

Adult Social Care Activity and Finance Report: Detailed Analysis

England 2017-18

Published 23 October 2018

This report contains aggregate information submitted by 152 Councils with Adult Social Services Responsibilities (CASSRs) in England, to provide insight into adult social care activity and expenditure for the period 1 April 2017 to 31 March 2018.

Key findings

In 2017-18:



Gross current expenditure on adult social care by local authorities was £17.9 billion. This represents an increase of £402 million from the previous year, a 2.3% increase in cash terms and a 0.4% increase in real terms.



The area of care which saw the largest increase in expenditure was long term support, which increased by £369 million to £14.0 billion in 2017-18, an increase in cash terms of 2.7%.



1.8 million requests for adult social care support from 1.3 million new clients, for which an outcome was determined in the year, were received by local authorities in 2017-18. This was an increase of 1.6% since 2016-17. This is equivalent to more than 5,000 requests for support received per day by local authorities.



Overall, the number of clients receiving long term care has decreased each year since 2015-16, to 857,770 in 2017-18. This has been mainly driven by a decrease in clients aged 65 and over receiving long term care, down 22,110 to 565,385 since 2015-16. However, the number of clients aged 18 to 64 receiving long term care has increased slightly over the period, up 7,360 to 292,380 since 2015-16.

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ASC-FR Data as National Statistics

National Statistics status means that official statistics meet the highest standards of trustworthiness, quality and public value.



All official statistics should comply with all aspects of the Code of Practice for Statistics. They are awarded National Statistics status following an assessment by the Authority's regulatory arm. The Authority considers whether the statistics meet the highest standards of Code compliance, including the value they add to public decisions and debate.

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<https://www.statisticsauthority.gov.uk/code-of-practice/>

SALT Data as Official Statistics



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Find out more about the Code of Practice for Statistics at
<https://www.statisticsauthority.gov.uk/code-of-practice/>

This report may be of interest to members of the public, policy officials and other stakeholders to make local and national comparisons and to monitor the quality and effectiveness of services.

A note regarding these statistics

This is the second year in which the adult social care activity and finance data have been brought together in an official statistics report.

Activity data is sourced from the Short and Long Term (SALT) return, while finance data is taken from the Adult Social Care Finance Return (ASC-FR). In previous years the report included analysis of the Deferred Payments Agreement (DPA) collection, which is now a separate publication and can be found here:

<http://digital.nhs.uk/pubs/ascdpa1718>

This report presents the main themes only, based on mandatory data, at England level. Regional and local analysis can be found in the publication reference tables. The full data collected including voluntary elements of the data are available in both Excel and CSV format from <http://digital.nhs.uk/pubs/ascactfin1718>

Further information around the data collections can also be found here:

<https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/social-care-collection-materials-2018>

NHS Digital plans to continue to develop and release user friendly outputs relating to this data.

Adult social care activity provided or arranged by local authorities covers a wide range of services including long term and short-term care, plus support to carers. Clients may take a variety of different pathways through the system, according to their needs.

This report will look in detail at the breakdown of expenditure by local authorities on adult social care, and the activity that is provided or arranged by the local authorities. As such, it does not cover adult social care activity and expenditure that is provided or funded elsewhere, for example, if the care is arranged and funded by the client without any involvement from the local authority.

While the two collections have been designed to be as complementary as possible, there are some differences in how data is categorised and so direct comparisons between the two sources should be made with care.

It is possible however, to consider broader similarities and differences in the trends shown in the data. For more information see the “How can the data be used?” section on page 6.

Where there are differences in the definitions used between the collections these will be clearly pointed out in this document, and you can also find further information in the Equalities and Classifications standard (EQ-CL)¹ which sets out the definitions for each of the collections, as well as within the guidance documents for each collection². If you require any further information about how the data used in this report can be compared, please contact us at enquiries@nhsdigital.nhs.uk

¹ https://digital.nhs.uk/binaries/content/assets/website-assets/data-collections/social-care-collections-2018/eq-cl_2017-18_framework.pdf

² <https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/social-care-collection-materials-2018>

Please note these documents are primarily designed for use by Local Authorities submitting the returns.

The finance elements of this report focus primarily on gross current expenditure. This is defined as the total expenditure less capital charges, and less all income except for client contributions.

Finance data within the commentary of this report is rounded to the nearest million. Figures in billions are reported to one decimal place.

Activity data within the commentary of this report is rounded to the nearest five.

Percentages are rounded to one decimal place.

All data is collected from Councils with Adult Social Services Responsibilities (CASSRs) in England, however for ease of reading CASSRs will be referred to as local authorities throughout this report.

Next release

This is an annual publication and the next release with 2018-19 data is planned for autumn 2019.

How can the data be used?



Do use this report to consider similarities and differences in the trends shown in the data for example, where expenditure has increased or decreased for a particular type of social care provision, it is also important to consider trends in activity for that same type of care to fully understand the whole picture.



Do use this data to increase your understanding of the approaches to the commissioning and delivery of social care, by local authority.



Do contact the NHS Digital Social Care Statistics Team if you have any questions around the data published



Do not divide expenditure by activity to derive a cost per person. For example, the SALT return does not differentiate between a long term client receiving one week of care during the reporting period, and a client receiving long term support for the full year.



Do not use this data to attempt to identify good or bad performance.



Do not directly compare long term SALT and long term ASC-FR. Activity data includes those receiving long term care with a Primary Support Reason (PSR) of Social Support, whereas this PSR is not included in long term expenditure (instead being recorded as a combined short term/long term spend on the PSR).

Data quality issues to note

For the 2017-18 collections NHS Digital used inbuilt validation checks within the data templates and post-submission data quality reports for each collection to identify logical inconsistencies in the data, and where the data submitted is an outlier against either local and national data or against submissions from previous years. Local authorities could then review and resubmit data ahead of the deadline or provide explanations for any identified issues.

Both the SALT and ASC-FR data returns contain complex elements and this, combined with the aggregate nature of the collections, means that some data quality issues are not always immediately apparent. Furthermore, the annual nature of the collections means that any issues with the submitted data can sometimes take a while to be identified and worked through with local authorities.

Through the respective collection Working Groups, NHS Digital work with local authorities and other stakeholders to continually develop the data template and the accompanying guidance documents to improve clarity and ease of completion.

Whilst the quality of data submitted in the two returns – and SALT in particular – has improved in recent years, users should be aware of the following specific data quality points to note when reading this report:

- Limitations with case management systems for reporting of some data items, particularly new items introduced this year around full cost clients and outcomes to Short Term support to maximise independence (ST-Max) for existing clients.
- Several local authorities have mentioned difficulties obtaining and/or quality assuring data from third party organisations such as mental health or carer data.
- Allocating expenditure by Primary Support Reason (PSR) in the ASC-FR can be challenging as many finance systems are not configured to collect this data.
- The allocation of Better Care Fund (BCF) expenditure in the ASC-FR has improved in 2017-18 compared to previous years, so care should be taken when comparing to historic data.

Throughout the report we will identify data quality issues where appropriate to aid user interpretation. Further detail on the data quality of both collections can be found in the accompanying data quality summary.

1. Activity and Finance Overview

Overall trends in activity and expenditure

While expenditure has risen there has been a small change overall in the levels of activity, which may be linked to the increasing costs in the provision of care.

Local authorities received 1,843,920 [requests for support](#) from new clients in 2017-18, an increase of 1.6% (29,505 requests) since 2016-17, and an increase of 1.8% since 2015-16. At a local authority level, just under half (74 of 152 local authorities) saw a decrease in requests compared to last year.

Requests from clients aged 65 and over account for 71.6% of all requests received, which is approximately the same proportion as in the previous two years.

The total number of completed episodes of [short term care to maximise independence](#)^{3 4} (ST-Max) was 246,035. This is an increase of 1.7% (4,225 episodes) from 2016-17. Eighty-eight per cent (187,550) of these completed episodes were delivered for adults aged 65 and over. The number of completed episodes of ST-Max for new clients increased by 3.0% compared to the previous year, whereas for existing clients the number of episodes dropped by 5.4%.

Overall, the number of clients receiving long term care has decreased each year since 2015-16, decreasing to 857,770 in 2017-18. This has been mainly driven by a decrease in clients aged 65 and over receiving long term care, decreasing by 22,110 to 565,385 since 2015-16. However, the number of clients aged 18 to 64 receiving long term care has increased slightly over the period, increasing by 7,340 to 292,380 since 2015-16. More detail can be found in the [long term care](#) section of this report.

Gross current expenditure on adult social care by local authorities was £17.9 billion. This represents an increase of £402 million from the previous year, a 2.3% increase in cash terms and a 0.4% increase in real terms.

Some local authorities provided comments⁵ regarding the change in expenditure for their authority, citing factors including the Improved Better Care Fund and an increase in those requiring support for complex needs, leading to much higher costs of providing care.

What is the Improved Better Care Fund?

In the Spring Budget 2017, the government announced that an additional £2 billion would be given to councils in England over the next 3 years for adult social care. According to the grant determination, the funding can be spent on three purposes:

- Meeting adult social care needs
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready
- Ensuring that the local social care provider market is supported

Source: [Integration and Better Care Fund Policy Framework 2017-19](#)

³ For both new and existing clients, where an outcome had been determined within the reporting period.

⁴ Short term support to maximise independence is terminology introduced in the EQ-CL framework to describe a range of services that are of short duration (typically being provided for a few weeks) and that have the explicit aim of trying to minimise the person's use of ongoing social care services.

⁵ Full details of all comments provided by councils can be found in the data quality tables which accompany this report.

This effect can also be seen in the average costs of care per week for residential and nursing care (known as unit costs) which have risen in 2017-18.

The average cost of residential care for a person aged 65 and over per week was £565 in 2016-17, but has now risen to £604, while the cost of nursing care for the same age band has increased from £606 to £638 a week. For those aged 18 to 64, the number of clients in residential or nursing care are much smaller, but a similar effect can be seen with unit costs increasing, from £911 to £921 a week for nursing care and from £1,236 to £1,274 a week for residential care.

Unit Costs

In addition to gross current expenditure, this report also gives information on unit costs. A unit cost is the average cost of providing services per week per person and is calculated as follows:

Unit Cost = (Total Expenditure – Grants to voluntary organisations) ÷ Total Activity (in weeks)

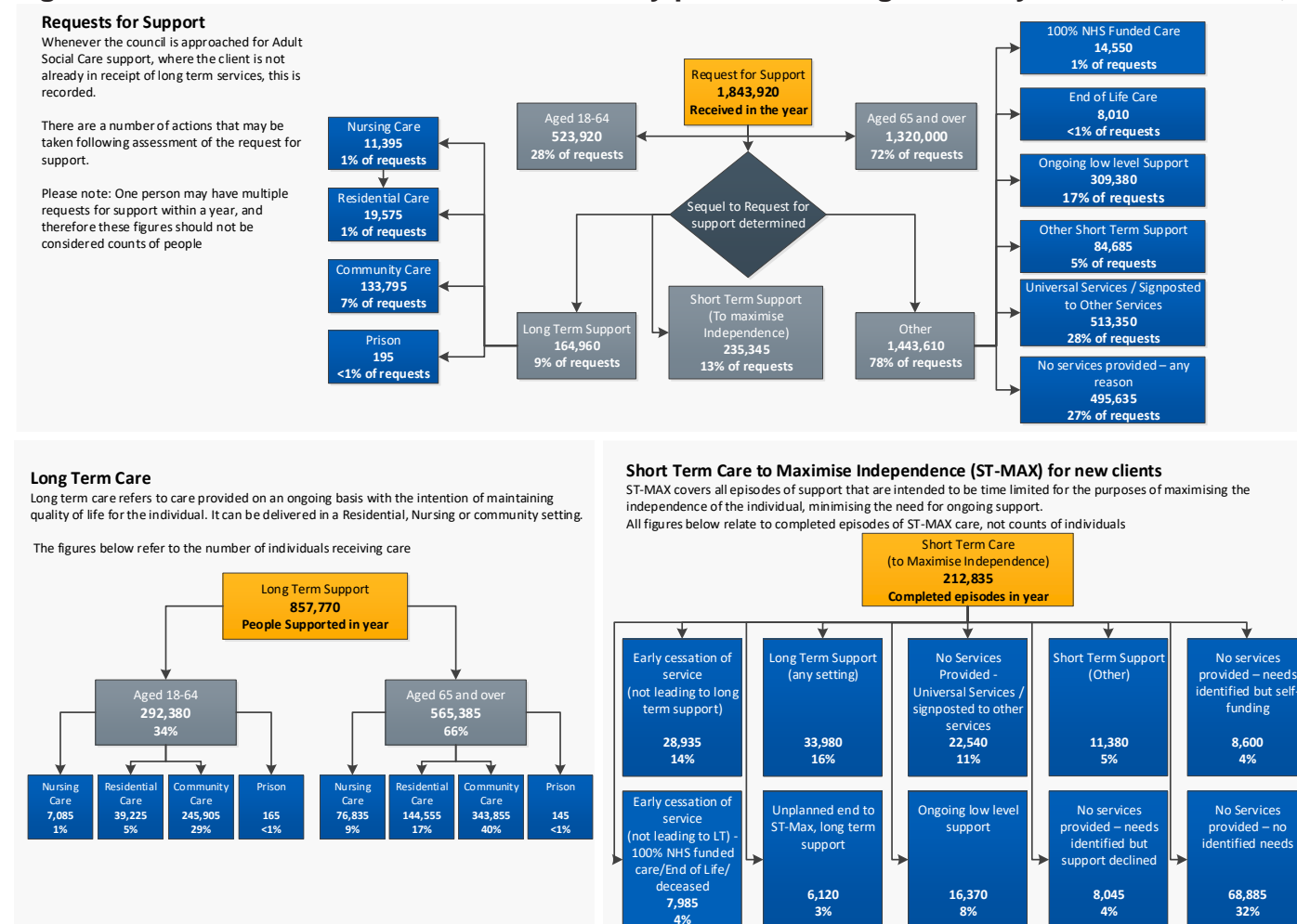
***Please note:** Unlike other figures in this report, unit costs are based on the **total expenditure minus grants to voluntary organisations**, not the Gross Current Expenditure. No income is excluded from the figure.*

The activity data used in the unit cost calculation is collected as part of the ASC-FR return. Local authorities provide the number of weeks of care provided, which is calculated as follows:

Activity (Weeks) = (Hours of care provided in week ÷ Total hours in the week) multiplied by the number of weeks for which care was provided

The total hours in a week is based on a 24 hour day, and therefore 168 hours in a week.

The csv files accompanying this report provide a full breakdown of all expenditure and activity figures provided by local authorities as part of the ASC-FR collection.

Figure 1: Overview of adult social care activity provided or organised by local authorities⁶, 2017-18

Source: SALT Collection, 2017-18, NHS Digital - See Table 9, 21, and 34 in Reference Data Tables

⁶To note, the breakdowns on long term and short term support include all support, not just those with the relevant sequel following a request. The long term support figures in the diagram above relate to all those receiving care at some point in the year. Short term care to maximise independence only shows new clients due to a collection change around outcomes for existing clients this year.

Trends in expenditure

Total expenditure on adult social care by local authorities in 2017-18 was £21.3 billion (up £684 million since 2016-17, a 3.3% uplift), however this includes capital charges and some of this expenditure is offset by income from other sources such as the NHS⁷.

In 2017-18 gross current expenditure on adult social care (which accounts for spending by social care departments and also includes client contributions), was £17.9 billion, and this is the measure of expenditure used throughout this report (except where otherwise stated).

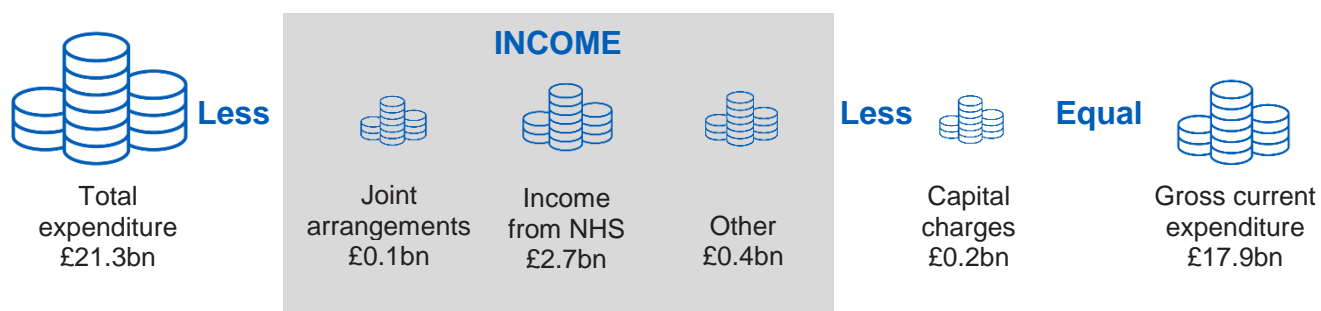
Why do we use gross current expenditure?

Gross current expenditure covers the amount of spend by local authorities that is not offset by income from clients and does not include a capital charge. It is the fiscal metric used to denote local government spending, so unless otherwise stated gross current expenditure is used as the main source for figures in this report.

It is important to be aware of the constituent parts that contribute to calculating gross current expenditure, as shown in Figure 2 below, as any year on year changes to gross current expenditure will be driven by increases or decreases in one or more of these areas.

This could be due to increased funding through the Better Care Fund or improved recording of data. For example, some local authorities have reported that some of the change to the data captured in “Income from NHS” is due to improved guidance regarding how they should record Better Care Fund.

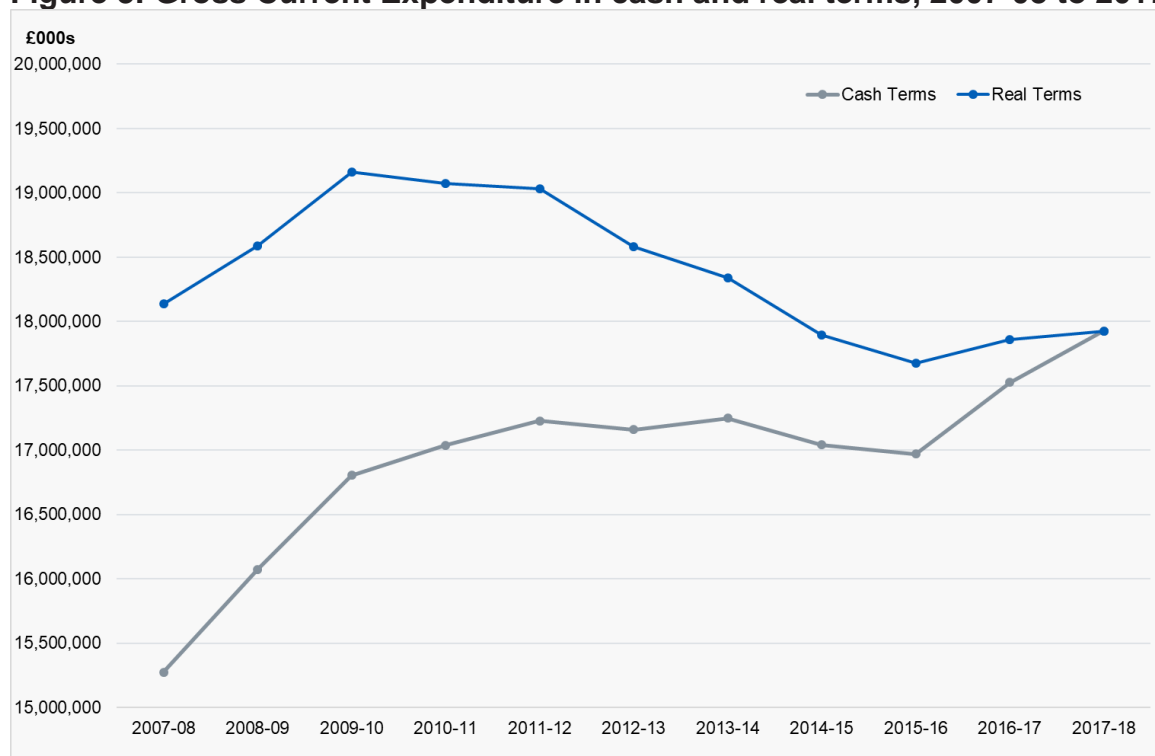
Figure 2: How gross current expenditure is calculated



Source: ASC-FR Collection, 2017-18, NHS Digital - See Table 3 in Reference Data Tables. The sizes of the images are indicative and are not to scale.

Gross current expenditure has increased £0.4 billion since 2016-17, which is a 2.3% increase in cash terms and a 0.4% increase in real terms. As shown in Figure 3, this is the second consecutive year gross current expenditure in real terms has increased since 2009-10.

⁷ A full breakdown of how total expenditure is split between local authority spend and income from other sources can be found in [Table 2](#)

Figure 3: Gross Current Expenditure in cash and real terms, 2007-08 to 2017-18

Source: ASC-FR Collection, 2017-18, NHS Digital - See Table 4 in Reference Data Tables, and ONS deflators found here <https://www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-september-2018-quarterly-national-accounts>

Cash Terms versus Real Terms

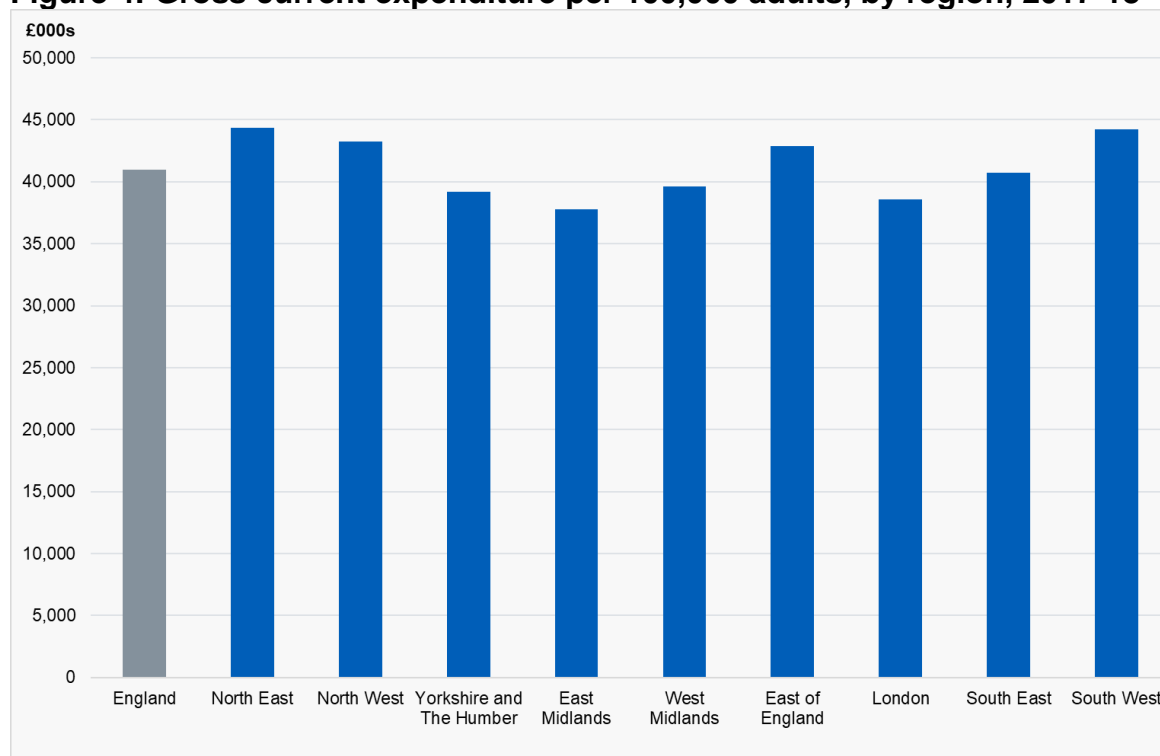
A comparison in cash terms compares corresponding values between years, without any form of adjustment. A comparison in real terms accounts for the effect of inflation between figures, and so allows for the comparison of corresponding values, whilst controlling for any changes in the value of the pound.

More information on the process of obtaining these adjusted figures using Gross Domestic Product (GDP) deflators is available in Appendix A.

In addition to the usual funding of adult social care through council tax and grants from central government (such as Improved Better Care Fund), in the last two years, local authorities have been able to use an adult social care precept to raise additional funds.

- The additional adult social care precept in 2017-18 generated £552 million
- 147 out of 152 local authorities with adult social care responsibilities utilised some or all of this 3% precept in 2017-18⁸.

⁸https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/603781/Council_tax_levels_set_by_local_authorities_in_England_2017-18.pdf#page=6

Figure 4: Gross current expenditure per 100,000 adults, by region, 2017-18

Source: ASC-FR Collection, 2017-18, NHS Digital - See Table 16 in Reference Data Tables

When considering year on year changes at a local authority level, the change in gross current expenditure was variable, with a cash terms increases of over 10% reported by eleven local authorities. Meanwhile 50 local authorities reported a decrease from the previous year.

Local authority level data showing the differences in expenditure levels between 2016-17 and 2017-18 can be found in Table 3 of the reference data tables which accompany this report.

Figure 5 on the next page provides a summary of gross current expenditure on adult social care and how this expenditure is allocated

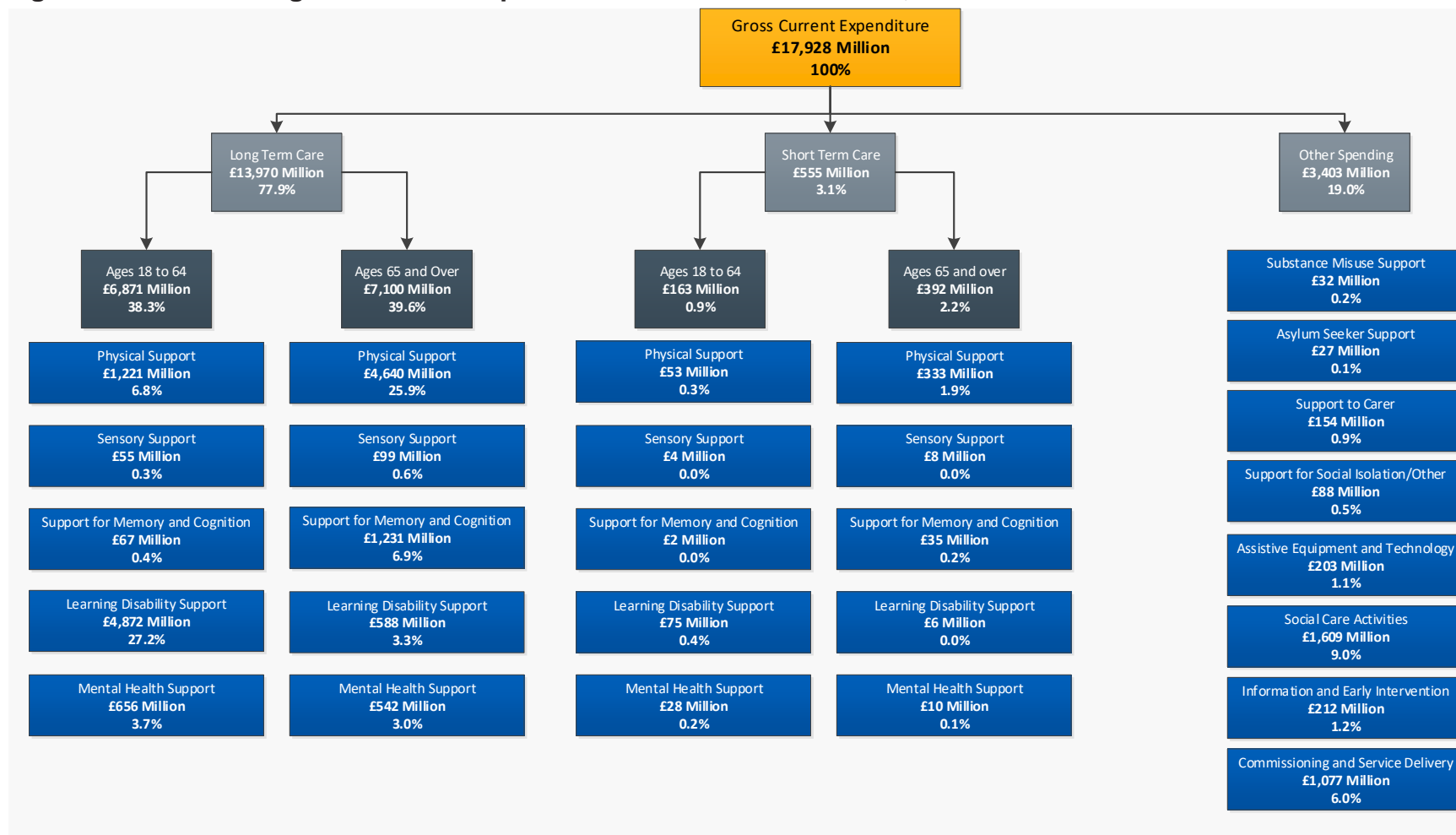
Table 1 below shows total gross current expenditure and its constituent parts compared to last year. As a whole, gross current expenditure has increased by 2.3%. This is mainly due to increases in long term support and other spending (for example commissioning and service delivery and social care activities)⁹ which make up 77.9% and 19.0% of the gross current expenditure respectively. Short term support makes up the smallest proportion of gross current expenditure, and it has seen a decrease of 0.6% (£3 million) from the previous year.

Table 1: Gross current expenditure, by care type, 2016-17 and 2017-18

	Gross Current Expenditure (GCE)		Long Term Support GCE		Short Term Support GCE		Other GCE	
	2016-17	2017-18	2016-17	2017-18	2016-17	2017-18	2016-17	2017-18
England	£17,526,378	£17,928,188	£13,601,452	£13,970,382	£558,398	£554,982	£3,366,528	£3,402,824
£ change		£401,810		£368,931		£3,416		£36,295
% change		2.3%		2.7%		-0.6%		1.1%

Source: ASC-FR Collection, 2017-18, NHS Digital - See Table 15 in Reference Data Tables

⁹ The definition of the costs of Social Care Activities is any revenue expenditure associated with social work practice

Figure 5: Overview of gross current expenditure on adult social care¹⁰, 2017-18

Source: ASC-FR Collection, 2017-18, NHS Digital - See Table 14, 19, 20 and 44 in Reference Data Tables

¹⁰Numbers may not add up due to rounding

Public spending on adult social care

Users of this report may be interested in the overall estimate of public spending on adult social care, which consists of the net current expenditure (local authority spend) plus planned spending on the minimum Better Care Fund for social care or direct with social care providers, to give a total of £17.1 billion in 2017-18. A full time series of the estimated public spend on adult social care can be found in Table 2 below.

Table 2: Net current expenditure¹¹ on adult social care services in cash terms, by source of funding¹², 2009-10 to 2017-18

England, 2009-10 to 2017-18									£bn
	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Social services departments	14.5	14.6	14.8	14.6	14.7	14.4	14.3	14.8	15.1
Valuing People Now	1.3	1.3	-	-	-	-	-	-	-
NHS transfer to local authorities	-	-	0.7	0.6	0.9	1.1	-	-	-
Planned Better Care Fund expenditure on social care	-	-	-	-	-	-	1.8	2.0	2.1
Winter pressures transfer	-	0.2	0.2	0.1	-	-	-	-	-
Total net expenditure estimate	15.7	16.1	15.6	15.4	15.5	15.5	16.1	16.8	17.1

Why might you use net current expenditure?

Net current expenditure is useful for understanding how much of adult social care is funded from local authority monies – be they raised locally such as council tax (including the adult social care precept), business rates, etc, or where they are centrally funded such as the improved Better Care Fund or the local government finance settlement.

Net current expenditure removes capital charges and external income and is thus not impacted by changes in client contributions and income from the NHS, the two largest income components.

For users specifically interested in this metric, an additional set of net current expenditure reference tables based on data collected in the ASC-FR has been created this year.

Income – how is social care funded?

Of the £21.3 billion total expenditure in 2017-18, 71.5% (£15.2 billion) is funded directly by the local authority (this includes capital charges and is known as net total expenditure, as seen in Figure 7 on page 17). This represents a 1.8% increase (£262 million) from 2016-17, which may be driven by local authorities being able to raise additional funds for social care through the precept which first came into force in April 2016 (as discussed on page 11).

The remaining 28.5% (£6.1 billion) of total expenditure is funded by income from other sources, which has increased by 7.5% (£422 million) since 2016-17 (as seen in Figure 6 on the next page). Income from joint arrangements has decreased, while income from the NHS, client contributions and other income have all increased.

For the 2017-18 adult social care finance return, recording of the income from the Better Care Fund became mandatory. Local authorities stated they received a combined total of £1.8 billion income from Better Care Fund, which accounted for

¹¹Net current expenditure is total expenditure excluding capital charges and less all income.

¹²Full details of the sources of these data can be found in Appendix B

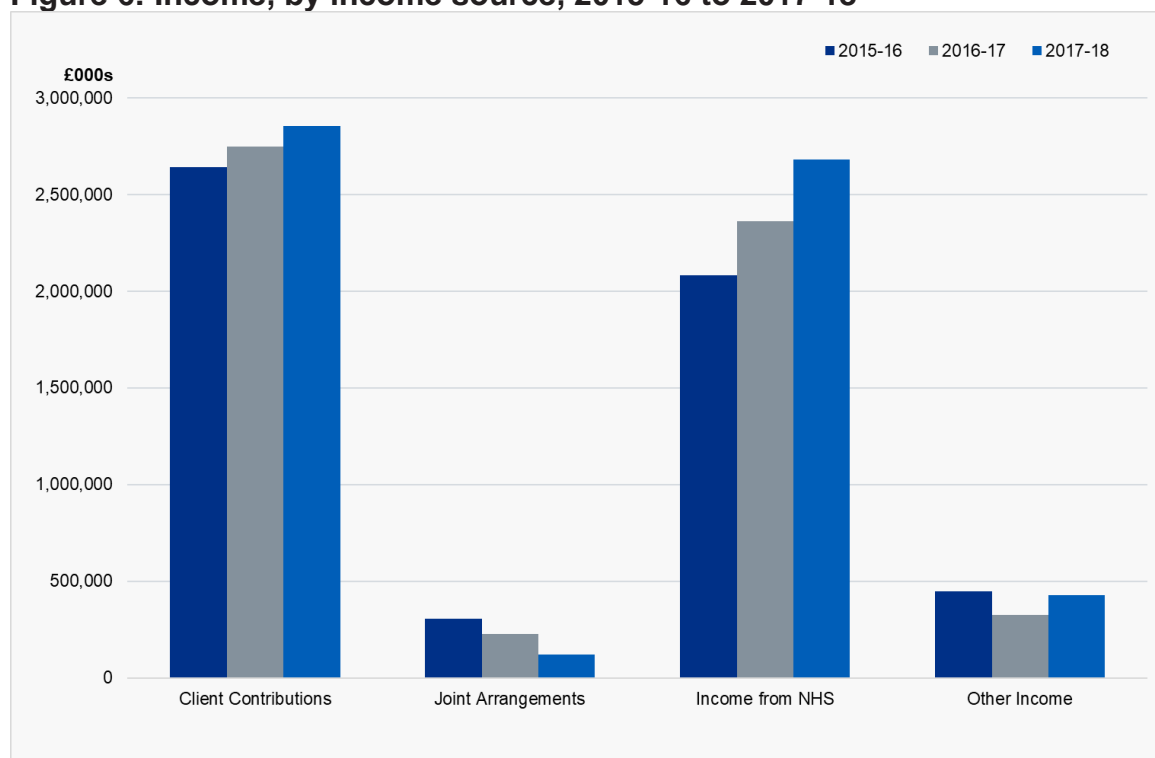
68.5% of their Income from NHS. Please note that this relates to actual expenditure reported by local authorities in the ASC-FR return when considering it against the *planned* minimum Better Care Fund spend for social care or direct with social care providers, reported in Table 2.

What is the Better Care Fund?

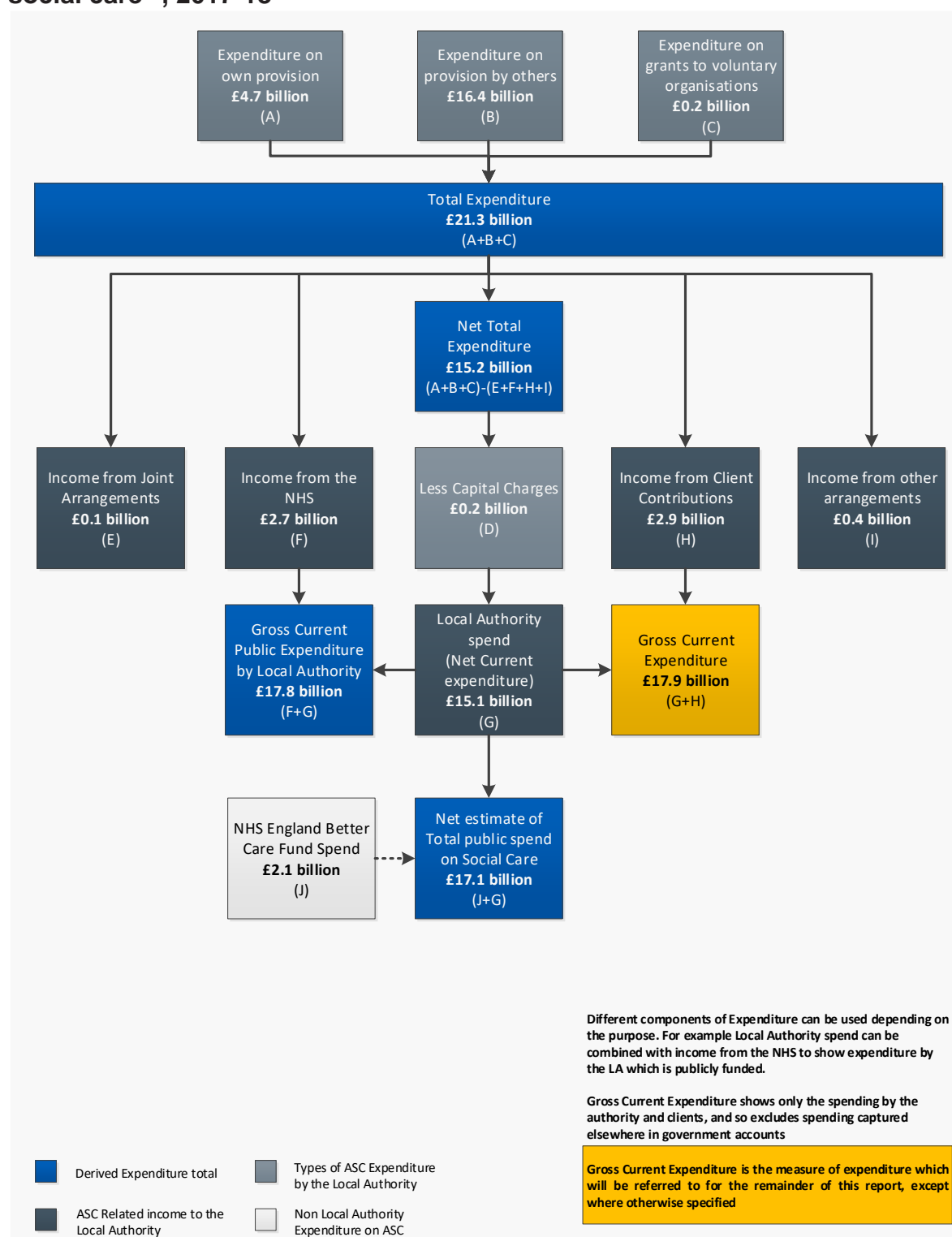
The £5.3bn Better Care Fund was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. The Better Care Fund (BCF) creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their wellbeing as the focus of health and care services, and shifting resources into adult social care and community services for the benefit of the people, communities and health and care systems.

Source: <https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/integration-and-better-care-fund/better-care-fund>

Figure 6: Income, by income source, 2015-16 to 2017-18



Source: ASC-FR Collection, 2017-18, NHS Digital - See Table 6 in Reference Data Tables

Figure 7: Overview of total local authority expenditure and income on adult social care¹³, 2017-18

Source: ASC-FR Collection, 2017-18, NHS Digital - See Table 3 in Reference Data Tables

¹³Net estimate of total public spend is based on local authority expenditure plus NHS Better Care Fund spend, some of which is spent directly by the NHS and so would not be included in the ASC-FR return made by local authorities. It is important to note that although the Income from the NHS reported by local authorities in the ASC-FR return does include some Better Care Fund spending, it will also include local arrangements with the NHS. Therefore, the Income from NHS and Better Care Fund figures in the diagram above are related but are not directly comparable.

2. Requests for Support

This chapter shows the number of requests for support received by local authorities from new clients¹⁴ and the outcome of those requests¹⁵. Depending on the structure in each local authority, these requests may be received directly into adult social care departments, into partner agencies such as mental health trusts, via a contact centre handling all requests for support from the local authority, or a combination of any of these.

The finance collection does not specifically breakdown expenditure related to frontline requests and so it is not possible to identify the spend on these activities.

Key Findings

A total of 1,843,920 requests for support were received from new clients by local authorities in 2017-18, compared with 1,824,415 requests for support in 2016-17. This equates to an average of 5,052 requests for support from new clients received each day, up from 4,971 last year. Those aged 65 and over accounted for 71.6% (1,320,000) of all requests.

Data is now collected on how many clients these requests relate to. In 2017-18, there were an average of nearly 1.4 requests for support per person as the 1,843,920 requests for support were made by 1,346,875 clients.

In 2017-18 there were over

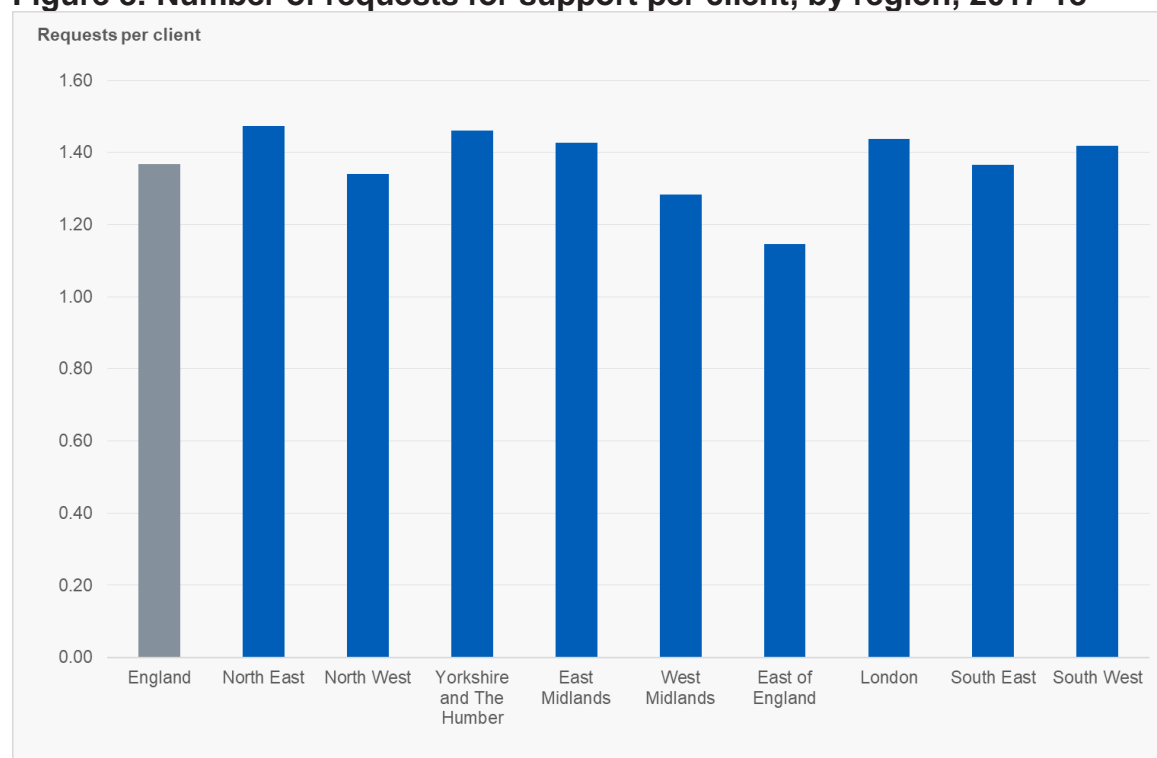
1.8 million

requests for support from new clients received by local authorities

As can be seen in Figure 8 below, the North East region has the largest number of requests for support per client with 1.5 requests per client. East of England has the lowest number of requests per client (1.1).

¹⁴Those clients not currently in receipt of long term support.

¹⁵Only those requests for which an outcome, also known as a sequel, had been determined in the reporting period are included in these figures. As such, these figures may include requests received in the previous year where the outcome was determined in 2017-18.

Figure 8: Number of requests for support per client, by region, 2017-18

Source: SALT Collection, 2017-18, NHS Digital - See Table 13 in Reference Data Tables

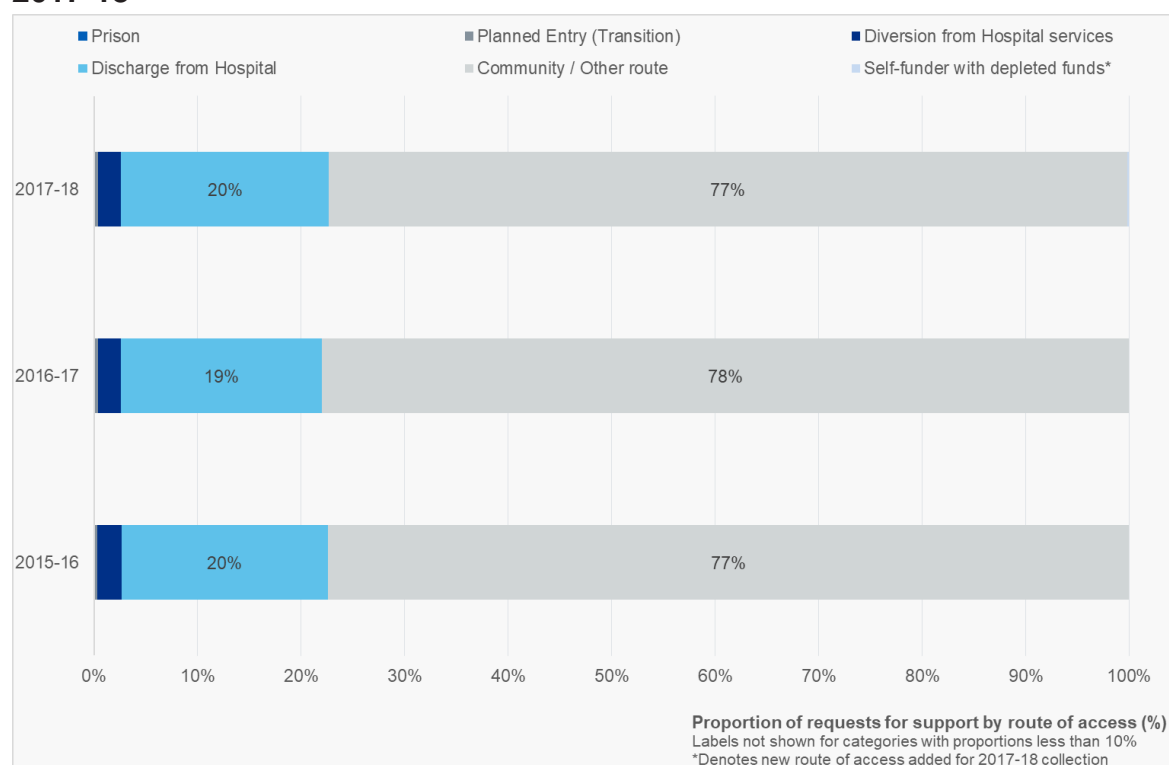
A client can request social care support while detained in prison. This route of access was made mandatory for 2017-18, although not all local authorities in England have a prison within their area¹⁶. There were 1,430 (0.1% of all requests) requests for support via a prison route.

¹⁶<http://www.justice.gov.uk/contacts/prison-finder>

Route of access

The majority of all requests (77.1%, 1,421,910) originated from the community. The next highest category was discharge from hospital, where 20.1% (370,045) of all requests originated from. Planned entry, diversion from hospital, self-funders with depleted funds and prison referrals made up the remaining 2.8% of requests. As seen in Figure 9 below, over the last three years the proportions of requests for support by route of access have remained largely similar.

Figure 9: Proportion of requests for support, by route of access, 2015-16 to 2017-18



Source: SALT Collection, 2017-18, NHS Digital - See Table 9 in Reference Data Tables and previous publications

Outcomes to requests for support

The outcome of the request for support can be categorised into three main support areas; short term care to maximise independence (ST-Max), long term care, and other support. There were 12.8% of requests resulting in clients receiving short term care to maximise independence and 8.9% of requests resulted in long term care being provided to the client. These areas of support are covered in more detail later in the report.

Figure 10 on the following page shows the outcomes of the requests for support by new clients by age group.

For 18 to 64 year olds, 5.8% of requests resulted in the client being offered ST-Max whereas for clients aged 65 and over, 15.5% of requests were resulted in ST-Max.

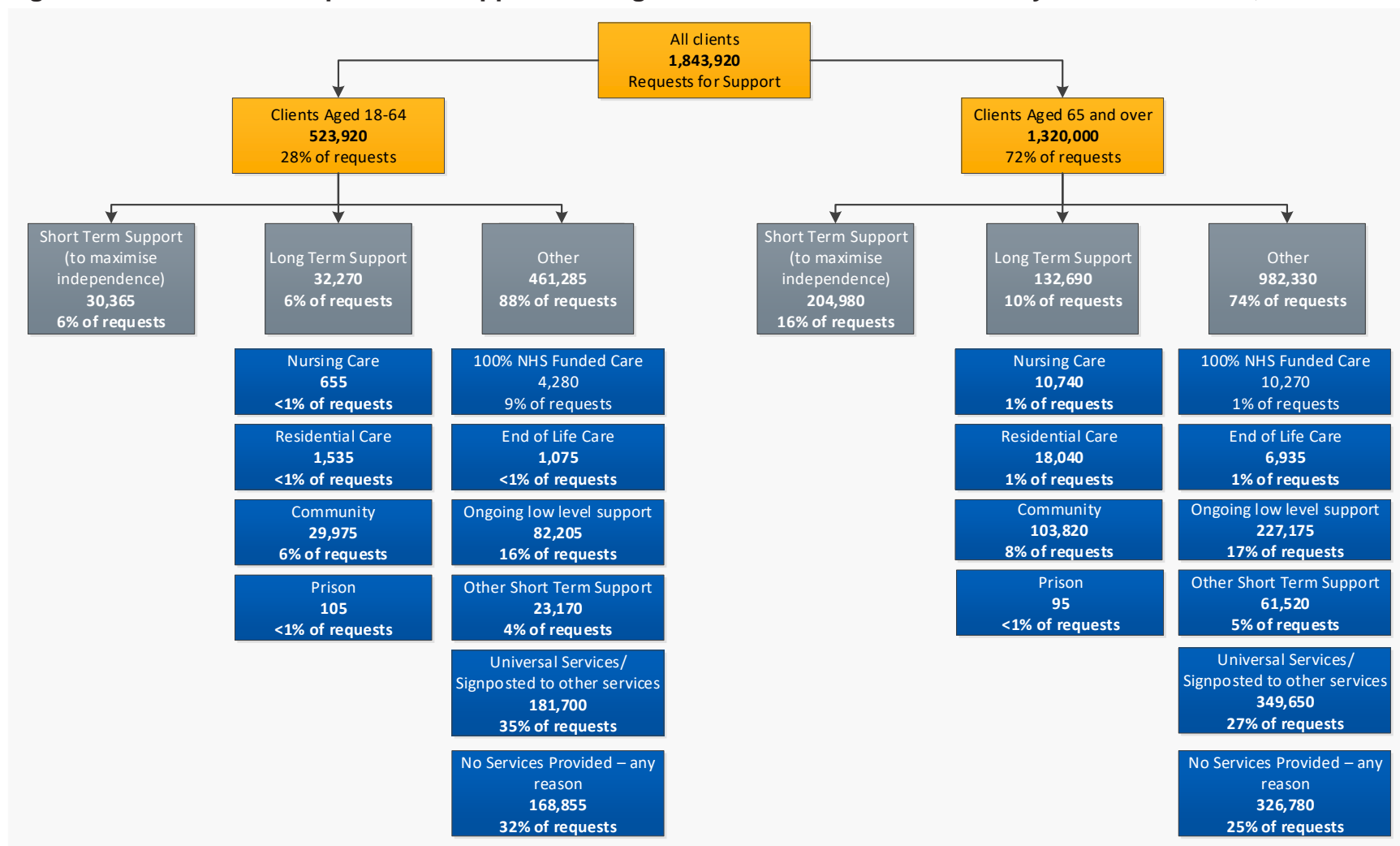
Almost a third (32.2%) of requests from 18 to 64 year olds resulted in no services provided compared to a quarter (24.8%) of requests from those aged 65 and over. Where no services were provided, 32,110 clients (6.5%) died after requesting services, but before receiving any.

One in three (34.7%) requests for support from 18 to 64 year olds resulted in universal services ¹⁷compared to one in four (26.5%) requests for support from clients aged 65 and over.

These outcomes to a request for support can sometimes be difficult to interpret and should not be seen as reflecting negatively on a local authority, but more as a statement about the nature of request for support that was made.

¹⁷ See Glossary, page 50

Figure 10: Overview of requests for support relating to Adult Social care received by local authorities, 2017-18

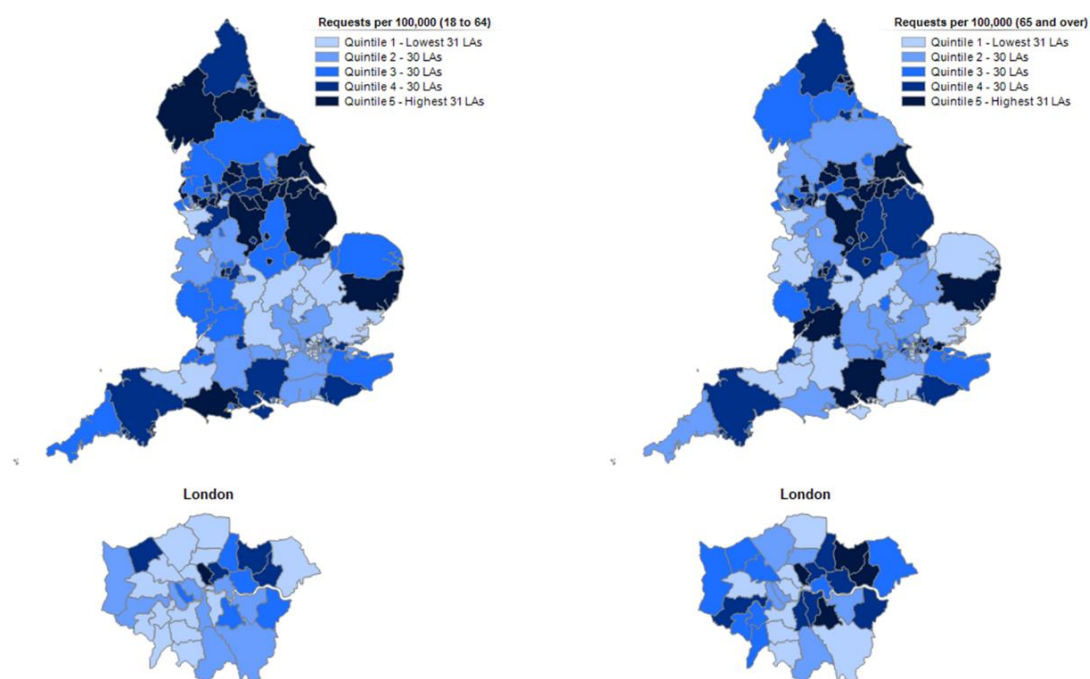


Source: SALT Collection, 2017-18, NHS Digital - See Table 10 and 11 in Reference Data Tables

Regional trends of request for support

The maps below illustrate that demand differs by location, as well as by age band. Overall the highest rates of requests for support per 100,000 population were found in the Yorkshire and the Humber and North East regions.

Figure 11: Requests for support per 100,000 adults by local authority, 2017-18



Source: SALT Collection, 2017-18, NHS Digital - See Table 12 in Reference Data Tables

3. Short term care

Following a request for support, clients may be provided with a period of short term care.

Short term care falls into two categories;

- **Short Term Support to Maximise Independence (ST-Max)**
This includes all episodes of support provided that are intended to be time limited, with the intention of maximising the independence of the individual and reducing / eliminating their need for ongoing support by the local authorities.
- **Other Short Term Support**
All other short term services, for example, emergency support not otherwise included in short term to maximise independence.

Please Note: There are a number of differences in how information on short term care is collected between the ASC-FR and SALT returns.

For example, activity data includes those receiving short term care to maximise independence with a Primary Support Reason (PSR) of Social Support, whereas this PSR is not included in short term expenditure (instead being recorded elsewhere).

Therefore, care must be taken when comparing the two returns; some comparisons of general trends can be made, but more direct comparisons, such as a cost per episode of care, are not recommended.

Key findings

Expenditure data combines ST-Max (£319 million) and other short term care spending (£236 million) to give an overall gross current expenditure on short term care of £555 million. This accounts for 3.1% of the total gross current expenditure. Adults aged 65 and over accounted for 70.6% (£392 million) of the total short term spend.

Both expenditure on ST-Max (up 4.6%, £14 million) and activity on ST-Max (up 1.7%, 4,225 completed episodes) showed an uplift in 2017-18. However, total spending on short term care dropped by £3 million (0.6%), driven by a fall in other short term spending.

In 2017-18

3.1%

of gross
current
expenditure
was spent on
short term care

Short Term Care to Maximise Independence (ST-Max)

ST-Max is a time limited period of short term support intended to maximise the independence of clients and reduce, or prevent, longer-term reliance on social care. In 2017-18 there were a total of 246,035 completed episodes of ST-Max¹⁸, an increase of 4,225 (1.7%) since the previous year. Eighty-eight per cent (216,160) of these completed episodes were delivered for adults aged 65 and over. It is important to note that one person may have multiple episodes of ST-Max within the year. As such, the 246,035 episodes of ST-Max related to 210,400 clients, which equates to an average of 1.2 completed episodes of ST-Max per client during the year.

ST-Max is typically provided to those clients with a primary support reason¹⁹ of physical support. This is where an individual requires help because they find physical things difficult to do by themselves. Physical support was stated as the primary support reason for 89.0% (219,030) of completed ST-Max episodes in the period.

The same can be seen when considering the £319 million (up £14 million since 2016-17) gross current expenditure on ST-Max, where 82.7% (£264 million) was allocated to services for clients with a primary support reason of physical support.

ST-Max is not only offered to new clients. Many (though not all) local authorities offer this to existing clients, who account for 13.5% (33,195) of the total completed episodes of ST-Max in the period. Given that existing clients already have long term needs, the outcomes are very different. As such, the collection was changed to collect different outcomes for existing clients in 2017-18, however some local authorities have experienced difficulties in recording these different outcomes accurately.

The following section will only discuss the outcomes for new clients (those not already in receipt of long term care). Data on outcomes for existing clients can be found in the reference tables²⁰ and data files accompanying this report, although analysis of this information should be done with caution due to data quality issues²¹.

¹⁸Where the outcome is known within the reporting period

¹⁹The Primary Support Reason describes why the individual requires social care support

²⁰See Reference table 27

²¹Details regarding these issues can be found in the data quality tables accompanying this report.

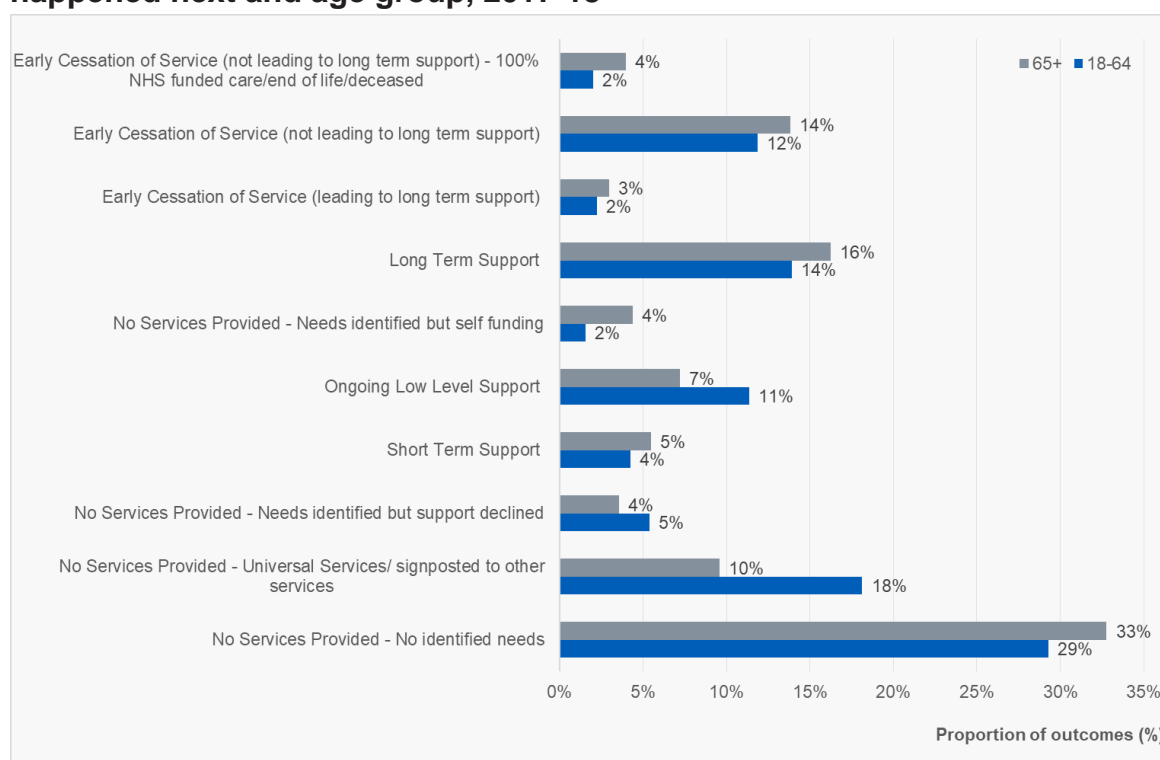
Outcomes following an episode of ST-Max for new clients

A primary aim of ST-Max is to provide short term rehabilitative support allowing a client to avoid ongoing long term support needs.

Completed episodes of ST-Max for new clients have increased by 3.0% from 206,720 in 2016-17 to 212,835 in 2017-18. Around a third of these episodes (32.4% or 68,885) resulted in the client having no identified needs, therefore they had no further ongoing requirement for adult social care support.

As Figure 12 below shows, this was the most frequent outcome for both those aged 18 to 64 and aged 65 over. After this, differences are noted between the age groups, with the second most frequent outcome for those aged 18 to 64 being 'Universal Services / Signposting to other services' compared to 'Long Term Support' for those aged 65 and over.

Figure 12: Number of completed episodes of ST-Max for new clients, by what happened next and age group, 2017-18

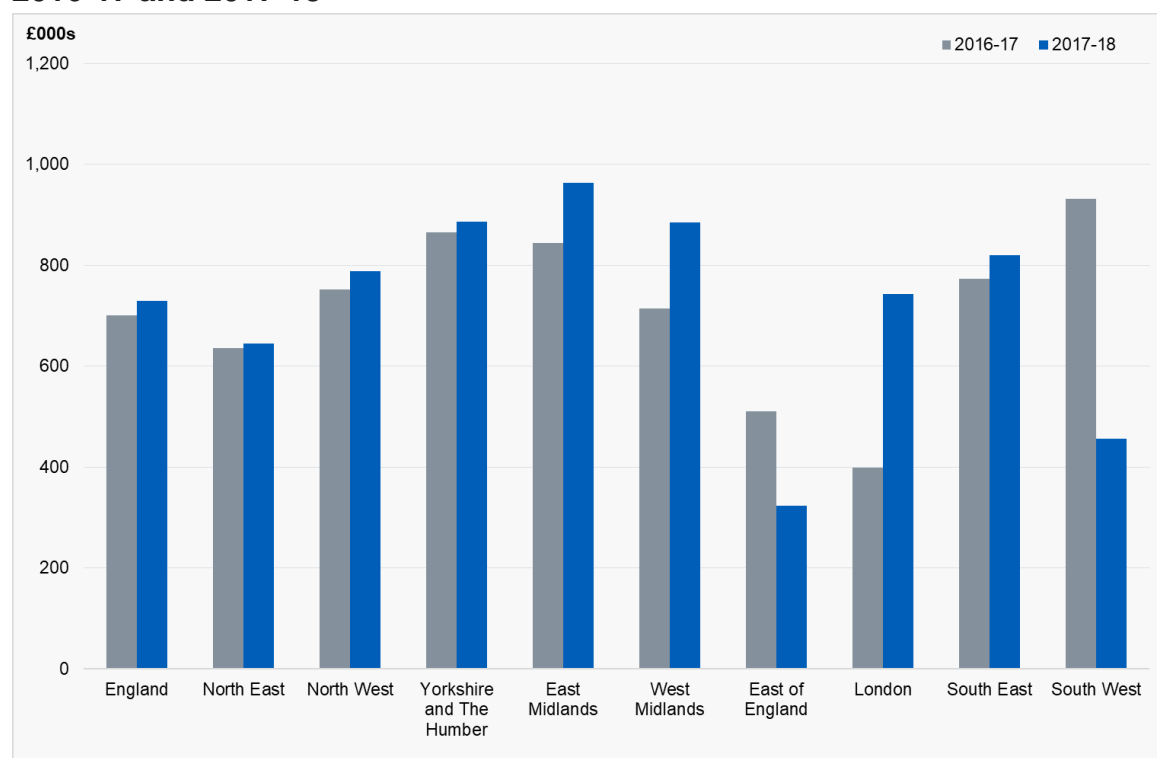


Source: SALT Collection, 2017-18, NHS Digital - See Table 21 in Reference Data Tables

Regional Trends

There is considerable regional difference in expenditure on the provision of ST-Max per 100,000 population, as can be seen in Figure 13.

Figure 13: Gross current expenditure on ST-Max per 100,000 adults, by region, 2016-17 and 2017-18

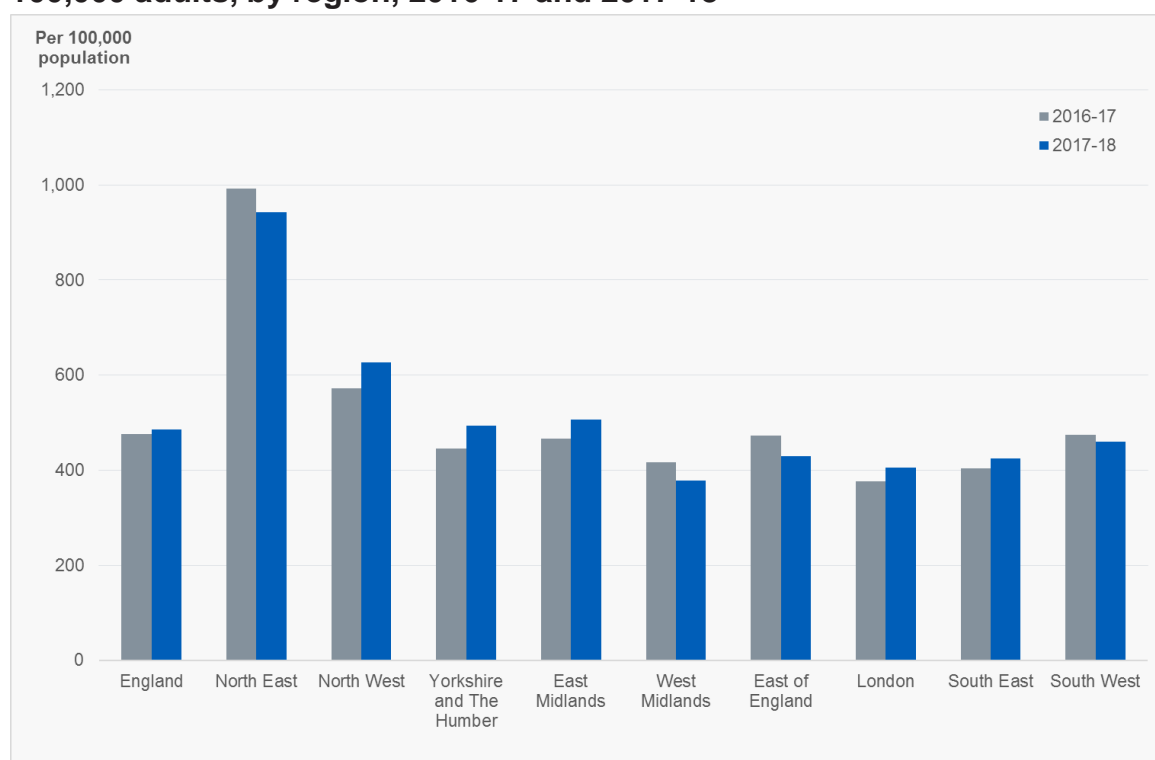


Source: ASC-FR Collection, 2017-18, NHS Digital - See Table 32 in Reference Data Tables

Gross current expenditure on ST-Max per 100,000 population varies between the lowest spend of £322,614 per 100,000 adults in the East of England, to the highest spend of £963,419 per 100,000 adults in the East Midlands region.

When compared to 2016-17, nationally there has been an increase of £27,767 gross current expenditure on ST-Max per 100,000 population. All regions saw an increase since 2016-17 except East of England which decreased by 36.7% and the South West region by 51.0%. London had the biggest increase, doing so by 86.1%. Although these were considerable changes year on year, there were no noticeable patterns emerging, or context provided, to account for this.

Figure 14: Number of completed episodes of ST-Max for new clients per 100,000 adults, by region, 2016-17 and 2017-18



Source: SALT Collection, 2017-18, NHS Digital - See Table 24 in Reference Data Tables

There is little variability between regions in the number of completed episodes of ST-Max for new clients per 100,000 population (see Figure 14 above), with the exception of the North East which has a much higher rate than other regions. The North East had over 50% more completed episodes of ST-Max per 100,000 than the next highest region.

The expenditure and activity figures above do not cover exactly the same care provision (activity data, for example, includes care for social support where finance data does not; finance data includes new and existing clients whereas the activity data above relates only to new clients). However, the differences in trends between the rate of expenditure per 100,000 population and completed episodes per 100,000 population may be indicative of variations in local practice in terms of how ST-Max services are provided.

Tables 21 to 28 in the reference data tables accompanying this report provide local authority and regional level data regarding the numbers of completed episodes of ST-Max in the year, as well as what happened next for the client.

In terms of the proportion of new clients receiving each outcome of ST-Max, all nine regions (and 85 of 152 local authorities), reported “No Services Provided – no identified needs” as being the most likely outcome following a period of ST-Max. Nationally, “No Services Provided – no identified needs” accounted for 32.4% of ST-Max outcomes. Regionally, this ranged from 24.1% in the North West to 45.7% in the East of England region. Five out of nine regions reported the client going on to receive long term support following a fully completed episode of ST-Max, as the second most likely outcome.

4. Long term care

Long term care is provided to clients on an ongoing basis and varies from high intensity provision such as nursing care, to lower intensity support in the community such as the provision of direct payments to arrange regular home care visits.

Whereas short term care is designed for a time limited period, and in the case of ST-Max with the aim of reducing or removing the clients need for ongoing care, long term care has no fixed time period and is delivered for as long as it is required.

Please Note: There are some differences in how information on long term care is collected between the ASC-FR and SALT returns.

For example, activity data includes those receiving long term care with a Primary Support Reason (PSR) of Social Support, whereas this PSR is not included in long term expenditure (instead being recorded as a combined short term/long term spend total.).

In addition, information regarding support settings is recorded using different categories between the returns, and so this data cannot be directly compared.

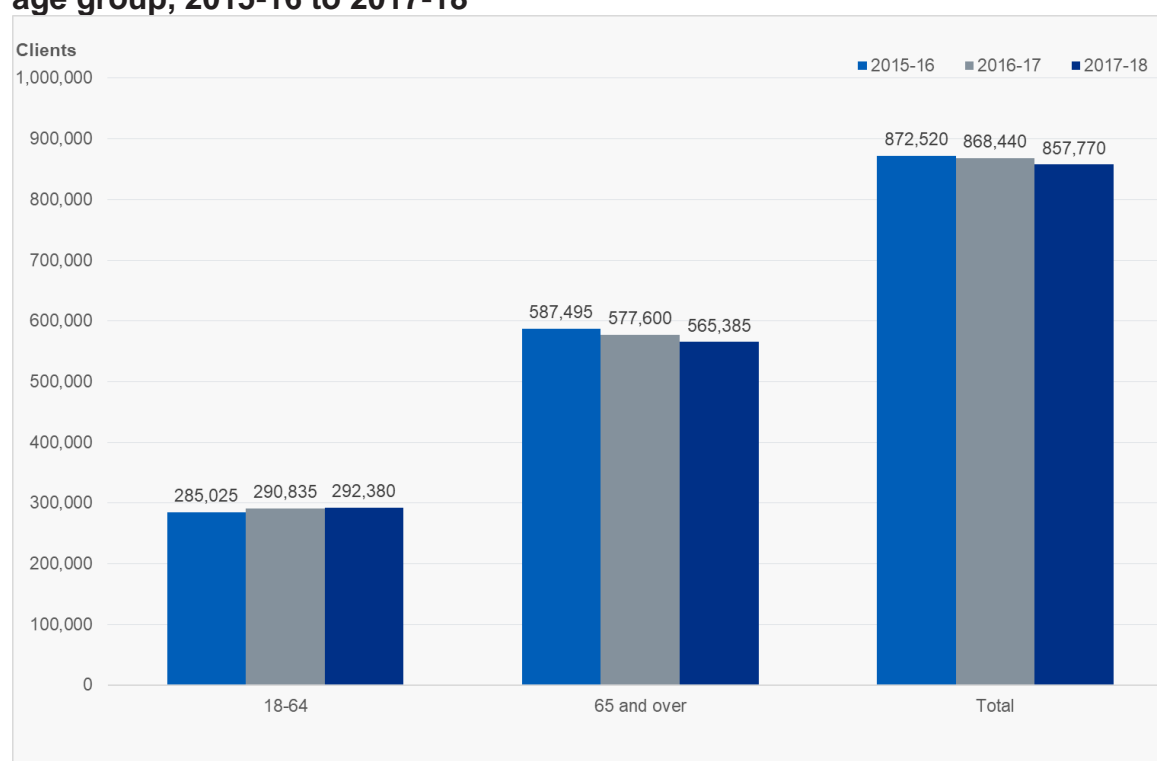
Therefore, care must be taken when comparing the two returns; some comparisons of general trends can be made, but more direct comparisons, such as an average cost per person, are not recommended.

Key findings

Just over three quarters of total gross current expenditure (77.9% of gross current expenditure or £14.0 billion) is spent on long term care, which consists of residential, nursing and community care.

This represents an increase of £369 million (2.7%) compared to 2016-17, and accounts for a large proportion of the overall increases in gross current expenditure during the year. This increase was split evenly between the two age groups (18 to 64 and 65 and over).

In activity terms, the total number of clients receiving long term support has fallen in each year since 2015-16. In 2017-18 there were 857,770 clients in receipt of long term support, a decrease of 10,670 (1.2%) clients from the previous year and 14,750 clients (1.7%) since 2015-16. However, when considering those accessing long term support by client age, there has been an increase each year for clients aged 18 to 64.

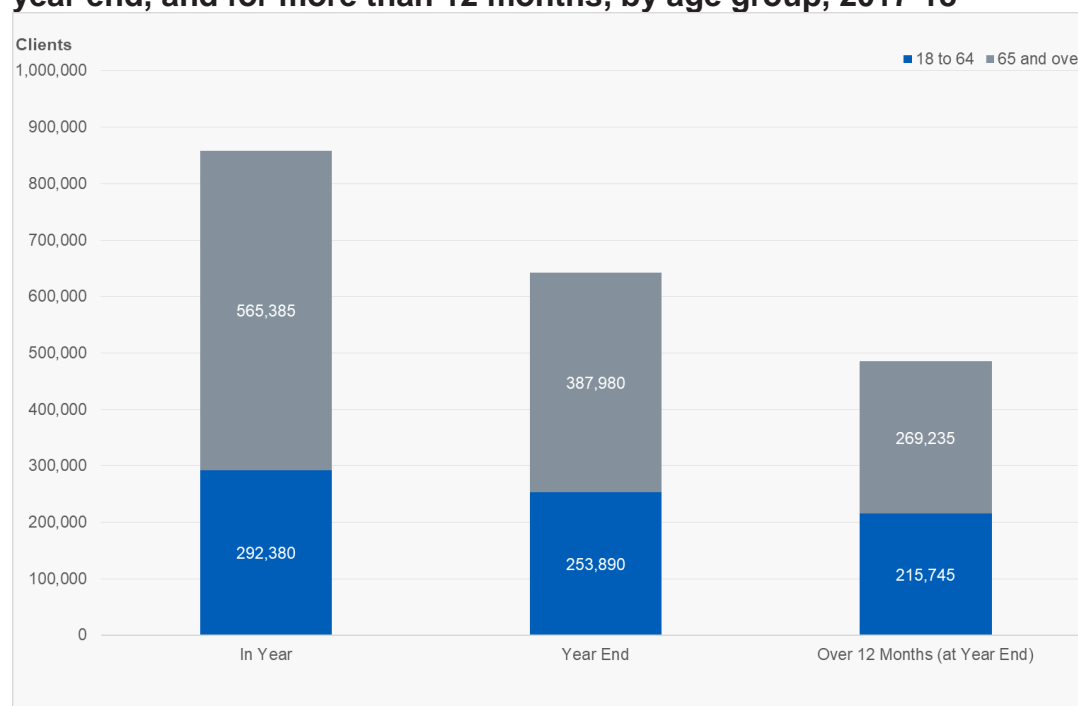
Figure 15: Number of clients accessing long term support during the year, by age group, 2015-16 to 2017-18

Source: SALT Collection, 2017-18, NHS Digital - See Table 2 in Reference Data Tables and previous publications

In total, 857,770 clients were supported at some point in the year, with 641,870 of these clients (74.8%) in receipt of long term support at year end. Of this latter group, 484,980 clients (75.6%) had been receiving long term support for one year or more.

Although the collections do not capture intensity of support, the high proportion of clients that had been supported for 12 months or more at the end of the year reflects a need for ongoing support and this proportion has increased from 73.7% in 2016-17.

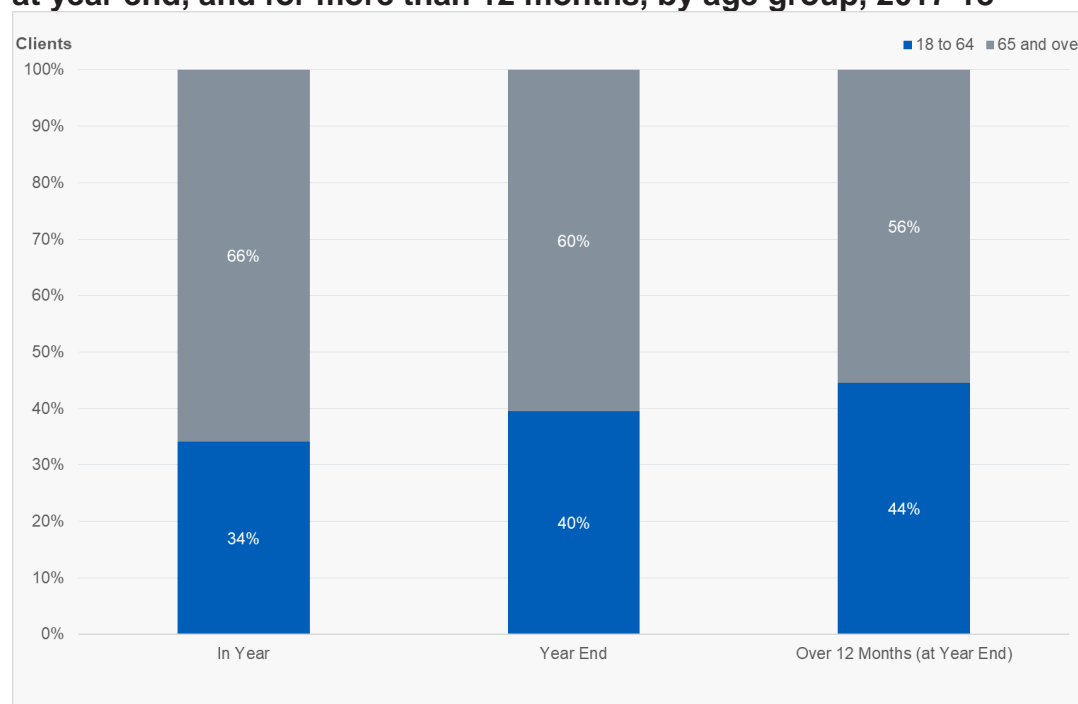
Figure 16: Number of clients accessing long term support during the year, at year end, and for more than 12 months, by age group, 2017-18



Source: SALT Collection, 2017-18, NHS Digital - See Table 33 in Reference Data Tables

Figure 17 illustrates that there is a greater proportion of clients aged 18 to 64 who have accessed services for more than 12 months at year end (44.5%), when compared to the total number accessing services at year end (39.6%). The 18 to 64 age group accounts for 34.1% of all adults that accessed long term support at any point during the year.

Figure 17: Proportion of clients accessing long term support during the year, at year end, and for more than 12 months, by age group, 2017-18

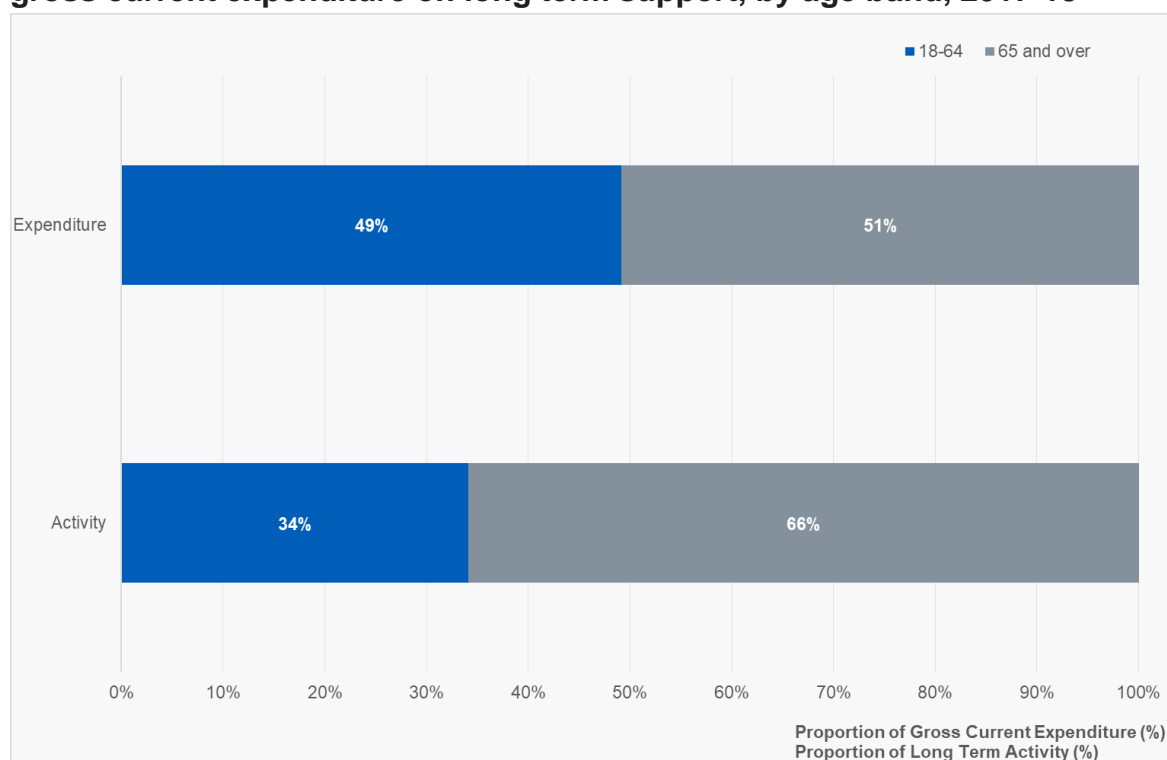


Source: SALT Collection, 2017-18, NHS Digital - See Table 33 in Reference Data Tables

Long term care

In 2017-18, 9 in 1,000 18 to 64 year olds received long term support during the year, while 56 in 1,000 clients aged 65 and over received this type of support.

Figure 18: Number of clients accessing long term support during the year and gross current expenditure on long term support, by age band, 2017-18²²



Source: ASC-FR and SALT Collections, 2017-18, NHS Digital - See Table 33, 41 and 42 in Reference Data Tables

Figure 18 shows that although one-third of long-term activity was provided to clients in the 18 to 64 age group in 2017-18, this age group accounted for almost half of the gross current expenditure for long term care during the period.

One explanation for this is that long term support for 18 to 64 year olds typically covers more complex care needs, and as a result, unit costs for both nursing and residential are much higher for this age band (unit costs are not available for community care). This is explored in more detail in the section regarding Primary Support Reasons below.

Over half (58.6%) of all clients receiving long term support at the year-end are female. Data is not collected on gender split for short term care.



²²As referenced at the start of the long term section, long term activity and long term expenditure are not directly comparable

The proportion of female clients increases further when we consider those supported in a residential home (61.9%) and further still (63.4%) when considering those in a nursing home.

Office for National Statistics (ONS) population figures show that there are more women than men aged 65 and over (accounting for nearly 55% of the total population in this age group)²³. Therefore, the numbers receiving long term care within the year may partially be a result of differences in the population for this age group.

Long term care activity by support setting

Support setting is the primary setting where the client receives services. Expenditure and activity data collect information regarding support setting using different categories. The main difference is for the community care setting. Expenditure data is captured using a mixture of delivery mechanism and support setting, whereas activity data is captured by delivery mechanism only, and so comparisons regarding support setting are limited between the two data sources, and discussion of the two collections has been separated in this section.

Use of hierarchies in support setting

An individual may receive care in multiple support settings throughout the year. To avoid double counting a hierarchy is used to ensure counts of those receiving support in the year are not duplicated.

An individual can only be counted under one setting in the hierarchy – for example if an individual received both residential and nursing care in the year, they would be counted under nursing care only.

For the purposes of this section therefore, analysis on support setting will focus instead on those receiving services at the end of the year. This provides a snapshot figure of the number of people in each support setting at year end.

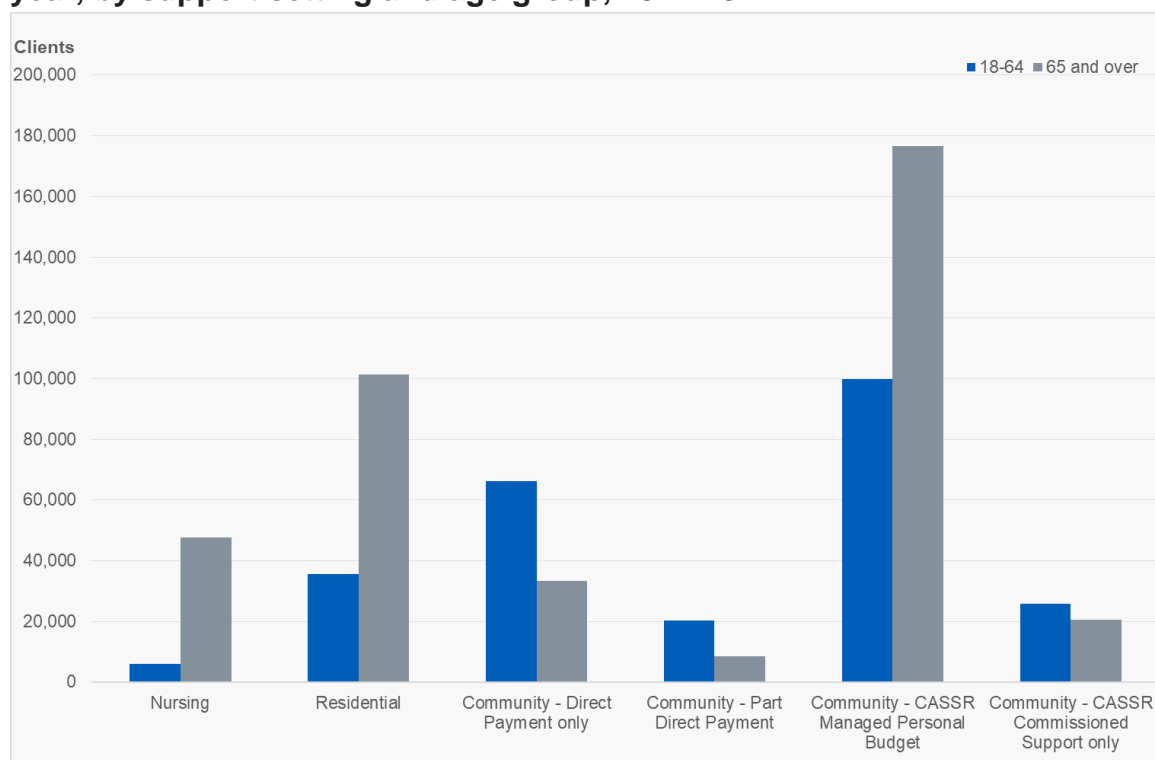
Data on the support settings for those receiving care in the year can be found in the reference tables accompanying this report.

In both age groups, clients who were receiving long term support at the end of the year were most commonly in receipt of community care²⁴ (83.6% of those aged 18 to 64 and 61.6% of those aged 65 and over).

²³<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland>

²⁴See glossary in [Appendix C](#)

Figure 19: Number of clients accessing long term support at the end of the year, by support setting and age group, 2017-18



Source: SALT Collection, 2017-18, NHS Digital - See Table 38 in Reference Data Tables

Those aged 65 and over were much more likely to be receiving residential or nursing care at the end of the year than those aged 18 to 64, with 12.3% of clients in the 65 and over age group being in nursing care (compared to 2.3% of 18 to 64 year olds), and 26.1% in residential care (compared to 14.0% of 18 to 64 year olds).

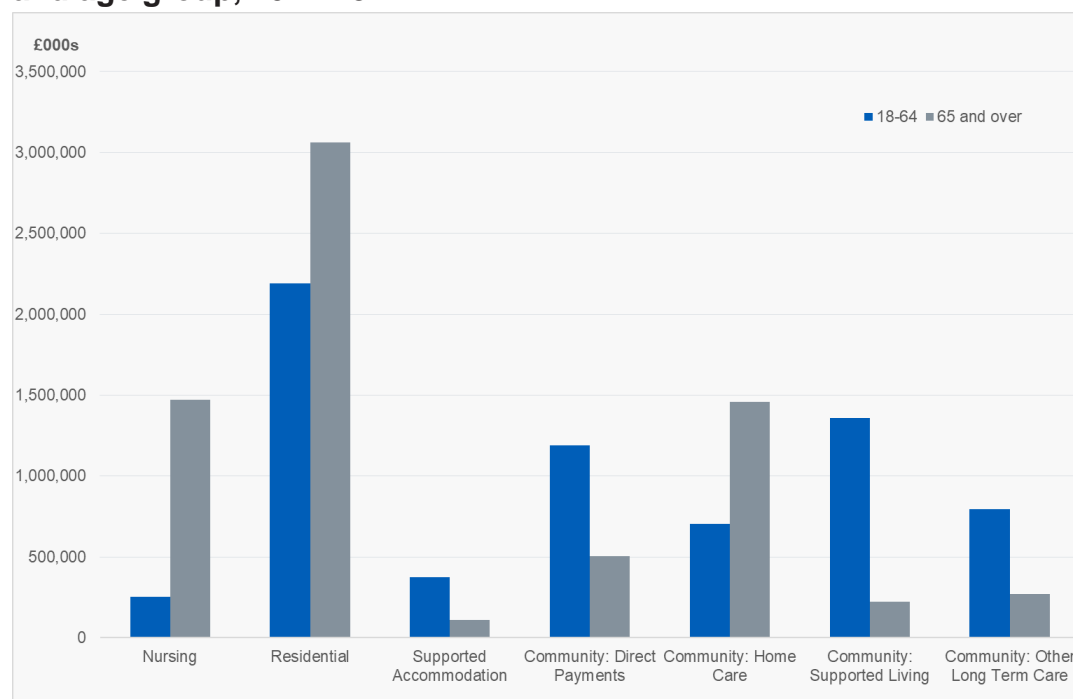
Long term care expenditure by support setting

As seen in Figure 20 on the next page, for both age groups, residential care accounted for the highest proportion of gross current expenditure.

However, when considering all elements of community care (consisting of direct payments, home care, supported living and other long-term care), this accounts for 46.6% of gross current expenditure on long term care, while residential care accounts for 37.6%.

Expenditure on nursing care (20.7%) and home care in the community (20.6%) were also key areas of expenditure for those aged 65 and over. Supported living (19.8%) and direct payments (17.3%) accounted for the second and third highest proportions respectively of expenditure (after residential care) for those aged 18 to 64.

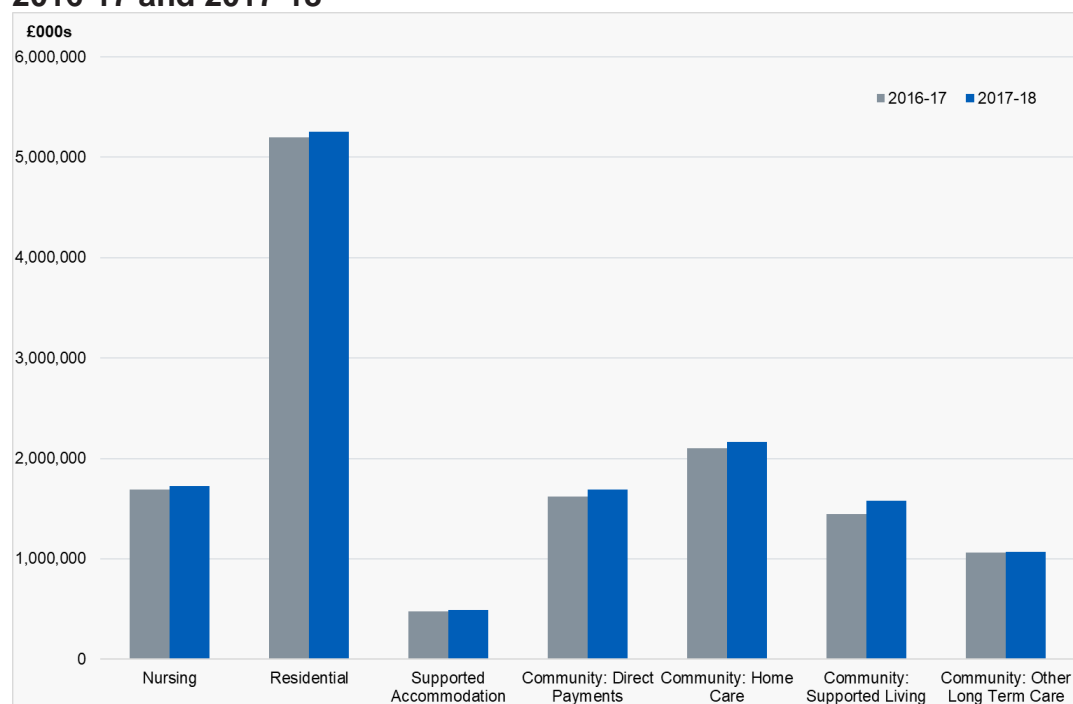
Figure 20: Gross current expenditure on long term support by support setting and age group, 2017-18



Source: ASC-FR Collection, 2017-18, NHS Digital - See Table 41 and 42 in Reference Data Tables

In 2017-18 gross current expenditure on long term care increased by £369 million (2.7%), and this was split across support settings. Although increases in expenditure were noted in all support settings, supported living in the community increased the most, by 9.2% (£133 million).

Figure 21: Gross current expenditure on long term support by support setting, 2016-17 and 2017-18



Source: ASC-FR Collection, 2017-18, NHS Digital - See Table 43 (2017-18 figures) in Reference Data Tables

Primary support reason and long-term care

A primary support reason describes why the individual requires social care support. This is collected in both the activity and finance data collected by NHS Digital.

Some local authorities have reported difficulty in correctly allocating activity and expenditure across these categories²⁵, and this should be taken into consideration when analysing this data. Comparison of trends in the data, however, does provide useful insight into how long-term care is provided by local authorities.

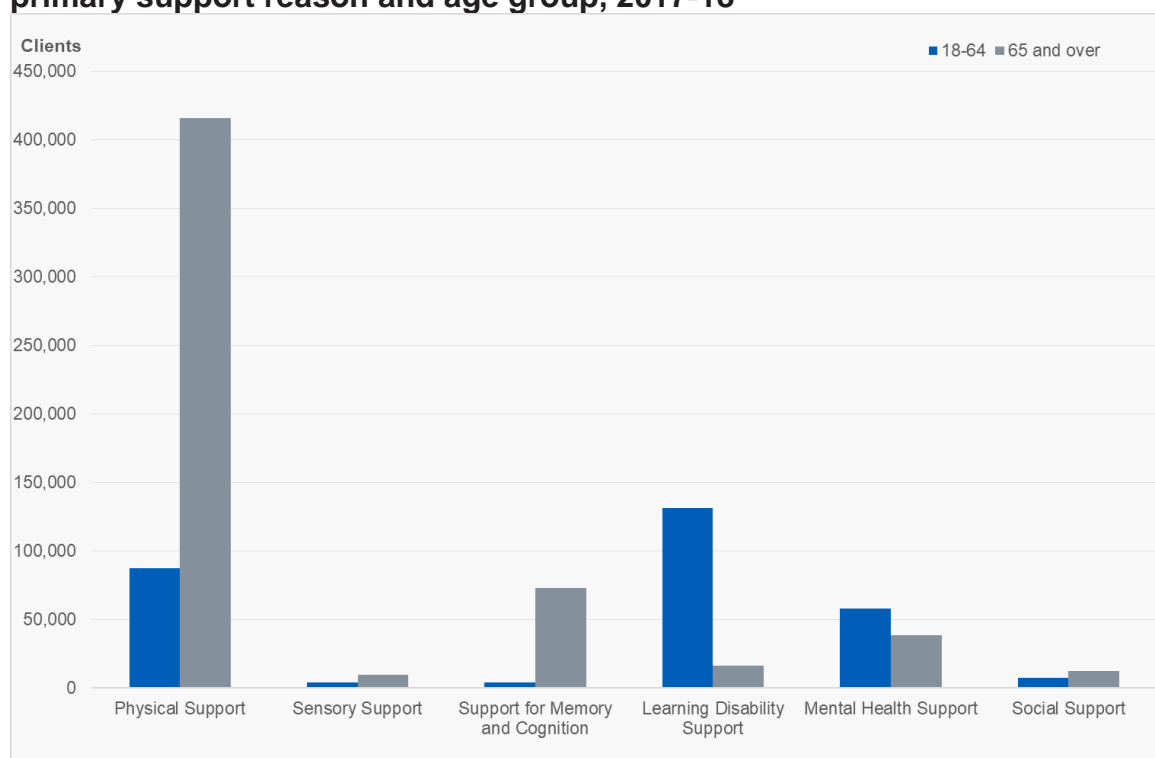
Whereas ST-Max is predominantly provided to clients with a primary support reason of physical support, the picture in long term care is more varied. In particular, the most common primary support reason for the client needing support differs by age group.

As can be seen in Figure 22, for those aged 18 to 64 the most common reason for requiring support was learning disability (this was the primary support reason for 45.0% of clients receiving long term support in the year). The next most common support reasons were physical support (29.9%) and mental health support (19.8%).

45%

of those aged 18-64 receiving long term support in the year had a primary support reason of learning disability

Figure 22: Number of clients accessing long term support during the year, by primary support reason and age group, 2017-18



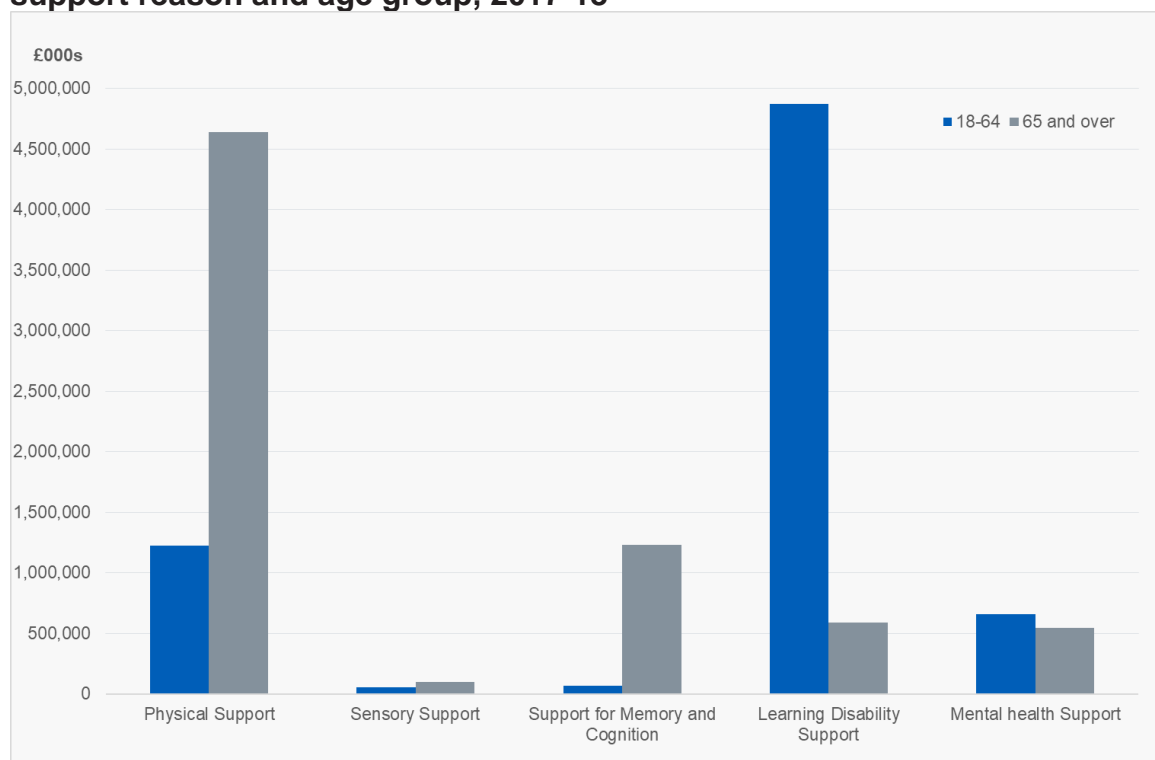
Source: SALT Collection, 2017-18, NHS Digital - See Table 35 in Reference Data Tables

For those aged 65 and over the most common primary support reason was physical support (73.6%) followed by support for memory and cognition (12.9%).

²⁵Please see the Data Quality summary for further detail

Although the expenditure return does not include the Social Support primary support reason, examination of this data shows a similar trend to that of activity data. Physical Support accounted for the majority of gross current expenditure on those aged 65 and over (65.4%), while learning disability Support accounted for 70.9% of expenditure on those aged 18 to 64.

Figure 23: Gross current expenditure on long term support, by primary support reason and age group, 2017-18



Source: ASC-FR Collection, 2017-18, NHS Digital - See Table 43 in Reference Data Tables

At England level, learning disability support has the highest unit costs for both those aged 18 to 64 and 65 and over. As seen on the following page, as care for those clients aged 18 to 64 is more likely to be due to a primary support reason of learning disability, these increased costs are likely to have more impact on overall unit costs for this age group.

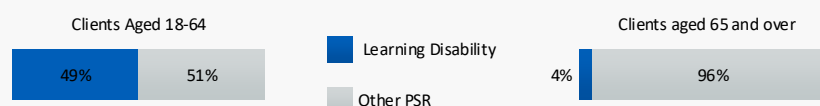
In addition, within the 18 to 64 age group, learning disability accounts for almost half of the activity by primary support reason in residential or community support settings. In a nursing setting for the 18 to 64 age band, clients with learning disabilities make up only 18.3% of all clients accessing services at year end, but 65.8% of those in a residential care setting.

As a result, residential unit costs tend to be higher than nursing costs for this age band, due to the increased expenditure associated with learning disability support, as seen in Figure 24.

Figure 24: Overview of weekly costs of care by primary support reason, 2017-18

Residential Care 18-64	Residential Care 65 and over	Nursing Care 18-64	Nursing Care 65 and over
Physical Support £950	Physical Support £587	Physical Support £862	Physical Support £627
Sensory Support £1,159	Sensory Support £574	Sensory Support £766	Sensory Support £602
Support with Memory and Cognition £792	Support with Memory and Cognition £577	Support with Memory and Cognition £806	Support with Memory and Cognition £651
Learning Disability Support £1,476	Learning Disability Support £961	Learning Disability Support £1,246	Learning Disability Support £833
Mental Health Support £828	Mental Health Support £587	Mental Health Support £825	Mental Health Support £660

Care costs for clients with a primary support reason of learning disability are higher than the other support reasons for all age groups and care types.



Clients with a primary support reason of learning disability make up 49 per cent of clients aged 18-64, but only 4 per cent of clients aged 65 and over, accessing long term support at the end of the year.

Due to the increased cost of care for clients with this primary support reason this has meant that expenditure on those aged 18 to 64 is roughly the same as on those aged 65 and over, although clients aged 18 to 64 account for only 34 per cent of those receiving care in the year.

Support setting and primary support reason for clients aged 18 to 64, accessing long term support at the end of the year



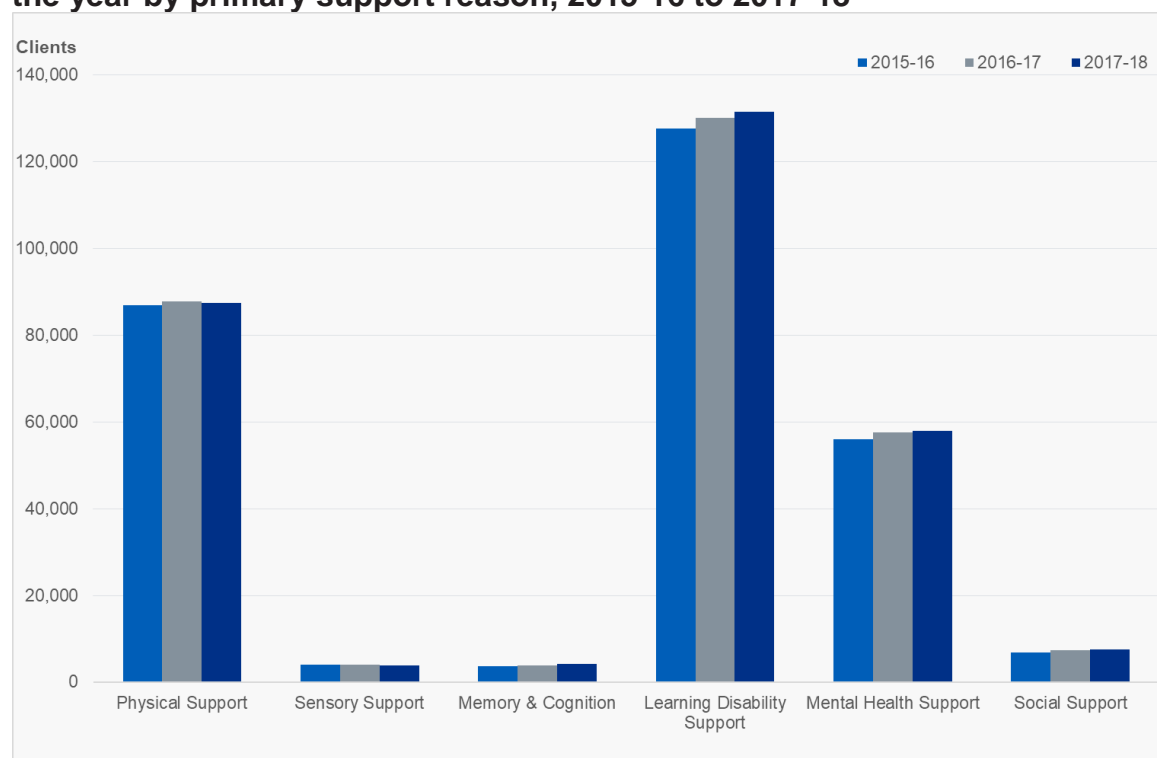
For those aged 18 to 64, learning disability was the most common primary support reason in residential care.

Although nursing care is typically more expensive, the high number of clients with learning disability as a primary support reason in residential care means that for this age group the overall average residential care unit cost is higher than for nursing care, due to the increased costs associated with the learning disability primary support reason.

Source: SALT and ASC-FR Collection, 2017-18, NHS Digital - See Table 51, 52, 37 and 38 in Reference Data Tables

Activity data also shows that the number of clients with a primary support reason of learning disability is increasing year on year within the 18 to 64 year old group.

Figure 25: Number of clients aged 18-64 accessing long term support during the year by primary support reason, 2015-16 to 2017-18



Source: SALT Collection, 2017-18, NHS Digital - See Table 35 in Reference Data Tables

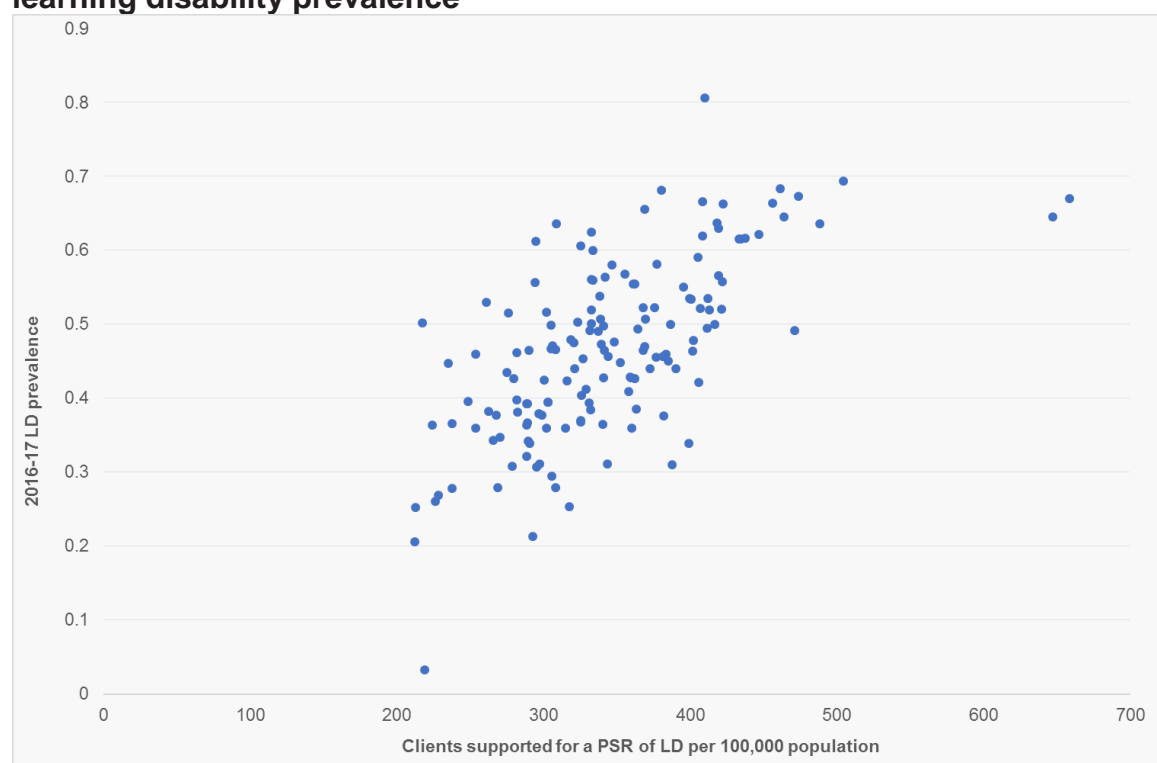
Learning disability prevalence (calculated as the number of GP patients with learning disabilities divided by the number of patients on the GP practice list) is published as part of the Quality Outcomes Framework (QOF) data²⁶. This shows that learning disability prevalence is increasing in England year on year (from 0.44% in 2014-15 to 0.47% in 2016-17²⁷), which supports the activity data shown in Figure 25.

²⁶ <https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/quality-and-outcomes-framework-qof-2016-17>

²⁷ 2017-18 data is due for release after the publication of this report

Figure 26 shows that as learning disability prevalence increases, so does the proportion of clients supported for a primary support reason of learning disability.

Figure 26: Number of clients aged 18 and over with a primary support reason of learning disability accessing long term support per 100,000, against learning disability prevalence



Source: SALT Collection, 2017-18, NHS Digital - See Table 36 in Reference Data Tables, and LD prevalence data from <https://fingertips.phe.org.uk/profile/learning-disabilities/data#page/3/gid/1938132702/pat/6/par/E12000003/ati/102/are/E08000034/iid/200/age/1/sx/4>

Activity data is collected on those with a primary support reason of learning disability. It is important to recognise that there may be additional clients included in the activity data who also have learning disabilities however are supported primarily for a different reason.

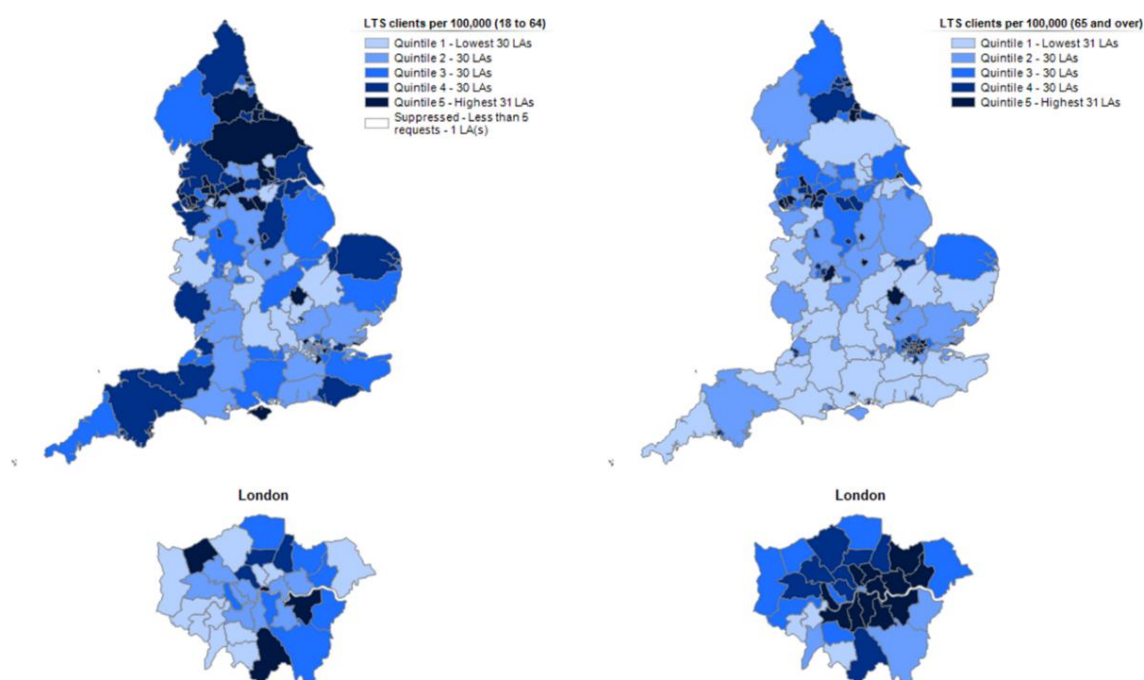
Regional trends in long term care

The numbers of clients supported in long term care during the year varies regionally, as can be seen in Figure 27 below. This shows the number of clients receiving long term support in the year per 100,000 population by age group.

The North West Region has the highest number of clients aged 18 to 64 accessing long term support during the year, with 1,085 clients per 100,000 population. In the 65 and over age group the North East is highest with 7,450 clients per 100,000 population, closely followed by London with 7,255 clients.

From a local authority perspective, the two local authorities with the highest number of clients aged 65 and over accessing long term support per 100,000 are both in London. The London region reports six of the ten local authorities reporting the highest proportion of clients aged 65 and over supported per 100,000 population.

Figure 27: Number of clients accessing long term support during the year per 100,000 adults, by age group and local authority, 2017-18



Source: SALT Collection, 2017-18, NHS Digital - See Table 36 in Reference Data Tables

5. Carers

Local authorities report information relating to carers in both the activity and finance returns. This information includes the number of carers being supported, and the costs associated with providing this support, as well as those that have been assessed or reviewed by the local authority but received no support in the year. Data on carers relates to unpaid carers of all ages who provide a substantial amount of care on a regular basis for someone aged 18 or over.

Please Note: Local authorities noted a variety of data quality issues relating to their carer data. For example, some local authorities have difficulties obtaining data from third parties, or some case management systems can only record carers and cared-for clients on a one to one basis. Full details of the data quality issues can be found in the accompanying data quality report. It should also be noted that a number of local authorities advised us of continued data cleansing and as such year-on-year trends may be a result of this rather than service provision. This should be considered when examining the data relating to this area, and particularly when considering local trends.

Key Trends

In 2017-18 360,310 carers were either supported or assessed by the local authorities during the year. This represents a decrease of 2.4% from the 368,990 carers supported in 2016-17. The change from last year varied regionally from a 10.6% decrease in the North East to an 8.5% increase in the Yorkshire and The Humber region.

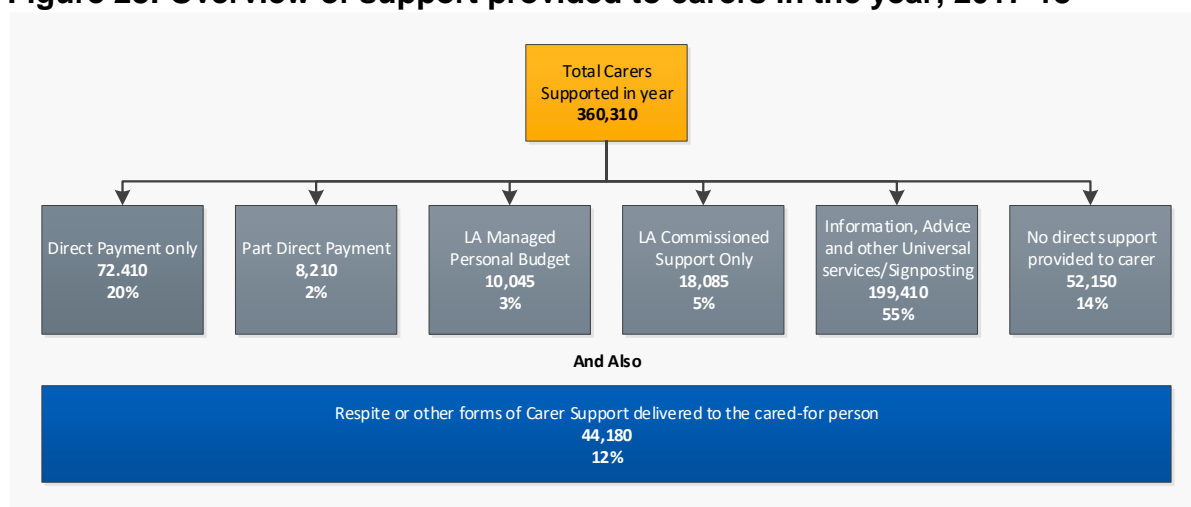
Gross current expenditure on social support: support to carers was £154 million in 2017-18, a 7.2% decrease from £166 million in 2016-17. Local authorities advised that expenditure related to carers could sometimes be captured within a different category in ASC-FR (see the data quality summary for full details) and so this expenditure should not be directly compared with the activity data.

Whilst over half (53.2%) of local authority supported carers are aged 18 to 64, 1.2% are aged under 18, 36.7% aged 65 to 84 and almost one in ten (8.9%) are aged 85 and over.

The South West region has the highest proportion of supported carers under 18 at 3.9% (1,340 carers) and also 18-25 year olds at 5.3% (1,840). London has the highest proportion of 26 to 64 year old carers supported (57.6%). The South East has the highest proportion of carers aged 85 and over (12.1%)

Support Received

Figure 28: Overview of support provided to carers in the year, 2017-18



Source: SALT Collection, 2017-18, NHS Digital - See Table 45 in Reference Data Tables

Of the total 360,310 carers supported in 2017-18, 85.5% (308,160) received Direct Support, which includes Direct Payments, Part Direct Payments, Local Authority Managed Personal Budgets, Local Authority Commissioned Support and the provision of Information Advice and other Universal Services or Signposting. This is an increase from the previous year where 81.8% of carers received Direct Support.

The most common support for carers consisted of Information, Advice and other Universal Services or Signposting, with 199,410 carers receiving this as the most intensive form of support²⁸ during the year. This accounted for 55.3% of carers receiving support in 2017-18, up from 50.9% last year).

In addition, 44,180 (12.3%) carers received respite or other forms of carer support delivered to the cared-for person in 2017-18 compared to 14.1% in 2016-17. The most common example of respite is care arranged by the local authority which might involve the client being placed in a residential setting in order to give the carer a break from their caring responsibilities.

²⁸A hierarchy is used to avoid double counting. Those carers who received Direct Payments, Part direct payments, LA managed personal budgets or LA commissioned support may also have received Information advice and other universal services or signposting.

6. Reviews

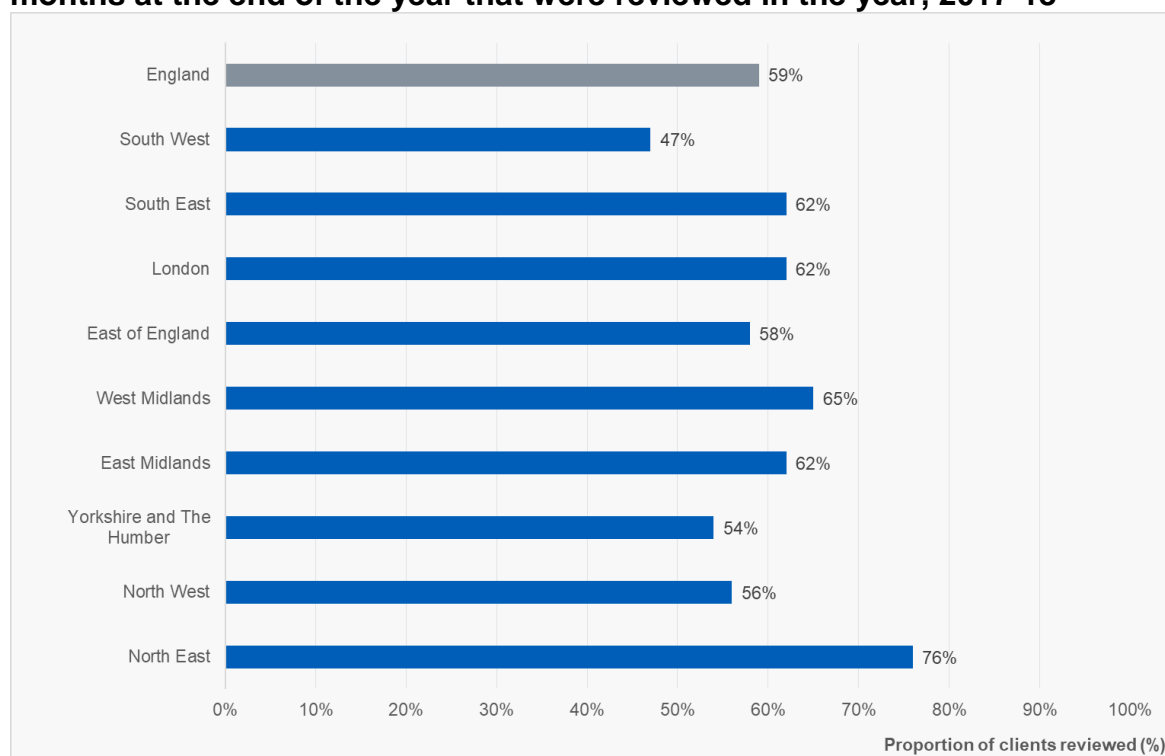
The local authority has a legal responsibility to review the needs of an individual, which may result in a change in care plan for an individual to make sure that the adult's needs continue to be met and they can achieve their desired outcomes. The person themselves also has the right to request a review of their care and support plan, if they wish.

Please Note: local authorities reported a variety of data quality issues relating to their reviews data, for example, allocation between planned/unplanned reviews, reviews recorded as assessments or updates and so not captured as reviews; details of which can be found in the accompanying data quality report. This should be considered when examining the data relating to this area, and particularly when considering local trends.

In 2017-18, 59.3% of clients who had been in receipt of long-term support for more than a year were reviewed within the reporting period.

As can be seen in Figure 29, the proportion of clients being reviewed varied by region from 46.8% to 76.0%. The highest review rate can be seen in the North East region.

Figure 29: Proportion of clients accessing long term support for more than 12 months at the end of the year that were reviewed in the year, 2017-18



Source: SALT Collection, 2017-18, NHS Digital - See Table 48 in Reference Data Tables

Data is available on the number of planned and unplanned reviews carried out within the year, as well as the outcomes of these. This information can be found in the data file which accompanies this report.

Appendix A: Use of GDP deflator

When looking at changes in monetary amounts over time it can be difficult to see whether more or less money has been spent as the real change is often masked by the effects of inflation. Therefore, it is useful to strip out the effects of inflation so the real change in expenditure can be examined, and one way to do this is by use of a deflator.

In this report the Gross Domestic Product (GDP) deflator is used. The GDP deflator is a much broader price index than the Consumer Price Index (CPI), Retail Price Index (RPI) or Retail Price Index excluding mortgage interest payments (RPIX), which only measure consumer prices. This is because it reflects the prices of all domestically produced goods and services in the economy. The GDP deflator also includes the prices of investment goods, government services and exports, and excludes the price of UK imports. The wider coverage of the GDP deflator makes it more appropriate for deflating public expenditure series.

The GDP deflator can be viewed as a measure of general inflation in the domestic economy which can be described as a measure of price changes over time. The deflator is usually expressed in terms of an index, (i.e. a time series of index numbers), and percentage changes on the previous year are also usually shown.

It reflects movements of hundreds of separate deflators for the individual expenditure components of GDP, which includes expenditure on such items as bread, investment in computers, imports of aircraft, and exports of consultancy services.

The time series for the GDP deflator allows for the effects of changes in price (inflation) to be removed so a time series of data, in this case adult social care expenditure, can be expressed in 'real' terms.

Information on GDP deflators is sourced from HM Treasury. These are updated quarterly, and the GDP deflators used throughout this report were National Accounts figures from the ONS made available on 2 October 2018 (downloaded 10 October 2018) and are given in the following table.

Table 3: GDP deflator at market prices and per cent change on previous year

Financial year	Index number and percentages	
	GDP deflator at market prices	per cent change on previous year
2007-08	84.205	2.48
2008-09	86.491	2.71
2009-10	87.716	1.42
2010-11	89.348	1.86
2011-12	90.522	1.31
2012-13	92.345	2.01
2013-14	94.039	1.83
2014-15	95.247	1.28
2015-16	96.009	0.80
2016-17	98.137	2.22
2017-18	100.000	1.90

Source: GDP deflators at market prices, and money GDP September 2018, HM Treasury. Made available on 2 October 2018 and downloaded 10 October 2018 from <https://www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-september-2018-quarterly-national-accounts>

Example

In 2007-08, £100 was spent on a piece of equipment for a client. In 2017-18, a replacement piece of equipment had to be bought for £110. In cash terms, the cost of this piece of equipment has risen by £10 (10%). If, however the rate of inflation is taken into account, the cost of the product in 2007-08 at 2017-18 prices would have been £119 (see calculation below). This would mean that the product is cheaper in real terms in 2017-18 by £9 (8%).

$$\text{2007-08 price in 2017-18 real terms} = \text{2007-08 price} \times \frac{100}{\text{GDP deflator 2007-08}}$$

therefore:

$$\text{2007-08 price in 2017-18 real terms} = £100 \times \frac{100}{84.205} = £119$$

Appendix B: Expenditure on adult social care, 2009-10 to 2017-18

Time-series showing net current public expenditure on adult social care, including expenditure from sources other than social services departments

The main body of this report considers expenditure on adult social care services by the social services departments of Councils with Adult Social Services Responsibilities (CASSRs) in England. Estimates of expenditure therefore do not include public expenditure funded through other routes (e.g. NHS expenditure on adult social care services).

As a consequence of changing government policy, responsibility and funding for providing certain adult social care services often shifts between different public bodies, most commonly between the NHS and local authorities. This means that it is not always meaningful to compare expenditure on adult social care over time if based only on expenditure by social services departments.

Table 4 below provides information about net public expenditure on adult social care services by social services departments²⁹ and other organisations and gives an estimate for total net current expenditure on adult social care services in England. The sources of funding included are not exhaustive (for example, expenditure by local authorities from budgets other than social services, such as housing, are not included) and only include those for which expenditure can be readily quantified. The sources included are thought to cover those considered necessary to be able to provide a comparable time-series on public expenditure on adult social care. Data have not been adjusted for inflation.

National expenditure includes data from 152 local authorities.

The figures in Table 4 below show that in 2017-18 the total net expenditure estimate was £17.1 billion, an increase in cash terms of 2.3% from the 2016-17 figure and an increase of 11.6% from the £15.4 billion spent five years previously in 2012-13. This table can also be seen in the [Public spending on adult social care](#) section of this report.

²⁹Net current expenditure by local authorities is total expenditure excluding capital charges, less all income. Gross current expenditure, as used throughout this report, includes income from client contributions.

Table 4: Net current expenditure¹ on adult social care services in cash terms: by source of funding

England, 2009-10 to 2017-18									
	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Social services departments ²	14.46	14.61	14.75	14.63	14.65	14.41	14.33	14.78	15.07
Valuing People Now ³	1.28	1.31	-	-	-	-	-	-	-
NHS transfer to local authorities ⁴	-	-	0.65	0.62	0.86	1.10	-	-	-
Planned Better Care Fund expenditure on social care ⁵	-	-	-	-	-	-	1.81	1.97	2.06
Winter pressures transfer ⁶	-	0.16	0.15	0.10	-	-	-	-	-
Total net expenditure estimate	15.74	16.08	15.55	15.35	15.51	15.51	16.14	16.75	17.13

1 Net current expenditure is total expenditure excluding capital charges and less all income.

2 Including Supporting People expenditure, and inclusive of expenditure on assessment, care management and other overheads.

Source: 2017-18 ASC-FR collection, NHS Digital: <https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/social-care-collection-materials-2018>

3 The Valuing People Now initiative aimed to give greater independence to young adults with learning disabilities. Responsibility for providing services to this cohort lay with the NHS before being transferred to local authorities in 2008-09. Until 2011-12 funding continued to be provided through the NHS and so was not included in the net expenditure by social services departments. From 2011-12 funding for this initiative was allocated directly to local authorities and therefore is included in the net expenditure of social services departments. The actual value of the transfer is known for 2010-11 only and has been assumed to be flat in real terms (adjusted using the GDP deflators as shown in Appendix B) to provide a figure for previous years.

Source: Local government finance settlement, 2013-14, Department for Communities and Local Government:

<http://webarchive.nationalarchives.gov.uk/20140505104649/http://www.local.communities.gov.uk/finance/1314/settle.htm>

4 These monies are transferred from the NHS to local authorities for the provision of social care services that also benefit health. As they are considered to be income, the sums are not included in the net expenditure reported by social services departments.

For 2014-15, this funding consists of £900m to support adult social care which has a health benefit and an additional £200m for preparing for implementation of mandatory pooled budgets between local authorities and clinical commissioning groups in financial year 2015 to 2016 (i.e. Service integration the Better Care Fund).

Source: Department of Health:

www.gov.uk/government/uploads/system/uploads/attachment_data/file/300805/FINAL_Directions_to_NHSE_on_s256_payments_2014.pdf

www.gov.uk/government/uploads/system/uploads/attachment_data/file/215824/dh_123473.pdf

<https://www.gov.uk/government/publications/funding-transfer-from-the-nhs-to-social-care-2013-to-2014-directions>

5 The Better Care Fund (BCF) was introduced in 2015-16. This figure specifically relates to planned spend from the minimum contribution made by CCGs to the total BCF joint fund pool. This figure constitutes jointly agreed planned expenditure classified as 'Social Care' in BCF plans (all commissioner types and all provider types) and; planned expenditure that was not classified as 'Social Care' but was commissioned from non-NHS providers (local authority, charity/ voluntary sector & private sector; by all commissioner types).

Source: Annual HWB BCF Plan collection by Better Care Support Team, based at NHS England

6 These monies are transferred from the NHS to local authorities for the provision of social care services that also benefit health, specifically over the winter period. As they are considered to be income, the sums are not included in the net expenditure reported by social services departments.

Source: Department of Health:

http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215237/dh_132044.pdf

http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215824/dh_123473.pdf

Appendix C: Glossary of Key Terms

<u>Glossary</u>	<u>Definition</u>
ASC	Adult social care
ASCFR	Adult Social Care Finance Return
Carer	The definition of a carer is taken from the <i>Carers and Disabled Children Act 2003</i> which utilises the following description: “Carers (aged 16 and over) who provide or intend to provide a substantial amount of care on a regular basis for another individual aged 18 or over”. Although the Act only refers to carers aged 16 and over, younger carers of adults should be included in this return. The Act excludes from the definition of a carer, paid care workers and volunteers from a voluntary organisation. It is possible for a client to have more than one carer, and for a carer to additionally be a client in his or her own right.
CASSR	Councils with Adult Social Services Responsibility
Community care	In ASC-FR, this includes direct payments, home care, supported living and other long-term care
EQCL	Equality and Classification Framework – Full definitions attached to PSRs and support settings.
Gross Current Expenditure	Total Expenditure excluding capital charges, minus all income except client contributions
Home Care	Unit costs for Home care are the average hourly rate costs for homecare provided by the local authorities and home care provided by an external organisation.
Learning Disability Support	Support and services provided to assist individuals with understanding new or complex information and learning and applying new skills – ‘I need help because I find it difficult to learn how to do things on my own’
Long Term Support	Any service or support which is provided with the intention of maintaining quality of life for an individual on an ongoing basis, which has been allocated based on eligibility criteria/policies (i.e. an assessment of need has taken place) and is subject to regular review.
Mental Health Support	Support for mental health or mental illness – ‘I need help because my psychological / emotional state makes it difficult for me to do certain things on my own’
Nursing	Will apply to those clients who live in registered care homes where nursing services are also provided.
Other Expenditure	All other Social Care Costs that do not fall within Short or Long Term. This includes FR003 (Social Support), FR004 (Assistive equipment and Technology), FR005 (Social Care Activities), FR006 (Information and Early Intervention) and FR007 (Commissioning and Service delivery).
Other Short Term Support	All other short term services for example emergency support not otherwise included in short term to maximise independence
Physical Support	Access, mobility and personal care related to mobility. ‘I need help because there are physical things I find difficult to do on my own’

<u>Glossary</u>	<u>Definition</u>
Primary Support Reason (PSR)	The Primary Support Reason describes why the individual requires social care support; the primary disability / impairment impacting on the individual's quality of life and creating a need for support and assistive care. The primary support reason should be identified and recorded at the point of assessment, and then any changes recorded during subsequent reviews.
PSSEX1	Personal Social Services Expenditure and Unit Costs Return
RAP	Referrals, Assessments and Packages
Residential	Will apply to those clients who live in registered care homes, even if they receive some community based services.
SALT	Short and Long Term Support
Sensory Support	Services for visual or hearing impairments and dual sensory impairments. 'I need help because there are things I can't see / hear well enough on my own'
Sequel to Request for Support	This is the sequel identified as the result of an initial screening/assessment with the client/representative before any type of support is provided. Note that this measure is about the sequels to requests for support and therefore the longer-term care pathways for these clients may not be known until much later. To be counted in this measure only the immediate sequel to the request need be known. Any clients whose request was made in the previous reporting year but where the response was only determined this year, should be included.
Short Term Support	All episodes of support intended to be time limited with a formal assessment or review held at the end to determine what will follow. Note that there is no requirement to know what will follow in order to be counted in this measure.
Short Term Support to Maximise Independence (ST-Max)	Includes all episodes of support provided that are intended to be time limited, with the intention of maximising the independence of the individual and reducing /eliminating their need for ongoing support by the local authorities.
Support for memory and cognition	Support and services for clients with conditions affecting their thinking, knowing, awareness and remembering process – 'I need help because my memory or understanding make it difficult to do certain things on my own'
Unit Costs	Unit costs describe measures of cost for social care provision which are included in the ASC-FR return. Unit costs are derived from the comparison of expenditure and activity data and are currently expressed as cost per week or average cost per hour.
Unit Costs Long Term	This is the average weekly expenditure per client for residential and nursing care for each Primary Support Reason. Unit costs are broken down further by age group and services provided by the local authorities and services provided by an external organisation.
Unit Costs Short Term	This is the average hourly expenditure per client for support to maximise independence for each Primary Support Reason. Unit costs are broken down further by age group and services provided by the local authorities and services provided by an external organisation.
Universal Services	A 'universal service' is any service or support (other than those above) for which national eligibility criteria (following Care Act) are not relevant. It includes the provision of information and advice.

Appendix D: Related publications

Other adult social care publications

This report forms part of a suite of statistical reports. Other reports cover information on the wider scope of activity and social services provided for adults by local authorities and people in contact with NHS specialist mental health services.

In addition to this publication, NHS Digital publishes a suite of reports on adult social care in England which cover:

- Experience – surveys of clients and carers which include questions on satisfaction with services received and quality of life for the individual
- Workforce – the number and characteristics of staff employed by local authority adult social services departments
- Safeguarding – information on adult safeguarding concerns and enquiries
- People registered as blind or partially sighted
- Adult Social Care Outcomes Framework
- Deprivation of Liberty Safeguards (DoLS)
- Guardianship under the Mental Health Act 1983

Data for Children's Social Services

Information on social care for children is available at:

<https://www.gov.uk/topic/schools-colleges-childrens-services/data-collection-statistical-returns>

Expenditure on children's social services is available at:

www.gov.uk/government/collections/statistics-local-authority-school-finance-data

Data for the UK

Information within this report relates to England data, similar publications for Wales, Scotland and Northern Ireland can be found via the following links:

The Welsh Assembly Government

<http://gov.wales/topics/health/publications/socialcare/reports/?lang=en>

The Scottish Government

<http://www.gov.scot/Topics/Health/Support-Social-Care>

Northern Ireland: Department of Health

<https://www.health-ni.gov.uk/topics/social-services>

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