

Economic and social value of the UK adult social care sector

Independent research by Alma Economics

Prepared for Skills for Care and Development

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About the authors



Alma Economics combines unparalleled analytical expertise with the ability to communicate complex ideas clearly.

www.almaeconomics.com

About the commissioning organisation

Skills for Care and Development is an Alliance of seven organisations in the UK and Republic of Ireland, that focuses on regulation and workforce development in social care, social work, and early years. The Alliance consists of Skills for Care; Northern Ireland Social Care Council; Scottish Social Services Council; Social Care Wales; CORU; Early Years Alliance and Social Work England.

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Northern Ireland Social Care Council (NISCC) is a public body established by the Department of Health to support high quality standards of social work and social care. NISCC helps raise standards in the social care workforce in Northern Ireland.

See: www.niscc.info



Scottish Social Services Council (SSSC) is the regulator for the social work, social care and children and young people workforce in Scotland. Their work means the people of Scotland can count on social work, social care and children and young people services being provided by a trusted, skilled, confident and valued workforce.

See: www.sssc.uk.com



Skills for Care is the strategic workforce development and planning body for adult social care in England. They work with employers, Government and partners to ensure social care has the right people, skills and support required to deliver the highest quality care and support now and in the future.

See: www.skillsforcare.org.uk



Social Care Wales is the regulator for the social care workforce in Wales, as well as supporting service improvement in social care.

See: www.socialcare.wales

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Abbreviations

List of acronyms

Acronym	Definition
A&E	Accidents and Emergencies
ASC	Adult Social Care
ASCOF	Adult Social Care Outcomes Framework
ASCS	Adult Social Care Survey
ASC-WDS	Adult Social Care Workforce Dataset
ASHE	Annual Survey of Hours and Earnings
BCR	Benefit-Cost Ratio
DALY	Disability Adjusted Life Year
EBITDAR	Earnings Before Interest Taxes Depreciation Amortisation and Restructuring or Rents
FTE	Full-Time Equivalent (called Whole-Time Equivalent or WTE in Scotland)
GOS	Gross Operating Surplus
GVA	Gross Value Added
INA	Immediate Needs Annuities
PAs	Personal Assistants
PAYE	Pay as You Earn
PSSRU	Personal Social Services Research Unit
QALY	Quality-Adjusted Life Year
SCRQoL	Social Care-Related Quality of Life

List of definitions

Key term	Definition
Adult Social Care Survey	The Personal Social Services Adult Social Care Survey is an annual survey of all service users 18 and over who have received long-term support services in England. The aim of the survey is to understand how effective adult social care services are in supporting their users (NHS Digital, 2023).
Benefit-Cost Ratio (BCR)	The ratio of the estimated value of benefits compared to costs. If the BCR exceeds 1, this indicates that £1 of expenditure returns more than £1 of benefit.
Day care	Care provided for service users in a day care centre (non-residential) or the provision of activities outside the home.
Direct effects	The economic effects created by the operation of the adult social care sector itself. These include the earnings of employees in the sector, the gross operating surplus of independent care providers, and the number of jobs created.

Direct payment recipient	An individual who receives payment from the Government or local authority to pay for their own care, rather than having prescribed care provided to them.
Disability Adjusted Life Year (DALY)	DALYs measure years lost and years lived adversely due to illness, disability, or injury. One DALY is equal to losing one year of healthy life due to premature death.
Domiciliary care	Care and support provided in a service user's own or family home.
Earnings Before Interest, Taxes, Depreciation, Amortisation, and Restructuring or Rents (EBITDAR)	EBITDAR is a standard measure of operating profitability for the private sector. EBITDAR focuses on a company's main operations, excluding expenses such as taxes, rent, and non-cash expenses. This facilitates comparison across companies as it minimises differences arising from factors not related to the core operations of a company.
Formal carer	Someone employed to provide paid help to adults with disabilities and or physical or mental illnesses.
Full Time Equivalent (FTE)	An FTE is equal to the hours a person employed full-time would work in a week. While this varies across countries, in England, Wales, and Northern Ireland, it is equal to 37 hours. As a result, a person working 0.5 FTEs, works half as many hours as a person employed full-time would (i.e. 18.5 hours per week).
Gross Operating Surplus (GOS)	The GOS is defined as income minus operating costs. It captures the income generated through profits and rents by independent providers of adult social care after subtracting, for instance, staff costs, costs associated with day-to-day services, and transportation costs.
Gross Value Added (GVA)	The amount of goods and services that have been produced, minus the cost of all inputs and raw materials that are directly attributable to that production.
Independent care	Private and voluntary sector providers of adult social care.
Indirect effects	Indirect are the effects created by the demand for intermediate goods and services by adult social care to provide its services.
Induced effects	Induced are the effects created by changes in the purchasing behaviour of individuals directly and indirectly employed in the adult social care sector.
Informal carer	Someone who provides unpaid help to a friend or family member needing support, perhaps due to illness, older age, disability, a mental health condition or an addiction (Department of Health & Social Care, 2018). Informal carers are referred to as "unpaid carers" in Wales.
Loss ratio	The loss ratio is a term used in the insurance sector, defined as the losses an insurer incurs from paying claims as a percentage of premiums earned. It represents the proportion of the income an insurer gains that is then claimed by insurance customers.
Macroeconomic impact	The macroeconomic impact includes the contribution of the adult social care sector to the economy, including wages of carers and operational profits of providers (direct impact), as well as the demand and income generated in other sectors because of adult social care (indirect and induced impacts).

Non-regulated care	Employers in the adult social care sector which are not subject to inspections or regulation.
Nursing care	Support provided to individuals with a higher level of needs. This support is delivered by specially trained carer and overseen by nurses.
Personal assistants (PAs)	Personal assistants are people hired directly by someone who requires support. They can also be employed by a family member or representative when the person they are supporting does not have the physical or mental capacity to be the employer. A PA works directly with the individual they are supporting in a person-centred way to enable them to live their life according to their wishes and interests.
Private care	Employers in the adult social care sector owned by for-profit private enterprises.
Public care	Employers in the adult social care sector owned and operated by local authorities and the NHS.
Quality-Adjusted Life Year (QALY)	A measure of the state of health of a person or group in which the benefits, in terms of length of life, are adjusted to reflect the quality of life. One quality-adjusted life year (QALY) is equal to 1 year of life in perfect health.
Regulated care sector	Employers in the adult social care sector that are inspected and regulated by the national social care inspectors (or Care Inspectorate Officers in Scotland).
Residential care	Care provided in a residential setting rather than in a service user's own or family home.
Social Care-Related Quality of Life (SCRQoL)	SCRQoL is part of the Adult Social Care Outcomes Framework (ASCOF) and Adult Social Care Survey (ASCS) captured in metric "1A: Quality of life of people who use services". This measures the care users' reported experience in eight outcome domains covering control, dignity, personal care, food and nutrition, safety, social participation and accommodation.
Socioeconomic impact	The socioeconomic impact includes wider benefits to the society, not captured in the macroeconomic models, such as wellbeing of adults receiving care.
Voluntary care sector	Service providers in the adult social care sector run by not-for-profit organisations.
Whole Time Equivalent (WTE)	A WTE is equal to the hours a person employed full-time would work in a week. While this varies across countries, it is equal to 37.5 hours in Scotland. As a result, a person working 0.5 WTEs works half as many hours as a person employed full-time would (i.e. 18.75 hours per week).

Executive summary

According to the latest available evidence, around 1.8 million people in the UK worked in the adult social care sector in 2022 (Dodsworth & Oung, 2023; Scottish Social Services Council, 2023; Skills for Care, 2021; Social Care Wales, 2023a). The sector encompasses a diverse range of services tailored to support adults with care and support needs, spanning across public, private, and voluntary sectors. The demand for social care is expected to grow in the UK overall, as the population over 85 is projected to grow by 62% by 2037 (Office for National Statistics, 2024a).

Recognising the importance of the adult social care sector, Skills for Care and Development (herein referred to as “the Alliance”) commissioned Alma Economics to analyse the economic and social value of the adult social care sector in the UK and each of the four nations. The findings of this project will be used by the Alliance to inform public policy and improve public understanding, as well as reframe social care as an essential social and economic investment. This report focuses on the adult social care sector in the UK; the research team has produced separate reports discussing the findings for each nation.

For this research, our team developed two types of models: one focusing on macroeconomic impacts and the other on socioeconomic impacts. Both models consider a wide range of care settings (e.g., residential) and types of service provision (e.g., local authority/local trust (NI)), including informal care, across regulated and non-regulated sectors.

The macroeconomic models estimate the contribution of the adult social care sector to the UK economy. We estimated the macroeconomic impact by accounting for wages and earnings of employees in the sector, as well as the operating profits of independent care providers (direct impact). **Our estimates suggest that the adult social care sector creates over £33.5 billion in Gross Value Added (GVA) and supports 1.3 million full-time equivalent (FTE) jobs, with a labour productivity of approximately £26,600 per FTE. When informal care is included, the direct GVA is estimated at nearly £139.5 billion, and the number of FTEs at almost 6 million, yielding a labour productivity of £23,200 per FTE.**

The research also considered the indirect and induced effects of adult social care in the UK. The indirect effect arises from increased demand in other sectors that are part of the adult social care sector’s supply chain, such as personal protective equipment or home adaptations. Both direct and indirect effects lead to a rise in household income across the economy, driven by increased employment. A portion of this additional income is spent on other goods, which constitutes the induced effect. **The indirect effect, i.e., the value and employment created in other sectors due to the adult social care sector, is estimated at 446,300 FTEs and £15.5 billion of GVA. Similarly, the induced impact, resulting from the additional spending of**

individuals directly or indirectly employed in the sector, is estimated at 255,700 FTEs and £22.4 billion of GVA.

Overall, the adult social care sector in the UK supports 2 million full-time equivalent (FTE) jobs and generates £71.4 billion in value when considering direct, indirect, and induced impacts, not including informal care. The estimated GVA of the adult social care sector represents approximately 3% of the total GVA in the UK in 2023, up from 1.4% in 2016 (ICF, 2018d; Office for National Statistics, 2024b). However, we recommend such direct comparisons be treated with caution, given methodological changes and data quality concerns.

The majority of the impact originates from England, with £60.2 billion of GVA and 1.6 million FTEs. Scotland has the second greatest macroeconomic impact due to adult social care, with the sector creating £5.2 billion in GVA and 171,400 FTEs. In Wales, the adult social care sector contributes £4.6 billion in GVA and 116,700 FTEs, while the respective estimates for Northern Ireland are £1.5 billion and 46,500 FTEs. However, care should be taken when drawing conclusions from national comparisons due to the significant differences in care provision across nations.

The adult social care sector also creates a wide range of benefits that are not captured in GVA or employment measures, such as the wellbeing of adults receiving care and peace of mind for the general population. To estimate the magnitude of these socioeconomic impacts, we compared the costs and benefits of adult social care to a hypothetical scenario in which the adult social care sector (both formal and informal) ceases to exist. The results of this analysis suggest that the socioeconomic benefits of the adult social care sector in the UK are £332.6 billion while costing £141.6 billion. This means that for every £1 spent, there are £2.35 in socioeconomic benefits.

As with the macroeconomic impact, England has the highest socioeconomic impact (i.e. total benefits minus total costs) (£151.8 billion), followed by Scotland (£16.9 billion), Wales (£14.5 billion), and Northern Ireland (£7.8 billion). Northern Ireland achieves the highest Benefit-Cost Ratio (BCR), with a return of £2.82 for each invested pound. Wales ranks second, with a BCR of £2.78, followed by England (£2.36) and Scotland (£1.98).

As evident from the above analysis, there are significant differences in the macroeconomic and socioeconomic impacts across the four nations. Several factors may explain these differences, including variations in the definitions of the adult social care sector and the underlying socioeconomic factors in each country. Below, we highlight some key distinctions in how adult social care is defined in our analysis.

1. The estimates for Northern Ireland do not include unregulated sector provision and personal assistants due to a lack of relevant data. As a result, the earnings and GVA for Northern Ireland appear lower than they would be with the inclusion of these sectors.
2. There is no separate nursing care home provision in Scotland. As a result, the figures for residential care in Scotland include both care homes with and without

nursing, which partially explains the larger size of this care type relative to the remaining ones.

3. The category for “other” care provision includes different services for each country, thus its size is directly affected by the number and type of services included.
4. It is worth noting that data relating to certain types of social care provision¹ in Wales is taken from data collected by Social Care Wales (SCW) as part of their unpublished 2023 Workforce Data Collection. SCW suggested that this data required the use of estimation methods to account for missing data. Triangulation with other available data shows that these figures may exhibit some inaccuracies, so our findings may be somewhat affected as a result.

Socioeconomic and demographic differences across countries may also impact our estimates. For instance, England appears to have the highest totals in our analysis due to the larger size of its care population (both formal and informal) compared to the other four nations. Similarly, one of the key factors affecting socioeconomic impacts and the resulting BCR is the growth rate of the adult social care workforce and of adults receiving care in each country. As a result, if a nation has a significantly higher growth rate for adults receiving care, this would lead to proportionately larger socioeconomic benefits compared to the other nations. Another factor affecting our estimates is the wage of carers. Policies such as the introduction of the living wage for carers in Scotland and Wales significantly impact the earnings in the sector, which in turn affects GVA and productivity calculated as part of the macroeconomic impact.

¹ This concerns day care and other care provision.

1. Introduction

To ensure the sustainability of the sector, Skills for Care and Development has commissioned Alma Economics to analyse the economic and social value of the adult social care sector in the UK and each of the four nations. The project estimated the value of the sector, and the findings will help inform investment cases and policymaking, and enhance public understanding of the sector's importance.

The chapters in this document are: 1. Introduction, 2. Methodological approach, 3. Findings, 4. Technical appendix, and 5. References.

1.1. Background

Skills for Care and Development is an Alliance of seven key organisations in the UK and Republic of Ireland, that focuses on regulation and workforce development in social care, social work, and early years. The Alliance consists of Skills for Care; Northern Ireland Social Care Council; Scottish Social Services Council; Social Care Wales; CORU; Early Years Alliance and Social Work England.

To support the long-term sustainability of the sector, Skills for Care and Development is seeking to build upon the economic information the Alliance have and inform the economic case for investment in the adult social care sector. To that end, Skills for Care and Development commissioned Alma Economics to analyse the adult social care sector's economic and social value in the UK as a whole and in each of the four nations.

The overall aim of the project is to:

- inform the economic case for investment in the social care sector and its workforce in the UK as a whole (as well as having national breakdowns), influencing policymaking and national spending review decisions on investment.
- improve public understanding of the value of the sector, emphasising the importance of investing in social care.

1.2. Structure of the document

This document outlines our methodological approach and main findings from analysing the macroeconomic and socioeconomic impacts of the adult social care sector in the UK. It should be read alongside the reports for each nation, which offer additional insights.

- [Chapter 2](#) provides an overview of our methodological approach, covering the definition of the sector, the groups analysed, the direct and indirect effects considered, and the types of impacts assessed in the socioeconomic costs and benefits.

- [Chapter 3](#) presents the key findings from our macroeconomic and socioeconomic analyses.
- [Chapter 4](#) presents illustrative case studies of interventions or programs in adult social care across all nations.
- [Chapter 5](#) lists all sources used across the analyses for each nation.
- The report concludes with a [Technical Appendix](#), which elaborates on our methodology, sources, and assumptions used to determine the sector's direct, indirect, and induced value, as well as its benefit-cost ratio.

2. Methodological approach

The methodological approach used to estimate the economic impact of adult social care in the UK is common across the four nations. In particular, following a thorough desk-based review, we identified key areas of impact of the adult social care sector and used these to create two types of models, one including the macroeconomic impacts and another focusing on the socio-economic ones.

Social care is a wide term, with different definitions across nations. To facilitate comparability and aggregation of findings we defined adult social care as “[...] the support provided to adults (both older people and people of working age) with physical disabilities, learning disabilities, or physical or mental illnesses, and their carers. This may include personal care (such as support for eating, washing or getting dressed) or help with domestic routines (such as cleaning or going to the shops).” (Foster, 2024)

Where possible, we examined a wide range of care settings (e.g. residential) and types of service provision (e.g. local authority), including informal care, across the regulated and non-regulated sectors.

The macroeconomic impact of the sector consists of direct, indirect, and induced effects. The direct impact has been estimated using the Gross Value Added (GVA), as the total value of wages and earnings of employees of the adult social care sector and the gross operating surplus of independent care providers. We also estimated the socioeconomic costs and benefits of the adult social care sector, encompassing both direct and induced costs, as well as tangible and intangible benefits.

2.1. Overview of approach

Our methodological approach consisted of three phases. In the first phase, we carried out scoping and impact mapping to identify the main areas of impact and develop a detailed analysis plan. In the second phase, we developed an economic model to update the analysis of direct, indirect, and induced impacts, as well as calculate wider and wellbeing benefits. In the last phase, we drafted the report of findings for each nation and the UK as a whole.

In particular, Phase 2 consisted of:

- Calculating the [macroeconomic impact of adult social care in the UK](#), including direct, indirect, and induced impacts (explained in a following section of this chapter).

- Estimating the [socioeconomic costs and benefits](#) of the adult social care sector in England.
- Creating [indicative case studies](#) of interventions and programmes that have proven successful in adult social care (presented in the last chapter).

2.2. Sector Definition

Social care does not have an established definition. We used the following definition: *“Adult social care is the support provided to adults (both older people and people of working age) with physical disabilities, learning disabilities, or physical or mental illnesses, and their carers. This may include personal care (such as support for eating, washing or getting dressed) or help with domestic routines (such as cleaning or going to the shops).”* (Foster, 2024)

The definition does vary depending on the country and context. In England, the UK Government (2014) defines care and support as the provision to meet adults’ and carers’ needs, as well as the provision of services, facilities or resources, or other steps under local authorities’ duties to individuals’ wellbeing. The Scottish Government defines adult social care as comprising: *“all forms of personal and practical support for adults who need extra support (which also applies to children and young people). It describes services and other types of help, including care homes and supporting unpaid carers to help them continue in their caring role.”* (Jepson, 2020). In Wales, the Social Services and Wellbeing (Wales) Act 2014 defines the duties of local authorities to meet adults’ needs for care and support, if the adult is within the local authority’s area or the ordinary resident in the authority’s area, but outside its area. Similarly, the act specifies the duties of local authorities to meet the needs for support of a carer, where appropriate (Welsh Government, 2014).

Social care does not have an established definition in Northern Ireland. The Department of Health in Northern Ireland has established the Adult Social Care Collaborative Forum. The Forum uses an indicative definition of adult social care, based on the Department of Health’s relevant 2013 consultation, which describes adult social care as *“[...] the activities, services and relationships that help us to live an independent, healthy and inclusive life. It is available to any adult with eligible needs who requires assistance due to disability, vulnerability, illness, incapacity or old age, and is designed to promote independence, social inclusion, safeguarding and wellbeing.”* (Department of Health, 2013).

2.2.1. Groups of interest

For the purpose of this study, we built on the ICF (2018a) work and defined as part of adult social care the following groups: (i) regulated providers across the private, public, and voluntary sectors; (ii) non-regulated providers; and (iii) personal assistants. However, we recognise that informal care is a significant part of adult social care. To

that end, we went beyond the ICF methodology and analysed the economic contribution of informal carers and the financial support provided to them.

There are considerable differences across the four nations in care settings (e.g. residential) and types of service provision (e.g. local authority/local trust²), as well as forms of regulation. To facilitate aggregation and comparability, we present results in 5 common care settings (presented below). However, **care should be taken when directly comparing figures across nations.** Footnotes throughout the report and the technical appendix mark the most significant differences between nations.

- Residential (or care homes without nursing)
- Nursing (or care homes with nursing)
- Domiciliary (or homecare)
- Day care
- Other care settings

2.3. Impacts and approach to quantification

Following a detailed literature and evidence review, we have identified direct, indirect, induced, and wider impacts of adult social care. The direct, indirect, and induced impacts were used to calculate the macroeconomic impact of the adult social care sector in the UK, while the wider socioeconomic impacts were used in our socioeconomic impact analysis.

The subsections below present the impacts we quantified, the indicators used, and the underlying rationale. All figures are reported in 2023 values. Estimates before 2023 were adjusted to 2023 values using GDP deflators.

2.3.1. Gross Value Added (GVA)

Indicators:

- **Wages and earnings** of employees of the adult social care sector.
- **Gross Operating Surplus** to capture income generated by the sector, other than wages.

GVA is the standard metric to estimate the macroeconomic impact of a sector. GVA measures “*The value generated by any unit engaged in production and the contributions of individual sectors or industries to GDP. It is measured at basic prices, excluding taxes less subsidies on products.*” (Office for National Statistics, n.d.). There are alternative approaches to calculating GVA, namely income, expenditure and output

² In Northern Ireland, both health and social care services are provided by combined statutory bodies known as Health and Social Care Trusts. In the remaining UK countries, health services are provided by the NHS while care is provided by local authorities (Northern Health and Social Care Trust, n.d.).

approaches. However, based on all ICF reports, the three approaches to calculating GVA would have yielded similar results (ICF, 2018a; 2018b; 2018c; 2018d; 2018e).³

As a result, we followed the approach of the KD Network Analytics and Skills for Care (2021) report and Office for National Statistics (2017), and calculated GVA using the income approach (i.e. quantified the total income generated by the sector).

We chose the income approach because the required indicators are readily available, consistently defined, and robustly calculated. This facilitated aggregation to the UK level and comparisons across countries.

2.3.2. Labour productivity

Indicators:

- **GVA**
- **Full Time Equivalent (FTE)**

Productivity is a key metric of macroeconomic value, as emphasised by the Green Book guidance (HM Treasury, 2022). In this context, we focused on labour productivity. This is defined as GVA produced for a given measure of labour. The Office for National Statistics (2023) calculates productivity as GVA per hour worked, per worker, or job. However, to ensure comparability with previous reports on adult social care (i.e. ICF, 2018a and KD Network Analytics & Skills for Care, 2021 reports), we calculated labour productivity as GVA per FTE.

2.3.3. Avoided financial costs to the NHS

Indicators:

- **Hospital admissions**
- **Accidents and Emergencies (A&E) admissions**
- **Discharges from acute care**

Health and social care sectors work complementarily. Care workers can help prevent hospitalisation and accidents, reducing the frequency of emergency attendances. Furthermore, social care arrangements are a prerequisite for discharge from acute care. As a result, without adequate adult social care capacity, the NHS will incur additional costs due to having to accommodate medically fit individuals who could have been discharged.

³ The kd Network Analytics and Skills for Care (2021) report notes that “in theory, and with perfect data, all three methods give the same answer”.

2.3.4. Peace of mind benefits

Indicator:

- **Loss ratio** of providers of private long-term care

Evidence suggests that individuals who buy insurance pay more in premiums than they receive through claims (Forder, 2011). This suggests that they are receiving other benefits apart from monetary ones. We propose that people are willing to accept the monetary cost because they value the peace of mind that insurance provides. As a result, we can calculate the size of the peace-of-mind benefit using the monetary loss that individuals are willing to accept through insurance. We expect that adult social care also provides peace of mind to the general population by ensuring that support will be available when needed.

2.3.5. Quality of life and wellbeing

Indicators:

- **Social Care-Related Quality of Life (SCRQoL)** as captured in the Adult Social Care Survey: The Green Book emphasises the importance of wellbeing in policy appraisal and evaluations and suggests various metrics (HM Treasury, 2022). Following the KD Network Analytics & Skills for Care (2021) report, we quantified and monetised the impact of adult social care on the Social Care-Related Quality of Life. We used the adjusted SCRQoL, following Forder et al. (2016), to account for (i) external factors that might influence the quality of services and (ii) different preferences across the SCRQoL metrics.
- **Quality of Life Adjusted Years (QALYs):** Access to social care significantly reduces the likelihood of individuals experiencing injuries and falls, thereby preventing the deterioration of their health. Thus, social care may improve health outcomes for those receiving care. Health outcomes are typically measured in terms of quality-adjusted life years (QALYs), which can be quantified and monetised. QALYs represent the additional healthy years gained by individuals due to receiving support. As per HM Treasury (2022) Green Book guidance, QALYs can be monetised by applying a £70,000 value (in 2020 prices) for each QALY gained. For instance, if an intervention has been found to create 0.4 QALYs (i.e. 40% of a year in perfect health and wellbeing), that means that the monetary benefit of the intervention is £28,000 in 2020 prices.

2.4. Indirect and induced effects

The adult social care sector generates additional value through indirect and induced effects on top of its direct economic impact. Indirect effects are those created by the demand for intermediate goods and services by adult social care to provide its services. For instance, adult social care services need medical supplies, education and training for employees, cleaning products and services, furniture and household goods, among

others. As a result, adult social care supports additional employment and GVA in addition to its direct contribution. Induced are the effects created by the purchases of goods and services by individuals employed in the adult social care sector (directly or indirectly).

2.5. Estimating the socioeconomic impact of the sector

This section outlines the approach used to estimate the economic and social costs and benefits of adult social care in England. In subsection 2.5.1, we present our methodological approach, including the analytical scenario and types of impacts. In subsection 2.5.2, we outline our approach to calculating the costs and benefits included in our analysis.

Our approach accounted for both direct and indirect costs, as well as both tangible and intangible benefits that can arise from the sector. The direct costs concerned the financial investment needed for the day-to-day operations of the sector, such as the labour costs of care workers. Indirect costs include non-cash side-effects of adult social care that arise indirectly from the operation of the sector and are not part of the operating expenses. In particular, we included the salaries of formal carers that would need to be paid to provide the same level of care currently offered by informal carers. Tangible benefits, such as the reduction of A&E admissions, were quantified and monetised based on avoided costs. Intangible benefits, such as peace of mind benefits, were monetised using evidence from the international literature on people's preferences and willingness to pay for such benefits.

2.5.1. Analytical scenario

To quantify and monetise the costs and benefits associated with adult social care, we needed a basis of comparison. As a result, we compared the costs and benefits of the adult social care sector (baseline) with a scenario where both formal and informal adult social care do not exist. Under the analytical scenario, we would expect some people to receive no support, while others would access NHS to receive the support that would otherwise be provided by adult social care. Those receiving no support would experience adverse health and wellbeing impacts due to not receiving care and would be more likely to experience increased injuries or illnesses, as adult social care helped prevent injuries and illnesses in the baseline scenario. Those accessing NHS would create an additional strain on NHS, as they would stay in NHS due to the absence of adult social care.

2.5.2. Socioeconomic costs and benefits

We considered the following costs and benefits for the baseline scenario where adult social care exists:

Costs:

- Salaries of formal carers: Earnings of people providing formal care.
- Replacement cost of informal carers: The equivalent costs required to provide the level of care offered by unpaid carers.
- Resources spent on the delivery of adult social care: Expenditure on other non-labour costs, such as buildings and land.

Benefits:

- Improved wellbeing due to receiving social care: The improved wellbeing benefit relates to satisfaction with social care services. It captures care users' reported experience in eight outcome domains of control, dignity, personal care, food and nutrition, safety, social participation and accommodation. It does not include the impact of avoiding injuries on wellbeing or quality of life
- Improved health/quality of life due to not getting injured and being hospitalised (prevention): This benefit reflects the impact on quality and quantity of life due to injuries avoided through social care. This does not include the 8 domains mentioned above.
- Increased peace of mind benefits for the general public: The peace of mind benefits concern a different population compared to the previous two. While the aforementioned benefits apply to adults receiving social care, the peace of mind benefits apply to the general public, reflecting the benefit of knowing adult social care exists if needed (similar to insurance).
- Reduced NHS costs due to prevented hospitalisation and emergencies: As mentioned in the second benefit, adult social care helps prevent injuries. Apart from the impact on health and quality of life of adults in care, this also creates savings for the NHS through avoided hospitalisations.
- Increased efficiency in care provision from adult social care compared to the NHS: There is evidence that adult social care enables medically fit people to leave the hospital. The lack of available adult social care placements is one of the main reasons for delayed hospital discharges. As a result, the existence of the adult social care sector helps free up NHS capacity and could prevent additional discharge delays if sufficient placements were available.

3. Findings

The adult social care sector in the UK, covering formal care, creates approximately 2 million FTEs and £71.4 billion in economic value across direct, indirect and induced impacts (excluding informal care). The estimated GVA is equivalent to approximately 3% of the total GVA in the UK in 2023.

The majority of this impact originates from England, with £60.2 billion of GVA and 1.6 million FTEs. Scotland has the second greatest macroeconomic impact due to adult social care. In particular, the operation of adult social care in Scotland creates £5.2 billion and 171,400 FTEs. The adult social care sector in Wales represents £4.6 billion of GVA and 116,700 FTEs, while the respective estimates for Northern Ireland are £1.5 billion and 46,500 FTEs.

The direct impact constitutes the largest portion of this macroeconomic value in all countries. In total, the direct impact of the adult social care sector in the UK reaches more than £33.5 billion in GVA and 1.3 million FTEs. As a result, each FTE in the adult social care sector creates approximately £26,600. Including informal care in the calculations, the direct GVA increases to almost £139.5 billion and the number of FTEs to almost 6 million. Consequently, labour productivity is almost £23,200 per FTE.

The adult social care sector also creates employment and economic value in other sectors due to the demand for intermediate goods and services (e.g. medical supplies) to provide care (indirect effects). Our analysis suggests that the indirect effects of formal care create 446,300 FTEs in other sectors, generating approximately £15.5 bn. Furthermore, the spending of individuals directly or indirectly employed in the formal adult social care sector creates additional employment and economic value in other sectors (induced effects). In particular, the induced effects create 255,700 FTEs and generate £22.4 bn in GVA.

Beyond employment and GVA, the adult social care sector also generates wider impacts on society. Our analysis suggests that the socioeconomic benefits of the adult social care sector in the UK are £332.6 billion, while the costs are £141.6 billion. This means that for every £1 invested in adult social care in the UK, £2.35 in benefits are generated.

As with the macroeconomic impact, England has the highest socioeconomic impact (i.e. total benefits minus total costs) (£151.8 billion), followed by Scotland (£16.9 billion), Wales (£14.5 billion), and Northern Ireland (£7.8 billion). Northern Ireland achieves the highest BCR, with a return of £2.82 for each invested pound. Wales ranks second, with a BCR of £2.78, followed by England (£2.36) and Scotland (£1.98).

This chapter presents our findings across the macroeconomic and socioeconomic analyses. A detailed presentation of the underlying methodology and sources is included in the Technical Appendix. All figures presented have been rounded so adding individual lines may not always sum to the quoted total.

3.1. Macroeconomic impact findings

3.1.1. Formal care

To estimate the total macroeconomic impact due to the operation of the adult social care sector in the UK, we considered direct, indirect, and induced effects. The following section presents our findings regarding the direct impacts.

Direct impact

As mentioned in the previous chapter and detailed in the technical appendix, the direct impact consists of GVA and employment. GVA was estimated using the (i) wages and earnings of all carers across provision types and care settings; and (ii) the Gross Operating Surplus of private and voluntary residential and domiciliary care providers. The subsection below presents the results for the first component, namely the wages and earnings of carers in each UK nation.

Wages and earnings

The results suggest that the total value of wages and earnings in the adult social care sector in the UK, excluding informal care, is approximately £30 billion. Across all four nations, apart from Wales, workers in domiciliary and residential care are the biggest contributors to this value, with earnings of £9.8 billion and £8 billion respectively. The top contributor for Wales appears to be “Other” care provision, with workers in the sector making approximately £560.7 million.

Table 1. Income of formal carers, million pounds, 2023 ^{4 5 6 7 8}

Type of care	UK	England	Scotland	Wales	Northern Ireland
Residential care	£8,077.2	£6,340.2	£1,011.9	£382.1	£343.0
Nursing care	£5,299.6	£4,947.8	-	£351.8	-
Domiciliary care	£9,827.7	£7,766.7	£1,400.0	£470.9	£190.2
Day care	£797.3	£574.8	£104.9	£60.1	£57.5
Other	£4,527.4	£3,491.4	£404.6	£560.7	£70.8
Total excluding personal assistants and informal care	£28,529.2	£23,120.9	£2,921.3	£1,825.6	£661.4
Personal assistants	£1,569	£1,453.1	£74.4	£41.5	Not applicable
Total including personal assistants but excluding informal care	£30,098.2	£24,574.0	£2,995.7	£1,867.1	£661.4

⁴ All residential and domiciliary care services have been assumed to be regulated in their entirety in Scotland. This decision is in line with (ICF, 2018c) and has been reached following discussion with Scottish representatives and sector experts.

⁵ All nursing care in England is regulated. Nursing care is not separated in Scotland and Northern Ireland. As a result, the residential care estimates for these countries include care homes both with and without nursing.

⁶ Day care provision is not regulated in England.

⁷ This category includes: (i) England: other residential and non-residential care provision by CQC and non-CQC regulated providers; (ii) Scotland: adult placement services and fieldwork services (generic and for adults); (iii) Northern Ireland: supported living services; and (iv) Wales: adult placement services, advocacy services, supported living, social work teams, central staff, and residential care staff.

⁸ Domiciliary care in Scotland includes services that provide domiciliary support, not only care support.

Gross Operating Surplus

The table below presents the results of our analysis of the Gross Operating Surplus (GOS) of private and voluntary providers by type of care. The results suggest that the total GOS in the adult social care sector is approximately £3.4 billion. Across all countries, residential care providers constitute the vast majority of the total GOS.

Table 2. Gross Operating Surplus of private and voluntary providers by type of care, million pounds, 2023

Type of care	UK	England	Scotland	Wales	Northern Ireland
Residential	£3,019.9	£2,547.9	£217.1	£196.9	£58.0
Domiciliary	£383.6	£318.3	£35.3	£18.5	£11.5
Total	£3,403.4	£2,866.2	£252.4	£215.4	£69.4

Total direct impact

The total direct impact consisting of GVA and employment is presented in the table below. We also calculated the labour productivity as the ratio of GVA per FTE.

The findings suggest that there are approximately 1.3 million direct FTEs in the sector, producing £33.5 billion of direct GVA. This suggests that the labour productivity in the adult social care sector is almost £26,600 per FTE.

As in the ICF reports (2018), Scotland remains the nation with the highest level of labour productivity per FTE. One possible explanation is the introduction of the living wage in adult social care, which increased the earnings in the sector. Similarly, the productivity in both Wales and Northern Ireland is higher than England, which can be partially explained by the higher earnings of workers in adult social care, as per the Annual Survey of Hours and Earnings. However, care should be taken when drawing conclusions from the national comparisons due to the significant differences in care provision across nations. Additional details on the underlying calculations for these estimates can be found in the Technical Appendix.

Table 3. Total direct impact and productivity (excluding informal care), 2023⁹

Type of impact	UK	England	Scotland	Wales	Northern Ireland
GVA (million pounds)	£33,501.6	£27,440.2	£3,248.1	£2,082.5	£730.8
Number of FTEs	1,259,100	1,042,500	114,300	74,900	27,400
Productivity (£ per FTE)	£26,600	£26,300	£28,400	£27,800	£26,700

⁹ FTEs in Scotland are calculated as 37.5 hours per week, as opposed to 37 hours in the remaining UK countries.

Indirect and induced impacts

The adult social care sector also creates employment and value in other sectors due to the demand for intermediate goods and services (e.g. medical supplies) to provide care (indirect effects). Furthermore, the spending of individuals directly or indirectly employed in the adult social care sector creates additional employment and value in other sectors (induced effects).

As shown in table 4, there are significant indirect and induced benefits resulting from the operation of adult social care. In particular, the adult social care sector generates 446,300 FTEs and £15.5 billion of GVA across other sectors. Similarly, 255,700 FTEs were created due to the spending of individuals directly or indirectly employed by adult social care, which led to an additional value of £22.4 billion.

Table 4. Indirect and induced GVA and employment (excluding informal care), 2023

Type of impact	UK	England	Scotland	Wales	Northern Ireland
GVA (million pounds)					
Indirect	£15,517.5	£13,418.3	£899.6	£1,018.4	£181.2
Induced	£22,362.3	£19,312.0	£1,049.2	£1,456.1	£545.0
Number of FTEs					
Indirect	446,300	379,500	34,300	27,000	5,500
Induced	255,700	204,200	22,900	14,900	13,700

Total macroeconomic impact

The following table summarises the direct, indirect, and induced impacts of adult social care in the UK. These figures represent the total macroeconomic value of the sector in terms of GVA and employment. The table excludes the contribution of unpaid carers, who are typically family members or friends providing care informally. As shown below, the existence of the adult social care sector in the UK creates approximately 2 million FTEs and £71.4 billion of value across direct, indirect and induced impacts.

Table 5. Direct, indirect, and induced impacts, 2023

Impact	Type of impact	UK	England	Scotland	Wales	Northern Ireland
Productivity (£ per FTE)	Direct	£26,600	£26,300	£28,400	£27,800	£26,700
GVA (million pounds)	Direct	£33,501.6	£27,440.2	£3,248.1	£2,082.5	£730.8
GVA (million pounds)	Indirect	£15,517.5	£13,418.3	£899.6	£1,018.4	£181.2
GVA (million pounds)	Induced	£22,362.3	£19,312.0	£1,049.2	£1,456.1	£545.0
GVA (million pounds)	Total	£71,381.4	£60,170.5	£5,196.9	£4,557.0	£1,457.0
Number of FTEs	Direct	1,259,100	1,042,500	114,300	74,900	27,400
Number of FTEs	Indirect	446,300	379,500	34,300	27,000	5,500
Number of FTEs	Induced	255,700	204,200	22,900	14,900	13,700
Number of FTEs	Total	1,961,100	1,626,200	171,500	116,800	46,600

Informal care

Informal carers comprise a significant part of adult social care provision in the UK. The table below shows the estimated number of informal carers in each of the four nations, as well as the FTEs they produce. As can be seen below, England has the highest total number of informal carers and FTEs, while Scotland produces the most FTEs per informal carer. The reason for Scotland's increased FTEs per carer is that more than half of Scotland's informal carers seem to provide more than 50 hours of unpaid care per week (Scottish Government, 2023a). However, it is worth noting that there are differences in data collection and aggregation across the four nations that hinder the comparability of informal care figures.

Table 6. Informal carers per country, 2023

Type of impact	UK	England	Scotland	Wales	Northern Ireland
Number of carers	5,958,000	4,725,000	697,000	312,600	223,500
FTEs	4,830,000	3,569,000	820,000	256,400	184,000

Informal carers, similar to formal ones, create significant value in the sector. We present below the estimates for direct, indirect, induced, and total macroeconomic impacts including the contribution of informal carers. In particular, if informal carers were replaced with formal carers, it would cost almost £106 billion to maintain the same level of care, as shown in the table below.

Table 7. Replacement cost of informal carers in the UK, million pounds, 2023

Wages and earnings	Informal care ¹⁰	Total excluding informal care	Total including informal care
England	£82,673.2	£24,574.0	£107,247.2
Scotland	£13,726.4	£2,995.7	£16,722.1
Wales	£6,032.3	£1,867.1	£7,899.4
Northern Ireland	£3,571.3	£661.4	£4,232.8
UK	£106,003.3	£30,098.20	£136,101.5

The table below shows the total direct impacts including informal care. In particular, there are more than 6 million FTEs in the sector, which would contribute more than £139.5 billion, with a labour productivity of £23,200 per FTE.

Table 8. Total direct impact and productivity (including informal care), 2023

Type of impact	UK	England	Scotland	Wales	Northern Ireland
GVA (million pounds)	£139,504.9	£110,113.4	£16,974.5	£8,114.8	£4,302.2
Number of FTEs ⁶	6,088,500	4,611,200	934,700	331,200	211,400
Productivity (£ per FTE)	£23,200	£23,900	£18,200	£24,500	£20,300

The table below presents GVA and FTEs with the addition of informal carers. The indirect GVA, including informal carers, is approximately £17.4 billion, and the associated indirect FTEs are 803,700. The induced GVA amounts to approximately £25.1 billion, while the induced FTEs are almost 470,000.

¹⁰ The replacement cost of informal carers has been assumed to be equal to the average earnings of all adult social care employees, weighted by the number employed in each care setting and type of provision. This was then converted to an FTE basis using the ratio of FTEs per informal carer.

Table 9. Indirect and induced GVA and employment (including informal care), 2023

Type of impact	UK	England	Scotland	Wales	Northern Ireland
GVA (million pounds)					
Indirect	£17,393.4	£15,035.3	£992.4	£1,132.7	£233.0
Induced	£25,117.3	£21,639.3	£1,157.4 ¹¹	£1,619.6	£701.0
Number of FTEs					
Indirect	803,700	681,100	59,500	48,100	15,000
Induced	470,000	366,500	39,600	26,500	37,400

Finally, the table below collates and aggregates the aforementioned direct, indirect, and induced impacts of the sector, including informal care.

The inclusion of informal carers lowers labour productivity in all countries. The key factors leading to the changes between table 5 and the one below are the size of the informal care population and the FTEs they provide in each nation. Informal carers have the highest share of the total care workforce in Northern Ireland (82%), while they have the lowest in Wales and England (76%). In total, the inclusion of informal carers reduces labour productivity, as the replacement cost of one informal carer is assumed to be equal to the earnings of a formal carer. However, one informal carer's FTEs are, on average, higher than those of a formal carer. This is particularly evident in Scotland, where informal carers work more than 1 FTE per week, leading to the greatest decrease in productivity. Overall, the nominator of the productivity ratio, i.e. the total GVA including both formal and informal care, will not increase proportionately to the denominator, which is the FTEs of both formal and informal carers.

Table 10. Direct, indirect, and induced impacts (including informal care), 2023

Impact	Type of impact	UK	England	Scotland	Wales	Northern Ireland
Productivity (£ per FTE)	Direct	£23,200	£23,900	£18,200	£24,500	£20,300
GVA (million pounds)	Direct	£139,504.9	£110,113.4	£16,974.5	£8,114.8	£4,302.2
GVA (million pounds)	Indirect	£17,393.4	£15,035.3	£992.4	£1,132.7	£233.0
GVA (million pounds)	Induced	£25,117.3	£21,639.3	£1,157.4	£1,619.6	£701.0

¹¹ Scotland has a relatively lower induced GVA compared to the other nations, primarily due to having the lowest induced GVA multiplier of all nations. Additional details can be found in the Technical Appendix.

Number of FTEs	Direct	6,088,500	4,611,200	934,700	331,200	211,400
Number of FTEs	Indirect	803,700	681,100	59,500	48,100	15,000
Number of FTEs	Induced	470,000	366,500	39,600	26,500	37,400

3.1.2. Comparisons with past evidence

Previous attempts have been made to estimate the macroeconomic value of the adult social care sector in the UK. Most notably, ICF published a report in 2018, using 2016 data.

The box below presents high-level comparisons of findings between this report and ICF. It is important to note that the findings are not necessarily comparable due to differences in (i) data; (ii) methodology; and (iii) other external factors. As a result, we cannot comment on the causes of any changes in figures since 2016, since these are not necessarily attributable to the sector itself.

Our findings suggest that the adult social care sector, covering formal care, in the UK, creates approximately, 1,961,100 FTEs and £71.4 billion in economic value across direct, indirect and induced impacts (excluding informal care).

The ICF report estimated that the adult social care sector in the UK creates approximately 1.8 million FTEs and £46.2 billion. Below we break down the differences between the two estimates by direct, indirect, and induced impacts.

We have estimated the direct impact at £33.5 billion in GVA and 1.3 million FTEs, compared to £24.2 billion GVA and 1.2 million FTEs in ICF. As a result, each FTE in the adult social care sector creates approximately £26,600 in value in 2023, compared to £19,700 in 2016. The increase in GVA between 2016 and 2023 is roughly 38%.

Our analysis also suggests that the indirect effects create 446,300 FTEs in other sectors, generating approximately £15.5 billion in GVA. The ICF estimates are 425,100 and £10.8 billion respectively, resulting in an increase of approximately 43% in GVA.

Finally, the induced effects in this report have been estimated to create 255,700 FTEs and generate £22.4 billion in GVA. In contrast, ICF estimated the induced impacts to generate 176,100 FTEs and £11.1 billion in GVA. This suggests an increase of approximately 101% in GVA from 2016.

If we look at the percentage differences between our estimates and ICF's, the direct impacts appear to have increased the least, while there is a gradual increase as we move to the indirect and induced impacts.

3.2. Socioeconomic impact

The second part of our analysis explored the costs and benefits of the adult social care sector in the UK. Below, we present high-level findings from this analysis. Additional details on our sources and methodology can be found in the technical appendix.

3.2.1. Costs

The following table presents the main costs associated with the operation of the adult social care sector in the UK. As indicated below, the total cost of the adult social care sector in the UK is estimated to be approximately £141.6 in 2023. The most significant cost within the adult social care sector is related to the value generated from informal care, which equals the cost to replace informal carers with care staff offering the same volume of care (£106 billion in 2023).

Wales spends the most on salaries of formal carers compared to other UK countries (as a share of each country's total cost). Northern Ireland appears to have the greatest relative cost due to the replacement cost of informal carers (as a share of its total cost). This could be due to a combination of factors. First, Northern Ireland has the second-highest share of informal carers' FTEs relative to all carers' FTEs. This, combined with the third-highest weighted average earnings, leads to the highest relative informal carers' replacement cost. Lastly, England spends the most on other non-labour costs (i.e. resources spent on the delivery of adult social care) as a share of total adult social care costs.

Table 11. Costs due to the operation of adult social care, UK, million pounds, 2023¹²

Costs	UK	England	Scotland	Wales	Northern Ireland
Salaries of formal carers	£31,004.3	£25,466.4	£3,051.8	£1,903.4	£582.7
Replacement cost of informal carers	£106,002.9	£82,672.4	£13,726.8	£6,032.3	£3,571.4
Resources spent on the delivery of adult social care	£4,614.6	£3,819.3	£472.8	£187.4	£135.2
Total costs	£141,621.71	£111,958.1	£17,251.3	£8,123.1	£4,289.2

¹² Please note that there is a small discrepancy between the total salaries of formal carers in the socioeconomic and macroeconomic models. This discrepancy arises because the macroeconomic impact model uses earnings per FTE, whereas the socioeconomic model uses earnings per person. The total earnings differ because the macroeconomic model calculates earnings per FTE based on care setting and provision type, while the socioeconomic model uses weighted average earnings to determine earnings per person. We chose different earnings measures for each model due to their distinct purposes. The macroeconomic model employs earnings per FTE for a more accurate bottom-up approach. In contrast, the socioeconomic model serves as a legacy tool for projecting future costs and benefits. To this end, using earnings per carer would be more suitable for projections as it allows the application of growth rates of cared-for individuals and carers.

Benefits

Similarly, the following table presents the benefits of adult social care. As shown below, the total socioeconomic benefits of the adult social care sector in the UK, including informal care, are estimated to be around £332.6 billion in 2023. The most significant benefit is the improvement in wellbeing due to receiving social care, estimated at approximately £298.6 billion in 2023. This benefit represents the monetary value that care users would be willing to pay to achieve improvements in outcomes such as safety, personal care, and accommodation (as captured by the SCRQoL). The size of this benefit can be explained from: (i) the magnitude of the impact that care services have on wellbeing; (ii) the monetary value of wellbeing impacts; and (iii) the size of the populations affected (i.e. the entire population receiving unpaid care and those receiving formal care, excluding nursing care).

Scotland has the highest wellbeing and health (quality of life) benefits due to care (as a share of total benefits in each country). England has the highest relative benefits due to reduced NHS costs from both prevented hospitalisations and avoided discharge delays (NHS efficiencies). This appears to be driven by the number of adults receiving care, as the more people receiving care, the more people avoid injuries and discharge delays. In contrast, our calculations suggest that Scotland has lower savings for the NHS, both in terms of avoided hospitalisations and efficiencies. This is due to the relatively lower incidence of hospitalisations in Scotland compared to the other UK nations, regardless of adult social care provision. As a result, fewer hospitalisations can be avoided through social care, given there is already a relatively small number of hospitalisations in Scotland. Additional details and underlying data are included in the Technical Annex.

Table 12. Benefits due to the operation of adult social care, million pounds, 2023

Benefits	UK	England	Scotland	Wales	Northern Ireland
Improved wellbeing due to receiving social care	£298,624.1	£234,552.8	£32,156.2	£20,915.5	£10,999.6
Improved health/quality of life due to not getting injured and being hospitalised	£1,028.3	£816.8	£119.3	£52.7	£39.4
Increased peace of mind benefits for the general public	£6,545.9	£5,117.4	£732.0	£416.1	£280.7
Reduced NHS costs due to prevented hospitalisation and emergencies	£24,718.5	£21,694.0	£1,105.9	£1,139.2	£779.4
Increased efficiency in care provision from adult social care compared to NHS	£1,688.8	£1,568.4	£8.6	£99.1	£12.7
Total benefits	£332,605.6	£263,749.4	£34,121.9	£22,622.7	£12,111.5

Net benefits and Benefit-Cost Ratio

Overall, the analysis suggests that the benefits of the adult social care sector significantly outweigh the costs. In summary, the adult social care sector in the UK creates more than £190.9 billion in net benefits (i.e. total benefits minus total costs).

Furthermore, the adult social care sector achieves a Benefit-Cost ratio of £2.35, suggesting that for every £1 invested in adult social care in the UK, £2.35 of benefits are generated.

Northern Ireland achieves the highest BCR, with a return of £2.82 for each invested pound. Wales ranks second, with a BCR of £2.78, followed by England (£2.36) and Scotland (£1.98). However, it is important to note that these BCRs are not necessarily comparable and thus, drawing any cross-country conclusions could be misleading. For instance, the analysis for Northern Ireland does not include non-regulated sector carers and personal assistants, which artificially drives the costs down.

4. Case studies

We identified several case studies of impactful programmes and interventions to showcase what works for adult social care provision across the UK. In summary, there are several lessons to be learned and applied to adult social care provision, namely:

- **Better integration and collaboration across services:** Cross-disciplinary and integrated approaches yield significant improvements in care outcomes and cost savings.
- **Technology utilisation:** Innovative technologies can support independent living and reduce healthcare costs.
- **Leveraging community and volunteer support:** Engaging volunteers and community resources enhances care delivery and reduces the burden on formal healthcare services.
- **Making care more human-centred:** Personalised and compassionate care approaches improve satisfaction and reduce anxiety among care recipients.
- **Investing in prevention:** Investing in preventative and integrated care models can lead to substantial financial returns and social benefits.
- **Addressing underlying issues:** Interventions targeting loneliness and mental health are crucial for improving overall well-being.

This chapter presents case studies of impactful programmes and interventions addressing the social care needs of adults.

4.1. The Care Home Innovation Programme

Giebel et al. (2020) evaluated the effectiveness of the Care Home Innovation Programme (CHIP). The programme ran from 2015 to 2018 across 32 care homes in South Sefton, Merseyside, aiming to reduce potentially avoidable hospital admissions.

The CHIP consisted of introducing: (i) care home matrons (senior nurses), who supported residents by establishing an advanced care plan, dealing with acute minor illnesses, and offering clinical advice to care home staff; (ii) a multidisciplinary team including nurses, urgent care teams, community geriatricians, and medicines management; (iii) new protocols to address common conditions; (iv) installing a 24-h 7-day week tele-video system across all homes; and (v) a quarterly training bringing together care homes to share best practices.

The CHIP was implemented in 32 care homes over four years, comprising 17 residential and 15 nursing homes. One year prior to joining the programme, the average number of emergency calls from the care homes was 143 calls per month. The evaluation of the CHIP over four years concluded that the programme was effective in reducing both the number of emergency calls and hospital conveyances. In particular, there was a 15% reduction in the number of emergency calls and a 19% reduction in the number of conveyances to hospitals compared to the 12 months before the programme's launch. However, the authors highlighted challenges in attributing the impact to any individual part of the CHIP, such as the impact of tele-video on conveyances being difficult to assess.

4.2. British Red Cross “Support at Home” hospital discharge scheme

Knapp et.al (2019) evaluated the effectiveness of the Support at Home hospital discharge scheme by the British Red Cross. The scheme consists of volunteers offering short-term (4-12 weeks) support for older people recently discharged from the hospital. The support offered includes: (i) practical support with everyday tasks; (ii) emotional support; (iii) transport to and from hospitals; and (iv) companionship. The evaluation indicated that the scheme enabled safe discharge, supported carers, and enabled patient advocacy.¹³ These benefits resulted in financial savings of £884 per person on average (in 2019 prices) and lasted up to six months after the intervention. These consisted of:

- £167 saved per person due to reduced use of paid homecare workers
- £411 saved per person due to avoided unpaid care and £75 saved per person due to avoided general help costs
- Reduced healthcare costs for treatment of falls (£153 per person), malnutrition (£74 per person), and depressive symptoms (£4 per person).

4.3. ImpactAgewell Community Project

The ImpactAgewell programme was launched in 2017 in the Mid and East Antrim region (The Dunhill Medical Trust, 2020). It is a community-led integrated care model, bringing together local GPs, pharmacists, and the Northern Health and Social Care Trust with the aim of improving the quality of life of older people who might struggle to navigate the health and care system. GPs, pharmacists, social services, and voluntary organisations discuss an individual's case and collaboratively decide on the appropriate care offering.

¹³ Patient advocates are people who liaise with health and social care services on behalf of patients to make sure their voices are heard and their needs are met. Advocates are independent of the social services and the NHS and can help during the care needs assessment, care and support planning, and safeguarding and reviews (NHS, 2022).

An advisor is then assigned to each older individual who acts as a point of contact and facilitates access to services for up to six months. The report on fiscal return from investment (The Dunhill Medical Trust, 2021) in 2020-2021 explored the programme's impact on 407 service users who participated in data collection before, during, and after programme participation. The authors estimated that for every £1 invested, there was a social return¹⁴ of at least £2.22. Furthermore, the project led to financial savings of £2.38 for every £1 invested. In particular, the savings were due to a reduction in A&E attendance (39%), hospital admissions (74%), hospital bed days (69%), primary care (7%) and prescription provision (7%).

4.4. London Borough of Barnet, care technology promoting independence

The Local Investment Programme of 2017/18 funded 19 local authorities to “promote independence and wellbeing through the use of digital services and technology”. In the case of Barnet, the funding was used to help people with learning disabilities remain independent through the use of assistive technology in supported living¹⁵ facilities (LGA, 2018a). In particular, it covered engagement with service users, providers, carers and families, as well as training, technology assessments, monitoring, and evaluation. The specific technologies used were decided following individual assessments by social workers to ensure the needs of the users were met. This investment was estimated to result in £2,000 of cost savings per year due to avoided care and a reduction in overnight care.

4.5. An intervention targeting loneliness and isolation for older people in North Wales

Age Cymru Gwynedd and Môn provided a service called Cadwyn Môn, aiming to reduce the loneliness and isolation of older people living in Anglesey, North Wales. It involved a volunteer working with individuals to identify goals and integrate them into society. Through weekly one-on-one sessions, the volunteer offered companionship, practical and psychological support, and helped increase social networks, confidence and independence. A mixed-methods evaluation in 2019 identified significant improvements in loneliness (decrease from 3.43 to 2.49 on average in the De Jong

¹⁴ Social return is the ratio of benefits over costs to the society in Social Cost Benefit Analysis. “Social Cost Benefit Analysis quantifies in monetary terms the effects on UK social welfare.[...]. Costs to the public sector are counted as a social welfare cost. It generates measure of social value. When combined with an appropriate public sector cost measure a BCR is produced which provides a social unit cost measure” (HM Treasury, 2022).

¹⁵ Supported Living in the English context is defined as “schemes that provide personal care to people as part of the support that they need to live in their own homes. The personal care is provided under separate contractual arrangements to those for the person’s housing.” (CQC, 2015).

Gierveld Loneliness Scale¹⁶) and wellbeing (increase from 18.99 to 21.59 on average in the Satisfaction with Life Scale¹⁷) one year after the intervention (J.R. Roberts & G. Windle, 2019).

4.6. Integration authorities in Scotland

Integration authorities were established in Scotland to enable the vertical integration of local health and social care organisations. These authorities are responsible for planning and allocating resources for adult social care, primary care, community health, and unscheduled hospital care at the local level. Alonso & Andrews (2022) evaluated the authorities' impact on delayed discharges and premature mortality rates compared to local authority areas in Northern England from 2013 to 2019. The results suggest that health and social care integration resulted in a decrease in the number of delayed discharges ranging from 14% to 27%. However, no statistically significant impact was observed on premature mortality rates.

4.7. Community connector service

The service is aimed at individuals aged over 18 residing in Powys (Wales), along with their families or caregivers. Community connectors are individuals working with unpaid carers, local organisations, and people over 16 years old who feel isolated to facilitate access to community-level services and activities. The service offers support on, for instance, (i) creating effective partnerships and working relationships with community groups and third sector organisations; (ii) handling referrals or requests from organisations or individuals seeking support; (iii) accessing community services or activities; (iv) providing support and guidance for local multi-disciplinary teams in community hospital settings on what services are available locally; and (v) identifying areas of unmet need or gaps in service provision.

In 2023, over 2,500 people were supported by the [Community Connector Service](#). Over 90% of them believed that the service helped them reduce or delay GP appointments. All service users were satisfied with the support and treatment they received. In particular, they believed that:

“The Connector service was very helpful. They were very friendly and didn't make me feel that I couldn't open up and talk to them which I really valued”

¹⁶ The Loneliness Scale consists of 11 items that assess emotional and social loneliness. The scale ranges from 0 to 6, with a score of 2 or higher indicating loneliness and score of 6 indicates severe loneliness (de Jong-Gierveld & van Tilburg, 1999).

¹⁷ The Satisfaction with Life Scale asks five questions measuring overall satisfaction with one's life, providing a maximum total score of 35. The levels of life satisfaction included are: Very high (30–35), High (25–29), Average (20–24), Below average (15–19), Dissatisfied (10–14) and Extremely dissatisfied (5–9) (Diener et al., 1985).

'I was struggling a lot before I contacted you. I would now phone you first before my GP'

'I was treated with the utmost respect and felt well supported'

'Very, very good, very caring, very efficient'

'I'm always treated with dignity and respect by the Community Connectors''

4.8. Retirement homes

Holland et. al (2015) carried out a longitudinal evaluation of the ExtraCare Charitable Trust villages and schemes in England (ExtraCare, 2024). The ExtraCare Charitable Trust is a charity whose mission is to create sustainable communities by providing older people with (i) homes, (ii) lifestyles they can enjoy, and (iii) care. The Trust builds villages, including retirement homes as well as social, health, and leisure facilities for local residents. The villages also house volunteers who help the residents of retirement homes to participate in physical and social activities, building a sense of community and addressing loneliness. The authors compared measures of health, wellbeing, cognitive ability and mobility of 162 new residents against 39 control participants through interviews, focus groups, and case studies at entry, 3, 12, and 18 months later. The results suggest that the intervention reduced:

- NHS costs by 38% in 12 months, saving on average £1,114.94 per person per year.
- duration of unplanned hospital stays, from 8-14 days on average to 1-2 days.
- routine and regular GP visits by 46%.
- anxiety symptoms by 23%.

4.9. Carer support: The Surrey example

A report by the Local Government Association (2015) sought to expand the evidence base for investing in carers, based on a sample analysis from the Surrey County Council. Surrey County Council Adult Social Care supported over 25,000 people per day and provided carer support services¹⁸ for over 13,000 carers a year at an annual cost of approximately £5 million in 2015. These services are offered by local authorities help carers with their mental health and wellbeing. The report explored the impact of charging carers for the support they receive. The authors explored different scenarios for how many carers would stop offering care support if they are charged for the services they receive by the local authority.

The analysis suggests that if a charge was introduced, 10,000 carers would not access any support and up to 40% of them would be unable or unwilling to continue offering

¹⁸ Under the Care Act (UK Government, 2014), local authorities can charge carers for these services if these are not directly provided to the individuals receiving care. The carers can then choose not to offer care services if the charge is too high.

care services within a few months. In this case, the local authority would need to support the individuals that these 10,000 carers previously cared for. Assuming that 10% of adults left unsupported are eligible and seek publicly funded support, the annual cost to cover their needs would be approximately £14.7 million, compared to the £5 million currently given in support for all 13,000 carers.

4.10. IMPACT, value-based recruitment

Recent research by Skills for Care (2023), highlights that the adult social care sector faces challenges of recruitment and retention. In response to these issues, IMPACT, the UK-wide centre for implementing evidence in adult social care, established a value-based recruitment¹⁹ network in 2022 (UKRI & The Health Foundation, 2023).

The network consisted of local care and support providers, practitioners, carers, and decision-makers, meeting regularly over a six-month period to address common challenges and share learnings. Participating organisations included Care Workers Charity, Cardiff University, National Care Forum, and Scottish Care.

Research commissioned by Skills for Care (2016) highlighted, that value-based recruitment could lead to a number of benefits, such as lower staff turnover (19% compared to traditional methods) and a positive return to investment (£1.23 return for every £1 spent) due to reduced turnover rates.

4.11. The lived experiences of service users, families and carers engaging with Social Work services in Northern Ireland

The project “My Experience of Social Work Services” was commissioned by the Social Work Strategy Outcomes Delivery Board in September 2019 and aimed to explore how social work services have impacted service users' and their families' lives (Department of Health & Social Care, 2023).

In total, 552 stories were collected between 2021 and 2023, including the lived experiences of carers, service users (both adults and children), and family members or friends of someone supported by a care worker. Participants were encouraged to share their experiences through a variety of methods, such as social media promotions.

Narrative analysis of the views collected suggested that more than half of the respondents (55%) had a positive experience of Social Work Services. In particular, 34% rated the overall experience as strongly positive and 21% as positive. Adult care

¹⁹ Value-based recruitment is a health and social care method to address recruitment challenges by attracting individuals with the right values, enhancing retention rates, and improving overall quality of care. This approach involves understanding candidates' motivations to ensure they align with the organisation's values and the roles being recruited for.

programmes were viewed even more positively, as more than 60% of respondents rated their experience as positive. The most commonly mentioned theme among respondents having a positive experience was appreciation for the “human touch” factor in the social workers’ approach.

“... it was not only about getting what my Mother needed but I had someone who understood what I needed and became a friend - who I could depend on. Through my experience trust is most important and it takes away any anxieties’ - Family member, Older Persons

Furthermore, respondents believed that social workers communicated effectively and felt that they acknowledged their concerns and fears, and acted in their best interest.

“...The crisis team social worker spoke with me in December when I was feeling suicidal, she listened to me, to everything I said. Her and a psychiatric nurse encouraged me to get admitted, quite frankly they saved my life. The social worker intervention put me in a safe place where I'm getting the best possible treatment...” -Service user, Adult Mental Health

Lastly, respondents believed that social workers also helped them understand and identify new sources of help.

“...For me, having a social worker has been quite a positive experience. I have struggled with my mental health and a social worker helped me to improve my overall mental well-being by referring me to a day centre 2 days a week. This opportunity has improved my overall wellbeing and has provided me with the opportunity to engage with people that I would not have personally meet...” - Service User, Adult Mental Health

4.12. My Home Life England Professional Support and Development Programme

My Home Life England (MHLE) is part of an international initiative that aims to support people in care, their families and loved ones, as well as care workers. To that end, MHLE works closely with care services, NHS, statutory bodies, and community organisations.

One key element of MHLE’s approach is the Professional Support and Development Programme (PSDP) (City University of London, 2023).The programme began in England, hosted by City, University of London and has since been delivered to over 2,400 care home leaders across Scotland, Northern Ireland, Wales, and more. The PSDP consists of

- Three initial workshop days, where participants are introduced to the My Home Life evidence base, and encouraged to participate in group exercises, discussion, and reflection.

- Seven monthly action learning sets with an MHLE facilitator. The facilitator encourages participants to listen and actively engage with the rest of the group, fostering the exploration of new ideas.
- A completion day where participants reflect upon their learning and outcomes, potentially engaging with invited local system leaders.

A 2019 impact evaluation of the PSDP programme across 42 care home managers in NW London identified considerable reductions in A&E and hospital admissions as well as ambulance call-outs (My home life, 2019). In particular, care homes participating in the programme experienced the following annual impacts compared to the previous 2 years:

- 14% decrease in ambulance callouts
- 16% decrease in ambulance conveyances
- 9% decrease in A&E attendances
- 5% decrease in non-elective admissions

4.13. Discharge to recover then Assess

A key priority for the Welsh Government and NHS Wales is the improvement of discharge planning. As a result, the Discharge to Recover then Assess (D2RA) model from England has been adapted and trialled in north Powys, Wales (Welsh Government, 2021).

The aim of D2RA is to (i) provide quicker access to community based health and care; (ii) ensure timely discharge; (iii) avoid inappropriate admissions; and (iv) reduce the length of stay. After patients are discharged from an acute or community hospital to their own homes, a team of therapists provides comprehensive support for up to 10 days post-discharge, while assessing their needs to determine what type of support or intervention is required. This is made possible through the development of an Integrated Community Team that helps people remain at home without relying on social services.

The trial has been shown to lead to several positive outcomes, including:

- Increased engagement from staff in acute settings
- Increased collaboration of multiple third sector organisations and community groups to deliver advice, information and practical support
- Half of the patients discharged from the hospital did not require ongoing statutory services, such as reablement²⁰ or community therapy

²⁰ Reablement is short term care provided to people who have been in a hospital recently or experienced injuries or illnesses. Reablement supports individuals in relearning how to perform daily activities and regain their independence. It can involve professionals, such as a nurse, a physiotherapist, or a social worker (NHS, 2022).

4.14. Pembrokeshire Intermediate Voluntary Organisations Team

Pembrokeshire Intermediate Voluntary Organisations Team (PIVOT) is a collaborative, multi-agency team delivering holistic support for older people who need support. The aim of the service is to fill in gaps in more formal provisions to help people remain independent at home and avoid hospital admissions unless necessary (Welsh Government, 2021).

PIVOT offers: (i) out of hours transport; (ii) basic groceries; (iii) ensuring utilities are fully functioning; (iv) coordination with families; and (v) follow-ups with isolation support services.

During the first half of 2020, PIVOT helped:

- 31 people during an Accident and Emergency discharge.
- 157 people get home from the hospital.
- 109 people remain at home after a hospital stay.
- 177 people avoid hospital admission.

4.15. Housing First Projects in Scotland

As per the Public Service Reform Act Scotland 2010, Schedule 12, subsection 19, housing support services are defined as care services and are thus regulated by the Care Inspectorate in Scotland (Scottish Government, 2010). Furthermore, most housing support and care at home services are registered to provide both housing and care services. As a result, interventions targeting housing could also help address social care needs in Scotland.

Scotland's Housing First Pathfinder is an example of a housing support programme that could positively impact adults in need of social care services. The programme aimed to scale up Housing First delivery in five areas across Scotland: Aberdeen City and Aberdeenshire, Dundee, Edinburgh, Glasgow, and Stirling. The programme secured up to 830 one-bedroom flats for people experiencing rough sleeping and having complex needs, and it was committed to providing dedicated support where needed. To that end, the programme developed partnerships with key stakeholders across housing providers, health and social care, and criminal justice systems.

A 2022 evaluation by Heriot-Watt University of Scotland's Housing First Pathfinder programme aimed to assess its effectiveness and collate lessons learned (Johnsen et al., 2022). From 2018 until 2022, 579 individuals were supported, with 44% of them previously being homeless for at least five years. The programme was found to be effective in several housing outcomes in the 2021 follow-up. For instance, 88% of service users maintained their tenancy for at least one year, while 80% maintained it for at least two years post-intervention. Furthermore, there is some evidence that the pathfinder could also have had a positive impact on wider outcomes, including mental

and physical health. For instance, some interviewed tenants reported improvement in their health, reduction or stabilisation of substance misuse, and increased engagement with healthcare providers. However, some respondents also noted that they remained in poor health despite the pathfinder's support.

5. Technical appendix

This appendix presents in detail the calculations and data sources used to estimate the macro and socioeconomic impact of the adult social care sector in the UK. Section 5.1 of this chapter outlines our approach to calculating the macroeconomic impacts. In particular, subsection 5.1.1 explores the direct benefits resulting from the operation of the adult social care sector, namely the Gross Value Added (GVA). Subsection 5.1.2 briefly outlines our approach to calculating the productivity benefits, while subsection 5.1.3 describes our methodology for calculating the indirect²¹ and induced²² impacts of adult social care, consisting of GVA and employment. **The direct, indirect, and induced effects together constitute the total macroeconomic impact of the adult social care sector.** Section 5.2 in this chapter outlines our approach to calculating the wider socioeconomic costs (subsection 5.2.1) and benefits (subsection 5.2.2) of the adult social care sector, as described in the previous chapter.

5.1. Macroeconomic impact

5.1.1. Direct effects

Gross Value Added

To calculate GVA, we summed the total earnings and profits generated by the adult social care sector. This includes:

- **Wages and earnings** of the employees in the regulated and non-regulated sectors, as well as personal assistants and informal carers. We first collated data on the number of jobs and FTEs in the adult social care sector. These were then multiplied by the average earnings per FTE for each type and setting of care.
- **Gross operating surplus** in the independent sector across care settings. Our aim was to capture the additional value generated by the sector due to the profits of private and voluntary providers, apart from wages and earnings. To that end, we applied average profitability ratios (EBITDAR)²³ to the care home and domiciliary care placements provided by the independent sector. Day care and any other types of care were not included in this calculation as there is no information available for their profitability.

²¹ Indirect are the effects created by the demand for intermediate goods and services by adult social care to provide its services (ICF, 2018d).

²² Induced are the effects created by changes in the purchasing behaviour of individuals directly and indirectly employed in the adult social care (ICF, 2018d).

²³ Earnings Before Interest Taxes Depreciation Amortisation and Restructuring or Rents (EBITDAR) is a standard measure of operating profitability for the private sector (Competition & Markets Authority, 2017).

Detailed technical discussion

1. Number of jobs and FTEs

England: Data on employees from all care settings and for the regulated and non-regulated sectors was taken from the Adult Social Care Workforce Dataset (ASC-WDS) (Skills for Care, 2021). The number of informal carers and the hours of care provided was taken from ONS (2023b) census data. We calculated separately the number of informal carers claiming Carer's Allowance using Department of Work and Pensions (DWP) data, although the allowance was not included in the direct economic contribution (DWP, 2024). While Carer's Allowance is not explicitly exclusive to informal carers, the criterion of maximum net income of £139 per week makes it unlikely that a significant number of claimants are formal carers, given their gross weekly income is £393 (Annual Survey of Hours and Earnings, Office for National Statistics, 2022). As a result, we assumed that all claimants of Carer's Allowance are informal carers receiving support from local authorities.

To calculate the number of personal assistants in adult social care, we leveraged analysis done by Skills for Care (2023a), showing the number of individuals receiving direct payments and the share of individuals employing personal assistants (PAs) directly (as opposed to employing through registered providers). These estimates were then multiplied to get to the number of people directly employing PAs. Lastly, we multiplied the result by the average number of workers per employer, as per the aforementioned Skills for Care report.

Scotland: We used Scottish Social Services Council (2023) estimates for the number of employees in the regulated sector. The total number of jobs in non-regulated services in Scotland was calculated by multiplying the number of non-regulated service sites by the number of posts/FTEs per site in England due to the lack of Scotland-specific data (Skills for Care, 2023c). The number of non-regulated service sites was estimated by: (i) identifying relevant Standard Industrial Classification (SIC) code classes²⁴ in the Inter-Departmental Business Register (ONS, 2021), (ii) multiplying the above by the share of sites offering adult social care using the ASC-WDS (Skills for Care, 2021), and (iii) subtracting from the above the number of regulated sites (Care Inspectorate, 2022).²⁵ The results of this calculation suggest there are approximately 200 non-regulated service sites in Scotland in 2023.

The number of personal assistants was calculated as described above for England.

The number of informal carers in Scotland was taken from the Scottish Government (2022) statistics. To calculate the WTEs, we used evidence from the Carers' Census

²⁴ Following ICF (2018c), we included SIC 87: Residential care activities and SIC 88: Social work activities without accommodation.

²⁵ The number of regulated care sites was calculated as the sum of care homes for learning disabilities, mental health problems, older people, physical and sensory impairment as well as support services for care at home and for care other than care at home.

(Scottish Government, 2023a), which shows the share of surveyed carers providing up to 19, up to 49, and over 50 hours of unpaid care per week. We then assumed the sample in the Census is representative of the entire informal care population and applied the breakdowns by hours of care to the total informal care population (including a small number of young carers, as mentioned in the findings section).

To estimate their income, we replicated the approach described above for England.

Wales: To estimate the number of employees and FTEs in the regulated sector in Wales, we combined various sources. The number of employees for residential, nursing, and domiciliary care was taken from internally held data of the Care Inspectorate Wales (CIW). The number of employees for day care and other types of care provision was data from the Social Care Wales (SCW) workforce report for 2023. The workforce report was also used to estimate the FTEs for day care and other types of care. In particular, we calculated the ratio of FTEs per person using data on the number of hours worked per week. However, both the CIW and SCW do not differentiate between private and voluntary provision. As a result, we applied the ratio of private to total commissioned placements from the ICF (2018e) report to the figures used in the shared datasets.

It is worth noting that data relating to certain types of social care provision²⁶ in Wales is taken from data collected by Social Care Wales (SCW) as part of their unpublished 2023 Workforce Data Collection. SCW suggested that this data required the use of estimation methods to account for missing data. Triangulation with other available data shows that these figures may exhibit some inaccuracies, so our findings may be somewhat affected as a result.

To estimate the number of non-regulated providers, we replicated the approach for Scotland, described above. Data on the number of informal carers and the hours of care they provide is captured in ONS (2023b), similar to England. Lastly, to calculate the number of personal assistants, we followed the approach outlined for England and Scotland above. Data on the number of individuals receiving direct payments was taken from Social Care Wales (StatsWales, 2023a).

Northern Ireland: Employees working in the regulated sector are captured in the Social Care Council Register of Social Work. However, to ensure comparability with the rest of the UK, we took the following steps to calculate the number of employees in ASC:

- Collate data from the ASC-WDS on the number of carers and FTEs in England (Skills for Care, 2021).
- Divide the above by the number of sites providing adult social care in England.
- Multiply the result by the number of adult social care sites in Northern Ireland.

²⁶ This concerns day care and other care provision.

Informal carers and the hours of care provided were taken from Census 2021 statistics (Northern Ireland Statistics and Research Agency, 2021b). As noted in the second chapter, personal assistants and non-regulated providers cannot be robustly calculated at the moment.

2. Wages and earnings

England: The wages and earnings of employees in the regulated and non-regulated sectors were taken from the ASC-WDS (Skills for Care, 2021). The earnings estimate for the formal sector employees were also used to calculate the value of informal care. In particular, we used the average earnings of employees in the formal sector, weighted by the number of employees in each setting, as a proxy for the compensation that formal carers would receive to offer the same volume of care. Any benefits or allowances received by informal carers were not included in the direct economic contribution, as we were interested in the value of the output produced by informal carers.

Scotland: Earnings for the regulated sector in Scotland are collated in the Annual Survey of Hours and Earnings (ASHE; Office for National Statistics, 2022). However, the ASHE does not include self-employed workers or those in non-Pay as You Earn (PAYE)²⁷ registered jobs. As a result, we followed ICF (2018c) to proxy earnings in the Scottish regulated and non-regulated sector using data from the respective sectors in England, as described below:

- We calculated the average earnings in the adult social care sector in Scotland and in England using the Annual Survey of Hours and Earnings (Office for National Statistics, 2022). The results suggest that care workers and home carers across seniority levels in England earn £418 gross, per week, compared to £465 in Scotland.
- We calculated the ratio of the above-average earnings.
- The ratio was multiplied by the earnings in regulated and non-regulated settings in England. The earnings in the regulated sector were sourced from the ASC-WDS, while earnings for the non-regulated sector were provided by Skills for Care.

We recognise the limitations of this approach, given the significant regulatory differences between England and Scotland. For instance, housing support services are legally defined as care services in Scotland but not in England. To that end, we discussed the best approach with Scottish representatives. We ultimately decided to follow <https://www.sssc.uk.com/knowledgebase/article/KA-02264/en-us> ICF (2018c), excluding all domiciliary and residential care services from the non-regulated sector.

²⁷ Pay As You Earn (PAYE) is HM Revenue and Customs' system to collect Income Tax and National Insurance from employment. Employers with no employees earning £123 or more a week, getting benefits, or having another job or pension are not required to register in PAYE.

The earnings estimate for the formal sector employees was also used to calculate the value of informal care. In particular, we used the average earnings of employees in the formal sector, weighted by the number of employees in each setting, as a proxy for the compensation that paid carers would receive to offer the same volume of care. This average was then applied to the hours of unpaid care (Scottish Government, 2023a, pp. 2022–2023) provided by informal carers, calculated as in the previous subsection. Any benefits or allowances received by informal carers were not included in the direct economic contribution, as we were interested in the value of the output produced by informal carers.

Wales: Given the lack of Wales-specific data, the regulated and public sector earnings will be calculated as described above, using the Annual Survey of Hours and Earnings (ONS, 2022) and English data from the ASC-WDS (Skills for Care, 2021). This approach leads to higher wages for Wales compared to England, which is in line with the implementation of the Real Living Wage in Wales. Earnings for non-regulated providers will be calculated by multiplying the number of FTEs by the earnings per FTE in Wales (as calculated in the previous step). As above, the earnings of employees in the formal sector will be used to proxy the value of informal care.

Northern Ireland: Our approach to calculating earnings for the regulated care sector in Northern Ireland is the same as the approach described earlier for Scotland. In particular, we followed ICF (2018c) to proxy earnings in the Northern Ireland regulated sector using data from the regulated sector in England, as described below:

- We calculated the average earnings in the adult social care sector in Northern Ireland and in England using the Annual Survey of Hours and Earnings (ONS, 2022).
- We calculated the ratio of the above-average earnings.
- The ratio was multiplied by the earnings for England quoted in the ASC-WDS (Skills for Care, 2021).

As with Scotland, the earnings estimate for the formal sector employees was also used to calculate the value of informal care. The average weighted earnings of employees in the formal sector were multiplied by the hours of unpaid care provided by informal carers (Northern Ireland Statistics and Research Agency, 2021a). Any benefits or allowances received by informal carers were not included in the direct economic contribution, as we were interested in the value of the output produced by informal carers.

3. EBITDAR

Following the KDNA & Skills for Care (2021) report, we combined various sources to estimate the EBITDAR in residential, nursing, and domiciliary care settings. In particular, we first created a time series for EBITDARs using the following sources:

- EBITDARs from 2012 to 2016 are taken from Competition & Markets Authority (2017), Care Homes market study.

- EBITDARs for 2017 and 2019 are taken from the National Audit Office (2021), The adult social care market in England.
- EBITDAR for 2018 has been imputed from KDNA in the KDNA & Skills for Care (2021), The value of adult social care in England.

We then calculated the average annual growth rate of EBITDARs from the time series described above, and applied this growth rate to the latest available data to project the EBITDARs to 2023.

4. Output of the private sector

To calculate the Gross Operating Surplus, we multiplied the EBITDAR for the domiciliary and homecare settings, calculated in the previous step, by the output of the private and voluntary sector in the respective care settings. The output was calculated by multiplying the number of occupants in private and voluntary residential and domiciliary care settings by the respective unit costs of care, including establishment costs, personal living expenses, and external services. Due to the lack of Scotland-specific data, we used unit cost information for England, taken from the Personal Social Services Research Unit (PSSRU) (PSSRU, 2021) and the Homecare Association (2023). These costs were then adapted to the Scottish context using the Annual Survey of Hours and Earnings, as described in subsection 5.1.1 of this chapter.

England: Unit cost information was taken from the Personal Social Services Research Unit (PSSRU, 2021) while capacity and occupancy of care homes in England were calculated using data from ONS (2023a) and CQC (2023). To estimate homecare occupancy, we used the annual Adult Social Care Activity and Finance Report (NHS England, 2023).

Scotland: We multiplied the respective unit costs by the number of adults in independent provision care homes and domiciliary care in Scotland (Public Health Scotland, 2023c; Public Health Scotland, 2022).

Wales: We used data from Social Care Wales to estimate the number of adults in independent provision care homes and domiciliary care in Wales (Social Care Wales, 2023b).

Northern Ireland: We multiplied the respective unit costs by the number of adults in independent provision care homes and domiciliary care (Department of Health, 2023a; Department of Health, 2023b).

5.1.2. Productivity

Following ICF (2018d), we calculated labour productivity as GVA per FTE. GVA, including the contribution of informal carers, was calculated as a standalone benefit, while FTE was an intermediate output in the calculation of GVA. These indicators were then divided to calculate labour productivity.

5.1.3. Indirect and induced impacts

The indirect and induced impacts on GVA and employment were estimated by using impact multiplier tables. Type I multipliers were used to estimate the indirect impacts on employment and GVA, while Type II multipliers were used for induced impacts. Type I multipliers are available from the ONS Input-Output tables at the UK level (Office for National Statistics, 2022b). The ONS multipliers were used for England and Wales. The Scottish Government (2023c) and the Northern Ireland Statistics and Research Agency produce their own Input-output tables, including both Type I and Type II GVA and employment multipliers (NISRA, 2023). Both Type II multipliers were applied to the direct and the indirect GVA and employment, excluding the contribution of informal carers.

In both the indirect and the induced impact, we have not included the contribution of formal carers as calculated in the direct impact. This is because indirect and induced impacts are created from realised spending, which cannot be achieved by the value of replacing informal carers with formal care staff (i.e. our proxy for their direct impact). As a result, to estimate the indirect and induced impact of informal carers, we used Carer's Allowance payments, as these are realised earnings that could be spent and affect other sectors. The number of Carer's Allowance recipients and the amount claimed have been calculated using DWP data, as described in an earlier section (DWP, 2024).

5.2. Socioeconomic impacts

5.2.1. Costs of Adult Social Care

Below, we present our approach to calculating the socioeconomic costs associated with the adult social care sector.

Salaries of formal carers

One of the main costs of the adult social care sector is the salaries of formal carers. We included the earnings of carers in both the regulated and unregulated sectors and across the public, private, and personal assistants sectors. These were estimated as described in section 1.1.2 during the calculation of the macroeconomic impact of the sector.

Below, we present a summary of our approach for each country.

- **England:** The earnings of employees in the regulated and non-regulated sectors were sourced from the ASC-WDS (Skills for Care, 2021).
- **Scotland:** These were estimated as described in subsection 5.1.1 during the calculation of the macroeconomic impact of the sector. In summary, the earnings of employees in the regulated sector were sourced from the ASC-WDS and adapted to the Scottish context using the ASHE, as described in the wages and earnings section of the macroeconomic impact analysis (Skills for Care, 2021; ONS, 2022a).
- **Wales:** the earnings of employees in the regulated sector were sourced from the ASC-WDS and adapted to the Welsh context using the ASHE, as described in

the wages and earnings section of the macroeconomic impact analysis (Skills for Care, 2021; Office for National Statistics, 2022a).

- **Northern Ireland:** These were estimated as described in subsection 5.1.1 during the calculation of the macroeconomic impact of the sector. In summary, the earnings of employees in the regulated sector were sourced from the ASC-WDS and adapted to Northern Ireland using the ASHE, as described in the wages and earnings section of the macroeconomic impact analysis (Skills for Care, 2021; ONS, 2022a).

Replacement cost of informal carers

We understand that informal carers make up a significant share of the adult social care service provision. As a result, we included their contribution both in the costs and benefits of the sector. To calculate the costs due to the existence of informal care, we replicated the approach described in subsection 5.1.1 of the macroeconomic analysis. In particular, we used the average earnings of employees in the formal sector, weighted by the number of employees in each setting. This figure was assumed to be equal to the value created by each informal carer and was then converted to an FTE basis using the ratio of FTEs per informal carer. The earnings were then multiplied by the number of FTEs that informal carers provide, as calculated in subsection 2 of the detailed technical discussion, using the Carers' Census (Scotland), ONS (England and Wales), and Northern Ireland Statistics and Research Agency (Northern Ireland) (Scottish Government, 2023a; ONS, 2023c; NISRA, 2021c). This means that informal carers create value equal to the earnings that formal carers would make to provide the same level of care.

Resources spent on the delivery of Adult Social Care

Apart from labour, the adult social care sector requires several other inputs. As a result, we have accounted for additional non-labour cost elements involved in the provision of adult social care. In particular, we used unit cost estimates from the PSSRU for items such as buildings and oncosts, and land costs (Personal Social Services Research Unit, 2021). These costs were again adapted to Northern Ireland using the ASHE, as described in the wages and earnings section of the macroeconomic impact analysis (ONS, 2022a).

We recognise that using unit costs for large-scale interventions does not represent best practice in estimating their total costs, as costs are not always linear. This means that the cost of providing care for the first adult is not necessarily the same as the cost for the 100th adult. This is because services, programmes, or interventions can exhibit economies of scale or diminishing returns. However, at the time of writing, the PSSRU unit costs represented the best available evidence.

5.2.2. Benefits of Adult Social Care

This section includes our approach to quantifying and monetising socioeconomic benefits. In particular, we included: (i) quality of life and wellbeing impacts, (ii) peace of mind benefits, and (iii) avoided costs to the NHS.

Avoided costs to the NHS

1. Hospital admissions

Adult social care helps reduce the need for hospitalisation by offering care services. In the analytical scenario without adult social care, we expect an increase in hospitalisations. To estimate the share of hospital admission costs that are avoided through social care, we used evidence from Bakx et al. (2020) showing that a care home admission in the Netherlands reduces the probability of hospital admission by 28%. We then applied this coefficient to the number of admissions from adults receiving adult social care in the baseline scenario. To calculate how many adults from adult social care are hospitalised, we leveraged research by the Health Foundation & Nuffield Trust showing that 8.2% of all hospital admissions come from care home residents (Smith et al., 2015).

England: We then applied this coefficient to the total number of hospital admissions in England (NHS England, 2021). Lastly, the number of avoided admissions from adult social care was monetised using unit costs for elective and non-elective inpatients from the NHS England National Cost Collection (NHS England, 2021).

Scotland: We then applied this coefficient to the total number of hospital admissions in Scotland (Public Health Scotland, 2023a). Lastly, the number of avoided admissions from adult social care was monetised using unit costs for elective and non-elective inpatients from the NHS England National Cost Collection, which were then adapted to Scotland using the ASHE, as previously described (NHS England, 2021; ONS, 2022a).

Wales: The number of hospital admissions was taken from Digital Health and Care Wales (2023), while the cost of hospitalisation was proxied using the NHS England National Cost Collection and the ASHE, as described above (NHS England, 2021; ONS, 2022a).

Northern Ireland: We then applied this coefficient to the total number of hospital admissions in Northern Ireland (NISRA, 2023b). Lastly, the number of avoided admissions from adult social care was monetised using unit costs for elective and non-elective inpatients from the NHS England National Cost Collection, which were then adapted to Northern Ireland using the ASHE, as previously described (NHS England, 2021; ONS, 2022a).

2. A&E admissions

Adult social care also helps prevent accidents and emergency admissions, reducing the strain on the NHS. Under the analytical scenario, for example, people previously in care would be more likely to get injured and would receive care from the NHS. We explored

different approaches to calculating avoidable A&E admissions. Ultimately, we used estimates from the Health Foundation, indicating that 41% of all A&E admissions from care home residents were potentially avoidable (Wolters et al., 2019). The same percentage for the general population was 27%. We assumed that the 14 percentage point difference in avoidable admissions was due to the support provided by care homes. We then multiplied this percentage point difference to the average number of A&E admissions per care home resident aged over 65²⁸, per year (Wolters et al., 2019). This calculation results in the number of A&E admissions that could be avoided per person, per year, which we then applied to all adults receiving informal care under the analytical scenario and all adults in non-nursing²⁹ residential, domiciliary, and personal assistants, calculated during the macroeconomic impact analysis of each UK nation. These impacts were then monetised using estimates for excess bed day costs which were adapted to the context of each country using the ASHE (NHS Improvement, 2020; ONS, 2022a), as previously described.

3. Discharges from acute care

The existence of adult social care helps the NHS discharge people from the hospital, increasing the capacity of the NHS to accommodate new patients and reduce costs associated with bed days. As a result, avoiding delayed discharges is associated with reduced costs to the NHS due to fewer bed days.

We estimated two types of delayed discharges that could be avoided due to the existence of adult social care. First, we estimated the number of delayed discharges that could be avoided if adult social care had sufficient placements (thereafter “potentially avoidable delays”).

The share of delayed discharges potentially avoidable due to adult social care, as well as the share of those not realising due to adult social care placements were then applied to (i) current NHS patients, (ii) additional NHS patients receiving care previously offered by adult social care, and (iii) additional people entering NHS through A&E that adult social care helped avoid under the baseline scenario. These impacts were then monetised using estimates for excess bed day costs which were adapted to the context of each country using the ASHE, as previously described (NHS Improvement, 2020; ONS, 2022a).

1.3.1 Potentially avoidable delays

England: We used estimates from an NHS England and DHSC report suggesting that approximately 24% of delayed discharges are due to waiting for home care support,

²⁸ Due to data limitations, we used the incidence of hospital admissions from care home residents over 65 as a proxy for the total hospital admissions among all care home residents.

²⁹ As previously mentioned, there is no separate nursing care in Scotland. To estimate the number of adults receiving nursing services we use data from Public Health Scotland (2022) showing, that 63% of all long-stay care home residents receive nursing care.

16% for a care home placement, and 24% for intermediate care (DHSC & NHS England, 2023). However, other evidence suggests that only increased care home capacity is associated with fewer delayed discharges, thus, only 16% of delayed discharges were classified as potentially avoidable through social care (Spiers et al., 2018). To estimate the number of these discharges we used data from NHS England on the number of discharges from acute and community care (NHS England, 2022; NHS England, 2024).

Scotland: We used estimates from Public Health Scotland (2023c) suggesting that 24% of all delayed discharges are due to the unavailability of care home placements. As a result, 24% of all delayed discharges could be avoided through adult social care.

Wales: We used estimates from StatsWales (2023) showing the number and reason for delayed discharges, which allowed us to calculate the share of all delayed discharges that are delayed due to unavailability of care placements (67%).

Northern Ireland: We used data held internally by the Department for Health, showing the number of delayed discharges and the associated reasons for the delays. This allowed us to calculate how many discharges are delayed due to insufficient adult social care capacity and thus could be potentially avoided through adult social care (17%).

1.3.2 Not realised delays

The second type of delays we examined were delays that are not realised in the baseline scenario due to the existence of adult social care. These delays are avoided because adult social care offers placements for people medically fit to be discharged. However, in the analytical scenario, these placements are no longer available, leading to additional discharges getting delayed.

England: The aforementioned datasets on acute and community care also provide information on the discharge destinations of each patient, allowing us to estimate the share of all discharges that are made possible due to the existence of adult social care placements (NHS England, 2022; NHS England, 2024).

Scotland: To estimate the share of all discharges that are made possible due to the existence of adult social care placements, we used evidence from Public Health Scotland (2023b), showing the number of attendances resulting in a transfer of care.

Wales: we used evidence from the Welsh Parliament Health and Social Care Committee (2022), showing the percentage of discharges to a different residence compared to all discharges. In the absence of more accurate data, we assume that all discharges to a different residence are discharges to adult social care.

Northern Ireland: To estimate the share of all discharges that are made possible due to the existence of adult social care placements, we used evidence from the Healthcare Pricing Office (2019) showing that 5.9% of all discharges are to adult social care.

2. Peace of mind benefits

There is a lack of evidence on peace of mind benefits due to adult social care in the UK. As a result, we explored alternative approaches to calculating this benefit. In all reviewed studies, peace of mind benefits were calculated as the difference of insurance payments subtracting the insurance claims paid out. The claims divided by the total insurance payments represent the loss ratio. For instance, if a loss ratio is 40%, this means that someone paying for insurance can expect to get back only 40% of the money they pay in insurance premiums. As a result, the remaining 60% must represent another form of benefit to the insurance buyer, otherwise they would be willing to pay only the 40% they would get back in claims. Research suggests that the remaining value (60% in this case) represents peace of mind benefits.

Forder (2011), explored the peace of mind benefits of Immediate Needs Annuities (INA), one of the few private insurance products in the UK. The author concluded that the average person would pay a lifetime cost of care of up to £69,000 through an INA, while they would pay £66,000 without one. The difference of £3,000 (or 4% of the premium) is the minimum peace of mind benefit holders of INAs accept (or equivalently, 96% is the maximum loss ratio). A report by Buckle et al., (2019) on 15 private UK health insurers calculated the medical insurance loss ratio ranging from 59% to 73%. Lastly, evidence from the US long-term insurance market suggests that the loss ratio is between 40% to 60% (DHSC, 2022).

Overall, the loss ratios range from 40% to 96% across studies and sectors. Due to the lack of a single, widely accepted loss ratio in the UK, we used the average of the UK's lower and higher bound estimates (i.e., the average of 59% and 96%).

The resulting ratio (78% loss ratio or 22% peace of mind benefit) was multiplied by the fair price of care, calculated as the total net expenditure on adult social care from HM Treasury's Public Expenditure Statistical Analyses (HM Treasury, 2023). In particular, we used the cost line of "personal social services" for old age and sickness and disability.

Quality of life and wellbeing benefits

1. *Social care-related quality of life*

SCRQoL is part of the Adult Social Care Outcomes Framework (ASCOF)³⁰ and Adult Social Care Survey (ASCS) captured in metric "1A: Quality of life of people who use services". This measures the care users' reported experience in eight outcome domains of control, dignity, personal care, food and nutrition, safety, social participation and accommodation. As a result, the impacts captured are distinct from the wellbeing of avoided injuries, captured in QALYs below, thus avoiding the risk of double-counting.

³⁰ The ASCOF measures how well care and support services achieve the outcomes that matter most to people.

To ensure that the measured quality of life impact is not affected by non-service related factors, we used metric “1B: Quality of life of people who use services” from the ASCS, which is the metric 1A adjusted for preferences of service users and external factors that might influence perceived wellbeing. Using this metric follows the methodological approach outlined in Forder et al. (2016). However, the ASCS is produced only for England. To estimate the impact of adult social care expenditure on SCRQoL for the remaining UK countries, we explored different approaches and ultimately decided to divide England’s expenditure on adult social care by the achieved SCRQoL. This allowed us to estimate the cost per SCRQoL, which was then applied to each nation’s expenditure on formal adult social care. The expenditure per country was sourced from HM Treasury’s Public Expenditure Statistical Analyses, as described above (HM Treasury, 2023).

We then used evidence by Stevens et al. (2018) showing that the adjusted SCRQoL is the wellbeing equivalent of a QALY. As a result, we monetised the impact on SCRQoL by applying the monetary value of a QALY (HM Treasury, 2021). Lastly, the monetised impact was applied to adults receiving informal care under the baseline, as well as to those receiving formal care under the baseline but not receiving any support in the analytical scenario.

2. Quality of Life Adjusted Years

Access to social care significantly reduces the likelihood of individuals experiencing injuries, thereby preventing the deterioration of their health (Crawford et al., 2020; Miller et al., 2022). Thus, social care may result in increased “quantity and quality of life”, captured by Quality Adjusted Life of Years (QALYs), by preventing injuries and illnesses (Office for Health Improvement and Disparities, 2020). Under the analytical scenario, people would no longer receive adult social care and would potentially suffer preventable injuries. According to Wolters et al. (2019), the most common avoidable admissions are for pneumonia, urinary tract infections, and fractures or sprains. To estimate the number of these admissions, we applied their incidence rates to the number of potentially avoided A&E admissions due to the existence of adult social care (as calculated in 1.2) for adults who previously received care but would not access any support under the analytical scenario. The impact of these potentially preventable injuries or illnesses on the quantity and quality of life was then monetised to estimate the savings that adult social care generates by preventing injuries.

To estimate the impact of injuries and illnesses on quality and quantity of life, we first applied disability weights³¹ for the most commonly avoided injuries and illnesses in care homes to Disability Adjusted Life Years (DALYs) (Institute for Health Metrics and

³¹ Disability weights are values representing the health impact associated with specific diseases and are generated through consultations with clinicians, experts, or community members. These are applied to Disability Adjusted Life Years (DALYs) to estimate mortality and morbidity of specific diseases (Hagell & Cheung, 2019).

Evaluation, 2019).³² To translate DALYs to QALYs, we explored different approaches and ultimately assumed that the gains in QALYs are broadly equal to losses in DALYs, following Bevan et al. (2007). These QALY impacts were then monetised using the latest monetary value for a QALY, which is £70,000 in 20/21 prices, according to the Green Book (HM Treasury, 2022).

³² QALYs measure equivalent healthy years lived, whereas DALYs measure loss of health. A QALY value of 1 is equivalent to a year in perfect health, while a DALY value of 1 is equivalent to death (National Collaborative Centre for Infectious Diseases, 2015).

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