Developing social care:
the current position
Executive summary

Martin Knapp, José-Luis Fernandez, Jeremy Kendall,
Jennifer Beecham, Sara Northey and Ann Richardson

1   Introduction

- The Personal Social Services Research Unit (PSSRU) was commissioned by the Social Care Institute for Excellence (SCIE) to undertake a literature survey on trends and gaps in service development in social care from the late 1980s to the present.

2   Conceptual framework

- Key criteria for evaluating the allocation of resources include: economy, effectiveness, efficiency, equity, user choice, autonomy, community participation and social solidarity.
- The production-of-welfare approach, which provides a framework for analysing trends in social care, distinguishes seven elements: need for support; funding base; resource inputs; costs of inputs; non-resource inputs; intermediate outputs; and final outcomes.
- Social care, in addition to being a productive process (as outlined above), can be viewed as a process of management, coordination–integration, politics and learning.
- Social care services take place in a 'mixed economy of care', in which it is important to distinguish between the provision and finance of care.

3   Social care-related partnership processes

- Recent overviews of developments in social care, by the Audit Commission and the Social Services Inspectorate (SSI), present a positive picture. It is argued that user choice has been extended and that users are generally satisfied with services. Services are also said to have become more community-based, diverse and better coordinated.
- General willingness for those involved in social care to learn is evident among many social care professional groups, and there are some indications that evidence-based policy and partnership-oriented information systems have developed at a local level. Arrangements for practical skills acquisition have been strengthened, and more inter-agency research has emerged. However, the overall national picture – the sum of the local parts – is not clear, and certainly the extent to which national policy is evidence-based is questionable.
- Evidence on joint working between social care and other professionals – often thought to be undermined by differing professional cultures, planning cycles, decision-making processes and funding structures – is very mixed. Some argue that joint working has deteriorated, with increasing medical dominance, whereas others note that new alliances have developed with respect to both policy and practice.
- Changes in the relative power of different professions are neither straightforward nor unidirectional: growing medical influence has brought increased resources at the interface with social care as well as greater accountability.
- The politics of social care are characterised by confusion, with little consensus on how to match institutional structures and types of partnership to differing needs, forms of care or client-group attributes. More obviously, development has also been constrained by the political decision to limit public investment in this area, by comparison with education and health.

- Users have made gains, both in certain procedural rights and in the expectation that their views should be heard. However, despite the rhetoric of 'empowerment', the academic and policy literatures, coupled with voluntary and community sector critiques, point to numerous shortfalls in terms of empowerment as an expression of citizenship (as opposed to an act of private consumption), and in the way in which concrete practices unfold.

4 Older people

Policy context

- The context for services for older people is dominated by the NHS and Community Care Act 1990, involving a major transfer of funding from central to local government, greater emphasis on the local authority role as 'enabler', changes to encourage community-based rather than institutional care, better targeting of services, and emphasis on needs-led provision.
- Subsequent legislation and guidance have stressed individual independence, prevention of crises, statutory regulation, better partnership working and more help to carers. The National Service Framework for Older People sets out eight standards for services.

Needs

- Older people form slightly less than one fifth of the population, with some variation between England, Wales and Northern Ireland, and considerable geographic variation within these countries. The health status of older people has slightly deteriorated over the past decade, probably because of longer life expectancy. Health status is somewhat poorer among the very elderly (aged 75 or over) in Wales and Northern Ireland.
- On average, older people using social care services today have greater needs than their counterparts 10 or more years ago.
- The concept of meeting 'needs' is increasingly widely interpreted, and involves helping older people to attain positive benefits as well as reducing the negative aspects of their lives. Greater attention is also paid to listening to their views. Instead of focusing attention on needs defined in terms of deficits or shortfalls, stemming from dependency or frailty, greater emphasis is now placed on needs defined in terms of opportunities and inclusion.
- The pressures on social care services arising from the needs and preferences of older people are increasing. This is due to growing numbers, changes in the availability of informal care, and rising expectations. There are many unmet needs for health and other services, which are especially acute among older people with mental health problems and among black and minority ethnic communities.

Funding

- Financing of social care for older people comes from a variety of sources, with support from local authorities, the social security budget, private households and the NHS. Relative contributions vary according to whether people are in care homes or living at home.

- Gross expenditure on social services for older people has grown substantially in real terms in England and Wales, but not in Northern Ireland. The proportions spent on different services have not changed markedly in the last decade.
- Significant increases in the unit cost of running care homes, due to increased resident dependency levels and rising standards, have not been matched by equivalent rises in prices. This has contributed to the closure of many care homes.
- Many older people have been wrongly charged for personal care costs. The charging regime in general continues to be contentious.
- The cost of home care has increased significantly in recent years, and charging policies vary across authorities, affecting take-up of these services. These are long-standing problems that policy has so far failed to tackle.
- Older people have had the potential to use direct payments since 2000, but take-up has been very slow, due in part to a lack of information among care managers, a lack of support services for those involved and a general lack of enthusiasm among local authorities.
- The average gross weekly expenditure on supporting adults and older people in care homes and via intensive home care has increased significantly in the last five years. This is a result of changes and increases in average dependency levels. However, costs vary considerably between different types of local authority.

Resource inputs

- There are roughly four million unpaid carers (for all service user groups), of whom one quarter provide more than 50 hours a week of care, giving practical help, companionship and general supervision. Nearly 90% of older people with dependency problems receive some informal care (some alongside formal care).
- There is likely to be a fall in the future supply of such carers, arising from changes in the population age structure, rising divorce rates, decline in family size, rising childlessness, growing employment among married women, changing household composition of older people, and changing preferences of older people.
- Carer well-being (including health status and coping skills) is a key influence on the decision to admit an older person to a care home.
- The impact of caring on carers can be considerable. Although many gain satisfaction from helping others, major health problems and lack of support can affect their willingness to continue in this role. Respite care is particularly sought. Labour supply decisions are influenced by caring responsibilities.
- Volunteers also play a major part in providing social care. It has been estimated that their contribution represents the equivalent of 221,000 full-time employees, or roughly one in every five hours of formal caring. Many such volunteers are older people themselves.
- Although there appears to be no definitive data on this, it is likely that roughly one million paid employees work in social care. About half of these work in care homes, one fifth in domiciliary care and the remainder in day care and other forms of social care. The private sector is now the largest employer, followed by the public sector and voluntary sector in turn.
- Recruitment and retention of employees are currently considerable challenges for services for older people. High levels of stress and dissatisfaction are reported by staff, and although low pay is an issue, the introduction of the national minimum

wage should have eased recruitment. It is widely felt that training needs to be improved.

Services

- The introduction of care management – by which services are tailored to individual needs following an assessment – has changed the nature of social work: 1 in 10 local authority social workers is now a care manager. However, there is a lot of variation in practice. There has been disappointing progress with the implementation of care management services. Few care managers have small caseloads or devolved budgets, and there are substantial restrictions on their ability to determine the services provided (such as policies to favour 'in-house' services). Intensive forms of care management (and its near relatives) are being introduced in an effort to improve the utilisation of health and social care services.

- The proportion of service users receiving written statements of their needs and how they will be met has grown, reaching 86% in England by 2002/03. There has been less progress in assessing the needs of carers. The Single Assessment Process (SAP) for older people was introduced in April 2004, but not all authorities achieved this target implementation date. Generally, there is now greater transparency of eligibility criteria.

- Commissioning external services was a pivotal responsibility that was passed to local authorities by the NHS and Community Care Act 1990. Following initial resistance to it, local authorities – concerned to be pragmatic – have increasingly commissioned such services. However, many independent sector providers feel they have uneasy relationships with local authorities, not helped by the low fees paid and the latter's preferential use of in-house services. Contracting arrangements appear to be improving, but with considerable variation. Generally, commissioning skills have moved forward some distance since the early 1990s.

- Targeting has improved over the past decade, with a commitment to needs-led decision making, clearer eligibility criteria and more frequent carer assessments. Nonetheless, there are substantial unmet needs, as well as age discrimination and some evidence that people from black and minority ethnic populations are less well served. Targeting is also poor for older people with mental health problems and for people in certain other circumstances.

- In 2003/04, there were just over 400,000 care homes (compared to 460,000 in 1996), with occupancy levels at about 90%. Provision has changed dramatically, with a rapid growth of private-sector care facilities and a fall in in-house provision. The average size of homes has also been increasing, to about 34 beds per home.

- Care home closures have been disproportionately common among small homes and those which have had a positive social environment which they have been able to offer through higher fees. This has arisen because the fees paid by local authorities do not always cover costs (which are exacerbated by rising dependency levels and rising standards) and staff recruitment can be difficult. Although there has been a recent growth in corporate provision, some areas currently face a shortage of care homes.

- Extra care housing, including 'enhanced sheltered housing' and retirement communities, offers another choice to some older people. Authorities are likely to reach the national target of an additional 6,900 places by 2006. The 'Supporting People' initiative has helped this sector to grow.

- No data exist on the overall provision of home care, but there has been a significant increase in the volume of care hours purchased by local authorities. These are being supplied to fewer but more vulnerable older people than before. The privately funded sector has not been closely regulated.

- The independent sector's share of the home care market has grown much faster than expected, but varies enormously between areas. Providers complain about the commissioning playing field is not level. Home care provision has tended to be delivered by a multiplicity of small providers covering a modest area, although there has recently been some consolidation. There is considerable pressure to reduce costs.

- Recently, the number of people receiving other community-based services, such as professional support and day care centres, has increased significantly.

- In-patient care has fallen since 1990, although not as quickly as was hoped. There are currently roughly 28,000 geriatric hospital beds, with a growth in occupancy rates, but older people also occupy other hospital beds.

- Delayed discharges from hospital are problematic to policy makers because they waste resources and are both inefficient and inequitable. They are also problematic to individual older people because they confine them to longer stays in hospital than they or their families would wish.

- Analyses have corroborated the view that provision of social care services (both community- and institution-based) can significantly reduce delayed discharge rates. Local resource levels and input prices are significant in this matter.

- Discharge planning – which affects the availability of hospital beds for new patients as well as the well-being of the individuals involved – is, in turn, affected by the availability of social care, particularly home care services (one of the 'vicious circles' of delayed discharge). A number of initiatives have been set up to improve discharge planning, and delayed discharges have now been reduced, although there is still considerable variation.

- Intermediate care services are intended to help older people respond to or avert a crisis and maximise independent living. Many local authorities are developing such arrangements with good results, but they are not always integrated with mainstream activities. Many factors limit the supply of intermediate care, including pressures on care home places, local authority financial difficulties (including the diversion of funding to other uses), poor joint working between the NHS and local authorities and lack of advice for managers.

- There is a strong interest in developing preventive services, such as respite care, telecare, befriending schemes and day care, but provision is limited and very uneven.

- Another concern is for 'whole system' approaches to the identification and meeting of needs, but these are relatively rare and the evidence for them is limited.

Outcomes and cost-effectiveness

- It was impossible to examine all the evidence on effectiveness (including cost-effectiveness) of services for older people for this review, although we covered a great deal of the field. There appears to be surprisingly little good research; most outcome evidence does not capture the impact of social care on users and their families because of the inherent difficulties of doing so. Key issues should include

nutrition, personal care, social involvement, safety and control over daily life, all of which feeds into the improvement of quality of life.

- The last decade has witnessed both a very significant increase in the rate of intensive home care as a proportion of intensive home and residential care and an improvement in the ratings of councils providing good-quality (ithat is, 3* or better) care homes.

- User satisfaction surveys among older people are skewed by the latter's reluctance to complain, but a recent (first) national survey of users of home care services found that about 25% were extremely satisfied and 88% quite satisfied with the care received, although significantly lower satisfaction was expressed by black and minority ethnic groups. Another recent large survey of older people found that almost 60% were 'very' or 'extremely' satisfied with their social care support. Caution should be exercised in interpreting findings from satisfaction surveys as most of them are poorly designed.

- There is now fairly substantial evidence of the effectiveness of services for carers. A recent synthesis argues that day care, home care, institutional respite care and social work/counselling can all improve outcomes for carers. Day care, home care and institutional respite care were also shown to delay admissions of older people to institutional care.

- Early research on care management showed that it reduced the need for admission to institutional care and increased satisfaction among both users and carers; a recent study confirms these findings. As noted earlier, a sizeable implementation gap exists between the models of care management that produced encouraging evidence of outcomes and cost-effectiveness and the models actually in use today.

- There is a worrying paucity of research on care homes. One study found a positive relationship between the educational preparation of nursing home staff and resident autonomy. An evaluation of nurse-managed NHS nursing homes found positive outcomes for users, and another found that people's mental and functional abilities deteriorated more rapidly in nursing homes than in hospital, although the quality of life was superior in the former. A review of the literature comparing nursing home and hospital care suggests that the former can provide an alternative to hospital care, but challenges such as staff skills remain.

- Research on psychosocial interventions on older people with dementia suggest benefits for cognition and behaviour, but there is no evidence of cost-effectiveness. Cognitive stimulation therapy for older people with dementia has recently been found to be both effective and cost-effective.

- There is surprisingly little recent evaluative research on home care in the UK, but some US evidence suggests that home visiting can reduce mortality and nursing home admissions, but does not reduce functional decline. Apart from the evidence coming from one large English study described below, we know very little at all about the effectiveness of home care in the UK in the post-1990 period.

- With respect to intermediate care, hospital at home schemes do not appear to be cost savers. Hospital at home schemes providing care in the patient's home that is traditionally provided in hospital have grown in importance in health services in both Europe and North America and are seen as a possible substitute for in-patient care in the NHS. Rehabilitation services may reduce the risk of hospital readmission or admission into long-stay care homes, and may improve survival rates and physical and cognitive functioning, but they are not always acceptable to users.

- Very little research has been carried out on outcomes for prevention in social care, but more has been done in healthcare. Some reviews have shown some benefits from interventions to reduce falls by older people, modifications to homes and geriatric day hospitals.
- The most substantial study of the marginal productivity of social care services post-1990 found that the patterns of service use seemed to be based on policy priorities, that is, they were needs-led rather than supply-driven. Significant improvements were found in a wide range of outcome indicators both for users and for carers. The greatest improvements occurred with users who had higher levels of dependency, and community care services were found to have a significant impact on preventing hospital admissions. Finally, important evidence was also offered on the nature of the relationship between resource use and outcomes.

Choice

- Despite much concern to increase choice, progress remains slow. Because of block purchasing and in-house first policies which prefer the use of in-house services over the purchasing of external homes or beds, older people are rarely given much choice of care home, although there is now a greater diversity from which to choose. Information is improving, but many people need better information on what is available and how to use it.
- A number of studies stress a lack of active participation by users in decisions, whether about a particular home or the nature of services provided. Promoting independence is seen more as a matter of enabling people to undertake physical activity rather than to exercise autonomy. Staff seem to remain in control, although the use of direct payments and other initiatives may change the balance here.

Future demand for long-term care

- The number of older people is projected to increase very substantially in the next 50 years, with an 81% increase in those aged 65 and over (and a 255% increase in those aged 85 or over), although such estimates are necessarily uncertain. Levels of dependency are currently higher for older age groups and for women.
- Future demand for long-term care is likely to increase substantially over this period, with projections (based on demographic changes, but not on possible changes in dependency rates) suggesting a need for a 151% increase in residential places and a 137% increase in home care hours. Such projections are very sensitive to assumptions about trends in life expectancy, dependency and unit costs.
- Long-term care expenditure would need to increase by 317% in real terms between 2002 and 2051 to meet demographic pressures and to allow for real rises in unit costs of care. This would mean an overall increase in expenditure from about £12.2 billion in 2002 to £53.9 billion in 2051.

5 People with mental health problems

Distinguishing social care

- Due to good partnership working between health and social care, it is difficult to separate social care from other inputs to mental health services, so this discussion necessarily reviews overall developments in mental health.

Policy context

- The NHS and Community Care Act 1990 had great import for mental health services, including the introduction of the care programme approach, care management and greater attention to assessment. A mixed economy of provision was given further encouragement and the policy of moving to community-based provision affirmed. Progress during the 1990s was quite rapid, but the dominance of a risk minimisation approach was criticised, as was under-funding of key developments in mental health care.
- The 1997 White Paper on the NHS included attention to greater partnership working and avoidance of cost shifting, with much relevance to mental health. A concern to make services safe, sound and supportive led to support for specialist mental health trusts as well as assertive outreach and crisis-resolution teams.
- The National Service Framework for Mental Health set national standards, defined service models and suggested measures of performance and milestones to gauge progress over a 10-year programme. A policy implementation guide elaborated commitments with respect to mental health services.
- Current concerns regarding mental health services include social exclusion, discrimination, services to support community reintegration, housing, paid employment, financial advice, transport and supporting families.

Needs

- Roughly 1 in 200 adults experiences a severe and enduring psychiatric disorder each year, and about 1 in 25 adults has a personality disorder. At any one time, it is estimated that 1 person in every 6 has a common mental health problem. Prevalence and need have been linked to deprivation.
- Much emphasis is now being given to meeting the social inclusion needs of people with mental health problems.
- People with mental health problems articulate a range of needs, including obtaining help in a crisis, information, help with ordinary living, and more opportunities for personal development. Carers want professional support available at all times, as well as more information and help to cope.
- Many needs for better mental health treatment and care remain unmet, partly because quite a few people do not access services; these unmet needs also exist among those who do access services.

Funding

- For the last few years, NHS expenditure on mental health care has been about 12% of its total expenditure, representing a visible growth: in real terms, it was 60%

higher in 2000/01 than in 1990/91. However, there are indications that mental health expenditure by the NHS is now not keeping up with the growth in total NHS spending.

- The main change has been spending on community health services. Although the proportion spent on hospital in-patient services has fallen, actual expenditure has grown, presumably due to the growing use of secure provision.
- Although NHS funding formulae now include a separate equation for mental health services, actual spending diverges significantly from allocation. Underspending relative to allocation occurs more frequently in deprived areas, although there is overspending (above the allocation) in some inner London authorities.
- Expenditure on mental health services by local authority social services comprises roughly one fifth of NHS mental health expenditure, but there is a wide range across areas. There has been rapid growth in recent years. Local authorities voiced expectations of continued growth in real terms, although a modest settlement in the July 2004 spending review may curtail some ambitions.
- There are many hidden costs in supporting people with mental health problems, including indirect costs to social care, education, housing, criminal justice and social security budgets, as well as the high costs to individuals and their families of unemployment and other difficulties.
- Take-up of opportunities for direct payments by people with mental health problems is particularly low (roughly 200 people nationally in 2003).

Resource inputs

- Both the recruitment and retention of trained social work staff working in mental health are proving difficult. A vicious circle is created of high turnover arising from pressures on existing staff, followed by high costs of using agency staff and recruiting new staff.
- Approved social workers report greater job dissatisfaction and higher stress than other social workers. There are concerns about the disappearance of a distinctive social work role in mental health.
- Considerable attention has been given to supporting the carers of people with mental health problems, including assessing their needs. Expenditure has increased on carers generally, as has the number of carers helped, but this has not been proportional for those caring for someone with mental health problems.

Services

- There was a striking shift away from hospital care over the past five decades, which accelerated in the 1980s and 1990s. In the UK, psychiatric in-patient bed numbers were around 155,000 in 1954, 100,000 in 1975 and 32,750 by 2002/03.
- Despite this, admission rates escalated in the 1980s and early 1990s, representing a substantial increase in hospital throughput, with some variation by specific diagnosis. There were delayed discharges for 'new long-stay' patients (as for older people), but there is relatively little research evidence in this area.
- Despite the general trend to provide community-based care, some in-patient facilities continue to be needed: one estimate suggests this to be 9-10 beds for every 100 discharged patients. Bed occupancy rates are high (125% in some areas), and the conditions of the buildings are often very poor.

- The proportion of NHS and local authority social care expenditure on in-patient and residential services fell from 90.7% in 1977 to 71.7% in 1994 and to 56.1% in 2000.
- The closure of hospital beds was complemented by the opening of accommodation and other community facilities, although whether a sufficient amount was opened is questionable. There were marked variations in availability, with a number of out-of-area transfers and under-provision of accommodation for people with the most challenging needs. Poorly coordinated services have often been reported.
- The number of people with mental health problems supported by English local authorities has grown from under 10,000 to over 13,000 in just five years, while the proportion living in facilities staffed by local authorities has fallen. In-house provision is almost entirely used for temporary placements.
- The average cost of accommodation in care homes has grown over a five-year period, particularly in London, suggesting that average 'dependency' levels have been increasing.
- There has been a striking rise in independent sector provision since the mid-1970s, but in-house provision did not fall until fairly recently. Much private residential care was provided by owner managers. The voluntary sector was a large provider, mostly by nationally known organisations.
- Official emphasis has increasingly been for supported living options. The 'Supporting People' programme has opened up opportunities for supported accommodation, but shortages of suitable housing in some areas limit the extent to which this is a real option.
- Although most people with mental health problems want to work, employment rates are very low. Increasing emphasis has been given to models of individual placement and support, rather than specialist work schemes or other day services.
- Community mental health teams (CMHTs), which coordinate and deliver non-hospital mental health services, have been criticised for ambiguous aims, over-large caseloads and not targeting people with the most needs. Despite recent guidance urging better integration within teams, practice varies considerably.
- The National Service Framework and subsequent documents urged the establishment of three specialist teams: (1) an early intervention psychosis service, to manage new cases; (2) a crisis resolution team, to reduce the number of in-patient admissions; and (3) an assertive outreach team, to support people who might not engage with services or take their medication. There is some variation in the extent to which these have been set up.
- A number of models of case management, as well as the care programme approach, have been used to help people with mental health problems. Each model tends to differ significantly in practice, and together they are not well integrated. A key difficulty has been the fragmented nature of the multiple services required.
- Despite encouraging developments, research, audit and inspection suggest that much more could be done to target services to meet overall needs, ensure links between accommodation and other services, offer preventative services and appropriately address the needs of black and minority ethnic groups.

Outcomes and cost-effectiveness

- It is difficult to disentangle the outcomes or cost-effectiveness of social care contributions to services, especially where such services are determined through multi-disciplinary processes.

- Moreover, major difficulties arise in evaluating arrangements, due to lack of clear definitions, lack of fidelity to evidence-based models and adaptations of previous models to suit local contexts. Community interventions are inherently context-bound.
- Two areas where there is good evidence are (1) community provision for former long-stay hospital residents and (2) intensive community support for people with acute mental illnesses.
- Studies have found community-based care to be more cost-effective than hospital care for most people, particularly those with less severe illness or fewer dependencies. People with very challenging needs are more costly to accommodate in the community than in hospital, although there are improvements in their clinical and social outcomes.
- Despite methodological difficulties and some varying early findings on care management, assertive community treatment, CMHTs and crisis intervention teams, a recent review suggests that 'home treatment' schemes, broadly defined, reduce hospital stays by 3.3 days per person per month on average. This effect arises from visiting patients at home and by the CMHT taking dual responsibility for health and social care.
- In terms of cost-effectiveness, a study of people facing crisis admission found that a form of assertive outreach had better outcomes and lower costs than standard care in the short term, but no differences after four years. The programme was more cost-effective than standard hospital care during the four years. Other studies confirm the cost-effectiveness of community-based crisis interventions, while for case management, the evidence is mixed.
- There is little hard UK evidence on the cost-effectiveness of supported housing schemes or employment-related interventions. US research suggests that supported employment programmes generate the best outcomes.

Choice

- Despite many barriers to user involvement in service planning, a majority of local implementation teams seem to be involving users in the planning and monitoring of services.
- Involvement of service users in their own care planning is still very limited.

6 Children and young people

Policy context

- The Children Act 1989 is the principal legislation underpinning services for children in need, defined as those who need the help of social services to maintain their health or development or who are disabled.
- Children in need fall into a range of groups, including those suffering from abuse, neglect, parental illness and disability. Environmental factors, such as poor housing and unemployment, tend to play a role.
- Recent years have seen a number of key reports and central government initiatives focused on children in need, including preventive and early intervention services.

Needs

- There are about 9.8 million children aged 0-15 in England, of whom 3.5 million can be said to be 'vulnerable' (living in poverty). It is estimated that there are 325,000 children in need, 25,700 children on the Child Protection Register and 70,000 looked-after children.
- Looked-after children suffer disproportionately from both physical and mental health problems, are more likely than other children to be in trouble with the police and to be behind in their intellectual development.
- Disabled children include those with physical or learning disabilities. They are often the source of heavy financial and other demands on families, but they do not always get the help they need from social services.

Funding

- Expenditure on children in need has increased over the past decade: in 2001/02, it represented 22% of the total expenditure on personal social services. About one quarter of the budget is spent on commissioning social work services; the proportion spent on residential care has been falling.
- Specific central government grants are an important part of children and family services budgets and help develop targeted services and supports.
- Expenditure on independent sector placements is growing, commonly due to insufficient in-house capacity. There are concerns about the high cost of these placements compared to in-house services.

Resource inputs

- Roughly 350,000 people work in child care every day, the numbers having increased over the past decade. Most have below-average qualifications and low earnings. Staff working with children and families comprise 15-23% of total social services office/fieldwork staff. The number of children and family social workers has also increased, with most working full time.
- There are about 8,400 residential staff in children's homes (down from 10,500 in 1994), reflecting the contracting market and staff shortages.
- Lack of access to mental health services is a perennial problem in children's services. This is especially important for children with challenging behaviour or uncertain emotional development.
- It is estimated that, every week, fieldwork and centre-based staff spend 6.5 hours with looked-after children and 18.9 hours with other children in need. On average, staff spend about one third of their time on non-child-related activities. Social workers spend roughly 50 hours each year on work directly related to children, with home visits absorbing 40% of that time.
- The current national vacancy rate for children and family social workers is 11% (20% in London) and the vacancy rate for children's home staff is 10% (17% in London). These high rates are thought to be due to a poor public image, the low status of childcare work, variable management and supervision, high workload and a number of other issues.
- There is a national shortage of foster carers, a shortfall of 8,000, which is particularly acute for black and minority ethnic children, teenagers, children with special needs

and groups of siblings. Foster carers seek more advice, training and support, and some innovative initiatives are seeking to improve their recruitment and retention.

- Despite concerns about the health of children in need, around 30% of 'designated doctor' posts for child protection teams are unfilled, possibly because of fears of complaints by parents and lack of proper training. Attendance by doctors at child protection conferences is low, often because of poor timing.
- The incidence of young carers is growing: 2,300 had been identified in 1997, supported by 36 designated projects across Britain; their average age is 12 (range: 2-18). Most of them care for ill or disabled mothers and a few (12%) care for more than one person. Numbers are likely to rise with an increase in lone-parent households.
- Independent visitors, usually volunteers, have an important role for disabled children and young people who are looked after and have little contact with their parents. By 1996, about a third of local authorities were still not using independent visitors, despite their provision being a legal duty under the Children Act 1989.

Services

- In March 2003, there were 60,800 looked-after children, with 80,000 looked after at some time during the year, and 24,600 who start to be looked after in any given year. In recent years, more children are being successfully supported within their families, but those who do become looked after remain so for longer periods.
- The proportions of children looked after in different types of placement have remained fairly constant over the past three years, with around 66% placed in foster care and 15% in residential homes.
- In 2000, there were 1,146 children's homes in England, offering 9,164 places. Of these homes, 59% were local authority maintained and 22% were registered for-profit homes. Of the children in residential homes, 58% were aged 10-15 years and 35% were under 10 years.
- Research indicates the importance of residential care, but has also shown that homes need more external support, good internal management and qualified and experienced staff, and that children need more support from other professionals. A combination of children being difficult to manage and a high turnover leads to unsettled care environments; there is still a paucity of research on how to ensure appropriate placements.
- A total of 37,900 children were looked after by foster carers in 2000, with an average of two children placed with each one. Foster carers have become more diverse in terms of age, ethnicity and marital status. Difficulties in finding appropriate placements are well known.
- Independent fostering agencies (IFAs) have grown over the last decade, with 120 agencies in operation by 2000; these are generally small-scale non-profit operations, funded primarily by local authority placements. By March 2000, IFA carers looked after 31% of all fostered children. The IFAs generally provide better support to foster carers than local authorities as well as better-structured remuneration.
- In March 2001, 6,600 children were looked after in foster placements with family or friends, primarily grandparents. This arrangement can help to maintain social networks for children, but these carers may be poorer than others and less well supported.
- Roughly 3,600 adoptions of looked-after children took place in 2003. There is a disruption rate of adoptions of about 20%, varying with a range of factors,

and suggesting a need for careful placement and good preparation. Progress in developing adoption services appears to be uneven and attention may be needed to the financial situation of families caring for these troubled children.

- There are a number of areas where there is little robust research evidence on effectiveness: family support by social workers, help to young people leaving care, and youth offending teams.
- Social services support for disabled children, including short-term breaks, have been shown to be helpful for families as well as for children. Only a minority of families with disabled children have keyworkers, although research has shown positive benefits for families. Direct payments are rarely used.
- Information on the ethnicity of children in need is poorly recorded. Some data suggest that 83% of looked-after children and 82% of those supported in their families are white, but there are differences between authorities. Expenditure per child also varies by ethnicity.
- A major review of research on services for children of minority ethnic origin suggests that there is great variability in the way local authorities respond to their needs, but such needs were similar to those of other children in need.
- The provision of information and support to carers – whether foster carers, residential workers, adoptive parents or parents of disabled children – is a clear gap in service provision.

Outcomes and cost-effectiveness

- Progress on achieving stability for children is positive, but variable. Half of all longer-term looked-after children stay in the same home for over two years and fewer have three or more placements in a year. The proportion of children being adopted is increasing and placements are being made somewhat quicker. Placement breakdowns vary enormously by the age of a child.
- Progress in protecting children from significant harm is difficult to measure: numbers on the Child Protection Register are falling slightly and rates of child protection reviews are rising. There is a lot of variation in child protection services and some concerns about insufficient support.
- Overall progress in ensuring that children in need gain education and health and social care is mixed: services are often linked to concerns about significant harm, but this may limit access by others. Positive outcomes are expected from a number of new preventive initiatives, such as Sure Start, but may not be seen for some years.
- There is progress on the same measures for looked-after children, with respect to health checks and achieving some qualifications, but there is a long way to go on both fronts, with these children lagging markedly behind those in the general population.
- A lack of research on the effectiveness of care-leaving services makes it difficult to measure progress in helping young people leaving care, but increasing numbers continue to receive social services support, remaining in care until the age of 18, and more care leavers seem to be obtaining employment, education and training.
- There has been some progress in ensuring that the needs of disabled children are adequately met – for instance, through increased joint working across services. However, there are still many shortcomings and considerable unmet needs, especially among minority ethnic families, those with pre-school children and teenagers with autism spectrum disorder.

- There is some evidence to suggest progress in ensuring that referral and assessment procedures discriminate effectively between different types and levels of need, but not on whether these lead to better service planning and provision or better outcomes for children.
- Progress in involving children and their carers in decisions appears to be variable, but there is a lack of information to assess this.
- Information on progress in ensuring that children in regulated services are protected from harm through regulatory powers will be improved by the collection of data by the new National Care Standards Council.
- It is difficult to assess progress in ensuring that social care workers have appropriate training because of a lack of data on the training of staff in children's services. Around a third of residential care staff have attained the required qualification level.
- Progress on ensuring that services are cost-effective is difficult to measure because of lack of information. There are, however, some detailed research data on the costs associated with particular children's services.

Choice

- Although children want to be fully involved in decisions that affect them, evidence of this happening in practice is limited and some children do not feel that they are listened to. More help may be needed to facilitate their involvement.
- Parents are supposed to be actively involved in decision making about their children, but this is hampered by staff attitudes and a lack of support to families to facilitate their participation.

7 People with physical disabilities

Policy context

- The Chronically Sick and Disabled Persons Act of 1970 and the Disabled Persons Act 1986 sought to improve services, but many of the intended changes in the latter never took place, mainly due to lack of resources.
- The Independent Living Fund was established in 1988, comprising a statutory charitable trust to provide cash for care assistance in the community. More restrictive criteria for entry were introduced from 1993.
- The NHS and Community Care Act 1990 was again key for this population, with a concern to enable people to live independently and encouraging user and carer involvement in assessment and determining appropriate services.
- There have been a number of policy initiatives over the past decade, including the Disability Discrimination Act 1995 nand Disability Rights Commission, the 1998 white paper *Modernising social services*, and the New Deal for Disabled People launched in the same year. The Welfare Reform and Pensions Act 1999 overhauled some of the main disability benefits.

Needs

- The prevalence of disability is estimated to be 14% for people aged 16-65. Thus there are at least seven million disabled people in the UK, many of whom receive support from the NHS or local authorities.

- Only a small proportion of disabled people of working age are long-term disabled, although at any one time the latter represent a high proportion of all disabled people. Disability is more common among older people and among women of working age.
- The number of people registered as sensory disabled has risen steadily in the last 20 years, most notably in the numbers who are hard of hearing or partially sighted. These changes may be due to the ageing of the population or to a growing willingness to register as sensory disabled.
- The needs of disabled people span accommodation, finance, education, employment, leisure, transport and access, as well as the personal, social and healthcare needs that are of primary concern here. There is considerable evidence that these needs are often not being met.
- Families with disabled children often face additional expenses associated with the needs of their children, including practical help and information about services, yet such families tend to have little help.
- Stroke is the most common cause of disability in the UK, affecting people of all ages. People who have had a stroke report many unmet needs, including help with mobility, therapy, respite arrangements and financial difficulties.
- Injuries are a key cause of mortality and morbidity in young adults: there are 720,000 hospital admissions and more than six million attendances at A&E each year by people with serious non-fatal injuries. A key issue for many is the long-lasting nature of disability, which can affect their ability to work.
- The Carers (Services and Recognition) Act 1995 gave carers a statutory right to an assessment of their needs, although few have received such an assessment. In 1999, carers were given the right to expect the NHS and social services to help maintain their general physical and mental health.

Funding

- Expenditure by social services in England on home care for physically disabled adults under the age of 65 increased faster then inflation from 1994/95 to 2002/03. In that last year, direct payments accounted for 6% of this expenditure. Spending on nursing home placements also grew over the same period.
- In Wales between 1997 and 2003, total expenditure on social services for physically disabled people increased above the level of inflation.
- The initial budget of the Independent Living Fund (ILF) was £15 million, but by 1993 it had increased to £97 million, with around 22,000 people receiving funding. Two new trusts have been established, one with a budget of £117 million to provide continuing payments to those already receiving ILF funding, and the other with an initial budget of £4 million for new awards to around 1,500 severely disabled people of working age each year.
- Disabled people represented almost 70% of all those receiving direct payments in 2002, yet only a small proportion (1.8 per 10,000) received such payments, with variations by type of disability. Various measures have been taken to promote the use of direct payments.
- The costs of adaptations and aids for younger physically disabled people and their families are high, but it has been argued that it might be cheaper in the long run to meet them than to fail to do so. Local authorities with housing responsibilities can pay Disabled Facilities Grants to fund adaptations – such as wheelchair

accessible showers – for disabled people in owner-occupied or private sector rented accommodation, but there are long waiting times.

- Although English local authorities began implementing government guidance on charging for care services in 2002, research suggests that there are some inconsistencies with charging policies, and that a majority of service users and carers find it difficult to get information on the policies of their local authority.
- The 'Supporting People' programme, funded from April 2003, is intended to encourage the independence of vulnerable people through housing-related support, but the needs of disabled people have generally been given low priority.

Resource inputs

- The shift to community care over the past 15 years has, along with others, affected disabled people under the age of 65. Convalescence and rehabilitation now tend to occur in private nursing homes or domiciliary settings, rather than in hospital, with a shift from universal access to NHS provision to 'residual' local authority provision.
- Many disabled people are receiving domiciliary home help and day care services, which are increasingly subject to means-tested charges.
- We found only limited research on the families and other carers of younger disabled people, but many seem to suffer strain and psychological distress. Poor quality of life of the carer may be associated with depression in the disabled person.

Services

- A major review of the performance of social care services for disabled people concluded that they had improved: more people are receiving help to live at home, more are receiving direct payments, employment opportunities are expanding and councils are developing alternatives to traditional day services and adopting the social model of disability.
- This report added that home care needs to become more flexible and reliable, greater attention should be given to promoting independence and more disabled people should receive direct payments.
- Other research suggests that services are best where there is joint commissioning and explicit budgets for disabled people, effective links with health and other services, the involvement of disabled people in strategic planning and specific initiatives, a dedicated adult disability team and ongoing staff training and development.

Recent trends

- In England between 1998 and 2003, the number of adults with physical disabilities helped to live at home increased, except in London. The number receiving community-based services increased from 2001/02 to 2002/03, the services most commonly used being the provision of equipment and adaptations, professional support, home care and meals.
- Conversely, admissions of people with physical disabilities to various forms of accommodation fell over a similar period. The number living in independent residential care homes increased, but those in council-staffed accommodation fell. The numbers in independent nursing homes remained the same.
- The period that physically disabled people must wait for an assessment appears to have lengthened in 2002/03, compared to the previous year, with the modal period

from first contact to completed assessment being between two and six weeks. Unacceptably long waits for receipt of services are also common.

- In Wales, the number of places in local authority homes for physically disabled people grew steadily between 1980 and 1995, but stabilised after 1997, with the vacancy rate having increased since 1980. The number of residents in private and voluntary homes has fallen considerably in the last two decades.

- In Northern Ireland between 1998 and 2003, the number of people offered social services help increased. The private sector has grown more than other sectors, particularly with regard to nursing home care. The number of physically disabled people receiving home help services has also increased since 1998.

- Equipment services are vital to many disabled people, providing self-sufficiency, independence, dignity and self-esteem. Roughly four million people receive some help with equipment from the NHS or local authorities. A major report found that the organisation of equipment services was very inefficient and urged more integration between health and local government and a review of waiting times. Progress has been slow, however.

- A number of targets pertain to equipment services. An NHS and social care planning framework set a target that, by December 2004, all community equipment should be provided within seven working days. The NHS Plan set out an intention to achieve an integrated community equipment service by April 2004. Guidance in March 2001 set a target to increase the number of people benefiting from equipment services by 50% and to improve the quality of equipment. To meet this last target, additional funding of £105 million was provided and a national implementation team established.

- In Wales, problems were experienced in developing equipment services. In 2001/02, £2.25 million was spent on improving the infrastructure. A further £1.7 million was allocated to health authorities in 2002, primarily to purchase new technology hearing aids. In 2002, the improvement of these services was found to be patchy. Progress made in audiology and in community equipment services had not been matched by progress in mobility services.

- Research on blind or partially sighted people, most of whom are over the age of 60, suggests the existence of extensive poverty, significant care needs that are not being met and widespread social isolation.

- Service users and carers are becoming somewhat more involved in the planning of services, but choice remains constrained, with insufficient information about services and a lack of support to allow people to live independently.

8 People with learning disabilities

Policy context

- The NHS and Community Care Act 1990 again affected learning disability services, with its emphasis on living in ordinary accommodation with appropriate support, a mixed economy of provision and needs-based planning.
- The 2001 White Paper *Valuing People* called attention to a number of problems in learning disability services and set out objectives to achieve four key principles: legal and civil rights, independence, choice, and inclusion.
- A Learning Disability Development Fund was established in April 2002, as well as a fund to promote advocacy and information. In addition, a Learning Disability

Task Force and Implementation Support Team were created to monitor the implementation of the White Paper objectives.

- The Health and Social Care Act 2001 required the Department of Health to report on learning disability each year.

Needs

- There are three to four people with severe learning disabilities per 1,000 of the general population, and 10 per 1,000 people with mild learning disabilities, using estimates of people who are in touch with services. Higher rates are found when whole populations are screened, suggesting a proportion of 25-30 per 1,000 for people with mild learning disabilities. In absolute numbers, according to the 2001 White Paper, there were in England about 210,000 people with severe learning disabilities and about 1.2 million with mild or moderate disabilities.
- Prevalence is marginally higher in males, in younger people, in South Asian communities (severe learning disabilities) and in people who are relatively poorer or from adverse family backgrounds (mild learning disabilities). Consequently there are some variations in numbers across the country.
- The numbers are expected to grow because of increased life expectancy, the post-war baby boom and greater birth rates among minority ethnic groups with higher prevalence rates. A 1% annual growth in the number of people with severe learning disabilities is expected over the next 15 years.
- In Wales, the number of individuals on local authority registers of people with learning disabilities has grown by 27% since 1990 to reach 12,930 in 2003.
- There are many dimensions to the needs of people with learning disabilities, including the ability to control their own lives through empowerment, civil rights, 'normalisation' and inclusion. Attention is also being given to these individuals' need to make their own decisions, to their relationships and to various forms of abuse.
- This group of service users can also have a number of health needs, both general and specific, such as sensory impairment, physical disabilities, epilepsy, communication difficulties, autism spectrum disorders, challenging behaviour, mental health issues and dementia.

Funding

- Limited data are available on total learning disability expenditure, although this is being addressed by the Learning Disability Task Force.
- Expenditure in England on health and social care services for adults with learning disabilities in 1999/2000 was over £3 billion, of which £1.4 billion was on healthcare. Equivalent expenditure in Wales was £193 million, suggesting a higher level proportionately than in England.
- Spending has increased substantially, with a falling proportion represented by health, reflecting the policies of moving care from long-stay hospitals and shifting the balance of responsibility towards local authorities.
- Hospital and community health services for people with learning disabilities accounted for 5% of total NHS hospital and community health services' expenditure in England in 2001/02, varying by age groups (falling throughout an average individual's lifetime) as well as between individuals.

- Social services expenditure on adults with learning disabilities aged under 65 increased substantially (more than 2.3 times) in 1994/95-2002/03, partly due to the transfer to local government of responsibility for funding new placements. This money is increasingly spent on home care and supported and other accommodation services.
- Much expenditure extends beyond health and social services – for instance, on day activities for those living with their families or in other private households.
- There are striking expenditure variations, generally related to higher need (severe disability or challenging behaviour) as well as other factors, such as the numbers accommodated in one facility.
- Research suggests that higher costs are associated with better outcomes (in the well-being and quality of life of service users and carers), but the association is not straightforward.
- Take-up of direct payments has been very slow, with only 736 people with learning disabilities using them by September 2002. A development fund has been set up to promote wider use of direct payments, and attention is being given to setting up bank accounts for people with learning disabilities.

Resource inputs

- Estimates suggest that roughly 83,000 people are in the learning disability workforce, of whom three quarters are unqualified. There are major problems in recruitment and retention, limited training opportunities, and little workforce planning or involvement of service users and carers in planning. Multi-professional community teams have been in existence for some years.
- The 2001 White Paper was concerned to increase the help and support provided to carers. Some improvements include the establishment of the Learning Disability Helpline, carer grants for respite breaks, more support for carers who are from black and minority ethnic communities, and plans for older carers.
- Research suggests that carers are primarily women, often mothers, most of whom are happy to provide care, but some are either resigned or dissatisfied with the role. A significant minority experience stress, particularly where the emotional and behavioural needs of the person cared for are great. Many would value more health and social care support.

Services

- A strong commitment to providing a person-centred approach (under a variety of terms) has been expressed, but implementation has been patchy in practice with a tendency to redefine terms such as 'care management'. Person-centred planning (PCP) is a now a key component of policy, with an individualised approach to both assessment and planning, but its potential success may be compromised by organisational and funding constraints.
- There are no data on the use of PCP for people with learning disabilities or the numbers supported through care management, but it is known that only a minority receive an assessment and there are often long delays in the assessment process.
- There is a pressing need for a range of family support services, including respite and information provision, especially for carers from some minority ethnic communities.

Poverty can be a big problem here, particularly for families supporting people with high support needs.

- The number of people resident in long-stay NHS 'mental handicap' hospitals in England has fallen dramatically, from over 58,000 in 1969 to roughly 700 in 2004. Many of these individuals have great support needs.

- Although specific estimates vary, staffed residential care home provision has grown substantially over the past decade, with the creation of many small registered homes. Since the 1980s, the private and voluntary sectors have increased considerably and the proportion of homes owned by local authorities has fallen strikingly. Wide variations have been found in the quality and costs of facilities, and much of the accommodation is isolated from mainstream community life, as well as remote from residents' family homes.

- The number of people with learning disabilities supported in ordinary housing settings has grown, with around 2.6 people per 1,000 of the population aged 18 to 64 in England living in the community. The government's 'Supporting People' programme has achieved a great deal for those with mild-to-moderate learning disabilities, with plans to extend this to those with more complex needs.

- The number of places in both adult training centres and social education centres grew substantially from the late 1970s to the early 1990s, although some people lacked access to such places. The White Paper announced a programme to modernise day services, including greater emphasis on flexible services, choice, the development of social skills, enhancing employability and improving the community welcome to people with learning disabilities.

- A range of supported employment schemes help people with learning disabilities to find work. Most of these schemes are reliant on social services or health funding, and development remains patchy. In 2002/03, roughly 11% of people with learning disabilities known to local authorities had jobs.

- Poor targeting of services on needs is an issue for minority ethnic groups and for people with profound learning disabilities, challenging behaviour, sensory impairment, physical disability, autism, mental illness, or who have committed offences.

- Quality assurance was given much attention in the White Paper, especially the regulatory framework in the Care Standards Act 2000, evidence-based practice to be recommended by SCIE, local quality frameworks and clinical governance, user surveys and complaints procedures, the new Learning Disability Partnership Boards, the 'No Secrets' guidance to protect vulnerable adults from abuse and harm, better support for vulnerable witnesses, and guidance on the use of physical interventions.

Outcomes

- There is little evidence on the outcomes of PCP, but one study found that 'intensive' was more effective than 'standard' care management for people with mild learning disabilities (and psychosis) in terms of hospital days over a two-year period, cost and the number of unmet needs.

- Research on moves from long-stay hospitals has shown that, on most outcome measures, living in the community is preferable. A recent study found that supported community housing compared favourably with respect to the material environment, the resident-oriented milieu, staff attention, access to community

activities, opportunity for the use of skills, choice, the amount of constructive activity, and resident satisfaction with life.

- There is a lot of evidence on community-based accommodation and associated services and opportunities. Among these findings is that people living in community settings (especially in group homes) report greater satisfaction with their places of residence and with life in general than those living in hospital, as do their parents. Levels of satisfaction tend to be higher when people have more independence and privacy, are supported in activities, have more friends with learning disabilities and are more active in the community. But people with learning disabilities across all settings appear to have little influence over major life decisions.

- People moving from hospital to community-based settings can show some modest gains in adaptive skills that are likely to be maintained for a period, but may decline after some years. Changes in challenging behaviour are less clear.

- There are few differences in levels of friendships or contact with families between service models. Contact with friends appears uniformly low across all types of services. Compared to those in large homes, those in small group homes have larger social networks that include more people with no learning disabilities or who were not staff.

- Community participation is greater for people in dispersed housing compared to village communities or NHS campuses, and frequency and variety of such participation increases over time. Neighbours and local business people report few concerns about living next to or serving people with learning disabilities.

- Studies of the comprehensive costs of residential services have all reported marked variation within models. There are no clear differences between the comprehensive costs of community-based services and 'mental handicap' hospitals.

- There is a striking lack of evidence on many aspects of day services and supported employment, compounded by a lack of consensus on how to define outcomes. Users seem to like day centres, but also have many complaints about them. A person's level of ability appears to predict engagement in meaningful activities, with enormous variation. Success in developing wider relationships is quite limited. Rates of pay have improved and most people appear to gain, albeit modestly, from working.

- Limited research on supported employment suggests that the cost of running programmes exceeds the financial benefits for the taxpayer, although there are modest financial gains for those employed and other possible advantages.

- There is very little evidence on the effectiveness or cost-effectiveness of preventive services, and on mental health treatments for people with learning disabilities.

Choice

- Underpinning the White Paper proposals was the core objective of promoting independence, choice and control for people with learning disabilities, although with a recognition of the substantial difficulties of doing so.

- More local advocacy groups have been established, stimulated by some central government financial support, although not enough to satisfy the Learning Disability Task Force.

- There is some agreement about how to improve choice and control, including the need to broaden the range of accommodation and day and other services. Housing options are growing, albeit unevenly, and there are more supported employment

arrangements. Diversity will not guarantee choice if people lack information – and practice varies widely here – and the power to use that information.

9 Reflections

Reflections on social care changes – from institutional to community care

- Since the late 1980s, the balance of care for all service user groups covered in this report has shifted very significantly away from institutional forms of care towards community-based arrangements. This includes: more home care provision for older people; the closure of old psychiatric and 'mental handicap' hospitals; the greater use of foster placements for looked-after children; and independent living for people with physical disabilities.
- These major achievements are not always appreciated, as the nature of earlier provision is forgotten and concern with the privatisation of services has overtaken celebration of the extent of change.
- There have been many challenges associated with this shift in the balance of care, including:
  > the need to overcome perverse financial incentives (especially in transferring resources across agencies)
  > political commitment to higher costs in the short run to invest in new services and systems
  > developing more local models of care for people with high support needs
  > minimising the risks of adverse events, while maximising opportunities for independence
  > training the workforce to support people in more independent settings
  > offering flexibility in community services to widen the choices open to individuals who need support.

Greater diversity of provision

- There has been a growing diversity in services, along with a diversity of providers and a changing sectoral balance in provision, with many common trends across service areas. Developments include: intermediate care, supported employment schemes, PCP, intensive care management, crisis teams, early intervention services, new forms of day activity settings, and housing with care.
- Considerable attention is now being given to the financial fragility of many small providers – evidenced, for instance, by closures (and changes of ownership) of care homes for older people – with a growing awareness of the vulnerability of social care markets to external forces.

Attending to human resources issues

- Recruitment and retention of social care staff have long been challenges for the public and other sectors across service user groups, with growing local authority attention to such issues.
- A number of unmet training needs remain, such as communication with people with learning disabilities, managing challenging behaviour without recourse to

sedating medication (for all service user groups), supporting people to take up direct payments, and using assessments to develop arrangements for users responsive to their needs.

- A basic, pervasive and persistent recruitment problem is the level of pay relative to responsibility – for instance, for home care workers.
- Over the past decade or so, increasing attention has been paid to the needs of unpaid carers, with greater awareness of the often-negative impact of caring responsibilities, although research in this field is uneven in its coverage. Information on volunteer workers is scarce.

Matching needs and priorities to services

- Services appear to be becoming more responsive to individual needs, with improvements across service user groups, although progress has been slower in practice than it appears in policy.
- The explicit targeting of services on those with greatest need has been successful in the case of older people, but less widely achieved for other service user groups. The impact of such targeting on people who are no longer able to access state-funded services is, however, unclear and may be undermining potentially valuable preventive activity (although there is growing attention to the need for preventive services).
- People from black and minority ethnic communities are less well served than people from the white majority, across all service user groups.
- A feature of policy discussion across service user groups has been some rethinking of the concept of 'need', with a greater accentuation of the positives (promoting independence, choice and control) and less of the negatives (overcoming 'problems', compensating for deficits, reducing 'shortfalls').

Supporting independence and promoting choice

- The promotion of choice is a central plank of much current public policy – interpreted in this context to include user participation, independence and empowerment – although lack of service diversity (and sometimes a basic lack of services) can limit the choices available. This raises questions about the need for margins of spare capacity and a political willingness to allow services to operate at less than full capacity.
- It remains unclear whether choice leads to improvements in service quality (through the exercise of consumer pressure) or to improvements in user outcomes, as much activity appears to be driven by the process rather than by outcomes. Attention to the use of direct payments may provide useful insights here.

Better inter-agency working

- Important new alliances have been created across agency boundaries, differing to some extent by service user group, with joint planning, commissioning, team working and provision all becoming more commonplace. These arrangements seem to work best where they are seen as a means to an end, with a clarity of shared purpose and governance, when there are efforts to develop a common culture, explicit agreement about risk and resource sharing, attention to staff development, and agreement about the yardsticks for success.

- Professional and organisational cultural barriers are still widespread, however, and the new budget flexibility powers are still rarely used. There are particular problems at points of transition, such as the moving of children to adult services, the discharging of elderly people from hospital, the transferring of people to new areas or at times of crisis, as well as when services themselves change, as in the closure of care homes.

Developments in funding and expenditure flows

- Expenditure on social care has grown in real terms over the period of this review. However, some of the growth is the result of a redirection of money previously reaching services through social security channels, and some represents substitution for health service expenditure.
- It is difficult to know the overall scale of the funding change, however, as existing statistics do not make it possible to paint a comprehensive picture of funding patterns and trends in the increasingly complicated mixed economy of social care.
- Whether apparent recent rates of growth will be maintained is debateable. In the July 2004 spending review, it was announced that social services expenditure would be expected to rise by less than 3% each year over three years, with most of the growth to be in 2005/06 and little in the subsequent two years. Local government efficiency savings of 2.5% per year could mean almost no real increase in social care spending.

Overall reflections on service changes

- The SSI and Audit Commission reviews argue that there is evidence of steady improvement in social care services, with services well regarded by users, but that a gap remains between the best and worst councils as well as between the intentions of providers and the experiences of users. They also argue that spending and performance are unrelated, although this deserves further investigation.
- Nonetheless, there is no room for complacency, given evidence that user satisfaction levels are not improving, that outcomes for looked-after children still lag markedly behind the rest of the population and that their numbers continue to grow. Major service gaps remain (notably for children with disabilities and mental health needs, older people with mental health problems, and carers). The availability of independent living and rehabilitation opportunities varies greatly; few users are able to choose to manage their own care; workforce problems adversely affect users' experience; and financial crises continue to destabilise social services.

Reflections on managerial capacity

- Social care has been a fast moving field over the past 15 years, generating many management challenges.
- Many improvements can be seen in relation to financial management. There is more long-term planning of budgets, better linking of activity and finance, a greater understanding of what things cost, better appreciation and realisation of potential efficiency savings, and a more transparently comparative and competitive approach to decision making. On the other hand, some authorities have overspent their budgets, resulting in damaging short-term expediency.
- Lack of management capacity could threaten the achievement of planning targets.

Inspections have drawn attention to limitations in the assessment and management of quality and service performance. Eligibility criteria are not consistently applied. However, over time there were improvements.

- Market management capabilities have also improved but are still being questioned. There is still mistrust and misunderstanding of independent sector providers in some localities, leading to unimaginative, sometimes aggressive; commissioning. Overall, however, there was more intelligent commissioning of services.

- Partnerships are growing by the month. Structural change of this kind is not sufficient on its own to bring about improvements: there needs to be development of shared values and a common culture, plus involvement of staff and users. Partnership must be seen as a means to an end rather than an end in itself.

- An overall assessment of managerial capacity and achievement would need to bear in mind the many management challenges that now have to be faced. This is a fast moving field, with many new responsibilities alongside growing expectations. Public scrutiny of personal social services continues to grow. Other challenges can include growing 'external' markets, uncertain local political contexts, low investment in management information systems, partnership working, users' and carers' involvement in decision-making, and the need to ensure service flexibility in response to changing needs and preferences.

Reflections on the quality of the evidence

- The SSI and Audit Commission Reviews team state that there has been improvement in the local use of the data mentioned above. They note that this is most common where councils:
  > are evidence-driven
  > involve frontline staff in constructing indicators and reporting systems
  > take a wider view in analysing and interpreting data
  > use activity, cost and quality measures
  > give feedback to staff and partners
  > put information in the public domain
  > strive to improve the quality, relevance and accuracy of information.

- The quality of some locally generated and employed information has been questioned on the basis of the research methods used. There may be concern about decisions taken on the strength of inadequate evidence.

- Evidence from inspections and audits by central government or agencies may have a considerable impact on local decision makers and perhaps national ones, but its quality is very mixed. Coverage of the evidence from these sources is generally good, inasmuch as it tends to be drawn from a fairly wide sample of localities, collected from a number of different people and focused on most elements in the organisation and delivery of care (funding levels, resource inputs, services, individual packages of care and, sometimes, service user satisfaction).

- Yet such evidence rarely provides much information on the impact of social care on final outcomes for service users and their families with respect to their overall needs. Instead, much of it concerns indicators of 'intermediate output' – for instance, delays in receiving equipment.

- User satisfaction surveys are not a sufficient measure of success. There are numerous methodological questions to be asked of such data. Moreover, such evidence is limited by the context within which local social care systems operate,

with insufficient attention given to local resource market prices and needs, including levels of deprivation, population movements and demographic factors.

- The Department of Health's assessments of aggregate performance via routinely collected statistical indicators also contribute to the pool of evidence. However, these performance indicators do not measure the impact of services on service users or carers. It has also been suggested that they do not necessarily relate well to performance and may embody perverse incentives.

- Outcome measurement requires assessment of change over time, comparing one service situation with another. The key question – the association between the activities measured by performance indicators and the effectiveness (or cost-effectiveness) for service users – remains largely unanswered.

- The evidence coming from research studies reviewed was found to be good in parts, occasionally excellent, but with too many studies poorly designed, executed and interpreted. Generally, there is limited evidence of robust quality on most key policy questions in social care, although some service user areas appear to be better researched than others.

- Too many *quantitative* studies collect data that are not demonstrably valid or reliable, from atypical groups of service users living in localities not clearly representative. Data were often analysed with insufficient rigour. In addition, *qualitative* research designs were often faulty, with methods not described, a lack of clarity about the generalisability of the information and poor analysis. Interpretations of both forms of evidence often seemed partial.

- A major problem in this area is the antipathy of social care researchers towards the approaches to evaluation and the evidence-based practice commonly accepted in health research and an unwillingness to engage in multi-disciplinary research.

- The fundamental problem with all sources of evidence is the generalisability of the information.