Using Data to Improve Services

Discussion material

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IMPACT
Improving Adult Care Together

The Health Foundation

UKRI Economic and Social Research Council

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Discussion material

How you can use this discussion material

Before our first session, we'd like everyone to read this document which summarises the evidence from research, practice and lived experience about 'Using Data to Improve Services' in Adult Social Care. The aim of this material is to spark discussions in your local Networks about your experiences and ideas for change. There are questions throughout and at the end for you to discuss in your first Network meeting. The material may also leave you with questions you'd like to ask the IMPACT Networks team, or other Networks across the UK - you can feed these back to your Local Network Coordinator to pass on.

This discussion material:

- Explores the challenges to using data in Adult Social Care to improve services
- Outlines the policy landscape in the four UK nations regarding data and Adult Social Care
- Examines the strategies of digitalisation and integration of health and social care data
- Provides some examples of how data can improve Adult Social Care practices and policies.

What's the issue?

The term 'data' generally refers to a collection of facts, figures or details. Data comes in many forms, but it's typically categorised into two main types:

- **Quantitative Data**: This is data that can be counted or measured and is expressed in numbers. It answers questions like "how much?" or "how many?". For example, the number of people using a day centre, how long a care visit was, or activities a person might need support with when recorded as 'yes/no' answers are all quantitative data points. This type of data is often used for statistical analysis and is often included in large datasets to help with service planning.
- **Qualitative Data**: This is descriptive data that can't be measured with numbers. It describes qualities or characteristics and answers questions like "how?" or "why?". Examples include a narrative account of how a person feels about the care they receive, and why they feel this way. This kind of data is often collected through observations, interviews, or surveys with open-ended questions. This is also more likely to be unique personal data such as that included in care plans.

This discussion material focuses mainly on the use of quantitative data to improve services. By analysing data, we can turn this into information to help people to make decisions, for example policy makers, commissioners, managers and people who use care. This process of combining the best available information to provide better services is called 'evidence-based policy' or 'evidence-based practice'.

Data collection in social care is the foundation of evidence-based policy and practice (Mendes et al., 2023; Tawodzera and Glasby, 2024). This provides the necessary insights to understand the needs of people using social care services, evaluate the effectiveness of interventions, and inform decisions at both the frontline and systemic levels (Nutley et al., 2019; BASW, 2020). For example, support social workers to identify the best strategies for supporting people who are vulnerable and isolated (See Moriarty, 2012 for more details).

Using Data to Improve Services

Discussion material

By systematically collecting and analysing data, social care professionals and policymakers can move beyond anecdotal evidence and make decisions grounded in facts (Mendes et al., 2023; BASW, 2020). This process helps ensure that resources are allocated efficiently and that care services are designed to achieve the best possible outcomes for individuals and communities (Mendes et al., 20Ch23; Tawodzera and Glasby, 2024).

The importance of data is summed up by this quote from the Department of Health and Social Care:

"Data can make a life better, or even save it" (DHCS, 2023)

This short video by Dominique Kent from *Sodexo UK and Ireland* highlights how data has been useful to improve safety and provide better care:

Why does data matter to adult social care?

However, when we reviewed what evidence said about data and social care, most sources highlighted the numerous systemic barriers to collecting and sharing good quality data in social care, for example the fragmentation of the system and limited digitalisation, as well as people's concerns about privacy (Burton et al., 2022; Malone and Hayes, 2017). The poor quality of social care data was brought sharply into focus at the start of the Covid-19 pandemic (Hanratty et al., 2020), and while this highlighted the fragmented nature of UK social care data, it also accelerated the development and roll out of technology to support care.

Other more critical resources noted that social care would benefit from a different approach to evidence and data collected for health care (Williams and Glasby, 2010; Nutley et al., 2019) starting with the inclusion of people with lived experience (Tawodzera and Glasby, 2024). Additionally, while there is a much longer tradition of the use and collection of data in health care, this is still very limited in social care (Mendes et al., 2023). As such, social care policy in all four nations of the UK is calling for increased digitalisation of care records to better harness the data for decision makers, often alongside a greater integration of health and social care.

For all these reasons, IMPACT identified this as an important issue to explore as data can improve Adult Social Care.

Using Data to Improve Services

Discussion material

Question: What do you know about the data collected in Adult Social Care? Do you have ideas or experiences on how data is used to improve Adult Social Care services?

Challenges of Using Data in Social Care

While there is a long tradition of using data in healthcare, the implementation of evidence-based practices and policies in Adult Social Care is still limited (Mendes et al., 2024; O'Donovan, 2023). Mendes et al. (2024) conducted a study that highlighted the poor quality of Adult Social Care data compared to the NHS data system. In particular, while health care data is generally standardized across the NHS via clinical coding and consistent data infrastructure, this is very poor in the Adult Social Care context. Their study highlighted many barriers to the development and establishment of using data in Social Care, **starting with the complexity of social care data.**

Adult Social Care across the four nations encompasses different populations and services. This means that Adult Social Care data includes a **wide range of information about care services, people who use services, and carers**. Simpson et al. (2022) conducted a review to assess how Adult Social Care need(s) have been defined in the UK context and then, captured in primary care big databases. First of all, the study noted that a definition of Social Care need has to consider "both a person's social care provision needs and their wider social needs, which enable full participation in society" (Simpson et al., 2022). This type of data is more difficult to capture in quantitative data because of the individual, social and very specific needs of each person. Secondly, the authors found that there is not a consistent definition of 'social care need' and this makes it difficult to identify ways to measure it. Therefore, they recommended more research aimed at understanding and measurement of Adult Social Care needs, with the aim to support more effective, holistic personalised care.

A second level of complexity relates to the **various organisations and institutions involved in the provision of Adult Social Care.** For example, a review of the care home market (CMA, 2017 - Care Homes Market study) found that there are around 5,500 different providers in the UK operating 11,300 care homes for the elderly, with around 95% of their beds being provided by the independent sector (both for-profit and charitable providers). Care providers collect a variety of data in different formats so without a minimum dataset that providers are required to collect, it is hard to link data. Adult Social Care data includes administrative records concerning residential care, day care, and home care, as well as crucial support for unpaid family carers. A survey by Davey et al (2025) of homecare providers found that all collected some data on care plans and care delivery, there was a wide variation in data collection practices and standard measurement tools were uncommon. They suggest that staff will need more training on what and how to collect data if a minimum standard data set is to be introduced.

Using Data to Improve Services

Discussion material

While routine administrative Adult Social Care data can be a rich source of information, there are few national resources available and the data is often kept in silos (Lugg-Widger et al., 2024). Additionally, data are not only for national purposes, a big issue concerns also how data is created and shared **on a practice level.** For example, Chotvijit et al. (2019) examined how data was collected, shared and travelled through a social care department in Birmingham City Council, from referral and assessment, to the resulting provision. The study highlighted the complexity of the system and found that data was fragmented and did not flow smoothly through the system. Many records were incomplete, for example data being recorded for a support plan but not an earlier part of the process such as assessment. The problem with this was that those people analysing data did not have all the information to make a real picture of the needs of the population. Therefore, this fragmentation meant that social care workers had little understanding as to whether people's care needs were being met, or if there were any needs for staff training to better support the people using the services (Chotvijit et al., 2019).

Another important challenge is given by **the sensitive nature of social care data.** While there is a general call for collecting and sharing more data to improve Adult Social Care service, there is also attention to ethical considerations surrounding privacy and security (Fylan and Fylan, 2021; De Bell et al., 2024). A key tension exists between the need for data sharing to provide joined-up care and the need for robust data protection (Ford et al., 2021). A paper from Ford et al. (2021) highlighted this issue in the context of mental health data access and sharing which limit research to produce evidence that can inform and guide policy makers, practitioners and also the general public. The authors noted the complex issues that researchers encountered in accessing administrative Mental Health data under the guardianship of the NHS (Ford et al., 2021). This issue about gaps and lack of availability of data has been reported also by an independent review conducted about 'data on mental health inpatient settings' (Gov.uk, 2024). However, recording certain types of data can be very challenging due to the complexity of making sure that people provide informed consent to their collection and use. This is the case for data about people in inpatient care. In this blog, a group of activists made a call to stop research collecting data about self-harm on patients in hospitals. The study aimed to improve safety in inpatient mental health settings by identifying what happens before the self-harm, making blurred video recording of the patients. However, the campaign noted that this study was conducted without proper consent from the participants.

Question*:* What do you think of these challenges in collecting and using data in Adult Social Care? Is there anything that surprised you? Or is there anything missing?

Using Data to Improve Services

Discussion material

The policy context across the four UK nations

Policies in relation to data for the Health and Social Care sectors across the four UK nations have strong similarities, but there are some differences, particularly in relation to Adult Social Care. In England, Wales and Scotland Adult Social Care is provided by local authorities (LAs) or councils, whereas in Northern Ireland it is the responsibility of regional Health and Social Care Trusts. Across all four nations, Adult Social Care is a "means and needs" tested service, with differences in Scotland where personal care is provided for free.

In **England**, the government's 10 year plan to reform social care was set out in the policy white paper People at the Heart of Care in December 2021. This was followed by a series of strategy and guidance documents providing detail on how this was to be achieved, including the policy paper Data Saves Lives (DHSC, 2022), and the Care Matters roadmap (DHCS, 2023). The stated aim was 'to increase the quantity and the quality of care data available' by 'joining up health and social care records and enhancing digital technologies' (DHSC, 2023). By improving the use of data and digital technologies, it is stated that this would help deliver:

- better joined up care for individuals
- more staff time to care
- greater understanding of people's care journeys
- better management of the health and care system

This was described as a "necessary first step to realising the benefits of data as an enabler for changing and improving people's lives and the care they receive" (DHSC, 2023).

Although the need for better social care data had been expressed for many years (Cooper et al., 2014; Dickson et al., 2015), it was the Covid-19 pandemic which was a driving force for developing social care policy towards digitalisation and integration of health and social care data (O'Donovan, 2023). According to O'Donovan (2023) the policy paper 'Data Saves Lives' (DHSC, 2022) and the corresponding Goldacre report on health data ('Better, broader, safer: using health data for research and analysis', 2022) formed the basis for the strategic policy proposals for adult social care data, but he argues "replicates their neglect of certain people" (p.9). The concern is that an increased integration of social care and health data will result in a dominance of health data at the expense of social care. O'Donovan (2023) argues for the need to be clear about what the data should do, and for whom, as we have the perfect opportunity to redesign social care data infrastructures, alongside appropriate safeguards and governance. However, given concerns about the sustainability of funding for social care reform, the sector needs to cultivate the political capital to support change (O'Donovan, 2023).

In **Wales**, the improvement of social care data also forms part of national reforms to care and support services. The Social Services and Well-being (Wales) Act came into force with effect from April 2016 and sets out the priorities for developing sustainable social care services in Wales. A 2020 report by Social Care Wales set out the strategy for improving social care in Wales, including the need to improve data, and a greater integration of health and social care. The increased attention to data is reflected in a National Framework for Commissioning Care and Support: code of practice (Welsh Government, 2024). The framework has seven principles, the second of which is:

> **Effective leadership is inclusive, transparent and honest**: The rebalancing of the health and social care system requires leaders and commissioners to be accountable for creating positive, learning focussed cultures. Decisions should be evidence informed and leaders should seek to continuously improve and develop digital, technological and human learning systems required to collect, share and understand evidence including impact and any unintended consequences (positive, negative and neutral), including data; with the aim of minimising data duplication (collect once, use many times).

The National Office for Care and Support (a team within the Welsh government) forms a key part of the drive for improvement by taking on "an enhanced role in data collection and reporting, turning this into intelligence which can be used in early identification of risks within the sector and to drive improvement" (Welsh Government, 2024). Wales has the SAIL Databank (Secure Anonymised Information Linkage) which is a national data safe repository of de-identified datasets principally about the population of Wales, including social care data, that is available in anonymised form to researchers across the world.

Scotland's policies for social care data are primarily defined by the Data Strategy for Health and Social Care, published in February 2023 and updated in July 2025, which outlines how to manage and secure data for better outcomes and innovation. Key initiatives also include the Health and Social Care Data Board for governance, and legislation like the Social Care (Self-Directed Support) (Scotland) Act 2013, which uses digital data to empower individuals. The overarching goal is to create a consistent, secure, and accessible system for data to support people and improve care. However, some challenges were identified to reach these goals, including lack of analytical capacity and issues of consent for data sharing (Atherton et al., 2025).

Policies for data in **Northern Ireland**'s social care sector are governed by UK-wide legislation like the Data Protection Act 2018 (incorporating GDPR - General Data Protection Regulation) and the Health and Social Care (Control of Data Processing) Act (NI) 2016, alongside specific Northern Ireland policies on data use beyond direct care. The main aims of these policies were to make sure that procedures for sharing data were clear, transparent and fair. To support the data sharing process, the Digital Strategy - Health and Social Care Northern Ireland 2022-2030 supported the implementation of a digital health and care record for each citizen. However, a report from Digital Poverty Alliance (2025) noted the strong digital divide that still persists in the country.

In all four nations we have seen a two-fold strategy which includes a push towards greater digitalisation to enable data collection, which can drive a greater integration of health and social care.

Question: Were you aware of the UK national policies about refugees and asylum seekers? Does your experiences of seeking asylum, entitlement and access to services resonate with what described in the section you have just read?

Strategies to Improve Data and Social Care

The national strategies of 1) increased digitalisation and 2) the integration of health and social care data are often presented as working hand in hand. The rationale being that by increasing digitalisation this will enable the integration of health and social care data and provide a more seamless experience for people. However for the purposes of this discussion material we will treat these two areas of focus separately.

1. The Digitalisation of Data

The 'Why'? The rationale for digitalising data

According to O'Donovan (2023) the "Covid-19 pandemic exposed long standing neglect in social care" and "this neglect cost lives". In June 2022, the Department for Health and Social Care (DHSC), together with the NHS, published a strategy document setting out the vision for digitally transformed health and social care services: A Plan for Digital Health and Social Care (2022). This stated that the "long-term sustainability of health and social care is dependent on having the right digital foundations in place". It was argued that 'going digital' would help the health and social care system to improve through four priorities: prevention, personalisation, performance and people. The stated aims were to digitalise all health records and for 80% of Care Quality Commission (CQC) registered social care providers to have digital social care records by March 2025. This increased digitalisation, it was argued, would make it easier to access information about the health and social care sectors to assist with strategic planning, commissioning care and service development, but also assist with the integration of health and social care. However, the fragmented nature of social care means that many providers are still to digitalise, with the potential for some groups to become less visible (O'Donovan, 2023). There is also a lack of consistency in the use of identifiers when gathering data making it difficult to understand the bigger picture (Burton et al., 2020).

Using Data to Improve Services

Discussion material

The 'How'? Digital Social Care Records

Software companies which create and market digital social care record systems argue that using data and also artificial intelligence (AI) can help providers to anticipate potential health and care issues, such as fall risks, which allow for early interventions and therefore produce better care outcomes (Colborne-Baber, 2025). One of the main 'selling points' for care management software is that it saves staff time, thereby freeing up time to care. In England, funding was provided to help providers reach the pledge from the People at the Heart of Care White Paper that 'by March 2024, we will ensure that at least 80% of social care providers have a digitised care record in place that can connect to a shared care record' (p. 44), effectively doubling the proportion of providers using these systems in three years. As of February 2024, it was reported that only 63% of providers had adopted digital social care records, with the target deadline date then extended by the former social care minister Helen Whately to March 2025. A further £25 million was also added to the funding to support providers registered with the regulator the Care Quality Commission to adopt digital social care records (UK Parliament, 2024).

The evidence on digital social care records is emerging. In 2021, a review was commissioned by Strategy Unit in collaboration with NHSX (Greenstock, 2021) which reported 'efficiency and productivity' benefits and improved sharing of information which helped with risk management. The review used a range of sources including academic papers (Brittain, 2020; Curtis and Brooks, 2020) and evaluations conducted by or in collaboration with digital social care record providers (Birdie, 2021; Gatawa et al., 2019). Another recent review found the evidence available did not have a consistent definition of what 'digital social care records' are (Snow et al., 2025). Other research has also found that each software system is slightly different and while some may save time recording information, some can take longer or create new tasks for care workers (Hamblin, 2020; Dewsbury and Ballard, 2015). Emerging findings from a survey-based study exploring the use of digital social care records in practice in UK homecare providers found a multitude of different systems in use, often with dissatisfaction with their design which appeared to lack input from the homecare sector regarding the realities of the context within which they are designed to be used (Healey et al., 2024). The study also identified significant costs for homecare providers who wished to change their DSCR system, as well as other hidden charges. Independent consultants Dewsbury and Ballard (2015) offer some guidance for residential care home providers when choosing a digital social care records system. They highlight the variety available with many packages consisting of core elements with add ons. They are usually made up from a number of databases, such as one for staff and one for residents, another for costs, and the challenge for some software is to get these databases to communicate effectively. Where this doesn't happen, it can mean that entries have to be duplicated in each relevant part of the system, which can create additional work for staff. This is counter to the idea of increased efficiency, and when systems are not designed with the users in mind it can mean that data is incomplete and may be meaningless.

A further problem with an increased reliance on collecting data digitally is the poor digital infrastructure. This was illustrated by the UK switchover from analogue to digital telephone services which formed the basis of many personal alarm systems, and highlighted poor internet connections and geographical disparities (Hamblin, 2020). Poor internet connectivity is particularly problematic in remote and rural areas, and hinders data collection in care settings and people's homes.

The 'What'? What data is being collected?

To harness the power of 'big data' which provides an overview of social care for policy, data often first needs to be captured at the point of care. However, as explained above, there are many companies creating the software to capture this data, with different systems and capabilities and one of the issues encountered for those driving the digitalisation is what data should be collected. Studies have found that often health data is prioritised over social care data and quality of life (Burton et al., 2020; 2022). Burton et al. (2022) undertook a study which piloted and developed a minimum data set for care homes with the aim of establishing the feasibility of extracting data directly from digital social care records (Burton et al., 2022; Gordon et al., 2025). They used existing digital software and added further measures based on validated measures of delirium, cognitive impairment, functional independence, and quality of life, which was then piloted across 45 care homes, accounting for 727 residents. They encountered several problems, not least that the care homes were reluctant to switch from their existing digital care record systems to adopt the new test systems. They also argued that there is a need to standardise digital care systems across the sector to enable data to be used more effectively, but the information governance for linking data across multiple data owners and data processors is complex and time consuming. They argue that there is still the potential for digital care records to enable data to be used more effectively across the care home sector (Gordon et al., 2025). A review of 31 papers on digital social records also found "misalignments between care practices within the social care sector and recording practices demanded by new digital systems" (Snow et al., 2025: 11), and that "Prescripted data fields limited the recording of social and emotional activities and care provision, leading to an overly clinical focus in the data" (pg. 11). In addition to what data is collected, there are questions around the quality of data, as explored below. For more discussion around technology and social care - please see this working paper from the Centre for Care.

Integration of data between Health and Social Care

As mentioned above, the drive to integrate health and social care data is a goal of policy in the four UK nations. However, health records already capture some aspects of social care such as 'social care needs' (Simpson et al., 2022). Supporters of integration argue for the need for digitalisation to be able to capture the insights from data.

In Northern Ireland (where there is a greater history of health and social care integration), Integrated Care Partnerships were established in 2013 as part of healthcare reform policy. The partnerships are made up of doctors, nurses, pharmacists, social workers, specialists,

paramedics and other professionals, as well as voluntary and community sectors, local councils, service users and carers, who co-design and coordinate the delivery of services. A review of progress (Malone and Hayes, 2017) suggested a number of improvements to care services and delivery:

- Reduced emergency department attendance and hospital admission for frail older people with over 4000 bed days avoided
- Integrated and proactive diabetes care, including enhanced foot care, resulting in a 90% reduction in minor amputations
- Ambulance crews ability to treat and refer rapid home-based care instead of conveyance to hospital
- Social prescribing and community-based integrated health and wellbeing programmes for older people
- A Nursing home In-Reach programme reducing emergency department attendances and hospital admissions for residents by a third.

It has been said that integrating health and social care funds is one way to improve care, particularly for people with complex care requirements. However, in a scoping review of integrated funds, Mason et al. (2015) found that the evidence for the link between better outcomes and lower costs was weak. They suggest that this is because a more integrated approach uncovers unmet care needs, so while this delivers improvements it is likely to lead to higher costs. This approach may still therefore offer value for money.

A further scoping review of the effectiveness of integrated approaches to care was conducted by Marques et al. (2025) by looking at broader methods of evaluation such as Social Return on Investment (SROI) approaches. Of the 11 studies identified, most were from the UK. They noted the most common mode of integration was between health settings and community activities (7 studies); two integrated health and homecare, and a further two linked health and residential care. They noted that studies often used proxies to determine cost benefits such as the number of GP appointments, but most used a combination of qualitative and quantitative data. The benefits of SROI evaluations are the inclusion of different viewpoints and data sources, but the challenges include the different methodologies which make comparisons difficult. SROI evaluations showed that studies consistently reported positive outcomes in relation to health interventions, however they conclude that there are significant gaps in the data.

Question: After reading about the strategies used across the 4 UK nations to support the collection and use of data in Adult Social Care, what are your thoughts? Are you aware of any examples of these strategies (digitalisation and integration of data) in your local area?

Using Data to Improve Services

There is an increased attention of evidence-based practice and policies in adult social care (Williams and Glasby, 2010; Nutley et al., 2019; Tawodzera and Glasby, 2024). To provide an idea of how data can support better practices, policies and service, we have collected a few **examples of how data could support better services on the practice and policy level.**

Data-Driven Decision-Making in Practice

At the practice level, data can provide an important tool to support frontline professionals' decisions. Social workers, for example, can use quantitative data from needs assessments to identify services and necessities that a particular population lacks access to, whether defined by age, income, or geographic region (BASW, 2020). This data enables them to identify gaps between a population's actual circumstances and its needs (See **Box 1 - for a case study**).

Box 1: **Case study - Reducing Challenging Behaviour of Adults with Learning Disabilities in Supported Accommodation**

A study was conducted to understand what social workers working in supported accommodation with people with learning disabilities could do to reduce the number of challenging behaviours (McGill et al., 2018). Staff in the accommodation was trained on using positive behaviour support principles, and then, this was tested in 24 homes. Data collected during this experiment showed an improvement in communication and the overall quality of life of the residents. Most importantly, there was a reduction in the number of challenging behaviours (McGill et al., 2018). Following this result, this approach has been adopted more widely by the organisations which are involved in the research to continue to test the effectiveness (BASW, 2020).

This case study used a method called **Randomised Controlled Trial (RCT)**. This method tests if an intervention works by dividing people into groups at random, with one group receiving the intervention (called 'experimental group') and another group not receiving it (called 'control group'). Researchers then compare the outcomes between the groups to see if the intervention caused a difference. This method is considered the Gold standard in Health research. However, some authors explain that Adult Social Care might require a more complex approach to understand the needs of a person and provide a more personalised support. While RCT can be very effective when testing a drug or a medical intervention, wider health and social care interventions might need a different approach to evidence what works (Williams and Glasby, 2010).

While this case study shows the importance of using evidence-based practices to improve service, critical approaches to evidence/data in Adult Social Care challenges those traditional experimental models (Nutley et al., 2019; Williams and Glasby, 2010). Swinkels et al. (2002) questioned the dominance of RTCs in Adult Social Care because the tendency to create 'standards' and protocols can fail to acknowledge the local context.

Others challenged RCTs as they are often led by academics or professionals limiting the importance of involving people with lived experience in the definition of what is data (Tawodzera and Glasby, 2024).

Question: What do you think of this first case study? After reading about RCT, do you have any comments about the critiques of traditional experimental models to collect data to improve practices?

Data-Informed Policy Formulation

At the policy-level (both nationally and locally), data has long been used to formulate public policy. Historically, social data from sources like the census were used to write and assess laws. A project run by What Works Growth (2019) looked at what data can do to develop better policies in deprived areas in England. One of the main learnings of the project was that evidence does not provide a ready "recipe" for policy but it provides principles and tools to adapt interventions locally (What Works Growth, 2019). In Adult Social Care, this meant building trust with vulnerable groups, keeping people engaged through small 'nudges', and ensuring services were delivered at the right intensity and time (What Works Growth, 2019). From this project, What Works Growth developed a guideline for local authorities to use data (see Image 1)

Image 1: What Works Growth (2019) - Six steps to better evidence-based policy

The project explains also that databases that integrate more information together can support Local Authorities and National Governments to define more focused strategies to support certain populations (What Works Growth, 2019; Hussein, 2015) (See **Box 2 - for a case study**).

Box 2: **Case study - The use of data to understand the needs of specific populations**

To support the implementation of evidence-based policies and plan support and services for certain groups, two centres have collated data from available big publicly available data set archives (e.g. Census). This effort could support the better integration of existing data for Adult Social Care. These examples are: 1) the Ageing Better Measures Framework; and 2) the Unpaid Care Dashboard

1. **The Ageing Better Measures Framework - UK (Centre for Ageing Better)**

The Ageing Better Measures Framework has been developed by the Centre for Ageing Better and it is a good example of how to bring together all data related to one policy area: ageing and later life. The framework put together 63 measures related to ageing and the aim is to provide an accessible tool for anyone who is interested in ageing-related data or evaluating ageing-related activities (What Works Growth, 2019).

The Ageing Better website describes the Framework as "a versatile tool that is useful for a variety of audiences from the private, public and voluntary sectors". Some of the potential people using it include:

- An individual or organisation working in an area to co-ordinate efforts around ageing locally looking to measure progress against objectives (for example in age-friendly communities);
- A funder aiming to ensure that funding is informed by monitoring and evaluation, therefore providing the greatest impact and value for money;
- A researcher or evaluator interested in gathering data on individual outcomes related to ageing in your projects.

2. **The Unpaid Carers Dashboard - UK (Centre for Care)**

The Unpaid Carers Dashboard has been co-created by Petrillo et al. (2025) at the Centre for Care in partnership with Carers UK, the South Yorkshire Integrated Care Board and people with lived experience of care. This interactive tool brings together data from the 2011 and 2021 England and Wales Censuses (with plans to extend this to Scotland and Northern Ireland). The co-produced and interactive nature of this tool

makes it a great example of how data can be created and used engaging all people who are involved in adult social care.

The Centre for Care webpage explains that the dashboard can be used to see which groups of people are providing unpaid care within local authorities, and compare this with other places in England and Wales. It can be used to explore patterns of unpaid care, such as gender differences, regional variations and changes over time – helping to identify inequalities and disparities within different regional areas (Carers UK, 2025). The dashboard is supported by written reports on Valuing Carers: assessing the value of unpaid care (Carers UK, 2024) and Cycles of Caring: transitions in and out of unpaid care (Carers UK, 2022)

The dashboard can be also used to see how unpaid carers as a group have changed over time – for example, how much care they provide, whether their health is better or worse, and which types of jobs they do. The dashboard also allows combining data for multiple local authorities that make up different geographical or administrative areas such as an Integrated Care Board.

To have a better understanding of the why the Unpaid Carers Dashboard is important, please watch the video clicking on this link

Question: Have you heard of any of these examples (The Ageing Measurement Framework and/or the Unpaid Carers Dashboard)? Do you think this could be a good way to improve the use of data in Adult Social Care? Why?

Summary

Data refers to a collection of facts, figures or details, and can be either quantitative or qualitative. When analysed it can be turned into information to help people make better decisions about care and support services. Adult Social Care data is often seen as of poor quality compared to health data due to fragmentation and the complexity of social care. In all four nations of the UK, Adult Social Care policies focus on increasing digitalisation and a greater integration of health and social care data. Problems of digitalisation include the poor digital infrastructure, increased staff workload, and a lack of consistency in data collected making comparisons difficult. There is also a risk that when data collection is incomplete, that this makes some groups people less visible and in turn may mean services and support developed do not adequately consider their needs. Integrating health and social care data has been criticised for focussing more on health data. There are

examples of frameworks, dashboards' and tools to help harness data related to Adult Social Care to enable people to inform data-driven policies and practice.

Having read the material above, in the first Local Network Meeting, we'd like you to discuss:

Your experiences…

- Would anyone like to share your experiences of using data, either as a person who receives support, a carer, or care service provider.

Thinking about this discussion document…

- Does anyone have any experience with any of the ways of using data mentioned here?
- Were there any ideas in this document that you thought were interesting and could help to change services?
- What do you think about the challenges identified? Was there anything missing? How might these challenges be overcome?
- Was there anything in this document that you didn't agree with, or that didn't match your experience?

Next steps…

- Are there any next steps you'd like to agree as a group? Anything you'd like to discuss?
- Do you think there is anyone else who should be involved in your meeting?
- Is there anything you need from the IMPACT team?

IMPACT Surveys

Thank you for taking part in our IMPACT Network. We'd like to know a bit more about everyone taking part, and what they hope to achieve. We have two surveys: one is to help us make sure we are being as inclusive as possible and the other is to understand what people hope to accomplish by being part of a Network. The data is anonymous and may be used for evaluation of the Networks and potentially in papers about the Networks.

You can complete our IMPACT network surveys by scanning these 'QR codes' with your phone's camera - Open your phone's camera app and point it at the QR code.

If you don't see a notification, you might need to enable QR code scanning in your phone's settings.

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