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New horizons

What can England learn from
the professionalisation of care
workers in other countries?

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Key points

It is over 13 years since the Department of Health and Social Care last produced a dedicated long-term adult social care workforce strategy. In this time, care workers have faced a formidable number of challenges: issues with low pay, poor terms and conditions, hugely variable access to training, and limited opportunities for career development are longstanding concerns. These have been exacerbated in recent years by increased rates of sickness and burnout during the pandemic and changes to immigration rules following Brexit, leading to intensified recruitment and retention challenges.

Perceptions of care work as ‘low skilled’ continue to persist, despite the pandemic highlighting just how vital care workers are. Their dedication and capability has also been recognised in Baroness Cavendish’s report. In recent years there has been increased debate around the ‘professionalisation’ of this staff group. This generally refers to the creation of a statutory register of staff and their professional regulation, and can involve improvements to pay, training and career development, and terms and conditions.

Our review of the evidence about the professionalisation of care workers in other countries – both elsewhere in the UK and abroad – found that:

- **Evidence from the other UK countries shows that registration and professional regulation can reduce risk to the public, improve outcomes for people drawing on social care services, improve confidence in the workforce, and can drive up workforce standards through mandatory minimum training.** England is the only country in the UK that has not introduced registration and professional regulation of care workers. But the experience in Scotland and Wales also warns that it could introduce unnecessary barriers to recruitment and retention, and such a system could be costly.
- **Care workers who receive relevant, high-quality training are more likely to stay in their role** and be equipped with the skills and confidence to deliver better care. Mandatory minimum training, or the right to receive

training, are approaches used internationally to good effect. Benefits to these approaches include improved outcomes for people drawing on services, improved confidence and status among workers, improved person-centred care, and reduced turnover. Programmes tend to be most effective when training is relevant to the role, equitable in terms of access, and sits alongside alternative routes for workers to demonstrate their skills.

- **Evidence demonstrates that increasing pay to competitive wages would reduce staff turnover, particularly for staff paid at lower wage levels.**

Countries around the world have used a number of different routes to improve pay: Scotland and Wales are taking steps to standardise pay and increase it beyond the National Living Wage, and pay bonuses have been awarded in all three devolved countries. Germany has introduced a sector minimum wage and policymakers are seeking to implement collective wage agreements to increase and standardise wages across the country. The national pay and progression framework introduced in New Zealand has helped improve retention, and this more attractive pay scale has also attracted new starters who are male, younger, or with graduate degrees.

- **The day-to-day working terms and conditions of care workers in England need urgent attention.**

Countries around the world have sought to address precarious employment and improve conditions in a variety of ways. New Zealand funds home care workers' travel time and travel costs, while Germany has introduced childcare grants and additional days of annual leave. Scotland is distinct in the UK for requiring providers to take staff wellbeing into account in their staffing decisions. Other countries such as Norway and Germany offer much more generous sick pay provision.

- **International experiences suggest that measures must be designed and implemented together rather than introduced in isolation.**

Unless reforms are designed in tandem, they are likely to have limited effectiveness, and could even risk exacerbating workforce recruitment and retention challenges. The evidence base on the impact of the different measures is still emerging, and should be closely followed. While there are many examples of positive impact, there have been a number of notable unintended consequences which can be learned from. For example, mandatory training may introduce unnecessary rigidity, making

it more difficult to retain specific groups of staff. Pay increases may further minimise the difference in pay for more senior staff, and attempts to introduce guaranteed hours at a national level may not benefit all staff consistently.

- Care workers are a diverse staff group. One in four are from Black, Asian or minority ethnic backgrounds and these groups are less well represented in senior positions. **Professionalising the workforce and providing consistent opportunities to access training and development opportunities could help to address inequalities in progression and earnings, and could also help attract underrepresented groups into the workforce.**

Care workers are first on the front line, delivering care in precarious conditions, but last to see meaningful acknowledgement of their perseverance. Protecting the health and safety of these staff should be a longstanding priority for employers and the DHSC, and not just during a pandemic. Ensuring that pay, training, and terms and conditions better reflect the value of care work to wider society is in the public interest. A number of workforce initiatives have recently been introduced, however, and there is now an opportunity for policy-makers to go further to reverse the deepening workforce recruitment and retention crisis in England. As governments across the world are taking increasingly bold and creative action to embed workforce reforms, there is much for England to learn as it pushes forward with planned reforms while considering further action as part of a longer-term adult social care workforce strategy.

1 Introduction

This evidence review focuses on care workers in England and investigates the emerging evidence base on professionalisation (see Figure 2 on p9 for an overview of the concept). It draws on the experiences of other countries to inform policy reforms that the government may wish to consider as part of a longer-term strategy for the adult social care workforce.

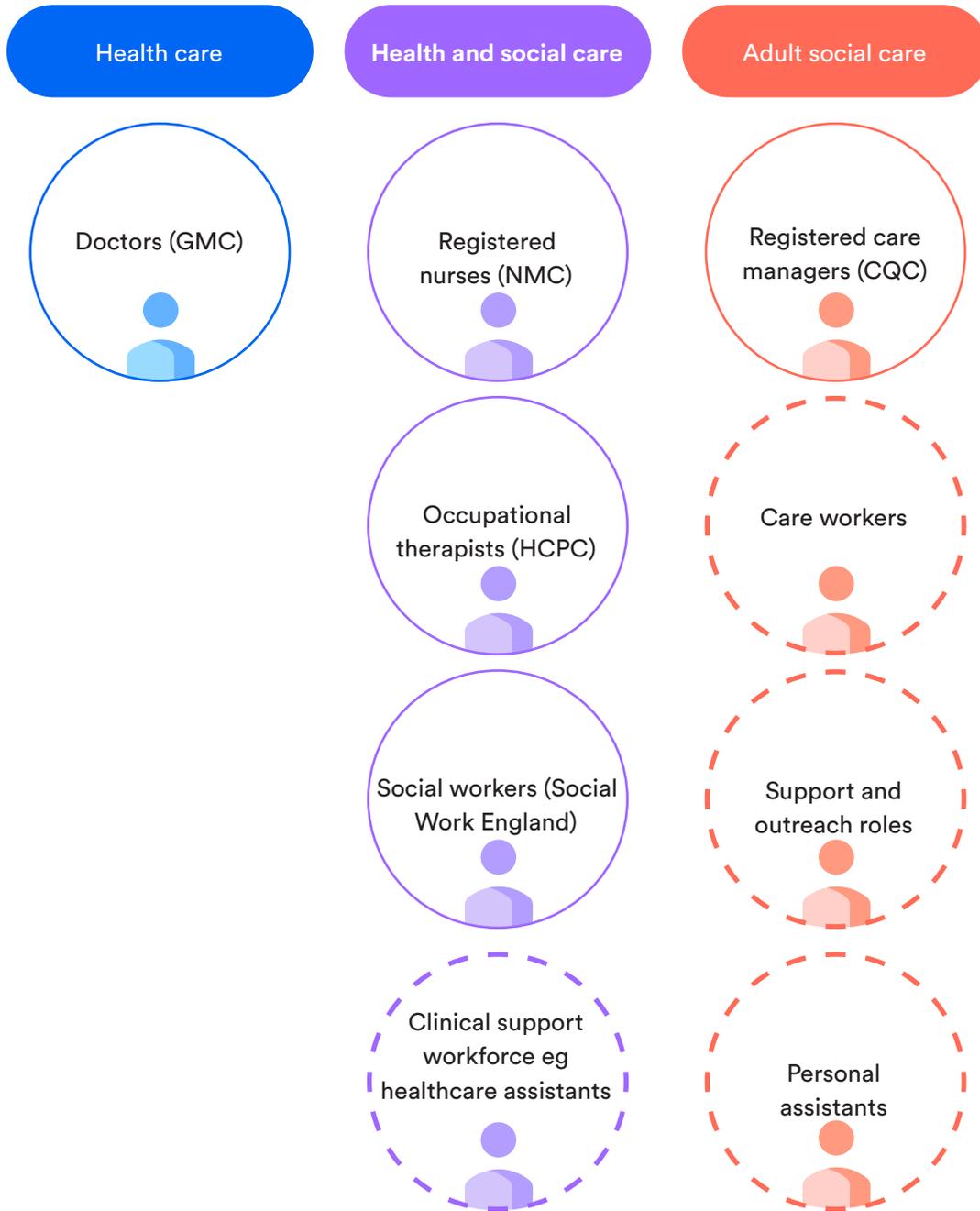
Over the course of the pandemic, care workers have demonstrated that the work they do has significant public, economic and societal value. The human toll from the crisis must not be forgotten: between March 2020 and May 2021, nearly 1,000 care workers died from Covid-19.¹ Many went above and beyond their roles, exhibiting great bravery and personal and professional sacrifice.

There is a clear and growing public expectation that the pay, reward, training and working conditions of staff in social care are unacceptable and must be urgently reassessed.² There are two likely grounds for this: that low pay and poor conditions lead to poorer quality care, for individuals and for the entire care system; and that social care workers do not get a fair reward for the work they put in. There is an urgent need to recruit and retain a stable, skilled and motivated care worker workforce to address ever-growing waiting lists for care, and it is imperative that the government and employers promote and protect the health, wellbeing and development of care workers.

Care workers

The majority of jobs providing direct care in England (76%) comprise roles such as care workers, which are not professionally regulated and do not formally require a qualification (Figure 1). As of 2021, there were 895,000 care worker roles in England, equivalent to over half of the total care workforce.³ An estimated 5% of jobs in the adult social care workforce in England are held by regulated professionals such as registered nurses and social workers, with 7% held by managerial roles and 12% by other roles (including administrative and ancillary roles).

Figure 1: Examples of occupations and their registration and regulation status in England



* Solid lines indicate roles with a statutory register, dashed lines without. Statutory regulator in brackets

Care workers in England are a diverse staff group, and include people who are completely new to social care to those with extensive care experience.⁴ Care workers are predominantly women (84%), and one in four are from Black, Asian or minority ethnic backgrounds, although this drops to fewer than one in five for senior care workers (18%). The mean age is 43, with one-quarter aged 55 or older. Lastly, the majority of care workers in England are British, with 8% of care workers from EU countries, and 11% from non-EU countries.⁵

Perceptions of care work as ‘low skilled’ continue to persist in society, despite the fact that the pandemic has clearly highlighted just how vital their work is. Furthermore, there are reports from before the pandemic of some care workers undertaking delegated health interventions or complex activities, including installing catheters, using flexible feeding tubes, stoma care and giving insulin.⁶ During the pandemic, many have stepped up to take on additional duties usually undertaken by other professions – such as dressing wounds, using digital technology to enable remote health care, and providing verification of deaths.⁷ In addition to these technical skills, care workers are considered to require a number of qualities, including empathy, dedication and open-mindedness.⁸

Scale of workforce challenges

While welcome, recent workforce proposals in the government’s social care white paper do not amount to a comprehensive plan to tackle the recruitment and retention crisis. There has been no dedicated, long-term adult social care workforce strategy for 13 years. This is remarkable, given that there are an estimated 1.5 million people working in social care⁹, around the same number as employed by the NHS.¹⁰

Over this period, and in the last two years in particular, the sector has witnessed a formidable number of challenges. These include the longstanding issues of low pay, poor terms and conditions, wide variation in access to training, and limited opportunities for career development. These have been exacerbated by pandemic-specific factors, such as increased rates of sickness and burnout and the impact of the mandatory Covid-19 vaccine policy on staff retention.¹¹ On top of this, changes to immigration rules following Brexit and a growing backlog of people waiting for social care services have intensified recruitment challenges and workload pressure on existing staff.

Given the relationship between declining unemployment levels in the wider economy and increasing social care vacancies¹², it is no wonder that the number of filled care worker posts is estimated to have fallen by 5.7% between March 2021 and March 2022.¹³ There are 105,000 care worker job vacancies in the independent sector. Over one in three care workers leave their jobs every year, and while two-thirds of these will likely stay within social care, many others opt for better paying jobs as retail assistants or cleaners.¹⁴ The difference in pay between senior and entry level care workers is stark, with care workers with five or more years' experience earning only six pence per hour on average more in March 2021.¹⁵ Sickness rates increased from 5.6 days on average pre-pandemic to 9.1 days in the 12 months prior to March 2022.¹⁶ Working terms and conditions are precarious, with inconsistent access to adequate sick pay. Limited opportunities exist for progression, supervision and support can be thin (particularly in homecare), and there is wide variation and inconsistency in access to education, training and development. Workforce projections are daunting when set against this backdrop: an estimated 490,000 additional jobs overall are required by 2035 to keep pace with projected demand for services.¹⁷

It is within this context that the professionalisation of care workers has been proposed as a solution to workforce challenges.

What is professionalisation?

Professionalisation is a somewhat fuzzy concept but, in the context of care workers, is commonly thought to be realised through a number of key dimensions (Figure 2).¹⁸

Figure 2: The concept of professionalisation



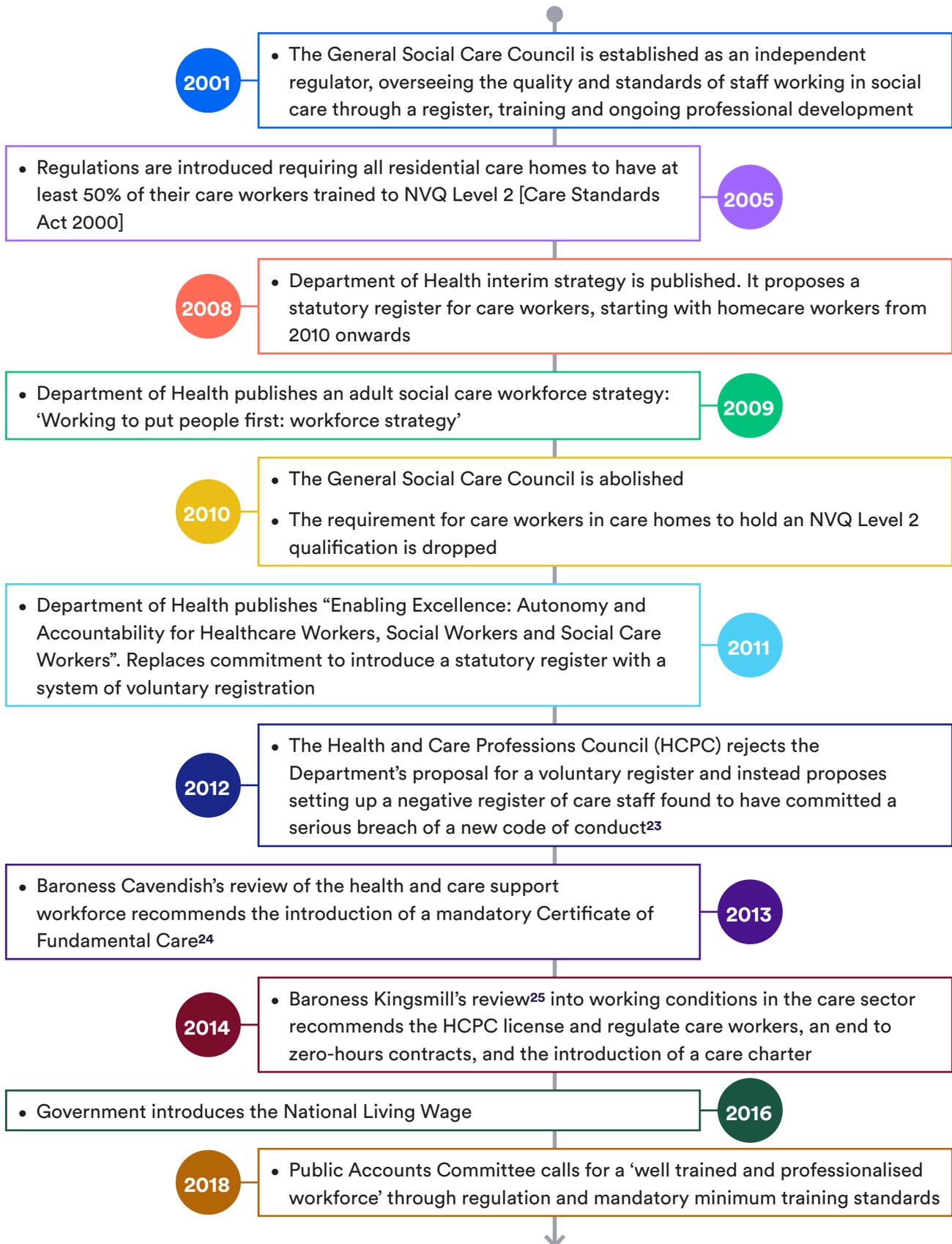
Although the professionalisation of care workers is currently much debated, it is by no means a new idea. There have been multiple attempts by previous governments over the last two decades to implement various aspects (Figure 3). The term ‘professionalisation’ is wide-ranging, with no single agreed definition. It is often held up as a silver bullet to the chronic challenges

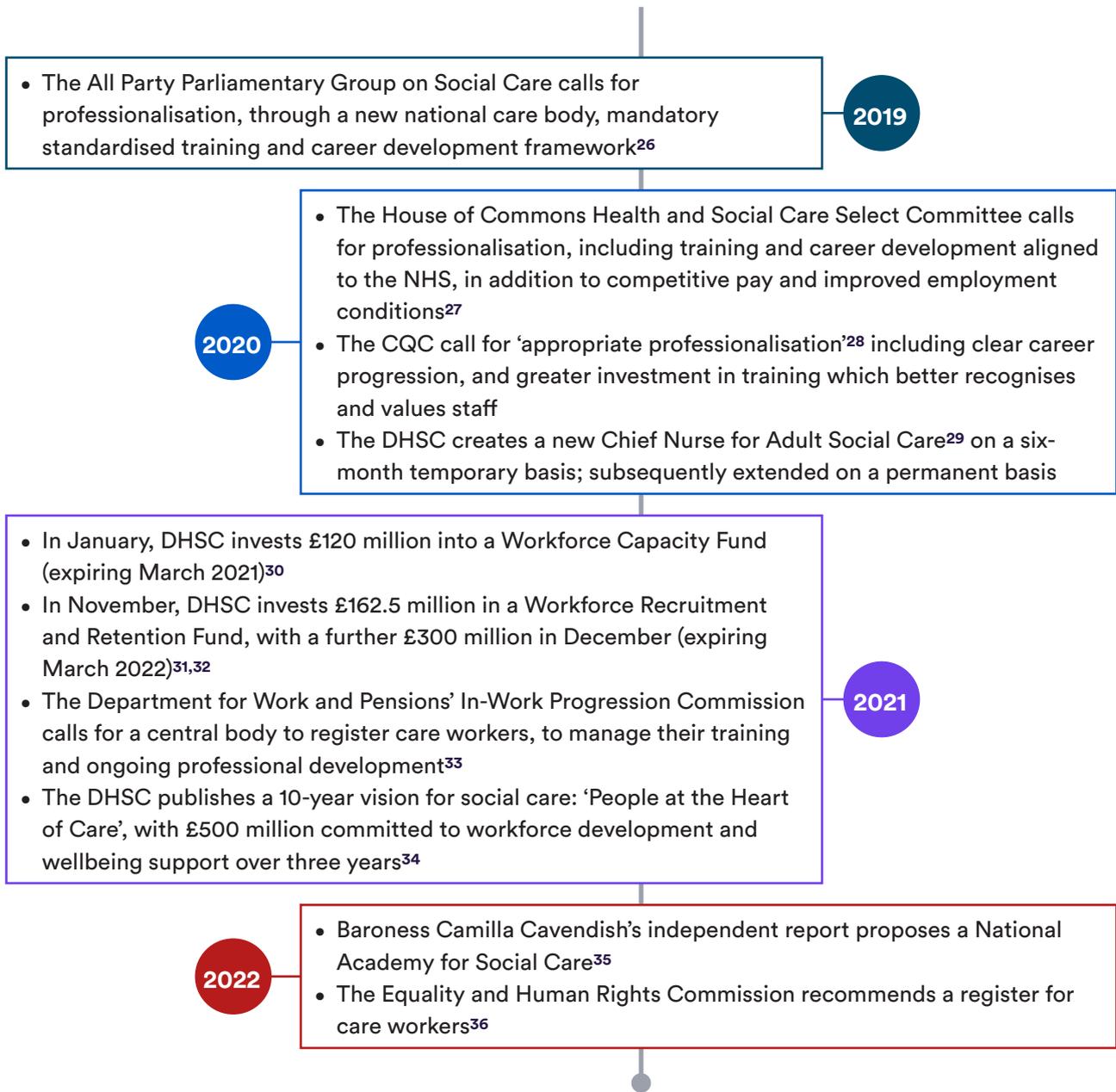
facing care workers, and over the years, it has been called for by a range of parliamentary committees, sector leaders, and politicians. Yet each proponent appears to define it slightly differently. It is notable that proponents include the independent regulator of health and care services in England, the Care Quality Commission.

In order to recognise this range of definitions, this report adopts a broader approach to professionalisation which accounts for the overlaps between registration, training, pay, career progression and working conditions (see Methods, p66).

Furthermore, within the social care sector, there is not universal support for all elements of professionalisation across the workforce. The aims of certain policies, and whether they are appropriate or necessary for different direct care roles, very much depends on perspective.¹⁹ Some organisations such as the National Care Forum have espoused the benefits of increased statutory regulation and a register for currently unregulated roles²⁰, with the Homecare Association acknowledging a need for proportionate regulation not just for care workers, but personal assistants and so-called ‘micro-providers’ who are not usually CQC registered.²¹ Others, including some people who employ personal assistants, have cautioned about the risks of a register that overly favours qualifications, which they feel may not be the most important factors in achieving person-centred care – instead prioritising co-production, attitude, values and personal qualities.²²

Figure 3: Timeline of key professionalisation policies, recommendations and milestones in England





To date, no country has found a perfect fix for workforce challenges, and it continues to be the more pressing issue for most. However, significant action to professionalise care workers is being taken by governments around the globe, in many cases catalysed by the pandemic. England’s reforms include some elements of professionalisation and therefore it is valid to explore the experiences of other countries to illuminate what is known about what works, and any potential unintended consequences.

2 Registration and professional regulation

Key points

- There is some evidence to show that registration and professional regulation can reduce risk to the public; improve outcomes for people using social care services; improve confidence in the workforce; and can drive up workforce standards by making minimum training and continuing development mandatory. It also has the potential to help strengthen a sense of professional identity and responsibility.
 - In other countries, a statutory central register has been shown to be a useful tool to improve understanding of trends in recruitment and retention and their underlying causes through analysis of the register data, and in turn support better long-term workforce planning.
 - However, the experience in Scotland and Wales warns that it could introduce unnecessary barriers to recruitment and retention. Such a system could be costly, and experience from Canada suggests having the appropriate infrastructure and governance in place is important to maintaining a register.
 - England is an outlier, as the only UK country not to have introduced registration and professional regulation of care workers. The advantages of these systems across the other UK countries appear promising, but to date there has been no independent review of the benefits, risks and cost effectiveness of such a system.
 - The aims, scope, costs and implementation of any such system therefore requires careful consideration, with engagement and consultation needed with workers, people drawing on care and support, employers and trade unions, to avoid unintended consequences.
-

Introduction

The establishment of a central body to oversee registration and professional regulation is not a new idea: it has been on and off the political agenda since 2008 (Table 1). In recent years, calls have been increasingly made for this as a key step towards the professionalisation of care workers.^{37,38,39,40} Some countries and regions have implemented a register, including Denmark, Japan, Canada (British Columbia), the USA (California), and the UK's devolved countries, whereas others have piloted and then subsequently abandoned such schemes (such as Ontario in Canada).

Since devolution on this matter began in 2001, England is the only country in the UK that to date has not introduced registration and professional regulation of care workers.⁴¹ In order to work, care workers in England must instead pass an enhanced Disclosure and Barring Service (DBS) check and submit acceptable employer references, and then are expected to follow a code of conduct (a set of behaviours and attitudes) and standards set out in a voluntary Care Certificate.^{42,43} Care providers registered with the CQC are inspected to ensure the staff employed are 'fit and proper persons' of good character, with the qualifications, competence, skills and experience to do their work, and to ensure that employers provide the necessary training, learning and development for care workers. In addition, the CQC inspect registered care managers, but they do not assess the quality of training provided to care workers. They are currently considering how to regulate 'micro-providers' (such as two to three individual self-employed care workers who team up to deliver care).

In many countries, registration can be contingent on achieving minimum qualifications or ongoing training. These are considered in more detail in the next chapter.

What does registration and professional regulation look like in the UK devolved countries?

In Northern Ireland, Scotland and Wales, statutory registration is overseen by a workforce regulator – the Northern Ireland Social Care Council, Scottish Social Services Council, and Social Care Wales.⁴⁴ These bodies work in partnership with Skills for Care in England.⁴⁵ Notably the other UK countries are forging ahead with registration and professional regulation, although at different speeds and with slightly different approaches (Table 1, see full table in Appendix, p. 67).

Some of the other UK countries have shown flexibility in their approach to professional regulation in response to the pandemic. Scotland has made several changes, including extending the period for registering or renewing registration, increasing the timeframe for achieving qualifications, and covering the cost of fees for new starters, a scheme which ended on 25th June 2022.^{46,47} They are consulting on further changes to make the registration system more agile.⁴⁸ Workers in Wales can register through an employer's assessment of competence or if they hold three years' experience, and Wales has also granted homecare workers more time to register.⁴⁹

Table 1. Summary of requirements for social care workers to register and practice in the UK

	Northern Ireland	Scotland	Wales	England
Professional regulator	Northern Ireland Social Care Council	Scottish Social Services Council	Social Care Wales	N/A (Skills for Care oversee workforce development)
Numbers registered (care homes)	Voluntary from 2011; mandatory from 2014 (15,252 registered)	Mandatory from 2015 (32,005 registered)	Voluntary from 2020; mandatory from Oct 2022	N/A
Numbers registered (domiciliary care)	Voluntary from 2015 Mandatory from 2017 (14,439 registered) ⁵⁰	Mandatory from 2020 onwards (58,524 registered) ⁵¹	Voluntary from 2018 Mandatory from 2020 (22,131 registered) ⁵²	
Timeframe	Within six months	Within six months	Within 12 months	
Title protected in law	No	No	Yes ⁵³	N/A
Standards/code of conduct	Standards of Conduct and Practice for social care workers	Code of Practice for social service workers and employers	Code of Professional Practice for Social Care	Code of Conduct
Post-registration training and learning	90 hours (15 days), over five years	60 hours (10 days), over five years	90 hours (15 days), over five years	
Mandatory qualifications	No (intend to introduce this) ⁵⁴	Yes (within five years)	Yes (within three years)	N/A (voluntary Care Certificate)
Previous experience	N/A	N/A	Can register after assessment of competence by employer	N/A

Sources: Scottish Social Services Council; Social Care Wales; Northern Ireland Social Care Council; Hayes and others 2019; Oung and others 2020. Full table in appendix, p. 67.

What benefits could such a system bring?

The benefits of registration may be difficult to quantify⁵⁵, but the evidence base points to a number of advantages.

Registering care workers in each of the devolved countries has been designed to act as a lever to advance professional development, with lower criteria for entry-level jobs and a higher bar to re-register, which is designed to help employers drive up consistent standards across the workforce as a whole.

The devolved countries have improved data and knowledge of what has historically been a transient and fluid workforce. In Wales, nearly 20,000 homecare workers have registered to date, which is 4,000 more than they originally anticipated.⁵⁶ However, it is not clear whether the scale of the workforce was initially underestimated, or perhaps if registration attracted more workers to the sector. Their registration process means granular information is available on, for example, individual demographics, qualifications and experience, and career progression. During the pandemic, we heard that registration in Wales was valuable in helping managers identify and stay up to date on which of their staff had undergone infection control training. By linking homecare workers' professional registration records with electronic health records, it has also enabled a greater understanding of staff exposure to Covid infection, mortality, and the impact of Covid-19 on other health outcomes and how these vary by demographic factors.⁵⁷ This data will be important to policy-makers both now and in the longer term.

In Scotland, registration data offers insights into the stability index of their workforce, with 81% of staff in the same post as the previous year.⁵⁸ In Northern Ireland, analytics tools are being applied to map where people work and where services are required.⁵⁹ While workforce planning is recognised as challenging in health and social care in general⁶⁰, these insights will be critical to accurate modelling and long-term workforce planning and could also help inform our understanding of the impact of changes to immigration rules both now and in future.

While evidence is still emergent, some survey data suggests that three-quarters of care providers believe mandatory qualifications lead to improved

care outcomes for people drawing on services.⁶¹ Registration and professional regulation can also improve confidence in care quality. In Northern Ireland, an initial survey found that 68% of the public believed registration would improve quality of care.⁶² Following registration, three-quarters of employers thought the standards had improved quality of service delivered, and two in three workers said they had improved confidence and believed registration had reduced the risk to people they care for.⁶³ The level of skill required to join the register, and requirements around fitness to practise, can influence employers to improve their performance monitoring and appraisal.⁶⁴ Registration and professional regulation also offers a way for a regulator to pick up on conduct or performance issues from previous employment, whereas in England, employers are solely reliant on a criminal records check and employer references.⁶⁵

There is some potential for further, future benefits based on the direction of travel in the devolved countries so far. Registration and professional regulation can help bring care ‘in line’ with other professions. By protecting the title of ‘care worker’ and enshrining it in law, regulators can prosecute unregistered people who inappropriately use the title. The symbolic meaning attached to a title and licence to practise should not be underestimated – removing vague job titles and identifying what is distinct about a role compared to others may help strengthen and validate a sense of collective professional identity. To a degree, this supports arguments that a licence to practise can instil credibility among the public and workers themselves, and enhance the professional status of care work.

There is potential to learn from the registration of wider roles in care more generally, such as social workers who gained a protected title in 2000⁶⁶, and childminders who are registered and subject to inspections by Ofsted.⁶⁷ Evidence suggests professional regulation has instilled greater public awareness of social workers as professionals,⁶⁸ and regarding childminders, that the introduction of a register and formal qualifications has helped lead to a perceived raised status among childminders themselves.⁶⁹ There is also some evidence from professional regulation of other low-paid roles, such as security guards, which show that regulation may be associated with an increase in earnings over time, but this depends on how it is implemented.⁷⁰

Of the countries reviewed in this paper, no country has introduced registration without accompanying mandatory training requirements. In the devolved UK administrations, having a central body oversee training does appear to have ended the practice of retraining staff when they switch employer, as training is certified and recognised by employers through the registration process. There is a risk that introducing registration too quickly could lead to staff departures – a phased approach can help reduce the risk of existing staff leaving. Scotland, Wales and Northern Ireland all started out with voluntary schemes, and gradually phasing in the mandatory requirement seems to have potentially mitigated against an initial loss of staff.

The flexibility of having a combination of different routes to register appears to be key in implementing such a system. Among domiciliary workers who have registered in Wales, a significant proportion have used the practice qualification (64%), induction for new starters (22%) and proof of competence through experience (14%).⁷¹ Different routes are more appealing to some groups, for example proof of competence among those aged over 65, and the online induction is favoured by those aged under 25.

What remains unknown and what are the potential risks?

Given the fairly embryonic evidence around benefits, a number of questions remain, and there appear to be some potential emerging risks.

It should be noted that the UK Professional Standards Authority warn that aspiring to regulation as ‘a badge of professional status’ is an out-of-date attitude and the use of statutory regulation unnecessarily can be inefficient and wasteful.⁷² It is also unclear how the benefits of registration and regulation compare to other assurance mechanisms. There continues to be debate about the extent to which registration and professional regulation protects the public significantly more than is currently achieved through the current code of conduct (DBS) system.

There are questions about the costs and infrastructure needed. In Northern Ireland, the smaller relative size of the workforce compared to England may

have helped enable the rollout of registration. However, questions remain over the sustainability of the NISCC's funding to oversee the increase in volume and complexity of fitness to practice referrals as the register grows in size.^{73,74} Maintaining a register will require investment and a regulatory body with the capability to oversee it, and there are lessons to be learnt from the now defunct General Social Care Council in England, which was financially dependent on government and experienced challenges in the effectiveness, efficiency and governance of its conduct function.⁷⁵

Implementing and maintaining an effective registration and regulation system has also proved to be a challenge elsewhere. In Ontario, Canada, the government trialled mandatory registration for home and residential care workers with a two-year pilot from 2018 to 2020.⁵² It aimed to provide patients and families with information about their personal support worker, to improve transparency and the complaints process, and establish a code of ethics, roles and responsibilities. In so doing, the government hoped to ensure better public protection and worker accountability. Workers could also only join the register after completing a personal support worker qualification with specific requirements demonstrating they could provide competent and safe care, recognised with an official technical qualification.⁷⁶ However, the government struggled with implementation, particularly in terms of the complaints mechanism in removing care workers from the register.

There are concerns that the fees and training requirements may be restrictive and counterproductive, and act as barriers to existing and potential workers joining the register. However, given limited data on turnover by profession, the extent to which introducing registration has exacerbated existing levels of turnover for care workers specifically remains unclear. In Wales for example, by March 2021 Social Care Wales reported £106,000 of registration fees outstanding across all roles, and 1,497 people (4%) in all types of roles left the register during 2020/21.⁷⁷ Given current turnover levels in England, this compares quite favourably. There are signs in Scotland, however, of employees being suspended for not completing training in time, and a lack of funding for mandatory qualifications prompting some staff to exit⁷⁸ (see p.30).

Research suggests a lack of understanding of the registration requirements and implications, particularly in homecare. Support from employers,

workforce regulators and trade unions is important in ensuring staff understand their responsibilities and relieving workers' anxieties about registration.⁷⁹ In Wales, more could have been done to consult and engage the workforce before the requirements were rolled out, particularly among older care workers who may be reticent about becoming returning adult learners. Previous experience in Wales with the introduction of regulation of teaching assistants may be relevant here. It suggests that trade unions can play a key role in this process, such as by visiting school premises to present and explain the registration process, standards and requirements to teaching assistants. However, in the social care sector, they faced challenges trying to reach a fragmented care workforce across private providers of various types and sizes, especially where their ability to visit providers was inconsistent.

Care workers wanting to remain in social care could sidestep registration requirements by taking up roles as unregulated personal assistants instead. Some have noted this may be a more important factor for certain workers, such as staff from abroad.⁸⁰ It is worth noting that personal assistants support people in a variety of ways and some might not necessarily provide personal care – as such, registers and qualifications may be less beneficial. However, voluntary registers are used by some personal assistants to accredit, access training, vet or simply advertise their services, and some personal assistants view these registers as good practice.⁸¹ There may be a role for other forms of lighter touch regulation (voluntary registers or accreditation), in promoting person-centred care and better protecting both holders of personal budgets and personal assistants. There may in time be learning from Scotland as they propose to initially trial a central register (but not statutory regulation) for personal assistants.⁸²

3 Education, training and continuing professional development

Key points

- Staff who receive relevant, high-quality training are more likely to stay in their role and be equipped with the skills and confidence to deliver better care. The pandemic has highlighted the need for consistent training to ensure a minimum standard skill level for all care workers. However, currently there is no compulsory training for care workers, although a voluntary care certificate is available. There is also wide variation in the opportunities available for those who want to further specialise or to enhance their skills.
- A number of developed countries have taken far more comprehensive approaches to education and continuous training. These include mandatory training requirements; granting worker rights to training; integrating training with the health sector through placement rotations and training in health interventions; and training targeted at underrepresented groups, such as men and younger people.
- There are a number of key benefits to these approaches, including improved outcomes for people drawing on services; improved confidence and status for workers; improved ability to provide certain health interventions and person-centred care; and reduced turnover.
- The experience of other countries suggests that careful consideration should be paid to design and implementation. Where these programmes seem to have worked well, education and training is high quality, relevant to the worker's role and equitable in terms of access. They also incorporate practical forms of training (such as mentoring and paid shadow shifts to learn on the job from more experienced staff), alongside

alternative routes for workers to demonstrate skills through length of experience.

- The funding arrangements are also key. Governments have grappled (not all successfully) to ensure that training is fully funded, completed during paid working hours and paid at trainee or normal wages. Without these, there is a risk that recruitment and retention issues may be exacerbated.

Introduction

There is a clear link between investment in learning and retention in social care, with care workers who receive some form of training around 9% less likely to leave their posts than those who receive none at all, and those with a relevant social care qualification 9% less likely to leave.⁸³ Despite this, no formal training, qualifications or experience are needed to work as an entry-level care worker in England. There are also no mandatory standards for the education and training of care workers. A voluntary Care Certificate comprising 15 standards was designed to provide a basic induction to new workers, who are encouraged to complete it and abide by an accompanying voluntary Code of Conduct. Employers are not obligated to offer it, however, and the content and lack of portability of the certificate are well-known challenges.

Training organised by employers varies considerably by type and quality. In 2020/21, around one in three care workers new to the sector had not started the Care Certificate, and nearly half (47%) of care workers in care homes had not started it.⁸⁴ There is some limited data on types of training offered beyond the Care Certificate, but care workers report inconsistent access to this, and many receive no regular ongoing training as part of continuing professional development (CPD) or specialised training, at all.^{85,86} Currently, providers appear to want to provide training but may be put off by having to meet the costs of this themselves. Employer requests to Skills for Care's Workforce Development Fund, which allocates £10 million funding on average for training and CPD from the DHSC, outstripped the budget 10 to one.⁸⁷ The change to the Workforce Development Fund's funding cycles (from three-year to annual) may also be a disincentive to investing in the workforce over the longer term.⁸⁸

Various skills gaps are known to exist for care workers by setting and by type of care.⁸⁹ They are likely to need skills in end-of-life care, learning disability or autism, diabetes or dementia care. They also likely to need to be digitally literate and able to use remote care innovations, and to work seamlessly within multidisciplinary teams of health and care professionals. However, access to formal training to support these skills has been inconsistent, and the pandemic has also pointed to an absence of preparedness training for disaster or crisis situations.⁹⁰

There is anticipation that demand for care will increase as a result of population ageing, increases in life expectancy, increases in the prevalence of complexity and co-morbidity⁹¹ and increasing rates of disability among working-age adults. Meeting this demand will require not only more care workers, but workers with the appropriate skills to care and support people at home and in the community. Many bodies, such as the House of Commons Committee of Public Accounts, have recommended mandatory minimum training to ensure the workforce is adequately equipped.⁹² Over the pandemic, social care leaders and managers reported changes in the types of skills they required from their workforce – including digital capability, technical and specialised skills, and leadership and managerial skills.⁹³ Currently, there is limited evidence on the extent of skills gaps related to delegated interventions specifically.⁹⁴ However, there are reports of care workers being increasingly delegated more complex health interventions – such as giving medication via feeding tubes, and catheter care – which is driven in part by the pandemic and the need for providers to take on additional responsibilities.⁹⁵ This suggests that where care workers are safely enabled to work at the top of their practice, they can play a key role in multidisciplinary teams. There is also some evidence that training in digital skills can help retain staff and improve job satisfaction.⁹⁶

There can be a good return on investment for training, with opportunities for staff to specialise, such as through technology or end-of-life skills training, which can benefit the people being supported, employers and the wider system. For example, evaluations of the Wellbeing and Health for People with Dementia (WHELD) intervention, which involves training care staff on social interactions, demonstrate that such training can improve quality of life, reduce hospital admissions, reduce agitation and pain in people living with dementia, and deliver cost savings of up to £2,000 per care home.^{97,98} In homecare, a

pilot trial of person-centred dementia training for homecare workers was valued for the time and space for reflection on ways to improve care, enhanced peer learning, and built workers' skills and confidence.⁹⁹

It is important to reiterate that care workers' values and aptitude are equally important as holding relevant qualifications, and for some employers, demonstrating these is more important. Wider research by Social Work England echoes this, suggesting that for some members of the public, life experience and practical real-world experience can be more important than understanding theory.¹⁰⁰

Lastly, apprenticeships represent a potential key route for new and existing staff to earn while learning and progress in their careers, but there remain barriers to uptake and completion of these courses. In 2020/21, 2,700 people started a care leadership and management apprenticeship, and 1,330 started a health and care apprenticeship. However, only 56% and 40% of apprentices typically complete these apprenticeships respectively.¹⁰¹ What's more, there is very little difference in the hourly pay rates between care worker apprentices and those not studying for an apprenticeship.¹⁰² Of 7,000 nursing associates enrolled between 2017 and 2019, only 140 (2% of the total) were employed by social care providers.¹⁰³

There remain many barriers to greater uptake of the nursing associate role in social care. Understanding of the role and how it can contribute to care is low among employers, and the costs of training and backfill are estimated to stand at over £43,000 – a key challenge particularly for small employers. There is limited training infrastructure to enable mentoring and supervision of trainees, and adequate pay to retain nursing associates upon qualification is also an issue.¹⁰⁴ As such, there remains scope for further action to make this career pathway a viable route.

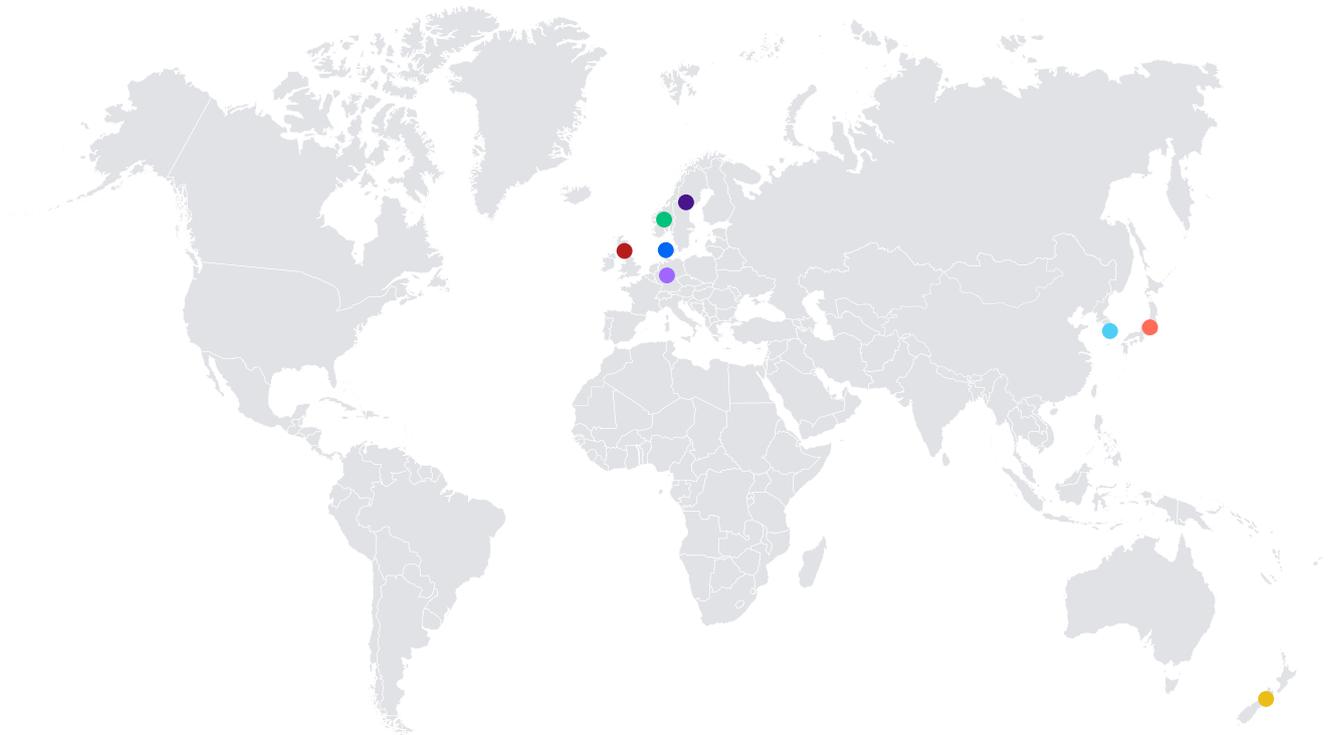
Overview of international approaches and their benefits

Like England, many countries have historically only required care workers to undertake minimal or basic training. However, a number of developed countries have broken from this model. Initiatives include the introduction of mandatory training requirements, granting worker rights to training, integrating training with the health sector through placement rotations or training in health interventions, and training targeted at underrepresented groups. Some of these approaches are outlined in Figure 4, with further detail and benefits outlined in the appendix (Table 5, p. 69).

It is important to note the different contexts for the reforms noted in this review. Countries with histories of social-democratic welfare systems (like Denmark, Norway and Sweden) have long-term care systems where the main responsibility for the organisation, provision and financing of care traditionally lies with the public sector.¹⁰⁵ With the focus on universalism and equality as core policy aims, it is perhaps unsurprising that their workforce demonstrate relatively higher levels of trade union membership and standardisation with respect to training and pay.^{106,107,108,109}

Countries with social insurance-based long-term care systems and more mixed models of provider ownership (like Germany, Japan and South Korea) similarly point to higher standards for training and professional regulation.^{110,111} Lastly, and similarly to England in some respects, New Zealand’s long-term care system incorporates elements of means-testing for residential care, and their long-term care market is predominantly private provider-led.¹¹² However, their government in this context has introduced relatively radical interventions to standardise workforce training, pay and to improve working conditions.

Figure 4: Summary of care worker education and training approaches in other countries



Denmark

- 1.5–3.5 years integrated training across health and care, with rotations across hospitals, care homes and homecare
- Protected time off to study and paid at trainee rate
- Right to training within three years of employment

Germany

- Apprenticeship-based approach with a fully-funded retraining route for workers from other sectors
- National training standards and professional development paths are clearly defined
- Personal care is viewed as qualified work

Japan

- More comprehensive coordinator role requiring two to four years of training
- Training on health interventions
- Employers offered financial incentives to offer CPD

New Zealand

- Qualifications and length of experience are tied to pay and progression
- Three levels of qualification designed to train workers in person-centred support and leadership
- Employers must support staff to achieve qualifications within set timescales
- Government funds employers for two days of training per employee per year

Norway

- Bespoke training program designed to recruit men, who are underrepresented in the workforce
- 2.5 years of class, practice and mentoring to become so-called ‘health workers’
- Paid salary while training

Republic of Korea

- Care workers must undertake 240 hours (around 40 days) of training plus an exam to be certified
- The government is developing a career ladder so that after five years’ experience, homecare workers can progress to director of homecare services

Sweden

- Government-funded training for 10,000 care workers to become nursing assistants, introduced over the pandemic
- Paid at usual wage while studying
- Government also funds backfill costs; municipalities offer permanent contract upon completion

UK countries

- Must achieve relevant qualification within five years (Scotland) or three years (Wales)
- Post-registration, between 60–90 hours (10–15 days) of CPD required over five years

There are a number of key benefits to these approaches, including improved outcomes for people drawing on services and improved confidence and status for workers. There is also improved ability to provide certain health interventions and person-centred care, better recruitment of underrepresented groups, and reduced turnover.

In Scotland, evidence from surveys of independent care providers suggest that the introduction of qualifications are believed to have improved outcomes for people drawing on services. In addition, the qualifications are thought to have improved staff understanding of person-centred care, confidence, status, and reflection on their practice.¹¹³ While research suggests 75% of care homes have seen an improvement in recruitment and retention, this compares to only 44% in homecare.¹¹⁴

In New Zealand, employers must support their staff to achieve qualifications within certain time periods.¹¹⁵ The government also funds employers for two days per employee per year as a contribution towards education and training. Early evidence suggests the way this framework was implemented has helped provide a clearer training pathway and also a pay structure which rewards more qualified and experienced staff. There are also suggestions that it has narrowed the traditional divide between registered nurse and senior care and support workers as they carry out more complex tasks such as wound and medication management, while also improving retention.¹¹⁶

Workforce standards in Japan are notably high compared to most other OECD countries. In Japan, care workers play a more comprehensive role as professional case managers, responsible for coordinating all the services gravitating around the person requiring support. They undertake extensive training both pre- and post- employment, which incorporates health care interventions, such as use of feeding tubes. The government offers care providers financial incentives for hiring certified care workers and providing them with continuing professional development opportunities, such as bonus payments to nursing homes which recruit staff with specific expertise in nutrition, dementia care, and those with prior work experience.¹¹⁷ Notably, the number of certified care workers increased by 20% between 2011 and 2015.¹¹⁸

A similar approach to integrated training is used in Denmark, where the Danish Health Authority regulates care workers and oversees their

accreditation and licensing. Social Care and Health Helpers study for 19 months, focusing on the provision of personal care. This includes an introductory course, classroom-based study, and placements which rotate across hospital, care home and homecare settings – granting crucial insight and experience of long-term care. Upon completion they can progress onto the Social and Health Care Assistant role, requiring a further 20 months of integrated training. These assistant roles, which take on more tasks and responsibilities of nurses, are being increasingly favoured as care activities become more medicalised.

Norway stands apart from other countries in their approach to recruiting and training underrepresented groups into the care workforce. Their ‘*men i helse*’ (Men in Health Recruitment Programme) targets men aged 26-55, who are unemployed or have previous work experience such as being car mechanics or shop assistants. The programme started as a municipal initiative in 2007, and is now being implemented nationwide.¹¹⁹ The programme is 2.5 years long and involves eight weeks of classroom training, a 12-week trial period in a nursing home, and mentoring by an alumnus of the programme. During the training, so-called ‘health recruits’ receive state benefits or a salary from their municipality. Following this, graduates are awarded a diploma as a ‘health worker’. The job title, branding of the campaign, and male-only classes are designed to appeal to men specifically. The scheme has effectively expanded through a snowballing strategy where graduates recruit men they know, who otherwise would not have typically considered a career in care.¹²⁰

Germany has adopted an apprenticeship-based approach, with clearly defined national training standards and professional development paths that aim to improve care quality, increase status, and aid recruitment. Apprentices earn while learning on the job, and a retraining route for people from other sectors is fully funded by the government. Notably, personal care is viewed as qualified work for trained staff, with 45% of homecare workers holding three years of training as nurses or caregivers; 7% holding three years’ of equivalent occupational training; and 17% holding two months of training as nursing or care assistants. Turnover is relatively low in Germany, which may be partly due to the level of qualification needed, as those who have committed to complete a three-year nursing apprenticeship are unlikely to leave for jobs in hospitality or retail. There is evidence that comprehensive training, and integrated provision of personal care with nursing care services in homecare, has helped foster a stable and qualified homecare workforce in Germany.¹²¹

Lastly, in Sweden, recent reforms aim to improve staff skills and retention in response to the pandemic and the reliance on casual workers with limited training. In May 2020 the government took swift steps to invest in a training programme for up to 10,000 care workers to become ‘nursing assistants’, as part of an agreement with the Swedish Municipal Workers’ Union (Kommunal), and Swedish Association of Local Authorities and Regions.¹²² This reform is expected to cost a total of SEK 4.5 billion (£3.6 billion) between 2020 and 2023¹²³, with the government investing SEK 2.2 billion (£1.8 billion) in 2020 and 2021 to fund staff training and backfill costs. Staff continue to work and are paid at their usual wages while training, on the condition that municipalities offer a permanent contract to staff who complete the programme.

The design and implementation of education and training programmes

Key to the successful implementation of training are sufficient resources and funding arrangements to ensure equitable access.

In Japan, even though providers are offered financial incentives to provide CPD to staff, and wages are considered low, training is completed entirely at the care worker’s own expense.¹²⁴ Evidence from one survey in Scotland suggests that, given scarcity of funding, a notable portion of the workforce pay their own qualification costs upfront, or negotiate other arrangements such as splitting the cost with their employer or using salary schemes that are reimbursed once the employee has worked for the employer for a set period of time. These are more predominant in homecare than care homes, likely as a result of the commissioning models in homecare. For workers who cannot afford this, a lack of organisational or other funding options for training suggests they will work until the last date possible then leave at short notice.¹²⁵

A critical factor is employers’ ability and willingness to provide access to training and support, in the form of paid and protected study time during working hours, paid tuition fees, or group study sessions at work.¹²⁶ Across the UK devolved countries, as in New Zealand, there are no clear obligations on employers to provide paid time for training.^{127,128} While 40% of care workers

in New Zealand reported undertaking training during work time, 25% report receiving no training at all.¹²⁹ In Scotland, there are inconsistent approaches to training as it is not an explicit requirement within contracts, despite it being a requirement of workers to practise.¹³⁰

The feasibility of completing training must be balanced with the value and assurance it provides. Given pressure on services, surveys point to care workers frequently having to complete qualifications and training in their own time.¹³¹ There is concern therefore that asking workers to complete qualifications may be too onerous for staff who work part time, night shifts, or who juggle other caring responsibilities. Longer term, it is not clear how many care workers will keep up with training requirements or may instead choose to enter jobs which do not require qualifications, such as personal assistants or in retail.

Scotland's experience also suggests that mandatory qualifications are likely to push some older workers close to retirement age out of the workforce earlier than they had intended, bringing the loss of a wealth of experience and knowledge.¹³² Ensuring sufficient capacity of training providers is also an issue in the medium term, as large numbers of care workers approach the end of their timeframes to complete qualifications and CPD training.¹³³

The quality and relevance of qualifications and training is a recurring issue in some countries. Mixed models of education and training, which involve theory, class-based, practical and on the job learning, have been shown to work well in certain countries. This can help ensure the appropriateness and relevance of qualifications and training.

The Welsh *Principles and Values Award* for new starters is conducted entirely online, and does not include any practical elements, even via direct observation. While this has helped expedite the registration of new joiners, who must then go on to achieve a qualification within three years, there is a risk that new starters won't be adequately prepared for the realities of the work involved. Similarly in New Zealand, some registered managers are not convinced of the quality or relevance of qualifications – particularly courses that did not include a practical skills assessment, meaning qualifications did not always equate to competence.¹³⁴ It is important therefore that practical forms of training routes are also factored in, such as mentoring and paid

shadow shifts to learn on the job from more experienced staff¹³⁵, and that training is directly relevant to the type of service being delivered.

The experience of other countries suggests the attraction, and benefit, of training for both workers and employers is diminished where wider conditions undermine staff's ability to use their skills. In Japan, while setting higher training requirements may help to enhance the status of care work, it has not been matched with improved working conditions and improved pay. This may have exacerbated workforce shortages, as providers are tasked with the contradictory goals of expanding the workforce while keeping wages low and certification requirements high.¹³⁶ In Denmark, despite care workers in the public sector undergoing training to hold care qualifications, working conditions are reportedly poor and four in 10 care workers 'seriously consider' quitting their job.¹³⁷ In South Korea, social care is considered an unattractive sector due to poor working conditions and low pay¹³⁸ – only one-quarter of people holding certificates are employed, and turnover in the sector remains high at 41%.¹³⁹

These international examples suggest qualifications and training must be affordable, and bring a balance of work and life commitments, with flexible routes which account for prior learning, experience and the demographics of a diverse workforce. But on its own, it will only go so far to improve the current situation. Completing training must also lead to advantages in terms of pay and future career opportunities.^{140,141,142}

4 Pay and progression

Key points

- There is a strong evidence base to demonstrate that increasing pay to competitive wages would reduce staff turnover, particularly for staff paid at lower wage levels.
- Countries around the world have used a number of routes to improve pay, including incremental wage increases, bonus payments, pay and progression frameworks, and negotiating pay levels through collective wage agreements.
- Some countries such as New Zealand and Scotland have favoured using a national, independent job evaluation of job titles, skills, and responsibilities, to accurately inform decisions on pay increases and how pay could be benchmarked to other sectors.
- Steps have been taken to standardise pay and increase it beyond the National Living Wage in Scotland and Wales. Scotland has increased pay to £10.50 per hour, the equivalent of NHS Agenda for Change band 3, and providers since 2018 are expected to pay the Scottish Living Wage for sleep-in shifts. In Wales, pay has been uplifted to the Real Living Wage (£9.90 per hour), with additional funding to help maintain higher pay rates for more experienced staff. In all three devolved countries, pay bonuses were awarded to recognise care workers' contributions over the pandemic (between £500 and £1,498). The impact of these specific reforms in these contexts is not fully clear yet.
- The government in New Zealand introduced a national pay and progression framework, which awarded a pay uplift in recognition of historic gender pay inequity. The reform has increased pay for the majority of care workers, helped provide a clearer progression pathway, brought a pay structure which rewards more experienced and qualified staff, as well as a sense of pride and recognition felt by staff, and has improved retention. The more attractive pay scale has also attracted new starters who are male, younger, or with graduate degrees. However, there

have been a number of unintended consequences, some which have undermined the aims of the Act.

- Collective wage agreements have been used in France during the pandemic to drive up pay first for public residential care workers, then subsequently homecare workers. In Germany, a sector minimum wage is set to increase for both untrained care workers (to well above the national minimum wage) and trained care workers. More recently, the German government has sought to go further by introducing collective wage agreements to increase and standardise wages across the country.

Introduction

24 years ago, the Low Pay Commission’s inaugural report stated that ‘we believe it is neither desirable nor sustainable for the sector to continue to operate on the basis of low wages for its staff’.¹⁴³ However, care worker pay has continued to remain low both in absolute terms and also when considering the responsibilities involved.¹⁴⁴ While there have been periods of relative workforce stability over the last 24 years, a confluence of pressures currently mean the workforce is reaching a tipping point. These include increases in requests for social care support, high vacancy rates, competitive pay in other sectors and changes to immigration rules, all of which are causing deep concerns in the sector.

In England and Wales, NHS staff salaries are collectively set under the national Agenda for Change agreement, and reviewed annually by a single arm’s-length pay-review body. However, the vast majority of care workers are employed by independent, private organisations where pay decisions are unregulated, with wide variation between (and even within) providers. Pay scales for care workers employed by local authorities, however, are set through a pay scale determined by the Local Authority Services National Joint Council. Therefore, the mean annual pay for a care worker and senior care worker varies greatly between those working in the independent sector (£17,900) and local authority sector (£20,700). The same is true for senior care workers (£19,200 and £25,700 respectively), with local authority pay scales better able to reward progression.

There is a strong evidence base to demonstrate that increasing pay to competitive wages would reduce staff turnover^{145,146}, particularly for staff paid at lower wage levels. For example, previous analysis suggests that the lowest paid care workers have the highest turnover. In the year to March 2021, around 28% of those paid at or marginally above National Living Wage (£8.21) left their roles, compared to 25% for those with an hourly pay of £9.50 and above.¹⁴⁷ The introduction of the National Living Wage in 2016 and its increases over time have helped increase care workers' median pay in the independent sector. But at the same time the National Living Wage has led to some unintended effects, such as narrowing the pay differential between junior and more senior roles¹⁴⁸, and an increase in the use of zero-hours contracts by employers.¹⁴⁹ By March 2021, care workers with five or more years of experience saw their pay differential squeezed to just six pence per hour on average.¹⁵⁰

A lack of transparency and accountability on pay issues is rife in social care. Employers are not required to separate out travel time and so can potentially mask underpayment.¹⁵¹ Employers are required by law to provide clear payslips, including the number of hours worked, but these have not been put into practice consistently in social care – with one survey indicating 75% of homecare workers were unable to determine if they had been paid the national minimum wage.¹⁵² Financial anxiety is acute among homecare workers on zero-hours contracts, who face fluctuating earnings from week to week.¹⁵³ Enforcement of the statutory minimum wage, including paid travel time between appointments for homecare workers, has been lacklustre, with observers noting the latter in particular is an ‘unfunded legal obligation... which has been effectively unenforced by HM Revenue and Customs’.¹⁵⁴ This is despite significant evidence of non-compliance in social care, with HMRC estimating 15,000 underpayments and £6.1 million in arrears in 2018/19.¹⁵⁵ In 2019, more than half of councils had no stipulation in their contracts that providers must pay staff for travel time.¹⁵⁶

The Migration Advisory Committee maintains that ‘one cannot seriously address the workforce issues in social care unless pay is improved; this is essential to boosting recruitment and improving retention’.¹⁵⁷ They estimate that increasing the hourly wage of care workers to £10.50 per hour (equivalent to NHS AfC band 3) represents an increase to the wage bill of between £0.7 billion and £2.1 billion, depending on whether the pay increase is tapered (i.e. further narrows the differential with more senior roles) or applies across

the pay differentials, preserving them. The DHSC’s own estimate indicates that bringing the salaries of the lowest paid care and supporter workers in line with NHS AfC band 2 would cost in the region of £1.2 billion.¹⁵⁸

Despite calls by the Migration Advisory Committee, Health and Social Care Select Committee, Public Accounts Committee and many more, there are no further ambitions to improve pay within this parliament – a notable absence in the government’s social care white paper. Recent central government funding to help providers recruit and retain staff enabled some employers to increase wages (for example, in some cases by up to 17%) or to offer bonuses.¹⁵⁹ However, these sums will not facilitate the transformation in pay which would pull in dramatically more UK workers from a domestic labour market where social care competes with other sectors.

A lack of progression opportunities is also a longstanding issue – with around one in five staff citing this in their exit interviews.¹⁶⁰ Skills for Care note the most common career path is into management, with care workers progressing to senior care worker or supervisor, to first-line managerial roles and then registered manager roles.¹⁶¹ Routes also exist to progress into enhanced care worker roles, care home assistant practitioner, regulated roles such as nursing associates, and into health care, including through apprenticeships. However, they often can be inaccessible or difficult to navigate, particularly where employers do not have the resources or incentive to offer training or support with career development.

This chapter looks at interventions taken in a number of countries to understand how pay increases and career progression have been achieved in other countries, and what is known about the impact to date. Issues around paid travel time, costs and sick pay are covered in the next chapter.

Gender pay equity settlement: revaluating care work in New Zealand

In 2012, the New Zealand Human Rights Commission led an inquiry into the care sector and recommended that district health boards should develop pay parity between health care assistants and carers working in residential and

home care. A coalition of commissioners, trade unions and providers was formed following the inquiry, campaigning for better pay.¹⁶²

This momentum helped prompt Kristine Bartlett, a care worker, and her trade union, to file a pay equity claim against her employer. Her claim resulted in a landmark Equal Pay Settlement, brought forward by the New Zealand government in 2017, which awarded a significant pay uplift for 55,000 workers across residential, home and disability care settings, in recognition of the historic gender pay inequity experienced by their largely female workforce.^{163,164} Kristine Bartlett was also named New Zealander of the Year by Kiwibank. The settlement recognised that care and support workers had been historically underpaid relative to the skills and responsibility that the work entails. Pay levels were established through a government-led mapping exercise and principles developed by a joint working group, which made comparisons to similar types of work performed mostly by men.¹⁶⁵

The government implemented this through a new national pay scale that set out clear differentials. Pay rises ranged from 15-50%, with workers on the minimum wage of \$15.75 per hour moving to at least \$19 per hour (a 21% rise).¹⁶⁶ The government committed to funding \$2.048 billion over the five years to July 2022. In turn, local commissioners of services increased their payments to providers to cover the cost of increased wages. The Crown negotiator appointed by the New Zealand government was key in leading negotiations with stakeholders in good faith, and in providing access to increased funding for the higher wages.¹⁶⁷

The structure is designed specifically to incentivise care workers to continue formal training and gain qualifications, without penalising those without, who instead can qualify for progression through length of continuous service with their employer. Employers must support their care workers to achieve these levels within certain timeframes¹⁶⁸ (see Table 3, p52).

An early evaluation and survey in 2019^{169,170}, suggests the framework has increased the pay of the majority of care workers (69%) and helped provide a clearer progression pathway. It also suggests the framework has brought a pay structure which adequately rewards more experienced and qualified staff, makes staff feel a sense of pride and recognition, and has also increased staff engagement in training. For many it has had a profound impact on their

quality of life, making visits to the dentist or holidays abroad affordable. A 2019 survey indicated a positive effect on retention, with an average of 77% of care workers who had stayed with their employer. Some of this is likely due to care workers who had gained level 3 and level 4 through length of service with their employer, meaning they cannot change employer without a reduction in their hourly rates.

The type of applicant has also changed in some sectors, particularly the ‘disability support’ sector. The more attractive pay scale appears to have attracted new starters who are male, younger, or with graduate degrees in social work and psychology – with hopes they will build longstanding careers in care. Care workers’ responsibilities and tasks have increased since the introduction of the Act, with the divide between a nurse and care worker thought to be ‘closing quite dramatically’, and a quarter of care workers indicating they had gained more responsibilities in their existing level.

However, there have been a number of unintended consequences, some of which undermine the aims of the Act. Managers have reported shortfalls in the funding provided by central government, leading to some smaller providers struggling to stay in operation or changing the types of services they offer.

Some managers mitigated this through being more selective about who they offer training to, noting that in home and community care services there was less need for these more advanced roles.¹⁷¹ Other managers reduced the regular, guaranteed hours of their Level 3 and 4 care workers, some by almost half, meaning that a cohort of more qualified and experienced care workers were financially worse off than before. On the other hand, around half of care workers working across all sectors chose to reduce their weekly hours themselves¹⁷² for various reasons. These included not moving into a higher tax bracket, spending more time with family, or to rest after years of choosing to work as many hours as possible due to low pay rates (see ‘Offering guaranteed hours or permanent contracts’, p. 50). Challenges appear to be greatest in home and community care, with care workers less likely to have remained with the same employer, more likely to report that their hours had reduced, with 18% reporting that their take-home pay had decreased since the Act.

The framework has in some cases exacerbated tensions between care workers and other professions in their teams. Pay increases have narrowed the pay

differential between Level 4 care workers (team leaders) and other roles such as registered nurses and middle managers. What is more, some managers did not understand the pay increase was designed to redress historic pay inequity, and instead have asked care workers to ‘go harder and faster’ in terms of their workload.¹⁷³

Lastly, there have also appear to have been potential consequences for quality of care. While 23% of respondents to a 2019 survey felt standards of care had improved, 18% felt they had declined¹⁷⁴, with continuity of care impacted by the changes to rostering in some cases.¹⁷⁵

New Zealand’s experience suggests that framing pay increases in a broader context of human rights and historic gender pay equity has been particularly effective. However, a number of challenges during implementation have led to mixed results, including insufficient central funding of the additional wage and training costs, and a lack of rigorous engagement with staff and piloting. The legislation was due to expire in July 2022 and negotiations on extending the settlement stalled over the summer, as the government’s initial offer of a 3% pay rise was rejected by workers and unions as falling short of pay parity with workers in health care. However, in June 2022, the Ministry of Health introduced a Bill to preserve existing conditions alongside an interim pay increase of 4.6%.¹⁷⁶

Wage increases and pay bonuses: UK countries

Steps have been taken to standardise pay and increase beyond the National Living Wage in Scotland and Wales. Across the UK, Scotland stands apart as having taken the most decisive steps to increase care workers’ hourly pay (Table 2). Pay arrangements in Scotland are agreed between the government and COSLA (Convention on Scottish Local Authorities), and over 2020/21 Scotland increased care worker pay in line with the Real Living Wage. They enforced this through stipulations in their National Care Home Contract, which enables commissioners to directly verify pay rates with employees and stipulates that costs cannot be offset by employers onto staff.¹⁷⁷

The Scottish government subsequently increased pay levels to the equivalent of NHS Agenda for Change band 2, £10.02 per hour in October 2021, for care workers and personal assistants.¹⁷⁸ More recently, they invested £48 million for a 4.8% pay lift, to £10.50 per hour, equating to NHS AfC band 3.¹⁷⁹ The new rate compares favourably to the average pay rate in England, but it is not clear what impact this will have on the narrow pay differential for more experienced senior care workers. Notably since 2016, Scotland has also recommended providers pay the Scottish living wage for day shifts, and from 2018, for sleepover hours too, which contrasts to England. However, funding shortages suggest this is not always achieved in practice.

The Welsh government has uplifted care worker pay to the Real Living Wage (£9.90 per hour). Importantly, the government has provided central funding to help maintain pay differentials for more experienced staff undertaking additional responsibilities, and funding to cover the increased ‘on-costs’ which rise as a result of the increase to staff pay (including national insurance contributions, employer pension contributions, and holiday pay). The pay uplift also applies to personal assistants, and the government are commissioning an independent evaluation to assess the impact of the Real Living Wage.¹⁸⁰

Table 2. Differences in care worker pay across the UK countries

	England	Wales	Scotland	N. Ireland
Current pay per hour	April 2022: National Living Wage (NLW) £9.50 No entitlement to minimum wage for sleep-in shifts	April 2022: Real Living Wage, £9.90	December 2021: £10.50 per hour Scottish Living Wage for sleep-in shifts	April 2022: NLW £9.50
Policy development on pay	December 2021: the Social Care White Paper proposes moving towards paying providers a fair rate for care, ‘including workforce’ ¹⁸¹	September 2020: Social Care Fair Work Forum established	Fair Work Convention and development of a potential body to advise the National Care Service is under consultation ¹⁸²	May 2021: Fair Work Forum announced
Covid-19 one-off payments	November – December 2021: DHSC invested a total of £462.5 million, enabling local authorities to passport funds directly to providers to make retention payments if desired ^{183,184}	May 2020: (£500) March 2021: (£735) April 2022: £1,000 (£1,498) ¹⁸⁵	November 2020: (£500)	January 2021: £500 (£735)

Notes: figures in brackets indicate payment before tax and national insurance deductions.

The Scottish government also introduced a national bonus payment during the pandemic, designed to aid retention over the winter and recognise care workers’ contributions. Similar one-off bonus payments have been offered in Wales, Northern Ireland and France. Such a measure was recommended in England by the DHSC Social Care Taskforce, tied to requirements for staff to stay in post over winter 2020, but this was not introduced nationally (see p. 61).¹⁸⁶ Instead, additional funding was made available by the government for providers to pay their staff retention payments if desired

(see Considerations, p54). Anecdotal reports suggest the way in which these payments were initially implemented in the other UK countries and experienced by individual workers (slowly, and subject to tax) may have, to some extent, diluted the positive impact of the initiative. One-off payments by themselves are also not sufficient to keep pace with rises in the cost of living. Given high levels of burnout and stress among the workforce, care workers in some cases reduced their working hours as the bonus meant they had made enough income that month to take time off.

All the devolved countries have, or are in the process of establishing, national forums for sectoral collective bargaining. The social partnership model has been demonstrably effective in New Zealand, the Netherlands, Austria and many other countries, including Germany and France.

Wage increases and a sector wage: Germany and France

France has experienced similar difficulties to England around the recruitment and retention of staff working in social care settings. Wages are set through collective agreements which differ according to ownership (public, not-for-profit, and private for-profit) and setting (residential or home care). Average pay for homecare staff is €14.22 per hour on average.

Following the first wave of the Covid-19 pandemic in 2020, reforms were introduced to improve pay for staff working in the social care sector. For staff working in residential and nursing homes for older people, pay was increased by €183 per month in public and not-for-profit settings, and by €160 per month in for-profit care homes.¹⁸⁷ In homecare settings, salaries were increased by 13-15% per hour based on experience.¹⁸⁸

Although wage increases were welcomed, the introduction of salary increases in several stages – first to public residential care, and only to homecare through extensive negotiation between the government and sector bodies – have created feelings of being undervalued among staff who did not initially benefit from the reforms. These implementation issues, coupled with continuing work-induced stress and long hours, have led to significant exits

from the sector, in particular among homecare staff, who have moved to other industries with better pay and working conditions.^{189,190} Our forthcoming NIHR-funded research explores these issues in more detail.¹⁹¹

In Germany, wages have similarly been a major focus of recent debate and there are attempts to mandate for higher wages across the sector. There are two mechanisms to achieve this: via the introduction of a sector-specific minimum wage, or collective wage agreements, as in France.

In 2010, a social care minimum wage for untrained care staff was introduced in Germany. In 2019, the Care Wages Improvement Act of 2019 created a legal basis to improve their wages, and additional wage increases were passed in February 2022. In a stepped-up approach, wages for unqualified care assistants will increase from €12.00 to €14.15 by the end of 2023 (an increase of 18%), well above the national minimum wage of €9.82. For qualified care assistants (with a minimum of one year's training), the minimum wage will increase from €12.50 to €15.25 (an increase of 22%). A minimum wage for qualified care staff (with a minimum of 3 years' training) has also recently been introduced following recommendations by an expert commission established as part of the last big reforms and pressure from the trade union Ver.di. This will increase from currently €15.00 to €18.25 (an increase of 22%). In addition, the minimum wage will be standardised across regions in eastern and western Germany to tackle problems such as the drain of workers to more affluent parts of the country.

In addition to the minimum wage, over the last few years policy-makers have been seeking to establish collective wage agreements across the sector, which would further increase wages of care staff. Collective wage agreements are a common way of regulating wages across many sectors of the German economy, and are seen as more advantageous for workers as they can negotiate higher wages. A reform has recently been passed which stipulates that from 1 September 2022, only care providers paying staff according to collective wage agreements can enter the market. It is estimated that care staff can, on average, expect a monthly increase of €300. Rather than pass the costs onto people using services, the government plans to finance the wage increase through a 0.1% increase in insurance premiums for childless adults.¹⁹²

The process of establishing a collective wage across the entire care sector has proven difficult to achieve despite political will. First, the workforce is not well organised and trade union membership is low, especially among staff working for private providers. Second, while collective wages can be more easily implemented across public and charitable care providers, it is difficult to mandate this for private providers, many of whom are against collective wage agreements as they argue it would impede competition. Initial attempts to extend a collective wage agreement negotiated between the BVAP, the largest employers' association, and the trade union Ver.di failed in January 2021 due to a veto by a large church-run non-profit provider, which prompted widespread criticism.^{193,194}

5 Working terms and conditions

Key messages

- Working terms and conditions are key in determining care workers' decisions on whether to stay in their roles or leave, but they are widely recognised as unacceptably poor in England. Care workers are too often expected to work on unstable contracts and through difficult working conditions which threaten their health, safety and wellbeing.
- Countries around the world have sought to protect and improve conditions in a variety of ways. New Zealand funds travel time and travel costs, while Germany has introduced childcare grants and additional days of annual leave. Scotland is distinct in the UK for requiring providers to take staff wellbeing into account in their staffing decisions.
- Care workers in England have limited access to occupational sick pay – they face being financially penalised for self-isolating if they are unwell. However, other countries have offered care workers much more generous sick leave arrangements. Norway offers sick pay at full wage for one year, whereas in Germany workers receive six weeks sick pay at full wage, followed by up to 78 weeks paid at 70% of their gross salary.
- Analysis in England shows that care workers on a full-time or guaranteed-hours contract have a reduced probability of leaving compared to those on zero-hours contracts, and yet 55% of care workers in domiciliary care are employed on zero-hours contracts.
- Countries have sought to address precarious employment and build workforce stability in different ways. New Zealand and Wales have taken steps to introduce guaranteed hours at national level, but they have encountered challenges – in terms of the funding needed, implementation challenges given the fluctuations and flexibility needed in social care provision, and in ensuring compliance. Germany has introduced a 20%

cap on zero-hours contracts for providers. Lastly, Sweden has negotiated 10,000 permanent contracts for care workers who graduate from a nursing assistant programme.

Introduction

While pay, progression and training are important, the day-to-day working terms and conditions for care workers in England need urgent attention. Working hours, holiday and sickness arrangements, health and safety, equality policies, and other such issues have a material impact in shaping the working lives of staff. They are paramount in determining care workers' wellbeing, the quality of care they can deliver, and ultimately how valued they feel, informing their decisions on whether to stay or leave their roles. Protecting the health and safety of care workers should be a longstanding priority for employers and the DHSC, not just in times of a pandemic.¹⁹⁵

Pay in the sector is low, but this is exacerbated by underpayment in other areas: whether for contracted hours or when working overtime; for travel time between appointments; or for sleep-in shifts. Services are frequently described as running on staff goodwill, with some care workers in practice subsidising the cost of public services through working additional hours unpaid or absorbing increased fuel costs.¹⁹⁶ Survey data from the Homecare Association indicates one in five providers are seeing homecare staff leave the sector due to increases in the cost of living, with only 2% of providers paying homecare staff mileage reimbursement rates at the level approved by the HMRC¹⁹⁷, let alone at the higher rate available to NHS staff.

The consequences of low pay are stark, with hundreds of care workers applying for charitable crisis grants simply to afford daily living costs, prevent eviction and repair their cars.¹⁹⁸ Since the 1980s, the setting of terms and conditions at work has moved towards a 'take it or leave it' culture¹⁹⁹ – with longstanding funding constraints and outsourcing practices leading to cuts in wages and pensions.²⁰⁰ As England emerges from the pandemic, care workers are overwhelmingly choosing to leave in favour of jobs in hospitality or retail, where the physical and emotional aspects of the job are less demanding. Data on trade union

membership among care workers is not publicly available, but a recent survey of care workers suggested more than half (58%) of respondents are, or have been at one point in their careers, a member of a trade union.²⁰¹

Zero-hours contracts are prevalent in domiciliary care, with 55% of care workers employed on zero-hours contracts, and less so in residential care (11%).²⁰² While these contracts are valued by some staff for their flexibility, they are also symptomatic of a model of time-based commissioning rather than outcomes-based commissioning. There is a clear association between contractual terms and staff retention. The turnover rate for care workers on zero-hours contracts is 37.5% in residential care and 31.9% in homecare. However, for those not on zero-hours contracts it is relatively lower, at 23.6% and 21% respectively.²⁰³ Modelling also indicates that being employed on a full-time or guaranteed-hours contract reduces the probability of leaving by -2.6 percentage points for residential care staff, and -4.3 percentage points for domiciliary care staff.²⁰⁴

Employers with good track records in retention offer permanent contracts or salaried hours²⁰⁵, and increased pay for night shifts, public holiday and weekend working. Enhancements for working unsocial hours are therefore a key route to keeping staff, but these can be challenging to provide given scarcity of funding. In 2021, a precedent was set for the sector following a Supreme Court ruling whereby care workers have no legal right to national minimum wage for time spent asleep on a sleep-in shift, despite being available for work.²⁰⁶ While a relief to employers who would otherwise be facing a potentially significant wage backfill, this poses additional challenge for recruiting workers into settings which deliver a 24-hour service.

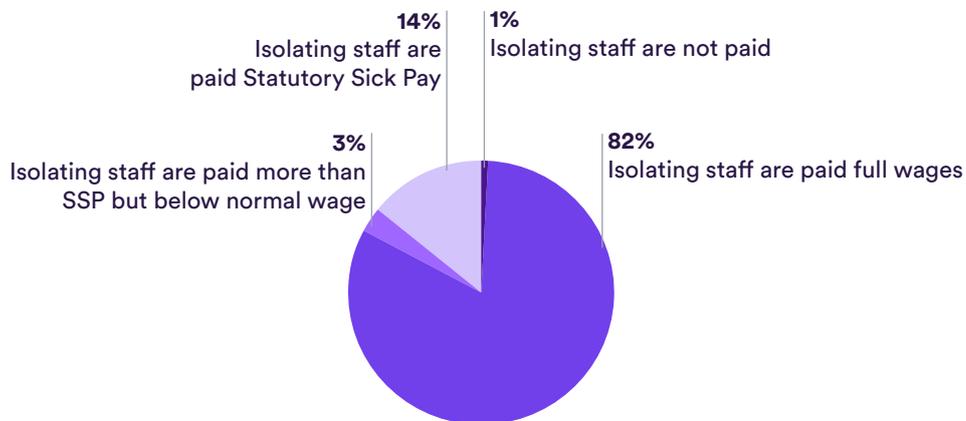
Workforce surveys conducted over the pandemic help to shed some light on the unique experience of care workers, with one-third of care workers responding to a 2021 survey indicating their work had increased without additional pay, and one-quarter reporting abuse from people using services, colleagues or the public.²⁰⁷ These insights show a direct impact on retention, with those experiencing multiple accounts of abuse 27 percentage points more likely to report intending to quit their job in the next 12 months.²⁰⁸ It is important to note that homecare workers often describe feeling isolated, with no common collective workplace, busy schedules and limited opportunity for peer support.²⁰⁹ Factors such as recognition and relationships with

people being supported, supportive teams, job autonomy and altruism, organisational culture, values and leadership, can be as important as matters such as pay for many care workers.^{210,211,212}

The contractual and employment models used in social care are widely considered to be not fit for purpose. Care workers frequently work in hazardous working conditions and there had been limited action on infection control within social care until the Covid-19 pandemic.²¹³ For example, our NIHR-funded research has highlighted the importance of occupational sick pay for a sector in which 24% of workers are on zero-hours contracts²¹⁴, and therefore only eligible for statutory sick pay.

It is important to note that some staff reported having no access to any form of sick pay at all. In the absence of formal support, the Care Workers Charity issued 233 emergency grants over 2021 to enable staff to take time off work to self-isolate.²¹⁵ The Infection Control Fund was introduced to support employers to uplift sick pay for staff self-isolating in line with government guidance. Data – while limited – indicates that the proportion of care homes offering directly employed staff full wages stood at only 82% when the scheme came to an end in April 2022, with around one in seven care staff being paid statutory sick pay (Figure 5). Sickness rates among care workers increased from an average of 5.6 days before the pandemic to 9.9% in March 2022²¹⁶, and following the end of the Infection Control Fund, there is now concern that any progress gained during the pandemic will now be reversed.

Figure 5: Proportion of care homes in England offering wage replacement for self-isolating care home staff (week ending 22 March 2022)



Source: DHSC adult social care monthly statistics.²¹⁷ Directly employed care home staff in England only.

Flexible hours are valued by some workers, but there remains concern that the particular use of zero-hours contracts facilitates precarious employment, with consequences for both staff wellbeing and quality of care. The time and task model (for example, 15-minute homecare visits) dominates much of social care commissioning, which impacts on the type and quality of care that can be delivered and also on staff satisfaction. It is important to note that no amount of staff training can make up for this – even the most skilled staff will be limited in the care they can deliver if constrained to work within a 15-minute window. In order to deliver high-quality care, the wider conditions of work must therefore change too.²¹⁸

This chapter outlines a number of key measures taken by governments around the world to attempt to improve working terms and conditions.

Paid travel time and travel costs

Following a recommendation by the New Zealand Human Rights Commission in 2012, and a legal case brought to the Employment Relations Authority by a homecare worker, in 2014 the New Zealand government introduced an ‘In-Between Travel Settlement’. This was agreed between the Ministry of Health, district health boards, home and community support providers, and unions.²¹⁹ Part A of the settlement was designed to pay for homecare workers’ travel time and mileage. The settlement was agreed on the basis that none of the parties would be financially disadvantaged overall by the new arrangement. As a result, the government provided significant additional funding of \$36.2 million in 2015/16 and \$38.6 million in 2016/17, with a commitment to review travel rates every year.²²⁰ The payments commenced in 2015 so that workers could benefit immediately while the settlement was passed into legislation.

Homecare workers are paid national minimum wage for time spent travelling between appointments (regardless of mode of transport) if it is up to 15km, with paid exceptional travel for the first visit or last visit of the day if this exceeds 15km. A tax-free mileage reimbursement is set at 50 cents per kilometre for fuel costs.

The policy was broadly welcomed at the time it was introduced, and the government continues to fund homecare providers for these costs. However, there have been a number of implementation challenges and criticisms. Providers struggle with payroll software that can automatically calculate travel payments. They also must schedule care workers' travel as efficiently as possible, which has had consequences for people's choice and continuity of care. With rising fuel costs, there are concerns that the blanket rate of reimbursement for any travel under 15km – whether 1km or 14km – is not sufficient, as many care workers are still paying a significant amount for fuel costs from their own pockets.

Offering guaranteed hours or permanent contracts

Some countries have taken steps at national level to address precarious employment by, for example, offering staff guaranteed hours of work, offering permanent contracts upon meeting certain criteria, or capping the proportion of staff on zero-hours contracts.

In New Zealand, part B of the In-Between Travel Settlement set out to 'regularize' the workforce from 2017 onwards. This entailed offering all home and community workers guaranteed hours contracts, which aims to entitle workers to a minimum, regular income (either 80% of a worker's average hours over the last three months to a maximum of 40 hours, or the average hours as agreed between the worker and employer, whichever is higher). The settlement also included support for providers to transition to guaranteed hours wages, with one-off funding to help providers with implementation costs. This includes \$8.3 million per year in order to 'top up' an individual worker's pay in instances where need for services dip and guaranteed hours cannot be filled, up to a period of three weeks.²²¹ It also stipulated training requirements, wages tied to qualifications (see Chapter 2, p13), and a caseload mechanism to ensure safe staffing levels.²²²

New Zealand has experienced real challenges implementing guaranteed hours at national level and, as a result, the effect on retention is not clearcut. Rather than stabilising workers' income, there are reports that some homecare

workers' take-home pay has fluctuated or even decreased while pay rates have risen, as a result of having their guaranteed hours reduced whenever there are shortfalls in demand for services.^{223,224} It is unclear whether this has been caused by a shortfall of central funding to top up unfilled hours, implementation challenges experienced by providers, or a combination of these.

Slightly different approaches have been taken elsewhere around the world. Wales introduced regulations in 2018 which require employers to offer permanent contracts to domiciliary care workers on zero-hours contracts after three months. The regulation aims to improve quality of care and continuity of care through more stable contracts.²²⁵ Evidence on the impact appears limited, and it seems that zero-hours contracts are still widely used, with 44% of homecare staff in commissioned services employed on zero-hours or casual contracts in 2021.²²⁶ Welsh providers who do offer some permanent, guaranteed hours contracts describe challenges when there are fluctuations in demand for services, resorting to giving care workers office work instead.²²⁷

In 2020, the Swedish government collaborated with local authorities and the trade union Kommunal to offer 10,000 permanent contracts to graduates of a nursing assistant programme (see p. 30).^{228,229} It is too early to know what impact the programme has had on recruitment and retention. Lastly, in Germany, caps on precarious employment practices are imposed through regional contract frameworks. Typically this means a provider is only allowed to employ up to 20% of its workforce on zero-hours contracts. Despite this, the proportion of care workers on these contracts (29%) remains high compared to other professions.²³⁰

Enhanced sick pay

There is a clear association between access to statutory sick pay and reduced transmission of Covid-19 within long-term care facilities.²³¹ As such, the pandemic has reiterated the role of care providers and the DHSC in protecting the wellbeing of the social care workforce. Staff in the NHS are entitled to sick pay at full wage, which increases with length of service²³², and this extends for example to roles such as health care assistants working in private general practice surgeries. But in social care, care workers were left to fend

for themselves at the start of the pandemic. As a result of poverty or fear of entering poverty, many were left with no choice but to work while ill with Covid-19. Others, in particular those on zero-hours contracts, reported having no access to statutory sick pay at all.

In Norway, the government funds 100% of care workers’ wages for up to one year.²³⁴ In Germany, all care staff on permanent contracts with public health insurance hold the right to six weeks’ full pay (covered by their employer) followed by 70% of their gross salary for up to 78 weeks (covered by their health insurance).

Across the UK, funding was temporarily invested to provide care workers with occupational sick pay beyond statutory sick pay (now set at £99.35 per week). The Northern Ireland Executive invested funding to replace 80% of wages, whereas the other countries enhanced sick pay to care workers’ full wages (Table 3). However, the schemes in England and Northern Ireland were not extended, whereas Wales extended their scheme to August 2022 and Scotland to September 2022. The OECD explicitly states that permanently improving access to paid sick leave for the workforce must be firmly on the political agenda.²³⁵

Table 3. Sick pay enhancements across the UK devolved administrations

	Northern Ireland	England	Wales	Scotland
Sick pay enhancements	80% of salary (ended March 2021) ²³⁶	ICF funding for sick pay at full wage (ended 31st March 2022) ²³⁷	Funding for sick pay at full wage (ended 31 August 2022) ²³⁸	Funding for sick pay at full wage (until 30 September 2022) ²³⁹

Note: for staff ill with confirmed or suspected coronavirus, or required to self-isolate under Covid-19 guidance.

Wellbeing and work-life support

In Scotland, regulations require care providers to proactively consider staff wellbeing in their staffing decisions, which is distinctive in the UK.^{240,241} To ensure this is consistently upheld, the Scottish Care Inspectorate interviews staff in addition to people drawing on care, as part of their unannounced audits for annual quality assessments.²⁴²

In Germany, a reform was passed in 2019 to improve working conditions and strengthen the workforce. It is the most comprehensive workforce reform to date and required a rise in long-term care insurance contributions of 0.2% to cover the costs. The reform included investment in better working conditions, such as grants available until 2024 for childcare services tailored around the specific working hours of care staff, and greater investment in workplace health.²⁴³ Staff will also receive more holidays. Full-time staff will receive an additional seven days in 2022 and an additional nine days in 2023 and 2024.

6 Considerations for England

This chapter considers the reforms introduced in other countries and explores potential learning for England. The evidence emerging from around the world is of mixed quality and there is clearly no country that offers a perfect blueprint for next steps. However, there is much to be gained from closely observing the approaches of others and learning from both successes and failures. It is also important that learning is considered in the English context and adapted accordingly. Below, we explore what English policy-makers might want to take away from the reforms in other countries, and we set out a number of key considerations. These are not exhaustive but designed to complement the priorities and frameworks already published by social care leaders and the Future Social Care Coalition.^{244,245}

Registration and regulation

The experience of other countries in introducing registration and regulation systems suggests the government needs to carefully weigh up the potential benefits and risks, and take a holistic approach, taking into account developments in the devolved administrations in particular.

The other UK countries have opted to phase in mandatory registers over time, whereas the government's social care white paper for England proposes a voluntary digital platform with an accompanying 'skills passport' in the first instance, to act as a foundation for potential registration in future.²⁴⁶ It will be important to assess in due course whether these alternative measures achieve the desired aims or whether further, mandatory professional regulation is needed.

There are some potential benefits to a statutory register. It could offer improved data on the workforce, and reduce risk to the public. It could also

improve confidence among the public and staff, and bring a sense of collective professional identity. In Wales, it was critical in aiding care managers' understanding of which of their staff had completed infection control training over the pandemic. Such a register could also enable DHSC to communicate guidance directly to individual staff and to implement a national workforce survey to inform workforce support and planning.²⁴⁷

Existing surveys often rely on employers to act as conduits – instead, a national staff survey would offer opportunities to collect more data than is currently available, by collecting information on wellbeing, job satisfaction, type of training received, career intentions and harassment and discrimination by protected characteristics, as exists for the NHS workforce²⁴⁸ and social workers.²⁴⁹ A national staff survey would be instrumental in supporting wider policy initiatives such as the Social Care Workforce Race Equality Standard (WRES) and could also help strengthen care workers' collective voice.

There are also some potential risks should England not take a consistent approach to the other UK countries. In time, care workers in England might be considered by the public, employers or staff themselves as having a lower status than their regulated care worker peers.²⁵⁰ There is also a small but notable risk, particularly at the borders, that care workers who are struck off a register could in theory seek employment in an unregulated role in England.²⁵¹

As shown in the other countries, there remain a number of risks and unknowns, and concerns that without clearly articulated aims, such a system could become an exercise in bureaucracy. There are considerable costs and infrastructure required and risks that, without flexible routes to register, such a system could introduce unnecessary restrictions.

A number of stakeholders and observers have called for a Royal College or national academy for care workers, to bolster their collective professional identity, recognition of their work and potentially oversee a register.^{252,253} While there is potential for such a body in England to raise the status of care work, there is also learning to be made from history about the potential challenges in store. For example, early attempts to launch a College for Social Work in 2010 proved unviable in the face of waning membership fee income.²⁵⁴

Given existing evidence gaps, the DHSC should consider working with Skills for Care and Development, an alliance comprising the sector skills councils in each UK country. They could conduct an independent review of statutory registration and professional regulation of care workers across the devolved countries, to identify the benefits, risks and cost effectiveness of such a scheme regarding recruitment, retention, the perceived status of the workforce, and quality of care. The review should investigate the impact of these systems on personal assistants and the people who directly employ them. Lastly, given concerns regarding the aims and scope of a formal register, it is vital that the DHSC continue to listen to those who draw on social care and staff themselves about what is important to them.²⁵⁵

Education, training and continuing professional development

The government has committed £500 million towards workforce development and wellbeing support over three years. This is a notable increase on previous levels, as the annual centrally allocated budget for training and CPD in social care has typically stood at around £10 million on average. However, it remains unclear whether these new levels are sufficient. Even if half of the £500 million was spent on training for care workers specifically, this equates to around £93 per care worker per year, which falls significantly short of the cost of, for example, a Skills for Care-approved Level 2 Diploma in Care (£1,000) or Level 4 certificate for aspiring managers.²⁵⁶ There is also no commitment for ongoing CPD for care workers.

The government's impact assessment states the funding pledged is to 'pump-prime' the market and signals an assumption that employers themselves will, in time, take responsibility for funding future training. It is important therefore that realistic training costs, and the capacity of training providers and employers, are factored into local authorities' fair cost of care exercises if they are to be sustained. New Zealand's experience points to a potential oversupply of qualified staff compared to the centrally allocated budget, suggesting decisions on training in England should be informed by workforce projections to model the number of senior care workers with enhanced skills that will be needed in future.

The experiences of countries with nationally mandated standards for qualifications and training shows this does have potential to drive up workers' skills and confidence. However, careful consideration is needed on how to implement these in a sustainable and equitable way. Where these do seem to have worked abroad, standards are relevant to workers' roles and to their future progression and increased pay; training is high quality with a focus on practical on-the-job learning; and access is equitable. As information from the Social Care WRES comes to light, providing consistent opportunities to access training and development opportunities could therefore help to address inequalities in progression and earnings, and could also help attract underrepresented groups into the workforce.

However, there are risks to mandating training where the funding costs fall fully on individual staff, where training is not accessible during paid working hours, or where there is no flexible, alternative route to demonstrate competence or prior learning for more experienced workers. In England, it is notable that previous regulations which required 50% of care home workers to be trained to NVQ level 2 did lead to an increase in qualifications and job-related training, but it did not in itself lead to improvements in their wages.²⁵⁷

As the DHSC works with employers and training providers to understand skills gaps and to design and roll out training places to care workers, it is critical that they put systems in place to monitor and evaluate the impact, in order to further build the evidence base on what works in England, including the effect on quality of care.

The social care white paper commits to developing a new knowledge and skills framework, and to making the voluntary care certificate more portable. However, there are concerns that the content of the care certificate is no longer appropriate – in terms of training care workers for the types of delegated health interventions some are expected to undertake, or the specialised skills some are expected to use routinely, such as in dementia or end-of-life care. There is scope to build these into standardised training such as the care certificate, alongside the national voluntary framework for delegated health care interventions, which is in development.²⁵⁸

There is much for England to learn from the more comprehensive training offered in Japan, Denmark and Germany, which includes training on

delegated health interventions, rotated placements in different settings, and clear career pathways spanning health and care. Previous research has shown that in England, unregulated roles in both health and care are frequently overlooked for skills development and training²⁵⁹, and there is much potential for intermediate roles such as enhanced care workers to use digital technologies.²⁶⁰

As such, there remains further scope to explore joint or integrated training for unregulated roles spanning health and care, as proposed in the government’s integration white paper²⁶¹ and as part of ongoing development of NHS workforce plans. In addition, as ICSs continue to develop their workforce plans and work more closely together, there is a role for NHS trusts and primary care organisations to play in supporting small and medium sized social care employers to navigate and embed training programmes, such as nursing associate apprenticeships.²⁶²

Lastly, other countries are designing their training programmes to reshape their workforce for the future. Norway’s experience shows the potential to design training programmes to effectively recruit underrepresented groups into the workforce, such as men and younger people. Elsewhere, South Korea are taking proactive steps on succession planning by designing a career ladder for homecare workers with five years’ experience to progress to manager level. In England, given that nearly one in three registered managers are aged 55 or over²⁶³, there is potential to explore similar schemes such as the NowCare initiative, a pilot graduate scheme for registered managers^{264,265}, including how such a scheme could complement existing apprenticeships in care leadership and management.

Pay and progression

In England, a number of different routes to increase wages have been voiced by sector leaders: by benchmarking to the Real Living Wage, to local government pay scales, to the NHS Agenda for Change pay scale, or set at a more competitive rate within local economies. Notably, the Migration Advisory Committee have recommended a fully funded minimum rate of pay set at £10.50 per hour, akin to Scotland, to be implemented immediately. They add that the government should go significantly further by increasing pay for

senior care workers and reinstating a historic pay premium to care workers, in recognition of the unique nature of their work.²⁶⁶ However, the social care white paper does not indicate an appetite for the government to take a more central and deliberate role in ensuring pay is increased in the social care sector in the same way we have witnessed in other countries, which have markets that are similarly mixed and complex.²⁶⁷

Increasing pay will require a notable investment and sustainable central funding (see pp. 35–6), but these costs must also be seen against the alternative – a growing backlog of over half a million people waiting for care services²⁶⁸, as well as costs which could be offset elsewhere, such as through reduced DWP benefits payments and higher tax receipts.²⁶⁹ The government’s fair cost of care policy has been recognised as a welcome intervention in the market, with hopes the policy will enable a shift towards improved wages for staff. However, there are concerns, acknowledged in the government’s own impact assessment, that the funding allocated to the fair cost policy simply will not be enough to enable an uplift to wages and working conditions across the board.^{270,271}

Given these funding constraints, any decisions by local authorities and providers to raise wages may entail trade-offs for other aspects of social care, such as investment in training or numbers of care packages. In order to ensure pay reaches workers pockets, local authorities must be funded adequately according to their fair cost of care exercises, with robust stipulations in commissioning and contracting, and the potential for a more proactive role by HMRC to enforce the minimum wage²⁷², particularly on homecare workers’ travel time between appointments.

Whether any future pay increases are designed to improve quality of care, or to deliver social justice for care workers, there are opportunities for England to learn from the experiences of other countries which have trialled various ways to increase pay in social care. These include a sector minimum wage, collective wage agreements to drive increases and ensure pay progression, benchmarking pay to other sectors, increasing pay for sleep-in shifts, or through one-off bonuses. The international experiences in this paper suggest that a number of principles are key when it comes to pay-setting. These include ensuring that:

- pay increases and their associated on-costs are fully funded through a sustainable funding model that offers certainty to the care sector
- pay adequately reflects progression – rewarding additional qualifications, responsibilities or experience
- pay is set at a competitive and attractive rate compared to other sectors
- care is taken to avoid unintended consequences that could result in lower pay for certain cohorts of staff
- appropriate mechanisms and minimum requirements are in place to ensure pay increases reach workers’ pockets.

New Zealand’s experience suggests that introducing a national pay and progression framework can be effective if designed carefully, and their experience in framing pay issues within a broader context of human rights, gender equity and parity with health care workers has also been particularly persuasive. However, the sustainability of the reform continues to be a pressing concern due to underfunding by central government.

As in Scotland and Northern Ireland²⁷³, to inform decisions around pay-setting in the first instance, the government in England could consider commissioning an evaluation of jobs across the sector.²⁷⁴ This would aim to establish consistency and clarity, and help ensure equal pay for work of equal value. Providing pay at a level which is benchmarked to NHS pay scales, for example, has the potential to cement parity of esteem and may lessen the gravitational pull that the NHS has on staff working in social care²⁷⁵, but this would require significant investment. It is worth noting that an initial job mapping exercise conducted as part of Baroness Cavendish’s independent review concluded that ‘social care is not less skilled; and that care workers often have to demonstrate more independence and maturity than health workers who are more likely to be working under supervision.’²⁷⁶ A similar job mapping exercise commissioned by Community Integrated Care indicated that support workers would need to be paid 39% more (£7,000 per year) to be on equal terms with their counterparts employed in the NHS or in local authorities.²⁷⁷

International experiences also point to the importance of agreeing a process for setting and enforcing pay increases. The other UK devolved countries are following in the footsteps of Germany and New Zealand, which have national fair work forums representing workers, trade unions, commissioners, employers and the government. In recent years there has been some increased appetite for collective wage bargaining in England, with Mencap and GMB Union united in calling for a re-evaluation on pay rates for sleep-in shifts.²⁷⁸ In this light, there could be scope for the DHSC to take a greater role in coordinating a similar national forum to collaborate in good faith, and negotiate pay-setting and national minimum terms and conditions as key requirements for commissioning.

Some countries have introduced bonus payments for care and health staff. The experience of the other UK devolved countries and France suggests there must be clarity over the purpose of any bonus payment – whether to recognise and reward workers’ contributions over the pandemic, or as an incentive to stay in post.

In England, the DHSC taskforce called for such a loyalty bonus in 2020, tied to a commitment to stay in post over winter²⁷⁹, but this was not implemented nationally. Instead, some care providers chose to introduce bonuses using the government’s Workforce Recruitment and Retention Fund or through other means. For example, some CCGs such as Staffordshire and Stoke on Trent have invested their own funding for winter loyalty bonuses for social care staff.²⁸⁰ While these appear to have been welcomed and have boosted morale, the full effect on retention in the longer term is not yet known.

Similarly, research on the use of pay supplements for NHS staff suggests careful monitoring and evaluation is needed to understand their impact on recruitment and retention, and cost effectiveness. The benefits of bonus payments should therefore be compared to alternative options, such as a material increases in salaries, alongside accompanying pension contributions and wider remuneration, which may be more effective in retaining staff over the longer term.

Working terms and conditions

The pandemic has highlighted the serious consequences of a care system that perpetuates insecure and precarious employment, inadequate sick pay and unsafe workplaces. It has renewed public attention on the working conditions of care workers, and the 2021 British Social Attitudes survey points to a vested public interest in ensuring the terms and conditions better reflect the value society places on their work.²⁸²

In England, efforts have been made at local level to improve conditions. For example, Northumbria Healthcare NHS FT is finding ways to work with local authorities and care providers to launch its own homecare service, which aims to employ social care staff under full Agenda for Change terms and conditions and offer the same terms and conditions as employees in the NHS.²⁸³ These include retail and transport discounts and priority shopping hours, pay enhancements to reward antisocial hours or overtime working, an attractive pension scheme, and occupational sick pay which increases with years of service. The government’s Workforce Recruitment and Retention Fund enabled care providers to put similar measures in place over winter 2021 – including buy back schemes for annual leave, support for childcare costs, and overtime payments.²⁸⁴ These are key measures to make workers’ lives better and demonstrate value, and should be sustained.

In addition, a number of councils have adopted voluntary ethical care charters – such as those established by UNISON and the GMB union – which set out minimum standards in homecare including the real living wage, paid travel time, guaranteed hours, time to meet colleagues to share learning and best practice, and occupational sick pay.^{285,286} Southwark is the first local authority to implement a residential care charter, which stipulates the London Living Wage, payment for time to conduct proper handovers between shifts, permanent contracts (unless a zero-hours contract is requested by staff), and fully funded training within working hours.²⁸⁷

An initial evaluation suggests these charters have been effective where funding was committed from local authorities’ central corporate budgets rather than existing adult social care budgets, and by making travel time payments transparent on payslips.²⁸⁸ Some local authorities have been able

to take such steps with financial support from the Workforce Recruitment and Retention Fund, or through adopting block contracts. However, in the absence of any further funding, for some local authorities it may mean taking difficult decisions; for example, contracting providers to pay higher wages but acknowledging this may impact on the total number of packages of care they are able to commission.

While there are pockets of progress and innovation in this area, improvements are far from widespread. Experiences in New Zealand and Wales suggest that efforts to provide guaranteed hours across an entire system is no small undertaking – in terms of the funding needed, the implementation challenges (given the fluctuations and flexibility needed in social care provision), and in ensuring compliance. New Zealand’s experience suggests guaranteed hours are not a perfect solution – they still require workers to be available for work outside their guaranteed shift hours and have been considered problematic for some staff with family responsibilities or without access to affordable childcare, who prefer the flexibility that zero-hours contracts offer.²⁸⁹

As councils undertake fair cost of care exercises as part of wider reforms, it will be vital to consider all facets of workforce costs. New Zealand’s experience highlights the importance of factoring in travel time and realistic mileage costs, and the costs of enhancing sick pay to full wage should also be considered, as is the case in Norway and Germany. These rates should be reviewed and agreed by commissioners, providers, trade unions and the DHSC to ensure they are realistic.

The government has committed a portion of the £500 million to be spent on workforce wellbeing and occupational health, to address high levels of burnout and sickness leave. This will include a workforce wellbeing fund, occupational health pilots, and a bespoke support helpline. There is an impetus to act sooner rather than later, such as in Scotland where providers must account for staff wellbeing when designing staff rosters. Our research, as well as other observers in England, have pointed to the need for more proactive measures – one example is to consider expanding the remit of the CQC in England to routinely investigate the health and wellbeing of staff.²⁹⁰

New horizons, or a reverse to business as usual?

The international evidence suggests that introducing elements of professionalisation is complex and there is no perfect model to follow. In some countries, the evidence is diffuse and still emerging. However, it does suggest that pay, progression, training, terms and conditions of work are all intricately connected. For example, Japan and Germany's experiences point to the importance of rewarding higher qualifications and responsibilities with higher pay to bolster retention, and the importance of good working conditions. The potential for staff to do their best work will always be capped when they are working under conditions where their time or autonomy is limited. New Zealand's experience points to the importance of tying relevant learning and development to pay and progression, and to overhauling working conditions in parallel. As such, 'improvements must be made on all fronts' in any deal new for care workers in order to make a tangible difference to their recruitment, retention, recognition, and quality of care they can deliver. This must be backed up by funding – as the Health and Social Care Select Committee stated, securing adequate funding from central government 'will not come cheaply but is an absolute necessity in the wake of the commitment the social care workforce has shown in the biggest health crisis of our lifetimes'.²⁹²

The funded proposals in the government's social care white paper spanning the next three years are a welcome step, but urgent calls remain for a longer-term strategy which addresses the challenges around pay and working terms and conditions head on, to realise a path to a stable and motivated workforce. As any such future strategy is developed, it will need to be consistent with wider policy, including the fair cost of care, integrated care systems (ICSs) and health workforce strategies. There is a risk that different parts of the health and care system are being reformed in isolation, with concerns that ICSs will struggle to bring about positive change while the pay and working conditions of NHS and social care staff remain so disparate. As NHS organisations, local authorities and wider system partners come together to develop local workforce plans, there must be a renewed focus on seizing opportunities to transform the pay, training, career progression and terms and conditions of social care workers.

Care workers have undoubtedly been first on the front line, delivering care in perilous conditions, but last to see any meaningful acknowledgement and reward for their continuing perseverance. There is now an opportunity for policy-makers to reverse the deepening workforce recruitment and retention crisis in England by learning from what has worked in other countries, to better recognise, value and reward care workers.

Appendix

Methods

While not intending to be exhaustive, this review aimed to understand the strength of the evidence base on several key aspects of the ‘professionalisation’ of care workers. There are many factors associated with recruitment and retention in social care, and the existing evidence base largely points to their potential dynamics rather than definite conclusions on their causal effects.²⁹³

An initial literature review on the topic of professionalisation and recruitment, retention, quality of care and care worker status was conducted in the autumn of 2019. This included policy papers and academic papers. The initial literature search strategy is available upon request. This was supplemented with a manual international literature review, drawing on recommendations from experts and snowballing references. The topic of ethical international recruitment was excluded given the Migration Advisory Committee’s extensive reviews on the subject.^{294,295}

Information was gathered through 15 scoping calls with stakeholders in the UK and abroad, including workforce regulators, academics, care providers, trade unions, and voluntary sector organisations representing people who draw on care and care staff. The briefing also draws on findings from an NIHR-funded study investigating social care recovery and resilience in other countries, which is currently ongoing²⁹⁶, and a roundtable in July 2022 involving 28 stakeholders across the four UK countries.

Table 4: Requirements for social care workers to register and practise in the UK

	Northern Ireland	Scotland	Wales	England
Registration fee*	£30 (renew every five years)	£25 (renew every five years)	£30 (renew every three years)	N/A
Numbers registered	Care home workers: Voluntary from 2011 Mandatory from 2014 (15,252 registered) Domiciliary care workers, day care workers and supported living care workers: Voluntary from 2015 Mandatory from 2017 (14,439 registered) ²⁹⁷	Care home workers: Mandatory from 2015 (32,005 registered) Domiciliary care workers: Mandatory from 2020 onwards (58,524 registered). ²⁹⁸	Care home workers: Voluntary from 2020; mandatory from Oct 2022 Domiciliary care workers: Voluntary from 2018 Mandatory from 2020 (22,131 registered) ²⁹⁹	N/A
Timeframe to achieve registration once started in post	Within six months	Within six months	Within 12 months	N/A
Title protected in law	No	No	Yes ³⁰⁰	N/A
Standards/ code of conduct	Standards of Conduct and Practice for social care workers	Code of Practice for social service workers and employers	Code of Professional Practice for Social Care	Expected to abide by a Code of Conduct (shared with health care support workers)
Post-registration training and learning	90 hours (15 days), over five years	60 hours (10 days), over five years	90 hours (15 days), over five years	N/A

	Northern Ireland	Scotland	Wales	England
Mandatory qualifications	<i>Intend to introduce this³⁰¹</i>	Hold or be working towards relevant qualifications for their role within five years (e.g. SVQ at SCQF level 6 or Modern Apprenticeship)	Hold or be working towards a qualification Level 2 or 3 in health and social care (Diploma, QCF or NVQ) or new starters can complete an induction, such as the All Wales induction framework (a workbook-based course). They must then complete the practice qualification within three years.	Voluntary Care Certificate (shared with health care support workers) GCSEs and other qualifications sometimes desirable
Previous experience	Not required for registration – must hold offer of employment	Not required for registration – must hold offer of employment	If no qualification, must have competence certified by manager	N/A (desirable)
Occupational regulator	Northern Ireland Social Care Council	Scottish Social Services Council	Social Care Wales	N/A. The CQC regulate settings; Skills for Care oversee the development of the workforce; employers conduct pre-recruitment DBS and reference checks

Sources: Scottish Social Services Council; Social Care Wales; Northern Ireland Social Care Council; Hayes and others 2019; Oung and others 2020. *Note that fees are tax-deductible. Numbers registered may have changed over the course of the pandemic.

Table 5: Care worker education and training approaches in other countries

Denmark	<p>The Danish Health Authority regulates care workers and oversees their accreditation and licensing. Social Care and Health Helpers study for 19 months, focusing on the provision of personal care. This includes a 20-week introductory course, classroom-based study (24 weeks), with practical placements (31 weeks) which rotate across hospital, care home and homecare settings.³⁰² Upon completion they can progress onto the Social and Health Care Assistant role, requiring a further 20 months of integrated training.³⁰³ These assistant roles, which take on more tasks and responsibilities of nurses such as administering medicines and wound care, are being increasingly favoured as care activities have become more medicalised.³⁰⁴ Collective sectoral bargaining was key for social and health care staff to secure an agreement giving all non-qualified employees the right to take a training programme if they wish to, and employers are required to offer the training after three years of continual employment. Importantly, workers are entitled leave to pursue training and compensated at a trainee pay rate.³⁰⁵ Care workers employed by the municipality are generally expected to hold a qualification, whereas those employed by for-profit providers are not.</p>
Germany	<p>Training standards and professional development paths are clearly defined in order to improve care quality, increase status and aid recruitment. Apprentices earn while learning on the job, and there is also a fully funded retraining route for people from other sectors. Notably, personal care is viewed as qualified work for trained staff, with 45% of homecare workers holding three years of training as nurses or caregivers; 7% have three years of equivalent occupational training; and 17% have two months of training as nursing or care assistants. Turnover is relatively low in Germany, which may be partly due to the level of qualification needed (those dedicated to undertake and complete a three-year nursing apprenticeship are unlikely to then go on work in hospitality or retail). There is evidence that comprehensive training and the integrated provision of personal care and nursing care services has helped promote the development of a stable and qualified care workforce in Germany.³⁰⁶</p>

Japan

Workforce standards are notably high compared to most other OECD countries, as this is designed to be the primary quality-assurance mechanism in their long-term care system. The government envisions care workers as playing a more comprehensive role as professional case managers, responsible for coordinating all the services gravitating around the person requiring support. Care workers must undertake extensive training both pre- and post-employment at their own expense. This comprises two to four years of theory and practical training, or an equivalent education at a college or university in a care-related subject, followed by a state exam. In total this can take between 1,190 and 1,650 hours. The training also incorporates some health care interventions, such as use of feeding tubes.³⁰⁷ The government offers care providers financial incentives for hiring certified care workers and providing them with continuing professional development opportunities, such as bonus payments to nursing homes which recruit staff with specific expertise in nutrition, dementia care, and those with prior work experience.³⁰⁸ Notably, the number of care workers increased by 20% between 2011 and 2015.³⁰⁹

New Zealand

In 2017, the government introduced a national pay and progression framework tied to qualifications and length of experience. The framework is designed to incentivise care workers to continue to learn and gain qualifications, without penalising those without, as care workers also have the option of demonstrating competence through length of experience. Employers must support their staff to achieve qualifications within certain time periods – within 12 months for level 2 (80 hours' work experience), three years for level 3 (100 hours), and six years for level 4 (200 hours).³¹⁰ The government funds employers for two days per employee per year as a contribution towards education and training.³¹¹ Early evidence suggests the way this framework was implemented has helped provide a clearer training pathway, a pay structure which adequately rewards more qualified and experienced staff, and has improved retention.³¹² The traditional divide between registered nurse and senior care and support worker has narrowed as care workers carry out more complex tasks such as wound and medication management. However, among providers there are some concerns that the qualifications do not always reflect competency.



Norway	<p>Norway stands apart from other countries in their approach to recruiting and training underrepresented groups into the care workforce. Their ‘<i>men i helse</i>’ (Men in Health Recruitment Programme) targets men aged 26-55, who are unemployed or have previous work experience such as being car mechanics, industrial workers, carpenters, or shop assistants. The programme started as a municipal initiative in 2007 and is now being implemented nationwide.³¹³ It is 2.5 years long and involves eight weeks of classroom training, a 12-week trial period in a nursing home, and mentoring by an alumnus of the programme. During the training, so-called ‘health recruits’ receive state benefits or a salary from their municipality. Following this, graduates are awarded a diploma as a ‘health worker’ – the job title, branding of the campaign, and male-only classes are designed to appeal to men. The scheme has effectively expanded through a snowballing strategy where graduates recruit men they know, who otherwise would not have typically considered a career in care.³¹⁴</p>
South Korea	<p>A care worker certificate is required in order to practise. This involves 240 hours (around 40 days) of training: 80 hours in a classroom, 80 hours of practice, and 80 hours of on-the-job training followed by an exam. The costs (\$400-800) fall on the individual and the certificate is awarded by the head of local government.³¹⁵ The Ministry of Health and Welfare are developing a career ladder so that after gaining five years’ experience, care workers can progress to director of homecare services.³¹⁶</p>
Sweden	<p>High rates of sick leave during the pandemic led to a greater reliance on casual staff with limited formal training. In response, in May 2020 the government took swift steps to invest in a training programme for up to 10,000 care workers to become nursing assistants or auxiliary nurses, as part of an agreement with the Swedish Municipal Workers’ Union (Kommunal), and the Swedish Association of Local Authorities and Regions.³¹⁷ This reform is expected to cost a total of SEK 4.5 billion (£3.6 billion) between 2020 and 2023³¹⁸, with the government investing SEK 2.2 billion (£1.8 billion) in 2020 and 2021 to fund staff training and backfill costs. Staff continue to work and are paid at their usual wages while training, on condition that municipalities offer a permanent contract to staff who complete the programme. The government is also investing funds so that 10,000 adults can attend health and social care education and training part-time at regional vocational colleges in 2020. Municipalities were expected to fund 30% of places in 2021.³¹⁹</p>

UK countries Care workers must achieve relevant qualifications for their role within five years in Scotland or three years in Wales (see Table 4, p67). After registering, they must undertake between 60–90 hours (10–15 days) of CPD over five years. Survey data suggests that in Scotland, the introduction of qualifications are believed to have improved outcomes for people drawing on services. In addition, the qualifications are thought to have improved staff understanding of person-centred care, confidence, status, and reflection on their practice.³²⁰ While surveys suggests 75% of care homes have seen an improvement in recruitment and retention, this compares to only 44% in homecare.³²¹ In Northern Ireland, following registration, three-quarters of employers thought the training requirements had improved quality of service delivered, and two in three workers said they had improved confidence and believed the reforms had reduced the risk to people they care for.³²²

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