significant variation in these assessments across LAs, and the eligibility criteria LAs applied, although over time more and more councils restricted eligibility to those with only the most substantial needs (National Audit Office, 2014). The Care Act 2014 means that from April 2015 onwards a common approach to assessment and minimum eligibility

[3] NHS England response to a Freedom of Information request, available at: https://www.whatdotheyknow.com/request/continuing_healthcare_spend_and#incoming-878831.

criteria apply nationally. Currently, a person is deemed eligible under the minimum criteria if:

- they have care and support needs as a result of a physical or mental condition;
- because of those needs, they cannot achieve two or more of a number of outcomes related to daily living, such as dressing or feeding themselves appropriately, keeping themselves safe, maintaining personal relationships, etc.;[4]
- as a result of this inability, their well-being is significantly negatively affected.

The somewhat subjective nature of these criteria (especially that related to the effects on well-being) means that, in practice, different LAs may interpret these national rules in somewhat different ways. Also, LAs remain able to set eligibility criteria that are more generous than these national minima if they so wish. Thus, it remains the case that an individual with a particular set of care needs may be deemed eligible for support in one LA area and not in another.

Second, once their underlying eligibility is assessed, individuals are subject to a financial means-test. The means-test applies to both income, and assets and savings. The income test is based on rules about the income people in different circumstances are assumed to need after any contribution to their social care costs.[5] Individuals with incomes sufficiently high to cover the full cost of care themselves must do so, while those with incomes high enough to make some contribution must make co-payments to or alongside their LA.

Irrespective of income, those with assets above £23,250 are not entitled to any financial support from their LA.[6] Those with assets below £14,250 are entitled to the maximum that someone with their income could receive. An individual's home is excluded from this assets-test if they, their partner or another dependent continues to live in that home.

2.2 Social care funding and the local government finance system

Although there are national minimum eligibility criteria and means-test rules, it is the responsibility of each LA to choose how much of their overall budget to allocate to adult social care. A number of factors will affect the amount each LA chooses to allocate, including:

- local social care needs, which will be affected by things such as the health and age structure of the adult population in the area;
- the local cost of providing social care services, which may be affected by the efficiency of the LA in question, as well as local labour and property markets;

[4] A full list of the relevant outcomes that individuals are expected to be able to achieve is set out in the regulations that sit alongside the Care Act 2014, available at: www.legislation.gov.uk/uksi/2015/313/pdfs/uksi_20150313_en.pdf.
[5] Figures relate to 2016–17. Further information is available in Department of Health (2016) and Age UK (2016a, b).
[6] The capital rules are mandatory for residential care, but LAs have discretion to provide support to those adults with assets above these limits who require care in their own home.

- the amount that the LA is able to recover in co-payments, which will depend on the maximum fees they set, and the incomes and assets of those with care needs;

- the trade-offs each LA makes between adult social care spending, other service spending and council tax levels, in the context of the funding from grants, business rates and the NHS that they receive. (Recall that LAs retain a degree of discretion over the application of eligibility criteria and can go beyond the minimum criteria if they decide to, making such trade-offs potentially important.)

In Chapter 3 of this report, we examine the distribution of spending on adult social care across LAs that results from these various factors. Unfortunately, it is not possible to break down the overall variation into separate components that can be explained by each of these factors in turn. However, we can and do examine how spending correlates with a number of proxies for local needs – including local demographic and socio-economic characteristics, and the last official assessment of adult social care spending need – and the overall levels of LA funding and grant funding from central government.

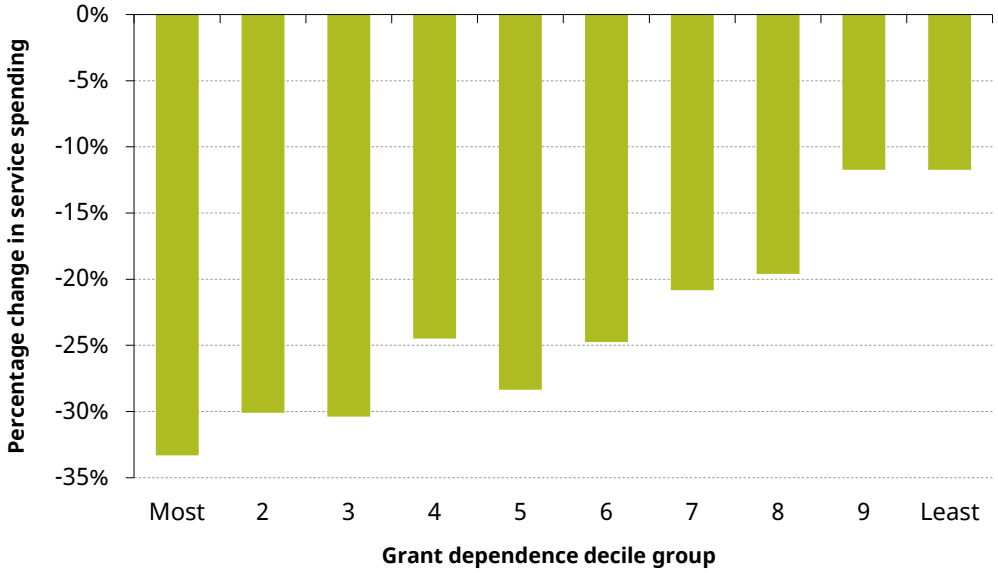
We also consider how social care spending has changed over time. This is in the context of several years during which LAs have seen reductions in funding, driven by large cuts to grants from central government, and significant changes to the way revenues from grant funding and business rates are allocated to them. Drawing on Amin Smith et al. (2016), in Appendix C we provide detailed information on these changes, but the following two things are worth noting.

- The traditional annual updating of the grants LAs receive from central government, on the basis of local relative spending needs (including for social care) and local ability to raise revenues via council tax, has ended. The funding LAs have is therefore less linked to need than previously.

- More generally, the way cuts to grants were allocated across LAs between 2009–10 and 2015–16 meant that LAs that were initially highly dependent on grants (whether due to high needs, low revenues, or both) faced much larger cuts to their overall budgets. For instance, Figure 2.1 shows that those LAs that were among the 10% of authorities most dependent on grant funding reduced their service spending by 33%, on average, in real terms between 2009–10 and 2016–17, while those among the 10% least dependent on grant funding cut their spending by 12% (compared with an average of 23% across all LAs).

In Chapter 4 of this report, we examine how these big differences in overall funding and spending cuts across LAs translate into differences in changes in social care spending needs. We also consider how changes in social care spending correlate with initial levels of spending, grant dependence and proxies for needs, and with changes in a number of these variables.

Figure 2.1. Real-terms change in local government service spending by decile group of grant dependence, 2009–10 to 2016–17



Note: Grant dependence decile groups are derived by dividing all LAs into 10 equal-sized groups according to the proportion of their core revenues (grants plus council tax) derived from government grants in 2009–10. Decile group 1 contains the most grant-dependent tenth of LAs, decile group 2 the second-most grant-dependent, and so on up to decile group 10, which contains the tenth of LAs least dependent on government grants in 2009–10.

Source: Authors' calculations using Department for Communities and Local Government (DCLG) LA revenue expenditure and financing statistics, available at: https://www.ifs.org.uk/publications/8781.

However, before moving on to the quantitative analysis of social care spending by LAs in Chapters 3 and 4, it is worth discussing in more detail one further feature of the local government finance system: ring-fenced funding specifically for social care.

For several years, in addition to their revenues from council tax, business rates and general grants from central government, LAs have been in receipt of the Better Care Fund – 'ring-fenced' transfers from the NHS to help fund social care expenditure that provides a 'health benefit'. These transfers increased from effectively zero in 2010–11 to approximately £1.84 billion in 2015–16, around 11% of what LAs were spending overall on adult social care in that year (Luchinskaya et al., 2017; see also Appendix A). Taking into account these transfers, LA spending on adult social care fell by 6.4%, on average, between 2009–10 and 2015–16, compared with 16.8% excluding these transfers.

However, it is important to note that we do not know what LAs would have spent on adult social care in the absence of these transfers: they may have decided to spend more of their own revenues from council tax, business rates and general grants on social care services. In other words, the 'ring fence' on the Better Care Fund need not mean that all the transfers are used to provide genuine increases in spending on social care, above what LAs would otherwise have spent; some of the transfers may implicitly be being used to support other areas of LA spending, such as children's social services, refuse collection and disposal, and housing.

Similar 'ring-fence' rules apply to funding from the 'Social Care Precept', an additional and increasing charge added to council tax from 2016–17 onwards worth £1.7 billion in 2019–

20,[7] and the so-called 'Improved Better Care Fund' and associated additional grant funding for social care, to be introduced in April 2017 and worth another £1.7 billion a year (on top of the existing Better Care Fund transfers from the NHS) by 2019–20.[8] Recent analysis by IFS researchers shows that if these revenues were used in full to increase social care budgets beyond their level if they tracked the change in overall local government spending, across England as a whole, social care spending would be around 11% higher by 2019–20 than in 2016–17, and 2.5% higher than in 2009–10, just before the recent cuts began (see Simpson, 2017). In practice, LAs could choose to increase spending by more or less than this (and perhaps even reduce spending). Either would be consistent with the ring-fencing requirements, which require LAs to state that they are spending more on adult social care than they would have in the absence of these funding streams. What LAs actually spend on social care will depend on a range of factors including: how spending pressures in social care compare with pressures in other service areas; the priority they place on social care relative to other service areas; and their willingness to levy (or the willingness of their residents to pay) higher council tax.

We do not consider future changes in social care spending in the remainder of this report – our focus is on historic differences in the levels of and changes to social care spending.

[7] The Social Care Precept allows councils with social care responsibilities to increase their council tax without requiring a referendum by more than the limits set by the usual council tax referendum limit of 1.99% a year. In April 2016, councils could increase council tax by an extra 2 percentage points (for a total increase of 3.99%), with limits of 3 percentage points (for a total increase of 4.99%) applying in April 2017 and April 2018. The overall limit is 8 percentage points by April 2019.

[8] The funding from the Improved Better Care Fund is allocated to LAs in such a way as to compensate for differences in their ability to raise their own revenues via council tax. The aim is that taken together, revenues from the Social Care Precept and the Improved Better Care Fund grants will provide each LA with a share of the national funding available from the two sources that is roughly equal to what it would receive if funding were allocated according to the 2013–14 adult social care relative needs formula.

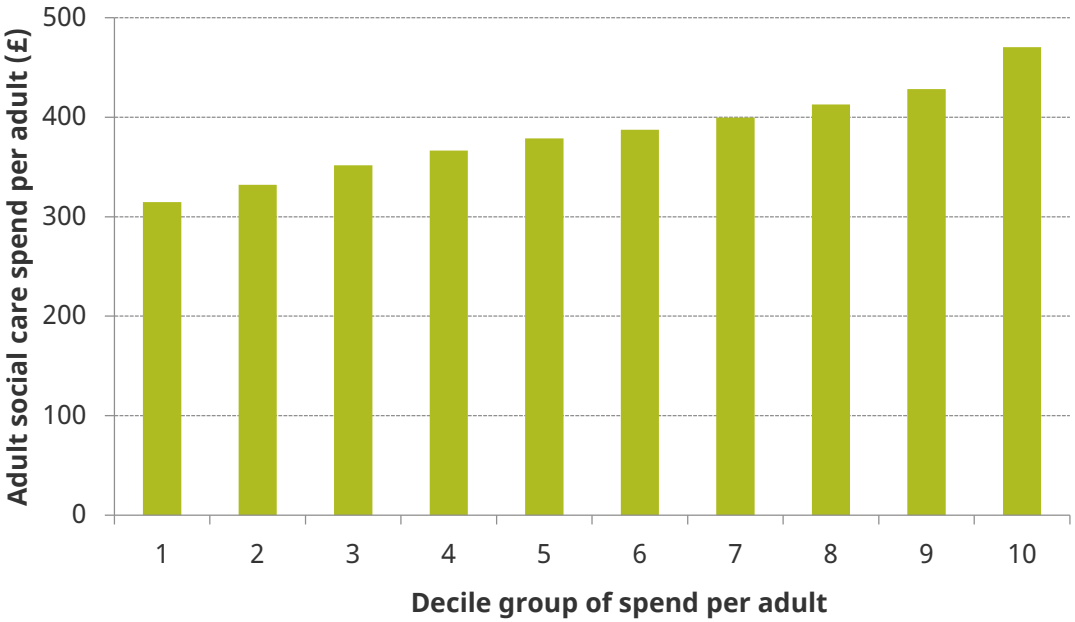
3. Adult social care spending in 2015–16

In this chapter, we examine how social care spending by LAs varies across England, and the extent to which this variation correlates with local characteristics.

3.1 Cross-local authority variation in public spending on social care

Social care spending by LAs in England in 2015–16 amounted to £16.4 billion in today's prices, including an estimated £1.84 billion of spending funded by transfers from the NHS via the Better Care Fund (these and all subsequent figures are in 2016–17 prices). At a local level, the amount spent varied from around £500,000 in the lowest spending LA to close to £500 million in the highest spending LA. Of course, most of this variation is driven by the size of the population of different LA areas. Therefore, we focus on LA spending on social care per adult resident (aged 18 or over). This measure of spend per adult picks up differences both in the amount spent per recipient of LA-funded care and in the proportion of the adult population of different LAs receiving LA-funded care.

Figure 3.1. Average adult social care spending per adult in 2015–16 (in 2016–17 prices), by decile group of spend per adult



Note: Adult social care spending measured by LA net expenditure on adult social care plus portion of the Better Care Fund minimum contributions (see Appendix A for details).

Source: Authors' calculations using DCLG local government revenue expenditure and financing statistics, and ONS population estimates. The Better Care Fund allocations are taken from the 2015–16 local government finance settlement 'spending power 2015 to 2016 support information' document, which is available here: https://www.gov.uk/government/publications/change-in-spending-power-final-local-government-finance-settlement-2015-to-2016 (see Appendix A for details).

On average, across England, social care spending in 2015–16 was £381 per adult. The bottom 10% of authorities spent less than £325 per adult resident, whilst the top 10% spent more than £445 per adult resident. This means that for a median-sized LA with a population of about 212,000 adults, a move from the 10th to the 90th percentile would take spending on adult social care from £68.7 million to £94.2 million, which is an increase of £25.5 million (37%).

To look right across the distribution, Figure 3.1 shows average adult social care spending per adult by decile group of spending (i.e. each group includes 10% of LAs, ranked from lowest to highest spending). For example, it shows that, on average, the lowest-spending tenth of LAs spent around £315 per adult on adult social care, and the highest spending 10% of authorities spent, on average, around £470 per adult. There is clearly a wide range of social care spending across England.

In Table 3.1, we summarise spending by region and LA type. At the regional level, there are roughly three groups of authorities. The highest spending group consists of the East of England, South West, North East, North West and London, where spending in 2015–16

Table 3.1. Adult social care spending per adult in 2015–16 (2016–17 prices), by region and LA type

Area	Spending per adult
Region	
East of England	396
South West	395
North East	395
North West	389
London	389
South East	380
West Midlands	366
Yorkshire and The Humber	361
East Midlands	356
LA type	
Unitary Authority (South)	392
London Borough	389
Shire County (South)	387
Metropolitan District	380
Unitary Authority (North and Midlands)	379
Shire County (North and Midlands)	357

Note: City of London and Isles of Scilly are not included in calculation of subnational spending figures.

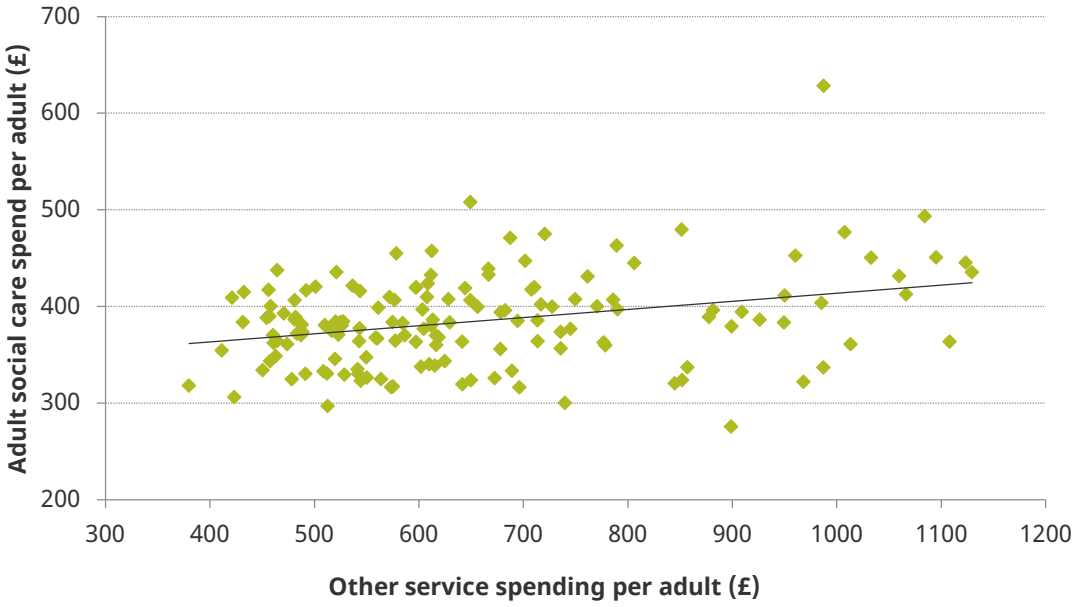
Source: See Figure 3.1.

averaged £390–£395 per adult. The West Midlands, Yorkshire and The Humber and East Midlands make up the lowest spending cluster, with spending around £360 per adult. In the middle sits the South East, with spending of £380 per adult.

Spending per adult also varies by LA type. Unitary authorities in the south of England, London boroughs and the Shire Counties of the south were the highest spenders, with spending of around £390 per adult. Spend was lowest in the Shire Counties of the North and Midlands (£357 per adult).

LAs that are more generally high spending tend to spend a relatively high amount on adult social care. This can be seen in Figure 3.2, which shows the correlation between overall spending per adult on other service areas (such as children's social services, transport, libraries and refuse management[9]) and spending per adult on adult social care. However, the relationship is far from one-for-one, and variation in other service spending only explains around 10% of variation in social care spending (after dropping the City of London and Isles of Scilly[10]). This means that there is significant variation in the fraction of overall service budgets that is accounted for by adult social care: while the average in 2015–16 was 38%, in a tenth of LAs it was less than 29%, whilst in another tenth it was more than 45%.

Figure 3.2. Correlation between adult social care spending per adult and other LA service spending per adult resident, 2015–16 (2016–17 prices)



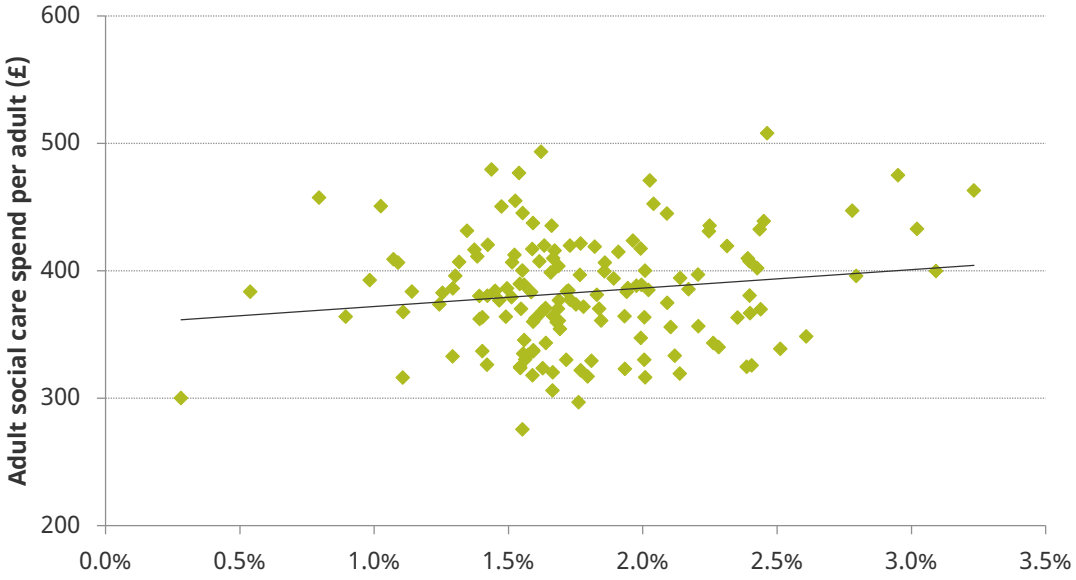
Note: Other service expenditure excludes police, fire, education and public health.

Source: See Figure 3.1.

[9] We exclude spending on police, fire, education and public health from these figures because of inconsistencies across LAs and over time in these areas of spending. Note that, in two-tier areas, other service spending includes spending by the constituent district authorities.
[10] We drop these two LAs – which have very low populations and highly unusual spending patterns – in the remainder of this section.

There is also variation in the proportion of the population that is receiving LA-funded care. The share of adults in receipt of long-term care is 1.7% in the median authority, but it is less than 1.3% in around a tenth of LAs and more than 2.4% in another tenth. As shown in Figure 3.3, there is a weak positive correlation between adult social care spending per adult and the share of the population receiving long-term care – however, this explains only 5% of the variation in adult social care spending. Therefore, other factors – such as the severity of the needs of people being cared for; their ability to contribute co-payments and the level of co-payments charged; and differences in the quality and costs of care provided – must play a significant role in determining social care expenditures.[11]

Figure 3.3. Correlation between adult social care spending per adult and the share of the adult population receiving LA-funded long-term care in 2015–16



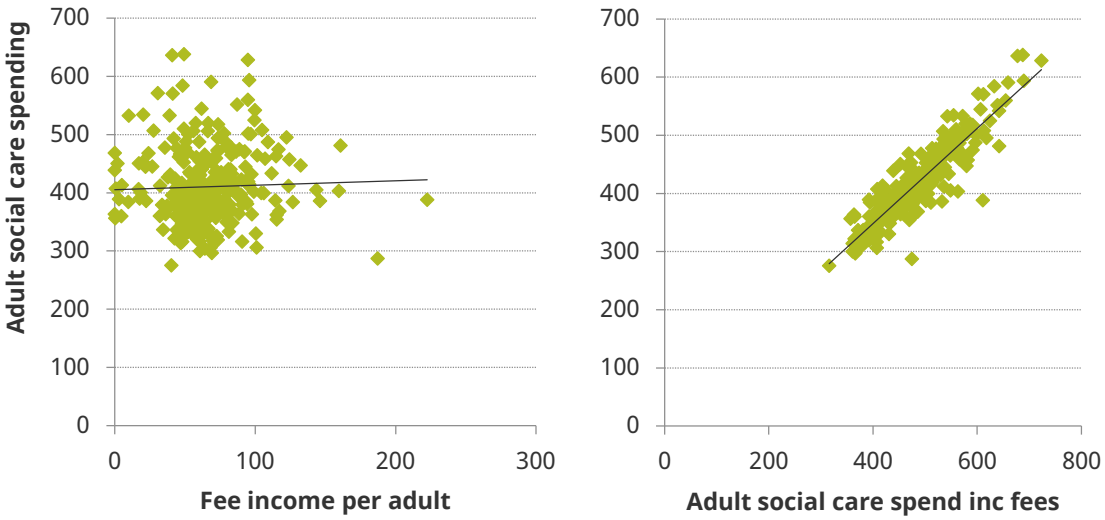
Source: Spending and population data as per Figure 3.1. Long-term care recipients from Community Care Statistics.

Figure 3.4 considers one of these 'other' factors: income received as co-payments from fees and charges. The spending figures reported so far focus on the *net* spending by LAs on social care (including transfers from the NHS), and therefore exclude the income generated through fees and charges on service users. This income is not insignificant: an average £63 per adult resident, compared with LAs' own average expenditure of £381 per adult resident. It also varies widely across the country, from less than £35 per adult in a tenth of LAs to more than £96 in another tenth. However, as the left panel of Figure 3.4 shows, there is little relationship between fee income per adult and LAs' own expenditure per adult. Therefore, while different LAs raise significantly different amounts from fees

[11] It also means that spending per recipient of care varies significantly around the country. For instance, figures calculated by NHS Digital (2016), using a broader definition of spending (including income from fees and charges and additional income from the NHS and other public bodies) than that used in this report, show that the cost-per-week of residential care for an adult aged 65 or over varies from less than £445 per week in 10% of LAs to more than £791 in the top 10% of LAs in 2015–16. Appendix D shows how these 'unit costs' for social care vary across England using these statistics.

and charges, there is no clear pattern of either high spenders receiving high (or low) co-payments or low spenders relying on high income from co-payments to meet demand. The right-hand panel of Figure 3.4 shows that there is therefore a strong almost one-to-one correlation between net social care spending per adult and gross spending per adult (including fee income).

Figure 3.4. Left panel: correlation between LA net adult social care spending per adult, and fee income per adult. Right panel: correlation between LA net spending per adult on adult social care, and LA gross spending per adult on social care (where gross spending is net spending plus income fees and charges)



Note: Figures do not show City of London and Isles of Scilly. Fee income data are unavailable for Reading Unitary Authority.

Source: See Figure 3.1.

3.2 Explaining variation in spending across local authorities

As discussed in Chapter 2, differences in spending on adult social care across LAs could arise for several reasons: variation in local needs and costs of social care; differences in the ability of individuals to pay for their care themselves; and differences in how LAs prioritise social care relative to other service areas and council tax levels, in the context of the funding they receive from grants, business rates and the NHS.

With this in mind, in this section we examine how social care spending by LAs relates to a number of demographic and socio-economic characteristics, which may be thought of as indicators of need and ability to pay. We also examine the link between the relative amounts different LAs spend on social care and their relative social care spending needs as of the last official assessment in 2013–14. However, we do not claim that any of the measures examined captures the true need for LA-funded social care. The ongoing debate about the design of LA needs assessment is testament to the fact that indentifying and

measuring underlying drivers of need for LA-funded services, such as adult social care, are conceptually and practically difficult.[12]

Age, benefit claims and other population characteristics

First, we consider the relationship between social care spending and a number of demographic and socio-economic characteristics of the local population, including age, disability status, income and benefit receipt, and housing tenure.

Most of these measures are (or are similar to) indicators for need included in the adult social care funding formulae used in official needs assessments. However, while we may expect such variables to be correlated with the need for social care spending, they are unlikely to fully capture such variation. For a start, they are unlikely to capture variation in the severity of needs or income deprivation, which may be a significant driver of spending per person receiving care. Furthermore, eligibility criteria for means-tested and disability benefits differ from criteria for LA-funded support. Moreover, while we have data for the proportion of the population that is claiming disability benefits, and the proportion claiming income-related benefits by LA, we do not have data on the proportion that is claiming both: the latter may be a better proxy for eligibility for the *means-tested* social care that LAs fund.

Bearing these issues in mind, Figure 3.5 shows the correlation between LA spending on social care per adult resident and each of these local population characteristics. These raw correlations show the following.

- Perhaps surprisingly, LAs with a higher fraction of the population aged 65 or over do not spend more on adult social care than those with younger populations (the same is true for the share of the population that is aged over 85).

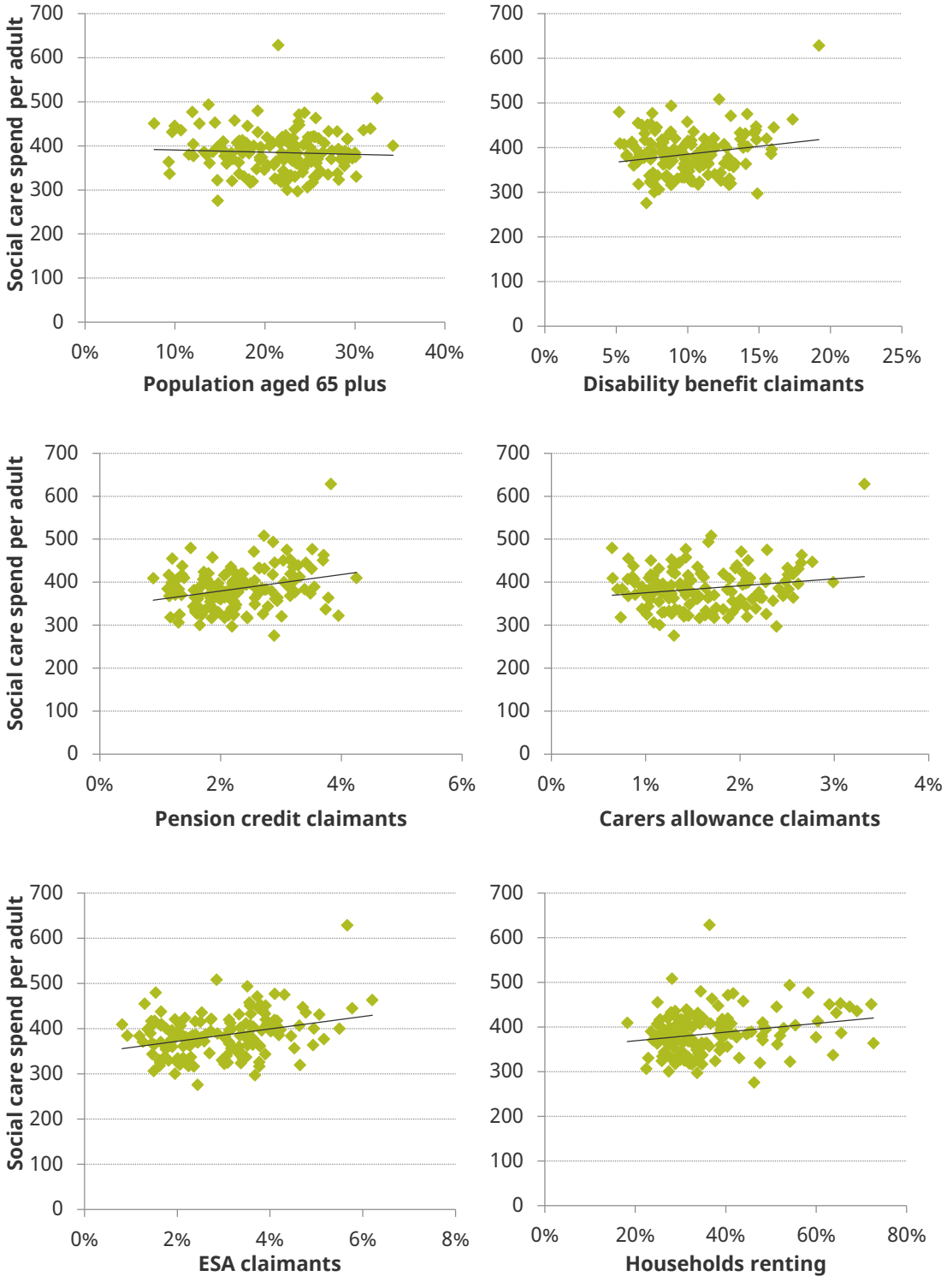
- There are positive (albeit relatively weak) correlations between social care spending and the proportion of the local adult population claiming disability benefits,[13] pension credit guarantee credit (PCGC; a benefit for low-income pensioners), employment and support allowance (ESA) – which is a benefit largely for low-income working-age adults with disabilities that limit their work capabilities – and carers' allowance. The strongest of these correlations (explaining 8–10% of variation in spending) are for pension credit and ESA.

- There is also a positive (but weak) correlation with the proportion of households that are renting – which is a proxy for the (long-run) incomes and assets of local residents.

Differences in average spending of LAs towards the bottom and top of the distributions of these population characteristics are relatively modest in relation to the overall variation in social care spending. For instance, the trend line for ESA implies that an LA at the 90th percentile of the distribution of LAs by proportion of adults claiming ESA would be expected to spend £37 more on social care per adult, on average, than an LA at the 10th percentile of that distribution.

[12] See, for instance, Department for Communities and Local Government (2016).
[13] When splitting disability benefit recipients by age, there is a stronger correlation between social care spend and working age disability benefit recipient numbers than for disability benefit recipients aged 65 or over.

Figure 3.5. The correlation between LA social care spending per adult resident in 2015–16 (in 2016–17 prices), and local population characteristics



Note: Disability benefit claimants include all claimants of Disability Living Allowance, Personal Independence Payment and Attendance Allowance. Pension credit eligibility is based on the income of a couple. In order to calculate the number of people benefitting from pension credit, we double any claimant who is in a couple. For ESA, we use only claimants of the 'income' component.

Source: Spending and population data as per Figure 3.1. Disability benefit claims from DWP data via ONS/NOMIS. Households renting from 2011 Census.

Of course, the local needs for social care spending will depend upon a combination of population (and other) characteristics. And while the variables in Figure 3.5 are correlated, these correlations are far from perfect. Column 2 of Table E.2 in Appendix E reports the results of a simple statistical regression of adult social care spending on the set of variables featured in Figure 3.5, as well as LA-level median weekly earnings, and the proportion of the over-65 population that was single, divorced or widowed as of the 2011 census. In combination, these variables explain 24% of the variation in social care spending per adult across LAs. In other words, 76% of the variation in spending relates to other factors affecting needs, costs and LA social care spending decisions.

Few of the variables are individually statistically significant 'explainers' of social care spending: the share of the adult population claiming ESA (which may reflect the number of working age adults with care needs); and median gross-weekly earnings (which may reflect the higher costs of providing social care in areas with higher wages). Interestingly, the fraction of the population that is aged 65 or over has an almost statistically significantly positive relationship with social care spending, once controlling for these other factors. This suggests that one reason why, on its own, having a higher fraction of over 65s is not associated with higher social care spending, is because such LAs tend to have other characteristics that are correlated with low levels of spending, masking an underlying positive relationship between local age structure and social care spending.

Table E.3 in Appendix E shows that the same set of variables are able to explain a much larger proportion of the differences in the share of the population receiving care: almost 50%. This reflects the fact that there is significant variation in spending per care recipient – perhaps due to differences in quality, costs, co-payments by recipients, or severity of need.

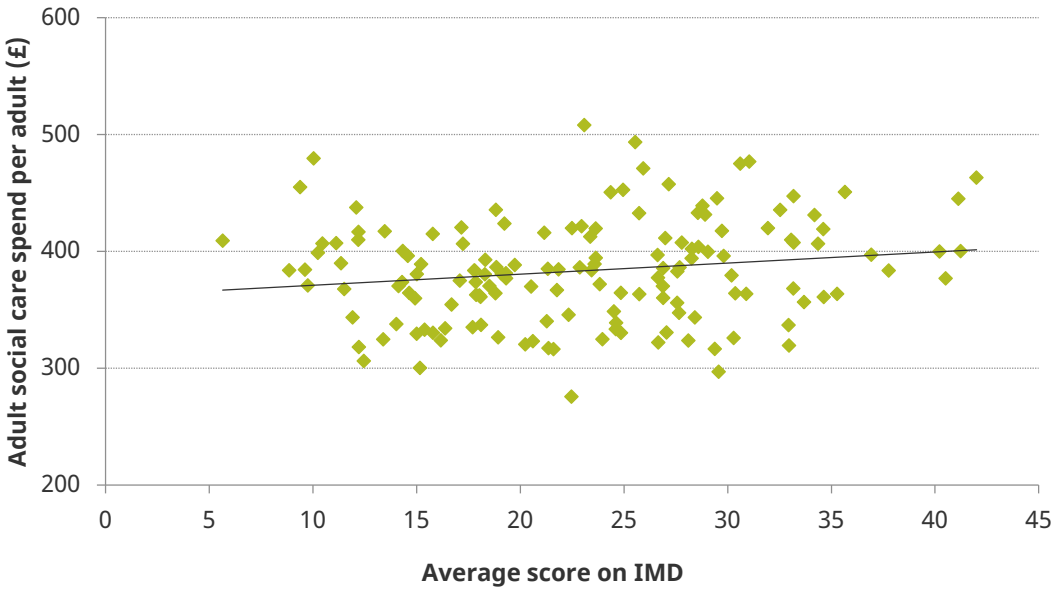
The index of multiple deprivation

The index of multiple deprivation (IMD) is a composite measure of deprivation at the neighbourhood level in England.[14] Last updated in 2015, it combines 37 different ways in which an area can be deprived into one overall measure and seven more focused measures including income deprivation and health deprivation, which seem particularly relevant given the two eligibility criteria for LA-funded adult social care.

Figure 3.6 shows that areas which score higher on the IMD on average spend a little more on adult social care per adult.[15] Again, the correlation is relatively weak: variation in IMD scores 'explains' about 5% of the variation in spending. Similar results are found for the health and income dimensions, though the income dimension is relatively more strongly correlated with social care spending than the health dimension, explaining 7% of the variation as opposed to 2%.

[14] For data and an explanation of the 2015 English indices of deprivation, see https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015.
[15] The IMD is collected at the neighbourhood level, rather than the LA level. There are several alternative ways to aggregate the data to the LA level and the choice will affect the final ranking or deprivation score given to an LA. We have chosen to use the average score of all the neighbourhoods in an LA, but similar results were found using the average rank.

Figure 3.6. Average score on IMD versus adult social care spending per adult in 2015–16 (2016–17 prices)



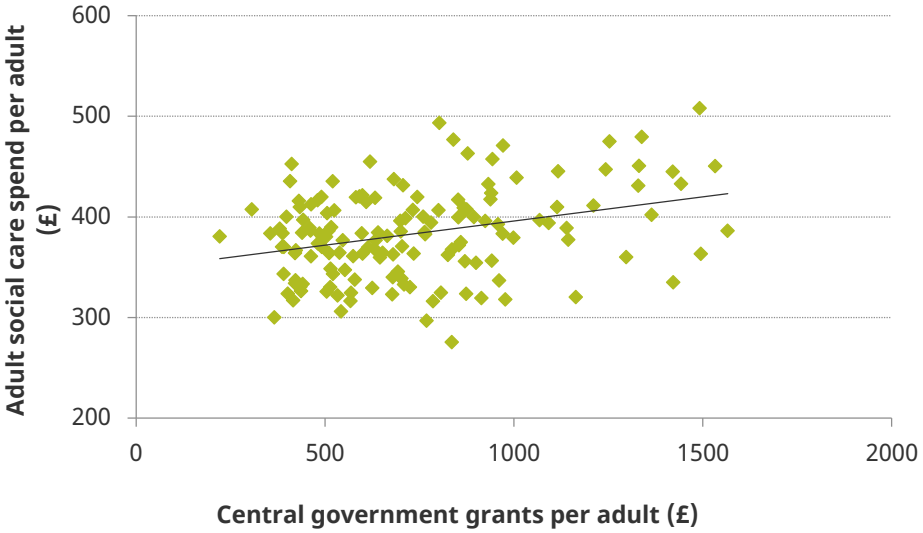
Source: Spending and population data as per Figure 3.1. IMD from DCLG English indices of deprivation 2015.

LA grant income and dependence

Historically, the share of income that an LA receives from central government has reflected a mixture of the LA's need for local service spending (as assessed by central government) and their ability to raise revenues locally. As discussed in Chapter 2 and Appendix C, over time, the role of needs assessment in the allocation of central funding has declined – and the needs assessment has not been updated since 2013–14 – but the grant an area receives likely still gives some indication of its relative need for local service spending as judged by central government.

Figures 3.7 and 3.8 show how the amount of grant received per adult resident and grant-reliance (measured as grants as a proportion of overall revenues) correlates with social care spending. The figures show that LAs that receive more grant per adult, and which rely on grants for a higher share of their overall revenues, spend more on adult social care per adult, on average. As with previous figures though, there is significant dispersion around the trend lines: variation in grant levels and grant dependence explain approximately 11% and 4% of variation in social care spend per adult, respectively.

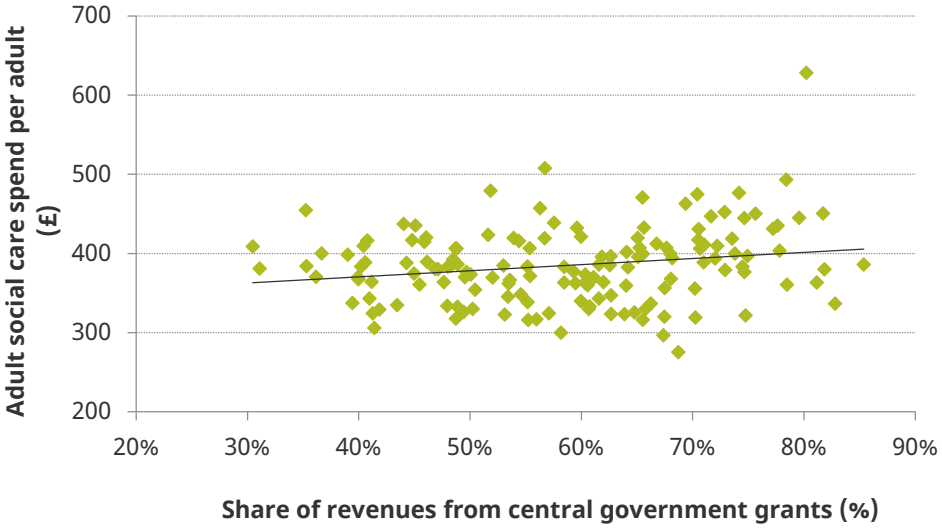
Figure 3.7. Central government grants versus LA net adult social care spending per adult in 2015–16 (2016–17 prices)



Note: Central government 'grants' include the Revenue Support Grant, Business Rates Supplement, Community Infrastructure Levy, Local Services Support Grant, retained business rates revenues and specific grants inside Aggregate External Finance (with the exception of specific grants for police, fire, public health and education).

Source: See Figure 3.1.

Figure 3.8. Share of LA revenues from central government grants versus LA net adult social care spending per adult in 2015–16 (2016–17 prices)



Note: See Figure 3.7.

Source: See Figure 3.1 and Note to Figure 3.7.

Social care spending needs assessment

Given that, to the extent they reflect needs at all, central government grants will reflect needs for spending on other services as well as on adult social care, it is perhaps unsurprising that the correlations above are relatively weak. A more precise measure of what central government thinks is the relative amount different LAs should spend on

adult social services is the official relative needs assessment for social care. The ending of the annual updating of needs assessments in 2013–14 means that this is the latest year for which we have this assessment.[16]

The needs assessment done at that point was based on examining the relationship between how much different LAs were spending on social care and a set of local area characteristics (including many of the variables examined above). These relationships were then used to predict a relative need for social care spending for each LA. Each LA's relative need is reported as a proportion of social care spending in all of England that it is assumed to need (rather than an absolute cash figure).

Variation in these needs-based spending shares will arise from both differences in populations across LAs, as well as differences in the amount they were assessed to need to spend per adult on social care. Because our focus is on spend (and spending need) per adult, we therefore divide each LA's spending-needs share by the number of adult residents in that LA. To make figures more interpretable, we then normalise them so that an LA with an average level of assessed need per adult is assigned a value of '100': values above 100 indicate above-average assessed needs per adult resident, and values below 100, below-average assessed needs. We can also normalise actual spending in the same way (by dividing each LA's spending per adult, by the average spending per adult for England as a whole, and multiplying by 100).

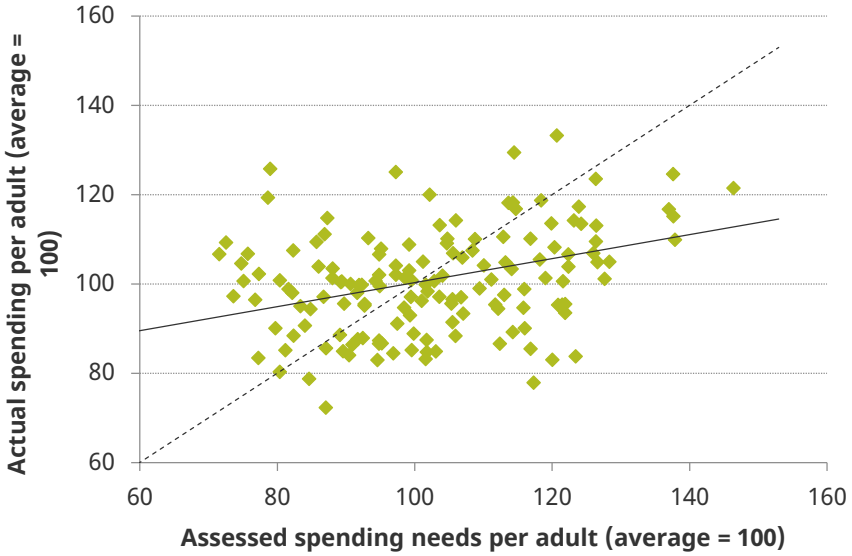
Doing this, Figure 3.9 shows the correlation between assessed needs per adult and actual spending per adult: an LA whose spending per adult matched its assessed spending needs per adult would be on the dashed 45-degree line. While there is a positive correlation between assessed spending-needs and actual spending per adult (the trend line is positive), the relationship is relatively weak: variation in assessed needs spending shares explains around 13% of variation in actual spending needs.

This could be explained by several factors: the official needs assessment may not capture true relative needs; relative needs may have changed significantly between 2013–14 and 2015–16; and/or factors other than differences in needs (such as differences in the priority placed on social care, or differences in the cost-efficiency of service delivery) must play a significant role in determining spending on social care.

The relatively flat slope of the trend line in the figure implies that those LAs with relatively low levels of assessed spending needs tend to spend more, on average, than their assessed needs share. However, those with relatively high levels of assessed spending needs tend to spend relatively less, on average, than their assessed needs share. This may again reflect variations in actual need from assessed need (or differences in priorities, costs and efficiencies). Alternatively, it may reflect the differential impact of recent cuts to local government budgets across LAs – an issue we turn to in Chapter 4 – which mean that the resources available to different LAs increasingly diverge from their assessed relative needs.

[16] Information on the relative needs formula for adult social care is available at: http://webarchive.nationalarchives.gov.uk/20140505104649/http://www.local.communities.gov.uk/finance/1314/calcffs.pdf.

Figure 3.9. Assessed relative spending needs for social care per adult (*x*-axis) versus actual relative social care spending per adult (*y*-axis)



Note: We normalise both assessed relative spending needs per adult and actual spending per adult so that the average figures across England are equal to 100. A score of, for example, 120 for assessed spending needs per adult then indicates that an LA is assessed to need to spend 20% more per adult on adult social care than the average across England. A score of 80 would indicate that it is assessed to need to spend 20% less per adult.

Source: Actual spending and population data as per Figure 3.1. Assessed spending needs shares are taken from the 2013–14 Local Government Finance Settlement, available at: http://webarchive.nationalarchives.gov.uk/20140505104649/http:/www.local.communities.gov.uk/finance/1314/settle.htm.

Perhaps unsurprisingly, given their inclusion as explanatory variables in the formula underlying the government's official relative, the demographic and socio-economic characteristics examined earlier correlate much more strongly with assessed spending need than actual spending. For instance, variation in the average IMD scores of LAs explains around 70% of the variation in assessed (relative) spending needs per adult, compared with 5% of variation in actual spending per adult. The full set of demographic and socio-economic variables analysed in Table E.2 of Appendix E explains 96% of variation in assessed spending needs per adult, compared with 25% of the variation in actual spending per adult.

3.3 Summary

In this chapter, we have shown that there is significant variation in the amount different LAs spend on adult social care, and the proportion of adults in receipt of care in different LA areas. Spending correlates with local demographic and socio-economic characteristics that may be expected to correlate with needs for LA-funded care, such as local rates of disability and means-tested income receipts, and deprivation levels. However, these variables, and the official needs assessment based on a similar set of characteristics, can only explain a minority of the variation in adult social care spending. This implies that these variables do not capture a significant part of the variation in spending needs and/or that other factors, such as variation in costs or the priority different LAs place on social care, must have an important role in explaining differences in spending.

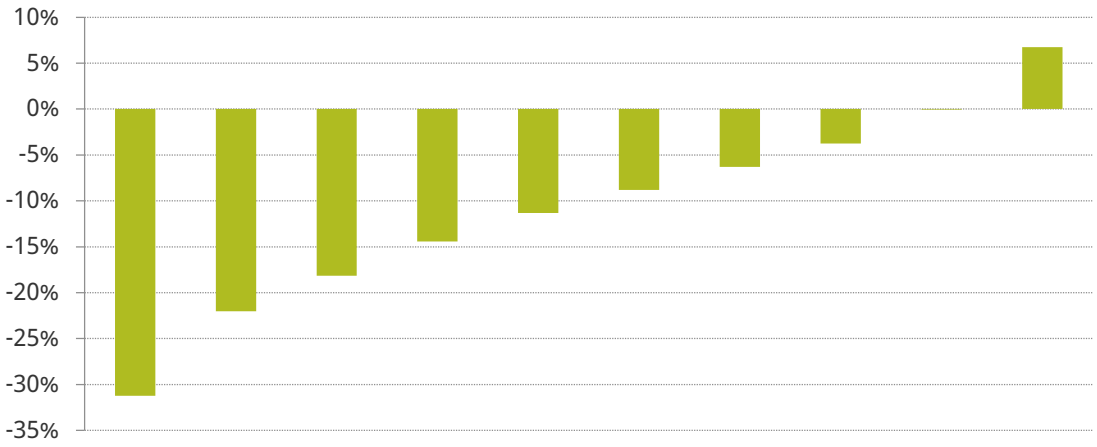
4. Changes to adult social care spending since 2009–10

As part of wider cuts to public sector spending, LAs in England have experienced large cuts to their budgets since 2009–10. Although LA spending on adult social care (including transfers from the NHS) has been relatively protected, it still fell by 6.4% in real terms between 2009–10 and 2015–16 across England as a whole (Luchinskaya et al., 2017), which equates to around 11% per adult resident, due to growth in the adult population during this period. In this chapter, we look at the distribution of cuts to social care spending across the country, and how this relates to their original levels of spending, and demographic and socio-economic characteristics.

4.1 How much has the level and distribution of adult social care spending changed since 2009–10?

Changes in LA social care spending per adult between 2009–10 and 2015–16 varied widely across England, from a cut of almost 40% to an increase of 26%. Just under one-tenth of LAs made cuts of more than a quarter, whilst more than one-in-seven actually increased spending in real terms during this period. Figure 4.1 divides local authorities into 10 groups according to the size of the cut they made to adult social care spending per capita, and it shows the average cut to per adult spending for each of these decile groups. The tenth of LAs making the biggest cuts to adult social care spending per adult saw an average cut of 31%, whilst the tenth making the biggest increases saw spending increase by 7% per adult, on average.

Figure 4.1. Real-terms change in adult social care spending per adult by deciles of cuts, 2009–10 to 2015–16 (%)



Note: For consistency over time, adult social care spending in 2009–10 includes funding for the 'Valuing People Now' initiative.

Source: See Figure 3.1 for 2015–16. The Valuing People Now allocations for 2010–11 were taken from the government response to 2011 funding changes consultation, which is available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_122563.pdf. See Appendix A for further details.

Table 4.1 shows a breakdown of changes in spending on adult social care per adult between 2009–10 and 2015–16 by region and LA type. Cuts have been largest in London (18%), the North East (18%), the West Midlands (17%) and the North West (13%). Looking at LA types, cuts have been largest in the urban London Boroughs (18%) and Metropolitan Districts (16%). Outside these areas, cuts have been larger in the north than the south. Table 4.1 also shows spending per adult in 2009–10. It is notable that the South West, which started as a low-spending region but has since seen the smallest cuts, had become a high-spending region by 2015–16 and that London, despite cuts of almost a fifth, remains an area where spending per adult is (a little) above average (see Table 3.1).

Table 4.1. Percentage change in adult social care spending per adult between 2009–10 and 2015–16, by region and LA type

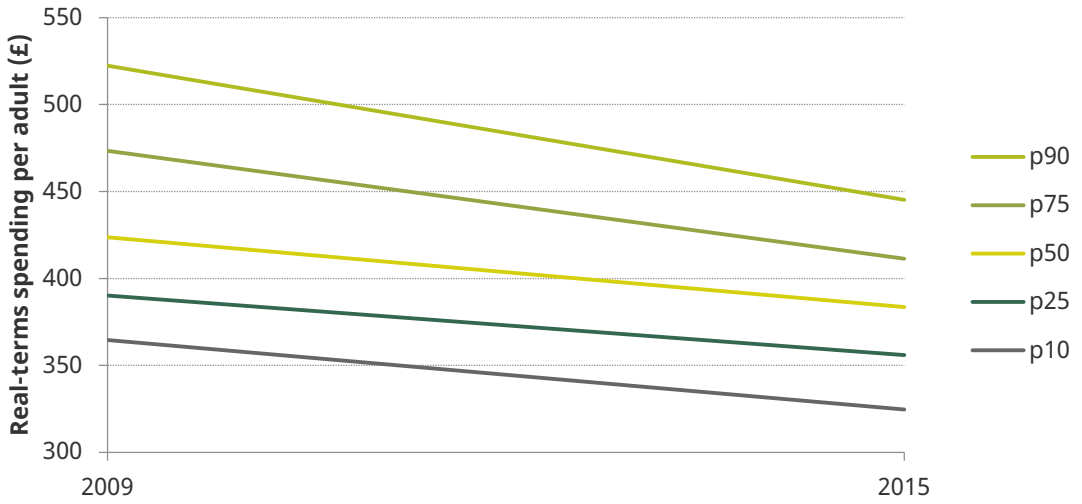
Area	Spend per adult in 2009–10 (2016–17 prices)	Percentage change in spending per adult
Region		
London	475	–18%
North East	479	–18%
West Midlands	440	–17%
North West	448	–13%
East Midlands	394	–10%
East of England	435	–9%
Yorkshire and The Humber	388	–7%
South East	407	–7%
South West	401	–2%
Authority type		
London Borough	475	–18%
Metropolitan District	453	–16%
Shire County (North)	395	–10%
Unitary Authority (North)	420	–10
Shire County (South)	414	–7%
Unitary Authority (South)	412	–5%
England (average)	**429**	**–11%**

Note: Subnational figures exclude City of London and Isles of Scilly Unitary Authority.

Source: See Figure 4.1.

Figure 4.2 shows how the level of spending at several different percentiles of the spending distribution changed between 2009–10 and 2015–16. It shows that, for example, in 2009–10 the median (p50) LA spent £424 per adult on adult social care. By 2015–16, the median LA spent £384 per adult on social care, a fall of 9.5%.

Figure 4.2. Percentiles of LA adult social care spending per adult in 2009–10 and 2015–16



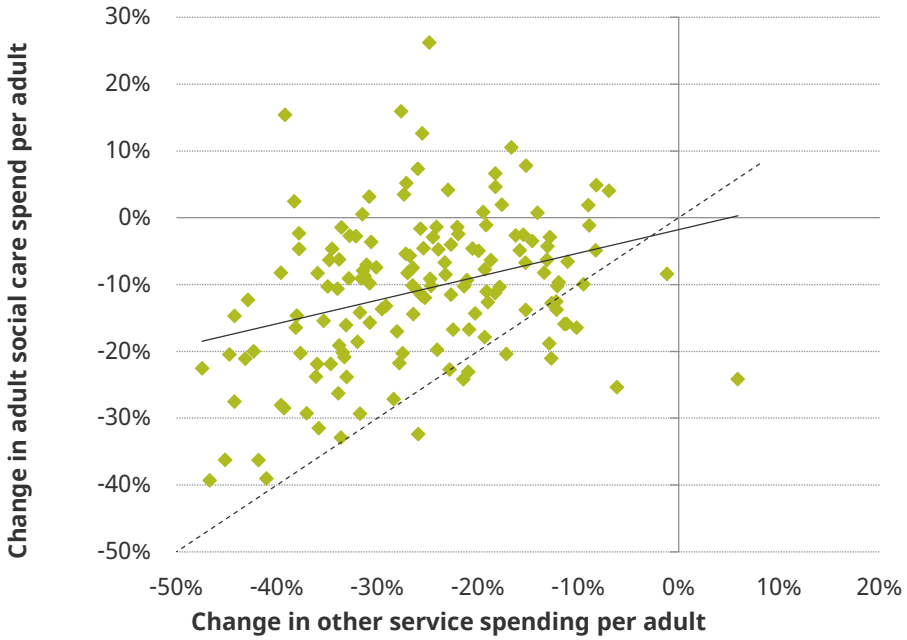
Source: See Figure 4.1.

Spending per adult has fallen across the distribution. However, over this period, the distribution of spending across the country has narrowed as higher-spending LAs in 2009–10 have, on average, made larger cuts as a proportion of their budget. In 2009–10, an LA at the 90th percentile spent £158 more per adult on adult social care than an LA at the 10th percentile, or 43% more in percentage terms. In 2015–16, the gap narrowed to £120 per adult, a difference of 37%.

Figure 4.3 plots the change in each LA's adult social care spending per adult between 2009–10 and 2015–16, against its change in spending on other service areas.[17] If an LA had changed adult social care spending in line with other service areas, then they would sit on the dashed 45-degree line. Any LA above this line has relatively protected adult social care: it is clear this is the case in the vast majority of LAs. A comparison between the slope of the (solid) trend line and the dashed 45-degree line also shows that those LAs that made larger cuts to their other service spending were able to offer greater relative protection to adult social spending. More generally, LAs facing larger cuts to their overall service budgets (including for adult social services) offered relatively greater relative protection to adult social care.

[17] Again, we exclude spending on police, fire, education and public health from these figures because of inconsistencies across LAs and over time in these areas of spending. Note that, in two-tier areas, other service spending includes spending by the constituent district authorities.

Figure 4.3. Change in adult social care spending per adult versus change in other service spending per adult, 2009–10 to 2015–16



Source: See Figure 4.1.

4.2 Changes in care recipient numbers and fee income

In order to make such substantial cuts, LAs have several options options: to reduce the number of people receiving care, to increase the co-payment fees charged to care recipients, or to reduce the cost of service provision, whether by reducing care quality or cutting prices paid to service providers.

As highlighted in other research, reductions in numbers receiving care appear to have played a major role in delivering spending cuts.[18] Between 2009–10 and 2013–14, the number of people receiving LA-organised care across England fell by 25%, from 1.7 million to 1.3 million. (Unfortunately, changes to the relevant data in 2014–15 mean that we cannot construct a consistent data series for the full period in question, to 2015–16, preventing an examination of the correlation between spending and care recipient change numbers for this period as a whole.[19]) This is greater than the reduction in spending (which, in aggregate, amounted to 6.4% between 2009–10 and 2015–16), implying that although spending per adult resident has fallen, spending per care recipient has increased in real terms since 2009–10.

However, this does not necessarily mean that spending on those still in receipt of care is higher than it was in 2009–10, or that spending cuts have not affected this group; there are at least two reasons for this. First, those who no longer receive care are likely to be

[18] See, for instance, Health Foundation (2017), for analysis of changes in the number of older adults receiving social care.
[19] Information on these data changes is available in the data quality section of: http://www.content.digital.nhs.uk/catalogue/PUB21934/comm-care-stat-act-eng-2015-16-rep.pdf.

those with lower and less costly needs: spending per remaining recipient will automatically increase when these less needy/costly recipients are no longer in receipt of care. Second, changes in labour and other costs may also affect how far budgets could stretch in 2015–16, compared with 2009–10.

Turning to fees and charges, between 2009–10 and 2015–16, almost two-thirds of LAs have seen a real-terms reduction in income from this source. Whilst the median LA reduced fee income by 6.4%, there was a lot of variation around this: one in ten LAs saw fee income fall by more than 44%, while a further one in ten saw an increase of more than 43%. This strongly suggests that different LAs have been pursuing very different strategies when it comes to their fees policies.

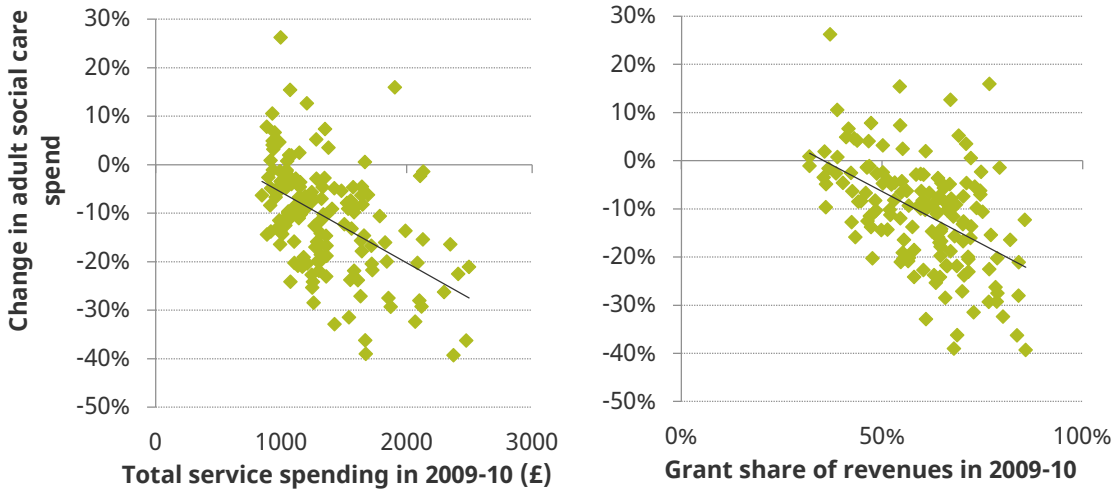
Nationally, because declines in fee income are smaller, on average, than the decline in the number of care recipients, fee income per care recipient increased between 2009–10 and 2015–16. Again, this may reflect, in part, the fact that those still in receipt of care have greater needs and require more costly care, and therefore are liable to greater co-payments, as well as changes in fee schedules.

4.3 Correlation between spending changes and needs indicators

We now turn to the correlation between changes in spending and indicators of spending needs as of 2009–10, and the changes in (some of) these indicators between 2009–10 and 2015–16.

Figure 4.4 shows that LAs that spent more per adult on all services in 2009–10 made larger cuts to adult social care spending between 2009–10 and 2015–16, on average. It also shows that areas that were initially more dependent on grant funding also made larger cuts, on average: variation in the initial grant dependence of LAs on its own explains almost a quarter of the variation in cuts to adult social care spend per adult.

Figure 4.4. Changes in adult social care spending per adult between 2009–10 and 2015–16 versus level of total service spending per adult in 2009–10 and grant share of total revenues in 2009–10



Source: See Figure 4.1.

This is unsurprising given the changes to local government funding over this period discussed in Chapter 2 and Appendix C: higher spending areas of the country in 2009–10 were, on average, more dependent on central government grants; and more grant-dependent areas have been more exposed to cuts as the same proportional cut to their grant resulted in a larger overall cut to their budget. Adult social care has been relatively protected by LAs (see Figure 4.3), but nonetheless larger cuts to overall spending have translated into larger cuts in adult social care spending per adult for these areas.

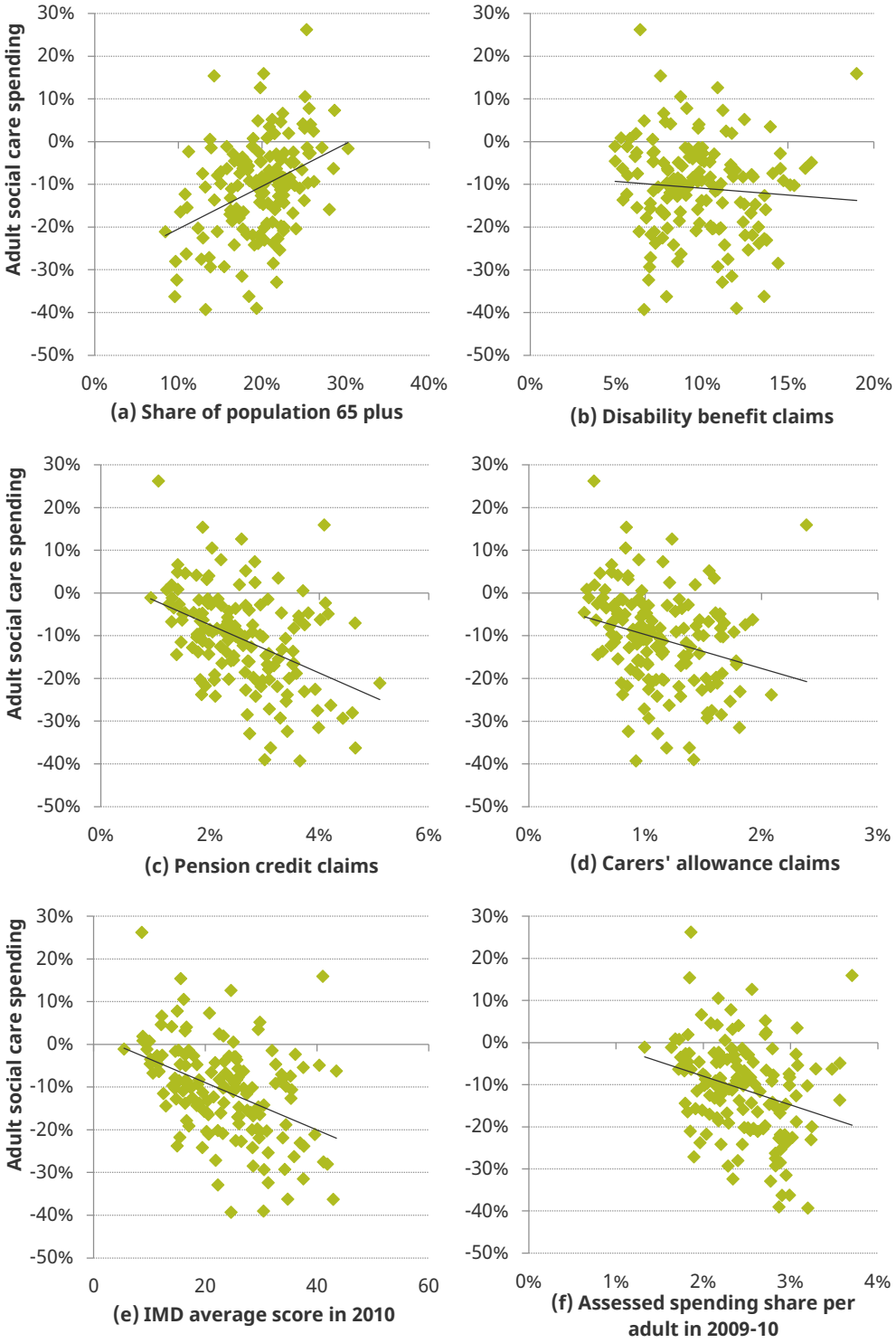
Higher grant dependence in 2009–10 was at least in part determined by the relative needs of a local area. To the extent that this was the case, given that more grant-dependent areas have made larger cuts on average, we might also expect areas that had higher need (as measured by our indicators) in 2009–10 to have made larger cuts to adult social care spending.

Figure 4.5 shows that this is the case for almost all of the needs variables considered in this report. In particular, a higher average IMD score in 2010, higher benefit claimant rates and lower average local incomes are all associated with having made larger cuts to adult social care spending per adult between 2009–10 and 2015–16. (The relationship is strongest for income-related variables such as the share of the adult population claiming pension credit.) As a result, areas that were assessed to have the highest relative spending needs in 2009–10 also saw bigger cuts to social care spending in the following six years.

A notable exception to the pattern is the share of the population that is over 65. Areas of the country with a higher share of the population aged over 65 made, on average, smaller cuts to their social care spending per adult. In Table E.4 of Appendix E, we regress changes in adult social care spending on all of our needs indicators (including benefit claims, median earnings, households renting) to better understand this pattern. We find that when controlling for other variables, the fraction of the population that was over 65 in 2009–10 no longer has a statistically significant relationship with subsequent cuts. This suggests that correlations between the proportion of elderly residents and other variables (notably initial levels of grant dependence, for which the correlation coefficient is –0.7) drive the patterns seen in Figure 4.5(a). In other words, it seems that elderly people tend to live in parts of the country that have had to make smaller cuts to their social care spending for other reasons (such as smaller cuts to their overall budgets due to their lower reliance on central government grants).

The needs of a local area seem unlikely to change dramatically over a six-year period, but they can change somewhat. Therefore, in Table E.5 in Appendix E, we explore how changes in social care spending relate to the changes in several of the demographic and socio-economic variables that we use as proxies for needs, while continuing to control for initial (2009–10) levels of social care spending and grant reliance. It shows the following (conditional upon each of the other variables included in the regression).

Figure 4.5. Change in adult social care spending per adult versus need indicators in 2009–10



Source: For spending data, see Figure 4.1. For 'needs' indicators, see Figure 3.5. Adult social care spending per capita – authors' calculations using DCLG local government revenue expenditure and financing statistics (RO3 return). Population statistics and benefit claims from ONS. IMD from DCLG English indices of deprivation 2010 release. Assessed spending share from the 2009–10 local government finance settlement documentation, available at: http://webarchive.nationalarchives.gov.uk/20120919132719/http://www.local.communities.gov.uk/finance/0910/grant.htm.

- The initial level of spending per adult has a much more statistically significant relationship with subsequent spending cuts than any of the changes in needs measures. Every £10 increase in initial spending level is associated with approximately a 1 percentage point greater reduction in spending.

- Bigger percentage point increases in the share of the population claiming pension credit or ESA are associated with smaller cuts to social care spending.

- Bigger percentage point increases in the share of the population claiming carers' allowance are associated with larger cuts to social care spending. Whether this reflects substitution between formal LA-organised care and informal care is unclear.

Taken together, around 45% of the variation in changes in social care spending per adult across LAs between 2009–10 and 2015–16 can be 'explained' by the changes in demographic characteristics and the initial levels of spending and grant reliance.

4.4 Summary

In this chapter, we have examined how changes in social care spending per adult varied across LAs between 2009–10 and 2015–16. We have shown that cuts were larger, on average, in areas that initially had high levels of spending and that relied on central government grants for a higher proportion of their overall budgets. This has translated into larger-than-average cuts in areas such as London, the North East and in metropolitan areas such as Manchester and Birmingham. It is also reflected in the fact that there are larger than average cuts in areas that initially had higher levels of assessed social care spending need, higher levels of deprivation and higher levels of disability and means-tested pensioner benefit claims.

5. Conclusion

Adult social care is the largest area of spending over which English LAs have discretion.[20] It is also an area that has seen pressures arising from an ageing population and that, according to previous research, has seen significant spending cuts, despite its protection from the full force of cuts to local government budgets (Luchinskaya et al., 2017). This report has taken a closer look at how spending and recent spending cuts vary across England, and how these patterns relate to local area characteristics that may affect needs for social care. Although we must be careful not to draw too strong causal conclusions from this analysis of correlations, several interesting findings emerge.

First, while there is significant variation in social care spending per adult resident, the link between this and the sort of demographic characteristics – such as proportion of older residents, disability and means-tested benefit receipts, local wages and deprivation levels – that might be expected to drive social care needs and costs, is relatively weak. Indeed, such variables explain only around 25% of the variation in social care spending per adult in 2015–16. They are a much better predictor of the government's assessment of local needs – explaining 96% of the variation in this – which is perhaps unsurprising, as these are just the sort of variables that the government assumes drive social care need. The upshot of this is that the government's last assessment of local needs in 2013–14 also explains relatively little of the variation in actual spending on social care per adult (around 13%).

This divergence between assessed need and actual spending could arise for a number of reasons, including: differences in the local priority placed on adult social care; differences in the availability of funding, in the context of a weakening of the role of needs assessment in the allocation of funding to LAs; or the fact that the needs assessment fails to reflect the 'true' need for social care spending in a local area. The latter is not inconceivable, as spending needs are inherently difficult to estimate because they depend on such a wide range of factors and, in any case, are to some extent subjective.

The government's assessment of needs was based on estimating the relationship between a series of indicator variables and historic patterns of spending. If needs are affected by factors beyond these indicators, then the resulting assessed level of needs may deviate significantly from true needs. Moreover, to the extent to which historic variation in spending reflects factors other than differences in needs, assessed needs may actually reflect differences in local prioritisation and preferences, rather than needs. Our findings therefore highlight the challenge both government and LAs will face as they seek to update the needs assessment methodology, as part of the ongoing local government 'fair funding review'.[21]

This report has also considered changes in social care spending between 2009–10 and 2015–16, a period characterised by big cuts to LAs' overall budgets. Perhaps the starkest finding is that those LAs that were initially spending more on social care, and/or were dependent on central government grants for their overall budgets, made larger cuts to adult social care spending over this period. This reflects the bigger cuts to their budgets

[20] Spending on schools is typically higher, but is largely funded by ring-fenced grants from the Department for Education.
[21] For information, see Department for Communities and Local Government (2016).

that high-spending grant-reliant councils have faced in recent years (Amin Smith et al., 2016). It helps to explain why cuts have been larger in London and metropolitan districts, and, outside these areas, larger in the north than the south of England.

It also means that those LAs ranking higher on our (imperfect) indicators of social care spending need in 2009–10 subsequently made larger cuts to adult social care spending, on average. The apparent exception to this – the proportion of the population aged over 65 in 2009–10, which on its own is correlated with smaller subsequent cuts to adult social care spending – is explained by the typical relative affluence of the LAs that have larger shares of their population over 65. The elderly are therefore clustered in areas less dependent on grants in 2009–10, which have subsequently seen smaller cuts to their overall budgets, and therefore have been able to make smaller cuts to their social services, than typically more deprived areas with relatively few older residents.

This emphasises the role that the overall budgets of LAs are likely to play in the amount available for social care in the coming years. Even additional ring-fenced money for social care may not find its way fully to social care if LAs are facing broader budget cuts, and struggling to fund other service areas such as children's social services. With moves to the full devolution of business-rate revenues to LAs (so-called '100% business rates retention'), the government will also need to think carefully about the balance between providing councils with incentives to grow their own revenues, and redistributing revenues to support spending in areas that are seeing increasing demand for services such as adult social care. Future IFS research will examine these trade-offs and will look in more detail at the interactions between social care and the health service.

Appendix A: Calculating adult social care spend

LAs are required to submit annual returns to the DCLG setting out their expenditures and incomes by service area, including for adult social care.[22] The basis for the figures used in this report is the net expenditure on adult social care as reported in these returns.

However, the period between 2009–10 and 2015–16 saw shifts in responsibilities between LAs and the NHS, and new pooling arrangements via the Better Care Fund. The net expenditure figures reported in these returns would therefore not provide a consistent measure of LA spending on social care over time. We therefore make several adjustments to obtain a more consistent measure.

- In 2009–10, we add on local expenditure associated with the 'Valuing People Now' initiative. This is spending on long-term support for those with learning disabilities, which prior to 2011–12 was the responsibility of the NHS but has shifted to LAs since that year. Our source for these data lists expenditure on this programme in 2010–11;[23] we assume that real-terms expenditures were the same in each LA area in 2009–10 as in 2010–11.

- In 2015–16, we add on an estimate of transfers from the NHS for social care via the Better Care Fund. Total Better Care Fund allocations are taken from the Supporting Information to the 2015–16 local government finance settlement.[24] The share of this total allocation going to social care is based on national-level analysis by the NHS, which implies that just over half (£1.81 billion in cash-terms) of the NHS's compulsory contributions to the Better Care Fund (£3.46 billion) supported social care activities.[25]

This approach is the same taken in NHS Digital (2016). We have tested the sensitivity of the findings of this report to these assumptions and they are robust. However, the assumptions may not hold for individual LAs. For instance, if spending on 'Valuing People Now' changed significantly between 2009–10 and 2010–11 at a local level, or if local allocations of Better Care Fund monies to social care vary significantly from the national level, then spending on social care may differ by a few percentage points from the amount calculated via this method. Unfortunately, there is no comprehensive published source of spending on the Valuing People Now monies or Better Care Fund social care monies at an LA level. It is hoped that better data on the latter will be available in NHS Digital's analysis of social care spending in 2016–17.

[22] These Local Authority Revenue Expenditure and Financing data are available at: https://www.gov.uk/government/collections/local-authority-revenue-expenditure-and-financing.
[23] See government response to consultation on this funding shift, available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_122563.pdf.
[24] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/400630/Spending_Power_2015-16_Supporting_Information_FINAL.xlsx.
[25] Available at: https://www.england.nhs.uk/wp-content/uploads/2015/06/bcf-meta-analysis-summary-feb-update.pdf. £1.81 billion is £1.84 billion in 2016–17 prices.

Appendix B: NHS continuing healthcare

NHS continuing healthcare refers to a package of health and social care services that is organised and fully funded by the NHS, at a cost of around £3.1 billion in 2015–16.[26] For those who remain in their own home, NHS funding will fully cover the cost of support with both 'health' needs (such as services from a nurse) and social care needs (such as assistance with shopping, cooking and personal hygiene). For those in a residential care home, the NHS will pay the full costs of support with health and social care needs, and board and accommodation charges. Because, unlike LA-funded care, there are neither means-tests nor co-payments, eligibility for continuing healthcare is very valuable.

Eligibility for continuing healthcare is assessed by an individual's local NHS clinical commissioning group (CCG) using a two-stage process: an initial assessment using the so-called 'Checklist Tool', followed by a more in-depth assessment using the 'Decision Support Tool'. The aim is to target continuing healthcare funding at those with long-term, significant and complex medical and care needs, who are deemed to have a 'primary health need' for care. There is no legal definition of what constitutes a 'primary health need', but guidance issued states that 'an individual has a primary health need if, having taken account of all their needs [...], it can be said that the main aspects of majority part of the care they require is focused on addressing or preventing health needs.'[27]

Nonetheless, there is significant variation in the relative number of people in receipt of continuing care in different CCG-areas, and related major differences in the cost of continuing care per adult resident of these areas (much greater than the variation in LA-funded social care spending described in this report). Figure B.1 shows, for instance, that reported spending per adult resident varied from £0 in several authorities to as high as £180 in 2015–16, compared with an average of around £72 per resident across England as a whole. Around 10% of CCGs incurred expenditure of less than £39 per adult resident, while another 10% incurred expenditure of more than £117 per adult resident. In addition to genuine variation in needs across the country, such wide variation may reflect differences in the stringency with which different CCGs assess eligibility.

The proportion of adults eligible for continuing healthcare was broadly stable between 2013–14 and 2015–16, although The King's Fund reports that previous increases mean that the number of recipients of continuing care increased by 38% between 2009–10 and 2015–16, in stark contrast to the substantial declines in the number of people in receipt of LA-funded care (Robertson, 2016). It is not clear whether the increase in the number of people receiving continuing healthcare is linked to the decline in the number receiving LA-funded care.

Finally, it is worth noting that those deemed ineligible for continuing healthcare may still be eligible for NHS-funded nursing and medical care (at home or in a residential nursing home) – again, this support is not means-tested.

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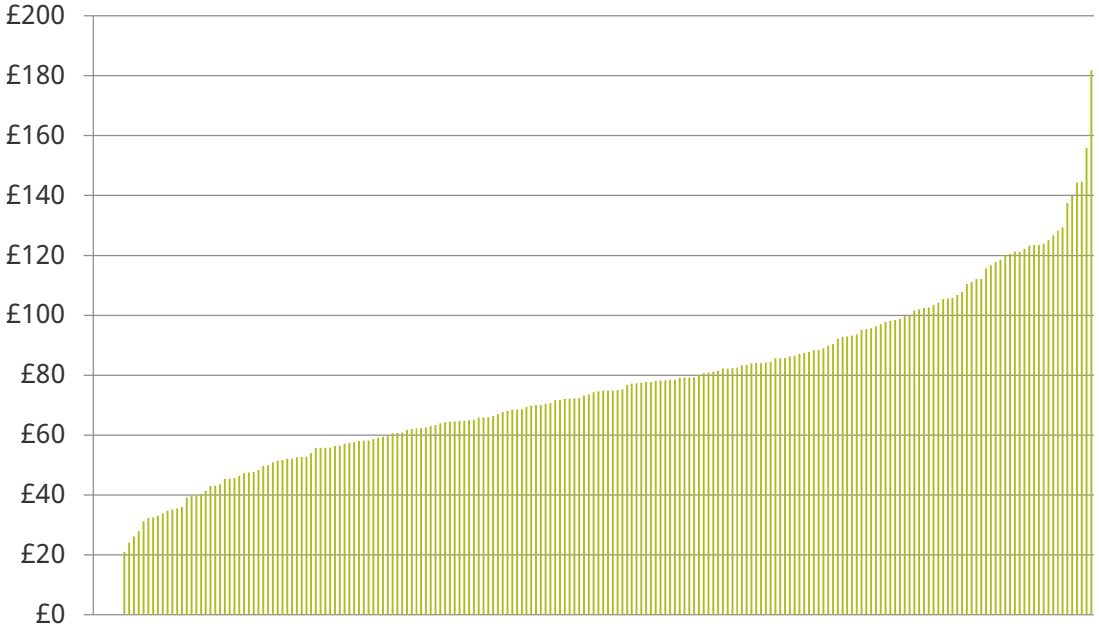
[26] In this appendix, we draw on information on the continuing healthcare programme, available on the NHS website: http://www.nhs.uk/chq/Pages/2392.aspx?CategoryID=68. Spending figures are taken from: https://www.whatdotheyknow.com/request/continuing_healthcare_spend_and#incoming-878831.
[27] See Department of Health (2012).

Figure B.1. Spending on continuing healthcare per adult resident by CCG, 2015–16



Source: Authors' calculations using population figures and expenditure figures discussed in footnote 26.

Appendix C: Recent changes to the local government finance system

Historically, the allocation of grants to LAs was based, at least notionally, on an assessment of local relative spending needs (including for adult social care) and the amount each LA could raise itself via council tax.[28] In particular, there were needs assessment formulae for different service areas, with each formula including variables understood to be drivers of local needs or costs for the service in question, and with the weight placed on each variable based on the historic relationship between that variable and spending on the service area in question by LAs. Each year, these needs assessments were updated.

This system was notional in the sense that layered on top of it was a system of 'damping' arrangements to guarantee minimum increases in funding or grants, and cap reductions in grants. Together with differences in funding that arise from LAs' decisions to set council tax above or below the average level for England as a whole, this 'damping' meant that the system never led to a full needs-based equalisation of funding for local services across England. However, recent years have seen big changes that have further weakened the link between each LA's relative level of spending need and their relative level of funding.

- First, the way the 'Four Block Model' of grant allocation, in use between 2007–08 and 2013–14, was used to allocate cuts to grants from 2010–11 onwards does not appear to have properly taken into account differences in the ability of different LAs to raise their own revenues via council tax.[29] This meant that between 2010–11 and 2013–14, LAs with relatively small council tax bases (and hence high dependence on grant funding) saw substantially larger cuts to their overall budgets than those with relatively large council tax bases (low dependence on grant funding).

- Second, since 2013–14, part of the grant funding LAs receive has been replaced by a locally retained portion of business rates. While there continues to be redistribution of these business-rate revenues from LAs with high revenues to low revenues, this redistribution was fixed in real terms in 2013–14 and has been increased in line with inflation since then. This provides an incentive for LAs to grow their business-rate revenues – as they gain or lose depending on whether their revenues grow by more or less than inflation. However, it also means that the allocation of this portion of funding is not updated to account for changes in relative needs or relative revenues.

- Third, the annual updating of needs assessments for remaining grant funding was also ended. In 2014–15 and 2015–16, in effect, each LA saw the same proportional cut to its grant funding, further increasing the tendency for LAs with relatively small council tax

[28] This appendix draws heavily on the analysis in Chapter 2 of Amin Smith et al. (2016).
[29] The Four Block Model was so called because it had four elements: a 'relative needs' block based on spending needs assessments for different service areas; a 'relative resources' block based on the ability of LAs to raise revenues themselves via council tax; a 'central block' allocating a fixed per-person amount to LAs that depends only on the type of LA in question; and a 'damping block' to guarantee minimum increases or maximum cuts to LAs.

bases (and hence high dependence on grant funding) to see larger cuts to their overall budgets than other LAs.[30]

Amin et al. (2016) have shown that these various factors led to significant differences in the cuts to overall budgets faced by different LAs (see Figure 2.1 of the current report, which shows the variation by the grant dependence of an LA).

[30] This system was further reformed in 2016–17 so that grants are now set in such a way as to deliver an equal proportional change to overall spending power (not the grant itself).

Appendix D: Adult social care unit costs

LAs provide and commission a range of adult social care services, and they are responsible for negotiating their own prices for these services. The prices they pay will reflect a combination of the local costs of inputs to these services (e.g. wages), the quality of service provision, the severity of needs of the users of services and the efficiency with which they are delivered.

Table D.1 shows for each region the implied hourly rate paid for home care services, and the weekly rate paid for residential and nursing care services for adults under and over 65. These are calculated by NHS Digital as part of their Personal Social Services: Expenditure and Unit Costs statistics. It is worth noting that they are based on a broader measure of expenditure than used in the rest of this report (including fee income and some other income from the NHS).

Table D.1. Unit costs for adult social care services by region and service type 2015–16 (2016–17 prices)

Region	Hourly rate for home care		Cost per week for residential and nursing care	
	Internal provision	External provision	Users age 18–64	Users age 65+
East	16.9	14.9	1,320	604
East Midlands	37.7	14.2	1,085	514
London	37.7	14.5	1,262	683
North East	31.6	13.0	1,000	519
North West	21.8	12.7	941	480
South East	33.6	16.3	1,242	611
South West	40.8	16.6	1,293	629
West Midlands	25.6	14.0	1,202	520
Yorkshire and The Humber	32.1	13.9	1,004	506

Note: Externally provided home care rate is the average hourly rate of all domiciliary care that is out-sourced to other providers. The internally provided home care rate is the average standard hourly rate of home care provided by the LA itself. Differences in these rates may reflect a number of factors including differences in severity of the needs of individuals receiving home care delivered by different organisations. Weekly/hourly costs are calculated as follows: total cost of an activity (including income from NHS and fees and charges) minus the portion that covers grants to voluntary organisations, divided by total activity (in weeks/hours).

Source: Authors' calculations using NHS Digital (2016) Reference Tables T14 and T16.

Appendix E: Further analysis of factors correlating with social care spending

Table E.1. Summary statistics for local needs-related characteristics

% of population in **2015–16**, unless otherwise stated	Median	10th percentile	90th percentile
LA net adult social care spending per adult in 2015–16 (£, 2016–17 prices)	383.50	324.60	445.10
Population age 65 or over	22.2%	14.0%	28.4%
Claiming disability benefits	9.7%	6.8%	14.0%
Claiming carers' allowance	1.5%	1.0%	2.4%
Claimant PCGC	2.2%	1.4%	3.3%
Claiming ESA (income-related)	2.9%	1.6%	4.3%
Median gross weekly earnings (£)	420.00	374.40	547.20
Share of households renting (as of 2011 census)	32.8%	26.1%	53.4%
Share of 65+ population not in a couple (as of 2011 census)	42.2%	37.1%	53.6%
LA average IMD score (as of 2015)	23.2	12.2	33.4

Source: Authors calculations using sources listed in Chapter 3.

Table E.2. Regression results – relationship between social care spending and local area characteristics in 2015–16

	LA net adult social care spending per adult		
	(1)	(2)	(3)
Share of adult population age 65 plus	92.8 (0.60)	335.2 (1.79)	325.7 (1.74)
Share of adult population claiming disability benefits	447.4 (0.81)	578.2 (1.05)	480.5 (0.87)
Share of adult population claiming carers' allowance	–4794.0* (–2.23)	–2808.6 (–1.16)	–1118.5 (–0.41)
Share of adult population claiming PCGC	1359.7 (1.39)	1046.9 (0.97)	1185.0 (1.10)
Share of adult population claiming ESA	2085.2 (1.95)	2100.9 (1.67)	3063.9* (2.12)
Median gross weekly earnings		0.32*** (3.38)	0.25* (2.22)
Share of households renting		90.1 (0.83)	127.6 (1.15)
Share of 65+ population not in a couple		–104.6 (–0.44)	–53.8 (–0.22)
LA average IMD score			–3.06 (–1.34)
Constant	304.6*** (10.60)	83.8 (0.96)	106.3 (1.20)
Observations	150	150	150
R^2	0.15	0.24	0.25
Adjusted R^2	0.12	0.19	0.20

Note: *t* statistics in parentheses. * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

Table E.3. Regression results – relationship between proportion of adult population receiving long-term care and local area characteristics in 2015–16

	Share of adults receiving LA funded long-term care	
	(1)	(2)
Share of adult population age 65 plus	0.047**	0.045**
	(3.06)	(3.03)
Share of adult population claiming disability benefits	–0.028	–0.045
	(–0.62)	(–1.02)
Share of adult population claiming carers' allowance	0.26	0.55*
	(1.33)	(2.58)
Share of adult population claiming PCGC	0.070	0.094
	(0.80)	(1.10)
Share of adult population claiming ESA	0.15	0.31**
	(1.43)	(2.74)
Median gross weekly earnings	–0.000	–0.000*
	(–1.01)	(–2.40)
Share of households renting	–0.022*	–0.015
	(–2.47)	(–1.71)
Share of 65+ population not in a couple	0.043*	0.052**
	(2.20)	(2.69)
LA average IMD score		–0.001**
		(–2.95)
Constant	–0.007	–0.003
	(–0.96)	(–0.42)
Observations	150	150
R^2	0.48	0.51
Adjusted R^2	0.45	0.48

Note: *t* statistics in parentheses. * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

Table E.4. Regression results – relationship between percentage change in adult social care spending per adult (2009–10 to 2015–16) and local area characteristics in 2009–10

	Change in adult social care spend per adult (%)			
	(1)	(2)	(3)	(4)
Share of adult population age 65 plus	1.00***	0.23	0.21	0.49
	(5.10)	(1.04)	(0.51)	(1.08)
LA adult social care spend per adult		–0.001***	–0.001***	–0.001***
		(–6.04)	(–6.36)	(–6.27)
Share of LA revenues from grants		–0.15	–0.27	–0.34*
		(–1.76)	(–1.94)	(–2.11)
Share of adult population claiming disability benefits			0.33	0.82
			(0.39)	(0.94)
Share of adult population claiming carers' allowance			–5.37	1.31
			(–1.00)	(0.19)
Share of adult population claiming PCGC			1.63	1.23
			(0.78)	(0.51)
Share of adult population claiming ESA			12.8	22.6
			(1.09)	(1.66)
Median gross weekly earnings				0.00029
				(1.61)
Share of households renting				0.33
				(1.46)
Share of 65+ population not in a couple				–0.19
				(–0.37)
LA average IMD score				–0.0041
				(–1.04)
Constant	–0.30***	0.29**	0.35**	0.17
	(–7.72)	(3.28)	(3.10)	(0.97)
Observations	150	150	150	146
R^2	0.15	0.40	0.42	0.45
Adjusted R^2	0.14	0.39	0.39	0.41

Note: *t* statistics in parentheses. * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

Table E.5. Regression results – relationship between percentage change in adult social care spending per adult and percentage point change in local area characteristics (2009–10 to 2015–16)

	Percentage change in adult social care spend per adult	
	(1)	(2)
Δ share of adult population age 65 plus	2.27**	0.97
	(3.04)	(1.23)
Δ share of adult population claiming disability benefits	−1.12	2.21
	(−0.45)	(0.96)
Δ share of adult population claiming carers' allowance	−3.67	−13.6
	(−0.49)	(−1.97)
Δ share of adult population claiming PCGC	19.3***	10.6*
	(3.77)	(2.18)
Δ share of adult population claiming ESA	0.43	4.89**
	(0.24)	(2.71)
LA adult social care spend per adult in 2009		−0.001***
		(−5.86)
Share of LA revenues from grants in 2009		−0.16
		(−1.55)
Constant	−0.084*	0.31***
	(−2.58)	(3.99)
Observations	150	150
R^2	0.31	0.45
Adjusted R^2	0.28	0.43

Note: *t* statistics in parentheses. * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

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