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Ideas that change health and care

Social care 360

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www.kingsfund.org.uk/social-care-360

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Introduction

This Social care 360 review for the year 2018/19 outlines the state of the sector before the Covid-19 (coronavirus) pandemic struck.

The review outlines and analyses 20 key trends in adult social care in England. It draws on data that is:

- publicly available
- published at least annually
- comprehensive (or, at the very least, a representative sample)
- from a reliable source.

It takes a broad perspective – a '360 degree' – view of the sector.

A fragile sector

The data shows us that the social care sector had been fragile for several years and that the unprecedented challenges for the sector in responding to Covid-19 started from this unsteady foundation.

The data shows that spending by councils on social care has risen since the low of 2014/15 (though in real terms it remains below the 2010/11 level). Much of that money has been spent on trying to shore up a fragile provider market, with a consistent, above-inflation increase in the fees paid for residential, nursing and home care. While overall expenditure by councils on social care is now £942 million more in real terms than in 2015/16 (*see* indicator 6), spending on commissioned services from external providers has risen by £1.4 billion.

However, this spending has had only limited impact: local authorities continue to report companies handing back contracts or going out of business, and service users report difficulties in finding the care they need. And while some of the extra money has been used to provide a welcome boost to care workers' pay, this has not stopped vacancies from rising. Tackling these problems will be at least as important a challenge after the coronavirus epidemic as it was before.

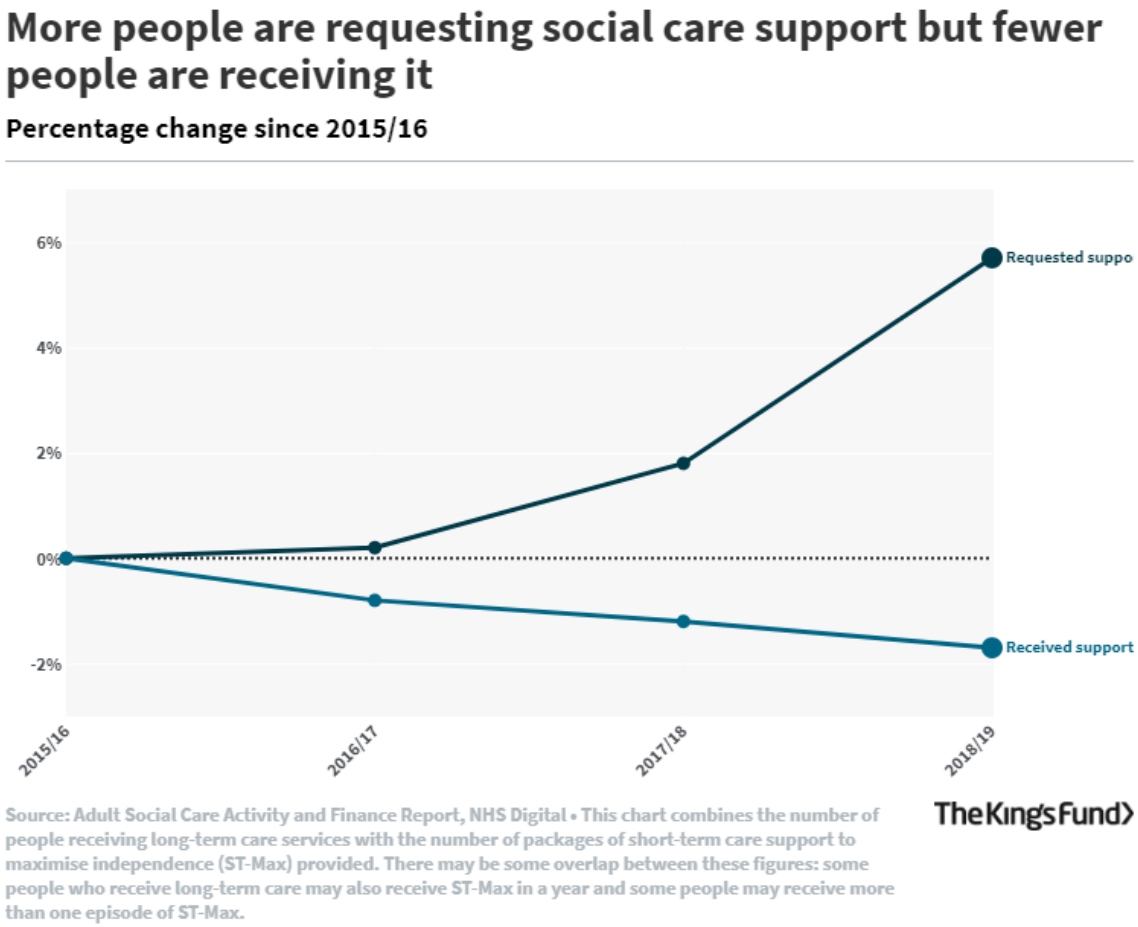
As well as shining a harsh light on the fragility of the sector, the epidemic is already causing changes to the delivery of social care and its connections to other services, most obviously the NHS. It will certainly have effects – even if short term – on some of the key indicators in this report, such as requests for support, receipt of care, expenditure, and on specific measures such as delayed transfer of care from hospital. Some of next year's indicators may therefore look quite different from this year's.

However, alongside understanding these, it will also be important to remember some of the key longer-term trends in social care that reform will need to address. These may not have been as obvious during the Covid-19 crisis.

Key longer-term trends

Fewer people are receiving publicly funded care…

A key trend in adult social care continues to be an increase in demand for care (*see* indicator 1) but a fall in the numbers of people accessing it (*see* indicator 2). Since 2015/16, local authorities have received over 100,000 more requests for social care support (a 5.7 per cent increase) but more than 18,000 fewer people[1] have received it (a 1.7 per cent decrease).



[1] This figure combines the number of people receiving long-term support and the number of packages of short-term support to maximise independence (ST-Max). There will be some overlap between these two numbers because some people receive both types of support in a year and some people receive more than one package of short-term support. Nonetheless, it is the best available figure of overall care system output. have received it (a 1.7 per cent decrease).

...but there is a big difference between age groups

The overall picture obscures a big difference between the numbers of under-65s and over-65s receiving care. More working-age adults (under-65s) are getting support, but that increase is wiped out by a much larger fall in the number of older people (over-65s) getting support. Increasing demand for care from working-age adults does not just raise questions about meeting need but also challenges many people's assumptions that the pressures on adult social care are simply the result of an ageing population. It also raises questions about the models of care we want, the type of system we may need in future, and how we should fund it.

There is a shift from long-term to short-term support

The type of care being received is also changing, in that more people are receiving short-term care and fewer are receiving long-term care. This is seen most obviously in long-term care packages for older people, which have fallen by 7 per cent since 2015/16, while short-term care packages designed to maximise independence (ST-Max) have increased by 2 per cent. This trend can also be seen in provision of NHS Continuing Healthcare, where the numbers receiving short-term 'fast track' care have increased by 40 per cent but the numbers receiving standard, long-term care have fallen by 16 per cent. Short-term care can be the most appropriate form: in social care, it may involve helping people get back on their feet rather than going into long-term care. But it is not clear whether this is really what is driving the shift or whether other factors – including service availability and funding – are playing more of a role.

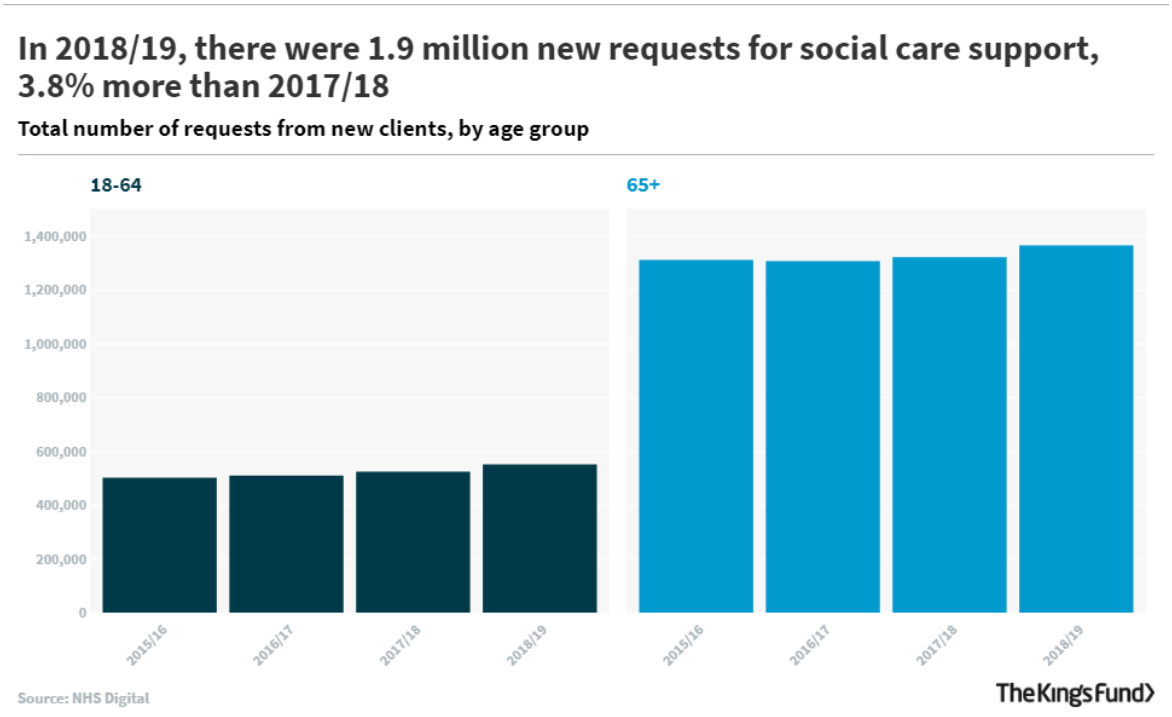
There remain too many knowledge gaps to explain all these trends

There are too many gaps in our knowledge to paint a full picture of trends in adult social care. We can identify those gaps even if we cannot yet fill them. A critical gap concerns data about self-funders, where in most cases we are reliant on estimates of service use, expenditure and satisfaction. An even more fundamental gap, however, concerns the outcomes of receiving care; we know far too little about the impact of using adult social care services on the lives of those accessing care, their families, and on the wider health and care system. A further issue is local variation: here, we have the data but remain largely in the dark about the reasons for the differences it reveals. Addressing these gaps should be a fundamental part of the wider reform of social care.

Access

1 More adults are asking for help

The number and rate of requests for support – from both working age adults and those over-65 – has increased



There were more than 70,000 new requests for support in 2018/19, a 3.8 per cent increase, bringing the total to more than 1.9 million requests.

Why are there more requests for support than people requesting it?

The number of requests for support is not the same as the number of people requesting support since there are, on average, 1.4 requests per person. The 1.9 million new requests therefore came from 1.3 million people, and the increase in requests during 2018/19 was from around 50,000 people.

Some of this increase can be explained by a growing population. Between 2017/18 and 2018/19 alone, the working-age population of England (those aged 18–64) grew by more than 121,000 (0.4 per cent) while the number of older adults (those aged 65 and over) increased by nearly 150,000 (1.5 per

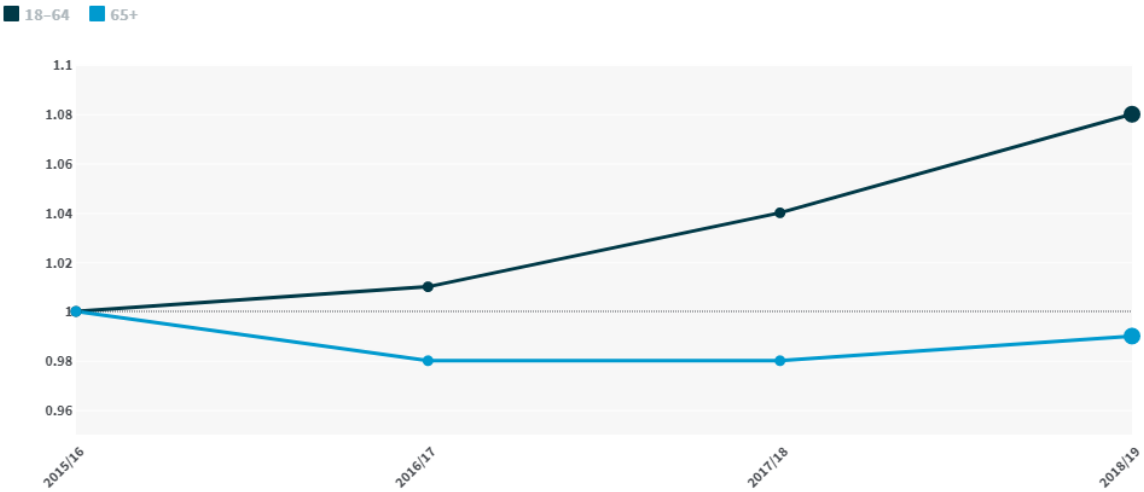
cent). On average, therefore, local authorities had around 800 more working-age adults and 1,000 more older adults in their populations than the previous year.

Of the 70,610 additional requests, more than 44,000 were from older people – an increase of 3.3 per cent over the previous year. There was a bigger percentage increase in requests from working-age adults – 5.1 per cent – continuing a trend seen since 2015/16. However, because fewer working-age adults ask for help than older people, the number of new requests (26,515) was smaller.

However, population growth alone does not explain the increase in requests because there was also an increase in the 'rate of requests' – ie, the number per 100,000 of the relevant, age-banded part of the population.

The rate of requests for social care from working-age adults has risen but remained relatively static for older people

Requests for support per 100,000 population, indexed to 2015/16(value in 2015/16 = 1)



Source: NHS Digital

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One reason for this might be increased need, particularly among working-age adults. Medical advances mean that more children and young people are surviving into adulthood and beyond with complex, lifelong conditions that may nonetheless require ongoing social care support. There is also evidence that more working-age adults are reporting mental health conditions (*see* indicator 4).

There was also very significant local variation in the number of requests for support. Even taking into account size of population, the 10 local authorities with the most requests from working-age adults on average recorded more than 12 times the number of requests than the 10 local authorities with the fewest. For older people, the figure is 6 times more. There is no simple explanation for this; there are likely to be many reasons, from levels of deprivation to administrative differences in contact-handling and recording practice.

Most requests for support (77 per cent) came from people in the community, with only 22 per cent originating in diversion or discharge from hospital. This is an important rider to the national debate about care, which often focuses on the need for care services to support hospitals to discharge people more quickly. Inability to do this leads to 'delayed transfer of care' (*see* indicator 17).

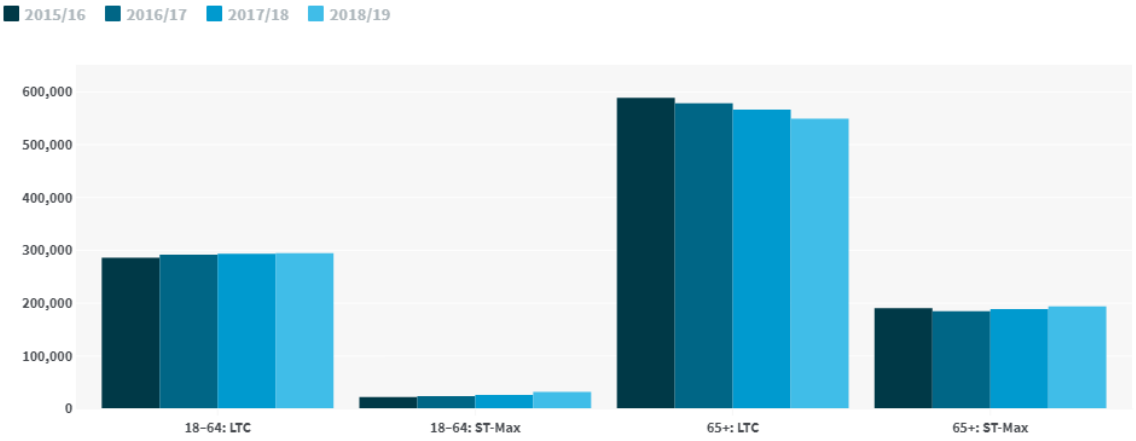
The remaining one percent of requests for support came from prisons and from people who had been paying for their own care, typically in care homes, but ran out of savings and approached local authorities for support. This is a relatively small but increasing number (5,385 people in 2018/19, up from 3,905 in 2017/18) and a potentially challenging issue, since local authorities may not be able to pay the same rates for care as some self-funders will have been paying. In these instances, providing there has been a proper assessment of need, the care home may have to reduce its fees, families may have to top up the rate the person has been paying, or the person may have to move to a cheaper care home.

2 Overall, fewer people are receiving support

Fewer older people – but more working-age adults – are receiving publicly-funded care

Packages of short-term care to maximise independence (ST-Max) have increased, while the numbers receiving long-term care (LTC) have remained static (working-age adults) or fallen (older adults)

Numbers of ST-Max packages provided and numbers of people receiving long-term support



Source: Adult Social Care Activity and Finance Report, NHS Digital • ST-max is a subset of short term care that refers to short term support to maximise independence, as opposed to other short term support

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Although more working-age adults and older people requested support in 2018/19 (*see* indicator 1), only the former actually received more support. In total, around 12,500 fewer older people received support, compared to around 5,500 more working-age adults.

What is long-term care?

Long-term care is any ongoing service or support provided by a local authority to a person to maintain quality of life. It is provided after a formal assessment and is subject to regular review.

What is short-term care to maximise independence (ST-Max)?

Short-term care is an episode of time-limited support – for example, reablement (*see* indicator 18) – intended to reduce or eliminate the need for ongoing support. The numbers for ST-Max refer to the numbers of packages of support provided and there are an average of 1.2 completed episodes of ST-Max per person during the year.

The key trend was a continuing fall in the number of older people receiving long-term care – down nearly 17,000 (3 per cent) – bringing the total fall to 7 per cent since 2015/16. In that year, more than 587,000 older people were receiving formal long-term care, but by 2018/19, this had fallen to less than 550,000, despite an increase in the older population of nearly 468,000 over that period. For every 100,000 older people, there has been a fall of 662 people receiving long-term support since 2015/16. There were however just over 5,000 more packages of ST-Max delivered to older people in 2018/19.

The trend for working-age adults is different: just over 1,000 more received long-term care in 2018/19 – essentially unchanged as a percentage – but just over 5,000 more packages of ST-Max, up 22 per cent. Compared to 2015/16, the change among this age group is even more notable: long-term care has increased by 3 per cent but ST-Max has increased by 44 per cent, albeit from a very low base.

These different trends for older people and working-age adults may reflect differing trends in underlying disability (*see* indicator 4). They may also reflect changes in the financial eligibility criteria (*see* indicator 3), which are likely to affect older people more than working-age adults. But there is one other factor that is likely to be contributing significantly to these trends: faced with continued pressure on expenditure (*see* indicator 6), local authorities are having to restrict their services to those with the greatest need. In addition, many councils are citing the adoption of asset-based and self-help approaches (*see* below), which can involve less uptake of formal services and greater use of the voluntary and community sector. However, it is currently impossible to measure how extensive – or indeed effective – such approaches are in practice, and there are concerns that the voluntary and community sector may not have the capacity to provide support in all areas.

How do asset-based approaches work?

Asset-based approaches aim to signpost people to less formal types of support, often provided by the voluntary and community sector, while strength-based approaches aim to support an individual's independence, resilience and ability to make choices. The two terms are often used interchangeably.

The increase in short-term care to maximise independence may also reflect an increased focus on some types of preventive approaches by local authorities. Certainly, many local authorities have indicated that this was a feature of

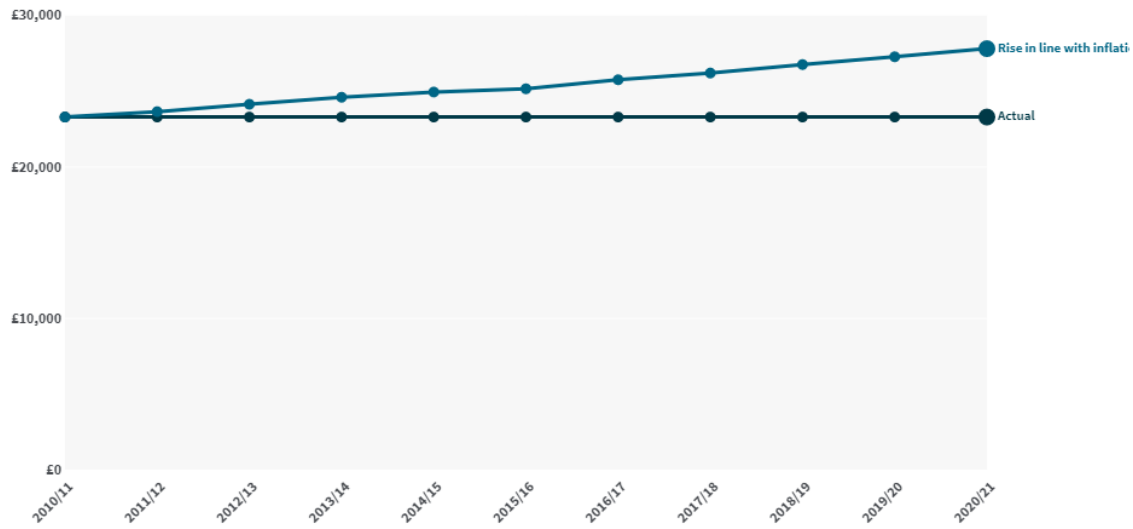
their plans to cope with budget restrictions, while also noting the tension between meeting their statutory duties and investing in such services.

An apparent paradox is that the overall number of long-term care packages has declined, yet in 2018/19, spending on long-term care actually increased by £674 million (4.8 per cent). One explanation for this is costs: the fees that local authorities pay for residential, nursing and home care have been rising more quickly than inflation, as councils try to shore up a fragile provider market (*see* indicator 7). Also, use of the most expensive element of residential care (for working-age adults) has increased while the less costly element (for older people) has fallen. Finally, this data only captures the number of care packages being provided, not their intensity or complexity, and it may be that these aspects have changed in response to increased need of those receiving care.

3 The means test has got even meaner

The freezing of financial thresholds has excluded more people from publicly funded social care

If the social care means test threshold had kept pace with inflation it would have been nearly £3,500 higher in 2018/19



Source: Local Authority Circular • GDP deflators at March 2020 used from HMT

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Unlike the NHS, social care services are means tested (*see* below): only people with low levels of savings and other assets are entitled to publicly funded services. Since 2010/11, central government has not increased the means test thresholds to take account of inflation; if it had, the upper

threshold would have been nearly £3,500 more (at £26,711) in 2018/19 than it actually was. The freeze in the threshold has been maintained up to and including 2020/21, so by 31 March 2021, the gap will have risen even further to more than £4,500.

The £23,250 limit in England is different from that in other UK nations. Scotland has increased its upper threshold to £28,000 and Wales has increased its threshold to £50,000 for residential care.

How does the means test work?

Financial assets are typically people's savings and – if a person is moving into a care home – their property. The means test sets two important cut-off points ('thresholds') for these assets.

The lower threshold – currently £14,250 – is the point below which an individual does not have to contribute anything towards their care from their assets (though will most likely still have to contribute to the costs of their care from their income).

The upper threshold – currently £23,250 – is the point above which an individual will have to fund all their social care costs.

Between these two thresholds, individuals have to contribute on a sliding scale using a formula which assumes that individuals have £1 of income for every £250 of assets.

For more information on the financial assessment, *see* the Age UK website.

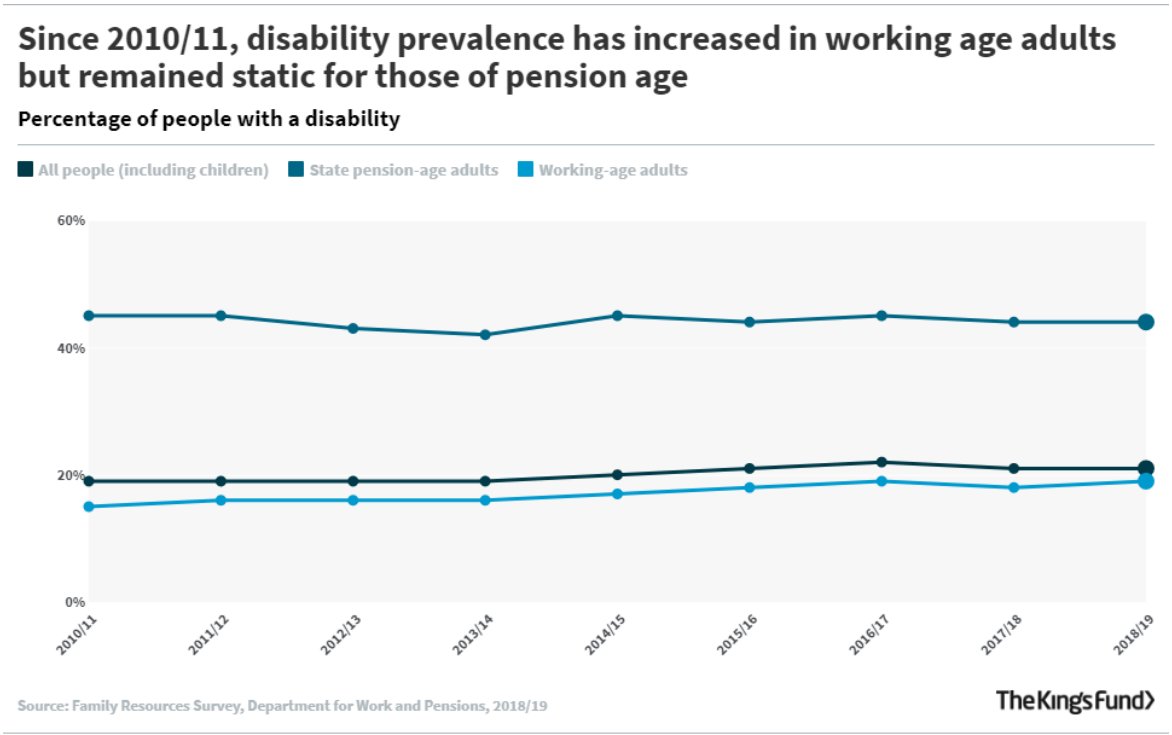
So in England, people who had assets in 2018/19 of between £23,250 and £26,711 had effectively lost their entitlement to publicly funded social care support, compared to 2010/11, and by the end of March 2021, those with assets of up to £27,759 will have done so. They will have to pay for their care themselves, rely on informal care from friends and family, or go without. This is likely to affect older people more than working-age adults, as they have had more lifetime opportunity to build up the level of savings or property that would put them above the threshold.

Working-age adults may be affected by the similar failure to raise the minimum income guarantee - the amount of weekly income with which home care users must be left after local authorities have charged them for social

care services. It has not increased since 2015 and, to make matters worse, many local authorities who used to apply a more generous income guarantee than was legally necessary are now reducing it to the statutory minimum.

4 Reported levels of disability have changed little

Overall levels of disability have stayed flat, though there has been a small rise in working-age disability



*Note: From 2012/13 disabled people have been identified as those who report any physical or mental health condition or illness that lasts or is expected to last 12 months or more, and which limits their ability to carry out day-to-day activities. This is consistent with the 2010 Equality Act. Figures from 2004/05 to 2011/12 are based on those reporting barriers across nine areas of life. In April 2018, the State Pension age was over 64 years 5 months for women and 65 years for men. On 6 March 2019, the State Pension age for both men and women increased to over 65 years 2 months. The State Pension age for both men and women will continue to increase at the same rate, reaching 66 by October 2020.

The level of disability in the population is a good indicator of the need for social care. The Family Resources Survey asks 19,000 households[2] about levels of disability (defined very broadly as a long-term physical or mental health condition or illness which limits ability to carry out day-to-day activities). It suggests that the level of disability stayed the same in 2018/19 as in 2017/18 and remains broadly the same as in 2010/11. However, there are important differences in trends between older people and working-age adults, which are mirrored in benefit receipt (*see* indicator 5).

In 2018/19, the Family Resources Survey found that 44 per cent of pension-age adults[3] reported a disability, unchanged from 2017/18 and similar to the 2010/11 level (45 per cent). However, the percentage of working-age adults reporting disability rose slightly in 2018/19 to 19 per cent, compared to 15 per cent in 2011/12.

Types of disability may be changing. In each of the three years to 2018/19, mobility was the most common impairment reported but this has fallen slightly from 51 per cent in 2016/17 to 48 per cent in 2018/19. The proportion of people reporting a mental health impairment increased from 24 per cent in 2016/17 to 27 per cent.

This rise in disability among working-age adults may help explain concerns expressed by the Association of Directors of Adult Social Services (ADASS): 39 per cent are most concerned about financial pressures arising from working-age adults, while 51 per cent are equally concerned about the pressures on services from working-age adults and older people.

The smaller Health Survey for England finds that the overall prevalence of disability among over-65s in England (it does not measure need among under-65s) has fallen in recent years, though it rose slightly in 2018/19. The percentage of over-65s needing help with at least one activity of daily living – for example, washing or dressing – has fallen from 32 per cent in 2011 to 27 per cent in 2018.

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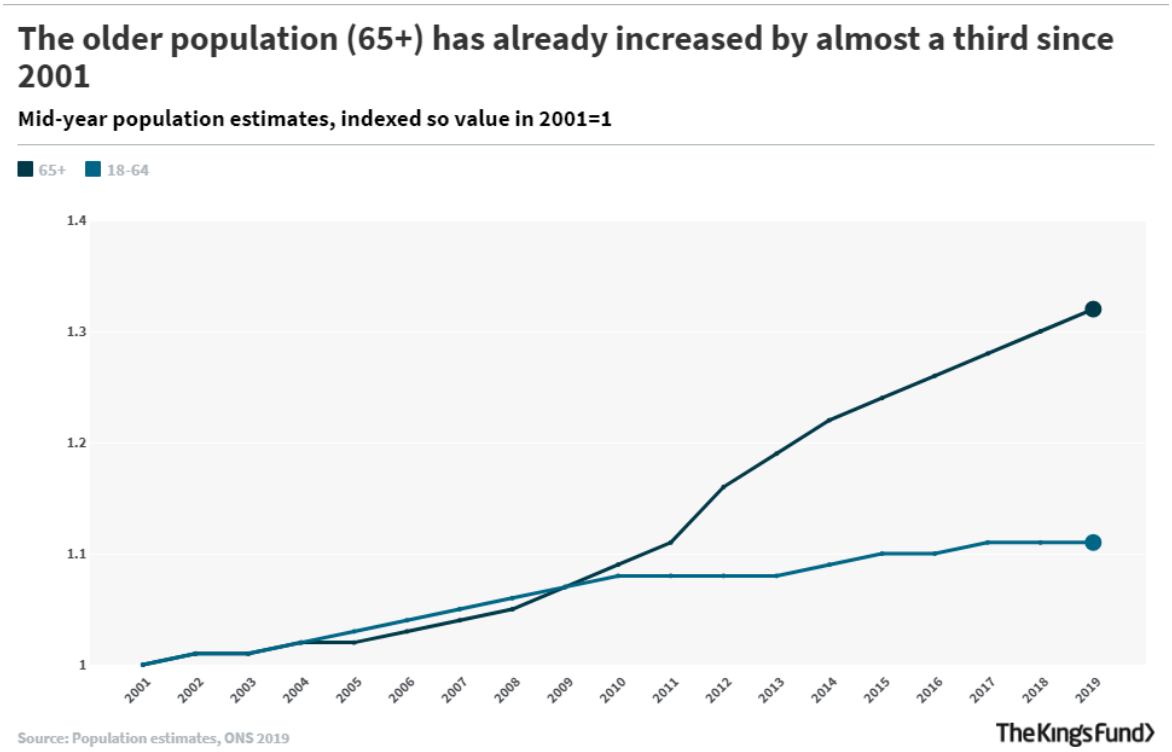
2 Unlike the other indicators in this review, the Family Resources Survey data is for the UK as a whole, not just England.

3 The survey notes that the state pension age for women has been gradually increasing since 2010, though the age for men has remained the same.

The Health Survey for England does, however, find that levels of unmet need remain significant: among those who needed help, 24 per cent did not receive any, compared to 26 per cent in 2011. Furthermore, the measure of unmet need used by the survey does not capture those who say they receive some support but not enough. Age UK has alternative, higher, estimates of unmet need, using the English Longitudinal Study of Ageing.

Reported disability is not an exact proxy for the numbers of people entitled to state-provided social care which, in practice, sets the barrier for receiving help quite high. Nor is disability and need necessarily the same across all age cohorts of older people.

And, of course, the number of people with a disability depends not just on the prevalence of disability but also on the size of the population. The older population has been rising, which will increase the number of people with a disability. The rate of population growth in England is shown in the graph below.

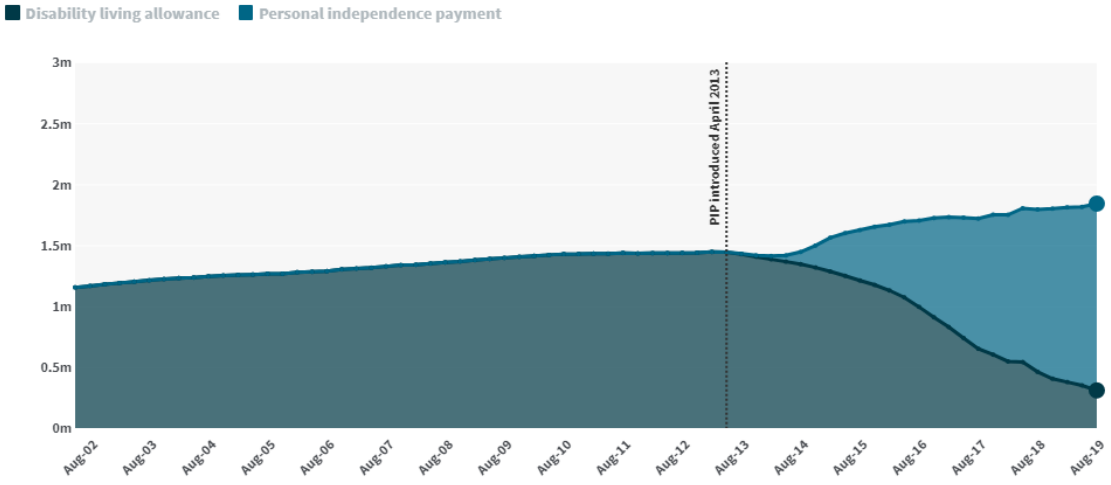


5 More people are receiving disability benefits

More working-age adults are claiming disability benefits but among older people the number of claimants is flat

There has been a steady rise in the number of working age adults (18–64) claiming a disability benefit

Number of claims in payment



Source: Stat-Xplore, DWP • Personal independence payments (PIP) were introduced in April 2013 and will gradually replace Disability living allowance (DLA)

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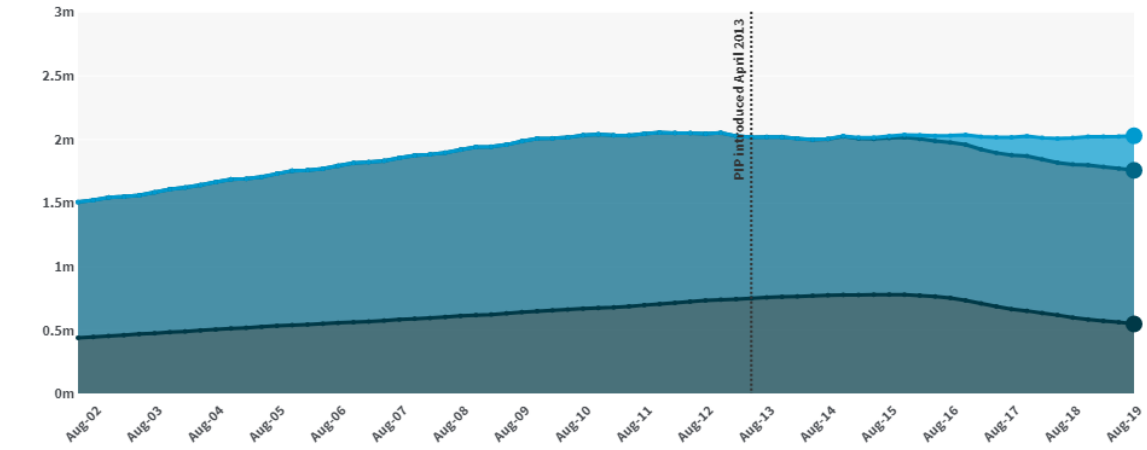
The number of older adults (65+) claiming a disability benefit has remained static in recent years, despite a growth in the older adult population

Number of claims in payment



Source: Stat-Xplore, DWP • Personal Independence Payments (PIP) were introduced in April 2013 and will gradually replace Disability Living

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The number of people claiming disability benefits such as Disability Living Allowance (DLA), Personal Independence Payment (PIP) and Attendance Allowance should be a useful indicator of the rate of disability in the population and therefore of the need for social care (though it can also, of course, be influenced by other factors such as changes to eligibility criteria).

Just over 2 million older adults and 1.8 million working-age adults[4] were receiving disability benefits in August 2019. As with other indicators, there are significant differences between working-age adults and older people in terms of uptake. A greater proportion of working-age adults are now receiving disability benefits than in 2002, and the upturn has been greatest since the DLA was replaced by PIP in April 2013. This growth is consistent with the increasing proportion of working-age adults reporting disability in the Family Resources Survey (*see* indicator 4).

The number of older people receiving disability benefits has remained broadly static, despite a large rise in that population group. The Office for Budget Responsibility also notes that the proportion of pension-age adults receiving disability benefits peaked at 26.8 per cent in 2009/10 and has since declined by more than enough to offset the effect of the rising pension-age population on the caseload.

This trend could be explained by a reduction in the prevalence of disability, as suggested by the Health Survey for England. However, it might also reflect other factors such as awareness of entitlement to benefits.

What are the differences between the social care support system and the disability benefits system?

There are important similarities as well as differences between the social care support system and the disability benefits system. Disability benefits are intended to pay for additional costs of everyday life for someone with an illness, disability or mental health condition, rather than specifically for their statutory care needs, which are assessed, paid for and administered separately by local authorities.

[4] In November 2018 the state pension age started to rise for men and women and the upper age for claiming PIP rose in line with this. Disability benefit receipts from May 2019 onwards are therefore for people who have reached state pension age rather than 65 years of age.

Unlike social care support, disability benefits are not means tested. However, local authorities can take some income from disability benefits into account when carrying out their means test for social care. In practice, therefore, some disability benefit income moves from individuals to local authorities to pay for care and support.

The level of need required to qualify for disability benefits is lower than that for receiving social care support from local authorities – people who do not qualify for social care support can receive disability benefits. Similarities between the two systems had become stronger in recent years because the trend had been for social care to be provided in the form of direct payments – a cash sum, like a disability benefit. However, this trend has now stalled (*see* indicator 15).

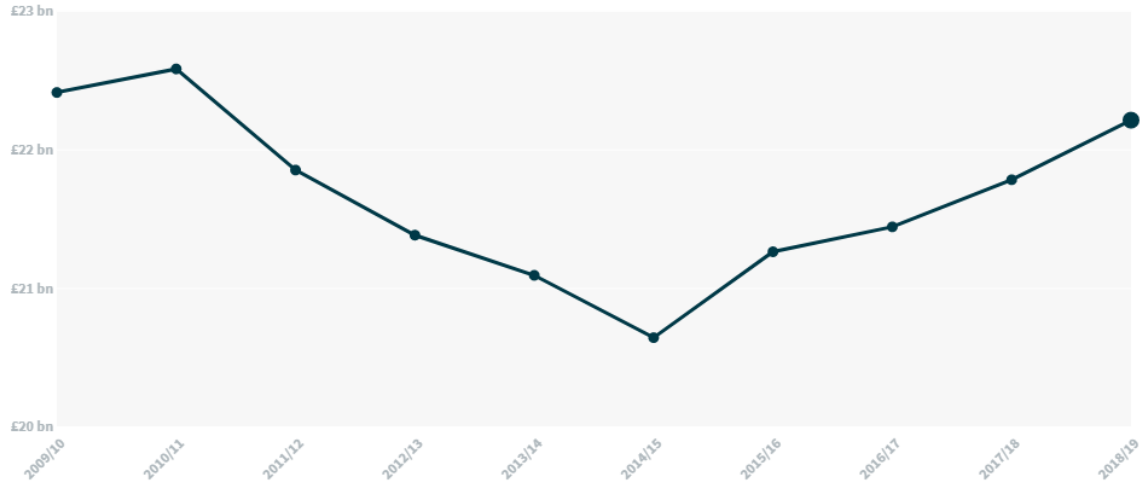
Expenditure

6 Spending is still not back to the level of 2010/11

Spending on social care is increasing but remains lower than it was nearly a decade ago

While spending on adult social care has risen, it is still nearly £0.4 billion below the 2010/11 level

Yearly total expenditure, adjusted to 2018/19 prices



Source: NHS Digital • GDP deflators at March 2020 used from HMT. 'Total expenditure' on social care includes spending that derives from three main sources – money which councils allocate to social care from their central budget (including money they raise from the additional 'social care precept' on council tax), income from social care service users (through fees and charges) and income from the NHS.

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In 2018/19, total expenditure on social care by councils was £22.2 billion, a real-terms increase of £426 million (2 per cent). This continues the trend of more spending on social care, which started in 2015/16, after council expenditure hit rock bottom in 2014/15. However, the current level of expenditure is still below the 2010/11 level, and it does not reflect the increases in population and levels of demand explored in indicator 1.

Nor have cuts in social care been evenly distributed: between 2010/11 and 2017/18, the 30 councils with the highest levels of deprivation cut services by 17 per cent per person, compared to cuts of 3 per cent per person in the 30 least-deprived areas.

How is social care spending decided?

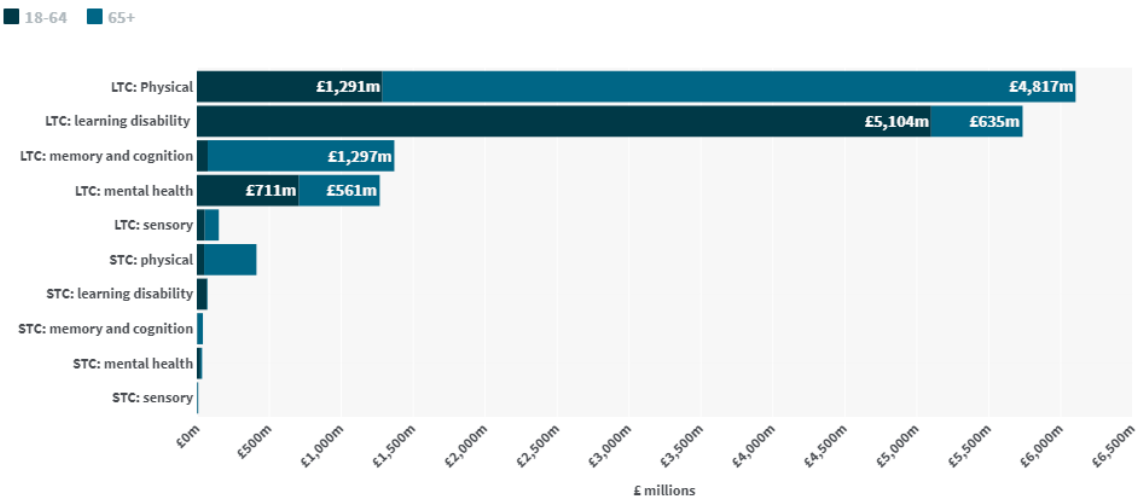
Spending on adult social care is decided, individually, by 152 local authorities. There is no national social care budget, though the amount available to spend locally is affected by national government decisions on the formula underpinning local government finance.

'Total expenditure' on social care includes local authority spending that derives from three main sources: money that councils allocate to social care from their central budget (including money they raise from the additional 'social care precept' on council tax); income from social care service users (through fees and charges); and income from the NHS.

However, to understand what types of services the money is being spent on, we have to use a different measure – gross current expenditure – which excludes income from the NHS. This reduces total council expenditure on social care to £18.7 billion.

£14.6 billion is spent on long-term care, with nearly £10 billion on two areas: learning disability support for working age adults and physical support for older people

Expenditure by primary support reason for long-term care (LTC) and short-term care (STC) (£millions)



Source: NHS Digital

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Of that £18.7 billion, most (£14.6 billion) is spent on long-term care, split almost equally between working-age adults and older people. Short-term care accounts for £580 million, with the remainder spent on a broad range of services, including support for carers, information and prevention, assistive

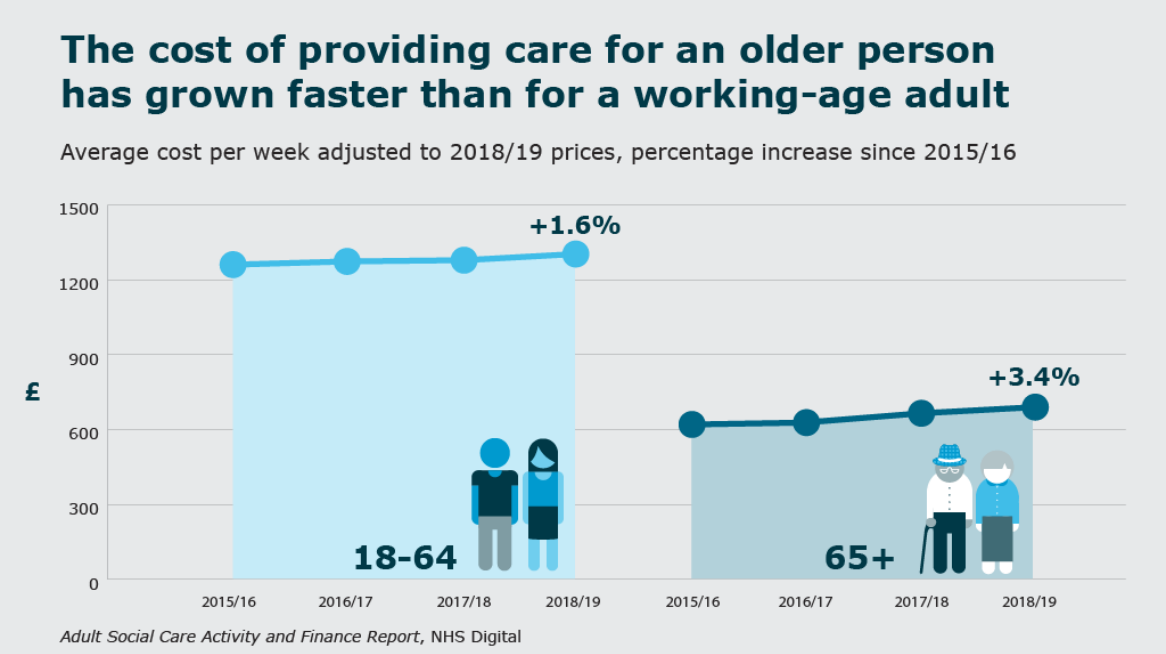
technology, support for social isolation, and the costs of commissioning and service delivery.

More money – £5.2 billion – is spent on support for working-age adults with a learning disability as on physical support for older people. Other large sums are spent on physical support for working-age adults (£1.3 billion), support with memory and cognition for older people (£1.3 billion), and mental health support for both age groups (again, £1.3 billion, of which nearly £750 million is spent on working-age adults).

It is important to note that this is purely council spending on social care. None of the expenditure data includes private spending on care, for which – as the Office for Statistics Regulation noted in its 2020 report – there are no reliable estimates of trends (though the National Audit Office estimated the total size of the self-funder market at £10.9 billion in 2016/17). There is also significant expenditure on disability through the benefits system, which was covered in indicator 5.

7 The cost to councils of buying care continues to increase

The cost of services rose again last year, especially residential care for older people and home care



Since 2015/16, there has been a consistent, above-inflation increase in the cost to local authorities of purchasing residential, nursing and home care. Partly as a result, all the extra money – and more – that local authorities have spent on adult social care since 2015/16 has been absorbed by external suppliers. Overall expenditure in 2018/19 was £941 million more in real terms than in 2015/16 (*see* indicator 6) but spending on commissioned services rose by £1.4 billion. Spending on councils' own provision and grants to voluntary organisations has fallen.

The biggest increase – by 10.4 per cent in real terms – has been in the costs of residential and nursing care for older people. Last year alone, the increase was 4.6 per cent. Costs of the same care for working-age adults have increased by 3 per cent since 2015/16, and 1.6 per cent last year. However, these costs were much higher to begin with.

The cost of home care (which we are not able to split between older people and working-age adults) has increased by 9.6 per cent since 2015/16 and by 2.9 per cent last year alone. It was below the £18.01 (at January 2019) recommended minimum rate proposed by the United Kingdom Homecare Association (UKHCA). As with other indicators, there is also very wide local variation in costs.

The cost of home care is rising but is still below the UK Homecare Association's recommended minimum price

Average hourly rate for externally provided homecare, adjusted to 2018/19 prices

Source: Adult Social Care Activity and Finance Report, NHS Digital, UKHCA, 2018

The King's Fund

At least some of this expenditure on fees is being used to cover increasing workforce costs of adult social care providers. Between 2017/18 and 2018/19,

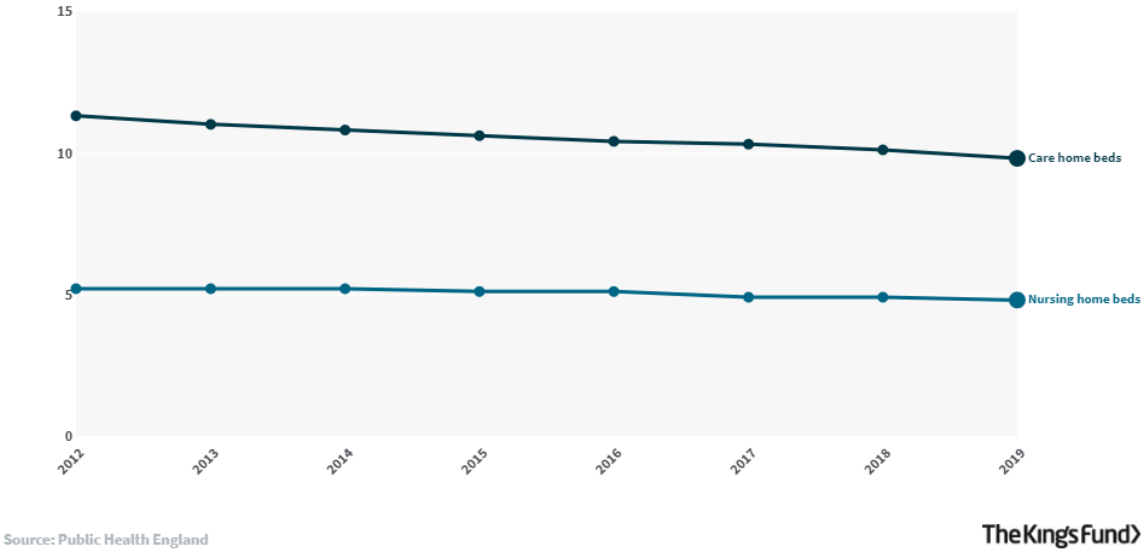
the social care sector wage bill increased by 4 per cent (though the number of full-time equivalent (FTE) jobs increased by only 0.5 per cent), driven by an increase in the statutory minimum wage of 4.4 per cent in cash terms. For 2020/21, the increase in the main rate of the living wage is 6.2 per cent. Another factor is the unit price of packages for people with increasing complexity of needs.

Higher fees may also have helped restore margins in the sector, potentially stabilising a market that has seen significant numbers of providers either go out of business or withdraw from the publicly funded sector altogether. If so, it has not been entirely successful since another large provider, the Mears Group, has recently opted to sell its home care business, citing the lack of a sustainable public funding model for the sector.

Providers

8 The number of care home beds continues to decline

The number of care home beds is falling while the number of nursing beds is more stable, but with wide regional variation in both



There has been a long, slow decline in the number of care home beds available, which continued in 2018/19 with the loss of more than 250 care homes and 3,000 beds. The number of nursing homes also fell, though the number of beds increased slightly because – as with care homes – the average size of newbuilt homes is increasing.

What is the difference between nursing homes and care homes?

Nursing homes differ from care homes in that they have registered nurses on site at all times.

There are now fewer than 15 nursing or residential home beds for every 100 people over the age of 75. This downward trend might be expected, since it fits with a broad policy direction towards supporting more people at home, rather than in residential or nursing care. This trend away from admissions to residential care may, however, be flattening out now, and an increasing population means that the actual number of admissions has in fact increased slightly (*see* indicator 16). Note though, that because data is not available, we do not know whether home care capacity has increased to compensate for the decline in residential care capacity.

The national trend also obscures sharp regional differences. While there has been little national change in the number of nursing beds overall, since 2013 the East of England, South East and West Midlands have seen increases of 7–8 per cent, while the North East has seen a fall of 7 per cent and Yorkshire and Humberside a fall of 9 per cent. For residential care beds, the overall 4 per cent fall breaks down into very steep falls in London (15 per cent) and the South West (9 per cent), but smaller falls elsewhere. The exceptions are Yorkshire and Humberside (which has seen a 1 per cent increase) and the East Midlands (a 4 per cent increase).

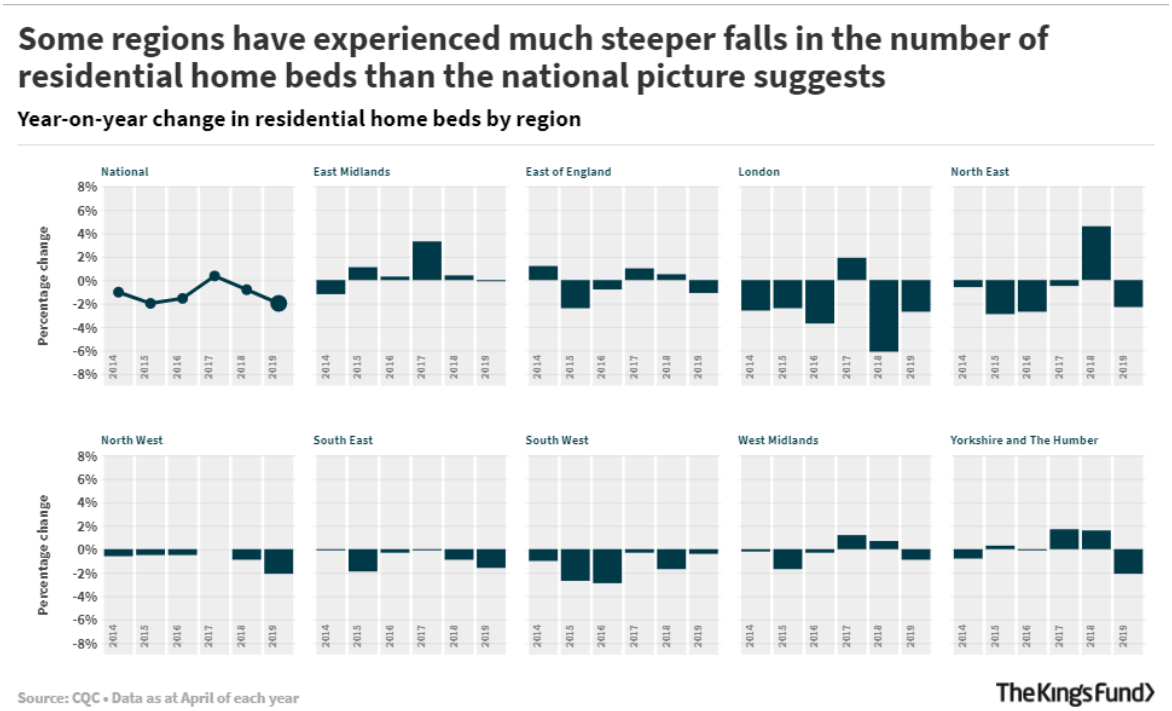
One factor explaining this variation may be homes switching between residential care and nursing care registrations. Homes may switch from nursing to residential status because they struggle to find enough nurses (the vacancy rate is 9.9 per cent – *see* indicator 9).

Although the number of nursing home beds has stayed relatively static in the past two years, some regions have seen substantial decreases

Year-on-year change in nursing home beds by region

Source: CQC • Data as at April of each year

The King's Fund

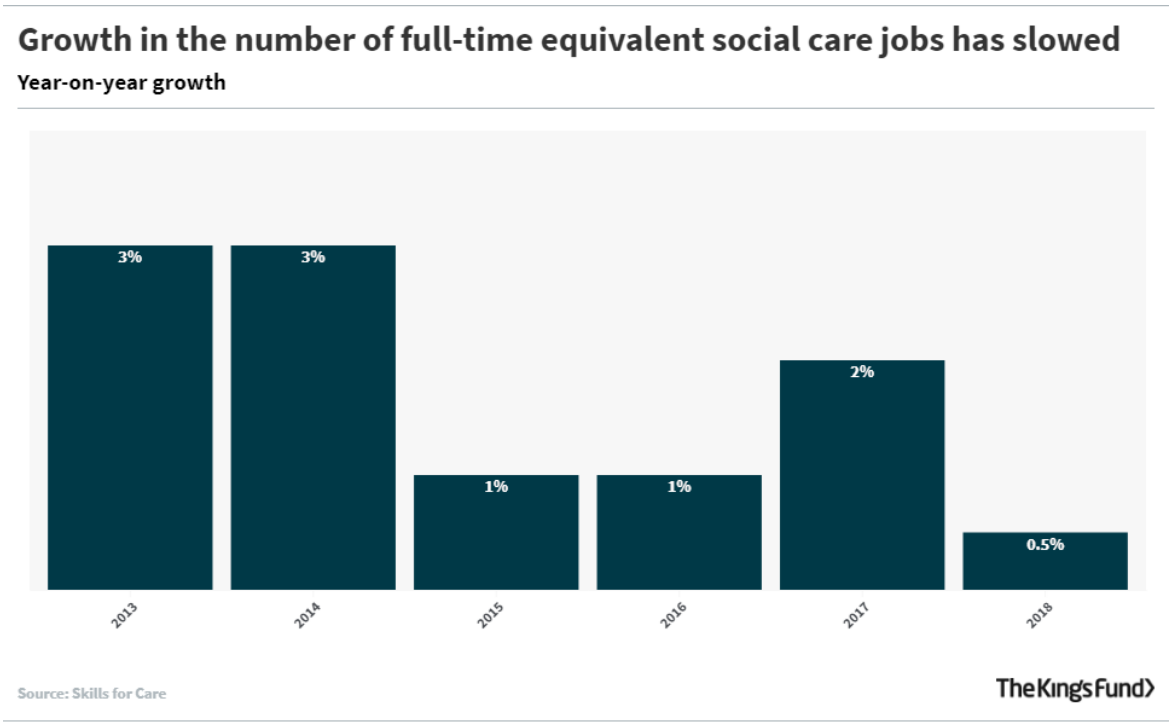


One factor in this is the number of self-funders in each region. Though the fees paid by local authorities for publicly funded clients have been increasing faster than inflation (*see* indicator 7), there is a significant historic difference between the two. In 2017 the Competition and Markets Authority estimated that fees paid by local authorities were 41 per cent below the prices paid by self-funding clients. This creates more incentive for providers to build new homes in areas with larger numbers of self-funders, which has led to concerns about the existence of 'care deserts' caused both by lack of provision and/or lack of staff (*see* indicator 9).

Workforce and carers

9 Growth in the number of jobs has slowed

Jobs growth is almost at a standstill and vacancies are harder to fill



Though adult social care remains a large and important employment sector in England, it is not continuing to grow quickly. According to Skills for Care (on whose report this section is based), in 2018, the number of full-time equivalent (FTE) jobs increased by just 0.5 per cent to 1.13 million (around a further 5,000 jobs). This continues a trend that has seen jobs growth in the sector stall since 2014.

The reasons for this are unclear. Demand for social care – if measured by the number of people approaching local authorities for help – has risen and, while more of these people are being turned down for publicly funded social care (*see* indicator 2), it might be expected that they would instead buy their care privately, creating an equivalent number of jobs to those 'lost' in publicly funded care. However, the very small growth in overall jobs in the sector and the decline in care home and nursing home beds does not suggest that this is

happening, though we would need to understand whether there has been compensating growth in self-funded home care to be more certain.

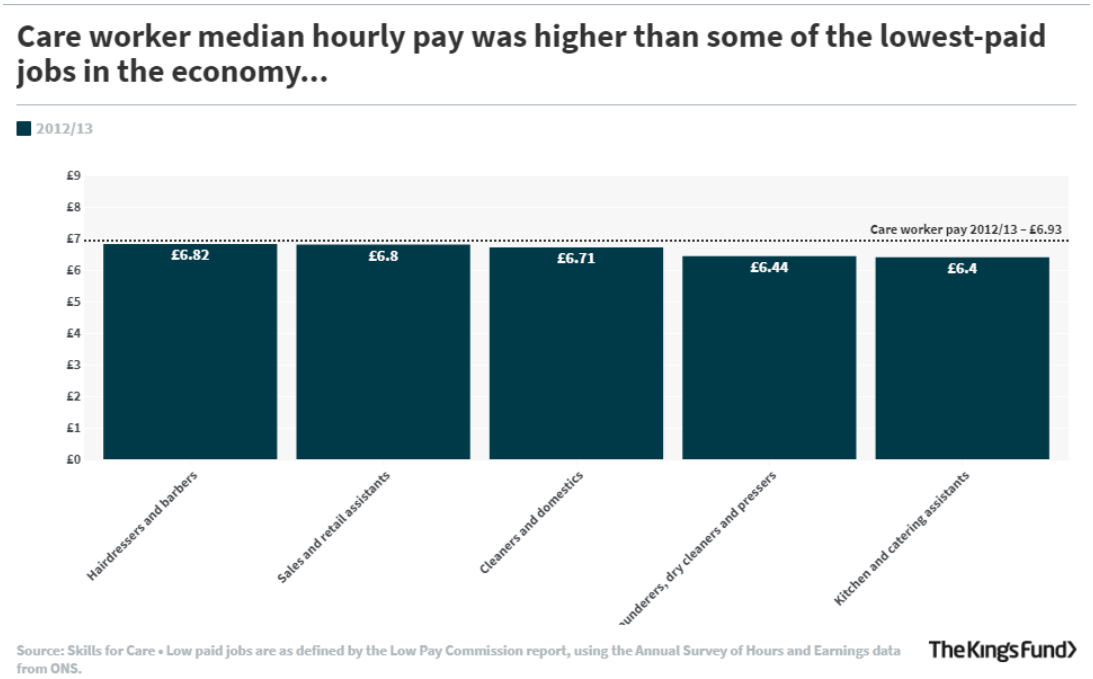
It may be that many of those who are ineligible for publicly funded care are either relying on unpaid family carers or going without care. However, there are other possibilities. For example, it is possible that staffing ratios have increased – that, on average, workers are caring for more people. Since we have no official data on issues such as staffing ratios in care homes, average visit lengths for home care workers or indeed the overall size of the home care market, it is impossible to say.

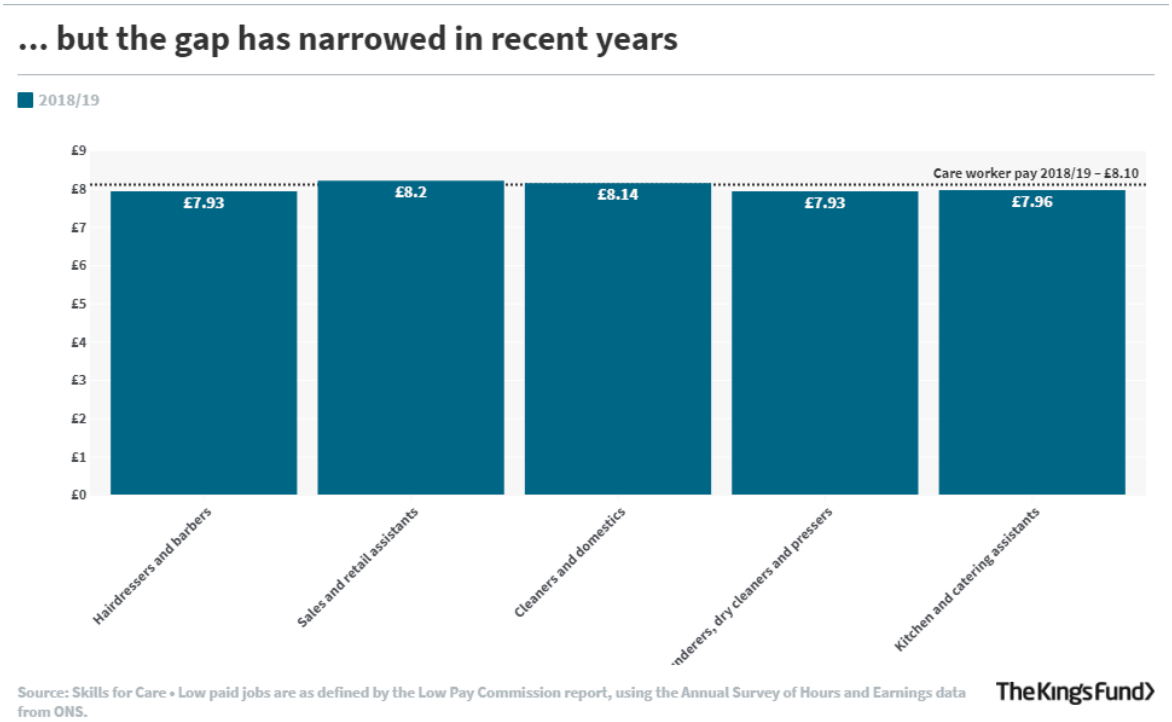
Part of the reason for the slowdown in jobs growth is the increasing difficulty in filling posts, with the number of vacant posts now standing at 122,000 (7.8 per cent). This is an increase from a vacancy rate of 5.5 per cent in 2012/13, and puts social care on much the same standing as the NHS.

This vacancy rate is much higher than the 2.8 per cent UK vacancy average across all industries. Moreover, it is continuing to increase.

10 Pay has increased, but more slowly than in other sectors

In 2018/19, care workers were paid less than shopworkers and cleaners





Looked at in isolation, care worker pay appears to be a social care success story. Since 2015/16, driven by the introduction of national living wage legislation, care worker pay has increased by 7 per cent in real terms and 14 per cent in cash terms. The typical, independent sector care worker in 2018/19 saw £8.10 an hour in his or her pay packet compared to £6.93 in 2012/13.

Yet the problem for social care employers – and the temptation for care workers – is that staff can now earn more in other sectors. In 2012/13, the average hourly rate for sales assistants in the retail sector was £6.80 (below social care), but in 2018/19 it was £8.20, above that of social care. All the major supermarkets (with one partial exception) now offer higher minimum hourly pay than the average social care worker hourly rate. Meanwhile, other major employment sectors like cleaning and catering are catching up. And in the NHS, in 2018/19 a health care assistant might expect to earn between £8.93 and £9.57 per hour.

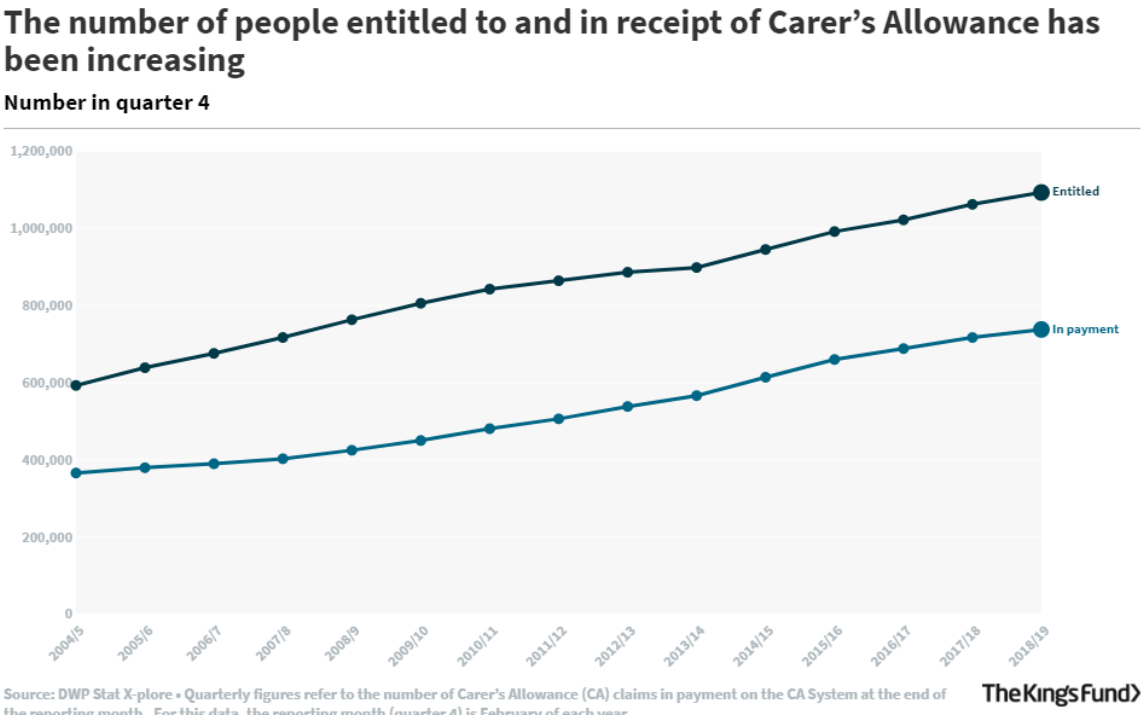
This issue also affects pay progression of more senior care workers. Those with more than five years' experience on average earn just 15p more an hour than those with less than one year's experience, down from 37p more an hour in 2013.

Uncompetitive levels of pay are a factor in the high vacancy rates (*see* indicator 9) besetting the care sector and also have an impact on staff

turnover. Nearly one in three social care staff (30.8 per cent) leaves their job during the course of the year, equivalent to 440,000 people. For care workers in the home care sector, the figure is closer to one in two. While most stay within the sector, it adds a further cost to employers – and results in lack of continuity of care for those receiving that care. However, pay is by no means the only factor: lower turnover is associated with other factors, including shorter travel-to-work time, higher age of staff (and more experience in the sector), access to training, more contracted hours and greater permanence of posts.

11 The level of support for family carers is mixed

More people receive the national benefit for carers but fewer get support from local authorities



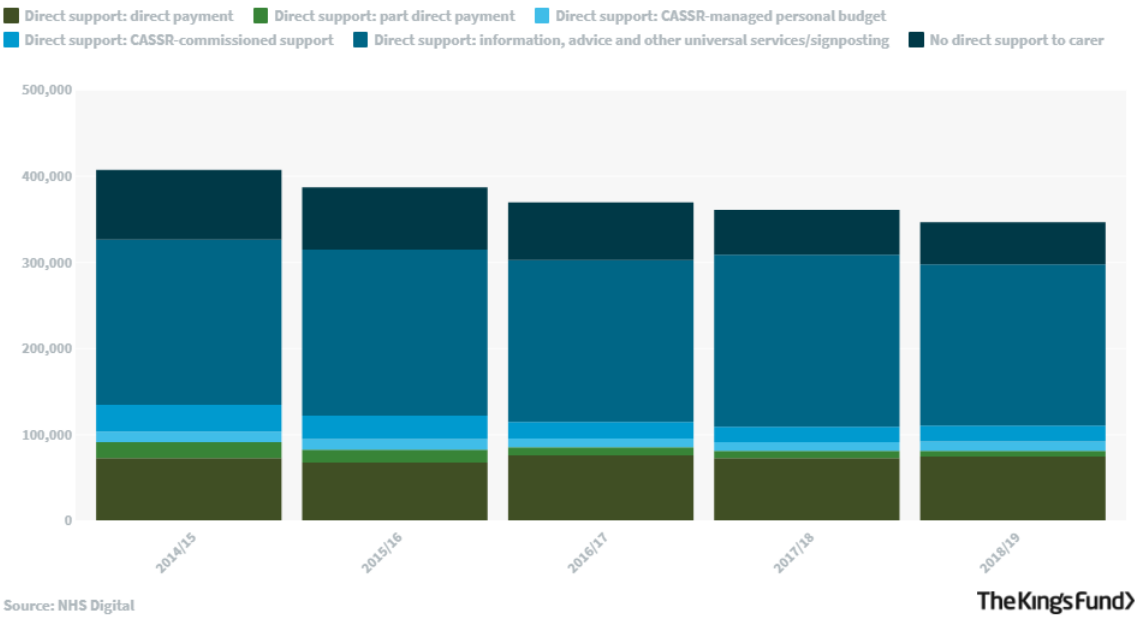
There are two main types of support available for unpaid family carers in England: a state benefit, Carer's Allowance, which acts as an income replacement for people unable to work full-time because of their caring responsibilities, and support from local authorities, which are legally required to provide carers with advice, services and/or direct payments to purchase services.

There is a stark contrast in take-up of the two types of support. The number of people entitled to Carer's Allowance has increased to more than 1 million

(of whom around three-quarters receive money; the remainder claim it because it acts as a 'passport' (an 'underlying entitlement'[5]) to other benefits). This increase will have been influenced by an increase in the number of people claiming the qualifying disability benefits (*see* indicator 5) and by changes to state pension entitlement (some women are having to wait longer to claim their pension but can claim Carer's Allowance in the meantime).

In contrast, the number of people supported by local authorities has fallen and less money is being spent on carers than in 2015/16. The number of carers receiving direct support from local authorities in 2018/19 was 297,300 compared to 308,160 the previous year. Within that total, the proportion receiving financial support or services increased slightly (which may explain a small increase in spending in 2018/19) while the proportion receiving information, advice or signposting fell, although still comprised nearly two-thirds of all direct support. In addition, 42,300 'cared-for' people received support such as respite care, a marginal fall compared to the previous year.

The number of carers receiving support from their local authority decreased in 2018/19



[5] According to Carers UK, having an 'underlying entitlement' to Carer's Allowance can increase any means-tested benefits a person is already getting or might mean they become entitled to means-tested benefits for the first time. To claim an 'underlying entitlement' to Carer's Allowance a person must meet all of the conditions for Carer's Allowance and must still make a claim for Carer's Allowance.

It is difficult to reconcile the fall in local authority support with the increase in the number of people claiming Carer's Allowance, since the latter support should be more difficult to obtain (it is only available if the cared-for person is already receiving a qualifying disability benefit, whereas many council carer services – such as advice and information – are more freely available). The most obvious explanation is that council services have been cut back because of budget pressures.

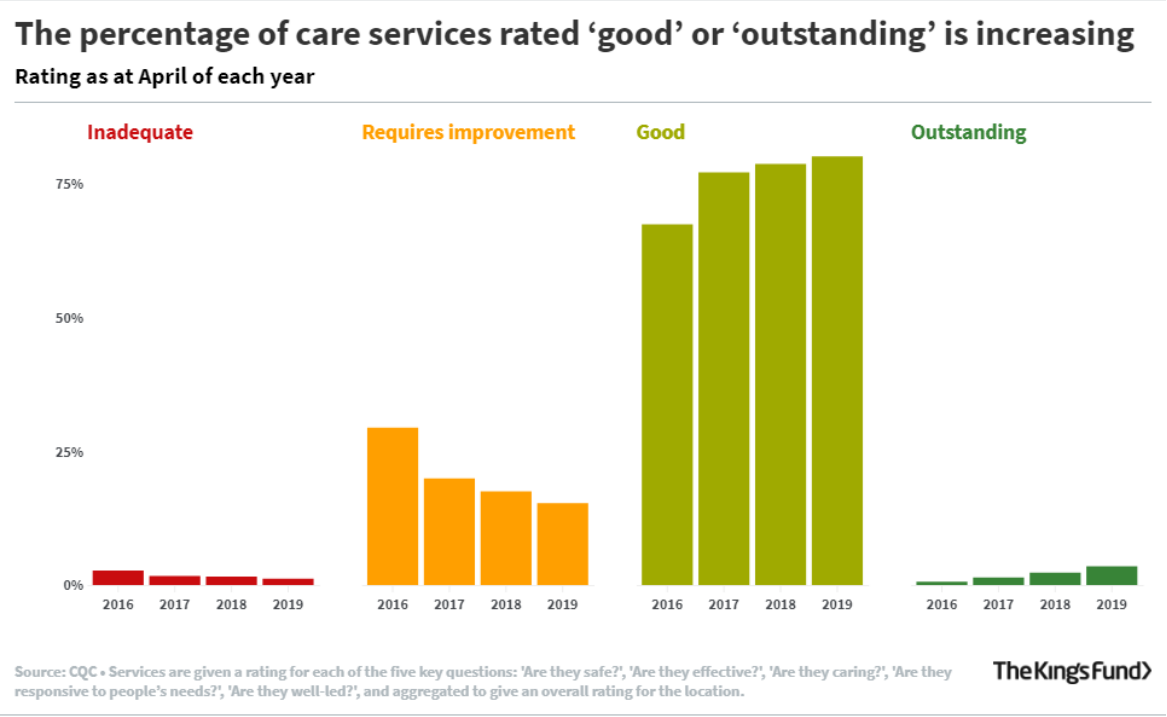
There is limited data to tell us whether the number of people with a caring responsibility is rising (as the Carer's Allowance uptake would suggest) or falling (as local authority service provision might indicate). Nonetheless, it is clear that both heavily under-represent the number of carers in England. The Family Resources Survey in 2018/19 found that the number of people who self-identify as carers (at least once a week) was 7 per cent. The most comprehensive, albeit dated estimate of the number of carers in England comes from the 2011 census, which found around 10 per cent of the population – 5.4 million people – to be carers. The 2021 census will be the next comprehensive update on these figures.

However, all estimates may reflect the fact that individuals often do not self-identify as carers. For example, Carers UK found that most carers took more than a year to recognise their caring role and almost one in four took more than five years to do so.

Quality

12 Care quality ratings have increased slightly

More services are now rated 'good' or 'outstanding' but 1 in 6 are still below standard



Over the past four years, the percentage of adult social care services rated 'good' or 'outstanding' by the Care Quality Commission (CQC) has continued to edge upwards. By April 2019, 3.5 per cent of services were rated 'outstanding' and a further 80 per cent were rated 'good', up slightly on April 2018.

This suggests there are some excellent care services in England to be celebrated (and learnt from: an Outstanding Society, comprised of care homes rated outstanding by the CQC, exists to share their experience and help to drive up quality across the sector). Similarly, people using care services report high levels of satisfaction (*see* indicator 13).

Why, then, are public perceptions of care services (*see* indicator 14) not as positive as might be expected?

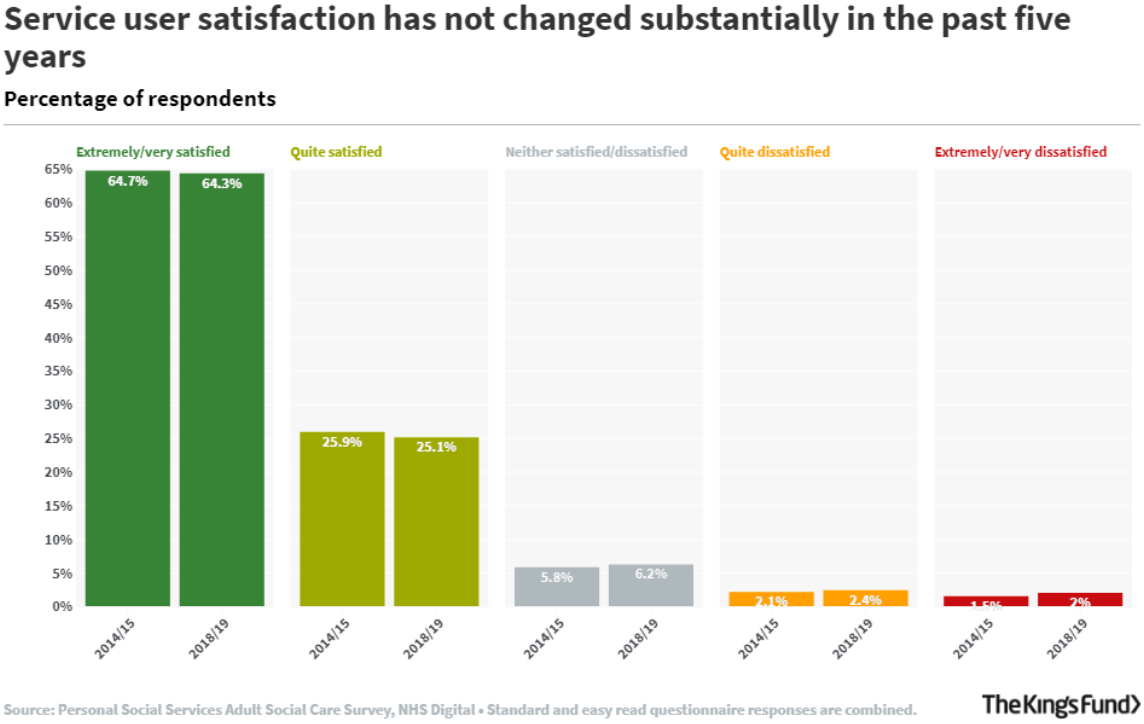
One factor is that there are still 1 in 6 services – more than 3,700 care homes and home care services – that are below par. They are not evenly distributed across England, so in some parts of the country the ratio of poor performers is actually much higher.

Another factor is likely to be media coverage. There have been several high-profile reports of the very worst care, including abuse, which understandably stick in people's minds.

And not every person using even a highly rated service will necessarily have a good or outstanding experience (though, of course, it is equally true that some people in lower-rated services will have a good experience).

13 Satisfaction among people using services remains high

Two-thirds of people receiving publicly funded services say they are 'very' or 'extremely' satisfied



Since 2014/15, the annual survey of people using local authority social care has consistently found that around two-thirds of people are satisfied with the services they receive.

The simplest, most positive explanation of these results is that the quality of services received has held up well. This high level of satisfaction is consistent with CQC ratings of care services (*see* indicator 12). Certainly, councils do receive compliments about the services they provide, as well as complaints, though they do not necessarily record or report positive feedback.

However, there are reasons to be cautious about these findings. First, there is research evidence to suggest that a positive satisfaction rating of social care may conceal variations in the experience of people using services. Some people, for example, may be expressing gratitude for a service received rather than satisfaction. Others may even fear withdrawal of services if they express dissatisfaction.

There is also alternative evidence from carers. A biennial survey of satisfaction with services received from social services – for carers themselves but also services for the people they care for – finds only 39 per cent satisfaction with services. One explanation for this is that, in the face of the decline in publicly funded care, carers are having to do more.

There are also other systemic indicators of problems with satisfaction. The Local Government and Social Care Ombudsman found in its 2018/19 report that the number of complaints was static but they were 'ever more serious'. More complaints were being upheld, with two-thirds of investigations finding faults – 'many of which appear to be driven by attempts to ration scarce resources'.

Finally, the Office for National Statistics uses a measure of user-rated quality in its annual survey of adult social care productivity. This includes but goes beyond the satisfaction data from service users[6] headlined in this indicator. Between 2016/17 and 2018/19, it found that quality had in fact declined, notably in community support for people with learning disabilities.

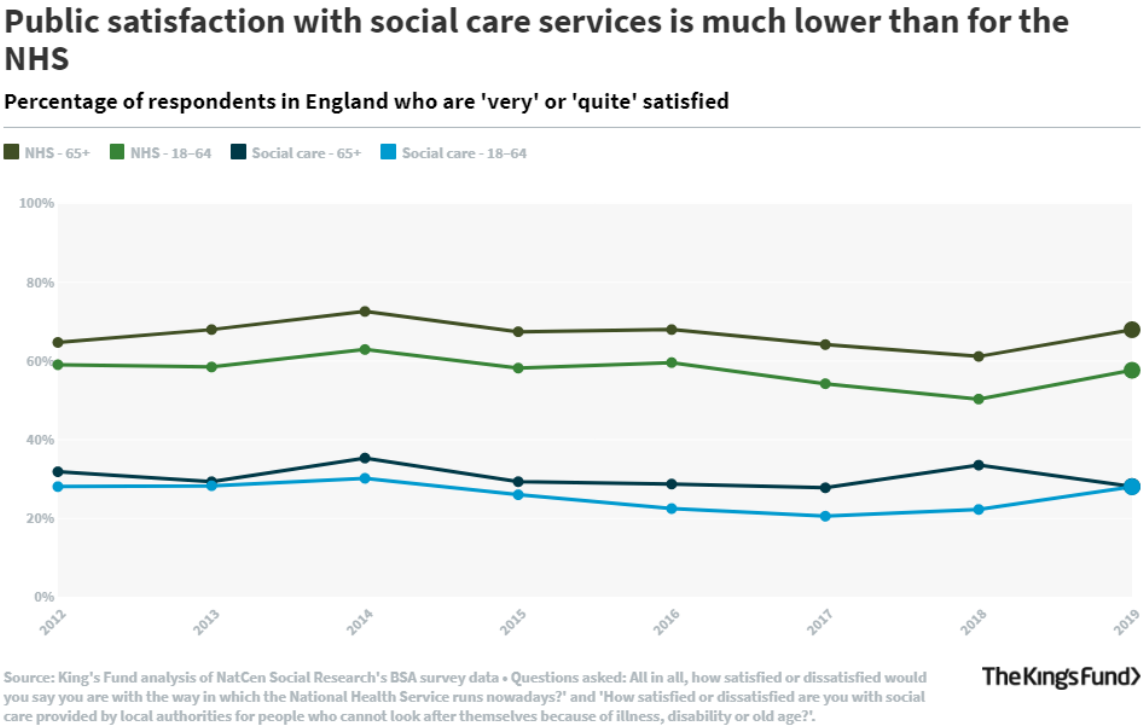
Satisfaction also varies between service users and according to setting. Working-age adults are significantly more satisfied with their care (68 per cent) than older adults (62 per cent); white service users report higher satisfaction than black and minority ethnic service users; people using residential care report higher satisfaction than nursing care or community

[6] Think Local, Act Personal notes that 'not everyone likes the term "service user" and may prefer to be described simply as a 'person who uses services'. We use the term 'service user' occasionally in this report for brevity.

care service users; and service users and carers in London report lower satisfaction than service users in other areas of the country.

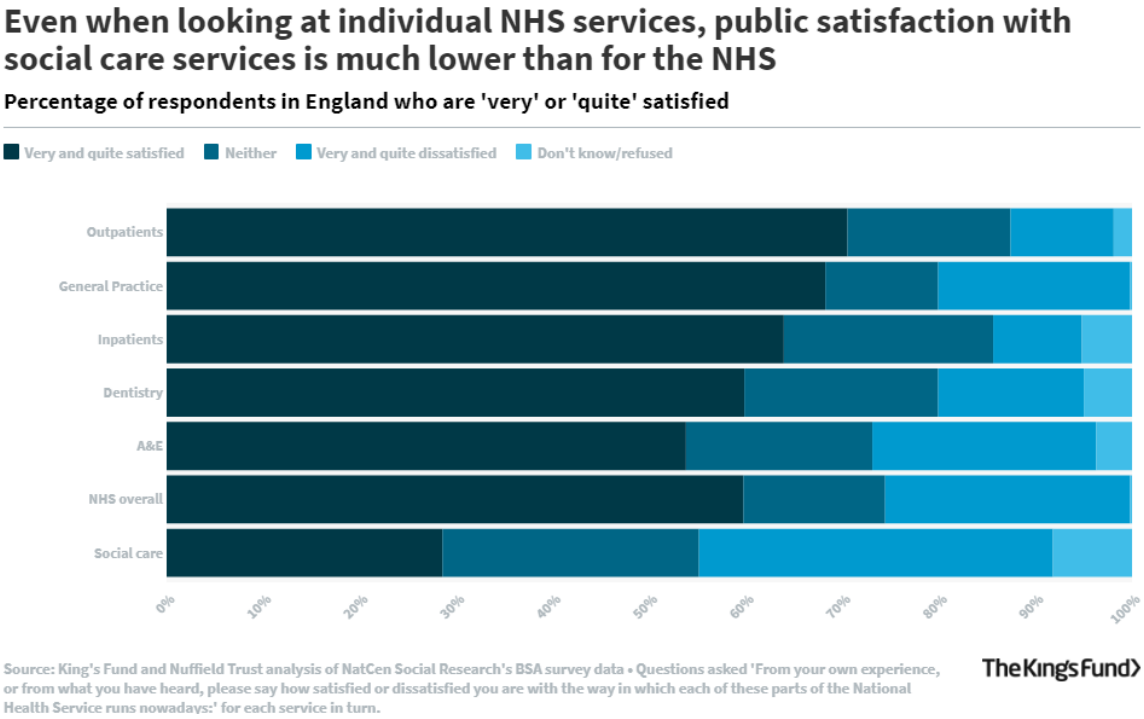
14 Public satisfaction remains low

The public is less satisfied with social care than the NHS but has less experience of it



Public satisfaction with social care services in England, measured by the British Social Attitudes (BSA) survey, was 29 per cent in 2019, a figure that has remained broadly unchanged since 2012. The level of satisfaction with social care has also been consistently lower than that for the NHS since 2012. Unlike the NHS, in 2019 there was no difference in satisfaction with social care between age groups.

Satisfaction with social care is also lower than that for individual NHS services. For example, public satisfaction with GP services was 68 per cent, 60 per cent for dentistry, 71 per cent for outpatient services, 64 per cent for inpatients, and 54 per cent for accident and emergency (A&E) services.



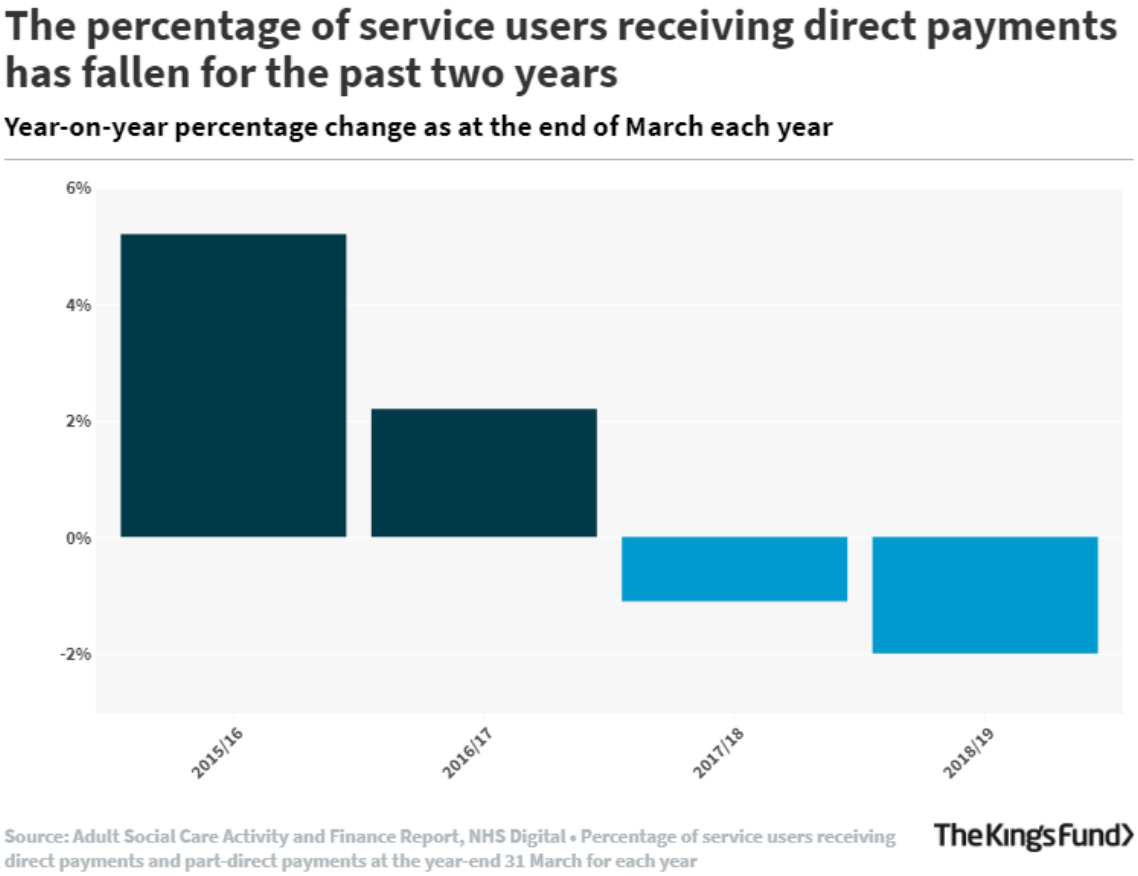
For the first time, the 2019 BSA survey measured whether there are differences in satisfaction between users and non-users of social care. It finds that 14 per cent of respondents said they had used or been in contact with adult social care services in the previous 12 months, with a fairly even split between those who were satisfied (38 per cent) and those who were not (47 per cent).

However, it is important to bear in mind that previous work has shown that many people may not understand what the term 'social care' means, or may not understand the distinction between services provided by the NHS and those provided as social care.

We also have to be cautious because, as with some health areas such as 'inpatients', social care is a very broad area. Services in the community for younger adults with a learning disability are very different to those provided for much older people with dementia in care homes, for example. Yet we only have this one measure to describe them all. Additionally, we have no way of knowing whether satisfaction or dissatisfaction relates to eligibility for publicly funded care (since social care is means tested), quality of services (*see* indicator 12) or availability of services locally.

15 Usage of direct payments may have peaked

The proportion of service users receiving direct payments fell again in 2018/19



Direct payments – cash paid to an individual to allow them to purchase their own care – should in theory allow people greater choice over the services they receive. Yet the numbers taking up direct payments have been falling since 2016/17 and the proportion has levelled off at around 28 per cent. Working-age adults are far more likely to use direct payments than older people – 39.9 per cent and 17.6 per cent respectively.

What is a direct payment?

Since 2015, everyone receiving support in the community from their local authority must receive a personal budget setting out the money allocated to meet their needs. People can choose how to receive their personal budget. One option is a direct payment – money paid to the person to organise and pay for their own care and support themselves (often by hiring someone to

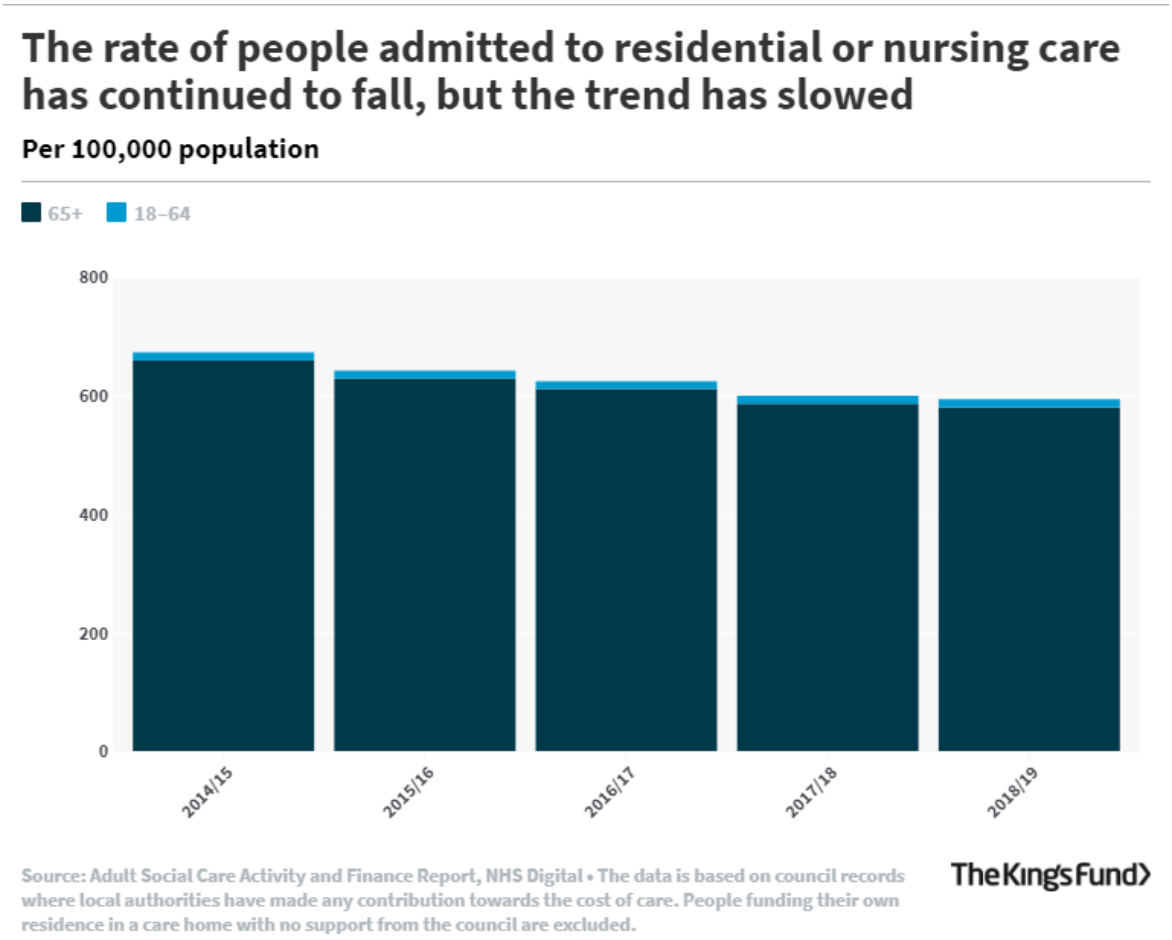
work for them as a personal assistant who carries out a wide range of support tasks for them in the home, at leisure or in work).

There is likely to be more than one reason why direct payments appear to be falling after having peaked. Opting for direct payment requires more involvement and responsibility than simply receiving a service, and people need support to manage one. However, service user groups say some local authorities offer far more support than others. This may reflect different approaches to personal budgets by local authorities or even individual social workers within those authorities.

Similarly, if there is little choice of local services on which to spend a direct payment, people may wonder whether it is worth the extra work. If an individual wants to employ their own carer (personal assistant), then direct payments certainly make that possible. If they do not, then direct payments may be less appealing. Just under half (47 per cent) of people receiving a direct payment for their care and support needs were estimated to be employing staff in 2018.

16 The fall in care home admissions has slowed

More older people entered care homes in 2018/19 but the overall trend remains downward



The continuing fall in the number of permanent placements by councils in residential or nursing homes is seen as a quality marker because it suggests that more people are living independently at home, where they prefer to be.

Yet this trend has slowed almost to a standstill, and there are some underlying issues.

- For older people, the rate of decline has slowed significantly from a 5 per cent fall per 100,000 population between 2014/15 and 2015/16 to a 1 per cent fall between 2017/18 and 2018/19. With a larger population, the actual number of admissions in 2018/19 has, in fact, increased.
- Care home placements now make up a slightly larger percentage of social care services being provided by local authorities.

- The proportion of working-age adults going into a home dropped slightly in 2018/19 but it remains above the 2015/16 level.

Why has the rate slowed so much? One explanation would be that most of the improvement has already been made – in effect, the proportion of the population that could be supported to remain at home is already getting that support and only those who really need residential care are taking it up.

However, there are several other possible explanations that are less positive. One is the cost of care. For people (often working-age adults) who require very intensive support, home-based packages may be more expensive than a care home. Councils – who are entitled to take cost of care into account when deciding on care packages (though they cannot set arbitrary upper limits on cost) – may in practice be funding more of these high-cost individuals in care homes.

Another explanation could be pressure to reduce delayed transfers of care from hospital. In 2018, directors of adult social services expressly warned that the total number of people admitted to care homes might increase because of the need at the time to free up hospital beds as quickly as possible (*see* indicator 17). Four in five directors of adult social care said there had been an increase in rapid discharges to short-term care home placements that then became long term.

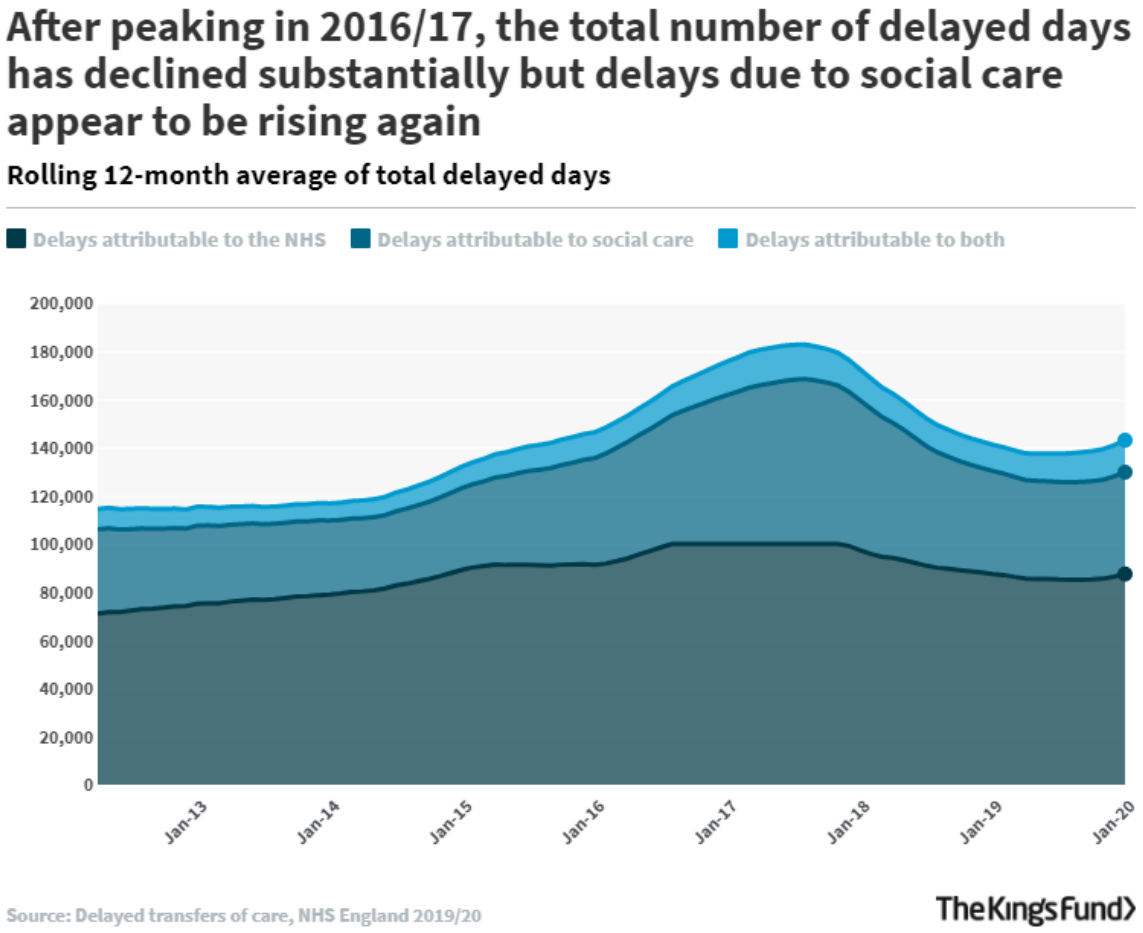
One other possible explanation is service reductions. Councils are focusing their long-term support on people with the greatest needs. A higher proportion of these people are likely to need a care home, which would explain why the proportion of service users going into care homes has increased.

A note of caution on this indicator though: it does not include data on people who fully fund their own care home place and do not rely on the local authority to manage the placement. Since these decisions to enter a home are made by individuals and their families without any financial support – and, quite possibly, without advice – from local authorities, the trend could be different.

Connections to other services

17 Delayed transfers have been inching back up again

Delayed transfers from hospital due to social care are well below their peak but have increased



Delayed transfers from hospital attributed to social care are still well below their peak in the winter of 2016/17, but in September 2019 the monthly rolling average started to increase. However, it remains the case that the NHS rather than social care accounts for most delayed transfers.

What is a delayed transfer of care?

A delayed transfer of care occurs when a patient is ready to leave a hospital or similar care provider but is still occupying a bed. It is sometimes described as 'bed-blocking' (and, even worse, the individuals described as 'bed-blockers') even though in reality it is typically the system causing the delay.

Administratively, delays are attributed either to the NHS or to social care (or both) and can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice. The most common reason for delay is awaiting a care package at home, followed by awaiting further non-acute NHS care. Other reasons for delay include waits for assessments, waits for funding, and patient or family choice.

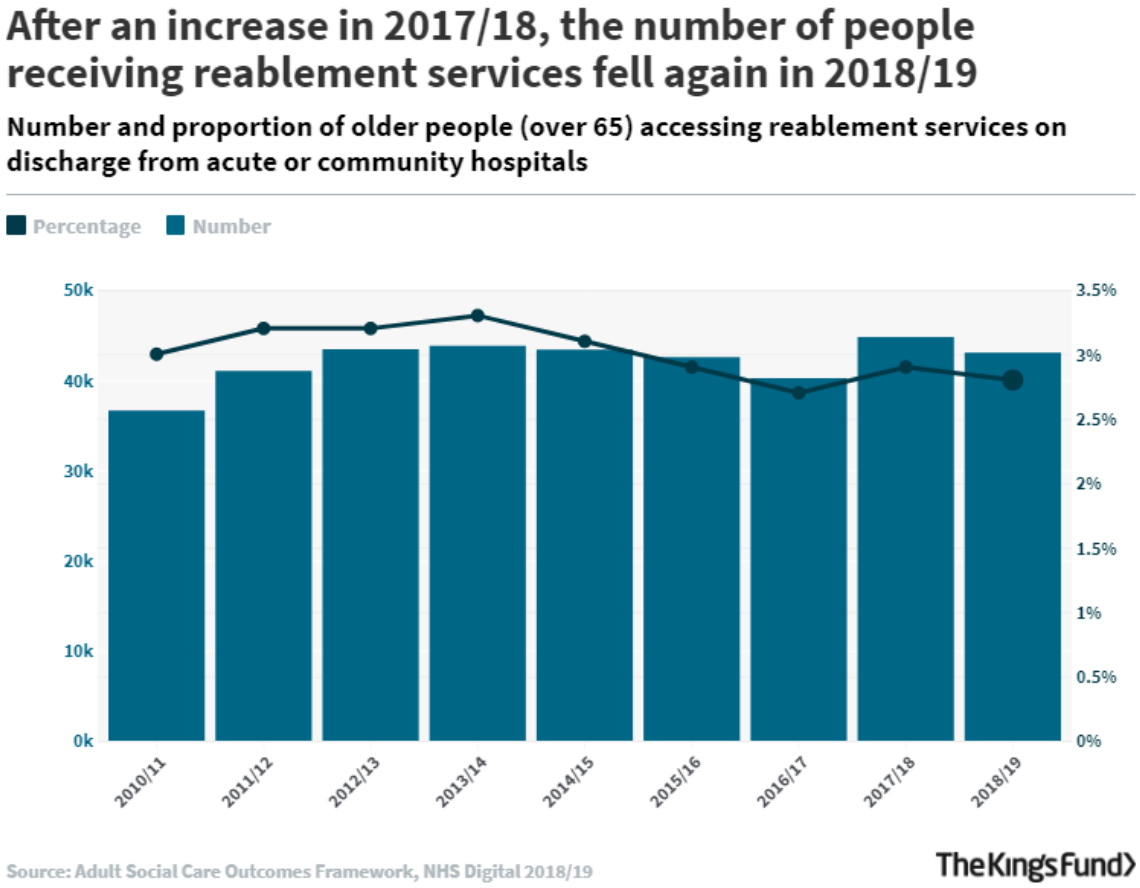
The figures for delayed transfers attributable to both social care and the NHS are higher than they were in 2012, despite a concerted effort by local authorities and NHS organisations – under intense scrutiny from the government and NHS England – to reduce pressure on acute hospital beds. A key factor in the decrease in delayed transfers has been the extra money provided to councils through the Better Care Fund.

Clearly, it is important that people do not spend more time in hospital than is necessary, both in terms of the impact on their overall health and the need to make best use of beds, which are at record occupancy levels. However, there has been a concern that focusing too heavily on delayed transfers can detract attention from preventing avoidable admissions in the first place, and from ensuring that transfers are not just made promptly but also appropriately. In 2019, ADASS said it believed that pressure to get older people out of hospital was sometimes leading to them being moved directly into residential care when they did not need to be there.

The focus on delayed transfers of care can also overshadow the reality for councils: four in five of their referrals come not from hospitals but from community settings, and the greatest rate of increase in demand for social care services is coming not from older people but from working-age adults.

18 Fewer older people receive reablement

The trend for reablement services contrasts with that for short-term care generally



In 2018/19, 1,700 fewer people over 65 received reablement when they were discharged from acute or community hospitals – down 4 per cent on the previous year. This is despite a great deal of evidence that reablement works. The National Audit of Intermediate Care shows that 75 per cent of people improve their independence as a result of reablement, with typical gains in mobility and other abilities of more than 33 per cent. On average, four in five of those receiving reablement services are still at home 90 days after leaving hospital.

What is reablement?

Reablement is one of a range of short-term services for people whose health has deteriorated and/or who need support to re-learn skills to keep them safe and independent at home. It is categorised as a type of intermediate care, most commonly delivered by social care staff. The other types are crisis response, home-based intermediate care and bed-based intermediate care. Reablement can be provided to anyone who would benefit but often, in practice, it is arranged as someone leaves hospital, with the aim of preventing them being readmitted.

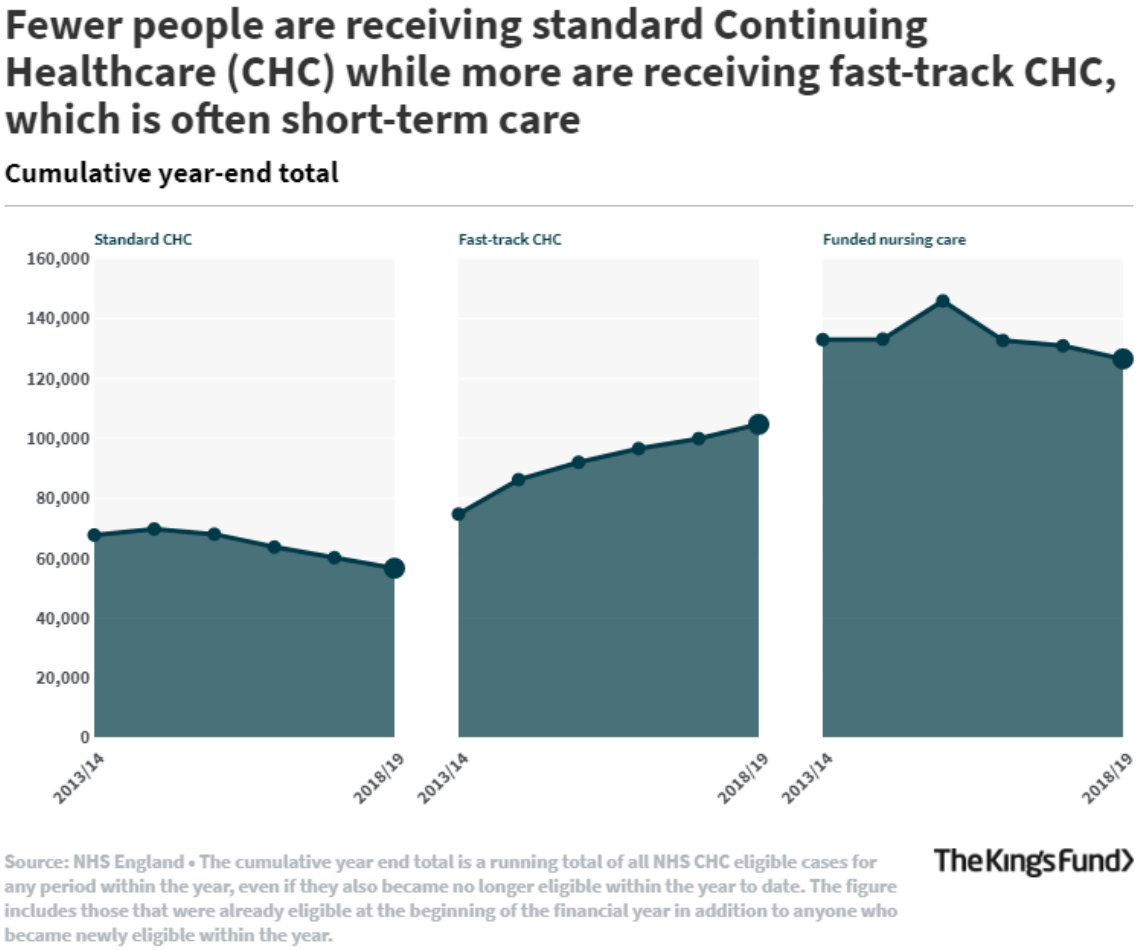
The fall in numbers of people receiving reablement from hospital does contrast with the wider trend on short-term care to maximise independence (ST-Max), uptake of which rose by 3 per cent among older people last year and 22 per cent among working-age adults. This may suggest a more enablement-focused approach to social care generally. However, the growth is from a low base – only around 2 per cent of the older population access short-term care services and the proportion of older people using ST-Max per 100,000 population has in fact fallen slightly since 2015/16. The trend for working-age adults, for whom uptake of ST-Max has increased by 44 per cent since 2015/16, may be more significant – albeit it from an even lower base.

Why might reablement services from hospital have decreased? One possibility is that older people in particular are being routed into different types of care than reablement. Though it is hard to find data, many areas have an increased focus on 'discharge to assess' and 'Home First' approaches, either in people's own homes or in residential care. This may mean that service users are receiving services that are not recorded as 'reablement'.

However, there was concern from directors of adult social services in 2019 that discharge to assess approaches may be being used inappropriately, leading to a warning of the risk that short-term placements might become long term, permanent ones. It is noticeable that there was indeed an increase in the number of older people admitted to permanent residential care in 2018/19 (*see* indicator 16).

19 NHS Continuing Healthcare has shifted towards short-term provision

Fewer people are receiving standard, long-term CHC but more get fast track funding



NHS Continuing Healthcare (CHC) is a critical issue for local authorities and people who need social care because CHC funds not only an individual's health care – which would be free under the NHS anyway – but also their social care, which otherwise would be means tested. Since social care costs can be very expensive, it can make a huge financial difference to an individual if they have to pay these costs themselves or, if that person has low enough assets to qualify for publicly funded social care, to the local authority, who would otherwise have to pick up the bill.

Between 2013/14 and 2018/19, there has been a 13 per cent increase in the number of people receiving NHS Continuing Healthcare (CHC), but that overall increase involves a 16 per cent fall in the number of people receiving long-

term 'standard' CHC and a 40 per cent rise in the numbers receiving short-term 'fast track' CHC. The overall rise also involves a small fall in the overall 'rate' of receipt – the number receiving CHC for each 50,000 of the adult population.

In terms of expenditure, in July 2017, the National Audit Office reported that NHS England estimated spending on CHC, NHS-funded nursing care and assessment costs would increase from £3.6 billion in 2015/16 to £5.3bn in 2020/21. It reported that NHS England wanted CCGs to make £855 million of savings on CHC and NHS-funded nursing care by 2020/21 on this prediction of growth.

Data supplied to us by NHS England and adjusted for inflation (*see* table below) shows that real-terms expenditure on standard and fast track CHC had both increased from 2014/15 to 2016/17. Since then real terms expenditure on standard CHC has fallen and fast track has stayed level. However, spending on CHC through personal health budgets has increased significantly since 2014/15.

Annual Continuing Healthcare expenditure, adjusted to 2018/19 prices

£ millions

Year	CHC Standard	Fast Track	Personal Health Budgets	Fully Funded Adult Packages of Care	Funded Nursing Care	Other Adult Packages of Care	Total Adult Packages of Care	Other costs (Admin & Assessment / Children)	Total Continuing Care
2014/15	2489	377	58	2924	549	384	3857	358	4215
2015/16	2635	392	91	3118	533	354	4004	566	4571
2016/17	2706	405	123	3234	710	385	4328	433	4761
2017/18	2606	379	225	3210	702	345	4256	387	4644

Source: Data from NHS England Continuing Healthcare team • Figures are adjusted using March 2020 HMT GDP deflators The King's Fund

The data shows large disparities in spending between CCGs. For example, in 2018/19 the highest-spending CCG spent £13.7 million on 'standard' CHC per 100,000 of the adult population, whereas the lowest-spending CCG spent £1.5 million. For 'fast track' CHC, the lowest-spending CCG spent £0.2 million and the highest £2.8 million.

There is little agreement about what accounts for these trends in take up and spending.

A revision to the national framework on CHC and FNC was published in 2018 but NHS England told us that national eligibility criteria, as set out in the Department of Health and Social Care NHS CHC policy and associated guidance and tools, have not changed and that a factor in the reduction of the rate of receipt may be attributed to carrying out assessments for CHC in the community or at home, rather than in hospital where an individual is most vulnerable and may be assessed for care that they don't in fact need.

Campaign groups argue this is not the main reason for the reduction and instead say there has been an effort by some clinical commissioning groups (CCGs) to reduce their costs by in practice setting the eligibility bar higher than previously. They argue the wide variation in individual CCGs' provision of CHC goes beyond demographic variation. In addition, in an annual survey of Directors of Adult Social Services, four in five councils said they had been subject to additional cost pressures due to reduced CCG funding of CHC.

NHS England told us CHC is 'part of a complex health system and there are multiple and complex drivers which may impact on levels of NHS CHC, including the availability of, and access to, other community services. These cannot be "quantified" and therefore it is not possible to analyse the levels of NHS CHC using data alone.'

Total spending on funded nursing care has increased in real terms from £512 million in 2014/15 to £678 million in 2018/19. This may be related to a significant increase in the rate paid for funded nursing care, from £112.00 (standard) and £154.14 (higher) per week in 2015/16 to £158.16 (standard) and £217.59 (higher) in 2018/19.

However, funded nursing care has also shown a decline in the rate of receipt and again the reason is difficult to unpick. There may be a connection to the fall in the number of nursing home beds in relation to the over-75 population (*see* indicator 16), which in turn may be related to the trend towards supporting people in their own homes for longer.

How do NHS Continuing Healthcare and NHS-funded nursing care work?

NHS Continuing Healthcare (CHC) is a package of care provided outside of hospital that is arranged and funded solely by the NHS – via local clinical commissioning groups – for individuals who have been assessed as having a 'primary health need' as set out in the National Framework for NHS Continuing Healthcare and NHS-funded nursing care.

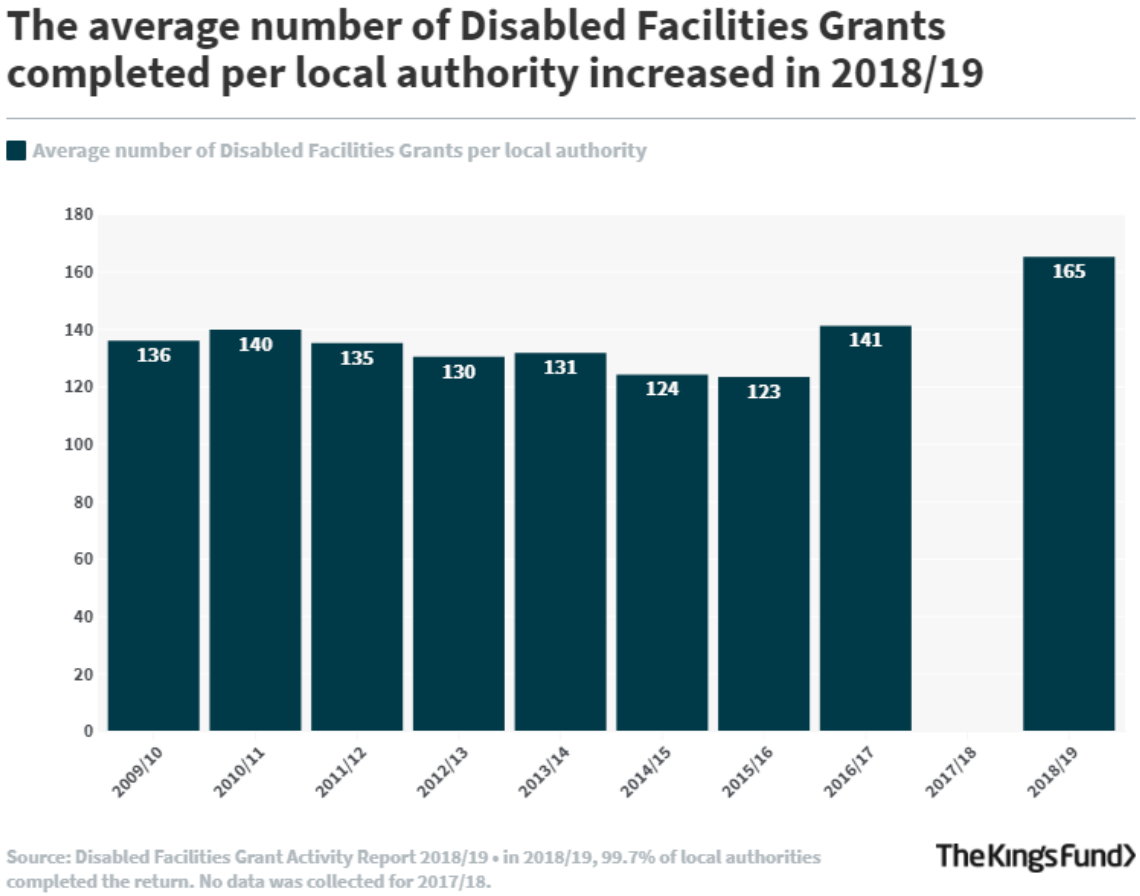
NHS-funded nursing care is when the NHS pays for the nursing care component of nursing home fees. The NHS pays a flat rate directly to the care home towards the cost of this nursing care.

What is fast-track CHC?

Individuals are eligible for fast track if they have a rapidly deteriorating condition that may be entering a terminal phase; for this reason, fast track is usually provided for a much shorter period of time than standard CHC.

20 Grants to improve disabled people's homes have increased

Increased central government funding has led to more Disabled Facilities Grants



Central government funding for Disabled Facilities Grants (paid through the Better Care Fund) has increased significantly since 2015/16 and this has led to a rise in the number of people with disabilities' homes being adapted by local authorities. The average number of grants by each local authority rose from 123 in 2015/16 to 165 in 2018/19.[7]

[7] The computer system for processing Disabled Facilities Grants changed in 2017/18, affecting data capture.

What do Disabled Facilities Grants cover?

Disabled Facilities Grants help the growing number of homeowners on low incomes to fund essential adaptations like level-access showers ('bathroom modifications' make up over half of all grants), stairlifts and ramps. They are not the only source of adaptations; local authorities and CCGs provide smaller adaptations (such as grab rails) and loaned equipment (such as bath seats) through the Integrated Community Equipment Service. However, it is not possible to identify nationally the numbers provided or the amount spent on them.

Disabled Facilities Grants are potentially an important part of strategies to enable older and disabled people to live independently in their homes for as long as possible, so the increase in the number of grants is good news. There may be some caveats though. Local authorities do not appear to have matched the increase in central funding with their own money, because while central funding has more than doubled since 2015/16, the number of grants increased by only a third.

The 53,500 completed grant applications in 2018/19 is a significant improvement on the 41,000 estimated to have been completed in 2014/15, though there is still some way to go to meet expectations that grants would double from that point.

Social care 360: methodology

	Definition	Methodology	Source
Demand	Number of requests for support received from new clients	As reported, and calculated as a per 100,000 population rate and indexed to 2015/16	Adult Social Care Activity and Finance Report, NHS Digital
Service users	New clients with a package of short-term support to maximise care (ST-Max) care and a known sequel Long-term support during the year	As reported	Adult Social Care Activity and Finance Report, NHS Digital
Financial eligibility	Means test threshold upper limit	Adjusted to 2018/19 prices using March 2020 GDP deflators	Social care charging for local authorities, Department of Health & Social Care

	Definition	Methodology	Source
Need	Disability prevalence by age group	As reported	Family Resources Survey, Department for Work and Pensions
	Mid-year population estimate	As reported	Mid-year population estimates, Office for National Statistics
Disability benefits	Attendance Allowance: cases in payment Disability Living Allowance: cases in payment Personal Independence Payments: claims in payment	As reported	DWP Stats-Xplore, Department for Work and Pensions
Local authority expenditure	Expenditure (including capital) – total	Adjusted to 2017/18 prices using December 2018 GDP deflators	Adult Social Care Activity and Finance Report, NHS Digital

	Definition	Methodology	Source
	Expenditure by primary support reason	As reported	Adult Social Care Activity and Finance Report, NHS Digital
Cost of buying care	Unit costs for clients accessing long-term support – residential and nursing	Adjusted to 2018/19 prices using March 2020 GDP deflators	Adult Social Care Activity and Finance Report, NHS Digital
	Unit costs, average weighted standard hourly rate for the provision of home care by activity provision	Adjusted to 2018/19 prices using March 2020 GDP deflators	Adult Social Care Activity and Finance Report, NHS Digital
Number of nursing and care home beds	Care home beds per 100 people 75+ Nursing home beds per 100 people 75+	As reported	PHE fingertips tool (Palliative and End of Life Care Profiles)
	Care home beds by region Nursing home beds by region	Calculated year-on-year change	Data from the CQC

	Definition	Methodology	Source
Jobs	Estimated number of full-time equivalent (FTE) adult social care jobs	Calculated year-on-year change	Size & structure report, Skills for Care 2019
Vacancies	Vacancy rate – all job roles	As reported	State of adult social care, Skills for Care
Pay	Median hourly pay for care workers and other low paid jobs		State of adult social care, Skills for Care
Carers	Support provided to carers during the year, by type of support provided	As reported	Adult Social Care Activity and Finance Report, NHS Digital
	Carer's Allowance: cases in payment	Number in payment as at Q4	DWP Stats-Xplore, Department for Work and Pensions
Care quality	The percentage of care services rated outstanding or good	As reported	Chart published in State of Care, numbers provided

	Definition	Methodology	Source
			directly by CQC
User satisfaction	Question 1 combined - overall, how satisfied or dissatisfied are you with the care and support services you receive?	As reported	Personal Social Services Adult Social Care Survey, NHS Digital
Public satisfaction	How satisfied or dissatisfied are you with social care provided by local authorities for people who cannot look after themselves because of illness, disability or old age? All in all, how satisfied or dissatisfied would you say you are with the way in which the National Health Service runs nowadays? From your own experience, or from what you have heard, please say how satisfied or dissatisfied you are with the way in which each of these parts of the National Health	As reported	British Social Attitudes Survey, King's Fund and Nuffield Trust analysis of NatCen Social Research's BSA survey

	Definition	Methodology	Source
	Service runs nowadays: for each service in turn		
Direct payments	Number of service users receiving direct payments and part-direct payments at the year-end 31 March	As reported	Adult Social Care Activity and Finance Report, NHS Digital
Care home admissions	The number of council-supported younger/older adults whose long-term support needs were met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)	Data calculated as a per 100,000 population rate	Adult Social Care Activity and Finance Report, NHS Digital
Delayed transfers of care	Number of delayed days during the reporting period, acute and non-acute, for NHS organisations in England by the responsible organisation	Data calculated as 12-month rolling average	Delayed transfers of care, NHS England
Reablement	Number/proportion of older people (aged 65 and over) discharged from acute or community hospitals to	As reported	Adult Social Care Activity and Finance

	Definition	Methodology	Source
	their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting)		Report, NHS Digital
NHS Continuing Healthcare	NHS Continuing Healthcare cumulative activity year to date from 1 April, England	As reported	Time series data provided directly by NHS England, most recent years available publicly
	NHS Continuing Healthcare expenditure	As reported	Time series data provided directly by NHS England
Disabled facilities grant	Average number of disabled facilities grants completed per authority	As reported	DFG Activity Report, Foundations

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