# The value of adult social care in England

## Why it has never been more important to understand the economic benefits of adult social care to individuals and society

October 2021

**The value of adult social care in England**
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Skills for Care is the employer-led strategic body for workforce development in social care for adults in England. It is part of the sector skills council, Skills for Care and Development.
This work was researched and compiled by Keith Derbyshire, David Halsall and Jane Parkin of KDNA.

# Table of contents

Table of contents ..... iii
Acknowledgements ..... v
Executive summary ..... 1
1. Introduction and aims of this research ..... 3
1.1 Background ..... 3
1.2 This project ..... 3
1.3 Research aims ..... 4
2. Update and review of Gross Value Added (GVA) of adult social care in England ..... 6
2.1 Updated GVA ..... 6
2.2 Indirect and induced effects ..... 7
2.3 Recent trends and the effect of the pandemic on the size of social care ..... 8
2.4 Market failure and the problem of GVA as a measure of full economic value of adult social care ..... 10
2.5 Summary of chapter ..... 12
3. Quality and outcomes for people being supported ..... 13
3.1 The relationship between quality and outcomes ..... 13
3.2 Measuring adult social care quality ..... 14
3.3 Adult social care outcomes based on the first-hand experience of service users 16
3.4 Monetising the improvements in wellbeing ..... 18
3.5 Summary of chapter ..... 19
4. Some of the additional benefits of adult social care that can be monetised ..... 22
4.1 Benefits to working age adults drawing on care and in employment ..... 22
4.2 Outcomes to carers and families ..... 24
4.3 Employment benefits to carers ..... 26
4.4 Benefits / savings to the NHS ..... 26
4.5 Chapter summary ..... 28
5. Labour market analysis ..... 30
5.1 The problem with the adult social care labour market ..... 30
5.2 What is the ‘market clearing rate’ for care workers? ..... 31
5.3 What are the consequences of permanently high vacancies? ..... 34
5.4 Chapter summary ..... 36
6. Marginal analysis. What could an extra £6.1 billion pounds deliver in a phased program of investment? ..... 38
6.1 Modelling the benefits of a strategic increase in resources ..... 38

6.2 The full economic benefits arising from the investment....39
6.3 Chapter summary....41
7. Conclusions and recommendations....42
7.1 Conclusions....42
7.2 The recommendations flow from this analysis....43
8. References....46
9. Annex A....50

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# Executive summary

**Purpose and background**

Skills for Care commissioned this project to demonstrate the full economic value of the adult social care sector in England to make a case for investment in the sector.

Following the pandemic, most people know that adult social care is an essential part of our society, helping to support people to live the lives they want to live. But few people know anything about the scale or scope of the contribution adult social care makes to the economy, or its potential for future growth.

The purpose of this project was to:

- Estimate the 'full economic value' delivered by the sector currently, including benefits to carers and to the NHS
- Explore how an increase in resources to the sector might raise those benefits.

**What we did**

During the preliminary work in chapters two to five we:

- Calculated the direct, indirect, and induced effects of the formal provision of adult social care (public funded and self-funded) on the wider economy from 2012/13 to 2020/21
- Explained why, because of market failures in social care, the direct Gross Value Added (GVA) methodology which is typically used to explain the economic value of a sector might be a significant underestimate of the full economic value that adult social care provides (or could provide)
- Explored monetising the reported outcomes of adult social care
- Investigated the scale of wider benefits of adult social care
- Looked at how the challenges in the adult social care labour market may be affecting quality and capacity.

This enhanced understanding of the baseline economic position allowed us to identify a realistic investment scenario in chapter six and quantify the additional benefits that would arise. Chapter 7 draws conclusions and makes recommendations, especially on the need to address critical workforce issues and emerging shortages.

**Key findings**

Economic value

- The Gross Value Added (GVA)[1] of adult social care was £25.6 billion in 2020/21. This is 1.6% of total England GVA. It is a bigger sector than electricity and power, water and waste management and twice as big as agriculture.
- Adding in the indirect and induced 'multiplier effects' to adult social care GVA means that it generates £50.3 billion of economic activity.

[1] GVA is important because it is used as a key metric to assess the overall success of the national economy. It is also used to assess the contribution of different sectors to the national economy.

- Adult social care is an important sector across the whole country, but is a relatively bigger share of regional GVA in the North and Midlands. It is a very large employer everywhere, accounting for 5% of all jobs.
- Sustained investment in adult social care would benefit the North in particular, and act as an automatic stabiliser to the business cycle.
- Market failures hold back demand and under value and under provide quality. We have estimated a shortfall in investment of £6.1 billion from these market failures.

<u>The wellbeing created by adult social care</u>

- The improvements to Social Care Related Quality of Life (SCRQoL) attributable to adult social care average 43% on a scale where 1 is the best possible state of wellbeing and 0 is the worst possible state[2].
- Assigning two values for a SCRQoL taken from the health based equivalent Quality Adjusted Life Year (QALY) measure, of £25,000 and £60,000, the total wellbeing benefit has a 'value' of £9.2 billion and £23.3 billion respectively.

<u>Additional benefits</u>

- In addition to the economic value arising from GVA and improvement in wellbeing, we have estimated additional benefits of £7.9 billion from increased employment opportunities to carers and working age adults, plus wellbeing benefits to carers and family members and some savings to the NHS.

<u>The adult social care labour market</u>

- The market failures in adult social care manifest themselves most strongly in the adult social care labour market, where vacancies of front line staff have been 7% for the last five years.
- There is strong evidence emerging that the level of vacancies is reducing capacity to take on new commissions from local authorities, with growing numbers of providers handing back contracts.
- Investment in higher pay, more training for staff and a career and progression structure that rewards the most skilled workers is now essential.
- Provider level analysis and local authority level analysis suggested a more skilled and more highly-trained workforce will deliver higher quality care.

<u>The benefits of additional investment</u>

- It is estimated that a £6.1 billion additional investment in adult social care would address the current structural imbalances caused by the market failure and also provide full economic benefits of £10.7 billion - a return on investment of 175%.

[2] To put this into context, the health equivalent Quality Adjusted Life Year or QALY improvement resulting from a total knee replacement is 33% on a 0-1 scale. A hip replacement is 46%

# 1. Introduction and aims of this research

**Chapter 1 introduces the project and:**

- Describes earlier work to estimate the economic value of adult social care by ICF Consulting
- States the research aims of this project
- Lists subsequent chapters and cross-references these to the accompanying Technical Report.

## 1.1 Background

Skills for Care is an independent charity that aims to help create a well-led, appropriately skilled, and highly valued adult social care workforce in England. In 2018 the sector skills council, Skills for Care and Development (of which Skills for Care is a partner) commissioned ICF Consulting to estimate the economic value of the adult social care sector in the UK, and in each of the four nations individually. Skills for Care and Development published ICF's report on 'The economic value of the adult social care sector – UK' (ICF, 2018) and a report focused on England (ICF, 2018a).

These reports were published to make the case for investment in adult social care. ICF calculated the Gross Value Added (GVA)[3] of adult social care in England and the whole of the UK. The figure for 2016/17 for England was £20.3 billion. ICF also added the indirect and induced effects of the production of adult social care on the wider economy, through supply chain and employees' expenditure. This brought their estimate of 'economic value' up to £38.5 billion.

We have revised and updated these figures for England. The GVA figure for 2020/21 is £25.6 million and the economic value figure is £50.3 billion.

## 1.2 This project

The COVID-19 pandemic has exposed the challenges faced by the adult social care sector, as well as highlighting the true value of the workforce as key workers. Advocates for the sector are united in arguing for a sustained investment to improve access and quality, stabilise the provider sector and deliver a sustainable social care workforce for the future (Adult Social Care Leaders, 2021).

The Health and Social Care Select Committee report on adult social care articulated the concern felt by many on the funding and resilience of the sector (Health and Social Care Select Committee, 2020). It recommended both immediate funding increases and a

[3] The GVA of a sector of an economy is a measure of the value of the goods and services produced in an industry or sector. It is the value of output minus the value of intermediate consumption.

long-term sustainable funding solution to meet people's needs and avoid market collapse.

The Committee went on to say: "Providing adequate funding for social care will also help the NHS and may itself have positive economic and long-term social impacts, given that social care is an important part of the economy."

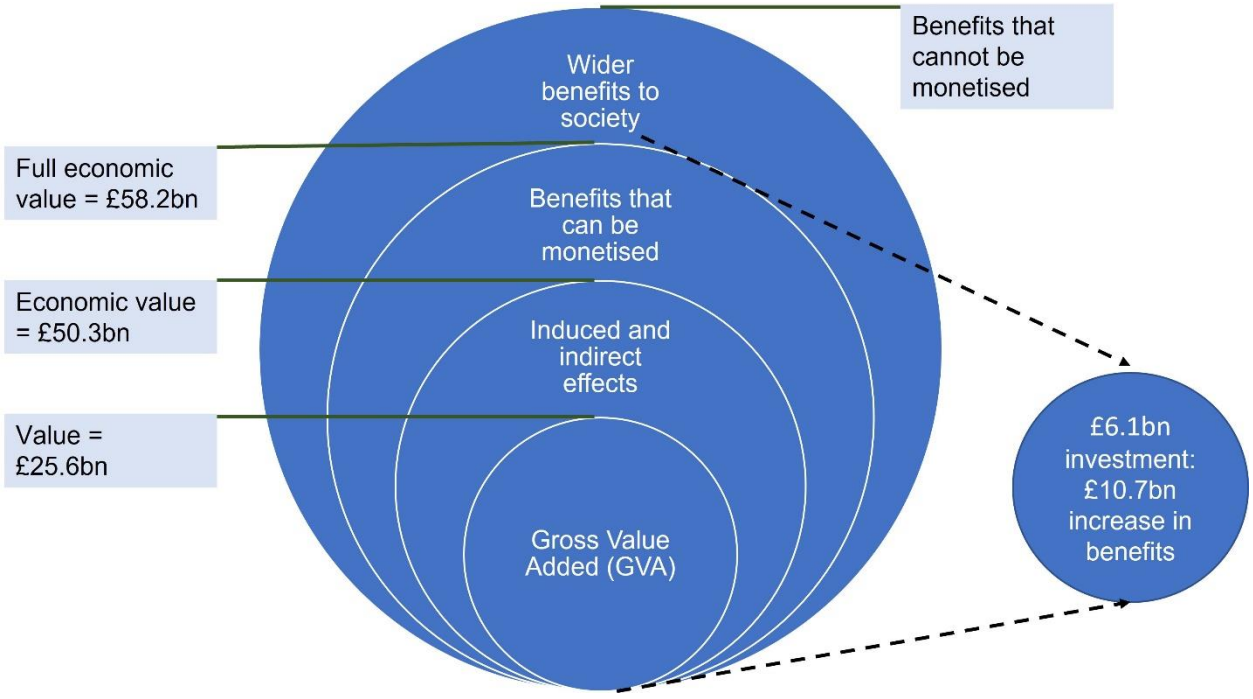
## 1.3 Research aims

To provide further evidence of the benefits of increased investment in adult social care, Skills for Care commissioned KDNA, an independent economics consultancy, to:

- estimate the 'full economic value' delivered by the sector
- explore how an increase in resources to the sector might raise those benefits.

This is illustrated below. Figure 1 includes the updated figures for GVA, induced and indirect effects and adds further benefits that can be monetised.

**Figure 1**. We estimate the full economic value of adult social care and explore the additional benefits that would arise from a significant, targeted investment.




The calculation of wider societal benefits that cannot be monetised (e.g. increased peace of mind, knowing the care offered by adult social care providers was of consistent high quality) is beyond the scope of this report.

**Structure of this report and accompanying Technical Report**

In addition to this main report on 'The value of adult social care in England' we have produced an accompanying Technical Report: 'Assessing the full economic value of adult social care in England.' This presents more of the evidence base and technical detail behind the work. The Technical Report will be referred to at appropriate points throughout this report.

**Table 1** shows the chapter headings for this report and their read-across to the Technical Report.

| Final report: The value of adult social care in England | Technical Report: Assessing the full economic value of adult social care in England |
|---|---|
| 1 Introduction and aims of research | 1 Background |
| | 2 Literature review |
| | 3 Methodological approach |
| 2 Update and review of Gross Value Added of adult social care in England | 4 Gross Value Added calculations and adult social care market failures |
| 3 Measuring and quantifying outcomes | 5 Quality and outcomes |
| 4 Wider benefits | |
| 5 Adult social care labour market | 6 Adult social care labour market |
| 6 Benefits of increased investment | |
| 7 Conclusions | |

# 2. Update and review of Gross Value Added (GVA) of adult social care in England

**The Gross Value Added (GVA) of a sector is the measure of the value of the goods and services produced in that sector.**

- GVA is important because it's used as a key metric to assess the overall success of the national economy. It's also used to assess the contribution of different sectors and regions to the national economy.
- Regional GVA will be an important metric to gauge success of the 'levelling-up' agenda.
- The GVA of adult social care in England in 2020/21 was **£25.6 billion,** representing just under 1.6% of total GVA in England.
- This was a £1.8 billion (7.7%) increase on 2019/20 when adult social care represented 1.4% of England's total GVA.
- This growth was above the long run trend growth of 5.5% p.a., and we believe some of that growth was the sector's response to the COVID-19 pandemic.
- Adult social care is a significant employer everywhere in England, comprising 5% of the workforce. In addition to the direct GVA added to each local authority's economy, there are indirect and induced effects of £12.5 and £12.0 billion respectively.
- The *minimum* economic value of adult social care in 2020/21 was therefore **£50.3 billion**.
- We say *minimum* because GVA is a market valuation and we discuss how the economic characteristics of the current adult social care market will tend to undervalue, and therefore under-provide, it.
- We estimate how much untapped potential there could be in the provision of more and higher quality adult social care at £6.1 billion.

## 2.1 Updated GVA

The GVA of a sector of the economy is the measure of the value of the goods and services produced in that sector. It's the value of output minus the value of intermediate consumption and it's a measure of the contribution to GDP made by each sector[4].

[4] The sum of all the GVAs of all the industries of an economy is equal to Gross Domestic Product (GDP) plus subsidies on products minus taxes on products.

**The original estimate of the GVA of adult social care in England**

The estimate of the economic value of adult social care, made by ICF consulting in 2018, began with the measurement of GVA. The ICF results for 2016 using the income method[5] gave an estimate of GVA of £20.3 billion.

Skills for Care produced updated estimates of the income-based method of GVA each year from 2016. Jointly reviewing these estimates with Skills for Care, we had access to an improved and consistent time series of staff in post and wages, including NHS staff working in the adult social care sector. (Skills for Care, 2020) We also replaced two assumptions used to derive the Gross Operating Surplus with more recent data and more robust assumptions. These are described in the Technical Report, Chapter 4.

The original and new time series of GVA from the original ICF estimate in 2016 is shown in Table 2 below.

**Table 2** The GVA of Adult Social Care in England, new and old methods.

| | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
|---|---|---|---|---|---|
| GVA estimated using new method and data | £21.1bn | £22.3bn | £22.9bn | £23.8bn | £25.6bn |
| GVA estimated using ICF original method and data | £20.3bn | £20.3bn | £20.9bn | £21.6bn | |

***Source*** *KDNA, Skills for Care, ICF.*

From 2016/17 the new GVA estimate is consistently higher than the previous estimate, due mainly to the inclusion of NHS staff providing adult social care.

At £25.6 billion, adult social care is a significant part of the economy. It is about the same size (in GVA terms) as energy supply, water supply and significantly higher than agriculture forestry and fishing[6].

## 2.2 Indirect and induced effects

The GVA of adult social care is an indication of its *direct* impact on the economy via the employment of inputs such as labour, premises, and equipment to produce something that has value to buyers.

[5] GVA can be calculated via the income method, the output method and expenditure method. In theory, and with perfect data, all three methods give the same answer.

[6] These smaller sectors are vital parts of the England economy but dwarfed by England's biggest sectors: real estate at £220 billion; health excluding adult social care £140 billion; and construction at around £100 billion.

This creates productive employment and businesses, but it also has indirect benefits via its supply chain and second-order effects arising from the spending power of the people employed in the sector. These are known as the indirect and induced effects:

- **Indirect** effects (sometimes referred to as supply chain or Type 1 multipliers) arise as the adult social care sector increase their demands for goods and services from supplier businesses.

- **Induced** effects (sometimes referred to as income or Type 2 multipliers) arise from the spending by those employed in the sector on goods and services from other businesses.

We have calculated the indirect and induced effects from the new estimates of GVA using the same method and multipliers as ICF used in 2016. They are shown in Table 3 from 2012/13 to 2020/21.

**Table 3** Adult social care: the GVA plus indirect and induced effects gives the 'economic value' in £ billion.

| | 12/13 | 13/14 | 14/15 | 15/16 | 16/17 | 17/18 | 18/19 | 19/20 | 20/21 |
|---|---|---|---|---|---|---|---|---|---|
| **Direct GVA** | £18.4 | £18.8 | £19.4 | £20.1 | £21.1 | £22.3 | £22.9 | £23.8 | £25.6 |
| **Indirect** | £9.4 | £9.6 | £9.8 | £10.0 | £10.4 | £10.9 | £11.3 | £11.8 | £12.6 |
| **Induced** | £8.8 | £9.0 | £9.2 | £9.5 | £10.0 | £10.5 | £10.8 | £11.2 | £12.1 |
| **Economic impact** | £36.6 | £37.3 | £38.4 | £39.6 | £41.5 | £43.8 | £45.0 | £46.8 | £50.3 |

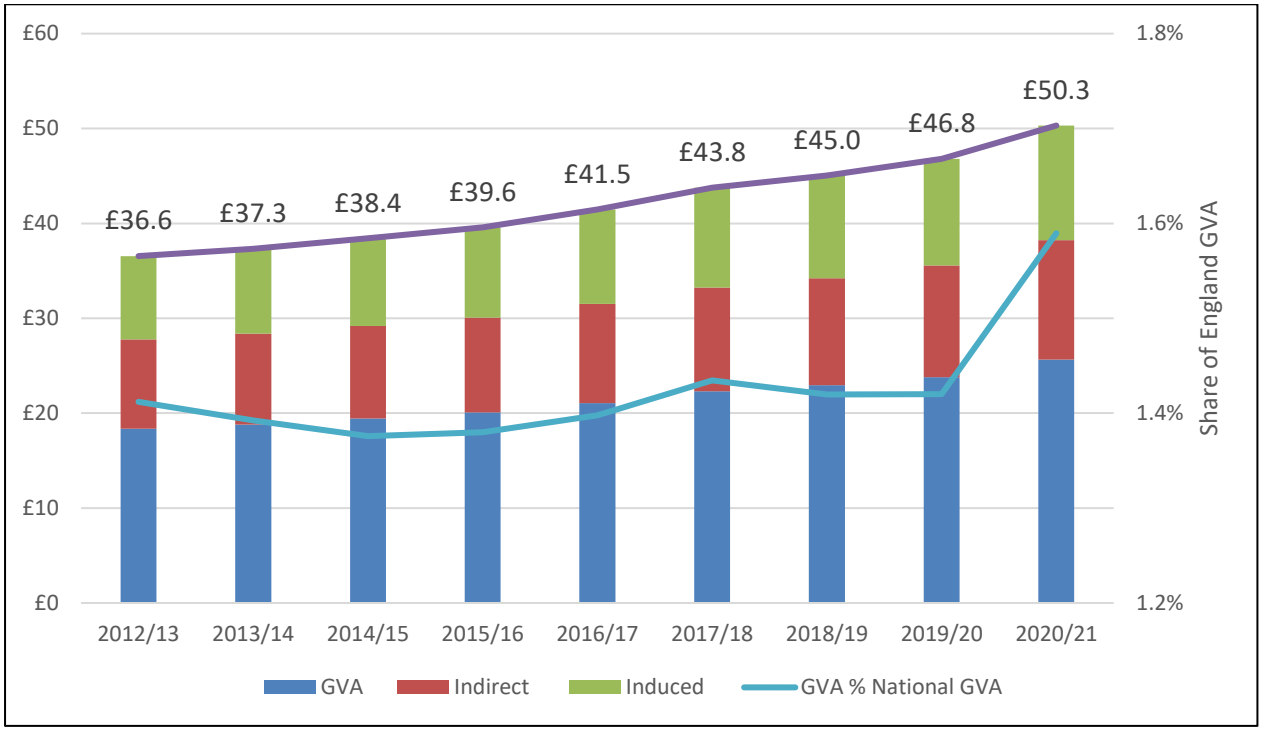
*Source KDNA, Skills for Care*

The average rate of increase in adult social care GVA from 2012/13 to 2020/21 was 4.3% reflecting both the increase in staff numbers (1.6% p.a.) and wages (2.8% p.a.) and any change in Gross Operating Surplus. The smallest rate of growth was 13/14 over 12/13 at 2.4% and the fastest was 2020/21 over 2019/20 at 7.7%

## 2.3 Recent trends and the effect of the pandemic on the size of social care

The data from Table 3 is plotted in Figure 2 alongside the ratio of adult social care GVA to total England GVA (shown on the right-hand scale).

**Figure 2** The time series of adult social care GVA, indirect and induced effects in £ billion and GVA share of total England GVA.




***Source*** *KDNA Skills for Care*

From Figure 2 and looking at the adult social care GVA as a percentage of all England GVA, we can see that there was a period of real terms reductions in adult social care from 2012/13 to 2015/16, a slight recovery to 2017/8, followed by a flat line to 2019/20. Table 4 summarises the average growth in wages and average annual growth in staff numbers in these three periods and compares it to the above trend growth in 2020/21.

**Table 4** Growth in average wage, and staff numbers since 2016/17.

| | 12/13 to 15/16 | 16/17 to 17/18 | 18/19 to 19/20 | 12/13 to 19/20 | 19/20 to 2021 |
|---|---|---|---|---|---|
| Staff numbers | 1.4% | 1.6% | 1.1% | 1.4% | 3.1% |
| Wages | 2.1% | 2.5% | 3.4% | 2.6% | 4.4% |
| GVA | 3.0% | 5.4% | 3.3% | 3.8% | 7.7% |

***Source*** *KDNA Skills for Care using Adult Social Care Workforce Data Set for % increase in labour component of GVA.*
*Note the staff number and wage increase do not sum to GVA because GVA also includes GOS.*

We believe the majority of the increase in the GVA of adult social care in 2020/21 was in response to the increase in the National Living Wage of 6.2%, but some of the increase was the sector's response to the pandemic. Social care was an essential societal (including NHS) response to the COVID-19 pandemic.

The increase in capacity and responsiveness in adult social care occurred despite years of relative underinvestment. Adult social care increased as a share of total GVA during the pandemic from 1.4% to 1.6%. Some of this was due to the GVA of the economy falling back by 4%, but some was the result of the expansion of adult social care.

**Notable features of adult social care**

Many other sectors of the national economy are larger in GVA terms than adult social care, but there are five notable features that make social care's economic contribution, and potential future contribution, worthy of further investigation:

1. Social care is highly labour intensive and is a much larger employer of labour than other sectors of similar size (5% of the total workforce producing just 1.6% of total GVA).

2. The publicly funded demand for adult social care is driven by long run demographic factors that are independent of the business cycle. If consistently funded, on the basis of need, it would help to stabilise the economy during recessions.

3. Adult social care is undertaken everywhere in England rather than being concentrated in particular regions or centres.

4. Social care will be an increasing employer of labour for the foreseeable future, when other sectors may be reducing their employment.

5. Social care has potential for immediate growth to:
   - meet current unmet need
   - improve the quality and outcomes of care
   - innovate in service delivery and improve productivity.

Any sustained growth in adult social care will boost local economies via the induced and indirect effects (as shown in Table 3 above). The resultant economic growth would take place throughout England, but would have the greatest impact in Northern and Midlands regions, where adult social care GVA is around 2% of total GVA compared to less than 1% in London and the South East.

## 2.4 Market failure and the problem of GVA as a measure of full economic value of adult social care

Not all the goods and services produced and consumed in a modern economy have the same economic characteristics, and these characteristics affect the efficiency with which the service can be delivered via a market mechanism. The three most relevant characteristics for adult social care are:

- The level of competition
- Incomplete information
- The existence of positive externalities.

Any one of these can cause a market failure. These are discussed more fully in the Technical Report but in summary:

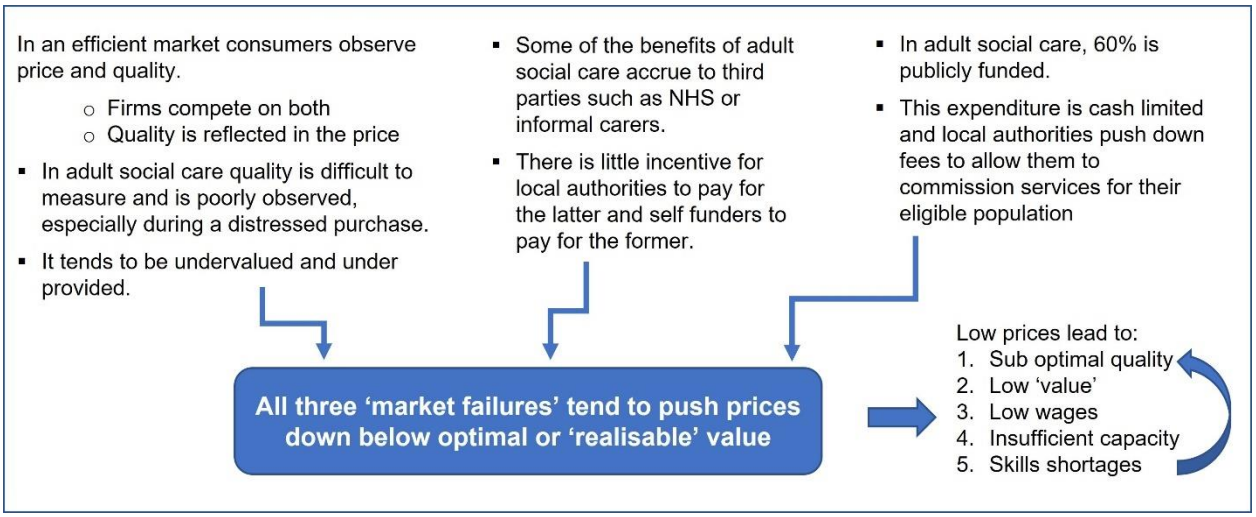
- **Competition:** although there is competition in the provider market for social care, local authorities are dominant commissioners in all areas and use their market power to hold down fees.

- **Incomplete information:** efficient markets require buyers and sellers to have perfect and equal information about the attributes of the products and services they are buying and selling, and the different prices being charged. This is not the case in adult social care, where quality is difficult to assess, especially when people need access to social care in a crisis. This tends to lead to the quality of care being undervalued and under provided.

- **Externalities**: the purchase of social care has an impact outside (external to) the market transaction. For example, the provision of adult social care to older people might help to prevent emergency hospital admissions. This is a positive externality but is not captured in the price of social care or in the GVA calculation.

All of these market failures have consequences for the volume and quality of provision of adult social care and the prices charged. This is illustrated in Figure 3.

**Figure 3** Market failures in adult social care mean that its GVA is not an accurate reflection of its value.




**Funding gap?**

In the Technical Report, Chapter 3, we explain more about these market failures and describe how they are holding down the size of adult social care GVA, by a combination of higher thresholds for treatment for publicly funded care and downward pressure on fees. To reduce the levels of unmet need we would need to increase the volume of local authority funded long term care by 15%. This would not be possible without a strategic fee increase of up to 25% to enable higher pay for more staff and to sustain the provider market. We estimate a combined cost of £6.1 billion, and this is used in chapter six to explore the benefits of additional investment in adult social care.

Although £6.1 billion is a large number, it is less than that recommended by three recent and authoritative sources.

- In 2019 The Lords Economics Affairs Committee (House of Lords Economics Committee, 2019) said £8 billion was required to 'Restore care quality and access to 2009/10 standards, addressing the increased pressures on unpaid carers and local authorities and the unmet need that has developed since then'.

- In 2020, the Local Government Association put a price tag of £7.9 billion to address the 'provider market gap, to pay the difference between the cost of delivering care and what councils currently pay and meet core pressures.'

- In 2020, the House of Commons Health and Social Care Committee (Health and Social Care Select Committee, 2020) recommended a social care funding increase of "an additional £7bn per year by 2023/24 to cover demographic changes, uplift staff pay in line with the National Minimum Wage and to protect people who face catastrophic social care costs and address shortfalls in the quality of care currently provided, reverse the decline in access and stop the market retreating.

## 2.5 Summary of chapter

Gross Value Added (GVA) is an important measure of economic activity that enables people to understand and compare the contribution of different sectors and regions to the national economy. The GVA of adult social care is a 1.6% of England GVA but a larger share of some of the less prosperous local authorities.

It is also a large employer in every local authority, though GVA per worker is low and consequently wages are low.

Working with Skills for Care we have revised the estimate of GVA and produced a consistent nine-year time series that can be updated annually. We have also added the indirect and induced effects. GVA in 2020/21 was £25.6 billion adding in the induced and indirect effects gives it an economic value just over £50.3 billion.

However, we argue that GVA is not a robust measure of the full economic value of adult social care because of various market failures that drive fees down toward cost and under-reward quality. We estimate an additional £6.1 billion investment in long term care would is needed to sustain the sector and release its full potential.

# 3. Quality and outcomes for people being supported

**In this chapter we briefly discuss the relationship between outputs, quality, and outcomes. We give examples of monetising outcomes in four adult social care settings.**

- The previous chapter valued the output of adult social care (using GVA). It noted that measuring the quality of this output and therefore assessing the true value, was difficult.
- An alternative way to consider the 'value' is to look at the outcomes of care, the impact adult social care has on people's quality of life and wellbeing.
- Monetising the outcome measure requires an assumption of the value society places on one Social Care Related Quality of Life (SCRQoL).
- Adopting two alternative values used for the SCRQoL derived from the two values used for the Quality Adjusted Life Year (QALY) we show how adult social care outcomes can be monetised

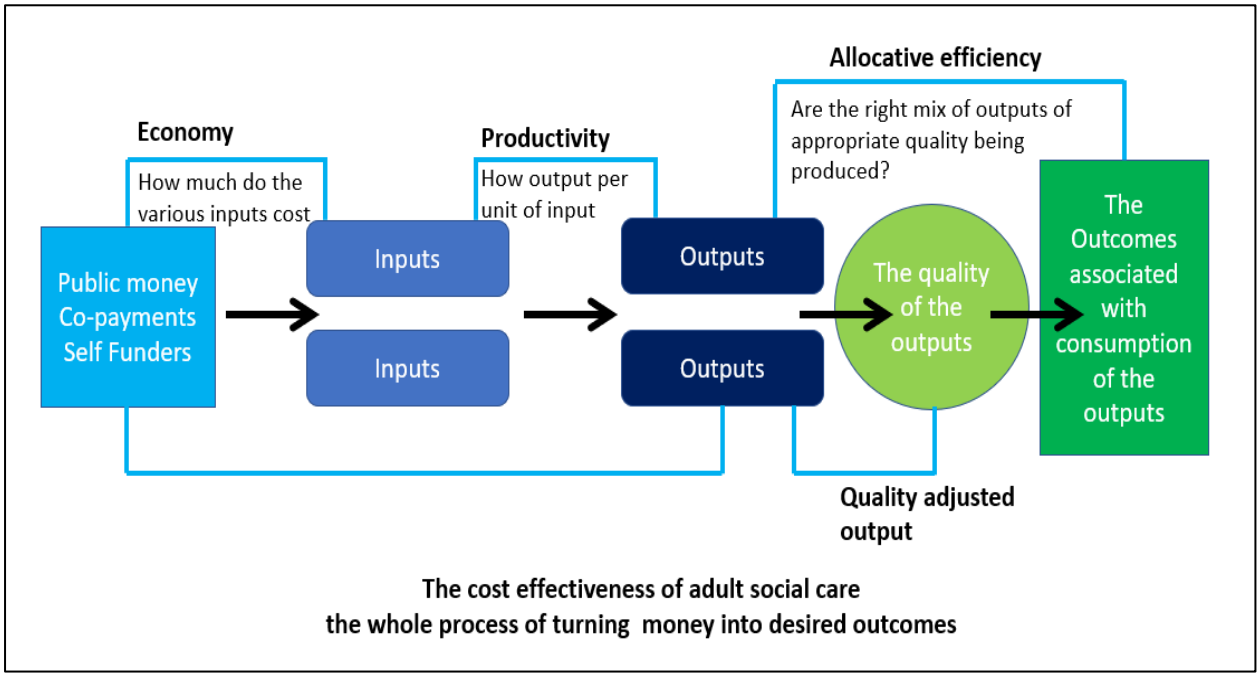
## 3.1 The relationship between quality and outcomes

Improving the outcomes of people drawing on adult social care and support has been on the government agenda since at least 2010 (Department of Health, 2010) and on the research agenda for much longer (Knapp, 1984), (Kings Fund, 2006).

The Kings Fund 2006 study 'Securing good care for older people' was particularly farsighted when it came to articulating the case for measuring the outcomes of care rather than the intermediate processes: 'Since services are used to improve people's outcomes, the best way to measure service performance is in outcome terms. At present, the majority of social care commissioning is based on service inputs (so many places, hours of home care etc). There is a relationship between inputs and outcomes, but it is complicated and depends on what conditions the service user is suffering, their family and housing circumstances, the location and quality of care and so on. Commissioning on the basis of outcomes, not inputs, is likely to improve the targeting of resources.'

A focus on the outcomes of Government expenditure (not the intermediate outputs) was also proposed by the Public Sector Efficiency Group of Government Chief Economists from 2014 to 2019 and is presented in Figure 4 below.

**Figure 4** Adult social care represented as the production of care outputs of varying quality and their ultimate impact on the quality of life of people receiving care.




*Source KDNA, from author's work on measuring public sector efficiency in the NHS (Aldridge, January 2016)*

Output is a physical something at the end of the production process, e.g. a week in a nursing home. The quality adjusted output could be a week in a nursing home modified for the number of adverse events, such as medication errors and falls. The ultimate goal of adult social care however, is the improvement in wellbeing that arises from the care and support delivered in the nursing home compared to what it would be without that support.

A focus on the output side – which is easier to measure – risks focussing attention on technical efficiency, holding down wages, reducing the contact time in domiciliary visits and having minimal night staff in nursing homes. A focus on outcomes encourages investigation of what aspects of care most improves people's quality of life and innovation on the best ways to achieve it.

## 3.2 Measuring adult social care quality

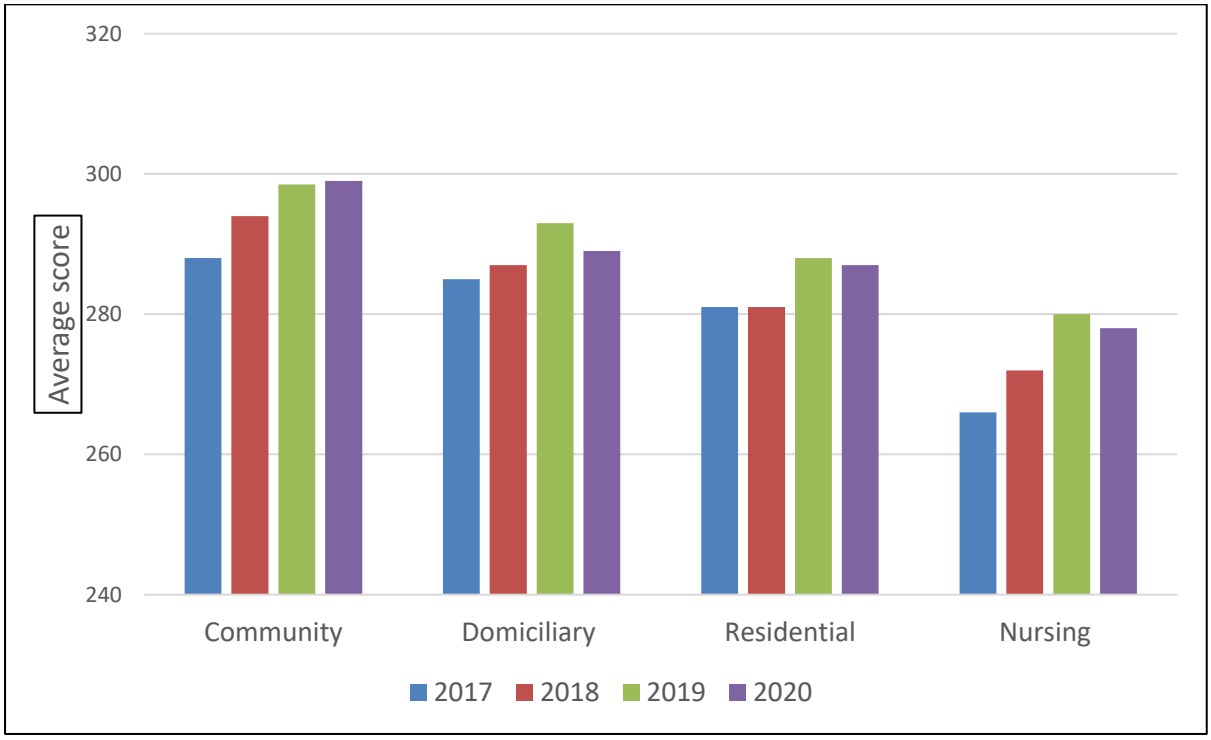
We have already noted that quality is difficult to observe in adult social (it is an elusive concept for most goods and services (OECD, 2013)). One possible definition of quality in the health and care sectors involves measuring the level of compliance with jointly agreed standards, e.g. between a provider and regulator.

The Care Quality Commission (CQC) registers, monitors and inspects adult social care providers, and publishes its assessments and provider ratings. The CQC can also take enforcement action when care falls below fundamental standards. In 2017, CQC completed its initial comprehensive inspection programme of adult social care covering around 24,000 registered providers. The CQC found almost four out of five adult social

care services in England were rated as good or outstanding. On the other hand, nearly a fifth of services were rated as 'requires improvement', and 343 locations (2%) were rated as inadequate. (In 2020 the numbers requiring improvement had fallen to 14% and only 1% were inadequate.)

A simple aggregate measure of the CQC ratings has been created for this study. We score outstanding as 4, good as 3, needs improvement as 2 and inadequate as 1. The results for four years of CQC ratings are shown below in Figure 5.

**Figure 5** CQC ratings *(Care Quality Commission , 2017-2020)* showing significant improvement from the first year of ratings across all service types (with biggest improvement, from low base for nursing homes).




*Source KDNA analysis of CQC State of Care reports. Notes (1) year of publication refers to previous financial year performance. (2) The average score is the percentage providers in each setting obtaining a quality score of 4 for outstanding, 3 for good, 2 for needs improvement and 1 for inadequate. (3) The average score of 300 for community in 2020 can be interpreted as a setting average of 3 or 'good'. This is made up of 8% outstanding, 88% good, 5% needs improvement and under 1% inadequate.*

In Chapter 5 we explore if we can identify any relationship between the inputs of care (e.g. staff numbers and seniority) and the quality of the outputs, as measured by this aggregated CQC score.

The next section of this chapter, however, considers how we might measure the outcomes of adult social care directly and attach a pound sign to them.

## 3.3 Adult social care outcomes based on the first-hand experience of service users

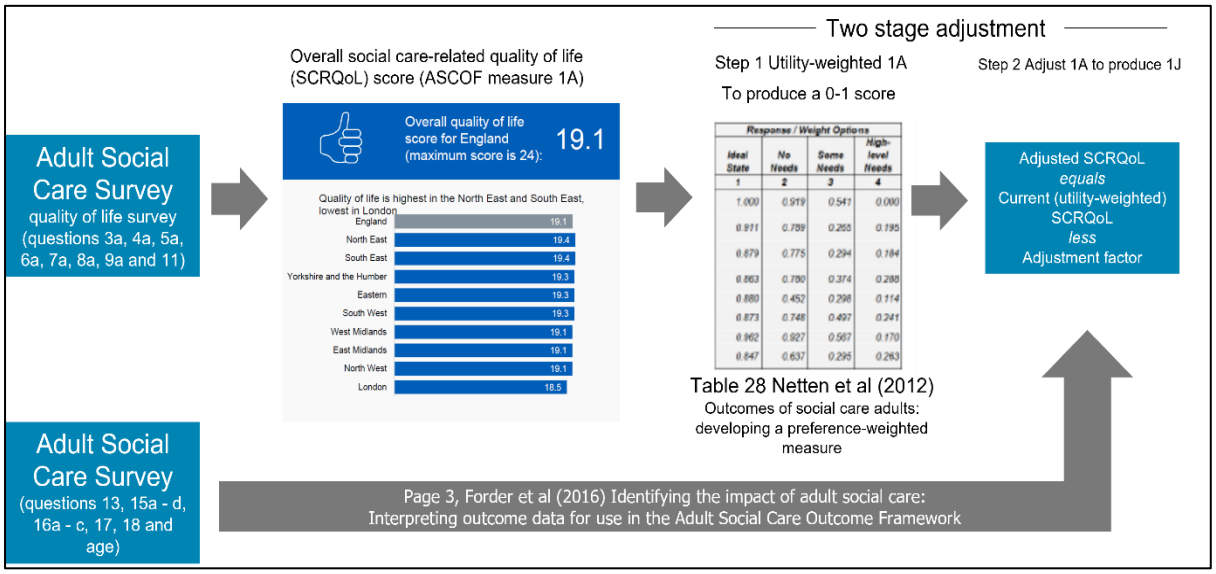
The 2010 white paper 'A Vision for Adult Social Care: Capable Communities and Active Citizens' (Department of Health, 2010) set out how 'to make services more personalised, more preventative and more focused on delivering the best outcomes for those who use them.'

In the document published alongside the white paper 'Transparency in outcomes: a framework for adult social care' (Department of Health, 2010) a range of indicators was proposed for use in the Adult Social Care Outcomes Framework (ASCOF). One of them was a Social Care Related Quality of Life (SCRQoL) indicator which would gather care users' reported experience in seven outcome domains of control, dignity, personal care, food and nutrition, safety, social participation and accommodation.[7] Subsequently, an Adult Social Care Survey (ASCS) sent to local authority funded users of social care, gathers this data every year.

**Adult social care outcomes**

The derivation of the key adult social care outcome measure included in the ASCOF is measure 1J. Its derivation is described in a paper titled 'Identifying the Impact of Adult Social Care' (IIASC) (Forder J. , et al., 2016) and summarised in Figure 6, below

**Figure 6** The weighting and adjustment calculations used to calculate the ASCOF measures 1A and 1J from the ASCS.




*Source KDNA*

The original ASCOF outcome indicator 1A tells us about the 'overall social care-related quality of life' of people using social care, but not the impact that care and support services are having on that person's care-related quality of life. It is drawn from the

[7] It was anticipated that the SCRQoL indicator could be based on research that underpinned the adult social care outcome toolkit (ASCOT), produced by quality and outcomes of person-centred care policy research unit at the University of Kent.

answers to eight questions in ASCS which reflect how the person drawing on support rates their quality of life, now, with support in place.

**Two-step process from ASCOF Indicator 1A to ASCOF Indicator 1J**

The first step converts the raw scores from the eight ASCS questions into a utility preference and scaled SCRQoL on a 0-1 scale. The preference weightings reflect the relative importance of different aspects of outcome with final scores anchored to 1 (the ideal state) and 0 (being dead). Scores on a 0-1 scale are easier to interpret and also support comparison with the Quality Adjusted Life Year (QALY) used in evaluations of health. The resultant SCRQoL measures an individual's wellbeing now, when they are in receipt of care.

The second step uses a further 10 questions in the ASCS to adjust for the respondent's underlying health status, age, and external factors such as housing and proximity to amenities, (NHS Digital, 2016). The adjustment factor is then subtracted from SCRQoL to obtain a 'net outcomes score', an outcome measure that is attributable to the adult social care being drawn on.

**Calculating Adjusted SCRQoL for all valid ASCS results**

The IIASC methodology was principally validated in a community setting excluding learning disabilities support. The work reported here has drawn on the source ASCS data to calculate IIASC scores in four settings. Accepting that further research on the IIASC methodology in the future may refine the coefficients in the calculation for different settings, we use the same calculation for all four care settings, with average Adjusted SCRQoL shown in Table 5.

**Table 5** The Adjusted SCRQoL score for different support settings, calculated from the adult social care survey using the IIASC methodology.

| | Age 18 to 64 community | Age 18 – 64 residential | Age 65 and over community | Age 65 and over residential | Age 18 – 64 total | Age 65 and over total |
|---|---|---|---|---|---|---|
| **2019/20** | 0.419 | 0.440 | 0.424 | 0.490 | 0.421 | 0.444 |
| **2018/19** | 0.419 | 0.437 | 0.424 | 0.496 | 0.421 | 0.447 |
| **2017/19** | 0.416 | 0.432 | 0.428 | 0.498 | 0.418 | 0.450 |
| **2016/17** | 0.435 | 0.451 | 0.425 | 0.496 | 0.438 | 0.447 |

***Source*** *KDNA analysis of Adult Social Care Survey (NHS Digital, 2021) Notes (1) Sample sizes average 40,000 over the four setting over the four years but have been declining year on year (34,000) in 2019/209 split 8,000 and 1,000 for community and residential for working age; and 19,000 and 8,000 for community and residential for 65 and older.*

One way to interpret the numbers in Table 5 is as a percentage improvement in SCRQoL attributable to adult social care, i.e., 44.4% for the 65 and over age group in 2019. A total knee replacement improves the equivalent QALY score, on average, by 33%. (NHS Digital, 2021)

The 65+ age group in a community setting has been stable over the period. All other settings have shown a small drop over the period. The question as to why the outcomes

seem to be dropping was put to the External Reference Group. They suggested that the funding was not keeping pace with need and the increasing funding was being spent on a decreasing number of people with more complex needs.

**Case study 1 - Using quality of life measures as part of care planning[8]**

For over 70 years, Whiddon have been providing support for older people in New South Wales, Australia. They currently have 2,000 staff over 40 locations with 16,000 residential and home care packages.

In 2015 the MyLife model of care was launched to support Whiddon's long held belief that quality of life, personal growth and meaningful activity can be possible for everybody.

The ASCOT social care quality of life tool is used with individuals to support care planning. A major benefit of this approach has been found that it empowers people being supported and their families to have a formalised way of giving feedback to staff. Under normal circumstances those receiving care would be reluctant to talk about their social and emotional needs because they would consider it not important enough or worry about being perceived as ungrateful.

Underpinning the MyLife model is relationship-based care using ASCOT, which when it was introduced, was a cultural shift away from the traditional task-focussed care delivery. Relationship-based care is built on a partnership between staff and those being supported. It has three key elements – continuity of staffing, greater personal contact and meaningful activity.

The conversations around the eight domains of wellbeing make residents and their families feel staff truly care about them and their needs. Family members have reported that they felt much more involved in their loved one's care through the conversations, and that it gave them something tangible to follow up on when they came to visit.

The measure of outcomes of adult social care can be done remotely (e.g. by survey) or as a process between those offering care and support and the person drawing on care. The latter can be help both parties understand what is most important to the person drawing on care, but only if the information collection is honest and impartial.

## 3.4 Monetising the improvements in wellbeing

[8] https://dachastudy.com/care-planning-for-quality-of-life-in-care-homes-a-circle-of-care-approach-involving-residents-and-their-families/

The adjusted SCRQoL can be thought of as the wellbeing equivalent of the Quality Adjusted Life Year (QALY) which measures health status, also on a scale of 1 (best possible health state) to 0 (equivalent to being dead). Recent academic work (Stevens, Brazier, & Rowen, 2018) has estimated an exchange rate between the Quality Adjusted Life Year (QALY) measured using the EQ-5D instrument and the SCRQoL

This is useful because the QALY is an accepted part of economic valuation in health care and has been assigned two valuations that are used in practice.

- The National Institute of Health and Care Excellence (NICE) adopt a widely known threshold of cost per QALY of £20k to £30k when considering whether to approve new technologies, especially drugs, for use in the NHS.
- The HM Treasury Greenbook valuation of a QALY is £60,000 based on a willingness to pay (WTP) study carried out by Department of Transport study looking at WTP to avoid a traffic fatality.

We follow Forder's pragmatic approach to monetising SCRQoL by taking the Brazier and Rowen research on the near equivalence between QALY and SCRQoL and using the valuation of a health QALY as equivalent to a SCRQoL (Forder J. , The impact and cost of adult social care, July 2018). Table 6 shows how the value of the outcomes of adult social care can be monetised at £9.2 billion to £23.3 billion depending on the valuation of the wellbeing of people drawing down adult social care.

**Table 6** The 'value' of outcomes of adult social care using two valuations of an SCRQoL.

| | 18 to 64 | | 65 and over | | TOTAL |
|---|---|---|---|---|---|
| | **community** | **residential** | **community** | **residential** | |
| **2019/20 @ £25k per SCRQoL** | £2.56bn | £0.50bn | £3.50bn | £2.68bn | £9.24bn |
| **2019/20 @ £60k per SCRQoL** | £6.15bn | £1.20bn | £8.40bn | £6.42bn | £23.33bn |

***Source*** *KDNA analysis of Adult Social Care Survey data* (NHS Digital, 2021) *and Adult Social Care Activity and Finance Report* (NHS Digital, 2020)

## 3.5 Summary of chapter

In this chapter we described at a high level the CQC inspection and compliance regime and presented a time series of results by using a simple aggregate domain score that will be used in subsequent chapters.

The focus of the chapter is to explore if it is possible to measure (and attach a pound sign to) outcomes of adult social care. This is done using all of the individual adult social care survey data available on NHS Digital website for the last four years and two valuations of a SCRQoL. These calculations are illustrative. The actual value of a gain in wellbeing resulting from adult social care is ultimately a societal decision and requires information on what outcomes are most important to individuals and society and how much individuals and society are willing to pay for these outcomes. The key point is, if we put the emphasis on maximising the outcomes of care, rather than the number and

cost of the care packages, we will enable a system to focus on personalised services that deliver the best outcomes with the means available.

The design of the actual payment mechanism to operationalise this approach is beyond the scope of this study, but a payment based on the cost of a care package plus an uplift for an outcome above an expected level would be the simplest form of incentive.

**Case study 2 - Using the Quality-of-Life domains in the assessment and review process[9]**

The Care Act 2014 requires local authorities to have an assessment and review process "which will reflect the needs and desired outcomes of the person." This requirement builds on previous moves to the personalisation of social care, and notably the introduction in 2007 of personal budgets.

This set a challenge to the local authorities on how to redesign assessment process to meet this aspiration. Cumbria Country Council decided to test out using the ASCOT self-reported questionnaire to gather information about individuals' quality of life (SCRQoL). This was done with the aim of increasing the sensitivity of the assessment to outcomes of social care activities.

The success of this aim can be gauged in feedback from the practitioners who undertook the trial:

*"It really helps to prioritise from the service users' frame of reference – which is where we should be."*

*"In an ideal world I think we should be starting with quality of life assessment and then move on to the functional aspect."*

*"I have found in a couple of situations that it has highlighted an area which simply would not have come up through the usual functional assessment."*

Of course, there are limitations to using a questionnaire survey in assessing the quality of life in the diverse range of people seeking support:

*"The tool is not useful at all for people with moderate/advanced dementia or people who are very poorly."*

Overall, the move to an outcomes-based assessment was viewed positively, with this final comment given the overall summary balancing the advantages and disadvantages.

*"I think it can be a useful tool, I'm positive about using it, as long as we can use our professional discretion about when not to use it too."*

[9] http://ssrg.org.uk/wp-content/uploads/2015/04/Johnstone-Page2.pdf

# 4. Some of the additional benefits of adult social care that can be monetised

**The additional benefits of adult social care in this study are limited to employment benefits to working age adults drawing on adult social care, quality-of-life improvements and employment opportunities to carers and potential savings to the NHS.**

- **Employment opportunities for supported 18–64-year-olds**: 214,000 people aged 18-64 are accessing long-term care and community support from the adult social care sector. Of these, 57.1% are able to work. Assuming that all those receiving support in their community are empowered to work because of the care they receive, the societal benefit is **£4.7bn.**
- **Improved wellbeing for carers receiving support:** there is a small but significant wellbeing gain to carers who are receiving long-term support, worth between **£180m** and **£380m** (SCRQoL £60k or £25k).
- **Benefits to family and carers not receiving support:** the IISAC work (referenced above) has estimated benefits to family and informal carers at around a third of the benefits that accrue to people drawing on adult social care. We use this with a low estimate of the number of beneficiaries and a 75% reduced valuation to make a conservative estimate of this benefit of **£1.4bn to £3.5bn** (SCRQoL £60k or £25k).
- **Employment opportunities for carers:** up to **£1.4bn** of benefit has been estimated from carers who are able to work because of support provided by locally authority funded care.
- **Benefits to the NHS**: reduced adult social care provision has been associated with reduced costs to the NHS of accident and emergency attendances and delayed transfers of care. Estimates of readily available data suggest savings of around **£300m.**

All figures are recurrent, p.a.

## 4.1 Benefits to working age adults drawing on care and in employment

According to NHS Digital, there were 254,000 people aged 18-64 accessing long-term care and support from the adult social care sector at the end of the financial year 2019/20; 214,000 of these were receiving community care. According to Leonard Cheshire (Leonard Cheshire , 2021) the current economic inactivity among people receiving support is 43%, with 57% in employment.

We have used estimates of the value of a person returning to work and leaving the benefit system from the Greater Manchester Cost-Benefit Analysis (GM-CBA) model (Greater Manchester Combined Authority, 2019)[10]. This estimates the fiscal benefit of moving people off benefits and into work to the Department of Work and Pensions (DWP) and HM Treasury at £19,153; the improved health outcomes to DHSC at £15,963; and the increased income to individuals at £10,504. The total value of someone returning to work is thus estimated to be £45,620. The Greater Manchester CBA model does not provide an estimate of the value of a person returning to part-time work, so we have used half the total figure for a full-time worker.

**Case study 3** - **An education, a career, a home and a family.**

*"I am normal in my head. It is adults, including healthcare professions, that make assumptions about my disability"*

When Abbie's daughter's friends ask why her arms shake, she tells them it is because they are naughty arms. It was around the age of three when Abbie's arms and legs started to show signs of the characteristic tremors of cerebral palsy, almost certainly a result of a difficult birth.

*"I don't mind children asking about why I am wobbly when I walk, they are curious and are happy with the explanation I give."*

With a support worker, she attended a mainstream school until she was 16. With personal assistant support she completed a degree at university.

It was while watching her brother play rugby that she first noticed Tom. And Abbie and Tom got married at a big family wedding. Once married it only seemed natural to start a family, despite coming across attitudes questioning if someone with a disability should have a mortgage, husband, and children.

*"I can drive, I have a job what is the problem?"*

*"But with a small baby and arms that have tremors I felt more disabled then than I have ever felt before."*

Now, with a second daughter, Abbie feels she is winning over the disability.

*"My husband and children will care for me, but they are not my carers. I don't want them to be. While I get PA support from somebody I trust, I hope I can love and care for my husband and children as much as they love and care for me. That's all I ever wanted out of life."*

[10] The tool is constantly refreshed and uses up-to-date data from Government departments and other sources. It was adopted as supplementary guidance to HM Treasury Green Book in 2014.

ONS estimates that 37% of disabled people work full-time, and 16% work part-time. If we assume that all those receiving community care are empowered to work and do so in proportion to the ONS figures on part time and full time working, the value added is to £4.7 billion, which is shown in Table 7, below.

**Table 7** Value of people receiving community care returning to work assuming a split between full-time and part-time work

| | Percent | Numbers | Value £m |
|---|---|---|---|
| Working full-time | 70% | 85,345 | £3,893 |
| Working part-time | 30% | 36,906 | £841 |
| **Total value** | | 122,251 | **£4,735** |

*Source: KDNA based on NHS digital, ONS and Greater Manchester CBA*

## 4.2 Outcomes to carers and families

The majority of informal carers receive no support. The 300,000 carers who have been assessed by local authorities compares with estimates of the total number of informal carers in England of from 5.3 million (1 in 8 adults) (Age UK, 2020) to 7.5 million (17% of adults) (NHS Digital (HSE), 2019). The literature suggests that the high level of unmet need for adult social care has resulted in an increasing number of unpaid and unsupported carers, who are disproportionately female and often suffer poor health, loneliness, financial hardship, and poor quality of life (Carers UK, 2018).

**Benefits to carers who are receiving support**

The Survey of Adult Carers in England (SACE) (NHS Digital, 2019) samples all carers known to local authorities aged 18 and over who either received "support direct to carer" or "no direct support to carer"[11]. The total eligible population for the 2018/19 survey was 292,360.

**Table 8** Responses to carer survey question on satisfaction with support received

| Overall, how satisfied or dissatisfied are you with the support or services you and the person you care for have received from social services in the last 12 months? | | |
|---|---|---|
| | **% respondents** | **Weighted respondents** |
| Extremely, very, or quite satisfied | 53.7% | 157,000 |
| Neither satisfied nor dissatisfied | 12.2% | 36,000 |
| Extremely, very, or quite dissatisfied | 10.9% | 32,000 |
| No support | 23.1% | 68,000 |

***Source**: SACE, NHS digital, 2019*

[11] Not all the carers who are assessed by local authorities are deemed eligible for support. To receive support the assessment process must determine (1) your needs as the result of you providing necessary care; (2) the caring role has an effect on you; and (3) there is, or is there likely to be, a significant impact on your wellbeing.

Carers who stated that they were extremely, very, or quite satisfied with the support they received scored higher on the wellbeing questions in the survey than respondents who said they had no support; these in turn were higher than scores from respondents who were extremely, very, or quite dissatisfied with their support. Replicating the method developed in Chapter 3 above for valuing quality of life for people drawing on care shows that carers who were receiving satisfactory support had, on average, a wellbeing score 0.04 higher than those receiving no support. Multiplying this by the estimated number of carers reporting satisfactory support gives a monetary valuation of increased carers' wellbeing between £160m and £380m (SCRQoL £60k or £25k)

**Benefits to carers of publicly funded care not receiving support themselves**

The above benefit, however, excludes the benefits that might be received by family and informal carers who have *not* been assessed for support by their local authority. This does not mean they receive no benefit from the care and support provided to the person they are supporting. This 'carer benefit' has been tentatively estimated (Forder J. , 2018)[OBJ] at 36% of the net benefit of the service user. (In his paper, Forder, reduces the value to 75% of this as a sensitivity test.)

We do the same and adopt a cautious estimate of the total number of informal carers who might be subject to this benefit. We assume there are 0.75 beneficiaries per younger adult and 0.5 beneficiaries per person aged 65 and over. The results from this conservative calculation are significant and deliver benefits to informal carers of between £1.4 billion and £ 3.5 billion depending on whether we use the QALY value of £25k of £60k. (This is 16% of the direct benefits to people receiving care).

The calculation of the wellbeing benefit is presented in Table 9 below.

**Table 9** Calculation of benefits to the family members/informal carers of those receiving publicly funded adult social care who are not receiving any support themselves

| | Age 18 to 64 | Age 18 to 64 | Age 65 and over | Age 65 and over | **Total** |
|---|---|---|---|---|---|
| 2019/20 | community | residential | community | residential | both |
| 1 Adjusted SCRQoL | 0.41 | 0.44 | 0.42 | 0.49 | 0.44 |
| 2 Numbers being cared for | 244,000 | 45,000 | 329,000 | 218,000 | 836,000 |
| 3 Estimated family and carers | 183,000 | 33,750 | 164,500 | 109,000 | 490,250 |
| 4 SCRQoLs to people drawing on care | 76,677 | 14,850 | 69,748 | 53,410 | 214,685 |
| 5 SCRQoL to carers at 0.36 of full rate | 27,604 | 5,346 | 25,109 | 19,228 | 77,287 |
| 6 £ bn 75% value at SCRQoL = £25k | 0.52 | 0.10 | 0.47 | 0.36 | 1.4 |
| 7 £ bn 75% value at SCRQoL = £60k | 1.24 | 0.24 | 1.13 | 0.87 | 3.5 |

*Source KDNA calculation Notes (1) This is the wellbeing benefit to the people receiving care taken from Table 5 (3) This is a cautious estimate of the total number of family and carers who might benefit from seeing their family member receive publicly funded care. It is at Row 2 * 0.75 for working age adults and 0.5 for aged 65 plus. It sums to less than one person per person drawing on care after taking off the 292,000 carers who had been assessed by local authorities. (4) This is Row 1 * Row 3. (5) This is the quality of life going to carers, 36% of the benefit of in Row 4. (5&6) This is further reduced to 75% and multiplied out at £25k and £60k per SCRQoL.*

## 4.3 Employment benefits to carers

We have used estimates of the value of a person returning to work and leaving the benefit system from the Greater Manchester Cost-Benefit Analysis model.

From the Survey of Adult Carers in England referred to above, the best weighted estimate of the number in the eligible population of carers who received local authority support is 226,000. Of these, 10.5% stated that they were working full-time and 13.9% that they were working part-time. This compares with Health Survey of England (NHS Digital (HSE), 2019) estimate of 10% of workers with caring responsibilities not being able to work because of their caring responsibilities.

We therefore assume 14.4% of supported carers are working because of the support they receive. This is 42,000 individuals who we expect to be split between part-time and full-time working in the ratio 57% part-time to 43% full-time (following the 13.9:10.5 ratio, above.)

Table 10 below shows the value of the additional carers being able to work as a result of the support they draw on.

**Table 10** Value of carers returning to work

| | Number of carers in employment because of support | Benefits |
|---|---|---|
| Working full-time | 18,000 | £0.81bn |
| Working part-time | 24,000 | £0.55 bn |
| Total value | | **£1.36 bn** |

***Source:*** *KDNA based on SACE HSE and Greater Manchester CBA*

## 4.4 Benefits / savings to the NHS

Health and social care have many complex interactions and interdependencies. Adult social care can reduce costs to the NHS in at least three ways:

- People being supported in the community, in nursing homes or residential care homes might otherwise need to be supported in community hospitals.
- Adult social care support to people in their own home helps avoid emergencies e.g. from falls or general deterioration that may get worse without support.
- The third saving arises when a hospital spell of acute care is finished and a person is medically fit to be discharged, but cannot be discharged without some form of adult social care and support, either in a nursing or residential home or in their own home.

**Impact of delayed admission to care and residential homes**

In the Netherlands, the majority of long-term care is financed by a public insurance scheme so the decision of when to go into a care home is not influenced by financial factors. People are assessed by an independent government agency after they apply

for a care home place (those referred for a care home place after a hospital admission were excluded from the study).

A recent study of the Netherlands system (Bax, 2020) found that a care home admission in the Netherlands compared with continuing care at home significantly reduces the probability of having at least one hospital admission in the following year.

In the twelve months after moving into care homes, residents spent €1,500 less on medical care than those not admitted. The authors conclude that appropriately timed nursing home admission has a combined health and care spending impact of zero. (The higher costs of care home compared to home care are offset by lower health expenditures.)

The decision to go into a nursing or care home in England is strongly influenced by financial considerations. If a significant proportion delay the decision until they have a medical event, such as a fall, this transfers what should be adult social care costs to acute hospital and is almost certainly a worst outcome for the person. If there are 10,000 delays of admission to a nursing or care home each year that result in an emergency admission of ten days[12] duration the cost to the NHS would be £22 million.

**Impact of reduced adult social care on accident and emergency attendances**

A study into adult social care spending and hospital use by the older population in England (Crawford, 2021) explored the relationship between local authority spending on adult social care and accident and emergency (A&E) attendances. Average adult social care spending on the over 65s fell by 31% between 2009/10 and 2017/18, but the scale of the reduction varied by local authority. Their regression equation of adult social care spend and A&E admission indicate that a £100 increase in per capita long-term care spending is associated with 0.017 fewer visits to hospital per person aged 65 and above.

Spending on adult social care fell by £391 per capita between 2009/10 and 2017/18 and this will have increased A&E use among older people over the period by 19%[13]. This represents an increase in the total number of A&E attendances of one million. The average cost of an A&E attendance is £160, so the direct cost is £160 million.

The paper also investigated if the increased activity affected the quality of NHS care in A&E. They found there was a statistically significant increased risk of patients over 65 revisiting A&E after their first attendance. They considered the extra million visits per annum were putting further strain on a system that was already stretched.

[12] The average cost of an emergency admission day is taken from Nice Guidance in 2016 and cited by A Marie Curie study of 2018 (Marie Curie, 2018)

[13] The increase was from 0.37 visits per 65+ resident in 2009/10 to 0.49 in 2017/18, an increase of 0.12 per person, 0.07 (50%) of which is attributable to the reductions in adult social care spending.

**Delayed transfers of care**

There has been an efficiency agenda on delayed discharges from acute hospitals to adult social care for a long time (NAO, 2003). In 2016 the NAO estimated that increasing social care services for older patients after hospital discharge could cost around £180 million a year. But that could help deliver potential savings of £820 million suggesting a net saving of £640 million on an investment in adult social care to help reduce discharges.

There were 194,000 delayed discharge days in January 2019, compared to 114,000 in January 2011, an increase of 40%. The proportions due to either social care cause or joint social care and NHS cause were 62% in 2010 and 58% in 2019. If these delays could be reduced to the level that is caused by the NHS (42% in 2019) it would save the equivalent of 372,000 bed days a year; if the proportion could be reduced to 25% it would save 768,000 bed days saving £80 million and £170 million respectively at a cost of £220 per bed day.

## 4.5 Chapter summary

In this chapter we have explored potential benefits of adult social care that would not be included in the cost/price paid for adult social care, including:

- employment benefits of working age adults in employment
- wellbeing benefits to carers receiving some support
- employment benefits to carers receiving some support who are working
- wellbeing benefits to family members/ informal carers of people who are receiving adult social care
- potential savings to the NHS.

**Table 11** Estimates of potential benefits to society over and above the 'economic value' calculated in chapter two.

| 2019/20 | Low estimate | High estimate | Best estimate[2] |
|---|---|---|---|
| Working age adults in employment | £4.7billion | £4.7 billion | £4.7 billion |
| Wellbeing benefits to carers receiving support [1] | £0.16 billion | £0.38 billion | £0.16 billion |
| Wellbeing benefits to family members/ informal carers not receiving support[1] | £1.4 billion | £3.5 billion | £1.4 billion |
| Employment benefits to carers | £1.4 billion | £1.4 billion | £1.4 billion |
| Potential savings to the NHS[2] | £0.26 billion | £ 0.35 billion | £0.3 billion |
| **Total** | £7.8 billion | £10.3 billion | £7.9 billion |

*Source KDNA Notes (1) The two values for these wellbeing benefits relate to the choice of monetary value of SCRQoL of £25k or £60k. (2) We always use the low with regard to the cost per SCRQoL and the average when there is uncertainty between the range.*

The £7.9 billion of additional benefits are over and above the economic value of £50.3 billion calculated in Chapter 3.

Although the benefits to the NHS appear small, pressures on adult social care that put unnecessary burdens on the NHS should be avoided in a post-covid period when hospital capacity is at a premium.

# 5. Labour market analysis

**The persistent high vacancy rates for jobs in adult social care increases unit labour costs (through agency use and high turnover), reduces capacity and might compromise the quality of care being delivered.**

Analysis of labour markets at a local authority level has provided many insights.

- The vacancy rate is typically over 6% of staff, twice the average across different industries, and for front line care workers is 8%.
- Adult social care is 'counter cyclical'. As the number of people being registered as unemployed goes up, adult social care vacancies go down.
- A statistically significant relationship has been found between the lower quartile wages in an area and the adult social care vacancy rate, demonstrating that 'relative wages' in competitor sectors affect recruitment and retention.
- We show how the 'relative wage' in adult social care is forced down, below the market clearing rate, by low fees and large increases in National Minimum Wage.
- We explore the relationship between vacancies and available quality measures to test if quality is being affected by vacancies and other measures of labour inputs.
- We also review some recent market intelligence which suggests the vacancies are reducing the capacity of the system to deal with increasing referrals from local authorities.

## 5.1 The problem with the adult social care labour market

The adult social care workforce represents 5% of all jobs in England and is present in every labour market in England. Adult social care employment at local authority level varies from 8.6% of the total workforce in Middlesbrough to 2.6% in Newham.

The defining feature of the adult social care labour market from an economic perspective is that, nationally it has had vacancy rates over 6% (twice the national average) for the last five years. The vacancy rate for direct care staff has been above 7% for the last five years and almost 8% in the last three. There were 7.3% vacancies (112,000 jobs) in 2019/20 and turnover was 30.4% (Skills for Care, 2020).

In labour markets that are working effectively, persistent vacancies force employers to increase wages to 'the market clearing rate'[14]. This has not happened in the adult social

[14] The market clearing rate for a job, sometimes referred to as 'the going rate' is the rate of pay that matches the supply and demand for workers. Vacancies will be low, 1-3% representing natural churn in workforce.

care labour market, and in the next sections we will attempt to explain the cause and consequences of this.

**What causes 'static vacancies' in adult social care?**

Vacancies in labour markets that persist over a long period are called static vacancies and require some explanation. In order to explore the possible causes of persistent vacancies, we looked at general labour market data and the Adult Social Care Workforce Data Set (ASC-WDS) by local authority for the financial year 2019-20.

Vacancy rates for care workers vary between 1.9% in North East Lincolnshire to 18.7% in Newham. We expect there is some random element, or 'noise' in this measure as it is a snapshot obtained on a single day. Despite this, analysis of domiciliary care support worker staff shows that there are modest but statistically significant positive correlations between adult social care vacancies and the general labour market at local authority level.

**Table 12** Relationships between adult social care vacancies and general labour market characteristics

| Correlations between ASC vacancies and general labour market measures | | |
|---|---|---|
| **Measure** | **Correlation** | **Vacancies are higher where** |
| Lower quartile wages | 0.325**[15] | LQ wages are higher |
| Proportion self-employed | 0.262** | Self-employment is higher |
| Proportion with NVQ4+ | 0.316** | Education levels are higher |
| Wage differential between LQ wage and ASC care worker wages | 0.284** | There is a higher wage differential |
| Proportion of benefit claimants | -0.263** | Benefit claimants are lower |

*Source: KDNA*

These correlations support economic theory. If wages in similar occupations are higher than in adult social care, adult social care vacancies will be higher. If the workforce is more highly-qualified, adult social care vacancies will be higher. If job seeker plus claimants as % of population increase, adult social care worker vacancies decrease. This shows that vacancies in adult social care are sensitive to conditions in the local labour market, but it does not tell us what the 'market clearing rate' for adult social care jobs might be. Only that it will be different in different local authorities.

## 5.2 What is the 'market clearing rate' for care workers?

Recent research published by Community Integrated Care[16] 'Unfair to Care: Understanding the social care pay gap and how to close it' suggests the adult social care workforce is being underpaid compared to other job roles that require similar levels

[15] **Correlation is significant at the 0.01 level; *Correlation is significant at the 0.05 level

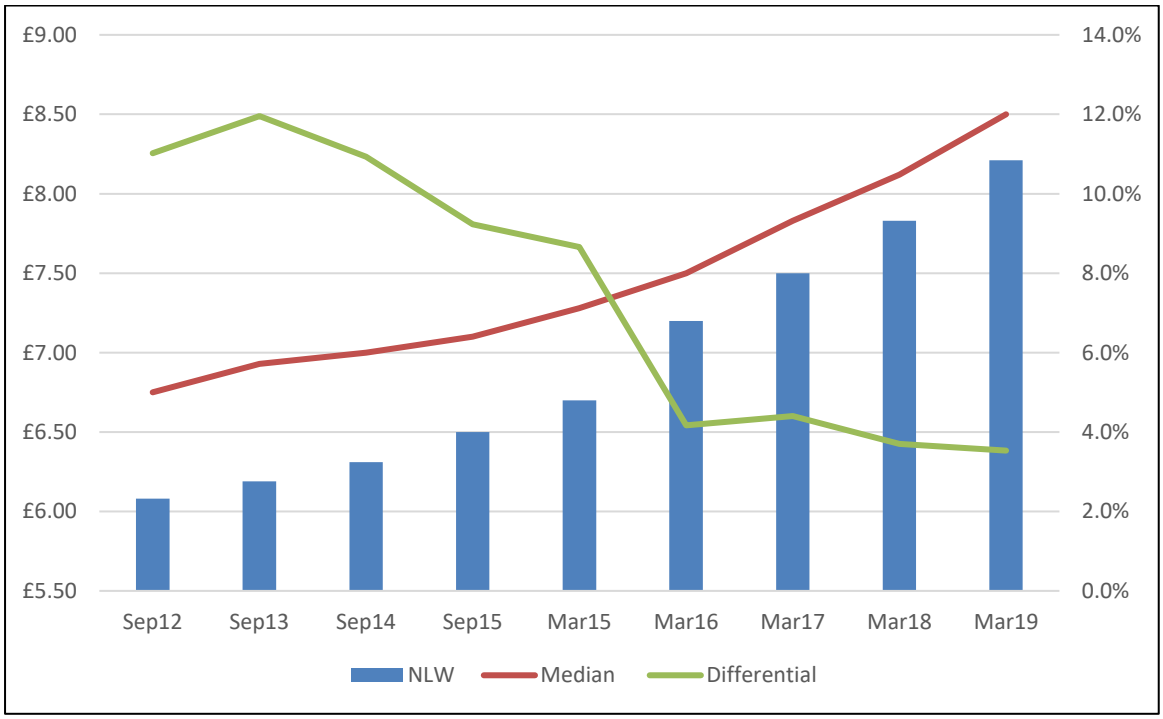
[16] http://www.unfairtocare.co.uk/

of skill. Using the Korn Ferry method[17] of job evaluation applied to the 'support worker, supported living' job role found that the median salary for equivalent positions in public and not-for-profit providers, such as the NHS and local authorities, would be £24,602.

If the NHS is used as the benchmark, this would be an Agenda for Change Pay Band 3 position with average annual pay of £25,142. This compares with support and outreach workers in the independent sector being paid £17,300 on average and care workers (with similar skills and responsibilities) £16,900 in 2019/20: a 45% plus difference.

The NAO believes public sector fees for adult social care are below average cost (NAO, 2021). This prohibits providers whose income derives largely from local authorities from paying £25,000 or even £20,000 for support workers or other front line care workers. In fact, as shown in Figure 7. the adult social care sector has struggled over the past eight years to keep pace with increases in National Living Wage (NLW).

**Figure 7** In 2013 the median care worker wage was £6.75, 12% higher than the NLW. By 2019, it had risen to £8.50, but was now only 3.5% above the NLW.




*Source (Skills for Care, 2020)*

The increase in the NLW put pressure on adult social care providers to match the pay increases for care workers (78% of all employees). The chart shows they could not afford to do so as the median care worker wage was 12% higher than NLW in 2013 but only 3.5% higher in 2019.

As economic theory would predict, the reducing pay differential with NLW made recruitment and retention for care worker staff more difficult and vacancies for care workers rose in all regions (though the period also saw falling unemployment which would have added to the pressures).

[17] https://www.kornferry.com/uk/solutions/rewards-and-benefits/work-measurement/job-evaluation

This also led to greater compression of care workers' wages (Skills for Care, 2020). In 2012 half of all care workers earned within 10% of median pay; in 2019 half of all workers earned within 8% of median pay. Also, in 2012 the highest 10% care worker roles were paid 27% above the lowest 10%. In 2019 this premium was only 19%.

The compression of care worker wages would have contributed to higher turnover, if not vacancies. Such intra role differentials are important to compensate staff for the more difficult positions within the broad spectrum of care worker roles and perhaps, offer increments in recognition of experience and acquired skills. Without such inducements staff who wish to stay in adult social care may seek other employment in less challenging positions.

**Other staff**

If employers could not match % increase in NLW for care workers, it is unlikely they could have afforded to match pay to general labour market increases in pay for other staff groups. In fact, excluding senior managers and registered professions, pay increases were lower than for care workers and vacancies increased for all staff groups bar registered managers, which had flat, but very high vacancies of 11% from 2013 to 2019.

**Is pay that important to adult social care staff?**

It is important to note that we are not arguing that the only thing that matters to the adult social care workforce is their pay (or even their pay relative to other employers). All we have to believe is that pay has some influence, however small, to be alert to the fact that a change in pay relativities will affect recruitment and retention of adult social care staff, now and in the future. And the literature suggests there are no 'silver bullets' to fix recruitment; with automation (Moriarty et al, 2018), volunteers (Cameron et al, 2020; Moriarty et al, 2018), unpaid carers (McKechnie et al, 2019), and integration (National Audit Office, 2018), all being dismissed as potential solutions to the recruitment problem.

It is a long-term problem that is likely to get worse as demand for care workers will increase. Skills for Care (Skills for Care, 2021) estimates the adult social care workforce will need to grow by 29% (490,000 extra jobs) by 2035. This is a growing share of the total workforce which can only usually be delivered by a faster growth in earnings than in the rest of the economy[18].

[18] The long run determinant of pay in an industry and country is labour productivity. Some sectors' labour productivity grows more quickly than others allowing them to pay higher wages and attract more staff. Some other sectors, especially in areas like health and care, are both labour-intensive and cannot increase productivity by substituting capital for labour. To grow adult social care workforce as a share of the total workforce will require higher than private sector pay increases without the benefit of higher productivity (at least in the medium term). This phenomenon is known as Baumol's Disease and should spur policy makers to focus on finding sustainable solution to adult social care workforce issues in the short term.

## 5.3 What are the consequences of permanently high vacancies?

High turnover and vacancy rates in adult social care might contribute to unsafe staffing levels, risk of infection, poor continuity of care and poor quality of care. This is likely to be true for all types of staff shortage, but particularly so for registered managers, without whom quality standards are much less likely to be fulfilled (Institute for Government, 2019).

We undertook two 'sets' of analyses to test this. The first was at local authority level, and the second at provider level. These analyses are written up in Chapter 5 of the Technical Report, but summarised below.

**Local authority level analysis**
We used two measures of 'quality' at local authority level, the ASCOF 1J score for community care and the aggregate CQC score (described in Chapter 3) for domiciliary care only. We examined the relationships between ASCOF 1J and CQC domiciliary care quality measures, general labour market measures and adult social care workforce data for the domiciliary care sector. We found:

- there is no relationship between quality scores and vacancies at local authority level. This may be due to the 'averaging out' of variation in both vacancies and quality scores at local authority level
- there were, however, positive and statistically significant correlations between the proportion of senior care workers and the ASCOF 1J and aggregate CQC score
- some weak relationships between quality measures and general labour market characteristics. Quality of adult social care appeared higher in labour markets with lower wages and lower the number of NVQ level 4 in the workforce. (Factors which were shown to reduce recruitment and retention difficulties.)

**Provider level analysis**
For the provider level analysis, the total CQC scores at individual organisational level were grouped into quintiles based on score and compared with workforce measures across the whole sector and all services. The provider level analyses show that organisations with a higher quality score tend to have:

- a higher level of pay for care workers (and a lower wage differential with the general labour market)
- lower turnover
- lower numbers of vacancies
- a higher ratio of staff to service users (particularly noted in nursing homes)
- a higher proportion of care workers holding a Care Certificate or and entry-level social care qualification
- more stable management.

The main consequence of unfilled vacancies however, may be reductions in capacity.

Recent survey data received suggest the way the system copes with static vacancies is by scaling back service provision, handing back contracts and contributing to a permanent capacity shortage and backlog of provision.

A 2021 Association of Directors of Adult Social Care Services by (ADASS) sponsored survey conducted 14 to 20 August found 294,000 people were awaiting social care assessment, delivery of care, or reviews.[19]

- 186,000 (63% are awaiting reviews)
- 70,000 (24% are awaiting initial assessment)
- 38,000 (13%) have being offered care and support such as residential care that they would not have chosen, due to recruitment and retention issues.

The number of people in one of these three queues increased by 76,000 (26%) in the previous three months and the number of hours of care that are needed locally but that there is not the capacity to deliver has doubled over the last six-month period. (ADASS, August 2021)

A recruitment and retention survey of the UK Home Care Association between 5 to 10 August 2021 (n=837) found:

- 78% of respondents declared that recruitment and retention of new staff was the' hardest it had ever been' - only 1% thought it was easier than before the pandemic
- this was consistent between providers that were predominantly state funded (79%), mixed (81%) and predominantly self-funding (75%) across the regions of England (86% to 72%) with only London having a lowish figure, of 52%
- 65% respondents declared that more care workers were leaving their jobs than before the pandemic, with only 4% saying fewer.

Not surprisingly the same survey found that providers were having to cut back provision as a consequence of their inability to recruit and retain staff.

- 38% were unable to take on any new care and 57% were able to take on some, but not all new care, leaving just 5% of the market able to meet all new care requested.
- 676 of the 837 providers who took part in the survey delivered some service to local councils. Of these, 1% of providers intended to hand back all care (8% in Yorkshire and Humber); 29% intended to hand back some, but not all care.

[19] Under the Care Act 2014's statutory guidance, councils should review care plans of people who receive no later than every 12 months. This is important because care needs often increase.

## 5.4 Chapter summary

The low fees paid by the public sector mean that wages for care workers are kept below the market clearing rate, leading to persistent vacancies.

There is strong evidence emerging that the level of vacancies is reducing capacity to take on new commissions from local authorities.

The analysis at local authority level suggested that vacancies were not associated with lower quality but this may be due to ‘averaging out’ the variation between individual providers. The local authorities with higher wage labour markets did tend to have lower quality scores.

Both the provider level analysis and local authority level analysis suggested a more skilled and more highly-trained workforce delivered higher-quality care.

Having a registered manager in post for an extended period was a good predictor of provider level quality.

**Case study 4 - Employers of care workers feel guilty that they cannot afford to pay wages that reflect the skill and dedication of their staff**

Lara manages the family-run business of residential care homes and supported living environments for just over a hundred adults with learning disabilities and mental health issues. Specialising in complex care some of the residents have been with them since Lara's mum started the business 22 years ago. They provide step-down care from secure facilities and act as a referral centre when more general settings are unable to prove sufficient support.

*"We do far more than just provide task-based care, everybody we support we try to find their goals and expectations of life."* Lara explains about the philosophy of how they approach care. But goes on to explain that given the income she gets from commissioners it is hard to pay her dedicated, compassionate, and dynamic staff the true value of their contribution to those who they support.

*"We took a referral for somebody who needed five staff to manage him at another provider. When he arrived, he was a young man weighing about 10 stone, we couldn't understand why it would need five staff to manage him. It must have cost the local authority a great deal of money. Anyway, we asked him what he wanted, and he said it was to feel important. After talking to him some more we suggested he might like to apply for a cleaning job we had going. We interviewed him and offered him the job. He has an ID badge, which he is most proud of, and regular employment. That is success in anybody's terms."*

Lara goes on to explain that her mum taught her that you have to care for the carer if you want a sustainable support system, and that is built into the ethos of the company.

*"Does it take a certain type of person to do our job? Yes, it does. But we are being asked to do more and more for no extra funding. I would like to pay my staff the equivalent to a band 5 nurse, but I just can't."*

If Lara's organisation had been paid on the basis of the outcomes of care, she could have rewarded the team that cared for the young man referred from another provider. (This need not necessarily have been higher pay, but could have included more access to learning and development.)

# 6. Marginal analysis. What could an extra £6.1 billion pounds deliver in a phased program of investment?

**The downward pressure on publicly funded adult social care has created a labour market that cannot deliver the volume and quality of care required. A program of targeted investment is required to meet unmet need, improve quality, and make the system sustainable. This chapter looks at an investment plan informed by the foregoing analysis.**

- Additional funding should be phased in with capacity-building, to minimise the risk of cost inflation without proportional volume and quality gains.
- A 'Strategic Fee Increase' is designed to restore equilibrium to the adult social care labour market, stabilise providers and provide an incentive to stay in business, expand and innovate.
- Alongside the 'Strategic Fee Increase' is an investment designed to restore access to the levels in 2005 to 2010.
- The strategic fee increase is expensive, and to some extent a deadweight cost but it is an essential precondition before we can expand access and deliver:
    - improved average outcomes of care by around 5%, worth £0.4billion
    - increased economic value by £10.1 billion
    - £0.6 billion of additional societal benefits
    - a total added value of £10.7 billion, a 175% return on investment.

## 6.1 Modelling the benefits of a strategic increase in resources

The scale of the possible underfunding was given in Chapter 2 at £6.1 billion. This is composed of £3.8 billion for quality and £2.3 billion for unmet and under-met need. The two go in tandem. Adding £2.3billion for 'improved access' into the system (15% more activity) would not deliver good value for money unless it was done in step with an increase in capacity associated with the £3.8 billion investment in the form of a 'strategic fee increase'. This is a 25% increase in local authorities' payment to providers and is a realistic figure phased over several years to restore equilibrium to the adult social care labour market and build stability and enhance capacity of providers.

## 6.2 The full economic benefits arising from the investment

The benefits arising from the two investments are different in size and scope. They are discussed under four headings:

- Increased GVA[20]
- Induced and indirect effects
- Outcomes[25]
- Wider benefits to society.

**Increased GVA**

The strategic fee increase and improved access investments would both increase the GVA on a 1 for 1 basis, adding £6.1 billion (24%) to the current £25.6 billion (in 20/21 prices.

**Indirect and induced effects**

The indirect and induced effects would rise, but not in proportion. The £3.8 billion strategic pay increase would have an induced multiplier effect on the rest of the economy from workers' increased consumption. The £2.3 billion to increase access would have an indirect and induced effect.

We estimate the indirect effect at £1.1 billion the combined induced effect at £2.9 billion. Adding these benefits to the GVA increase, the economic value of adult social care would rise from just over £50.3 billion to £60.4 billion. The economic boost would be highest in areas where adult social care was a larger share of GVA, such as the North East.

**What would be the effect on outcomes?**

The effects on the outcomes of people drawing on care would also differ between the two types of investment.

**Strategic fee increase**

The outcomes benefit from the strategic fee increase could and should deliver a general uplift in the ASCOF score across the current base of people being supported. This would arise from the stabilisation of the workforce and a greater focus on quality of care and improved outcomes.

We do not know what the size of this premium would be but can estimate the potential scale by looking at the current distribution of average local authority adjusted ASCOF 1J score. The standard assumption made by the NAO when looking at public sector performance e.g. across local authorities or CCGs, is that unexplained variation is a measure of inefficiency and potential 'catch up'.

[20] Note only three of these four elements can be added together. The GVA increase is a measure of the production value of adult social care, the outcomes are an alternative way to assess the value of that production. They cannot be added to each other, but either can be added to the other two elements.

The local authority interquartile range on ASCOT is in fact only 3% and the interdecile range is 10%. If we assume a 5% improvement across the board, benefit to the current 840,000 people who receive long-term care in year would be £445million at £25k/ SCRQoL or £1.069 billion at £60k/ SCRQoL.

**Improved access**

The data on activity growth in adult social care suggests the majority of unmet needs is in the 65 and over age category. We assume 80% of the £2.3 billion goes into improved access for older people. The remaining £0.5 billion goes to working age adults. We do not have the data to assess precisely where, or to what effect, the £0.5 billion would be spent and so concentrate this section on the older age group.

The increase in SCRQoL arising from providing adult social care to those previously deemed ineligible would be substantial. Assuming £1.8 billion is invested in older people with 77% going into domiciliary care and 23% into residential[21] and using the average outcomes obtained from our analysis of adult social care ASCOF data, for older people the value of the additional welfare gain would be £1.9 billion using the £25k cost per QALY figure or £4.7 billion using the £60k cost per QALY.

Combining the strategic fee increase and improved access benefits, we have a total improvement in wellbeing equal to £2.3 billion at £25k/SCRQoL or £5.7 billion at £60k/ SCRQoL

**The SCRQoL improvements to informal carers**

The quality-of-life improvements to carers would follow in proportion to the quality-of-life improvements to the people receiving care. Using the same conservative assumptions shown in Table 9, the additional benefits would add £0.4 billion at £25k per SCRQoL and £0.9 billion at £60k per SCRQoL.

The wellbeing benefits are summarised in Table 13, below.

**Table 13** The improved wellbeing benefits arise from a general improvement in quality of care arising from the strategic fee increase and the improved access to older people.

| | £25k per SCRQoL | £60k Per SCRQoL |
|---|---|---|
| Strategic fee increase | £0.4 billion | £1.1billion |
| Improved access | £1.9 billion | £4.7 billion |
| Subtotal | £2.3 billion | £5.7 billion |
| Outcomes to family and carers (See Table 9) | £0.4 billion | £0.9 billion |
| Grand total wellbeing increase | £2.6 billion | £6.7 billion |

[21] This is an assumption derived from a paper which looked at the patterns of historic adult social care expenditure and the SCRQoL benefits that might arise from a marginal change in funding. (Forder J. , The impact and cost of adult social care, July 2018)

**Employment and NHS benefits**
Our estimate in chapter five of £1.4 billion of employment benefits to 55,000 carers from increased labour market participation could be scaled pro rata the increased activity arising from the £2.1 billion investment in unmet need. This would add £190m. A similar pro-rata of the modest benefits to the NHS would add £30m.

**Table 14**: Full economic benefits of a significant £6.1 billion investment in adult social care (all wellbeing benefits at £25k per SCRQoL).

| | Strategic fee Increase | Improving access | Totals |
|---|---|---|---|
| GVA[1] | £3.8bn | £2.3bn | £6.1bn |
| Indirect | | £1.1bn | £1.1bn |
| Induced | £1.8bn | £1.1bn | £2.9bn |
| Outcomes to people receiving care[1] | £0.4bn | £1.9bn | |
| Carers Outcomes[2] | | £0.4bn | £0.4bn |
| Carers Employment[2] | | £0.19bn | £0.19bn |
| NHS | | £0.03bn | £0.03bn |
| Total[1] | £5.6bn | £5.1bn | £10.7bn |

*Source KDNA analysis Notes, (1) The GVA and outcomes are alternative ways to measure the increased output of care going to people drawing down care. GVA is the cost of producing the care. Outcomes are the benefits to the people who draw on that care, so you cannot add them. (2) The increased employment and wellbeing of carers are additional benefits and can be added.*

## 6.3 Chapter summary

**Strategic fee increase**
The investment in quality appears to give a modest return in terms of economic value: £3.8bn delivers an economic value of £5.6 billion (a 147% return). The returns in terms of outcomes of people drawing on care are small, but it is an example of an expensive problem that needs to be addressed before any other improvements can be made.

Without an expanding workforce and stabilising the provider market, adult social care cannot meet existing levels of need satisfactorily, let alone handle demographic pressures and rising public expectations over the next ten years. The strategic fee increase is therefore a necessary condition before access can be improved.

**Improving access**
The return on improving access is significantly higher, giving an economic value of £4.5 billion and an additional £0.6 billion of wider socio-economic benefits. This gives a full economic value of £5.1 billion, a return of 182%.

Combining the two investments of £6.1 billion would give full economic benefits of £10.7 billion; a return of 175%. (The full economic value is 175% of the initial investment.)

# 7. Conclusions and recommendations

This chapter summarises the key findings of chapters three to six and concludes that the current adult social care system is afflicted by both lack of funding and significant market failures.

- The market failures drive the publicly funded system toward a low cost, low value low outcome solution.
- This creates problems in the adult social care labour market which will become increasingly difficult in the short term if there is a strong post COVID-19 recovery and over the medium term with increasing demand.
- The market failure also distorts the self-funded sector and results in increasing levels of unmet need and higher burdens on informal carers.
- The recommendations stem from our analysis that the system must begin to pay for the outcomes of care, rather than the care processes.
- A societal valuation of those outcomes also provides a mechanism to pay for the skilled workers to deliver those outcomes, both now and in the future.

## 7.1 Conclusions

**Diagnosing the problem**

The quality and outcome component of adult social care is far more difficult to observe than the process, care package, time required to do specific tasks, aspect. This is compounded by the dominant commissioner for adult social care, local authorities, being forced to keep down fees as the only way to meet increasing levels of need and stay within their spending limits.

Private purchasers pay higher fees and are partly cross subsidising the publicly funded sector. They also have difficulty choosing their preferred combination of price and quality because of the cross-subsidisation issue and the difficulty of gathering complex information on quality of care at short notice. The quality component therefore tends to be under-rewarded and under-produced.

**Impact on the adult social care labour market**

This combination of ‘price-sensitive’ demand and relatively ‘quality-blind’ demand produces a low value equilibrium with less than feasible and less than desirable quality and outcomes. This low-cost solution creates three problems in the adult social care labour market.

- Wages are driven down to below the ‘market clearing rate’ meaning wages and turnover are high and persistent.
- The job becomes more demanding (because vacancies are not filled) and there is not time to fulfil the vocational aspect of care and deliver high quality, compassionate care.
- The capacity of the sector is falling behind people deemed eligible for publicly funded care (UK Home Care Association, August 2021).

This low value equilibrium (barely able to keep pace with even the restricted access to the publicly funded system currently in operation) will become an increasing problem as the numbers of people of working age and aged 65 and over, who need care increases.

Adult social care will require a growing workforce for the foreseeable future. It therefore needs to be a sector where:

- Providers are able to make an economic return and see future expansion
- The workers can be sure of a decent standard of living and job that has significant nonpecuniary rewards
- Innovators can find new ways of delivering improved outcomes, through IT and different models of care.

**Is the solution commissioning for outcomes?**

It is for this reason that we have focussed on the measurement of adult social care outcomes. We believe the outcomes of social care must become the focus of the debate about the level of funding and the means to ensure the funding is well spent, i.e., on improving the wellbeing, dignity and security of the people receiving care.

Only by placing a realistic societal value on the outcomes of adult social care and commissioning to obtain the best and most cost-effective level of improvement can we guarantee that the publicly funded system will not be caught in a low value, low cost equilibrium.

By putting a pound sign on outcome, you not only find a mechanism to pay fair prices and market wages, you also encourage the workers with empathy and compassion to gravitate toward adult social care work.

## 7.2 The recommendations flow from this analysis

**Recommendations: investment to restore equilibrium to labour market**

Figure 7 in Chapter 5 showed that the pay of care workers had not kept pace with the rise in the national living wage. Restoring the differential between front line care workers’ median wage and the national living wage to the level it was in 2012 and 2013 would require a real-terms pay increase of 8%.

We believe higher overall levels of pay to increase the competitiveness of the market and enable employers to attract - and have more discretion to employ - workers with the right values are essential.

The Government has also allocated £500 million across three years to support workforce needs, and our analysis suggests this should focus on:

- developing a clearly defined career structure linked to training, supported by consistent investment
- addressing pay differentiation between senior and entry-level care worker roles, linking to career structures
- recognising and rewarding the central role registered managers play in high quality service delivery.

The cost would be partly offset by reducing agency expenditure and costs associated with excessive turnover. This would improve the continuity of care and the outcomes of care. The analysis of the adult labour market also suggests that quality of care would be improved by increasing the grade mix (e.g. raising the proportion of senior care workers), improving retention of registered managers and investing more in training.

This economics driven approach chimes with the values driven strategy of the 'Vision for a future workforce strategy'[22] drawn up by the e.g. leaders of (ADASS), Care Provider Alliance (CPA), Care and Support Alliance (CSA), Local Government Association (LGA), Skills for Care, Social Care Institute for Excellence (SCIE) and Think Local Act Personal (TLAP).

Their priorities for adult social care workforce are:

- staff recognition, value and reward
- investment in training, qualification and support
- career pathways and development
- building and enhancing social justice, equality, diversity and inclusion in the workforce
- effective workforce planning across the whole social care workforce
- expansion of different workforce in roles.

The first three and last bullet are strongly supported by the foregoing analysis. The fourth bullet, social justice in the workforce, but also in society, can be helped by renewed focus on improved outcomes for the people drawing on care and support.

Workforce planning for adult social care is essential given it already accounts for 5% of the workforce and that figure is set to rise.

[22] https://www.skillsforcare.org.uk/About/News/News-Archive/Adult-Social-Care-Leaders-come-together-with-a-vision-for-a-future-workforce-strategy.aspx

**Recommendations: commission for outcomes**

We believe outcomes based on what people want must become the focus of the debate about the level of funding and the means to ensure that funding is well spent.

Linking a proportion of fees to improving outcomes would provide the self-improving mechanism by which providers are incentivised to invest more in training their workforce, creating new roles, and employing the workers who had the most empathy, compassion, and capacity to improve people's wellbeing.

This would require:

- processes to measure outcomes consistently, routinely and in all settings
- local authorities to consistently use and strengthen their approach to outcome-based commissioning.

**Recommendations: the research agenda**

This project has also highlighted areas which would benefit from further research, including improving outcome measures in adult social care, researching societal valuation of these outcomes, improving ways of collecting outcomes measurement in real time and how best to commission for outcomes.

New research exploring the potential integration benefits between adult social care and the NHS, and how to realise them, would also be enormously helpful to the system as a whole.

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# 9. Annex A

## 9.1 Annex A Expert reference group

Care Quality Commission (CQC)
Care England
Devon County Council
Health Education England (HEE)
Individuals with lived experience of social care
Kings College London
Local Government Association (LGA)
National Care Forum (NCF)
Social Care Futures
Skills for Care and Development
United Kingdom Home Care Association (UKHCA)
University of Kent

Officials from the Department of Health and Social Care also joined meetings of the group.

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