Health Survey for England 2017
Adult Social Care

Published 4 December 2018

This report examines need for social care among adults aged 65 and over in England in 2017 and the extent to which these older adults receive the support they need. It also covers adults aged 16 and over who provide unpaid care to family members or friends.

Key findings

- 23% of men and 28% of women aged 65 and over needed help with at least one Activity of Daily Living (ADL). 22% and 30% respectively needed help with at least one Instrumental Activity of Daily Living (IADL).
- 20% of men and 25% of women aged 65 and over had some unmet need with at least one ADL, and 12% of men and 15% of women had some unmet need with at least one IADL. Unmet need for care increased with age for both ADLs and IADLs.
- The majority of adults aged 65 and over who received help did so from unpaid helpers only (68%). The proportions who received help from paid helpers, whether alone or as well as unpaid help, increased with age.
- 16% of adults aged 16 and over reported providing unpaid help or support to at least one person with long-term mental or physical health problems, disabilities or problems related to old age. Women were more likely than men to have done so (18% and 14% respectively).
- The majority of adults (56%) said that they had received no support in providing care. Adults aged 16 to 44 were more likely to report receiving support from other family members than those aged 65 and over.
- Just over half of adults aged 16 and over said that their caring role had an effect on their health (51%). Women were more likely than men to report these effects on their health. The most common impacts on carers' health were feeling tired (29% of men and 39% of women), general feelings of stress (24% of men and 37% of women) and disturbed sleep (21% of men and 28% of women).

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This report may be of interest to members of the public, policy officials, people working in public health and to commissioners of health and care services interested in the social care needs of older adults and the prevalence of unpaid caring among adults in England.

Introduction

Contents

Since 2011, the Health Survey for England (HSE) has included questions on adult social care. This report presents findings on the need for social care among adults aged 65 and over, whether they received care and how it was provided. Separately, it examines provision of social care by adults aged 16 and over. Analysis is presented by age, sex and area deprivation. The data were based on a representative sample of the general population who participated in the Health Survey for England 2017.

Background

Social care for adults aged 65 and over

Social care is the provision of help with personal care and domestic tasks that enables people to live as independently as possible. Care and support helps people to do everyday tasks that most people take for granted, such getting in and out of bed, getting dressed and getting around the house. It also provides emotional support as well as enabling more independent activities like getting out of the house, seeing friends and family and being part of the wider community.[1] While care and support is needed at any stage of life by people of all ages, many older people need help and support because of problems associated with long-term physical or mental ill-health, disability or problems relating to old age. In 2016-17 local authorities received 1.8 million new requests for adult social care and support, 1.3 million of which were for adults aged 65 and over.[2] Two thirds of adults (66%) accessing long-term support were those aged 65 and over.[2]

Social care services face increasing demands and challenges because of a changing and ageing population. Population estimates predict that the number of people aged 85 and over will increase, while the number of people living with dementia is projected to double. Changes to birth rates, family structures and expectations of care provision are also expected to increase demand and put additional pressure on social care services.[1,3]

Policy makers have identified long-standing issues relating to the provision of social care, including a lack of coordination between agencies providing these services, variation in the level and quality of social care, and a tendency to focus on reactive rather than preventative care[1]. A central focus of recent government policies has been to help people maintain their independence and live in their own home for as long as possible. Emphasis has also been placed on the personalisation of care as well as early preventative interventions as a means to reduce the need for more

[1] HM Government. *Caring for our future: reforming care and support*. The Stationery Office, Norwich, 2012. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/136422/White-Paper-Caring-for-our-future-reforming-care-and-support-PDF-1580K.pdf

[2] NHS Digital. *Adult social care activity and finance report: detailed analysis, England 2017-18*. https://files.digital.nhs.uk/35/6A192B/Activity%20and%20Finance%20Report%20201718.pdf

[3] Department of Health. *Independence, Well-being and Choice: Our vision for the Future of Social Care for Adults in England*. The Stationery Office, London, 2005.

intensive support or crisis intervention at a later stage.[4,5,6] The Care Act 2014 implemented several national strategies to improve social care and support in the UK. The independence and wellbeing of those in receipt of social care continue to be promoted, as well as early intervention and prevention.[7] The legislation introduced standards and duties for local authorities, including national eligibility criteria for care, and changes to the way that local authorities complete assessments for those in need of support.[8]

Provision of unpaid care

Care and support can take the form of formal care arranged by the local authority or privately paid-for care, or unpaid care provided by family, friends or another voluntary source. The number of unpaid carers in England and Wales continues to increase; in, 2011, just over 1 in 10 people provided unpaid care to a family member or friend.[9] The policy emphasis on maintaining independent living at home, as well as the ageing population and increasing pressure on social care services means that unpaid carers play an important role in social care, as well as wider society.[5]

Recent policies have highlighted the crucial role of unpaid carers in the provision of social care and recognised the demands that such a role can place on the carer and their lives. *The National Carers Strategy*[10] and *Caring for our Future: reforming care and support*[4] highlighted the important contribution that carers make and that recognising, valuing and supporting carers should be a central part of government policy. The Care Act 2014[7] introduced new rights for carers, including the right to an assessment of, and support for, their needs. The *Carers Action Plan 2018-2020*[11] builds on the Care Act 2014 and details action points and priority areas for the next two years to support carers in England.[12]

[4] HM Government. *Caring for our future: reforming care and support*. The Stationery Office, Norwich, 2012. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/136422/White-Paper-Caring-for-our-future-reforming-care-and-support-PDF-1580K.pdf

[5] Department for Communities and Local Government. *Lifetime Homes, Lifetime Neighbourhoods. A National Strategy for Housing in an Ageing Society*. DCLG, London, 2008.

[6] HM Government. *The Coalition: Our Programme for Government*. Cabinet Office, London, 2010.

[7] Department of Health. *Guidance: Care and support: what's changing?* DH, London, 2014

[8] The Care Act, 2014. http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

[9] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/articles/2011censusanalysisunpaidcareinenglandandwales2011andcomparisonwith2001/2013-02-15#provision-of-unpaid-care-across-english-regions-and-wales

[10] DHSC. *Carers at the heart of 21st-century families and communities.* The Stationary Office, 2008. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/136492/carers_at_the_heart_of_21_century_families.pdf

[11] DHSC. *Carers Action Plan 2018-2010 Supporting carers today*. 2018. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/713781/carers-action-plan-2018-2020.pdf

[12] Proposals for the future of adult social care are to be published in a forthcoming Green Paper. At the time of writing, November 2018, the publication date had not been announced.

Methods and definitions

Methods

The current modules of social care questions were developed in 2009 and 2010 and first used in the HSE 2011. The aim is twofold: to deliver robust data on the need for, receipt and provision of social care services for adults aged 65 and over; and to explore the characteristics of people providing unpaid care, and on people to whom they provide care and support. More detailed information about the module can be found in the 2011 report.[13]

The first of the modules focuses on the population aged 65 and over in private households, who constitute by far the largest group receiving care in the community.[14] It does not cover those living in care institutions. Longer and shorter versions are asked in alternate years; in 2017, the shorter version was used.[15] As with HSE 2016, the questionnaire included the revised questions on social care provision and payment that reflect changes in the Care Act 2014.

Questions about provision of care are included in alternate years. In 2017, the questions were largely unchanged since 2015 the last time they were included in the survey. All participants aged 16 and over were asked about the help and support that they provided to others, including the characteristics of people to whom help and support was provided, the amount and type of care provided, and the impact of providing care on the carers' own health and employment.

The full questionnaires can be found within the survey documentation.[16]

Definitions

Measuring need for and receipt of social care: ADLs and IADLs

The need for and receipt of social care is measured using a number of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). ADLs are activities relating to personal care and mobility about the home that are basic to daily living. IADLs are activities which, while not fundamental to functioning, are important aspects of living independently. The ADLs and IADLs used in the HSE and shown in Table A were carefully selected to represent a full range of key activities.[17]

[13] Craig R, Mindell J (eds). *Health Survey for England 2011: Volume 1 Health, Social Care and Lifestyles*. Health and Social Care Information Centre, Leeds, 2012. http://digital.nhs.uk/catalogue/PUB09300

[14] While social care may be needed by and provided for people of any age, the sample size for the HSE (and most general population surveys) does not deliver sufficient numbers of social care recipients in children and adults aged under 65 for robust analyses of the patterns of need and receipt of care among different groups.

[15] The longer version includes more detailed questions on receipt of unpaid and paid care, along with questions on care services used, and on the experience of bladder and bowel problems.

[16] Available via the report website https://digital.nhs.uk/pubs/hse2017

[17] The ADLs and IADLs included in the social care module allow an approximation of the Barthel Index, a measure of ability to live independently at home for older people. For further details see Craig R, Mindell J (eds). *Health Survey for England 2011*; full reference above.

Table A: Summary of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)

ADLs	IADLs
Having a bath or shower	Doing routine housework or laundry
Using the toilet	Shopping for food
Getting up and down stairs	Getting out of the house
Getting around indoors	Doing paperwork or paying bills
Dressing or undressing	
Getting in and out of bed	
Washing face and hands	
Eating, including cutting up food	
Taking medicine	

ADLs and IADLs and the Care Act 2014 eligibility criteria

The Care Act 2014 outlines the eligibility criteria for accessing adult care and support under The Care and Support (Eligibility Criteria) Regulations 2014.[18] Under these guidelines, a person is eligible for care if they cannot achieve two or more specified outcomes in their day-to-day life, and as a result experience significant impact on their well-being. This criterion differs to the HSE definition of need which defines adults aged 65 and over to be in need of care and support if they said there was at least one ADL or IADL that they could manage on their own with difficulty, could only do with help, or could not do at all.

Although the national eligibility criteria threshold appears to be higher, there are differences between the outcomes it uses and the ADLs and IADLs measured in the HSE. In some ways the outcomes in the eligibility criteria are broader and they do not distinguish between types of activity as the HSE does for ADLs and IADLs. An instrumental activity such as getting around in the community safely and being able to use facilities such as public transport, is one outcome alongside others focused on more personal activities, such as being able to dress and being appropriately dressed. Table B compares the national eligibility criteria with the ADLs and IADLs where there is an obvious correspondence.

[18] The Care and Support (Eligibility Criteria) Regulations 2014. https://www.legislation.gov.uk/ukdsi/2014/9780111124185

Table B: Comparison between national eligibility criteria, ADLs and IADLs

National eligibility criterion	ADL	IADL
Managing and maintaining nutrition.	Eating, including cutting up food.	Shopping for food.
Maintaining personal hygiene.	Having a bath or shower. Washing face and hands.	
Managing toilet needs.	Using the toilet.	
Being appropriately clothed.	Dressing and undressing.	
Being able to make use of [their] home safely.	Getting up and down stairs. Getting around indoors. Getting in or out of bed.	
Maintaining a habitable home environment.		Doing routine housework or laundry.
Making use of necessary facilities or services in the local community, including public transport and recreational facilities or services.		Getting out of the house.

There are no direct equivalents among the eligibility criteria for the ADL 'taking medicine' or the IADL 'doing paperwork and paying bills'. Similarly, several of the national eligibility criteria – developing and maintaining family or other personal relationships; accessing and engaging in work, training, education or volunteering; and carrying out childcare responsibilities – have no equivalent ADLs or IADLs. Some of the ADLs and IADLs affect more than one criterion, for example being able to get in or out of bed, get up and down stairs and get around indoors all have an impact on most of those eligibility criteria concerned with daily home life, for example maintaining personal hygiene and managing toilet needs.

Although the two measures are not directly comparable, both sets of criteria identify adults with multiple needs for care and support, and there is likely to be some overlap between those needing help with two or more ADLs or IADLs and those qualifying under the national eligibility criteria.

Provision of unpaid care

All adults aged 16 and over were asked whether they had personally provided help or support to anyone in the last month because they had long-term physical or mental ill-health problems, a disability or problems relating to old age. Help provided in a professional capacity or as part of a job was excluded, but not help provided to family or friends for which some payment was received.[19]

[19] The term 'unpaid' carer has been used in this report to distinguish those providing care but not in a professional capacity. This is to avoid any implication that these carers provide more or less important care than those who provide care as part of their employment or on behalf of a voluntary agency. When asked about payment for the care they gave, apart from those in receipt of Carer's Allowance, a very small number of 'unpaid' carers reported receiving any kind of payment (n=18).

Age-standardisation

Age-standardised data are presented in this report for some analyses shown in the text, tables and charts. Age-standardisation allows comparisons between groups, after adjusting for the effects of any differences in age distributions between those groups.

About the survey estimates

The Health Survey for England, in common with other surveys, collects information from a sample of the population. The sample is designed to represent the whole population as accurately as possible within practical constraints, such as time and cost. Consequently, statistics based on the survey are estimates, rather than precise figures, and are subject to a margin of error, also known as a 95% confidence interval. For example, the survey estimate might be 24% with a 95% confidence interval of 22% to 26%. A different sample might have given a different estimate, but we expect that the true value of the statistic in the population would be within the range given by the 95% confidence interval in 95 cases out of 100.

Where differences are commented on in this report, these reflect the same degree of certainty that these differences are real, and not just within the margins of sampling error. These differences can be described as statistically significant.[20]

Confidence intervals are quoted for key statistics within this report and are also shown in more detail in the Excel tables accompanying the Methods report. Confidence intervals are affected by the size of the sample on which the estimate is based. Generally, the larger the sample, the smaller the confidence interval, and hence the more precise the estimate.

[20] Statistical significance does not imply substantive importance; differences that are statistically significant are not necessarily meaningful or relevant.

Care needs of adults aged 65 and over

Ability to perform ADLs and IADLs in the last month, by age and sex

Adults aged 65 and over were asked whether they had needed help in the last month with a list of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). For each ADL and IADL, adults aged 65 and over were asked whether they were able to carry out the activity on their own, manage on their own with difficulty, only do the activity with help, or could not do the activity at all.

Two thirds of these adults (68%) reported that they could perform all of the ADLs and IADLs on their own without help. 73% of men and 64% of women aged 65 and over needed no help with ADLs or IADLs in the last month.

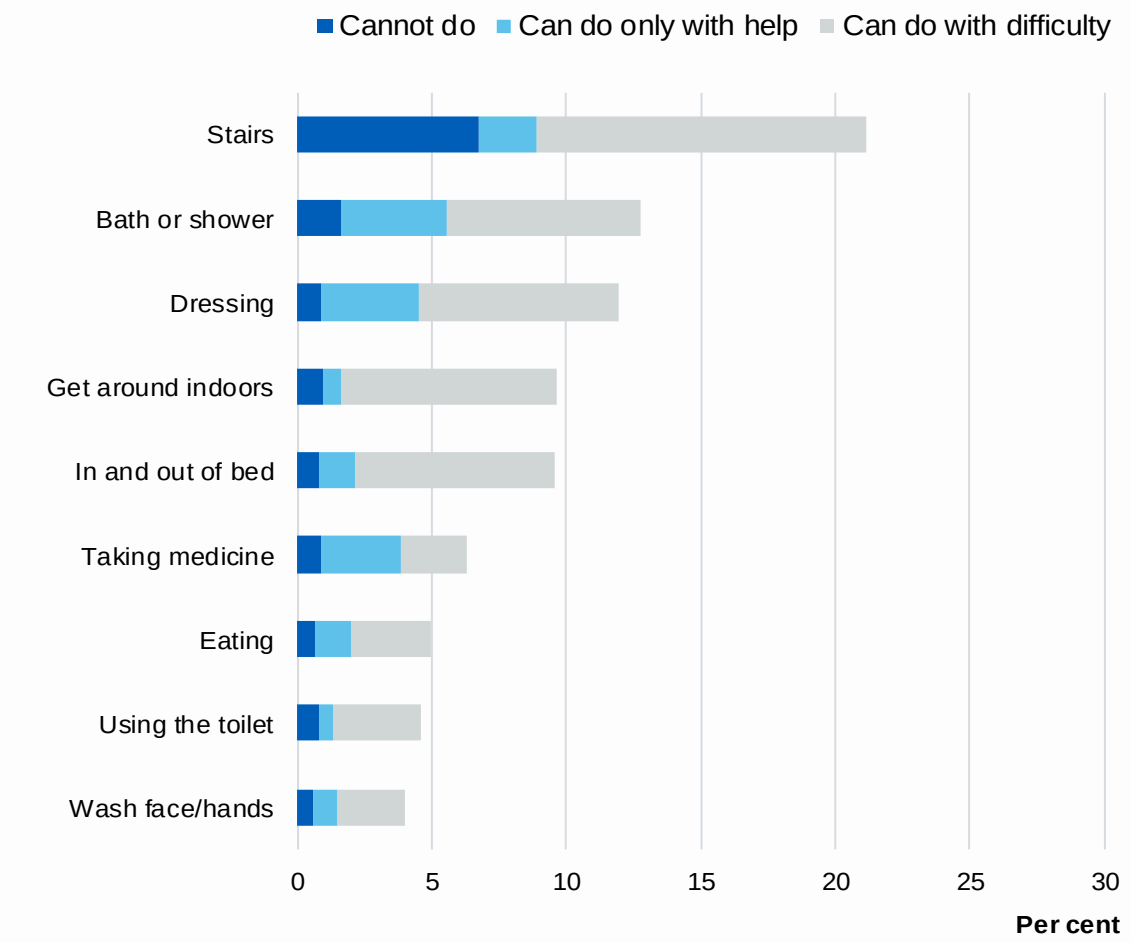
Where help was needed, participants were most likely to say that they could do the activities with difficulty but manage on their own. A much smaller proportion of adults aged 65 and over said that they could do these activities only with help, or not do these activities at all. These three groups have been combined into one group to show adults aged 65 and over who had some level of difficulty in completing ADLs or IADLS, and consequently had some need for help.

Adults aged 65 and over who needed some help with ADLs were most likely to need help with getting up and down the stairs (18% of men and 24% of women), having a bath or shower (13% of adults aged over 65) and dressing and undressing. IADLs that participants were most likely to need help with were shopping for food (18% of men and 26% of women) and doing routine housework or laundry (17% of men and 23% of women).

Figures 1 and 2, Table 1

Figure 1: Ability to perform ADLs in the last month

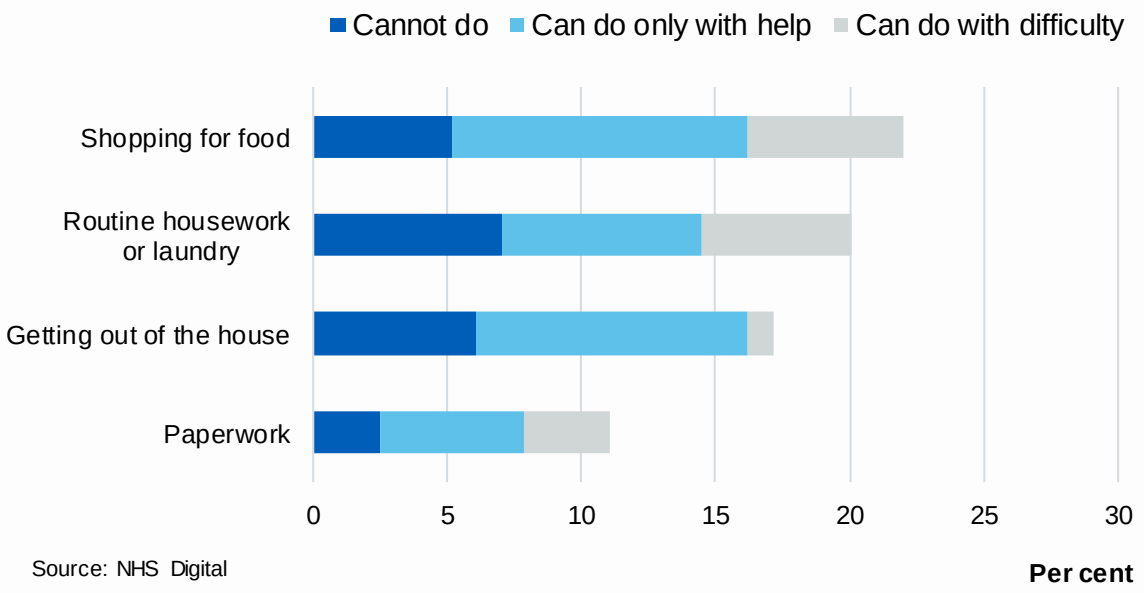
Base: Aged 65 and over



Source: NHS Digital

Figure 2: Ability to perform IADLs in the last month

Base: Aged 65 and over



Source: NHS Digital

Among adults aged 65 and over, 26% needed help with at least one ADL and 26% needed help with at least one IADL. A higher proportion of women than men needed help with ADLs (28% of women and 23% of men) and IADLs (30% and 22% respectively).

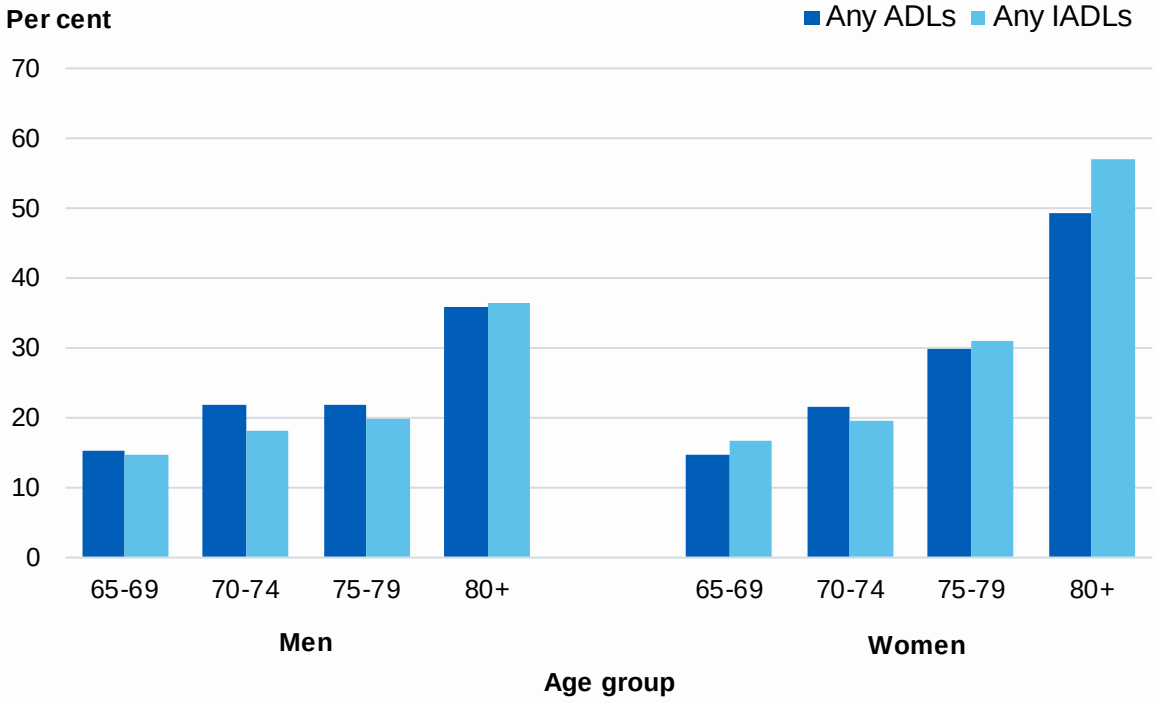
Table 3

The need for help with ADLs and IADLs increased with age. Among adults aged 65 to 69, 15% needed help with at least one ADL, increasing to 43% of adults aged 80 and over. The need for help increased more steeply among older women, ranging from 30% of those aged 75 to 79 to 49% of those aged 80 and over. Need for help with at least one IADL increased with age among both men and women and followed a pattern similar to ADLs.

Figure 3, Table 3

Figure 3: Needed help with ADLs and IADLs in last month, by age and sex

Base: Aged 65 and over



Source: NHS Digital

Need for help with multiple ADLs and IADLs

Nearly one quarter of adults aged 65 and over needed help with two or more ADLs or IADLs (24%).

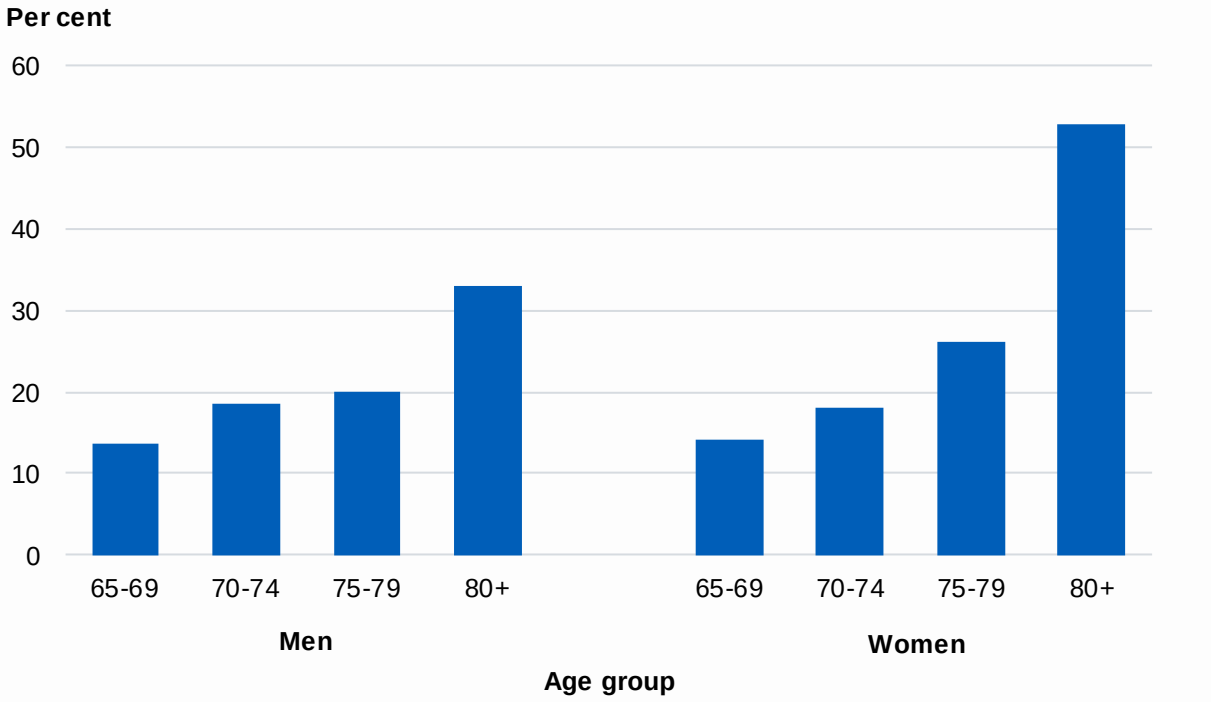
The proportion of adults needing help with two or more ADLs or IADLs increased with age. 14% of adults aged 65 to 69 needed help with two or more ADLs or IADLs, compared with 44% of adults aged 80 and over. This age-related pattern was evident for both men and women, although increase in need alongside age was more gradual

among men. The proportion of women needing help with two or more ADLs or IADLs doubled between the ages of 75 to 79 and 80 and over (26% and 53% respectively).

Figure 4, Table 2

Figure 4: Need for help with two or more ADLs or IADLs in last month, by age and sex

Base: Aged 65 and over



Source: NHS Digital

Receipt of help, by age and sex

Adults aged 65 and over who said they needed help with ADLs or IADLs, were asked whether they received help with these tasks. For the IADLs relating to shopping, housework and paperwork, participants were asked to exclude help which was provided simply because of the way household responsibilities were divided.

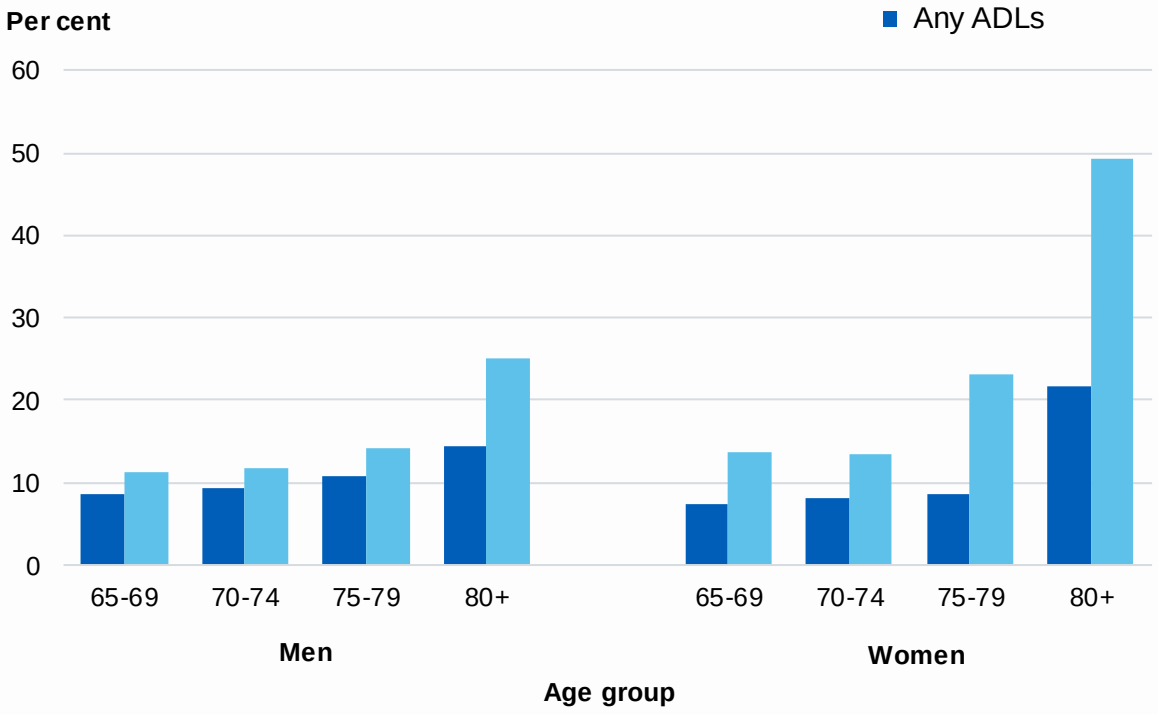
Similar proportions of men and women had received help with at least one ADL in the last month (10% and 11% respectively). Women were more likely to have received help with IADLs in the last month: 24% of women compared with 15% of men had received help with at least on IADL.

As with need, proportions receiving help with ADLs in the last month increased with age; 8% of adults aged between 65 and 69 received help with at least one ADL, compared with 18% of adults aged 80 and over. Receipt of help for at least one IADL followed a similar pattern. Among men this increase was more gradual. Receipt of help among women increased from 13% among women aged 70 to 74, to 49% among women aged 80 and over.

Figure 5, Table 3

Figure 5: Receipt of help with ADLs and IADLs in last month, by age and sex

Base: Aged 65 and over



Source: NHS Digital

Unmet need, by age and sex

Unmet need has been defined as being able to complete a particular ADL or IADL with difficulty, only with help, or not at all, but not receiving help with that activity in the last month. The assumption is that those who have at least some difficulty with an activity may need help.[21]

Among adults aged 65 and over, 20% of men and 25% of women had some unmet need with at least one ADL. Similar proportions of men and women had some unmet need with at least one IADL (12% of men and 15% of women).

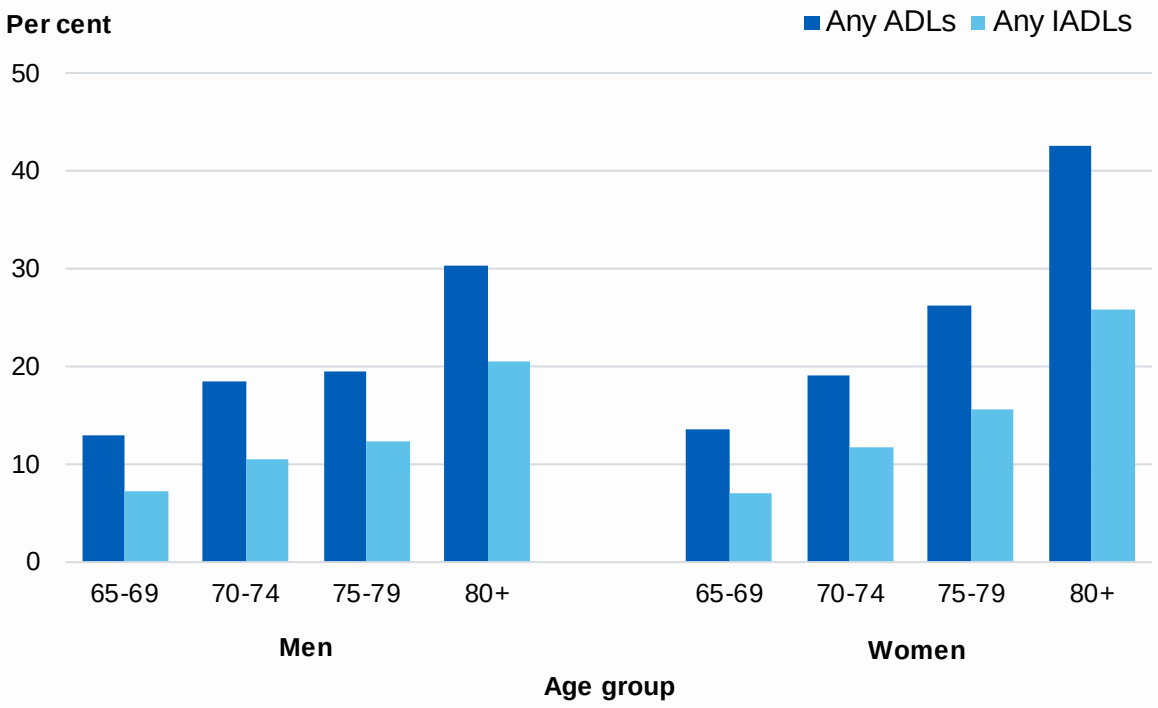
Unmet need for care increased with age for both ADLs and IADLs. 13% of adults aged 65 to 69 had some unmet need for at least one ADL, compared with 37% aged 80 and over. 7% of adults aged 65 to 69 had some unmet need for at least one IADL, compared with 23% of adults aged 80 and over.

Figure 6, Table 3

[21] There was a change to the routing of these questions from 2013 onwards; see note 4 to Table 4. This change has had a negligible impact on results.

Figure 6: Unmet need for ADLs and IADLs in last month, by age and sex

Base: Aged 65 and over



Source: NHS Digital

Trends in need and receipt of help and unmet needs

The need for help with ADLs and IADLs has declined since 2011, when 32% of adults aged 65 and over needed help with ADLs and 33% needed help with IADLs.

Table 3

Unpaid and paid help in the last month, by age of care recipient

Participants who had received help in the last month with ADLs or IADLs were asked who had provided help. Paid carers included home care workers, home helps or personal assistants; members of reablement or intermediate care teams; occupational therapists; physiotherapists; voluntary helpers; wardens or managers of sheltered housing; cleaners; and council handymen. Unpaid carers were defined as family members, friends or neighbours.

The majority of participants aged 65 and over reported receiving help from unpaid helpers only (68%). 21% said that they had received help from both unpaid helpers and paid helpers, and 10% said that they had received help from paid helpers only.

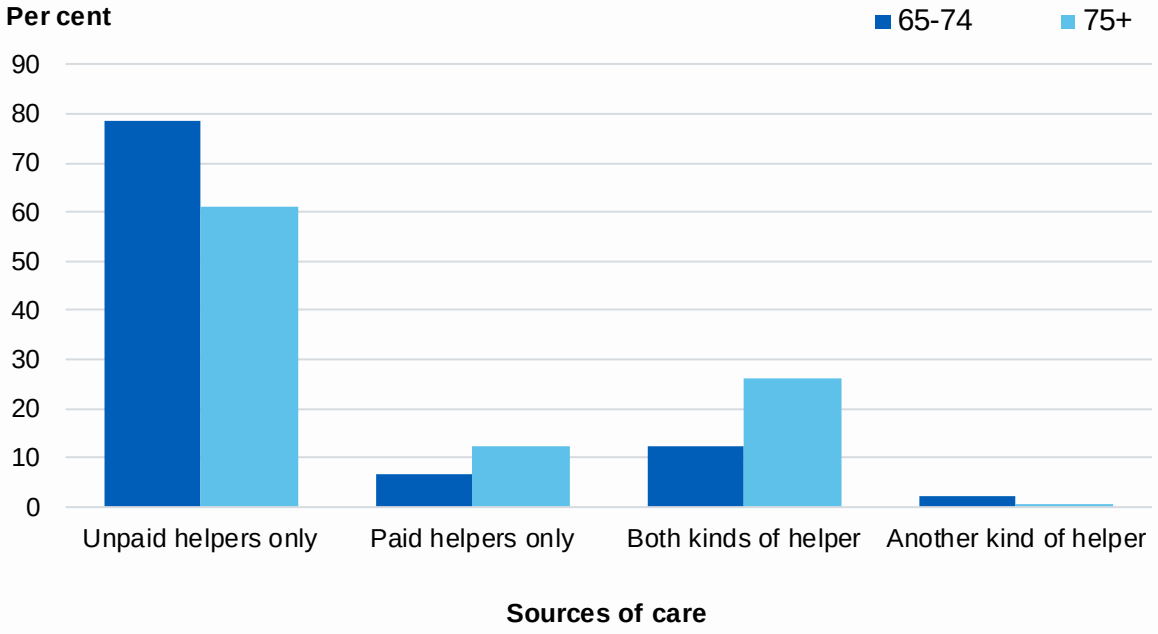
Receipt of care from paid helpers increased with age. 7% of adults aged 65 to 74 received care from paid helpers only, increasing to 12% of adults aged 75 and over. The same pattern was apparent for individuals who received care from both kinds of helpers; 12% of adults aged 65 to 74, increasing to 26% of adults aged 75 and over. The proportions receiving care only from unpaid helpers decreased with age from 79% aged 65 to 74 to 61% of those aged 75 and over. In both age groups, less than

half of adults who described themselves as receiving care were getting some or all of it from paid helpers.

Figure 7, Table 4

Figure 7: Summary of who provided help with ADLs and IADLs in the last month, by age

Base: Aged 65 and over, received help with ADLs or IADLs



Source: NHS Digital

Payment for care, by age of care recipient

Adults aged 65 and over who had received care for at least one ADL or IADL in the last month were asked whether they had received a personal budget, any care paid for by the local authority, or privately paid-for care.

As described in the previous section, only a minority accessed paid-for care. 16% had received privately paid-for care and 5% had received a personal budget from their local authority.

The proportion of adults who had received privately paid-for care increased with age. 6% of adults aged 65 to 74 reported paying privately for care, compared with 23% of adults aged 75 and over.

Table 5

Provision of care

Provision of unpaid care, by age and sex

Adults aged 16 and over were asked whether they had provided unpaid care or support to anyone in the last month because they had long-term physical or mental ill-health problems, a disability or problems relating to old age. Help provided in a professional capacity or as part of a job was excluded, but not help provided to family or friends for which some payment was received.

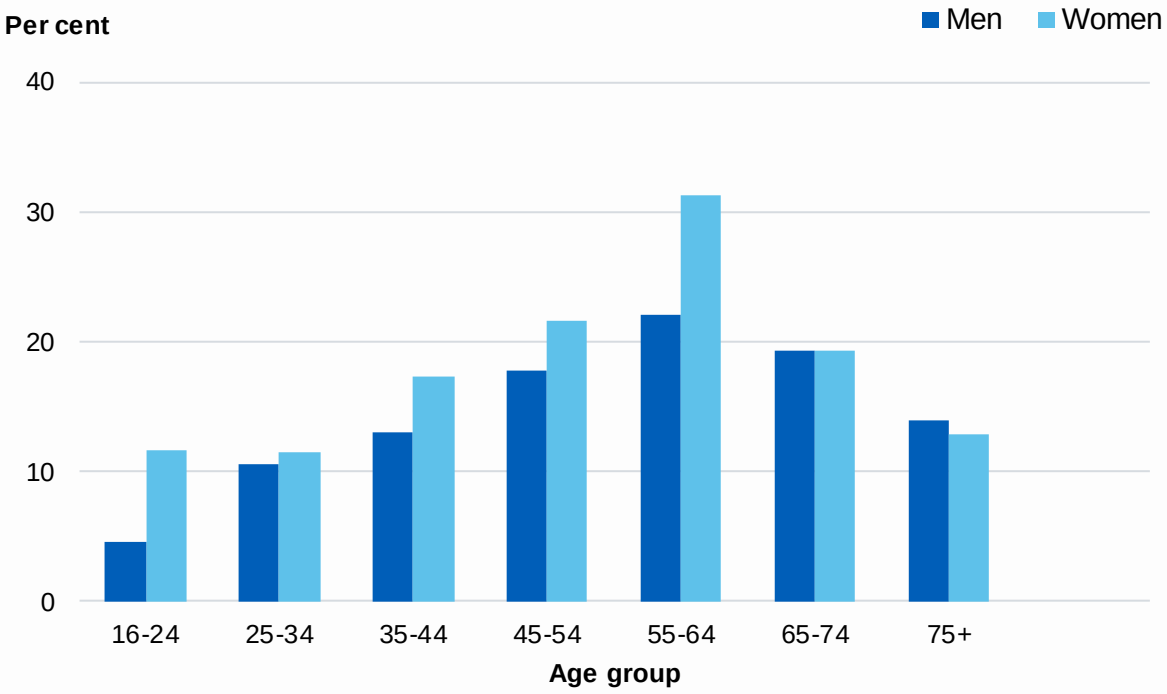
16% of adults reported providing unpaid help or support to at least one person, with women more likely than men to have done so (18% and 14% respectively). The majority of adults aged 16 and over had not provided unpaid care to anyone (86% of men and 82% of women).

Provision of unpaid care varied by age, more so among women than men. The proportions of men and women providing care to at least one person increased with age and were highest among 55 to 64 year olds, and then declined among the oldest age groups.

Figure 8, Table 6

Figure 8: Provision of unpaid care in the last month, by age and sex

Base: Aged 16 and over



Source: NHS Digital

12% of men and 14% of women reported caring for one person, whilst 2% of men and 4% of women reported caring for two or more people. Provision of care varied with age. Among both men and women, those aged 45 to 64 were most likely to report that they provided unpaid care to two or more people.

Table 6

Provision of unpaid care, by Index of Multiple Deprivation (IMD) and sex

The Index of Multiple Deprivation (IMD) is a measure of area deprivation, based on 37 indicators, across seven domains of deprivation.[22] IMD is a measure of the overall deprivation experienced by people living in a neighbourhood, although not everyone who lives in a deprived neighbourhood will be deprived themselves. To enable comparisons, areas are classified into quintiles (fifths).[23]

After age-standardisation, there were no statistically significant differences in the proportions of adults providing care according to neighbourhood deprivation.

Table 7

Support received by unpaid carers, by age and sex

Adults providing unpaid care in the last month were asked whether they were receiving different types of support for the care they were providing.[24] The majority of adults said that they had received no support for the care that they provided (56%).[25]

The proportions of unpaid carers who reported receiving no support varied by age, with 54% of men and 52% of women aged 16 to 44 receiving no support, compared with 68% of men and 63% of women aged 65 and over.

The most frequent source of support came from other family members (35%), with less than 10% of carers receiving support from each of the other sources asked about. Adults aged under 45 were most likely to report receiving support from other family members; 40% of adults aged 16 to 44 had received help from family members, compared with 36% of those aged 45 to 64 and 26% of those aged 65 and over.

Table 8

Impact on carers' health, by whether support received and sex

Adults who had provided unpaid care in the last month were asked about what impact, if any, caring had had on their health.[26] About half of adults (51%) reported one or more of the listed impacts, and 49% of adult carers said that their caring role had no such effects on their health. Men were more likely than women to report that caring had not had any impact on their health (54% of men and 45% of women).

The most common impacts on carers' health were feeling tired (29% of men and 39% of women), general feelings of stress (24% of men and 37% of women) and disturbed

[22] The seven domains used to calculate IMD are: income deprivation; employment deprivation; health deprivation and disability; education; skills and training deprivation; crime; barriers to housing and services; and living environment deprivation.

[23] For more information on the Index of Multiple Deprivation, see Health Survey for England 2017: Methods, available via the report website https://digital.nhs.uk/pubs/hse2017 .

[24] The types of support asked about were help from a GP or nurse; access to respite care; help from professional care staff; help from a carers' organisation or charity; help from other family members; advice from local authority or social services; or help from friends or neighbours.

[25] Carers were not asked whether they had asked for any type of support, so it is not possible to distinguish between those who asked for support that they did not receive and those who had not asked for any of these types of support.

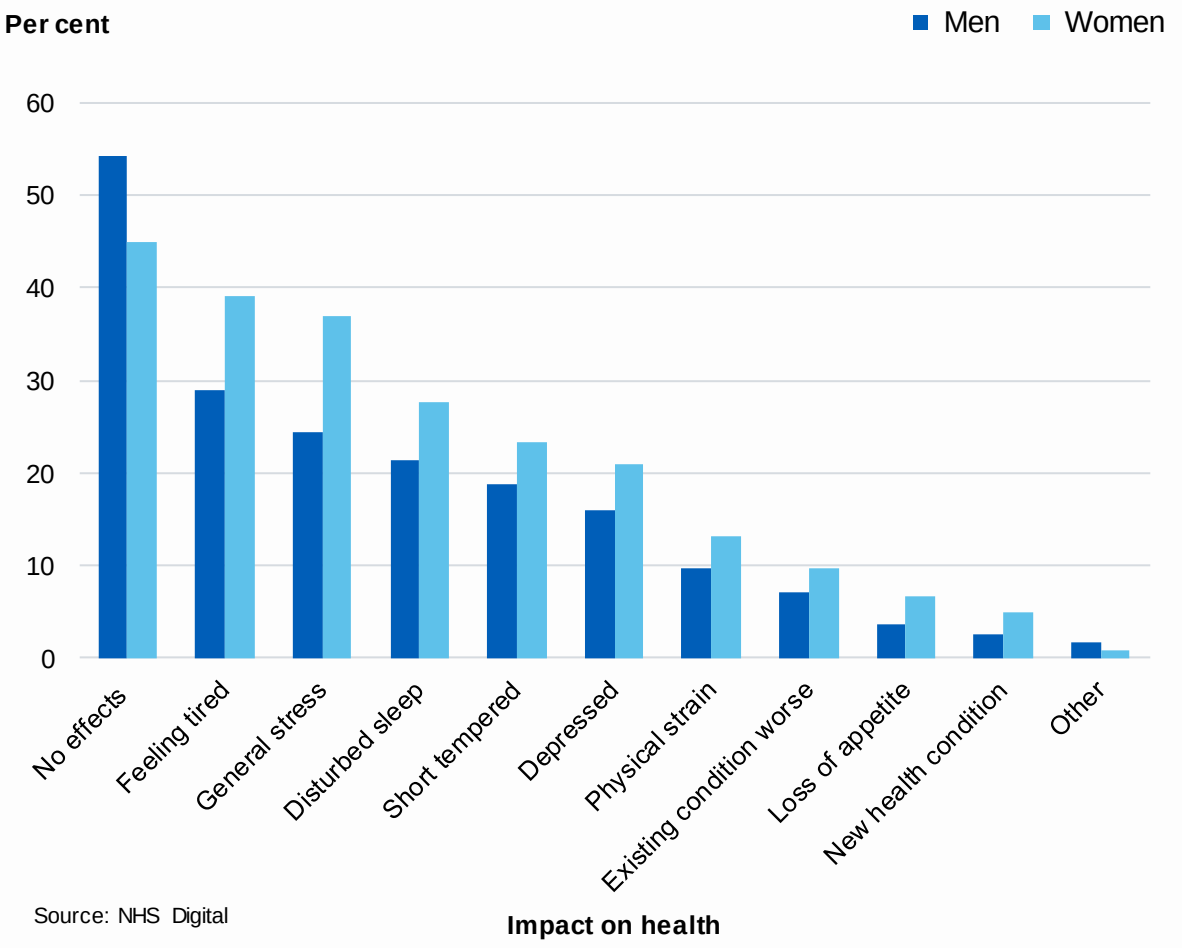
[26] The health conditions asked about were feeling tired; feeling depressed; loss of appetite; disturbed sleep; general feeling of stress; physical strain; short tempered; developed own health condition; made an existing condition worse.

sleep (21% of men and 28% of women). Women were more likely than men to report negative effects on their health.

Figure 9, Table 9

Figure 9: Impact on carer's health, by sex

Base: Aged 16 and over, provided care in the last month



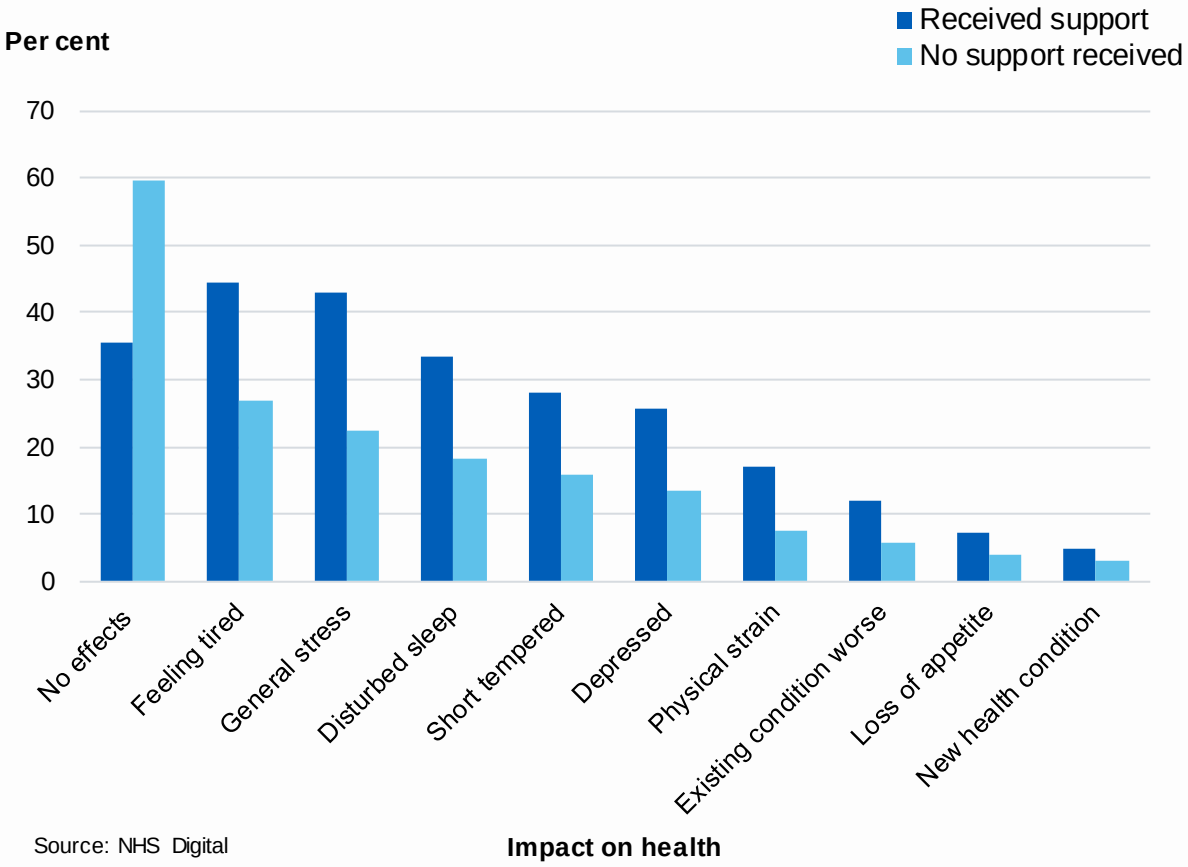
Higher proportions of adults who had received support for their caring role reported health effects as a result of their caring responsibilities compared with those who had not received support. But, as noted above, those who had not received support may not have asked for it, or may have asked for support that they did not receive.

Health impacts where this was apparent included feeling tired (45% of those who had received some support compared with 27% of those who had received no support), general feelings of stress (43%, compared with 22% respectively), disturbed sleep (33% and 18% respectively), feeling depressed (26% and 14% respectively), and physical strain (17% and 7% respectively).

Figure 10, Table 9

Figure 10: Impact on carer's health, by whether support received

Base: Aged 16 and over, provided care for more than 10 hours per week in the last month



Source: NHS Digital

Receipt of local authority carer's assessment, by age and sex, and hours of care provided

A similar proportion of men and women (15% and 14% respectively) providing unpaid care in the last month had received a local authority carer's assessment.[27]

Table 10

Whether adults providing unpaid care had received a carer's assessment by the local authority varied by the number of hours of care they had provided in the last week.[28] 26% of carers who provided 20 or more hours of care in the last week had received a

[27] Carers have a right under the Care Act 2014 to have their needs assessed every 12 months, but in practice this will occur only if they request an assessment or are referred by a third party. See Department of Health and Social Care (2018) *Care and support statutory guidance.* https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#first-contact-and-identifying-needs

The question did not specify a reference period, so it is not possible to conclude whether those who had not received an assessment were referring to the last 12 months or to a longer period.

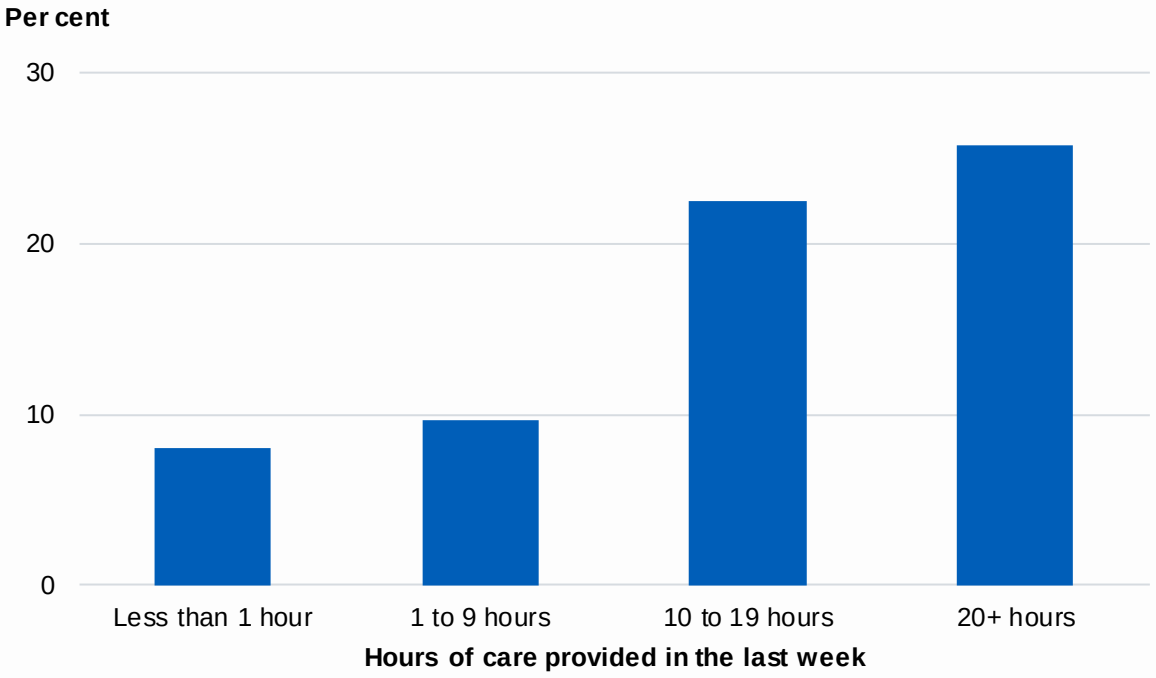
[28] The hours of help provided in the last week relate to one person the participant helped. In cases where a participant had helped more than one person, details are recorded for the person to whom they provided the most help. If they helped two people for the same amount of time, the first one recorded is reported.

local authority carer's assessment, compared with 8% of carers who had provided less than one hour of care.

Figure 11, Table 11

Figure 11: Received local authority carer's assessment, by hours of care provided in last week

Base: Aged 16 and over, provided care in the last month



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