

Institute for Public Policy Research



FAIR CARE

A WORKFORCE STRATEGY FOR SOCIAL CARE

**Joe Dromey and
Dean Hochlaf**
November 2018

CONTENTS

Summary	3
Introduction	6
The adult social care sector	6
The adult social care workforce	6
1. There is a workforce crisis in social care – and without action it will get worse	8
Low pay	8
Denial of employment rights	9
Insecurity	10
Low training and low progression	11
The growing social care workforce crisis	12
Recruitment, retention and vacancies	13
Growing replacement demand	13
Brexit and the social care workforce crisis	14
Growing demand from an ageing society	17
2. The social care workforce crisis has a negative impact both on the workforce and on quality of care	18
The impact of poor working conditions	18
The impact on quality of care and on care recipients	19
Pressure on time and quality of care	19
Low levels of training and quality of care	20
High turnover, under-staffing and quality of care	20
3. The workforce crisis is the result of an under-funded and dysfunctional social care system	22
Under-funding and poor commissioning practices	22
Price-based competition among independent providers	23
Lack of bargaining power	24
Lack of enforcement of employment rights	25
Lack of workforce planning	26
The under-valuing of social care and the social care workforce	26
A dangerous combination	28
4. We need a workforce strategy for social care based on sectoral collective bargaining	29
Establishing a long-term funding settlement for social care	29
Introducing the real Living Wage in adult social care	30
Setting minimum standards and improving job quality through sectoral collective bargaining	31
Boosting training and quality through a mandatory Care Certificate and professional regulation	32
Enforcing minimum standards through a wider role for CQC and improved commissioning	33
Minimising the impact of Brexit on social care	34
Overseeing workforce strategy	35
References	36

ABOUT THE AUTHOR

Joe Dromey is a senior research fellow at IPPR.

Dean Hochlaf is a researcher at IPPR.

ACKNOWLEDGEMENTS

The authors would like to thank the UNISON Campaign Fund and Independent Age for supporting the project. We would like to thank our colleagues Tom Kibasi, Clare McNeil, Harry Quilter-Pinner and Carys Roberts for their comments on the draft, Mary Reader for her support with the early stages of the research and Marley Morris for his support with data analysis.

We would also like to thank the many organisations who took part in the research – either through interviews or our stakeholder roundtable. We would particularly like to thank the care workers who joined our focus group to give their first-hand experience.

Download

This document is available to download as a free PDF and in other formats at:

<http://www.ippr.org/research/publications/fair-care>

Citation

If you are using this document in your own writing, our preferred citation is:

Dromey J and Hochlaf D (2018) *Fair care: A workforce strategy for social care*, IPPR. <http://www.ippr.org/research/publications/fair-care>

Permission to share

This document is published under a creative commons licence:

Attribution-NonCommercial-NoDerivs 2.0 UK

<http://creativecommons.org/licenses/by-nc-nd/2.0/uk/>

For commercial use, please contact info@ippr.org



SUMMARY

Adult social care is an essential public service and a growing part of our economy. However, the social care system in England faces a workforce crisis which is set to grow in the coming years; by 2028, we estimate there will be a shortage of over 400,000 workers in social care.

The challenges of recruiting and retaining workers in the sector is inextricably linked to low pay and poor working conditions. This is itself related to the under-funding of social care and a commissioning and delivery model based on cost not quality. Providers have competed by driving down pay and conditions, and they have faced little resistance given the limited bargaining power of the workforce and the limited enforcement of employment rights. These factors are combining to create a social care workforce crisis.

If we are to solve the workforce crisis, we need to deliver a sustainable long-term funding settlement for social care and a transformation of the social care workforce model. This should be based on the establishment of decent pay and terms and conditions through sectoral collective bargaining, and a professionalisation of the social care workforce. These measures would help ensure high-quality work for care workers, and high-quality care for those who need it.

1. There is a workforce crisis in social care – and without action it will get worse

- Social care is characterised by endemic low pay. **Over 500,000 workers in social care – and half of all care workers – are paid below the real living wage.** The sector accounts for one in 10 of all jobs paid below the real living wage and there is evidence of widespread avoidance of the minimum wage.
- Social care is characterised by chronic levels of insecurity. One in four workers in social care – and one in three care workers – are on a zero-hours contract.
- While social care is a vital service and a skilled task, there are no effective minimum training requirements for care workers, and half of care workers have no relevant social care qualification. There are currently limited opportunities for progression in social care.
- As a result of low pay and poor working conditions, social care is struggling to recruit and retain the workers that it needs to meet rapidly rising demand. Constraints on EU migration post-Brexit threaten to exacerbate the growing workforce crisis. Our modelling shows that – on current trends, and assuming the ending of freedom of movement – there will be a **shortage of nearly 400,000 workers in social care by 2028.**

2. The social care workforce crisis has a negative impact both on the workforce and on quality of care

- High-quality work and high-quality care are inextricably linked.
- The poor conditions and widespread exploitation of the social care workforce has a significant negative impact on workers. Care workers highlighted how low pay required colleagues to work excessive hours

or multiple jobs and how the widespread use of zero-hours contracts leaves many in an insecure position.

- The poor treatment and widespread exploitation of the social care workforce has a significant negative impact on quality of care. Under-staffing and pressure on time leads to care needs being unmet and the lack of training inhibits the ability of workers to provide high-quality care.

3. The workforce crisis is the result of an under-funded and a dysfunctional social care system

- The chronic under-funding of social care has contributed to the workforce crisis. Government funding for local authorities has been cut by half since 2010, leading to cuts to care budgets just as demand is rising. Six in seven councils are commissioning homecare at below the minimum rate required to deliver a sustainable service.
- The growth of outsourced provision and the rise of price-based competition has driven down pay and employment standards in social care. In an under-funded and under-regulated market, care providers have seen labour as a cost to be minimised.
- The social care workforce currently has limited bargaining power to improve pay and conditions. With low levels of union membership, widespread use of zero-hours contracts and a lack of enforcement of basic employment rights, there is a power imbalance in social care, which prevents workers from winning fair pay and conditions.
- Underlying all these factors is the under-valuing of social care and of the social care workforce. Despite the growing crisis, just one in 10 adults sees social care as an important issue. The social care workforce is under-valued due to perceptions that the work is unskilled and due to gendered norms around care work.

4. The UK needs a workforce strategy for social care based on sectoral collective bargaining

- Increasing funding for social care is a vital pre-condition for improving pay and conditions and tackling the workforce crisis. Government should set out a long-term funding settlement for social care, with a 1p increase in national insurance.
- While we have seen some improvements in pay since the introduction of the national living wage, there remains an urgent need to increase pay in social care. Government should **ensure that all workers in social care are paid at least the real living wage**. Raising all workers in social care to the real living wage in England would require an additional £445 million beyond current funding needs.
- Increasing funding is a necessary but not sufficient step to boosting pay and tackling the workforce crisis in social care. In order to ensure that increased funding leads to higher pay, **sectoral collective bargaining should be introduced in social care to drive up employment standards**. Government should establish a sector council to bring together representatives of employers and workers to negotiate a legally binding sectoral agreement, setting out minimum standards for pay and terms and conditions. Additional funding for the sector should be conditional on securing a sectoral agreement.
- Government should seek to professionalise the social care sector and boost levels of training. The Care Certificate should become a

mandatory licence to practise, and care workers should become a regulated profession in order to drive up standards and prestige.

- In order to enforce minimum standards, the Care Quality Commission (CQC) should be given a wider remit to focus on quality of employment as well as quality of care. Government should establish a minimum commissioning cost for local authorities to ensure care is not commissioned at unrealistically low levels, and ensure that local authorities have sufficient funding to meet this requirement
- If government ends freedom of movement, it should minimise the impact of Brexit by revising the Shortage Occupation List to include social care occupations and introducing a Trusted Sponsor Scheme that enables care providers who demonstrate good employment practice to be eligible for an increased range of visa benefits.

INTRODUCTION

THE ADULT SOCIAL CARE SECTOR

Adult social care – which covers social work, personal care and practical support for adults with a physical disability, a learning disability or physical or mental illness – is an essential public service.

Demand for social care is set to rise in the future. This is being driven primarily by our ageing society; the proportion of the UK population aged over 75 will increase by 59 per cent by 2035 (IPPR analysis of ONS 2017a). Recent modelling for The Lancet projects that the number of people aged 85 and over requiring 24-hour care will double by 2035 (Kingston et al 2018). Demand for social care is also being driven by growing life expectancies for adults with learning disabilities (Carter and Jancar 1983; Puri et al 1995).

However, despite growing demand for care, spending on social care has been cut in recent years as a result of reductions in funding for local authorities. Spending on social care in England declined by 8 per cent in real terms between 2009/10 and 2016/17 (Simpson 2017). As spending on social care has fallen, so the number of people in receipt of social care has declined; there are 27 per cent fewer people receiving state-funded adult social care today than in 2010 (Darzi 2018).

THE ADULT SOCIAL CARE WORKFORCE

In addition to being a vital public service, social care is a vital and growing part of the UK economy.

Adult social care provides 1.3 million jobs in England, making the workforce larger than the NHS (Skills for Care 2018). Women account for 82 per cent of the social care workforce and 84 per cent of care workers.

The rapid increase in demand for adult social care in the future will require a considerable increase in the social care workforce. Modelling commissioned by the Department of Health & Social Care suggests the workforce would need to grow by 2.6 per cent a year up to 2035, by when there would be two million jobs in social care (SCIE 2016).

However, the adult social care workforce is currently growing at well below this rate. Over the last four years, the average rate of growth has been just 1.4 per cent, and the rate of growth has slowed in recent years (IPPR analysis of Skills for Care 2017).

In this report, we examine the challenges facing the social care workforce in England, and the evidence of the growing social care workforce crisis. The report is based on a literature review of existing evidence, analysis of quantitative data on the social care workforce, interviews, a focus group with stakeholders in the sector and a focus group with workers in social care.

We argue that the social care workforce faces poor working conditions and widespread exploitation, with the sector being characterised by low pay, insecurity and a lack of investment in training. The poor conditions in the sector have contributed to a growing workforce crisis, with employers struggling to recruit and retain the workers they need to meet rapidly growing demand.

We show that the poor conditions of the workforce is not just bad for workers; it is bad for quality of care too, and it is undermining the very sustainability of the system. We identify that the root causes of the care workforce crisis lie in the dysfunctional social care system, with a dangerous combination of price-based competition, an under-funded and under-regulated market, and a disempowered workforce inevitably leading to exploitation. We then set out a workforce strategy to tackle the care workforce crisis, and to ensure that we are able to provide high-quality care for those who need it and high-quality work for those who provide it.

1. **THERE IS A WORKFORCE CRISIS IN SOCIAL CARE – AND WITHOUT ACTION IT WILL GET WORSE**

In this section we examine the conditions of the social care workforce. We argue that the social care workforce faces poor conditions and widespread exploitation. The sector is characterised by low pay, widespread denial of employment rights, chronic insecurity, low investment in training and a lack of opportunity for progression.

LOW PAY

The adult social care sector is characterised by endemic levels of low pay.

In 2018, median pay in the UK for a care worker was just £9.14 per hour, with the average senior care worker earning just £9.62. Median pay for a care worker is 28 per cent lower than median pay across the economy as a whole, and it is nearly half the level of median pay for a nurse (IPPR analysis of ONS 2018a).

The National Minimum Data Set for Social Care, produced by Skills for Care, puts pay even lower. This shows that average hourly pay for a care worker in England in 2017 was £7.84, £8.65 for a senior care worker and £15.11 for registered managers (Skills for Care 2018).

Pay tends to be far lower in the private sector. Median hourly pay for care workers directly employed by local authorities in England in 2017 was £9.80, compared to just £7.76 for those employed by independent providers (ibid).

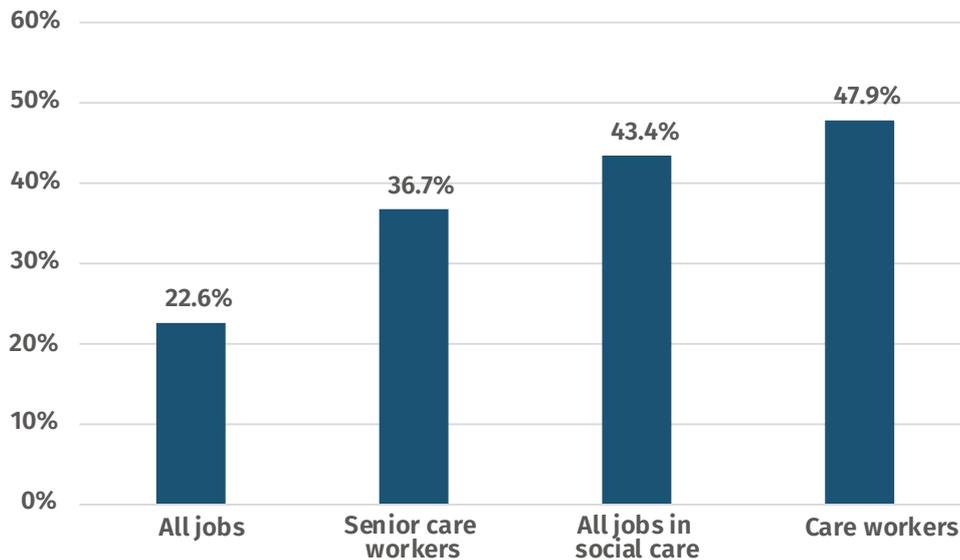
The introduction of the national living wage in 2016 did lead to a significant pay rise for lower paid care workers. Pay for the lowest paid 10 per cent of care workers in the independent sector increased by 6.8 per cent in real terms between 2016 and 2018. However, pay rises for those above the wage floor were far smaller. This has led to significant compression, with over three in 10 care workers being paid the national living wage of £7.50 per hour (ibid).

IPPR analysis of the Office for National Statistics' Annual Survey of Hours and Earnings (ASHE) shows that, in 2018, nearly half (43.4 per cent) of all jobs in social care paid below the real living wage, nearly double the rate of the economy as a whole (22.6 per cent).¹ As figure 1.1 shows, half of care workers are paid below the real living wage.

¹ The real living wage is a voluntary rate set by the Living Wage Foundation based on the amount needed to meet the real cost of living. It is higher than the national living wage, the statutory minimum wage for adults aged 25 and over, which is set by government. In 2018/19, the real living wage was £10.55 in London and £9.00 across the rest of the UK.

FIGURE 1.1: HALF OF CARE WORKERS EARN BELOW THE REAL LIVING WAGE

Proportion of employees earning below the real living wage, 2018



Source: IPPR analysis of ONS (2018a)

Given the size of the sector and the endemic nature of low pay, social care accounts for a significant proportion of low-paid workers in the UK. In 2018, 517,000 jobs in social care were paying below the real living wage. This represented nearly one in 10 (9.4 per cent) of all jobs paying below the real living wage (IPPR analysis of ONS 2018b).

Social care is devolved, and the Scottish Government has recently introduced the real living wage for care workers in Scotland (Scottish Government 2016). Under the deal, the Scottish Government provides additional funding for local authorities, on the condition that they negotiate with providers to ensure all staff are paid the living wage.

DENIAL OF EMPLOYMENT RIGHTS

Beyond the evidence of low pay, there is significant evidence pointing to the widespread denial of employment rights in the care sector and the illegal under-payment of the minimum wage.

Analysis of ASHE suggests that 25,000 care workers in 2016 were paid below the relevant minimum wage for their age, representing 2.4 per cent of the social care workforce (ONS 2016).² This was one of the highest rates for any industry.

However, the real extent of under-payment of the minimum wage may be far greater than this figure. This is due to the combination of low hourly rates of pay – as set out above – with widespread non-payment of what should be working hours, particularly in homecare. This has the impact of turning low but legal levels of pay into illegal under-payment of the minimum wage.

² ONS warns that this data cannot be used as a measure of non-compliance with minimum wage legislation. For example, some workers included in the data may have received benefits in kind – such as free accommodation – which employers can offset against hourly pay rates.

Travel time in social care is regularly unpaid. A survey of homecare workers last year found that nearly two in three (63 per cent) said they were only paid for contact time, and not for travel between the homes of people they cared for (UNISON 2017). This is despite clear guidance from HM Revenue & Customs (HMRC) that this should be treated as working time and paid accordingly (UK Government 2018). Recent legislation passed by the Welsh Government compels service providers to delineate travel and care time in a way in which it ensures that workers have enough time to carry out their duties (Welsh Government 2017). The purpose of this change is to promote compliance with the national minimum wage and working time obligations.

In our focus group, care workers highlighted evidence of regular unpaid working time. Most of those in the homecare sector reported not being paid for travel time, or for unscheduled hours they have to work.

“If you come across an emergency, and you have to stay for longer, you don’t get paid for that. You always have to stay late, and you never get paid for it.”

Caroline, homecare worker

When taking into account unpaid time, illegal under-payment of the minimum wage is far more common. Analysis by Dr Shereen Hussein found that in 2011 between nine and 13 per cent of care jobs – representing some 157,000 to 219,000 workers – were being paid below the statutory minimum wage (Hussein 2011). Building on her analysis, Resolution Foundation calculated that care workers underpaid the minimum wage lost – on average – £815 a year in 2013/14, representing a total under-payment of the minimum wage equivalent to £130 million (Gardiner 2015).

There has been a greater focus on enforcement of the minimum wage in social care in recent years. Social care has been identified by HMRC as a priority sector, and there has been an increase in both inspections and the number of employers found to be illegally underpaying. In 2017/18, 80 employers in social care were found to have illegally underpaid the minimum wage, with over 1,500 workers having been underpaid by a combined total of £751,000 (IPPR analysis of BEIS 2018). However, enforcement remains limited compared to the scale of under-payment in the sector.

INSECURITY

The social care workforce is characterised by chronic levels of insecurity.

Use of zero-hours contracts – which do not guarantee a worker a minimum number of hours – is higher in social care than other sectors. According to the Labour Force Survey (LFS), 6.1 per cent of workers in residential care and 9.7 per cent of care workers are on a zero-hours contract, compared to 2.3 per cent of employees across the whole economy.

However, the real prevalence of zero-hours contracts is likely to be far higher. According to the National Minimum Data Set for Social Care, one in four (24.1 per cent) workers in adult social care in England are on a zero-hours contract, rising to one in three (33.7 per cent) care workers and over half (56.6 per cent) of care workers in homecare (Skills for Care 2018).

As with pay, there is a significant difference by sector. Care workers employed by independent providers in England are over three times more likely to be on zero-hours contracts than those employed by local authorities (34.8 per cent compared to 10.1 per cent) (ibid).

The Welsh Government has recently acted to address the issue of zero-hour contracts, passing legislation compelling employers to offer their workforce the choice of a guaranteed hours contract following three months of employment (Welsh Government 2017).

LOW TRAINING AND LOW PROGRESSION

Social care is vitally important work. It involves supporting the vulnerable and those with complex needs, and providing both social and emotional support as well as carrying out important medical tasks. As one care worker explained in our focus group:

"Care work is – and should be – skilled."

While some occupations in the sector, including registered nurses, social workers and occupational therapists, are regulated professions with rigorous training requirements, care workers have no professional regulation and no mandatory training.

The Cavendish Review in 2013 sought to address this by recommending common training standards across the health and social care sector through a 'Certificate of Fundamental Care' (DHSC 2013). Following this, the Care Certificate was developed by Skills for Care, Skills for Health and Health Education England. It is intended that the certificate is completed within 12 weeks of starting work and that it includes a personal development plan. However, the certificate is not mandatory or enforced by a regulator, and concerns have been raised about quality assurance, portability and suitability (Allan et al. 2014).

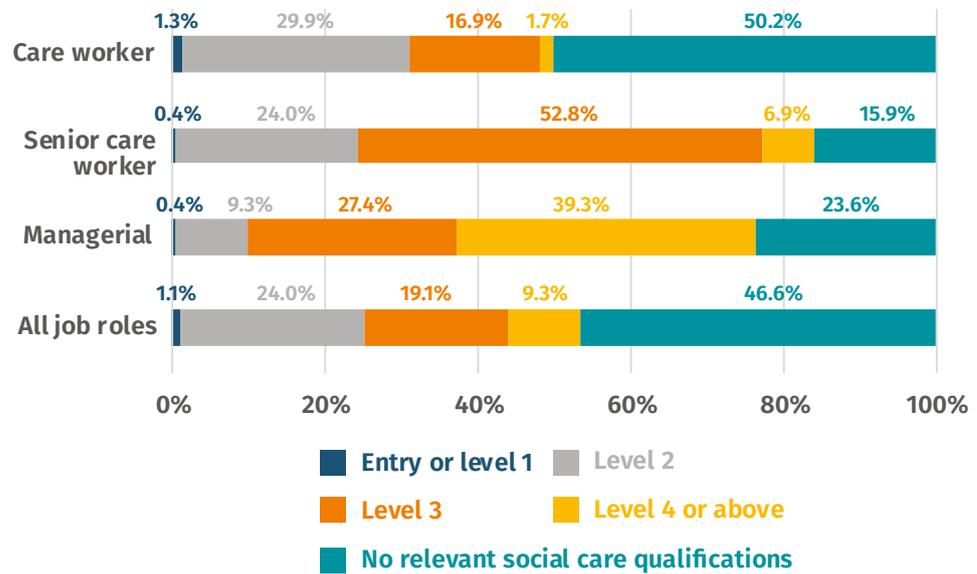
Take-up of the Care Certificate has been slow. Just one in three (33 per cent) care workers have completed their Care Certificate, with slightly more than a third (37 per cent) in progress or partially complete. Three in 10 care workers have not started their Care Certificate (Skills for Care 2018).

There were also concerns expressed about the quality of training in the sector by both workers and stakeholders. One provider described how the Care Certificate was seen as 'worthless' by some employers, and that training by one provider tended not to be seen as portable to another. Care workers in our focus group described much of the training they did as being a 'box-ticking exercise' rather than something which supported them to do their job better. Most said their training was primarily done online, with many expected to do it unpaid in their own time.

The low levels of qualifications required in the sector are matched by low levels of qualification among the workforce. As figure 1.2 below shows, half (50.2 per cent) of care workers have no relevant social care qualifications at all. One in five care workers without a recognised qualification had not even had induction training.

Again, there is a significant difference by sector. Over half (55.7 per cent) of care workers in the independent sector have no relevant social care qualifications, compared to just one in five (19.6 per cent) in local authorities (ibid).

FIGURE 1.2: HALF OF CARE WORKERS HAVE NO RELEVANT SOCIAL CARE QUALIFICATIONS
Qualification level by job role in social care in England (2017)



Source: Skills for Care (2018)

Both care workers and stakeholders highlighted concerns that the low levels of training provided were not adequately preparing workers for an increasingly complex role. In a recent survey of care workers, one in four (23.6 per cent) care workers said they did not feel that they received the specialist training required to care for people in the way they would like, while 14 per cent said that they had carried out medical tasks beyond the level they had been trained to do (UNISON 2018).

Opportunities for progression in the social care sector are extremely limited. Analysis by Resolution Foundation has shown that workers in social care are among the least likely to escape from low pay. Between 2003 and 2013, half (49 per cent) of workers in residential nursing care facilities were ‘stuck’ in low pay, never earning more than two-thirds of median hourly pay (D’Arcy and Hurrell 2014). The increasingly flat workforce structure and the increasingly compressed pay distribution for care workers also limit the ability of workers to progress. This was highlighted by many of the workers in our focus group who said there were limited opportunities for pay progression in the sector.

The very limited training requirements for care workers, the low qualification level of the workforce and the low employer investment in skills is in stark contrast to the NHS, where nurses must renew their registration every three years by confirming that they have met established continuing professional development (CPD) standards (Cory et al 2017).

THE GROWING SOCIAL CARE WORKFORCE CRISIS

The social care sector already faces a significant workforce crisis. In this section, we show how the poor conditions of the social care workforce have led to difficulties in recruiting and retaining sufficient workers to meet rising demand. We also show that the situation is set to get far worse in coming years, as the care workforce ages, as Brexit restricts access to migrant workers and as demand rises.

RECRUITMENT, RETENTION AND VACANCIES

It is increasingly clear that the poor conditions and widespread exploitation of the social care workforce is contributing to an escalating workforce crisis which is undermining the ability of the sector to recruit and retain the workers it needs to meet growing demand.

There are growing and unsustainable levels of turnover in the social care sector. In 2017/18, 30.7 per cent of the care workforce and 37.5 per cent of carers left their job (Skills for Care 2018). Turnover is even higher for new care workers; nearly half (48 per cent) of care workers leave within a year (CLG Committee 2017). In a recent survey of care workers, half (49 per cent) said they had thought about leaving their job (UNISON 2018).

With high levels of employee turnover, many care providers struggle to recruit and retain enough staff. In 2017/18, social care had vacancy rates of 8 per cent, rising to 9.1 per cent for care workers (Skills for Care 2017). This represents 88,000 unfilled vacancies in the sector. The vacancy rate in the sector is over double the vacancy rate for the whole economy, which stood at 2.5 per cent as of July 2018 (ONS 2018b). Turnover rates of those working in direct care are nearly three times higher in the independent sector than in local authorities (36 per cent and 12.5 per cent respectively) (Skills for Care 2018).

There is a clear link between the poor conditions of the workforce and the challenges with recruitment, retention and vacancies.

The evidence is most compelling in relation to pay. Turnover rates are consistently higher for lower paid care workers than for higher paid care workers. However, the difference in turnover rates reduced significantly in 2017/18 (ibid). This coincided with a significant real-terms pay rise for workers at the bottom of the income distribution as a result of the national living wage and slower pay rises for those further up the income distribution, suggesting that pay rises in the sector could be effective in reducing turnover.

Pay is seen by care workers as the biggest driver of the growing workforce crisis. In a recent survey of care workers, three in four (73 per cent) of those who were thinking of leaving the profession were doing so because pay was too low. When asked what could be done to encourage more care workers to stay in the sector, nine in 10 (89 per cent) highlighted the need for better pay (UNISON 2018).

This was reflected in our focus group, with many care workers explaining how low pay contributed to difficulties with recruitment and retention.

“Pay everywhere is just bad. They keep saying that the country has a deficit of carers. Maybe if they improved terms and conditions and paid care workers a bit more, they would get more people wanting to do it.”

Nicole, former care worker retraining as a nurse

Echoing the view of the workforce, commissioners of social care see low pay as the biggest barrier to recruitment and retention in the sector. A recent survey of over 150 directors of adult social services found that increasing pay was identified as the most important factor in ensuring sufficiency of care workers in their local area (ADASS 2018).

GROWING REPLACEMENT DEMAND

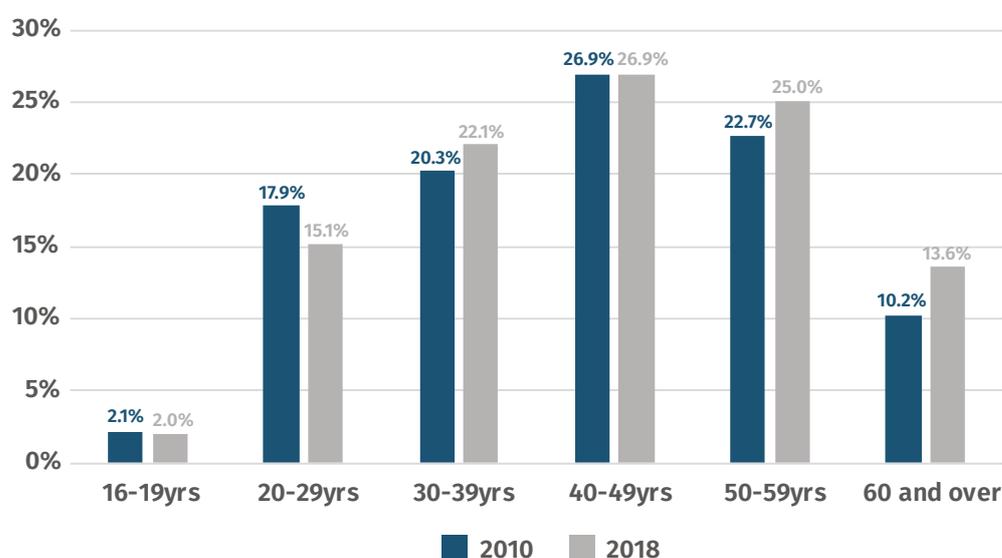
The social care workforce is ageing. As figure 1.3 shows, between 2010 and 2018, the proportion of employees in the sector aged 50 and over increased from 32.8 per cent to 39.5 per cent. Over the same period, the proportion of the workforce aged 16 to 29 fell from 20 per cent to 17.1 per cent.

In 2017 there were 450,000 workers aged 50 and over in the social care sector who will retire in the next two decades. This figure has increased by two-thirds since 2010.

The ageing profile of the social care workforce will lead to a significant increase in replacement demand in the future, with the social care sector having to attract and retain a growing number of workers just to maintain the current size workforce.

FIGURE 1.3: THE SOCIAL CARE WORKFORCE IS AGEING

Workers in residential care activities and social work without accommodation by age cohort, England, 2010 and 2018



Source: IPPR analysis of LFS

BREXIT AND THE SOCIAL CARE WORKFORCE CRISIS

The social care sector has become increasingly reliant on migrant workers in recent years, with the number of workers joining the sector from the European Union (EU) growing rapidly .

As table 1.1 shows, there are some 95,000 EU nationals working in the social care sector, representing 7.1 per cent of the total workforce, and 7.8 per cent of care workers. There are also 127,000 non-EU migrants working in social care, accounting for 9.5 per cent of the workforce.

While the proportion of EU workers in adult social care remains relatively modest, it has increased in recent years. Between 2012/13 and 2017/18, the proportion of EU workers rose from 4.9 per cent to 7.6 per cent. The increase of 38,700 EU nationals working in the sector over the last five years accounts for a third (34.1 per cent) of the increase in the workforce over that period (IPPR analysis of Skills for Care 2017).

The social care sector in London is particularly dependent on migrant workers. Only 37 per cent of the adult social care sector workforce in London is UK born, with 12 per cent being from the EU and 51 per cent being non-EU migrants.

Brexit and the proposed ending of freedom of movement could exacerbate the social care workforce crisis.

TABLE 1.1: MIGRANT WORKERS PLAY AN IMPORTANT ROLE IN THE ADULT SOCIAL CARE SECTOR

Proportion of workforce and total workers by nationality, 2017/18

	EU nationals as a proportion of the workforce (%)	Non-EU nationals as a proportion of the workforce (%)	Total EU nationals in the workforce	Non-EU nationals in the workforce
Total	7.1%	9.5%	95,000	127,000
Care workers	7.8%	10.7%	72,000	103,000
Senior care workers	6.1%	11.3%	5,100	9,600

Source: Skills for Care (2017)

The Migration Advisory Committee (MAC) recently set out recommendations to government on a post-Brexit migration system for future migration from the European Economic Area (EEA). Their recommendations included ending freedom of movement, and extending the Tier 2 system to EEA nationals as well as migrants from other countries (MAC 2018). The government has laid out similar plans for migration policy post-Brexit, pledging to end differential treatment for EEA nationals and placing a focus on prioritising high-skilled workers.

If implemented, these recommendations would risk having a very big impact on the social care sector. In order to estimate the potential impact of tighter migration policy post-Brexit, we modelled the impact of the MAC recommendations on EEA nationals currently living in the UK and working in social care. While these workers would be allowed to stay in the UK post-Brexit, applying this potential future migration system to this group allows us to understand the potential future impact of changes in migration policy for the sector.³

We found that four in five (79 per cent) of EEA employees working full-time in social care would have been ineligible to work in the UK under the skills and salary thresholds proposed by MAC (IPPR analysis of LFS 2016).

The potential impact of the proposals is acknowledged by MAC, which states that it is ‘seriously concerned about social care’, and that government action is needed to solve the sector’s many problems (MAC 2018).

3 The findings are based on IPPR analysis of the Labour Force Survey (2016 Quarters 1-4) and on Appendix J of the Immigration Rules. We have estimated the implications of the Migration Advisory Committee’s proposals by applying their recommended skills thresholds (occupations at RQF level 3 and above) and salary thresholds (£30,000 for experienced workers alongside appropriate occupational salary rates as detailed in the Immigration Rules) to EU migrants working in the UK. Our figures are based on the nationality of migrants rather than their country of birth, and we have included EEA/EFTA (European Free Trade Association) countries within our categorisation of ‘EU migrants’. The findings only apply to full-time employees; self-employed are excluded as salary data is unavailable for these workers. This analysis is modelled on our previous work on the labour market impacts of Brexit, of which more details can be found here: <https://www.ippr.org/publications/striking-the-right-deal>

The growing workforce crisis

Based on the trends outlined, it is possible to make a projection of the potential shortage of social care workers in England over the next decade.

As we have shown, demand for social care will grow rapidly in the coming years. The Department of Health & Social Care expects that the social care workforce will need to grow by 2.6 per cent a year up to 2035 (SCIE 2016) in order to meet rising demand. This means that by 2028 the sector will require 1.79 million workers.

The growth of the social care workforce has fallen short of rising demand in recent years. Skills for Care estimated that there were 88,000 vacancies in the sector in 2017. Between 2012/13 and 2017/18, the net number of British workers joining the sector each year on average has been below 15,000. During the same period the net number of new EU staff joining the sector each year on average has been below 8,000.

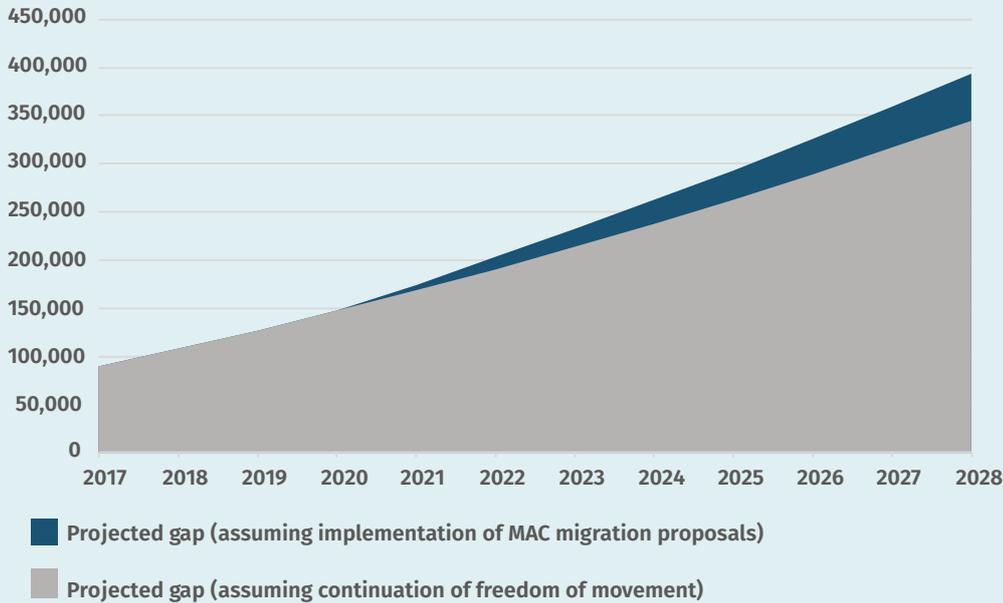
The net flow of EU nationals is likely to reduce significantly post-Brexit. Our analysis suggests that four in five (79 per cent) current EEA nationals working in the care sector in the UK would not have been able to come to the UK had the Migration Advisory Committee (MAC) proposals been in place.

Our analysis suggests that if demand rises as forecast, and assuming that the MAC recommendations are implemented after the planned ending of freedom of movement in December 2020, then by 2028 there will be a shortage of nearly 400,000 workers in adult social care. While a more restrictive migration policy could contribute to the growing shortage of workers in social care, maintaining freedom of movement would not solve the recruitment challenge in the sector. Assuming no change in migration policy – and assuming that recent migration flows remain the same – the projected workforce shortage in the next decade will still rise to nearly 350,000⁴.

⁴ The projections are calculated based on recent trends in the net total of new staff joining the sector and the assumption that demand will grow by 2.6 per cent a year over the next decade. Taking the average number of new net staff by nationality (UK, rest of EU, non-EU) over the last five years, we assume that these trends will continue over the next decade.

FIGURE 1.4: SOCIAL CARE IS SET TO SEE A GROWING WORKFORCE SHORTAGE, WHICH WILL BE LARGER IF FREEDOM OF MOVEMENT ENDS

Projected vacancies in adult social care



Source: Authors' analysis using data from Skills for Care, adult social care workforce estimates

It is clear that there will be a stark shortfall in staff over the next decade if the sector continues to fail to attract significant numbers to join. A more relaxed migration system may mitigate this shortfall to some extent, but there will remain a sizeable gap. Efforts to recruit and retain workers in this sector must focus on addressing the poor conditions endemic in adult social care or face the realities of being unable to cope with the increasing pressures of demand.

GROWING DEMAND FROM AN AGEING SOCIETY

Finally, in addition to growing replacement demand as a result of an ageing workforce, and in addition to the significant potential impact of restrictions on migration post-Brexit, the social care sector will face rapidly growing demand in the future.

As we set out in the introduction, demand for social care will continue to rise as a result of an ageing population. The number of adults aged 85 and over who require 24-hour care is set to double by 2035 (Kingston et al 2018). This will necessitate a significant increase in the size of the social care workforce in the coming years, and growth at rates far higher than we have seen in recent years.

Having examined the growing workforce crisis in adult social care, in the following section we examine the impact of the crisis both on the workforce and on care recipients.

2. THE SOCIAL CARE WORKFORCE CRISIS HAS A NEGATIVE IMPACT BOTH ON THE WORKFORCE AND ON QUALITY OF CARE

Having set out the evidence of the poor conditions and widespread exploitation of the social care workforce, in this chapter we examine the impact of this on the care workforce and on care recipients. We show that the low pay and poor conditions in social care is not just bad for the workforce – it undermines quality of care too.

THE IMPACT OF POOR WORKING CONDITIONS

Low pay and poor conditions in adult social care have a significant negative impact on workers themselves, culminating in many considering leaving the profession.

Social care workers in our focus group highlighted the impact that endemic low pay in the sector has on themselves and their colleagues. They described that – as a result of low hourly rates of pay – many of their colleagues had to take second and third jobs to make ends meet. Others described how their colleagues were forced to work excessive, anti-social and potentially dangerous hours.

“At my workplace, most of the people that are there are single mums or the main income earner. Yet nobody at my company – unless they are a manager – make over £8 an hour. Women – because it is mostly women – would work double shifts, back to back shifts, split shifts, probably in violation of any working time regulations. I’d ask them ‘why are you doing this, why are you working like this?’ and they just say ‘I need the money’... That impacts on the safety of the clients as well.”

Nicole, care worker

Insecurity and the prevalence of zero-hours contracts were also generally seen as having a negative impact on the workforce. In our focus group, some workers identified some potential benefit of flexibility offered by zero-hours contracts in enabling workers to manage their hours around other responsibilities. However, many workers highlighted concerns around zero-hours contracts, particularly in not being able to turn down any hours that were offered.

“You are supposed to be able to refuse work. But my experience is not like that.”

Brenda, care worker

“It is really very bad... If I refused, they would take my hours away.”

Florence, care worker

This seems to show that in some cases, zero-hours contracts in social care represent a one-sided flexibility, with the employer able to call on a highly flexible workforce, but with the workforce feeling unable to turn down work.

Social care workers also highlighted the insecurity and uncertainty that zero-hours contracts caused in their income.

“The impact is never knowing what you can afford, whether you can pay your rent or feed yourself. Basically you can’t have a life. You are on call 24/7 on zero hours.”

Caroline, homecare worker

Many care workers highlighted the impact of excessive workloads and the physically and emotionally demanding nature of the work on the workforce.

“You come early, and you leave late. The contract we have now is making us overwork. It’s not good for us, and it physically affects their health.”

Beatrice, care worker

While social care workers in our focus group were passionate about the work that they do and the people who they care for, many had considered leaving the profession. Several gave the impression that it was only their passion for their work and their commitment to those they cared for that kept them from leaving.

“The only thing that keeps you is that it is a really rewarding job.”

Carmela, live-in carer

This was reflected in a recent survey of care workers which showed that half (49 per cent) said they had considered leaving the profession (UNISON 2018).

THE IMPACT ON QUALITY OF CARE AND ON CARE RECIPIENTS

There is extensive evidence that the poor working conditions and the failing workforce model is undermining quality of care and impacting on care recipients.

Often job quality and care quality are seen as separate issues, but in reality they are inextricably linked (Eaton 2000). This link was highlighted by care workers in our focus group, who explained how both poor pay and poor working conditions had an impact on the ability of the sector to recruit and retain workers, and on the ability of those workers to provide high-quality care.

“If conditions are better, if pay is better, you will attract a better quality of care staff. And that will mean better for the residents.”

Nicole, former care worker retraining as a nurse

Below we highlight how a number of the factors highlighted in chapter 1 can have a negative impact on quality of care.

PRESSURE ON TIME AND QUALITY OF CARE

There is evidence that excessive time pressure on the care workforce is undermining quality of care, and resulting in unmet need.

Person-centred care is key to high-quality care (CQC 2017). But that requires time to build relationships and emotional/physical investment by staff: quality of social care is intimately linked with establishing relationships, social connection and support (Eaton 2000).

However, in a recent survey of homecare workers, three in four said that they did not feel they got enough time to do their job without being rushed and without

compromising the dignity or wellbeing of the people they look after (UNISON 2017). One in three reported that they often don't have enough time to prepare a meal (35 per cent) or to help with washing and bathing (30 per cent), toileting (30 per cent) or personal care such as stoma care (29 per cent). However, with excessive time pressure, it is the social aspect of care which is most commonly lost; nine in 10 (89 per cent) care workers say that they don't get enough time to have a chat with the people they are caring for (ibid).

This was reflected in our focus group, with one care worker describing the impact of excessive and unrealistic workloads.

“Sometimes you cut corners because you have to. To catch up for the next person, because they're waiting for you.”

Caroline, homecare worker

Nearly half (47.9 per cent) of survey respondents disagreed that they had enough time to deliver dignified and compassionate care (UNISON 2018). Not only will this likely be demoralising for care workers who feel unable to perform their responsibilities to desired standards, but it will diminish the quality of care a recipient can expect.

“The main category of abuse is neglect and omission... this is about people experiencing forms of abuse because there simply is not the time and resources to provide them with the care they need. Neglect is built into the system.”

Dr Lydia Hayes, Cardiff University, Reader in Law

LOW LEVELS OF TRAINING AND QUALITY OF CARE

The low levels of training provided to the care workforce also risk undermining quality of care.

In a recent survey of homecare workers, one in seven (14 per cent) said that they have not been provided with the necessary training to deal with their care recipients' conditions (UNISON 2017).

Again, lack of training provided to the workforce was identified by care workers in the focus group.

“A lot of people come in with zero experience. But you are expected after three shadow shifts, with someone who may or may not be a good care worker, to hit the ground running and be a good carer. People just aren't getting the training.”

Nicole, care worker

HIGH TURNOVER, UNDER-STAFFING AND QUALITY OF CARE

A recent Care Quality Commission (CQC) report found that staffing levels are a key factor in determining quality (CQC 2017).

Under-staffing in care homes often led to care needs going unmet. In homecare, under-staffing often led to rushed care and to inconsistent staffing, with care recipients receiving a different care worker every day.

The CQC has identified a link between high vacancy and turnover rates, and poorer levels of care being provided (ibid).

High turnover rates can also limit the ability of care providers to deliver high-quality, person-centred care. It will also mean that care workers will be less likely to build sustained relationships with the people they are caring for.

“If you’ve got a revolving door of carers coming into your home, you can’t deliver person-centred care. They don’t know how you like your tea, they don’t know whether you need your food cut... a care worker who knows the person they’re visiting will be a more effective and efficient worker.”

Joel Lewis, Age UK, Policy officer for health and care

While there is extensive evidence of the negative impact of low pay and poor job quality on quality of care, there is also evidence that improving workforce conditions can deliver improvements in quality of care. Some local authorities – including the London Borough of Southwark – have seen an increase in care user satisfaction since the introduction of the UNISON Ethical Care Charter (London Borough of Southwark 2018).

Job quality and care quality are inextricably linked. Having set out the impact of the dysfunctional workforce model on both care workers and care recipients, in the next chapter we go on to examine the root causes of the growing workforce crisis in social care.

3.

THE WORKFORCE CRISIS IS THE RESULT OF AN UNDER-FUNDED AND DYSFUNCTIONAL SOCIAL CARE SYSTEM

Having highlighted the poor conditions of the care workforce and the impact of these conditions on care workers and quality of care, in this chapter we examine the underlying causes of the problems in the sector. We show that the workforce crisis is the direct result of an under-funded and dysfunctional social care system. We show how the combination of price-based competition in an under-funded market with a disempowered workforce contributes to the poor conditions and widespread exploitation of the workforce.

UNDER-FUNDING AND POOR COMMISSIONING PRACTICES

The chronic under-funding of social care contributes both to low pay and poor job quality for the workforce, and to unmet needs and poor quality for care recipients.

Local government, which is responsible for providing social care, has faced large funding cuts in recent years. Between 2010/11 and 2017/18, government funding for local authorities in England was cut by 49.1 per cent. Even when taking into account increases in council tax over that period, the spending power of local authorities has been cut by 28.6 per cent (NAO 2018a).

As social care makes up a large and increasing proportion of local authority spending, reductions in funding for local government have inevitably led to reductions in spending on social care. Spending on social care in England declined by 8 per cent in real terms between 2009/10 and 2016/17 (Simpson 2017). This compares to an increase in NHS spending of 9.5 per cent in real terms over the same period (IPPR analysis of Harker 2018).

Yet at the same time that spending has fallen, demand for adult social care has risen significantly. This has led to significant pressure on adult social care budgets in local authorities. One of the responses has been to raise thresholds on entitlement to publicly funded care. So, even while demand has been increasing, the number of adults in receipt of social care has declined by a quarter (27 per cent) since 2010 (Darzi 2018).

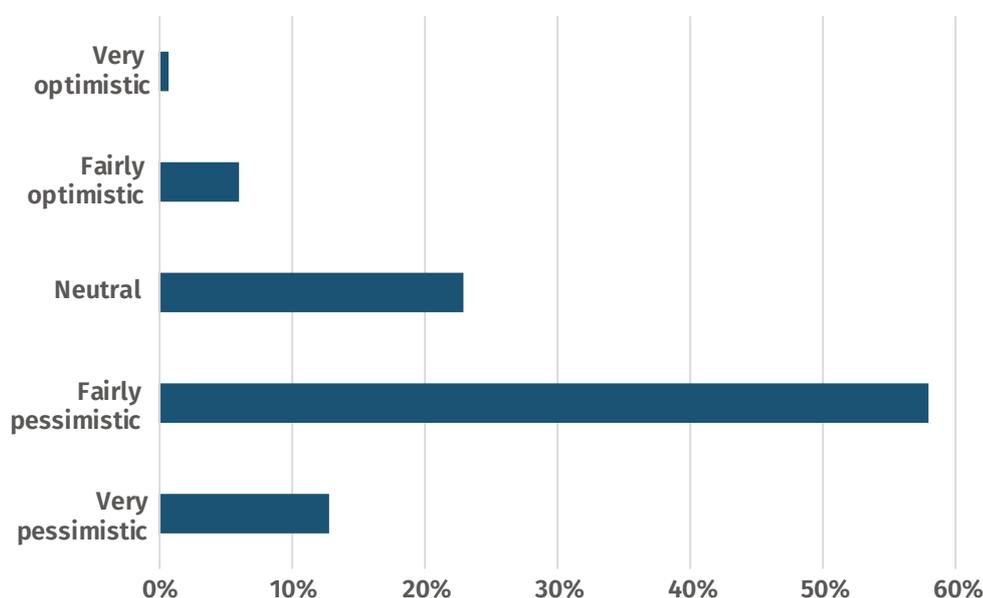
In addition to restricting entitlements to publicly funded care, local authorities have also responded by under-funding care. The United Kingdom Homecare Association (UKHCA) found that only one in seven authorities paid providers over £18.01 an hour, the price they deem necessary to comply with minimum employment standards and to ensure the sustainability of the sector. The average paid by local authorities in 2018 is £16.12 (UKHCA 2018). Under huge pressure from rising demand and shrinking resources, local authorities are

too often commissioning social care at a price that affords neither decent employment conditions nor decent care for the vulnerable.

As a result, more providers are struggling to stay in business. A recent survey of directors of adult social services found that two in three (66 per cent) had either had a care provider close or cease trading in the last six months, or had a contract handed back (ADASS 2018). The same survey found that just 6.7 per cent of directors of adult social services were positive about the financial state of health and social care in their area, compared to 70.9 per cent who were negative.

FIGURE 3.1: SEVEN IN 10 DIRECTORS OF ADULT SOCIAL SERVICES ARE NEGATIVE ABOUT THE FINANCIAL STATE OF HEALTH AND SOCIAL CARE

Overall, how do you feel about the financial state of the wider health and social care economy in your area over the next 12 months? (2018/19)



Source: ADASS (2018)

PRICE-BASED COMPETITION AMONG INDEPENDENT PROVIDERS

In recent years, there has been a progressive shift away from social care being provided by local authorities and a growth of outsourcing to independent providers. These include private, for-profit providers and trading charities.

In 1979, 64 per cent of residential and nursing home beds were still provided by local authorities or the NHS. By 2012 this had fallen to just 6 per cent. In homecare, the change has been quicker still: in 1993, 95 per cent of homecare was provided by local authorities; by 2012 this had fallen to just 11 per cent (Hudson 2018).

The transition from largely public to largely private provision has had a profound impact both on the social care sector and on the social care workforce. Providers – particularly in the current context of severe underfunding – are forced to bid competitively for contracts from resource-starved local authorities and other commissioning organisations. In doing so, many seek to minimise their labour costs, with both pay and terms and conditions being driven down as a result. While this shift from largely public to largely private provision has led to a large

reduction in the cost of care – with unit costs falling by half – the majority of savings have come from halving the cost of care workers’ labour, rather than through greater efficiency (Hayes 2017b).

As we set out in chapter 1, many of the challenges facing the social care workforce are more acute in the independent sector. In the independent sector, average pay for care workers is £2.04 an hour (21 per cent) lower than in the public sector, the prevalence of zero-hours contracts is over three times higher and workers are over twice as likely to have non-relevant social care qualifications (IPPR analysis of Skills for Care 2018).

In addition to poorer labour standards, there is some evidence of differential care quality between sectors. In a systematic review and meta-analysis of observational studies and randomised control trials, Comondore et al (2009) found higher-quality staffing in non-profit nursing homes. These homes provided on average 0.42 more staff hours per resident each day than for-profit homes (ibid). However, single studies do not find a significant difference.

As we argue below, it is not the shift towards independent providers alone which has undermined quality of care. There is some poor quality in both employment and care at local authorities, and some good practice at private providers. However, as we explain below, the introduction of the profit motive and of competition between providers in an under-funded and under-regulated market has contributed to poor conditions in social care and the widespread exploitation of a care workforce which is lacking in bargaining power.

LACK OF BARGAINING POWER

The social care workforce is atomised and lacking in bargaining power, which contributes both to poor conditions for the workforce and – therefore – to poorer quality of care.

Trade unions help to aggregate the bargaining power of workers in order to assist them in winning a fair share of the wealth that they contribute towards generating, and to improve job quality. However, union membership and collective bargaining coverage has fallen significantly in the UK over the last four decades (Dromey 2018). It is the workers who could most benefit from union membership – low-paid workers, with lower levels of qualifications, who individually lack bargaining power – who are the least likely to join a union (ibid).

In keeping with this trend across the economy, union membership is relatively low in the social care sector, and particularly low among lower-paid and lower-qualified workers. Just one in five care workers (19.8 per cent) and senior care workers (20.6 per cent) are a member of a trade union or a staff association. This is below the average for the whole economy (20.6 per cent), but the contrast with the NHS is stark: four in five nurses (82.6 per cent) are members of a trade union or a staff association (IPPR analysis of LFS).

In addition to low levels of union membership, the social care sector has very low levels of collective bargaining coverage. While the vast majority of social care workers in local authority employment would be covered by collective bargaining – where pay and terms and conditions are agreed between unions and employers – very few in the independent sector are. This leaves pay to be set by employers alone, at a level dictated by the market. Again, this contrasts with the NHS, where pay and terms and conditions are collectively agreed nationally.

In addition to the lack of union density and collective bargaining coverage, the workforce model in social care contributes to an uneven balance of power. For the three in five (56.6 per cent) care workers in homecare who are on zero-hours

contracts, raising concerns, joining a trade union or pushing for pay could leave them open to having their hours reduced. The perception of vulnerability of workers on zero-hours contracts was vividly highlighted by care workers in our focus group.

The low levels of union membership and collective bargaining coverage – along with the insecure nature of the work and the perception that care work is low-skilled – leave the workforce with little bargaining power. As a result, their ability to push for decent terms and conditions, and their ability to secure a fair share of the funding paid to their employers, is severely constrained.

While under-funding of the social care sector is a significant cause of low pay, addressing the funding crisis alone will be insufficient to address chronic low pay in social care. Research has shown that while paying higher fees in social care commissioning does increase pay, the impact can be small. Despite the fact that labour costs represent the majority of a provider's cost, for every additional £1 that is paid to care providers, just 14p in care homes and 18p for homecare makes its way to care workers' pay (Grimshaw et al 2015). Therefore, while boosting funding is a necessary pre-condition, it will need to be combined with measures to increase the bargaining power of employees in the sector, and enforcement of minimum standards. This was reflected by the social care workers in the focus group.

“If we give more money to companies, the companies are just going to make more profit.”

Caroline, homecare worker

Low levels of union membership, combined with high levels of insecurity and the low-skilled nature of the workforce, contribute to a power imbalance between workers and employers and the inability of the workforce to improve their conditions. This was summed up by one of the participants in our focus group.

“As individuals we are powerless. We will lose our jobs if we complain because someone can do it for less. The only way we can have power is if we are in a union.”

David, care worker

LACK OF ENFORCEMENT OF EMPLOYMENT RIGHTS

The social care sector suffers from a lack of regulation of employment standards.

The employment rights system in the UK relies largely on individual rights, enforced through the courts, rather than inspection and regulation (Hayes 2017b). This system is poorly suited for the social care sector as it relies on individuals both to know and understand their rights and to have the confidence and willingness to enforce them.

First, even if employees do understand their rights, many are not able to enforce them. Low levels of union membership leave many employees in the sector without independent support and advice. The widespread use of zero-hours contracts leaves employees in a precarious position and vulnerable to employer retribution. The interaction between insecure hours and vulnerability to exploitation is demonstrated in the recent Skills and Employment Survey, which showed that three in five workers on insecure hours across the economy as a whole felt vulnerable to victimisation, compared to fewer than one in five on secure hours (Felstead et al 2017). Until recently, employment tribunal fees also served as a barrier to justice, particularly among low-paid workers.

Social care workers in our focus group explained their reluctance to raise concerns or challenge poor practice by employers for fear of being seen as a ‘troublemaker’.

“You won’t get any more work if you do. Your managers take it personal, and the hours that you do can be cut.”

Beatrice, care worker

Second, while HMRC has stepped up enforcement in social care recently, it remains insufficient. Despite evidence of widespread avoidance of the minimum wage in social care, just 80 employers in social care were actually found to have underpaid the minimum wage last year.

It appears that the enforcement of basic employment rights may be in tension with the very sustainability of the under-funded care sector. Following a recent court decision that employees working sleep-in shifts should be paid at least the minimum wage for the whole shift, HMRC temporarily suspended the enforcement of the minimum wage in the sector due to concerns that the cost of paying arrears and future wages for sleep-ins would threaten the ‘stability and long-term viability of providers’ (UK Government 2017). While the court decision has since been overturned, and is subject to further appeal, the decision to suspend the enforcement of employment law demonstrates the unsustainable nature of the system.

LACK OF WORKFORCE PLANNING

There is a lack of focus on workforce planning in social care, which is hindering the ability of a fragmented sector to address the growing workforce crisis.

The Department of Health & Social Care (DHSC) is responsible for overseeing adult social care policy and workforce strategy. It both funds and works in partnership with Skills for Care, a charity which aims to create a well-led, skilled and valued social care workforce.

Earlier this year, a report by the National Audit Office declared that the Department had “no national strategy” to address workforce challenges in the sector (NAO 2018b). Recommendations included collaboration between relevant departments and more investment into provider fees, wages and training.

Workforce planning in social care is severely underfunded. Skills for Care received £27 million in income in 2017, of which just over £20 million came from DHSC (Skills for Care 2017). This is dwarfed by the budget for Health Education England (HEE) – the body which leads on workforce planning in the NHS – which had a budget of £5 billion in 2016/17 and staff costs of £152 million (HEE 2017).

A significant challenge for workforce planning in social care is the excessive fragmentation of the sector. There were 21,200 organisations providing care in 2017, with the vast majority being small and medium-sized enterprises (Skills for Care 2018).

Skills for Care also lacks employee voice and participation. Unlike in the NHS, where there is a longstanding practice of social partnership working, there is no formal representation from the care workforce or from trade unions in the sector on Skills for Care.

THE UNDER-VALUING OF SOCIAL CARE AND THE SOCIAL CARE WORKFORCE

Finally, underlying all of the above factors is the fact that both social care as a public service – and the social care workforce – are chronically under-valued.

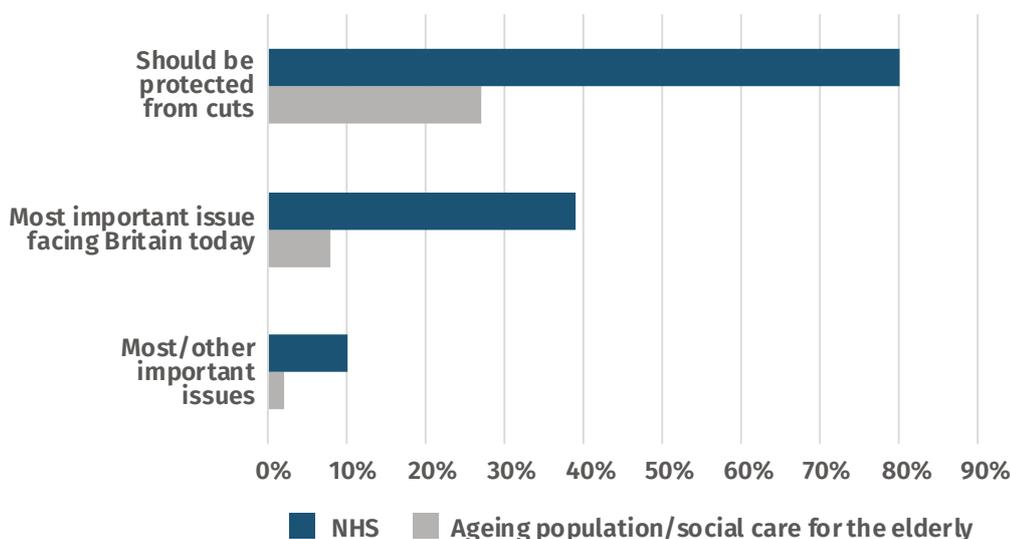
Despite widespread evidence of severe under-funding, and despite the growing workforce crisis in the sector, social care remains a low priority for public spending. As figure 3.2 illustrates, a recent Ipsos MORI poll shows that 39 per cent of adults see the NHS as an important issue facing Britain – the second highest of any issue – and 8 per cent see it as the most important issue. In both

cases, the NHS is second only to Brexit. However, just 10 per cent see social care as an important issue, with just 2 per cent saying it is the most important issue.

Similarly, looking at spending priorities, 80 per cent of adults in the UK say that the NHS should be protected from cuts, compared to just 27 per cent who think social care should be protected from cuts. This is despite the fact that the NHS has seen a real-terms increase in funding while social care has seen real-terms cuts in recent years.

FIGURE 3.2: SOCIAL CARE IS SEEN AS A LOW PRIORITY FOR VOTERS COMPARED TO THE NHS

Perceptions of most important/other important issues facing Britain, and priorities for spending among adults, UK (September 2018)



Source: Ipsos MORI (2018)

This is partially explained by the fact that, while the NHS is used regularly by much of the population, the social care system is poorly understood and little valued until it is needed. As one of the focus group participants put it:

“Everyone is focused on the NHS and what we can do to fix it, but they ignore that care is a ticking time bomb, and poor treatment of the workforce is at the root of it all. I think it is because people don’t use social care unless they have to, so they don’t think about it, they don’t want to think about it, that when they’re 90 they might be in a care home. But they use the NHS regularly so they might think they are more involved in that. They just think social care is for other people.”

Nicole, care worker

The under-valuing of the social care workforce is in part related to the systematic under-valuing of the service they deliver. However, it is also related to the perception of the work and to the perception of the workforce. Participants in the focus group highlighted the common perception that social care was unskilled work – a view which they challenged.

“I think caring needs to be recognised as a proper profession, which is very demanding and which requires training.”

David, care worker

Perceptions of care work are also shaped by the current conditions of the workforce. Social care is in part under-valued because it is underpaid, and vice versa. As one participant explained:

“It is a vicious circle. We are low paid because the public don’t think what we do is important, but they will never think it is important until we are paid more.”

Nicole, care worker

However, the under-valuing of care work is also related to gender, ethnicity and class. Over four in five (84.1 per cent) care workers are women and nearly a quarter (22.5 per cent) are from BAME backgrounds (Skills for Care 2018). Not only is adult social care one of the most heavily gender-segregated workforces in the UK, it is also one of the single largest female workforces, with over 900,000 women participating in the sector. As with many other sectors with a high proportion of female employment, work in social care is under-valued by society.

A DANGEROUS COMBINATION

The combined impact of the factors set out above is to drive down pay, employment standards and quality in social care.

With local government having seen significant reductions in funding, local authorities are having to reduce spending on social care at the same time that demand is rising. This is leading both to restrictions to entitlement and to care being commissioned at unrealistically low rates.

Providers – both private and charity – are forced to compete by minimising costs to win contracts. With the main costs for providers being labour, pay and terms and conditions are seen as a cost to be minimised in order to ensure providers can win contracts and – in the case of private providers – to make profit (Hayes 2017a). This has led to downward pressure on pay and on terms and conditions.

While an organised and empowered workforce may be able to push back against this, the social care workforce is lacking in bargaining power. With low union membership and minimal collective bargaining, the workforce is atomised, insecure and disempowered. In addition to exploitative but legal treatment, minimal enforcement means that illegal under-payment of the minimum wage is relatively widespread.

A perverse element of the current system is to undermine employers who want to do the right thing. While there are benefits for employers of decent pay, good terms and conditions, and investing in training, it is difficult to do so in a chronically under-funded system where you can be undermined by providers who do not demonstrate such good practice. The remorseless logic of the system itself is to drive down pay, job quality and service quality.

“We want a motivated workforce, we don’t want a 30 per cent turnover in our workforce, we want people to enjoy coming to work...in that sense we want exactly the same things as the workforce and the unions...we just can’t do it on the money we get paid”

Large private sector provider

4.

WE NEED A WORKFORCE STRATEGY FOR SOCIAL CARE BASED ON SECTORAL COLLECTIVE BARGAINING

Having examined the evidence of the workforce crisis in adult social care, its causes and its impact, in this chapter, we set out a workforce strategy for social care, and the need for additional funding to deliver this. We argue that both a sustainable long-term funding settlement and sectoral collective bargaining are essential if we are to address the endemic exploitation of the care workforce, and ensure both decent conditions for care workers and decent care for those who need it.

ESTABLISHING A LONG-TERM FUNDING SETTLEMENT FOR SOCIAL CARE

At the heart of the poor conditions endured by the social care workforce is a chronic lack of funding. The combination of reductions in government funding and increasing demand has led to local authorities both restricting entitlements to publicly funded care and commissioning social care at unrealistic prices. In the context of price-based competition in an under-funded market, providers have driven down labour costs, leading to low pay and poor conditions.

As we have highlighted in this report, the commissioners of care, the providers of care and also the workforce recognise the need to improve pay, but under-funding of social care limits the ability to deliver this.

Government must introduce a long-term funding settlement for social care in order to meet growing demand and to improve pay and conditions in the sector.

Previously IPPR have called for an increase in National Insurance contributions by 1p in the pound from 2019 in order to increase spending on the NHS and social care (IPPR 2018). We argued that this should be used to introduce free personal and nursing care for all, regardless of the ability to pay⁵.

In addition to meeting growing demand in the NHS and social care, this funding should be used to boost pay and improve conditions in social care in order to tackle the growing workforce crisis.

However, while increasing funding for adult social care is essential, it is a necessary but not sufficient condition for tackling low pay in the sector. Research has shown that while paying higher fees in social care commissioning does increase pay, the impact is small. Therefore, an increase in funding for the sector will need to be complemented by other measures to ensure that it helps boost pay.

⁵ IPPR will be setting out our proposals for delivering free personal social care ahead of the green paper on social care.

INTRODUCING THE REAL LIVING WAGE IN ADULT SOCIAL CARE

IPPR have previously called for the national living wage to be raised to the level of the real living wage (IPPR 2018). However, there is a particularly strong case and a particularly pressing need to tackle low pay in adult social care.

As we set out in chapter 1, low pay in social care is a major driver of the workforce crisis. Endemic low pay means the sector is struggling to recruit and retain the workers that it needs to meet growing demand.

Government should introduce the real living wage in adult social care in order to fairly reward the care workforce and to help alleviate the workforce crisis.

Given both the size of the sector and the endemic levels of low pay, introducing the real living wage in social care would not be cheap.

Using the most recent available evidence from the Annual Survey of Hours and Earnings (ONS 2018b), we can estimate the potential costs associated with increasing pay to at least the living wage in social care.

The 2018 rate of the real living wage is £10.55 in London and £9.00 outside London. It is higher than the national living wage, which stands at £7.83.

Based on pay levels in the sector in 2018, we estimate that the additional costs of increasing pay in social care to the living wage would be £645 million. Factoring in National Insurance contributions of 9 per cent and pension contributions of 6 per cent, the net additional cost would be £740 million. As not all social care is publicly funded, we estimate the gross public cost of increasing wages in social care to the real living wage to be an additional £445 million on top of current funding needs in the sector.⁶⁷

Introducing the real living wage in social care would directly benefit over 500,000 workers. It would reduce the number of people earning below the real living wage by 9.4 per cent (IPPR analysis of ONS 2018b).

These costs only represent the amount necessary to raise pay in the sector to the real living wage. However, in order to introduce the real living wage in the sector, government could follow the approach in Scotland. In 2016, the Scottish Government announced its intention to introduce the living wage in social care (Scottish Government 2016). This has been delivered through offering additional funding for local authorities, conditional on them successfully negotiating a pay rise for care workers in their area to raise all to at least the level of the real living wage. Alternatively, as we recommend below, introducing the living wage in the sector could be delivered through sectoral collective bargaining.

As was the case in Scotland, additional funding for the social care sector should be contingent on the introduction of the real living wage.

While introducing the real living wage in social care would have a significant positive impact on the sector, it alone would not solve the workforce crisis. First, as we saw with the introduction of the national living wage, raising the wage floor would do little to boost pay further up the income distribution. Second, raising pay alone would not address the wider challenges facing the workforce, including widespread insecurity and low levels of investment in training. Given this, further measures are needed to improve pay and job quality across the care workforce.

6 This assumption is based on Gardiner and Hussein (2015), who estimate the gross public cost of pay in social care to be equivalent to 60.7 per cent of net pay in the sector.

7 We believe this may be a conservative estimate, and that the real cost may be slightly higher. While ASHE is an official ONS survey, it uses a relatively small sample size in social care, and it is thought to over-state the incomes of lower-paid workers in the sector. As we showed in chapter 1, the National Minimum Data Set for Social Care has lower figures for pay than ASHE.

SETTING MINIMUM STANDARDS AND IMPROVING JOB QUALITY THROUGH SECTORAL COLLECTIVE BARGAINING

Alongside the introduction of the real living wage in the social care sector, further measures are needed to boost pay across income distribution, and to improve working conditions, in order to tackle the growing workforce crisis. This should be delivered through sectoral collective bargaining for adult social care.

As we set out above, increasing funding for social care is a necessary but not sufficient step to improving pay and conditions in social care. If we are to tackle low pay and exploitation in the social care sector, and if we are to improve quality of care, we need to establish and enforce higher minimum employment standards in the sector.

Alongside introducing the living wage for adult social care, there is a strong case for the introduction of sectoral collective bargaining in adult social care.

Collective bargaining is the process of negotiating between trade unions and employers to agree terms and conditions of employment. It can take place at enterprise level, or across an entire industry. Sectoral collective bargaining is used in the NHS to set nationally agreed pay and terms and conditions, and it is used in adult social care sectors in many other advanced economies.

As IPPR have previously recommended, government should establish a sector council in social care, with a responsibility to promote sectoral collective bargaining (Dromey 2018). The sector council would bring together trade unions, representatives of employers and government to develop a collective agreement for the sector, setting out minimum conditions. The process could also involve representatives of care recipients in order to ensure they have a voice in the standards set for the workers who support them.

While encouraging sectoral bargaining in social care would be challenging, given the fragmented nature of the sector with over 20,000 employers, the reliance on public funding within the sector gives government a powerful lever to deliver this. The additional funding the sector needs should be conditional on the conclusion of a sectoral agreement which addresses the challenge of low pay and poor conditions in the sector. Local authorities should use commissioning to bolster the collective agreement by requiring providers to demonstrate that they comply with the terms and paying at a level that allows them to do so.

The terms of the collective agreement should be mandatory and offer a legally enforceable minimum for all workers in the sector. Employers would be free to improve on the terms in order to attract and retain staff, and to compete based on quality, but they would be forbidden from undercutting the minimum conditions.

The sectoral agreement should be used to introduce the real living wage in the sector. Should the minimum wage be raised to the level of the real living wage – as IPPR have argued (IPPR 2018) – then sectoral collective bargaining in social care should ensure the minimum wage floor in the sector is sufficient both to attract and to fairly reward workers.

In addition to setting a reasonable wage floor, the collective agreement for social care should cover pay for defined roles – from care workers and senior care workers to registered nurses, social workers and care home managers. As is the case with the NHS Agenda for Change, pay scales in adult social care should:

- include increments in order to reflect increasing experience and expertise, and to give workers greater opportunity for pay progression, and greater incentives to stay in the profession

- include London weighting to take account of the higher cost of living
- be updated annually in order to reflect the cost of living, changes in productivity and affordability.

Beyond pay, the sectoral agreement in social care should include other key elements of job quality. Building on the UNISON Ethical Care Charter (UNISON 2016), this could include:

- **Training** – entitlement to basic induction training and to regular ongoing continual professional development, minimum qualification levels for given roles and minimum requirements for apprenticeship investment and standards.
- **Job security** – including the right to a fixed-hour contract and protections for workers who choose zero-hour contracts. As IPPR have argued previously, the minimum wage should be set 20 per cent higher for those on zero-hours contracts in order to discourage their use where possible and to ensure workers are compensated for greater insecurity where they are necessary (IPPR 2018).
- **Fair payment** – with workers paid for travel time and costs, training time and sleep-ins.
- **Need-based commissioning** – with the starting point for homecare visits being the need of the care recipient, not minutes or tasks, and no 15-minute visits.
- **Facility time** – to support union reps in carrying out their duties in supporting members and facilitating positive employment relations.
- **Occupational sick pay** – with entitlement beyond the minimum under statutory sick pay.
- **Occupational pension** – with employer contributions beyond the statutory minimum.
- **Wellbeing** – including the right for homecare workers to be given the opportunity to regularly meet co-workers to share best practice and limit isolation, and access to an Employee Assistance Programme.

Sectoral collective bargaining in adult social care would ensure that competition between providers is based on quality rather than just on cost. It would ensure that pay is not driven down below a reasonable minimum, and it would ensure a decent level of employment rights, tailored to the needs of employees and care recipients (Hayes 2017b).

By raising pay to reasonable levels and improving terms and conditions in adult social care, sectoral collective bargaining would increase the funding requirement for the sector over and above that which would be required to introduce the real living wage. However, through strengthening labour power and enforcing a reasonable minimum standard, collective bargaining would also ensure that additional funding would benefit the workforce, rather than merely increasing profits and pay for senior staff.

BOOSTING TRAINING AND QUALITY THROUGH A MANDATORY CARE CERTIFICATE AND PROFESSIONAL REGULATION

Social care is vital work and skilled work. However, employer investment in training is relatively low, and for care workers there is currently no minimum qualification or professional registration system.

The situation for care workers contrasts with other areas of healthcare, such as nursing, which requires extensive initial training, ongoing CPD and professional registration with the Nursing & Midwifery Council. The situation contrasts with Scotland, Wales and Northern Ireland – which will soon all have compulsory

professional registration for care workers – and with the situation in other advanced economies, which often have more rigorous minimum training and qualification requirements.

The low levels of training required and provided and the lack of regulation in social care undermine quality and contribute to the low esteem of the occupation and the wider industry. Mandatory training and professional regulation could both improve quality, boost the reputation of the sector and encourage people to see it as an attractive career choice.

In order to support the professionalisation of social care, the Care Certificate should become a robust and mandatory licence to practise for all care workers. As recommended by The Kingsmill Review, the Care Certificate should be required of all care workers (Kingsmill 2014). This should be enforced by the CQC in inspections of providers, with providers required to demonstrate to CQC that all of their workers have completed the certificate (Cory et al 2017). The content of the certificate should be overseen and maintained by Care Skills England to ensure high quality and to ensure it meets the needs of employers and workers in the sector.

In addition to a mandatory and high-quality Care Certificate, care work should become a regulated profession under the Health & Care Professionals Council (HCPC). This would ensure that care workers have to register with the HCPC, and that those found not to be meeting the standards expected would be stopped from practising. Through setting and enforcing high standards, professional regulation could help boost the prestige of the profession. Recent survey evidence suggests that this would be hugely popular with care workers; 94 per cent of respondents to a recent survey said they believed that England should follow the example set by Scotland, Wales and Northern Ireland and have an official professional register for care workers (UNISON 2018). Given the prevalence of low pay for care workers, registration fees should be kept low, while registration should be part of wider efforts to boost pay.

ENFORCING MINIMUM STANDARDS THROUGH A WIDER ROLE FOR CQC AND IMPROVED COMMISSIONING

Despite the evidence of the widespread denial of employment rights in the sector, enforcement of basic employment rights remains insufficient. Despite the importance of good employment practice to high-quality care, there is an insufficient focus on job quality in provider inspections.

Given the widespread evidence of poor and often illegal employment practice, and given the link between job quality and care quality, the remit of CQC should be expanded from focusing on care quality to focusing on employment quality too. Building on the recommendations of Cory et al (2017), CQC should be given two new duties:

- A duty to enforce minimum standards in the sector, by requiring employers to demonstrate they have a sufficiently trained workforce, including compliance with the Care Certificate.
- A duty to tackle exploitation of low-paid care workers, including reporting on non-payment of the minimum wage to HMRC. After the introduction of sectoral collective bargaining, the CQC should be responsible for ensuring providers comply with the terms of the sectoral agreement.

In recognition of this expanded remit, the recent cuts to the CQC's budget should be reversed.

In addition to the actions of providers, the approach of local authorities to commissioning also plays a significant role in shaping both job quality and care quality in social care. As funding for local government has fallen and as demand for social care has risen, so local authorities have commissioned care at unrealistic and undeliverable costs.

In addition to inspecting providers, CQC should be responsible for inspecting local authority commissioning of care to ensure that it supports both high-quality care and high-quality employment. Expanding CQC inspections to care commissioners was mooted by the previous Secretary of State for Health and Social Care (Hunt 2018). It should now be implemented.

Alongside introducing inspections for care commissioners, there should be a legal minimum commissioning cost for local authorities. This should be set in discussion with the Local Government Association, providers and care recipients, and it should reflect the agreed rates set out in the sector deal, with some regional flexibility. Establishing a legal minimum commissioning cost should ensure that no provider takes a contract at a rate which is not deliverable, and that competition is based on quality rather than just on lowest cost.

MINIMISING THE IMPACT OF BREXIT ON SOCIAL CARE

As we set out in chapter 1, the government's plans to end freedom of movement and restrict migration from the EU after Brexit threaten to aggravate the growing workforce crisis in social care.

Alongside addressing the root causes of the care workforce crisis, government should ensure that migration policy post-Brexit does not significantly add to the crisis.

In order to do this, government should revise the Shortage Occupation List to include occupations in social care which experience high staff shortages. This could include social workers, occupational therapists, registered nurses and care workers.

Second, if government does end freedom of movement, it should consider introducing a new Trusted Sponsor Scheme that enables employers who meet a set of criteria on responsible employment practices to be eligible for an increased range of visa benefits. Such a scheme could involve allowing employers who pay the collectively agreed rate and who invest in apprenticeships to recruit a wider array of skilled workers with more flexibility in salary thresholds – both from the EEA and other countries – than in the current Tier 2 system (Morris 2018). This would both help ensure employers have the access to the skills that they need and ensure that migration policy can be used as a tool to improve employment standards.

However, the solution to the social care workforce crisis cannot lie in migration policy. As the MAC report recently highlighted:

"Its basic underlying problem is that poor terms and conditions paid to workers in this sector [is] in turn caused by the difficulty in finding a sustainable funding model. We are concerned that special immigration schemes for social care will struggle to retain enough migrants in the sector if work in it is not made more attractive."

Given this, alongside short-term measures to prevent a sudden shock as a result of Brexit, government should urgently address the underlying causes of the social

care workforce crisis: the poor conditions and widespread exploitation of the workforce driven by the under-funding of the sector.

OVERSEEING WORKFORCE STRATEGY

The current system for overseeing workforce planning in social care is insufficient. Skills for Care is under-resourced, and there are insufficient links with NHS workforce planning and insufficient input from the workforce itself.

Government should establish Care Skills England to oversee and drive workforce strategy for social care. Established as a non-departmental public body, Care Skills England should be a social partnership organisation, with representatives from employers and from the workforce, as well as the Department of Health & Social Care, the Local Government Association and care recipients.

Care Skills England should be responsible for developing and overseeing a national workforce strategy for adult social care. It should also be responsible for overseeing the Care Certificate and other training content for the sector, including apprenticeship standards.

Care Skills England should work closely with Health Education England in order to manage the workforce implications of health and social care integration. This should include developing pathways for progression that link the two sectors and addressing differences in pay and conditions (NAO 2018a).

IPPR has previously called for the establishment of 10 Health Care Authorities (HCAs) on a regional level to become the strategic commissioners of health and care services (IPPR 2018). Care Skills England should be responsible for working with HCAs and local authorities to produce regional care workforce strategies that complement the national workforce strategy.

REFERENCES

- ADASS (2018) ADASS Budget Survey. <https://www.adass.org.uk/media/6434/adass-budget-survey-report-2018.pdf>
- Allan T, Thomson S, Filsak L and Ellis, C (2014) *Evaluation of the Care Certificate Pilot*, Skills for Care <https://www.skillsforcare.org.uk/Document-library/Standards/Care-Certificate/Care-Certificate-Evaluation-Report.pdf>
- BEIS (2018) 'National Living Wage and National Minimum Wage: Government evidence on compliance and enforcement 2017/2018', dataset. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/742668/nmw-nlw-enforcement-compliance-report-2018.pdf
- Carter G and Jancar J (1983) 'Mortality in the Mentally Handicapped: A 50 year survey at the Stoke Park group of hospitals (1930-1980)', in *Journal of Intellectual Disability Research*, 27(2) pp143-156.
- CLG Committee (2017) *Adult Social Care: Ninth report of session 2017-17*. <https://publications.parliament.uk/pa/cm201617/cmselect/cmcomloc/1103/1103.pdf>
- Comondore VR, Devereaux PJ, Zhou Q, Stone SB, Busse JW, Ravindran NC, Burns KE, Haines T, Stringer B, Cook DJ and Walter SD (2009) 'Quality of Care in For-profit and Not-for-profit Nursing Homes: Systematic review and meta-analysis', in *BMJ*, 339 pb2732
- Cory G, Roberts C and Thorley C (2017) *Care in a Post-Brexit Climate: How to raise standards and meet workforce challenges*. https://www.ippr.org/files/publications/pdf/care-in-a-post-Brexit-climate_Feb2017.pdf
- CQC (2017) *The State of Adult Social Care Services 2014 to 2017*. https://www.cqc.org.uk/sites/default/files/20170703_ASC_end_of_programme_FINAL2.pdf
- D'Arcy C and Hurrell A (2014) *Escape Plan: Understanding who progresses from low pay and who gets stuck*, Resolution Foundation. <https://www.resolutionfoundation.org/app/uploads/2014/11/Escape-Plan.pdf>
- Darzi A (2018) *The Lord Darzi Review of Health and Care: Interim report*, IPPR. <https://www.ippr.org/publications/darzi-review-interim-report>
- DHSC (2013) *The Cavendish Review: An independent review into healthcare assistants and support workers in the NHS and social care settings*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/236212/Cavendish_Review.pdf
- Dromey J (2018) *Power to the People: How stronger unions can deliver economic justice*, IPPR. <https://www.ippr.org/publications/power-to-the-people>
- Eaton SC (2000) 'Beyond Unloving Care: Linking human resource management and patient care quality in nursing homes', in *International Journal of Human Resource Management*, 11(3) pp591-616. <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.623.6193&rep=rep1&type=pdf>
- Felstead A, Gallie D, Green F and Henseke G (2017) *Insecurity at Work in Britain: First findings from the skills and employment survey 2017*. https://www.cardiff.ac.uk/__data/assets/pdf_file/0011/1309457/6_Insecurity_Minireport_Final.pdf
- Gardiner L (2015) *The Scale of Minimum Wage Underpayment in Social Care*, Resolution Foundation briefing. <https://www.resolutionfoundation.org/app/uploads/2015/02/NMW-social-care-note1.pdf>
- Gardiner L and Hussein S (2015) *As if we Cared: The costs and benefits of a living wage for social care workers*. <https://www.resolutionfoundation.org/publications/as-if-we-cared-the-costs-and-benefits-of-a-living-wage-for-social-care-workers/>
- Grimshaw D, Rubery J and Ugarte SM (2015) 'Does Better Quality Contracting Improve Pay and HR Practices? Evidence from for-profit and voluntary sector providers of adult care services in England', in *Journal of Industrial Relations*, 57(4) pp502-525. <http://repositorio.uchile.cl/bitstream/handle/2250/134682/Does-better-quality-contracting-improve-pay-and-HR-practices.pdf?sequence=1>

- Harker R (2018) 'NHS Funding and Expenditure', House of Commons Library briefing paper. <http://researchbriefings.files.parliament.uk/documents/SN00724/SN00724.pdf>
- Hayes LJB (2017a) *8 good reasons why adult social care needs sectoral collective bargaining*, Institute of Employment Rights
- Hayes LJB (2017b) *Stories of Care: A labour of law: Gender and class at work*
- HEE (2017) *Facing the Facts, Shaping the Future: Workforce strategy*. <https://www.hee.nhs.uk/our-work/workforce-strategy>
- Hudson B (2018) 'Adult Social Care: Is privatisation irreversible?', in *British Politics and Policy at LSE*. <http://eprints.lse.ac.uk/88796/1/politicsandpolicy-adult-social-care-is-privatisation.pdf>
- Hunt J (2018) Speech: 'We need to do better on social care'. <https://www.gov.uk/government/speeches/we-need-to-do-better-on-social-care>
- Hussein S (2011) 'Estimating Probabilities and Numbers of Direct Care Workers Paid under the National Minimum Wage in the UK: A Bayesian approach', in *Social Care Workforce Periodical*, 16 pp1-33. <https://www.kcl.ac.uk/sspp/policy-institute/scwru/pubs/periodical/issues/scwp16.pdf>
- IPPR (2018) 'Put 1p on National Insurance to Secure the NHS and Social Care, say Former Labour and Tory Ministers and IPPR', press release. <https://www.ippr.org/news-and-media/press-releases/put-1p-on-national-insurance-to-secure-the-nhs-and-social-care-say-former-labour-and-tory-ministers-and-ippr>
- Ipsos Mori (2018) Issues Index January 2018: Public concern about the NHS rises. <https://www.ipsos.com/ipsos-mori/en-uk/issues-index-january-2018-public-concern-about-nhs-rises>
- Kingsmill D (2014) *The Kingsmill Review: Taking care, an independent report into working conditions in the care sector*. https://www.policyforum.labour.org.uk/uploads/editor/files/The_Kingsmill_Review_-_Taking_Care_-_Final_2.pdf
- Kingston A, Comas-Herrera A and Jagger C (2018) 'Forecasting the Care Needs of the Older Population in England Over the Next 20 Years: Estimates from the Population Ageing and Care Simulation (PACSim) modelling study', in *The Lancet Public Health*, 3(9) ppe447-55. [https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667\(18\)30118-X/fulltext](https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(18)30118-X/fulltext)
- Labour Force Survey (LFS) various quarters
- London Borough of Southwark (2018) Council Cabinet meeting. [http://modern.gov.southwark.gov.uk/documents/g5755/Public reports pack Tuesday 06-Feb-2018 16.00 Cabinet.pdf?T=10](http://modern.gov.southwark.gov.uk/documents/g5755/Public%20reports%20pack%20Tuesday%2006-Feb-2018%2016.00%20Cabinet.pdf?T=10)
- MAC (2018) *EEA Migration in the UK: Final report*. <https://www.gov.uk/government/publications/migration-advisory-committee-mac-report-eea-migration>
- Morris M (2018) *The Charity Workforce in Post-Brexit Britain: Immigration and skills policy for the third sector*, IPPR. https://www.ippr.org/files/2018-04/1523968694_brexit-and-the-charity-workforce-april18.pdf
- NAO (2018a) *Financial Sustainability of Local Authorities 2018*. <https://www.nao.org.uk/report/financial-sustainability-of-local-authorities-2018/>
- NAO (2018b) *The adult social care workforce in England*, National Audit Office. <https://www.nao.org.uk/report/the-adult-social-care-workforce-in-england/>
- ONS (2016) 'Low Pay in the UK: Apr 2016', statistical bulletin. <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/bulletins/lowpay/apr2016>
- ONS (2017) 'Principal projection: UK summary', dataset. <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/tablea11principalprojectionuksummary>
- ONS (2018a) 'Occupation (4 digit SOC) – ASHE: Table 14, Annual Survey of Hours and Earnings 2017', dataset. <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/datasets/occupation4digitsoc2010ashtable14>
- ONS (2018b) 'Earnings and hours worked, industry by two-digit SIC: ASHE Table 4', dataset. <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/datasets/industry2digitsicashetable4>

- ONS (2018c) 'Labour Market Economic Commentary: September 2018', article. <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/labourmarketeconomiccommentary/september2018>
- Puri BK, Lekh SK, Langa A, Zaman R and Singh I (1995) 'Mortality in a Hospitalized Mentally Handicapped Population: A 10-year survey', in *Journal of Intellectual Disability Research*, 39(5) pp442-446
- SCIE (2016) *Forecasting the Adult Social Care Workforce by 2035: Workforce intelligence report*. <https://www.scie-socialcareonline.org.uk/forecasting-the-adult-social-care-workforce-to-2035-workforce-intelligence-report/r/a11G000000CePdFIAV>
- Scottish Government (2016) 'Living Wage for Care Workers', news article. <https://news.gov.scot/news/living-wage-for-care-workers#downloads>
- Simpson P (2017) *Public Spending on Adult Social Care in England*, Institute for Fiscal Studies (IFS). <https://www.ifs.org.uk/uploads/publications/bns/BN200.pdf>
- Skills for Care (2017) Trustees' report and consolidated financial statements. <https://www.skillsforcare.org.uk/Documents/About/What-we-do/SIGNED-SfC-Trustee-Report-and-Accounts-1617.pdf>
- Skills for Care (2018) *The State of the Adult Social Care Sector and Workforce in England*. <https://www.skillsforcare.org.uk/NMDS-SC-intelligence/Workforce-intelligence/publications/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx>
- UK Government (2017) Government Extends Suspension of Minimum Wage Enforcement in the Social Care Sector <https://www.gov.uk/government/news/government-extends-suspension-of-minimum-wage-enforcement-in-the-social-care-sector>
- UK Government (2018) 'Minimum Wage for Different Types of Work', webpage. <https://www.gov.uk/minimum-wage-different-types-work>
- UKHCA (2018) *The Homecare Deficit 2018*, United Kingdom Homecare Association. <https://www.ukhca.co.uk/downloads.aspx?ID=589#bk1>
- UNISON (2016) UNISON's Ethical Care Charter. <https://www.unison.org.uk/content/uploads/2013/11/On-line-Catalogue220142.pdf>
- UNISON (2017) Home Care Survey 2017. <https://www.unison.org.uk/content/uploads/2017/09/UNISON-home-care-survey-2017.pdf>
- UNISON (2018) 'Employers in the Care Sector are Hiding Behind Complex and Incomplete Pay Slips to Break Wage Laws', news article. <https://www.unison.org.uk/news/2018/04/employers-care-sector-hiding-behind-complex-incomplete-pay-slips-break-wage-laws/>
- Welsh Government (2017) The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017. https://www.legislation.gov.uk/wsi/2017/1264/pdfs/wsi_20171264_mi.pdf

Institute for Public Policy Research

The image features a solid blue background with several large, overlapping yellow shapes. One large yellow shape is on the right side, partially overlapping the blue background. Another yellow shape is on the left side, partially overlapping the blue background. A third yellow shape is at the bottom left, partially overlapping the blue background. The shapes are simple, flat, and have no text or other details.

