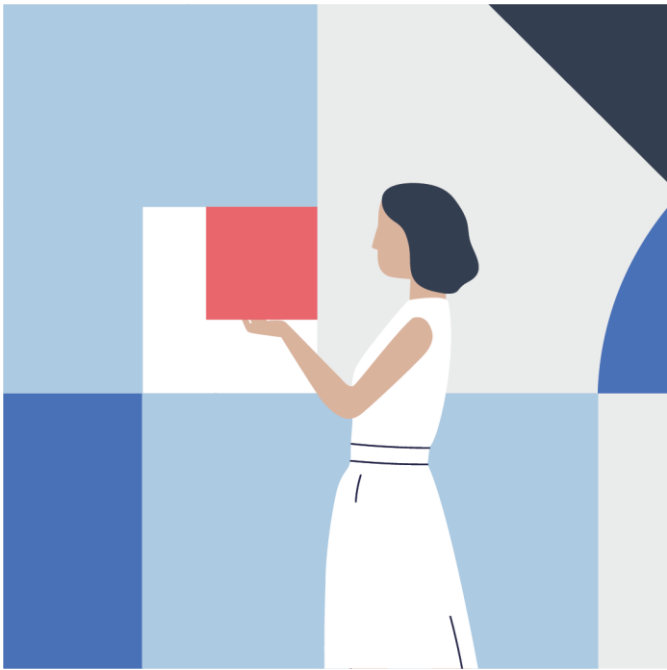


# Economic analysis of policy recommendations

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Prepared for Skills for Care

July 2024





## About the authors



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

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## About the commissioning organisation



This independent analysis was commissioned by Skills for Care. The analysis and findings are those of the authors and do not represent the views of Skills for Care.

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# Abbreviations

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## List of acronyms

Acronym	Definition
<b>ASC-WDS</b>	Adult Social Care Workforce Dataset
<b>ASYE</b>	Assessed and Supported Year in Employment
<b>AP</b>	Advanced Practitioner
<b>BCR</b>	Benefit-Cost Ratio
<b>NAAS</b>	National Assessment and Accreditation System
<b>NLW</b>	National Living Wage
<b>NPV</b>	Net Present Value
<b>NQSW</b>	Newly Qualified Social Worker
<b>OT</b>	Occupational Therapist
<b>QALY</b>	Quality-Adjusted Life Year
<b>RM</b>	Registered Manager
<b>RN</b>	Registered Nurse
<b>SfC</b>	Skills for Care
<b>SSP</b>	Statutory Sick Pay

## List of definitions

Key term	Definition
<b>Benefit-Cost Ratio (BCR)</b>	The ratio of the estimated value of benefits compared to costs. If the BCR exceeds 1, this indicates that £1 of expenditure returns more than £1 of benefit.
<b>Cost-Benefit Analysis (CBA)</b>	A cost benefit analysis (CBA) examines all the costs and benefits of the intervention and quantifies them in monetary terms as far as possible, in order to examine the balance of costs and benefits
<b>Discounted</b>	A discounted value is a future cost or benefit translated to its present-time equivalent by considering the time value of money. This calculation assumes that people prefer to receive benefits now rather than in the future. Discounting allows future values to be compared on an equal basis.
<b>Net Present Value (NPV)</b>	The NPV represents the yearly sums of costs and benefits throughout the evaluation period, aggregated and discounted to the present. A positive NPV indicates that the examined sector produces more benefits than costs in present terms, throughout the examined period.
<b>Quality-Adjusted Life Year (QALY)</b>	A measure of the state of health of a person or group in which the benefits, in terms of length of life, are adjusted to reflect the quality of life. One quality-adjusted life year (QALY) is equal to 1 year of life in perfect health

# Executive summary

Skills for Care is developing a national workforce strategy for adult social care to improve service delivery. Alma Economics was commissioned to provide costings for some of the proposed recommendations, including workforce training, digitisation, and wellbeing.

It is important to note that the policies proposed are not fully scoped. Therefore, the aim of this work was to provide high-level estimates of likely costs. Where possible, we used assumptions from existing work to estimate the financial costs of introducing the policy recommendations as well as benefits, including wider societal benefits.

The recommendations and their average impacts per year are summarised in the table below.

Recommendation	Cost to public finances (million)	Savings (million)	Workforce impacts	
			Retention	Recruitment
<b>R1. Improving digital skills and expanding the use of technology and AI in adult social care<sup>1</sup></b>	N/A	N/A	N/A	N/A
<b>R2. Extending AYSE to NQSW in OT and RM roles</b>	£13.8	£18.2	125	0
<b>R3. Creating AP roles for OT and RN</b>	£2.0	£5.3	37	0
<b>R4. Promoting the existing NHS Health Checks among the adult social care workforce</b>	£5.2	£12.2	0	0
<b>R5. Expanding the enhanced NHS health and wellbeing offering to adult social care workers</b>	£87.3	£131.0	0	0
<b>R6. Enforcement of the current minimum wage<sup>2</sup></b>	£30.4	£126.7	43	477
<b>R7. Introducing a sector minimum wage<sup>3</sup></b>	£1,400- £3,600	£1,700- £4,300	19,700- 51,100	12,000- 31,000
<b>R8. Introducing a national pay scale aligning with the existing NHS framework (Band 3 or Band 2)<sup>2</sup></b>	£2,300- £4,000	£2,800- £4,800	32,900- 56,700	19,900- 34,300

<sup>1</sup> We did not undertake a full costing exercise for R1. However, we present a range of indicative BCRs by technology area in the findings chapter.

<sup>2</sup> Please note that figures for R6, R7, and R8 are not comparable with other recommendations as they are not fully scoped and have not been adjusted for optimism bias.

<sup>3</sup> Estimates vary depending on the pay target. Additional information is presented in the findings chapter.

The table below presents the same costs and benefits over the 15-year horizon of the workforce strategy

Recommendation	Cost to public finances (million)	Savings (million)	Workforce impacts	
			Retention	Recruitment
<b>R1. Improving digital skills and expanding the use of technology and AI in adult social care</b>	N/A	N/A	N/A	N/A
<b>R2. Extending AYSE to NQSW in OT and RM roles</b>	£207	£273	3,700	0
<b>R3. Creating AP roles for OT and RN</b>	£31	£79	1,100	0
<b>R4. Promoting the existing NHS Health Checks among the adult social care workforce</b>	£77	£183	0	0
<b>R5. Expanding the enhanced NHS health and wellbeing offering to adult social care workers</b>	£1,300	£1,900	0	0
<b>R6. Enforcement of the current minimum wage</b>	£456	£1,900	653	7,100
<b>R7. Introducing a sector minimum wage</b>	£21,000- £54,800	£25,800- £65,200	296,300- 766,900	179,800 – 463,600
<b>R8. Introducing a national pay scale aligning with the existing NHS framework (Band 3 or Band 2)<sup>2</sup></b>	£35,300- £60,800	£42,700- £72,100	493,600- 850,700	299,000- 514,000

# Introduction

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## Background

Skills for Care is developing a national workforce strategy for adult social care to improve service delivery. Adult social care is a vital part of the English economy, as shown in previous work by Alma Economics for Skills for Care and Development. That analysis suggested that the adult social care sector in England generates approximately £152 billion in Net Present Value in 2023, resulting in a BCR of £2.36.

Alma Economics was commissioned by Skills for Care to provide costings for some of the proposed recommendations, including workforce training, digitisation, and wellbeing.

The recommendations include:

1. Improving digital skills and expanding the use of technology and AI in adult social care
2. Extending the Assessed and Supported Year in Employment (ASYE) to newly qualified social workers (NQS) in occupational therapist (OT) and registered manager (RM) roles
3. Creating advanced practitioner (AP) roles for occupational therapists and registered nurses (RN)
4. Promoting the existing NHS Health Checks among the adult social care workforce
5. Expanding the enhanced NHS health and wellbeing offering to adult social care workers
6. Enforcement of the current minimum wage
7. Introducing a sector minimum wage in line with:
  - a. Real Living Wage (RLW)
  - b. National Living Wage (NLW) +£1
  - c. NLW +£2
8. Introducing a national pay scale aligning with the existing NHS framework (Band 3 or Band 2)

It is important to note that the policies proposed are not fully scoped. Therefore, to estimate costs and benefits, our team relied on several assumptions. In particular, using evidence from the literature, we determined the key parameters and assumptions to feed into the model. We estimated the financial costs of introducing the policy recommendations as well as benefits, including wider societal benefits where possible, compared to a business-as-usual analytical scenario.

The aim of this work was to provide high-level estimates of likely costs associated with the recommendations. Estimates for recommendations 1-5 are adjusted for optimism bias, in line with [HM Treasury Green Book](#) guidance. In particular, we applied a 30% uplift to all estimated costs and a 20% reduction in all estimated benefits for the first 5 recommendations. Given the lack of evidence on some of the potential costs of the recommendations and the fact that benefits are in some cases calculated based on other interventions, these adjustments ensure that our estimates are conservative and account for any potential overestimation of benefits or underestimation of costs.

The sections below describe our approach including the methodology adopted, key assumptions, and data sources.

# Recommendations

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## Digitisation

### Recommendations:

1. Improving digital skills and expanding the use of technology and AI in adult social care

### Recommendation 1: Improving digital skills and expanding the use of technology and AI in adult social care

The adult social care workforce continues to lag behind the NHS in digital working, despite significant progress during the COVID-19 pandemic. As a result, adult social care is missing out on the benefits of digitisation, such as facilitating transitions of care, reducing admin costs, expediting discharges, and increasing the quantity and quality of care. To that end, there are proposals to (i) build on and develop the digital skills and confidence of the existing workforce, as well as attract people with expertise in Digital, Data, and Technology and (ii) improve access to and use of technology, data and AI.

### Methodology

Our approach to calculating the returns on investment is underpinned by [HM Treasury Green Book](#) guidance and best practice for developing health and social care business cases. We conducted a review of evidence to explore potential digital technologies that could enhance adult social care services. We then identified case studies of technologies with evidenced cost-effectiveness. The costs and benefits of digital adoption were quantified for each case study and were aggregated to produce a range of estimates for each technology. This range of estimates was then used to calculate the return on investment and benefit-cost ratio for each type of technology.

As previously mentioned, there is a wide range of benefits that could be gained from adopting digital ways of working in the adult social care sector. In particular, we identified four broad benefit areas:

- **Financial savings and efficiencies accruing to care providers**, such as saved care worker time and avoided care home costs. All financial benefits are assumed to be efficiency benefits (non-cash releasing) which relate to the freeing up of capacity rather than cash releasing savings.
- **Wider NHS efficiencies**, which result from benefits to acute and community settings. For example, technologies that reduce falls will avoid hospital admissions which results in NHS efficiency. These benefits are not financial benefits from the perspective of the care provider and so are considered wider socioeconomic benefits.
- **Health and wellbeing outcomes for people**, such as impacts on quality-adjusted life years (QALY), which have been monetised into financial values so they can be included as part of the analysis.

The magnitude and type of benefits depend on the digital technology implemented. Due to the wide range of available technologies, we have grouped them into five technological areas based on their shared characteristics.

- **Telecare:** Allows the use of virtual appointments which reduces the need for carer workers to travel to people's homes. These technologies result in time savings, as care workers can help



people remotely and do not need to visit in person, while also avoiding costs associated with care homes, as people drawing on care and support are able to remain independent for longer.

- **Assistive technologies:** Technologies which enable users to be cared for at home rather than in care homes which are higher in cost. This includes remote monitoring and communication technologies, as well as technologies that can reduce the risk and impact of health deterioration.
- **Digital records:** This includes digitising social care records to allow faster recall of information and sharing between people, care staff, organisations and health and social care sectors. These technologies can lead to benefits including staff time efficiencies and cost savings from reduced paper handling.
- **Care management technologies:** This covers a range of technologies that seek to improve the quality of care being delivered, such as through the application of data analytics and artificial intelligence to monitoring data which can identify people at risk of deterioration; as well as decision support systems that can reduce the risk of medication errors and unnecessary escalations.
- **Workforce planning software:** Digital systems to improve the planning and management of staff time, including the optimal scheduling of routes to the homes of people drawing on care and support. The evidence review conducted identified savings in staff time, administration, and travel time resulting from these technologies.

## Findings

Below we present some indicative returns on investment for each technological area. The results suggest that investing in any type of digital technology in the adult social care sector would yield significant benefits for providers, the NHS, and people drawing on care and support. Assistive technologies seem to have the highest return on investment. For instance, the financial benefit-cost ratio to the provider is £4.21. This means that every £1 invested in adopting assistive technologies generates £4.21 of net benefits, which is above the £1.0 threshold required to be considered value for money in public sector investment appraisal.

**Table 1. Returns on investment for each technological area by type of return (per adult in care, 2023)**

Technology	Financial	NHS	QALY
<b>Assistive technology</b>	£4.21	£4.10	£4.87
<b>Care management</b>	£1.20	£0.36	£2.16
<b>Digital records</b>	£6.77	N/A	N/A
<b>Telecare</b>	£2.84	N/A	N/A
<b>Workforce planning</b>	£1.32	N/A	N/A

# Training

## Recommendations:

2. Extending the Assessed and Supported Year in Employment (ASYE) currently available to newly qualified social workers (NQSW) in occupational therapist (OT) and registered manager (RM) roles
3. Creating advanced practitioner (AP) roles for occupational therapists and registered nurses

## Recommendation 2: Extending ASYE in OT and RM roles

The proposal is to extend the Assessed and Supported Year in Employment (ASYE) to all NQSW occupational therapists and registered managers. ASYE is a 12-month support and assessment programme for newly qualified social workers across child, adult, and family services. The programme offers regular supervision, protected development time, and shadowing of experienced social workers ([Department for Education, n.d.](#); [Skills for Care, n.d.](#)).

## Methodology

The costs of implementing this recommendation include:

- **Funding to Local Authorities.** Funding to local authorities was assumed to be the same as the current funding per NQSW (£2,000 per person).
- **Programme administration costs.** To estimate the administration cost, we used the administrative cost of a new early career framework, as costed by the DfE ([Alma Economics, 2022](#)).
- **Delivery partners' training costs.** The delivery partners' training cost has been assumed to be £1,500 per NQSW, following estimates from the [Independent Review of Children's Social Care](#).

These costs were then applied to all NQSWs in OT and RM roles, using the starter rate for these roles ([Skills for Care, 2021](#)).

As a result of the introduction of this recommendation, we estimated the impact on **turnover, absence, and agency rate**. We used evidence from the [National Assessment and Accreditation System \(NAAS\)](#) showing that providing social workers with training to develop their skills and knowledge led to a reduction in turnover, absences, and the use of agency workers. In particular, the NAAS includes training for child and family social workers, such as theoretical and practical sessions on legislation and therapeutic techniques. Therefore, we assume that the impact of the examined recommendation is comparable to the impact of the NAAS.

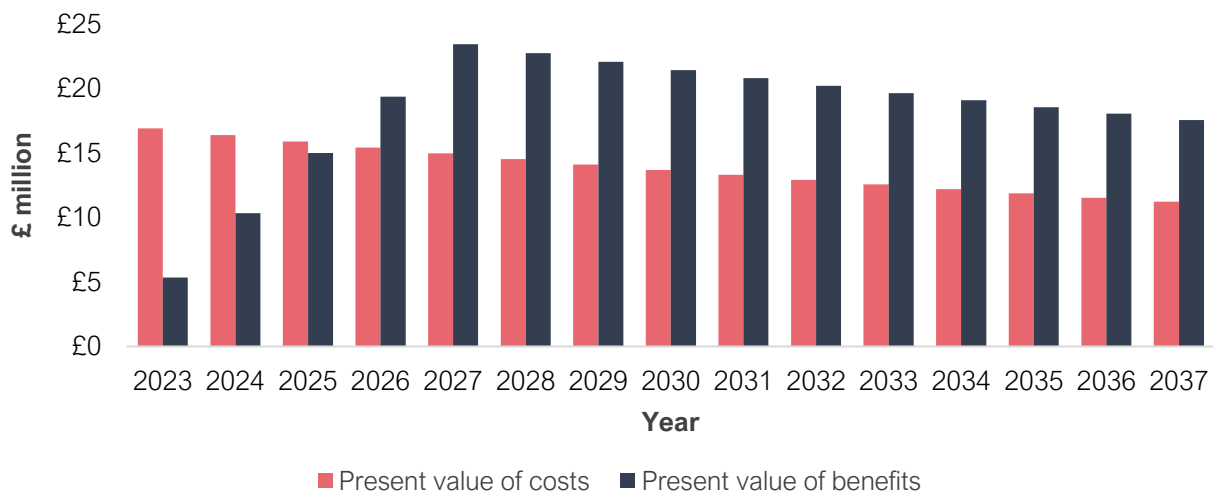
The savings due to reduced turnover (1.6 percentage points) were calculated using evidence from [Care England](#) on the cost of hiring a social worker (approximately £6,000), which was then adapted to OT, RM, and RN roles using the wage differential between these roles and social workers. The result was then multiplied by the number of people remaining in employment in the sector as a result of the recommendation. The savings of reduced absences were estimated by multiplying the number of people enrolling in the programme by the cost of absenteeism per person, per year (estimated around £300 in [Deloitte, 2020](#)). Finally, the savings due to reduced agency use were calculated as the difference in costs to LAs between agency and LA staff, multiplied by the number of workers that would have been recruited from agencies ([Kantar, 2020](#)).

## Findings

Our analysis suggests that the recommendation would achieve a benefit-cost ratio (BCR) of £1.3. This means that for every £1 spent, the sector would generate £1.3 in socioeconomic benefits. In total, the NPV generated by this recommendation would be approximately £66 million in the period 2023-2037. Moreover, the reduction in turnover would prevent approximately 3,700 workers in RM and OT roles from leaving the sector.

The figure below presents the evolution of costs and benefits in present value terms, over the examined period. As shown below, the costs would exceed the benefits in the first three years, while after 2026 the benefits would outweigh the costs. The reason for the costs initially exceeding the benefits is that the effect of providing training to NQSW has been assumed to persist for 5 years. As a result, the benefits accumulate as more NQSW enrol in AYSE and stabilise 5 years into the programme.

**Figure 1. Present value of costs and benefits of recommendation per year (2023-2037)**



## Recommendation 3: Creating AP roles for OT and RN

The proposal is to create advanced practitioner roles for OT and RN. By offering pathways of further specialisation and career progression, sector stakeholders want to increase retention and recruitment in the sector. Advanced practitioners are more experienced workers with usually at least 2 years of experience and a Bachelor's degree. Social worker APs typically provide assessments, coordinate service provision, and offer steers to other social workers ([Social Personnel, 2023](#)).

### Methodology

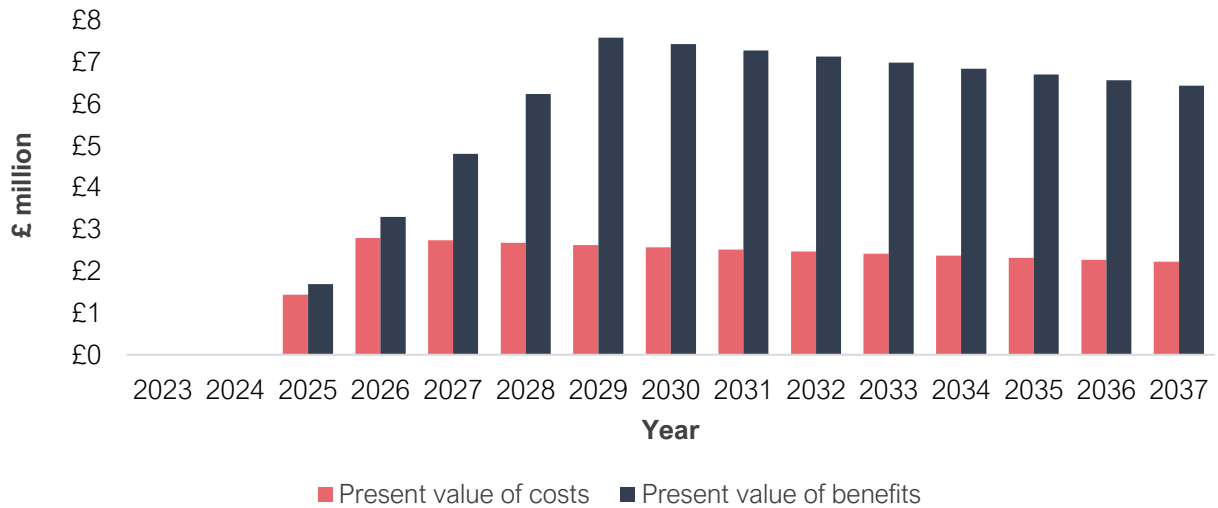
The **cost of creating AP roles** has been assumed to be equal to the **training cost to upskill existing social workers to the level of advanced practitioners**, following the [Independent Review of Children's Social Care](#) (about £1,500 per person). This cost was then applied to the number of OTs and RNs enrolling for AP. To calculate the number of workers enrolling, we first assumed that only workers with 3 or more years of experience can enrol. We then assumed that only 20% of each of the eligible OTs and RNs would enrol, using the ASYE take-up rate as a proxy ([Johnson, C. et al., 2021](#)).

The **benefits** of creating AP roles have been assumed to be the same as extending ASYE to NQSW, namely a **reduction in turnover, absence, and agency use rates**. The reason is that both the ASYE and AP offerings help upskill, train, and educate adult social care workers. While the ASYE targets NQSWs, the AP training would apply to those already 3 years in the job. As a result, both recommendations work complementary to reshape the training offering for OTs, RMs, and RNs.

## Findings

The results show that creating AP roles for OT and RNs would achieve a BCR of £2.5. In total, the recommendation would generate approximately £48 million of NPV between 2023-2037 and would allow 1,100 workers in OT and RN roles to remain in employment. As presented in Figure 2, the recommendation will produce higher benefits than costs from the first year of implementation. There will be no costs or benefits for the first two years, while OT and RN entering the system in 2023 gain 3 years of experience to qualify for AP roles.

**Figure 2. Present value of costs and benefits of recommendation per year (2023-2037)**



# Health and wellbeing

## Recommendations:

4. Promoting the existing NHS Health Checks among the adult social care workforce
5. Expanding the enhanced NHS health and wellbeing offering to adult social care workers

## Recommendation 4: Promoting the existing NHS Health Checks among the adult social care workforce

All people between 40 and 74 years old, including adult social care workers, are eligible for free NHS Health Checks to ensure the overall health of the population. These checks are carried out mostly by GPs (93% according to the [NHS delivery model survey in 2020](#)) and aim to identify and prevent the deterioration of health. In particular, the checks led to the diagnosis of: (i) hypertension (1 for every 27 checks), (ii) type 2 diabetes (1 for every 110 checks), and chronic kidney disease (1 for every 265 checks; [NHS, 2016](#)). Furthermore, there is evidence that these diagnoses would have happened at a smaller rate in the absence of the health checks. [Robson et al. \(2015\)](#) found that hypertension and type 2 diabetes were diagnosed almost three times more frequently and chronic kidney disease almost twice as frequently, compared to the usual health services available. Overall, research by the [University of Cambridge \(2017\)](#) suggests that the NHS Health Check Programme could prevent at least 650 premature deaths per year.

## Methodology

Given the challenges of adult social care and the significant potential benefits of the NHS health checks, there are proposals for a targeted promotion of the existing health checks to employees in adult social care.

The cost of this recommendation consists of:

- **Promotion costs.** The promotion costs were calculated as the cost of telephone calls to targeted individuals, sourced from [Tanner, L. et al. \(2022\)](#). The number of adult social care workers targeted by the recommendation (i.e. the number of people currently not undergoing health checks) is calculated based on the share of adult social care workers that are eligible and the take-up rate at the national level. To calculate the adult social care workers that are eligible we use the age breakdown of the workforce from the adult social care dataset (ASC-WDS) and use those between 40 and 74 years of age. In the absence of data on take-up rates among adult social care workers, we assume that their take-up rate is the same as the national take-up rate (40%; [Office for Health Improvement & Disparities, 2024](#)). We also assumed that the success rate of the aforementioned telephone calls among adult social carers is 18% ([Tanner, L. et al., 2022](#)). Finally, our model is built on the assumption that the intervention will be implemented every year (i.e. the take-up rate is constant and people who don't take up the health checks are reached out to every year). This is a conservative assumption as it may be the case that those who have been reached by the intervention in one year are more likely to take up the health checks in the following years as well. In that case, there would be a reduction in costs and an increase in the benefits of this recommendation over time. However, because of the high turnover in the adult social care sector and anecdotal evidence suggesting that social care workers are reluctant to take up health checks, we assume a constant take-up rate.
- **Cost of delivering additional health checks.** The delivery costs were calculated as the average costs quoted in the NHS Health Checks delivery survey (i.e. £21-40 per check) multiplied by the

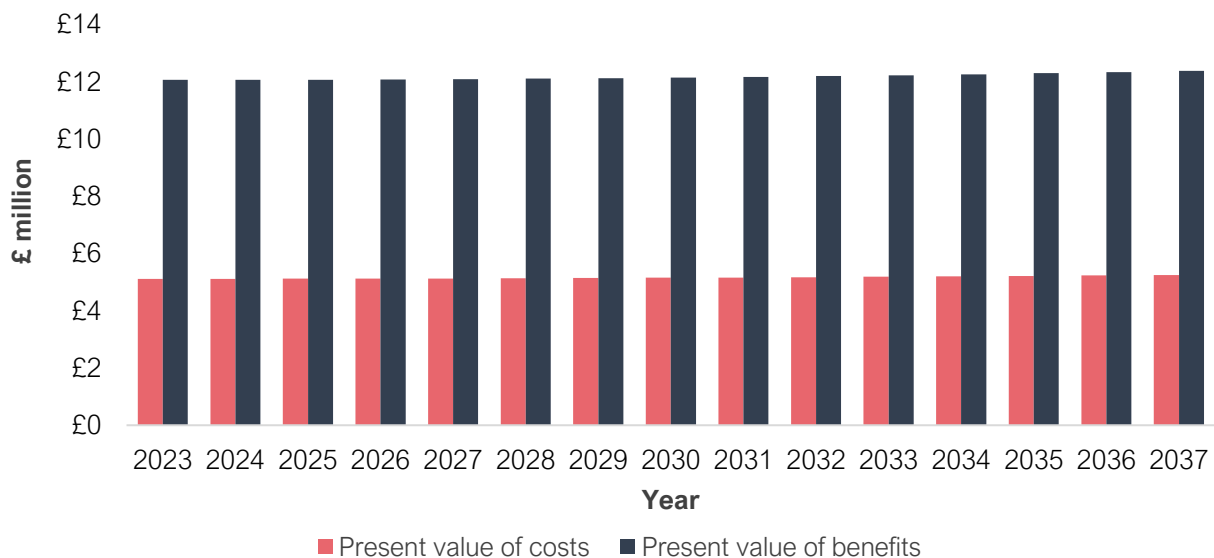
additional numbers of adult social care workers undergoing health checks, as calculated above (Public Health England, 2021).

The main impact of this recommendation is the improvement in wellbeing of workers receiving health checks, as found in the evaluation conducted by NHS England (2016). The evaluation shows how many QALYs are gained through health checks depending on the amount invested in health checks (approximately 1 QALY per £2,458, in 2008 prices).<sup>4</sup> Health outcomes are typically measured in terms of quality-adjusted life years (QALYs) which can be quantified and monetised. QALYs represent the additional healthy years gained by individuals from an intervention and are monetisable by multiplying the QALY value with £70,000 as per HM Treasury Green Book guidance.

## Findings

Promoting the take-up of the existing NHS Health Checks among the adult social care workforce would generate benefits. In particular, our analysis shows that every £1 spent in the sector would generate £2.4 in socioeconomic benefits. As shown below, the benefits outweigh the costs in all years between 2023-2037. In total, this recommendation would create approximately £105 million in NPV across the examined period.

**Figure 3. Present value of costs and benefits of the recommendation per year (2023-2037)**



## Recommendation 5: Expanding the enhanced NHS health and wellbeing offering to adult social care workers

The NHS Long-Term Workforce Plan has reinforced the health and wellbeing offering by providing occupational health services for NHS staff. Occupational health focuses on the health and wellbeing of employees in the workplace, aiming to determine how work affects the physical and mental health of employees and ensure they receive appropriate support. Most occupational health services are proactive, aimed at preventing illnesses and injuries and promoting overall wellbeing. Some of the services include (i) pre-employment health assessments, as well as screening and surveillance services during employment, (ii) advising on ergonomic issues and workplace design, for example by completing risk assessments, and (iii) providing organisational-wide steps to reduce sickness

<sup>4</sup> A 2017 study by the University of Cambridge also estimated a similar cost per QALY achieved through the NHS Health Checks. This estimate was approximately £3,000 in 2017 prices, which is very similar to the estimates used in our model if we account for inflation.

absence, as well as offering independent advice on staff unable to work due to illness. The proposal is to extend the enhanced offering to social care staff by using the integrated care systems that promote local collaboration across health and care services.

## Methodology

There is a lack of evidence in the literature specific to the NHS enhanced offering. As a result, both the costs and benefits of this recommendation were estimated using evidence from multidisciplinary preventive health and well-being interventions in the workplace, which are similar to the NHS enhanced offering. In particular, the **delivery costs** were calculated as the average of the costs per person quoted in [Mills, P. et al. \(2007\)](#) and [Knapp, M. et al. \(2011\)](#). The average cost was then multiplied by the number of workers in adult social care that would take-up this offering. To calculate the number of workers taking up the offering, we used the take-up rate of the NHS health checks (40%, see recommendation above for details).

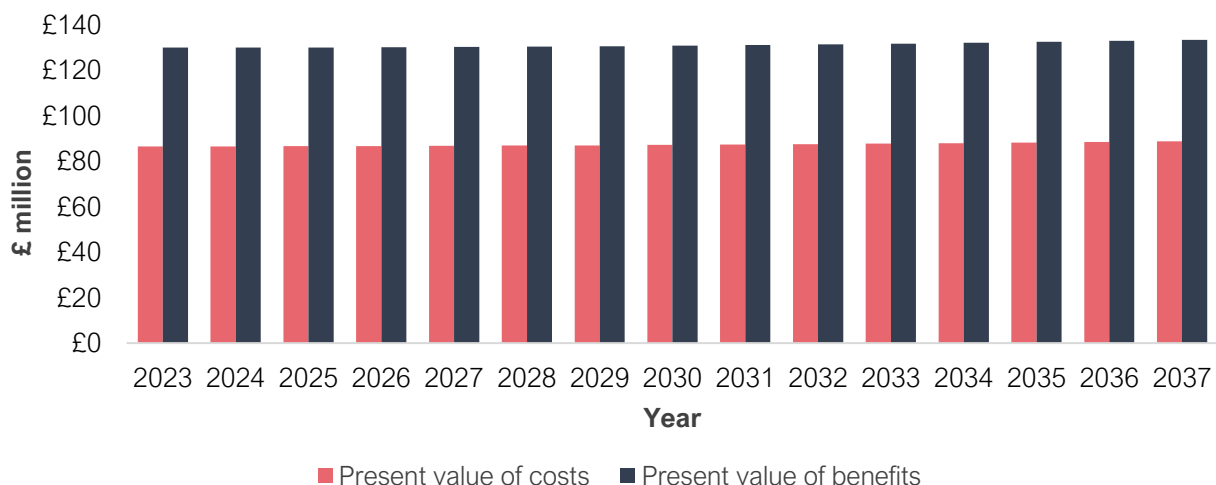
Based on evidence from similar occupational health interventions, we expect one main benefit from this recommendation to be a **reduction in absenteeism**. The savings due to reduced absenteeism were calculated by multiplying the absenteeism reduction impact (0.36 fewer absenteeism days per month), by the average cost of one day absent (£299), and the number of adult social care workers taking up the offering. The absenteeism reduction impact was sourced from [Mills, P. et al. \(2007\)](#), while the cost of one day absent was calculated by dividing the cost of absenteeism per person per year by the number of sick days per adult social care worker ([Deloitte, 2020](#); [Skills for Care, 2023](#)).

Similar to the one above, this recommendation is likely to have a wider impact on the wellbeing of workers who take up the enhanced offer. For example, there is some evidence that occupational therapy and multidisciplinary health interventions in the workplace can improve the mental health and QALYs of employees ([Lambert, R. et al., 2010](#)). Moreover, according to evidence from [NHS England \(2018\)](#) the wellbeing of NHS staff can have an impact on the quality of services, which in turn affects the wellbeing of people. However, due to a lack of robust estimates of wellbeing impacts we have not included them in the model.

## Findings

Under the assumptions mentioned above, expanding the enhanced NHS health and wellbeing offering would generate £1.5 in socioeconomic benefits for every £1 invested in the sector. As shown in the figure below, expanding the NHS enhanced offering to adult social care workers would generate more benefits than costs each year, resulting in approximately £657 million in NPV between 2023 and 2037.

**Figure 4. Present value of costs and benefits of the recommendation per year (2023-2037)**



# Adult social care workforce pay

## Recommendations:

6. Enforcement of the current minimum wage
7. Introducing a sector minimum wage corresponding to alternative targets
8. Introducing a national pay scale aligning with NHS Band 3

There are three proposed recommendations to increase adult social care workforce pay. It is important to note that the costs and benefits will depend on how these recommendations will be implemented. (e.g. who will fund them, who they will apply to, how they will be enforced, etc.). As mentioned in the introduction, the recommendations are not fully developed at this stage, thus the aim of this work is to provide high-level estimates of costs and benefits. Therefore, the estimates presented below do not take into consideration potential impacts that are likely to arise as a consequence of the recommendations proposed (e.g. changes in demand for adult social care, the impact on other sectors in the economy, etc.). Additional modelling exercises will be required for a comprehensive analysis once the recommendations have been fully scoped.

The estimates below are produced based on the assumption that any pay increase proposed will be fully funded, i.e. pay increases will come with extra resources from the government. However, it is important to note that if the pay increase is not fully funded using extra resources, an increase in wages will reduce the amount of social care service provided. For example, setting a new minimum wage in the adult social care sector, above the existing one could reduce the average weekly hours of care and the number of staff supporting each adult (Vadean, F. & Allan, S., 2020). This is because in order to meet the new pay, providers will likely need to cut costs, which could be in the form of reduced hours of care or the number of staff supporting each person. Similarly, the hours of care offered and the number of carers employed by self-funders could also decrease, as self-funders would incur the entirety of the wage increase cost. For the purposes of this exercise, we have assumed that the demand for care would remain constant, as there is anecdotal evidence that the demand for care by self-funders might be inelastic (i.e. not responding significantly to changes in price).

## Methodology

The **key costs** of implementing the recommendations specified above are calculated as the difference between the current wages of adult social care workers and the proposed wage increase as described below:

- **Enforcing the minimum wage:** There are proposals to ensure that all adult social care workers get at least the NLW. While the basic pay of all social care staff is above the NLW, according to the UK government, the minimum wage should also account for time spent: “*travelling in connection with work, including travelling from one work assignment to another*” and “*training or travelling to training*” (UK Government, n.d.). However, research by the [Low Pay Commission \(2020\)](#) suggests that approximately 15% of low-paid social care workers were earning below the National Living Wage (NLW) in 2020 due to non-compliance and enforcement challenges in compensation for travel and training time.

To calculate the cost of enforcing the minimum wage for all adult social care workers we multiplied the degree of underpayment by the number of adult social care that are underpaid. Applying the 15% estimate mentioned above to low-paid adult social care staff in the ASC-WDS allowed us to



calculate the number of underpaid staff. We applied the incidence of underpayment to the care workers in domiciliary care settings, following discussions with SfC. We then used evidence from the [Resolution Foundation \(2023\)](#) showing that if we account for travel time of adult social care workers, they would be paid approximately 3% below the minimum wage. As a result, we used this as a proxy for the magnitude of underpayment for those 15% low-paid workers with earnings below the NLW.

- Sector minimum wage:** Stakeholders in adult social care have explored several alternative pay targets for the sector. As a result, we modelled the costs and benefits of introducing the following pay targets: (i) RLW; (ii) NLW +£1; and (iii) NLW +£2. To estimate the cost of such pay increases we multiplied the difference in pay between each target and current pay for all job roles and applied this to the affected population (i.e. any staff earning below the target). Both the current pay and the number of staff by job role were sourced from the ASC-WDS. It is important to note that we adjusted the ASC-WDS pay data to reflect the possible incidence and degree of underpayment mentioned above. As a result of this adjustment and following discussions with SfC, care workers in domiciliary care settings will need additional investment to reach each pay target compared to using the ASC-WDS earnings data. Finally, we also included the cost of additional pay increases for senior staff in order to maintain at least part of the wage differentials between seniority levels. In particular, we assumed that social workers with more than 3 years of experience would receive an additional £2 per hour, as discussed with SfC.
- Introducing a national pay scale aligning to NHS Band 2 or Band 3:** Research by [Community Integrated Care \(2024\)](#) suggests that the average support worker gets paid 10.3% lower than the average NHS Band 3 worker. Another proposal in the sector is increasing the minimum wage to match the pay of NHS staff in Band 3 (or Band 2). Given there is different pay within Band 3 depending on years of experience, we have calculated two different estimates, one aligning with NHS Band three for staff with under 2 years of experience, and one for those with 2 or more years of experience. The costs are calculated as described above.

It is worth noting that the model does not include the costs of producing and enforcing a new regulation. In addition, only part of the above costs would apply to public finances, as a significant share of adults receiving care are self-funders. As a result, we used data from the ONS showing the percentage of self-funders relative to all adults in care homes and community care settings to calculate the cost applicable to the Exchequer and self-funders (ONS [2023a](#), [2023b](#)). We applied the share corresponding to each care setting affected by the recommendation. For instance, if a pay target affected only care workers in care homes, we split the total cost based on the share of self-funders in care home settings.

Key benefits across the three recommendations are presented below. It is worth noting that the benefits are calculated over the total costs. As a result, the benefits are the same regardless of whether the cost applies to self-funders or public finances.

- Increase in adult social care labour force:** one of the potential benefits is an increase in the supply of adult social care workforce, including both recruitment and retention. There is no consensus in the literature on the size of the elasticity for the adult social care sector (i.e. how many additional people would become adult social care workers for a 1% increase in wages). Previous research estimates a wage elasticity between 1.6% and 4% ([Vadean, F. & Allan, S., \(2023\)](#) and [Allan, S. et al., \(2021\)](#)). We present results using a conservative assumption of wage elasticity at 1.6%.
- Reduced turnover:** according to estimates produced by [Vadean, F. & Saloniki, E.C. \(2023\)](#), a 26% increase in pay would reduce turnover by 27% in residential care settings. Similarly, a 23% increase in pay in domiciliary care settings would reduce turnover by 22%. We estimate savings due to reduced turnover based on the cost of recruiting new social workers (as calculated in the

training recommendations; [Care England, 2024](#)). Subtracting the total number of people recruited from the total employment impact (calculated above) allowed us to also estimate separately the number of people recruited.

- **Savings to NHS** due to:
  - An increase in the number of people receiving social care services. As a result, a proportion of people receiving care from the NHS (in the absence of the recommendation) can now be accommodated by adult social care services at a reduced cost. We assume that this proportion is equal to the proportion of adults in nursing care compared to all adults in care, as the nursing care population has more intensive needs and would need to receive support in either case.
  - A reduction in costs due to avoided injuries. In particular, fewer people would receive social care without the new social workers recruited, some of which would experience injuries that would be treated by the NHS. To calculate the reduced cost due to avoided injuries, we use evidence from the [Health Foundation & Nuffield Trust \(2015\)](#) showing that 8.2% of all hospital admissions in England come from care home residents. We then apply the average unit cost of hospital admissions, using unit costs for elective and non-elective inpatients from the [NHS England National Cost Collection](#).
- **Wellbeing of people receiving care as a result of additional staff.** As mentioned above, the increase in supply of adult social care workers allows more adults to receive care. Apart from the savings to the NHS, receiving care also improves the wellbeing of adults. In particular, metric “1B: Quality of life of people who use services” included in the [Adult Social Care Outcomes Framework](#) measures the impact of social care on the quality of life of people who receive these services. To monetise this wellbeing impact, we used evidence by [Stevens et al. \(2018\)](#) showing that the information in metric 1B can be monetised by applying the [monetary value of a QALY](#).

## Findings

### Recommendation 6: Enforcement of the minimum wage

Our analysis suggests that enforcing the 2023 NLW to adult social care workers would cost approximately £42 million per year (or £637 million in total). Out of this cost, £30.4 million (or £456 million in total) would be paid by the state, while the remaining £12 million (or £181 million in total) would be paid by self-funders.

The reduction in turnover would prevent approximately 653 domiciliary care workers from leaving their jobs (leading to £7 million savings due to avoided recruitment costs) and attract an additional 7,100 domiciliary care workers. The additional people recruited will create new care placements leading to approximately £111 million benefits in wellbeing for adults in care and £15 million in NHS savings per year (or £1.7 billion and £224 million respectively in total).

It is important to note that a regulation to enforce the minimum wage is already in place. Therefore, it is unclear at this stage how the recommendation will be implemented and what actions will be taken to ensure that all workers are paid the minimum wage.

### Recommendation 7: New sector minimum wage

This section presents the impacts of setting a new sector minimum wage equal to the RLW, NLW +£1, or NLW + £2 per hour. The total cost per year of introducing each target would be approximately £2.1 billion, £3.2 billion, and £5.7 billion (or £32.8 billion, £48.4 billion, and £85.8 billion in total). However, not all of this cost would be borne by the Exchequer, as a significant share of adults receiving care are self-funders. As a result, the cost applicable to public finances would be £1.4 billion, £2.0 billion, and

£3.6 billion per year, respectively (in 2023 prices). The respective total costs to public finances for each target would be £21.0 billion, £30.9 billion, £54.8 billion.

The table below summarises the results of our analysis for each pay target. In particular, we present the cost to public finances, savings, and the impacts on the adult social care workforce over the 15-year horizon of the workforce strategy. The results suggest that introducing any of the proposed pay targets would create benefits ranging from £4.8 to £10.4 billion over the examined period. The recommendations could also lead to recruiting at least 179,800 new social workers and help more than 296,300 social workers remain in employment across care work, support and outreach, and personal assistant roles.

As mentioned above, the impact of this recommendation will depend on how it will be implemented. Future work will need to consider the cost of producing a new regulation for the new sector wage as well as consider the implications of increasing the minimum wage in the social care sector on other sectors of the economy.

**Table 2. Impacts on public finances by pay target, 2023-2037**

Pay target	Costs to public finances (m)	Savings (m)	People recruited	Workers remaining in the sector
Real Living Wage	£21,000	£25,800	179,800	296,300
National Living Wage +£1	£30,900	£37,700	263,500	434,700
National Living Wage +£2	£54,800	£65,200	463,600	766,900

## Recommendation 8: Introducing national pay scales aligning with NHS Band 2 or 3

Following the approach detailed above, we have calculated the costs (to public finances) and benefits of aligning with (i) NHS Band 2; (ii) NHS Band 3 with under 2 years of experience; and (iii) NHS Band 3 with 2 or more years of experience.

- Aligning pay to NHS Band 2 would cost approximately £2.3 billion per year to public finances and £1.3 billion to self-funders, **preventing approximately 493,600 workers from leaving their jobs and attracting an additional 299,000 people in the sector by 2037.**<sup>5</sup> The recommendation would create savings of approximately £580 million in 2023 due to avoided recruitment costs and £2.2 billion in improved wellbeing and £298.6 million in NHS savings per year. The respective savings over the 15-year period are £4.8 billion, £33.5 billion, and £4.5 billion.
- Aligning pay to NHS Band 3 with under two years of experience would cost approximately £2.7 billion per year to public finances and £1.5 billion to self-funders, **preventing approximately 568,200 workers from leaving their jobs and attracting an additional 344,000 people in the sector by 2037.** The recommendation would lead to savings of approximately £659.7 million in 2023 due to avoided recruitment costs as well as £2.5 billion in improved wellbeing and £341.8 million in NHS savings per year. The respective savings over the 15-year period are £5.5 billion, £38.3 billion, and £5.1 billion.
- Aligning pay to the NHS Band 3 (2+ years of experience) would cost approximately £4.0 billion

<sup>5</sup> All workforce impacts in this section concern the following job roles: (i) care workers; (ii) senior care workers; (iii) support and outreach staff; (iv) personal assistants; and (v) other care staff.

per year to public finances and £2.3 billion to self-funders, while **preventing approximately 850,700 adult social care workers from leaving their jobs and attracting an additional 514,000 people in the sector by 2037**. The workers remaining in employment would create savings through avoided recruitment costs equal to £949 million in 2023. Similarly, recruiting additional care workers allows more adults to receive care, which creates approximately £3.8 billion in wellbeing savings and £503.0 million in NHS savings per year. The respective savings over the 15-year period are £8.2 billion, £56.4 billion, and £7.5 billion.

## Sick pay

There are proposals for increasing sick pay for care workers or abolishing the 3-day waiting period of Statutory Sick Pay (SSP). While a costing exercise was beyond the scope of this work, this section offers background information and summarises key work in this area.

In England, all employees earning above £123 per week are entitled to SSP, which amounts to £116.75 per week from the fourth day of being off sick and can be paid for up to 28 weeks of sick leave ([UK Government, n.d.](#)). Research suggests that sick pay is highly valued by employees. For instance, [Adams-Prassl, A. et al. \(2023\)](#) found that over a third of the respondents in their survey would give 20% of their salary in exchange for sick pay. Furthermore, the study found that 41% of employees without sick pay would go to work even when ill (compared to 31% for those with sick pay). Going to work while sick has significant negative impacts on the employer and one's coworkers. In particular, [WPI Economics \(2023\)](#) found that even mild health conditions such as headaches can decrease productivity by 20-25%. The same study also found that if a sick employee goes to work, 12% of all staff will also contract the illness through primary and secondary transmission.

This suggests that SSP is highly valued by employees, and increasing its size or days of provision could have a wide range of benefits such as reduced presenteeism for beneficiaries and avoided illnesses for their coworkers.



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