



abrdrn

Financial Fairness Trust

ReWAGE

Evidence Paper

Work, Wages and Employment in the Adult Social Care Sector

Published August 2024

Work, Wages and Employment in the Adult Social Care Sector

ReWAGE Evidence Paper

Acronyms

Acas	Advisory, Conciliation and Arbitration Service
ADASS	Association of Directors of Adult Social Services
ASC-WDS	Adult Social Care Workforce Data Set
ASHE	Annual Survey of Hours and Earnings
CQC	Care Quality Commission
DHSC	Department of Health and Social Care
FW	Fair Work
CPD	Continuous Professional Development
COSLA	Convention of Scottish Local Authorities
EHRC	Equality and Human Rights Commission
FWC	Fair Work Convention
ICB	Integrated Care Boards
MAC	Migration Advisory Committee
NLW	National Living Wage
NMW	National Minimum Wage
NA	Nursing associate
LD	Labour demand
LS	Labour supply
ONS	Office for National Statistics
RWL	Real Living Wage
SCFWF	Social Care Fair Work Forum
SFW	Scottish Fair Work
SSSC	Scottish Social Services Council
TNA	Training nurse associate

Contents

1	Introduction.....	1
2	Size and structure of the adult social care sector in the UK.....	5
3	Skills, training and development	9
3.1	Policy and regulation.....	11
3.2	Training and development in practice	14
3.3	Challenges	15
3.4	Career progression: flat organisations	15
3.4.1	Funding.....	16
3.4.2	Training infrastructure	17
3.5	Workforce profile.....	18
3.5.1	Fragmented and uneven playing field	19
3.6	Current and future skill needs	19
4	Wages	22
4.1	Brief economic analysis of the labour shortage in the care market	23
4.2	Eroding pay differentials compared to other sectors	25
5	Work, working conditions and wellbeing	32
6	Recruitment and retention	38
6.1	Reasons for recruitment challenges.....	40
6.2	Strategies to help address recruitment challenges	41
6.3	The extent of retention challenges	42
6.4	Implications for care quality.....	43
6.5	Where do leavers go?.....	43
6.6	Reasons for leaving and measures to help increase retention.....	44
6.7	UK evaluations of recruitment and retention measures in social care.....	46
7	Unpaid and informal carers.....	47
8	Fair Work and other key adult social care reforms in the four UK nations	53
8.1	Devolution and social care	53
8.1.1	Migration Regime.....	53
8.1.2	Employment Regime.....	54
8.2	Implementing Fair Work in Scotland, Wales and Northern Ireland.....	55
8.2.1	Scotland.....	55
8.2.2	Wales.....	58

8.2.3	Northern Ireland.....	60
8.3	Social dialogue and employee voice in the social care sector	61
8.4	Funding reforms in England impacting the adult social care workforce	65
8.4.1	Market Sustainability and Fair Cost of Care Fund	65
8.4.2	Vision of a National Care Service	68
9	Recommendations.....	69

1 Introduction

Adult social care supports adults who experience physical or mental illness, are frail or have a disability in settings a range of settings, including domiciliary care, residential care, nursing care, supported living or day care, to enable them to continue to live as independently as possible in a safe environment. The adult social sector has received increased media attention following the outbreak of the Covid-19 virus as the residential care sector was particularly impacted by the Covid-19 pandemic. The outbreak also shone more light on the paid care workforce with reports about paid care workers selflessly supporting vulnerable services users in the most difficult circumstances. Despite the size of the adult social care workforce, which is larger than the NHS workforce, most of the care is provided by unpaid carers, with a new study putting an annual value of £162 billion on the services they provide in England and Wales.¹ The sector continues to experience challenges, that affect stakeholders, including the paid care workforce, informal carers and care providers. There are reports that current workforce capacity constraints affect care service supply and impact service delivery² and therefore those receiving care services. Some of these challenges facing the sector have been exacerbated as a result of Brexit creating pressure on labour supply, placing high demands on the workforce.

Health and social care is one of the policy areas devolved to the political administration in Scotland, Wales and Northern Ireland, with different care models and regulations having evolved.³ Despite the devolution, the workforce challenges in terms of recruitment and retention in the four home countries are similar due in large part to low pay and poor terms and conditions.⁴

Addressing workforce challenges is expected to become even more pressing in future as demand for care services is expected to rise due to the ageing of society and the related increase in people with co-morbidities and chronic conditions.⁵ The demand for care workers⁶ is projected to grow by around 13% between 2021 and 2035⁷ And

¹ Carers UK (2023) *Valuing Carers 2021. England and Wales*. Authors Maria Petrillo and Matt Bennett. Available [here](#).

² See for example, Care Quality Commission (CQC) (2022a) *The state of health care and adult social care in England 2021/22*. Available [here](#).

³ Needham, C. and Hall, P. (2020) *Social Care in the UK's Four Nations. Between Two Paradigms*. Bristol: Bristol University Press.

⁴ Dodsworth, E. and Oung, C. (2023) *What does the social care workforce look like across the four countries? (Blogpost)*. Available [here](#).

⁵ Skills for Care (2021) *The State of the Adult Social Care Sector and Workforce in England, 2021*. Available [here](#); Wass, V. (2022) The market for social care, carers' wages, aging population and fiscal risks, unpublished manuscript. Mental health issues have been on the rise during the Covid-19 pandemic, including at the workplace. A recent report stated 'growing concern regarding the rise of mental health conditions in older age' ([Chief Medical Officer \(2023\)](#): 8), yet there is lack of data on age specific mental health rates for projections ([Emerson et al. 2012](#), cited in [Hu, Hancock and Wittenberg, R. \(2020\)](#)).

⁶ This refers to Standard Occupational category 6315 (care workers and home carers).

⁷ Wilson, R., Bosworth, D., Bosworth, L., Cardenas-Rubio, J., Day, R., Patel, S., Bui, H., Lin, X., Seymour, D., and Thoung, C. (2022). *The Skills Imperative 2035: Occupational Outlook - Long-run employment prospects for the UK, Baseline Projections*. Working Paper 2a. Slough: NFER. Available [here](#)

projections for the adult social care workforce to 2035 using a different model estimate a 25% base line increase.⁸

Publicly funded social care will only be provided to those with the highest needs and the lowest financial assets.⁹ Those who do not meet the eligibility criteria need to self-fund their own care. Experimental estimates suggest that 37% of all care home residents are self-funders¹⁰ with figures on domiciliary care likely to be lower than that.¹¹ Local authority commissioned care is highly dependent on public funding and has thus been impacted by public sector austerity measures following the 2007/08 economic crisis.

The adult social care sector consists of a mix of private, not for profit and public providers. The large majority are small and medium sized organisations operating locally or regionally and on the other end of the spectrum there are also large providers operating nationally. Due to the marketisation and privatisation, by far most of the services are now provided by private and not for profit providers, with local authorities commissioning publicly funded services from these providers through different procurement schemes and contracts, offering different levels of pricing and planning security. There is little to no flexibility in negotiating service fees with local authorities as they operate within a budget largely determined by central government. This then has important implications for the pay and the type of contract private and non-profit providers offer their staff.

More recently, the substantial increase in the cost of utilities added to the financial pressure of care home providers.¹² However, there is also scepticism among local authority care commissioners as to whether higher service rates paid to providers will improve outcomes for staff and services users.¹³ There is also some evidence suggesting that too strong a focus on profit margins for investors can impact working conditions negatively, including e.g. overtime pay, and quality of care.¹⁴

In addition to publicly funded care services people can privately buy care services at a higher rate than local authority funded care as the price is entirely determined by the provider. These higher rates are often used by providers to cross-subsidise lower local authority funded care services. This helps providers with their bottom line as local

⁸ Skills for Care (2023) The state of the adult social care sector and workforce in England. Available [here](#).

⁹ King's Fund (2023). Social care in a nutshell. Available [here](#).

¹⁰ ONS (2023) *Care homes and estimating the self-funding population, England: 2022 to 2023*. Available [here](#).

¹¹ ONS (2022) Estimating the size of the self-funding population in the community, England: 2021 to 2022. Available [here](#). A figure of 26% was reported here.

¹² See for example, Hft and Care England Analysis by CEBR (2023) *Sector Pulse Check A snapshot of finances and workforce in the adult social care sector in 2022*. Available [here](#).

¹³ Jefferson, L. , Cream, J., Birks, Y., Bloor, K. and Murray, R. (2017) *Adult Social Care Local Authority Commissioning Behaviours*. Available [here](#).

¹⁴ Corlet Walker, C., Kotecha, V., Druckman, A. and Jackson, T (2022) *Held to ransom: What happens when investment firms take over UK care homes*. CUSP Working Paper Series, No 35. Guildford: Centre for the Understanding of Sustainable Prosperity. Available [here](#).

authority funded services do not fully cover the costs, as different reports show.¹⁵ Yet this arguably places an unfair burden on self-funders. The Fair for Care Fund, set up by the government in England in 2021/21, seeks to address this, providing funding to local authorities to be able to pay higher locally determined fees to help stop the cross-subsidising practice by 2025, yet questions have been raised as to whether these funds will be sufficient and what funding commitment will be put in place beyond 2025.

Care services are regulated in all four home countries by the Care Quality Commission (England), the Care Inspectorate Wales, the Care Inspectorate (Scotland) and the Regulation and Quality Improvement Authority (Northern Ireland). This means inspections are conducted on a regular basis to assess the quality of care provided and, if necessary, how the service needs to improve, with findings being publicly reported and the quality of services having high visibility on the regulator's website. While Scotland, Wales and Northern Ireland have set up a register for social care staff there is no register in England¹⁶, except for social workers and nurses who are registered with their respective professional body.

Given cumulative and likely intense future pressures on adult social care, and the depleted and uncertain organisational capacity to address them, not least in workforce terms, this paper seeks to review the most recent evidence on work, wages and employment in adult social care¹⁷ in the UK, drawing on an analysis of published articles and grey literature.

Adult social care services are labour-intensive, largely reliant on the direct and unmediated relationship between the worker and services user. The structure and state of the adult social care workforce is therefore crucial to the nature and quality of services both now and in the future. The report looks at adult social care in the four UK home countries with a slight emphasis on England due to greater availability of workforce data.

Following an overview of the size and structure of the adult social care sector in the UK (section 2), the evidence paper outlines the nature and extent of skills, training and development in the sector and discusses key challenges for training and skills development (section 3). It then focuses on wages with trends showing eroding pay differentials compared to other sectors (section 4), and research on working conditions

¹⁵ The King's Fund (2018) *Approaches to social care funding. Social care funding options*. Authors: Lillie Wenzel, Laura Bennett, Simon Bottery, Richard Murray and Bilal Sahib. Available [here](#); Jarrett, T. (2018) *Social care: care home market – structure, issues, and cross-subsidisation (England)*. Briefing paper. Available [here](#); The Care Provider Alliance (2022) *The State of Social Care and Support Provision in England - Care Provider Alliance briefing*. Available [here](#).

¹⁶ Dodsworth, E. and Oung, C. (2023) *What does the social care workforce look like across the four countries?* (Blogpost) <https://bolt.nuffieldtrust.org.uk/public/news-item/what-does-the-social-care-workforce-look-like-across-the-four-countries>.

¹⁷ Social care comprises adult and children's social care. The focus of this paper is on adult social care, as the larger of the two sub-sectors (with around 838,530 adult service users receiving long-term care in England in 2019/2020 ([Kings Fund](#)) and 80,850 looked after children in 2021 receiving care ([Competition and Market's Authority](#))), which continues to dominate public discussions at times. Children's social care, however, is also experiencing pronounced workforce challenges, particularly among social workers, as the recent independent review (MacAlister, 2022) and the government response (Department for Education, 2023) demonstrate.

in adult social care, particularly in terms of insecure work and work experiences during the Covid-19 pandemic (section 5). Section 6 reviews the evidence on the extent of and reasons for recruitment and retention challenges among the paid workforce. Given the important roles informal carers play in the adult social care sector section 7 looks at their contribution and experiences. With the UK having devolved social care to the four UK nations different models of care and different ways of addressing workforce challenges have developed and continue to develop, with section 8 exploring Fair Work and other adult social care reform debates in the four UK countries. The evidence paper concludes with recommendations (section 9).

2 Size and structure of the adult social care sector in the UK

A UK study estimated that in 2016 there were 1.8 million jobs in adult social care representing around 6% of the UK's workforce.¹⁸ This figure includes 151,300 jobs provided by individual employers who received direct payments from the local authority to arrange their own care services and are employing personal assistants. It is estimated that the adult social care sector contributed £46.2 billion gross value added (GVA) per annum to the UK economy in 2016, including £24.3 billion direct contribution through the wage bill, equating to 1.4% of GVA.¹⁹ Updated estimates for England in 2022/23 report that adult social care contributions to GVA increased to £55.7 billion (up from £38.5 billion in 2016), including £26.6 billion from wage bills (up from £20.3 billion in 2016).²⁰ These figures suggest that the direct wage contributions increased at a lower rate than the other contributions arising from the purchase of intermediate goods and services from the adult social care sector and purchases made by those directly and indirectly employed in the adult social care sector.

The adult social care sector comprises a number of distinct settings and forms of provision. Direct state provision of care has historically occurred alongside services provided by independent organisations, the latter including both private and non-profit (voluntary or third sector) organisations.²¹ Over the last 30 years, there has been a process of marketisation in adult social care in England, Scotland and Wales, one outcome being a decline of 'in-house' state-provided care²² with the majority of residential and domiciliary care now being outsourced. Commissioning, and the promotion of markets in care, play key roles in the sector, with more recent developments including a rise in the individual purchasing of care²³ giving individuals choice over their care service through a local authority.

¹⁸ ICF (2018a) *The Economic Value of the Adult Social Care sector – UK*. Final report. Available [here](#).

¹⁹ ICF (2018a), op. cit.

²⁰ Skills for Care (2023) *The State of the Adult Social Care Sector and Workforce in England*. Available [here](#).; ICF (2018b) *The Economic Value of the Adult Social Care sector – England*. Final report. Available [here](#).

²¹ Cunningham, I., Baluch, A. Cullen, A. and James, P. (2018) *Implementing the Scottish Living Wage in adult social care: An evaluation of the experiences of social care partners, and usefulness of Joint Guidance*, Coalition of Care and Support Providers Scotland. Available [here](#); Kessler, I. Bach, S. Griffin, R. and Grimshaw, D. (2020) *Fair care work A post Covid-19 agenda for integrated employment relations in health and social care*, Kings College London COVID-19 Research Impact Paper, <https://www.kcl.ac.uk/business/assets/PDF/fair-care-work.pdf>; National Audit Office (2021) [The adult social care market in England \(nao.org.uk\)](#).

²² Bessa, I., Forde, C. Moore, S. and Stuart, M. (2013) *The National Minimum Wage, earnings and hours in the domiciliary care sector*. Low Pay Commission. Available [here](#); Cunningham, I. and James, P., 2009. The outsourcing of social care in Britain: what does it mean for voluntary sector workers? *Work, Employment and Society*, 23(2), pp.363-375; Rubery, J., Grimshaw, D., Hebson, G. and Ugarte, S.M. (2015) "It's all about time": Time as contested terrain in the management and experience of domiciliary care work in England. *Human Resource Management*, 54(5), pp.753-772.

²³ Bessa, I., Forde, C., Moore, S. and Stuart, M. (2013) *The National Minimum Wage, earnings and hours in the domiciliary care sector*. Low Pay Commission. Available [here](#); Malbon, E., Carey, G. and Meltzer, A., 2019. Personalisation schemes in social care: are they growing social and health inequalities? *BMC Public Health*, 19, pp.1-12; National Audit Office (2021) [The adult social care market in England \(nao.org.uk\)](#).

Services provided by private and voluntary sector providers are undertaken under contracts, organised through commissioning processes at local authority level, underpinned by a national level regulatory framework.²⁴ The state is the biggest purchaser of care²⁵ and dominates the market, acting as a de facto price setter for care.²⁶ Work and employment in adult social care then typically involves a complex four-way relationship, involving workers, providers of care, a local authority, along with the ‘user’ or consumer of care.²⁷

In 2022/23, there were around 18,000 registered care enterprises in **England** (with 41% providing residential care and 59% non-residential care) and 39,000 care establishments, including local units (equally distributed across residential and non-residential care services)²⁸. In the same period, over 835,000 people received local authority funded long-term care: nearly 545,000 community care (with 42% being of working age) and around 250,000 residential care (with 17% being of working age and 83% being 65 and over). In addition, more than 250,000, received short-term care from local authorities in the same year, largely people aged 65 and over (88%)²⁹. In terms of the workforce, there were 1.635 million filled adult social care jobs in England in 2022/23 (compared to a headcount of 1.43 million in the NHS³⁰), with most of these jobs being in domiciliary care (43%) and residential care (41%), and the remainder being in community care (14%) and day care (2%). Most of the jobs provide direct care (76%), with 7% being managerial roles, 5% of jobs being undertaken by regulated professions (social workers, registered nurses, occupational therapists, and allied health professionals) and 13% consisting of a range of other jobs not providing personal care (including administrative posts, catering, cleaning, transport and maintenance roles.³¹

As indicated in Table 1 below, there are marked similarities in the personal characteristics of the adult social care or the social care workforces in the countries

²⁴ Cunningham, I., Baluch, A., Cullen, A. and James, P. (2018) *Implementing the Scottish Living Wage in adult social care: An evaluation of the experiences of social care partners, and usefulness of Joint Guidance, Coalition of Care and Support Providers Scotland*. Available [here](#); Kessler, I., Bach, S., Griffin, R. and Grimshaw, D. (2020) *Fair care work A post Covid-19 agenda for integrated employment relations in health and social care*, Kings College London Covid-19 Research Impact Paper, <https://www.kcl.ac.uk/business/assets/PDF/fair-care-work.pdf>.

²⁵ Cunningham, I., Baluch, A., Cullen, A. and James, P. (2018), op. cit.

²⁶ Grimshaw, D., Rubery, J. and Ugarte, S.M. (2015) Does better quality contracting improve pay and HR practices? Evidence from for-profit and voluntary sector providers of adult care services in England. *Journal of Industrial Relations*, 57(4), pp.502-525;. Rubery, J., Grimshaw, D., Hebson, G. and Ugarte, S.M. (2015) “It’s all about time”: Time as contested terrain in the management and experience of domiciliary care work in England. *Human Resource Management*, 54(5), pp.753-772; <https://www.napier.ac.uk/research-and-innovation/research-search/projects/career-trajectories-of-nurses-in-scotland-20012011>; Wass, V. (2022) The market for social care, carers’ wages, aging population and fiscal risks, unpublished manuscript.

²⁷ Rubery, J., Grimshaw, D., Hebson, G. and Ugarte, S.M. (2015), op. cit.

²⁸ Skills for Care (2023), op. cit.

²⁹ NHS Digital (2024) Adult Social Care Statistics in England: An Overview. Available [here](#).

³⁰ NHS Digital (2023) NHS Workforce. Statistics - February 2023 (Including selected provisional statistics for March 2023. Available [here](#).

³¹ Skills for Care (2023), op. cit.

comprising Great Britain. The workforces in all three countries are highly feminized, experienced - with a mean age in the mid-40s - and ethnically diverse, albeit slightly less so in Wales.

More specifically, the majority of the adult social care workforce in **England** are female (81%), and 23% of the workforce are Black/African/Caribbean/Black British ethnic minority / Asian / Asian British, and 19% of the workforce are non-British.³² Six per cent of the workforce are from the EU and 13% from outside the EU.³³ The proportion of workers in social care from the EU has declined since 2016 with the proportion from outside the EU increasing.³⁴ There are marked differences in the UK geographic spread of adult social care staff with an ethnic minority background and those born outside of the UK, largely reflecting the percentage of the population in this area. London has the highest share of ethnic minority staff among the social care workforce and the lowest share is found in the North East. Similarly, London has the highest share of non-British staff among the social care workforce, and the northern areas of England having the lowest share.³⁵

Table 1: Size and demographics of the (adult) social care workforce (estimated figures)

Workforce and demographics	England (adult social care) ¹	Scotland (adult social care) ²	Wales (social care) ³	Northern Ireland (social care) ⁴
Number of jobs/people	1.62 million adult social care jobs	134,640 (2020)	84,134 (2022)	44,000 ⁵
Percentage of women	82%	80%	82%	n/a
White	77%	69%	94.5%	n/a
Age	Average age 42.5	Average age 46	Not available in this format	n/a

Legend: Comparative data across the UK home countries are difficult to obtain as they are collected by different agencies and reported in different formats, and for example in Northern Ireland workforce figures are generally reported for the health and social care workforce combined.

¹ Skills for Care (2022) [The State of the Adult Social Care Sector and Workforce in England 2022](#).

² Scottish Government (2022) [The Adult Social Care Workforce in Scotland](#)

³ Social Care Wales (2022) [Social care workforce report 2022](#).

⁴ Detailed data not available as data are reported for health and social care combined.

⁵ <https://www.health-ni.gov.uk/news/adult-social-care-recruitment-campaign-launched>

³² Skills for Care (2023), op. cit.

³³ Alberti, G. and Dolezalova, M (2021) *Sector overview, Labour Mobility in Transition Project*, CERIC, University of Leeds, Available [here](#).

³⁴ Sumption, M., Forde, C., Alberti, G. and Walsh, P.W. (2022) *How is the end of free movement affecting the low-wage labour force in the UK?: ReWAGE and Migration Observatory Report*, August 2022. https://warwick.ac.uk/fac/soc/ier/rewage/publications/labour_shortages_paper_final.pdf; Alberti, G. and Dolezalova, M (2021). Op. cit.; Portes, J. and Springford, J. (2023) The impact of the post-Brexit migration system on the UK labour market, *Contemporary Social Science*, Early view. Available [here](#).

³⁵ Skills for Care (2023), op. cit..

The **Scottish** adult social care workforce in 2020 was estimated to be at least 134,640, with 43.5% being employed in the private sector, 34% in the voluntary sector and 22.5% in the public sector. The gender profile of the workforce remains heavily female at 80%, compared to 17% male (and 3% unknown). This gender imbalance is reflected in working hours. Sectors with large proportions of women generally have large numbers of part-time workers.

The Scottish adult care sector has 47% of its workforce on part-time contracts, with 53% full-time. The sector is largely white in terms of ethnic classification (at least 69%) while 2% are Asian and 1% black and 27% are unknown.³⁶

Overall, more than 84,000 people worked in social care in **Wales** in 2022. Residential care for adults is the largest employer, followed by domiciliary care, with a combined total of around 50%.³⁷ Approximately, two-thirds of the workforce are employed in private or non-profit services. Eighty per cent are employed on permanent contracts and 50% are employed on contracts of 36 or more hours a week.³⁸ Eighty-two per cent of this workforce are female and 18% male and in terms of its ethnic profile, 95% of the social care workforce are white.³⁹

Figures for **Northern Ireland** are more difficult to determine in terms of workforce numbers. It was estimated in 2016 that there were 38,500 jobs, with around 44,000 having been registered as care workers in 2021.⁴⁰ Fifty-four per cent of the workers in the residential social care sector work full-time (46% work part-time), and 57% in the non-residential social care sector work full-time (43% work part-time). As with Scotland, we are able to break employment down according to type of ownership. The largest proportion of these are based in private sector service providers (56%), with 27% working in the public and 19% in the voluntary sector.⁴¹

In 2018, the entire health and social care workforce in Northern Ireland was estimated to be 122,560⁴², including an estimated 31,000 'social care workers' and 6,100 social workers. There are also approximately 21,000 nurses and midwives of which some of the former may be employed in social care.

³⁶ Scottish Government (2022) The adult social care workforce in Scotland. Available [here](#).

³⁷ Social Care Wales (2022) *Social Care workforce report 2022*. Available [here](#).

³⁸ Social Care Wales (2022) *Social Care workforce report 2022*. Available [here](#).

³⁹ Social Care Wales (2022) *Social Care workforce report 2022*. Available [here](#).

⁴⁰ <https://www.health-ni.gov.uk/news/adult-social-care-recruitment-campaign-launched>.

⁴¹ Kearney, J. and White, A. (2018) *The Economic Value of the Adult Social Care sector - Northern Ireland*: Final report. ICF Consulting, London.

⁴² Department of Health (2019) *Health and Social Care Workforce Strategy 2026*. Department of Health, Stormont Estate, Belfast.

3 Skills, training and development

The adult social care workforce comprises a broad spectrum of skills as a means of providing services to community members with varied and increasingly complex needs and conditions. This span of skills is reflected in the occupationally diverse nature of the adult social care workforce, including work roles which range from graduate professions (including nurses and therapists in care homes and social workers mainly employed in local government) to lesser qualified workers often characterised as 'lower skilled'. The numerical balance in the workforce is, however, heavily weighted towards those considered lower skilled, typically providing direct care in roles variously titled care assistant, care worker, senior care assistant and team leader. The most recent figures indicate that of the 1.6 million adult social care jobs in England, over 1.2 million jobs are in direct care roles, with only around 81,000 being in regulated professions.⁴³

There has been much debate about the nature and the value of the skills required from and provided by those in direct social care roles. Overwhelmingly performed by women⁴⁴, some commentators have viewed care skills as tacit and drawn from their provision in a domestic context. It has been argued that such skills are often instinctive and 'natural', less open to or in need of development.⁴⁵ Indeed, the presentation of care skills in this way has arguably contributed to their undervaluation, not least in pay terms.⁴⁶ However, others have viewed care work, invariably resting on direct and intricate forms of social interaction, and the management of both the employee's and care recipient's emotions, as highly skilled work.⁴⁷ Indeed the 'heroic' contribution made by carers in social care settings during the Covid-19 pandemic has been viewed as bringing to the fore the skilled nature of care work, as well as the stresses and demands associated with it⁴⁸. It has been suggested that greater societal value needs

⁴³ Skills for Care (2023) *The state of the adult social care sector and workforce in England*. Available [here](#).

⁴⁴ Skills for Care (2023), op. cit.

⁴⁵ Payne, J (2009) Emotional labour and skill: a reappraisal. *Gender, Work and Organization* 16(3): 348–367.

⁴⁶ Barron, D. and West, E. (2013). The financial costs of caring in the British labour market: Is there a wage penalty for workers in caring occupations? *British Journal of Industrial Relations*, 51:1.; England, P., Budig, M. and Folbre, N. (2002). Wages of Virtue: The relative pay of care work, *Social Problems*, 49:4.

⁴⁷ Bolton, S. (2004) Conceptual confusions: emotion work as skilled work. In: Warhurst, C. et al. (eds) *The Skills That Matter*. Basingstoke: Palgrave Macmillan; Cranford, C. and Miller, D. (2013) Emotion management from the client's perspective: the case of personal home care, *Work, Employment and Society*, 27:5.

⁴⁸ Gordon, A. (2021). *Caring for our most vulnerable: lessons from COVID-19 on policy changes in the care home sector*. OUP blog. Retrieval at: <https://blog.oup.com/2021/10/caring-for-our-most-vulnerable-lessons-from-covid-19-on-policy-changes-in-the-care-home-sector/>.

Kierkegaard, P., Micocci, M., McLlster, A., Tulloch, J.S.P., Parvulescu, P., Gordon, A.L. and Buckle, P. (2021). Implementing lateral flow devices in long-term care facilities: experiences from the Liverpool COVID-19 community testing pilot in care homes – a qualitative study. *BMC Health Services Research*, 21: 1153. <https://doi.org/10.1186/s12913-021-07191-9>.

Manthorpe, J., Iliffe, S., Gillen, P., Moriarty, J., Mallett, J., Schroder, H., Currie, D., Ravalier, J., and McFadden, P. (2021). Clapping for carers in the Covid-19 crisis: Carer's reflections in a UK survey. *Health and Social Care in the Community*: 1-8, [tps://doi.org/10.1111/hsc.13474](https://doi.org/10.1111/hsc.13474).

to be placed on the typically under rewarded and unrecognised 'life making and sustaining skills' displayed by care workers.⁴⁹

Skills for Care⁵⁰ identified four core skills in care work: English, numerical, employability and digital skills. The former two are self-explanatory. Employability skills relate to team working, problem solving and learning. However, it is the digital skill set which has been attracting increasing attention in adult social care.

The introduction of digital technology in care work has largely been driven by efficiency savings and the well documented Taylorisation of care work through standardising tasks and work intensification.⁵¹ The Covid-19 pandemic has injected uncertainty into the debate concerning digital care skills, and whether this has brought greater recognition and reward of workforce skills. During the Covid-19 pandemic, care staff became more reliant on digital technologies to undertake their work.⁵²

The use of digital technology in care is widespread but mixed in terms of its use on front-line services. Consumer digital technology was increasingly part of the range of devices available to support care. Workers reportedly have a variable awareness of, and knowledge regarding, the application of care specific digital technology. Nevertheless, employees are reportedly keen to engage, as part of their career progression, and the Covid-19 pandemic has increased opportunities to develop digital skills, especially in communications technology.⁵³

A recent qualitative study reveals further concerns and doubts regarding whether the Covid-19 pandemic has led to the expansion of promising practices and workforce engagement with digitalisation. Yet workforces continue to not be included in decision making processes regarding the appropriateness of forms of digital innovations to particular care contexts. Instead, in keeping with the low value ascribed to care workers in society, their great ability (or even agility) to learn and adopt new digital skills has been undervalued and normalised by managers as just a necessary and

Marshall, F., Gordon, A., Gladman, J.R.F. and Bishop, S. (2021). Care homes, their communities, and resilience in the face of the COVID-19 pandemic: interim findings from a qualitative study. *BMC Geriatrics*, 21, 102.

⁴⁹ Farris, S. and Bergfeld, M. (2022) Low-skill no more! essential workers, social reproduction and the legitimacy-crisis of the division of labour *Distinktion: Journal of Social Theory*, 23 (2–3), 342–358.

⁵⁰ Skills for Care (not dated). What core skills do I need to work in social care? Available [here](#).

⁵¹ Hester, H. (2018) *Care under capitalism: The crisis of "women's work"*. IPPR Progressive Review, 24:343-352; Rubery, J., Grimshaw, D., Hebson, G. and Ugarte, S.M. (2015) "It's All About Time": Time as Contested Terrain in the Management and Experience of Domiciliary Care Work in England. *Human Resource Management*, 54: 753-772; Hayes, L. J. B. and Moore, S. (2017) Care in a Time of Austerity: the Electronic Monitoring of Homecare Workers' Time. *Gender, Work & Organization*, 24: 329– 344; Macdonald, F., Bentham, E., and Malone, J. (2018) Wage theft, underpayment and unpaid work in marketized social care. *The Economic and Labour Relations Review*, 29(1), 80–96.

⁵² IPSOS Mori (2021) *NHSX Adult Social Care Technology and digital skills review*. IPSOS Mori on behalf of Institute of Public Care and Skills for Care. London.

⁵³ IPSOS Mori (2021), op. cit.

expected part of the job. The results further consolidate how the work of a low status, largely female workforce goes unrecognised and unappreciated by their employers.⁵⁴

As already implied, the increasing complexity and acuity of social care needs also requires a deepening and broadening of clinical skills within the workforce, alongside the longstanding 'softer' skills associated with care work, such as communication, empathy and others covered by the Skills for Care employability skill set. The scope of practice for direct care workers is already quite broad, particularly in residential care homes, without the presence of the registered nurse as part of the workforce. In most care settings, however, the issue of upskilling the workforce to meet new and increasing care and clinical demands is emerging. Research also shows that the use of technology, such as robotics, can impact skill use of care workers as an element of valued human interaction is being replaced by new technology focused tasks, impacting their quality of work.⁵⁵

3.1 Policy and regulation

The regulatory and policy framework for skills development and training for the adult social care workforce is uneven and fragile. The relatively small numbers in professions in the sector are subject to statutory frameworks regulating their registration and administered by various regulatory bodies: for nurses, the Nursing and Midwifery Council (MNC), therapists the Health and Care Professions Council (HCPC) and social workers, Social Work England (and Social Care Wales, Northern Ireland Social Care Council and Scottish Social Services Council). In requiring re-validation this relatively tight form of regulation necessarily generates a training agenda in the form of continuing professional development. The Care Quality Commission (CQC) also has a model of registration for managers as a requirement of its care home registration procedure. Based on the acquisition of a Level 5 Diploma in Leadership and Management in Adult Care, this form of registration is not, however, predicated on revalidation, with ongoing personal development therefore a much weaker requirement.

For direct carers, as stressed the core of the adult social care workforce, the regulation of skills development and training is much lighter touch. Training and development requirements are set out in the 'Health and Social Care Act 2008 (Regulated Activities) Regulations 2014' and used by the CQC to inspect and categorise registered adult social care (and health care) providers. To meet Regulation 18, which covers staffing:

'Providers must provide sufficient numbers of suitably qualified, competent, skilled, and experienced staff to meet the needs of the people using the service at all times.'

The regulation continues:

⁵⁴ Baluch, A., Briken, K. and Cunningham, I. (2023) "*They all know how to use their phones at home!* Normalising and undervaluing digital skills in complex social care work". Paper to 41st International Labour Process Conference: Fair Work in the Global Economy?. Glasgow 12th – 14th April, 2023.

⁵⁵ Hamblin, K.A. (2022) Technology in care systems: displacing, reshaping, reinstating or degrading roles? *New Technology, Work and Employment*, 37,41–58. <https://doi.org/10.1111/ntwe.12229>.

‘Staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities.’

Broadly framed to cover providers in both health and social care the formulation of Regulation 18 gives rise to debate on whether and how training and development practices are viewed by the CQC and assessed for regulatory purposes. The CQC does provide guidance on how its regulatory requirements can be met⁵⁶ including: a ‘systematic approach’ to assessing skill mix; the provision of an induction programme; ‘regular’ reviews of training and performance; and ‘support’ for staff seeking to acquire ‘appropriate’ qualifications. However, such criteria lack substantive precision, with scope to explore in greater detail how such staffing requirements have in practice been applied by social care providers and administered by the CQC in their inspections.

The light touch nature of workforce training and development in social care is reflected in the application of the Care Certificate. Introduced in 2015 on the recommendation of the Cavendish inquiry⁵⁷, the Care Certificate is an induction programme for all service user-facing workers in both social care and healthcare. Sitting alongside the requirement for mandatory training on the basics of the work role, for example related to manual handling and health and safety, the Care Certificate rests on a new (or existing) care worker meeting 15 care standards. These derive from but broaden a former set of common induction standards which can be traced back to the requirements of the Care Standards Act, 2000.⁵⁸

The Care Certificate is not, however, mandatory. The CQC ‘support and expects to see the Care Certificate being used by providers’.⁵⁹ However, this ‘expectation’ might be seen to reflect a view that the Care Certificate model is the ‘best’ way to meet its Regulation 18 guidance on the need for an induction programme, rather than necessarily being the only way to achieve it.

In recent years national policymakers and practitioners have placed increasing emphasis on the need to train and develop the social care workforce. This emphasis is most clearly reflected in the last UK Government’s White Paper on adult social care ‘People at the Heart of Care’.⁶⁰ which had as its leading staff priority the establishment of a ‘well-trained and developed workforce.’ In the context of the White Paper, the aim was to deepen the skills needed to deliver ‘person centred care’ and meet new digital challenges in care delivery. More prosaically, it might be seen as a response to the skills gap in the sector. The lack of universal accreditation and the fragmented nature of the care workforce, together with the diverse client needs make the skills gap difficult to assess. What is clear is that the overall labour shortages in the sector result in many

⁵⁶ [Regulation 18: Staffing - Care Quality Commission \(cqc.org.uk\)](https://www.cqc.org.uk/publications/regulation-18-staffing).

⁵⁷ [The Cavendish Review \(publishing.service.gov.uk\)](https://www.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414447/cavendish-review.pdf).

⁵⁸ Gospel, H. and Lewis, P. (2011) Who cares about skills? The impact and limits of statutory regulation on qualifications and skills in social care) *British Journal of Industrial Relations*, 49:4, 601-622.

⁵⁹ [Our position on the Care Certificate - Care Quality Commission \(cqc.org.uk\)](https://www.cqc.org.uk/publications/our-position-on-the-care-certificate).

⁶⁰ Department for Health and Social Care (DHSC) (2021). People at the Heart of Care: adult social care reform, p. 68. Available [here](#).

providers operating at below the recommended staffing levels⁶¹ posing major challenges to the workforce, with unfilled posts resulting in intensification of work, and further undermining organisations' capacity to train and develop staff. One local authority is reported with serious concerns, including staff unable to prepare food because they had not completed the food safety aspect of training (a key feature of basic training) and the lack of relevance of the general training to the services provided.⁶² The authors concluded that training quality was variable, with little provision standardised or accredited. Interestingly, the one area of development that attracted confidence was the supply of compulsory equality and diversity training.

The possibility of training, especially linked to career development, has been seen by policy makers as a way of attracting new staff and keeping existing ones, which in turn is assumed to promote improved care quality. As the Department for Health and Social Care (DHSC) has noted in relation to the adult social care workforce:

'Good-quality learning and development, and opportunities for staff to consolidate skills and experience and develop their careers, helps to retain skilled people with the right values, which can have a significant impact on the quality of care and support people receive.'⁶³

Whether the last UK Government's White Paper proposals for England would have delivered the aim of a well-trained and developed workforce is open to debate. The proposals lacked specificity and remained largely centred on the professions. The White Paper committed to the development of a new Knowledge and Skills Framework and Career Structure for social care without providing details on the substantive knowledge and skills to be captured by it. Continuous Professional Development (CPD) budgets were proposed for registered nurses, nursing associates, occupational therapists, and other allied health professionals, and for investment in social worker training routes. There was little, if any, mention of CPD or training routes for the bulk of the workforce delivering direct care. The White Paper proposed £500 million 'to transform the way we support and develop the workforce' but was then halved to £250 million in an initial tranche of finance to provide support for the implementation of these plans.⁶⁴

Decisions around the Adult Social Care Training and Development Fund were paused with the announcement of the general election. The new UK Government has announced that it will discontinue the Fund due to pressures on public finances.⁶⁵

⁶¹ Institute of Health Care and Management (2021) cited in Luijnenburg et al. (2022). Luijnenburg, O., Manthorpe, J. and Samsi, K. (2022). Skills at the heart of care: a scoping review of evidence on skills gaps in the social care workforce. NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London. <https://doi.org/10.18742/pub01-08>.

⁶² Luijnenburg, O., Manthorpe, J. and Samsi, K. (2022) op. cit.

⁶³ [Care workforce pathway for adult social care: call for evidence - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/collections/care-workforce-pathway-for-adult-social-care-call-for-evidence).

⁶⁴ [Halving social care workforce funding in England an 'insult', ministers told | Social care | The Guardian](https://www.theguardian.com/social-care/2024/jul/30/halving-social-care-workforce-funding-in-england-an-insult-ministers-told).

⁶⁵ <https://questions-statements.parliament.uk/written-statements/detail/2024-07-30/hcws50>

3.2 Training and development in practice

The level and quality of training and development to address the skill gaps in social care remain limited and patchy. Drawing on Skills for Care's 2021-22 Workforce Data Set of around 19,800 care providers of direct care workers:

- Over half (52%) have not started the on-the-job Care Certificate; only a third have completed it (35%); with the rest (14%) having partially completed it.
- Over half (54%) have no relevant social care qualification.
- Only around one in five of direct care workers have a level 2 (22%) or 3 (18%) qualification.⁶⁶

The Migration Advisory Committee report⁶⁷ on the overall social care workforce reports that just over half of the adult social care workforce (53%) have a qualification at level 3 and above. However, this figure includes registered professionals and managers, and is still lower than the figure for all workers in the economy as whole, which stands at around two thirds (62%).⁶⁸

There are at least nine apprenticeships standards available to the adult social care workforce and employers:

- Adult Care Worker (Level 2)
- Lead Adult Care Worker (Level 3)
- Lead Practitioner in Adult Care (Level 4)
- Leader in Adult Care (Level 5)
- Nursing Associate (Level 5)
- Social Worker (Level 6)
- Occupational Therapist (Level 6)
- Physiotherapist (Level 6)
- Registered Nurse (Level 6).

Clearly over half of these apprenticeships are at (degree) level 5 and above, and a route into registered professional roles. However, there are apprenticeships at level 2 and 3 for direct care workers. Data are not readily available on the take up of apprentices by apprenticeship standard. Nonetheless Skills for Care⁶⁹ reports a dramatic fall over recent years in both the number of apprenticeship-starts in the social care sector and as a proportion of all apprenticeship-starts. The sector's 93,900 starts in 2014-5, fell by over half to 42,200 in 2017-18 and have continued to fall in 2021-22 to 28,700. The sharp fall in numbers was shared with other sectors and corresponds to re-adjustments with the transition to a new apprenticeship model in England based on standards rather than frameworks and the introduction of a statutory apprenticeship

⁶⁶ Skills for Care (2023), op. cit, 136-138.

⁶⁷ Migration Advisory Committee (MAC) (2022) [Adult Social Care and Immigration: A Report from the Migration Advisory Committee – April 2022 \(publishing.service.gov.uk\)](#).

⁶⁸ Migration Advisory Committee (2022), op. cit., 29.

⁶⁹ Skills for Care (2022) op. cit. and Skills for Care (2023), op. cit.

levy. This fall has, however, been relatively more pronounced in social care: in 2014-15 social care starts constituted 19% of all starts; in 2021-22 it was just 8%.

3.3 Challenges

The patchy and uneven pattern of training and development in adult social care and perhaps the broad and loosely formulated nature of policy proposals and aims, are indicative of the system, organisational and personal challenges faced in addressing the sector's skills gap and needs. The precise character of the challenges will be sensitive to various factors including: the particular job role (registered or unregistered), the care setting (care home without/with nursing or domiciliary care), the governance and organisational form taken by social care providers (family-owned, independent provider or large equity funded nationwide chain) and their size (small/medium or large). However, the following, often interrelated, challenges facing adult social care sector can be highlighted.

3.4 Career progression: flat organisations

In a workforce comprising myriad roles, there remain many career development opportunities for staff in adult social care. However, the spine of the workforce centred on direct care delivery, remains relatively flat. In a typical care home, the workforce will be predominantly made up of care assistants with a small number of senior carer or team leaders, then moving straight to the care manager and a deputy care manager. In a nursing home the registered nurse role is also an available career step, although nursing social care remains rather generic with few specialist nursing opportunities.⁷⁰

Policymakers have recognised the importance of developing clearer pathways for adult social care workers and have recently published a consultation document on this issue.⁷¹ It distinguishes four steps on the career pathway - care and support practitioner, advanced care and support practitioner, senior care and support practitioner and practice leader and specialist practitioner, with the ambition of introducing it for the direct workforce by autumn 2023. The document differentiates the knowledge, skills and responsibilities at the respective level, but is less expansive on the resource implications of developing these pathways, and with little, if any, mention of pay. It is not clear whether standard generic career roles command a standard pay rate and if so what is it and how will it be achieved and introduced into the sector.

Following the end of the consultation DHSC has now published the first phase for the introduction of the adult social care workforce pathway focusing on direct care roles. It outlines a slightly revised four step career structure: new carer, carer or support worker, supervisor or leader and practice leader. It also sets out the universal values of the sector, designed to inform existing organisational values, and role descriptions for these four roles. This encompasses what the role entails, the necessary behaviours expected of people, the required skills and knowledge and optional learning and

⁷⁰ Cornes, M. and Manthorpe, J. (2022) *The role and contribution of Registered Nurses in social care: A rapid evidence review*, NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London. Available [here](#).

⁷¹ [Care workforce pathway for adult social care: call for evidence - GOV.UK \(www.gov.uk\)](#).

development opportunities. Working with early adopters of the new pathway learning and evidence will be gathered informing future developments. Before the 2024 general election was called, it had been expected that the next phase would be published in summer 2024 with a focus on deputy managers, registered managers, personal assistants and enhanced care worker roles.⁷² At this point, the new Government has committed to ‘continue to develop a Care Workforce Pathway (the new national career structure) for adult social care.’⁷³

3.4.1 Funding

The challenge of funding the training and development of the adult social care workforce assumes various forms. In a sector mainly driven by the need for most providers to make a financial surplus, and at the very least remain financially viable, training and development can all too readily be squeezed out, and where available, through a limited training budget, it may be concentrated on the registered professions with their re-validation an organisational and personal imperative. In a mixed market for social care, where self-funding service users sit alongside those funded by local authorities and the NHS, there is scope to vary service offers and fees. However, the capacity of many social care providers to cover the cost of training might well depend on funding arrangements with NHS and local authority commissioners for their services. There are cases of commissioners providing support for training and development. This might be seen as a source of subsidy or financial support to profit seeking private sector providers, but where commissioners have statutory obligations to provide care they have a vested and shared interest in the development of a capable workforce by these providers. For example, Devon County Council was prepared to provide financial support for care homes to train carers for a new nursing associate role, introduced into health and social care in 2017.⁷⁴ Whether, to what extent and how widely commissioners are prepared to offer such support remains unclear. Funding for training may also be a lesser priority where there is a greater focus on profit margins as a key performance indicator, as some evidence in the residential care sector where properties have been financed by investment funds suggests.⁷⁵

On a narrower, technical point, the scope for social care providers to access funds for training has been affected by the introduction of the apprenticeship levy. The levy’s impact on the provision of training in adult social care has been mixed.⁷⁶ Larger social care providers, qualifying to pay the levy⁷⁷, might arguably have been encouraged to

⁷² DHSC (2024a) *Care workforce pathway for adult social care: overview*. Available [here](#).

⁷³ <https://questions-statements.parliament.uk/written-statements/detail/2024-07-30/hcws50>

⁷⁴ Kessler, I., Manthorpe, J., Harris, J., Moriarty, J., and Steils, N. (2022) *Evaluating the introduction of the Nursing Associate role in social care*. London: NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King’s College London.

⁷⁵ C.f. Corlet Walker, C., Kotecha, V., Druckman, A. and Jackson, T. (2022). *Held to ransom: What happens when investment firms take over UK care homes*. CUSP Working Paper Series, No 35. Guildford: Centre for the Understanding of Sustainable Prosperity. Available [here](#). Kotecha, V. (2023) *Extracting profits through care home real estate: the billion-pound property speculation fuelling Britain’s care crisis*. Available [here](#).

⁷⁶ Hill, J. (2023) Investigation: Why care training is in crisis and the solutions are falling short, *FE Week*, 9 May.

⁷⁷ To pay the levy the employer pay bill has to be over £3million a year.

provide training with a levy pot now in place and needing to be spent or else being clawed back by government. However, adult social care principally comprises small and medium sized providers who do not qualify to pay the levy, requiring them to rely on alternative sources of funding for their apprenticeships. Sources include drawing down from a central government fund and arranging levy transfer from other employers with levy money to reallocate if underspent. However, accessing these sources can be technically complex, time consuming and resource intensive for the small care provider often without a specialist training function (see below).

More broadly the apprenticeship model, not just the levy arrangements, have funding implications which smaller (and indeed larger) adult social care providers might have difficulties in addressing. While the levy covers the expenditure on training with a higher education body, it cannot be spent on backfill costs which arise from apprentices being away from the workplace, as required, at college and in the case of higher-level apprenticeship, on placements. The case of the nursing associate (NA) in social care is illustrative of this challenge. In primary care a state funded Additional Roles Reimbursement Scheme covers the backfill costs of the NA apprenticeship. This scheme is not available to social care providers, where covering the backfill costs of the NA apprenticeship over the two years of the programme has been calculated as £40,000.⁷⁸

As part of the new care pathway in adult social care DHSC has provided funding for social work and nurse apprenticeships (£20m) together with funding for a new level 2 Adult Social Care Certificate, and an uplift to the Workforce Development fund for subsidised training places.⁷⁹ It remains to be seen whether it addresses the specific challenges in apprenticeship funding outlined above, but the use and impact of this funding will be evaluated by DHSC.

3.4.2 Training infrastructure

In a fragmented sector dominated by small and medium sized providers, ASC lacks the underpinning infrastructure to deliver training. As implied, many such providers are not large enough to have a specialist training and development function and manager, or the capacity to provide pastoral support or, as a support for clinical training, supervision and assessment. The numbers of social care employees in any given care provider and at any given time is often small, making it difficult to justify the appointment of a dedicated post to provide support. Indeed, with such small numbers of trainees it can be difficult for a single care provider to procure the education and training needed to deliver a programme in a cost-efficient way.

A training infrastructure is more likely to be found in the larger social care providers, typically training at scale. Training on a much smaller scale, small and medium providers have been forced to seek infrastructural support through other agencies and by creating or joining networks or partnerships, able to pool resources. In recent years

⁷⁸ Kessler, I., Manthorpe, J., Harris, J., Moriarty, J., and Steils, N. (2022) *Evaluating the introduction of the Nursing Associate role in social care*. London: NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London.

⁷⁹ DHSC (2024b) Government sets out plans to develop the domestic care workforce. Available [here](#).

(the former) Health Education England has, for example, provided £8000 for each trainee nursing associate in social care (and health) to help cover backfill and infrastructure costs, as well as funding dedicated posts at systems level to support training nurse associates (TNAs) and their employers. Social care providers have also been members of NA partnerships in their catchment area, providing the basis for various supportive activities including joint procurement of training from colleges and universities. Other representative bodies have shared and pooled resources to fund infrastructure costs: For example, care home managers in a north London health and care home have jointly funded the appointment of a clinical supervisor and assessor essential to the training and management of NAs in various care homes across the patch.⁸⁰ Indeed, going forward, such pooling and sharing of costs to fund infrastructure raises the possibility of Integrated Care Boards (ICBs), which were legally established on 1 July 2022 in England, to help deliver more joined up health and care services in their local areas, acting in this way. The ability of ICBs to respond to the training and development needs of providers in their locality does however raise questions about the voice of the social care sector in this context. In any given catchment area covered by an ICB, the views of tens if not hundreds of social care providers need to be aggregated and coherently articulated often by a few representatives, in stark contrast to the way in which the handful of trusts in the area can project their views in an unmediated and much more coherent and focused way.

3.5 Workforce profile

The capacity and scope for training in adult social care is impacted by the feminised workforce, the nationality and the ethnically diverse nature of the workforce, and the distinctive pressures faced by this demographic in developing their careers. With few entry-requirements into direct care roles, the lack of formal qualifications in the workforce has been noted above. Many British workers left formal education early, often being let down by the system, and now face multiple work and domestic pressures, rendering training difficult. In this respect, the apprenticeship model is proving a 'mixed blessing'. It allows such workers to learn and earn at the same time, making training and development viable options. But with formal learning in a college setting 'hardwired' into the apprenticeship model, such workers often lack the confidence and study skills to seize the opportunity. In advancing into higher level qualifications, the lack of functional skills can also provide a major barrier to progression. For example, as a degree level qualification, the NA apprenticeship required level 2 functional skills which many carers do not have⁸¹, contributing to the relatively low take up of the NA role in social care.⁸²

⁸⁰ Kessler, I., Bach, S., Griffin, R. and Grimshaw, D. (2020) Fair care work A post Covid-19 agenda for integrated employment relations in health and social care, Kings College London COVID-19 Research Impact Paper, <https://www.kcl.ac.uk/business/assets/PDF/fair-care-work.pdf>.

⁸¹ Kessler, I., Manthorpe, J., Harris, J., Moriarty, J., and Steils, N. (2022) *Evaluating the introduction of the Nursing Associate role in social care*. London: NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London.

⁸² Skills for Care has calculated that there are just 450 NA jobs' in social care, a role introduced in 2017.

3.5.1 Fragmented and uneven playing field

The labour market for employees in adult social care remains a fragmented and uneven one. In any given catchment area there will be many different employment opportunities for care workers within and outside of social care. Perhaps most significantly such opportunities can also be found within the NHS, a major source of care work and with evidence suggesting that the most common route into the NHS healthcare assistant role is through experience of social care work in adult social care.⁸³ It is open to debate whether differences in pay rates between social care providers and the NHS encourage such a move, although the lack of pay standardisation within the social care sector and the non-alignment between pay in health and social care adds volatility to and churn amongst care workers (see section 4). Certainly, the scope for career development and the organisational support for it is often perceived as greater in the NHS and an attraction to social care workers.⁸⁴

In the circumstances, the lure of the NHS, and indeed other employing organisations, make investment in training of direct care workers a considerable risk for the social care provider. As stressed, the level of investment in terms of money and time, in say NA or registered nurse (RN) training, is significant and can readily be lost if the qualified workers leave. Indeed, this risk of lost investment in training is encouraging consideration of various options. Social care providers might decide to 'buy-in' an already trained worker rather than 'grow' their own through training, already beginning to occur as qualified registered NAs come onto the labour market. Social care providers might also seek more cost-efficient training options. Thus, as an explicit alternative to the registered NA, and the costs associated with developing it through a two-year training programme, some social care employers are simply training-up senior carers to (unregistered) Care Home Assistant Practitioners on the basis of a 10-12 week in-house training programme. While a cost-efficient employer option, this unregistered alternative to the registered NA fuels the continued under-regulation of the adult social care workforce, arguably with risks to care quality.

At the end of this section we are going to take a closer look at the current and future demand for skills and the impact of population ageing.

3.6 Current and future skill needs

Unmet social care needs are often difficult to see and assess. It is, however, obvious to those within the sector, and in 2022 Sarah McClinton, President of the Association of Directors of Adult Social Services (ADASS) described the scale of unmet need as 'staggering'.⁸⁵ It is visible in terms of its spill-over effects in the health sector. Under capacity in social care causes delayed discharge and this is made visible in ambulance queues outside hospital A&E departments, within A&E by crowded waiting rooms and corridors, and by long waiting times for ambulances, admission and treatment. When in 2022 the Prime Minister, Rishi Sunak, described the situation as follows: 'the most

⁸³ Kessler, I., Heron, P. and Dopson, S. (2012) *The Modernization of the Nursing Workforce: Valuing the Healthcare Assistant*, Oxford University Press, Oxford.

⁸⁴ Kessler, I., Manthorpe, J., Harris, J., Moriarty, J., and Steils, N. (2022), op. cit.

⁸⁵ Quoted in Booth and Duncan, *The Guardian*, 29th December 2022.

pressing priority we have is to move people into social care in the community to get ambulances flowing⁸⁶, the capacity crisis in care was for a moment near the top of the political agenda.

Sector statistics indicate that the gap between demand and capacity in social care is widening and that this is driven in part by labour constraints. There are potentially 7000 beds available in the care sector but, according to care providers, a shortage of staff to service them.⁸⁷ The supply of available workers is substantially lower than demand.⁸⁸ In the year to March 2022, demand for care increased by 100,000 as 50,000 care workers left the sector.⁸⁹ Unfilled vacancies are perhaps the best available indicator of excess demand and these increased from 6.8% in March 2021 to 10.7% in March 2022 and then fell to 9.9% in 2022/23⁹⁰. These figures are much higher than in 2013 (3.8%) and are much higher than the UK average vacancy rate of 4.3% in March 2022. There were 165,000 unfilled care posts on any one day in March 2022, with estimates in January 2023 up to 180,000.

Current capacity constraints in care are set to tighten as the population ages. Population ageing increases demand for care while simultaneously reducing the supply of carers. Population ageing is a market driver which is certain, large in both magnitude and impact and long-term. This is a global 'mega trend'⁹¹ and has been referred to as a 'population time bomb' and a 'cliff edge in care'. Population ageing is identified by the Office for Budget Responsibility (2022)⁹² as one of two major long-term underlying threats to public finances over the next 50 years. Skills for Care (2022)⁹³ estimates that an additional 480,00 carers will be needed by 2035 to meet a population-related increase in demand for care. At the end of 2022, there was a deficit of between 165,000 and 180,000 carers.

In Figure 1, presented in section 4, population ageing expands demand for care and shifts labour demand (LD) outwards. Assuming that labour supply is stable, the impact of demand expansion at a wage associated with Local Authority under-funding is an increase in labour shortage, seen in unfilled vacancies. The increased level of unmet care need puts upward pressure on wages. If the market is unable to respond by increasing wages due to funding limits, the visible symptoms of under-capacity and labour shortage will intensify.

⁸⁶ *Care Home Professional*, 4th January 2023.

⁸⁷ Kuchler and Oso-Alabi, *Financial Times*, 13th January 2023.

⁸⁸ Skills for Care (2021) *The State of the Adult Social Care Sector and Workforce in England, 2021*. Available [here](#).

⁸⁹ Skills for Care (2022) *The State of the Adult Social Care Sector and Workforce in England*, 1.12. Available [here](#).

⁹⁰ Skills for Care (2023) *The state of the adult social care sector and workforce in England*. Available [here](#).

⁹¹ Shediak, R., Bernnat, R., Moujaes, C. and Najjar, M. (2011) *New Demographics: Shaping a Prosperous Future as Countries Age*. Booz & Company NY.

⁹² Office for Budget Responsibility (OBR) (2022) *Fiscal Risks and Sustainability*. Available [here](#).

⁹³ Skills for Care (2022) op. cit.

In terms of population trends, care need and therefore demand for care workers is the outcome of two opposing forces: the increase in numbers of older people and the reduction in rates of old-age dependency on care at any given age as a consequence of improving health. Over the last four decades, much of the numbers effect on increasing care demand has been offset by the dependency rate effect. The outcome of this race between numbers and rates changed around 2015 in favour of the numbers and the gap will likely increase further and more rapidly over the next twenty years.⁹⁴ Other factors are also important. On the supply side an increase in the working age population and the proportion who are in employment has provided both the tax revenue and a source of supply of care workers able to meet the expansion in care demand. But supply conditions are changing. The growth in labour market participation has slowed and there are early indications of a reverse, especially among those groups who have traditionally supplied social care labour (older women and EU migrants). Furthermore, the population of care workers itself is ageing. The average age increased from 42.5 in 2012-3 to 44.4 in 2021-2. Over the next ten years 430,000 carers will have reached the age of 55 years. The sector currently struggles to recruit and retain young people. In terms of Figure 1, labour supply contracts, depicted by an upward shift in labour supply compounding the under-provision generated by increasing demand. Together expanding demand for care and contracting supply of carers generate a higher level of unmet care need and wages must rise to reduce it.

The crisis forecast by demographic trends was delayed by countervailing forces which contained the impact of increasing numbers of old people: migration, increased participation, and a continuing reduction in age-related dependence. It was not averted. These forces have weakened while population ageing continues such that the combination of the ageing boomers, stalling improvements in dependency rates and a contracting workforce will generate an ever-widening gap between demand and supply of care services.

⁹⁴ In terms of numbers, there is a population bulge as the baby-boomer generation (born 1946 to 1964) enter their 60s (1964) and 80s (1946). The birth rate peaked at 18.3 per 1000 in 1963. This cohort reached 60 years of age in 2023 and 65 years of age in 2028. In terms of the dependency rate at any given older age, the rate of health improvements and lengthening life expectancy has stalled.

4 Wages

The care workforce has always been vulnerable to these often closely related features: low pay (impacted by underfunding of care services, undervaluing of (feminised) care work and low trade union representation), precarious employment and limited career opportunities.

Most recently a combination of liberalisation, financialization and local authority commissioning under public sector austerity has resulted in employers in the care sector competing on the basis of reduced costs and this has caused further downward pressure on wage growth and working conditions. Wages and in particular relative wage rates are central to the capacity of the care sector to recruit and retain workers, and therefore deliver services. Skills for Care⁹⁵ identifies falling wages in care relative to other low pay sectors and found that wages in alternative sectors out-compete wages in care.⁹⁶

Minimum pay rates for care workers differ across the four UK countries reflecting different regulatory frameworks. While in England and Northern Ireland care workers need to be paid at least the National Living Wage (£11.44 as of April 2024), care workers in Wales and Scotland need to be paid the Living Wage (£12.00 as of April 2024), with Scotland setting the Living Wage as the minimum rate.

Data for England also show that care workers and senior care workers' pay rates are higher in the public sector than in the predominant independent sector (with the estimated mean full-time equivalent rates for care workers showing a difference of £2.60 per hour between public and independent sector and £6.40 for senior care workers.⁹⁷ While the pay, terms and conditions for local government services are determined by the National Joint Council (NJC - consisting of trade unions and employers), trade union involvement in the independent sector, which comprises many small and medium sized enterprises, is rather the exception than the norm. Moreover, independent providers need to work within the parameters of the contracts agreed with local authorities, limiting their scope for setting pay rates. There are also differences in pay rates across regions, with the highest median hourly rates being paid in the south of England (London, £10.50), South West (£10.25) and the South East (£10.17), and the lowest in the North East (£9.90) and the West Midlands (£9.90).⁹⁸ Care workers in domiciliary care are paid an hourly rate for the time they spend with the service user, yet they need to travel to the service users' homes often using their own means of transport. The pay rate does not adequately cover travel time⁹⁹ and transport costs, particularly in the current economic situation with high petrol costs that are not

⁹⁵ Skills for Care (2022) *The State of the Adult Social Care Sector and Workforce in England*. Available [here](#).

⁹⁶ Migration Advisory Committee (MAC) (2022) *Adult Social Care and Immigration: A Report from the Migration Advisory Committee*. CP665. Available [here](#).

⁹⁷ Skills for Care (2022) *The State of the Adult Social Care Sector and Workforce in England*. Available [here](#).

⁹⁸ Skills for Care (2023a) *Pay in the adult social care sector as at December 2022*. Available [here](#).

⁹⁹ See e.g. Unison (2023) Majority of homecare staff are unpaid for travel between visits. Available [here](#). Cominetti (2023), op. cit.

matched by the fuel allowance.¹⁰⁰ Legally, travel time between assignments set by the employer needs to be included in the National Minimum Wage calculation¹⁰¹, yet the payslips may not provide detailed information that would allow employees to quickly check it.¹⁰² In its recent report, the Low Pay Commission¹⁰³ states that there are still 'significant non-compliance issues' in social care due to lack of payment for travel time.

4.1 Brief economic analysis of the labour shortage in the care market

With a focus on wages, this section offers a simple economic analysis of the labour shortage in the market for care, evidence of wage competition for labour from alternative sectors and the likely pressures ahead for the care sectors. An ageing population requires more carers while downward pressure on wages risks supplying fewer.

In a free market, the supply of carers (care is labour intensive) and the demand for social care is brought into balance by the wages of carers. The wages of carers move relative to wages in alternative sectors in a way which seeks to clear the market of either excess demand for care (wages increase) or excess supply of carers (wages fall). Factors which strengthen demand for care tend to increase wages and factors which increase supply of carers (e.g. immigration) tend to depress wages, *ceteris paribus*. The simple underlying idea is that where demand for labour is growing, and where it exceeds supply of labour, wages increase to attract more labour and more hours into the care market. This is a simplified view but economists use supply and demand curves as tools to represent market forces and demonstrate the way markets seek to respond to an imbalance or change in those forces.

There are of course multiple factors acting as forces upon wages at any one time. They act in different directions and over different periods of time. They are not measured and their impacts are not measured. In terms of impact, they cannot be distinguished from each other. However, thinking about these factors, and the forces they exert in a labour market, provides a framework within which we can think about the current and future pressures on wages in the care sector.

While market forces will influence wage determination, the care market is not a free market. Academic research has focused on the monopsony power of the employer as a source of market imperfection in the care sector¹⁰⁴ which implies an ability of the organisation to suppress wages. This model is less useful as an explanation of the current crisis in care where the binding constraint is the impact of state-commissioning of care services at below market prices. Care providers pass on the difference

¹⁰⁰ Low Pay Commission (2023) *National Minimum Wage. Low Pay Commission Report 2022*. Available [here](#).

¹⁰¹ <https://www.gov.uk/hmrc-internal-manuals/national-minimum-wage-manual/nmwm08300>.

¹⁰² HM Government (2023a) *United Kingdom Labour Market Enforcement Strategy 2023/24 – Annex A: Emerging issues around Compliance and Enforcement in the UK Labour Market*. Available [here](#).

¹⁰³ Low Pay Commission (2024) *National Minimum Wage. Low Pay Commission Report 2023*. Available [here](#).

¹⁰⁴ Machin, S. and Manning, A. (2002) *The structure of wages in what should be a competitive labour market*, CEP and ESRC, ISBN 07530 1553 6; Machin, S., Manning, A. and Rahmen, L. (2000) *Care home workers and the introduction of the UK national Minimum wage*, unpublished CEP, LSE.

between the market price and the funded price to the staff they employ in the form of wages below the market clearing wage. According to the Local Government Association (LGA) in its evidence to the House of Commons Health and Social Care Committee (2022)¹⁰⁵, ‘pay is inexorably linked to funding’.¹⁰⁶ Local Authority underfunding is not new but it has been exacerbated since 2010 by public sector austerity. It will be exacerbated further by population ageing.

The model in Figure 1 depicts a simplification of the underlying forces of demand for and supply of care workers and the mechanisms through which wages seek to balance those forces in the presence of a wage floor. Imbalances occur when wages are not free to perform their market-clearing function. Figure 1 shows the relationship between the wage for care (vertical axis) and the employment of carers (horizontal axis). The supply of carers is given by the labour supply (LS) curve where higher wages increase the supply of care hours. The demand for carers is given by the labour demand (LD) curve where higher wages for care reduce demand for care. The market clearing wage would be at W^* . At equilibrium, employment in care is E^* , with neither excess demand for nor supply of carers.

Figure 1: The labour market for care

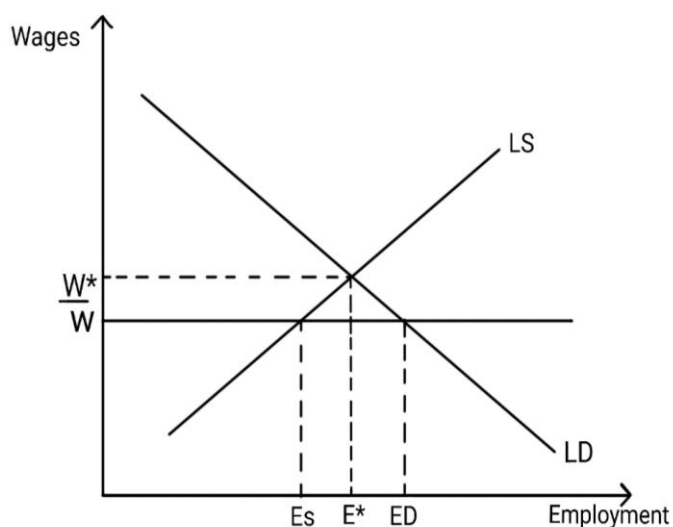


Figure 1 depicts a wage ceiling at \bar{W} and this creates unmet care need equal to $ED-ES$. The wage ceiling is imposed by the mass purchase of care by Local Authorities where funding for that care is below the market price. This fixes the wage at \bar{W} , below

¹⁰⁵ House of Commons Health and Social Care Committee (2022) *Workforce: recruitment, training and retention in health and social care*. Third Report of Session 2022–23. Available [here](#).

¹⁰⁶ Simon Williams’ (Director of Social Care Improvement at the LGA) evidence to the House of Commons Health and Social Care Committee (2022) is that “local authorities will not be able to pay providers the rates that provider need to pay to retain staff unless funding is sorted out.” (para 184). This is echoed by the LGA’s evidence “Increases in pay and improvements in terms and conditions will not be possible without an increase in social care funding.” (para 183).

the market clearing wage at W^* , where the number of people attracted to care work is less than the number required to meet the demand for care. There are unfilled vacancies and unmet care need. The impact of a wage floor is immediately clear: higher wages or unfilled vacancies are alternatives and, in order to fill the care need, the under-funding that fixes wages below the market rate must be corrected.

The wages and employment equilibrium, and any associated unmet care need, are also affected by the forces which act on labour demand and labour supply. The labour demand curve LD will shift outwards and upwards if the population ages and/or becomes more dependent. Prevention interventions, technological improvements which support self-care and independence will shift the LD curve inwards. The labour supply curve LS will shift upwards and inwards as the working-age population and/or the employment rate falls or in response to improved wages, terms and conditions in alternative occupations. The granting of immigration visas for care workers has the effect of shifting the LS downwards.

As wages in care are determined by public policy as much as by market forces, it is difficult to predict the balance between a wage or quantity response to the growing disequilibrium in Figure 1. To the extent that the unfolding difficulties in the NHS drive greater funding for and investment in social care, wages are likely to rise. To the extent that this funding remains constrained, the level of unmet care need will remain. When the impact of population ageing, a potentially large driver of demand for care, is included, unmet care need will increase.

4.2 Eroding pay differentials compared to other sectors

Pay in the sector, particularly in domiciliary care, is increasingly benchmarked against the National Minimum and National Living Wages.¹⁰⁷ Above average increases in minimum wages have, since 2012, been important in raising wage levels for those at the bottom end of the wage distribution.¹⁰⁸ These increases have had some impact on wage inequality in the sector, although it seems that increases have not impacted markedly upon vacancy rates. Pay in the sector remains relatively low.¹⁰⁹ Care workers' pay relative to other low paid occupations has declined.¹¹⁰ In 2012-3, care worker median pay was higher than for retail workers, cleaners, launderers and

¹⁰⁷ Bessa, I., Forde, C., Moore, S. and Stuart, M. (2013) *The National Minimum Wage, earnings and hours in the domiciliary care sector*. Low Pay Commission, Available [here](#); Datta, N., Giupponi, G. and Machin, S. (2019) Zero-hours contracts and labour market policy. *Economic Policy*, 34(99), pp.369-427; Vadean, F. and Allan, S., 2021. The effects of minimum wage policy on the long-term care sector in England. *British Journal of Industrial Relations*, 59(2), pp.307-334.

¹⁰⁸ Wass, V. (2022) *The market for social care, carers' wages, aging population and fiscal risks*, unpublished manuscript.

¹⁰⁹ Skills for Care (2022) *The State of the Adult Social Care Sector and Workforce in England*. Available [here](#); Foster, D. (2022) *Adult Social Care Workforce in England*, House of Commons Library Research Briefing, <https://commonslibrary.parliament.uk/research-briefings/cbp-9615/>.

¹¹⁰ Wass, V. (2022) *The market for social care, carers' wages, aging population and fiscal risks*, unpublished manuscript.

kitchen assistants. In 2021-22 it was lower than for retail workers and closer to the wages of cleaners, launderers and kitchen assistants.¹¹¹

Skills for Care¹¹² identifies two recent trends in pay that have increased the challenge of recruitment and retention of carers. The first is above average increases in the national minimum wage (NMW) and especially the National Living Wage (NLW) and the second is wage increases in alternative occupations above those in the care sector. Above average increases in the NMW and NLW have been important in setting wages in the care sector, particularly those at the bottom of the pay distribution. Pay increases at the bottom have exceeded those at the top and this has eroded pay differentials within care. Within care, pay progression is important for retention. Pay dispersion within provider firms, already narrow¹¹³, has narrowed further. A flat career structure is flattened further, removing incentives for carers to remain in order to progress.

The same compression effect is responsible for the erosion of pay differentials between care and other low paid occupations. Assuming mobility between sectors, labour responds to alternative opportunities in the market. This response is driven by relative wages and conditions of work. Increases in the NMW and NLW also cut pay differentials between care and lower paying sectors such as retail, cleaning and hospitality. Skills for Care (2022)¹¹⁴ argue that this relative pay decline in care started in 2012-3. The distinguishing feature of the care sector is State commissioning at low rates of funding which limits the ability of employers to fund wage rises. Respondents to the House of Commons Health and Social Care Committee consultation on the social care workforce highlighted competition from local supermarkets, 'I dread hearing an Aldi opening up nearby, as I know I will lose staff'.¹¹⁵ To attract labour from alternative sectors into care and begin to contain the increasing labour shortage will require a correction of any fall in relative wages.

When considering mobility in and out of social care, it is useful to start with what is attractive about the care sector and what draws people to the sector. According to a survey of care workers undertaken for the Scottish Government and the Convention of Scottish Local Authorities (COSLA), the 'desire to do a job that makes a difference is the main reason why people are motivated to take up a career in social care'.¹¹⁶ The same survey reveals why people are currently leaving the workforce: 'for better terms and conditions, particularly pay levels, and do a less demanding job for similar or better

¹¹¹ Skills for Care (2022), op. cit.

¹¹² Skills for Care (2022), op. cit.

¹¹³ Machin, S., Manning, A. and Rahmen, L. (2000) *Care home workers and the introduction of the UK national Minimum wage*, unpublished CEP, LSE.

¹¹⁴ Skills for Care (2022) *The State of the Adult Social Care Sector and Workforce in England*. Available [here](#).

¹¹⁵ House of Commons Health and Social Care Committee (2022), op. cit. Evidence reported by a researcher talking to care managers, para. 178.

¹¹⁶ Ekosgen (2019) *The Implications of National and Local Labour Markets for the Social Care Workforce: Final Report for Scottish Government and COSLA*, i.

rates of pay'.¹¹⁷ In focus groups conducted by the Resolution Foundation¹¹⁸, low pay was at the centre of job dissatisfaction in care. The care sector faces competition from health, hospitality, retail and cleaning sectors and carers are drawn to these because they are considered to be less demanding jobs for the same or better rates of pay.¹¹⁹ Insufficient pay relative to offers from competitor occupations featured strongly in the House of Commons Workforce inquiry (2022). 'Try bringing up your family on £9.50 per hour knowing you could earn £10.50 working in a supermarket, starting tomorrow.'¹²⁰

A further source of competition for care workers is the NHS Health Care Assistant role, where hourly pay is higher, for all hours worked, includes unsocial hours premia and comes with an NHS career pathway. This compares to lower flat hourly rates, lack of payment for travel time, zero-hours contracts, poor career pathways and limited training in social care.¹²¹

The Skills for Care¹²² proposition that relative wages in care have declined is investigated using Annual Survey for Hours and Earnings (ASHE) wages statistics 1997 to 2022. Earnings statistics for carers (SOC 6135 and 6136) published by the Office of National Statistics (ONS) in the Annual Survey of Hours and Earnings indicates wage rises for carers which are above growth in the aggregate wage but often below wage growth in competitor occupations. Table 2 demonstrates wage compression within and between sectors, especially since 2009. Hourly earnings are reported at the aggregate level at the median and at the quartiles (25th, 50th and 75th percentiles) for five alternative occupational groups (care, cleaning, laundry, kitchen assistants, retail sales) and the NMW (from 1999), replaced by the NLW in 2016, for 1997, 2007, 2015 and 2023. Each of the five occupational groups report median wages below aggregate median earnings and 25th percentile earnings above the NMW. Annualised average wage growth 1997-2023 is reported in the final column. Each wage level is expressed as a percentage of the NMW/NLW in parentheses. Comparisons with wages in the NHS are facilitated by including wages of Nursing Auxiliaries and with Local Authority-funded occupations by including the wages of salvage and refuse collectors. These occupations had the highest wages in 1997 and the lowest growth since 1997.

In terms of ordering by median earnings, each group of carers, cleaners, launderers, sales staff and kitchen assistants, have maintained their position: carers were highest paid in 1997 and in 2022 and kitchen assistants lowest paid in both years. However, there has been a narrowing of differentials between them. In the final column, wage

¹¹⁷ Ekosgen (2019), op. cit., i.

¹¹⁸ Cominetti, N. (2023) Who Cares? The experience of social care workers, and the enforcement of employment rights in the sector. Resolution Foundation Briefing.

¹¹⁹ Ekosgen (2019), op. cit., p. ii.

¹²⁰ Dimensions (RTR0025), cited in House of Commons Health and Social Care Committee (2022), op. cit., para. 178.

¹²¹ Holt et al., BBC News, 20th December 2022.

¹²² Skills for Care (2022) *The State of the Adult Social Care Sector and Workforce in England*. Available [here](#).

growth is higher for those with lower earnings both within and between occupations. Wage growth was lowest for those with highest pay in 1997 (refuse and salvage workers on 75th percentile). Wage growth was highest for carers, cleaners and laundry workers on 25th percentile earnings. Growth in the NMW/NLW has exceeded wage growth in each occupation. Wage compression is most clearly observed when measuring occupational wages relative to the minimum wage. These relatives are reported in parentheses in Table 2. In 2009 the median carer earned £7.93 per hour compared to £6.48 for the median sales assistant and a NMW of £5.80. The ratio of the carer wage relative to the NMW was 1.37 and 1.10 for the sales assistant. In 2023 the median carer earned £11.89 compared to £11.00 for the median sales assistant. The ratios of the occupational wage relative to the NMW (£10.42) has fallen for both groups but it has fallen much further for carers (to 1.14) than for sales assistants (to 1.06).

Relative wages are tracked over time in Figure 2. Median hourly earnings for sales staff, kitchen assistants, laundry workers and cleaners relative to the NMW/NLW are depicted in different shades of green. Median earnings for nursing auxiliaries are depicted in blue. Carers earnings are reported at the 25th, 50th and 75th percentiles in orange. There is a clear downward time trend in occupational wages relative to the minimum wage from 2009 particularly within the highest paid occupational groups.

Before 2009, wages for carers relative to the NMW/NLW were stable while relative wages in the competitor sectors were falling. As a result, wages in care relative to these sectors increased. This early trend is unique to carers and coincides with the regulation contained in the Care Standards Act 2000 which sought to raise the quality of care through training and professionalisation. Under the regulation, care providers

Table 2: Hourly Earnings (£) and relative to NMW/NLW 1997-2023, UK

	1997 ²	2009	2015	2023	Annualised growth 1997-2023
ASHE median	7.07 (2.13)	11.02 (1.90)	11.78 (1.76)	15.88 (1.52)	3.16
Carers (6115) ¹	3.55 (1.13)	6.68 (1.15)	7.10 (1.06)	10.94 (1.05)	4.42
	4.45 (1.38)	7.93 (1.37)	8.18 (1.22)	11.89 (1.14)	3.85
	5.73 (1.73)	9.82 (1.69)	9.88 (1.47)	13.71 (1.32)	3.41
Cleaners	3.41 (1.05)	5.89 (1.02)	6.52 (0.97)	10.46 (1.00)	4.41
	3.86 (1.18)	6.39 (1.10)	7.10 (1.06)	10.91 (1.05)	4.08
	4.60 (1.38)	7.36 (1.27)	8.00 (1.19)	12.01 (1.15)	3.76
Laundry	3.34 (1.00)	5.73 (0.99)	6.50 (0.97)	10.50 (1.01)	4.50
	3.97 (1.34)	6.52 (1.08)	6.82 (1.02)	10.79 (1.04)	3.92
	4.93 (1.39)	6.99 (1.21)	7.68 (1.15)	11.03 (1.06)	3.15
Sales	3.66 (1.11)	5.90 (1.02)	6.60 (0.99)	10.42 (1.00)	4.11
	4.21 (1.26)	6.48 (1.10)	7.21 (1.08)	11.00 (1.06)	3.76
	5.06 (1.49)	7.47 (1.29)	8.41 (1.26)	11.95 (1.15)	3.36
Kitchen assistants	3.25 (1.01)	-	-	10.18 (0.98)	4.49
	3.69 (1.13)	6.04 (1.04)	6.77 (1.01)	10.60 (1.02)	4.14
	4.17 (1.27)	6.96 (1.20)	7.67 (1.14)	11.36 (1.09)	3.93
Refuse and salvage	5.30 (-)	7.78 (1.34)	8.06 (1.20)	11.95 (1.08)	2.95
	5.99 (-)	8.68 (1.50)	9.16 (1.37)	11.28 (1.13)	2.64
	7.55 (-)	9.84 (1.70)	10.57 (1.58)	11.80 (1.22)	2.02
Nursing auxiliaries	4.88 (1.45)	7.97 (1.37)	8.16 (1.22)	11.24 (1.08)	3.26
	5.55 (1.65)	9.07 (1.56)	9.61 (1.43)	12.72 (1.22)	3.24
	6.11 (1.87)	10.59 (1.83)	11.30 (1.69)	15.42 (1.48)	3.62
NMW NLW	3.60 (1999)	5.80	6.70	10.42	4.53

Source: ONS ASHE

¹ Quartile earnings are reported for each of the occupational groups (25th, 50th and 75th percentiles), with the 50th percentile in bold. The 50th is the wage of the middle observation in a ranked series. It is also known as the median. The 25th is the wage which divides the bottom quarter from the top three-quarters of ranked observations. The 75th is the wage which divides the bottom three-quarters from the top quarter of ranked observations.

² Wages relative to the NMW/NLW in column 1 are measured for 1999.

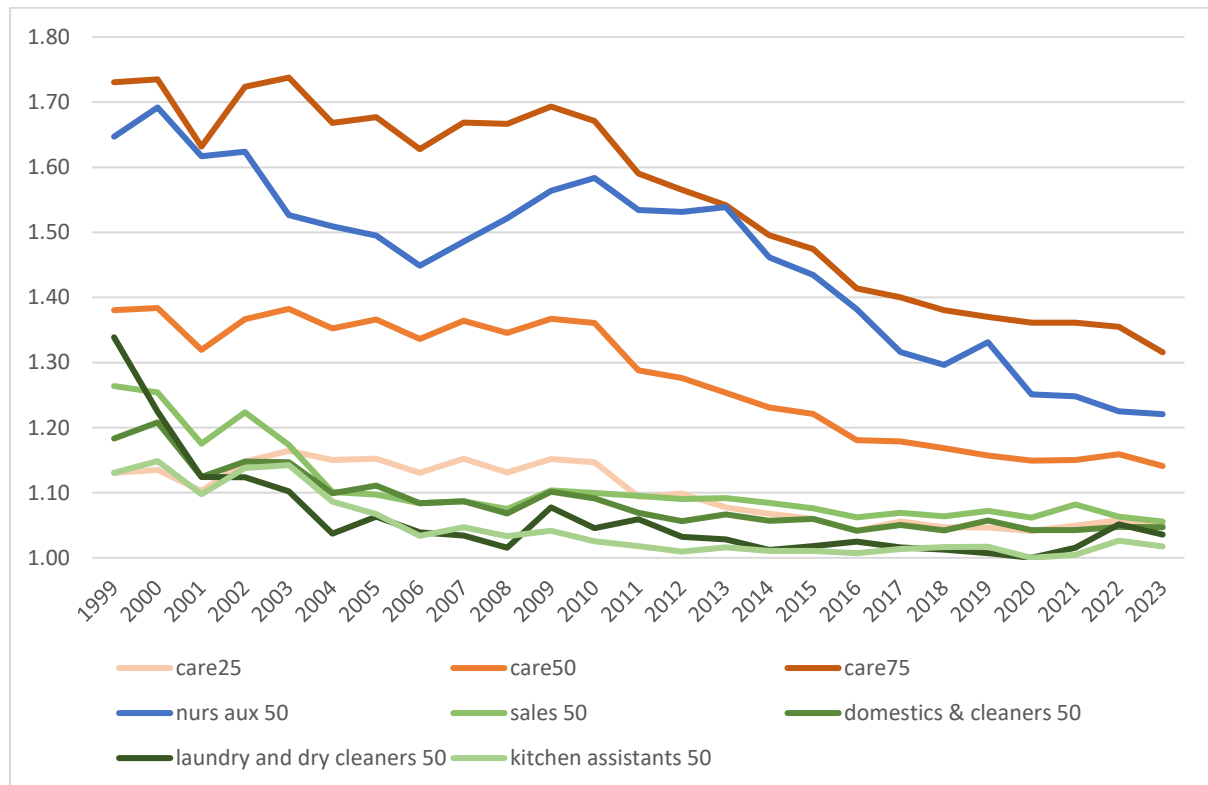
had until 2005 to ensure that half of their staff were qualified to at least NVQ level 2. Viewed as a form of occupational licensing¹²³, it had the expected effect of increasing the relative wages of carers. From around 2007, and due to rising concerns about the cost of care, the regulation was quietly dropped.¹²⁴ From 2009 to 2015, coinciding with public sector austerity, the relative wages in care fell sharply. They continued to fall at the 75th and 50th percentiles from 2015, though at a slower rate.

¹²³ Forth J., Bryson A., Humphris, A., Koumenta, M. and Kleiner, M. (2011). *A Review of occupational regulation and its impacts*. UK Commission for Employment and Skills. Evidence Report 40.

¹²⁴ Gospel, H. and Lewis, P.A. (2011), Who Cares about Skills? The Impact and Limits of Statutory Regulation on Qualifications and Skills in Social Care. *British Journal of Industrial Relations*, 49: 601-622. <https://doi.org/10.1111/j.1467-8543.2010.00828.x>.

Wage increases are generally above price inflation which was an average of around 2.5% in each year between 1997 and 2023 indicating modest real wage growth for all occupational groups. Real wage growth has been negative in the last two years due to unexpectedly high price inflation. This has led to hardship among carers with the third sector care provider Community Integrated Care providing food parcels for some staff and describing pay pressures as now ‘untenable and immoral’.¹²⁵

Figure 2: Wage for carers and alternative occupational groups relative to NMW/NLW, 1999-2023, UK



Source: ONS ASHE, see notes for Table 2

The low pay and the insecurity that characterise many social care jobs have wider and longer-term impacts for care workers and their families. The majority of care workers are women¹²⁶ and many social care workers find themselves in poverty and having to claim benefits to supplement low wages. This has negative impacts on both the immediate quality of life for individuals and families but also limits the life chances of children and future generations.¹²⁷

¹²⁵ Holt et al. (2022) BBC News 20 December.

¹²⁶ Fair Work Convention (2019) *Fair Work in Scotland's Social Care Sector*. Available [here](#).

¹²⁷ Shildrick, T., MacDonald, R., Webster, C. and Garthwaite, K. (2012) *Poverty and Insecurity: Life in low pay, no pay Britain*. Bristol, Policy Press; MacDonald, R., Shildrick, T. and Furlong, A. (2020) 'Cycles of disadvantage' revisited: Young people, families and poverty across generations, *Journal of Youth Studies*, 23(1).

A pre-requisite for increasing care provision to meet expanding care needs is an increase in the relative wages of care workers. In order to fill vacancies on a sustained basis, the wage catch-up in care will need to extend beyond a short-term restorative correction relative to competitor occupations into a long-term structural shift towards higher relative occupational pay. In fact, care needs a larger increase, a 'catch-up plus', because care is more labour intensive and more age-sensitive than the sectors which it competes with for labour. The pre-requisite for 'catch-up plus' is a long-term increase in real funding for care from the state. In 2022, the Migration Advisory Group (MAC) recommended an increase of wages for care workers in England to at least £10.50 (equivalent to the rate for the Real Living Wage at the time).¹²⁸ The Resolution Foundation¹²⁹ went further, recommending that the hourly rate for care which deals with staff shortages and ensures compliance with the NLW is £2 above the NLW. Without wage adjustment along the lines of that witnessed during the first half of the 2000s, quantity and quality will take the strain, in the form of increasing under-provision of care and increasing unmet care need.

¹²⁸ MAC (2023), op. cit.

¹²⁹ Cominetti, N. (2023) *Who Cares? The experience of social care workers, and the enforcement of employment rights in the sector*. Resolution Foundation Briefing.

5 Work, working conditions and wellbeing

Compared to other sectors, there are a higher proportion of insecure contracts in social care. One in four workers in the sector are employed on a zero-hours contract¹³⁰, rising to over half the workforce in the domiciliary care sector¹³¹ where service demand is more volatile, as the circumstances of the service user may warrant swift changes, e.g. due to the hospitalisation of a service user.¹³² Research undertaken by Skills for Care on England for a study by the Equality and Human Rights Commission (EHRC)¹³³ showed that ethnic minority care workers in the independent care sector were more likely to be on zero-hours contracts than White British care workers. This difference was particularly evident in the independent domiciliary care sector (71% vs 59%). Zero-hours contracts have grown to be the dominant form of employment in domiciliary care over the last 15 years.¹³⁴ This has been attributed to the highly marketized nature of the sector, and the commissioning regime for care, which providers have argued make it difficult to plan future staffing requirements with any certainty. Low trade union representation means that workers often lack power in the workplace¹³⁵. The reasons for low trade union representation and strategies being pursued in Scotland being discussed in greater detail in section 8.3.

With the widespread use of zero-hours contracts, the risks of exploitation and poor or even illegal employment practices is increased. Evidence from the national helpline of the Advisory, Conciliation and Arbitration Service (Acas) showed that many individuals were unaware of the nature of their contract until there was a problem.¹³⁶ Similarly, a recent general survey by Acas found that just over 60% are unaware of zero-hours contracts rights.¹³⁷ With regards to the social care sector, there is some qualitative

¹³⁰ Foster, D. (2022) *Adult Social Care Workforce in England*, House of Commons Library Research Briefing, <https://commonslibrary.parliament.uk/research-briefings/cbp-9615/>; Skills for Care (2022) *The State of the Adult Social Care Sector and Workforce in England*. Available [here](#).

¹³¹ Alberti, G. and Dolezalova, M (2021) *Sector overview, Labour Mobility in Transition Project*, CERIC, University of Leeds. Available [here](#); Skills for Care (2022) *The State of the Adult Social Care Sector and Workforce in England*. Available [here](#).

¹³² The *Workers (Predictable Terms and Conditions) Act 2023*, expected to come into force in autumn 2024, gives workers the right to request more predictable terms and conditions of work. It is particularly aimed at workers on zero-hours contracts and those in other atypical working patterns. There is scope for the employer to reject the request on business-related grounds, including for example because of a detrimental effect on ability to meet customer demand.

¹³³ Equality and Human Rights Commission (EHRC) (2022) *Experiences from health and social care: the treatment of lower-paid ethnic minority workers*. Available [here](#).

¹³⁴ Bessa, I., Forde, C., Moore, S. and Stuart, M. (2013) *The National Minimum Wage, earnings and hours in the domiciliary care sector*. Low Pay Commission. Available [here](#); Kessler, I. Bach, S. Griffin, R. and Grimshaw, D. (2020) *Fair care work A post Covid-19 agenda for integrated employment relations in health and social care*, Kings College London COVID-19 Research Impact Paper, <https://www.kcl.ac.uk/business/assets/PDF/fair-care-work.pdf>; Atkinson, C. and Crozier, S. (2020) Fragmented time and domiciliary care quality. *Employee Relations: 42*(1), pp.35-51.

¹³⁵ Cominetti, N. (2023) *Who Cares? The experience of social care workers, and the enforcement of employment rights in the sector*. Resolution Foundation Briefing.

¹³⁶ Acas (2014) *Give and Take? Unravelling the true nature of zero hours contracts*, Acas Policy Discussion Paper, cited in Dix, G and Warhurst, C with Daniels, K, Grimshaw, D., McBride, J. and Rubery, J. (2023) *Zero Hours Contracts*. ReWAGE Policy Brief. Available [here](#).

¹³⁷ Acas (2023) *3 in 5 workers are unaware of zero-hours contracts rights*. Available [here](#).

evidence that ethnic minority care workers have a low level of awareness of their employment rights (e.g. entitlement to holiday pay; or statutory sick pay when on zero-hours or agency contracts).¹³⁸ Moreover, the same study found there to be few opportunities, particularly among ethnic minority care workers ‘to have their voices heard in the workplace’.¹³⁹ Care workers can experience abuse from service users, their family and friends, coworkers and the public while doing their job. While 24% of White British care workers were reported to have experienced abuse during the Covid-19 pandemic, such as verbal abuse, bullying or threats, this rose to 40% among care workers from Black, Asian and minority ethnic backgrounds (40%).¹⁴⁰

Researching the impact on workers when investment firms have taken over care homes a small-scale qualitative study¹⁴¹ found that there were concerns about care companies exploiting care staff, cutting corners on service delivery, covering up mismanagement, failures of communications and prioritising profits over care.

Data show that one in five front line care workers are women with dependent children and a third of residential care workers live within two kilometres of their place of work.¹⁴² Whilst employing people locally can benefit both employers and employees, it can also lead to problematic working conditions where employers have been found to exploit the fact that they can contact workers at home when they are away from work.¹⁴³

Given the concerns raised, perhaps surprisingly workers in social care report high levels of job satisfaction.¹⁴⁴ Working in the care sector is often perceived of as a

¹³⁸ Equality and Human Rights Commission (EHRC) (2022) *Experiences from health and social care: the treatment of lower-paid ethnic minority workers*. Available [here](#).

¹³⁹ Equality and Human Rights Commission (EHRC) (2022), op cit., 53.

¹⁴⁰ Saloniki, E. and Hussein, S. (2023) *The Impact of the COVID-19 Pandemic on the Long-Term Care Workforce: Evidence from the United Kingdom* (blogpost). Available [here](#). Saloniki, E.-C., Turnpenny, A., Collins, G., Marchand, C., Towers, A.-M., Hussein, S. (2022) Abuse and Wellbeing of Long-Term Care Workers in the COVID-19 Era: Evidence from the UK. *Sustainability* 2022, 14, 9620. <https://doi.org/10.3390/su14159620>; Saloniki, E. and Hussein, S. (2023) *The Impact of the COVID-19 Pandemic on the Long-Term Care Workforce: Evidence from the United Kingdom* (blogpost). Available [here](#); Saloniki, E.-C., Turnpenny, A., Collins, G., Marchand, C., Towers, A.-M. and Hussein, S. (2022) Abuse and Wellbeing of Long-Term Care Workers in the COVID-19 Era: Evidence from the UK. *Sustainability* 2022, 14, 9620. <https://doi.org/10.3390/su14159620>.

¹⁴¹ Corlet Walker, C., Kotecha, V., Druckman, A. and Jackson, T. (2022) Held to ransom: What happens when investment firms take over UK care homes. CUSP Working Paper Series, No 35. Guildford: Centre for the Understanding of Sustainable Prosperity. Available [here](#).

¹⁴² Cominetti, N. (2023) Who Cares? *The experience of social care workers, and the enforcement of employment rights in the sector*. Resolution Foundation Briefing.

¹⁴³ Shildrick, T., MacDonald, R., Webster, C. and Garthwaite, K. (2012) *Poverty and Insecurity: Life in low pay, no pay Britain*, Bristol, Policy Press.

¹⁴⁴ Cominetti, N. (2023), op cit.; Daly, M. and Fisher, D.U. (2023) *The Job and Work Orientations of Workers in English Care Homes*. Available [here](#); Hebson, G., Rubery, J. and Grimshaw, D. (2015) ‘Rethinking job satisfaction in care work: looking beyond the care debates’, *Work, Employment and Society*, 29(2); Shildrick, T., MacDonald, R., Webster, C. and Garthwaite, K. (2012), op. cit.

vocation¹⁴⁵ or as ‘somewhere between employment and vocation’¹⁴⁶ and the ‘human element’ of the role is attractive and satisfying for many workers. They also tend to see their role as having high skills and high levels of responsibility.¹⁴⁷ At the same time workers recognise that the work is physically hard, that work conditions are often poor, with heaving lifting and potential exposure to hazardous substances. Care work in the words of one care worker is seen as ‘hard work, rewarding, stressful’.¹⁴⁸

The risks to mental health are also high with exposure to challenging and difficult behaviours.¹⁴⁹ Care workers tend to experience poorer wellbeing than the wider population¹⁵⁰. With regards to the wider economy there is mixed evidence on the impact of zero-hours contracts, often used in domiciliary care, on individuals, with some evidence showing increased self-reporting of mental health issues among those on zero-hours contracts compared to those in permanent studies and other evidence showing a positive impact of zero-hours contracts on the physical and mental health of zero-hours workers.¹⁵¹ It is widely known that the social care sector and its workforce suffered greatly during the Covid-19 pandemic, with the initial lack of testing care home residents returning from hospital wards¹⁵² making the situation worse. The rates of Covid-19 amongst social care workers are higher than in the general population and in a context where social care workers tend to have poorer general health overall.¹⁵³ A total of 42,341 care home residents died as a result of Covid-19 between March 2020 and April 2021 and 1,290 social care workers died of Covid-19 between March 2020 and February 2022.¹⁵⁴ Care homes were particularly affected by Covid-19 due to the difficulties in implementing infection control measures in care home settings.¹⁵⁵ Since the height of the Covid-19 pandemic systemic problems within the NHS also continue to impact social care, with many people who no longer need

¹⁴⁵ Cominetti, N. (2023), op. cit.

¹⁴⁶ Daly, M. (2023) Care Workers in English Care Homes: Managing Commodification, Motivations, and Caring Ideals, *Social Politics: International Studies in Gender, State & Society*, Volume 30, Issue 3, Fall 2023, pp 795–817, 796.

¹⁴⁷ Cominetti, N. (2023), op. cit.; Daly (2023), op. cit.

¹⁴⁸ Daly (2023), op. cit., 808.

¹⁴⁹ Eurofound (2020) *Long-term care workforce: Employment and working conditions*, Publications Office of the European Union. Available [here](#). Authors: Dubois, H., Leončikas, T.; Molinuevo, D. and Wilkens, M.

¹⁵⁰ Ravalier, J., McFadden, P., Gillen, P., Mallett, J., Nicholl, P., Neill, R., Manthorpe, J., Moriarty, J., Schroder, H., & Curry, D. (2023). Working conditions and well-being in UK social care and social work during COVID-19. *Journal of Social Work*, 23(2), 165-188.

¹⁵¹ Dix, G, and Warhurst. C. (2023), op. cit.

¹⁵² National Audit Office (2020) *Readying the NHS and adult social care in England for COVID-19*. Available [here](#).

¹⁵³ Fotaki, M., Horton, A., Rowland, D., Ozdemir Kaya, D. and Gain, A. (2023) *Bailed out and burned out? The financial impact of COVID-19 on UK care homes for older people and their workforce*. Coventry: Warwick Business School. <https://ficch.org.uk/resources/reports/>.

¹⁵⁴ Fotaki et al. (2023), op. cit.

¹⁵⁵ Sims, S., Harris, R., Hussein, S., Rafferty, A.M., Desai, A., Palmer, S., Brearley, S., Adams, R., Rees, L. and Fitzpatrick, J.M. (2022) Social Distancing and Isolation Strategies to Prevent and Control the Transmission of COVID-19 and Other Infectious Diseases in Care Homes for Older People: An International Review. *Int. J. Environ. Res. Public Health*, 19(6):3450. <https://doi.org/10.3390/ijerph19063450>.

hospital care remaining in hospital wards due to lack of capacity in social care¹⁵⁶, preventing new patients from being admitted to the hospital. The Care Quality Commission worked with health and care leaders who described the system they work in as one 'in crisis' and 'shared their fears that the risk of people coming to harm represents a worrying new status quo'.¹⁵⁷

Commentators place a significant proportion of the blame for the high number of deaths among people in long term care down to the undervaluation of care and its workforce. Covid-19 revealed the false economy behind years of underfunding and worker exploitation. The low priority given to long term care and its workforce were illustrated in the delays to distributing PPE and undertaking testing for staff in the early stages of the Covid-19 pandemic.¹⁵⁸

There is evidence that during the Covid-19 pandemic the workload particularly of direct care workers increased due to a combination of covering for staff absence, increased administrative duties and taking on additional tasks.¹⁵⁹ The workload increase alongside worries about infecting family or household members or the need to support infected family members had implications for care workers' mental health. Cross sectional studies have shown that mental wellbeing and the quality of working life declined significantly among social care workers and social workers between May/July 2020 and May/July 2021, with similar findings having been found for health care professionals included in the research.¹⁶⁰ The study also reported a significant decrease in positive coping strategies (including e.g. active coping or positive reframing) and an increase in negative coping strategies (e.g. venting or self-blame) between 2020 and 2021, the first year of the Covid-19 pandemic, and called for measures to help the workforce in coping with the demands of the Covid-19 pandemic.¹⁶¹ The latest phase of this study, undertaken over November 2022 to

¹⁵⁶ Care Quality Commission (CQC) (2022a) *The state of health care and adult social care in England 2021/22*. https://www.cqc.org.uk/sites/default/files/2022-10/20221024_stateofcare2122_print.pdf; CQC (2023) *The state of health care and adult social care in England 2022/23*. Available [here](#).

¹⁵⁷ CQC (2022a), op. cit., 4.

¹⁵⁸ Comas-Herrera, A., Zalakain, J., Lemmon, E., Henderson, D., Litwin, C., Hsu, A., Schmidt, A, Arling, G., Druse, F. and Fernandez, J. (2021) *Mortality associated with COVID-19 in care homes: international evidence*. International Long-term Care Policy Network, 2nd February 2021; OECD (2021) *Rising from the COVID-19 crisis: Policy responses in the long-term care sector*. Paris: OECD.

¹⁵⁹ Fotaki, M., Horton, A., Rowland, D., Ozdemir Kaya, D. and Gain, A. (2023), op. cit.; Hussein, S., Saloniki, E., Forth, J., Turnpenny, A., Allan, S., Collins, G., Towers, A.-M., Vadean, F., Gousia, K., Bryson, A. and Richardson, L. (2020) *COVID-19 and the Wellbeing of the Adult Social Care Workforce: Evidence from the UK*. https://www.pssru.ac.uk/resscw/files/2020/12/COVID19-and-the-UK-Care-Workers_FINAL_01dec20.pdf. McFadden, P., Schroder, H., Manthorpe, J., Ravalier, J., Naylor, R, et al. (2023) *Health and social care workers' quality of working live and coping while working during the COVID-19 pandemic. November 2022 – January 2023*. Available [here](#).

¹⁶⁰ Neill, R.D., Gillen, P., Moriarty, J., Manthorpe, J., Mallett, J., Schroder, H., Currie, D., Nicholl, P.; Ravalier, J., McGrory, S.; et al. (2022) Comparing Psychological Wellbeing and Work-Related Quality of Life between Professional Groups within Health and Social Care during the COVID-19 Pandemic in the UK. *Merits*, 2, 374-386. <https://doi.org/10.3390/merits2040026>.

¹⁶¹ Neill et al. (2022), op. cit.; Gillen, P.; Neill, R.D.; Manthorpe, J.; Mallett, J.; Schroder, H.; Nicholl, P.; Currie, D.; Moriarty, J.; Ravalier, J.; McGrory, S.; et al. (2022) Decreasing Wellbeing and Increasing Use of Negative Coping Strategies: The Effect of the COVID-19 Pandemic on the UK Health and Social Care Workforce. *Epidemiologia* 3, 26-39. <https://doi.org/10.3390/epidemiologia3010003>.

January 2023, indicated persistent challenges and a need to improve health and wellbeing support.¹⁶²

Financial worries may have contributed to increased stress levels as illness or caring responsibilities for family members affected by Covid-19 could impact take home pay for those already on low pay. During the Covid-19 pandemic, the governments in the four UK countries set up funds to cover sick pay during the time care workers were legally required to isolate when testing positive for Covid-19. Yet in England that practice was variable when care workers needed to care for affected family members, with some receiving full pay and others the lower statutory sick pay or no pay at all.¹⁶³ Terms and conditions for NHS workers who fell ill due to Covid-19 were better as they received full pay during this period. There was also evidence that for some, increased working hours resulted in a fall in income because of the loss of working tax credits.¹⁶⁴ Despite government support (including e.g. via a small one-off hazard payment¹⁶⁵) there was increased need for financial support among care workers as evidenced by the Covid-19 grants awarded by the Care Workers Charity.¹⁶⁶

Personal assistants (PA) represent a small yet important part of the adult social care workforce, supporting individuals who choose to take up direct payments from the local authority to arrange their own support.¹⁶⁷ However, research on PAs is still scant, and the lack of data on the overall population of PAs means survey data may be subject to some degree of sampling biases as data cannot be weighted. A recent Skills for Care survey in England indicates that PAs work on average for more than one employer (1.3) and that they are largely directly employed by the individual, with more than one in two (56%) reported to provide services to family and friends and comparatively fewer to individuals not known to them before. When employed, the same study found that PAs are less often working on zero-hours contracts than care workers (20% compared to 35%).¹⁶⁸ There are some similarities with a recent study on PAs in Wales finding that PAs work for 1.5 employers on average and are largely

¹⁶² McFadden, P., Schroder, H., Manthorpe, J., Ravalier, J., Naylor, R, et al. (2023) *Health and social care workers' quality of working life and coping while working during the COVID-19 pandemic. November 2022 – January 2023*. Available [here](#).

¹⁶³ Fotaki, M., Horton, A., Rowland, D., Ozdemir Kaya, D. and Gain, A. (2023), op. cit.

¹⁶⁴ Fotaki, M., Horton, A., Rowland, D., Ozdemir Kaya, D. and Gain, A. (2023), op. cit.

¹⁶⁵ For an overview of one-off payments as at May 2021 in the four UK nations see Reed et al. (2022). Reed, AC, Murmann, M, Hsu, A, Turnpenny, A, Van Houtven, C, Laberge, M, Low, L-F, Hussein, S, and Allin, S. (2022). Risk Recognition Policies for the Long-Term Care Workforce during the First Year of the COVID-19 Pandemic: A Multi-Country Study. *Journal of Long-Term Care*, (2022), pp. 22–39.

¹⁶⁶ [The impact report](#) lists nearly 2700 Covid-19 awards in 2020 across the UK. [Figures available for 2021](#) indicate that most grants were related to isolation from work followed by emergency repairs/other costs or support with daily living expenses.

¹⁶⁷ Equating to 8% of all filled posts in adult social care (authors' calculation, based on Skills for Care (2023), op. cit.).

¹⁶⁸ Skills for Care (2023b) *Individual employers and the personal assistant workforce*. March 2023. Available [here](#); Compared to the Skills for Care study, the Woolham et al. study (2019), based on 105 interviews and using a wider sampling strategy, found that PAs work for more individual employers (3.2 on average compared to 1.3) and are more often self-employed (32% compared to 8%). The Woolham et al. study also reported that half of the interviewed PAs had another employment beyond their PA work.

directly employed, yet with fewer reporting to be working for a family member or friend than in the study on England (30%).¹⁶⁹

A key finding of an interview-based study with more than 100 PAs is that PAs derive great job satisfaction from supporting individuals living independently and value the flexibility of their work, yet their employment conditions were being described as 'often poor' considering contractual arrangements, sick pay, holiday pay or payment of overtime. The authors also expressed concern about the lack of regulation and oversight should problems need to be addressed.¹⁷⁰ Similar findings on high job satisfaction and 'poor employment conditions' were reported in the Welsh PA study. The study suggests that those employment conditions may be related to the individual employer's lack of expertise on employment laws and rights as this may be the first time they have assumed employer responsibilities.¹⁷¹ While support is being offered to individual employers, the study indicates that timely support at the early stages of receiving direct payment is important.¹⁷²

People may consider recruiting a **live-in care worker** to provide round the clock services while living in their home through a care provider employing a live-in carer or an agency that matches a self-employed live-in carer with the client. There is a lack of evidence of statistical data about their scope and working conditions.¹⁷³ A small qualitative study¹⁷⁴ identified a number of risk factors that can and do contribute to exploitation of live-in carers such as: isolation; dependency on the employer for housing and work, with migrants working as live-in carers recruited from abroad being dependent on accommodation; blurred boundaries between workplace and home and standard working hours and on-call times not being applied to this setting; or people employing a live-in care worker not being aware of relevant regulations.

Fair Work initiatives have evolved in Scotland and Wales to address the wider conditions of work in social care. These initiatives are covered in section 8.2.

¹⁶⁹ Wallace, S., Llewellyn, M., Garthwaite, T., Randall, H. and Sullivan, S. (2022) *Research on the Employment of Personal Assistants in Social Care*. Cardiff: Welsh Government.

¹⁷⁰ Woolham, J., Norrie, C., Samsi, K. and Manthorpe, J. (2019) The employment conditions of social care personal assistants in England. *The Journal of Adult Protection*, 21(6), pp. 296-306.

¹⁷¹ For a wider discussion on the challenges that can arise when employing PAs see Acas (2013) *Disabled and elderly people and their personal assistants: the challenges of a unique employment relationship*. Available [here](#).

¹⁷² Wallace, S., Llewellyn, M., Garthwaite, T., Randall, H. and Sullivan, S. (2022), op. cit.

¹⁷³ Ahlberg, M., Emberson, C., Granada, L., Hussein, S. and Turnpenny, A. (2022) *'The vulnerability of paid, migrant, live-in care workers in London to modern slavery'*, Rights Lab University of Nottingham. Available [here](#).

¹⁷⁴ Ahlberg et al. (2022), op. cit.

6 Recruitment and retention

Labour shortages in the adult social care sector are acute and have worsened since Brexit and the Covid-19 pandemic. The number of vacancies in England¹⁷⁵ rose to 165,000 in 2021/22 – this was the highest figure on record since 2012/13 and represented an increase by around 50% compared to 2020/2021¹⁷⁶ when the Covid-19 pandemic was at its peak. Overall, this equated to a vacancy rate of 10.7%, which was much higher than figures for the NHS (7.9%) or the wider UK economy (4.3%).¹⁷⁷ The latest figures for 2022/23 show a slight decrease of vacancy rates, falling by 0.8% to 9.9% (equivalent to 152,000 vacancies) compared to the year before.^{178 179}

Vacancy rates differ across the adult social care sector and by job type. In 2022/23, estimates are higher among direct payment recipients (11.4%) and the independent sector (9.9%) than in the public sector (8.1%) and they are also higher in domiciliary care (12.5%) compared to e.g. residential care (7.4%), which is likely to be due to differing terms and conditions in these sub-sectors.

Estimated vacancy rates in England were highest among care workers (11.8%) and personal assistants (11.4%), followed by registered nurses (11.3%), and registered managers (10.6%).¹⁸⁰ The large majority of vacancies (65%) are direct care worker job roles. Vacancy rates mean that demand for care services cannot be met and that care providers have had to hand back contracts¹⁸¹, have been unable to take on additional clients or, as a last resort, have had to close services.¹⁸² For example, where nurses had left care homes for better paid jobs in the NHS the care home could no longer offer nursing care¹⁸³. This is reflected in homes switching their CQC registration from homes *with* nursing to homes *without* nurses, in turn reducing the number of available nursing home places.¹⁸⁴ On service reductions, a recent report from the Association of Directors of Adult Social Services reported that over half a million hours of homecare could not be delivered across England due to social care staff shortages.¹⁸⁵

¹⁷⁵ The focus is on England here as it provides detailed data on the adult social care sector.

¹⁷⁶ Skills for Care (2022) *The State of the Adult Social Care Sector and Workforce in England*. Available [here](#).

¹⁷⁷ NHS and ONS figures reported in Skills for Care (2022), op. cit.

¹⁷⁸ Skills for Care (2023) *The state of the adult social care sector and workforce in England*. Available [here](#).

¹⁷⁹ Estimates for the independent sector show a further decline to 8.1% in 2023/24 ([Skills for Care](#)).

¹⁸⁰ Skills for Care (2023), op. cit.

¹⁸¹ See for example, Association of Directors of Social Services (2023) *ADASS Spring Survey 2023*. Available [here](#).

¹⁸² Revealing Reality (2022) *Recruitment and retention in adult social care: A qualitative study*. Available [here](#); Hft and Care England Analysis by CEBR (2023) *Sector Pulse Check. A snapshot of finances and workforce in the adult social care sector in 2022*. Available [here](#); Care Quality Commission (CQC) (2023) *The state of health care and adult social care in England 2022/23*. Available [here](#).

¹⁸³ Care Quality Commission (CQC) (2022a) *The state of health care and adult social care in England 2021/22*. https://www.cqc.org.uk/sites/default/files/2022-10/20221024_stateofcare2122_print.pdf..

¹⁸⁴ Care Quality Commission (CQC) (2022a), op. cit.

¹⁸⁵ Association of Directors of Social Services (2023) *ADASS Spring Survey 2023*. Available [here](#).

In both domiciliary and residential care in England recruitment was reported to be a bigger issue than retention.¹⁸⁶

Brexit and the end of freedom of movement within the EU resulted in a decreased supply of labour for adult social care due to EU nationals leaving for their home countries¹⁸⁷ and a new points-based immigration system being introduced.

Disentangling the impacts of the end of free movement from other aspects of the post Covid-19 pandemic labour market is difficult.¹⁸⁸ However, the Migration Advisory Committee's review of the social care workforce found that the industry was facing serious staff shortages and that these have been worsened by the end of free movement, although they are predominantly caused by other factors, such as insufficient funding in the sector.¹⁸⁹

Senior care workers and registered managers were added to the shortage list of occupations in 2021, with care workers being included as of February 2022, bolstering the percentage of new starters arriving in the UK among all new starters to an estimated 11% in 2021/22.¹⁹⁰ While this is beginning to increase labour supply it is still short of the numbers required to fill the vacancies. In its latest submission to government the Migration Advisory Committee (MAC) recommends a number of changes, including opening the route for care workers indefinitely rather than for a year as in 2022. Their research has also shown that there are barriers to the take up of the visa due to the cost incurred and the administrative burden, particularly for SMEs.¹⁹¹ International recruitment was considered to be the fourth most successful recruitment strategy identified by 15% in a recent sector wide.¹⁹² The latest Home Office figures show a steep increase in visas granted to care workers and senior care workers via the Skilled Worker - Health and Care worker route, rising from just under 7,000 in year ending March 2022 to nearly 58,000 in year ending March 2023.¹⁹³ As a result of the increase in visas, the latest labour market enforcement strategy report has identified an increased risk of labour non-compliance in the social care sector, largely in terms of illegal working. Risks may include debt bondage, if migrants are charged fees to come to work in the UK or migrants working legally but being

¹⁸⁶ Care Quality Commission (CQC) (2022b) *Appendix A to Executive Team Report to the Board (Chief Inspector of Adult Social Care's report). Update on adult social care workforce*; CQC (2023), op. cit., with regard to adult social care.

¹⁸⁷ Revealing Reality (2022), op. cit.

¹⁸⁸ Sumption, M., Forde, C., Alberti, G. and Walsh, P.W. (2022) *How is the end of free movement affecting the low-wage labour force in the UK?*. ReWAGE and Migration Observatory Report, August 2022. https://warwick.ac.uk/fac/soc/ier/rewage/publications/labour_shortages_paper_final.pdf.

¹⁸⁹ Migration Advisory Committee (MAC) (2022) *Adult Social Care and Immigration*. CP665.

¹⁹⁰ Skills for Care (2022) *The State of the Adult Social Care Sector and Workforce in England*. Available [here](#).

¹⁹¹ Migration Advisory Committee (MAC) (2022) *Adult Social Care and Immigration*. CP665.

¹⁹² Hft and Care England Analysis by CEBR (2023) *Sector Pulse Check. A snapshot of finances and workforce in the adult social care sector in 2022*. Available [here](#).

¹⁹³ Home Office (2023) *Why do people come to the UK? To work*. Available [here](#).

exploited.¹⁹⁴ There is evidence that supports this increased risk. As an example, CQC referrals about modern slavery, rose from 4 in 2021-22 to 37 the following year, and are expected to rise even further, and Unseen, a Bristol-based anti-slavery charity, reported a more than 10 fold increase in people working in care ringing its helpline between 2021 and 2023.¹⁹⁵ Findings from a recent qualitative study on international recruitment indicate that treatments of care workers who have come to England via the visa route can range from ‘positive and supportive’ to “poor” perhaps ethically questionable treatment, to exploitative treatment’.¹⁹⁶

During the pandemic the mandatory vaccination policy for people deployed in care homes and other care settings, in place during November 2021 to March 2022, was also reported to have contributed to recruitment challenges¹⁹⁷ and loss of staff.¹⁹⁸

6.1 Reasons for recruitment challenges

A recent survey among adult social care providers in England identified four key reasons for recruitment challenges, listed in the order of importance: pay, better job opportunities elsewhere, poor perceptions of a care career and the challenging nature of care work.¹⁹⁹ Pay has also been identified as a key issue in earlier research alongside poor perceptions of social care.²⁰⁰

Adult social care is a low pay sector, with pay differentials to other sectors having been eroded over time (see section 4) and care providers being unable to pay wages similar to those in competing sectors as pay rates largely depend on the fee rates local authorities pay for the services care providers offer. Pay and working conditions affect the perceptions of social care as a career. Research also indicates that these perceptions are influenced by the public image of social care seeing it as a ‘low-skilled’ job and a media focus on negative social care news.²⁰¹ Care workers speak of their work being ‘un(der) appreciated’ by the public who were perceived as not fully

¹⁹⁴ HM Government (2023b) *United Kingdom Labour Market Enforcement Strategy 2023/24 – Annex B: Labour Market and Non-compliance Risk Analysis*. Director of Labour Market Enforcement Margaret Beels. Available [here](#).

¹⁹⁵ Booth, R. (2024) Modern slavery in social care surging since visa rules eased. *The Guardian*, 21 January 2024.

¹⁹⁶ Kharicha, K., Manthorpe, J., Kessler, I., and Moriarty, J. (2023) *Understanding the impact of changes to the UK Health and Care Visa System on the adult social care workforce in England, Phase 1: The Visa Study*. London: NIHR Policy Research Unit in Health and Social Care Workforce, p. 62. The Policy Institute, King's College London. Available [here](#).

¹⁹⁷ CQC (2022), op. cit., cited in Fotaki, M., Horton, A., Rowland, D., Ozdemir Kaya, D. and Gain, A. (2023), op. cit.

¹⁹⁸ A DHSC impact assessment gives an estimate of around 7% of staff in CQC registered homes or 40,000 staff unable to continue to work because they do not have the required vaccination (DHSC, 2021 cited in Hft and Care England Survey, Cebr analysis, 2023).

¹⁹⁹ Hft and Care England Analysis by CEPR (2023), op. cit.

²⁰⁰ See for example Moriarty, J., Manthorpe, J. and Harris, J. (2018) *Recruitment and retention in adult social care services*. Available [here](#).

²⁰¹ See for example Moriarty, J., Manthorpe, J. and Harris, J. (2018), op. cit.

understanding the nature of their care work, instead perceiving care as ‘menial and therefore not valuing care work and those who do it’.²⁰²

Some geographical areas may experience particular recruitment challenges due to lack of public transport in rural areas for those not driving, the need for care workers to use their own car, the distance of travel between service users that can impact their effective pay, or high housing costs in an area where there is demand for care services.²⁰³

6.2 Strategies to help address recruitment challenges

In the short-term care providers may have to resort to expensive agency staff to fill gaps in staffing, with about two thirds of adult social care providers having said that their agency costs have increased.²⁰⁴ There is also some evidence that agency workers are more difficult to recruit, adding further pressure on staffing.²⁰⁵

A recent survey among residential care providers found that they were collectively adopting a range of measures to help alleviate recruitment challenges, including for example, increased pay (38%), paid overtime (34%), wellbeing initiatives (32%), investment in staff training and qualifications (26%), developing career pathways (19%), and improved terms and conditions (17%).²⁰⁶ Another study highlighted some further innovations for social care workers, which include practice learning, fast-track graduate programmes and apprenticeships for social care workers.²⁰⁷

For a number of years, there has been a stronger focus on value-based recruitment and retention which pays greater attention to the motivations of applicants and how their values align with those of the organisation. Care providers who use value-based recruitment reported that this has a positive impact on staff developing their skills, their performance and their sickness absence rate²⁰⁸ and retention.²⁰⁹ In addition, there is

²⁰² Daly and Fisher (2023), op cit.

²⁰³ House of Commons Health and Social Care Committee (2022) *Workforce: Recruitment, Training and Retention in Health and Social Care*, July. HC 115.; Moriarty, J., Manthorpe, J. and Harris, J. (2018), op. cit.

²⁰⁴ Care Quality Commission (CQC) (2022b) *Appendix A to Executive Team Report to the Board (Chief Inspector of Adult Social Care’s report). Update on adult social care workforce*. Available [here](#); Hft and Care England Analysis by CEBR (2023) *Sector Pulse Check. A snapshot of finances and workforce in the adult social care sector in 2022*. Available [here](#); Fotaki, M., Horton, A., Rowland, D., Ozdemir Kaya, D. and Gain, A. (2023) *Bailed out and burned out? The financial impact of COVID-19 on UK care homes for older people and their workforce*. Coventry: Warwick Business School. <https://ficch.org.uk/resources/reports/>.

²⁰⁵ Care England (2023), cited in Hft and Care England Survey, Cebr analysis (2023) op. cit.

²⁰⁶ Care Quality Commission (CQC) (2022a) *The state of health care and adult social care in England 2021/22*. Available [here](#).

²⁰⁷ Edwards, D., Trigg, L., Carrier, J., Cooper, A., Csontos, J., Day, J., Gillen, E., Lewis, R. and Edwards, A. (2022) A rapid review of innovations for attraction, recruitment and retention of social care workers, and exploration of factors influencing turnover within the UK context. *Journal of Long Term Care*, pp. 205–221. DOI: <https://doi.org/10.31389/jltc.130>.

²⁰⁸ Consilium Research and Consultancy Ltd. (2016) *Study into the impact of a values based approach to recruitment and retention*. Available [here](#).

²⁰⁹ Skills for Care (2020) *A cross-sectional survey investigating the prevalence of values-based recruitment and retention approaches in the adult social care sector in England. Baseline report*. Available [here](#).

also some evidence from social care managers implementing value-based recruitment that it supports efficiency and staff retention.²¹⁰ However, there is also evidence that care providers may have to compromise on value-based recruitment to be able to fill a vacancy²¹¹ and that managers would benefit from training in recruitment processes.²¹²

National recruitment campaigns have been run by the DHSC for several years to help boost staff numbers. During the 'Made With Care' campaign, run over 2022 to 2023, advertising appeared on a range of digital channels and radio directing job seekers to a website with further information on careers in adult social care and local job opportunities.²¹³ While this twin approach is a great resource for those exploring and/or seeking jobs in social care, there is also a need to improve pay and working conditions to improve both recruitment and retention. There is however evidence that an earlier national recruitment campaign *Every day is different*, run in 2019, increased jobs enquiries and helped recruitment.²¹⁴ Successive evaluations of Scotland's social care campaign titled '*There's More to Care than Caring*', launched in 2020, found that while they increased awareness of social care and the probability of people beginning to move into social care jobs, it was mainly people already considering working in social care.²¹⁵

Looking at other innovative measures, there is evidence that the two-week subsidized pre-employment pilot programme for unemployed young people - that comes with a recruitment subsidy for the employer of £650 - helped employers with recruitment as it supported young people in terms of their basic care skills and soft skills.²¹⁶

6.3 The extent of retention challenges

The adult social care sector also faced retention challenges with a labour turnover rate of 28.2% among all directly employed staff in England in 2022/23.²¹⁷ Similar to recruitment, there has also been an upward trend in turnover rates since 2012/13 until 2019/20²¹⁸, followed by a fall in 2020/21 during the peak of the Covid-19 pandemic

²¹⁰ Rouse, J., Atkinson, C., Lupton, B., Willocks, K., Acton, S., Rivers, L., Shorley, J. and Woolnough, H. (2023) *How to develop the people management skills of line managers. Evidence from an evaluation of online learning interventions*. Available [here](#).

²¹¹ Moriarty, J., Manthorpe, J. and Harris, J. (2018) *Recruitment and retention in adult social care services*. https://kclpure.kcl.ac.uk/portal/files/86594147/Recruitment_and_retention_report.pdf; Rouse et al. (2023), op. cit.

²¹² Rouse et al. (2023), op. cit.

²¹³ <https://www.gov.uk/government/news/made-with-care-campaign-highlights-opportunities-for-careers-in-care>.

²¹⁴ Edwards, D., Trigg, L., Carrier, J., Cooper, A., Csontos, J., Day, J., Gillen, E., Lewis, R. and Edwards, A. (2022) A rapid review of innovations for attraction, recruitment and retention of social care workers, and exploration of factors influencing turnover within the UK context. *Journal of Long-Term Care*, pp. 205–221. DOI: <https://doi.org/10.31389/jltc.130>.

²¹⁵ Pringle, E. (2023) *Ad campaign can't shift negative view of care jobs*. Available [here](#). The blog uses Freedom of information data.

²¹⁶ Dobson, C. and Byrne, Y. 2010. *Evaluation of the Care First careers pilot: Employer research*. London: Department for Work and Pensions, cited in Edwards et al. (2022), op. cit.

²¹⁷ Skills for Care (2023), op. cit.

²¹⁸ Skills for Care (2022), op. cit.

and a slight further fall by 2022/23²¹⁹. On average, turnover was highest among the independent sector (30.4%) and much lower among personal assistants (19.9%) and in the public sector (15.4%), with high rates being reported among both the residential (30.7%) and the domiciliary care sector (28.2%), the two biggest care settings. Those occupations with the highest vacancy rates also had the highest turnover rates: care workers (35.6%), registered nurses (32.6%), and registered managers (23.2%), with the exception of personal assistants (19.9%).²²⁰

6.4 Implications for care quality

These difficulties in recruitment have negative implications for care quality.²²¹ Demand for multiple forms of care services is predicted to continue to rise and outstrip the numbers of available workers. In elder care, for example, the growth in workers has been outpaced by the growth in clients.²²² Particular concerns include the undermining of the reputation and legitimacy of organisations as reliable providers of services. There is also the drain on resources from repeated recruitment and induction and training rounds on already under-resourced organisations. Moreover, the inability to recruit is seen as reasons why some external for profit and voluntary sector providers hand back their contracts with local authorities, meaning they no longer provide those services.²²³

Moreover, a recent CQC report noted that staff shortages can result in a reduction of activity sessions in care homes, poor personal care and inappropriate responses to challenging behaviours in exhausted staff.²²⁴ More significantly, one study has found that a 10% increase in turnover is associated with higher mortality among nursing home care residents and a decrease in quality of care measured by the physical environment and infection control.²²⁵ A study using the ASC-WDS data set found that staff vacancies are negatively associated with care quality, indicated through good and outstanding CQC ratings, and retention was positively associated with care quality.²²⁶

6.5 Where do leavers go?

A recent analysis of the Annual Population Survey showed that leavers may either remain within the adult social care sector, take on care roles in the wider care sector, health care roles (particularly healthcare support workers) or jobs outside of the health and social care sector or they withdraw from the labour market altogether. Overall, the

²¹⁹ Skills for Care (2023), op. cit.

²²⁰ Skills for Care (2023), op. cit.

²²¹ CQC (2022a), op. cit.; Audit Scotland (2022) *Social Care Briefing*. Audit Scotland, Edinburgh.

²²² OECD (2020) *Spending on Long-term Care*, Paris: OECD, <http://www.oecd.org/health>.

²²³ Audit Scotland (2022) *Social Care Briefing*. Audit Scotland, Edinburgh; ADASS (2022) [ADASS Spring Budget Survey 2022](#).

²²⁴ Care Quality Commission (CQC) (2022a) *The state of health care and adult social care in England 2021/22*. Available [here](#).

²²⁵ Akosa, AY, and Bowblis, J (2016) *The Impact of Nurse Turnover on Quality Care and Mortality in Nursing Homes; Evidence from the Great Recession*, Upjohn Institute for Employment Research.

²²⁶ Allan, S., and Vadean, F. (2021) 'The Association between Staff Retention and English Care Home Quality'. *Journal of Aging and Social Policy*. 33(6):708-724.

analysis revealed that ‘most of the transitions in and out of care work in ASC [adult social care] are to or from other caring roles (broadly) defined in the Health and Social Care sector. The extent of mobility between ASC and other low-wage sectors such as Retail, Hospitality or Cleaning is very limited’.²²⁷ However, as mentioned before, there is anecdotal evidence that the opening of a retail outlet close to a care organisation can increase labour turnover.²²⁸ A recent study notes increasing job moves from care into retail or hospitality, in part because of increased wage rates being offered in hospitality.²²⁹

6.6 Reasons for leaving and measures to help increase retention

Pay was seen as the single most important reason for adult social care staff leaving their jobs²³⁰, followed by better job opportunities elsewhere and the challenging nature of the work.²³¹ Similarly when care workers were asked during the Covid-19 pandemic why they have considered leaving their job, pay, working conditions and impact on mental health were the most important reasons.²³² There is evidence that large numbers of providers have used (financial) incentives (pay (76%) and retention incentives (53%)) to help mitigate recruitment and retention challenges.²³³ This may have been facilitated in part by a recent government initiative providing additional funding to local authorities via the Fair Cost of Care Fund, enabling local authorities to an extent to raise the fee they pay to care providers.

Similarly, a study investigating direct care staff turnover within the social care sector using the adult social care workforce development dataset (ASC-WDS), found ‘that everything else being equal, wages and employment conditions (i.e. full-time contracts and contracts with guaranteed working hours) significantly reduce job separation’.²³⁴

Also using ASC-WDS, another study analysing the combined effect of several aspects of employment found a large reduction in retention between those ‘care workers who were paid over £9.50, worked full-time hours were not on a zero-hours contract, received training, and had a qualification relevant to social care; compared to those

²²⁷ Forth, J and Bryson, A. (2022) *Recruitment and Retention in Adult Social Care: Evidence from the Annual Population Survey*, p. 22. Available [here](#).

²²⁸ House of Commons Health and Social Care Committee (2022) *Workforce: recruitment, training and retention in health and social care*. Third Report of Session 2022–23. Available [here](#). (July 2022).

²²⁹ Hft and Care England Analysis by CEBR (2023) *Sector Pulse Check. A snapshot of finances and workforce in the adult social care sector in 2022*. Available [here](#).

²³⁰ House of Commons Health and Social Care Committee (2022), op. cit. and Hft and Care England Survey, Cebr analysis, op. cit.

²³¹ Hft and Care England Survey, Cebr analysis (2023), op. cit.

²³² Daly and Fisher (2023), op. cit.

²³³ Hft and Care England Survey, Cebr analysis (2023), op. cit.

²³⁴ Vadean, F. and Saloniki, E.-C. (2023) Job Quality and Job Separation of Direct Care Workers in England, *Innovation in Aging*, 7(2), 1. Their data analysis showed that a 10% increase in wages would result in a 3% reduction in the probability of direct care worker turnover. Using the example of domiciliary care, uplifting the mean wages in the independent sector to the mean wages of those in the public sector (equivalent to 23% increase in wages) would decrease the probability of staff changing jobs within the care sector by 23%. This would however not be possible without increased funding from central and local government.

‘whose role did not fit any of the criteria’ (28.1% compared to 48.7%)²³⁵. This suggests that the combined effect of different elements of good work does have an impact on retention.

Analysis of the Annual Population Survey showed that temporary contracts increased the likelihood of leaving one’s job (by 9%) and so did contracts involving non-standard working hours. Factors that reduced the likelihood of leaving included having recently received or been offered job related training (by 6%) and higher pay levels, although the authors emphasise that there is a weaker association between pay and leaving than compared to other job characteristics.²³⁶

Similarly, investment in learning and development was considered to be a key factor among organisations with a low turnover rate, alongside others including ‘involving colleagues in decision-making’.²³⁷ Modelling of the latest ASC-WDC data also showed that investment in training (i.e. more than 30 instances of training) reduced turnover substantially.²³⁸ This may be because training enhances skills in areas that have become more complex or because it may offer a progression route.

In contrast, an econometric analysis found that training led to a slight increase in the likelihood of domiciliary care workers changing jobs within social care, while it did not impact the likelihood of retention in residential care, with the data having been controlled for unobserved heterogeneity in both cases.²³⁹

Differences in findings may in part be due to the datasets being used. The ASC-WDS relies on employer data about their staff and is prone to missing data on the reasons for staff leaving as they may be unknown to the employer. In contrast, the Annual Population Survey collects data directly from individuals, including on reasons for any job change. This is likely to provide more accurate data yet the number of people it draws on is smaller than those covered by ASC-WDS. There are also different types of training: mandatory training and more professional development focused training, such as level 3 training for senior care workers or training helping to better support service users, which can help to retain staff as it offers development perspectives and it may also open up new opportunities elsewhere.

A recent ReWAGE policy paper²⁴⁰ suggested that social care labour market modelling could play a greater role in policy decisions, including in helping to better understand recruitment and retention by analysing the interplay of different good work indicators, including pay, on recruitment and retention, building on the research cited earlier. The ASC-WDS dataset, the author argues, provides rich data, that could be linked to other data sets, and that statistical advances can help to address any concerns about the

²³⁵ Skills for Care (2023), op. cit., p.169

²³⁶ Forth and Bryson (2022), op. cit.

²³⁷ [Skills for Care \(2017\)](#) cited in Skills for Care (2022), op. cit.

²³⁸ Skills for Care (2023), op. cit.

²³⁹ Vadean and Saloniki (2023), op. cit.

²⁴⁰ Bosworth (2023) *Reversing the staffing problems in adult social care – the case for a new approach*. ReWAGE Policy Brief. Available [here](#).

representativeness of the ASC-WDS data as data are provided on a voluntary basis by employers.

Overall, of the few studies identified, including those using ASC-WDS, most suggest that the combined effect of different elements of good work does have a positive impact on retention.

6.7 UK evaluations of recruitment and retention measures in social care

According to a recent rapid evidence review²⁴¹ there is limited evidence on innovative solutions addressing recruitment and retention in social care in the UK. The evidence that exists found (a) that the Skills for Care led care work Ambassador programme helped improve retention, (b) that the national recruitment campaign *Every day is different*, increased jobs enquiries and helped recruitment, (c) that value-based recruitment helped improve recruitment and retention, and (d) that the two-week subsidized pre-employment pilot programme helped employers with recruitment.

As mentioned before paid care workers are outnumbered by unpaid and informal carers supporting their partner, family or friends. This next section therefore explores the impact of informal care on the carer and argues that those considering becoming care givers should have a real choice how they can best support their loved one and receive better support if they become the informal carer.

²⁴¹ Edwards et al. (2022), op. cit.

7 Unpaid and informal carers

Few people are afforded the time and reflective space to think about and subsequently decide to take on an informal caregiving role. A combination of life events and social circumstances will typically unfold, often at pace, where people find themselves gradually and increasingly engaged in a range of activities and managing different responsibilities that are defined as informal caregiving. For many, the roles are undertaken due to affection, family kinship and structures, and expected and/or presumed as part of cultural, gender, social, and community norms and responsibilities, yet cost of buying care services may also play a role in the decision making.

Recent Census 2021 data suggest there are an estimated 5 million carers aged 5 and over in England and Wales²⁴², with Carers UK reporting an estimated 10.6 million in the UK in 2022²⁴³, who provide unpaid care and support to a relative, partner, or friend with long-term or terminal health conditions, disability, or care needs related to old age. Social mobility, housing, and employment considerations also mean that a sizeable proportion provide care from a geographical distance²⁴⁴ alongside their other roles and responsibilities such as caring for a young family, engagement in education, training, and/or employment. A higher proportion of females (10.3% compared to 7.6% of men in England) and those aged over 50 years provide unpaid care²⁴⁵, and overall higher rates of unpaid care are recorded in the North East (10.1%), the North West (9.7%) and Wales (10.5%, compared to 8.9% for England).²⁴⁶

Informal caregivers make substantial contributions to population health and wellbeing and have become an essential feature in our health and social care systems, and communities, with their numbers expected to rise by 2050.²⁴⁷ The annual financial value of informal care, across England and Wales, is calculated at £162 billion and reportedly exceeds the total NHS budget for England.²⁴⁸

Caregiving can be rewarding and associated with positive emotions and experiences that, for some, include an increased sense of self-worth, self-esteem, self-confidence, and awareness of their own strengths and capabilities. These positives might also include a greater sensitivity and appreciation of the needs of individuals and

²⁴² Office for National Statistics (ONS) (2023a), [Unpaid Care, England and Wales: Census 2021](#). Statistical bulletin.

²⁴³ Carers UK (2022) *State of caring survey 2022. A snapshot of unpaid care in the UK*.

²⁴⁴ Bei, E., Rotem-Mindali, O. and Vilchinsky, N. (2020) Providing Care From Afar: A Growing Yet Understudied Phenomenon in the Caregiving Field. *Frontiers in psychology*, 11, 681. <https://doi.org/10.3389/fpsyg.2020.00681>.

²⁴⁵ ONS (2023b) [Unpaid care by age, sex and deprivation, England and Wales: Census 2021](#).

²⁴⁶ ONS (2023a). op. cit.

²⁴⁷ Pickard, L. (2008). *Informal care for older people provided by their adult children: projections of supply and demand to 2041*. Report to the strategy unit (cabinet office) and the Department of Health. London, UK: Personal Social Services Research Unit.

²⁴⁸ <https://www.sheffield.ac.uk/news/cost-unpaid-care-england-and-wales-now-exceeds-nhs-budget#:~:text=The%20value%20of%20unpaid%20care,156%20billion%20for%202020%2D21>.

communities affected by disabilities and reorganisation of their life priorities.²⁴⁹ There are, however, negative health impacts commonly linked to being an informal carer, which can render carers with their own care, wellbeing, and social needs and adversely affect their quality of life and outcomes, including directly impacting their inclusion within the labour market and access to paid, secure, and flexible employment.

The evidence base highlights positive associations between informal caregiving roles and poorer health functioning of carers, which have been largely well established across different studies employing mixed methods, sampling frames, and carer participants. A greater proportion of these studies have tended to focus on and/or capture adverse effects of caring roles on mental wellbeing, including stress related conditions and carer reports of care burden. In a recent systemic review of carers of adults living with severe mental illness, rates of depression in carers ranged between 12-40% in studies.²⁵⁰

According to Carers UK, 72% of UK carers have reported their mental health had suffered because of their role²⁵¹ and more recently have described their mental health as being worse than their physical health.²⁵² The English National Adult Psychiatric Morbidity Survey (2007) identified a positive relationship between being an informal caregiver and reporting psychiatric symptoms that fell within a clinical range, and with a noticeable decline in carer mental health in those providing 10 hours of caregiving or more per week.²⁵³ Data from the UK Household Longitudinal Study suggests that it is women in longer-term caregiving roles (in this study, defined as those whose caregiving roles extended beyond 3 years) or engaged in intermittent episodes of caregiving, who were more likely to report the highest levels of poorer mental health when compared to non-caregiving peers.²⁵⁴ Likewise, data drawn from 195,364 carers, as part of 2011-2012 GP Patient Survey, highlighted poorer quality of life in carers compared to their non-caregiving peers, with the poorest levels in younger carers (aged less than 45years) and those with an increasing caregiving load (>50hrs per week).²⁵⁵

²⁴⁹ Lee, Y., and Li, L. (2022). Evaluating the Positive Experience of Caregiving: A Systematic Review of the Positive Aspects of Caregiving Scale. *The Gerontologist*, 62(9), e493–e507. <https://doi.org/10.1093/geront/gnab092>.

²⁵⁰ Prasad, F., Hahn, M. K., Chintoh, A. F., Remington, G., Foussias, G., Rotenberg, M., and Agarwal, S. M. (2023). Depression in caregivers of patients with schizophrenia: a scoping review. *Social psychiatry and psychiatric epidemiology*, 10.1007/s00127-023-02504-1.

²⁵¹ Carers UK (2018). *State of caring*. Carersuk.org/stateofcaring.

²⁵² Carers UK (2022). *State of caring survey 2022. A snapshot of unpaid care in the UK*.

²⁵³ Smith, L., Onwumere, J., Craig, T., McManus, S., Bebbington, P. and Kuipers, E. (2014). Mental and physical illness in caregivers: results from an English national survey sample 2007. *British Journal of Psychiatry*, 205, 3 197-203.

²⁵⁴ Lacey, R. E., McMunn, A. and Webb, E. (2019). Informal caregiving patterns and trajectories of psychological distress in the UK Household Longitudinal Study. *Psychological medicine*, 49(10), 1652–1660. <https://doi.org/10.1017/S0033291718002222>.

²⁵⁵ Thomas, G.P.A., Saunders, C.L., Roland, M.O. and Paddison, C.A.M (2015). Informal carers' health-related quality of life and patient experience in primary care: evidence from 195,364 carers in England responding to a national survey. *BMC Family Practice*, 16:62.

Despite the predominance of literature focusing on carer mental health, we also know that being in a caregiving role can also be associated with poorer physical health. Carers can report reduced satisfaction with their physical health²⁵⁶ and feel that their physical health has suffered because of their role and deteriorated over time.²⁵⁷ Carers UK 2022 survey data suggest that carers' self-reports of having overall better health (i.e., physical, and mental health) were more likely for those who were not struggling financially and who were employed. However, a greater proportion of carers who were also in employment worried most about not having time to prioritise their health (42%) compared to full time carers or those unable to work (36%).

A large proportion of carers who combine employment have worries about how they can continue to combine both.²⁵⁸ Factors underpinning these worries are varied but can include concerns about the inflexibility and incompatibility of work demands with caregiving and breaching revised benefit thresholds (e.g., carers allowance).²⁵⁹ Further, local authority spending and service support for carers has undergone a significant (11%) reduction from 2015/6 to 2020/21, including direct payment for carers and provision of and access to support services.²⁶⁰ This is set within a background context where 1 in 5 carers can report being socially isolated and just under half can have financial difficulties and struggle in low-income households.²⁶¹ A mixed economy of informal and paid care is essential to the sustainability of communities and society²⁶² and to date, we are not short of policies and public commitments of support to unpaid carers.²⁶³ There is, however, a struggle on how best to translate the proclamations, policy briefings and broad evidence base into an equitable, functional and transparent system that can deliver meaningful changes for unpaid carers and does not render

²⁵⁶ Thomas et al. (2015), op. cit.

²⁵⁷ Carers UK (2022). *State of caring survey 2022. A snapshot of unpaid care in the UK.*

²⁵⁸ Carers UK (2022), op. cit.; CIPD (2020) *Supporting working carers. How employers and employees can benefit.* Available [here](#).

²⁵⁹ The carer's allowance is paid to those who care for a person in receipt of certain benefits for at least 35 hours a week if their work-related income does not exceed a certain amount (£151 per week for 2024/25, after deductions). There have been recent media reports about carers having been asked by the Department for Work and Pensions (DWP) to repay their carers allowance as they had exceeded the earnings threshold without them being aware of it. Yet in those case reported, the DWP notice was only received some time after the earnings threshold had been exceeded, resulting in significant repayments for those affected. Crew, J. and Johns, T. (2024). *Unpaid carers shocked at having to repay thousands.* BBC News, 12 April 2024. Available [here](#).

²⁶⁰ Paddison, C. and Crellin, N. (2022) *How far have we come in improving support for unpaid carers in England?* Research report, Nuffield Trust.

²⁶¹ <https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-survey-of-adult-carers/england-2021-22>; Carers UK (2022). *State of caring survey 2022. A snapshot of unpaid care in the UK.*

²⁶² Archbishops' Commission on Reimagining Care (2023) *Care and Support Reimagined: A National Care Covenant for England*, The Archbishops of Canterbury and York.

²⁶³ For example, Archbishops' Commission on Reimagining Care (2023), op. cit. <https://www.nuffieldtrust.org.uk/research/falling-short-how-far-have-we-come-in-improving-support-for-unpaid-carers-in-england>
<https://www.health.org.uk/publications/long-reads/understanding-unpaid-carers-and-their-access-to-support>.

carers (and, by implication), care recipients, and health and social care systems more vulnerable and disadvantaged.

In a fair system, it could be argued that family carers, together with the person with care needs, would be free to choose whether they wanted to provide care and support and the level they wished to provide. Those who take on a bigger role would be supported to do so and could take breaks regularly.²⁶⁴

This suggests that too great a focus on the labour market and overall economic arguments could push the debate too far toward care being provided by the care workers at the expense of a reasonable balance which includes, but also supports, unpaid carers. Moreover, though it is important to know how much hidden subsidy unpaid carers contribute to the overall care budget, caution is required to avoid the message or implication that all care should be done by paid staff. Further, whilst we need to know how much income is foregone by unpaid carers²⁶⁵, such information should not be based on an assumption that all would prefer to be devoting the time to paid employment rather than informal care. It also means that future employment in the care sector should include roles which are focussed on supporting unpaid carers and that employment patterns allow the kind of flexibility that could resource things like respite for unpaid carers. This means that the shape of jobs in the sector should change.

The major proposal of the Archbishops' Commission on Reimagining Care²⁶⁶ is for the establishment of a National Care Covenant, which speaks to calls and recommendations from other groups (e.g. Carers UK²⁶⁷ and Nuffield Trust²⁶⁸).

The covenant would outline the mutual rights, responsibilities and role of citizens, families, communities, and the state both in providing support and paying for it. It is suggested to envisage something akin to the establishment of the NHS Constitution and the process which includes cross-party support and a co-production with patients and staff. A new deal for carers and communities would require the state to commit to providing a level of care and support that ensures that informal caring relationships can be entered into out of choice and out of their own affection rather than necessity. To achieve this, a realignment of the balance where responsibility lies is required. Further, the covenant would like to see a change in how carers are identified (e.g., care planning meetings), and that their contributions are recognised and valued, and they are supported and empowered. Specifically, the covenant would reflect the following:

- A greater role for, and investment, in communities which enables everyone to stay well, including older people and disabled people.

²⁶⁴ Archbishops' Commission on Reimagining Care (2023), op. cit., p.22.

²⁶⁵ See Thomson, S., Jitendra, A. and Woodruff, L. (2023) *The caring pay penalty*. Available [here](#).

²⁶⁶ Archbishops' Commission on Reimagining Care (2023), op. cit.

²⁶⁷ Carers UK (2022). *State of caring survey 2022. A snapshot of unpaid care in the UK*.

²⁶⁸ Paddison, C. and Crellin, N. (2022) *How far have we come in improving support for unpaid carers in England?* Research report, Nuffield Trust.

- A new deal for unpaid carers which ensures they have the practical, financial, and emotional support to be able to provide care, maintain their relationships and live a full life themselves.
- A stronger role for the state at national level in guaranteeing universal access to care and support, providing security against the costs of care, and defining entitlements and upholding rights.
- Acceptance of our mutual responsibilities as citizens, including as taxpayers, neighbours and members of communities, and as people who draw on care and support and family members.²⁶⁹

The Archbishops' Commission proposed that where family members have chosen to provide a large degree of care that would otherwise fall to the state, they should receive support to do this with financial benefits and protected restorative breaks. Financial awards should reflect the caregiving load in terms of the hours spent in caregiving activities and the intensity of their care. The Carer's Allowance is £81.90 per week in 2024/25, if you care for someone for at least 35 hours a week. A review of the Carer's Allowance is needed. Moreover, a system that can support direct payments to pay for family carers, as in Germany, and temporary provisions that were introduced during Covid-19, should be considered. Unpaid carers are often forced to reduce their hours or even leave their paid jobs. A consideration of policies and strategies to support unpaid carers who are working to remain in paid employment is key. Government support and legislation, to ensure employers prioritise, communicate and provide needs to Carer's Leave, including paid leave and rights to request flexibility from day one of hire, is needed.²⁷⁰ Carers have their own support needs that can be independent of care recipients. However, support for carers is typically provided during times of crisis. Unpaid carers should be entitled to take breaks at a time, place and duration that suits them and the person they care for, with longer paid breaks for those who need them.²⁷¹

Existing evidence shows that few carers (1 in 10) request support from their local authority and less than one third receive direct support.²⁷² It is important to acknowledge how caregiving roles can have negative implications for a carer's future finances, which might include their access to and level of state pension, and disposable income. The UK current system of state pensions provision relies heavily upon individual national insurance (NI) contributions. Consequently, carers in either low paid jobs (i.e. falling below the threshold to pay national insurance), unable to

²⁶⁹ Archbishops' Commission on Reimagining Care (2023), op. cit., p.31.

²⁷⁰ The Carer's Leave Bill, which has received royal assent on 24 May 2023 and is expected to come into force in April 2024, will introduce a statutory entitlement to five days unpaid carers leave per calendar year, for employees that are providing or arranging care from day one of the employment, with a 'growing number' of employers reported to already offering paid carers leave (Carers UK, Preparing for the Act, 2023. Available [here](#)).

²⁷¹ Archbishops' Commission on Reimagining Care (2023), op. cit., p.36.

²⁷² Onwumere, J., Creswell, C., Livingston, G., Shiers, D., Tchanturia, K., Charman, T., Russell, A., Treasure, J., Di Forti, M., Wildman, E., Minnis, H., Young, A., Davis, A. and Kuipers, E. (2021). COVID-19 and UK family carers: policy implications. *The Lancet. Psychiatry*, 8(10), 929–936. doi.org/10.1016/S2215-0366(21)00206-6.

work, and/or unable to supplement their NI contributions and contribution years can represent a vulnerable subgroup.²⁷³ Moreover, much of the data on unpaid carers has overlooked the different and additional profile of needs experienced by carers who are already part of marginalised communities. For example, those from Black and racially minoritised communities when compared to their White peers are less likely to be in paid employment and overrepresented in less secure and low paid posts.²⁷⁴ Thus, a care system that can adopt a more nuanced and intersectional framework, recognises the complexities of societal roles and structures, and gives equal attention to the health and wellbeing of care recipients and their informal carer remains the best way forward for health, social, economic, and moral reasons.

²⁷³ <https://www.litrg.org.uk/tax-guides/disabled-people-and-carers/caring-someone/pension-and-national-insurance-carers#toc-what-help-can-i-get-to-protect-my-state-pension-if-i-have-had-to-give-up-work-to-care-for-someone>; <https://www.gov.uk/new-state-pension/your-national-insurance-record-and-your-state-pension>.

²⁷⁴ Li, Y. and Heath, A. (2020). Persisting disadvantages: a study of labour market dynamics of ethnic unemployment and earnings in the UK (2009–2015). *Journal of Ethnic and Migration Studies*, 46(5), 857–878.

8 Fair Work and other key adult social care reforms in the four UK nations

There has been a policy push on ‘good’ and ‘fair’ work in recent years. The UK Government’s 2017 Taylor Review²⁷⁵ argued that: ‘All work in the UK economy should be fair and decent with realistic scope for development and fulfilment.’ Despite its adoption of ‘Good Work’, the UK government has not yet engaged significantly with the issue of higher pay for social care workers in England. However, ‘Fair Work’ and related initiatives developed during the second half of the 2010s in the devolved political administrations of Scotland, Wales and Northern Ireland, with the Scotland and Wales initiatives also having a specific focus on Fair Work in social care. Following a brief introduction on the impact of the devolution settlement this section explores the developments on Fair Work in the three devolved UK nations. It then looks at one of the dimensions of Fair Work, employee voice, in greater detail, discussing, in particular, the Scottish proposal on establishing sector wide collective bargaining. The final section returns to England, focusing on additional government funds made available to support market sustainability and aid recruitment and retention of care staff in the process.

8.1 Devolution and social care

There are divergences amongst the four home nations with regard to social care employment. For example, the national bodies in social care in Scotland, Wales and Northern Ireland have driven improvements to pay compared to England. Nevertheless, there remain powers that are reserved with the UK Westminster government that present common constraints on the nations’ efforts to do so. The ones that impact most significantly on employment are the migration and employment regimes.

8.1.1 Migration Regime

All care providers in Scotland, Wales and Northern Ireland are regulated by the UK’s new immigration system introduced from January 2021. This new system reduces the free movement of EU nationals and restricts the recruitment of migrant workers into the sector. The changes led to the introduction of the Skilled Worker route, which meant that EU and non-EU citizens could not enter the UK with the purpose of undertaking care work. Since 15th February 2022, care workers can be brought into the UK on the Skilled Worker Visa if they receive a salary of at least £20,480 per year, based on a 39-hour week of £10.10 per hour (Scottish Government, 2022).²⁷⁶ With care workers now being included in the shortage occupation list, asylum seekers can also apply for a work permission in social care if their claim has been outstanding for more than 12 months through no fault of their own.²⁷⁷ In order to help reduce migration to the UK, care workers applying for a Health and Care Workers Visa to come to the

²⁷⁵ Good work: the Taylor review of modern working practices (2017) Available [here](#).

²⁷⁶ Scottish Government (2022) *Scottish Government response to the Migration Advisory Committee Call for Evidence on the Impact of the Ending of Freedom of Movement on the Adult Social Care Sector*. Available [here](#). Accessed 26th February 2023.

²⁷⁷ Gower, M, McKinney, C.J. and Meade, L. (2022) *Asylum seekers: the permission to work policy*. Available [here](#).

UK will no longer be allowed to bring dependants as of 11 March 2024²⁷⁸, and this could reduce overall international recruitment.

Scotland is less reliant on migrants in social care than England - Skills for Care figures for England show 16% of the adult social care workforce were born overseas (9% from non-EU and 7% from EU).²⁷⁹ Nevertheless, the Scottish government recognises how Brexit has impacted on recruitment in social care. Due to restrictions on immigration, there has been a significant reduction in the capacity to grow and staff services to vulnerable people, especially in rural areas such as highlands and islands, and urban hotspots such as Edinburgh.²⁸⁰ Another study points to the difficulty appointing nursing grades in elder care since Brexit because of perceptions of uncertainty concerning eligibility for visas, and long-term security in terms of achieving settled status for migrant nurses.²⁸¹

The Scottish Government continues to encourage migration to help alleviate the above recruitment problems, as well as general falls in population size and low birth rates.²⁸² In terms of care, this means that social workers from a non-UK country can apply to the Scottish Social Services Skills Council (SSSC) to have their qualification assessed against the SSSC's qualification criteria. Other social services workers with non-UK qualifications who are working in a job that requires registration with the SSSC can also have their qualification assessed against the SSSC's qualification criteria if they have European Economic Area (EEA) mutual recognition rights.

8.1.2 Employment Regime

Employment law remains a reserved power for the UK Westminster government.²⁸³ This presents problems for the nation states attempting to introduce different forms of employment relations²⁸⁴ in social care and beyond. Any commitment to fairer work across the four nations, including improved pay and conditions, representation and more security, are undermined because any efforts are in a form of 'soft' regulation. That is, it has no statutory power to enforce its principles on employers. The reality is that the UK's employment regime remains one of the most lightly regulated among economies in the global north with tightening restrictions against trade unions and their power to organise, undertake collective bargaining and take lawful industrial action, including recent regulation on strikes in 'essential services'; and a wide range of individual employment rights, which lack sufficient protection and depth, leaving large

²⁷⁸ Home Office (2024) *Reducing Net Migration Factsheet – February 2024*. [Available here](#).

²⁷⁹ Scottish Social Services Council (SSSC) (2022) *Scottish Social Service Sector: Report on 2021 Workforce Data*. <https://data.sssc.uk.com/images/WDR/WDR2021.pdf>.

²⁸⁰ Scottish Government (2022), op. cit.

²⁸¹ Scottish Care (2021) *A Look to the Future – Achieving the Nursing Vision*, Scottish Care, June, Ayr.

²⁸² Scottish Government (2022), op. cit.

²⁸³ Although note that, for historical reasons, Northern Ireland has devolved powers over employment, though, to date, it has largely followed the UK.

²⁸⁴ Heery, E., Hann, D. and Nash, D. (2020) Political devolution and employment relations in Great Britain: the case of the Living Wage, *Industrial Relations Journal*, 1 (5), 391-409; Sisson, K. (2019) The Fair Work Wales report: a manifesto for all of us. *Industrial Relations Journal*, 50 (5): 564–579.

groups of workers unprotected.²⁸⁵ Moreover, the whole of the UK faces the threat of the eventual unravelling of European Union regulation protecting employment rights, such as equality, protection of part-time temporary workers, working time and family friendly leave as a result of Brexit.

Nevertheless, there is increasing evidence of clear differences from devolved governments in how they are working to provide fairer employment for social care workers compared to England.

8.2 Implementing Fair Work in Scotland, Wales and Northern Ireland

An exploration of introducing an alternative to the English regime of employment relations in social care shows several similar trajectories, but with regional differences in emphasis and pace. Common themes that emerge are commitment to the Real Living Wage, attempts to encourage national systems of collective bargaining, as well as efforts to improve other terms and conditions.

8.2.1 Scotland

The Scottish Government has introduced policy changes intended to influence employment, principally, a commitment to Fair Work.²⁸⁶

Prior to 2015, pay in the social care system was traditionally close to the national minimum wage. Since 2015-16, under pressure from unions and anti-poverty groups, the Scottish government has implemented 'soft' regulation that resourced and committed local authorities to fund services to outsourced providers in order to pay front-line social care workers the 'Real Living Wage' (RLW).²⁸⁷ These provisions were further updated so that Scottish local authorities can use contractual terms requiring outsourced providers to pay the RLW.²⁸⁸ Scottish Government also encourages public authorities and their suppliers to be charged with aspiring to be Fair Work employers.²⁸⁹

Fair Work in Scotland has five dimensions. The first covers worker voice with explicit support for collective bargaining.²⁹⁰ Under the Scottish Fair Work framework, representation through trade unions or other managerially sponsored mechanisms are seen as legitimate approaches to allow workers to contribute to debates and decision-making. The Fair Work Action Plan commits the Scottish Government to increasing

²⁸⁵ Dickens, L. (2014) The Coalition government's reforms to employment tribunals and statutory rights-echoes of the past, *Industrial Relations Journal*, 45 (3) 234-249; Trades Union Congress (2023) 'Fighting the anti-strike law', 20th January 2023, TUC, London. Available [here](#).

²⁸⁶ Heery, E., Hann, D. and Nash, D. (2020), op. cit.

²⁸⁷ Cunningham, I., Baluch, A., Cullen, A.M. and James, P. (2018) *Implementing the Scottish Living Wage in adult social care: An evaluation of the experiences of social care partners, and usefulness of Joint Guidance. Coalition of Care and Support providers Scotland*. Edinburgh. Available [here](#).

²⁸⁸ Cunningham, I., James, P., Baluch, A. and Cullen, A.-M. (2023) Introducing Fair Work through 'Soft' Regulation in Outsourced Public Service Networks: Explaining Unintended Outcomes in the Implementation of the Scottish Living Wage Policy. *Industrial Law Journal*, 52 (2), 312–341.

²⁸⁹ Scottish Government (2021) *Fair Work Action Plan: Boosting productivity by developing Scotland as a world-leading Fair Work Nation*.

²⁹⁰ Fair Work Convention (FWC) (2016) 'Fair Work Framework 2016'. Glasgow: Scottish Government. Available [here](#).

collective bargaining in social care along with other low paid sectors.²⁹¹ Moreover, there is a strong emphasis on ‘mutual gains’ as representation and voice are seen to benefit employers as well through improving organisational performance.²⁹²

A further acknowledgement of the importance of voice by the devolved government is provided in ‘The Statutory Guidance on the Selection of Tenderers and Award of Contracts: Addressing Fair Work Practices’ (2015) (updated in 2023). The guidance includes among its requirements the stipulation that providers have appropriate channels for effective voice. According to the guidance, unions are top of the list of recommended voice channels because countries with higher rates of membership and collective bargaining coverage have high employment rates, strong productivity growth, competitiveness and innovation. Moreover, the latest version of this guidance includes a requirement that those organisations providing services on behalf of the Scottish Government:

‘engage with the workforce and unions, where they are present, in defining and monitoring the commitments they make to advancing fair work in the delivery of the contract during the life of the contract’²⁹³.

The four other dimensions are security, respect, opportunity and fulfilment.²⁹⁴ In terms of working towards security for social care staff, the Scottish Government’s Fair Work plan for adult social care (2018) pressed for local authorities (the main funders of adult social care services) to not engage in contracts that encouraged the use and growth of zero-hour contracts for workers among provider organisations. Employers are influenced by ‘intermediary monitoring agencies such as the Fair Work Convention - an independent advisory body to Scottish Ministers and policymakers with a mission to advocate Fair Work principles.

In parallel with these developments, the Feeley Report of 2020²⁹⁵ has led to the Scottish Government committing to introduce a National Care Service by the end of the 2026 parliamentary term. Feeley’s recommendations retain the mixed economy of public, private and voluntary providers rather than nationalisation, but also professes a continuing commitment to Fair Work values, including worker voice. Indeed, one of its recommendations has been the establishment of sector-wide collective bargaining.

However, there are problems with the above. With regard to the commitment to the Real Living Wage, studies have found significant problems with the implementation of the policy including: slowness of implementation; underfunding of the policy so that horizontal and vertical differentials are disrupted and narrowed; other costs related to management fees, national insurance and cost of living are not included; and local

²⁹¹ Scottish Government (2021), op. cit.

²⁹² Scottish Government (2022) *Fair Work Action Plan: Becoming a leading Fair Work Nation by 2025*. Available [here](#). Accessed 27th July, 2023.

²⁹³ Scottish Government (2023) *Fair Work First Guidance Supporting the implementation of Fair Work First in workplaces across Scotland*, Scottish Government, Edinburgh. Available [here](#).

²⁹⁴ Fair Work Convention (2016) ‘*Fair Work Framework 2016*’. Glasgow: Scottish Government. Available [here](#).

²⁹⁵ Feeley, D. (2021) [Independent Review of Adult Social Care in Scotland \(2021\)](#).

authorities divert resources to other priorities.²⁹⁶ Higher levels of funding have been recommended to award increased rates of pay for front-line workers, and also maintain horizontal and vertical differentials between ancillary and supervisory staff respectively. Increased pay is also recommended to reduce competition for labour with other low paid sectors (retail and hospitality) that can pay the same rates, but do not have as much responsibilities job wise.²⁹⁷

After funding constraints previously imposed during austerity, the Scottish adult social care system is now facing the cost-of-living crisis. The comparative weakness of employee voice in outsourced adult social care services compared to the public sector will have significant consequences for the latter's workforce. Projected negotiated uplifts in pay within the public sector will not be passed onto those in outsourced services. This will exacerbate the gap in pay between employees in private and voluntary organisations, and equivalent public sector workers. Differences in annual salaries with public sector employees can be as much as £2,000 per annum less for voluntary and private sector employees.²⁹⁸ In addition, there are considerable gaps between public and private and voluntary sector employers in terms of pensions holidays, sickness entitlement and unsocial hours payments.

The recommendation by the Feeley report to introduce sector wide collective bargaining is facing challenges from employers and other stakeholders based on the unions currently having low membership density. The Scottish Government's main response to the Feeley Report is through the introduction of the National Care Service Bill (2022, June). The Bill has received some opposition. The original Bill proposed that statutory duties for social work should be transferred from local authorities to Scottish Ministers and sit with the local Care Boards. This reform raised fears that there would be no reason for local authorities to directly provide any social work/care services, leading to the fear of the end of direct public sector provision of social care transferring thousands (75,000 social work and social care employees) of staff to alternative providers. Two-thirds of UNISON members did not support these services being removed from councils, and 71% think ending direct public provision by councils will have a negative impact on the people who receive a social work service. Moreover, 77% say the changes will mean insecurity for staff and 64% are concerned about their pension.²⁹⁹ In response, the Scottish Government agreed with local authorities and NHS representatives that councils should retain responsibility for social care assets and continue employing staff. Moreover, it has slowed down implementation of the Bill, due to the need for further debate and consultations.³⁰⁰

²⁹⁶ Cunningham, I., James, P., Baluch, A. and Cullen (2023), op. cit.

²⁹⁷ Scottish Trade Union Congress (STUC) (2022) *Profiting from care: Why Scotland can't afford privatised social care*. STUC, Glasgow, June 2022.

²⁹⁸ Coalition of Care and Support Providers Scotland (CCPS) (2023). *The Scottish budget for third sector social care: is it all costs, no value?: There is no money: The mantra of the moment*. Available [here](#).

²⁹⁹ UNISON (2023) *National Care Service Bill Verdict from Social Work Staff*. Available [here](#).

³⁰⁰ Community Care (2023) <https://www.communitycare.co.uk/2023/07/12/councils-would-still-employ-social-workers-under-proposed-national-care-service-for-scotland/>.

Meanwhile, due to the estimated cost of introducing the National Care Service rising up to nearly double the original estimate a decision has been taken to delay its introduction to 2028-29. There are also suggestions to abandon the transfer of staff from councils to the new National Care Service as this would significantly reduce the costs of the National Care Service³⁰¹ (to between £631m and £916m of an estimated cost of between £800m and £2.2bn). Finally, as part of its Fair Work First policy, the Scottish Government has changed its guidance on whether local authorities can use contractual terms requiring providers to pay the Scottish Living Wage and in doing so stated that it is an option for them, providing certain conditions are met. This measure provides Scottish local authorities with greater powers to exclude employers who do not pay the Scottish Living Wage, and/or those tempted to withdraw from compliance on financial grounds to re-consider.³⁰²

At the same time, the change in guidance is only facilitative of the use of such contractual terms, it is left to individual authorities to decide whether to make use of them. Moreover, non-compliance is normally not an issue as most providers are probably already paying the Scottish Living Wage to their adult care frontline staff.

8.2.2 Wales

Wales has embarked on a similar pathway to introduce a more progressive employment regime for its front-line care workforce, which is linked to a broader commitment to fair work. The Welsh Government established a Fair Work Board in 2017, followed by the independent Fair Work Commission in 2018.³⁰³ The lack of access for opportunities for fair work in Wales is seen as a feature of the Welsh labour market. This access to better opportunities in work is related to a several factors including: low road employment strategies by employers; a focus by policy-makers on the volume rather than quality of jobs created; poor infrastructure in areas such as education, skills development and the tax and welfare system; the undervaluing of and unequal distribution of unpaid domestic work; a benefit system that compels workers to accept any job, rather than express choice. The nation's Fair Work Wales report by the Wales Fair Work Commission, as with its Scottish counterpart, identifies a series of characteristics of Fair Work. There are six characteristics that cover fair reward, employee voice and collective representation, security and flexibility, opportunity for access, growth and progression, a safe, healthy and inclusive working environment and legal rights respected and given substantive effect.³⁰⁴

As with Scotland's Fair Work agenda, there is insufficient space to address all of the elements of the framework and provide an in-depth appraisal, so this section will comment on those measures relating to social care. The Welsh Government has established a Code of Practice on Ethical Employment in Supply Chains that promoted the Real Living Wage through public procurement. This measure includes the insertion

³⁰¹ BBC News (2023) Scotland's National Care Service delayed by three years. 14 December 2023.

³⁰² Cunningham, I., James, P., Baluch, A. and Cullen, A.-M. (2023), op. cit.

³⁰³ Heery, E., Hann, D. and Nash, D. (2020) Political devolution and employment relations in Great Britain: the case of the Living Wage. 51 (5) *Industrial Relations Journal*, 391-409.

³⁰⁴ Welsh Government. (2019). *Fair Work Wales. Report of the Fair Work Commission*. Available at www.gov.wales/fair-work-wales. March 2019.

of a question in the tendering process asking those bidding for contracts whether they pay the living wage or are an accredited living wage employer.³⁰⁵

The above has relevance to social care, but there have also been other measures specific to specific care. The first is the establishment in 2020 of the Social Care Fair Work Forum (SCFWF). One of the SCFWF's priorities was to recommend that the Real Living Wage should be the minimum pay for social care workers. The Welsh Government's progress in this regard, can be seen as slower than that of Scotland. Up to this point, even during the period of the peak of the Covid-19 pandemic, commissioning practices meant that pay levels were at the statutory minimum.³⁰⁶ This shortfall in those paid below the Real Living Wage in Wales is comparable to England's social care workforce, and the UK average.³⁰⁷

The Welsh Government did introduce one off payments to social care workers in care homes and in domiciliary settings, which was extended to catering and cleaning staff.³⁰⁸ In addition, the SCFWF advocated for all social care workers to be paid the Real Living Wage and in April 2022 the Welsh Government provided £43m to local authorities and health boards to fund this commitment, and a further £70m was made for the year 2023/24 to resource the Living Wage Foundation's recommended rate of £10.90 per hour.³⁰⁹

In addition, the SCFWF is also advocating that all social care workers are covered by collective bargaining as most social care workers are based in the independent sector where collective agreements do not exist. During 2023 the group is committed to establish broad principles and a vision for collective bargaining and a voluntary membership. The aim is to establish a voluntary collective bargaining agreement for social care workers in Wales.³¹⁰ Thus the Scottish and Welsh Government's efforts to introduce collective bargaining in social care are roughly operating in parallel.

One interesting difference in the two nation's approach is how the SCFWF (2023) is prioritising sick pay. Here, the Forum correctly identifies sick pay as a major source of inequality between local authority, NHS and outsourced counterparts in private and voluntary providers of social care. The issue of sick pay was raised as part of the Covid-19 measures in Scotland. A Social Care Staff Support Fund was established to ensure that workers who were ill with Covid-19 or self-isolating would receive their normal income for that period.³¹¹ Yet, now that the Covid-19 pandemic has passed and this funding has stopped, a recent study found that at the organisational level a

³⁰⁵ Heery, E., Hann, D. and Nash, D. (2020), op. cit.

³⁰⁶ Sion, C. and Trickey, M. (2020) *The future of care in Wales: Resourcing social care for older adults*. Wales Fiscal Analysis, Cardiff University, 2020; SCFWF (2023) *Social Care Fair Work Forum: annual progress update 2023*. SCFWF, 23rd March 2023, Cardiff.

³⁰⁷ Sion, C. and Trickey, M. (2020), op. cit.

³⁰⁸ Sion, C. and Trickey, M. (2020), op. cit.

³⁰⁹ SCFWF (2023) [Social Care Fair Work Forum: annual progress update 2023](#). SCFWF, 23rd March 2023, Cardiff.

³¹⁰ SCFWF (2023), op. cit.

³¹¹ Lemmon, E., Bell, D., Burton, J., Henderson, D. and Hatton, C. (2022) *COVID-19 and the Long-Term Care system in Scotland (UK)*. Available at <https://ltccovid.org/country/scotland-uk/>.

significant proportion of Scottish voluntary sector providers did not pay sick pay for the first six months to new starts, and a small minority did not do so between 6-2 months.³¹² This finding suggests sick pay remains an area where further work needs to be undertaken by the Scottish Government in line with its Welsh counterpart.

8.2.3 Northern Ireland

In Northern Ireland 'Fair Employment' has its own particular meaning embedded in the context of the Troubles and relates to specific legislation to ensure fair and equal employment practices and opportunities against religious and other forms of discrimination, under The Fair Employment (Northern Ireland) Act.

Northern Ireland has similar social and economic challenges to those of Scotland and Wales but, with intermittent government in recent years, job quality policy per se is relatively under-developed compared to those countries. Nonetheless in 2015, the Executive Office of Northern Ireland acknowledged the importance of job quality with its *Good Jobs in Northern Ireland* initiative that aimed to create good jobs for all in Northern Ireland.³¹³ Then in 2016, around the time that Scotland was introducing its Fair Work policy, Northern Ireland published a draft Programme for Government Framework that included a commitment to increase the number of people working in 'better jobs'.³¹⁴ In doing so, addressing insecure employment and improving pay were argued to be the key priorities.³¹⁵ A number of sectors were suggested as in need of prioritising, though social care was not one.³¹⁶

A desire also existed to measure progress to achieving this commitment to better jobs. A recommendation was made that Northern Ireland should use the seven dimensions of the Good Work measures recommended by the post-Taylor Review Measuring Job Quality Working Group and which have been adopted subsequently by the ONS to evaluate and report job quality for the UK.³¹⁷ However, with the collapse of the Northern Ireland Executive, the proposed measure was neither adopted nor implemented and policy development stalled. Creating more better jobs did though feature again in the Executive's 2019 Outcomes Delivery Plan³¹⁸ but again the lack of Executive meant that practical action on this delivery could not be pursued.

With an Executive re-established in 2024, the new Minister for the Economy has highlighted a number of significant challenges facing the Northern Ireland economy

³¹² Cunningham, I., Baluch, A., Nikolova, M. and James, P. (2023) *Benchmarking Pay and Conditions, 2022*. Coalition of Care and Support Providers Scotland.

³¹³ Office of the First Minister and Deputy First Minister/New Economics Foundation (OFMDF/NEF) (2015) *Good Jobs in Northern Ireland*. Available [here](#).

³¹⁴ Northern Ireland Executive. (2016) *Draft Programme for Government Framework 2016-21*, Belfast: Northern Ireland Executive.

³¹⁵ Wilson, L. (2019) 'Measuring Job Quality: The 'Better Jobs Index'', <https://www.carnegieuktrust.org.uk/blog/measuring-job-quality-the-better-jobs-index/>.

³¹⁶ The three suggested sectors were: accommodation and food; wholesale and retail; and administrative and support services, see Wilson, L. (2016) *Job quality in Northern Ireland*. NERI Research in Brief no.41. Belfast: Nevin Economic Research Institute.

³¹⁷ Wilson (2019), op cit.

³¹⁸ Northern Ireland Executive Office. (2019) *Outcomes Delivery Plan*. Belfast: Northern Ireland Executive.

with job quality having re-emerged as one of four key policy priorities, with an aim to increase the number of good jobs.³¹⁹ As part of this turn again to job quality, the Executive is revisiting the need for a measure of progress and is currently developing a Good Jobs Index and seeking to make a business case for what are now termed 'good jobs. In June 2024, the Minister for the Economy announced that the Executive would adopt the Good Work measures.

During the hiatus in government, it was left to trade unions in Northern Ireland to campaign for improvements to work, wages and employment in its social care sector. Unison in particular has led a number of successful campaigns in Northern Ireland, including a campaign for a Social Care Fair Work Forum, established in 2021, and is representing the interests of its members on the new Social Care Collaborative Forum (SCCF, established in 2023). The SCCF, bringing together the Department of Health and key stakeholders to support the social care sector, has re-established a Fair Work Forum.³²⁰

There is some data relating to pay in the social care sector. In April 2022, levels of pay were seen to be at the level of the statutory National Living Wage of £9.50 an hour. Moreover, by January 2021, the government had introduced a £500 (£735) Covid-19 related bonus to social care staff³²¹, including similar pro rata payments for personal assistants.³²²

8.3 Social dialogue and employee voice in the social care sector

Returning to the low trade union representation in the care sector, this part explores the reasons behind it, arguing that there is a case for increased trade union representation in the care sector and looking at the situation in Scotland as it has been proposed to create a sector wide collective bargaining for Scottish social care.

Overall union density in the UK stands at 22.3% in 2022, which is a fall compared to the previous two years and stands at its lowest level since 2017.³²³

It is difficult to gain a full understanding of worker voice in the social care sector, as much of the workforce are spread across public, private and voluntary organisations, with most of them working in the independent sector, comprising private and voluntary organisations. In examining union representation in social care, figures are difficult to break down in the public sector. Currently health and social work activities make up the biggest group of union members accounting for 1.54m members.³²⁴ Total density in health and social care is approximately 38.2%, which is the second highest proportion behind education. Much of this membership is in health services, and

³¹⁹ Department for the Economy (2024) Statement from Minister Murphy - economic vision. <https://www.economy-ni.gov.uk/news/statement-minister-murphy-economic-vision>.

³²⁰ <https://niscc.info/app/uploads/2024/05/Turning-the-Dial-on-Social-Care.pdf>

³²¹ Oung, C and Hemmings, N. (2023) *Addressing social care workforce challenges: what can England learn from Wales, Scotland and Northern Ireland?* Nuffield Trust. Available [here](#).

³²² <https://www.health-ni.gov.uk/news/social-care-personal-assistants-receive-ps500>

³²³ Office for National Statistics (2023) *Trade Union Membership, UK 1995-2022*: Statistical Bulletin, 24 May.

³²⁴ Statista (2023) [The Number of trade union members in the United Kingdom by Industry](#).

although there remains strong union presence in the public sector compared to the private sector, there are several reasons why it does not represent a favourable environment for union stability or growth in the public social care sector.

The first reason is the aforementioned decline in membership and apparent difficulties maintaining density. The latest trends indicate declines in union presence in the public sector, with a reported fall in membership of 48,000 to 3.84 million in 2022. Overall density between 2021 and 2022 in the public sector fell from 50% to 48.8%. This is the first time that density has dropped below 50% since comparable records began in 1995.³²⁵

The second reason is related to potential motivation to join a union in the public sector. Since 2010, the public sector collective bargaining has been subject to wage freezes and pension cuts, limits on time-off for representatives to undertake their union duties, and greater outsourcing of public services to make union organising more challenging.³²⁶ The union wage premium is shrinking, with the most recent fall in 2022 of 1.2 percentage points to 3.5%. There has also been a large decrease of 7.2 percentage points in the public sector wage premium. The above pressures were also evident at the level at which much of adult social care is commissioned, i.e. at local government across the UK.³²⁷

In marketized care systems such as the UK, union influence is further limited as employment is outsourced to areas where collective bargaining has a weak presence compared to direct employment through the public sector. Private and voluntary sector care providers have traditionally been largely non-union. Many of the private sector providers of adult social care services in the UK are small to medium sized care homes for older people. Small to medium sized enterprises are traditionally difficult for unions to organise in. The larger organisations in adult social care can be multinationals, sometimes owned through private equity, which, with the exception of one or two providers, are not generally open to collective bargaining. Private equity companies are generally accused of consuming the resources of care homes (drawn from public funding), and undermining staff terms and conditions, including low pay, poor staffing ratios, surveillance of employees and retaliation against union members.³²⁸

The voluntary social care sector also provides challenges to worker voice. In 2007, the National Council for Voluntary Organisations estimated union membership was 15%, and that unions were involved in salary negotiations in less than a third of third sector organisations.³²⁹ Another report claimed that there were approximately 150,000

³²⁵ Office for National Statistics (2023) *Trade Union Membership, UK 1995-2022: Statistical Bulletin*, 24th May 2023.

³²⁶ Bach, S. (2016) 'Britain: Contracting the state: public service employment relations in a period of crisis'. In Bach S and Bordogna, L (eds) *Public Service Management and Employment Relations in Europe*. London, Routledge, 136-63.

³²⁷ Leisink, P. and Bach, S. (2014) Economic crisis and municipal public service employment: Comparing developments in seven EU member states. *Transfer*, 20 (3), 327-42.

³²⁸ Centre for International Corporate Tax Accountability & Research [CICTAR] (2020) *Caring for growth: Australia's largest non-profit aged care operators*, A CITAR Report. Available [here](#).

³²⁹ NCVO (2007) *The Voluntary Sector Almanac*. NCVO, London.

members in total in voluntary organisations, with individual unions such as the GMB, UNITE and UNISON recording 30,000, 60,000 and 60,000 members respectively.³³⁰ In 2011 alarm was raised over figures that reported that only 24% of domiciliary and support workers were unionised.³³¹ Currently, UNISON claims 85,000 members working in the community and voluntary sector³³² and UNITE, GMB and Community unions have been active in increasing membership. Where they have recognition in voluntary organisations, unions are seen to have wide ranging relations with employers. These relations range from partnerships, and full negotiations over pay and other issues. Others are merely consulted on pay, while others are subject to merely offering individual protection for workers.³³³ Anti-union views in voluntary organisations stem from fears that strikes and other forms of action can disrupt services and mission.³³⁴ In addition, there are problems with mobilizing the adult social care workforce in private and voluntary organisations to join unions. This is due to a lack of tradition of membership, so numbers of organisers are quite low compared to other sectors. There is also a lack of opportunity for recruitment at the place of employment (equivalent to the ‘factory gate’ in the industrial world) and to engage with workers in a collective manner³³⁵.³³⁶ Workers in adult social care work part-time on fragmented shifts, sometimes alone and in the community or in people’s homes so are difficult to contact. They also have limited tradition within their ranks of unionisation so are unsure what the movement can offer them.³³⁷

Where unions have a presence in private and voluntary providers the supply-chain and resource dependency effect make the prospects for effective collective bargaining quite limited. The below-inflationary funding settlements provided by government to providers has created the conditions for wages in voluntary and private organisations failing to keep up with public sector conditions. Unlike the public sector, collective bargaining in outsourced providers is at the enterprise level and not subject to national agreements. The state can act as a ‘third-employer’ or the ‘elephant in the room’ determining the funding settlement that shapes pay agreements while having no direct involvement in negotiations. Unions, in this decentralised bargaining system do not have the power to hold to account or negotiate with the state agency/agencies that hold the purse strings. Moreover, these bargaining structures mean that it is difficult

³³⁰ Association of Chief Executives in Voluntary Organisations (ACEVO) (2008) *The way ahead: trade unions and the third sector*.

³³¹ Community Care (2011) *Alarm over lack of union membership among care workers*. Available [here](#).

³³² UNISON (2023) <https://www.unison.org.uk/at-work/community/>.

³³³ Association of Chief Executives in Voluntary Organisations (ACEVO) (2008) *The way ahead: trade unions and the third sector*.

³³⁴ Baines and Cunningham (2020) ‘How Could Management Let This Happen?’ Gender, Unpaid Work and Industrial Relations in the Nonprofit Social Services Sector’, *Economic and Industrial Democracy*, 41(2), 436-456.

³³⁵ Hemmings, M. (2011) ‘What problems you got?’: managerialism and union organising in the voluntary sector. *Industrial Relations Journal*, 42 (5), 473-485.

³³⁶ Hemmings, M. (2011), op. cit.

³³⁷ Cunningham, I. and James, P. (2010) Strategies for union renewal in the context of public sector outsourcing, *Economic and Industrial Democracy*, 31 (1), 34-61.

for unions to apportion blame and mobilize collective action for poor pay rises on the immediate employer.³³⁸

There is limited information about the extent of direct, pro-social forms of voice in social care. The sector has used forms of non-union employee representation labelled 'Employee Forums' and 'Works Councils' etc.³³⁹ There have been claims that these bodies amounted to 'locally developed staff consultation - and in some cases with negotiations' ³⁴⁰ but these claims have never been substantiated.

There are other forms of voice in the sector, including the use of the 'supervision' approach in social care as a form of voice. Although this is an individualised, practice orientated tool used in social work, over the years it is seen to be something that employees use as a direct route into their line manager to raise issues of concern, i.e. work stress, violence from clients etc.

Overall, the above outline suggests a need for more effective voice channels for the social care workforce. Lydia Hayes³⁴¹ outlines eight reasons why collective bargaining is needed in adult social care. These reasons are:

- Because adult social care is an industry;
- Care work is highly skilled and increasingly complex;
- Terms and conditions of work are precarious;
- Poor quality jobs, mean poor quality care;
- Individual rights (statutory or otherwise) are insufficient to remedy these problems³⁴²;
- Care workers are silenced by the structure of care markets;
- Government has to raise quality of employment across social care; and
- Collective bargaining would create decent work and raise quality of care.

Scotland is currently pursuing a policy of constructing sector-wide collective bargaining in its social care sector, with the aim of including voluntary and private providers. This initiative is very much in its early days and there is a great deal of uncertainty regarding

³³⁸ Cunningham, I. (2008) Mobilizing worker collective interests within inter-organizational relationships: Some insights from the UK voluntary sector, *Industrial Relations Journal*, 39 (3), 191-211.

³³⁹ Hemmings (2011) op. cit.

³⁴⁰ Association of Chief Executives in Voluntary Organisations (ACEVO) (2008) *The way ahead: trade unions and the third sector*, p.17.

³⁴¹ Hayes, L. (2017) *8 Good Reasons Why Adult Social Care Needs Sectoral Collective Bargaining*. The Institute of Employment Rights, Liverpool.

³⁴² A concern regarding individual protection are the 'Fitness to practice' regulations. In Scotland these are run by the SSSC. They are designed to ensure that the Register of care workers meet "the standards of character, conduct and competence necessary for them to do their job safely and effectively in line with the SSSC Codes of Practice". Some of the procedures and public access to data is astonishing. There are parts of hearings that anyone can attend, i.e. with regard to impairment hearings that decide a worker's fitness to practice is impaired – "These are usually public hearings but all or part of the hearing can be held in private if the panel decides for the protection of vulnerable witnesses or if the hearing is about a worker's health." Anyone can easily access the list of workers who are currently in receipt of *Temporary Orders* to suspend a worker's registration and/or impose conditions on their registration until the allegations against them are investigated. <https://www.sssc.uk.com/fitness-to-practise/temporary-orders/>.

questions over should there be a separate structure of bargaining for outsourced providers or would bargaining arrangements be better by somehow being ‘bolted on to’ existing public sector arrangements. There are also questions over who should be in the room during negotiations, i.e. employers representing a diverse sector alongside government or local authority representative groups such as the Convention of Scottish Local Authorities (COSLA).

This work towards creating sector wide collective bargaining for Scottish social care is part of the recommendations of the Feeley Report.³⁴³ However, unless the funding settlement for social care is more generous, the issue remains what, realistically, can sector-wide collective bargaining achieve. A government commitment to increased resources to pay providers accurate and realistic prices for their services reflecting the skills of the workforce and a decent wage remains a prerequisite alongside sector-wide collective bargaining.³⁴⁴

In addition, the Fair Work First guidance in Scottish public procurement led to the Scottish Government writing to public bodies setting out guidance that all public sector partners must embed Fair Work in their supply chains. Fair Work First asks businesses bidding for a public contract to commit to progressing towards adopting the five Fair Work dimensions, including effective voice. Trade union recognition is mentioned in these expectations, but it does not prevent organisations establishing alternative forms of non-union forms of voice.³⁴⁵

8.4 Funding reforms in England impacting the adult social care workforce

This section discusses recent reforms in England providing additional funding to local authorities to pay local care rates that are more aligned to the actual cost of delivering social care. With scope for higher care rates being paid to care providers this is expected to help increase retention and recruitment of staff when these increased rates are used to help improve wages and workforce development.

The section also briefly touches on a vision for a new National Care Service promoted by the Fabian Society and Unison, calling for increased investment in the care workforce.

8.4.1 Market Sustainability and Fair Cost of Care Fund

In 2021, England introduced the *Market Sustainability and Fair Cost of Care Fund* in adult social care, covering service users above 65 years of age in care homes and aged 18+ in domiciliary care. Under this scheme local authorities should assure themselves that contract terms, conditions and fee levels are appropriate to deliver agreed levels of care and to ensure that they pay at least the minimum wage and provide effective training and development of staff. The measure is also intended to support recruitment and retention of staff.³⁴⁶

³⁴³ Feeley, D. (2021) *Independent Review of Adult Social Care in Scotland*. Scottish Government.

³⁴⁴ Feeley, D. (2021), op. cit.

³⁴⁵ Scottish Government (2021) *Scottish Procurement Policy Note SPPN 3/2021*. Available [here](#).

³⁴⁶ Department of Health and Social Care (DHSC) (2022) *Guidance. Market Sustainability and Fair Cost of Care Fund 2022 to 2023: guidance*. Updated 10 May 2023. Available [here](#). Accessed 5th June 2023.

The fund amounts to £1.36bn, from 2022-23. The allocation of funding is to the total of £162m in 2022-23, and a further £600m each year from 2023-24 and 2024-25. Local authorities are to produce market sustainability plans outlining risks, and how the funding is being spent. In addition, local authorities are to allocate at least 75% of the funding to increase fee rates paid to providers.³⁴⁷

Several observations regarding this initiative can be made. The first relates to the funding of care so that providers pay *at least* at the minimum wage. This falls below the commitment in Scotland and Wales (see below) who are currently funding care services so that front-line carers receive the 'Real Living Wage'. These initiatives from the devolved nations have, themselves, been struggling to make a positive impact on recruitment and retention by paying the Real Living Wage.³⁴⁸ Prior to the Covid-19 pandemic in Scotland, the overall vacancy rate in social care was already almost twice the Scottish average³⁴⁹ - a situation probably exacerbated in the current cost of living crisis.

Therefore, this initiative in England, that has at the core of its definition of 'market sustainability' the condition of 'sufficient investment in its workforce to enable the attraction of high-quality care staff'³⁵⁰ is unlikely to make a significant impact.

Moreover, the goals of achieving 'innovation and improvement'³⁵¹ are also far from realistic, given the sources of innovation and improvement that will be expected to come from the front-line workforce who are delivering care. How far fee levels that only allow staff to survive on the minimum wage are supposed to deliver 'innovations' is open to some doubt, unless the 'innovations' in mind are further efficiencies and demanding more for less from staff.

The guidance also notes that 'sustainability does not necessarily mean that providers do not ever exit the market (either due to business failure, a decision to close the business, or managed exits by local authorities) as it is normal in a healthy market for businesses to both enter and exit'.³⁵² This claim does not recognise the research undertaken in recent years that has placed responsibility for exit, including from local authority commissioned care, on problems with sustainability in the market, and that providers are continuing to walk away from contracts in social care because of poor funding and problems with recruitment and retention. Evidence further suggests that these contracts are handed directly back to local authorities who are then struggling

³⁴⁷ Department of Health and Social Care (DHSC) (2022), op. cit.

³⁴⁸ Cunningham, I., Baluch, A., Cullen, A.M. and James, P. (2018) *Implementing the Scottish Living Wage in adult social care: An evaluation of the experiences of social care partners, and usefulness of Joint Guidance. Coalition of Care and Support providers Scotland*. Edinburgh, Available [here](#).

³⁴⁹ NHS Scotland and COSLA (2019) *An Integrated health and social care workforce plan for Scotland, Edinburgh, Scotland*.

³⁵⁰ Department of Health and Social Care (DHSC) (2022), op. cit.

³⁵¹ Department of Health and Social Care (DHSC) (2022), op. cit.

³⁵² Department of Health and Social Care (DHSC) (2022), op. cit., 21.

to find alternative providers.³⁵³ Therefore, the assumption that exits are a reflection of a 'healthy market' appear far from the reality in many regions in the UK.

The requirement for local authorities to begin consulting with local providers and their national and local associations to evaluate 'the true cost of care' is an interesting development, as local authorities have previously been less than transparent regarding how they decide this. This is potentially a positive move, as calculations around the cost of care in Scotland remain far from transparent, ensuring continued difficulties with implementing the RLW. At the same time, in the calculations of 'the true cost of care', there must be recognition of hidden costs such as management overheads, increases in national insurance, pensions and training and development needs, which have traditionally had limited recognition in local authority estimations.³⁵⁴

In addition, as Scotland's Fair Work Convention³⁵⁵ has noted, sustainability is not just about hourly rates and associated fee levels but guarantees around the numbers of hours. The Convention has recognised that the personalisation of services can create unpredictable demand for care. This impacts on the number of hours available, and subsequently leads to the proliferation of zero-hours contracts. In response the convention has called for:

'... a radical overhaul of commissioning practices in social care to ensure that fair work drives high quality service delivery through the adoption of both minimum contract standards... and through engagement at a sector level between purchasers, providers and deliverers of social care services ... Such an overhaul should end current commissioning practices of noncommittal hourly rate-based competitive tenders and framework agreements.'³⁵⁶

The updated guidance³⁵⁷ raises further points. The grant to local authorities from the fund is ring-fenced, which is an improvement on other awards of additional money to social care which have not been ring-fenced and as a result funding has been earmarked for other areas.³⁵⁸ This guidance further stipulates the areas of working conditions the fee uplifts have to improve on. These include 'staff pay, benefits and retention, payment of travel time in domiciliary care, the elimination of call cramming³⁵⁹ and the ability to invest in estates and technology'.³⁶⁰ Moreover, the guidance

³⁵³ Association of Directors of Adult Social Services (ADASS) (2018) *ADASS Budget Survey, 2018*, ADASS. Available at <https://www.adass.org.uk/adass-budget-survey-2018>, Accessed at, 1/3/2019; Cunningham, I., Baluch, A., James, P., Jendro, E. and Young, D. (2019) *Handing Back Contracts: Exploring the rising trend in third sector provider withdrawal from the social care market*. Coalition of Care and Support providers Scotland. Edinburgh.

³⁵⁴ Cunningham, I. Baluch, A., James, P., Jendro, E. and Young, D. (2019), op. cit.

³⁵⁵ Fair Work Convention (2019) *Fair Work in Scotland's Social Care Sector 2019, The Fair Work Convention*, Edinburgh, Accessed at 1/3/2019, Available [here](#).

³⁵⁶ Fair Work Convention (2019) op. cit., 37.

³⁵⁷ Department of Health and Social Care (DHSC) (2023) Market Sustainability and Improvement Fund 2023 to 2024. Updated 2 June 2023. Available [here](#).

³⁵⁸ Cunningham, I., Baluch, A., Cullen, A. and James, P. (2018), op. cit.

³⁵⁹ Call-cramming refers to domiciliary care workers having to deal with too many visits, requiring them to leave clients early to rush to the next one.

³⁶⁰ Department of Health and Social Care (DHSC) (2023), op. cit.

suggests additional investment in staff including broader changes to terms and conditions, bringing forward planned uplifts in pay ahead of the new financial year, occupational health and wellbeing measures and incentive and retention payments.

8.4.2 Vision of a National Care Service

The Fabian Society recently published a vision of a new National Care Service in England that would take over a decade to develop. The report sets out ten building blocks to help achieve a national care guarantee based on their research and consultation.³⁶¹ As part of that vision it calls for improved terms and conditions for the workforce, including a sector minimum wage and national minimum employment conditions on par with similar roles in the NHS alongside other structural reforms to improve services. Conceived as a long-term strategy to support underfunded services it will require a very substantial increase in public funding over many years.³⁶²

³⁶¹ Cooper, B. and Harrop, A. (2023) *Support Guaranteed. The roadmap to a National Care Service*. Available [here](#).

³⁶² Cooper and Harrop (2023), op. cit., 49.

9 Recommendations

Adult social care provides a vital service for people of all ages to live as independently and safely as possible in a supported environment. With demand for care services expected to increase due to the ageing of society and growth in chronic conditions it is paramount to provide the conditions for the social care sector to grow to meet the current and future demand. However, social care has long been underfunded. Despite recent increases in funding, more is required to meet the predicted demand³⁶³ and any additional funding needs to feed through the commissioning process to reach the social care workers in order to ultimately benefit those being cared for.

Good quality, fairly valued and rewarded jobs are essential to making this happen and to provide high quality care valued by service users. To deliver these better-quality jobs that will help deliver better quality care, we make the following recommendations:

1. Increase the wages for care workers relative to other low paid occupations and restore pay differentials between care workers and senior care workers to incentivise progression.

The evidence has shown that relative wages in social care have declined, with the cost-of-living crisis and the rise in petrol costs for care workers supporting service users at home having reduced their purchasing power further. Restoring pay differentials to other low paid occupations is expected to reduce turnover, lowering costs for the recruitment and training of new staff. Rising wage floors over time coupled with underfunding of the social care sector resulted in reduced pay differentials between care workers and senior care workers. Restoring them would make career progression more attractive, as increased job responsibilities would be rewarded by commensurate pay which can contribute to improving retention.

Paying care workers at least the Real Living Wage, where it is not already in place, may ease some of their financial pressures, particularly during the rising cost of living, better reflect their level of skills and responsibility and offer a positive signal to people considering a career in social care. Over the longer term, there would be benefits in terms of recruitment and retention to achieve pay parity with Agenda for Change NHS equivalent posts. However, wage increases rely on increased central government funding and care providers receiving higher rates to use them to pay better wages.

2. Improve sick pay for social care workers to secure a decent living during periods of illness.

The pandemic has shone a light on the negative impact of current sick pay provision in social care leading to financial difficulties and even hardships or difficult choices to support themselves and their families. Improved sick pay from day one of employment will provide a safety net during periods of illness in a low paid job, making a contribution to improving care workers terms and conditions. This requires regulatory changes by central government.

³⁶³ See for example Foster, D. (2024) *Funding for adult social care in England*. Available [here](#).

3. Parallel to wage increases, improve working conditions and continue to support the mental health and wellbeing of the social care workforce.

Pay, followed by terms and conditions, have repeatedly been identified as key reasons for recruitment and retention challenges in a number of studies, with one study finding that wage and employment conditions significantly reduce job separation among direct care staff. Despite it being a rewarding career, pay, terms and conditions inform people's career choices. A key aspect to be mentioned here is the high degree of zero-hours contracts providing required flexibility while also generating insecurity for employees in terms of their actual take home pay and work schedules. Innovative workplace solutions are required to address the scope of zero-hours contracts, e.g. by exploring the suitability of guaranteed hours a few months after joining a care provider. In the meantime, more clarity is required round holiday and sick pay entitlements among zero-hours workers.

The Covid-19 pandemic had impacted social care workers mental health and wellbeing due to increased workloads and working hours and fear for their own and their families' health and safety. While the Covid-19 pandemic has now passed, ongoing support is required to support staff recuperating and/ or affected by continued high workloads due to ongoing, albeit slightly improving, recruitment and retention challenges. This will require primarily adequate support at the workplace level, including by management via voice channels.

4. Support training and career development to help make jobs in social care more attractive.

The level and quality of training and development to address the skill gaps remain limited and patchy. There is some evidence of investment in job-related training reducing labour turnover or turnover intentions in adult social care. There is scope for encouraging shared training between the health and social care sector to facilitate movement across the health and social care system. And it stands to be argued that good training and career development opportunities send out positive signals to potential new recruits considering a career in social care.

The Government of England's recent publication of career paths, underpinned by a knowledge and skills framework, initially for care workers, is a first step in supporting training and career development in the sector. It provides a useful framework for horizontal and vertical career development opportunities that still needs to be explored in practice, accompanied by adequate funding and attractive pay structures.

5. Create and support more effective and inclusive voice channels for the social care workforce.

Low trade union representation in the care sector often means that care workers lack channels to negotiate pay, terms and conditions or to voice their concerns effectively. There is some evidence that particularly ethnic minority workers often find it difficult to be heard, that they have a lower level of awareness of employment rights and are more affected by verbal abuse, bullying or threats than their White counterparts, leaving them open to lack of support or even exploitation. Having

more effective and inclusive voice channels can help to address areas of workplace discontent and ultimately support retention of staff when the situation begins to get resolved. Options to explore could include national collective bargaining strategies, currently being pursued in Scotland, other suitable forms at local or regional level or steps to encourage social care employer recognition of unions.

6. Better support unpaid carers who provide the majority of care.

Unpaid care is an essential pillar of the mixed care system. Caring for family or friends can be rewarding, yet studies also show associations between informal caregiving roles and poorer mental and physical health. Challenges maintaining employment (levels) due to concerns about inflexibility and incompatibility with work demands, can reduce income levels, including in later life.

To address this, measures need to be put in place by government and employers of informal carers to support those in employment (e.g. through carer's leave, flexible working and/or a carer's network at work), to reduce the care penalty and to support the carer's own health, e.g. by offering opportunities for breaks beyond those in crisis times. This will help to improve what could be considered the equivalent of 'job quality' of informal carers.

About the authors

This paper was authored for ReWAGE by Beate Baldauf (University of Warwick), Professor Irena Grugulis (University of Leeds). Professor Ian Cunningham (University of Strathclyde), Professor Ian Kessler (King's College London), Professor Victoria Wass (Cardiff University), Dr Juliana Onwumere (King's College London), Professor Tracy Shildrick (Newcastle University), Professor Chris Forde (University of Leeds), Malcolm Brown (Church of England) and Professor Damian Grimshaw (King's College London).

Comments and suggestions were provided by Professor Shereen Hussein (London School of Hygiene & Tropical Medicine), Gill Dix (University of Warwick), Professor Chris Warhurst (University of Warwick), Daniel Mortimer (NHS Employers) and Tony Wilson (Institute for Employment Studies).

This paper represents the views of the authors based on the available research. It is not intended to represent the views of all [ReWAGE members](#).

The evidence paper was commissioned and funded by the [abrdn Financial Fairness Trust](#).

About ReWAGE

ReWAGE is an independent expert advisory group modelled on SAGE that is co-chaired by the Universities of Warwick and Leeds. It analyses the latest work and employment research to advise the government on addressing the challenges facing the UK's productivity and prosperity.

For more information visit: <https://warwick.ac.uk/fac/soc/ier/rewage/>

Core funding for ReWAGE was provided by the Economic and Social Research Council.