Centre for Care

Economic and Social Research Council

FUNDED BY NIHR | National Institute for Health and Care Research

Research report / September 2025

Policy Drivers of Social Care Workforce Change: United Kingdom Insights, Impacts, and Future Directions

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SUMMARY

This report examines how national policy drivers influence social care workforce transformation, highlighting their intended outcomes and unintended repercussions within the ESRC Centre for Care's Workforce Change Research Group framework. It is focused on the study 'Understanding the drivers and implications of care workforce change,' which investigated national-level policy drivers of social care workforce change and their intended and unintended effects on the workforce.

1. INTRODUCTION

This report examines how national policy drivers influence social care workforce transformation, highlighting their intended outcomes and unintended repercussions within the ESRC Centre for Care's Workforce Change Research Group framework. It is focused on the study 'Understanding the drivers and implications of care workforce change,' which investigated national-level policy drivers of social care workforce change and their intended and unintended effects on the workforce.

The overarching aim of the Research Group is to understand how care workforce change occurs at all levels of the care ecosystem. In particular, we aim to identify drivers of workforce change and their effects on different actors. The study reported here investigated macro-level drivers of workforce change. Other inquiries of the Research Group have focused on meso- (digitalisation and workforce innovation) and micro-level drivers (care worker organising) and their effects on different actors.

The social care system comprises various stakeholders, including care providers, regulatory bodies, funding agencies, and service users, whose interactions shape workforce outcomes and care quality. The formal social care system spans state-funded support and self-funded care, operating alongside family and community support networks. The social care workforce comprises a diverse array of roles that provide essential support to older adults with complex medical needs, working-age individuals with physical and learning disabilities, those with long-term mental health conditions, and unpaid carers. Adopting the definition used by Skills for Care (2023a), this study is focused on direct care workers, managers, supervisors, regulated professionals (such as registered nurses), and non-care support roles. The social care workforce is predominantly female, reflecting global trends of feminisation of care work (England et al., 2002) and more ethnically diverse than the population as a whole (Skills for Care, 2024).

This workforce is inherently dynamic, with roles continually evolving and new tasks emerging. For example, the number of live-in care workers in England has grown significantly post-COVID-19, driven in part by increased concerns about the high mortality rates observed in residential care settings (Hussein et al., 2024). Additionally, care workers take on responsibilities traditionally performed by health professionals, such as administering medication, due to practical demands (Fitzpatrick et al., 2024), more recently supported by new voluntary guiding principles introduced in 2023 (Skills for Care, 2023b).

Macro-level drivers encompass national policy reforms, funding mechanisms, and regulatory changes that directly influence the structure and functioning of the social care workforce. Policy shifts require adjustments in workforce roles and practices to align with emerging standards and expectations. Integrating health and social care services has redefined job roles and responsibilities, yet their implementation frequently reveals systemic misalignments and resource gaps (Lloyd & Wait, 2006). The shift towards personalisation (self-directed support), such as introducing personal budgets and direct payments, reshaped workforce dynamics by altering the relationship between care workers and service users (Needham, 2011). Technological adaptations have driven workforce changes by introducing new digital tools and systems, such as digital social care records, telehealth services, and assistive technologies, aiming at streamlining operations while necessitating ongoing training and support for care workers (Hussein et al., 2023).

Readiness for change within the workforce is pivotal for successfully implementing new policies and practices. Organisational culture, leadership support and resource availability influence their readiness (Armenakis et al., 1993; Rahi et al. 2022). Conversely, resistance to change can emerge from a lack of understanding, fear of the unknown, or perceived threats to job security and professional identity (Piderit, 2000).

Long-term labour market trends and systemic shocks also shape the evolution of the social care workforce. The literature on workforce change (Rubery, 2015; Hussein, 2017) identifies the pivotal trends of flexibilisation, fragmentation, and financialisation that have redefined the sector. Labour flexibilisation, characterised by the rise of part-time and casual employment, significantly affects job stability and worker well-being (Rubery, 2015). Fragmentation of social care service delivery, marked by increased variety in service providers and employment arrangements, complicates efforts to standardise working conditions and ensure quality care (Carey, 2014). Financialisation, which prioritises cost-cutting over job quality and care standards, has also shaped workforce dynamics (Bayliss & Gidon, 2020).

Systemic shocks such as Brexit and the COVID-19 pandemic have introduced new challenges and accelerated existing trends. Brexit created uncertainties in workforce supply and disproportionately impacted migrant workers, a significant component of the social care workforce (Rolfe, 2019). The COVID-19 pandemic highlighted the essential role of care workers while exposing systematic vulnerabilities, leading to increased calls for better recognition and support (Kessler et al., 2020; Fitzpatrick et al., 2024).

AIMS:

This study aimed to investigate the national policy drivers influencing social care workforce change in the UK and examine their implications for the workforce across the UK's four home nations. We formulated the following research questions:

1. What key policy reforms have driven workforce change in the UK's four home nations?

2. What intended and unintended consequences have these policy reforms produced for the social care workforce?

3. How can policy reforms interact with other macro-level drivers to influence workforce change over the long term?

4. What synergies and tensions exist between different policy reforms?

2. RESEARCH METHODS

To explore the effects of national policies on social care workforce change in the medium and longer term, this study has adopted a foresight methodology to develop future scenarios for the social care workforce. Foresight/scenario development is an approach to 'futures thinking' that is increasingly used by organisations to inform decision making, alongside other methodologies, such as forecasting and modelling. Scenario building involves a range of diverse perspectives to overcome the limits of individual understanding of what is possible (Cameron et al., 2019). This study involved the voices of 25 social care stakeholders representing a cross section of institutions from the four home nations of the UK: sector bodies (e.g., Skills for Care, Social Care Wales), care providers' associations, care worker trade unions, charities working with people drawing on social care and informal carers, and researchers at think tanks and universities.

Scenarios are imaginative but realistic descriptions of potential futures intended to help explore rather than predict potential future outcomes. The OECD describes scenario planning as "developing multiple stories or images of how the future could look to explore and learn from them in terms of implications for the present" (OECD, 2019:3). In this study, scenarios were built around the question: 'What might the social care workforce in the UK look like in 2035?'

Organisations take different approaches to foresight/scenario building (Ramirez et al., 2017), but all approaches require time and commitment from the participants. We have adopted a multiphase approach, comprising a knowledge review, stakeholder consultations and scenario building workshops. The phrases of the scenario building process are summarised in Figure 1.

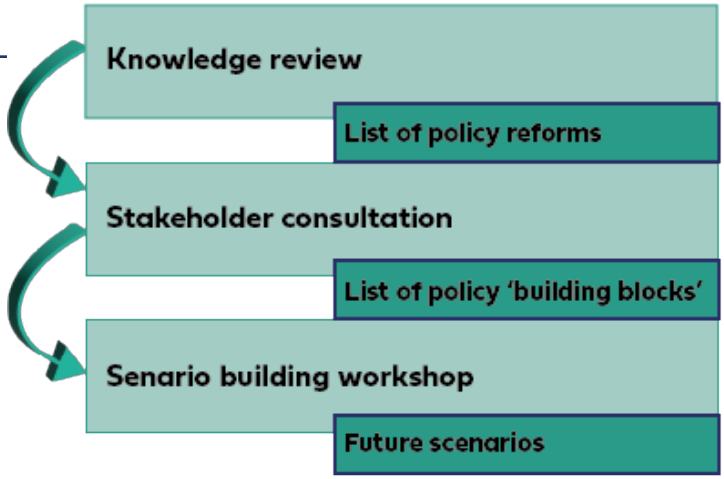

Figure 1: Summary of research methods used in the study

2.1 KNOWLEDGE REVIEW

Scenarios are built on information that covers the main drivers of change, in this study, national policies driving care workforce change, and the contextual environment. As a first step, the research team conducted a scoping review of academic and grey literature to identify the key national policy reforms driving changes in the social care workforce and examine the consequences of these policies for the workforce (research questions 1 and 2).

2.2 STAKEHOLDER CONSULTATION

In the next phase, stakeholder consultations were undertaken to refine and contextualise the findings of the knowledge review and explore stakeholders' views on national policy reforms and their impact on workforce changes in care. While conducting the knowledge review, we invited stakeholders to participate in the study, providing detailed information about the multiphase scenario-building process and the time commitment it involved.

The consultation consisted of two online roundtable discussions, with ten and nine participants, respectively. Stakeholders who could not attend these were invited to a one-on-one interview; we conducted seven interviews.

We then conducted a prioritisation exercise with twelve stakeholders. We adapted the method of 'rapid prioritisation' (Cowan et al., 2021) and asked stakeholders to consider the 'long list' of policy reforms that emerged from the knowledge review, the roundtable discussions, and the interviews, and vote for the most impactful policies driving care workforce change. By the end of the stakeholder consultation phase, we had a list of six key policy drivers, shown in Figure 2 below.

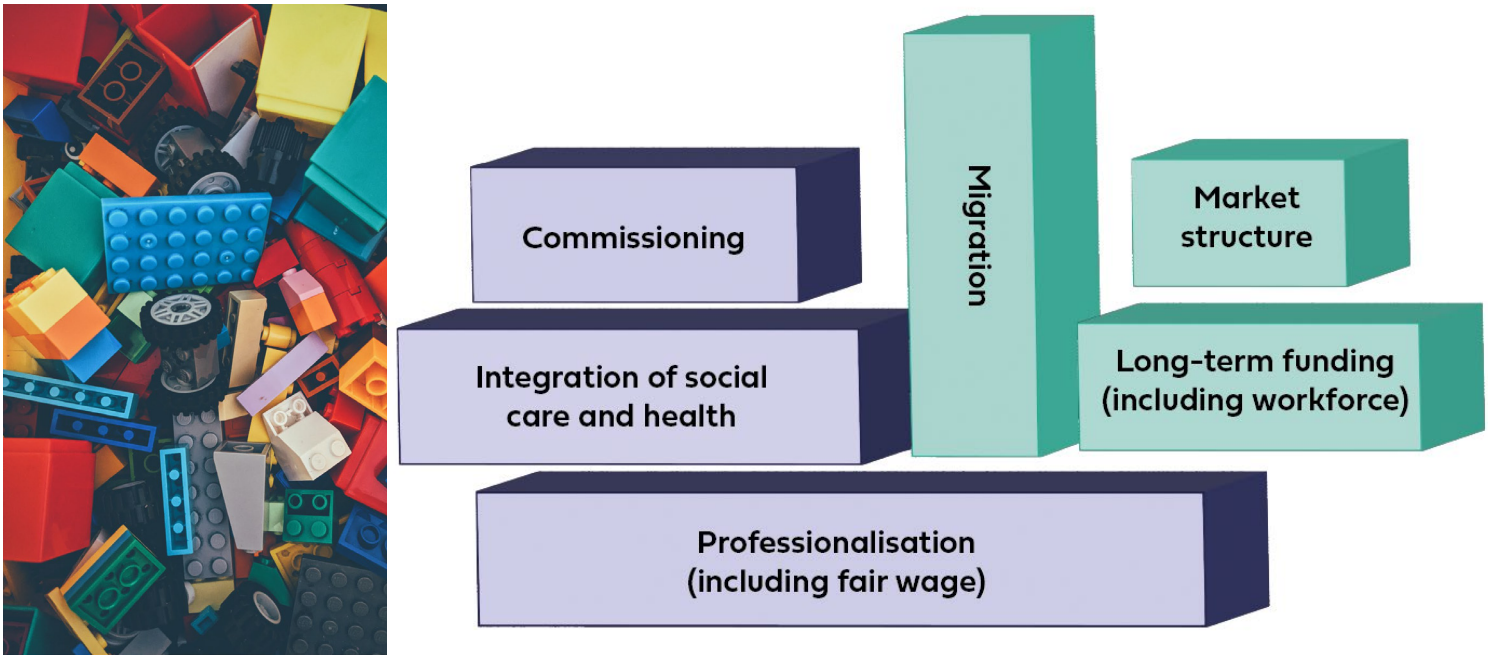

Figure 2: Scenario Building Blocks – Image Used in the Scenario Building Workshops

By this stage of the scenario-building process, stakeholders have become familiar with the study methodology and have started to build a strong working relationship.

2.3 SCENARIO BUILDING WORKSHOPS

We organised two scenario-building workshops. We asked participants to:

- use the six policy drivers of workforce change they voted for in the prioritisation exercise (we referred to these as the six policy 'building blocks');
- consider the broader economic, political, social, technological and environmental context of social care in the UK;
- allow for an unforeseen factor (e.g., an event or a macro-level development that could have a major impact on their scenario - a 'wild card' (UNGP, 2023).

After each team discussed the core components of their scenario, they considered the impact their scenario would have on different groups within the adult social care system, focusing particularly on the care workforce and informal caregivers. They also examined how their scenario would shape the relationship between social care and other systems, such as housing, vocational education, and training. To explore unanticipated factors that might influence these outcomes, participants engaged in the "Fortunately, Unfortunately" game—a narrative exercise in which alternating statements present positive and negative turns of events. This technique, commonly used in improvisational settings, encourages creative thinking and helps identify potential challenges and opportunities in scenario planning (Wilkinson et al., 2013).

2.4. DATA ANALYSIS

All parts of the stakeholder consultation (except small group discussions) were audio-recorded with informed consent from the participants. The recordings were transcribed verbatim, and the transcripts were de-identified. We adopted a thematic approach to the analysis (Braun and Clarke, 2006), coding the transcripts deductively, with codes drawn from the research questions.

3. FINDINGS

The findings in this section integrate insights from the literature review and stakeholder consultations.

3.1. KEY DRIVERS OF CARE WORKFORCE CHANGE

Analysis of the literature identified six key policy drivers influencing social care workforce change, organised under two headings: Social care policy reforms (specific to the social care sector) and intersecting drivers of workforce change (broader policies or macro-level factors). These are summarised in Table 1:

Social care policy reforms	Intersecting drivers of workforce change
Personalisation	Social care funding (reforms)
Integration of health and social care	Digitalisation
Professionalisation of the workforce	Policies affecting the flows of migrant workers

Table 1 Key Drivers of Change: Findings of Knowledge Review

While stakeholders generally agreed with these key policies, some questioned whether the policy reforms we have identified were the most relevant for workforce change, suggesting they represented "merely the highest profile ones" (Roundtable 1). Alternative policies that the stakeholders added to the list are discussed below in section 3.1.3.

3.1.1. SOCIAL CARE POLICY REFORMS

Personalisation, also referred to as self-directed support, has been central to social care policymaking across the four nations of the UK (Pearson et al., 2018). Its workforce implications are most evident in the emergence of the Personal Assistant (PA) workforce. While PAs often experience the poorest pay and employment conditions (Cominetti, 2023), they report higher job satisfaction than other direct care workers (Woolham et al., 2019). However, Eccles and Cunningham (2018) found that recruitment challenges in Scotland hindered the full implementation of personalisation. Furthermore, Hayes et al. (2019) found that social care workers could not always articulate what personalisation meant in their daily work practices.

Some stakeholders noted that personalisation has fundamentally altered the 'language' of social care services, yet its impact on workforce practices remained ambiguous. They emphasised the importance of care workers' autonomy in delivering personalised care but observed that systemic constraints often limit this autonomy:

> *The system does not enable frontline workers to be personalised in the way they deliver care. Often, frontline care workers are not listened to. 'You are just a care worker, you have to call the office, you have to talk to the manager, the GP, the social worker.' They can't make any decisions.* (Roundtable 2)

The integration of health and social care has been a longstanding policy goal across the four nations. Northern Ireland achieved formal structural integration in 1973. However, this emerged through a radical re-organisation of local government rather than a strategy of integration (Heenan, 2013). During the political and social unrest and the direct rule of the UK government that characterised much of this period, the focus was on service delivery rather than systemic reforms. As a result, the integrated system did not deliver its potential (Heenan, 2013).

The literature identifies various taxonomies of integration, with workforce integration as a key dimension (Goodwin et al., 2014; Reed et al., 2021; Wodchis et al., 2020). However, some interventions labelled as part of the integration process failed to enable collaborative working among staff (Baxter, 2018).

UK policies often emphasise structural integration rather than fostering shared norms and processes (Reed et al., 2021). Integration initiatives are frequently hindered by a lack of resources, infrastructure, and staff (Miller et al., 2020; stakeholder consultation); however, integration is most significantly hampered by the perception that social care is an add-on to health care services (Quilter-Pinner and Hochlaf, 2019). Focusing specifically on workforce integration, stakeholders reiterated the findings from the literature: it is challenging to integrate staff across two systems that follow different approaches to pay, holiday entitlements, and pensions (Reed et al., 2021), as well as career paths and training opportunities (stakeholder consultation).

Stakeholders identified para-professions, such as care technologists , as a positive outcome of integration specific to the workforce. These roles provide varied career pathways and bridge health and social care. However, there was a concern about the increasing 'clinicalisation', of social care roles:

> *The term social care might be a bit outdated, because we look after people with very complex health needs. ... Say, twenty years ago these people would have been looked after by the NHS. Things like end of life care, Parkinson's, stroke... (Roundtable 1)*

The professionalisation of the social care workforce includes initiatives such as registration and professional regulation, compulsory training, continuous professional development, career progression, and minimum employment standards (Hayes et al. 2019; Hemmings et al. 2022). Scotland,

Wales, and Northern Ireland have implemented mandatory registration and training frameworks, along with pay uplifts (Hemmings et al., 2022). In contrast, England only requires induction training through the 'Care Certificate' (Skills for Care, n.d.), which is neither a legal requirement nor a formal qualification. It is essential to highlight that Personal Assistants are excluded from these initiatives across all four nations.

Stakeholders noted unintended adverse consequences of professionalisation, particularly regarding part-time and older workers leaving the sector to avoid compulsory training and registration requirements (Scotland and Wales). This trend could increase existing inequalities among care workers. Some stakeholders were sceptical about whether compulsory training and registration have enhanced the status of care work, at least not in the short term:

> *In Scotland, we've deluded ourselves, thinking that if you get a registered, qualified and regulated workforce ... they should have the respect ... but unless you accompany [that] with a re-conception of the value of the social care workforce, you have all the obligations but none of the privileges, all the responsibilities but none of the rights. (Roundtable 2)*

3.1.2. INTERSECTING DRIVERS OF WORKFORCE CHANGE

Funding reforms: Stakeholders consistently highlighted the UK government's long-standing underfunding of social care as a critical driver affecting the workforce. Insufficient funding perpetuates low pay and poor terms and conditions, such as zero-hour contracts, minimal annual leave entitlements, a lack of sick pay, and instances of forced self-employment (Allen & Shembavnekar, 2023; Cominetti, 2023). Stakeholders also noted that limited financial resources hindered the implementation of other key policy reforms, including personalisation, professionalisation, integration, and digitalisation (Roundtables 1 and 2).

The literature supports these concerns. Even before the COVID-19 pandemic, experts warned that cuts to public expenditure, combined with a growing demand for care services, threatened the stability of the social care system and its workforce (National Audit Office, 2018). Fiscal austerity measures introduced in 2010 exacerbated these challenges, with subsequent governments failing to address systemic issues (Glasby et al., 2021). The workforce has faced increasing pressure, with rising workloads and deteriorating job quality further destabilising the sector (Hayes, 2017). Stakeholders emphasised the urgent need for sustainable funding to ensure that reforms lead to meaningful improvements.

Digitalisation: While discussions on the 'future of work' often centre on technology replacing manual labour, human services such as caregiving, teaching, and training remain dependent on human interaction (Smit et al., 2020: 23). Digitalisation has become a focal point in UK social care policy following the COVID-19 pandemic, with the government's 'People at the Heart of Care' White Paper (DHSC, 2021) committing to funding digital transformation in adult social care.

Digital technologies have significantly reshaped care roles. Hamblin (2022) identified the creation of new roles and jobs, such as in remote monitoring centres, but noted that these jobs remained invisible, with workers supporting care delivery 'on behalf of' technologies. In some cases, technology altered the nature of work, such as using robotics in residential care. While person-focused tasks diminished, technology-centred ones increased, leading to job degradation and the reconceptualisation of some care jobs as 'machine babysitters' (Hamblin, 2022).

However, digitalisation can also support innovative care models. For example, Gray et al. (2015) highlighted the Buurtzorg model, where autonomous teams of nurses utilised real-time digital tools to communicate, share data, and make decisions effectively. This example demonstrates the potential for technology to empower workers rather than constrain them.

Stakeholders expressed mixed views on digitalisation as a driver of workforce change. While recognising benefits such as shared digital care records, they raised concerns about the electronic monitoring of homecare staff. They questioned the feasibility of large-scale digitalisation in the absence of adequate government funding. As one stakeholder observed, "If there was not sufficient government funding to digitise the NHS, it was highly unlikely that there would be enough money to digitise social care" (Roundtable 1).

Immigration Policies: Migrant workers remain a cornerstone of the UK's adult social care sector, but their contributions have increased since the early 2000s and the enlargement of the European Union (Turnpenny and Hussein, 2021). The dominant model of migrant employment in the UK is characterised as 'migrant in the market', with relatively accessible labour market entry. However, migrant care workers are often concentrated in roles with poorer working conditions and lower wages (da Roit & Weicht, 2013; Ahlberg et al., 2022).

The UK's departure from the EU and the end of the free movement significantly disrupted the flow of migrant workers. In response, the UK government introduced the Health and Care Worker Visa in 2022. However, social care employers reported facing challenges navigating the immigration system with high costs and complex bureaucracy, and competition with NHS recruitment further complicates their ability to recruit sufficient migrant workers (MAC, 2022; stakeholder consultation).

Stakeholders emphasised the pivotal role of

migration policy in shaping the social care workforce, with one stating: "The UK has no social care policy, only migration policy" (interview, pt 2). This highlights the need for a more coherent strategy that aligns workforce development with migration policy to address ongoing recruitment and retention challenges.

3.1.3. DRIVERS OF WORKFORCE CHANGE IDENTIFIED BY STAKEHOLDERS

As outlined in the section on research methods, stakeholders were invited to suggest policy reforms and macro-level factors they believed had significant effects on the social care workforce. Their contributions, summarised below, enriched and refined the drivers identified in the knowledge review. Stakeholders extended the scope, adding local level drivers (e.g., commissioning) to the national policies identified in the knowledge review and including policies introduced before the timeframe covered by the review.

The introduction of the National Minimum Wage in 1996 and the National Living Wage (NLW) in 2016 was argued to be one of the most influential policy changes for increasing care workers' pay in the UK. The periodic uplift of the NLW directly impacts workforce stability by improving pay levels, albeit insufficiently addressing the sector's long-standing recruitment and retention challenges (Roundtable 2).

Devolution has enabled Scotland, Wales, and Northern Ireland to develop tailored social care policies that address regional priorities. Stakeholders noted a growing divergence in workforce impacts among the UK's four nations (Roundtables 1 and 2). Scotland's 'fair work' initiatives (Fair Work Convention, 2019) and the planned National Care Service (Scottish Government, 2021), along with Wales' ten-year workforce strategy (Welsh Government, 2019) were highlighted as examples of localised policy innovation diverging from England's more market-based approaches. Stakeholders emphasised that these devolved strategies allow for unique reforms, including professionalisation initiatives and workforce development schemes, but also introduce disparities in working conditions across the UK.

Commissioning. The process by which social care services are planned, purchased and monitored – was observed as a critical driver of workforce change. Local authorities in England, Wales, and Scotland, as well as Health and Social Care Trusts in Northern Ireland, play pivotal roles in determining job quality through their commissioning practices. These include setting fees for service providers, directly influencing care workers' pay and working conditions (Bolton, 2015; Wenzel et al., 2023; Rubery et al., 2015).

Stakeholders emphasised the importance of 'ethical commissioning', as promoted by the Scottish Government (Healthcare Improvement Scotland, 2024) (Roundtable 1). Ethical and collaborative commissioning models are increasingly being adopted across the UK, moving away from strictly market-based approaches (Hudson, 2019). These models prioritise fair pay, job security, and quality care delivery.

The skills and knowledge of commissioners were also identified as key to workforce change. Stakeholders noted gaps in the training and professional development of commissioners:

> We focus very much on the professionalism of care staff but it's a little bit unclear sometimes what it is that commissioners themselves are working to and the support and training that they've had (prioritisation exercise).

Market structure. Stakeholders noted that market forces both directly and indirectly drive workforce change. For instance, provider competition for care staff has resulted in pay increases in certain segments of the adult social care sector, while the market-driven adoption of digital technologies has influenced working conditions. Market dynamics also affect the availability and diversity of care services, as local authorities have a legal duty to "shape" social care markets to ensure a variety of options for service users.

Needham et al. (2020) investigated local authorities' market shaping in England, finding that the concept of market shaping lacks a consistent definition. Local approaches to market shaping vary significantly, depending on factors such as regulatory frameworks and the relationships among local authorities, providers, and stakeholders. Stakeholders highlighted that inconsistencies in market shaping could exacerbate inequalities in workforce conditions.

3.1.4. CONSENSUS ON MACRO-LEVEL DRIVERS

By the end of the prioritisation exercise, stakeholders reached a consensus on the key macro-level drivers of workforce change, revising the original list from the knowledge review. Personalisation was replaced by commissioning, and digitalisation was replaced by market structures (see Table 2).

Social care policy reforms	Intersecting drivers of change
Professionalisation (including fair wage)	Long-term funding (including workforce funding)
Commissioning	Market structures
(Improved) integration of health and social care	Migration

Table 2: Drivers of Workforce Change: Knowledge Review and Stakeholder Consultation

3.2. FORESIGHT OF WORKFORCE CHANGE

In the final stage of the study, stakeholders developed scenarios for the future of the social care workforce in the UK, envisioning what it might look like in 2035. Two scenario building workshops were conducted, resulting in three distinct scenarios.

3.2.1. FUTURE SCENARIOS

Scenario 1: System Transformation Focused on the Workforce

This scenario envisions a fully transformed social care system supported by significantly increased and consistent long-term public funding. The transformation prioritises the professionalisation of the workforce, improved job quality, pay parity with NHS staff, and supporting staff well-being. Care workers are central to the system, with clear career pathways and skills development. Technology, including AI, supports care delivery in homes and creates new jobs, including opportunities for asylum seekers.

This transformation would also require close cooperation between social care and NHS colleagues, underpinned by values-driven local partnerships. However, social care would maintain its distinct identity and not be subsumed into the health service.

Senario 1: Requirements

- Building a national consensus recognising social care as critical national infrastructure and supporting increased government funding.
- Engaging the public through mechanisms like citizens' assemblies to discuss trade-offs and questions around social care funding.
- Allocating resources effectively at the local level, enabling commissioners and providers to build partnerships and innovate.

Workforce Impact

- Improved job quality would ease recruitment and retention challenges, leading to a more sustainable workforce.
- Gender inequalities would be reduced, given the predominantly female workforce.
- The inclusion of asylum seekers in the workforce would promote social integration.

Broader Impact

- Better pay and support for care workers would improve the quality of care, benefiting people who draw on care and their informal carers.
- Innovations in service delivery and new care models would emerge.
- Funding increases could require higher taxes or the introduction of a dedicated social care insurance scheme.

Scenario 2: System Transformation Focused on Commissioning

This scenario envisions transformative change through optimising existing resources rather than relying on increased government funding. It emphasises innovative commissioning practices and focuses on domiciliary care.

Resources are used efficiently, with person-centred, outcomes-based care models replacing task-based commissioning. Care providers would creatively adapt personal budgets to individual needs, fostering trust between providers and local authorities.

Digital technologies would support providers and workers, while care workers' well-being would be prioritised, ensuring travel time is paid, and zero-hour contracts are used only by choice.

Scenario 2: Requirements

- Full implementation of the Care Act 2014, ensuring service users can manage their personal budgets with appropriate advice and information.
- Establishing a National Academy of Commissioning to support outcomes-based commissioning and improve local authority capacities.
- Comprehensive local planning supported by detailed data and collaboration between stakeholders.

Workforce Impact

- Job quality improvements for care workers, including better pay and conditions.
- Migrant home care workers may require advanced English language skills to adapt to the personalised commissioning system.

Broader Impact

- Opportunities for innovative, flexible care service providers able to adapt to the new system.
- Challenges for service users managing budgets and negotiating contracts.
- Local authorities would need to redefine their commissioning roles, moving from traditional procurement to supporting individualised care delivery.

Scenario 3: Legalisation of Assisted Dying

In this scenario, assisted dying will become legal and culturally accepted in the UK by 2035. Care workers are crucial in navigating ethical and emotional challenges, supported by comprehensive training and mental health resources. High-quality end-of-life planning and support are integrated into care services.

Scenario 3: Requirements

- Broad societal acceptance of assisted dying and early planning for end-of-life care.
- Significant investment in training and support for care workers, ensuring they are equipped to manage the complexities of assisted dying.
- Leadership from care providers to facilitate cultural shifts within organisations.

Workforce Impact

- Ethical dilemmas and mental health challenges for care workers, particularly those in end-of-life care.
- Potential workforce shifts, with some care workers choosing to work with younger adults rather than older people to avoid end-of-life care responsibilities.

Broader Impact

- Opportunities for organisations specialising in training and support for care workers.
- Challenges for care providers balancing workforce preferences with service demands.
- Societal concerns about inequalities, with less affluent individuals potentially opting for assisted dying due to care costs.

3.2.2. COMMONALITIES AND DIFFERENCES ACROSS THE SCENARIOS

The three scenarios—focused on workforce professionalisation, commissioning transformation, and the legalisation of assisted dying—highlight distinct yet interconnected visions for the future of the social care workforce in the UK. Despite their unique emphases, commonalities across the scenarios include a shared recognition of the need to improve job quality, better integrate digital technologies, and address systemic challenges such as recruitment, retention, and workforce sustainability. All scenarios underscore the importance of empowering care workers with the skills, resources, and support systems necessary to deliver high-quality, person-centred care.

Scenarios 1 and 2 highlight the necessity for systemic transformations while proposing different solutions and processes for change. Scenario 1 focuses on professionalisation and long-term public funding, aiming to achieve parity between social care and NHS workforce conditions. Scenario 2, meanwhile, emphasises the optimisation of existing resources through commissioning innovation and personalised care delivery. These scenarios reflect the contrasting approaches of stakeholders while maintaining equally optimistic visions for the future of the care workforce. According to Cameron and colleagues (2019), visions are defined as "preferred futures" based on a normative view of what the future should look like rather than what it could potentially be.

On the other hand, Scenario 3 addressed the ongoing public debate surrounding assisted dying and the proposed Assisted Dying Bill, which gained prominence following the foresight activities in October 2024 (BBC, 2024). The bill passed its second reading in the House of Commons in June 2025 and has since moved forward for consideration in the House of Lords. Unlike the first two scenarios, Scenario 3 introduces an ethical dimension to workforce transformation. It focuses on preparing care workers to navigate the complexities of legalised assisted dying while maintaining their mental well-being.

3.2.3. IMPLICATIONS FOR THE WORKFORCE

Across all scenarios, the care workforce is positioned as central to the transformation of the social care system. Scenario 1's focus on professionalisation and better pay directly addresses recruitment and retention challenges, while Scenario 2's commissioning reforms aim to create more efficient and person-centred service delivery models. Scenario 3 raises critical ethical considerations for care workers, particularly those involved in end-of-life care, highlighting the importance of mental health support and clear professional guidance.

3.3. POLICY TENSIONS AND SYNERGIES

Addressing Research Question 4, we drew on the knowledge review and stakeholder consultations to reflect on whether national policy reforms work harmoniously to drive workforce change or whether tensions exist between different policies and macro-level drivers. This section explores two critical areas of potential synergy and conflict, highlighting that professionalisation and integration are both potentially in synergy and conflict with personalisation.

3.3.1. PERSONALISATION AND PROFESSIONALISATION

Personalisation prioritises coproduction between care practitioners and those receiving support, aiming to empower individuals by granting them greater control over their care. In contrast, professionalisation focuses on the expertise of care workers, as reflected in formal qualifications and training, which may inadvertently prioritise professional credentials over care's relational and value-driven aspects. Concerns have been raised about the impact of professionalisation reforms on personalisation. For example, mandatory registration and qualification requirements might constrain the autonomy of individuals who employ personal assistants (TLAP, 2018). Echoing these concerns, some stakeholders argued that imposing a register for personal assistants could undermine service users' personal choice that is central to personalisation:

> *On what basis could you say to a working age adult with a disability, 'you can only employ someone from a register?' I mean, how could that ever make any sense? (Interview, pt 16)*

Others, however, highlighted the potential synergies between these two policies, arguing that training in skills that align with the ethos of personalisation was beneficial to both the workforce and the people they supported:

> *Some people may see it [professionalisation] as a threat, ... but there is evidence that training around person-centred care can be really beneficial (Roundtable 1)*

Research supports the view that the workforce requires tailored training to develop skills relevant to personalisation (Burn and Needham, 2021; Cunningham, 2015; Hayes et al., 2019). In line with this, the Care Certificate, an induction programme for hands-on care workers in England, includes personalisation as a core aspect of training (Skills for Care, n.d.). This demonstrates how professionalisation reforms, when aligned with the principles of personalisation, can enhance the delivery of person-centred care.

3.3.2. PERSONALISATION AND INTEGRATION

The relationship between personalisation and integration of health and social care is complex. While both aim to improve person-centred care, they adopt two distinct approaches with diverse, potentially contradictory workforce implications (Needham et al., 2023). Personalisation seeks to empower service users through individualised, tailored support, often fragmenting care services. In contrast, integration focuses on creating 'seamless support' through close collaboration among service providers, which can include health services, social care providers, and other forms of support. Stakeholders also noted that implementing integration initiatives often reveals tensions. Personalisation encourages diverse and flexible care options, but this approach can challenge the collaborative frameworks required for integration.

Further tension arises from the UK's approach to integration, which prioritises structural or systems-level integration over collaborative practices focused on seamless individual support (Allen et al., 2023; Reed et al., 2021). For example, Australia's disability services model focuses on collaboration to deliver person-centred care, contrasting with the UK's structural emphasis, which can sometimes neglect individualised service delivery. Despite these challenges, stakeholders argued that workforce integration was a promising dimension of integration and it might improve the working conditions of social care staff and personalisation, as the following quote demonstrates:

> *I think greater sharing of that clinical workforce with the community [workforce] has the potential to improve conditions for care workers who [are] perhaps struggling sometimes. (Prioritisation workshop)*

In summary, stakeholders and research agree that aligning personalisation and integration requires a nuanced approach. Policies must balance the need for individualised care with the efficiencies and coherence offered by integrated services. Efforts to develop shared frameworks, such as common care pathways and unified training, may help bridge these tensions.

4. DISCUSSION AND CONCLUSIONS

This study explored national policy drivers influencing the social care workforce change in the UK to better understand their interaction with broader macro-level factors driving long-term workforce change. We have adopted a foresight methodology and asked social care stakeholders to create future scenarios. As part of the scenario-building and foresight process, the study examined the policy drivers along their intended and unintended consequences through a knowledge review and stakeholder consultations.

The study identified significant insights into the dynamics of workforce transformation in social care. While the research began by focusing on macro-level policy drivers such as professionalisation and personalisation, as identified in the literature, stakeholder consultations highlighted the importance of meso-level factors operating at local and regional levels. In particular, commissioning and local social care market structures were prioritised over personalisation and digitalisation as more immediate and impactful drivers of workforce change. This shift reflects the decentralised nature of the UK's long-term care system, where local authorities are responsible for market shaping and commissioning.

Commissioning processes and local market dynamics directly influence the fees paid to providers, which in turn affect the pay, terms, and conditions of care workers. The prioritisation of these factors by stakeholders highlights the crucial role of local authorities in shaping the workforce environment, a dimension that often requires further exploration in national policy discussions.

One of the unique contributions of this study is its explicit focus on the workforce as a key agent of change in social care. Much of the existing literature overlooks how policies and macro-level drivers directly impact the workforce. By prioritising the experiences, skills, and agency of care workers, this research provides a more nuanced understanding of the dynamics of workforce change. For instance, while professionalisation is often framed as a top-down policy goal, stakeholders emphasised the importance of engaging workers to align these reforms with the realities of care delivery.

This perspective also shaped the future scenarios, placing care workers at the centre of proposed systemic transformations. The scenarios illustrated how empowering the workforce through better pay, training, and conditions can lead to more sustainable care models while addressing challenges such as recruitment and retention.

Despite their differences, the three future scenarios shared common assumptions and requirements for achieving positive outcomes. All scenarios acknowledged the need to improve job quality through better pay, enhanced training, and innovative commissioning practices. They also emphasised the importance of digital technologies, not as replacements for care workers but as tools to support and enhance care delivery.

A key requirement across all scenarios is the necessity of collaborative efforts among policymakers, local authorities, care providers, and the workforce. Effective partnerships will be essential for implementing reforms at both the national and local levels. Additionally, societal engagement has emerged as a critical factor, with mechanisms like citizens' assemblies proposed to build consensus around contentious issues such as increased funding and the professionalisation of care work.

The study revealed significant tensions and synergies between key policy drivers. For example, the relationship between personalisation and professionalisation reflects conflicting workforce expectations. Personalisation emphasises co-production and flexibility, empowering care recipients to make choices about their support. Conversely, professionalisation focuses on formal qualifications and structured career pathways, which may limit the autonomy valued in personalisation. Stakeholders highlighted the risk of these tensions leading to unintended consequences, such as reduced personal choice or a workforce unprepared for increasingly complex roles.

A similar tension exists between personalisation and health and social care integration. While both aim to enhance person-centred care, personalisation often leads to fragmented service delivery, while integration seeks to provide seamless, coordinated support. Stakeholders criticised the UK's current focus on systems integration, arguing that it prioritises structural changes over meaningful improvements in the experiences of individuals drawing on care. They called for a version of integration that prioritises collaboration and person-centredness.

4.1 IMPLICATIONS AND RECOMMENDATIONS

To ensure more positive outcomes for the social care workforce, the following actions are recommended:

Empowering Local Authorities: Strengthen the capacity of local authorities to commission effectively and shape care markets to support fair pay and better working conditions.

Balancing Policy Goals: Policymakers should explicitly address the tensions between competing goals, such as personalisation and professionalisation, by involving care workers and service users in co-designing solutions.

Investing in Workforce Development: Sustainable funding must support training, career progression, and mental health resources for care workers, recognising their central role in systemic transformation.

Aligning Integration Efforts with Person-Centred Care: Integration policies should prioritise seamless collaboration over structural changes, focusing on improving the lived experiences of both care workers and service users.

Building Public Consensus: Engage the public in discussions about the value of social care and its funding, fostering a collective vision for the future of care.

ENDNOTES

[1] The study was approved by the Observational/Interventions Research Ethics Committee of the LSHTM (Reference 28339).

[2] The care technologist project: https://scottishcare.org/the-care-technologist-project/

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ABOUT THE RESEARCH

ESRC Centre for Care: Funded as an ESRC Research Centre to address the need for evidence on care that can make a difference, we have built a large research team to co-produce excellent research on care topics that really matter. We work closely with partner organisations in the care sector and people with direct experience of care. The Centre for Care links experts on care in five universities, three major charities and the UK's Office for National Statistics.

The Centre for Care is funded by the Economic and Social Research Council (ESRC, award ES/W002302/1), with contributions from the Department of Health and Social Care's National Institute for Health and Care Research (NIHR) and partner universities. The views expressed are those of the author(s) and are not necessarily those of the ESRC, UKRI, NHS or NIHR.

Research Group C (RGC): Care Workforce Change is led by Professor Shereen Hussein at the London School of Hygiene and Tropical Medicine. Our research aims to understand the drivers, characteristics, and implications of changes in the care workforce, particularly how paid care work is interconnected with other aspects of the care ecosystem. We organize our investigations at three levels: macro (systems and national policies), meso (care delivery and provision), and micro (individual and groups of workers). Specific projects within RGC are developed in collaboration with relevant stakeholders, groups, and individuals through ongoing dialogues and priority mapping. Central to our research methodology and conceptual design are issues of diversity and inequalities experienced throughout the life courses of both care workers and those receiving care.

To cite: Hussein, S. and Kispeter, E. (2025). Policy Drivers of Social Care Workforce Change: United Kingdom Insights, Impacts, and Future Directions. Centre for Care Research Report, CIRCLE, Sheffield: University of Sheffield

ISBN 978-1-8382688-8-6

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