

Social care 360

Authors

Simon Bottery

Deborah Ward

Deborah Fenney

April 2019



This is a PDF of our online review, *Social care 360*. For access to the interactive charts and data please visit:

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

Contents

Introduction	3
Themes	5
Access	7
1 Working age adults increasingly ask for help	7
2 Older people are less likely to be getting support	10
3 The means test has got meaner	13
4 There's conflicting evidence on need	15
5 Overall, a higher proportion of people is receiving disability benefits	18
Expenditure	21
6 Spending has fallen in real terms	21
7 It's costing councils more to buy care	24
Providers	27
8 There are fewer residential and nursing homes places available for older people	27
Workforce and carers	29
9 There are more jobs in the care sector	29
10 ...but vacancies are growing	32
11 It's a mixed picture of support for carers	35
Quality	37
12 Care quality is rising. Probably.	37
13 Service users say they're satisfied	39
14 Public satisfaction is low	42
15 Direct payments remain at a low level	44

16 Fewer people are entering care homes	46
Integration with other services	48
17 Delayed transfers have improved	48
18 More people are receiving reablement	50
19 People are less likely to be receiving NHS Continuing Healthcare	52
20 The number of grants to improve to disabled people's homes has increased	55
Social Care 360: methodology	57
Acknowledgements	63

Introduction

People often complain about the lack of data about social care; there is, in fact, a significant amount but it is often held in fragmented databases that are rarely explored.

This review outlines and analyses 20 key trends in adult social care in England over recent years. 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, including indicators that relate closely to health, housing, benefits and carers, as well as to the services provided by local authorities, and in doing so provides a uniquely rounded – a ‘360 degree’ – view of the sector. The review is structured into six sections:

- access
- expenditure
- providers
- workforce and carers
- quality
- integration with other services.

Taking this broad approach does limit our ability to explore issues in depth: our analysis can often only scratch the surface, raising rather than answering questions about the trends the data shows.

To provide as much insight as possible, however, we have used two basic principles in reporting and analysing the indicators, we use:

- real-terms financial amounts – ie, adjusting for inflation

- activity and other measures in relation to the size of the population – typically per 50,000 or 100,000 people (though we do report actual numbers where useful).

Our full methodology is set out at the end of this document.

We intend to update – and explore – the indicators periodically to explore future trends.

Themes

Despite – or possibly because of – the breadth of this review, some clear themes emerge.

The growth in **support required by working age adults** is perhaps the single biggest trend. The Family Resources Survey (indicator 4) shows a consistent rise over the last decade in the number of working age adults identifying themselves as having a disability. More working age people are approaching local authorities for support, and more are getting it. And more working age adults are claiming disability benefits (indicator 5).

The trend in the **level of need for older people is less straightforward**. The indicators suggest that need for social care measured as the *proportion* of the population is stable, or even falling. However, the *numbers* of older people have grown significantly (and are projected to increase more sharply in the coming decades). There is also evidence that a significant amount of need among older people is not currently being met.

Together these three factors – rising disability among the working age population, growing numbers of older people and existing unmet need – suggest there are significant challenges for our care and support system now and in the future. Evidence from the NHS suggests this too, with sharp rises in the number of emergency admissions for patients aged 85 years or older and in admissions for patients with multiple health conditions. That in turn identifies a second theme: the **underinvestment in preventive services**. The investment is not decreasing, but began from a low point. For example, the number of people receiving Disabled Facilities Grants increased significantly in 2016/17 but from a very low level. Similarly, the number of people receiving reablement services has increased in 2017/18 but, despite the strong evidence for its effectiveness, to nowhere near the potential number that might benefit.

A third, related, theme – perhaps a more contentious one – is the tendency for **indicators that relate to local authority spending to remain the same or decline while those driven by central government are more likely to increase**. The most obvious example is that the number of carers supported by local government has fallen over the past four years while the number receiving

Carer's Allowance, a national benefit, has nearly doubled. Since 2015/16, the take-up of disability benefits by under-65s has also risen more than the take-up of long-term care provided by local authorities, and take-up of disability benefits among over-65s has fallen less.

There are some complicating factors. For example, there is wide **local variation** that that we were not able to explore. We also note that the rate of take-up of NHS Continuing Healthcare (as well as NHS Funded Nursing Care) is declining but the reason is heavily disputed. Similarly, there has been a small increase in the number of young people going into residential care but the reasons, or whether we should be concerned about them, are not clear.

It is also important to point out that we are generally reporting measures of *output* rather than *outcome*. In terms of service delivery, this means we are reporting on the numbers receiving social care services at a time when – as we show – many local authorities are moving towards a model which tries to *limit* receipt of formal services.

In the section on quality, some of our indicators can be seen as 'outcomes'; however, there are other gaps in this section. We report the Care Quality Commission's (CQC) ratings of care providers but not indicators of concern about quality, such as safeguarding alerts or complaints to the ombudsman. This is mainly because both are likely to be significantly affected by awareness of *how* to complain and who to complain to (we do not use complaints to the Local Government and Social Care Ombudsman as an indicator, for the same reason).

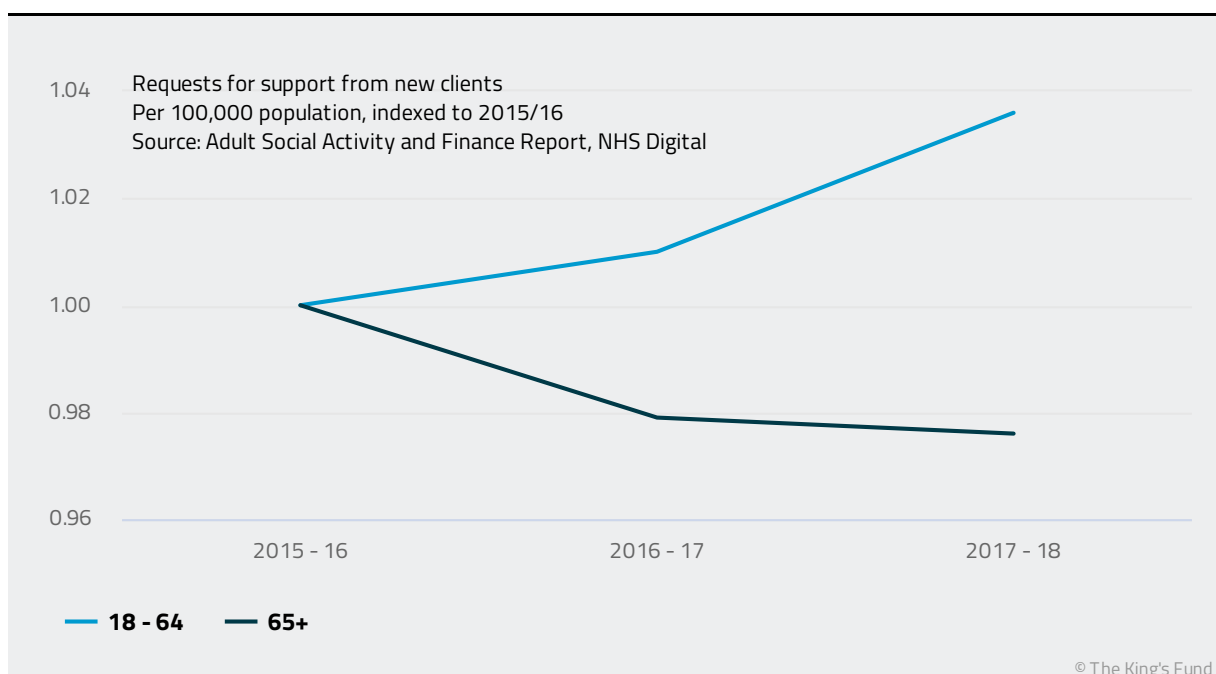
There is also a gap around the volume and type of services provided to self-funders. There are very few, if any, indicators that meet our criteria of being publicly available, annual and representative. This is a particular concern in relation to the 400,000 fewer people who receive publicly funded social care now compared to 2010/11; these people are now outside the system and, if they are receiving formal care, are paying for it themselves, yet we know very little about them.

Access

1 Working age adults increasingly ask for help

The rate of new requests is increasing from working age adults but falling from older people

Per 100,000 population, requests for social care have fallen for older people but increased for working-age adults



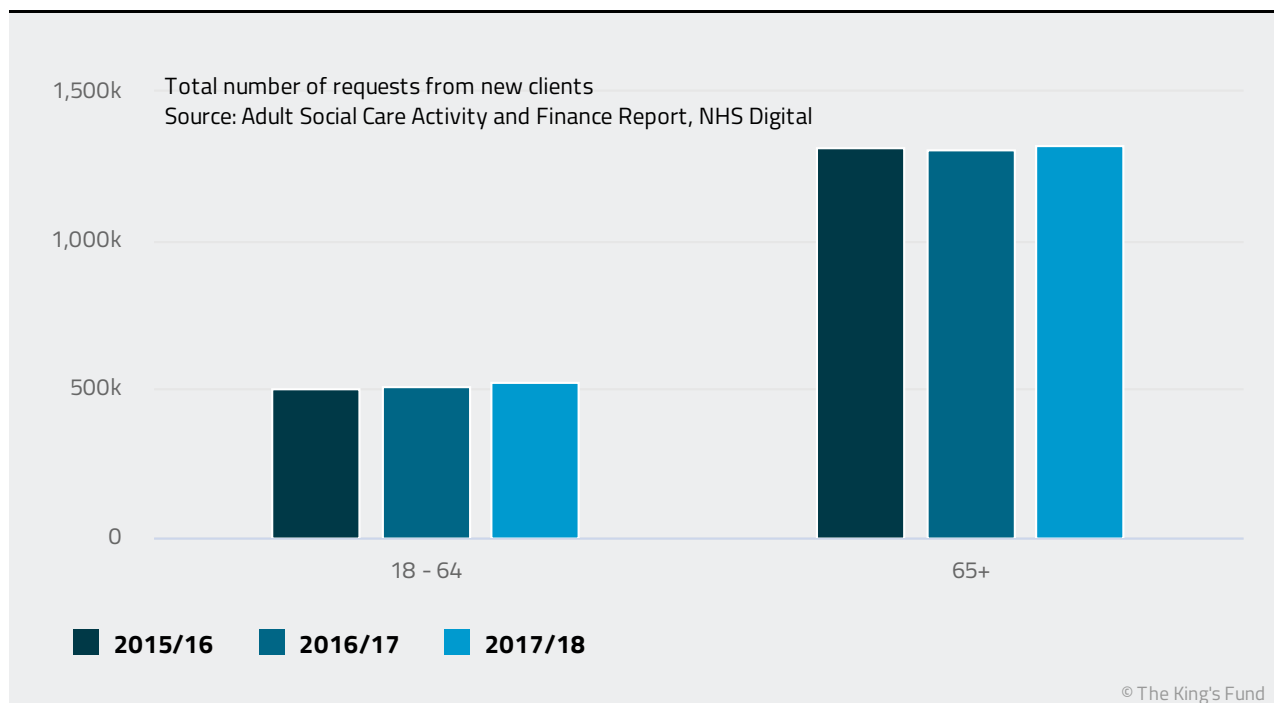
The proportion of working-age adults approaching local authorities for support (even if they do not necessarily receive it) has grown by nearly 4 per cent since 2015/16* while the proportion of older people has fallen by more than 2 per cent.

However, because the population has been growing, the actual numbers requesting help has grown over that period from 1.31 million to 1.32 million older people and from just over 500,000 to nearly 524,000 working age adults.

**Though data for this indicator are available from 2014/15, local authorities advised NHS Digital of issues with its collection for that year. As a result, this and other analysis in this review only uses data from 2015/16 onwards.*

In total, local authorities received 1.84 million requests for social care support from new clients in 2017/18, an increase of 2 per cent since 2015/16.

In 2017/18 there were over 1.8 million requests for social care support, 33,000 more than in 2015/16



The different trends between demand from working age adults and older people may, at least in part, be explained by different rates of growth in disability (see indicator 4).

There is also significant local variation in demand across England. In 2017/18 for England as a whole there were 1,554 requests for support for every 100,000 18–64-year-old, but the range was from 5,655 to 287. For over 65s, the England average is 13,160 per 100,000 older people but the published rate is as high as 77,220 and as low as 3,306. There are likely to be a range of reasons for these differences from large-scale demographic differences between local authorities and levels of deprivation to administrative differences in contact handling and recording practice.

How do we account for the broader, national trends in requests for support?

Possible explanations for the decrease in the proportion of older people requesting support include:

- less financial eligibility: financial thresholds have not changed since 2010 so fewer people will be eligible for local authority support (see indicator 3) and may not approach local authorities at all but instead purchase care directly (or go without)
- signposting away: many local authorities are developing 'asset-based' and self-help approaches to reduce the numbers of people receiving long-term care so some may be signposted away before a formal request is made
- public perception: some may be put off applying for support because of perceptions about the quality or availability of social care (two-thirds of the public are not confident social care services will be available when they need them) or concerns about their eligibility
- less need: the older population may have less disability (see indicator 4), which may in turn reduce need for social care services, though this is by no means clear.

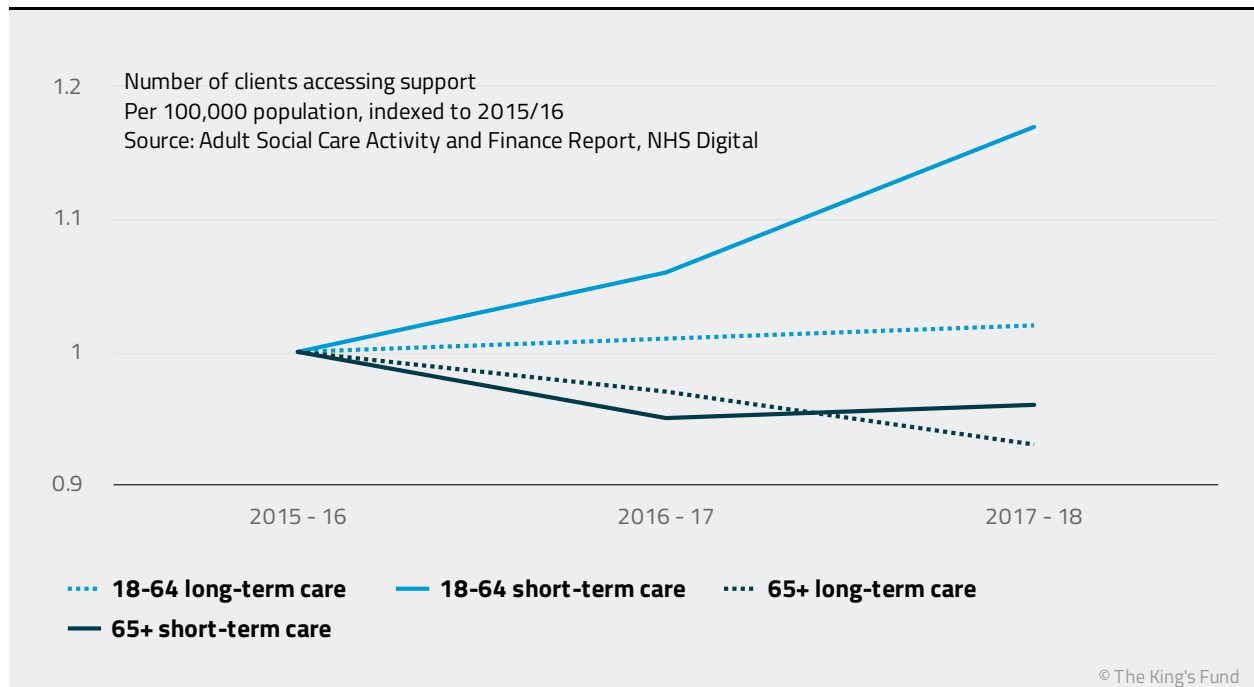
Possible explanations for more working-age people approaching local authorities include:

- increased need: due to medical advances, people are surviving into adulthood with complex, lifelong conditions that may nonetheless require ongoing social care support
- increased awareness: there is more public discussion of disability, especially 'hidden' disabilities such as autism, and of mental health conditions, which may lead more people to approach local authorities for support.

2 Older people are less likely to be getting support

A smaller proportion of older people – but a higher proportion of working-age adults – is now receiving long-term care.

Per 100,000 population, more working-age adults and fewer older adults are receiving social care support



While the proportion of working-age adults receiving long-term support has risen slightly, the proportion of older people getting long-term help is falling. This may be related to the trends in requests for support.

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.

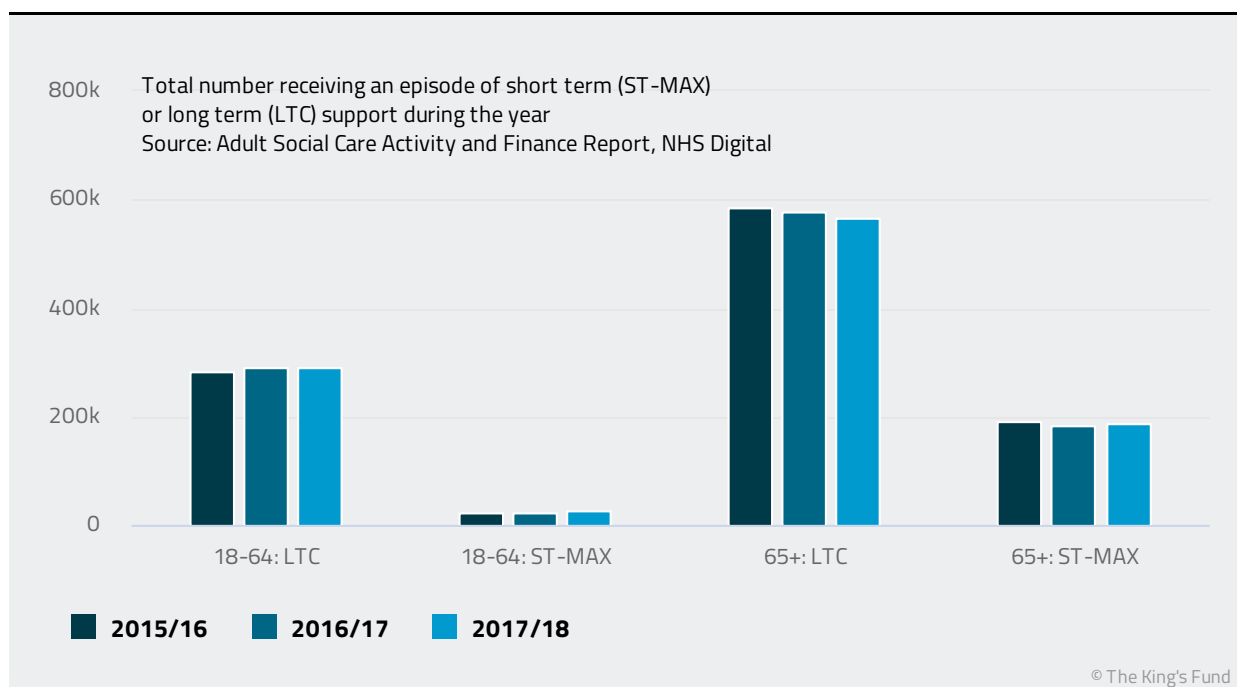
Over 7,000 more working-age people are receiving long-term support compared to 2015/16 but there has been fall of over 20,000 older people receiving it.

The trends for short-term support offered to promote independence – for example reablement (see indicator 18) – is more static, with the increase in working-age recipients slightly outnumbering the fall in older recipients.

What is 'short term care'?

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.

More working-age adults and fewer older adults are receiving social care support



There had also been a large decrease between 2009/10 and 2013/14 when the total number of adults receiving publicly funded care [fell by around 400,000](#). However, the system of recording changed in 2013/14 so numbers may not be exactly comparable with those since 2015/16.

One reason for the more recent decrease may be changes in the financial eligibility criteria (covered in indicator 3). In addition, faced with curbs on spending, local authorities are restricting delivery of formal services (even though they have typically protected adult social care budgets more than other budgets, except for children’s social care, which has had a real-terms increase).

At least partly as a result of curbs on spending, councils are also changing their approach to social care. In the ADASS [budget survey 2018](#), 75 per cent of adult social services directors said that reducing the number of people in receipt of care was important or very important to their planned savings in 2018/19. And 82 per cent of directors said the adoption of asset-based and self-help approaches, which can involve less provision of formal service, were very important.

How do asset-based approaches work?

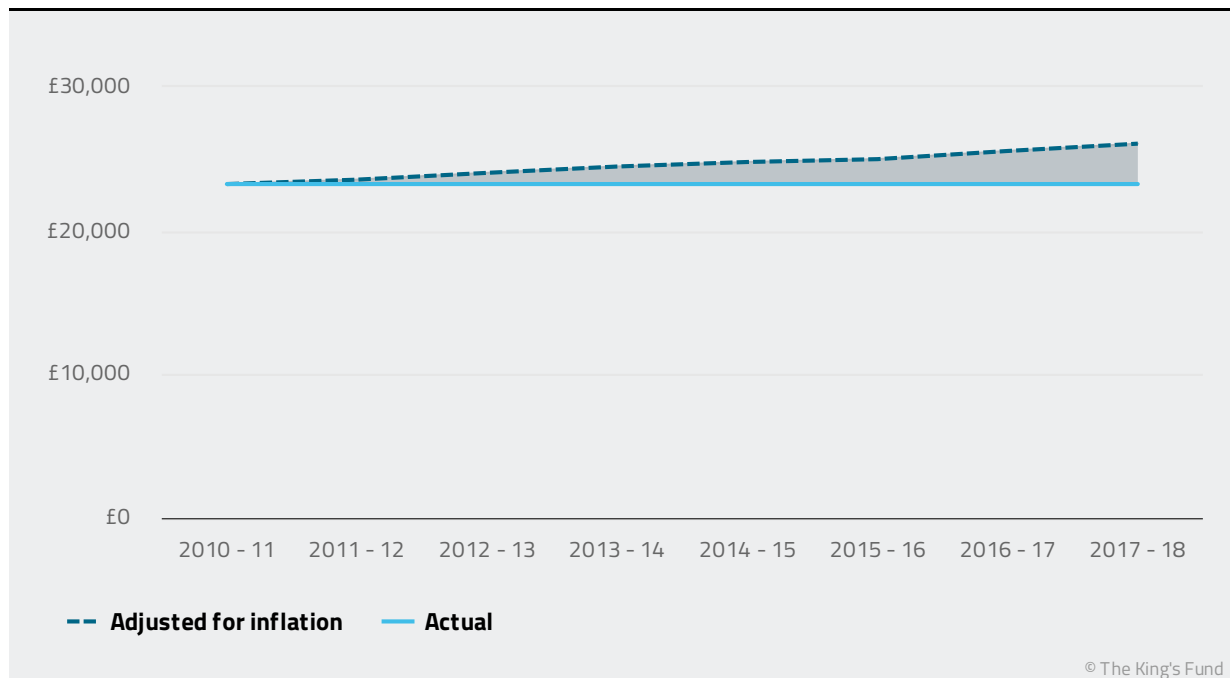
Asset-based approaches aim to signpost people to the types of support provided by the voluntary and community sectors while strength-based approaches aim to support an individual's independence, resilience and ability to make choices.

It is also important to note that these figures show only the numbers who receive care and support, not the intensity of support that those service users receive or, indeed, the cost of providing it (see indicator 7). Both factors will affect the overall amount local authorities spend on care (indicator 6).

3 The means test has got meaner

Fewer people now qualify for council social care support because financial thresholds haven't increased since 2010/11

If the social care means test threshold had kept pace with inflation it would be £2,811 higher than it currently is



Publicly funded social care is only available to people with low levels of financial assets, assessed through a means test.

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 (called '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 contribute to the cost 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 points, individuals contribute on a sliding scale using a formula which assumes individuals have £1 of income for every £250 of assets.

More information and detail about the financial assessment is available [here](#).

Since 2010/11, these means test thresholds have not been increased in line with inflation; if they had, the upper threshold would now be £2,811 higher at £26,061.

So people whose assets today are between £23,250 and £26,061 have effectively lost their eligibility for publicly funded social care support. They will either have to pay for their care themselves, rely on informal care from friends and family – or go without.

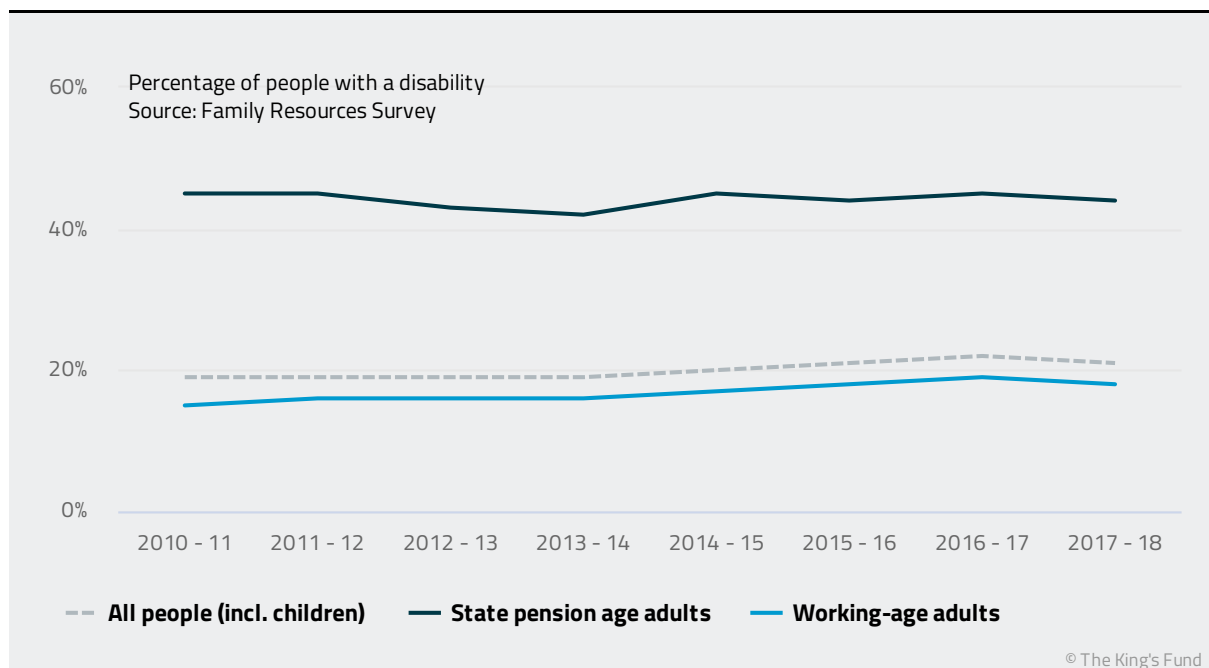
This is likely to affect older people rather than working-age adults, as they have had more lifetime opportunity to build up the level of savings or property that would leave them above the threshold.

Working-age adults may be affected by the similar failure to raise the minimum income guarantee since 2015. This is the amount of weekly income with which home care users must be left after local authorities have charged them for social care services. However – unlike for residential care – individual local authorities can adopt more generous charging policies for home care if they choose.

4 There's conflicting evidence on need

The prevalence of disability is increasing among working-age adults, but not among older people

Since 2010/11, disability prevalence has increased in working-age adults but remained static for those of pension age



Publicly funded social care is available only to people with high enough needs. But identifying the incidence of need in the population is far from straightforward.

The [Family Resources Survey](#)* asks 19,000 households about levels of disability – defined as ‘a long-standing illness, disability or impairment which causes substantial difficulty with day-to-day activities’. In 2017/18, 44 per cent of pension-age adults** reported a disability, slightly down from 45 per cent in 2010/11. However, the percentage of working-age adults has increased over the same period from 15 per cent to 18 per cent. The Office of Budgetary Responsibility analysis of this data finds that the proportion of disabled working age adults reporting mental health conditions increased from 24 per cent to 36 per cent in the five years to 2016/17.

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

***The FRS notes that the state pension age for women, though not for men, has been gradually increasing since 2010.*

This rise in working age disability may explain concerns expressed by directors of adult social services: 32 per cent are most concerned about financial pressures arising from working-age adults while a further 56 per cent are equally concerned about working age adults and older people. The smaller Health Survey for England finds that the overall prevalence of disability among the over-65 population in England (it does not measure need among under 65s) has fallen in recent years. The percentage of over-65s needing help with at least one ADL – for example, washing or dressing – has fallen from 32 per cent in 2011 to 26 per cent in 2017.

This survey does, however, find that levels of unmet need remain at very significant levels – 22 per cent compared to 26 per cent in 2011. Furthermore, the measure of unmet need used by the Health Survey for England does not capture those saying they receive some support but *not enough*. Age UK has alternative, higher, estimates of unmet need, using a third survey, the English Longitudinal Survey of Ageing (ELSA), here.

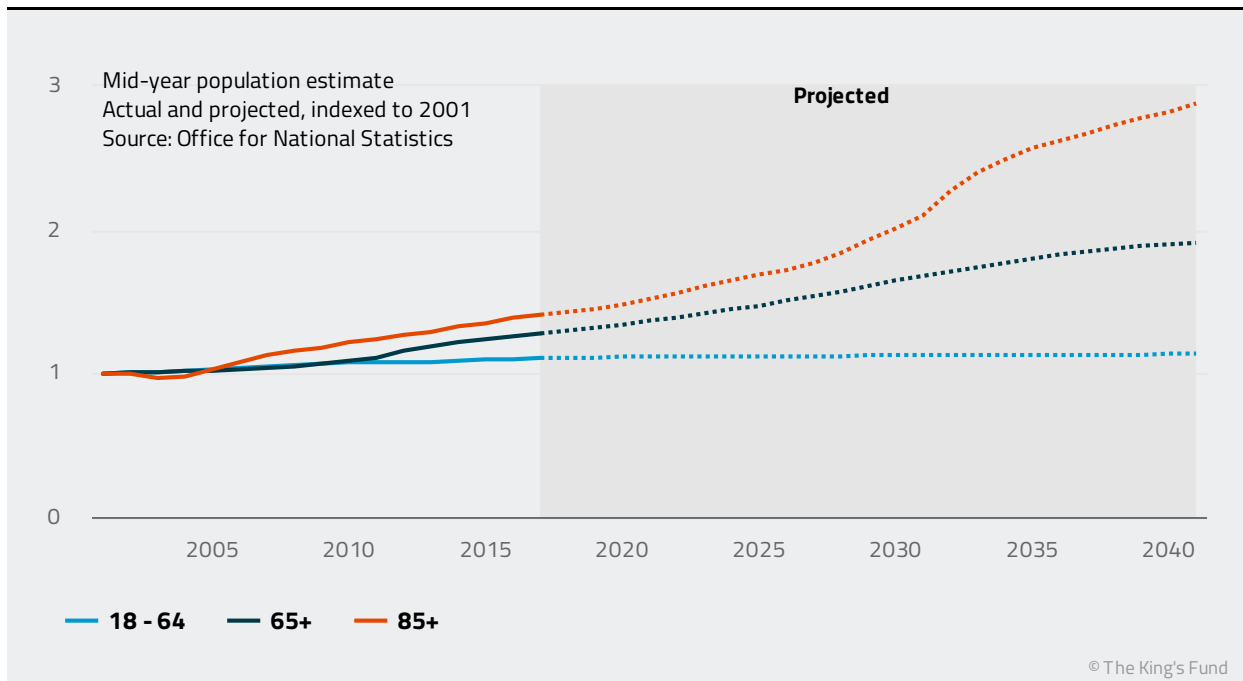
Even if we could get the numbers in these different surveys to correspond, disability – particularly where self-identified – is not an exact proxy for the numbers of people entitled to state-provided social care. Entitlement for this is set out in the 2014 Care Act and, in practice, the barrier is quite high – approximately the level of requiring help with three or more ADLs. Forthcoming Age UK analysis of ELSA suggests that prevalence of need at that level is static at around 6 per cent of people over 65.

A further complication is that measuring ADLs may not in itself indicate people's degree of dependency and therefore need for support – for example, a major study using an alternative measure found that between 1991 and 2011 there were significant increases in years lived with both low and high dependency from age 65 years for men and women.

Finally, the actual number with a disability will be determined not just by the proportion of the population with a disability but also the size of that population. The actual and projected rate of population growth in England is shown in the graph below.

Projections of increasing future need for publicly-funded adult social care are set out by the Personal Social Services Research Unit here.

The older population is growing much faster than the working-age population

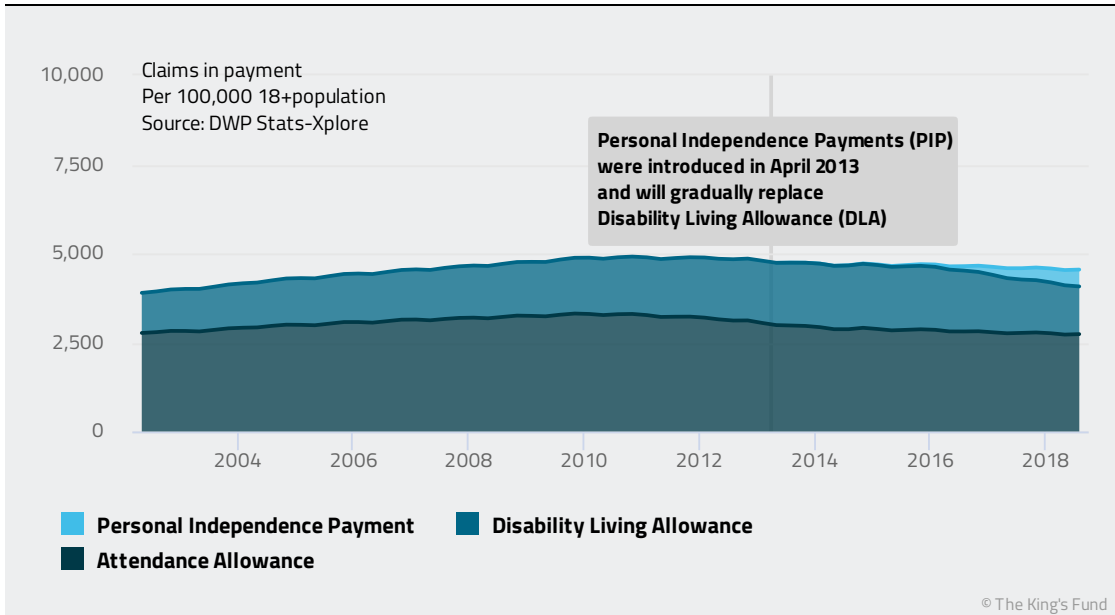


As we say our introduction, it therefore seems likely that – irrespective of whether the need of older people is growing – the trends of rising disability among the working age population, growing numbers of older people and existing unmet need are presenting significant challenges for our care and support system.

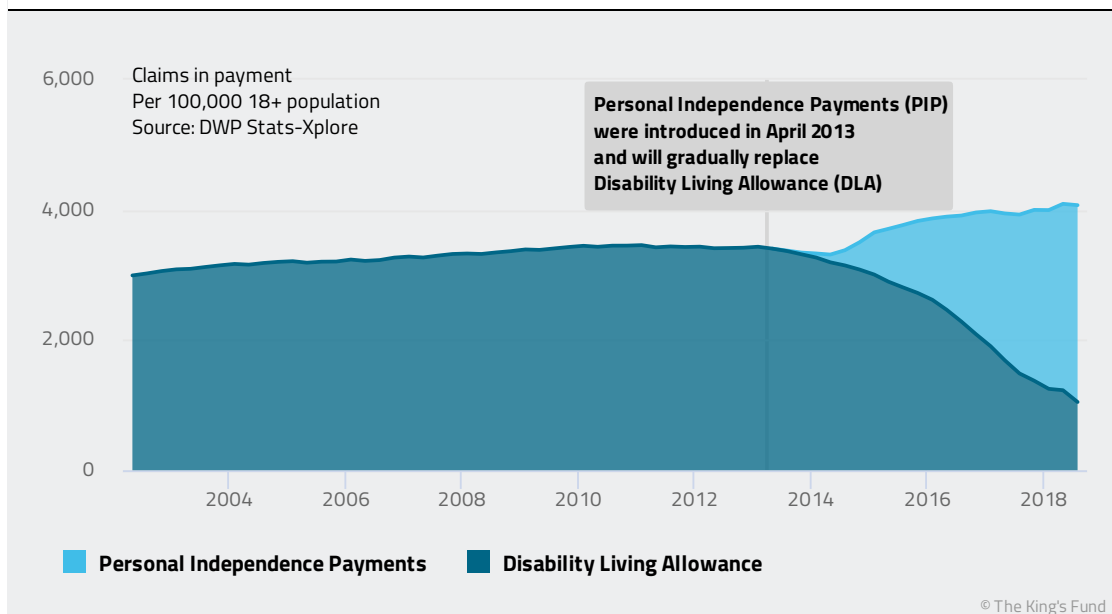
5 Overall, a higher proportion of people is receiving disability benefits

Long-term, receipt of disability benefits has increased among working age adults, though it has now fallen among older people

The number of older adults claiming a disability benefit has remained flat in recent years, despite a growth in the older adult population



There has been a steady rise in the number of working-age adults claiming a disability benefit



The proportion of people who claim disability benefits* such as Disability Living Allowance, Personal Independence Payment and Attendance Allowance is a useful further 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).

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

There are important similarities – but also important 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. One report estimates these additional costs average [£583 a month](#), an amount that would far exceed additional benefits payments received.

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. 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 will receive benefits who do not qualify for social care support.

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).

The graphs above show that a greater proportion of working age people are now receiving disability benefits* than in 2002, and the upturn has been greatest since the phased replacement of Disability Living Allowance by Personal Independence Payment in 2013 (though there have been some changes in the types of conditions most likely to be supported and this analysis focuses on the numbers of people receiving benefits, not the expenditure on them). This growth is consistent with the

increasing proportion of working-age people reporting disability in the Family Resources Survey (indicator 4).

The trend with older people is harder to explain. The Office for Budgetary Responsibility 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. In 2017/18 there were 2.4 million people receiving disability benefit compared to 2.6 million in 2009/10.

This trend could be explained by a reduction in the prevalence of disability, as suggested by the Health Survey for England. However, the Office for Budgetary Responsibility observes it may also reflect a recent absence of benefit take-up promotion, as was done for pension credit after its introduction in 2003, for example.

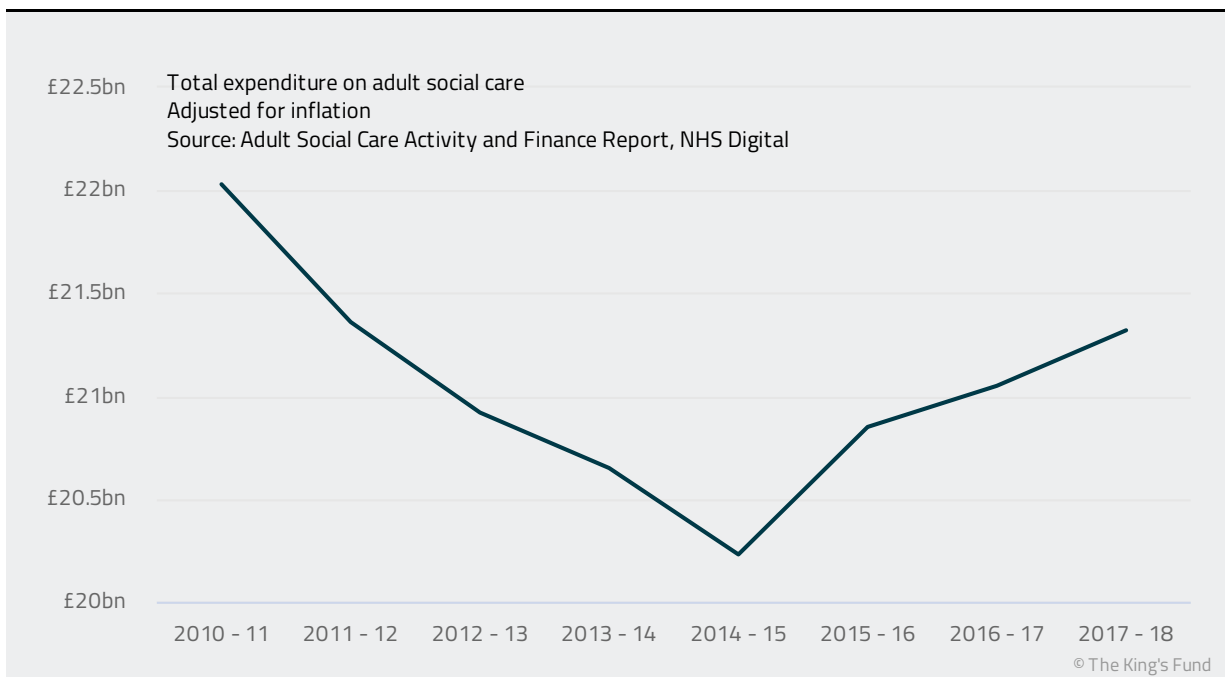
*We follow the [Office for Budgetary Responsibility](#) in distinguishing between disability benefits, which are intended to pay for additional costs for people with disabilities, and incapacity benefits such as Employment Support Allowance, which aim to replace income for those unable to work.

Expenditure

6 Spending has fallen in real terms

In real terms, total expenditure on social care by councils is still £700m below 2010/11

While adult social care funding has increased in recent years, it is still £700m below 2010/11 levels



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.

How are local authorities funded?

The overall way in which local authorities are funded is under major review, with a planned shift away from a central government support grant towards [increased local revenue-raising capacity](#).

In 2017/18, total expenditure on adult social care by local authorities was £21.3 billion, up £684 million (3.3 per cent) from the previous year.

However, while local authorities have sought to protect adult social care budgets, in real terms, expenditure is still £700m below the level of 2010/11, despite increasing demand for services.

Local authorities now spend nearly as much money on long-term care for working-age adults as for older people, though these percentages are essentially unchanged in the last three years.

The sources of funding are, however, changing. There are three main sources* for local authority expenditure on adult social care; the largest amount (technically, *net current expenditure*) is that which councils allocate to social care from their central budget. In recent years, this has been bolstered by the potential to raise more income from council tax through an additional 'social care precept'. Despite this, net current expenditure now accounts for less of total adult social care expenditure: in 2011/12, it was 76 per cent but by 2017/18 this had fallen to 70 per cent.

The other two main sources are income from client contributions – charges levied on users of social care services – and income from the NHS, much of which since 2015/16 has been channelled through the Better Care Fund.

What is the minimum income guarantee?

The means test for social care considers not just people's assets (their savings and house) but also their income. Users of services are expected to contribute from their income towards the cost of their care but must be left with enough income to live on – the minimum income guarantee.

The chart below shows that, for the three years for which this information is available, income from the NHS has increased.

**The Local Government Association has [a more detailed taxonomy](#), albeit estimated, of the sources of council expenditure on adult social care:*

Client contributions: 13.1 per cent

Government grants: 14.7 per cent

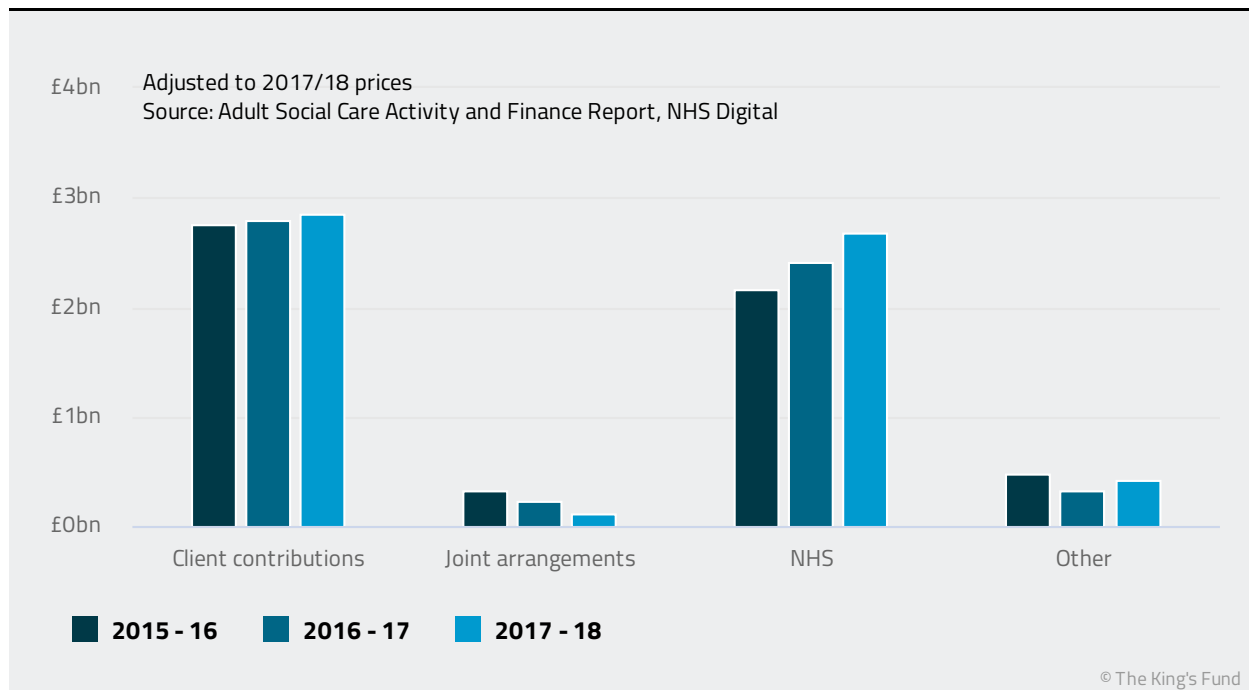
Other income (NHS partnerships): 15.5 per cent

Business rates: 18.1 per cent

Council tax: 38.6 per cent

Social Care 360 7: Unit costs for nursing and residential care

Social care income from client contributions and the NHS has significantly increased over the last three years



The chart also shows that client contributions – the fees and charges that local authorities levy on service users after means testing – have also increased by more than inflation, despite a reduction in the number of people receiving services. A survey of local authority directors of adult social services suggests that fees for community services may have been most affected.

As with other indicators in this review, there is variation between local authorities in how much they spend, at least part of which stems from differences in the level of central government support to their central budgets, their ability to raise money locally and the level of need in the local population.

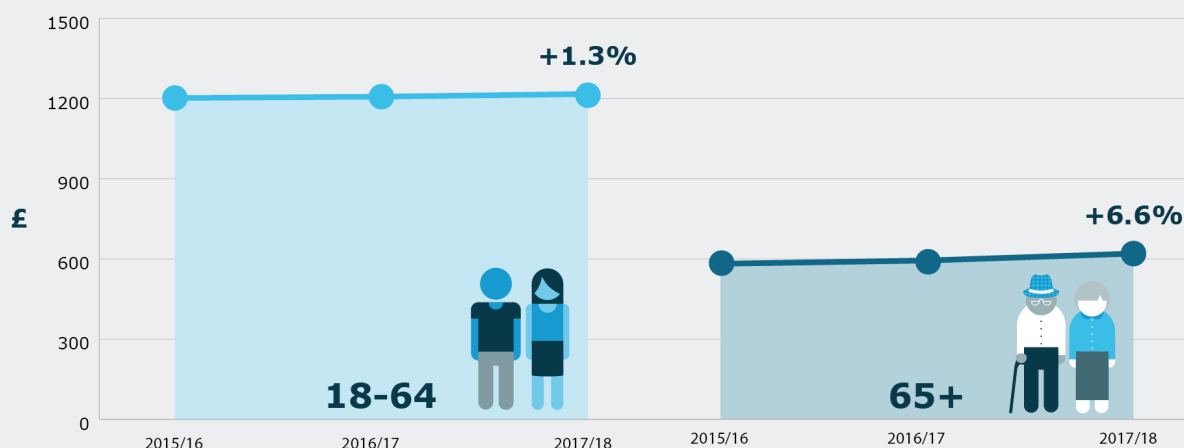
An important qualification is that this data only shows expenditure by local authorities (including money received from the NHS) on social care. It does not include private spending on care, for which there are no reliable estimates of trends (though the National Audit Office estimates the total size 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 It's costing councils more to buy care

Local authorities are having to pay more for nursing and residential care and for home care

The cost of providing care for an older person has grown faster than for a working-age adult

Average cost per week adjusted to 2017/18 prices, percentage increase since 2015/16



Adult Social Care Activity and Finance Report, NHS Digital

Though local authorities have increased spending on adult social care in the past two years, the cost to them of providing residential and nursing care and home care has risen at more than the rate of inflation.

Between 2015/16 and 2017/18 the average weekly unit cost for providing residential and nursing care to over 65s increased by 6.6 per cent to £615 and the average for under 65s increased by 1.3 per cent to £1,225.

As with other indicators, these figures relate purely to local authority expenditure; we have far less information about the costs to self-funders of residential and nursing care, though the [Competition and Markets Authority](#) estimates that on average they pay 41 per cent more than local authorities for the same level of care.

An underlying factor in the increased spending by local authorities may be increased costs faced by providers, for example arising from increases in the national living wage. Additionally, local authorities may feel they need to pay providers more in order to stabilise the market following closures and withdrawals.

Extra money provided by the government for social care in the 2017 budget through the Better Care Fund had, as one of its [three purposes](#), support for local social care provider markets.

[Surveys of local authorities](#) suggest this is more an issue with home care than residential and nursing care, though average care home fees remain well below the level [LaingBuisson](#) regards as the minimum to ensure acceptable rates of return for care homes.

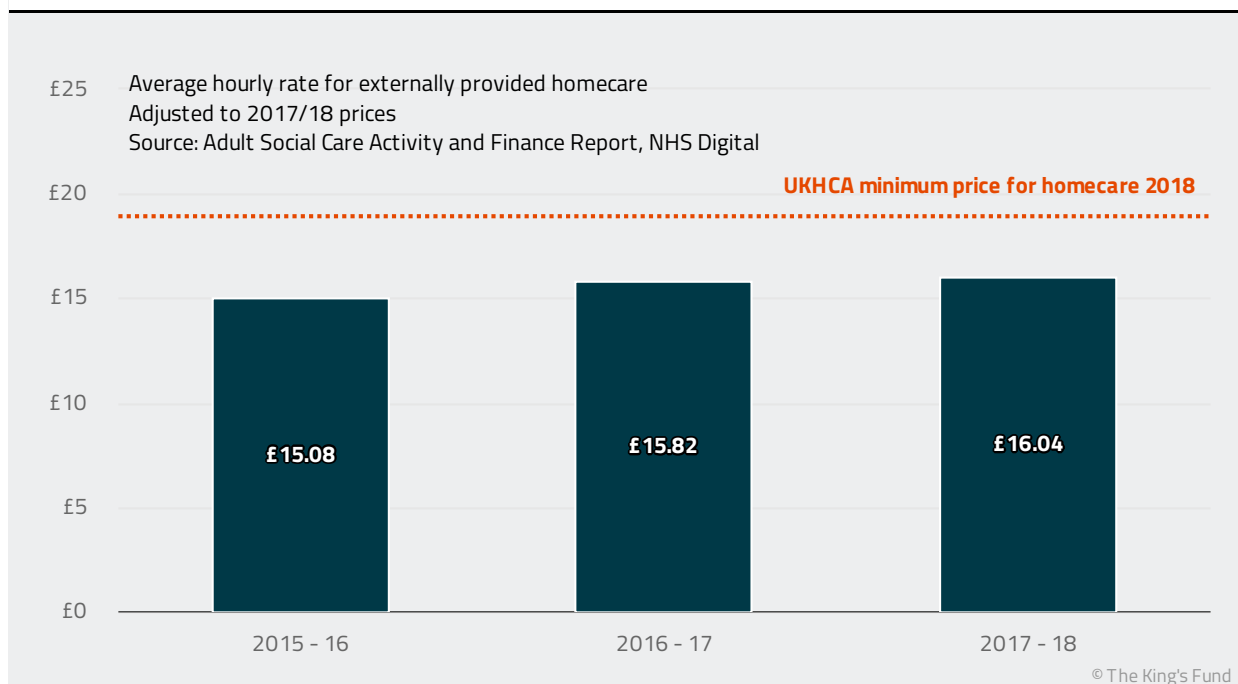
An additional or alternative explanation for rising costs is that residents require increasing amounts of support because only those with highest needs enter residential or nursing care in the first place. This in turn may be because more people are being cared for at home.

While far fewer working-age adults are in residential care, their costs are significantly higher than those for over 65s. This may be due to the *type* of support provided (around 45 per cent of working-age people have a learning disability as their [primary reason for support](#), compared to just 3 per cent of over 65s), but it may also be that a higher *level* of support is provided to younger people – an argument put forward by one of the care home industry representative groups, Care England.

Unit costs for the provision of care at home have also been increasing. Rates paid by councils for externally-provided home care averaged £16.04/hour in 2017/18, compared to a rate of £15.82/hour in 2016/17, when adjusted for inflation. However, the rate of increase has fallen compared to 2015/16 and the average rate remains well below the [£18.93 minimum put forward by the United Kingdom Home Care Association, which represents home care providers](#).

There are also local and regional differences in the cost of commissioning – the hourly cost of externally provided home care was lowest in the north east (£14.07) and highest in the south west (£18.27). As with residential and nursing care, these differences may reflect active attempts by local authorities to [shore up a fragile care market](#) and avoid closures or contracts being handed back. However, it may also reflect the [differences in costs of delivery](#) in rural areas and those where it is particularly difficult to recruit a workforce.

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



Care provided in-house by local authorities is significantly more expensive than that which is externally commissioned. The unit costs for in-house provision of long-term residential care were on average £1,785 for younger people and £933 per week for older people in 2017/18, compared with external provision at £1,263 and £591 respectively.

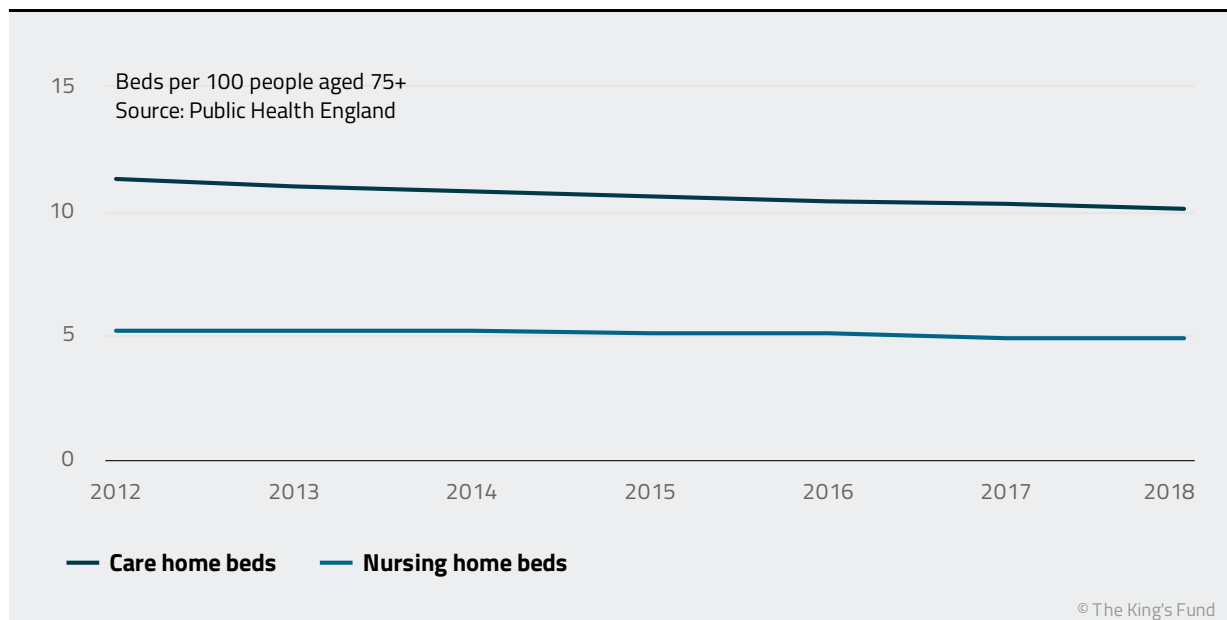
The hourly cost of in-house home care rose from £25.60 to £32.90 between 2016/17 and 2017/18. The additional cost of in-house home care provision may at least partly be because many reablement services – which are more expensive to provide than standard home care – are still provided in-house.

Providers

8 There are fewer residential and nursing homes places available for older people

The number of beds available for people aged over 75 – the main users – has declined consistently in the past few years

Compared to the size of the older population, the number of nursing home beds has remained flat while the number of care home beds has fallen



Overall there are slightly fewer care beds available now compared to 2012, with a small increase in beds in nursing homes offset by a slightly larger decrease in beds in care homes.

What is the difference between nursing homes and care homes?

Nursing homes differ from care homes in having registered nurses on site at all times.

This trend is clearer if we look at the availability of beds for the increasing numbers of [older people](#) as they make up an estimated [95 per cent of care and nursing home residents](#). These have declined from around 11.3 beds in care homes per 100 people aged 75+ to 10.1. Beds in nursing homes have shown a smaller decline.

The fall in bed availability may reflect the gradual change in social care policy, which has shifted towards providing care at home rather than in residential care. The reduction in people entering care homes is shown in indicator 16, though there is no reliable annual data on overall numbers of people receiving home care with which to substantiate an increase in service provision at home.

It is worth noting that these changes are very small changes compared to the longer-term trends. In 1996, there were more than 550,000 beds and [Grant Thornton](#) estimates that 25.2 per cent of the population aged 85+ was in elderly residential accommodation compared to 14.8 per cent in 2017.

There has also been a significant change in care home ownership in the past few decades: [in 1984, 57 per cent of places were in local authority-run residential homes](#) but by 2017 this had fallen to just 8 per cent.

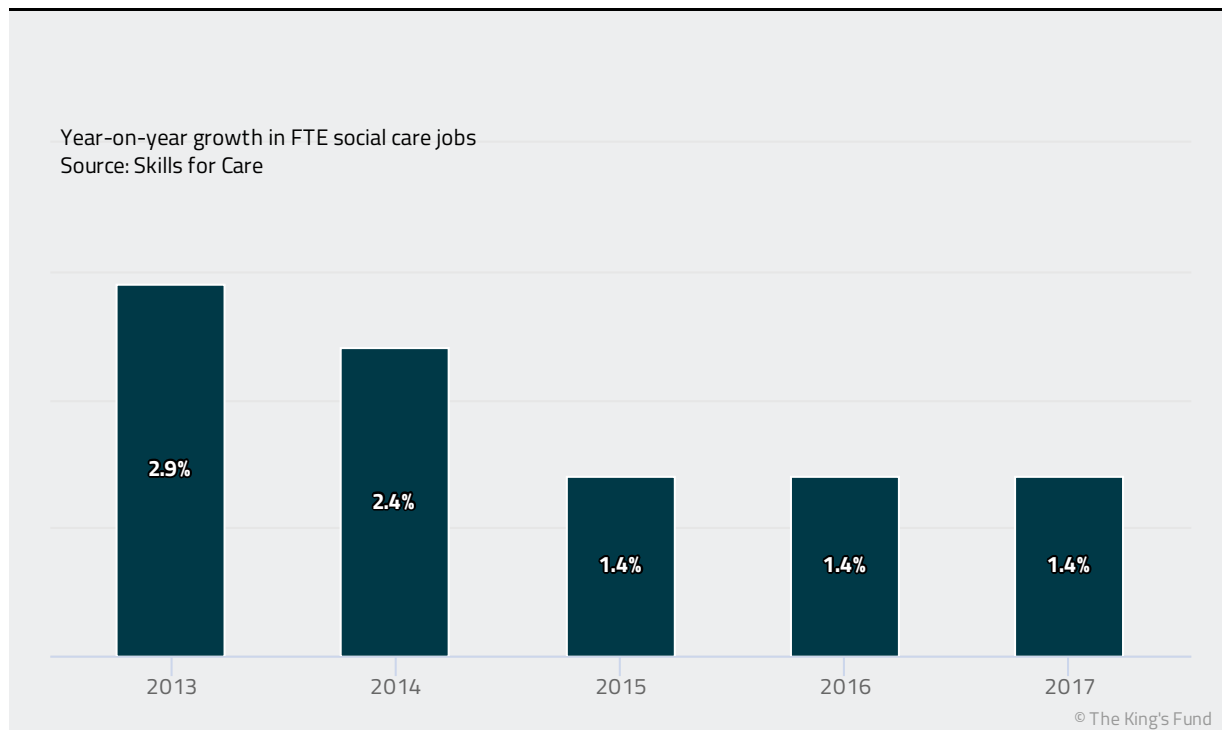
Though there has been little change in the availability of beds, there have been some changes in the average size of care homes. The average number of beds in a care home has increased from 18.9 in 2012 to 20.5 in 2018, and the average nursing home has increased from 46.1 to 49.7 beds. Similarly, a [Knight Frank survey](#) found that homes that were closing had an average of 30 beds and those opening had 60 beds.

Workforce and carers

9 There are more jobs in the care sector

The number of jobs in social care has increased but the rate of growth is slowing

Growth in the number of full-time equivalent social care jobs has slowed



Adult social care is a large and growing sector in England: nearly 1.5 million people work in an estimated 1.6 million jobs (1.1 million full-time equivalents) in around 21,000 organisations, according to social care workforce intelligence body, Skills for Care. Analysis in this indicator and the next one is based on its data.

The number of jobs has increased by around 275,000 since 2009 but the rate is slowing: the workforce grew by only around 15,000 a year between 2014 and 2017 compared to an average of 45,000 a year between 2010 and 2014.

Over three-quarters of social care jobs (78 per cent) are in the independent sector – the voluntary sector and for-profit sectors – with the rest split fairly evenly between local authorities (7 per cent), the NHS (6 per cent) and those directly employed by service users (9 per cent).

The table/infographic below shows how the 1.6 million (1.1 million full-time equivalent) jobs are distributed within the sector.

Job role	Total jobs	Percentage of jobs
	1.6 million	
Direct care – including care workers, senior care workers, personal assistants for direct payment recipients and community support/outreach workers	1.22 million	76
Managerial – including registered managers and supervisors	119,000	7
Regulated professionals (nurses, occupational therapists and social workers)	83,000	5
Other – administration and ancillary staff such as catering, cleaning, transport and maintenance	180,000	11

The annual growth in social care jobs has broadly tracked the growth in the older population in England. On average, one adult social care job is needed for every seven people over 65 and every three people over 75. This appears consistent with data from the Family Resources Survey suggesting underlying need among older people has remained static over time, though in practice the relationship between

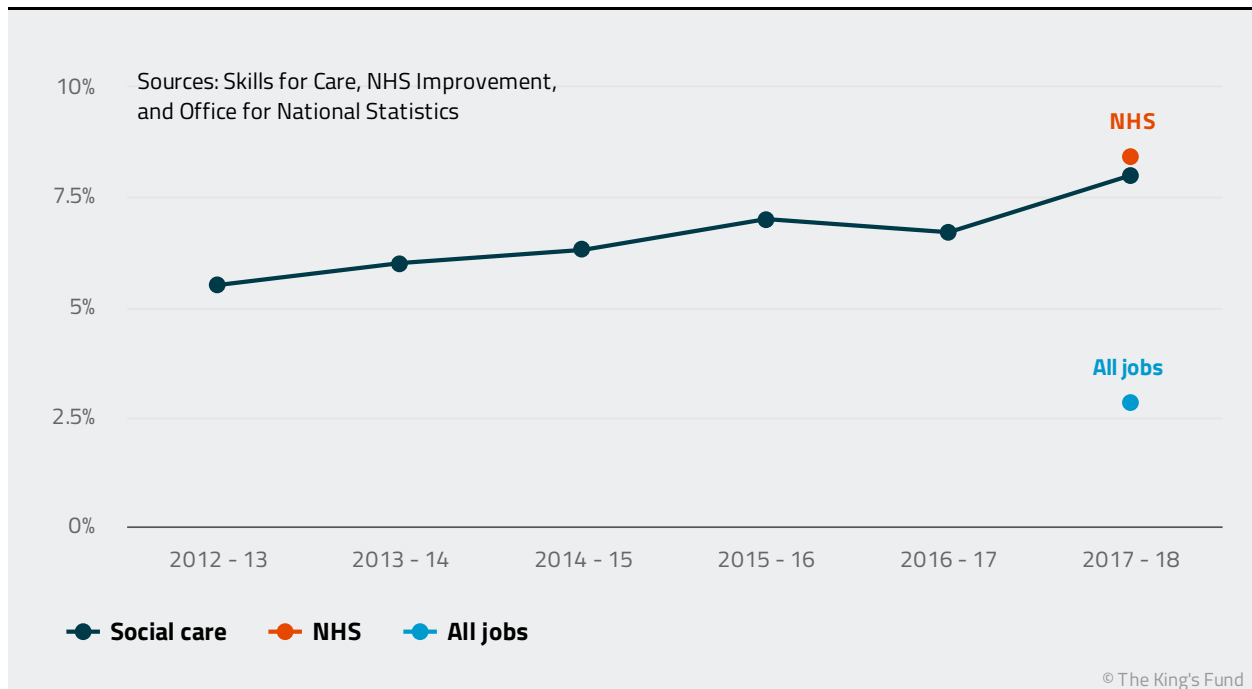
jobs and the older population is unlikely to be as clear-cut since half of the public spend on social care is not on older people but on working-age adults.

If the number of jobs *does* continue to grow in line with the growth in the older population, the implications are stark: Skills for Care estimates the need for between 650,000 and 950,000 new adult social care jobs by 2035. The difficulty in finding people to fill them is identified in the next indicator.

10 ...but vacancies are growing

Around 8 per cent of jobs are vacant and 390,000 staff leave their jobs each year

The vacancy rate in social care has been increasing and is similar to the vacancy rate in the NHS



[Industry workforce body Skills for Care \(on whose data this section is based\)](#) estimates that on average around 110,000 jobs – 8 per cent – are vacant in adult social care at any one time – similar to vacancies in the NHS and much higher than the 2.8 per cent figure for the economy as whole. Turnover of staff is also high at 30.7 per cent, equivalent to around 390,000 leavers over a year.

This is part of a long-term trend that has seen the vacancy rate rise since 2012/13. In 2016/17 the average vacancy rate was 20,000 lower at 90,000. Turnover rates have also increased steadily, from 23.1 per cent in 2012/13 to 30.7 per cent in 2017/18 – a worrying number, particularly since continuity of caregiver is an important factor for people who receive care.

Vacancy and turnover rates are high for most roles

Job role	Vacancy rate 2017/18 (%)	Turnover 2017/18 (%)
All roles	8.0	30.7
Direct care roles	8.6	34.8
Of which, care workers	9.1	37.5
Manager/supervisor roles	5.6	14.9
Of which, registered managers	11.8	22.0
Senior management	2.5	8.2
Regulated professional roles	11.4	26.1
Of which, social workers	10.2	15
Occupational therapists	9.0	13.8
Registered nurses	12.3	32.4

Within these figures, residential care has lower vacancy rates than home care (though its vacancy rate rose last year while home care's fell).

Difficulty in recruiting care workers comes despite their pay rising since the introduction of the national living wage in 2016 – in 2018 the average increase in careworker pay was 5.2 per cent (2.7 per cent in real terms).

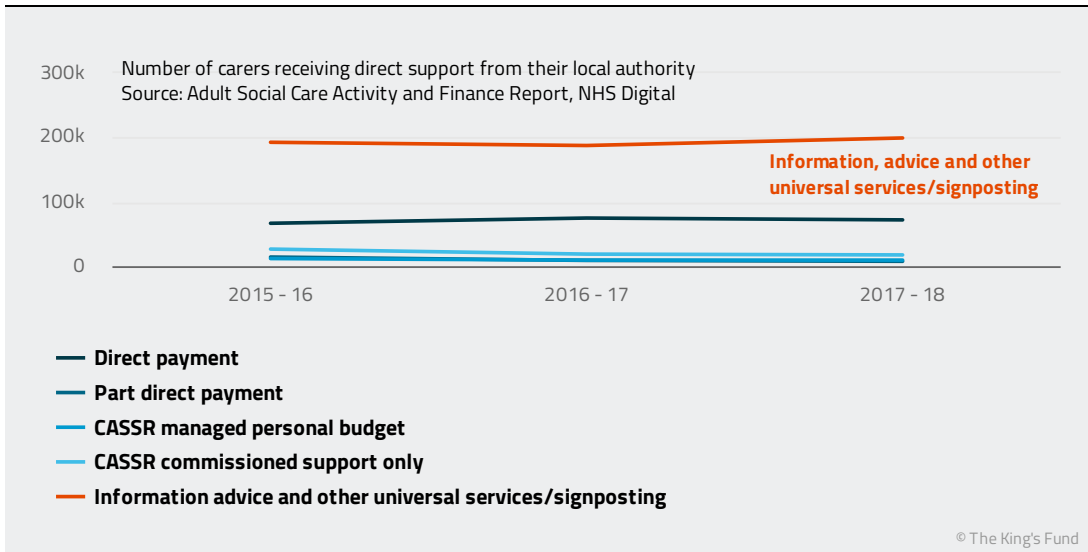
However, the rise has not necessarily made the sector more competitive with other industries. At £7.89, the average hourly rate for a careworker in the independent sector is far lower than that of store assistants in supermarkets such as Aldi, which pays £10.55 inside the M25 area and £9.10 outside.

And though the lowest paid care workers have seen an increase, the industry's pay bill as a whole increased by only one percent, with 30 per cent of care workers now paid in the bottom decile of the pay scale compared to just 10 per cent in 2016.

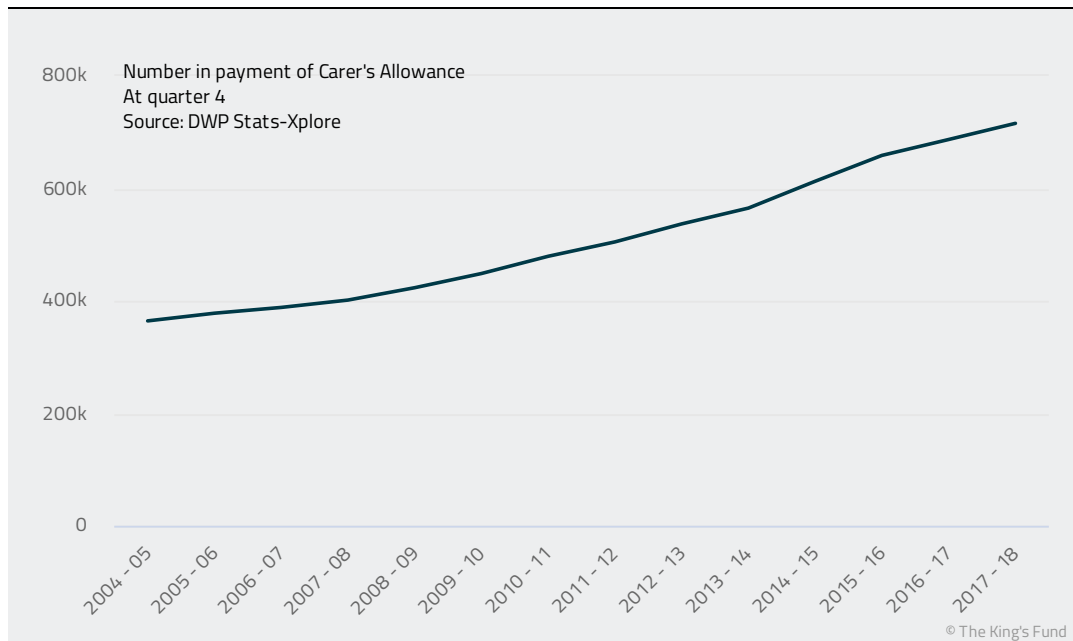
11 It's a mixed picture of support for carers

More carers are receiving Carer's Allowance but the number receiving direct support from local authorities is falling

More carers are receiving 'information, advice and other universal services/signposting' from their local authority, but other types of support have gone down



The number of people receiving Carer's Allowance has been increasing



Unpaid carers do the [work](#) of an additional four million paid care workers. There are two main statutory sources of support for them: local authorities offer financial support, services and advice; a national benefit, Carer's Allowance, is available to those caring for people receiving disability benefits.

The trends are very different for the two types of support.

The number of carers provided with direct support by local authorities decreased overall between 2015/16 and 2017/18. Within this overall decline, the percentage who received information, advice or signposting increased while the percentage receiving direct payments or services fell. Information, advice and signposting makes up the majority of direct support received by carers (64.7 per cent in 2017/18).

By contrast, the number of people claiming Carer's Allowance has been steadily increasing over this period (and, in fact, well before it), with an additional 29,000 receiving the benefit between February 2017 and February 2018.

The Family Resources Survey suggests that until 2016/17 the percentage of people who self-identify as carers was consistent at 8 per cent, which – when population growth is taken into account – means that the number of carers in the population increased. However, in 2017/18, the percentage of carers had fallen to 7 per cent, which equates to a reduction in the number of carers to 4.5 million from 4.7 million in 2007/08.

The most comprehensive – albeit dated – estimate of the numbers 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.

However, all estimates may reflect the fact that individuals often do not self-identify as carers. 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.

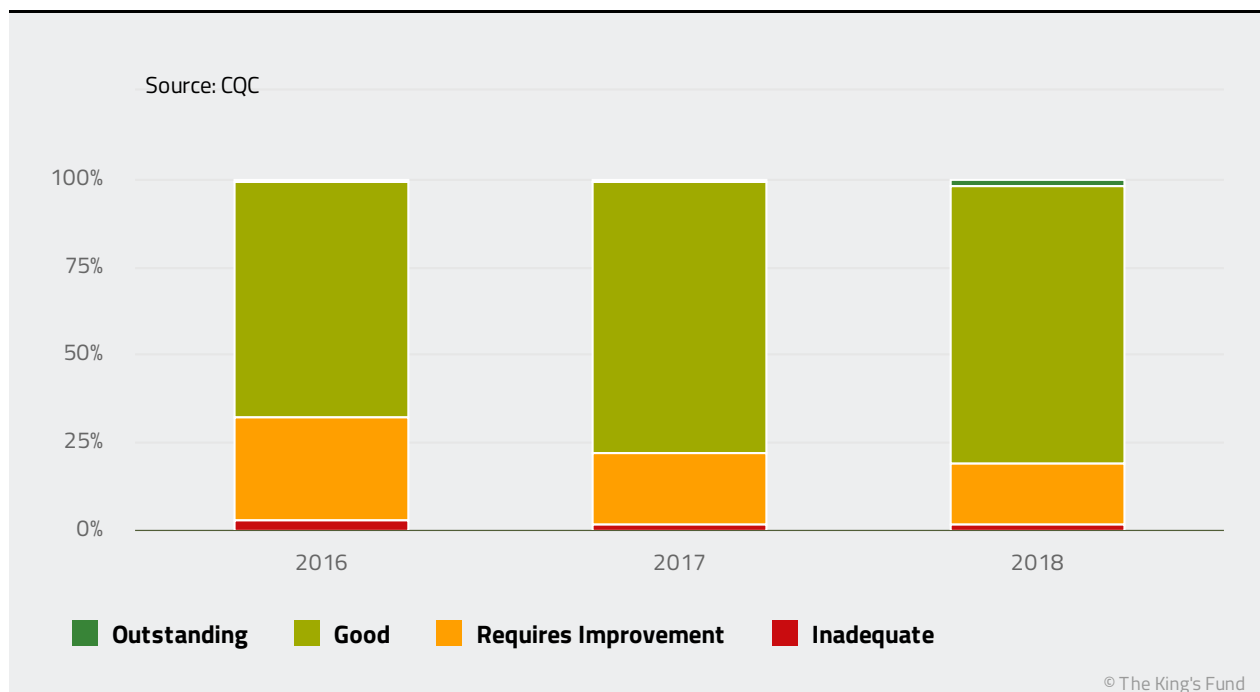
The increase in numbers receiving Carer's Allowance will also have been influenced by an increase in the numbers of people claiming the qualifying disability benefits (see indicator 5) and by changes to state pension entitlement, which mean that some women must wait longer to claim their pension but are able to claim Carer's Allowance.

Quality

12 Care quality is rising. Probably.

More services are rated good or outstanding, though we may need to be cautious about the apparent improvement

The percentage of care services rated outstanding or good has been increasing



In its 2018 [State of Care report](#), the Care Quality Commission (CQC) says the overall quality of social care has improved slightly. Its data shows a higher percentage of services rated good or outstanding for each of the past three years.

This sounds good news – and may well be – but there are several reasons to be cautious about this apparent increase. The CQC’s new inspection regime, introduced in late 2014 and generally regarded as tougher than its predecessor, brought forward inspections of services about which there were concerns. So it would not be surprising to find more homes requiring improvement in the first years of

inspections and for more better-quality services to be inspected as the years progress.

Once a service is rated good, it is inspected less frequently so its rating is held for longer, which again tends to push up reported standards. Services that have been rated as inadequate or requiring improvement are also more likely to close.

In 2016/17, the [CQC](#) said that factors associated with good services included the presence of a registered manager in care homes. Size was also a factor, with smaller care homes (1–10 beds) rated better than larger ones (more than 49 beds). This may be because many smaller homes are for people with learning disabilities and these homes tend to perform better overall, as in domiciliary care, where services catering to smaller numbers of people were also performing better.

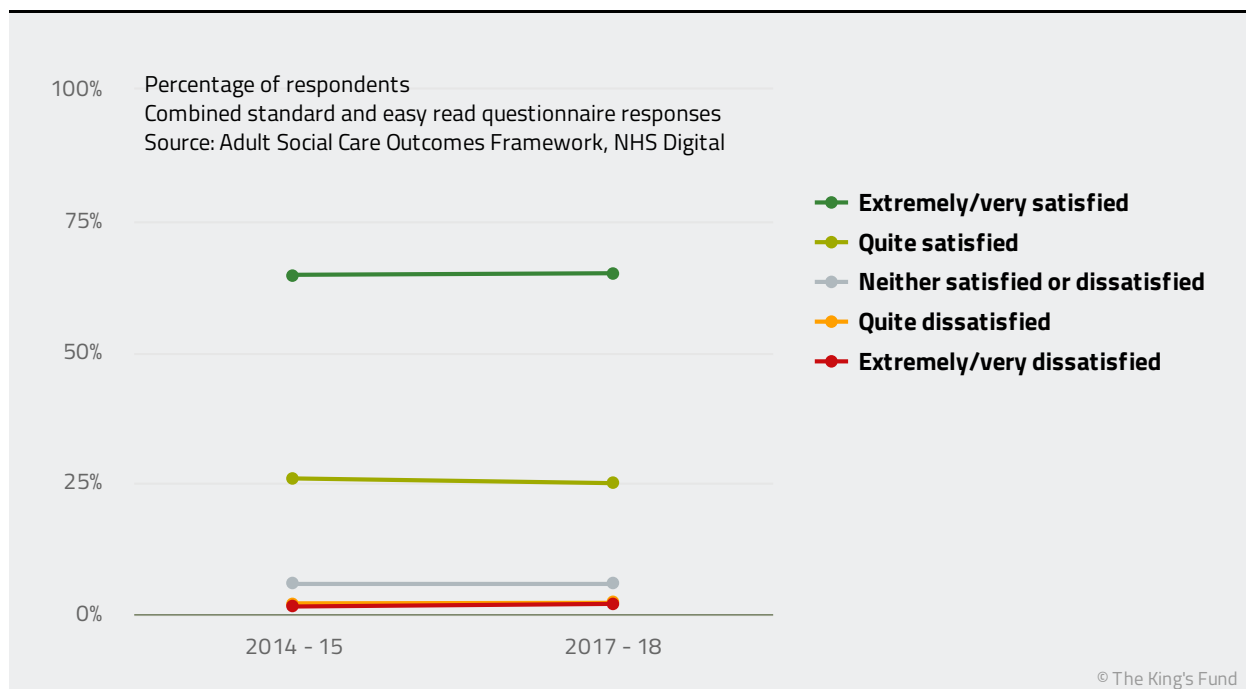
It is worth noting that inspections inevitably provide a measure based on a 'snapshot' of a service's performance, which may not necessarily be an accurate measure over a longer period.

There is also significant local variation in care quality but no clear answers as to why it exists. Local service make-up may be one factor: of the different types of adult social care, nursing homes tend to be lowest rated, so an area with a lower proportion of nursing homes may appear to have a higher overall quality of care. Some local authorities provide more support to struggling homes than others and this may also be a factor.

13 Service users say they're satisfied

Satisfaction with publicly funded care has remained at high levels

Social care service user satisfaction has not changed substantially in the past four years



Service users' satisfaction with the care funded by local authorities appears to have remained consistently high over the past four years, with approximately 65 per cent saying they are either extremely or very satisfied. Fewer than 5 per cent say they are dissatisfied.

In some ways this is a surprising figure, appearing to contradict anecdotal concerns that financial constraints have affected the volume and quality of the packages of care provided. There is little in the satisfaction data to suggest this, though there has been a small, statistically significant, increase in dissatisfaction between 2016/17 and 2017/18.

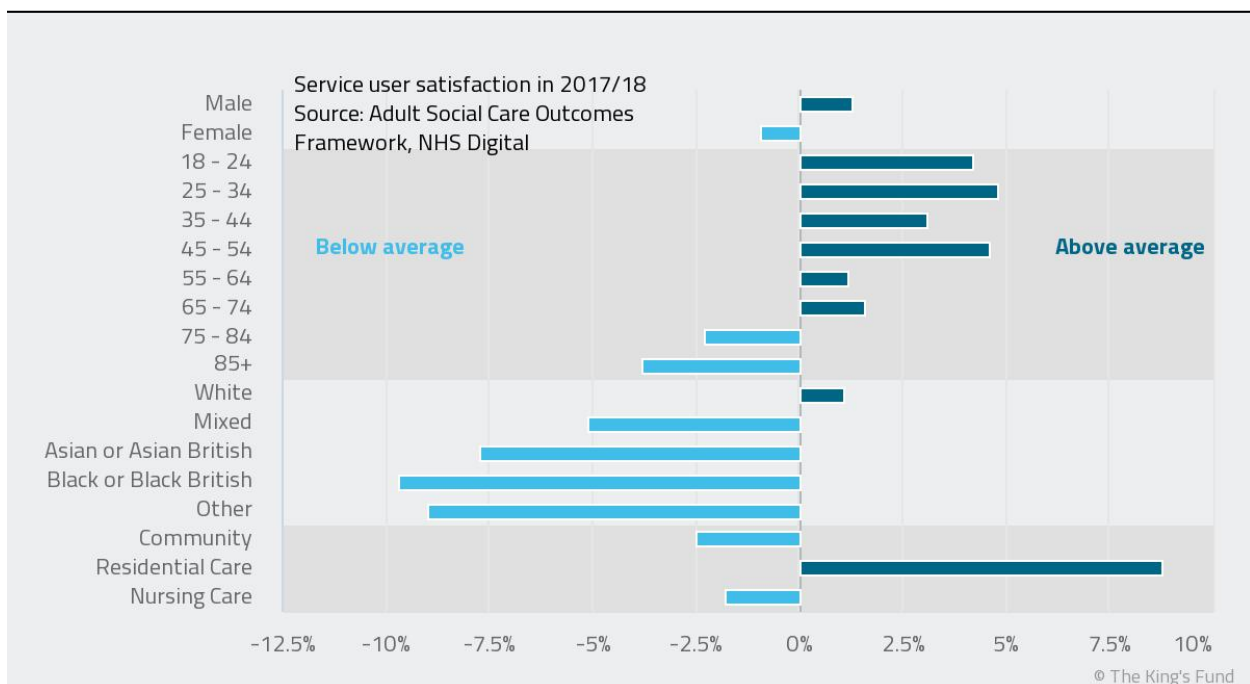
One interpretation of this data is therefore that, despite declining budgets, local authorities have managed to protect the services they provide to – an admittedly declining number of – individuals who are eligible for services.

However, the results do contrast with the bi-annual [survey of adult carers](#), which asks about satisfaction not only with services for carers themselves but also with services provided to the person they care for. Here, in 2016/17 only 39 per cent said they were extremely or very satisfied and this number may have declined since the first survey in 2012/13, although changes to methodology make this hard to determine.

Another reason for caution is [Local Government Ombudsman](#) data showing a rising number of complaints about adult social care. The LGO notes this may indicate greater awareness of the LGO and/or greater willingness to complain but also highlights concern that increasingly the complaints they see relate to 'systemic issues' rather than one-off mistakes.

Some [evidence](#) also suggests that a positive satisfaction rating may conceal variations in experience of social care.

The percentage of service users 'extremely/very satisfied' with their care varies by type of user



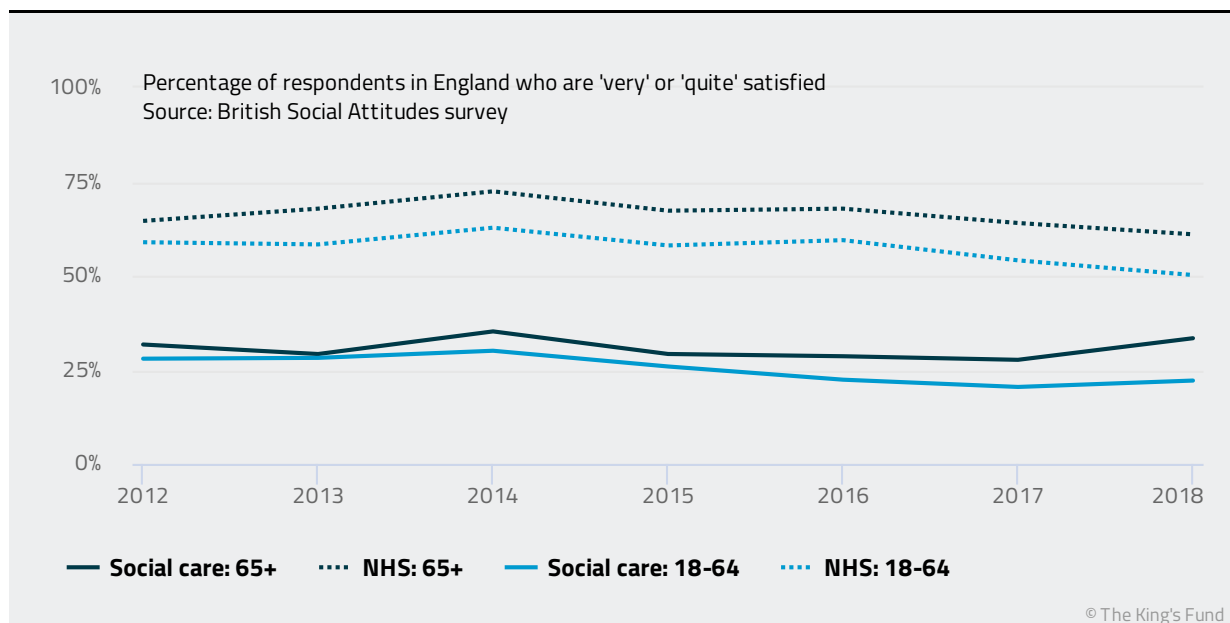
It is also important to note that, despite the high level of overall satisfaction, there is some variation between different groups responding to the survey. People over 65 report lower levels of satisfaction than those aged 18–64. Black and minority ethnic people also report lower levels of satisfaction than white respondents. People in residential care are more likely to be satisfied than those receiving nursing or community care services.

There is no data available about the satisfaction of people who fund their own care services (including any who no longer receive publicly funded care). However, we do have data about wider public satisfaction with social care, which is covered in the next indicator.

14 Public satisfaction is low

Satisfaction with social care is lower than for the NHS but this may reflect less experience and understanding of it

Public satisfaction with social care services is much lower than for the NHS, and older people are more satisfied with both services than working-age adults



Questions asked: 'All in all, how satisfied or dissatisfied would you say you are with the way in which the National Health Service runs nowadays?' (in 2018 n=782 for 65+, n=1748 for 18–64) and '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?' (in 2018 n=274 for 65+, n=570 for 18–64). The King's Fund analysis of NatCen Social Research's BSA survey data.

Public satisfaction with state-provided social care has remained stable at 25 per cent, compared to public satisfaction with the NHS of over 50 per cent.

This level of satisfaction also contrasts, of course, with much higher levels of satisfaction expressed by people who are actually using publicly funded services – see indicator 13. And, interestingly, whereas among actual users of services, older people are *less* satisfied with their care, among the public generally, older people are *more* likely to express satisfaction.

However, there are several reasons to be cautious about this measure of public satisfaction.

Unlike for the NHS, most people do not have direct experience of using adult social care services (though some will have direct experience of arranging care for someone else). Indeed, [many may not understand](#) what the term 'social care' means and may not understand clearly the distinction between services provided by the NHS and those provided as social care. Probably as a consequence, much higher levels of people sit on the fence: 31 per cent say they are neither satisfied nor dissatisfied and 10 per cent say they 'don't know'. This compares to the NHS, about which most people express a view, with 16 per cent saying they are 'neither satisfied nor dissatisfied' and hardly anyone (0.4 per cent) saying they 'don't know'.

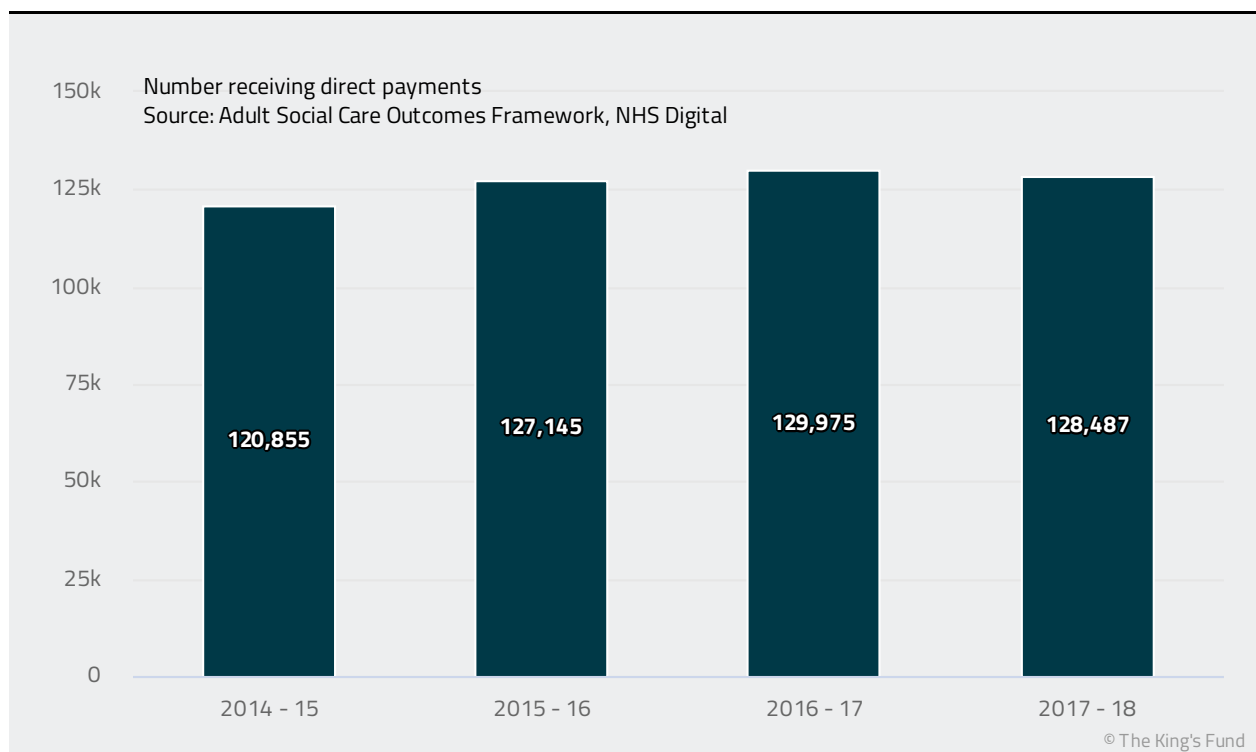
Another reason might be that some who express an opinion on social care may be basing it on what they hear in the news. [Analysis of national media coverage](#) for social care between June 2017 and April 2018 found the word 'crisis' was often used and that social care was predominantly framed in the press as an 'intractable problem that results from a combination of decreasing financial resources (mainly due to government policies) and increasing demands (due to a rising number of older people in need of support)'.

The indicator may therefore be mapping a public concern about social care and lack of understanding of it rather than – or as well as – public dissatisfaction.

15 Direct payments remain at a low level

The number of service users receiving direct payments has stalled, with a far higher percentage of working-age adults using them than older people

The number of service users receiving direct payments has stalled



Direct payments should be a valuable indicator of 'personalisation' of services – the amount of control an individual has over their care and support.

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 and one option is a direct payment – actual cash for the person to organise and pay for their care and support themselves (often by directly hiring people to work for them as personal assistants who will carry out a wide range of support in the home, at leisure or in work).

Yet the number of people receiving direct payments, after growing for several years, has now stalled. The proportion increased by just 0.2 per cent in 2017/18 and, since the total number of service users fell, 128,000 people were receiving direct payments at the end of the year, down from 130,000 the previous year.

We do not fully understand the reasons for this trend, but does it mean that personalisation is also stalling? Certainly older people in particular appear reluctant to take advantage of the options that direct payments offer: just 17.5 per cent of over-65s take direct payments compared to over 40 per cent of working-age adults.

However, the levelling-off may not be due simply to lack of interest. Support groups say that a key factor is support for take-up. People often need help to manage services, particularly if they opt to directly employ personal assistants, and this support has not grown in the way envisaged by the 2014 Care Act.

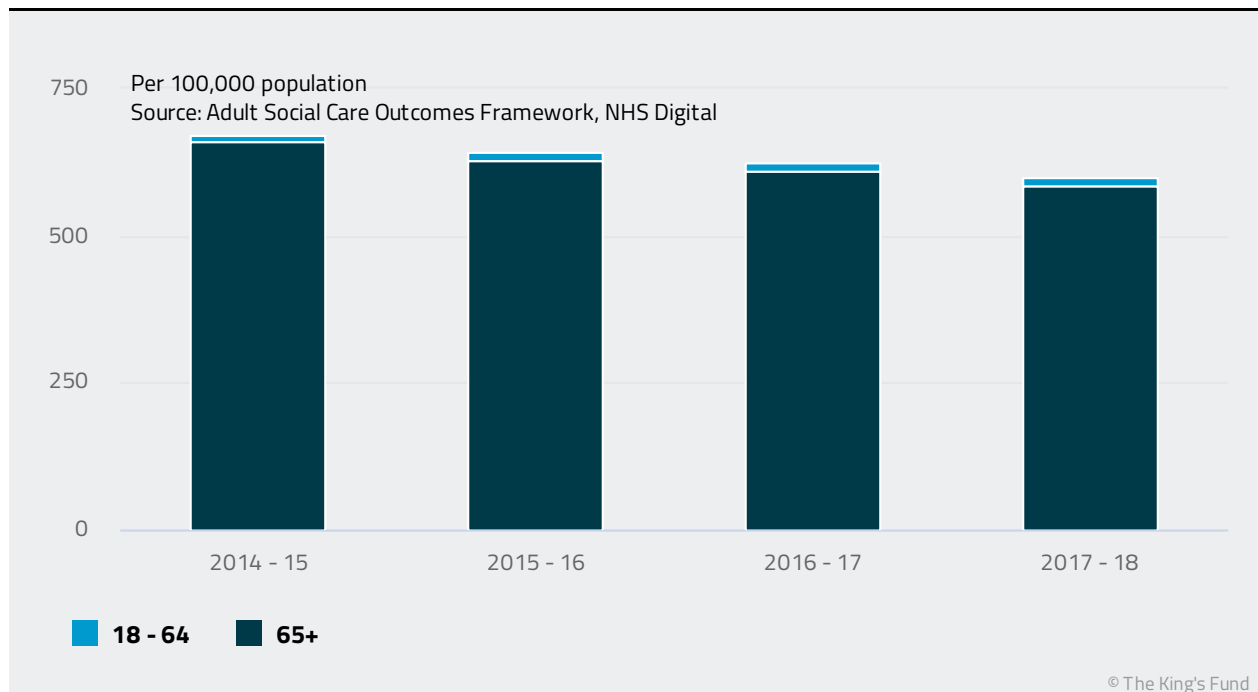
Availability of personal assistants and services to choose from may also be a factor: if local services are limited to one or two options, users may conclude they may as well receive them direct from the local authority rather than go to the extra effort of managing them themselves.

These factors may help to explain the wide variation between local authorities in the amount of take-up: in some local authorities fewer than 9 per cent of people opt for a direct payment yet in others it is nearly 60 per cent.

16 Fewer people are entering care homes

Overall there has been a decline in people going into residential and nursing care homes – but a surprising increase for working-age adults

Overall, the number of people admitted to residential or nursing care has gone down...



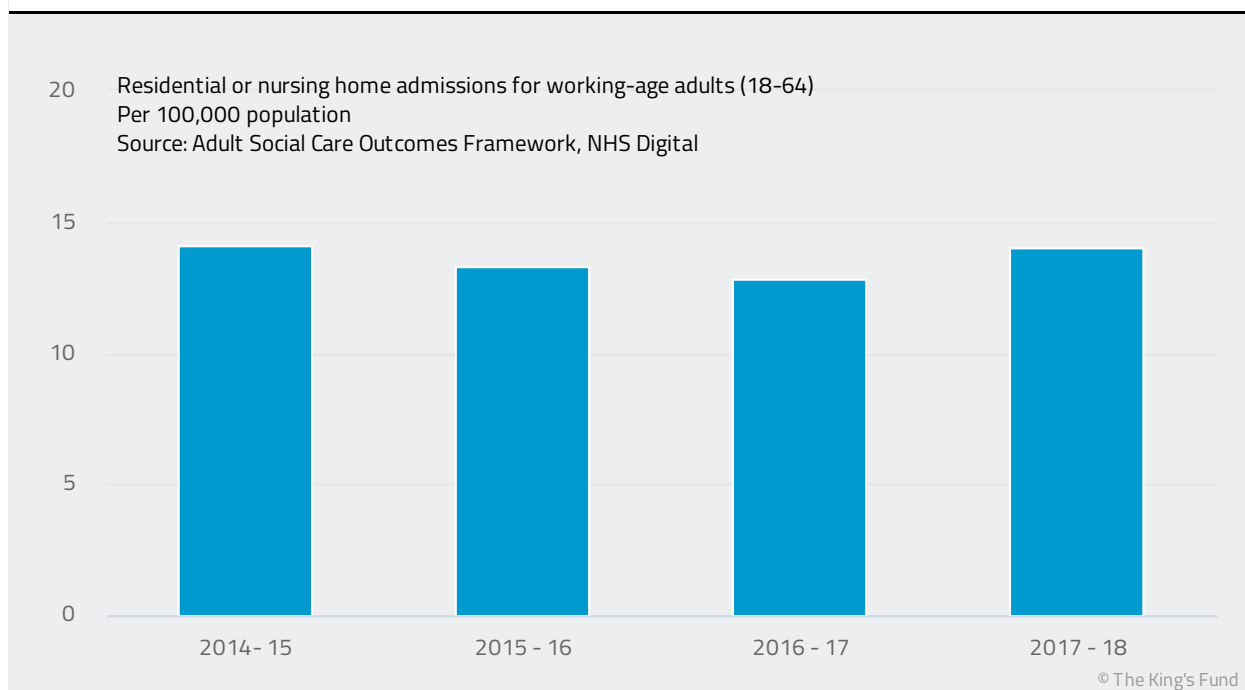
Avoiding permanent placements in residential care is seen as an indicator of the quality of the social care system, partly because it is a measure of delayed dependency and also because people prefer to remain independent at home for as long as possible. Residential care is also typically more expensive than home-based care (though this depends on the care provided at home – some high-intensity home-based packages can be very expensive).

It is therefore encouraging that the overall number of people entering residential or nursing care homes has – as the chart above demonstrates – declined over the past few years. For older people, the rate has fallen from 659 per 100,000 people in 2014/15 to 586 per 100,000 in 2017/18. For working-age adults, the fall has been marginal, from 14.1 per 100,000 in 2014/15 to 14.0 in 2017/18.

However, there are notes of caution. One comes from 'serious concerns' expressed by directors of adult social services in their autumn 2018 survey that overall numbers admitted to residential care may be set to increase again, partly as a result of the 'unintended consequences' of efforts to reduce the number of delayed transfers of care from hospital.

A second note of caution comes from an *increase* in the number of working-age adults entering homes in 2017/18 after three years of decline.

...however, if we look specifically at working-age adults the number increased in 2017/18



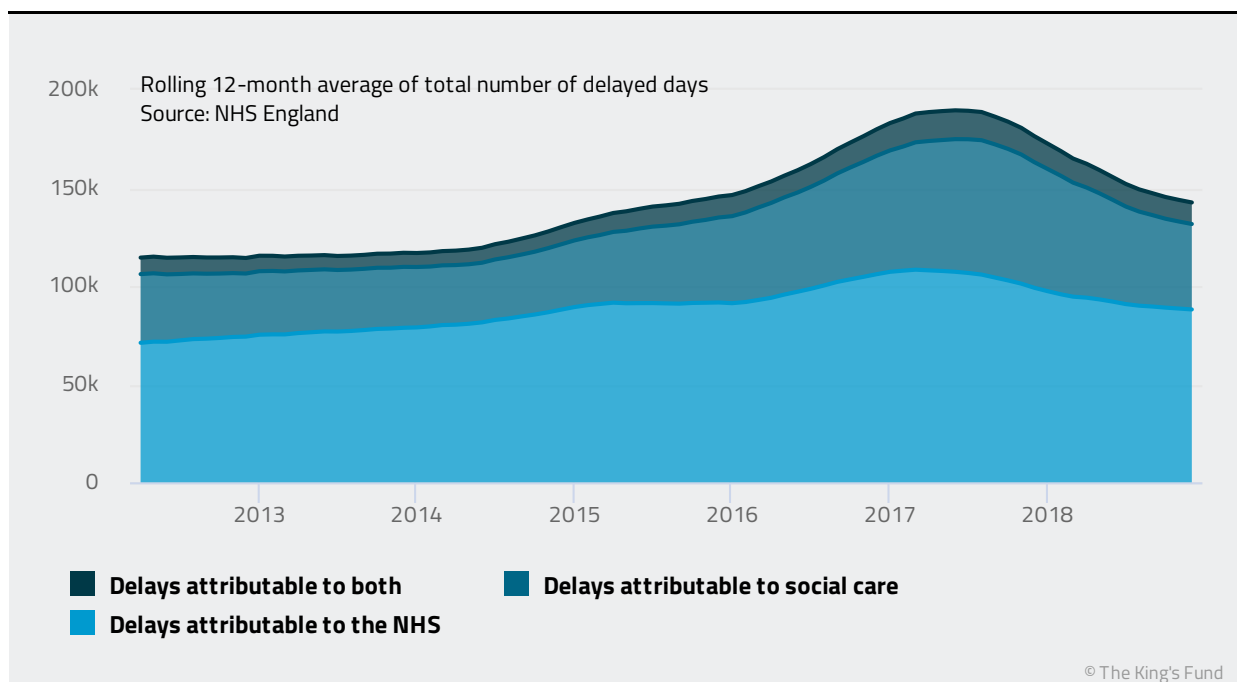
The increase is small and, because relatively few working-age adults enter residential care, amounts to only around 400 more people across 152 local authorities. It may therefore be a one-off anomaly. If not, an optimistic hypothesis would be that more working-age people are leaving NHS hospitals and entering residential due to the 'homes not hospitals' principles of the Transforming Care agenda for people with learning disabilities and autism. A less optimistic one would be that commissioners are considering residential care for some people with very high support needs because of the high costs of providing care at home.

Integration with other services

17 Delayed transfers have improved

Delayed discharge from hospital due to social care have fallen

After peaking in 2016/17, the total number of days patients were delayed leaving hospital has declined substantially



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. Administratively, delays are attributed either to the NHS or 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.

Delayed transfers from hospital due to social care have fallen sharply since a peak in the winter of 2016/17. This follows 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 has been extra money provided through the Better Care Fund, one of whose main goals was a reduction in delayed transfers.

So intense has that pressure been that it is easy to forget that it is the NHS, not social care, which accounts for most delayed transfers, albeit that they have risen less sharply (and have since declined less suddenly) than those in social care. And the reduction can also overshadow the reality that, for both social care and NHS delays, the figures are still higher than they were in 2012.

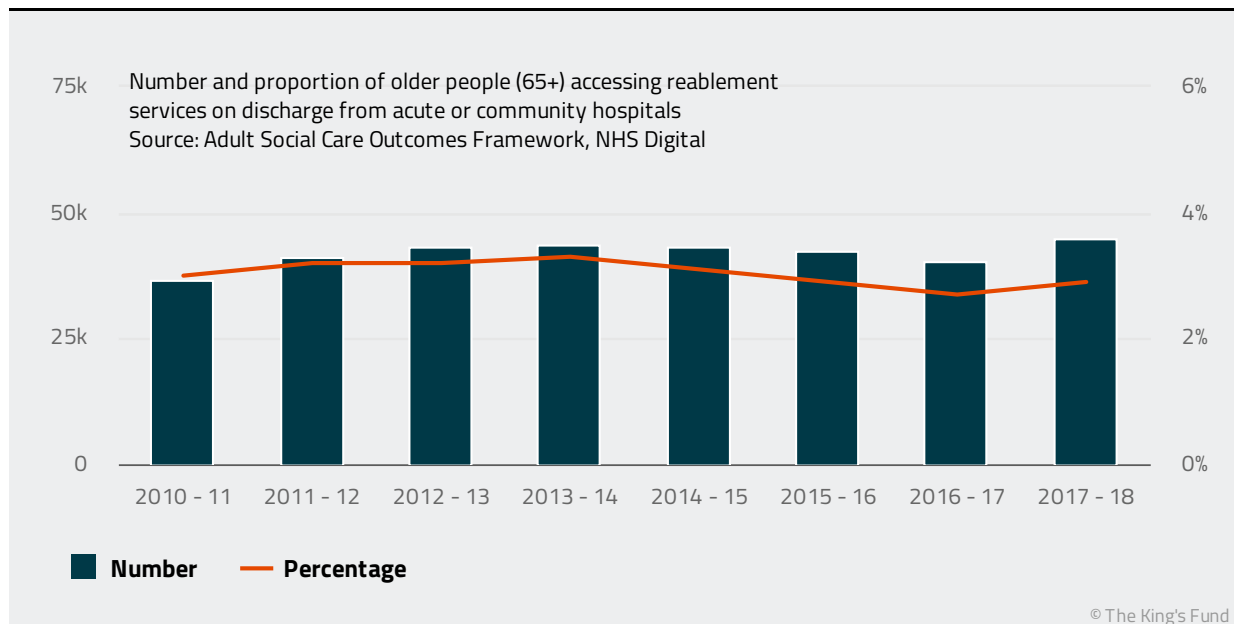
Clearly it is important that people do not spend more time in hospital than is necessary. However, too singular a focus on delayed transfers can take attention away from work to prevent admissions in the first place and from ensuring that transfers are not just made promptly but also appropriately. A recent review by the CQC also noted that focusing on delayed transfers in isolation can divert attention from other important opportunities to deliver better care. The Association of Directors of Adult Social Services believes that pressure to get older people out of hospital sometimes leads to them being moved directly into residential care when they do not need to be there.

And 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 community settings and the greatest rate of increase in demand is coming not from older people but from working-age adults.

18 More people are receiving reablement

After a period of decline, access to reablement has increased

After a recent decline, the number and proportion of older people being offered reablement services to help them regain independence when leaving hospital has increased



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 relearn 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. This measure shows that after a decline from 2013/14 onwards, the number of people offered reablement on leaving hospital increased in 2017/18.

The increase may stem from increased recognition of evidence that reablement works. The [National Audit for Intermediate Care](#) shows 75 per cent of people

improving independence as a result of reablement, with typical gains in mobility and other abilities of over a third.

The rise in reablement packages is consistent with indicator 2, which shows local authorities providing more short-term care in 2017/18. Interestingly, this increase is greater for under-65s and may potentially signal increased recognition that younger disabled people, including those with learning disabilities, can benefit from 'pathways to independence' planning.

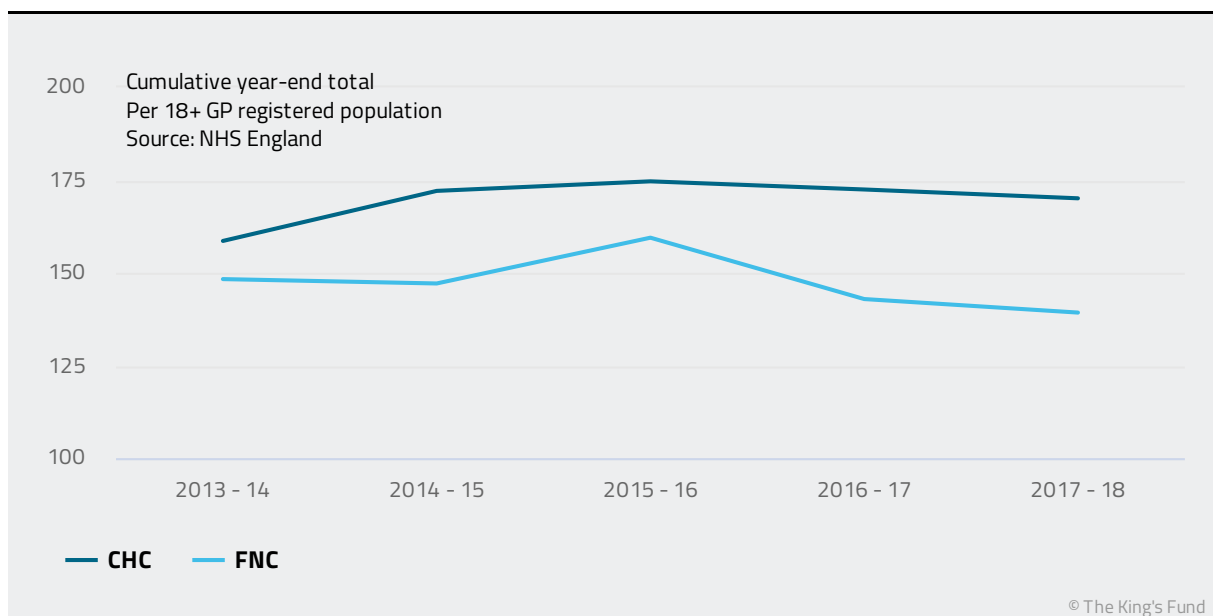
Despite the overall increase in packages, national data shows that numbers receiving reablement vary greatly from one local authority to another: fewer than 1 per cent of over-65s leaving hospital in some areas but more than 10 per cent in others.

And the National Audit of Intermediate Care estimates that – despite the effectiveness of services – in 2012 there was only around half of the capacity for intermediate care services needed to meet demand. This data does not suggest there has been much progress in closing the gap, particularly as some argue that at least 70 per cent of people who are assessed as having care needs should have an enablement-based service.

19 People are less likely to be receiving NHS Continuing Healthcare

The rate of take-up for NHS Continuing Healthcare is declining but there are wide differences of opinion about why

Per 50,000 population, the number of people receiving NHS Continuing Healthcare (CHC) and NHS Funded Nursing Care (FNC) has started to decline



The NHS funds two elements of care that are very closely related to social care: NHS Continuing Healthcare (CHC) and NHS-funded nursing care. The rate of receipt for both has begun to decline since 2015/16.

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

NHS 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.

CHC is a significant amount of expenditure – a National Audit Office report put it at £3.1 billion in 2015/16.

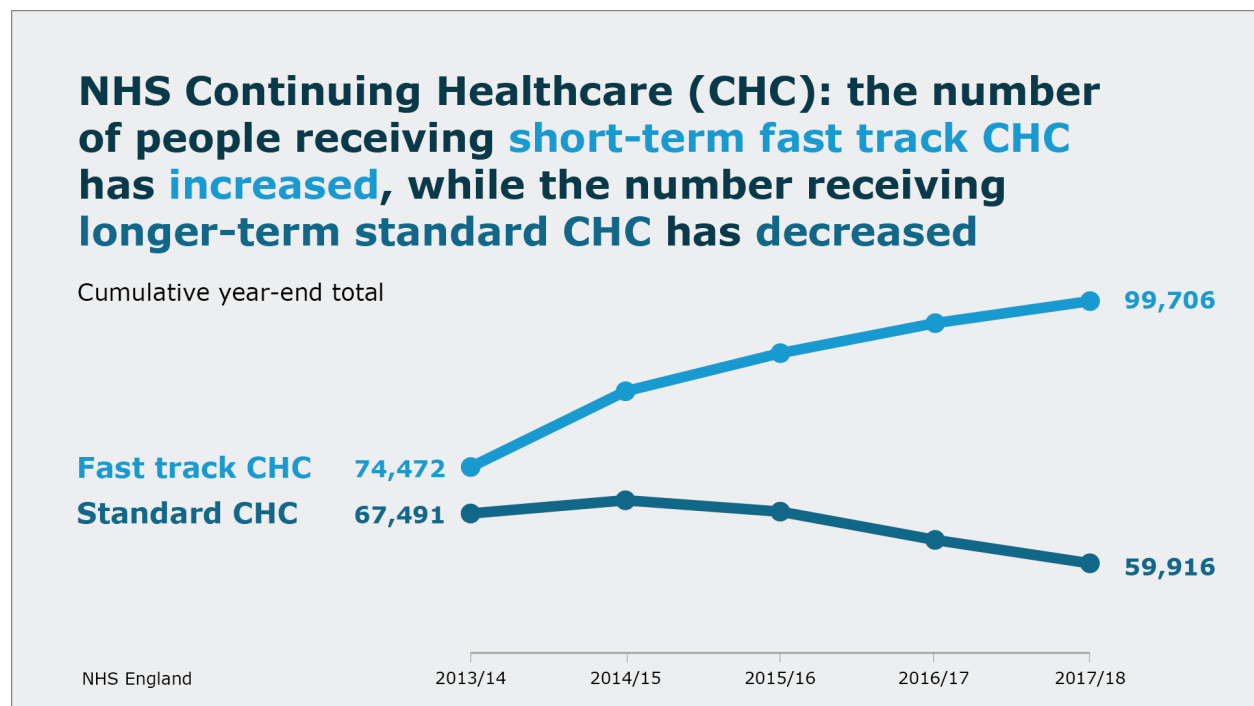
Crucially, CHC funds not only an individual’s health care – which would be free under the NHS anyway – but also their social care, which otherwise would be means tested. Since social care costs can be very expensive, it can make a huge financial difference to an individual if they have to pay these costs themselves or, if that person has low enough assets to qualify for publicly funded social care, to the local authority who will otherwise have to pick up the bill.

CHC is divided into standard and fast-track.

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.

The numbers of people receiving standard – more long-term – CHC have declined since 2013/14 while the numbers receiving fast track – ie, short-term – CHC have increased.



The reasons for the overall decline are opaque and disputed. In 2015/16, NHS England was set a target to save £855 million in the projected growth of CHC and FNC costs by 2021. It told us that national eligibility criteria have not changed and that a key factor in the reduction has been ensuring assessments for CHC take place in the community or at home, rather than in hospital where an individual is most vulnerable and may be assessed for care that they do not in fact need.

Campaign groups argue this is not the main reason for the reduction and instead say there has been a determined effort by many CCGs to reduce their costs by in practice setting the eligibility bar higher than previously. They point to wide variation in individual CCGs' provision of CHC beyond demographic variation. NHS England told us variation will always exist, due to a wide variety of local demographic and other factors.

The complexity of the assessment process for CHC makes it extremely difficult to identify the extent to which these differing explanations are valid, though the width of the difference between the two positions suggests an urgent need to do so.

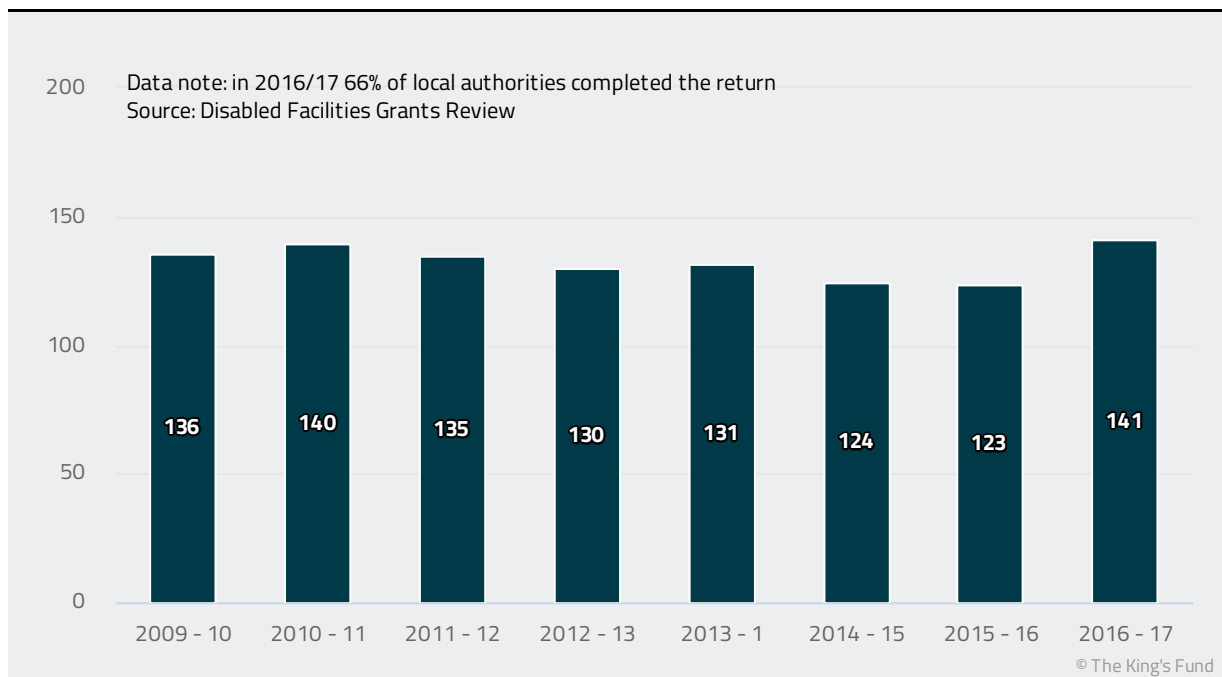
NHS-funded nursing care is only available to those who require the input of a registered nurse, live in a nursing home and have been assessed for CHC but found ineligible.

Reasons for its decline are again difficult to unpick, though there may be a connection to the fall in the number of nursing home beds in relation to the over-75 population (indicator 16), which in turn may be related to the trend towards supporting people in their own homes for longer.

20 The number of grants to improve to disabled people’s homes has increased

Increased central government funding may lead to bigger increases in Disabled Facilities Grants – but from a low level

The average number of Disabled Facilities Grants completed per local authority increased in 2016/17, but from a low base



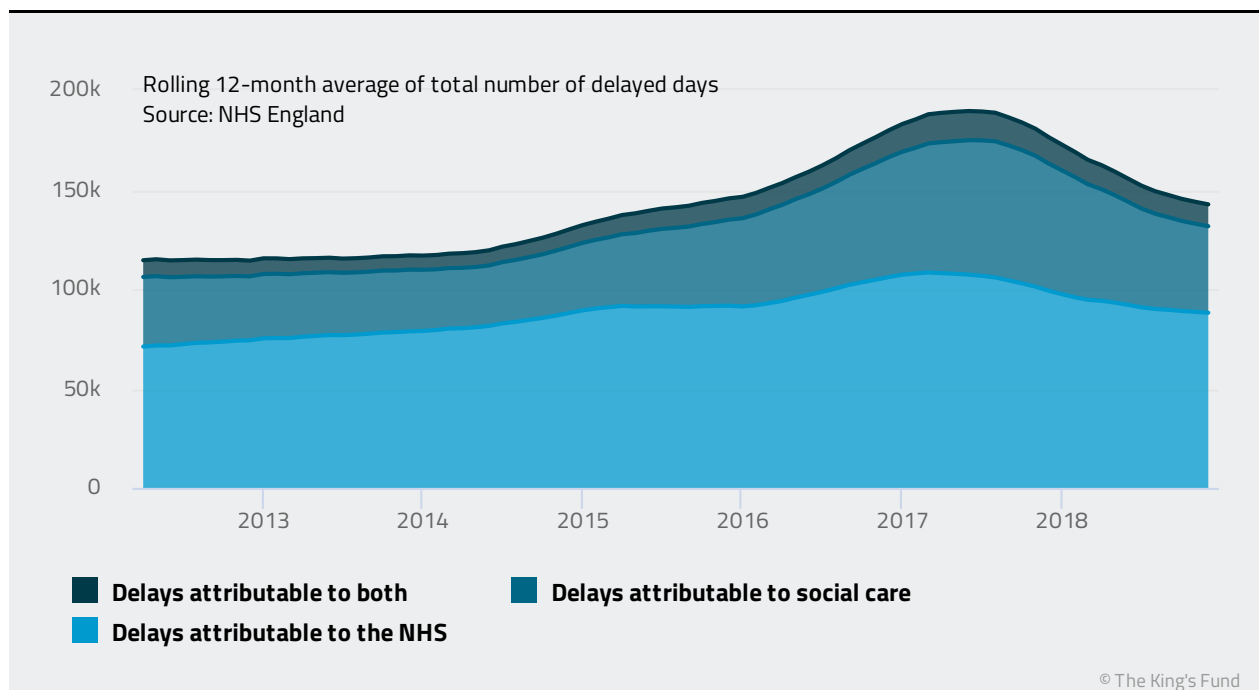
Disabled Facilities Grants are potentially an important part of strategies to enable older and disabled people to live independently in their homes for as long as possible.

What do Disabled Facilities Grants cover?

Disabled Facilities Grants especially help the growing numbers of home owners 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, as well as loaned equipment such as bath seats, through the Integrated Community Equipment Service but it is not possible to identify nationally the numbers provided or the amount spent on them.

Central government funding for Disabled Facilities Grants (paid through the Better Care Fund) has [increased significantly](#) – and will remain at higher levels until at least 2019/20 – but the average number of grants completed per local authority is now only marginally higher than it was in 2010/11. This may be because we only have data on the numbers of new grants until 2016/17. However, some funding for Disabled Facilities Grants also comes from local authorities and they have decreased the amount they invest, particularly in 2016/17, so the overall increase in expenditure may not be as great as thought.

After peaking in 2016/17, the total number of days patients were delayed leaving hospital has declined substantially



Certainly, there will have to be a step change if they are to [meet expectations](#) that grants would double from the 41,000 estimated to have been completed in 2014/15.

And even if it were achieved, it would fall far short of meeting all demand: [a 2014/15 survey](#) found that 1.9 million households in England had one or more people with a long-term limiting illness or disability that required adaptations to their home.

Social Care 360: methodology

The table below provides details of the measures used for the analysis in this review.

	Definition	Methodology	Source
Demand	Number of requests for support received from new clients	Data 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 an episode of short-term support to maximise care (ST-Max) care and a known sequel long-term support during the year	Data calculated as a per 100,000 population rate and indexed to 2015/16	Adult Social Care Activity and Finance Report, NHS Digital
Financial eligibility	Means test threshold upper limit	Adjusted to 2017/18 prices using December 2018 GDP deflators	Approaches to social care funding, Health Foundation and The King's Fund
Need	Disability prevalence by age group	As reported	Family Resources Survey
	Mid-year population estimate	As reported	Office for National Statistics

	Population projections		
Disability benefits	Attendance Allowance: cases in payment Disability Living Allowance: cases in payment Personal Independence Payments: claims in payment	Data calculated as a per 100,000 18+ population rate	Department for Work and Pensions (DWP Stats-Xplore)
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
	Income – client contributions, joint arrangements, income from NHS, other income	Adjusted to 2017/18 prices using December 2018 GDP deflators	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 2017/18 prices using December 2018 GDP deflators and	Adult Social Care Activity and Finance Report, NHS Digital

		calculated year-on-year change	
	Unit costs, average weighted standard hourly rate for the provision of home care by activity provisio	Adjusted to 2017/18 prices using December 2018 GDP deflators	Adult Social Care Activity and Finance Report, NHS Digital
Number of care and nursing home beds	Care home beds per 100 people 75+ Nursing home beds per 100 people 75+	As reported	Public Health England Fingertips Tool – End of Life Profile
Jobs	Estimated number of full-time equivalent (FTE) adult social care jobs	Calculated year-on-year change	The size and structure of the adult social care workforce, Skills for Care
Vacancies	Vacancy rate – all job roles	As reported	The state of the adult social care sector and workforce in England, 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:	Number in payment as at Q4	Department for Work and Pensions

	cases in payment		(DWP Stats-Xplore)
Care quality	The percentage of care services rated outstanding or good	As reported	Chart published in State of Care, numbers provided 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?	As reported	British Social Attitudes Survey, King's Fund analysis of NatCen Social Research's BSA survey data

Direct payments	Number of service users receiving direct payments and part-direct payments at the year-end 31 March	As reported	Adult Social Care Outcomes Framework, 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 Outcomes Framework, 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	NHS England
Reablement	Number/proportion of older people (aged 65 and over) discharged from acute or community hospitals to their own home or to a residential or	As reported	Adult Social Care Outcomes Framework, NHS Digital

	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)		
CHC	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
Disabled facilities grants	Average number of DFGs completed per authority	As reported	Disabled facilities grant (DFG) and other adaptations – external review
	Funding for disabled facilities grants – central government funding	As reported	Disabled facilities grants for home adaptations, House of Commons Library

Acknowledgements

With help at The King's Fund from Richard Humphries, Ruth Robertson, Dan Wellings, Siva Anandaciva, David Maguire, Dave Buck.

Many people in many other organisations provided support for this work by discussing the indicators and the trends behind them and by reviewing copy, often more than once. Their help was invaluable, though the final text, the analysis behind it and any errors or omissions remain the responsibility of the authors.

Thank you to:

- Sue Adams, Care and Repair England
- Sharon Allen, Skills for Care
- Phillip Anderson, MS Society
- Laura Arrowsmith, NatCen Social Research
- Graham Atkins, Institute for Government
- Tim Atkins, Care Quality Commission
- Fredi Cavander-Atwood, MS Society
- Clenton Farquarson, Think Local Act Personal
- Dave Griffiths, Skills for Care
- Dan Harbour, Beacon CHC
- Chris Hatton, University of Lancaster
- Matt Hibberd, Local Government Association
- Liz Hodgkinson, NHS England
- David James, Care Quality Commission
- John Jackson, Local Government Association and Association of Directors of Adult Social Services
- Jim Ledwidge, Independent Continuing Healthcare advisor to Association of Directors of Adult Social Services

- Sarah Liley, NHS Digital
- Sheila Mackintosh, University of Western England
- Brian O'Shea, Spinal Injuries Association
- Tim Parkin, Think Local Act Personal
- Caroline Speirs, Think Local Act Personal
- Duncan Stacey, Care Quality Commission
- Andy Tookey, NHS England
- Michael Varrow, consultant, Health Foundation
- Martin Walker, Think Local Act Personal
- Elizabeth Webb, Age UK
- Sally West, Age UK
- Robyn Wilson, NHS Digital
- Members of the Association of Directors of Adult Social NHS Continuing Healthcare National Reference Group

The King's Fund is an independent charity working to improve health and care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

www.kingsfund.org.uk

@thekingsfund