Witness name: Natasha Curry

Statement No: 1

Exhibits: NC/1- INQ000553851 – NC/41- INQ000553891

Dated: 16 January 2025

UK COVID-19 INQUIRY

WITNESS STATEMENT OF NATASHA CURRY

I, Natasha Curry, will say as follows: -

I am Deputy Director of Policy at the Nuffield Trust for Research and Policy Studies in Health Services (known as the Nuffield Trust), a position I have occupied since 2018.

The Nuffield Trust and our work relevant to the Inquiry

1. The Nuffield Trust is a charitable trust, registered with the Charity Commission as charity number 209169, and a company limited by guarantee registered in England with company number 00382452. It was founded as the Nuffield Provincial Hospital Trust in 1940 by Viscount Nuffield (William Morris), the founder of Morris Motors. The Nuffield Trust's charitable objects are "to promote the prevention or relief of sickness and the advancement of health of the people of the United Kingdom, in particular through the promotion of improvements in the quality of healthcare and health policy."
2. The Nuffield Trust pursues these charitable objects by carrying out research and policy analysis on health and social care, running discussions and seminars, offering commentary and expertise via media, social media, and mailing lists reaching officials and legislators across the UK.
3. Its strategic plan (2020-2025) sets out three core objectives for the Nuffield Trust's work:
    - 3.1 improving the evidence base that leads to better care by undertaking rigorous applied research and policy analysis
    - 3.2 using our independence to provide expert commentary, analysis and scrutiny of policy and practice
    - 3.3 bringing together policy-makers, practitioners and others to develop solutions to the challenges facing the health and social care system.

4. The Nuffield Trust's headquarters are on 59 New Cavendish Street in London. It has 47 full-time equivalent staff, with expertise in research, policy, communications, operations and strategy.
5. Adult social care is one of the Trust's ongoing areas of work. I lead a team undertaking research and policy analysis into various aspects of the social care systems in the UK. This was active throughout the relevant period for this module.
6. From hereon, in this witness statement, I will refer to the Nuffield Trust as "we".

The contents of this Witness Statement

7. Our research shed light on several areas which I believe will be important to the Inquiry's understanding of adult social care during the pandemic. My statement will summarise and discuss these. From 2019 onwards, we researched and produced a series of explanatory articles comparing adult social care in the four different jurisdictions of the UK – which organise and fund these services in significantly different ways, far more so than for health care. Our articles provide a resource to understand how adult social care was working in England, Scotland, Wales and Northern Ireland on the eve of the pandemic. As requested by Inquiry solicitors, Section A presents these explainers with material on their preparation and publication, and additional details we believe may be helpful to the Inquiry.
8. During the Covid-19 pandemic, we worked to try to understand the factors that shaped the response, as this often-neglected public service became critical to the course of a deadly and difficult pandemic in the UK. We also maintained our wider research, understanding differences between social care systems and approaches to reform in the UK countries and other countries. As requested, Section B presents updates to our four countries explainer published in 2023, which I hope will support the Inquiry in understanding the differences at the end of its period of interest, and how these had evolved. It should be noted that the intention of these explainers was not explicitly to track change in social care systems as a result of Covid-19, although some differences that are observed between 2019 and 2023 may be related to the pandemic.
9. Section B then presents as requested a summary of a report commissioned by the National Institute for Health and Care Research (NIHR), which we completed in Spring 2022 and which looks specifically at the structural and systemic factors which had affected the response in social care during the first wave of Covid-19 in 2020. My team and I looked for lessons on how to build a stronger system that could have

avoided some of the tragedies we saw and that should be heeded when preparing for future crises. This report was completed in April 2022 and published in May 2023, after we responded to extensive comments from the National Institute for Health and Care Research (NIHR) – our funders – and members of the Department of Health and Social Care (DHSC) who were invited to review the draft by NIHR. To present exactly its findings from the perspective of that time, we provide its Executive Summary at its time of publication, with recommendations and lessons about the system and governance of care; about the people who worked in the system and how well those at the top of the hierarchy understood it; and about resources and funding. As it is taken from the original draft, this summary does not reflect policy developments that have taken place since May 2023.

10. Lastly, my team and I have systematically looked through our other research from the relevant period and in Section B we have also included additional points which we believe will be helpful to the Inquiry, examining how other aspects of national policy for social care and related policy areas, and the sometimes poorly considered treatment of its workforce, influenced events during the pandemic. I end my statement with a handful of specific recommendations to the Chair of the Inquiry. I believe these would help governments to create a stronger system in the face of a future crisis, and avoid some of the deeply serious failings we saw.

----------Section A----------

11. In 2019, we began a project that aimed to explore and explain the social care systems in England, Scotland, Wales and Northern Ireland. These outputs, published in spring 2020, are presented in full at the Inquiry's request in this section, along with relevant contextual material. Updates to these outputs, published in 2023, are presented in Section B.
12. Following these descriptive pieces, we produced three more reflective comment articles, presenting lessons from the information we had assembled across the four countries on social care reform, the workforce, unpaid carers and the provider market. We also drew up and later published an article outlining the difficulties in comparing social care data across the four countries, and held a roundtable to inform a consultation by the Office for Statistics Regulation. This additional material of possible relevance to the Inquiry is summarised at the end of Section A.

2020 Four UK countries explainers

Overview

13. The work was undertaken between May 2019 and March 2020. We identified a gap in understanding around the similarities and differences of the social care systems in the four UK countries. The research team therefore set out to develop some high-level explainers that would allow readers to have a simple overview of key features of the social care system in each of the UK countries. The explainers were intended for policymakers, journalists, practitioners, and wider lay audiences.
14. To select topics for inclusion in the explainers, the researchers identified a number of indicators relevant to all social care systems: population characteristics; current system; organising body; state of care; workforce; reform. For each indicator, researchers identified whether the indicator would be descriptive (informed by literature and stakeholder conversations), or quantitative (relying on statistical data). The project was short in scope and therefore the researchers relied only on publicly available data.
15. For each of the quantitative data indicators that were originally identified under the wider themes, the researchers identified potential sources for each UK country and whether these were published by the same source organisation (such as the Office for National Statistics), or an organisation specific to each country in question. They then assessed how the data could be presented, whether there were quality and comparison issues, and whether the data were up to date. This enabled the researchers to prioritise certain indicators and data sources and exclude indicators that could not be presented quantitatively due to a lack of reliable or comparative information. The indicators that could not be presented due to a lack of comparable quantitative data included: estimates of unmet need; measures of delays to hospital discharge; average weekly expenditure on different services; within-country variation in spending; detailed workforce information; up-to-date estimates of unpaid carers; number of people in receipt of direct payments; number of reforms undertaken.
16. Relevant publications, literature, and sources were identified for each country and information collected into a thematic framework structured around the themes of the explainer. Most of the publications reviewed by the researchers were official government documentations, parliamentary publications, academic publications and grey literature, and some news articles.
17. The researchers undertook 15 stakeholder calls with key experts in the devolved administrations, using a high-level interview guide. These were intended to bring additional context, understanding and nuance to the findings from the literature review and quantitative data analysis.

18. The quantitative data analyses were quality assured by two Nuffield Trust researchers. The explainers were reviewed by external experts from each country and amended according to their input. As per the Inquiry's request, the next section consists of text pasted verbatim from the online explainers followed by an overview of preparation and publication for each.

19. **Explainer introduction: "Adult social care in the four countries of the UK: introduction" (2020)**

Text of explainer

It is more or less clear to people that, when they have a health need, they can easily access the NHS via their GP or A&E or other direct access clinics (such as a walk-in clinic or minor injuries unit). And, when health care is needed, it is also well understood across the whole of the UK that there will be no charge.

The same clarity is not so evident when an adult has a care need – such as when they need help dressing, bathing or preparing food. Not only is social care an entirely different system from health, organised and with mostly separate funding to the NHS, there are also a number of differences between what a citizen can expect from social care across each of the four countries in the UK.

Legislative and demographic differences have existed between the different countries' social care systems for many years, but since formal devolution settlements in the late 1990s, Scotland, Wales and Northern Ireland have assumed greater administrative and legislative powers. The pace at which these powers have been devolved has varied between countries – in Scotland[1] and Northern Ireland[2] social care has been (progressively more) administratively and legislatively devolved since 1998, and in Wales legislatively since 2006.[3] [4] The result of 15 to 20 years of devolution is that the social care systems in each of these countries have developed in different ways. As England continues to await long-promised social care reform, the other three countries of the UK offer learning that policy-makers should heed.

In this series of explainers, we describe the social care system in each of the UK countries, and shed light on where the systems diverge and the direction that each country is now taking.

The sections below look at funding, who receives help, other types of support, and the processes of reform in the different countries. They are accompanied by an article that draws out some key lessons that England may wish to take from the other countries.

Further explainers on the workforce, staff and carers, and the provider market will follow soon.

Acknowledgements

We would like to thank all stakeholders across England, Wales, Scotland and Northern Ireland from registration and regulation bodies, policy think tanks, and academia who advised on this project.

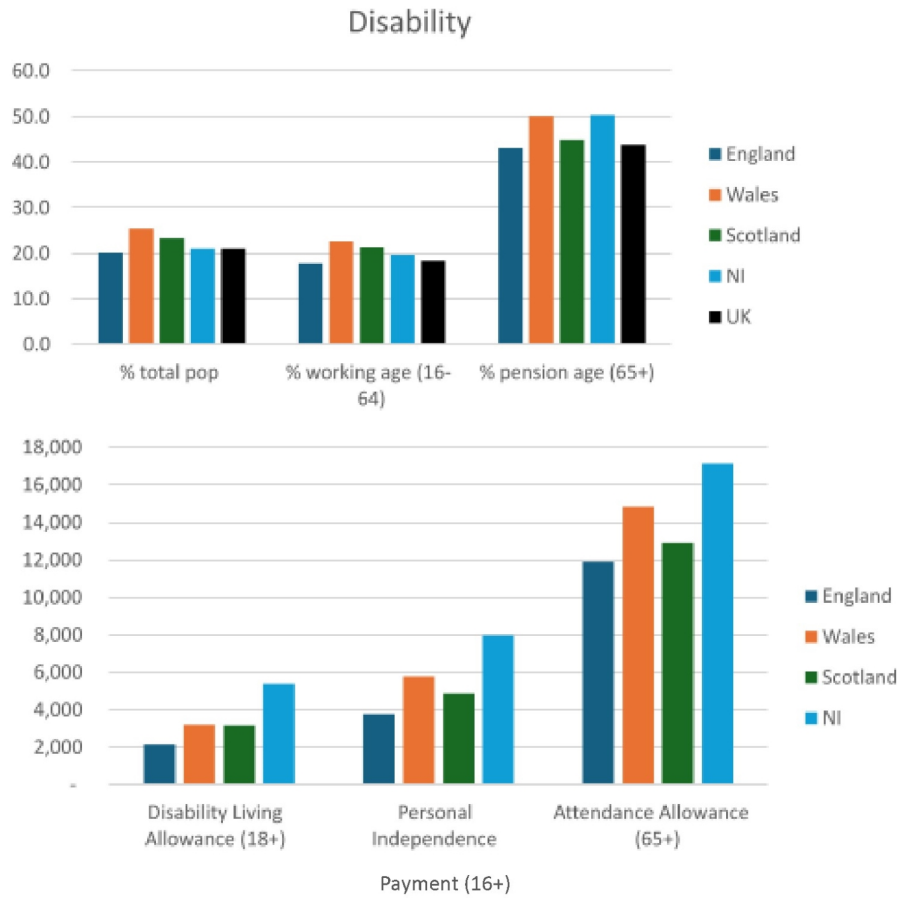
20. **Explainer I: "Other types of support - how do the countries compare?" (2020)**

Text of exaplainer

Key points:

- This explainer looks at what other types of support – such as welfare benefits and access to continuing health care – people with care needs might be eligible for.
- Although the proportion of individuals with a disability is similar across all four countries, the proportion of the population receiving disability living allowance, personal independence payments and attendance allowance is variable. However, across all types of benefit, the proportion of recipients is consistently lower in England than in the other countries. This could be explained by the others' relative higher rates of poverty, and/or individuals in those countries having comparatively more severe or complex disabilities.
- In all countries, there is a lack of clarity around which people with social care needs are eligible for funded health services. In England, Wales and Northern Ireland, the issues surrounding continuing health care (or its equivalent) are well rehearsed, particularly in relation to those with dementia who typically do not qualify for funding for care. Scotland is the only country to have reformed the system to offer more certainty about the delineation between the two services, although what impact this has had on access is unclear.

Welfare benefits



Source: Nuffield Trust analysis of disability living allowance, personal independence payment and attendance allowance data (2019) as a per 100,000 population rate (age standardised, 2018 population mid-year estimates).

The extent to which benefits are devolved is limited. The Department for Work and Pensions manages benefits, set at the same level, for England, Scotland and Wales (although this is set to change in Scotland over the course of the next few years). In the case of Northern Ireland, benefits are administratively devolved to the Department for Communities but the type and value are identical to benefits in the other countries under current arrangements.

Yet while the proportion of individuals with a disability is broadly the same in relation to the overall adult population of each of the four countries, spending on welfare benefits differs greatly. These differences in spending could be due to a number of reasons. A higher number of applicants in the other countries could reflect different expectations of the state, a higher proportion of individuals with a (more complex) disability in the other countries, and/or a greater proportion for whom the payout is of greater financial significance.

England

Benefits are centrally organised and administered by the Department for Work and Pensions. For working-age adults, the disability living allowance is progressively being replaced by the personal independence payment.[5]

Wales

As in England (and Scotland at time of writing), benefits are centrally organised and administered by the Department for Work and Pensions. Spending on benefits in Wales is comparatively higher than in England. Literature suggests there is a greater need in Wales for the state to provide support – the Wales Fiscal analysis reports the number of over 65s claiming disability living allowance and personal independence payments is almost twice as high as in England. This could potentially be explained by a comparatively higher level of disability due to higher incidence of chronic disease[6] and greater health inequalities.[7] Furthermore, the higher spending on benefits could be explained by a proportionally greater number of individuals for whom receiving a benefit payment is financially significant. Wales has the highest level of poverty in the UK, especially among working-age adults.[8]

However, there is currently some appetite in Wales to follow Northern Ireland and Scotland in the devolution of benefits, following reports this would increase the Welsh welfare budget.[9]

Scotland

Although Scotland currently operates its welfare benefits under the centrally administered Department for Work and Pensions, these are to be progressively devolved to, and managed by, Social Security Scotland[10] – starting in April this year.[11]

Social Security Scotland currently administers an additional benefit to Scottish carers, namely the carers' allowance supplement.[12] This additional benefit takes the form of two payments a year that align carer benefits with the job seekers' allowance, which will be incorporated into the carers' allowance when Social Security Scotland takes over the benefit's administration.[13]

Other changes that are planned for the newly acquired devolution is to replace the personal independence payment with disability assistance, starting in 2021.

Northern Ireland

In Northern Ireland, benefits are organised and administered by the Department for Communities, although in practice the rates of pay are the same as in England and Wales.

Although the country is also transitioning from the disability living allowance to personal independence payments, the devolved department has put in place additional support for those affected by the transition.[14] For example, if the loss is greater than £10 per week, the individual is entitled to a supplementary pay of up to 75% of the amount received under the disability living allowance – for a year. Individuals suffering from injuries relating to the Northern Ireland Conflict are also entitled to a supplementary payment from the Department for Communities[15].

Spending on benefits is comparatively high against the other countries of the UK. Conversations with stakeholders reflected that this is partly due to an increased expectation of the state to support individuals in the aftermath of the Conflict.

Support for health needs

England

Under the NHS Continuing Health care (CHC) scheme, individuals whose social care need is, according to an assessment process,[16] deemed to be the consequence of a primary health need do not pay for their social care.[17] They are instead fully funded by the NHS, regardless of the setting in which they receive their care or the type of package they need (this includes accommodation costs for residential and nursing care[18]). The assessment uses the national assessment tool and is undertaken by the local clinical commissioning group.[19] Individuals with a social care need who are deemed responsible for paying for their own care, and who require the medical support provided by a nurse in a registered care or nursing home, are entitled to a payment of £165.56 per week from the NHS, directly to the nursing home.[20]

There have been major concerns around CHC delivery in England, in particular around the low number of people deemed eligible after assessment, waiting times and where the responsibility lies between the health and social care systems.[21] It is furthermore felt to be a source of inequality particularly for dementia sufferers, whose needs are often perceived to fall under social rather than health care.[22] These were recognised by the government in 2018[23], but it is clear those problems continue to persist and have been the object of increasing public and media attention.[24] The House of Commons Library has recently published a briefing on CHC in England and UK-wide, suggesting this continues to be a political priority for debate.[25]

NHS Digital collects data from clinical commissioning groups, and records on average 56,000 service users eligible for CHC at any one point in 2018/19.[26]

Wales

As in England, the Welsh NHS covers the full social care costs of individuals who require social care arising from a health need after an assessment, regardless of the setting in which they receive their care or the type of package they need (this includes accommodation costs for residential and nursing care). Care is then organised through local health boards.[27] Most recent reports from the Welsh government indicate that, on average, approximately 5,000 Welsh people receive NHS-funded continuing health care at any one point.[28,29] Individuals with a social care need who are deemed responsible for paying for their own care, and who require the medical support provided by a nurse in a registered care or nursing home, are entitled to a payment of £179.97 per week from the Welsh NHS directly to the nursing home.[30]

As in England, there have been similar concerns raised in Wales about the consistency and fairness of the CHC assessment process.[31] Dementia sufferers are also deemed to be treated unfairly.[32] The CHC process in Wales was recently under consultation and a revised framework is expected shortly.[33]

Scotland

After an independent review of NHS Continuing Health care in 2014,[34] the scheme was replaced by Hospital Based Complex Clinical Care in 2015[35] – under which the NHS would fully meet the costs of care for service users with a health need if they needed to be delivered within a hospital setting.[36] Individuals whose care needs can be "properly met" in a setting other than a hospital must meet their own accommodation and board costs.

Their other social care needs are met in the same way as other service users who are not deemed to have a primary health need (see 'Offer and eligibility'), including the delivery of free personal care if the individual has an eligible need. In addition, all service users requiring nursing care within a care home setting receive this for 'free', delivered by the local GP.[37] This takes the form of a weekly payment of £80 from the local authority directly to the care home.[38]

According to the government inpatient status in 2018, around 940 individuals were receiving Hospital Based Complex Clinical Care. These numbers are not directly comparable to those in England, as they represent only those individuals whose care costs were fully met by the NHS in a hospital setting.

Northern Ireland

Continuing Health care in Northern Ireland is offered to individuals for whom the outcome of an assessment is a primary health need (as opposed to a primary social care need – for more details see 'Offer and eligibility'). In such cases, the health and social care trust must meet the full costs of the individual's care package, regardless of the setting (this includes accommodation costs).[39] Individuals with a primary social care need who are deemed responsible for paying for their own care, and who require the medical support provided by a nursing home, are entitled to a payment of £100 per week from the health and social care trust directly to the nursing home. As for all service users, individuals whose needs can be met in a domiciliary setting can do so for free.

A 2014 report from Age Northern Ireland denounced the denial of continuing health care to many citizens in Northern Ireland.[40] The report finds only 43 individuals who were eligible for continuing health care between April 2011 and September 2016, although this excludes service users receiving care within a domiciliary setting (as this is provided free to all users regardless of a primary health or social care need). As such, the Northern Ireland Executive started a consultation on a review of continuing health care in 2017.[41] The outcome of this consultation process isn't yet clear.[42]

Overview of preparation and publication

21. Two charts are presented in this explainer: (1) Disability estimates by country 2017/18
(2) Disability welfare benefits by age (2017/18) by country.

21.1 Data estimating the number of people living in each country living with a disability was obtained from the Family Resources survey 2017/18, referenced in the data table in Appendix A. There were no concerns about accessibility or comparability using this data source.

21.2 Data on estimates receiving disability welfare benefits in Great Britain are accessible via Stat Xplore, and referenced in the data table in Appendix A. The types of benefits included Disability Living Allowance, Personal Independence Payment, and Attendance Allowance. Difficulties encountered in gathering relevant data were minimal; although the data on benefits are published by different organizations, the content and type is identical while allows comparison. Since publication, an error in the title of the first chart that read 'Disability welfare benefits, by age' was amended to read 'Disability estimates (2017/18), by age'.

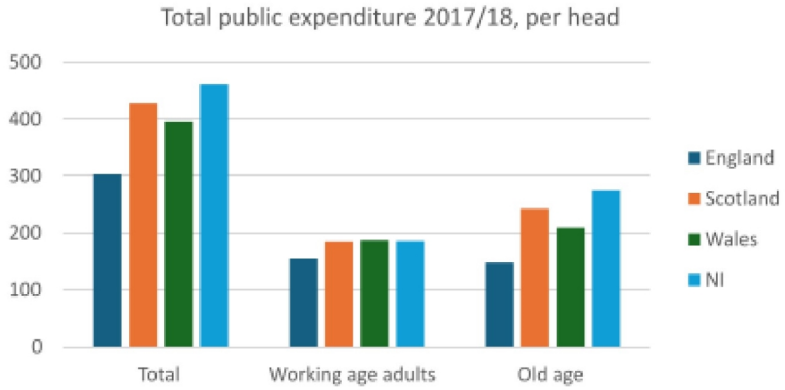
21.3 Data on estimates receiving disability welfare benefits in Northern Ireland are accessible via the Department for Communities. Data on Disability Living Allowance Personal Independence Payment, and Attendance Allowance are referenced in the data table in Appendix A.

22. The supporting information provided in this explainer was primarily derived from UK, Scottish, Welsh and Northern Ireland government publications and webpages, as well as from consultation responses, factsheets on charity and consumer websites, and news reports.

23. **Explainer II: "How much social care does each country fund?" (2020)** *Text of explainer*

Key points:

- This explainer covers Nuffield Trust analysis of public expenditure per capita for each country and discusses estimations of self-funders in relation to their publicly funded counterparts.
- There is wide variation in public expenditure per capita. England is by far the least generous, spending on average £303 per head, compared to £428 in Scotland, £396 in Wales and £461 in Northern Ireland.
- Estimates of self-funders also vary considerably by country – with England having the highest proportion.

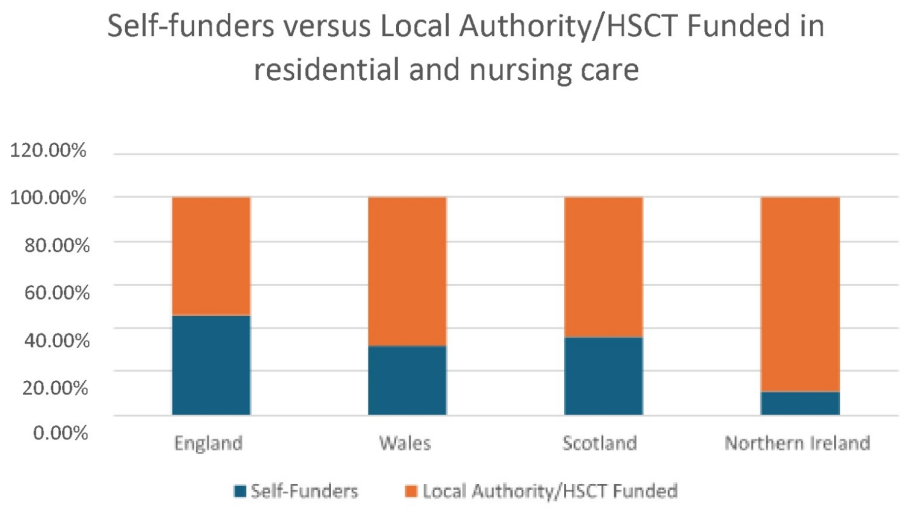


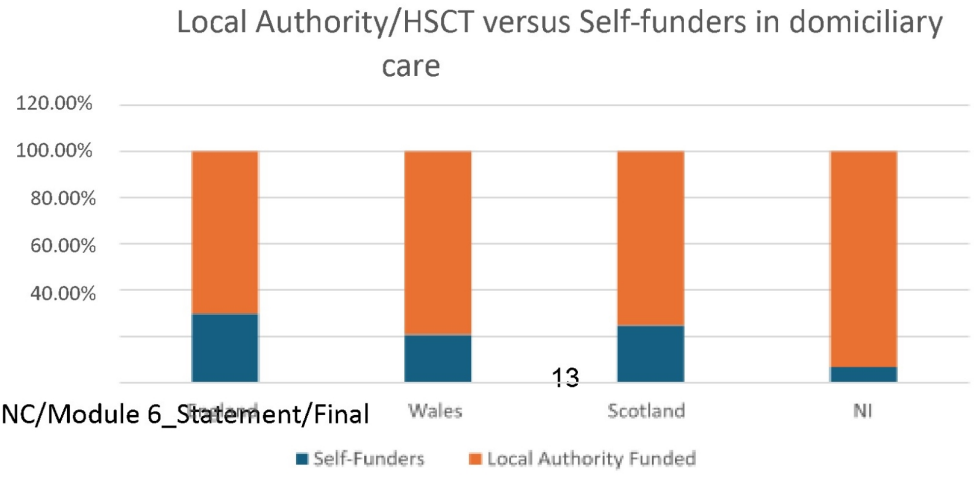
Source: Nuffield Trust analysis of HM Treasury Public Expenditure Statistical Analyses 2019.
Adult social care
expenditure is defined as personal social services spending on sickness and disability and personal social services spending on old age.

Across the board, England's public expenditure per capita is considerably lower than in the other countries.

The above graph represents the total identifiable expenditure on social care as collected by HM Treasury in the Public expenditure statistical analyses publication for each of the four countries.[43] Although these figures are derived from the same HM Treasury source, it is worth noting they may not be directly comparable due to the integrated nature of the system in Northern Ireland and should be used for indicative purposes only.

A large amount of social care services are funded privately by individuals who are not eligible for state support (see 'Offer and eligibility'). The proportion of state-funded to self-funded individuals varies substantially across the four countries. England in particular has a high proportion of self-funders, whereas Northern Ireland has the lowest (this is particularly the case in the domiciliary care sector, in which services are provided free in Northern Ireland).





20.00% 0.00%

Source: Skills for Care and Development reporting of Laing Buisson, 2018

There is no source that can estimate with certainty the number of individuals who self-fund across the UK, and their experiences with social care services are not reported in a similar way to publicly funded individuals.[44] This is due to a variety of reasons, including the different ways self-funders access and use care, as well as the complexity of defining self-funding across the varying social care settings. The proportions reported above are thought to be approximately representative of distribution within the sector and the differences between the UK countries.

While local authority (or HSCT) funded clients make up the higher proportions of social care users in all UK countries, England has the highest proportion of self-funders, especially in residential and nursing care. Estimates from various sources suggest self-funders represent approximately 46% of all residential and nursing care users, and in the domiciliary care sector they represent around 30%.[45]

In contrast, estimates of self-funders in Wales, Scotland and Northern Ireland are considerably lower. Around 32% of people receiving residential or nursing care in Wales self-fund, while in domiciliary care this proportion is around 21%.[46] In Scotland, approximately 36% of individuals in a residential or nursing home self-fund, while around 25% of care users pay for their domiciliary, day or other care themselves.[47] Northern Ireland has the lowest proportions of self-funders, with only 11% of service users in a residential or nursing care setting paying for their care themselves, while it is estimated that only 7% of domiciliary care users are selffunders.[48]

Overview of preparation and publication

24. Three charts are presented in this explainer: (1) Time-series trend in total public expenditure on social care per head 2017/18; (2) Self-funders versus local authority/HSCT funded in residential and nursing care (2018); (3) Local authority/HSCT versus self-funders in domiciliary care (2018). HSCT refers to Health and Social Care Trusts, which are responsible for providing health and social care services to local populations in Northern Ireland.

25. Data for chart (1), titled 'Total public expenditure 2017/18, per head', was derived from HM Treasury Public Expenditure Statistical Analysis (2017/18), referenced in the data table in Appendix A.

    25.1 The figures from the HM Treasury Public Expenditure Statistical Analyses are reliable and standardised across all four countries. However, due to contextual differences in how services are organised, such as the structurally integrated nature of the health and social care system in Northern Ireland, the figures are not directly comparable. Moreover, HM Treasury Expenditure data does not clearly define adult social care in a way that devolved national expenditure data sources would.

    25.2 For this analysis, we defined adult social care expenditure as personal social services spending on sickness and disability and personal services spending on old age. We opted for this data source over devolved national collections because it allows for cross-country comparisons. UK-wide datasets typically feature broad categories, which can lead to a loss of detailed, context-specific information relevant to each country.

26. We were limited by what data was available to produce Charts (2) and (3), estimating the number and proportion of those receiving publicly funded care versus those selffunding as there was no publicly available data source. The most up-to-date source available for this work was Laing Buisson data, quoted in 2018 Skills for Care and Development publications for each country, referenced in the data table in Appendix A. We were not able to access the methodology used by Laing Buisson to derive these figures.
27. The supporting information provided in this explainer is derived from publications from the Skills for Care and Development and the respective workforce bodies in each of the UK countries, as well as one academic publication.

28. **Explainer III: "Who organises and funds social care?" (2020)**

Text of explainer

Key points:

- This explainer covers how adult social care is funded, assessed and organised in each UK country.

- In England, Wales and Scotland, local authorities are responsible for adult social care and this duty is set in law. Funding comes from central grants, which can be subject to squeezes from central government, and from council tax on properties.
- In Northern Ireland, health and social care trusts have this responsibility due to the integrated nature of their health and social care system.

England

152 local authorities[49] organise and support care for those unable to fund it themselves. They are also able to organise care services for self-funding individuals who may require assistance to do so.

Local authorities fund social care through a combination of a grant from central government via the Ministry of Housing, Communities and Local Government, and local revenue-raising mechanisms, such as council tax and the specific social care precept. The local clinical commissioning group is mandated by the NHS to transfer a set amount to a local authority via the Better Care Fund.[50] Social care funding is not ring-fenced, which means that local authorities can decide how much of their budget they allocate to care. In addition, where an individual is assessed as eligible for NHS funding[51] under the continuing health care scheme, this funding will also cover their associated social care needs (see 'Support for health needs').

There are proposals to reduce the central government grant and to require local authorities to raise a greater proportion of their revenue themselves[52] – these continue to be discussed under the new government.[53]

Local authorities are responsible for the organisation of care and support plans and personal budgets (see 'Offer and eligibility'). The Care Act 2014 set out a national minimum threshold for eligibility to which all local authorities must comply.[54] However, local authorities have discretion to provide services to individuals outside of the eligibility threshold.[55]

Wales

22 single-tier local authorities organise and support care for those unable to fund it themselves. As in England, local authorities are able to organise care for individuals who selffund if they choose to do so. In time, this will move to delivery through seven statutory regional partnership boards to encourage closer integration with the health care sector.[56]

Local authorities receive grants from the Welsh Assembly via the revenue support grant. Local taxes are devolved to the Assembly[57], which means that the local revenue-raising

powers in Wales are subject to different legislation than in England, such as over business rates.[58,59] In Wales, the social care precept does not apply. Local authority revenue is also supplemented by NHS Wales funding through local health boards under the NHS continuing health care scheme (see 'Support for health needs').[60]

Local authorities are responsible for the format of care and support plans (see 'Offer and eligibility'), and are required to be consistent across the country with the use of the national eligibility criteria.[61]

Scotland

32 local authorities organise and support care for those unable to fund it themselves. They are also able to organise care services for self-funders who may require assistance to do so. In time, this will move to delivery through 30 integration joint boards[62] and one lead agency[63] (NHS Highland assumes responsibility for both health and social care), under the Public Bodies (Joint Working) (Scotland) Act 2014.[64]

Scottish local authorities fund social care through a combination of a grant from the Scottish government (General Revenue Funding of Local Authorities) and local taxes.[65] In Scotland, local taxes are devolved which means that the local revenue-raising powers are subject to different legislation from England.[66]. There are different council tax rates[67] and the social care precept does not apply as it does in England. Local authority revenue is also supplemented by NHS Scotland funding through NHS health boards[68], under the Hospital Based Complex Clinical Care scheme (see 'Support for health needs').[69]

Local authorities are responsible for the format of self-directed support plans (see 'Offer and eligibility'). Each local authority has their own eligibility criteria to determine whether an individual will be able to access social care, which must be compatible with the National Eligibility Framework.[70] National eligibility applies for service users with a need for personal care, under which those with a critical or substantial risk must receive services within six weeks of assessment.

Northern Ireland

In Northern Ireland, social care is integrated with health care under five health and social care trusts. These manage their own budget allocated by the Northern Ireland Executive through the Department of Health (NI). As health and social care services in Northern Ireland are integrated, provision of continuing health care is organised directly by the health and social care trust and thus does not represent an additional source of revenue (see 'Support for health needs').

Trusts are responsible for the format of self-directed support plans (see 'Offer and eligibility'). The Northern Ireland single assessment tool[71] is designed to ensure a consistency of assessment across different trusts and different professionals, whether undertaken by a nurse or a social worker. However, trusts have discretion to determine at what level of need an individual is entitled to social care support.

Overview of preparation and publication

29. No statistical data was presented in this section of the explainer as it sets out the organising bodies responsible for social care at a local level. The supporting information presented in this explainer is derived primarily from UK, Wales, Northern Ireland and Scotland government publications and webpages, as well as legislation in each of the respective countries, national audit reports, and research reports.

30. **Explainer IV: "Offer and eligibility - who can access state-funded adult care and what are people entitled to?" (2020)**

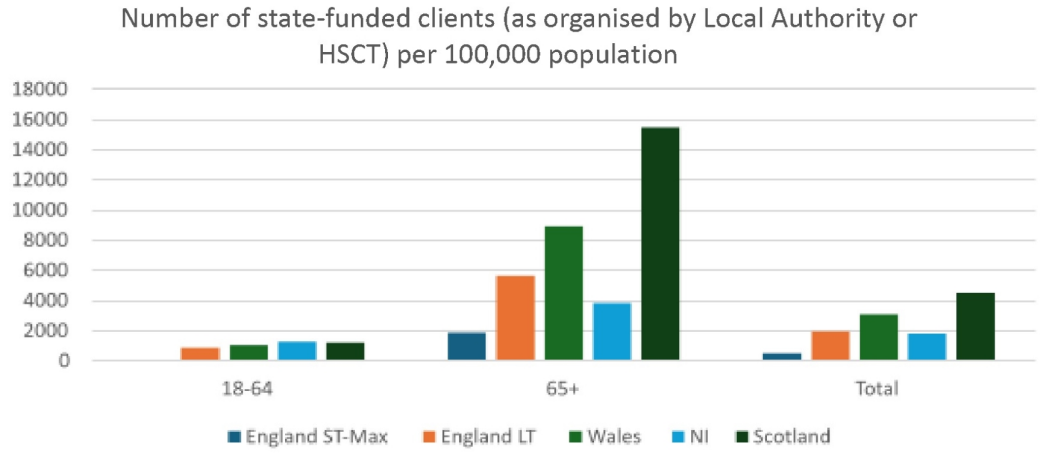
Text of explainer Key points:

- This explainer covers the number of state-supported individuals accessing care, the financial and needs criteria that determine access in each country, and the services supported for individuals who meet the means and needs criteria.
- All of the countries operate a means and needs test to determine access to social care support from the local authority or health and social care trust. England is the least generous country in its offer, as Wales, Scotland and Northern Ireland offer additional support outside of the means test.
- The number of state-funded individuals varies considerably across the countries, with the greatest differences arising for those over 65. The high number of over-65s accessing state-funded care in Scotland is likely a consequence of their free personal care policy.
- Across each country, there is a drive to promote the use of personal budgets (or selfdirected support) to push greater personalisation in social care.
- Determining which services are included in the offer (for example, in free personal care in Scotland) has proven a challenge in all of the other countries.

	England	Wales	Scotland	N. Ireland

Means test: Upper threshold Lower threshold	 £23,250 £14,250	 £50,000* *N.B. this applies only in residential care	 £28,000 £17,500	 £23,250 £14,250
Delivery mechanism name	Care and support plans with personal budgets	Care and support plans	Self-directed support	Self-directed support[72] with personal budgets
Formal additional support	N/A	Cap on non-residential care costs: £90/week	Free personal care Free nursing care[73]	Free domiciliary care

In practice, personal budgets and self-directed support are the same delivery mechanism. Stakeholders suggested the use of different terminologies reflected different emphases – and an aversion to the term "personal budgets" in the other countries.



Age-adjusted population rates using ONS mid-year population estimates 2017. Note that these figures include those who are in contact with local authorities or health and social care trusts in Northern Ireland and exclude those who self-fund or have their care arranged privately.

England: ST-Max: short-term support intended to maximise independence of clients. LT: Longterm care provided on an ongoing basis.

Wales: Number of adults receiving care and support during the year. Note that these are experimental statistics and some local authorities had missing returns.

Northern Ireland: Persons (Excluding Mentally ill) in Contact with HSC Trusts during 2017/18 (aged 16 and over).

Scotland: Number of people receiving social care services/support.

Source: Nuffield Trust analysis of NHS Digital – Adult Social Care Activity and Finance Report, England (2017), Welsh government – Adults receiving services by local authority and age group (2018), NISCC – Social Care Matters (2017), HSCB – Statistical Report (2016), DoH – Statistics on Community Care for Adults in Northern Ireland (2017), ISD Scotland – Insights into Social Care in Scotland (2017), ONS Mid-year population estimates (2017)

England

Access to state-funded care is determined both by a means test and a needs test. These are both carried out by a person's local authority, and were revised under the Care Act (2014),[74] which is enshrined in 'person-focused' principles.

Any individual deemed to have some need for care is entitled to an assessment by their local authority, regardless of whether they are financially eligible.[75] National eligibility criteria for need were set out under the Care and Support (Eligibility Criteria) Regulations 2014 around a person's ability to achieve their desired outcomes in relation to their wellbeing.[76] [77] There are three conditions that must all be met for an adult to be considered to have an eligible need:

i. The considered individual has a need arising from a physical or mental impairment or illness
ii. The considered individual is unable to achieve two or more outcomes as listed in the Care Act[78]
iii. Being unable to achieve these outcomes is likely to have an impact on the individual's wellbeing (as defined in the Care Act[79]).

For those meeting the needs assessment threshold, the second part of the eligibility process involves a means test.

- For anyone of any age with means (which includes income, assets and savings) in excess of £23,250, there is no state support available for care, and costs fall entirely on the individual. These represent the majority of social care users in England.

- Anyone with assets between £14,250 and £23,250 may be able to access some funding, depending on level of need.
- Anyone with assets below £14,250 are able to access full funding, depending on level of need, but may nonetheless have to contribute from their income where a care package doesn't fully meet a person's wants or needs (e.g. top ups for care homes).
- A person with more means than the upper threshold of £23,250 can ask their local authority to arrange support for them, but the local authority has no requirement to do so.

Any person meeting both the needs and means tests must be provided with a person-led care and support plan by the local authority. This includes a personal budget – an estimate of the total care costs that the local authority will fund, which can be delivered as follows[80]:

i. A direct payment to the service user ii. Service paid for and provided by the local authority iii. Funding from the local authority to the provider of choice iv. A mix of all these options.

If a person does not meet the needs or financial threshold, local authorities are required to provide information and advice to the individual. England has the highest proportion of selffunders of the four countries, especially in residential and nursing care. Estimates from various sources suggest self-funders represent approximately 46% of all residential and nursing care users, and in the domiciliary care sector they represent around 30%[81] (see 'How much care does each country fund?').

The inequalities in access between local authority-funded individuals and self-funders will be discussed further in an upcoming explainer in the series on the provider market.

Wales

Access to state-organised and funded care is determined both by a means test and a needs test. These are both carried out by a person's local authority and were revised under the Social Services and Wellbeing (Wales) Act 2014,[82] which is enshrined in co-production principles, among others. Any individual deemed to have some need for care is entitled to an assessment by their local authority, regardless of whether they are financially eligible.[83]

National eligibility criteria were set out under the Care and Support (Eligibility) (Wales) Regulations 2015,[84] but it is recognised in statutory guidance that the "pattern of service delivery will vary from authority to authority".[85] As the Social Services and Wellbeing Act is a

"people act", eligibility conditions apply to adults, children and their carers. There are four conditions to be met, which are:

i. The person's needs arise from circumstances in the eligibility regulations, for example around physical or mental ill health
ii. The needs of the person relate to one or more of those listed in the Act[86] iii. The person is unable to meet that need alone (regardless of whether they are receiving help from a carer or the community)
iv. The person is unlikely to achieve one or more of their personal outcomes without support from the local authority.

If a person does not meet the needs threshold, local authorities are required to provide information and advice to the individual.

Any person meeting the needs threshold must be provided with a care and support plan developed in partnership with the individual, which reports the outcomes, actions and needs identified and the resources that will be given to support these. Care and support plans also include details of the needs (some or all) to be met with direct payments, and how frequently these will be paid out. It is compulsory for local authorities to offer direct payments to older people who meet the necessary criteria.[87]

For those meeting the needs threshold, the second part of the eligibility process involves a means test. The process is different depending on the setting in which care is delivered.[88] In residential care, the process is as follows:

- For anyone of any age with means (which includes income, assets and savings, including the value of their home) in excess of £50,000, there is no state support and nearly all costs of care fall entirely on the individual.[89] A person with more means than the threshold of £50,000 can require the local authority to arrange support for them, and the local authority has a duty to do so.
- Anyone with assets below £50,000 will be able to access full funding support from the state, the level of which is set out in the care and support plan.[90] The raised threshold was announced in April 2019[91], meaning more people are now entitled to state support. Local authorities have discretion to disregard some sources of income as long as this is applied consistently within their jurisdiction. These individuals may nonetheless have to contribute from their income.
- There is no cap on costs in residential care.

Non-residential care costs (i.e. costs within an individual's home and the community) are capped at a national maximum £90 per week for all individuals, regardless of their means and how much care and support services they receive. Local authorities have discretion to provide these services for free, but none do so currently.[92] The level of the cap was raised by £10 per week in April 2019.[93] Local authorities can also choose to operate a lower cap, meaning individuals receiving non-residential services would have to pay less for their care.

Estimates of the proportions of self-funders in Wales suggest these are much lower than in England, both in residential/nursing and domiciliary care (especially in the domiciliary care sector). Approximately 32% of people receiving residential or nursing care in Wales self-fund, while in domiciliary care this proportion is around 21%[94] (see 'How much care does each country fund?').

More details about the inequalities in access to services between local authority-funded individuals and self-funders will be discussed further in an upcoming explainer in the series on the provider market.

Scotland

Local authorities are responsible for the assessment of a person's eligibility for social care under the National Eligibility Criteria[95] – eligibility was previously regional. These were developed between the Scottish government and the Convention of Scottish Local Authorities in 2009.[96] The eligibility assessment follows a two-stage process: assessing a person's needs and personal outcomes[97], and assessing whether achieving these outcomes require services to be put in place. The National Eligibility Framework sets out four levels of need: critical, substantial, moderate or low risk. Local authorities have discretion to set the level of need at which services are delivered.[98]

Any person meeting the needs threshold must be provided with a self-directed support plan[99], which is being progressively rolled out until 2021 and provides an estimate of the total care costs the local authority will fund.[100] It can be delivered as follows[101]:

i. A direct payment to the service user ii. Service paid for and provided by the local authority iii. Funding from the local authority to the provider of choice iv. A mix of all these options.

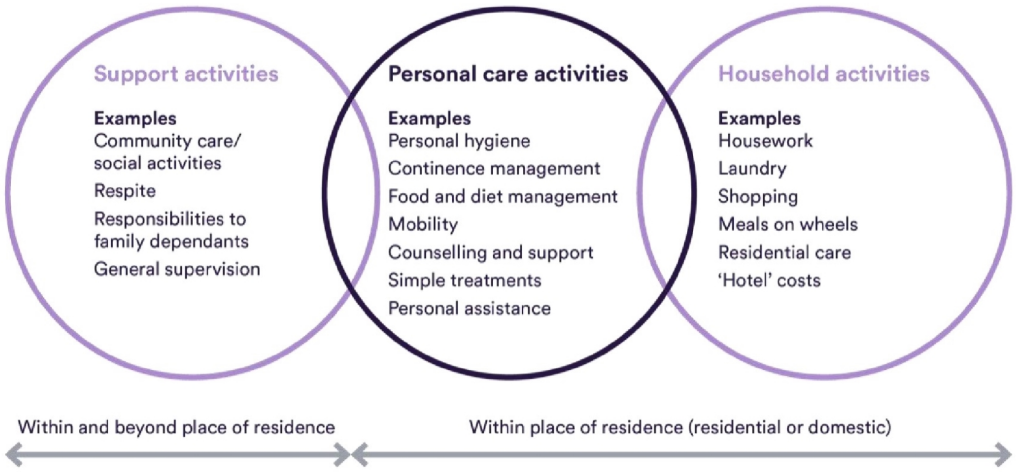
If a person's self-directed support plan requires personal care, this is provided for free to all adults by the local authority, and must be provided to individuals with a critical or substantial level of need weeks within six months of the assessment outcome.[102] Personal care includes

personal hygiene, continence management, food and diet management, assistance with mobility, counselling and support, simple treatments, and personal assistance.[103]

Individuals requiring personal care to be delivered within a care home setting receive a weekly payment of £177, directly from the local authority to the care home to cover the costs of this care.[104] Until April 2019, personal care was only free to the over-65s – this has now been extended to all adults after an extensive campaign.[105]

For social care needs identified in the self-directed support plan that fall outside of personal and nursing care, a means test is applied[106]:

- For anyone of any age with means (which includes income, assets and savings) in excess of £28,000, there is no state support for social care activities that fall outside of personal and nursing care.
- Anyone with assets between £17,500 and £28,000 may be able to access some funding, depending on level of need.
- Anyone with assets below £17,500 are able to access full funding, depending on level of need, and will nonetheless have to contribute from their income.



Source: Oung C, Hemmings N and Schlepper L (2019) "What might Labour's free personal care pledge actually mean?" Nuffield Trust.

Estimates of the proportions of self-funders in Scotland suggest these are considerably lower than in England, both in residential/nursing and domiciliary care. Around 36% of individuals in a residential or nursing home self-fund, while approximately 25% of domiciliary care users pay for their care themselves[107] (see 'How much care does each country fund?').

More details about how self-funders and local authority-funded individuals experience different access to services will be discussed further in an upcoming explainer in the series on the provider market. Northern Ireland

Access to state-funded care is determined both by a means test and a needs test. Any person in need of care and support is entitled to a health and social care needs assessment (under the Northern Ireland Single Assessment Tool[108]) by their health and social care trust[109] regardless of their financial eligibility. The assessment covers both health and social care needs due to the integrated nature of the system.[110] This is undertaken by all practitioners involved in the care of an individual.[111]

For individuals who are assessed as having a social care predominant need (as opposed to a health predominant need – see 'Other types of support'), the second part of the eligibility process involves a means test[112]:

- For anyone of any age with means (includes income, assets and savings) in excess of £23,250, there is no state support available for care and costs fall entirely on the individual.
- Anyone with assets (as above) between £14,250 and £23,250 may be able to access some funding, depending on level of need.
- Anyone with assets (as above) below £14,250, are able to access full funding, depending on level of need, and will nonetheless have to contribute from their income.

Any person meeting the needs test and the means test must be provided with a self-directed support plan, which is being rolled out across trusts in a phased approach.[113] This includes a personal budget that estimates the total cost of social care activities to meet 'individual outcomes', and can be delivered as follows:

i. A direct payment to the service user[114]

ii. A managed budget held by the trust but controlled by the service user iii. Support organised by the trust iv. A mix of all these options.

All individuals who qualify for social care support in the home are entitled to free domiciliary care[115] [116], which covers most personal care and domestic services[117] except usually meals on wheels[118]. It is widely understood that health and social care trusts have the power to charge for domiciliary care but normally choose not to do so.[119] Stakeholders in Northern Ireland suggest this is unlikely to change in the near future. Although the service is provided

for free, most recent data on domiciliary care provision[120] highlighted that over 30% of domiciliary care visits lasted 15 minutes or less, and over 43% of service users received a visit lasting 15 minutes or less.

Estimates of self-funders are, by a large margin, the lowest of the four countries. Only 11% of service users in a residential or nursing care setting pay for their care themselves, while it is estimated that only 7% of domiciliary care users are self-funders[121] (see 'How much care does each country fund?').

More details about the inequalities of access to services between self-funders and local authority-funded individuals will be discussed further in an upcoming explainer in the series on the provider market.

Overview of preparation and publication

31. The data presented in the chart 'Number of state-funded clients (as organised by Local Authority or HSCT) per 100,000 population' is derived from sources published between 2016 and 2018 as referenced in Appendix A. There were a number of issues with accessing and comparing this data. There were data quality issues and incomplete returns for some data from Wales and data for Northern Ireland were not as up to date as the other countries.
32. Across all four countries there is no data on the 'true' number of people who draw on social care - only those who come into contact with a local authority or the NHS/HSCT to fund their care. The percentage of self-funders is known to differ significantly across each of the UK's four countries This remains a significant barrier to understanding how social care services are planned and delivered.
33. Access data in England is broken down by short-term support to maximise independence, and long-term support, which it isn't in the other UK countries. It is not possible to add up these two categories as there may be overlap, and these were therefore presented separately.
34. There were challenges in definitions of services within each data source. For instance, in Northern Ireland data on clients receiving domiciliary care and residential and nursing care are presented separately. No amendments have been made to this chart since publication on 18/03/2020.
35. The supplementary information provided in this explainer is derived from UK, Scotland, Wales and Northern Ireland government publications and web pages, legislation, charity factsheets, and reports by the workforce bodies in each country.

36. **Explainer V: "What steps are currently being taken to reform social care?" (2020)**

Text of explainer Key points:

- This explainer analyses the main social care reform activities in each UK country.
- Although the systems in all four countries have diverged, it is clear that no UK country has adequately solved the 'problem' of social care. All are on the brink of reform, but it is unclear at this point if they will diverge further.
- While tangible reform to the system has remained persistently elusive in England, Wales has actively been trying to promote wellbeing and better integration of health and social care through various initiatives. Northern Ireland's ongoing political turmoil has been an obstacle to reform, although a recent power-sharing agreement might mean some movement in the near future. Scotland is the most advanced of the countries in its reform plans, having set out an ambitious and comprehensive vision for a social care service.
- Perhaps what unites all countries is their struggles with funding. Without significant new levels of funding, supported by a sustainable funding mechanism, it is unlikely that any ambitions for reform in any of the countries will be realised.

While many of the challenges across the four countries are shared, each has responded to these in different ways. We address these in the accompanying long read that identifies what England could learn from its UK neighbours.

Here we discuss the main policy developments under way in each country in turn.

<u>England</u>

The implementation of the most recent legislation around social care, the Care Act,[122] was delayed.[123] Following this, a green paper for reform was initially promised for 2017. This has now been delayed multiple times[124], reportedly due to internal disagreements over funding reforms[125] and a failure to achieve a cross-party consensus.[126] Recommendations for reform have been put forward from stakeholders at all levels, including individuals and service users in the form of a Citizens' Assembly report,[127] local government[128] and various political figures.[129]

The current government has promised to find a "long-term solution on social care" that commands "cross-party consensus", and which would "provide everyone with the dignity and

security they deserve" while protecting individuals from losing their homes.[130] In January this year, the Prime Minister promised a plan for reform in the coming year, and that these changes would be enacted under the current parliament.[131] However, in the same statement, Mr Johnson reiterated that plans would be focused on giving people the care they need "in old age", which raises concerns about reform to care for working-age adults. In early March, the Secretary of State for Health and Social Care Matt Hancock wrote to all MPs asking for their views and collaboration over social care reform.[132]

Wales

The Social Services and Wellbeing Act,[133] legislated shortly after England's Care Act, is being evaluated over a three-year period – the preliminary results of which were published in 2019.[134] As well as the Act itself, other pieces of legislation in accordance with the Act – such as 2015's Well-being of Future Generations Act[135] and the Regulation and Inspection of Social Care Act 2016[136] – have maintained its principles of wellbeing, community development, coproduction and prevention, and further cemented its implementation. Stakeholders have suggested the coherence of these acts has been facilitated by strong leadership from the

Welsh First Minister, who has a background in social care.[137]

In 2018, the Welsh government's published A Healthier Wales: our plan for health and social care.[138] This was supported by a transformation fund to help the development of collaborative ("co-operative") pilot projects in health and social care, led by multi-agency regional partnership boards.[139] By January this year, £89 million had been allocated for proposals across Wales, although progress has been slower than expected due largely to recruitment and procurement issues. A lack of substantial recurring funds is also suggested to have hindered the extent to which reform is possible, with stakeholders suggesting creative innovation has arisen out of necessity rather than by top-down direction. Moreover, the Wales Audit Office recently published a report on the Integrated Care Fund, an initiative designed similarly to support integrated working and new care models involving health, social care and the third sector. The report found little evidence of successful projects being mainstreamed into core budget or improving service outcomes.[140]

Measuring the mountain,[141] a report on citizens' views of social care in Wales, was published in 2019 and supported by the Welsh government. It suggests current implementation of the Social Services and Wellbeing Act has not been sufficient to resolve many problems in social care, particularly around access to information and support, the workforce, and support for

carers. The report recommends a continued emphasis on co-production between local authorities, service users and carers to develop a shared vision for social care.

The Welsh government has investigated alternative ways of funding social care[142], including the publication of Paying for social care,[143] in which proposals for an age-related levy were raised for debate in the last year. No firm proposals have so far been tabled, but the levy is being considered alongside income tax rises, and changing fees will form part of a consultation beginning this summer.[144] It is unlikely that any formal proposals will be brought forward until after the Welsh elections in 2021.

Scotland

Scotland has embarked on a comprehensive programme of reform in social care that was launched in June 2019.[145] The programme is driven by research commissioned by the Scottish government. It aims to represent all stakeholders in social care through co-production mechanisms, via the People-led Policy Panel[146] that represents individuals with experience of receiving social care (as well as their carers), and the Leadership Alliance[147] that brings together key leaders in the provision, regulation and delivery of social care.

The vision for a complete reform[148] of the social care system has been developed by key stakeholders in the sector, including regulators, providers and the government. It is centred around five key themes: human rights-based approach to social care, access to support, types of support, decision-making processes, and consistency across Scotland. In parallel, the SelfDirected Support Implementation Strategy[149] continues to be implemented over 2020/21. Over the next year, the Scottish parliament is also considering the development of a new financial scheme for social care, as well as improved data collection.[150]

Stakeholders suggested all changes in Scottish social care were moving in the same direction due to the complementarity of legislation. However, while the vision was felt to be ambitious, it was suggested current funding settlements would not be sufficient to enact the entirety of planned reform, and that plans for new funding mechanisms were not yet sufficiently developed.

Other reforms affecting the social care landscape have included the introduction of Frank's Law in April 2019[151], under which free personal care was extended to all adults. However, it was reported that only a third of under-65s stood to benefit from this extension.[152]

Northern Ireland

At the time of writing (January 2019), Northern Ireland had only recently found a power-sharing agreement in, having previously been without an Assembly since 2017.[153] As such, plans for reform such as Transforming Your Care[154] and Power To People[155] have lacked the necessary strategic and statutory backing to be enacted. Many other pieces of legislation, such as the Carers and Direct Payments Act[156] in 2002 (many others were enacted over 40 years ago[157]), are largely regarded as outdated by key stakeholders such as the Commissioner for Older People in Northern Ireland.[158,159] As such, many changes to service delivery, such as the progressive roll-out of self-directed support, do not appear in legislation but rather in policy.[160]

A new, shared power agreement in the New Decade, New Agreement proposal has committed to the implementation of the Transforming Your Care and Power to People policy proposals, which may lead to more active transformation in the future.[161]

Stakeholders reported that an implementation strategy for a social care-wide reform was being developed and due to be published in late 2019 or early this year, with topics such as workforce and informal carers also being addressed. At the time of writing this is unpublished.

Given the lack of statutory change in both health and social care in Northern Ireland over the past few years, the system is on the brink of collapse.[162] One of the big challenges specific to the country will be sustaining the delivery of free domiciliary care without a significant change in how funding is distributed.

Overview of preparation and publication

37. The reform plans presented in this explainer go up to end-2019. Information included in this explainer has changed substantially since its publication. Therefore, the information should serve as an indication of plans relating to social care in each of the UK's four countries ahead of the Covid-19 pandemic but are not an accurate representation of reform plans underway in each of the four countries at present. No quantitative data was published as part of this explainer.
38. The information provided in this explainer is primarily derived from UK, Wales, Scotland and Northern Ireland government publications and web pages, as well as news articles and research reports.

39. **Explainer VI: "What are carers in each of the four UK countries entitled to?"**

(2020) *Text*

of explainer

Key points:

- In each of the four UK countries there is a strong and heavy reliance on informal carers. Figures from the last census in 2011 estimate informal carers across the UK to be in the region of 6.5 million, and it is likely that this number has risen.
- Carers in each of the UK countries are eligible for assessments by their local authority or Health and Social Care Trust. Eligible individuals are entitled to a support plan.
- Different initiatives have been undertaken to support carers and their wellbeing. Of note is Scotland's Carers' Allowance Supplement, which brings Carers' Allowance in line with Jobseekers' Allowance.

	England	Wales	Scotland	N. Ireland
Estimated numbers of carers[163] (2011)	5,430,016	370,230	492,031 *759,000	213,980
Carers in legislation	Care Act 2014 Carers Action Plan 2018	Social Services and Wellbeing Act 2014	Carers Act 2016	Carers and Direct Payments Act 2002
Definition	'An adult who provides or intends to provide care for another adult'	'A person who provides care or intends to provide care for an adult or disabled child'	'An individual who provides or intends to provide care for another individual, the cared-for person'	No legislated definition

Legal entitlements	LA duty to provide an assessment and the required services that fall under national eligibility criteria	LA general duty to promote wellbeing of people in need and their carers, under national eligibility criteria	LA duty to provide support to carers under local eligibility criteria Specific adult carers support plan Requirement for LAs to have information/advice services for carers	HSCT duty to provide assessment, but HSCTs retain discretion whether or not to provide support

* All figures reported here are taken from the UK Census (2011)[164] and are the most recent comparable resource. The 759,000 figure is reported by the Scottish government (2015)[165] and represents numbers of carers over 16. The data are collected differently and are therefore not directly comparable. Assessing the 'actual' number of carers has been reported as a challenge across all four nations.

England

The Care Act (2014)[166] provided a new definition of a carer ("An adult who provides or intends to provide care for another adult"), and established duties for Local Authorities to provide an assessment and support to eligible needs.

As such, individuals providing informal care are entitled to a carer's assessment by the local authority to determine how to support the carer's needs and whether their role is sustainable in the long-term. Carer entitlement is subject to National Eligibility Criteria if the local authority believes the carer has needs[167]:

- Arising from the care and support provided to another individual;
- The carer is unable to achieve some of the outcomes listed in the Eligibility Regulations or is at a risk of their physical or mental health deteriorating;
- The carer's wellbeing is affected as a result of this.

Carers are also entitled to a Carers Allowance if they care for someone at least 35 hours a week, which is administered by the Department for Work and Pensions. This is set at £66.15

a week. While there have been calls to increase the Carers Allowance in line with Job Seekers' Allowance (see Scotland), it seems unlikely this will happen in the near future.

With strains on formal provision of care and a growth in need, it is likely that the number of informal carers has grown substantially since the 2011 Census[168] and indeed the number of people in receipt of the Carers Allowance is rising[169]. Surveys of carers suggest that their welfare is decreasing as their workload becomes greater and their access to local support is reduced[170]. Attempts to provide greater support to carers have included the development of the Carers Action Plan 2018-2020[171] and the Supporting carers in general practice framework.[172] However, many carers have reported that the provisions of the Care Act have made little difference[173], suggesting that more needs to be done to provide carers with the support they need.

Wales

Similarly to England, the Social Services and Wellbeing Act 2014[174] provides a new definition of a carer ("A person who provides or intends to provide care for an adult or disabled child") and establishes duties to Local Authorities to provide support to carers on the same grounds as the person being cared for[175].

As such, the local authority has a duty to assess any carer and the carer's ability and willingness to provide care and support to an individual. Any carer who meets the eligibility criteria (identical to the person in need of care and support) must receive a support plan from the local authority. As the Carers Allowance is administered by the Department for Work and Pensions and is not devolved, rates of pay and eligibility criteria are identical to England meaning eligible carers can receive £66.15 per week.

Stakeholders and citizens' reports such as Measuring the Mountain[176] have highlighted some positive examples of collaboration between local authorities and carer support groups in line with the "values base" of the Social Services and Wellbeing Act. However, Carers Wales reports that in 2018-19 up to 55% of carers had not received the appropriate information and support the Act legislates. 85% of respondents had also not received a Carers need assessments in the past year, despite demand. The number of informal carers has been growing rapidly, with Wales having the highest proportion of young carers in the UK[177].

Scotland

In Scotland carers are protected under carer-specific legislation; namely the Carers Act 2016,[178] which provides a definition of a carer, a young carer, and an adult carer (a carer is

"an individual who provides or intends to provide care for another individual, the cared-for person").

As such, the act establishes duties for Local Authorities and Health and Social Care Partnerships to provide support for carers under a self-directed support plan also specifically known as an Adult Carers' Support Plan[179]. Local authorities have discretion to set the level of eligibility at which carers can receive support under a self-directed support plan, which in practice means there are different access thresholds (although most are set at a "substantial" need for support).

In an attempt to recognise carers' contributions to the care of individuals and to the wider economy, the Scottish government introduced the Carers Allowance Supplement in 2018 to align the Carers' Allowance (currently of £66.15 per week and aligned with the Department for Work and Pensions) with Jobseekers' Allowance (see Welfare Benefits for more detail). Scotland has also developed a Young Carer Grant[180] which delivers an additional payment of £300 yearly to carers aged 16-18, which can be spent as the carer chooses.

Despite this active recognition of the role of informal care in supporting service users, Carers Scotland[181] recently reported that implementation of the Carers Act has varied across Scottish regions, and many carers have struggled under financial pressure. The report also acknowledges the skew towards older and female carers, which stakeholders suggest could be the result of societal expectations.

Northern Ireland

The Carer's Support and Needs Assessment[182] is a component of the Northern Ireland Single Assessment Tool (NISAT), but it can also be used as a standalone component of care[183]. Carers deemed eligible under the NISAT are entitled to a self-directed support plan. As with assessment for service users, the Health and Social Care Trust retains the right to determine whether an individual is eligible under the assessment[184]. Although benefits are devolved to the Department for Communities, carers are entitled to a Carers Allowance of £66.15 per week identical to the other UK nations, and under the same eligibility criteria[185].

It has been argued that legislation surrounding carers in Northern Ireland is outdated[186], with the most recent legislation, the Carers and Direct Payments Act dating back to 2002.[187] This provides no legislated definition of a carer. More recent policy papers, such as Transforming Your Care in 2013,[188] have recognised the need for carers to be included in strategic implementation plans and to have an increased uptake of the Carers Assessment. Power to

People,[189] in 2017, included specific proposals for reform of carer support, with an alignment with the English Care Act as a minimum.[190]

Stakeholders reported a very strong tradition of caring in Northern Ireland, with the majority being women[191], although this was felt to be changing. The heavy reliance on informal carers suggests this move away from traditional caring responsibilities could have impacts on the sustainability of the social care system. As with the other nations of the UK, concerns were raised about the health and wellbeing of carers, along with financial hardship[192].

Overview of preparation and publication

40. One table is presented in this explainer showing estimates of carers in each of the four countries. The data presented in the table are derived from the UK Census 2011 (referenced in the data table in Appendix A). The Census is undertaken every 10 years so at time of publishing in 2020, this was the most recent available data on the numbers of carers that could be compared across the UK countries. The UK census is the most reliable estimate of numbers of carers across the UK using the same definition. However, the lag between updates makes it difficult to make an accurate assessment of how carer numbers are evolving.
41. Scotland undertakes its own census of carers over 16 and uses different questions. The discrepancy between Scottish numbers reported in the UK Census (492,031) and the Scottish Health Survey (759,000) highlights the difficulties of understanding the 'true' number of carers across the UK. Moreover, definitions of unpaid carers in law vary across the UK countries. For instance, Wales considers adults and children carers, whereas England only considers adult carers. Duties of support also vary according to where the eligibility sits (national or local).
42. The supplementary information provided in this explainer is derived from UK, Scotland, Wales, and Northern Ireland government publications, research reports, charity reports and factsheets.

43. **Explainer VII: "What does the social care workforce look like across the four nations?" (2020)**

Text of explainer
Key points:

- In each of the UK nations the social care workforce represents a large proportion of employment. In England alone most recent figures estimate up to 1.6 million jobs in the sector.

- There are shared challenges around recruitment and retention of the workforce, linked to poor pay and conditions and perceptions of attractiveness of the sector.
- England is the only country that does not have a non-departmental public body which is responsible for the regulation and registration of its workforce. In the other UK countries, all social care workers must sit on a register, and in Scotland and Wales, a qualification is necessary to work in social care. There is early evidence that this is having a positive impact on retention and perceptions of the workforce.

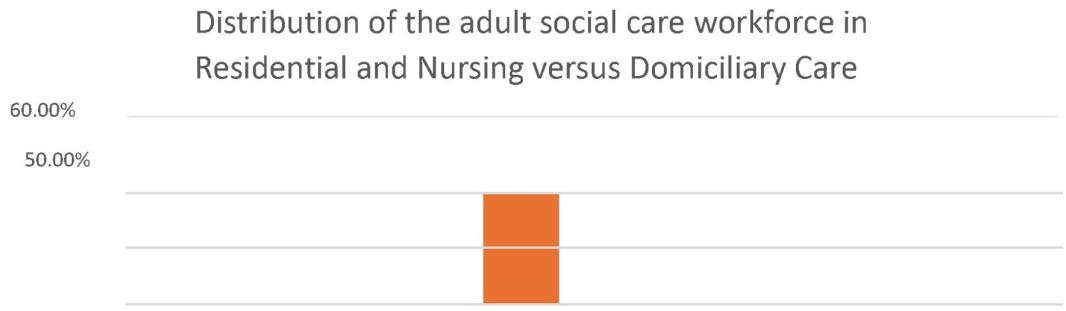
The total number of jobs in adult social care to be in the region of 2.6 million UK-wide (of which

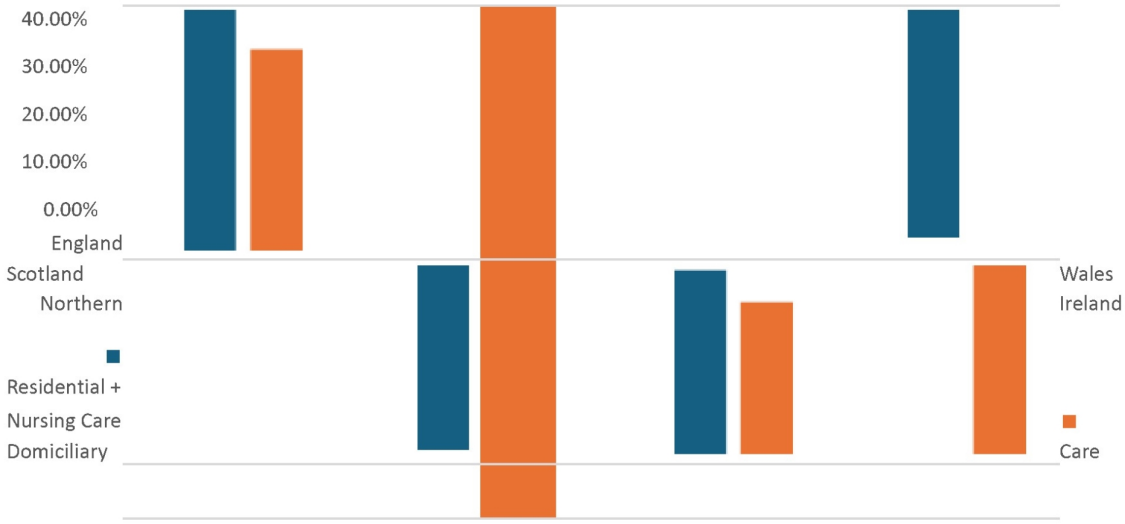
1.8 million are full-time equivalent)[193].

	England	Wales	Scotland	N. Ireland
Numbers of jobs in adult social care (2016)	c. 1,200,000 (800,000 FTE)	c. 72,000 (54,000 FTE)	c. 140,000 (103,000 FTE)	c. 38,500 (29,000 FTE)
Workforce Organisation/Workforce Regulator	Skills for Care	Social Care Wales (Workforce Regulator)	Scottish Social Services Council (Workforce Regulator)	Northern Ireland Social Care Council (Workforce Regulator)
Set Up	2001	2017 (previously Care Council Wales, set up 2001)	2001	2001

Type	Charity/Delivery Partner	NonDepartmental Public Body	Non-Departmental Public Body	NonDepartmental Public Body
Registration	N/A	Mandatory and qualifications-led	Mandatory and qualifications-led	Mandatory and not qualifications-led
Registration timeframe for frontline workers	N/A	Domiciliary carers to be registered April 2020 Residential carers: 2020-2022	Support Workers in care home for adult services to be registered by 2015. Workers in care at home and housing support to be registered by Sep 2020.	All social care workers designated by DoH registered by 2018, including domiciliary care

* There is no UK-wide dataset as each workforce organisation is responsible for its own data collection which means there are discrepancies in the ways data are collected and reported. While these are not the most recent numbers of workers reported for each nations, they have been collated and presented together by Skills for Care and Development,[194] the sector skills council for the sector and is the partnership of professional bodies across the four nations. These rounded figures are used for comparability purposes – for more recent figures see England, Wales, Scotland and Northern Ireland.





Source: Skills for Care and Development, 2018 – Note that the reports use 2016 figures, which are not most up-to-date but have been adjusted and approved by each professional body for comparative purposes in adult social care only (and excludes employment in adult social services and child services). Total proportions do not add up as the graph does not include other types of adult social care employment, e.g. day care and personal assistants.

Northern Ireland and Scotland do not record residential and nursing care separately, so the above graph presents residential and nursing care together. It's worth noting that proportions of domiciliary care workers are highest in Scotland, where personal care is free.

All four nations of the UK share similar challenges around the workforce. Workforce conditions are poor, with many on zero-hour contracts and earning close to the minimum wage (although the proportion of workers on zero hours contracts varies across the nations)[195]. In addition, there is little opportunity for continued professional development. As a consequence, the sector experiences high turnover due to low levels of recruitment and retention[196]. There are as such high levels of vacancy and we have previously calculated that to provide care for current unmet need in England alone would require up to 90,000 additional workers[197].

<u>England</u>

Skills for Care[198] came into being in 2001 and is the delivery partner to the Department of Health and Social Care for the development of the social care workforce in England.

Skills for Care acts as the main source of knowledge of the workforce, and collects comprehensive data in the Adult Social Care Workforce Dataset as well as publishing yearly reports.[199] Most recent figures published in 2019 estimate the total regulated adult social

care workforce at 1.49 million people in 2018 (and 1.62 million jobs)[200], of which 600,000 were employed in residential[201] and nursing[202] care (305,000 and 295,000 respectively), and 520,000 in domiciliary care[203].

England is the only nation in the UK for which there is no professional body which is mandated by – and accountable to – government, that is responsible for the regulation of social care workers. Stakeholders have suggested this has hindered the development of a strong professional identity underpinned by shared improved status, standards and qualifications (i.e. professionalization)[204], and as such, makes having an accurate picture of the workforce more difficult.

There is a growing interest in professionalization as a solution to the workforce shortages England faces. The rationale is that developing a strong professional identity for social care workers, facilitated by registration and adherence to common professional standards, would make the sector more attractive to new entrants as well as encouraging workers to stay within the sector by offering more opportunities for career progression in social care. However, there is to date a limited evidence base on the effect of professionalization on retention and recruitment levels[205]. Beyond this, one of the biggest challenges with the professionalization of the English social care workforce is its size, as well as the vast number of settings in which the workforce operates. Developing mandatory registration as a first formal step in professionalizing the workforce would require large amounts of planning and resources, especially if registration is to increase the attractiveness of working in the sector.

Wales

Social Care Wales[206] came into being in 2017 (as a continuation of the previous Care Council for Wales) and was set up under the Regulation and Inspection of Social Care Act (Wales) (2016)[207] in line with the Social Services and Wellbeing Act of 2014.[208] As such, Social Care Wales acts as a Welsh Government Sponsored Body, a non-departmental public body that is legislated, funded, and accountable to the National Assembly for Wales. It has three main functions around workforce regulation, workforce development and service improvement[209]. The act also creates a definition in law of a 'social care worker'[210], an individual engaging in relevant social work (and is not place-based).

Social Care Wales is in the process of implementing a mandatory qualifications-based register with continuous professional development schemes, under which all registrants must demonstrate compliance with Fitness to Practise[211]. Stakeholders have suggested this has formalised the need for more structured information.

Social Care Wales acts as the main source of knowledge for the workforce, and publishes workforce reports such as most recently the Workforce Profile 2018 for Commissioned Care Provider Services[212] and the Workforce Profile 2018 for Local Authority Regulated Services,[213] which both cover social care workers, social workers and workers employed in children's services. The Skills for Care and Development 2018 report[214] estimates jobs in the regulated social care workforce at around 72,100, of which 27,700 (38.4%) were in residential and nursing care and 22,900 (31.8%) in domiciliary care.

Due to the recent nature of registration activities, there has been little evidence of its impact on professionalization and whether it has enabled a greater recruitment and retention of the workforce. Some concerns have been raised that the need to undertake a qualification in order to be a social care worker could act as a disincentive for individuals, especially for those who only work a few hours a week[215]. A further complexity is where staff work across the English/Welsh border and are therefore subject to two separate legislations.

Scotland

The Scottish Social Services Council (SSSC)[216] came into being in 2001 under the Regulation of Care (Scotland) Act.[217] As such, the SSSC acts as a non-departmental public body that is legislated for, funded by, and accountable to the Scottish Parliament. Its main functions are around registration and regulation of workers, development, and ensuring Fitness to Practise[218]. It's important to note that social care workers (in legislation 'social service worker') are defined in relation to the place of their work, not their profession, which has arguably made the development of a professional identity more difficult.

Registration is mandatory, and qualifications-led, making it an offence to exercise social care work without being on the register. Applicants can sit on the register before acquiring their qualifications (Registration with condition)[219]. Registration started shortly after the Regulation of Care Act in 2001[220] with the aim of developing a strong professional identity that would be valued both by workers and service users[221] as well as strengthen the sector's skills base and is still ongoing. Workers employed in domiciliary care services are to be registered in their entirety by October 2020[222]. Stakeholders reported that holding a mandatory register for almost 20 years had real benefits in terms of knowledge of workforce makeup, its movements, and for future planning.

The Scottish Social Services Council develops and publishes official and national statistics on the social services workforce and publishes yearly reports on Workforce Data.[223] These cover social care workers and social workers for both adults and children in receipt of services. The Skills for Care and Development report[224] estimates jobs in the regulated adult

social care workforce at around 138,000, of which 53,700 (38.9%) are in residential and nursing care and 69,000 (50%) in domiciliary care. More recently, 2018 data reported by the SSSC the total adult social care workforce (using total registration data, excluding children's and social services) in the range of 140,000.[225] The domiciliary care workforce is increasing and is now estimated at around 71,350[226].

Beyond the shared challenges with the other nations of recruitment and retention, conversations with stakeholders have highlighted concerns around the sustainability of the workforce. This is further compounded by concerns around current MAC proposals for immigration, which could limit the number of foreign workers coming to Scotland to work in social care.

Northern Ireland

The Northern Ireland Social Care Council (NISCC)[227] came into being in 2001 under the Health and Personal Social Services Act (Northern Ireland).[228] As such, the NISCC acts as a nondepartmental public body that is legislated for, funded by, and accountable to, the Department of Health in Northern Ireland. Its main functions include the registration and regulation of social care workers, setting standards of conduct and practice, and supporting the learning and development of the workforce[229]. The Act also provides a definition of a 'social care worker', and as in Scotland this is defined around place-based employment rather than professional competencies.

Registration is mandatory but not qualifications-led, making it an offence to exercise social care work or call oneself a 'social care worker' without being on the register (although the offence falls on the registered employer rather than employee)[230]. Being on the register is intended to demonstrate that a worker is compliant with the standards of conduct and practice, making them accountable for the quality of care they provide[231]. Stakeholders suggested introducing mandatory qualifications would help to raise the quality and status of the workforce and it remains a long-term ambition.

The NISCC has completed the registration of the designated groups of social care workers, with the final group of domiciliary care workers registered in 2018. Northern Ireland is the first UK country to achieve complete registration of its domiciliary care workforce. It is also the first country to undertake an evaluation of its registration process[232], which finds that mandatory registration and adherence to Fitness to Practise standards has increased confidence among the workforce. Service users and workers have also reported a positive impact on the quality of care.

The Skills for Care and Development 2018 report[233] estimates social care workforce regulated jobs at around 38,500, of which 18,400 (47.8%) were in residential and nursing care, and 15,200 (39.5%) were employed in domiciliary care. A more recent study reports the social care workforce to represent 4% of all employment in Northern Ireland[234], and there are currently 36,753 people listed on the register[235].

Particular challenges to the nation include raising the value and status of social care and determining the most effective models of delivery for social care, given the current lack of legislative change to the social care system. The implications of Brexit have also raised concerns around free movement of workers across the currently open border with the Republic of Ireland, from which an estimated 500 workers are employed.

Overview of preparation and publication

44. One table is presented on the total number of people employed in adult social care across the UK and key workforce features for each country. A chart titled 'Distribution of the adult social care workforce in Residential and Nursing versus Domiciliary Care' is also presented.
45. The data presented in both the table and chart were collected by Skills for Care and Development in 2016 and published in 2018, referenced in the data table in Appendix A. There is no UK-wide dataset that presents the number of staff working in social care in a comparable way. This is because each workforce organisation (non-departmental public body in Wales, Scotland and Northern Ireland; delivery partner in England) are responsible for their own data collections. The numbers reported by each workforce organisation are not comparable as each uses different definitions and methodologies to count staff.
46. The lack of robust, and regularly updated, data sources on the number of staff working in social care at a UK level is a major issue for comparison. This makes it difficult to assess the potential varying impacts of different workforce policies adopted by each of the UK countries on staff recruitment and retention.
47. The research team chose to use the data presented by Skills for Care and Development for comparability purposes and because, at time of publication, it was relatively recent. These figures were collated and reviewed by the workforce organisations in each of the UK countries and therefore represented an accurate and robust comparator. The research team also presented the more up-to-date figures for each individual country, that were not directly comparable, in each of the country sections.

48. The research team chose these numbers over other sources, such as the ONS annual population survey. This was because stakeholders highlighted concerns about how the data presented in this survey are counted and whether other forms of employment outside of adult social care are also included.

49. The majority of the information presented in this explainer is derived from publications from each country's workforce body, as well as some legislation and research reports.

50. **Explainer VIII: "What does the provider market look like across the four countries?" (2020)**

Text of explainer

Key points:

- There are approximately 24,000 residential and nursing care homes UK-wide (18,000 and 6,000 respectively)[236], while there are approximately 13,670 domiciliary care organisations[237,238].
- The distribution between public, private, and voluntary providers, as well as their size, varies considerably across the four countries. England has the most privately owned providers.
- The four countries have shared issues around the stability of the market for care. Across the UK there is a high turnover of care providers with many being forced to hand back contracts for services.
- Many providers across the UK have a mix of self-funded and state-funded service users and as such all report issues of cross-subsidisation, whereby self-funding individuals are required to pay more for their services than state-funded individuals. Across the four countries on average an individual funding their care themselves would pay over £200 per week for the same service in a care home. However, it's estimated that England has a much more significant proportion of self-funders.
- In Wales and Scotland, inspection and regulation is undertaken by a dedicated regulator for social care and other social services. In contrast, the regulator in England and Northern Ireland also has responsibility for health.

England

Providers of social care in England are registered and regulated by the Care Quality Commission (CQC),[239] which acts as a non-departmental public body for both the health and social care sector. There is no regulation of local authority in England like there is in Wales and Scotland. In July 2019, there were around 9,000 registered domiciliary care providers and over 15,500 residential and nursing care providers registered with CQC[240]. Approximately 78% of all adult care services are privately owned and run[241].

The Care Act 2014[242] set out a legal framework which mandates local authorities and their delivery partners to protect vulnerable adults in receipt of social care from harm[243]. Through the development of Safeguarding Adult Boards, local authorities must, among other things, work with the CQC to investigate and address concerns of poor quality among organisations delivering care. The Care Act and the associated Market Oversight Regulations 2015[244] further set a legal duty on CQC to monitor the financial performance of large social care providers, and to warn and support local authorities where significant concerns are raised. Both duties on local authorities and the care regulator are intended to prevent large failures of care, both and financially and in terms of clinical quality[245].

The provider market in England is unstable, with a large turnover of providers exiting the market and fewer providers entering. Many providers are being forced to hand back contracts to local authorities[246], and many small/medium and high-profile businesses, such as Four Seasons[247], are going into administration. ADASS estimates from 2016 to 2018 that 1,211 residential care homes stopped delivering services, while only 580 new ones opened[248]. There is a similar turnover in domiciliary care, with approximately 500 organisations entering, and 400 exiting, the CQC register each quarter[249].

Providers cite the fact that the fees paid by local authorities are frequently lower than the actual costs of providing the care as a key reason for their financial struggles, and with local authority finance decreasing this is becoming an increasing concern[250]. It is common practice for providers of care to charge self-funders more in order to subsidise local authority-funded people for the same care – on average the differential is of £760 per week and £520 per week in care homes respectively[251]. England has the highest proportion of self-funders of the four nations (see How much care does each country fund?), especially in residential and nursing care.

Wales

The Care Inspectorate Wales (CIW)[252] undertakes the registration and regulation of social (care) services in Wales, for both adults and children. In practice this means the agency also regulates services such as adoption or children's day care[253], but does not regulate health services unlike the CQC in England and the RQIA in Northern Ireland. It also has the responsibility to inspect local authorities against their provision of care services in line with the principles of the Social Services and Wellbeing Act[254] [255].

As with the regulation of workers, the regulation of providers is legislated and local authorities in the Regulation and Inspection of Social Care Act 2016.[256]The register currently holds approximately 550 domiciliary care providers and around 1,300 residential and nursing homes[257]. It is estimated around 72% of all adult care services are run privately[258], while approximately 12% of care homes are run by local authority[259].

Similarly to England, the Social Services and Wellbeing Act[260] creates a legal framework for local authorities to safeguard adults (and children) under the Safeguarding Boards. These are supplemented by the 2019 Wales Safeguarding Procedures, to be fully implemented this year[261]. The duties conferred to local authorities by these bills are intended to minimise the potential for social care service users to encounter harm in the receipt of their care.

While self-funders in Wales also cross-subsidise care for local authority-funded individuals as they do in England, estimates of the proportions of self-funders in Wales suggest these are much lower than in England both in residential/nursing (32%) and domiciliary care (21%)[262]. The average weekly cost of care in a residential care setting is comparatively lower to England, with a cost of around £490 per week for local authority-funded individuals, against £710 for self-funders[263].

As in all four nations, providers in Wales are under significant financial pressure, but the care market is distinct to England in that small and single businesses make up to 75% of providers (compared to 62% in England); these often reported upcoming retirement as another reason for closure[264]. As such, most Local Authorities have reported shortages in care home placements, provision, and in nursing services[265].

Unlike in England, where the CQC regulates providers and administers a rating system of providers, there is no such mechanism in the Welsh system for assessing variation in quality between providers, although enforcement action is taken by Care Inspectorate Wales if a service does not comply with regulatory requirements or the conditions of their registration[266].

Most Local Authorities have reported shortages in care home placements, provision, and in nursing services[267].

Scotland

The Care Inspectorate (CI)[268] is responsible for the registration and regulation of care providers in Scotland. It does not regulate healthcare services, unlike the CQC in England or the RQIA in Northern Ireland[269]. The Care Inspectorate also inspects local authorities and their associated partnerships deliver care across local areas[270]. The register currently holds approximately 1,400 domiciliary care providers (reported as housing or care at home services) and 1,100 adult residential and nursing home services[271]. Most providers in Scotland are in the independent sector (including voluntary and private), and this is particularly the case for residential care among older people[272]. The voluntary sector provides the greatest number of services and employs the majority of the workforce in domiciliary care.

Social care users are protected against harm in the receipt of their care under the Adult Support and Protection Act 2007.[273] As in England, this means in practice that local authorities are legally obliged, with appropriate powers, to investigate reports of harm to service users in collaboration with the Care Inspectorate. This is being improved under the Adult Support and Protection Improvement Plan 2019-22.[274] These bills are intended, among other things, to reduce occurrences of failings of care.

Stakeholders reported similar challenges to England around the instability of the provider market and the cost of cross-subsidisation to self-funders. Estimates of the proportions of selffunders in Scotland suggest these are considerably lower than in England both in residential/nursing (40%) and domiciliary care (25%). Skills for Care and Development report the weekly cost of residential care for older people to average around £530 a week for local authority-funded individuals, against £760 a week for self-funders[275].

To address some of these issues, the Convention of Scottish Local Authorities, Scottish Excel, the Coalition of Care and Support Providers and Scottish Care have attempted to model the costs of care to help local authorities more accurate prices for care home places under the National Care Home Contract.[276] This is a distinct feature of the Scottish system, the implementation of which has been recommended to the other UK countries by the Competition and Markets Authority[277]. The Competition and Markets Authority also reports Integration Joint Boards are developing models to meet needs of the short- to medium-term[278].

The sustainability of the market was noted by stakeholders as a pressing concern, for example with a reduction in the number of care home places available (in part due to the drive to support people to stay at home longer)[279] despite a growth in demand[280]. One of the reasons noted for this was the brevity of the commissioning cycle of only one year, making long-term planning of service delivery increasingly difficult.

Northern Ireland

The Regulation and Quality Improvement Authority (RQIA)[281] regulates both health and social care organisations in Northern Ireland, and requires all social care providers to be on a register[282]. As all responsibility for social care is held by Health and Social Care Trusts, local authorities do not fall under the remit of the RQIA like they do in Wales and Scotland. The register currently holds approximately 500 residential and nursing care providers, and 300 domiciliary care agencies. Just over half (51%) of providers are private[283], compared to 78% in England.

Northern Ireland is the only nation of the UK in which there is no adult safeguarding legislation[284] - it appears only in policy[285]. Recent reports from the Commissioner of Older People in Northern Ireland highlight the concern that Northern Ireland is lagging behind the other nations in its protection of adult social care users. It is argued that Health and Social Care Trusts should, like local authorities in England, Scotland, and Wales, have some legal powers and duties to investigate reports of harm to social care users. This comes in the wake of large scandals of care failings, for example at Dunmurry Manor, which has increased the salience of the issue among stakeholders and the public[286].

Charging higher rates to self-funders to subsidise state-funded individuals appears to be common practice in Northern Ireland as well as the other nations although estimates of selffunders are the lowest of the four nations. Given that domiciliary care is free, it is unsurprising that Northern Ireland has the lowest proportion of domiciliary care users – only 7%. Residential and nursing care users are who self-fund are also few, with estimates at around 11%. The cost of a week in residential care is approximately £450 for HSCT-funded individuals, against £660 for self-funders[287].

There have been a number of provider failures which have been widely reported in the media in the past year[288]. It is felt the market is unsustainable and continues to be unstable as private providers face closures for financial or quality reasons, further complicated by an increase in complex cases requiring care home beds.

Overview of preparation and publication

51. There are no statistical data presented in this section. Data on the number of registered residential and nursing care homes and domiciliary care providers across the UK was presented by Skills for Care and Development published in 2018. The UK Homecare Association (now called the Homecare Association) also collects data on the number of domiciliary care agencies across the UK in line with their remit.
52. Care regulators are devolved across the four UK countries. As such, the Care Quality Commission regulates care for England, Care Inspectorate Scotland for Scotland, Care Inspectorate Wales for Wales, and the Regulation and Quality Improvement Authority for Northern Ireland. Each country holds registers for care organisations, which the research team reported for each country. However, we chose to report overall numbers as presented by Skills for Care and Development for comparison purposes, to ensure the definitions used to count care organisations were the same.
53. In each individual section, the research team also presents estimates of the number of self-funders and average care prices per week. These are also derived from Skills for Care and Development's Economic Value reports.
54. There are no consistent estimates of the share of independent (including for-profit and not-for-profit) and public providers across the UK. The research team reported information from the Skills for Care and Development economic value report. It is interesting to note the large differences in the share of large for-profit providers, that

    are represented more significantly in England than in the other UK countries. Similarly, there are large differences in the number of people who self-fund their care, who represent almost half of people in England but only a very small proportion in some UK countries such as Northern Ireland.
55. Data about provider market sustainability are generally opaque. Due to the high volumes of providers in the independent sector, and rapid turnover of some providers, it is hard to get an accurate number of providers across the UK, and similarly to assess proportions of self-funders.
56. Most of the information presented in this explainer is derived from reports from each country's regulator, research reports, information from each country's workforce bodies, and news articles.

Additional reflections and outputs relevant to the 2020 explainers

57. Following the learning from the preparation and publication of the explainers, a reflective comment piece was published on the difficulties of accessing and comparing adult social care statistics in the UK (Exhibit NC/01 - INQ000553851). This informed work that was undertaken by the Office for Statistics Regulation to try and harmonise data on social care across the four UK countries. The article highlights four main areas of improvement around comparability: (1) ease of access to data; (2) clear definitions and improved guidance on the statistics presented to aid with comparison; (3) consistent data over periods of time to evaluate the impact of different policies; (4) comprehensiveness to enable social care data to answer more robust questions. Learning from this contributed to a roundtable organised to support the preparation of a series of reports by the Office for Statistics Regulation (OSR), published in 2020, on Adult Social Care Statistics in England (Exhibit NC/02 - INQ000553852), in Scotland (Exhibit NC/03 - INQ000553853) and on a way forward for Great Britain (Exhibit NC/04 - INQ000553854).

58. A resulting output from the OSR has been a UK Statistics database for social care, which includes a 4 countries matrix that sets out their assessment of comparable information, including on Coronavirus, across the UK's four countries. As it is an online tool, this cannot be shared as an Exhibit, but is available here: https://analysisfunction.civilservice.gov.uk/dashboard/tools/adult-social-carestatistics/database.html

59. We also published three 'Learning from' blogs on the Nuffield Trust website:

    59.1 'Social care across the four countries of the UK: what can we learn?' (ExhibitNC/05 - INQ000553855). This blog explores lessons for reform that we identified from our work across the UK's four countries. Lessons include the need to back social care reform with funding, noting the impacts of underfunding of more generous policies in Scotland and Northern Ireland; the need to secure public buy-in for reform; and the need to provide clarity about what publicly-funded care is available.

    59.2 'Supporting those who deliver social care: what can England learn from the rest of the UK?' (Exhibit NC/06 - INQ000553856). This blog identifies learning for England emerging from the UK devolved countries on the social care workforce and unpaid carers, highlighting the importance of staff and carers during the Covid-19 pandemic. Lessons include the possible benefits of having a legally-mandated central body for workforce management, which England does not have; there are benefits to having a mandatory register but

this can lead to unintended consequences and would be costly to implement in England; Scotland has taken a more generous approach to supporting unpaid carers.

59.3 'Responding to Covid-19: the complexities of the social care provider market' (Exhibit NC/07 - INQ000553857). This blog covers the reasons the social care markets across the UK were particularly vulnerable to Covid-19: (1) a complex and diverse market structure, (2) financial fragility, particularly among areas with lower proportions of self-funders, (3) challenges in monitoring financial health.

----------***Section B***----------

60. Section A above presented the explainers that we published describing the Scottish, Welsh, English and Northern Irish systems based on our work before the Covid-19 pandemic and before the relevant period for the Inquiry. As requested, I will now present evidence which relates to our research and conclusions during and related to the relevant period itself. This includes:

- Updated versions of the country explainers, published in 2023, and updates to notes on their preparation;
- Additional reflections and nuances to the explainers emerging during this round of work. We produced three analytic pieces, and these were supported by two roundtables which provided further insights into the dynamics of adult social care in each of the four countries during the Covid-19 pandemic, which we summarise for the inquiry;
- A summary taken from the report "Building a resilient social care system in England - What can be learnt from the first wave of Covid-19?" (Exhibit NC/08 - INQ000553858)
- An overview of other lessons we learnt regarding the response of the adult social care sector to the pandemic;
- A description of our recommendations to government, describing which of these findings, conclusions and lessons were shared, and how and at what times this took place.

2023 four UK countries explainers

61. In the period of interest to the Inquiry but following the publication of the 2020 explainers, all four UK countries announced plans for reform of their social care

systems, each with different approaches and priorities. This included Wales proposing to implement a National Care Service free at the point of need, Scotland proposing a National Care Service that would move accountability for social care to a national level and away from local authorities, the People at the Heart of Care white paper for reform in England (Exhibit NC/09 - INQ000553859), and a consultation on social care reform in Northern Ireland.

62. The research team decided to update the original explainers and undertake a comparison of reform plans across each of the four countries, using framework analysis to compare how plans converged and differed on key questions, such as approaches to funding/charging, workforce, and social care markets. The research team considered adding a section on Covid-19, but due to the complexity of compiling rapidly changing information, and the limited longevity of such a publication, this was omitted from the final set of dimensions to evaluate as part of the research.

63. Given the work to identify relevant areas and indicators for consideration had already been undertaken for the first set of explainers, the research team chose to use the existing list of domains and indicators as the basis for updates and did not seek to identify any further indicators. For the descriptive sections, the research team used the same approach as for the first iteration of the explainers, drawing from similar sources, and with a particular focus of bringing in updates presented in each country's reform strategy documents.

64. To assess reform plans in each of the UK countries, relevant policy documents such as white papers, consultation documents and consultation responses were reviewed against a framework to document any proposals around: access and vision; charging; funding, law and governance; commissioning and provider market; workforce; unpaid carers; data and prevention. This is supplied in Exhibit NC/10 - INQ000553860.

65. To update the explainers, the research team reviewed each of the indicators and information included in the previous iteration of the explainer to assess whether more recent data or information was available. For each, the research team assessed whether the presentation of graphs or information could be improved, remain the same, or whether any needed to be removed. Some charts were removed as the team made the decision that the data presented was too out-of-date or would be better presented in other forms (e.g. in a table, in individual graphs). The explainers as quoted below in this witness statement were drawn from edited Word documents of the publications at the point of upload. Some minor proofreading changes and

edits to reflect the house style of the Nuffield Trust website may have been made at the point of upload, but there will be no substantial variance between the quoted explainers and the material published in 2023.

66. The research team ran two roundtables to gather learning from stakeholders across the UK (including policymakers, union representatives, provider representatives, civil servants, regulators, local authority representatives) on two topics in June/July 2022: the provision of social care, and the social care workforce. The learning from these roundtables is summarised alongside other learning reported in our Nuffield Trust outputs in paragraphs 101 to 107.
67. "**Adult social care in the four countries of the UK: introduction" (2023)**

Text of explainer

In this updated series of explainers, we take a closer look at social care across all four countries of the UK, and shed light on where the systems diverge and the direction that each country is now taking.

It is more or less clear to people that, when they have a health need, they can easily access the NHS via their GP or A&E or other direct access clinics (such as a walk-in clinic or minor injuries unit). And, when health care is needed, it is also well understood across the whole of the UK that there will be no charge.

The same clarity is not so evident when an adult has a care need – such as when they need help dressing, bathing or preparing food. Not only is social care an entirely different system from health, organised and with mostly separate funding to the NHS, there are also a number of differences between what a citizen can expect from social care across each of the four countries in the UK.

Legislative and demographic differences have existed between the different countries' social care systems for many years, but since formal devolution settlements in the late 1990s, Scotland, Wales and Northern Ireland have assumed greater administrative and legislative powers. The result of 15 to 20 years of devolution is that the social care systems in each of these countries have developed in different ways.

Social care reform has been delayed in England once more. Are there any lessons it could learn from the other three UK countries? And what are the social care challenges that each country share?

In this updated series of explainers, originally published in 2020, we describe the social care system in each part of the UK and shed light on where the systems diverge and the direction that each country is now taking.

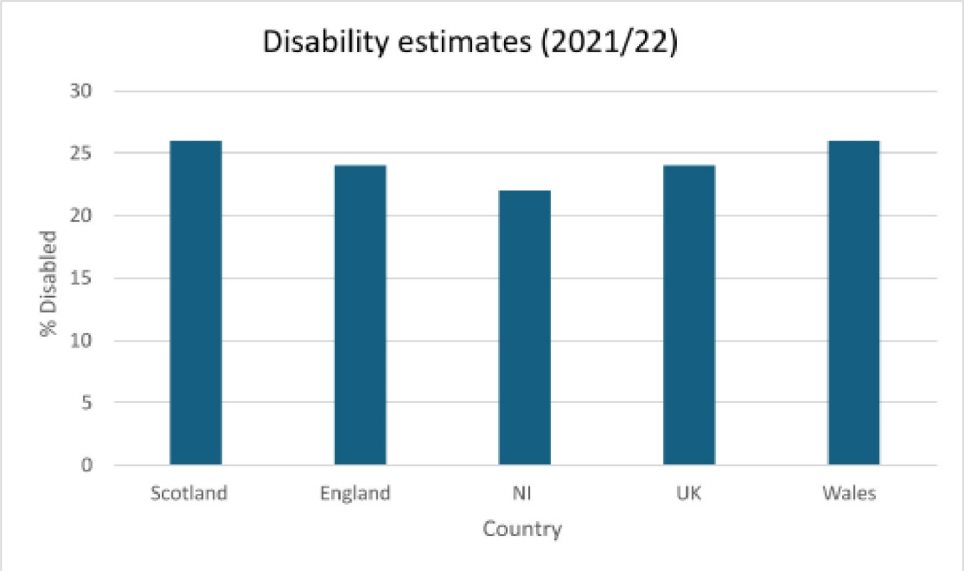
We thank all the stakeholders across England, Wales, Scotland and Northern Ireland who advised on this project, and in particular all the stakeholders who kindly gave up time to attend the roundtables that informed the development of this work.

68. **Explainer I: "Other types of support - how do the countries compare?" (2023)**

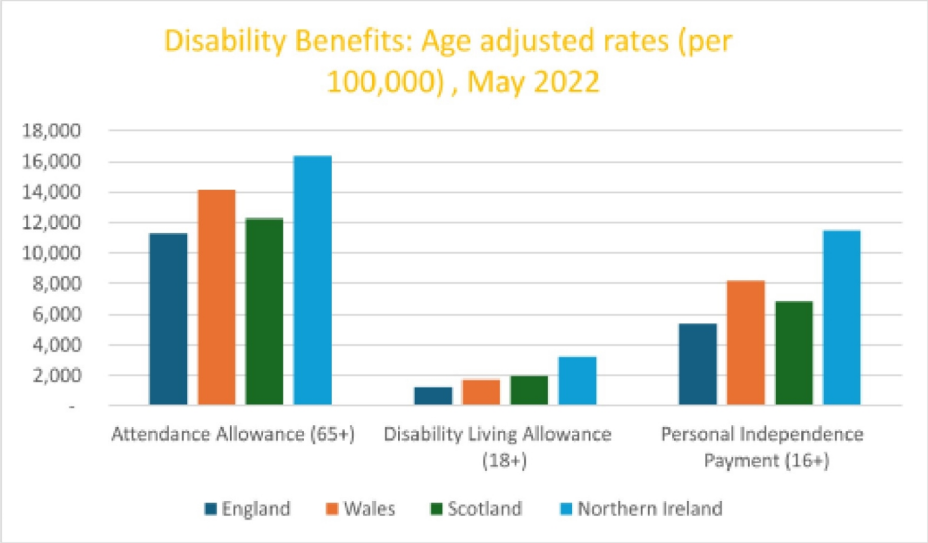
Text of explainer Key points:

- The proportion of individuals with a disability in 2021/22 varies with Scotland and Wales having the largest proportion of people living with a disability. However, the rates of people receiving disability living allowance, personal independence payments and attendance allowance is much more variable across the four nations.
- Across all types of benefit, the rate of recipients is consistently lower in England than in the three other UK countries. This could be explained by the other countries' relative higher rates of poverty, and/or individuals in those countries having comparatively more severe or complex disabilities.
- In all countries, there is a lack of clarity around which people with social care needs are eligible for funded health services. In England, Wales and Northern Ireland, the issues surrounding Continuing Health Care (or its equivalent) are well rehearsed, particularly in relation to those with dementia who typically do not qualify for funding for care. Scotland is the only country to have reformed the system to offer more certainty about the delineation between the two services, although what impact this has had on access is unclear.

Welfare benefits



Source: Nuffield Trust analysis of Family Resources Survey disability estimates, financial year 2021-22. Percentage of total population with a disability by nation. Note this includes children too.



Source: Nuffield Trust analysis of disability living allowance, personal independence payment and attendance allowance data (2021) as a per 100,000 population rate (age standardised, 2021 population mid-year estimates).

The proportion of individuals with a disability is broadly similar in England, Scotland, and Wales; Northern Ireland has a slightly smaller proportion of individuals with a disability.

However, spending on welfare benefits differs significantly. England falls behind the other nations in providing additional financial support, while Northern Ireland is the most generous.

These differences in spending could be due to several reasons. A higher number of applicants in the other countries could reflect different expectations of the state, a higher proportion of individuals with a (more complex) disability in the other countries, and/or a greater proportion for whom the pay-out is of greater financial significance.

The extent to which benefits are devolved is limited. The Department for Work and Pensions manages benefits, set at the same level, for England and Wales. For Scotland, both the Department for Work and Pensions and a new agency, Social Security Scotland, are responsible for health and disability benefits. Social Security Scotland is progressively taking ownership of the delivery greater number of benefits.[289] In Northern Ireland, benefits are administratively devolved to the Department for Communities, but the type and value are identical to benefits in the other countries under current arrangements.

England

Benefits are centrally organised and administered by the Department for Work and Pensions. For most adults, the disability living allowance (DLA) is progressively being replaced by the personal independence payment (PIP) for people who have both a long-term physical or mental health condition or disability, and difficulty with tasks as a result of these conditions.[290]

The personal independence payment is made up of two parts: the daily living part (lower weekly rate £68.10 / upper weekly rate £101.75, 2023/24 rates) and the mobility part (lower weekly rate £26.90 / higher weekly rate £71.00, 2023/24 rates).[291] Individuals can qualify for one or both parts.[292]

Attendance allowance is another benefit available to those over the age of 65 who are severely disabled physically or mentally and require personal care.[293] The 2023-24 weekly rates are £68.10 as the lower rate and £101.75as the higher. The rate you receive is dependent on the level of help you need, not on your means.[294]

Wales

As in England, benefits are centrally organised and administered by the Department for Work and Pensions. Spending on benefits in Wales is comparatively higher than in England. Literature suggests there is a greater need in Wales for the state to provide support – the Wales Fiscal analysis reports the number of over 65s claiming disability living allowance and personal independence payments is almost twice as high as in England.[295] This could

potentially be explained by a comparatively higher level of disability due to higher incidence of chronic disease[296] and greater health inequalities.[297] Furthermore, the higher spending on benefits could be explained by a proportionally greater number of individuals for whom receiving a benefit payment is financially significant.

There has been some appetite in Wales to follow Scotland in the devolution of benefits.[298] The Welsh Affairs Committee published its Fourth Report of Session, 2021-22: The Benefits System in Wales in March 2022 outlining potential options for improved better delivery of benefits including devolution.[299] This follows the signing of the Co-operation Agreement in November 2021 by the Welsh Government and Plaid Cymru stating their support for devolution of the "administration of welfare".[300] Note, this does not mean a comprehensive devolution of welfare and at present, no benefits have been devolved in Wales. Regardless of whether benefits are devolved or not, it is acknowledged by both the Welsh and UK governments that there needs to be greater awareness of benefit entitlements and support for people making claims.[301]

As in England, the DLA is being progressively replaced by the personal independence payment. Attendance allowance is also available for Welsh residents at the same rates as in England. Recipients of all three types of benefits are also eligible for an additional one-off £200 cash payment to provide support towards paying fuel bills in light of the cost-of-living crisis.[302] Scotland

Benefits in Scotland are partly devolved and operate under a new social security agency called Social Security Scotland, formed in 2018, and operational from 2021. However, the DWP still manages some benefits.

Those with a disability or long-term health condition may be eligible for an Adult Disability Payment. This scheme was initially introduced as a pilot to replace the Personal Independence Payment across certain regions in Scotland but was rolled out nationally in August 2022. The amount an individual receives is dependent on their care needs rather than means, and currently is identical to the Personal Independence Payment in England and Wales[303] This benefit is now being delivered by Social Security Scotland.[304]

For carers, Social Security Scotland currently administers an additional benefit, titled the carers' allowance supplement. This is an extra payment of £245.70 (2022) twice a year for recipients of the Carer's Allowance.[305] While DWP administers the Carer's Allowance, Social Security Scotland pays the Carer's Allowance Supplement.

In October 2019, Scotland introduced a new benefit to support young carers aged between 16-18 called the Young Carers Grant. This is an annual payment of £326.65 (2022) to young people to spend how they choose (reporting is not required).[306]

Northern Ireland

In Northern Ireland, benefits are organised and administered by the Department for Communities, although in practice the rates of pay are the same as in England and Wales.

Although the country is also transitioning from the disability living allowance to personal independence payments, the devolved department has put in place additional support for those affected by the transition.[307] Individuals suffering from injuries relating to the Northern Ireland Conflict are also entitled to a supplementary payment from the Department for Communities.[308]

Spending on benefits is comparatively high against the other countries of the UK. Conversations with stakeholders reflected that this is partly due to an increased expectation of the state to support individuals in the aftermath of the Conflict.

Support for health needs

England

Under the NHS Continuing Health Care (CHC) scheme, individuals whose social care need is, according to an assessment process,[309] deemed to be the consequence of a primary health need do not pay for their social care.[310] They are instead fully funded by the NHS, regardless of the setting in which they receive their care or the type of package they need (this includes accommodation costs for residential and nursing care).[311] The assessment uses the national assessment tool and is undertaken by the local clinical commissioning group.[312] Individuals with a social care need who are deemed responsible for paying for their own care, and who require the medical support provided by a nurse in a registered care or nursing home, are entitled to a funded nursing care (FNC) payment of £209.19 (2022/23) per week from the NHS, directly to the nursing home.[313]

There have been major concerns around CHC delivery in England, in particular around the low number of people deemed eligible after assessment, waiting times and where the responsibility lies between the health and social care systems.[314] It is furthermore felt to be a source of inequality particularly for dementia sufferers, whose needs are often perceived to

fall under social rather than health care.[315] These were recognised by the government in 2018[316], but it is clear those problems continue to persist and have been the object of increasing public and media attention.[317]

NHS Digital collects data from clinical commissioning groups, and records on average 54,000 service users eligible for CHC at any one point in 2021/22.[318]This figure has fallen from 56,000 in 2018/19.

Wales

As in England, the Welsh NHS covers the full social care costs of individuals who require social care arising from a health need after an assessment, regardless of the setting in which they receive their care or the type of package they need (this includes accommodation costs for residential and nursing care). Care is then organised through local health boards.[319] Most recent reports from the Welsh government indicate that, on average, approximately 5,000 Welsh people receive NHS-funded Continuing Health Care at any one point.[320] [321]

Individuals with a social care need who are deemed responsible for paying for their own care, and who require the medical support provided by a nurse in a registered care or nursing home, are entitled to a funded nursing care payment of £193.88 per week (2022/23; with an LA component of £7.86 totalling £201.74) from the Welsh NHS directly to the nursing home.[322]

As in England, there have been similar concerns raised in Wales about the consistency and fairness of the CHC assessment process.[323] Dementia sufferers are also deemed to be treated unfairly.[324] The CHC process in Wales was recently under consultation and a revised framework is expected shortly.[325]

Scotland

After an independent review of NHS Continuing Health Care in 2014,[326] the scheme was replaced by Hospital Based Complex Clinical Care in 2015[327] – under which the NHS would fully meet the costs of care for service users with a health need if they needed to be delivered within a hospital setting.[328] Individuals whose care needs can be “properly met” in a setting other than a hospital must meet their own accommodation and board costs.

Their other social care needs are met in the same way as other service users who are not deemed to have a primary health need (see ‘Offer and eligibility’), including the delivery of free personal care if the individual has an eligible need. If you’ve been assessed to having personal care needs

In addition, all service users requiring nursing care within a care home setting receive this for 'free', delivered by the local GP.[329] This takes the form of a funded nursing care (FNC) weekly payment from the local authority directly to the care home. The rates as of April 2022 are £95.80 for nursing care and £212.85 for personal care.[330]

According to the government inpatient status in 2022, around 575 individuals were receiving Hospital Based Complex Clinical Care[331]. There has been a fall in the number of individuals receiving HBCCC as in 2019, 889 individuals were receiving HBCCC[332]. These numbers are not directly comparable to those in England, as they represent only those individuals whose care costs were fully met by the NHS in a hospital setting.

Northern Ireland

Continuing Health Care in Northern Ireland is offered to individuals for whom the outcome of an assessment is a primary health need (as opposed to a primary social care need – for more details see 'Offer and eligibility'). In such cases, the health and social care trust must meet the full costs of the individual's care package, regardless of the setting (this includes accommodation costs).[333]

Individuals with a primary social care need who are deemed responsible for paying for their own care, and who require the medical support provided by a nursing home, are entitled to a funded nursing care (FNC) payment of £100 per week from the health and social care trust directly to the nursing home.[334] It is not clear whether Northern Ireland intends to increase this amount. As for all service users, individuals whose needs can be met in a domiciliary setting can do so for free.

In response to a 2014 report from Age UK outlining the extent of access to Continuing Health Care in Northern Ireland, along with other queries on eligibility from individuals and their families, a consultation led by the Department of Health was carried out in 2021 with the intention of creating a fairer and more transparent system.[335] As a result, reforming the assessment criteria to a single eligibility criteria question: *'can your care needs be properly met in any other setting other than a hospital?'* has been proposed[336]. It is argued that this will be more straightforward and allow for greater consistency in access across regions.[337] Next steps will involve the Department of Health working with key stakeholders to further develop and implement the proposed reform.

Overview of preparation and publication

69. Both charts were included in the previous explainer and updated using the same methodology described above. Data used to update the chart on disability estimates

is listed in the data table included in Appendix A. Since publication on 09/03/2023, the chart on disability estimates by nation was amended due to a data error and was updated in October 2024.

70. No changes were made to the chart on disability benefits since publication on 09/03/2023.
71. Supplementary information presented in this explainer is drawn from similar sources to the 2020 version, with additional updates from government publications and research reports.
72. For both the original 2020 and updated 2023 explainers, we were not able to provide any comparable statistics for the second section in this explainer 'Support for health needs', as we were not able to find comparable data for each country. Support for health needs (known as NHS Continuing Healthcare in England) is applied differently in each country and therefore access and eligibility vary. As such, most recent numbers for each country are referenced in-text rather than presented together to avoid false comparisons.
73. The supporting information provided in this explainer has been sourced from the same or most recent updated publications as the 2020 Explainer.

74. **Explainer II: "How much social care does each country fund?" (2023)** *Text of explainer*

Key points:

- This explainer covers Nuffield Trust analysis of public expenditure per capita for each country and discusses estimations of self-funders in relation to their publicly funded counterparts.
- There is wide variation in total public expenditure per capita (old age and working age adults). As of 2021, England remains by far the least generous, spending on average £352 per head, compared to £478 in Scotland, £494 in Wales and £550 in Northern Ireland.
- While England and Northern Ireland's old age expenditure per head has remained relatively stable, Scotland's old age expenditure has fallen considerably by 21% in the last ten years. Wales has seen the biggest increase in spending in support for older people with a 17% increase in real terms since 2020/21.

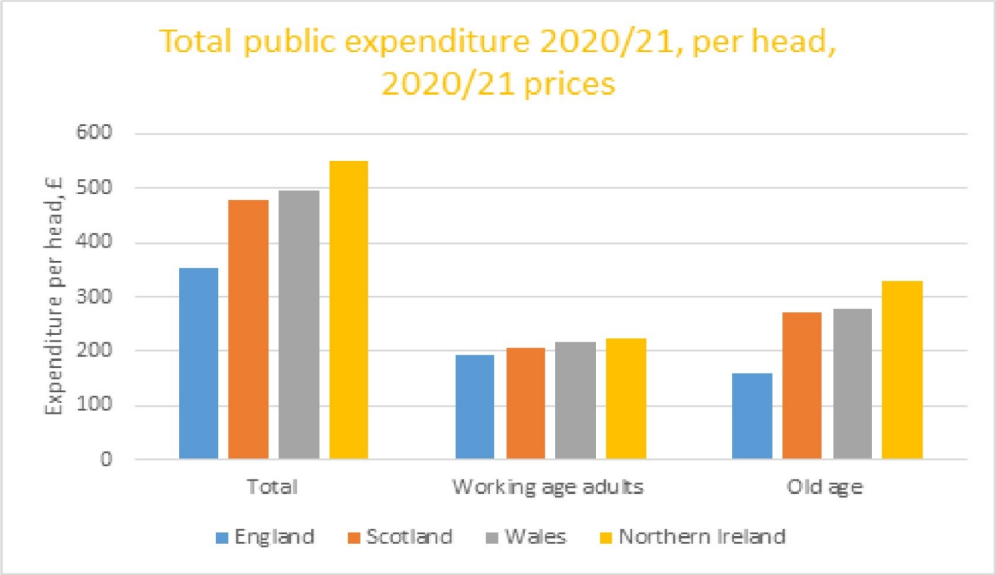


Figure 1. Public expenditure per head by nation in 2020/21, by working and old age adults.

Source: Nuffield Trust analysis of HM Treasury Public Expenditure Statistical Analyses 2020/21. Adult social care expenditure is defined as personal social services on sickness and disability and personal social services spending on old age. For more analysis of spending across the UK countries, see the Institute for Government's report on Devolved Public Services (2021).

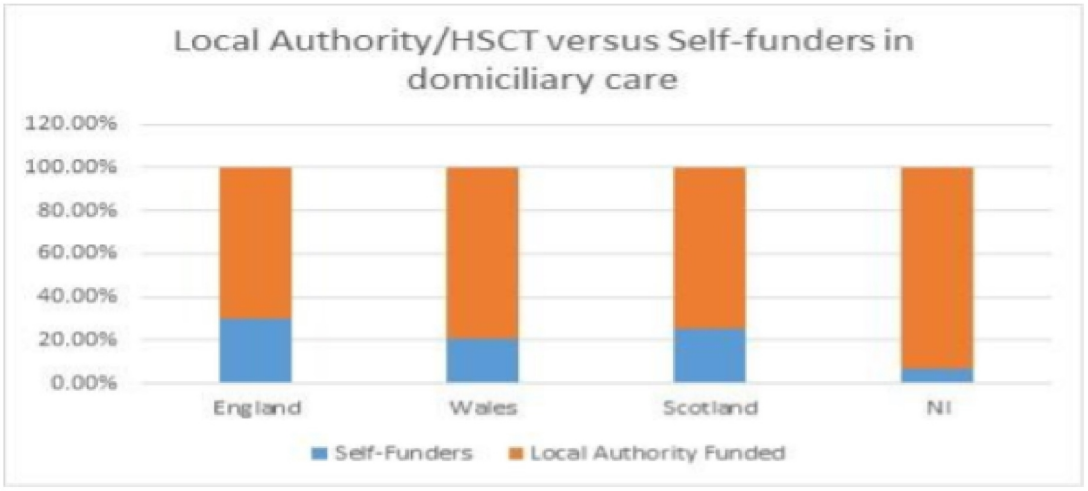
Across all four countries, England's total public expenditure per capita on adult social care is considerably lower than in the other countries, particularly so for old age (see above chart). Expenditure for working age adults is relatively similar across all countries, however.

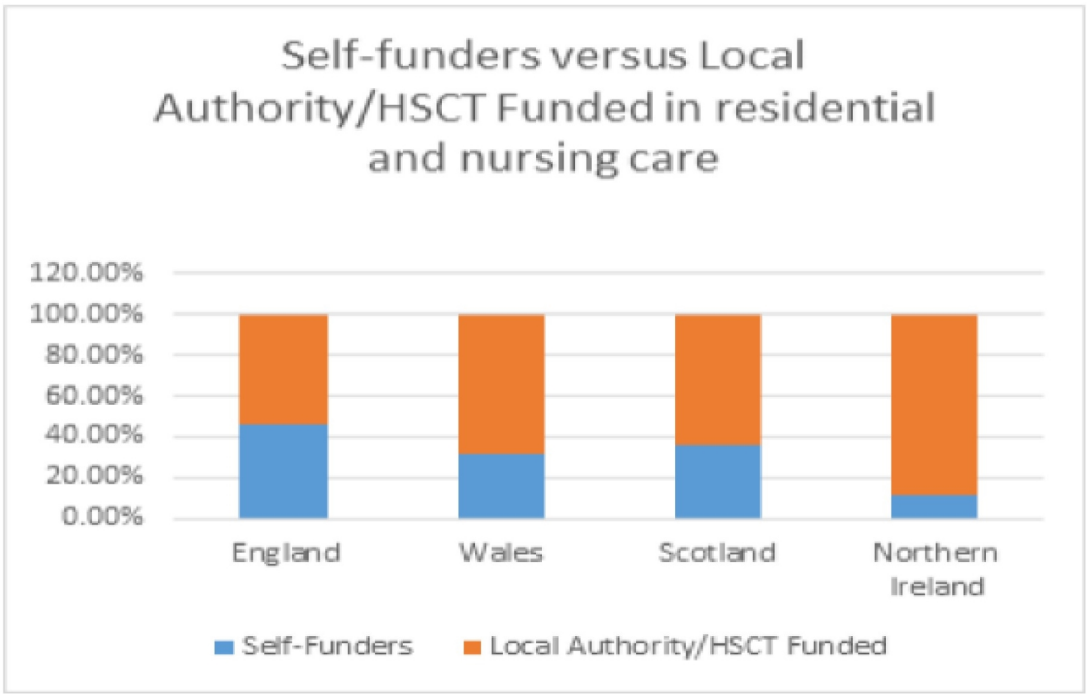
The above chart shows the total identifiable expenditure on social care. Although these figures are derived from the same HM Treasury source, it is worth noting they may not be directly comparable due to the integrated nature of the system in Northern Ireland and should be used for indicative purposes only.

There is no source that can estimate with certainty the number of individuals who self-fund across the UK, and their experiences with social care services are not reported in a similar way to those who can access state-funded care.[338] This could be because of the different ways self-funders access and use care, as well as the complexity of defining self-funding across the varying social care settings.

The true number of self-funded recipients of domiciliary and care home support remains unknown across all four countries. However, data from 2018 estimates that England have

the highest proportion of self-funders receiving residential, nursing, and domiciliary care, and Northern Ireland the lowest, as shown in the charts below. More up to date data from 2021/22 on estimates of self and state funders for England from the ONS suggest that 34.9% of care home residents are self-funders.[339] In the community care sector, they represent 25.8%.[340] The community care sector here refers to domiciliary care services, extra care housing services, and supported living services.





Source: Skills for Care and Development reporting of Laing Buisson, 2018

Overview of preparation and publication

75. Total expenditure per head 2020/21 by each nation was updated from the 2017/18 chart using the same methodology. 2020/21 HM Treasury PESA data is referenced in the data table in Appendix A. We encountered no additional difficulties in access or comparability in updating this chart. No changes have been made to the chart since publication on 02/02/2023.
76. With the exception of England, at time of writing, there were no further updated estimate for the number of self-funders versus publicly funded recipients of residential and nursing care or domiciliary care for each nation since Laing Buisson's 2018 publication. Therefore, this chart remained unchanged. However, we decided to include the Office for National Statistics (ONS) 2021/22 estimates regarding the proportion of self-funders in residential and nursing homes in England and those receiving domiciliary care in text. The ONS has provided these estimates for care homes in England annually since 2019/20 and for community care since 2021/22. It is important to note that the ONS publishes these figures as a guide only and advises caution when using these estimates for further analysis.
77. The supporting information is derived from the same sources as the 2020 explainer, as described above in Section A.

78. **Explainer III: "Who organises and funds social care?" (2023)**

Text of explainer

Key points:

- In England, Wales and Scotland, local authorities are responsible for adult social care and this duty is set in law. Funding comes from central grants, which can be subject to squeezes from central government, and from local revenue raising mechanisms (e.g. council tax).
- In Northern Ireland, health and social care trusts have this responsibility due to the integrated nature of their health and social care system.

<u>England</u>

152 local authorities[341] have responsibility for social care in their localities. They organise and fund support and care for those with moderate or high needs who are unable to fund it

themselves. They can also organise care services for self-funding individuals who may require assistance to do so.

Local authorities fund social care through a combination of a grant from central government via the Department of Levelling Up, Housing and Communities (DLUHC), and local revenueraising mechanisms, such as council tax, the specific social care precept and business rates. The local NHS is also mandated to transfer a set amount to a local authority via the Better Care Fund (BCF).[342] The BCF is a national programme that pools together budgets from the NHS, the Disabled Facilities Grant (DFG), and the improved Better Care Fund (iBCF) (a local authority grant).[343] The Better Care Fund framework for 2022/23 has set out increases in NHS contribution by 5.66%, and an overall increase in the improved Better Care Fund grant by £63
million.[344]

Social care funding is not usually ringfenced, which means that local authorities can decide how much of their overall budget they allocate to care. In addition, where an individual is assessed as eligible for NHS funding for care[345] under the Continuing Health Care scheme, this funding will also cover their associated social care needs (see 'Support for health needs').

However, the 2022 Autumn Statement announced additional central government funding via the social care grant (for children's and adult social care) and a ringfenced adult social care grant. The adult social care grant is attached to spending conditions under the Market Sustainability and Improvement Fund, which will mandate local authorities to deliver improvements under four key priorities (capacity, sustainability, workforce, and waiting
times).[346]

Local authorities were also given greater revenue raising powers through the ability to increase council tax by up to 3% and the social care precept by up to 2%.[347]

Local authorities are responsible for the organisation of care and support plans and personal budgets (see 'Offer and eligibility'). The Care Act 2014[348] set out a national minimum threshold for eligibility to which all local authorities must comply. However, local authorities have discretion to provide services to individuals outside of the eligibility threshold.[349]

Wales

The Welsh Assembly receives a block grant from general taxation gathered at an UK level, distributed to the devolved administrations via the Barnett formula, based on current and historical population size.[350] Spending decisions by the UK government (for instance via an

increase in health spending or a new grant for social care) will impact the size of the block grant passed on to the devolved administrations.

Local authorities receive grants from the Welsh Assembly via the revenue support grant, which are supplemented by local revenue raising to form the total spending budget. Local taxes are devolved to the Assembly[351], which means that the local revenue-raising powers in Wales are subject to different legislation than in England, such as over business rates.[352,353]In Wales, the social care precept does not apply. Local authority revenue is also supplemented by NHS Wales funding through local health boards under the NHS continuing health care scheme (see 'Support for health needs').[354]

Local authorities are responsible for the format of care and support plans (see 'Offer and eligibility') and are required to be consistent across the country with the use of the national eligibility criteria.[355]

Seven statutory regional partnerships boards were established in April 2016 to encourage closer integration with the health care sector.[356] Regional Partnership Boards assemble local authorities, health boards and third sector organisations to provide care and support to those residing in their area.[357] However, it remains the responsibility of Wales's 22 single-tier local authorities to organise and deliver care for those unable to fund it themselves, whether that be directly or through commissioning of services.[358]

The creation of a National Office to drive progress and strengthen work in the Regional Partnership Boards via a national framework for commissioning was announced in the Rebalancing Care and Support White Paper in 2021.[359]

Scotland

The Scottish government receives a block grant from general taxation gathered at an UK level, distributed to the devolved administrations via the Barnett formula, based on current and historical population size.[360] Spending decisions by the UK government (for instance via an increase in health spending or a new grant for social care) will impact the size of the block grant passed on to the devolved administrations.

Scottish local authorities fund social care through a combination of a grant from the Scottish government (General Revenue Funding of Local Authorities) and local taxes to form the total spending budget.[361] In Scotland, local taxes are devolved, which means that the local revenueraising powers are subject to different legislation from England.[362] There are different council tax rates[363] and the social care precept does not apply as it does in England. Local authority revenue is also supplemented by NHS Scotland funding through NHS health

boards[364], under the Hospital Based Complex Clinical Care scheme (see 'Support for health needs').[365]

The Public Bodies (Joint Working) (Scotland) Act 2014 was established to integrate health and social care. There are 31 health and social care partnerships in Scotland that are responsible for the commissioning of social care services via integration authorities.[366] Scotland's 32 local authorities are responsible for the procurement and contracting of care from providers for those unable to fund it themselves. They are also able to organise care services for selffunders who may require assistance to do so.

Local authorities are responsible for the format of self-directed support plans (see 'Offer and eligibility'). Each local authority has their own eligibility criteria to determine whether an individual will be able to access social care, which must be compatible with the National Eligibility Framework.[367] National eligibility applies for service users with a need for personal care, under which those with a critical or substantial risk must receive services within six weeks of assessment.

Plans to introduce a National Care Service by 2026 would remove responsibility for arranging social care from local authorities and place this with Scottish Ministers, with delivery through local care boards (see 'What steps are currently being taken to reform social care?').[368] Northern Ireland

The Northern Ireland Executive receives a block grant from general taxation gathered at a UKlevel, distributed to the devolved administrations via the 'Barnett formula', based on current and historical population size.[369] Spending decisions by the UK government (for instance via an increase in health spending or a new grant for social care) will impact the size of the block grant passed on to the devolved administrations.

In Northern Ireland, social care is integrated with health care under five health and social care trusts. These manage their own budget allocated by the Northern Ireland Executive through the Department of Health (NI). As health and social care services in Northern Ireland are integrated, provision of Continuing Health Care is organised directly by the health and social care trust and thus does not represent an additional source of revenue (see 'Support for health needs'). The newly formed Strategic Planning and Performance Group, accountable to the Minister for Health, is responsible for the planning, improvement, oversight, and delivery of health and social care services at a regional level across Northern Ireland.[370]

Health and social care trusts are responsible for the format of self-directed support plans (see 'Offer and eligibility'). The Northern Ireland single assessment tool[371] is designed to ensure a consistency of assessment across different trusts and different professionals, whether undertaken by a nurse or a social worker. However, trusts have discretion to determine at what level of need an individual is entitled to social care support.

Overview of preparation and publication

79. There are no statistical data presented in this section of the explainer as it sets out the organising bodies responsible for social care at a local level. Supplementary information presented in this explainer is drawn from similar sources to the 2020 version as described above, with additional updates from government publications and research reports.

80. **Explainer IV: "Offer and eligibility - Who can access state-funded adult care and what are people entitled to?" (2023)**

Text of explainer Key points:

- This explainer covers the number of state-supported individuals accessing care, the financial and needs criteria that determine access in each country, and the services supported for individuals who meet the means and needs criteria.
- All of the countries operate a means and needs test to determine access to social care support from the local authority or health and social care trust. England is the least generous country in its offer, as Wales, Scotland and Northern Ireland offer additional support outside of the means test.
- The charging reforms to England's adult social care, including a lifetime cap on the amount anyone will have to spend on their care and a more generous means-test for financial support, which would have made the English offer more generous, have been delayed until 2025 as outlined in the Autumn Statement 2022.
- The number of state-funded individuals varies considerably across the countries, with the greatest differences arising for those over 65. The high number of over-65s accessing state-funded care in Scotland is likely a consequence of their free personal care policy.
- Across each country, there is a drive to promote the use of personal budgets (or selfdirected support) to push greater personalisation in social care.

- Determining which services are included in the offer (for example, in free personal care in Scotland) has proven a challenge in all of the four countries.

	England	Wales	Scotland	N. Ireland
Delivery mechanism name	Care and support plans with personal budgets	Care and support plans	Self-directed support	Self-directed support[372] with personal budgets
<u>Means test:</u> Upper threshold Lower threshold	 £23,250 £14,250	 £50,000* 	 £29,750 £18,500	 £23,250 £14,250
Formal additional support		Cap on non-residential care costs: £100/week	Free personal and nursing care for all adults[373] with eligible need	Free domiciliary care

- N.B. upper threshold in Wales applied only in residential care.

<u>England</u>

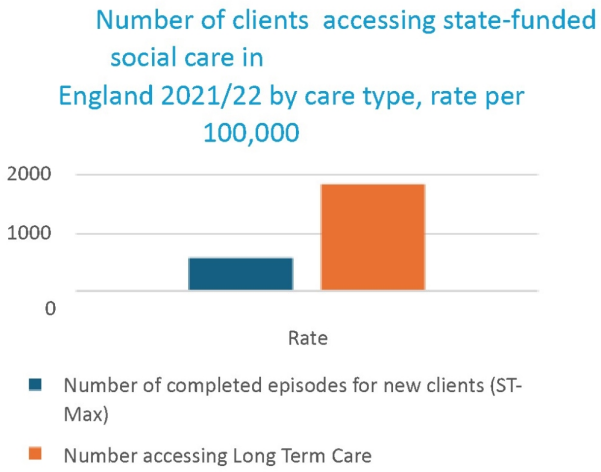


Figure 1. Number of clients accessing state-funded short-term support to maximise independence, and state-funded long-term support in England in 20201/22, rate per 100,000.

Source: Nuffield Trust analysis of NHS Digital – Adult Social Care Activity and Finance Report, England (2021/22). Figures are number of competed episodes of short-term support to maximise support for new clients, and number of people accessing long-term support provided on an ongoing basis. ONS Mid-year population estimates (2021).

The rate of people accessing state-funded adult social care services in England is 504 per 100,000 and 1840 per 100,000 for short-term support to maximise independence and longterm support respectively (Figure 1). Short-term support to maximise independence includes all episodes of time-limited support that are intended to maximise independence of the recipient and reduce the need for ongoing support. Long-term support is ongoing support that can be provided in a nursing or residential home, day services and community services. Community services here refer to support for those living independently (including those in sheltered housing).[374]

Access to state-funded care remains determined both by a means test and a needs test. These are both carried out by a person's local authority, and were revised under the Care Act (2014)[375], which is enshrined in 'person-focused' principles. In 2021, the People at the Heart of Care adult social care reform white paper outlined intentions to increase the number of people accessing state-funded support through a more generous means test and a cap on lifetime care costs, although this has since been delayed until 2025.

Any individual deemed to have some need for care is entitled to an assessment by their local authority, regardless of whether they are financially eligible.[376] National eligibility criteria for need were set out under the Care and Support (Eligibility Criteria) Regulations 2014[377] around a person's ability to achieve their desired outcomes in relation to their wellbeing.[378] There are three conditions that must all be met for an adult to be considered to have an eligible need:

- The considered individual has a need arising from a physical or mental impairment or illness
- The considered individual is unable to achieve two or more outcomes as listed in the Care Act[379]

- Being unable to achieve these outcomes is likely to have an impact on the individual's wellbeing (as defined in the Care Act[380]).

For those meeting the needs assessment threshold, the second part of the eligibility process involves a means test.

- For anyone of any age with means (which includes income, assets and savings) in excess of £23,250 there is no state support available for care, and costs fall entirely on the individual. These represent the majority of social care users in England.[381]
- Anyone with assets between £14,250 and £23,250 may be able to access some funding, depending on level of need.
- Anyone with assets below £14,250 are able to access full funding, depending on level of need, but may nonetheless have to contribute from their income where a care package doesn't fully meet a person's wants or needs (e.g. top ups for care homes).
- A person with more means than the upper threshold of £23,250 can ask their local authority to arrange support for them, but the local authority has no requirement to do so.

Any person meeting both the needs and means tests must be provided with a person-led care and support plan by the local authority. This includes a personal budget – an estimate of the total care costs that the local authority will fund, which can be delivered as follows[382]:

- A direct payment to the service user
- Service paid for and provided by the local authority · Funding from the local authority to the provider of choice
- A mix of all these options.

If a person does not meet the needs or financial threshold, local authorities are required to provide information and advice to the individual.

Proposed charging reforms to adult social care have been delayed until 2025. These included the introduction of a cap set at £86,000 on the amount anyone would spend on personal care over the course of their lifetime, an increase in the lower means test threshold to £20,000 and an increase to the upper means test threshold to £100,000.

Wales

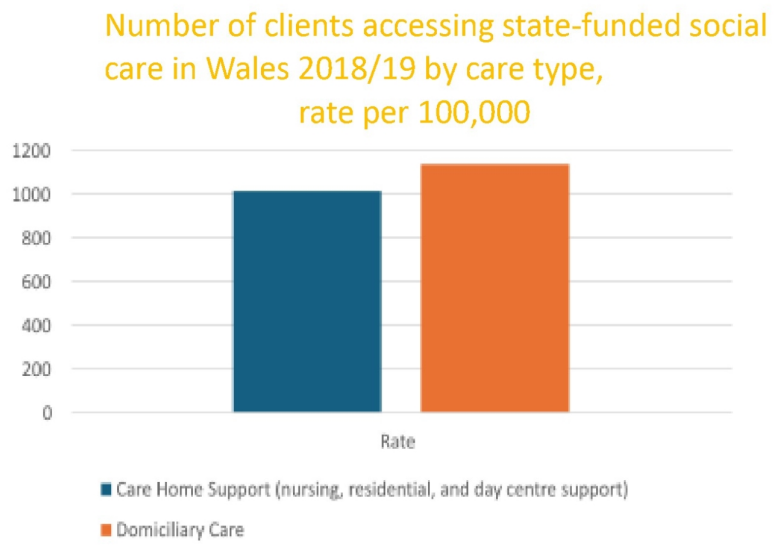


Figure 2. Number of clients state-funded care home support in a residential or nursing home or day centre, and domiciliary care in 2018/19, rate per 100,000.

Source: Nuffield Trust analysis of StatsWales – Social Services Activity, Wales (2018/19). Figures are number of adults receiving domiciliary care services – those services that assist individuals within their own home excluding reablement services. Care home support figures are a combined total of number of adults in receipt of day care support or living in residential and nursing care homes. ONS Mid-year population estimates (2019).

We do not have the most recent figures on the total number of people accessing state-funded social care in Wales, the most recent data are from 2018/19 and presented above in Figure 2. 1,011 per 100,000 people receive care either from nursing, residential or day centre services and 1,133 per 100,000 people receive domiciliary care (Figure 2).

Access to state-organised and funded care is determined both by a means test and a needs test. These are both carried out by a person's local authority and were revised under the Social Services and Wellbeing (Wales) Act 2014,[383] which is enshrined in co-production principles, among others. Any individual deemed to have some need for care is entitled to an assessment by their local authority, regardless of whether they are financially eligible.[384]

The implementation of the Act has been evaluated, and evidence suggests that the legislation has encouraged change and advanced local authority relationships with health, voluntary and independent sector.[385] [386]

National eligibility criteria were set out under the Care and Support (Eligibility) (Wales) Regulations 2015,[387] but it is recognised in statutory guidance that the "pattern of service delivery will vary from authority to authority".[388] As the Social Services and Wellbeing Act is a "people act", eligibility conditions apply to adults, children and their carers. There are four conditions to be met, which are:

- The person's needs arise from circumstances in the eligibility regulations, for example around physical or mental ill health
- The needs of the person relate to one or more of those listed in the Act[389]
- The person is unable to meet that need alone (regardless of whether they are receiving help from a carer or the community)
- The person is unlikely to achieve one or more of their personal outcomes without support from the local authority.

If a person does not meet the needs threshold, local authorities are required to provide information and advice to the individual.

Any person meeting the needs threshold must be provided with a care and support plan developed in partnership with the individual, which reports the outcomes, actions and needs identified and the resources that will be given to support these. Care and support plans also include details of the needs (some or all) to be met with direct payments, and how frequently these will be paid out. It is compulsory for local authorities to offer direct payments to older people who meet the necessary criteria.[390]

For those meeting the needs threshold, the second part of the eligibility process involves a means test. The process is different depending on the setting in which care is delivered.[391] In residential care, the process is as follows:

- For anyone of any age with means (which includes income, assets and savings, including the value of their home) in excess of £50,000, there is no state support and nearly all costs of care fall entirely on the individual.[392] A person with more means than the threshold of £50,000 can require the local authority to arrange support for them, and the local authority has a duty to do so.
- Anyone with assets below £50,000 will be able to access full funding support from the state, the level of which is set out in the care and support plan.[393] The raised threshold was announced in April 2019, from £40,000[394], meaning more people are now entitled to state support. Local authorities have discretion to disregard some sources of income as long as this is applied consistently within their

jurisdiction. Individuals in receipt of state funding may nonetheless have to contribute from their income.

- There is no cap on costs in residential care.

Non-residential care costs (i.e. costs within an individual's home and the community) are capped at a national maximum £100 per week for all individuals, regardless of their means and how much care and support services they receive. Local authorities have discretion to provide these services for free, but none do so currently.[395] Local authorities can also choose to operate a lower cap, meaning individuals receiving non-residential services would pay less for their care.

The Interministerial Group on Paying for Social Care was re-established in 2021 to review options for widening access to social care[396]. Previous work from the Group has considered options including making personal care at home free, removing charges for all non-residential care, and introducing a fixed weekly cost towards residential care[397].

Estimates of the proportions of self-funders in Wales suggest these are much lower than in England, both in residential/nursing and domiciliary care (especially in the domiciliary care sector). Approximately 32% of people receiving residential or nursing care in Wales self-fund, while in domiciliary care this proportion is around 21%[398] (see 'How much care does each country fund?').

More details about the inequalities in access to services between local authority-funded individuals and self-funders are explained in 'What does the provider market look like across the four countries?'.

Scotland

Number of clients accessing state-funded care in Scotland 2020/21 by care type, rate per 100,000

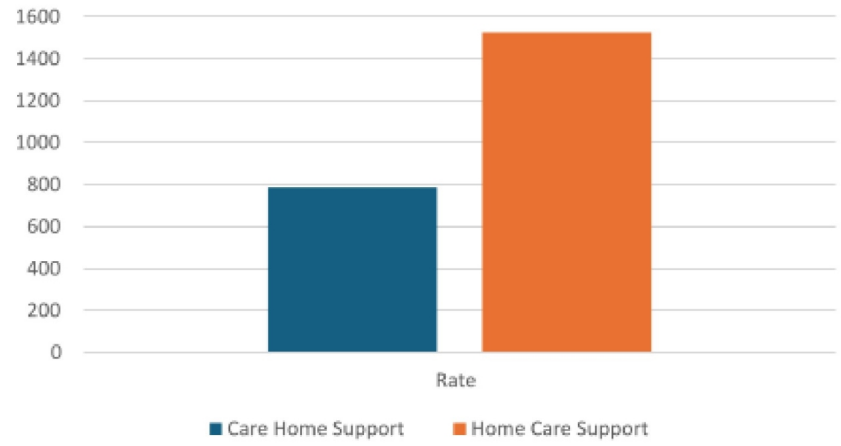


Figure 3. Number of clients accessing state-funded care in Scotland by those receiving care home and home care support in 2020/21, rate per 100,000.

Source: Nuffield Trust analysis of ISD Scotland – Insights into Social Care in Scotland (2020/21), ONS Mid-year population estimates (2021). Figures are adults receiving home care and number of care home residents (all length of stays).

This chart presents the number of clients accessing state-funded care in Scotland. 1,032 per 100,000 people receive care home support and 1,528 per 100,000 receive domiciliary support in Scotland.

Local authorities are currently responsible for the assessment of a person's eligibility for social care under the National Eligibility Criteria[399] – eligibility was previously regional. These were developed between the Scottish government and the Convention of Scottish Local Authorities in 2009.[400] The eligibility assessment follows a two-stage process: assessing a person's needs and personal outcomes[401], and assessing whether achieving these outcomes require services to be put in place. The National Eligibility Framework sets out four levels of need: critical, substantial, moderate or low risk. Local authorities have discretion to set the level of need at which services are delivered.[402]

Any person meeting the needs threshold must be provided with a self-directed support plan[403] , which provides an estimate of the total care costs the local authority will fund.[404] It can be delivered as follows[405]:

- A direct payment to the service user

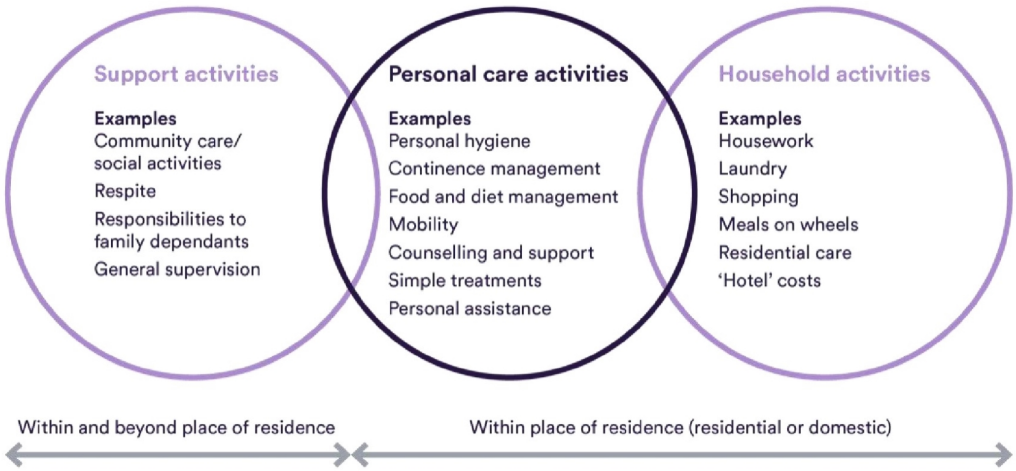
- Service paid for and provided by the local authority · Funding from the local authority to the provider of choice
- A mix of all these options.

If a person's self-directed support plan requires personal care, this is provided for free to all adults by the local authority and must be provided to individuals with a critical or substantial level of need within six weeks of the assessment outcome.[406] Personal care includes personal hygiene, continence management, food and diet management, assistance with mobility, counselling and support, simple treatments, and personal assistance.[407]

Individuals requiring personal care to be delivered within a care home setting receive a weekly payment of £212.85 [408], directly from the local authority to the care home to cover the costs of this care.[409] Until April 2019, personal care was only free to the over-65s – this has now been extended to all adults after an extensive campaign.[410]

For social care needs identified in the self-directed support plan that fall outside of personal and nursing care, a means test is applied[411]:

- For anyone of any age with means (which includes income, assets and savings) in excess of £29,750, there is no state support for social care activities that fall outside of personal and nursing care.
- Anyone with assets between £18,500 and £29,750 may be able to access some funding, depending on level of need.
- Anyone with assets below £18,500 are able to access full funding, depending on level of need, but may nonetheless have to make some contribution from their income.[412] (see 'How much care does each country fund?').



Source: Oung C, Hemmings N and Schlepper L (2019) "What might Labour's free personal care pledge actually mean?" Nuffield Trust.

More details about how self-funders and local authority-funded individuals experience different access to services will be discussed further in an upcoming explainer in the series on the provider market.

Northern Ireland

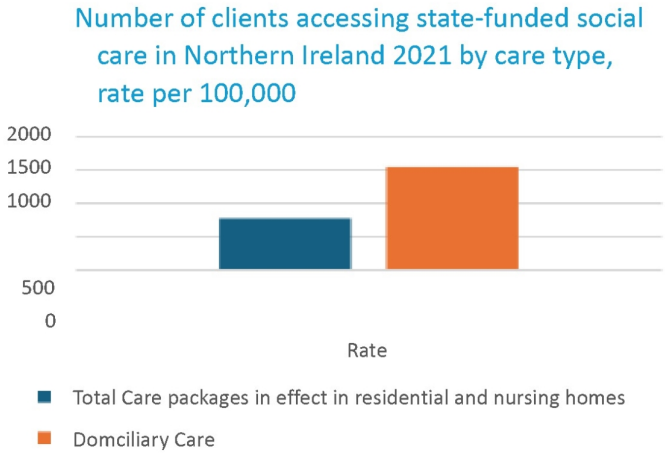


Figure 4. Number of clients accessing state-funded social care in Northern Ireland 2021, by those who are in receipt of a care package for residential and nursing homes, and those in receipt of domiciliary care, rate per 100,000.

Source: Nuffield Trust analysis of DoH – Statistics on Community Care for Adults in Northern Ireland (2021). ONS Mid-year population estimates (2021). Community support estimates are the total number of care packages in effect. Domiciliary care figure is the number of clients receiving domiciliary care services.

In Northern Ireland, there are many more people who receive domiciliary care than care home support, see Figure 4, this may be due to the fact that domiciliary care is essentially free. 1,560 per 100,000 people access domiciliary care compared to 1,011 per 100,000 who are in receipt of a care packages for nursing and residential accommodation.

Access to state-funded care is determined both by a means test and a needs test. Any person in need of care and support is entitled to a health and social care needs assessment (under the Northern Ireland Single Assessment Tool[413]) by their health and social care trust[414] regardless of their financial eligibility. The assessment covers both health and social care needs due to the integrated nature of the system.[415] This is undertaken by all practitioners involved in the care of an individual.[416]

For individuals who are assessed as having a predominantly social care need (as opposed to a health predominant need – see 'Other types of support'), the second part of the eligibility process involves a means test[417]:

- For anyone of any age with means (includes income, assets and savings) in excess of £23,250, there is no state support available for care and costs fall entirely on the individual.
- Anyone with assets (as above) between £14,250 and £23,250 may be able to access some funding, depending on level of need.
- Anyone with assets (as above) below £14,250, are able to access full funding, depending on level of need, and will nonetheless have to contribute from their income.

Any person meeting the needs test and the means test must be provided with a self-directed support plan, which is being rolled out across trusts in a phased approach.[418] This includes a personal budget that estimates the total cost of social care activities to meet 'individual outcomes', and can be delivered as follows:

- A direct payment to the service user[419]
- A managed budget held by the trust but controlled by the service user
- Support organised by the trust
- A mix of all these options.

All individuals who qualify for social care support in the home are entitled to free domiciliary care[420] [421], which covers most personal care and domestic services[422] except usually meals on wheels[423]. It is widely understood that health and social care trusts have the power to charge for domiciliary care but normally choose not to do so.[424] Stakeholders in Northern Ireland suggest this is unlikely to change in the near future. Although the service is provided for free, most recent data on domiciliary care provision[425] highlighted that over 30% of domiciliary care visits lasted 15 minutes or less, and over 43% of service users received a visit lasting 15 minutes or less.

More details about the inequalities of access to services between self-funders and local authority-funded individuals will be discussed further in an upcoming explainer in the series on the provider market.

Overview of preparation and publication

81. The chart included in the 2020 explainer was updated for this 2023 explainer. Similar challenges, as noted in the previous 2020 explainer, were encountered when estimating the number of adults receiving publicly funded social care, particularly due to variations in the definitions of services within each data source. Moreover, due to differences in the latest year of available data for each nation, direct comparisons could not be made. Therefore, charts for each nation on the number of adults receiving publicly funded social care were presented separately.
82. In England, the latest data from 2021/22 includes estimates of the number of people accessing publicly funded adult social care, covering both short-term supports to maximise independence and long-term support. For Wales, the most recent data was from 2018/19, detailing the number of clients receiving state-funded care in residential or nursing homes, day centres, and those receiving domiciliary care. Scotland's latest data, from 2020/21, provides information on clients accessing state-funded care, including care home and home care support. Finally in Northern Ireland, the latest available data, at time of writing, from 2021 included the number of clients receiving care packages for residential and nursing homes, as well as domiciliary care. ONS mid-year estimates were used for the corresponding year's data in each nation. The reference data are listed in the table in Appendix A.
83. The information presented in the updated explainer draws from similar sources to the 2020 version described above, with additional information derived from research reports and consultation documents.

84. **Explainer V: "What steps are currently being taken to reform social care?" (2023)**

Text of explainer

- Although the social care systems of each UK country are becoming increasingly different, each is experiencing significant challenges with their systems.
- All four countries have recently embarked on reform programmes to address shared issues around access, accountability, market stability and the social care workforce.

- Successfully embedding reform has proven a challenge across the UK, with financial pressures threatening current reform initiatives.

England

England's White Paper for reform, *People at the Heart of Care*, [426] was published in December 2021. It set out the government's vision for social care over the next 10 years as well as its plans for investment into the sector. This included £1.7 billion allocated to social care improvements up to 2024/25, which allocated £500 million for workforce support and training, £300 million for housing, £150 million for technology and digitisation, £70 million to support local authorities to commission and deliver social care and £25 million to support unpaid carers.

The proposed reforms also introduced a cap on individuals' lifetime care costs, set at £86,000 and an extension of the upper means test (known as the 'floor') from £23,250 to £100,000. Proposals also included plans to end the cross-subsidy often paid by people who fund their own care, by encouraging councils to pay higher fees to providers (known as the fair cost of care [427]). These changes were due to be implemented in October 2023, although some stakeholders had raised concerns that the funding and time given to implement these were insufficient.[428]

The Autumn Statement in October 2022 announced a delay to the introduction of the cap and means test extension to 2025, which had been in recognition of the significant financial pressures currently faced by local authorities[429]. This funding was repurposed in the form of a ringfenced fund intended to enable local authorities to make tangible improvements to adult social care, in particular to address discharge delays, waiting times, low fee rates and workforce pressures.[430] The Autumn Statement also announced additional funding for social care discharge. However, stakeholders, including the Lords Social Care Committee have raised concerns that the funding made available may allow the sector to keep pace with inflation but will not be enough to improve or increase the level of care.[431]

Wales

In January 2021, Wales consulted on proposals to improve social care arrangements and strengthen partnership working in its White Paper for reform *Rebalancing care and support*.[432] It set out plans for reform around three key areas: rebalancing the market for care provision, improving commissioning practices, and evolving integration with healthcare partners. In October 2021, the introduction of a strategic National Framework for care and

support was announced, alongside the establishment of a National Office within Welsh Government to oversee its implementation.[433]

The Welsh Government and Plaid Cymru have committed to delivering an implementation plan for a National Care Service, free at the point of need, by the end of 2023.[434] In November 2022, the Expert Group on the National Care Service published its recommendations for the development of the implementation plan.[435]

Scotland

The Independent Review of Adult Social Care published its report on how to reform Scottish social care in February 2021[436], which was followed by Scottish government's own consultation analysis in February 2022.[437] In June 2022, primary legislation to create a National Care Service was published.[438] The legislation sets out that responsibility for social care will be shifted from local government to Scottish Ministers by 2026.[439] At a local level, care boards will replace the existing integration authorities to shape social care in line with the vision set by the National Care Service.

However, several cross-party committees, including the Education, Children and Young People Committee[440] and the Finance and Public Administration Committee[441] have both expressed discontent with the limited cost information currently available to assess the potential impact of implementing a National Care Service. Councils have also called on Scottish Ministers to delay its plans given current inflationary pressures (at the time of writing).[442]

Northern Ireland

The Department of Health in Northern Ireland published a consultation document, *Reform of Adult Social Care in Northern Ireland*,[443] in January 2022. The consultation included a number of proposals to implement recommendations of the Power to People report published by the Expert Advisory Panel on Adult Care and Support in December 2017.[444] The Department of Health are currently analysing responses and progressing the development of social care reform.

However, the collapse of power sharing in October 2022 has left Northern Irish policymaking in an executive deadlock. At the time of writing, a power sharing agreement has not been reached.[445] Legislation to take forward the implementation of social care reform is likely to be more difficult until power sharing is restored in Northern Ireland.

Overview of preparation and publication

85. As in the 2020 edition, no statistical data are presented in this explainer, as it sets out policy developments in reforming social care. However, the information presented in this explainer has changed significantly and has been rewritten since its original publication. This is because in the last three years since the publication of the 2020 explainers, each of the UK countries have amended or put forward new plans for social care. These reflect changes in government, changes in expectation, disruption caused by Covid-19, and a lack of financial commitment among other reasons. The information provided in this explainer is primarily derived from the policy and consultation papers presented by each country around reform, research reports, and news stories.

86. **Explainer VI: "What are carers in each of the four UK countries entitled to?" (2023)** *Text of explainer*

Key points:

- In each of the four UK countries there is a strong and heavy reliance on informal carers. Figures from the census in 2021 estimate informal carers across the UK to be in the region of five million.
- Carers in each UK country are eligible for assessments by their local authority or health and social care trust. Eligible individuals are entitled to a support plan.
- Different initiatives have been undertaken to support carers and their wellbeing. Of note is Scotland's Carers Allowance Supplement, which brings Carers' Allowance in line with Jobseekers' Allowance.

	England	Wales	Scotland	N. Ireland
Estimated numbers of carers (2021)*	4,678,260[446]	310,742[447]	[census figures as yet unpublished] 696,000[448]**	222,213[449]
Proportion of				

population	9%	11%	13%**	12%
Carers in legislation	Care Act 2014 Carers Action Plan 2018	Social Services and Wellbeing Act 2014	Carers Act 2016	Carers and Direct Payments Act 2002
Legal definition	'An adult who provides or intends to provide care for another adult'	'A person who provides care or intends to provide care for an adult or disabled child'	'An individual who provides or intends to provide care for another individual, the cared-for person'	No legislated definition
Legal entitlements	LA duty to provide an assessment and the required services that fall under national eligibility criteria	LA general duty to promote wellbeing of people in need and their carers, under national eligibility criteria	LA duty to provide support to carers under local eligibility criteria Specific adult carers support plan Requirement for LAs to have information/advice services for carers	HSCT duty to provide assessment, but HSCTs retain discretion whether or not to provide support

* Figures for England, Wales and Northern Ireland reported here are taken from the UK Census (2021)[450] and are the most recent comparable and accurate resource. Unpaid carers are counted as aged five and over. Figures for unpaid carers aged 16 and over are also available for Northern Ireland.

** Scottish census 2021 figures have not been published at time of writing. Most recent figures published by the Scottish government are derived from the Scottish Health Survey and cannot be directly compared with figures for the other UK countries. The Scottish Health Survey is calculated by applying the percentage estimate of carers from 2017-2021 to 2021 mid-year estimates. The Scottish government considers figures from the Scottish Health Survey to be a more accurate representation of people providing low levels of care due to census data collection being at household level (rather than individual level). Unpaid carers are counted as aged four and over.[451]

A fall in the number of unpaid carers

Across the UK as a whole, there has been a fall in the number of unpaid carers. The fall in numbers has come as a surprise to many[452] as other evidence suggests that the number of unpaid carers increased during the Covid-19 pandemic.[453] There has, however, been an increase in the number of people providing care for more hours in the week in Wales and Northern Ireland. In Wales, the majority of people providing care provided 50 or more hours of unpaid care, which is different to England where the majority of unpaid carers provided nine hours or less.[454] Moreover, a greater proportion of people provided unpaid care in Wales compared to England, at 10.5% and 8.9% respectively.[455] In Northern Ireland, the number of people providing 50 or more hours of unpaid care each week has increased to 68,700, up from 56,300 people in 2011.[456] 63% of adult unpaid carers in Scotland provide 50 or more hours a week.[457]

England

The Care Act (2014)[458] provided a new definition of a carer ("an adult who provides or intends to provide care for another adult"), and established duties for Local Authorities to provide an assessment and support to eligible needs.

As such, individuals providing informal care are entitled to a carer's assessment by the local authority to determine how to support the carer's needs and whether their role is sustainable in the long term. Carer entitlement is subject to national eligibility criteria if the local authority believes the carer has needs[459]:

- Arising from the care and support provided to another individual
- The carer is unable to achieve some of the outcomes listed in the Eligibility Regulations or is at a risk of their physical or mental health deteriorating
- The carer's wellbeing is affected as a result of this.

Carers are also entitled to a Carer's Allowance if they care for someone at least 35 hours a week, which is administered by the Department for Work and Pensions. This is set at £69.70 a week (2022).[460] While there have been calls to increase the Carer's Allowance in line with Jobseekers' Allowance (see Scotland), it seems unlikely this will happen in the near future. England has provided limited support to withstand the financial impacts of the cost-ofliving crisis.[461] Claimants of Carer's Allowance will not receive the £650 one-off payment to aid with

the cost of living crisis - this is reserved to those who receive universal credit, tax credits and income support.

With strains on formal provision of care and a growth in need,[462] the number of people in receipt of the Carer's Allowance is rising.[463] Surveys of carers suggest that their welfare is decreasing as their workload becomes greater and their access to local support is reduced.[464] The Department for Health and Social Care reports that some progress has been achieved against areas outlined in the 2020 Carers Action plan with improvements to support unpaid carers in employment, and better identification of unpaid carers by health and social care services.[465] However, Nuffield Trust research[466] finds that support for unpaid carers in England has in fact diminished over time. Constraints on budgets and funding pressures, in addition to a lack of accountability and agreement on who is responsible for policy success and failure are cited as some exploratory factors.

The government's *People at the Heart of Care White Paper* outlined some new policies to support unpaid carers, including up to £25 million to work with the sector to kickstart a change in the services provided to unpaid carers; and a new obligation for integrated care boards (ICBs) and NHS England to involve carers when commissioning care for the person they care for.[467] The government-backed Carer's Leave Bill is passing through parliament in 2023, and if successful will entitle eligible employees who currently provide care to dependent family members up to five days of unpaid leave.[468]

Wales

Similarly to England, the Social Services and Wellbeing Act 2014[469] provides a new definition of a carer ("a person who provides or intends to provide care for an adult or disabled child") and establishes duties to local authorities to provide support to carers on the same grounds as the person being cared for.[470]

As such, the local authority has a duty to assess any carer and the carer's ability and willingness to provide care and support to an individual. Any carer who meets the eligibility criteria (identical to the person in need of care and support, see' Offer and eligibility') must receive a support plan from the local authority. As the Carers Allowance is administered by the Department for Work and Pensions and is not devolved, rates of pay and eligibility criteria are identical to England meaning eligible carers can receive £69.70 per week (2022/23).

Stakeholders and citizens' reports such as Measuring the Mountain have highlighted some positive examples of collaboration between local authorities and carer support groups, in line

with the "values base" of the Social Services and Wellbeing Act.[471] However, Carers Wales reports that in 2018/19, up to 55% of carers had not received the appropriate information and support the Act legislates. 85% of respondents had also not received a carer's need assessment in the past year, despite demand. The number of informal carers has been growing rapidly, with Wales having the highest proportion of young carers in the UK.[472]

The *Strategy for unpaid carers: delivery plan 202*1 published in November 2021 outlined four priorities: identifying and valuing unpaid carers; providing information, advice and assistance to carers, supporting life alongside caring, and supporting unpaid carers in education and the workplace.[473]

In addition, £7 million funding was announced in November 2021 with £5.5 million allocated to local authorities to provide targeted support to unpaid carers and £1.25 million for the Carers Support Fund.[474] To deal with the cost-of-living crisis unfolding in 2022, Wales has invested £29 million to give 57,000 unpaid carers a one-off payment of £500 to help deal with costs and to recognise the "pivotal role" they have played during the pandemic.[475] Carers can also apply for grants up to £300 to pay for food, household items and electronic items.[476] Scotland

In Scotland unpaid carers[477] are protected under carer-specific legislation. The Carers Act 2016,[478] which provides a definition of a carer, a young carer, and an adult carer (a carer is "an individual who provides or intends to provide care for another individual, the cared-for person").

As such, the Act establishes duties for local authorities and health and social care partnerships to provide support for carers under a self-directed support plan also specifically known as an Adult Carers' Support Plan.[479] Local authorities have discretion to set the level of eligibility at which carers can receive support under a self-directed support plan, which in practice means there are different access thresholds (although most are set at a "substantial" need for support).

Despite this active recognition of the role of informal care in supporting service users, Carers Scotland[480] reported in 2019 that implementation of the Carers Act has varied across Scottish regions, and many carers have struggled under financial pressure. The report also acknowledges the skew towards older and female carers, which stakeholders suggest could be the result of societal expectations.

An implementation plan for the Carers Act 2016 was published in 2021, and set out six key priorities over 2021-2023. These are strategy and leadership, legislation and guidance, workforce and systems support and development, raising awareness, carer involvement and choice, and measuring progress and impact.[481]

To recognise carers' contributions to the care of individuals and to the wider economy, the Scottish government introduced the Carer's Allowance Supplement in 2018 to align the Carer's Allowance (currently of £69.70 per week (2022/23)) and aligned with the Department for Work and Pensions) with Jobseeker's Allowance (see Welfare Benefits for more detail).

The Carer's Allowance Supplement is of £245.70 (2022).[482] In February 2022, 81,059 people were eligible for the Carer's Allowance Supplement.[483] Scotland has also developed a Young Carer Grant which delivers an additional payment of £300 yearly to carers aged 16-18, which can be spent as the carer chooses.[484] In 2022, Scotland consulted on plans to introduce Scottish Carer's Assistance to replace the Carer's Allowance as part of its wider work to devolve benefits.[485]

Scotland also operates a Short Breaks Fund that provides grants to third-sector organisations that support unpaid carers in taking breaks from their caring role.[486] The Scottish government has allocated an extra £5 million for short breaks in the 2022/23 budget, on top of the annual
£3 million voluntary sector Short Breaks Fund.[487]

Northern Ireland

The Carer's Support and Needs Assessment[488] is a component of the Northern Ireland Single Assessment Tool (NISAT), but it can also be used as a standalone component of care.[489] Carers deemed eligible under the NISAT are entitled to a self-directed support plan. As with assessment for service users, the health and social care trust retains the right to determine whether an individual is eligible under the assessment.[490] Although benefits are devolved to the Department for Communities, carers are entitled to a Carer's Allowance of £69.70 per week (2022/23) per week, identical to the other UK countries and under the same eligibility criteria.[491]

It has been argued that legislation surrounding carers in Northern Ireland is outdated[492], with the most recent legislation, the Carers and Direct Payments Act, dating back to 2002.[493] This provides no legislated definition of a carer. More recent policy papers, such as Transforming Your Care in 2013,[494] have recognised the need for carers to be included in strategic implementation plans and to have an increased uptake of the Carers Assessment. Power to

People[495] in 2017 included specific proposals for reform of carer support, with an alignment with the English Care Act[496] as a minimum.

Stakeholders reported a very strong tradition of caring in Northern Ireland, with the majority being women[497], although this is felt to be changing. The heavy reliance on informal carers suggests this move away from traditional caring responsibilities could have impacts on the sustainability of the social care system. As with the other countries of the UK, concerns were raised about the health and wellbeing of carers, along with financial hardship.[498]

In 2020, a new ID card was launched to improve recognition and support of carers in Northern Ireland.[499] These give carers greater access to food, medicine and other supplied that they need to support the person they care for.

In April 2021, the Support for Carers Fund was announced totalling £4.4 million.[500] Additional grants have been announced in grants since, including a further £1 million in March 2022[501], an additional £900,000 in August 2022.[502]

Overview of preparation and publication

87. The single table showing estimates of carers was updated for the 2023 explainer using the ONS 2021 Census data for England, Wales and Northern Ireland, considered the most accurate and comparable source. Scotland's estimates were taken from the Scottish Health Survey 2021. Scottish Census 2021 figures were not published at the time of writing; hence, we decided to use estimates from the Scottish Health Survey.

    This means they cannot be directly compared with figures from the other UK countries. Relevant data is referenced in Appendix A.

88. The Scottish Health Survey calculates estimates of carers by applying the percentage of carers from 2017-2021 to 2021 mid-year population estimates. The Scottish Government considers figures from the Scottish Health Survey to be a more accurate representation of people providing low levels of care due to census data collection being at the household level (rather than the individual level). Unpaid carers are counted as aged four and over. We included these caveats in the table.
89. No amendments to this table have been made since publication on 16/02/2023. Supplementary information presented in this explainer is drawn from similar sources to the 2020 version, with additional updates from government publications and research reports.

90. The Inquiry Module 6 team have requested a summary of the reasons for the fall in the number of unpaid carers. The most recent census data from 2021 indicated a fall in the number of unpaid carers since the previous census in 2011 from 5.8 million to 5 million (or from 11% to 9% of the population of the UK). This was unexpected as the perception among stakeholders in social care was that the responsibility for caring is increasingly falling on unpaid carers. In our analysis of the census data (Exhibit NC/10a - INQ000574186), we observed that, while there had been a fall in the overall number of carers, there had been an increase of 152,000 in the number of carers proving 50 or more hours of care per week. Analysis of local data also highlighted that the increase in carers providing high levels of care was concentrated in more deprived areas suggesting that there may be local variation underlying the overall trend. Further analysis by the Health Foundation (Exhibit NC/10b - INQ000574187) suggested that the fall in carer numbers could be attributed to a number of factors: it could mean that more people are going without support; that following the high mortality rate among people likely to be reliant on unpaid carers, fewer people needed care; or simply that many people do not identify as a carer. Changes to the wording of the census question could be a further factor. It is worth noting that other surveys, such as Understanding Society, the Health Survey for England and the General Practice Patient Survey all report higher numbers of unpaid carers than the latest census.

91. **Explainer VII: "What does the social care workforce look like across the four countries?" (2023)**

Text of explainer Key points:

- In each of the UK countries the social care workforce represents a large proportion of employment. In England alone, most recent figures estimate up to 1.6 million people are employed in the sector.
- However, there are shared challenges around recruitment and retention of the workforce, linked to poor pay and conditions and perceptions of attractiveness of the sector.
- England is the only country that does not have a non-departmental public body which is responsible for the regulation and registration of its workforce. In the other UK countries, all social care workers must sit on a register, and in Scotland and Wales, a

qualification is necessary to work in social care. There is early evidence that this is having a positive impact on retention and perceptions of the workforce.

Data on the numbers of people employed in adult social care services are collected by each of the nation's workforce regulatory bodies in the case of Wales, Scotland and Northern Ireland and by the Skills for Care (the workforce development and planning body) in England. A crosscountry comparison is difficult as each country categorises staff type differently and not all countries clearly disaggregate between adult and children's social care. Moreover, each country uses different approaches to measure social care employment, for example Northern Ireland uses live registration numbers while Wales, Scotland and England use snapshot estimates derived from surveys, which can make it difficult to have an accurate estimate of the total number of people employed in social care. To produce figures that are as comparable as possible we've had to use broad categories of employment, for example including central and strategic staff in the total despite this staff group not being disaggregated by adult and children's social care. The figures below should be interpreted with these limitations in mind. For further information on how we have estimated these figures, see the data notes at the end of text.

The information below was true at time of publication in February 2023. Please note further policy developments may have occurred since then.

	England	Wales	Scotland	N. Ireland
Number of people employed in adult social care Including central and strategic staff.	1,500,000 (Skills for Care, 2022)[503]	62,627 (Social Care Wales, 2022)[504]	140,160 Scottish Social Services Council, 2022)[505]	37,077* (Northern Ireland Social Care Council, 2023)[506]

Workforce Organisation/Workforce Regulator	Workforce development is overseen by Skills for Care (Delivery partner)[507]	Social Care Wales (Workforce Regulator)	Scottish Social Services Council (Workforce Regulator)	Northern Ireland Social Care Council (Workforce Regulator)
Set Up	2001	2017 (Previously Care Council Wales, set up 2001)	2001	2001
Type	Charity/Delivery Partner	Non-Departmental Public Body	Non-Departmental Public Body	Non-Departmental Public Body
Registration	N/A	Mandatory and qualificationsled	Mandatory and qualificationsled	Mandatory and not qualificationsled but intend to introduce

**The number here is the estimated number of people who are registered with the Northern Ireland Social Care Council who work in adult social care. As this is registrant data, it will likely be greater than the actual number of people who are currently working in adult social care.*

All four nations of the UK share similar challenges around the workforce. Workforce conditions are poor, with many on zero-hour contracts and earning close to the minimum wage (although the proportion of workers on zero hours contracts varies across the nations).[508] In addition, there is little opportunity for continued professional development. Therefore, the sector experiences high turnover due to low levels of recruitment and retention.[509] There are as such high levels of vacancy, and we have previously calculated that to provide care for people over 50 with high unmet needs in England alone would require up to 90,000 additional workers.[510] This figure is much higher when adults of all ages and needs levels are factored in.

Proposals for greater international recruitment of social care staff have been made by the government[511], although questions remain over how migration can be facilitated in a sustainable way. Following recommendations made by the Migration Advisory Committee (MAC) in December 2021, the government made care workers eligible for the Health and Care Worker visa. They must, however, earn at least £20,480 per year or £10.10 per hour to qualify (it is set at £13,520 for senior care workers).[512]

In December 2022, MAC raised concerns over the level at which this salary is set and whether the salary threshold may perpetuate the underlying issue of low wages in the sector.[513] A broader strategic and whole-system approach is required should international recruitment become a mainstay for the adult social care workforce.[514]

England

Skills for Care[515] came into being in 2001 and is the delivery partner to the Department of Health and Social Care for the development of the social care workforce in England. Skills for Care acts as the main source of knowledge of the workforce, and collects comprehensive data in the Adult Social Care Workforce Dataset as well as publishing yearly reports.[516]

Most recent figures published by Skills for Care in 2022 estimate the total regulated adult social care workforce at 1.50 million people (1.62 million filled posts).[517] However, there are significant challenges with the recruitment and retention of people working in social care. On average in 2020/21, there were around 105,000 vacancies across England on any one day. Turnover was around 34.4%.[518] The Resolution Foundation estimates that 61% of the care workforce in England were paid below the real Living Wage between 2017-2019.[519] This is a particular issue in domiciliary care where travel time and fuel costs often reduce actual take home pay to below the statutory minimum wage.[520]

England is the only country in the UK for which there is no professional body which is mandated by – and accountable to – government, that is responsible for the regulation of social care workers. Stakeholders have suggested this has hindered the development of a strong professional identity underpinned by shared improved status, standards and qualifications (i.e. professionalisation).[17] The absence of a professional body and associated register makes having an accurate picture of the workforce more difficult.

There is a growing interest in professionalisation as a solution to the workforce shortages that England faces.[521] The rationale is that developing a strong professional identity for social care workers, facilitated by registration and adherence to common professional standards, would make the sector more attractive to new entrants as well as encouraging workers to

stay within the sector by offering more opportunities for career progression in social care. However, there is to date a limited evidence base on the effect of professionalisation on retention and recruitment levels.[522] Beyond this, one of the biggest challenges with the professionalisation of the English social care workforce is its size, as well as the vast number of settings in which the workforce operates. Developing mandatory registration as a first formal step in professionalising the workforce would require large amounts of planning and resources, especially if registration is to increase the attractiveness of working in the sector.

As part of plans to reform the adult social care sector announced in December 2021, the government has committed an investment of at least £500 million into workforce development and wellbeing initiatives up to 2024/25.[523] This has been supplemented with a number of shortterm funding injections:

- £162.5 million was allocated in September 2021 via the Workforce Recruitment and Retention Fund to support local authorities which operated between October 2021 and March 2022.[524]
- An additional £300 million was announced in November 2021 to address workforce capacity pressures over winter 21/22.[525]
- Up to £15 million of funding to support international recruitment was announced in September 2022 for Winter 22/23. [526]

The Department of Health and Social Care has published its findings on the impact Workforce Recruitment and Retention Fund on staff recruitment and retention.[527] The additional funding has been perceived by local authorities to help keep staff in employment and address capacity issues. However, the short timeframe over which the fund was administered has limited the extent to which improvements have been embedded long-term.

Wales

Social Care Wales[528] came into being in 2017 (as a continuation of the previous Care Council for Wales) and was set up under the Regulation and Inspection of Social Care Act (Wales) (2016)[529] in line with the Social Services and Wellbeing Act of 2014.[530] As such, Social Care Wales acts as a Welsh Government Sponsored Body, a non-departmental public body that is legislated, funded, and accountable to the National Assembly for Wales. It has three main functions around workforce regulation, workforce development and service improvement.[531] A ten-year workforce strategy for health and social care was published by Social Care Wales and Health Education and Improvement Wales in October 2020.[532]

Social Care Wales is in the process of implementing a mandatory qualifications-based register with continuous professional development schemes, under which all registrants must demonstrate compliance with Fitness to Practise.[533] Stakeholders have suggested this has formalised the need for more structured information.

Social Care Wales acts as the main source of knowledge for the workforce and publishes workforce reports including workforce profiles for Commissioned Care Provider Services and Local Authority Regulatory Services. Social Care Wales estimates that there were 62,627 people working in adult social care in Wales in 2022.[534] This includes 29,100 in staff employed in adult residential care providers, and 19,571 staff employed by domiciliary care providers.[535]

As in England, Wales experiences challenges with the recruitment and retention of its staff working in social care. 56% of care staff in Wales earned less than the Real Living Wage between 2017-2019.[536] In December 2022, the Welsh government announced an estimated £70 million to local authorities and health boards to implement the real living wage uplift - to £10.90 an hour.[537] Employees will see this benefit in June 2023. This is considered to be a significant step to improving working conditions and esteem for the social care sector.

Social Care Wales estimates that there were 5,323 posts vacant or held in 2022, representing 9% of the workforce.[538] They also estimate that 61.4% of these vacancies are in commissioned care providers, while 38.6% are in local-authority owned providers.[539] To date, there has been limited evidence of the impact of registration activities on professionalization efforts and whether it has enabled a greater recruitment and retention of the workforce. Some concerns have been raised that the need to undertake a qualification in order to be a social care worker could act as a disincentive for individuals, especially for those who only work a few hours a week.[540] A further complexity is where staff work across the English/Welsh border and are therefore subject to two separate legislations.

Scotland

The Scottish Social Services Council (SSSC)[541] came into being in 2001 under the Regulation of Care (Scotland) Act.[542] As such, the SSSC acts as a non-departmental public body that is legislated for, funded by, and accountable to the Scottish Parliament. Its main functions are around registration and regulation of workers, development, and ensuring Fitness to
Practise.[543]

Registration is mandatory, and qualifications-led, making it an offence to exercise social care work without being on the register. Applicants can sit on the register before acquiring their qualifications (Registration with condition).[544] Registration started shortly after the Regulation of Care Act in 2001,[545] with the aim of developing a strong professional identity that would be valued both by workers and service users[546] as well as strengthen the sector's skills base, and is still ongoing. Workers employed in domiciliary care services have been registered in their entirety since October 2020.[547] Stakeholders we spoke to for the development of this explainer reported that holding a mandatory register for almost 20 years had real benefits in terms of knowledge of workforce makeup, its movements, and for future planning.

The Scottish Social Services Council develops and publishes official and national statistics on the social services workforce and publishes yearly reports on Workforce Data.[548] These cover social care workers and social workers for both adults and children in receipt of services.

In 2022, there were approximately 140,160 staff employed in adult social care services, of which 74,620 were employed in housing support/care at home services and 51,040 are employed in care homes for adults.[549] While the number of staff employed in adult care homes has decreased since 2013 (-2.7%), the number of staff employed in housing support/care at home services has grown substantially (+20.0%).

As in England, Scotland experiences challenges with the recruitment and retention of its social care staff. In 2022, 76% of care homes for adults reported vacancies, the highest since Scottish Social Services Council began reporting this data in 2017.[550] Reasons most frequently reported by adult care homes and care at home providers for vacancies being hard to fill included too few applicants and competition from other service providers.[551]

In February 2022, the Scottish government announced pay for those providing direct social care to adults will rise to £10.50 per hour.[552] This will rise to the Real Living Wage of £10.90 in

2023/24, supported by an additional £100 million of government funding.[553]

Northern Ireland

The Northern Ireland Social Care Council (NISCC)[554] came into being in 2001 under the Health and Personal Social Services Act (Northern Ireland).[555] As such, the NISCC acts as a nondepartmental public body that is legislated for, funded by, and accountable to, the

Department of Health in Northern Ireland. Its main functions include the registration and regulation of social care workers, setting standards of conduct and practice, and supporting the learning and development of the workforce.[556]

Registration is mandatory but not qualifications-led, making it an offence to exercise social care work or call oneself a "social care worker" without being on the register (although the offence falls on the registered employer rather than employee).[557] At present, there are no plans to introduce mandatory qualifications. Being on the register is intended to demonstrate that a worker is compliant with the standards of conduct and practice, making them accountable for the quality of care they provide.[558] Stakeholders suggested introducing mandatory qualifications would help to raise the quality and status of the workforce, and it remains a long-term ambition.

The NISCC has completed the registration of the designated groups of social care workers, with the final group of domiciliary care workers registered in 2018. Northern Ireland is the first UK country to achieve complete registration of its domiciliary care workforce. It is also the first country to undertake an evaluation of its registration process[559], which finds that mandatory registration and adherence to Fitness to Practise standards has increased confidence among the workforce. Service users and workers have also reported a positive impact on the quality of care.

The register continues to grow year on year, supported by improvements to facilitate the registration and renewal process. Between March 2020 and March 2021, the register increased by 16%, a large proportion of which (40%) is due to the introduction of an Emergency Register to respond to the Covid-19 crisis in 2020.[560] In December 2023, there were 37,077 registrants on the NISCC register, of which 16,100 adult residential care workers, 14,750 domiciliary care workers, 3092 supported living workers, and 2426 day care workers.[561]

As in England, Northern Ireland experiences challenges with the recruitment and retention of its social care staff. Staff vacancies remain high. In September 2022, the vacancy rate for social workers was 10.5% and 12.6% for other social care staff.[562] Particular challenges to the country include raising the value and status of social care and determining the most effective models of delivery for social care, given the current lack of legislative change to the social care system. The implications of Brexit have also raised concerns around free movement of workers across the currently open border with the Republic of Ireland.

Overview of preparation and publication

92. The table on employment in adult social care, included in the original 2020 explainer, was updated for this explainer using data published between 2022-2023. The data was derived from the following organisations: England from the workforce development and planning body Skills for Care (2022), Wales from Social Care Wales (2022), Scotland from Scottish Social Services Council (2022), and Northern Ireland from the Northern Ireland Social Care Council (2023). Data on the numbers of people employed in adult social care services are collected by each of the country's workforce regulatory bodies in the case of Wales, Scotland and Northern Ireland and by the Skills for Care in England. A cross-country comparison is difficult as each country categorises staff type differently and not all countries clearly disaggregate between adult and children's social care.
93. Moreover, each country uses different approaches to measure social care employment, for example Northern Ireland uses live registration numbers while Wales, Scotland and England use snapshot estimates derived from standardised data returns from employers, which can make it difficult to have a comparable estimate of the total number of people employed in social care.
94. To produce figures that are as comparable as possible we used broad categories of employment, for example including central and strategic staff in the total despite this staff group not being disaggregated by adult and children's social care, and social work in the case of Scotland. Furthermore, registrant data published by Northern Ireland Social Care Council will likely be greater than the actual number of people who are currently working in adult social care as an individual may leave the sector but their registration may still be valid for a period. The figures in the explainer should be interpreted with these limitations in mind. For a full breakdown of the categories used to estimate number of employees in Adult social care, see the data table in Appendix A.
    - 94.1 England: This figure is the estimate of people employed in adult social care. This will be less than the number of filled posts as some people will be doing more than one job in adult social care.
    - 94.2 Wales: The sum of the categories: adult residential care, domiciliary care, day services, supported living, mental health residential care, central staff.
    - 94.3 Scotland: The sum of the categories: adult day care, adult placement services, care homes for adults, central and strategic staff, fieldwork services (adults), housing support / care at home.

94.4 Northern Ireland: The sum of registrants in categories: adult residential care, domiciliary care, supported living, day care, domiciliary care manager, residential home manager, day care centre manager.

95. Since publication on 16/02/2023, this table was amended on 16/10/2024 after conversations with colleagues at Scottish Social Services Council to clarify employment definitions and final figures.
96. Supplementary information presented in this explainer is drawn from similar sources to the 2020 version, with additional updates from government publications and research reports.

97. **Explainer VIII: "What does the provider market look like across the four countries?" (2023)**

Text of explainer

Key points:

- There are approximately 17,000 residential and nursing care homes across the UK (12,000 and 5,000 respectively)[563] and approximately 10,113 organisations providing domiciliary care.[564]
- The distribution between public, private, and voluntary providers, as well as their size, varies considerably across the four countries. England has the most privately owned providers.
- The four countries have shared issues around the stability of the market for care. Across the UK there is a high turnover of care providers, with many being forced to hand back contracts for services.
- Many providers across the UK have a mix of self-funded and state-funded service users. All report issues with 'cross-subsidisation', where self-funders are required to pay more for services than those receiving state funding.[565] A 2017 UK-wide study found that this could be as much as £200 more being paid by self-funders[566], though more up-to-date evidence is needed.
- In Wales and Scotland, inspection and regulation are undertaken by a dedicated regulator for social care and other social services. In contrast, the regulator in England and Northern Ireland also has responsibility for health.

<u>England</u>

Organisations providing social care services that fall within the Care Quality Commission's

(CQC) definition of regulated activities are required to register with the Care Quality Commission, which acts as a non-departmental public body for both the health and social care sector.[567] As of January 2023, there are 11,544 registered domiciliary care services and 14,970 residential and nursing care services registered with CQC.[568]
There had previously been no regulation of local authority in England like there is in Wales and Scotland. However, the Health and Social Care Act (2021) introduced a new duty for CQC to assess local authority performance from 2023/24.[569]

The Care Act 2014[570] set out a legal framework which mandates local authorities and their delivery partners to protect people who draw on social care from harm.[571] Through the development of Safeguarding Adult Boards, local authorities must, among other things, work with the CQC to investigate and address concerns of poor quality among organisations delivering care. The Care Act and the associated Market Oversight Regulations 2015[572] further set a legal duty on CQC to monitor the financial performance of large social care providers, and to warn and support local authorities where significant concerns are raised. Both duties on local authorities and the care regulator are intended to prevent large failures of care, financially and in terms of clinical quality.[573]

There are many issues facing providers in England. Providers cite the fact that the fees paid by local authorities are frequently lower than the actual costs of providing the care as a key reason for their financial struggles, and with local authority finance budgets tightening, this is becoming an increasing concern.[574]

It is common practice for providers of care to charge self-funders more in order to subsidise local authority-funded people for the same care. In 2022 across Great Britain, nursing care fees paid by self-funders were on average £1,329 per week, versus £658 per week paid by local authorities; and £983 per week for personal care for self-funders, versus £609 per week paid by local authorities.[575] More recent empirical evidence of this cross-subsidy is limited. However, the government plans to eradicate the cross-subsidy by requiring councils to pay providers higher fees for care – the fair cost of care policy – and are in the process of being implemented (see 'What steps are currently being taken to reform social care').

Moreover, the provider market in England is unstable, with a large turnover of providers exiting the market and fewer providers entering, and many providers are being forced to hand back contracts to local authorities.[576] The CQC State of Care Report 2021/22 echoed similar trends, but also noted that occupancy has been increasing (albeit below levels seen

during the pandemic).[577] Coupled with issues around workforce retention, the social care system is struggling to provide sufficient capacity to meet demand, with increasing levels of unmet need and a higher burden on informal carers as a result.[578]

In 2021, the Department for Health and Social Care announced the introduction of a Market Sustainability and Fair Cost of Care Fund. The fund was intended to redress issues with crosssubsidisation by supporting local authorities to move towards paying a fair fee for care, and to prepare the sector for the implementation of charging reform (now delayed – see 'What steps are currently being taken to reform social care?'). In February 2023, local authorities were required to publish cost of care exercises for their residential and nursing care markets (65+) and domiciliary care markets (18+), alongside Market Sustainability Plans in March 2023.[579]
2022/23 funding has been maintained for subsequent years and combined with the new Market Sustainability and Improvement Fund, through which local authorities are able to further move towards paying sustainable fee rates.[580]

Wales

Care Inspectorate Wales (CIW)[581] undertakes the registration and regulation of social (care) services in Wales, for both adults and children. In practice this means the agency also regulates services such as adoption or children's day care[582], but does not regulate health services unlike the CQC in England and the RQIA in Northern Ireland. It also has the responsibility to inspect local authorities against their provision of care services in line with the principles of the Social Services and Wellbeing Act.[583] [584]

Similarly to England, the Social Services and Wellbeing Act[585] creates a legal framework for local authorities to safeguard adults (and children) under the Safeguarding Boards. These are supplemented by the 2019 Wales Safeguarding Procedures.[586] The duties conferred to local authorities by these bills are intended to minimise the potential for social care service users to encounter harm in the receipt of their care.

Unlike in England, where the CQC provides a rating system of the care services it regulates, there is no such mechanism in the Welsh system for assessing variation in quality between providers. While the introduction of quality ratings had been planned for April 2022, this has now been delayed. Silent delays will be introduced from April 2023, and full published ratings

available from April 2024.[587] Most local authorities have reported shortages in care home placements, provision, and in nursing services.

As with the regulation of, workers, the regulation of providers is legislated and local authorities in the Regulation and Inspection of Social Care Act 2016 (see 'What does the social care workforce look like across the four countries?').[588] In January 2023, there were 1,017 adult care homes[589] and 689 supported living domiciliary care services registered with the CIW.[590] Evidence from Wales Fiscal Analysis in 2020 suggested that locally authority-run care homes accounted for fewer than 9% of the total number of care home places available in Wales.[591]

More recent evidence on the number of local-authority owned providers is limited.

While self-funders in Wales also cross-subsidise care for local authority-funded individuals as they do in England, there is limited recent evidence around the size of this cross-subsidy. In 2018, the average weekly cost of care in a residential care setting was comparatively lower than England, with a cost of around £490 per week for local authority-funded individuals, against £710 for self-funders.[592]

A National Commissioning Board has been set up to support the sector to commission care services with representation from the health and social care sectors, and provide a strategic vision and leadership at a national level.[593] The Rebalancing Care and Support White Paper also committed to implementing a National Framework for Care and Support with the establishment of a National Office to drive its progress.[594]

As in all four countries, providers in Wales are under significant financial pressure, but the care market is distinct to England in that small and single businesses make up to 75% of providers (compared to 80% in England, as of 2018).[595] These often reported upcoming retirement as another reason for closure.[596] 8% of residential care home providers are owned by large groups.[597] As such, most local authorities have reported shortages in care home placements, provision, and in nursing services.[598]

With the growth of increasingly complex health needs, local health boards are increasingly procuring services from social care providers.[599]The Welsh Government has recognised challenges with local authority commissioning of social care, due to downward pressures on council budgets and capacity as a result of austerity and a complex market.[600]

Scotland

The Care Inspectorate (CI)[601] is responsible for the registration and regulation of care providers in Scotland. It does not regulate healthcare services, unlike the CQC in England or the RQIA in Northern Ireland.[602] The Care Inspectorate also inspects local authorities, and their associated partnerships deliver care across local areas.[603] The register holds approximately 1,190 domiciliary care providers (reported as adult day care or care at home services) and 1,044 adult care home services, as at September 2022.[604] Most providers in Scotland are in the independent sector (including voluntary and private), and this is particularly the case for residential care among older people.[605] The voluntary sector provides the greatest number of services and employs the majority of the workforce in domiciliary care.

Social care users are protected against harm in the receipt of their care under the Adult Support and Protection Act 2007.[606] As in England, this means in practice that local authorities are legally obliged, with appropriate powers, to investigate reports of harm to service users in collaboration with the Care Inspectorate. This was being improved under the Adult Support and Protection Improvement Plan 2019-22.[607] These bills are intended, among other things, to reduce occurrences of failings of care.

The regulation and inspection of social care in Scotland is being reviewed under the Independent Review of Inspection, Scrutiny and Regulation (IRISR) due to report in summer 2023.[608] The review will also consider what regulatory changes will be required under the new
National Care Service.[609]

Stakeholders reported similar challenges to England around the instability of the provider market and the cost of cross-subsidisation to self-funders. Skills for Care and Development report that, in 2018, weekly cost of residential care for older people to average around £530 a week for local authority-funded individuals, against £760 a week for self-funders.[610]

To address some of these issues, the Convention of Scottish Local Authorities, Scottish Excel, the Coalition of Care and Support Providers and Scottish Care have attempted to model the costs of care to help local authorities more accurate prices for care home places under the National Care Home Contract.[611] This is a distinct feature of the Scottish system - the implementation of which has been recommended to the other UK countries by the

Competition and Markets Authority.[612] The Competition and Markets Authority also reports Integration Joint

Boards are developing models to meet needs of the short- to medium-term.[613]

From 2022-23, standard rates in the National Care Home Contract for publicly funded users are £832.10 a week for nursing care and £719.50 for residential care.[614,615] This includes a requirement for contracted providers to pay front-line care staff a minimum of £10.50 an hour and a minimum pay increase of 3% for registered nurses in line with Agenda for Change commitments.[616,617]

The sustainability of the market was noted by stakeholders as a pressing concern, for example with a reduction in the number of care home places available (in part due to the drive to support people to stay at home longer)[618] despite a growth in demand.[619] One of the reasons noted for this was the brevity of the commissioning cycle of only one year, making long-term planning of service delivery increasingly difficult.

Northern Ireland

The Regulation and Quality Improvement Authority (RQIA)[620] regulates both health and social care organisations in Northern Ireland, and requires all social care providers to be on a register.[621] As all responsibility for social care is held by Health and Social Care Trusts, local authorities do not fall under the remit of the RQIA like they do in Wales and Scotland. The register currently holds approximately 500 residential and nursing care providers, and 300 domiciliary care agencies, as at October 2022.[622]

Northern Ireland is the only UK country in which there is no adult safeguarding legislation[623] - it appears only in policy.[624] Recent reports from the Commissioner of Older People in Northern Ireland highlight the concern that Northern Ireland is lagging behind the other countries in its protection of adult social care users. It is argued that Health and Social Care Trusts should, like local authorities in England, Scotland, and Wales, have some legal powers and duties to investigate reports of harm to social care users. This comes in the wake of large scandals of care failings, for example at Dunmurry Manor, which has increased the salience of the issue among stakeholders and the public.[625]

Charging higher rates to self-funders to subsidise state-funded individuals appears to be common practice in Northern Ireland as well as the other countries. The cost of a week in residential care is approximately £450 for HSCT-funded individuals, against £660 for selffunders (2018 figures).[626]

Only 14% of domiciliary care visits lasted over 30 minutes, with 55% of visits between 15-30 minutes and 31% of visits under 15 minutes.[627] A pilot for a new model of domiciliary care is currently underway in South Eastern HSCT. This model aims to encourage greater integration between health and social care by giving providers responsibility for specific regions enabling them to respond and adapt to local needs.[628] If the pilot's evaluation delivers promising results, the Department hopes to expand this geographic model to a national level.[629] In 2021, 85% of residential, nursing, and supported living services were provided by the independent sector.

15% were provided by the statutory sector, this is highest in supported living settings.[630]

The regional Health and Social Care Board (HSCB) sets the fees for state-funded residents of care homes – if Health and Social Care Trusts are unable to offer a place in a care home which operates at the regional rate, they are obliged to pay a higher fee. In 2021/22, fees were as follows:

Residential care homes	£ per week, rounded, 2021/22
Elderly	610
People with learning disability	610
Nursing care homes	
People with learning disability	765
People with physical disability	822
People with learning disability	765
All other people	765

In 2021, the Department approved an uplift to the regional fee for domiciliary care to £18 per hour.[631]

It is felt the market is unsustainable and continues to be unstable as private providers face closures for financial or quality reasons, further complicated by an increase in complex cases requiring care home beds.[632]

Overview of preparation and publication

98. Statistical information in this explainer is limited to estimates of the number of providers in each country by type of care provided (i.e., residential, nursing care, and domiciliary care). As described for the 2020 explainer in section A, there were challenges in comparability between these estimates published by each devolved country's care regulators. The data referenced in our 2020 explainer had not been updated in time for the preparation of the 2023, so we replaced this information with more up-to-date estimate of the number of services from the care regulators of each country. This is referenced in the data table in Appendix A.
99. We also present the overall number of care organisations in residential and nursing care, and domiciliary care across the UK in the key points of this explainer. It is worth noting that some provider organisations operate several services, so the number of services for each individual country will be higher than the number of care provider organisations. The overall number of care organisations across the UK is derived from UK Homecare Association (now called the Homecare Association), which collects data on the number of domiciliary care agencies, and by carehome.co.uk for residential care and nursing homes across the UK.
100. Supplementary information presented in this explainer is drawn from similar sources to the 2020 version, with additional updates from government publications and research reports.

Additional reflections and outputs relevant to the 2023 explainers

101. Alongside the explainers, three Nuffield Trust comment pieces were published in early 2023, summarising wider learning derived from the analysis.
    101.1 'Social care reform across the UK: why does it keep failing?' (Exhibit NC/11 - INQ000553861). Summarises a history of shared challenges across the UK's four countries and an acknowledged need for reform that is repeatedly delayed. Reasons include financial uncertainty, a lack of political leadership and stability, and reform plans too narrowly focused on a narrow issue rather than taking a comprehensive and holistic approach.
    101.2 'Addressing social care workforce challenges: what can England learn from Wales, Scotland, and Northern Ireland?' (Exhibit NC/12 - INQ000553862). This concludes that UK countries share challenges with recruiting and retaining their care workforce, but England has lagged behind in terms of developing better support for staff. Scotland, Wales and Northern

Ireland all introduced one-off Covid-19 bonus payments between 2020 and 2022. In England this could have been done at the discretion of local authorities through their use of the Workforce Recruitment and Retention Fund. Having a mandatory register for care staff has led to some benefits in the devolved administration, for instance to identify staff in Wales in need of infection prevention and control training.

101.3 'Local or national: what role should the government play in social care?' (Exhibit NC/13 - INQ000553863). This describes how each of the UK countries are seeking to increase the role of national government through their reforms, whether through regulatory inspections in England and stricter rules on spending, setting aspirations and standards in Wales, regional oversight of commissioning in Wales, or the development of a National Care Service in Scotland that was intended to shift accountability to Scottish Ministers. National leadership can have a role for urgent crises such as Covid-19, but local flexibility to adapt to local circumstances is paramount.

102. We undertook two roundtables as part of our work on the UK countries' four social care systems in July 2022. One roundtable was focussed on the provider markets across the UK, while the other was focussed on the social care workforce in each of the UK countries. The information gathered at the roundtable contributed to the three comment pieces (Exhibits NC/11 - INQ000553861; NC/12 - INQ000553862; NC/13 - INQ000553863). We did not publish all the content gathered from the roundtable but some learning may be relevant to the inquiry so we summarise this learning in the following paragraphs (103 to 107).

103. Visibility: Social care lacks visibility and parity with the NHS across all four UK countries. While all four countries were preparing to undergo some level of reform, accelerated by the pandemic, stakeholders at our roundtables expressed concerns that political attention was lacking to address some of the more fundamental challenges that were exacerbated by the crisis.

103.1 The Scottish government published legislation in Summer 2022 for a National Care Service that intended to move accountability for social care from local authorities to central government. Some stakeholders thought this might put social care on a more equal footing with healthcare and increase its visibility. However, others were disappointed that there had not been sufficient learning from the pandemic to shift focus away from the acute hospital sector and felt social care remained the 'poor relation'.

103.2 Stakeholders in Wales felt the framework for delivery outlined in the Social Services and Wellbeing Act enabled more voice and control for people in commissioning decisions, and a drive across all actors to deliver the values set out in the act. However, implementation challenges have arisen due to workforce and funding pressures.

104. Accountability: Stakeholders suggested that moves to increase national oversight across all four countries may have been prompted by pandemic experience. The ways in which the UK's governments have sought to achieve this are outlined in Exhibit NC/13 - INQ000553863.

104.1 Stakeholders in England were critical of the policy-making process during the pandemic, particularly due to the lack of levers through which national government could provide support or incentivise behaviour among social care providers. For example, there were limited options to ensure sick pay funding to support self-isolating staff was indeed reaching them.

104.2 Stakeholders outlined concerns in Scotland of moving accountability from local to national government and creating an 'over-centralised' system that would have a limited impact on addressing the fundamental issues of the sector laid bare by the pandemic.

104.3 In Northern Ireland, stakeholders referred to the 'extraordinarily complicated landscape' of accountability – despite having a fully structurally integrated system – in which it is unclear where responsibility for social care lies.

105. Integration: Stakeholders from all four UK countries noted challenges with joint working between local authorities and the NHS, and the dominance of the NHS in policy.

106. Workforce: All four countries experienced challenges with their workforce exacerbated by the pandemic, noting burnout and cost-of-living as key reasons for exit.

106.1 All four UK countries brought in compensation for sick pay for social care staff. Stakeholders noted challenges with implementation. In Northern Ireland, sick pay was set at 80% of salary.

106.2 Scotland, Wales, and Northern Ireland also provided Covid-19 bonuses for staff. In England, this was at the discretion of local authorities, but stakeholders noted the greatest portion of national workforce funding went into pay uplifts and bonuses. Stakeholders noted challenges around the

implementation of Covid-19 bonuses and questions around how and whether to support personal assistants and people employed through direct services. It is difficult to assess whether the bonuses awarded in the devolved administrations were helpful in retaining staff, particularly compared to England where these were not in place, due to the lack of updated and comparable data discussed in the following paragraph.

106.3 Stakeholders noted the lack of a mandatory workforce register in England may have impeded knowledge and understanding of the workforce and impacted the implementation of policies such as vaccination as a condition of deployment. Stakeholders from Scotland, Wales, and Northern Ireland reported registration was helpful during the height of Covid-19, for instance to implement workforce continuous professional development to support infection control. However, they also noted limitations due to the complexity of the registers and challenges in their ability to track key information such as number of staff or qualifications due to lags in re-registration or de-registration.

107. Funding: Across all four UK countries, stakeholders criticised the tendency to provide funding in last-minute short-term cash injections. In addition, there has been criticism of the lack of funding to back commitments such as around the workforce.

Our research specifically regarding Covid-19 in adult social care

108. The Nuffield Trust undertook a piece of research examining the factors that impacted and shaped the response to Covid-19 in adult social care in England during the first wave of infections. This culminated in a report (Exhibit NC/08 - INQ000553858) that was submitted for review to the Department of Health and Social Care's National Institute for Health and Care Research (NIHR) in April 2022, and subsequently published on the Trust's website in May 2023. For clarity, it should be noted that this work did not look at the other UK countries.

109. I present the Executive Summary of this report, and lessons and recommendations drawn from other work specifically regarding Covid-19 and the response of the adult social care sector to it. As requested by the Inquiry, I am setting these out separately to the presentation and discussion of our explainers above covering all four countries of the UK.

110. It should be noted that the report (Exhibit NC/08 - INQ000553858) was one part of a broader project that looked at what England could learn from other countries in

terms of social care resilience during Covid-19. Case studies of four other countries and an analysis of how and why their social care systems fared during Covid-19 are not yet published. Further summaries of experiences of Covid-19 in a wider range of countries were collected and published on a website www.ltccovid.org.uk established as part of the project. The project was funded by the National Institute for Health and Care Research and undertaken by LSE CPEC in partnership with the Nuffield Trust. Partners at LSE led on additional workstreams that mapped scientific evidence emerging from approaches to various aspects of the pandemic response from around the world that do not form part of this statement.

111. In addition to Exhibit NC/08 - INQ000553858 report, we have undertaken a number of pieces of research and analysis prior to, and during, the time period of interest that are relevant to Module 6. The further lessons and findings from these are detailed following the summary.

Summary of "Building a resilient social care system in England - What can be learnt from the first wave of Covid-19?", 2023 (Exhibit NC/08 - INQ000553858)

112. What follows in sub-section I (paragraphs 113 to 120), sub-section II (paragraphs 121 to 123), and sub-section III (paragraphs 124 to 126) is a summary of Exhibit NC/08 - INQ000553858 as drafted in 2022, as an exact copy of the report's original Executive Summary. The summarised lessons and recommendations are those we made at the time and are not retrospectively altered to reflect later events. As such, there are references to events that have since been superseded. The summary sets out the background and methodology to the report; the lessons we identified in the course of the research; and the set of recommendations that we made at the time. In paragraphs 127 to 139, we move on to consider further lessons relevant to the Inquiry's scope that emerged from our wider work.

Sub-section I: Methodology and background, copied from 2023 Executive Summary

113. The aim of this research is to identify actions that could be taken to build a more resilient social care system in the wake of Covid-19. This report is the result of a thematic analysis of 17 in-depth interviews with key social care stakeholders, six hours of workshops with a range of different stakeholders from the social care sector, and analysis of 72 policy documents, published papers and reviews. The interviews for this project were undertaken in spring and summer 2021.

114. The focus of the interviews was on experiences during the first wave of Covid-19 (Feb–May 2020) and what had subsequently been learnt by the time of the second major wave (winter 2020/21). The intention was not to critique the response itself but to identify the underlying factors that shaped the response in order to identify priorities for building resilience in the sector.

115. Stakeholders represented a range of types of providers, service users, unpaid carers, social care workers, local government, arm's-length bodies, disaster response experts and primary care networks. Officials at the Department of Health and Social Care were invited to be interviewed but no one was available. As such, this report presents the experiences and reflections of those involved in social care during the initial months of Covid-19, triangulated with information in publicly available documents. Relevant documents and literature published up until December 2021 were included for analysis. Documents published after this date have not been systematically identified and analysed and are only referenced where important for context.

116. Much has been written about the speed and adequacy of the government's response to the Covid-19 pandemic in the social care sector. In this report, we seek to go beyond providing a descriptive account of what happened and to analyse how structural and systemic factors influenced the initial national response and affected the ability of the sector to respond to the pandemic.

117. Social care entered the pandemic in a fragile state – a decade of austerity had seen council budgets being squeezed and spending on care falling. As a result, there were growing levels of unmet and undermet need in society; unpaid carers were increasingly stepping in to fill gaps in care; many of the small and medium-sized providers that make up the majority of the social care market were struggling financially; and workforce shortages were widespread (Exhibit NC/14 - INQ000553864).

118. Covid-19 has had far-reaching impacts on all those in the social care sector and has exposed and exacerbated many of these longstanding underlying issues. There is an opportunity now to use the learning gained during the pandemic to identify priorities so that the sector recovers and is put on a more resilient footing in the long term.

119. In the course of this work, we have tried to identify issues that stakeholders have highlighted that are amenable to change within the government's future reform plans. Through thematic analysis of interviews with stakeholders across the sector, workshop content and documents published during the spring, summer and autumn of 2021 (see Appendix 1), we have identified a number of lessons, with reference to the early months of the pandemic, that are grouped as follows:

- The system. A range of deeply rooted systemic issues, with unclear roles and responsibilities among levels and areas of government, impacted the coordination and timeliness of the response to the pandemic.
- People. A lack of deep understanding of the social care sector (in terms of who draws on support, the paid and unpaid workforce, and the range of different services) among those leading the response meant that measures and guidance were insufficiently sensitive to the diversity and complexity of this vast sector.
- Resources. A lack of sustained investment, and instead a reliance on sporadic injections of funding, over the preceding decade resulted in the sector entering the pandemic with patchy data, limited spread of technology and innovation and a residential care estate that was not fit for purpose.

120. Much learning took place over the course of the early months of Covid-19 and this report seeks to highlight where positive progress has been made as well as identifying where action is required for the creation of a more resilient system.

Sub-section II: 'Key lessons from the response to the pandemic', copied from the 2023 Executive Summary

121. Lessons on the system: visibility, accountability, collaboration and preparedness

121.1 It was not sufficiently clear who, or which organisation, was responsible for different aspects of the response for social care in the initial months. The lack of clarity was mentioned by all stakeholders interviewed, and by many during the workshops, who said they observed or perceived there to be confusion around where responsibility lay at different levels of the system. For example, they mentioned confusion at national level between government departments and arm's-length bodies, between local and national government as well as between care providers and government and they felt that that confusion had delayed parts of the response (e.g. PPE procurement and

supply and the roll out of asymptomatic testing in the sector). The complexity of accountability has been highlighted by the National Audit Office (Exhibit NC/15 - INQ000553865), with regard to PPE. It is important that clarity around responsibilities and leadership for all parts of the system is established both in 'normal' times but particularly in preparation for a future crisis.

121.2 Adult social care voices were not sufficiently embedded in decision-making structures. This rendered social care largely invisible in the early stages of the response. While all eyes and efforts were focused on the National Health Service (NHS), social care representatives struggled to raise the profile of the sector, despite its vast scale and critical role in the pandemic. With no dedicated director general for social care in the Department of Health and Social Care (DHSC), no adult social care voice on the Scientific Advisory Group for Emergencies (SAGE) at the outset of the pandemic and no regular channels of communication between people drawing on and providing social care and central government, social care was overlooked other than as an adjunct to the NHS. However, over the course of the pandemic, effort was made to establish better and more regular engagement with those in the sector, a SAGE Social Care Working Group and a social care taskforce were established, and a director general and a (now permanent) chief nurse for social care were appointed.

121.3 Good relationships between health and social care at a local level were helpful in supporting the sector but too embryonic in some areas. In areas where relationships were well developed, there were examples of the two services working together to share resources and support each other. However, the level of collaboration was variable and in areas with limited or fractious relationships, stakeholders offered accounts of health and social care not operating in a mutually supportive manner. There is now an opportunity for place-level structures within integrated care systems to build on progress and put in place foundations for more effective collaboration in future.

121.4 Opportunities to prepare the sector for a pandemic, or other crises, were missed. Several opportunities to strategically prepare the social care sector in the years immediately before Covid-19 were overlooked. A number of pandemic-planning exercises either excluded social care or, where social care was considered, action was not taken to address identified deficiencies. As

the pandemic advanced across the world, too little attention was paid to the experiences of social care (in particular, care homes) in other countries. And once infections took hold in England, pre-existing knowledge of infection spread in congregate care settings was not sufficiently applied to the emerging situation. Positive progress has been made during the pandemic to plan for ongoing outbreaks, for instance with the establishment of the social care taskforce in summer 2020 and the subsequent winter plan for 2020/21,4 but longer-term planning is needed.

122. Lessons about people: complexity of the sector, the formal workforce and unpaid carers

122.1 There was too little understanding of the complexity and diversity of social care among those leading the response. Once social care did feature in response plans, guidance did not sufficiently take account of this vast and complex sector, paying insufficient attention to non-residential care and certain groups such as those with learning disabilities. Stakeholders felt that limited capacity within the DHSC adult social care team as the pandemic struck, combined with the practice of moving civil servants between specialties, meant there was limited operational knowledge or understanding of the structure of social care among those developing guidance. Blanket guidance, often written with the NHS in mind, was inappropriate or difficult to interpret within social care settings, leading to delays in implementation and confusion among those in social care. Stakeholders reported that tailoring of guidance improved as the pandemic continued. Social care capacity at the DHSC has since been bolstered and the knowledge gained now needs to be retained and developed.

122.2 The wider Covid-19 response did not adequately take account of the structure of and pre-existing issues in the adult social care workforce. The impact on the adult social care workforce of policies on, for example, isolation and testing for non-NHS workers was not adequately understood. Crucially, the majority of the social care workforce did not have access to occupational sick pay and that had far-reaching implications for the ability and willingness of staff

to self-isolate. When initially proposed, policies to limit movement of staff introduced in September 2020 did not adequately take account of the nature of domiciliary care, high levels of staff vacancies and the fact that, as a largely

low-paid sector, many staff often work more than one job. Although some progress has been made to adapt policies to take account of some of these challenges, underlying issues of low pay and unstable contracts continue to be a problem and need to be addressed to ensure the sector can better withstand future shocks.

122.3 The social care system relies heavily on unpaid carers but limited support was provided to them as part of the response. Carers have played a pivotal role in supporting people who draw on social care over the course of the pandemic yet they have had access to little tailored support or respite. In fact, many carers have reported diminishing support during the pandemic as the regular community and voluntary services on which they previously relied closed. Stakeholders pointed to a lack of clear accountability at a national level for carers policy, and delays in identifying carers in routine data, as factors that rendered carers largely invisible in much of the early response.

123. Lessons on resources: funding, data and estates

123.1 Emergency financial support was welcome but did not offer sufficient certainty or flexibility to stabilise the sector. Emergency funding for providers was crucial in supporting many organisations through the pressures of Covid19 and interviewees clearly welcomed this and the Health and Care Act (2022) has since created provisions to enable faster emergency payments to providers in future. Many small and medium-sized organisations that provide the majority of care in the sector entered the pandemic with few financial reserves to meet the sudden increase in costs stemming from staff sickness, PPE purchases and lower occupancy (in residential care), and minimal back-office support to cope with new administrative burdens. While seen as a lifeline for providers, the short-term nature of the emergency funding – with extensions frequently announced with only weeks, days or in one case hours before the end of the scheme and in ways that interviewees felt did not allow providers sufficient flexibility in how it could be spent – offered little certainty to providers trying to plan into the future and did not allow those on the front line to spend it to meet the needs they could see. Interviewees reflected that the tendency over the preceding decade to allocate funding to social care in the form of sporadic injections of cash had limited the scope for strategic investment and had implications for how robust the sector, and its infrastructure, were entering the pandemic.

123.2 When Covid-19 struck, there was a lack of good quality data and information about who uses and provides adult social care services and how to communicate with them. Social care lacks a comprehensive information system or standard minimum dataset and, as a dispersed system funded via a mix of public and private money, many councils do not hold comprehensive information about everyone who draws on care services nor even all the people and organisations that provide care. This lack of adequate information and an absence of established routes of communication made coordinating and administering the response all the more complex. Covid-19 has accelerated efforts to collect data and this is helping to lay the foundations of a robust source of standard data.

123.3 The fragile state and the complexity of the adult social care infrastructure, in particular the residential care estate, were not adequately considered. In the run-up to the pandemic, the adoption of technology across all parts of the sector had been slow and innovation in service delivery had been patchy. In the absence of good data, the Covid-19 response made too many assumptions about the state of the social care estate and the ability of care homes to cope. Outdated buildings, many of which are small, had lacked investment in previous years and providers struggled to follow guidance to isolate or cohort infected residents and to accommodate wider infection control measures.

Sub-section III: 'Recommendations', copied from our 2023 Executive Summary

124. Recommendations regarding the system

124.1 The progress made in embedding social care voices in core decisionmaking, and giving the sector the prominence and visibility it needs, should be maintained and developed within central government to create strong foundations for reform. Making permanent some of the advisory groups (such as the social care taskforce) and channels of communication between the sector and government may be one way of ensuring that those with deep operational knowledge and direct experience of social care inform national policy and guidance.

124.2 The knowledge and understanding of the sector that have been gained across central and local government need to be retained and embedded to ensure that organisational memory and positive working relationships are not lost and that the new capacity in the DHSC social care team is retained and developed.

124.3 Clear lines of accountability for national and local government actors, including wider stakeholders such as public health actors, need to be established during 'normal' times as well as during times of crisis, paying close attention to what works best at a local level versus national level.

124.4 It is essential that the government places greater emphasis on long-term preparedness and risk monitoring, to put social care on a resilient footing to weather all types of potential future shocks. This should include: learning from successes; learning from other countries; and creating a central support structure that can click into place in the event of a crisis. This may, for example, take the form of operational blueprints that set out accountabilities and protocols for emergencies, which could include a range of potential emergencies such as other infectious diseases, climate events and political, economic and social crises. Places within newly establishing integrated care systems need to nurture and build on the local relationships that have emerged between health and social care over the course of the pandemic. Places should endeavour to learn from each other about initiatives that have been effective in building relationships (for example, having a social care representative in a primary care network). Social care needs to be seen as an equal partner in these new arrangements if it is to be put on a more resilient footing in the long term.

125. Recommendations regarding people

125.1 In times of crisis, the DHSC and other relevant bodies responsible for issuing guidance and advice need to fully consider the diversity and complexity of the social care sector to ensure that adequate and appropriate support is available to all in a timely and accessible manner.

125.2 A comprehensive, long-term workforce strategy (akin to the NHS People Plan) must be brought forward to build a stable, motivated and supported workforce with the skills and capacity to better weather future shocks. This must address not just the immediate issue of staff burnout but also the underlying weaknesses around pay and conditions. The strategy must also

effectively build career opportunities for staff, address the lack of parity with the NHS workforce and tackle perceptions that care work is low-skilled.

125.3 The government's reform programme needs to invest in measures to better identify and support carers. Improved data collection, reinstating respite and day services and supporting those who want to remain in employment by introducing paid leave are some priorities that need to be included. Clarifying accountability around policy for unpaid carers at national and local government levels will help to drive progress in this area.

125.4 As social care reform gathers pace, the DHSC and wider government need to ensure that unpaid carers are fully considered, paying attention to other policy areas (for example, work and pensions) that also impact on carers. Local government and social care providers (including voluntary and community groups) need to be given the tools and resources to ensure that support that has fallen away during the pandemic can be reinstated and expanded. 126. Recommendations regarding resources

126.1 Since completing this report in spring 2022, the government has announced that it will make available (from national funds and revenue to be raised locally) up to £7.5 billion for the sector over two years. However, there is a need not just for more central government funding for social care but also for funding to be more certain to enable stability and encourage strategic investment in new services that keep pace with need and changing preferences. A multi-year financial settlement would offer more certainty to the sector.

126.2 Investment in better data is essential to ensure a good understanding of people who draw on, and work in, social care, making sure that no groups are excluded. Implementation of the new data strategy should build on positive progress made in the pandemic and ensure that data is integrated and coordinated across services, offering maximum benefit and minimal burden for people in the sector. As part of this, it will be important to ensure the digital skills of providers, staff and unpaid carers are sufficiently developed to facilitate adoption, improve connectivity of care records and ensure cyber security.

126.3 Modernising the existing social care residential estate, including extra-care housing solutions, to withstand both future pandemics and other shocks (for example, those arising from climate change) is of utmost

importance. In the course of that investment, new and innovative models of care that offer greater choice and independence should be explored and encouraged. Commissioners of new care models need to use their market-shaping powers to ensure that increased public funding is used to improve infrastructure.

126.4 Evaluation of new models of care across all settings (including domiciliary care), as well as of the impact of digital technologies, innovations and treatments that have proven to be effective during the pandemic, will be important for generating an evidence base on which to scale and spread initiatives such as the 'Developing resources And minimum data set for Care Homes' Adoption' (DACHA) study (Exhibit NC/16 - INQ000553866) and the 'Vivaldi' study (Exhibit NC/17 - INQ000553867). Evaluations will need to pay special attention to the impact on digitally excluded groups.

126.5 In light of a shift in preference for home care over residential care that the pandemic has accelerated, and the government's commitment to putting housing at the centre of all care discussions, there is an opportunity to work with people who draw on and work in social care to develop innovative models of care that are fit for the future. It is important that sufficient funding is earmarked for such innovation.

126.6 The Inquiry Module 6 team have requested that we further expand on the sentence '*Covid-19 has accelerated efforts to collect data and this is helping to lay the foundations of a robust source of standard data'* by providing examples of the data that is now collected and the organisation/body that is responsible for collecting and collating this data. Since completion of our research in 2022, the previous government began work on addressing some of the data gaps that Covid-19 exposed and work is continuing under the current government. Plans are set out in the Department of Health and Social Care's document: Care data matters: a roadmap for better adult social care data (Exhibit NC/17a - INQ000574188), published in December 2023. There are various strands to this programme of improvement, the most significant of which is the launch of a Client Level Database, which is a repository of individual-level data of those approaching their council for support and those who then access publiclyfunded/arranged services. This data is submitted by local authorities on a monthly basis to the Department of Health and Social Care and will allow for much more granular understanding of people drawing

on care and their carers, including demographic details and type of support accessed. The dataset is still in development so quality is variable but it is an improvement on the aggregate council-level returns available previously and will eventually allow for health and social care data to be linked. Improvements have also been made to the capacity tracker which became an important tool during Covid-19 in understanding spare capacity and vaccination rates in the sector and it was made mandatory for providers to submit in July 2022. The DHSC administer the Capacity Tracker and care providers submit data monthly on factors such as care home bed vacancies, workforce resourcing, flu or covid-19 vaccination.

126.7 There remains a gap in data about people who access care services directly and pay for their own care and this is a limitation in government's understanding of demand and use of care and a limitation to local authorities' ability to shape their care markets. The ONS now has an experimental model that produces estimates of the self-funding population in England (Exhibit NC/17b - INQ000574189) but these are restricted to care homes (so excludes nonresidential care) and do not provide insights into the demographic characteristics of individual self funders.

126.8 The Inquiry Module 6 team have requested that we highlight any particular examples of good practice and innovation. The Nuffield Trust is not best placed to address this question currently as we are a research organisation that doesn't work directly with a large number of frontline providers and we have not worked specifically on evaluating innovative practice in social care. Therefore, we have not addressed this in our statement but we would be happy to suggest other organisations which would be better placed to provide materials on this topic if that would be helpful.

Additional or specific lessons emerging from other work

127. We also conducted other research activity before and during Covid-19 which touched on important themes for understanding the sector's response. The key lessons included in the 2023 report, summarised above, often overlapped with our findings. However, in this section, I will summarise where our wider work provided additional important findings on how adult social care responded to the pandemic, or provided more depth on particular subjects.

A failure to reform the system left it unprepared for the crisis

128. The consequences of a long-term failure to reform social care were felt in the slow and piecemeal response to Covid-19, as we outlined in a paper we produced in partnership with colleagues at LSE and other institutions in November 2020 (Exhibit NC/18 - INQ000553868).

129. We raised concerns about this in multiple publications before and during the Covid19 pandemic, and our other outputs illustrate its underlying causes in greater depth. Several failed attempts at social care reform in preceding decades can be attributed at least in part to low public understanding, poor political visibility and low policy priority. Examples of some of our relevant outputs which make these points include: a report in 2018 on learning from Japan (Exhibit NC/19 - INQ000553869); one on learning from Germany in 2019 (Exhibit NC/20 - INQ000553870); a pre-election briefing in 2019
(Exhibit NC/14 - INQ000553864); and a blog on principles for funding options in 2019 (Exhibit NC/21 - INQ000553871).

Unclear accountability and absence of central support infrastructure hampered the Covid-19 response

130. A research project we undertook during the early phase of Covid-19 (Exhibit NC/22 - INQ000553872) on the social care provider market highlighted the complexity of, and lack of clarity around, accountability (see p12 of that report for a diagram illustrating the arrangements). The research reflected that the split of accountability between national and local government, between central government departments, and with an almost entirely outsourced provider market, creates uncertainty about which body has responsibility for supporting providers of care.

131. An associated blog we published on the issue of provider fragility in May 2020 (Exhibit NC/07 - INQ000553857) noted the consequences of that unclear accountability in the face of the pandemic, where the absence of a central infrastructure (such as that in the NHS) impeded a swift response.

132. Our international research during Covid-19 found that clarity of accountability was a key enabler of a rapid response to the pandemic. In an analysis of responses to Covid19 submitted to the European Observatory's Covid-19 Health System Response Monitor (Exhibit NC/23 - INQ000553873), we found that most countries attempted to implement more oversight of their care system and to clarify lines of accountability. In a further piece of work not yet completed, we looked at four countries: those that had clear accountability arrangements prior to Covid-19 (Japan

and Denmark) were able, for the most part, to use existing infrastructure to manage the response. Countries with complex governance (France and the Netherlands) had to construct new channels of communication and oversight, overlaid onto existing infrastructure.

Unintended consequences of mandating vaccination highlighted the need for better understanding of the care workforce in policy and guidance

133. In 2021, the government announced a policy of mandatory vaccination for social care staff in an attempt to drive up vaccination rates, which were far lower than among NHS staff groups, as we outlined in a short piece of analysis (Exhibit NC/24 - INQ000553874). We warned about the risks and potential unintended consequences of mandating vaccination in this staff group. We published a summary of evidence (Exhibit NC/25 - INQ000553875) on international approaches to increasing Covid-19 vaccination uptake in May 2021 which was shared with the Social Care Working Group and referenced in a paper they prepared for the Scientific Advisory Group for Emergencies. This briefing found that very few governments across the world had mandated Covid-19 vaccination of staff in social care settings and instead had focused

on strategies to reduce vaccine hesitancy based on behavioural insights. It noted that several other countries were considering mandating vaccination but that there were concerns raised in those countries. Denmark's proposed legislation had not passed, instead opting for more building of trust, openness and information.

134. Our analysis of staff numbers in social care in the period leading up to the first deadline for mandatory vaccination (16 September 2021) found that up to 70,000 staff left their jobs between April 2021 and October 2021 (Exhibit NC/26 - INQ000553876). We noted that unwillingness to be vaccinated was the second most commonly cited reason for staff leaving employment in care homes in a survey conducted by the DHSC in December 2021 (Exhibit NC/27 - INQ000553877). The policy was eventually reversed but vacancy rates remained high.

Stalled attempts to introduce restrictions on staff movement highlighted the importance of understanding the care workforce in policy and guidance

135. The government's attempt to introduce a policy to restrict staff movement is another example where a better understanding of the characteristics of the workforce

was needed. International evidence had emerged that staff could be transmitters of infection when moving between settings, so the policy aimed to mitigate that risk by preventing staff from working in multiple settings. While a logical response based on evidence, the proposal did not sufficiently consider the nature and structure of social care work. We outlined in our response to the consultation in November 2020 (Exhibit NC/28 - INQ000553878) that there were a number of risks associated with the policy and amendments were required to mitigate adverse effects on care staff. Our response noted the challenges around administrative capacity in care homes, the lack of a workforce register to enable employers to know if staff had multiple jobs, and the unclear accountability for breaches to the policy. In particular, we demonstrated that the proposal would be unworkable in home care where the nature of the work requires staff to move between settings multiple times a day.

The impact of changes to policy in other areas of government (particularly immigration policy) on social care needs to be more routinely considered in order to build a more resilient workforce

136. Social care has been highly affected by a number of changes to immigration policy in recent years, possibly because of its low policy visibility and misconception of it as unskilled work. The tendency for rapid change in immigration policy and high reliance

in social care on overseas recruits makes for a very fragile workforce with low resilience.

137. In a briefing we drafted for the National Audit Office in September 2024 (Exhibit NC/29 - INQ000553879), we note that the changes to immigration rules introduced in 2021 resulted in a steep increase in international recruits (they made up 11% of the workforce in 2021/22 compared with 4% in 2020/21) but a sharp drop in domestic workers. More recently, the number of care visas issued has fallen as the government has introduced stricter rules around dependants (from April 2024) and closer scrutiny of applications.

138. As we noted to the Migration Advisory Committee in our response to its consultation on the impact of the end of free movement of labour (Exhibit NC/30 - INQ000553880), overseas recruits should be welcome but wholesale reliance on them to fill vacancies is not sustainable. The growth in staff joining from abroad during Covid-19 was helpful in maintaining services but many of them have since left their posts and returned to their country of origin. To grow a truly sustainable

workforce that is resilient in the face of a future pandemic or other crisis, there needs to be a stable domestic workforce and overseas recruitment based on stable policy.

139. Covid-19 also brought to the surface the disparity between employee benefits in the NHS and social care and the consequent impact on workforce resilience. Staff in the NHS are entitled to sick pay at full pay, which increases with length of service, and this extends for example to roles such as health care assistants working in general practice. But in social care, there was no such blanket entitlement and many, particularly those on zero hours contracts could not access sick pay when isolating. As we set out in a publication on international approaches to workforce development, published in September 2022 but researched during the timeframe of interest to the Inquiry (Exhibit NC/31 - INQ000553881), there is a clear association between access to statutory sick pay and reduced transmission of Covid-19 within long-term care facilities.

Making recommendations to government

140. Throughout the period of interest to the Inquiry, we presented the lessons and recommendations from our research to the UK government on multiple occasions. I, my team working on social care, and the Nuffield Trust's Directors communicated with civil servants and other government officials in direct meetings, through presentations we gave, by email, and through consultation responses. We also disseminated all of our published work via our newsletter, to which a number of civil servants in relevant areas subscribe. In the following paragraphs I will describe recommendations we raised in more detail, illustrating some the key channels and recipients where this is known.

141. We responded to a consultation held by the Department of Health and Social Care on proposals to restrict movement of staff working between care homes in November 2020 (Exhibit NC/28 - INQ000553878). We outlined in our response that while the proposal might reduce movement, there were a number of risks associated with the policy and amendments were required to mitigate adverse effects on care staff.

142. We emailed the civil servants leading the Department of Health and Social Care's consultation into mandatory staff vaccination in April 2021 to share the findings from our international review of strategies to support the uptake of vaccination among staff working in social care. Our review paper was shared with civil servants via our research manager contact at the Department (Exhibit NC/25 - INQ000553875). This review was also referenced in a paper prepared by the Social Care Working Group

for the Scientific Advisory Group for Emergencies in May 2021 (Exhibit NC/32 - INQ000553882). We met the winter planning team at the Department of Health and Social Care to talk through the findings from this review and our wider work during on at least three occasions during April – June 2021 and emailed the Covid-19 vaccination team to alert them to our review.

143. In the inquiry's timeframe, we made multiple representations of our work and analysis to civil servants at the Department of Health and Social Care; the Department for Levelling Up, Housing and Communities (now Ministry of Housing, Communities and Local Government); and the Migration Advisory Committee. Notable presentations include:

143.1 As part of the Social Care Recovery and Resilience project (from which Exhibit NC/08 - INQ000553858 is an output), we presented an overview of workstreams and progress to the Department of Health and Social Care on 24th March 2021 (Exhibit NC/33 - INQ000553883). This meeting was set up by NIHR leads who sent invitations to a number of teams within the Department of Health and Social Care they felt were relevant. The three workstreams presented covered progress on (1) The Covid-19 situation in England, (2) learning from country experiences with Covid-19 in the long-term care sector, and (3) scientific evidence from policy measures in social care during Covid-19 (note that item (3) was led by research partners at LSE and content is not covered in this submission).

143.2 As part of the wider Social Care Recovery and Resilience project, we ran two half day theory of change workshops in April and May 2021. Invitations were sent to members of the Department of Health and Social Care. No members of the Department attended the sessions but a briefing document outlining emerging findings from the work was circulated widely, including to NIHR colleagues at the Department (Exhibit NC/34 - INQ000553884).

143.3 We presented early findings and insights from our analysis of the Covid-19 situation in England as part of the Social Care Recovery and Resilience project, to civil servants in a number of relevant teams in the Department of Health and Social Care on 29th June 2021 (Exhibit NC/35 - INQ000553885). These included the findings outlined in paragraphs 113 to 126 above, alongside key quotes and questions to explore that might help to improve pandemic management going forward.

143.4 We presented project findings at a 'Covid-19 strategy session' to civil servants in the Department of Health and Social Care on 22 March 2022 (Exhibit NC/36 - INQ000553886). We covered the Covid-19 situation in England and what could be learnt; and which countries held potentially transferable lessons.

143.5 We presented on the adult social care workforce across the UK to the Migration Advisory Committee on 3rd November 2021 (Exhibit NC/37 - INQ000553887). This included our analysis of the challenges impacting the workforce situation at the time, the different approaches to registration and regulation, and pay, across the four UK countries. We also presented developments on the roll-out of Covid-19 bonuses across the UK.

143.6 We presented analysis drawn from a range of our work to the Department of

Levelling Up, Housing and Communities on 8th April 2022 (Exhibit NC/38 - INQ000553888). This included analysis of the impact of the pandemic on staff, such as: a lack of infrastructure to support and protect staff; an exacerbation of existing challenges for staff retention and their wellbeing; a lack of acknowledgment and valuing of care staff in the early months of the pandemic. The presentation also included approaches to registration and regulation across the UK, pay setting, and the implementation of Covid-19 bonuses across the UK.

143.7 We shared with the Department of Health and Social Care's social care workforce team, via email and in online presentations and roundtables, learning that we had gathered in the course of our work on a range of topics, including a slideset on sick pay policies introduced during the pandemic in each UK nation (Exhibit NC/39 - INQ000553889) and a presentation on learning from other countries including during Covid-19 (Exhibit NC/40 - INQ000553890) in 2022; and a learning session on challenges experienced by the workforce during the pandemic in July 2021 (Exhibit NC/41 - INQ000553891).

143.8 The report on social care in England during the pandemic (Exhibit NC/08 - INQ000553858) was submitted to NIHR and circulated among relevant DHSC teams who offered extensive comment. The research team responded to comments ahead of publication.

143.9 We met with Minister of State for Care, Helen Whately, in April 2023 to discuss the England report (Exhibit NC/08 - INQ000553858) in order to reiterate that the points we made in our report were robustly evidenced.

144. Several members of the Nuffield Trust's social care team engaged with the Department of Health and Social Care around social care reform and the development of the People at the Heart of Care White Paper (Exhibit NC/09 - INQ000553859). We attended multiple workshops and roundtables, sent comments via email, had ad hoc meetings with civil servants leading the workstreams and commented on written drafts. Throughout all this engagement, we contributed learning from our analysis of the pandemic in social care in England and emerging evidence from our international work. In particular, we contributed to the following workstreams: data and assurance, market shaping, vision for reform, and information, advocacy, and advice.

145. Throughout the period in question, as part of our ongoing public affairs activities, we had regular catch ups with civil servants on topics spanning social care. During many of these meetings, we shared learning emerging from our Covid-19 research work.

Recommendations to the Chair

146. The Covid-19 pandemic highlighted and exacerbated a number of pre-existing weaknesses in the social care system which left it ill-equipped to withstand a crisis on that scale. There are likely to be more crises on such a scale in future, whether caused by pandemics, extreme weather events, terrorist incidents or other serious risks. It is imperative that the learning from Covid-19 is not lost so that a more resilient social care system can be built. A programme of wholesale, long-term reform is required to address many of its wider deficiencies that go beyond the scope of this module. However, I would like to suggest a small number of focused recommendations which I believe the Chair should consider adopting to support the strengthening of adult social care in preparation for future crises.

146.1 Governments across the UK should ensure that social care is routinely embedded in key decision-making forums and processes as a matter of course.

This includes representation in the highest ranks of the civil service, interdepartmental committees, and bodies set up for contingency planning

and emergency response. This will help give social care visibility in a crisis and guard against policy and guidance being made in the absence of knowledge about the likely impact on the sector. From the difficult starting point we described in our report on England, some progress has been made towards this with the appointment of a dedicated social care Director General, a Chief Social Worker and Chief Nurse for Social Care.

146.2 Disaster preparedness exercises, plans and protocols need to have social care front and centre and not either ignored or tacked on as an afterthought. National plans need to have absolute clarity as to which body holds responsibility for what and thought needs to be given to how best to ensure the vast market of diverse providers are supported to be prepared. In the absence of existing central infrastructure, the government could consider bolstering existing formal and informal regional and local networks, such as Local Resilience Forums, Association of Directors of Adult Social Services regions and provider membership organisations to offer greater resilience in the event of a crisis.

146.3 Governments across the UK should take urgent steps to put the social care workforce on a more resilient footing. In particular, they should ensure that staff have consistent access to sick pay – a policy area controlled directly from Westminster across England, Scotland and Wales. The Employment Rights Bill currently going through Parliament is a positive step towards making this a reality. Careful implementation, with regard to the structure of the sector and characteristics of the workforce, needs to follow the passing of legislation.

146.4 Governments across the UK need to consider how to facilitate capital investment into the care sector in order to ensure the physical estate is more well suited to coping with a crisis. With the increasing likelihood of extreme weather events, having well-ventilated, spacious and flexible residential care buildings will be important. Such designs would also be more amenable to infection prevention and control. Other countries hold relevant examples in this regard and the government should be actively looking abroad to gather learning.

146.5 Data and information infrastructure needs to be seen as a core part of resilience and preparedness. In order to better respond to future crises, public authorities across the UK need to have good information on who draws on

social care and who provides it. Having data systems that link to NHS data would also enable a more joined up response.

Statement of Truth

I, Natasha Curry, believe that the facts stated in this witness statement are true to the best of my knowledge and belief. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

PD

Signed: _____

Dated: 27/02/25

Appendix A.

Explainer Title	Chart / Table title / Statistical reference	Data source	Year	Link	Reference (Publisher/author, title, year published)
2020: Other types of support: how do the other countries compare?	Disability welfare benefits by age	Family Resources Survey 2017/18	2019	http://doi.org/10.5255/UKDA-SN-8460-1	Department for Work and Pensions, Office for National Statistics, NatCen Social Research, Family Resources Survey, 2017-18, May 2019.
		ONS 2018 Mid-Year Estimates	2019	https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland	ONS, Estimates of the population for the UK, England, Wales, Scotland and Northern Ireland, Mid-2019: April 2019 local authority district codes edition of this dataset.
	Welfare benefits: Disability Living Allowance, Personal Independence	Disability Living Allowance (18+): England, Wales and Scotland	2019	https://www.gov.uk/government/organisations/department-forwork-	Department for Work and Pensions StatsExplore, Disability Living Allowance Recipients by Age and Gender 2019, 2019.

	Payment and Attendance Allowance			pensions/about/statisti cs	
		Disability Living Allowance (18+): Northern Ireland	2019	https://www.communit iesni.gov.uk/publications/ benefits-statisticssummary-publi cationnational-statisticsfebruary -2019	Department for Communities, Disability Living Allowance, February 2019.
		Personal Independence Payment (16+): England, Wales, Scotland	2019	https://www.gov.uk/go vernment/organisation s/department-forworkpensions/ about/statisti cs	Department for Work and Pensions StatsExplore, PIP Claims in Payment 2019, 2019.

		Personal Independence Payment (16+): Northern Ireland	2019	https://www.communit ies-ni.gov.uk/publications/ personalindependencepayment-statisticsfebruary-2019	Department for Communities, Personal Independence Statistics - February 2019, February 2019.

		Attendance Allowance (65+): England, Wales, Scotland	2019	https://www.gov.uk/go vernment/organisation s/department-forworkpension s/about/statisti cs	Department for Work and Pensions StatsExplore, Attendance Allowance: Cases in Payment 2019, 2019.
		Attendance Allowance (65+): Northern Ireland	2019	https://www.communit iesni.gov.uk/publications/ benefits-statisticssummary-publicationnational-statisticsfebruary-2019	Department for Communities, Attendance Allowance Summary Statistics - February 2019, February 2019.
2020: How much social care does each	Total public expenditure 2017/18, per head	HM Treasury Public Expenditure Statistical	2019	https://www.gov.uk/go vernment/statistics/pu	HM Treasury, Public Expenditure Statistical

country fund?		Analyses. Chapter 10, Tabs 10.1 - 10.4.		blic-expenditurestatistical-analyses-2018	Analyses 2017-2018, last updated February 2019.
	Self-funders versus local authority/HSCT funded in residential	Self-funding estimates for residential and nursing care in England, 2018 (note, report uses 2016 data)	2018	https://www.skillsforcare.org.uk/Documents/About/sfcd/Economicvalue-of-the-adult-	Skills for Care and Development, The Economic Value of the Adult Social Care Sector - England, June 2018.

	and nursing care by each nation (2018)			social-care-sector-England.pdf	
		Self-funding estimates for residential and nursing care in Scotland, 2018 (note, report uses 2016 data)	2018	https://skillsforcareanddevelopment.org.uk/wpcontent/uploads/2019/03/11-_-2018-TheEconomic-Value-ofthe-Adult-Social-Caresector-Scotland.pdf	Skills for Care and Development, The Economic Value of the Adult Social Care Sector - Scotland, June 2018.

		Self-funding estimates for residential and nursing care in Wales, 2018 (note, report uses 2016 data)	2018	https://socialcare.wales/cms_assets/fileuploads/TheEconomic-Value-ofthe-Adult-Social-Care-Sector_Wales.pdf	Skills for Care and Development, The Economic Value of the Adult Social Care Sector - Wales, June 2018.
		Self-funding estimates for residential and nursing care in Northern Ireland, 2018 (note, report uses 2016 data)	2018	https://www.skillsforcare.org.uk/Documents/About/sfcd/Theeconomic-value-ofthe-adult-social-caresector-Northern-Ireland-4.pdf	Skills for Care and Development, The Economic Value of the Adult Social Care Sector - Northern Ireland, June 2018.

	Local authority/HSCT versus self-funders in domiciliary care (2018)	Self-funding estimates for domiciliary care in England (note, report uses 2016 data)	2018	https://www.skillsforcare.org.uk/Documents/About/sfcd/Economicvalue-of-the-adultsocial-care-sector-England.pdf	Skills for Care and Development, The Economic Value of the Adult Social Care Sector - England, June 2018.

		Self-funding estimates for domiciliary care in Scotland (note, report uses 2016 data)	2018	https://skillsforcareand development.org.uk/w pcontent/uploads/2019/ 03/11-_-2018-TheEconomic-Value-ofthe -Adult-Social-Caresector-Scotland.pdf	Skills for Care and Development, The Economic Value of the Adult Social Care Sector - Scotland, June 2018.
		Self-funding estimates for domiciliary care in Wales (note, report uses 2016 data)	2018	https://socialcare.wale s/cms_assets/fileuploads/TheEconomic- Value-ofthe-Adult-Social-Care- Sector_Wales.pdf	Skills for Care and Development, The Economic Value of the Adult Social Care Sector - Wales, June 2018.
		Self-funding estimates for domiciliary care in Northern Ireland (note, report uses 2016 data)	2018	https://www.skillsforca re.org.uk/Documents/ About/sfcd/The- economic-value-ofthe-adult-social-caresector-Northern- Ireland-4.pdf	Skills for Care and Development, The Economic Value of the Adult Social Care Sector - Northern Ireland, June 2018.

2020: Offer and eligibility: Who can access state-funded adult care and what are they entitled to?	Number of statefunded clients (as organised by Local Authority or HSCT) per 100,000 population	NHS Digital – Adult Social Care Activity and Finance Report, England (2017)	2018	https://digital.nhs.uk/d ata-andinformation/publications/statistical/adultsocial-care-activityand-financereport/2017-18	NHS Digital, Adult Social Care Activity and Finance Report, England - 2017-18 2018.
		Welsh government – Adults receiving services by local authority and age group (2018)	2018	https://statswales.gov. wales/Catalogue/Health-and-SocialCare/SocialServices/AdultServices/ServiceProvision/adultsreceivi ngservices-bylocalauthority-agegroup and https://gov.wales/adult s-receiving-care-and-	Welsh Government, Adults receiving services by local authority and age group, 2018.

				support-april-2017march-2018	
		NISCC – Social Care Matters (2017)	2017	https://niscc.info/app/uploads/2020/12/FINAL-designed-SocialCare-Mattersreport.pdf	Northern Ireland Social Care Council, Social Care Matters, 2017.
		HSCB – Statistical Report (2016)	2016	http://www.hscboard.hscni.net/download/PUBLIC-MEETINGS/HSC%20BOARD/Board-Meetings-2016/october_2016/It em-08-03-DSF-Statistical-Report-March-2016.pdf [Link defunct]	HSC, Statistical Report, 2016.
		DoH – Statistics on Community Care for Adults in Northern	2017	https://www.healthni.gov.uk/sites/default/files/publications/healt	Information Analysis Directorate Department of

		Ireland (2017)			Health, Social Care - Statistics

				h/cc-adults-ni-17-18.pdf	on Community Care, October 2018.
		ISD Scotland – Insights into Social Care in Scotland (2017)	2017	https://scotland.shinyapps.io/nhs-socialcare/	ISD Scotland and NHS Scotland, Social Care Information Dashboard, 2018.
		ONS Mid-Year population estimates 2017	2017	https://www.ons.gov.uk/file?uri=/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland/mid2017/ukmidyearestimates2017finalversion.xls	ONS, Estimates of the population for the UK, England, Wales, Scotland, and Northern Ireland, Mid2017, 2018.

2020: What are carers in each of the four UK countries entitled to?	Table on numbers of carers and proportion of total population in each country	ONS 2021 Census England, Wales and Northern Ireland.	2011	As referenced in https://web.archive.org/web/20200605031733/https://www.carersuk.org/images/Facts_about_Carers_2019.pdf	ONS Census 2011, as referenced in Carers UK, Facts about carers, 2019.

		Scottish Health Survey 2012/13	2015	https://web.archive.org/web/20200427022238/https://www.gov.scot/publications/scotlands-carers/pages/2/	Scottish Government, Scotland's Carers, 2015.
2020: What does the social care workforce look like across the four nations?	Table on numbers of jobs in adult social care (2016)	Skills for Care and Development, (Note, 2018 report uses 2016 data)	2021/22	https://www.skillsforcare.org.uk/resources/documents/Aboutus/SfCD/Economicvalue-of-the-adultsocial-care-sector-UK.pdf	Skills for Care and Development, The Economic Value of the Adult Social Care sector - UK, June 2018.

	Distribution of the adult social care workforce in Residential and Nursing versus Domiciliary Care	Skills for Care and Development, (Note, 2018 report uses 2016 data)	2018	https://www.skillsforcare.org.uk/resources/documents/Aboutus/SfCD/Economicvalue-of-the-adultsocial-care-sector-UK.pdf	Skills for Care and Development, The Economic Value of the Adult Social Care sector - UK, June 2018.
2023: Other types of support: how do	Disability estimates (2021/22)	Family Resources Survey: financial years 2021 to 2022	2021/22	Family Resources Survey: financial year 2021 to 2022 - GOV.UK	Department of Work and Pensions, Disability, Family Resources Survey, financial year 2021 to 2022, United
the countries compare?					Kingdom, Family Resources Survey: financial year 2021 to 2022, March 2023.
	Disability welfare benefits by age: Age adjusted rates per 100,000	Department of Work and Pensions, Attendance Allowance: Cases in Payment (England, Wales, Scotland) (65+)	2022	https://www.gov.uk/government/organisations/department-forworkpensions/about/statistics	Department of Work and Pensions, AA : Cases in Payment, Stat-Xplore, May 2022.

		Department of Work and Pensions, Attendance Allowance Recipients (Northern Ireland) (65+)	2022	Benefits Statistics Summary Publication (National Statistics) - May 2022 | Department for Communities	Department of Work and Pensions, Northern Ireland Statistics & Research Agency, Attendance Allowance Recipients by Age and Gender 2022, February 2023.
		Department of Work and Pensions, Personal Independence Payments: Cases with Entitlement (England, Wales, Scotland) (16+)	2022	https://www.gov.uk/government/organisations/department-forworkpensions/about/statistics	Department of Work and Pensions, PIP Cases with Entitlement, Stat-Xplore, May 2022.
		Department of Work and Pensions, Personal Independence Payments: Claims in Payment by Age and Gender (Northern Ireland) (16+)	2022	Personal Independence Payment statistics | Department for Communities	Department of Work and Pensions, Northern Ireland Statistics & Research Agency, PIP CI in Payment by Age and Gender 2022, February 2023.

		Department of Work and Pensions, Disability Living Allowance Recipients (England, Wales, Scotland) (18+)	2022	https://www.gov.uk/government/organisations/department-forworkpensions/about/statistics	Department of Work and Pensions, DLA: Cases in Payment, Stat-Xplore, May 2022.
		Department of Work and Pensions, Disability Living Allowance Recipients (Northern Ireland) (18+)	2022	Benefits Statistics Summary Publication (National Statistics) - May 2022 | Department for Communities	Department of Work and Pensions, Northern Ireland Statistics & Research Agency, Disability Living Allowance Recipients by Age and Gender 2022, February 2023.
		ONS mid-2021 Population estimates by age group	2021	Estimates of the population for the UK, England, Wales, Scotland, and Northern Ireland - Office for National Statistics	ONS, Mid-Year Population Estimates, UK, June 2021, December 2022.

2023: How much social care does each country fund?	Total expenditure per head 2020/21 by each nation	HM Treasury Public Expenditure Statistical Analyses. Chapter 10, Tabs 10.1 - 10.4.	2020/21	https://www.gov.uk/government/statistics/public-expenditurestatistical-analyses-2021	HM Treasury, Public Expenditure Statistical Analyses 2021, July 2021.
	Self-funders versus local authority/HSCT funded in residential and nursing care by each nation (2018)	LaingBuisson analysis (methodology and raw data inaccessible)	2018	https://www.skillsforcare.org.uk/resources/documents/Aboutus/SfCD/Economicvalue-of-the-adultsocial-care-sector-UK.pdf	ICF Consulting Limited on behalf of Skills for Care, The Economic Value of the Adult Social Care sector - UK, June 2018.
	Local authority/HSCT versus self-funders in domiciliary care (2018)	LaingBuisson analysis (methodology and raw data inaccessible)	2018	https://www.skillsforcare.org.uk/resources/documents/Aboutus/SfCD/Economicvalue-of-the-adultsocial-care-sector-UK.pdf	ICF Consulting Limited on behalf of Skills for Care, The Economic Value of the Adult Social Care sector - UK, June 2018.
	Estimates of proportion of selffunders in residential and nursing care, and	ONS Care homes and estimating the self-funding population, England 2021 to	2021/22	https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare	ONS, Percentage occupancy of care home beds and percentage of care home residents who are self- or

		2022			
	those receiving domiciliary care in England only			/datasets/carehomesandestimatingtheselffundingpopulationengland	state-funded, Care homes and estimating the self-funding population, England 2021 to 2022, March 2022.
		ONS Estimating the size of the self-funding population in the community, England 2021 to 2022	2021/22	https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/datasets/estimatingthesizeoftheselffundingpopulationinthecommunityengland	ONS, Region by the proportion of self- and state-funded community care service users, Estimating the self-funding population in the community, England: 2021 to 2022, March 2022.
2023: Offer and eligibility: Who can access state-funded adult care and what are people entitled to?	Number of people accessing state-funded social care in England by care type (2021/22) Rate per 100,000	NHS Digital Adult Social Care Activity and Finance Report, England, 2021-22	2021/22	https://digital.nhs.uk/data-andinformation/publications/statistical/adultsocial-care-activityand-finance-report	NHS Digital, Adult Social Care Activity and Finance Report, England, 2021-22, October 2022.

		ONS mid-2021 Population estimates by age group England	2021	https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/ populationestimatesforukenglandandwalesscotlandandnorthernireland and	ONS, Mid-Year Population Estimates, UK, June 2021, December 2022.
	Number of people accessing state-funded social care in Wales by care type (2018/19) Rate per 100,000	StatsWales - Social Services Activity 2018/2019.	2018/19	https://statswales.gov. wales/Catalogue/Health-and-SocialCare/SocialServices/AdultServices/ServiceProvision/adultsreceivi ngservicesduringtheyear-by-localauthoritymeasure	StatsWales, Adults receiving services by local authority and measure, October 2019.

		ONS mid-2018 Population estimates by age group Wales	2018	https://www.ons.gov.u k/peoplepopulationan dcommunity/populatio nandmigration/populat ionestimates/datasets/ populationestimatesfo rukenglandandwaless	ONS, Mid-2001 to mid-2018 detailed time-series edition of this data, June 2019.

				cotlandandnorthernirel and	
	Number of people accessing state-funded social care in Scotland by care type (2020/21) Rate per 100,000	Public Health Scotland, Insights in social care: statistics for Scotland	2020/2021	People supported - Insights in social care: statistics for Scotland - Support provided or funded by health and social care partnerships in Scotland 2019/20 - 2020/21 - Insights in social care: statistics for Scotland - Publications - Public Health Scotland	Public Health Scotland, Insights in social care: statistics for Scotland: support provided or funded by health and social care partnerships in Scotland 2020/21, April 2022.

		ONS mid-2020 Population estimates by age group Scotland	2020	https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwaless	ONS, Mid-Year Population Estimates, UK, June 2020, December 2022.

				cotlandandnorthernirel and	
	Number of people accessing state-funded social care in Northern Ireland by care type (2021/22) Rate per 100,000	Department of Health Statistics on community care for adults in Northern Ireland 2021/22	2020/2021	https://www.healthni.gov.uk/publications/statistics-communitycare-adults-northernireland-202021	Department of Health, Statistics on community care for adults in Northern Ireland 2021/22, February 2022

		ONS mid-2020 Population estimates by age group Northern Ireland	2020	https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernirel and	ONS, Mid-Year Population Estimates, UK, June 2020, December 2022.
2023: What are carers in each of the four UK countries entitled to?	Table on numbers of carers and proportion of total population in each nation	ONS 2021 Census England and Wales	2021	https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/unpaidcareenglandandw ales/census2021	ONS, Unpaid care, England and Wales: Census 2021, ONS website, statistical bulletin, January 2023.

		ONS 2021 Census Northern Ireland.	2021	MS-D17 Provision of unpaid care by broad age bands: Census 2021 main statistics health, disability and unpaid care tables | Northern Ireland Statistics and Research Agency (nisra.gov.uk)	NISRA, Census 2021 main statistics health, disability and unpaid care tables, NISRA website, December 2022.
		Scottish Health Survey 2021	2021	https://www.gov.scot/ publications/scotlands -carers-updaterelease-december-2022/	Scottish Government, Scotland's Carers Update Release: December 2022, Scottish Government website, December 2022.
2023: What does the social care workforce look like across the four countries?	Table on numbers of people employed in adult social care	England: Skills for Care 2022	2022	https://www.skillsforca re.org.uk/Adult-Social-Care-WorkforceData/Workforceintelligence/document s/State-of-the-adultsocial-caresector/The-state-of-	Skills for Care, The State of the adult social care sector and workforce in England, 2022 (Leeds, 2022).

				the-adult-social-caresector-and-workforce-2022.pdf	
		Wales: Social Care Wales 2022	2022	https://socialcare.wales/cmsassets/documents/Social-care-workforcereport-2022.pdf	Social Care Wales, Social care workforce report 2022, 2022.
		Scotland: Scottish Social Services Council 2022	2022	https://data.sssc.uk.com/images/WDR/WDR2022_271123.pdf	Scottish Social Services Council, Scottish Social Service Sector: Report on 2022 Workforce Data: An Official Statistics Publication for Scotland, September 2023 [Revised November 2023].

		Northern Ireland: Northern Ireland Social Care Council 2023	2023	https://niscc.info/app/uploads/2024/04/LiveRegister-Overview-31Dec-23-Q3.pdf	Northern Ireland Social Care Council, The Social Care Council Register for Social Workers, Social Care Workers, Social Work Students in Northern Ireland Live Register Report, December 2023.

2023: What does the provider market look like?	UK-wide estimations of residential and nursing care homes, and domiciliary care providers	carehome.co.uk Care home stats: number of settings, population & workforce	2021	[na]	carehome.co.uk, How many care homes are there in the UK? Care home stats: number of settings, population % workforce, 2022.
		homecare.co.uk Home care statistics: number of providers, service users & workforce	2021	[na]	homecare.co.uk, How many home care providers are there in the UK? Home care statistics: number of providers, service users & workforce, 2022.

	England estimations of residential and nursing care home, and domiciliary care services	CQC, CQC Care Directory,	2023	https://www.cqc.org.uk/aboutus/transparency/using-cqc-data#directory	CQC, CQC care directory, January 2023.
	Wales estimations of residential and nursing care home, and domiciliary care services	Care Inspectorate Wales, StatsWales, Number of registered adult care homes	2023	https://statswales.gov.wales/Catalogue/Health-and-SocialCare/Services-for-Social-Care-and-Childrens-Day-Care/notifications-to-care-inspectoratewales-related-toCovid-19-in-adultcarehomes/numberofregistered adultcarehomesby-localauthority	Care Inspectorate Wales, StatsWales, Number of registered care homes, by local authority, January 2023.

	Scotland estimations of residential and nursing care home, and domiciliary care services	Care Inspectorate, Quarterly statistical summary report, Qtr. 2 (2021/22), No. of Registered Care Services	2021/22	https://www.careinspectorate.com/index.php/publicationsstatistics/172statistics-anddata/statistics/quarterly-statisticalreports/quarterlystatistical-summaryreport-qtr-2-2021-22	Care Inspectorate, No. of Registered Care Services, Quarterly Statistical Summary Report - Qtr. 2 (2021/22), October 2022.
	Northern Ireland estimations of residential and nursing care home, and domiciliary care services	Northern Ireland Regulation and Quality Improvement Authority (RQIA), Services registered with RQIA (Domiciliary Care Agencies, Residential and Nursing care providers)	2022	https://www.rqia.org.uk/what-wedo/register/servicesregistered-with-rqia/	RQIA, Services registered with RQIA, October 2022.