CARE ASSOCIATION ALLIANCE

August 2026

Towards a National Workforce Settlement

A proposal for a recognised profession, a national career framework, and a funded settlement for the adult social care workforce in England

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POLICY PAPER TWO

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What is in this paper

A NOTE ON SCOPE

This is the second paper in the Care Association Alliance's reform programme. Our first paper, Adult Social Care Funding Reform, argued that no funding model can succeed without a workforce capable of delivering it. This paper sets out what that workforce needs. It needs a recognised professional framework built on the existing Skills for Care Care Workforce Pathway, national professional levels, and a Fair Pay Agreement that is fully funded and tied to demonstrated competency. Not a new bureaucracy, and not a single national employer, but one recognised profession operating across many.

Foreword

Our first paper argued that the financial risk of growing old and needing care is a national risk, and should be managed nationally. Nothing in that argument has changed. But in the roundtables, commissioner conversations and official responses since, one theme has recurred more than any other. You can reform the money, but if you cannot recruit, keep and develop the people who deliver the care, the money will not translate into better outcomes.

Adult social care fills around 1.71 million posts, across close to 19,000 employers and, on our own count of the CQC register, more than 30,000 locations. Few parts of the British economy match that scale, spread and complexity. Yet it remains one of the only workforces of its size with no nationally recognised professional framework, no consistent career ladder, and no shared understanding, in government, among the public, or within the sector itself, of what a career in care actually looks like.

That has real consequences. A worker who has spent five years building genuine clinical and relational skill can move employer and start again on paper, because there is no register and no common language for what they can already do. A sector asked to take on more delegated healthcare responsibility and more complex need is paid and progressed as though none of that had changed. And an obvious opportunity goes begging: close to a million young people not in education, employment or training, against tens of thousands of unfilled care vacancies, with no bridge yet built between the two.

This paper does not propose a new bureaucracy, a single national employer, or the abolition of the diversity that makes adult social care what it is, spanning home care, residential care, supported living, learning disability and mental health services, all organised differently, all needed. What we propose instead is what every other recognised profession already has: shared standards, a national pathway for progression, and a mechanism through which the Fair Pay Agreement can reward competence rather than simply raise a floor. The starting point already exists in the Skills for Care Care Workforce Pathway; it is not yet fit for that purpose, but it would not take a great deal to bring it up to speed.

We have held ourselves to the same standard we asked of government in our first paper: evidence over assertion. Where we could find data to test our own arguments, including original analysis commissioned specifically for this paper, we went and found it. Where the evidence did not fully support a claim we had intended to make, we changed the claim.

We publish this paper as government itself has started to speak this language. In his speech on social care on 29 July 2026, the Prime Minister said the ambition should be “to lift it up, to lift it closer to NHS standards… to integrate it more with the NHS workforce and actually to start to think about progression routes,” with care staff recognised “in terms of pay, but also in terms of training and the wider support we give them.”[1] The same week, in Derby, he argued for “parity between academic and technical” routes into skilled work.[2] We agree with both. This paper sets out what delivering them actually requires.

England does not need a single workforce. It needs a single recognised profession. This paper sets out how to build one.

Melanie Weatherley MBE

Co-Chair, Care Association Alliance

EXECUTIVE SUMMARY

Funding reform alone cannot succeed. This paper sets out what the workforce needs.

~19,000
EMPLOYERS DELIVERING ADULT SOCIAL CARE IN ENGLAND[3]

6.2%
VACANCY RATE, AROUND THREE TIMES THE WIDER ECONOMY[4]

6–10P
HOURLY PAY PREMIUM FOR 5+ YEARS' EXPERIENCE IN 2025, DOWN FROM 33P IN 2016[5]

1.01M
16–24 YEAR-OLDS NEET AT THE JAN–MAR 2026 PEAK, FIRST TIME ABOVE ONE MILLION SINCE 2013; 981,000 IN APR–JUN[6,7]

67.9%
CARE WORKERS REPORTING DELEGATED HEALTHCARE TASKS[8]

£6.4BN
10-YEAR PRESENT-VALUE COST OF THE FAIR PAY AGREEMENT[9]

The Problem

The adult social care workforce in England is one of the largest in the country, and it is worth stating plainly what that means before the statistics take over: over one and a half million hard-working, dedicated professionals who deserve more support than the current system gives them. Skills for Care's most recent count puts filled posts at around 1.71 million in 2024/25, rising further in 2025/26.[10] On a comparable basis, comparing filled posts against NHS headcount in hospital and community health services, which excludes primary care, social care's workforce is now close to, and on some measures larger than, that of the NHS.[11] Whatever the precise comparison, a workforce of this scale has no nationally recognised professional framework, no consistent system of career progression, limited portability of skills and qualifications, and no agreed mechanism linking workforce capability to commissioning and funding.

This is not a failure of individual providers. It is a structural feature of a sector delivered by close to 19,000 separate employers, 37 per cent of which employ between one and four people, operating across several government departments' worth of policy interest, more than 150 local authorities and dozens of regulators and funders.[3] Fragmentation of this kind makes national standardisation harder, but as the international evidence in this paper shows, it does not make it impossible.

The real problem is retention, not recruitment. The sector is not short of people willing to join, it is short of reasons for them to stay. Care workers with five or more years' experience now earn between 6p and 10p an hour more than someone with under a year in the sector, down from a 33p premium in 2016; the pay gap between care workers and cleaners has fallen from £2.70 in 2008 to 90p today.[5,12] Vacancy rates, though falling, remain around three times the wider economy's.[4] And the boundary between health and social care work has moved without a corresponding framework. Two-thirds of care workers report being asked to carry out delegated healthcare tasks such as wound care, catheter and stoma care or PEG feeding, and 93 per cent of those have never received additional recognition for doing so. Medication administration is counted within that figure, though in most settings it is long-established practice rather than a new clinical transfer; Section 04 sets out why the absence of an agreed national definition is itself the problem.[8]

The Proposal

This paper proposes a National Workforce Settlement built on three principles: a single recognised profession, not a single employer; competency and progression that are portable between employers; and a Fair Pay Agreement that rewards demonstrated competence and responsibility rather than simply raising a wage floor.

The settlement has five core elements:

- a National Professional Framework built on the Skills for Care Care Workforce Pathway, organised around six pillars, namely parity, competency, portability, diversity, progression and professional identity;
- nationally recognised Professional Levels, leading to the registered professions already working in and alongside social care, including social workers, occupational therapists, physiotherapists, registered nurses and nursing associates, and to a new Care Technologist role for technology-enabled care;
- a National Delegated Healthcare Framework covering governance, competence, supervision, accountability and remuneration for clinical tasks already being carried out by unregistered but competent staff;
- a Fair Pay Agreement explicitly aligned to the Care Workforce Pathway, and fully funded through corresponding commissioning and fee-setting reform; and
- a national care-sector Youth Guarantee pathway, connecting entry-level social care roles to the 16–24-year-olds who are NEET, a group that passed one million in the first quarter of 2026 and stood at 981,000 in the second, alongside explicit recognition of the midlife career switchers the sector already depends on for over a quarter of its existing workforce.

The Five Components of a National Workforce Settlement

The settlement completes architecture the sector has already built, rather than replacing it.

What We Are Asking For Now

The full programme runs over ten years. Five elements should not wait, either because a funding decision is about to foreclose them or because the policy vehicle they need is moving now. Four of the five are costed in Section 5.7, with unit costs, sources and arithmetic set out in Appendix A.4; the fifth needs a decision to adopt rather than new money. A phased register for the senior tier, which Section 5.7 also costs at £8 million to £17 million a year once open, is deliberately not in this package: Section 06 sets out why it should follow the verification record rather than precede it.

IMMEDIATE ASK	ANNUAL COST
Reinstate funding for the Level 4 qualification, and designate it the progression route from the social care T Level, before funding is withdrawn on 1 September 2026	£9m–£14m
Restore the qualification fund to the £53.9 million scale at which it was designed, from the £10 million now available	£44m
Establish a national competency verification record, so that competence travels with the worker	£5m–£15m
Extend independent prescribing for social care nurses from 150 to 1,000, designed with the sector, and publish its results and impact	£3m
Adopt the CAA's existing Pathway into Care as the care-sector route within the Youth Guarantee, before the vehicle moves on without it	Within existing *Get Britain Working* funding
Total, and what it returns	**£61m–£76m**

This investment is easily recouped. The sector currently loses around 335,000 people a year, at a replacement cost of between £1.2 billion and £2.0 billion on published unit costs.[10,13] Reducing turnover by a single percentage point returns between £52 million and £87 million a year, more than the £61 million to £76 million the package above costs, at the midpoint of both ranges. That is before counting quality, continuity of care, or the £2.7 billion a year that delayed hospital discharges cost the NHS.[14] Section 5.8 sets out the calculation in full, and the reasons we have deliberately assumed less than the evidence would allow.

We tested our own arguments rather than simply asserting them, commissioning three original analyses for this paper, the third of them run three ways on different data, each set out in full with methodology and sources in the Appendix. On fragmentation, our regional dataset found the North East has just 8.3 CQC-registered providers per 1,000 filled posts against 15.4 in the East Midlands, nearly double, evidence that a settlement built on portable competency has to flex regionally rather than assume one national model fits every area. On pay, our reconstruction of Skills for Care's own historic data confirmed the experience premium has collapsed from a 33p-an-hour advantage in 2016 to between 6p and 10p today, the clearest evidence we found that the sector currently rewards presence over progression. On recruitment geography, the honest result did not support us: NEET rates and care vacancy rates are not simply co-located, so the Youth Guarantee pathway we propose in Section 07 has to be designed nationally, not targeted area by area.

England does not need a single workforce. It needs a single recognised profession, and the mechanism to build one already exists in the Skills for Care Care Workforce Pathway. What has been missing is not evidence, but the decision to complete it. This paper sets out exactly how, and what it costs to start now.

Ten steps to a recognised profession

01

Establish a National Workforce Settlement

Adopt parity, competency, portability, diversity, progression and professional identity as the organising principles for adult social care workforce policy.

02

Complete the Care Workforce Pathway

Resource Skills for Care to close the Pathway's remaining gaps in national competency recognition, portability between employers, and alignment with commissioning and pay, turning it into a National Professional Framework.

03

Professional Levels, and the Level 4 rung

Link career levels to pay and responsibility, protecting the differentials between frontline and supervisory roles that have been eroded since 2016. Reinstate funding for a Level 4 practice qualification, carrying delegated healthcare and Care Technologist specialisms, and designate it the progression route from the social care T Level before funding is withdrawn on 1 September 2026.

04

Create a Care Technologist career pathway

Build on Skills for Care's own 2025 commitment, with CQC and the Care Provider Alliance, to scope a recognised role for assistive technology, remote monitoring and digital inclusion.

05

Establish a National Delegated Healthcare Framework

Set national standards for governance, competence, escalation, supervision, accountability, insurance, training and remuneration for clinical tasks already carried out by unregistered but competent care staff.

06

Fully fund the Fair Pay Agreement

Align Fair Pay Agreement negotiations to the Care Workforce Pathway, and fund them through corresponding commissioning and fee-setting reform so pay reflects competency, not just a wage floor. Treat the Pathway, and the wider terms of employment the NHS settled through Agenda for Change, as the remit for negotiating years two to ten, rather than confining the Agreement to an entry-level hourly rate.

07

Recognise social workers, OTs and registered nurses in social care

Extend the National Professional Framework explicitly to these registered professions, and address why registered nurses are ageing out of the sector, where 33 per cent are already 55 or over. Fund a preceptorship route for newly qualified nurses, fund post-registration specialism in palliative and end-of-life care, and end the flat NHS-funded Nursing Care rate's indifference to a nurse's expertise.

08

Build pathways for both NEETs and career switchers

Connect DWP's Get Britain Working programme to entry-level social care roles nationally by adopting the CAA's existing Pathway into Care programme rather than designing a replacement, and recognise the 55+ workers and midlife career switchers the sector already depends on, since 27 per cent of today's workforce is already over 55.

09

Build Membership and Registration routes

Introduce Student, Associate and Professional Membership tiers, and a phased registration model beginning with Advanced Practitioners, Delegated Healthcare Specialists, Registered Managers and Professional Leaders.

10

Publish a funded 10-Year Workforce Plan

Link workforce capability, funding and provider sustainability through future commissioning arrangements, reviewed on a defined cycle rather than announced and abandoned. Fee models should carry an explicit workforce-development line and a capability-linked uplift, so that a provider investing in progression recovers the investment through the rate. Fund the four immediate elements costed in Section 5.7 now, at £61–76 million a year.

01

SECTION ONE

The Case for a National Workforce Settlement

A workforce comparable in scale to the NHS, delivered by close to 19,000 separate employers, with no national professional framework of its own.

1.1 A Workforce the Size of the NHS, Without the Recognition

Adult social care in England supports older people, people with learning disabilities, autistic people, people with mental health conditions and people living with long-term health needs. It enables independent living, supports economic participation, delivers prevention and early intervention before a crisis reaches a hospital bed, reduces pressure on hospitals, supports rehabilitation and recovery, and delivers highly personalised care.

It also employs a very large number of people. Skills for Care's most recent workforce count put filled posts at around 1.71 million in 2024/25, rising further in 2025/26 as the sector recorded its fourth consecutive year of growth.[10] NHS England's equivalent headcount for hospital and community health services, which excludes GPs and other primary care staff, stood at around 1.55 million in March 2026.[11] The two figures are not counted on an identical basis. Skills for Care counts filled posts, some individuals holding more than one, while NHS England counts headcount and excludes primary care entirely. We set out both figures, and the caveat, rather than collapse them into a single headline number, because a document intended for Whitehall should survive the scrutiny a looser comparison would not. On a fair reading, adult social care's workforce is, at minimum, comparable in scale to the NHS's, and quite plausibly larger.

Despite this, social care remains largely invisible within wider workforce and skills policy. Unlike nursing, social work, physiotherapy and other recognised professions, it lacks a coherent professional identity that is understood by the public, policymakers and, at times, the wider health system itself. This is not a new observation. Research commissioned by the All-Party Parliamentary Group on Adult Social Care found that England lacks the registration and regulation infrastructure that would underpin a recognised profession, in contrast to arrangements already in place elsewhere in the UK.[15]

1.2 Who This Workforce Actually Is

Before the case for reform goes any further, it is worth saying plainly who is doing this work. Adult social care is a female-dominated workforce, at 78 per cent women against 48 per cent across the England-wide employed population, and, as Section 1.1 has already set out, an ageing one, with a mean age of 44 and 27 per cent of the workforce already aged 55 or over.[10] Many are themselves carers outside their paid work; Carers UK, drawing on the 2021 Census, estimates that just under 2.5 million people in employment across England and Wales combine a job with unpaid caring responsibilities, and there is no reason to think a workforce built around caring for others is exempt from that pattern.[16] And most of that workforce sits in the lower-paid, entry-level tier this paper is about: care workers are paid barely above the statutory minimum, and Section 5.1 sets out in full how thin the reward for staying and progressing has become.[12] A settlement that improves pay, progression and professional recognition for a workforce shaped like this is not simply a sectoral fix. It reaches a very large group of predominantly female, often financially stretched workers who are themselves shouldering caring responsibilities at home, so the economic and social benefit of getting this right extends well beyond the balance sheet of any single provider.

1.3 Why Workforce Reform Matters: Retention, Not Just Recruitment

Workforce challenges in adult social care have historically been framed as a recruitment problem. The more persistent problem is retention. Skills for Care's latest data puts the sector's vacancy rate at 6.2 per cent in 2025/26, the lowest in a decade but still around three times the wider economy's, alongside a turnover rate of 23.6 per cent.[4] The costing in Section 5.8 uses the 2024/25 rate of 23.1 per cent instead, because that is the year for which Skills for Care publishes the leaver count the arithmetic needs.[10] People entering the sector frequently cannot see how they progress, what they can become, which qualifications matter, or how responsibilities increase, and this uncertainty, more than pay in isolation, drives people out.[17]

AN ORIGINAL REGIONAL DATASET

To test the fragmentation argument ourselves rather than repeat Skills for Care's national headline, we built an independent, region-level dataset combining Skills for Care's 2024/25 workforce figures with our own count of CQC-registered adult social care providers by region, aggregated from CQC's full public provider directory. Full methodology and source files are in the Appendix.

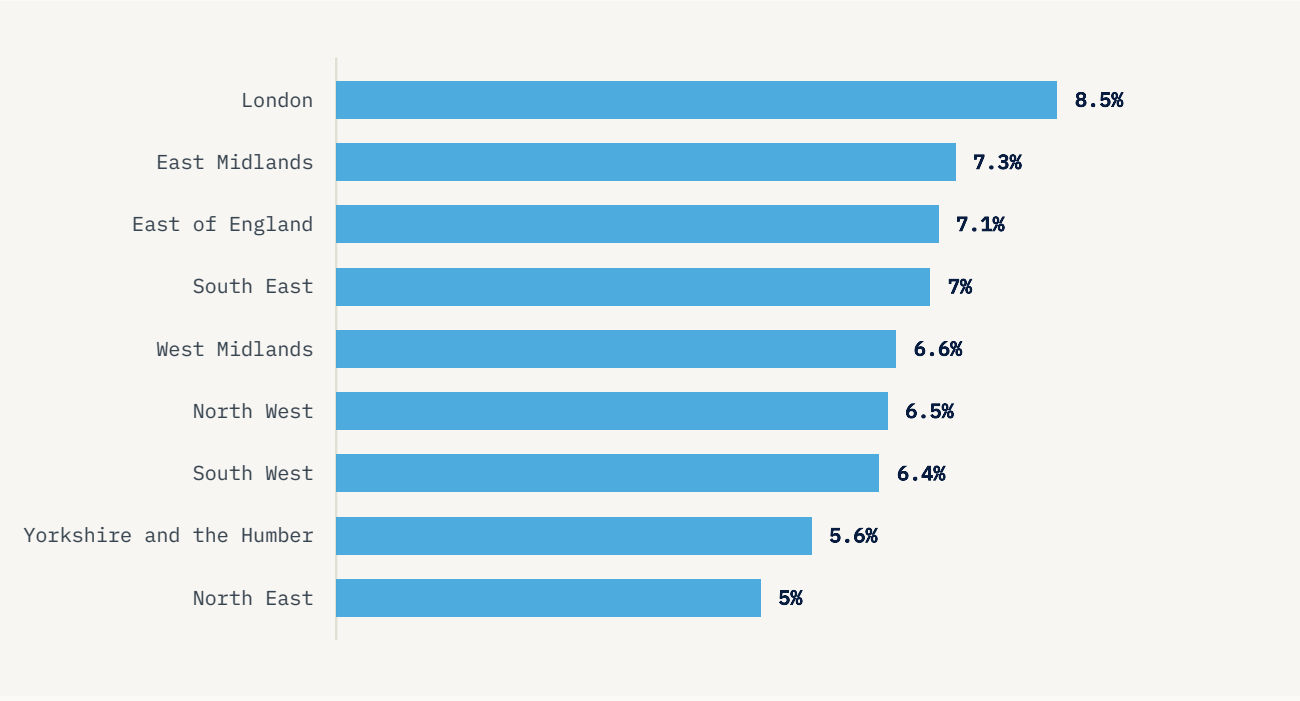
1.4 Fragmentation: Close to 19,000 Employers, Unevenly Distributed

Nearly 19,000 separate employers operate across adult social care in England, 37 per cent of them employing between one and four people, alongside a further 131,000 individually-employed personal assistants.[3] Our own aggregation of CQC's provider directory by region, a genuinely original count cross-checked against Skills for Care's national figure rather than simply repeating it, found 18,199 distinct CQC-registered providers nationally, a strong independent corroboration of the 19,000 figure using a different data source and methodology.[18]

That fragmentation is not evenly distributed. Our analysis found the North East has just 8.3 CQC-registered providers per 1,000 filled posts, compared with 15.4 in the East Midlands, nearly double, meaning the North East's workforce sits inside far fewer, larger employing organisations than the East Midlands' does. Regional vacancy and turnover rates diverge sharply too. London's vacancy rate is 70 per cent higher than the North East's, while the South East's turnover rate is the highest of any region even though London's is the lowest, an inversion a single national figure conceals entirely.[18]

Two caveats belong with this count. Not every adult social care employer is registered with CQC, so a provider count understates the true number of employers, particularly among directly employed personal assistants and services falling outside regulated activity. And CQC records a provider against the local authority where its location is registered rather than where care is delivered, which concentrates live-in and some domiciliary services in London. Neither materially changes the regional pattern reported here, but both are better stated by us than found by a critic.

Adult Social Care Vacancy Rate by Region, 2024/25 – Original CAA Analysis



This matters for the design of national policy. A settlement that assumes uniform regional conditions, or that tries to fix fragmentation with a single national employer, will fit some regions and fail others. A settlement built on portable competency and a shared professional framework, which can flex to genuinely different regional labour markets while still meaning the same thing everywhere, is better suited to what our own data shows.

1.5 The Structural Problems Fragmentation Creates

PROBLEM	WHAT IT LOOKS LIKE
Fragmentation	Close to 19,000 employers create significant variation in workforce development and progression opportunities, with no shared national standard for either.[3]
Lack of recognition	Frontline workers undertake increasingly complex responsibilities, including delegated healthcare tasks and mental health support at varying levels of acuity in the community, while remaining poorly understood and undervalued by wider systems.[3]
Pay compression	Insufficient differentials between frontline and supervisory roles reduce the incentive to progress or take on leadership responsibility, addressed in full in Section 05.
Workforce instability	Without a clear progression pathway, workers leave for careers that offer greater visibility and certainty, even where pay is comparable.[17]

These four problems compound one another. A worker who cannot see a career, who is not recognised for delegated clinical responsibility, whose progression is not rewarded in pay, and who works for one of 19,000 employers with no shared standard against which to measure their own competence, has every rational reason to leave for a sector that offers all four. The remainder of this paper sets out how a National Professional Framework, built on the Skills for Care Care Workforce Pathway, can address each in turn.

England does not need a single workforce.
It needs a single recognised profession.

CARE ASSOCIATION ALLIANCE – A NATIONAL WORKFORCE SETTLEMENT, 2026

02

SECTION TWO

Building on the Care Workforce Pathway

The CAA does not propose a new workforce framework. We propose completing the one Skills for Care has already built.

2.1 What the Pathway Already Gets Right

The Skills for Care Care Workforce Pathway is the most significant workforce development initiative undertaken within adult social care in many years. It already provides role descriptions, career routes, leadership pathways, specialist development opportunities, and recognition of increasing responsibility. It is, in short, the architecture on which a national profession can be built, and this paper does not propose starting again. Nor does it stand alone. Skills for Care also convened *A Workforce Strategy for Adult Social Care in England*, published in July 2024 and refreshed in July 2025, built with the sector and with people who draw on care and support rather than written in Whitehall.[19] It has not been adopted as government policy. That is part of the problem this paper describes. The sector has already done the work of setting out what it needs, and is still waiting for a government willing to own it.

2.2 What Is Still Missing

The Pathway currently lacks national competency recognition that would let a worker's progress be verified independently of the employer who trained them; portability between employers; alignment with commissioning; alignment with remuneration; and professional accountability frameworks. This last gap is not abstract. The Department of Health and Social Care's own 2021 White Paper acknowledges that although the Care Certificate is designed to be portable, in practice it has no central verification register, so a worker who has already completed it is routinely required to repeat it when they change employer, because only the employer who delivered the training can attest to it.[20] We correct our own earlier drafting of this point deliberately. A common care certificate has existed since 2015, and there is now also an accredited Level 2 Adult Social Care Certificate, developed by the Department of Health and Social Care with Skills for Care, regulated on the Regulated Qualifications Framework and funded up to £1,500 per learner through the Learning and Development Support Scheme.[21] Accredited qualifications of that kind are portable. The gap is narrower and more specific than we first put it. The original Care Certificate has no central verification register, and a large volume of in-house training sits outside any awarding body, so it cannot travel with the worker at all. That is, if anything, a stronger case for reform than the version we started with, because it identifies a specific, fixable failure rather than an absence.

QUALIFICATION PORTABILITY BETWEEN HEALTH AND SOCIAL CARE

There is also no single Level 4 apprenticeship standard spanning both health and social care support roles. The NHS-side "Healthcare Support Worker" apprenticeship and the social-care-side "Lead Practitioner in Adult Care" standard sit under separate governance, with no shared credit-transfer mechanism between them, a concrete, checkable gap in portability between the two systems this paper asks government to close. That gap is about to widen. On 16 March 2026 the Government confirmed the Level 4 Lead Practitioner in Adult Care among sixteen apprenticeship standards to be defunded from 1 September 2026, on the rationale that funding should be redirected towards younger learners and entry-level routes.[22] The effect runs against the stated intent. It removes the rung immediately above Level 3 and the social care T Level, so a young person completing that T Level has no funded apprenticeship route on into senior practice. A career framework cannot be built while its fourth rung is being withdrawn.

The CAA believes the Pathway should evolve into a National Professional Framework, the same architecture extended with the missing pieces above, rather than replaced.

2.3 The Six Principles of a National Professional Framework

The Six Organising Principles

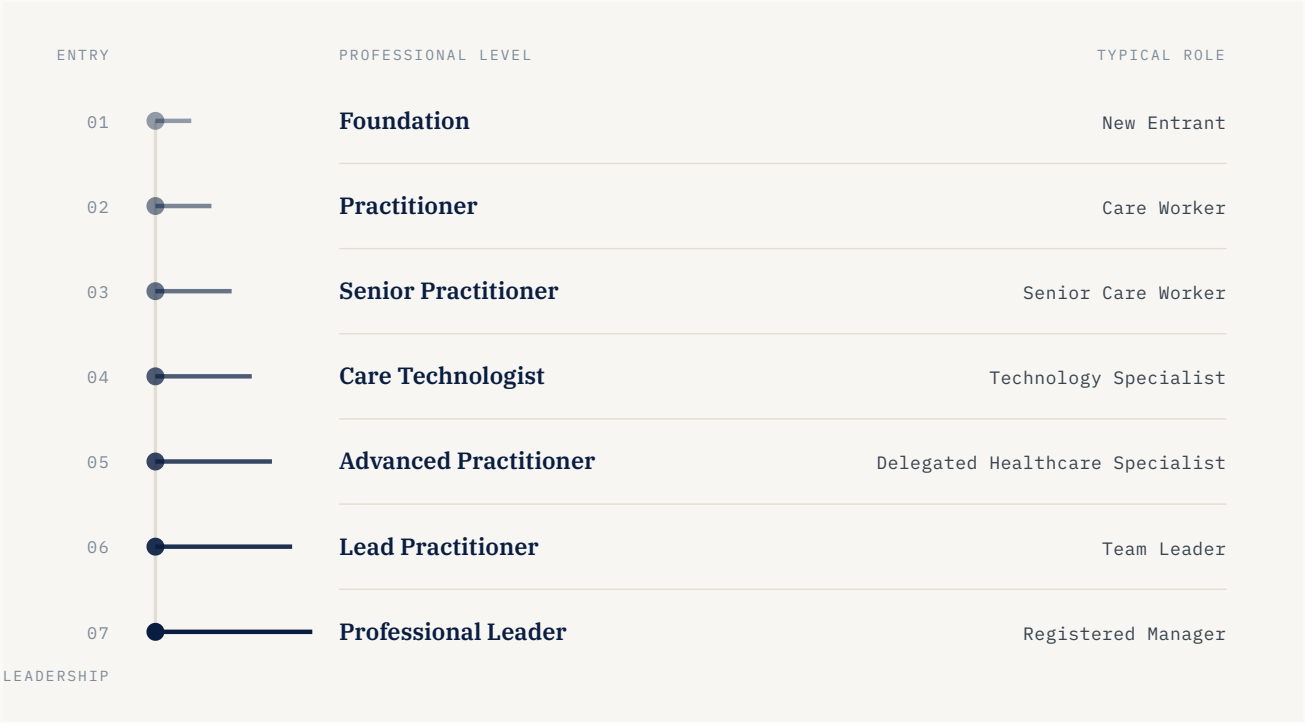
PRINCIPLE	WHAT IT MEANS IN PRACTICE
Parity	Comparable recognition where comparable responsibilities exist, without requiring identical contracts or employment models across health and social care.
Competency	Progression based on demonstrated competence rather than employer-specific training; competencies that are transferable and nationally recognised.
Portability	Workers can transfer recognised competencies and qualifications between employers without unnecessary duplication.
Diversity	The framework accommodates home care, residential care, supported living, learning disability services, mental health services and specialist services, without imposing a single model of delivery.
Progression	Every worker can identify a clear career journey from entry-level employment to leadership, specialist or advanced practice roles.
Professional Identity	Adult social care is recognised as a profession in its own right, with shared standards, values and expectations.

These principles create one recognised profession operating across many employers, preserving the diversity of adult social care while providing the consistency, recognition and career development that other established professions already have.

2.4 Professional Levels

We propose a nationally recognised progression framework built on typical roles already in use across the sector, rather than inventing new job titles wholesale:

The Seven Professional Levels



Read from entry level at the top to professional leadership at the foot. Rung length and tone indicate increasing recognised responsibility.

These levels describe professional capability rather than prescribe identical employment contracts, and are designed to map directly onto the Fair Pay Agreement structure set out in Section 05.

2.5 The Career, Described as a Parent or a Careers Teacher Would Ask For It

Everything above is written in the language of workforce policy. It is not the language in which a seventeen-year-old, a parent or a school careers lead decides anything. Their questions are narrower and harder. What do I study? What am I qualified to do at the end of it? Where does it go after that? And is it a career, or is it a job?

Adult social care can answer the first two questions today. It cannot yet answer the third, and that is why it loses the argument in school halls to nursing, to teaching and to the trades. The route below is the one the sector should be able to put in front of a careers teacher. Every rung on it either exists now or has been announced by government. Only one is missing, and it is being removed rather than built.

STAGE	ROUTE	STATUS TODAY
16–18	T Level in Social Care (Level 3), based on the Lead Adult Care Worker occupational standard with an Adult Social Care specialism; or a Level 2/3 apprenticeship in adult care.	The T Level was confirmed in July 2026, with outline content consulted on from summer 2026 and first teaching from September 2028. The apprenticeship routes exist now at £4,000 funding.[23,24]
18–21	Level 4 practice qualification, carrying delegated healthcare competence, Care Technologist specialism, or both. Professionally, this is the step from doing the work to being accountable for it.	**Being withdrawn.** The Level 4 Lead Practitioner in Adult Care is defunded for new starts from 1 September 2026.[22]
21+, clinical route	Nursing associate, then registered nurse; or social work; or occupational therapy. All are registered professions with their own regulators, and all already employ people inside adult social care.	The destinations exist. What does not exist is a recognised, credit-bearing bridge from a social care Level 4 into them, so time served in care counts for little on entry.
21+, leadership route	Team Leader, then Registered Manager, then multi-service and senior management. Around 26,400 registered manager posts exist, with an 11.4 per cent vacancy rate and 32 per cent of post-holders aged 55 or over.[10]	The destination exists and is actively short of people. The route to it is served almost entirely by internal promotion rather than by qualification.

Read as a single sequence, the problem is stark. Government has committed to building a social care T Level for first teaching in September 2028, and is removing funding from the qualification immediately above it in September 2026. The stated rationale for defunding sixteen standards was to redirect resources towards younger learners and entry-level routes.[22] In this sector the effect is the reverse of the intention. It leaves a young person who completes the new T Level with no funded route onwards, which is precisely the objection a careers teacher will raise, and precisely the reason a parent will steer their child elsewhere.

Skills England's own assessment makes the consequence measurable. It projects that 79 per cent of additional employment in these occupations to 2035 will require qualifications only at Level 2 or 3, with just 21 per cent at Level 4 or above, and records that 83 per cent of adult social care apprenticeship starters are already aged 24 or over.[25] Those figures are usually read as a description of the sector. They are better read as a description of its ceiling. A workforce with almost no funded rungs above Level 3 will, unsurprisingly, project almost no demand above Level 3, and will keep recruiting adults who arrive from other sectors rather than young people who choose it first.

The CAA's proposal is therefore specific. Reinstate funding for a Level 4 practice qualification and designate it, explicitly, as the progression route from the social care T Level, with delegated healthcare competence and the Care Technologist role as named specialisms within it. Confirm it before the T Level consultation concludes, so that the qualification is designed with somewhere for its students to go. Section 05 sets out what this costs, which is less than the sector currently spends in a single week replacing the people who leave.

03

SECTION THREE

A Recognised Workforce for Every Setting

A recognised Care Technologist role, and explicit places within the framework for the registered professions already working in and alongside social care, so that every part of this workforce can see itself in one career structure.

3.1 Care Technologists: A New Profession for a New Era

Technology-enabled care will become increasingly important over the next decade, yet there remains no recognised workforce role responsible for helping providers and citizens maximise the benefits of assistive technology and digital care solutions. We propose a recognised Care Technologist pathway, covering assistive technology assessment, remote monitoring implementation, falls prevention systems, smart home support, emerging digital care applications, digital inclusion, and data quality and interoperability.

THIS PROPOSAL IS NOT SPECULATIVE

The role was developed by the National Care Forum, which designed and piloted the first Care Technologist training programme, co-produced with people who draw on care and support and funded by The Rayne Foundation, with national rollout running from July 2026. Skills for Care's own *Workforce Strategy for Adult Social Care in England* (July 2025) has committed, with CQC and the Care Provider Alliance, to supporting that rollout, and the role is being added to the Care Workforce Pathway alongside the Nominated Individual and Activity Co-ordinator as a non-direct-care role.[19] We ask government to back a role the sector has already designed, piloted and begun to teach, not to invent a new one.

Technology should not replace care. Peer-reviewed evidence on technology in care systems finds it reshapes rather than displaces frontline roles, and research from the ESRC Centre for Care questions the assumption of a sector-wide digital "skills gap", arguing that existing frontline digital competence is routinely underestimated and overlooked rather than genuinely absent.[26] A Care Technologist role should enhance independence and free frontline staff to focus on activities requiring human relationship, judgement and compassion.

3.2 Registered Social Workers and Occupational Therapists

The steering group that reviewed this paper's early draft agreed that registered social workers, occupational therapists and physiotherapists working in or alongside adult social care must be explicitly named within the National Professional Framework, not left to be assumed within it. We support that addition, and unlike the position we started from, we can now put a current figure behind it rather than a stale one.

UPDATED FROM A 2017 FIGURE TO 2024/25 DATA

An earlier draft of this paper cited a 2017 estimate because it was the only adult-social-care-specific breakdown we could locate. Skills for Care's 2025 State of the Sector report in fact contains a current figure of an estimated 21,500 social worker filled posts in adult social care in 2024/25 (19,200 in local authorities, 2,300 in the independent sector, plus a further 4,900 adult social care social worker posts within the NHS, not counted in this total), and 3,900 occupational therapist filled posts (3,400 local authority, 450 independent, plus 1,000 occupational therapist assistant posts).[10] Both roles have grown substantially in local authorities over the past six years, with social worker posts up 13.2 per cent and occupational therapist posts up 27.3 per cent since 2018/19, linked in part to higher recent enrolment in social work higher education.[10] We withdraw our earlier recommendation to commission new data collection. The current data already exists, in Skills for Care's own published report, and simply needed to be found.

These professions already work inside a sector that has no shared framework for recognising them alongside the wider care workforce they work with every day, and Institute for Fiscal Studies analysis of career pathways within the NHS shows how much a coherent occupational mobility structure matters for retention and progression once it exists.[27] The same logic should extend across the health and social care boundary, not stop at it.

3.3 Registered Nurses: A Workforce Ageing Out Faster Than the Rest

Registered nurses are the clearest case of a regulated profession already embedded in adult social care without a recognition framework to match. Skills for Care counts an estimated 35,000 registered nurse filled posts in adult social care in 2024/25, almost entirely in care homes with nursing, up from 33,000 the year before, the second consecutive year of growth after the total fell from 37,000

in 2018/19 to a low of 31,000 in 2022/23.[10] That recovery is welcome, but it sits on top of a workforce that is ageing out faster than any other role in the sector bar senior management. The mean age of a registered nurse in social care is 47.8, and 33 per cent are aged 55 and over, against 27 per cent for the workforce as a whole and 23 per cent for care workers specifically.[10]

Nor is this confined to care homes. There are registered nurses in home care and in services supporting working-age adults outside residential settings, and they are less visible still. Turnover among registered nurses in adult social care ran at 32.8 per cent in 2024/25, around 9,700 leavers, the highest of any professional role in the sector.[10]

The funding point needs stating precisely, because it is easy to get wrong. The nursing element of a care-home place attracts NHS-funded Nursing Care, paid at a single national rate of £267.68 a week from April 2026.[28] That is an NHS payment, not a local authority one, and it is a flat contribution unrelated to what a nurse actually costs, to how experienced that nurse is, or to what specialist competence they hold. There is no mechanism anywhere in the system by which a nurse in social care becoming more expert makes their employer better able to pay them. The Royal College of Nursing campaigned for a separate pay spine that would address the comparison with equivalent NHS roles, a specific ask government ruled out in April 2025; the underlying problem the campaign identified, a flat rate indifferent to a nurse's expertise, has not gone away simply because that particular mechanism was rejected.[29]

3.4 What We Propose for Nursing in Social Care

The sector has tended to describe this as a problem of losing nurses. The more useful framing is that social care is not yet presenting itself as a place where nurses are made. A newly registered nurse in a care home, a supported living service or a home care service practises in a setting that is relationship-based rather than task-based, carries genuine autonomy early, and builds a breadth of assessment and long-term-condition experience that is harder to acquire on a ward. That is a strong foundation for a nursing career, whether the nurse spends it in social care or in the NHS. At present the sector recruits nurses predominantly towards the end of their careers, which is why its nursing workforce is the oldest in the sector. We propose four changes.

PROPOSAL	WHAT IT INVOLVES
A social care route for newly qualified nurses	A funded, supervised preceptorship year in adult social care, on the model of the Assessed and Supported Year in Employment already funded for newly qualified social workers, so that a first nursing post in social care is a recognised start rather than an unusual choice.
Post-registration specialism, funded	Nurses in social care are frequently the system's deepest expertise in palliative and end-of-life care, dementia and complex long-term conditions, and there is no funded route for them to study beyond registration as NHS colleagues can. Recognised specialist credentials should sit at Advanced Practitioner level within the National Professional Framework, with funded access.
Independent prescribing, done properly	Extend independent prescribing to social care nursing at meaningful scale, designed with the sector, with the training funded and the governance settled before rollout. Appendix A.5 sets out what the current pilot does and does not do.
A funding route that rewards expertise	NHS-funded Nursing Care should stop being a flat national rate unrelated to competence. A defined uplift where a service is staffed by nurses holding verified specialist credentials would, for the first time, make it rational for an employer to fund a nurse's development.

A National Workforce Settlement that recognises Advanced Practitioner and Delegated Healthcare Specialist levels, as set out in Section 02, without also addressing why registered nurses specifically are ageing out of the sector, will have missed one of its clearest test cases.

04

SECTION FOUR

Delegated Healthcare and the Health/Social Care Boundary

Two-thirds of care workers already carry out delegated healthcare tasks. Almost none are recognised or paid for it.

4.1 The Scale of Delegation Already Happening

As neighbourhood-based care expands, social care staff are increasingly expected to undertake delegated healthcare activities. This is not a future possibility; it is already the reality on the ground, and it is only going to grow. Neighbourhood health is built on the premise that more clinical activity moves out of hospitals and into the settings where people already live, which for a large share of the population needing ongoing care means a social care setting rather than a GP surgery or a community health team on its own. Every one of those models depends on the delegated-healthcare workforce this section describes, and none of the models currently being designed for neighbourhood health name that workforce, define what it is authorised to do, or fund it to do it. A 2026 survey by The Care Workers' Charity found 67.9 per cent of care workers report being asked to perform delegated healthcare activities such as wound management, catheter care, PEG feeding and insulin administration. Of those, 93 per cent have never received additional compensation for doing so.[8]

One clarification belongs with that figure. The survey's own definition of a delegated healthcare activity includes medication administration, which in most social care settings is long-established practice rather than a newly transferred clinical task. The report does not publish a task-by-task breakdown, so we cannot say what the figure would be with medication administration excluded, and we do not estimate one.

Guidance already exists, and this paper should say so plainly. Skills for Care, the Department of Health and Social Care and partners including CQC co-developed voluntary *Guiding Principles* for delegated healthcare activities in May 2023, refreshed in November 2024 after independent evaluation.[30] They cover the conditions for safe delegation, roles and responsibilities across health and social care, governance, and learning and development. What they are not is binding, tied to verified competence, connected to pay, or settled on accountability and insurance. The gap this paper identifies is not an absence of thinking. It is the absence of a framework with force.

The more important finding is that no shared definition exists at all. Care workers in the same study described catheter care, stoma care, wound management and monitoring vital signs as "just part of the job", without recognising them as clinically delegated interventions, and their first stated ask was a clearly defined, nationally recognised list of what counts. On competence, 60.9 per cent reported they had not been asked to work beyond their competence or training, which leaves a substantial minority who had. A National Delegated Healthcare Framework should therefore begin by publishing and maintaining that list, rather than adding governance on top of an activity nobody has defined.[8]

67.9%
CARE WORKERS ASKED TO PERFORM DELEGATED HEALTHCARE TASKS[8]

93%
OF THOSE, NEVER ADDITIONALLY COMPENSATED FOR IT[8]

2023
VOLUNTARY GUIDING PRINCIPLES PUBLISHED; REFRESHED 2024, STILL NON-BINDING[30]

Delegated Healthcare, and the Recognition Gap Inside It

Bar represents all care workers in England. Segments are shares of that whole.

Derived from The Care Workers' Charity 2026 survey. The 93 per cent uncompensated figure is a share of those asked, shown here as a share of the whole workforce.

4.2 What the Evidence Says About Safety

The academic evidence does not support treating delegation as inherently unsafe, nor as automatically safe. A systematic review of delegating medication administration from registered nurses to non-registered support workers in community settings found that safety and quality depend on training, supervision and role clarity, not on the fact of delegation itself.[31] A separate scoping review confirms that the absence of a standardised role for unregistered support staff creates genuine confusion about where responsibility begins and ends.[32] A meta-analysis of delegated therapy to allied health assistants found that outcomes can be maintained when delegation is properly structured and supervised.[33] Taken together, this evidence points in one direction. The risk is the absence of a framework, not the principle of delegation.

4.3 A National Delegated Healthcare Framework

A National Workforce Settlement should establish a framework covering governance, competence, escalation, supervision, accountability, insurance, training and remuneration for delegated healthcare tasks. This would support consistency and improve confidence among providers, health professionals and commissioners, and it would finally recognise, in pay and professional status, work that two-thirds of the workforce already report doing.

That is the destination. Because the sector has spent a decade being told what the problem is, it is worth being concrete about the steps, and about what already exists. The *Guiding Principles* described above, and the delegation toolkit developed within Skills for Care that preceded them, already contain most of the thinking on safe delegation.[30] What is missing is not analysis. It is a national definition, a way of verifying competence against it, and a price. Five steps would supply all three.

STEP	WHAT IT REQUIRES
1. Publish the list	A nationally recognised, maintained list of what counts as a delegated healthcare activity, distinguishing tasks that are long-established practice in social care from those genuinely transferred from a registered professional. This was care workers' own first stated ask, and nothing else on this list can be built without it.[8]
2. Attach a verified competence to each	Each listed activity should map to a competence recorded on the national verification record described in Section 2.2, so that a worker's authorisation to perform it travels with them and does not need re-establishing at every change of employer.
3. Settle accountability and indemnity	Convert the voluntary *Guiding Principles* into a binding national framework, agreed with the professional regulators, the Care Provider Alliance and the insurance market, so that the delegating professional, the employer and the worker each know where responsibility sits. This is the single question that most often stops safe delegation happening at all.
4. Recognise it in pay	Establish Delegated Healthcare Specialist as a Professional Level under Section 02, carrying a differential negotiated through the Fair Pay Agreement. At present 93 per cent of those asked to perform these tasks receive nothing additional for doing so.[8]
5. Fund it through the contract	Where a clinical task is delegated into a social care service, the fee should carry the competence, supervision and indemnity that task requires, as set out in Section 5.6. Delegation that is free to the delegating body and unfunded for the receiving one is not a framework, it is a transfer of risk.

Taken together these steps also answer the safety objection in Section 4.2 directly. The academic evidence found that safe delegation depends on training, supervision and role clarity. Steps one to three supply exactly those three things, which is why the CAA regards a national framework as a patient safety measure and not only a workforce one.

None of this is a side issue to the wider integration agenda; it is a precondition for it. Every future model of integrated, neighbourhood-based care assumes a workforce able to move fluidly across the boundary between health and social care, picking up clinical tasks close to where people live rather than routing them back through acute settings. That workforce already exists, doing that work, today, described at the start of this section. What integration policy has not yet done is name it, define what it is competent and authorised to do, and pay for it accordingly. A National Delegated Healthcare Framework is not a separate ask alongside neighbourhood health; it is the workforce foundation neighbourhood health cannot be built without.

05

SECTION FIVE

Fair Pay, Funding, Commissioning and Cost Effectiveness

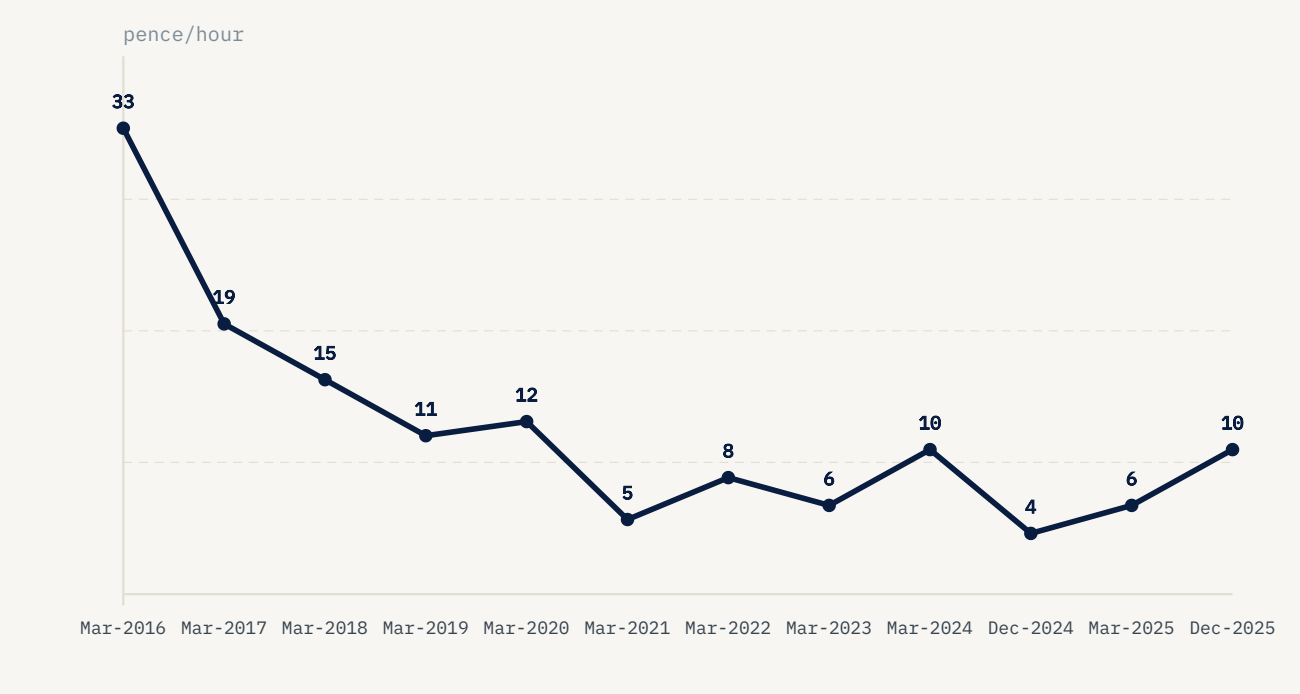
The experience premium has fallen from 33p an hour to single figures since 2016. What the first steps cost, what they return, and why an employer should want any of it.

5.1 An Original Reconstruction of Pay Compression Since 2016

The claim that experience in adult social care has stopped being rewarded is frequently made and rarely tested against primary data. We tested it ourselves.

Rather than rely on a secondary source's framing of the trend, we reconstructed it directly from twelve editions of Skills for Care's own "Pay in the Adult Social Care Sector" reports, spanning March 2016 to December 2025.[5]

The Experience Pay Premium Has Nearly Disappeared, 2016–2025 – Original CAA Analysis (pence per hour, 5+ years' vs under 1 year's experience)



The premium for five or more years' experience over under one year's fell from 33p an hour in March 2016 to a range of 4–10p between 2021 and 2025, a near-total erosion confirmed directly from Skills for Care's own reports rather than taken on trust from a secondary source.[5] A related but distinct measure, the role-based differential between senior care worker and care worker pay, tells the same story from a different angle, having fallen from around 10 per cent to around 6 per cent over the same period.[5] Even the raw premium of frontline pay above the statutory minimum wage has fallen, from 58p an hour in 2016 to 39p in December 2025, showing this is not simply a mechanical effect of minimum wage upratings.[5]

A NOTE ON PRECISION

Resolution Foundation's widely cited figures (33p in 2016, falling to 7p in 2025) sit within, but do not exactly match, Skills for Care's own published series (33p in March 2016; 6p in March 2025; 10p in December 2025), most likely reflecting a different ASC-WDS data pull date.[12] The direction and scale of the erosion are fully independently corroborated; we cite Skills for Care's own range rather than restate the exact 7p figure as independently verified, because a document going to Whitehall should not repeat a number we could not reproduce ourselves to the penny.

5.2 Fair Pay Agreements and Workforce Recognition

The proposed Fair Pay Agreement represents one of the most significant opportunities in a generation to improve recruitment, retention and recognition in adult social care. But pay alone will not create a sustainable profession. Workforce sustainability depends equally on career progression, professional identity, development opportunities, recognition of responsibility and public esteem.[34] We therefore propose that the Care Workforce Pathway provide the workforce architecture through which the Fair Pay Agreement is implemented. The Pathway identifies progression routes and increasing responsibility across the profession, and Fair Pay Agreements should provide the mechanism through which those increasing levels of competence and responsibility are recognised and rewarded, mapped against the Professional Levels set out in Section 02.

It is worth being precise about what a Fair Pay Agreement can actually cover, because the public debate has narrowed it to an hourly rate, and because the mechanism is being built right now. The Employment Rights Act creates Social Care Negotiating Bodies, whose remit is set by regulations, and those regulations may expressly "specify additional matters relating to employment as a social care worker".[35] So the remit is not fixed by the Act. It is a choice made in secondary legislation.

Government has already indicated the direction. Its own factsheet states that it expects negotiations "on pay, terms and conditions and other matters such as training and career progression" to be held in 2027, with the agreement implemented in 2028, and it says plainly that "the scope of the FPA process is yet to be determined", with a public consultation on scope in England still to come and a sector working group already convened.[35] What this paper proposes is therefore not an expansion of the Fair Pay Agreement into unfamiliar territory. It is a request that the scope consultation, and the regulations that follow it, put career progression and portable competence inside the remit rather than leaving them adjacent to it.

The sequencing still matters. Year one will be dominated by entry-level pay, because the £500 million attached to it will not stretch further. That is a funding constraint, not a definition of the remit. What we propose should be understood as the agenda for years two to ten: alignment to the Care Workforce Pathway, and then the wider terms of employment that the NHS settled with its own workforce through Agenda for Change and that adult social care has never had. The window for putting that in scope is the consultation, not the negotiation.

Skills for Care's own data supports treating the non-pay terms as substantive rather than peripheral. Care workers whose employer contributed above the minimum 3 per cent into the workplace pension had a turnover rate of 21.7 per cent against 25.9 per cent where the employer did not; where the employer paid more than Statutory Sick Pay, turnover was 23.3 per cent against 26.0 per cent.[10] These are associations rather than proven causes, and the same caution applies to them as to the qualification finding in Section 5.8. But they point the same way, and they are the kind of terms a Fair Pay Agreement is designed to settle.

5.3 Fair Pay Must Be Fully Funded

The Government's own impact assessment puts the cost of the Fair Pay Agreement process at an average of £0.8 billion a year, a £6.4 billion present-value cost over ten years, and £10 million in transition costs.[9] The £500 million announced for care worker pay in the June 2026 Spending Review does not land until 2028, and is more than offset in the near term by increased employer National Insurance contributions, a real-terms funding shortfall in the interim that providers cannot be expected to absorb.[36] Implementation should be accompanied by a transparent national approach to fee-setting, recognition of workforce capability within commissioning frameworks, and sustainable workforce investment, following the five national pay-policy options set out jointly by the Health Foundation and Nuffield Trust.[34] Without corresponding funding reform, workforce improvements risk increasing financial pressure on providers and destabilising local care markets, exactly the outcome our first paper warned against.

5.4 Provider Sustainability

Provider sustainability is inseparable from workforce sustainability. A National Workforce Settlement, aligned with Fair Pay Agreements and commissioning reform, would create a transparent relationship between workforce capability, remuneration, funding and service delivery, helping ensure providers who invest in

workforce development are recognised through commissioning arrangements, rather than expected to absorb rising workforce costs unsupported.

5.5 Why an Employer Should Want This

Most of this paper argues from the position of the worker and of the public. That is not sufficient. A settlement that close to 19,000 employers have no commercial reason to support will not be delivered, however well it is designed.

So it is worth stating the employer's objection in its strongest form, because it is a rational one and it is heard constantly in the sector. Why would a provider fund a worker's progression to a nationally recognised, fully portable competence, when the predictable result is that the worker takes it to the NHS or to the local authority, both of which pay more and neither of which paid for the training?

Three things need saying in answer, and the first is that the fear is larger than the flow.

THE CHURN IS OVERWHELMINGLY INTERNAL TO SOCIAL CARE

Skills for Care records that 53 per cent of all starters in adult social care were recruited from within adult social care itself. Of the 47 per cent recruited from outside, around 7 per cent came from the health sector and 40 per cent from other sectors and international recruitment.[10] In other words, for every worker arriving from the NHS or the wider health system, roughly seven arrive from inside adult social care itself, and roughly six more from other sectors and from international recruitment. The dominant movement in this labour market is provider to provider, not social care to NHS. That does not make the leakage to health imaginary, and Section 03 shows it is real and specific among registered nurses. But it means the great majority of the training an employer funds today is lost to another social care employer, who then pays to establish competence that was already established, while the worker repeats a course they have already passed.

Read that way, portability is not what causes the loss. It is what stops the loss being paid for twice. A provider recruiting a worker with verified competence at a recognised Professional Level does not fund that competence again, and the 53 per cent of starters who arrive from within the sector arrive with something the receiving employer can rely on. The present arrangement, in which competence cannot travel, does not protect the employer who trained the worker. It simply taxes the employer who hires them next, and the sector as a whole pays that tax roughly 335,000 times a year.

The second answer is that where the leak to health is real, it is a pay and recognition problem rather than a training problem. Registered nurses in social care turn over at 32.8 per cent, and the sector holds no mechanism by which a nurse's growing expertise improves what their employer can pay them, as Section 3.3 sets out.[10] Withholding development does not close that gap. It keeps the gap and removes the capability.

The third answer is the one that matters most, and it is the one this paper has not previously made explicit. None of the above is enough on its own, because an individual provider operating on a fee rate set without reference to workforce development cannot fund workforce development out of goodwill. The mechanism has to run through commissioning, and it has to run in both directions.

5.6 How the Framework Should Feed Into Commissioning and Fee Levels

The National Professional Framework gives commissioners something they do not currently have, which is an objective, externally verified statement of what a provider's workforce can actually do. At present a commissioner buying care has almost no way of distinguishing a provider that has invested in its people from one that has not, other than by reading a CQC report written about something else. Recognised Professional Levels, verified independently of the employer, make workforce capability a property of the service that can be specified, evidenced and paid for. That is what makes the exchange two-way: the provider gains something to be paid for, and the commissioner gains something worth buying.

MECHANISM	WHAT IT WOULD MEAN IN A FEE MODEL
A workforce-development line in the fee	Fee models should contain an explicit, published line for workforce development, calculated on a national methodology rather than left to be absorbed. Today this cost sits nowhere in most rate-setting, which is the practical reason providers cannot fund progression.
Capability-linked uplift	A defined uplift where a service is staffed at specified Professional Levels, including verified delegated healthcare competence, so that a provider investing in progression recovers the investment through the rate rather than absorbing it.
A no-repeat rule	Where the national record verifies a competence, no commissioner or provider should be able to require it to be retrained as a contractual condition. This removes duplicated training cost from the system without any new money.
Delegated healthcare, priced	Where a commissioner or an NHS body delegates a clinical task into a social care service, the fee should reflect the competence, supervision and indemnity that task requires. Two-thirds of care workers already carry out such tasks and 93 per cent of them are not paid for it, as Section 04 sets out, because nothing in the contract says they should be.[8]
Nursing expertise, priced	NHS-funded Nursing Care is paid at one flat national rate irrespective of the nurse's experience or specialism.[28] A specialist-credential uplift would create the first direct financial reason for a care home to fund a nurse's post-registration development.

None of these mechanisms requires a new bureaucracy, and none requires the single national employer this paper has consistently argued against. They require the framework to exist, to be verifiable, and to be referenced in the documents through which public money actually reaches providers. Recommendation 10 asks government to make that reference explicit rather than aspirational.

5.7 What the First Steps Cost

The steering group asked a fair question of an earlier draft: the paper described what should happen without saying what it costs. Several of the components proposed here run over a decade and cannot be costed credibly today. But the elements the CAA believes should begin now can be, and we set them out below with their unit costs, their sources and their arithmetic. Where a figure is published we cite it. Where the figure is our own estimate, we say so and show the derivation, in Appendix A.4, rather than presenting an estimate as a finding.

ELEMENT	BASIS	ANNUAL COST
Reinstate the funded Level 4 rung	ST0007 Lead Practitioner in Adult Care at its £7,000 funding band, for 1,300–2,000 starts a year. The lower bound reflects the 1,320 Level 4/5 apprenticeship completions Skills England currently records entering these occupations.[24,25]	£9m–£14m
Restore the qualification fund to its original scale	The Level 2 Adult Social Care Certificate was originally funded at £53.9 million for 37,000 staff, about £1,457 each. The successor Learning and Development Support Scheme is £10 million for 2026/27. This line is the difference.[37,21]	£44m
A national competency verification record	CAA estimate, not a published figure. Built on the existing Adult Social Care Workforce Data Set rather than as a new regulator; benchmarked against, and deliberately far below, Social Work England's £30 million cost of running a full register for around 106,000 registrants.[38]	£5m–£15m
Independent prescribing at meaningful scale	The current pilot provides £461,000 for the 150 nurses announced, about £3,073 each. Extending to 1,000 nurses, under 3 per cent of the 35,000 registered nurse posts in the sector.[39]	£3m
A phased register for the senior tier (Phase Three, not in the total)	A first tranche of 30,000–60,000, beginning with the 26,400 registered managers. Costed at Social Work England's cost per registrant of around £283 a year, which is an upper bound because it includes full fitness-to-practise functions. Shown here so the running cost is on the record; Section 06 sequences registration behind the verification record, so it is excluded from the immediate total.[38]	£8m–£17m
Total, immediate package	The four lines above the register. Gross, before any fee income. The CAA's position is that a registration fee, when a register opens, should not fall on individual workers at current pay levels.	**£61m–£76m**

Three comparisons put that range in proportion. It is between 8 and 10 per cent of the £0.8 billion a year the Government's own impact assessment attaches to the Fair Pay Agreement.[9] It is between 2.3 and 2.8 per cent of the £2.7 billion a year The King's Fund attributes to delayed hospital discharges, the largest single cause of which is the unavailability of a social care package.[14] And expressed per worker, it is £36 to £44 a year for each of the sector's 1.71 million filled posts, against the £10 million now available through the Learning and Development Support Scheme, which is under £6 per post per year.[21,13]

5.8 The Return on That Investment

The return is easiest to see in the cost the sector already carries. Skills for Care puts turnover among directly employed staff at 23.1 per cent in 2024/25, approximately 335,000 leavers in a single year.[10] Skills for Care's own recruitment cost template puts the cost of replacing one worker at over £3,600, and Care England puts it at over £6,000.[40,41] On our own arithmetic, that places the sector's annual replacement bill between £1.2 billion and £2.0 billion. Care England's widely quoted £3 billion sits above our range because it assumes a higher turnover rate than Skills for Care's published figure; we report our own calculation, from the published leaver count and both published unit costs, rather than adopt a number we could not reproduce.[13]

335,000	£1.2–2.0BN	£52–87M

LEAVERS IN A SINGLE YEAR, AT A 23.1 PER CENT TURNOVER RATE[10]

WHAT REPLACING THEM COSTS THE SECTOR ANNUALLY, ON PUBLISHED UNIT COSTS[13]

RETURNED BY TAKING A SINGLE PERCENTAGE POINT OFF THE TURNOVER RATE[13]

That third figure is the whole argument. One percentage point off the sector's turnover rate is around 14,500 fewer people leaving, taking the base implied by Skills for Care's own two figures, since the 23.1 per cent rate is a rate for directly employed staff and not for all 1.71 million filled posts. On the same published unit costs that returns between £52 million and £87 million a year, against a package costing £61 million to £76 million. At the midpoint of both ranges the investment pays for itself on retention alone, recurring annually, before counting a single improvement in quality, in continuity of care, or in pressure on the NHS.

The obvious question is whether a one-point reduction is plausible. The most directly relevant evidence is Skills for Care's own, and it is stronger than a single point. Care workers holding a relevant social care qualification left at 21.0 per cent over the year, against 27.2 per cent for those who did not, a gap of 6.2 percentage points across a workforce in which 55 per cent hold no relevant qualification on record.[10]

WE QUOTE SKILLS FOR CARE'S OWN CAUTION IN FULL

"It should be noted that gaining a qualification may not make somebody more likely to stay in their role. It could be the case that people who have decided they want to pursue social care as a career are less likely to leave, and those people are also more likely to gain formal qualifications."[10] We reproduce that caveat rather than bury it. The 6.2-point gap is an association, and part of it is certainly selection rather than effect. Our costing therefore does not assume it. It assumes one percentage point, less than a sixth of the observed gap, and still breaks even. If the true effect is larger, as the pension and sick-pay findings in Section 5.2 suggest it may be, the return improves. We would rather understate a return we cannot prove than overstate one we can.

Two further returns sit outside that arithmetic and are worth naming even though we have not monetised them. The first is the NHS. Delayed discharges cost around £2.7 billion a year on a bed-day unit cost of £562, and the largest cause is the absence of an available social care package.[14] On those figures, the nurse prescribing element of this package would cover its entire cost if each participating nurse averted between five and six hospital bed days a year, which is the effect the Government's own pilot was designed to test.[39,13] The second is demand. Skills England projects that adult social care and its related occupations will need around 685,000 additional and replacement workers by 2035, including 281,000 from growth alone.[25] A sector cannot recruit at that scale into a career whose fourth rung is being removed. The cost of building the rung is £9 million to £14 million a year. The cost of not building it is a recruitment target that will not be met.

5.9 Who Pays, and Who Saves

One objection belongs in the open, because it is the first a finance official will raise. The replacement costs set out above are borne by providers, while the investment this paper asks for falls on government. On its own, therefore, "it pays for itself" is a statement about the system rather than about the department writing the cheque.

We think an exchequer case still holds, for two reasons. Delayed discharges cost the NHS around £2.7 billion a year and their largest single cause is the unavailability of a social care package, so workforce capability that keeps people out of hospital, and moves them out of it sooner, returns public money directly.[14] And a sector with lower turnover is a cheaper sector to legislate for, because the Fair Pay Agreement's £0.8 billion a year is applied to a workforce that currently has to be continually replaced.[9]

We have not attempted to quantify the exchequer share of the return, and we do not claim one. We say only that the saving is real, that part of it is public, and that we would welcome the Department testing both propositions against its own models. The arithmetic is set out in Appendix A.4 precisely so that it can be.

“

A care worker with five years’ experience now earns a few pence more an hour than someone who started last week. In 2016, the gap was 33p.

CARE ASSOCIATION ALLIANCE – A NATIONAL WORKFORCE SETTLEMENT, 2026

06

SECTION SIX

Professional Recognition and Registration

Membership and registration, built the way nursing built theirs, through standards rather than a single reform moment.

6.1 Student, Associate and Professional Membership

The CAA supports creating a membership pathway aligned to workforce progression, with a Student Member tier for those on social care T Levels, apprenticeships, foundation degrees or other recognised programmes; an Associate Member tier for newly employed workers developing competence; a Professional Member tier for practitioners meeting recognised competency standards; and a Fellow or Advanced Practitioner tier for leaders, educators and specialists. This would strengthen professional identity from the earliest stages of a person's career, rather than only once they reach a senior role.

6.2 A Phased Approach to Professional Registration

Professional registration should form part of the long-term vision for social care, but it should be phased, beginning with Advanced Practitioners, Delegated Healthcare Specialists, Registered Managers and Professional Leaders, before consideration is given to wider registration arrangements. The objectives are public confidence, safeguarding, accountability, professional recognition and workforce portability, the same objectives that justify registration in nursing, social work and the allied health professions today.

6.3 Why Registered Managers Belong at the Front of the Queue

Registered Managers deserve more attention than a single line in a phasing list, because the case for starting with them is stronger than for any other tier. There are around 26,400 registered manager posts in adult social care, carrying an 11.4 per cent vacancy rate, and 32 per cent of post-holders are already aged 55 or over, the oldest profile of any role in the sector bar senior management.[10] That is not a distant succession problem. It is a tier the sector will need to replace at scale within the working life of this settlement, without a national pipeline currently designed to do it.

Their responsibilities have grown faster than their recognition has. A Registered Manager already carries direct regulatory accountability to CQC, is legally responsible for the quality, safety and lawful running of the service, and sits at the point where safeguarding, workforce development, delegated healthcare oversight and commissioning relationships all converge. Yet, uniquely among the senior tiers this paper discusses, that accountability exists without any of the professional recognition, portable qualification or national standing that would ordinarily accompany it.

The practical case for prioritising them is just as strong as the professional one. The CQC registration process a Registered Manager already goes through, the "fit person" assessment against fitness, competence and character, is itself a form of individual accountability check that no other tier in the sector holds.[42] That is a foundation professional registration can build on rather than invent from nothing, which is exactly why Section 6.2 places Registered Managers in the first tranche rather than a later one. Beginning registration, and the wider recognition this paper proposes, with the tier that already carries the most regulatory weight and the least professional standing is not just administratively convenient. It is where the mismatch between responsibility and recognition is currently at its widest.

This is a theoretically well-grounded strategy, not an improvised one. The classic sociological account of how professions establish and defend jurisdiction over their own work, based on codified knowledge claims rather than employer status, explains why registration built around demonstrated competency, rather than around who employs you, is the right sequencing for a fragmented sector like adult social care.[43] It is also, as Section 8.1 sets out, the route the other three UK nations have already taken.

6.4 The Objection to Registration, and Our Answer

Registration is the proposal in this paper most likely to worry our own members, and it would be dishonest to present it without the objection. A register is a barrier to entry. This is a sector with 37 per cent of employers employing between one and four people, a vacancy rate around three times the wider economy's, and margins that do not absorb new administrative duties.[3,4] Done badly, registration would slow recruitment into a workforce that cannot afford to recruit more slowly, add cost to microbusinesses least able to carry it, and charge

a fee to workers earning a few pence above the minimum wage. Those are not hypothetical risks. They are the predictable result of designing a register for the convenience of the state rather than the reality of the sector.

Our answer has four parts. Begin with the senior tier, as Section 6.2 sets out, so the first cohort is a few tens of thousands of people in roles that already carry accountability, rather than 1.71 million. Build it on the Adult Social Care Workforce Data Set, which already holds much of the information, rather than as a new institution. Do not charge the individual worker: the CAA's position, stated in Section 5.7, is that a registration fee should not fall on people at current pay levels. And sequence registration behind the verification record, not ahead of it, so that the first thing a worker gets from the system is portability that saves them repeating training, and the accountability follows the benefit rather than preceding it.

If registration cannot be delivered on those terms, our view is that it should wait. The case for it is strong but it is not urgent in the way the Level 4 rung is urgent, and a badly designed register would set the argument back a decade.

07

SECTION SEVEN

A Pathway for Every Age – NEETs, the Youth Guarantee and Career Switchers

Almost a million young people are NEET, and the number crossed one million earlier in 2026 for the first time since 2013. Over a quarter of the existing care workforce is already 55 or older. This sector needs both ends of working life, and different policy tools for each.

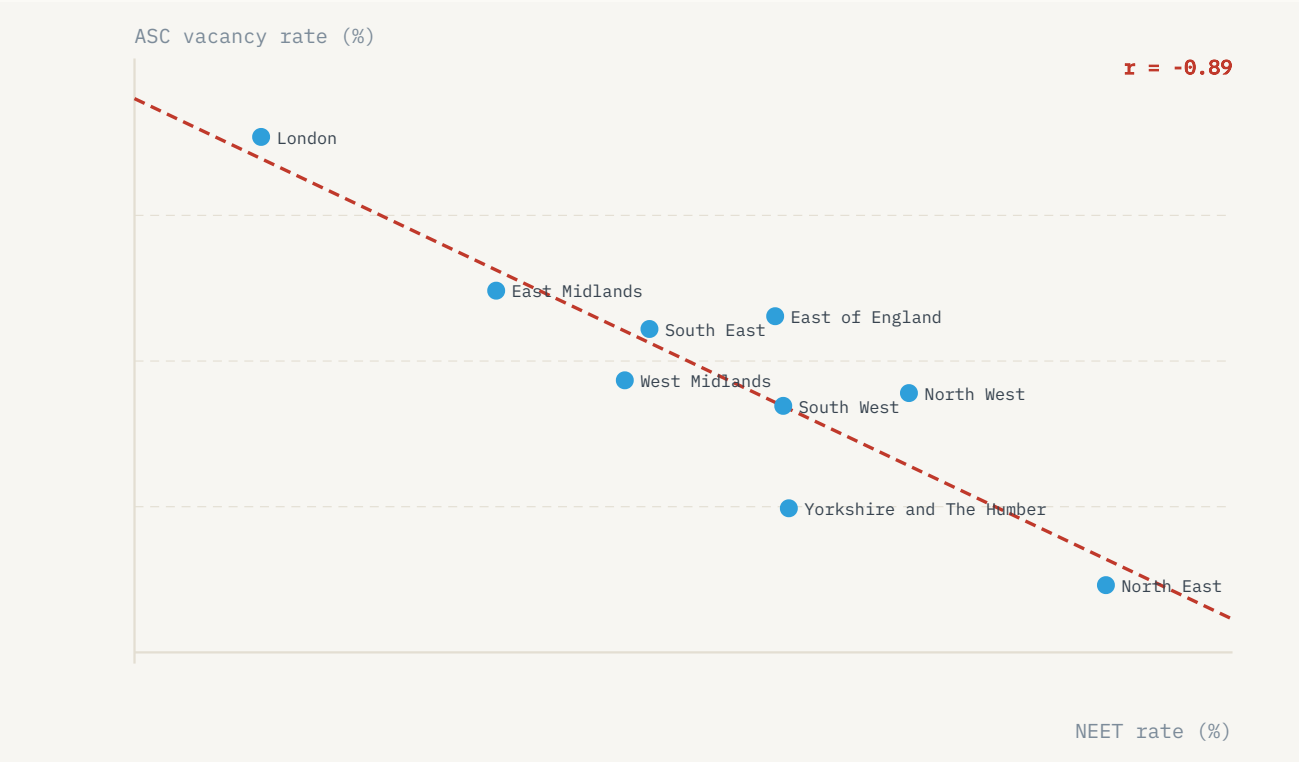
7.1 The Scale of the Opportunity

In the first quarter of 2026, an estimated 1,012,000 young people aged 16–24 in the UK were not in education, employment or training, 13.5 per cent of that age group, and the first time the figure has exceeded one million since 2013.[6] It has since edged back below that line, to 981,000 or 13.0 per cent in April to June, down 30,000 on the quarter but still 30,000 higher than a year earlier.[7] The trend across the year, rather than the movement in any single quarter, is what the policy has to answer to, and the independent review of young people and work led by Alan Milburn takes the same view: its interim report, published in May 2026, projects that without reform the share will rise from one in eight young people to one in six within five years, around 1.25 million. The same review found that 84 per cent of the NEET young people it surveyed want a job, education or training, which places the problem in opportunity and support rather than in aspiration.[44] Government's own *Get Britain Working* White Paper, and the Youth Guarantee and Pathways to Work programme it establishes, is the live policy vehicle for addressing this.[45] Adult social care, with a vacancy rate around three times the wider economy's, is an obvious sector to connect it to.

7.2 Testing Our Own Hypothesis

It would have been easy to stop at the paragraph above. Instead, we tested whether the opportunity is as simple as it sounds. Do the areas with the most NEET young people also have the most social care vacancies, such that a locally targeted scheme could match one to the other directly? Our first pass combined Department for Education NEET data with Skills for Care's vacancy figures aggregated to the nine English regions, on the understanding that region was the finest level at which vacancy data could be broken down.[46]

NEET Rate vs. Adult Social Care Vacancy Rate by English Region – First-Pass Analysis

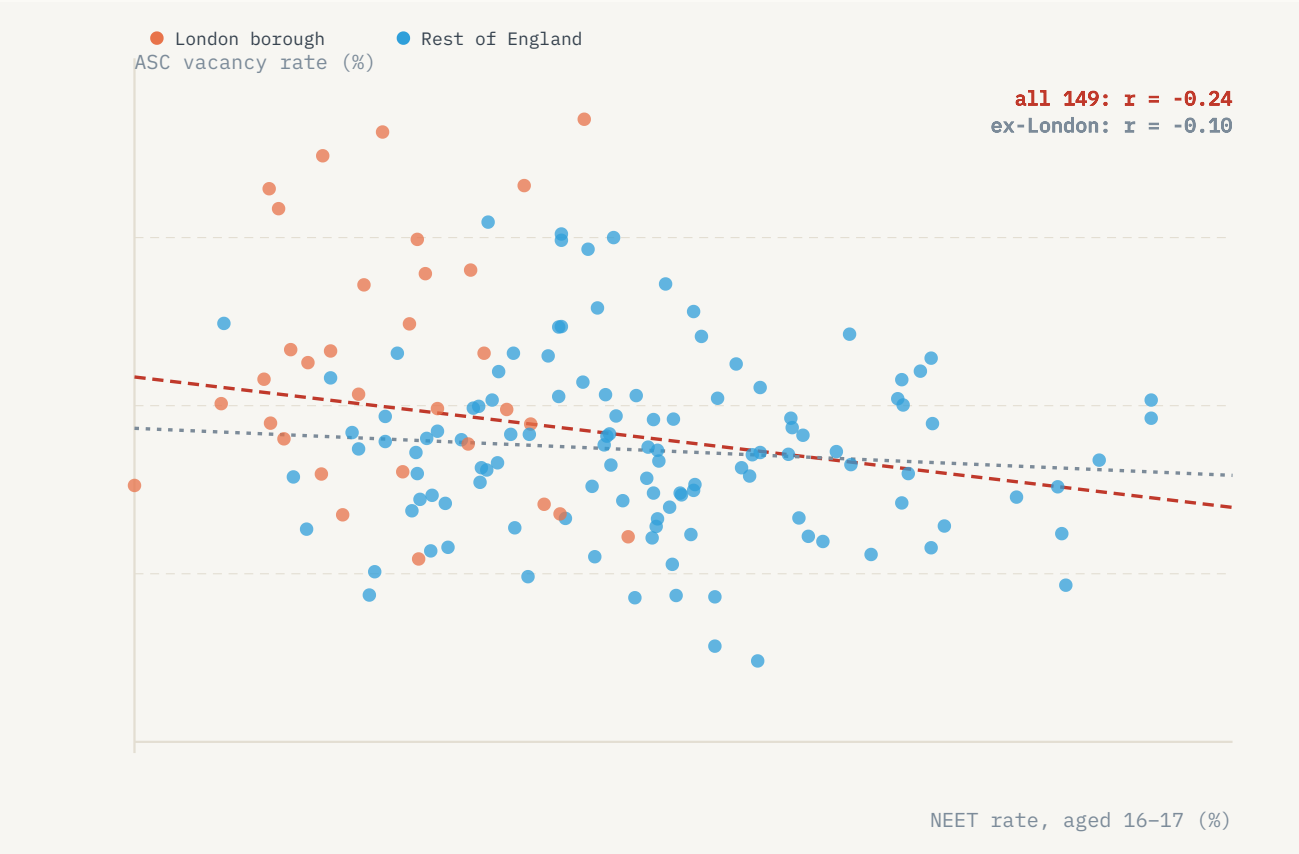


A RESULT TOO CLEAN TO PUBLISH WITHOUT CHECKING

Across the nine English regions, a higher NEET rate is associated with a *lower* adult social care vacancy rate (r = -0.89), which looks decisive and would support a simple "match the highest-NEET areas to the highest-vacancy areas" scheme. Nine data points is a small base for a claim of that size, and London is doing almost all of the work in it: the lowest NEET rate of any region sitting against the highest ASC vacancy rate. Before we put a regional correlation this strong in front of Whitehall, we went back to Skills for Care's local area workforce data and found that vacancy rates are, in fact, available down to individual local authority, populated for 149 of 152 English upper-tier authorities once the correct data split is used. Our original filtering had picked a split of that dataset that is suppressed at local-authority level and wrongly concluded the finer data did not exist.[46]

Re-running the comparison at the level a real scheme would actually operate at, local authority rather than region, changes the answer. This is what a textbook ecological fallacy looks like in a live policy dataset: nine regional averages can make a relationship look far stronger, or in this case simply different, than it is on the ground.

NEET Rate vs. Adult Social Care Vacancy Rate, 149 English Local Authorities



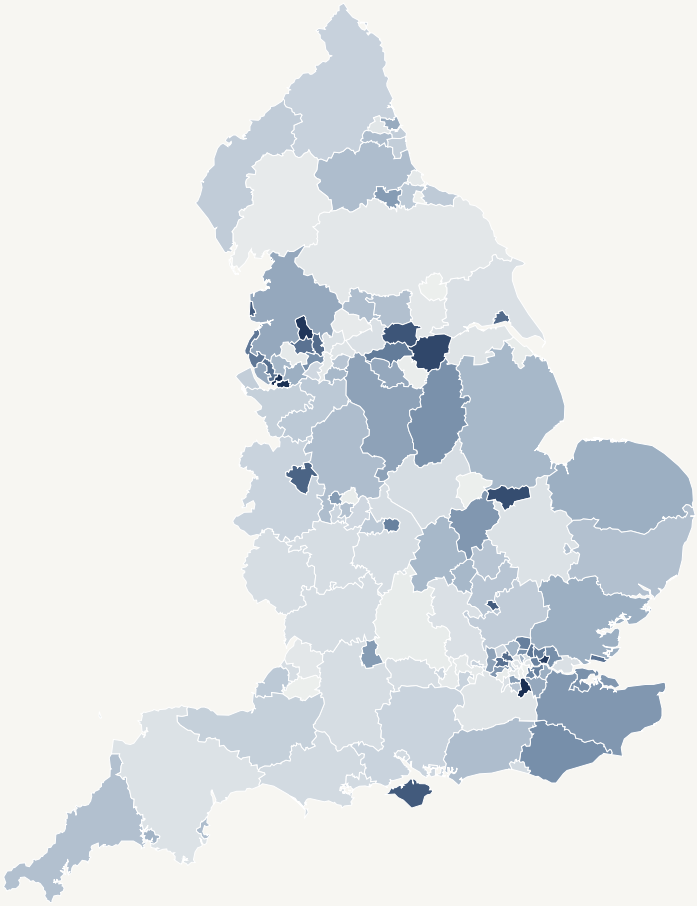
THE HONEST RESULT

At local-authority level, across all 149 authorities we could calculate a rate for, the relationship all but disappears: r = -0.24 (R^2 = 6 per cent, p = 0.002). Remove London's 32 boroughs, the outlier driving the regional result, and it falls to r = -0.10 (p = 0.29, n = 117), which is not distinguishable from zero. A local authority's youth NEET rate tells you essentially nothing about its care vacancy rate, in either direction. The strong regional correlation above was London, not a national pattern.

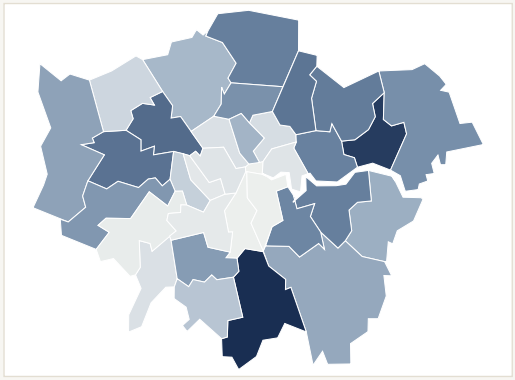
This does not mean the underlying opportunity is imaginary, since both figures are real and independently well-evidenced: the UK's 16–24 NEET population passed one million in the first quarter of 2026 and stood at 981,000 in the second, and the 149 authorities in this dataset alone carry 107,950 vacant adult social care posts between them.[6,7,46] It means a scheme designed around "match the highest-NEET areas to the highest-vacancy areas" is not supported by the data, at either level of aggregation, and would in fact have been built on a correlation that a finer look at the same sources dissolves. We report the correction, not just the original finding, because a paper that only tests the hypotheses it expects to confirm, and stops checking once the first result is convenient, is not the kind of evidence the CAA wants to bring to Whitehall. Full methodology, the suppressed-authority caveats and the source data are set out in Appendix A.2.[46]

We then ran the test a third time with a different measure of youth worklessness, to make sure the null result was not an artefact of the DfE's 16–17 NEET indicator. The Care Workforce Mismatch Index, built for this paper and published alongside it, ranks all 152 upper-tier English authorities on the share of 16–24-year-olds claiming unemployment-related benefits, against Skills for Care's 2025/26 vacancy rate.[47] The correlation is r = -0.04, indistinguishable from zero, which is the same answer from a different dataset. The map below shades each authority by the *lower* of its two percentile ranks, so an area only darkens where young jobseekers and unfilled care posts are both concentrated. 37 authorities sit above the median on both measures, led by Croydon, Halton, Blackburn with Darwen, Barking and Dagenham, Doncaster. Those are the places where a local youth-to-care pilot has the people and the posts in the same borough or county, and they are scattered across London, the North West, Yorkshire and the East rather than clustered in any one region, which is exactly why the pathway has to be national in design and local only in delivery.

Where Young Jobseekers and Unfilled Care Posts Coincide – The Care Workforce Mismatch Index, 152 English Authorities



LONDON, ENLARGED



High on neither — High on both

TEN HIGHEST ON BOTH MEASURES

1. Croydon	**94**
2. Halton	**93**
3. Blackburn with Darwen	**91**
4. Barking and Dagenham	**89**
5. Doncaster	**85**
6. Peterborough	**83**
7. Wakefield	**80**
8. Isle of Wight	**78**
9. Blackpool	**77**
10. Luton	**77**

n = 152 upper-tier authorities. 37 above the median on both measures. Pearson r = -0.04. Claimant count July 2026; vacancies 2025/26.

7.3 What This Means for Policy Design

The right conclusion is not to abandon the idea, but to design it nationally rather than as local geographic targeting. We recommend a national care-sector Youth Guarantee pathway within *Get Britain Working*, built on standard entry routes into the Professional Levels set out in Section 02, rather than a scheme that assumes NEET young people and unfilled care vacancies are conveniently co-located. Social care already offers more flexible working arrangements, and in some cases higher pay, than specific NHS bands, and can be positioned as both a viable career in its own right and a gateway into wider health and care careers, a pathway supported by NHS Health Careers' own signposting between the two systems.

The sector is not starting from nothing here either. The Care Association Alliance has already developed a Pathway into Care programme, which takes the components of the Youth Guarantee and adds the elements a young person's first experience of working in a care setting actually requires, including structured supervision, realistic preparation for the emotional content of the work, and a defined route from placement into employment. It is designed to serve career switchers and economically inactive adults as readily as school and college leavers, which matters for the reasons set out in Section 7.4 below. What it lacks is national adoption and funding. We ask government to use it, rather than commission the design of something the sector has already built.

Nor is this untested ground between the sector and the Department. The CAA is already working with the Department of Health and Social Care on engaging with the Youth Guarantee, though at present on a very small pilot scale. That is the right instinct and the wrong order of magnitude. There are some 981,000 young people not in education, employment or training, a figure that topped a million in the first quarter of this year, and a sector that needs 685,000 additional and replacement workers by 2035; a pilot is a reasonable way to test a mechanism and an unreasonable way to meet a gap of that size. We ask for the pilot to be evaluated before the Fair Pay Agreement negotiations open in 2027 and, if it works, scaled inside this Parliament rather than deferred to the next spending review.

7.4 The Sector Already Depends on Career Switchers, Not Just Young Entrants

The opportunity at the other end of working life is, if anything, better evidenced than the youth case, because the sector is already living it. The average adult social care worker in England is 44 years old, and 27 per cent of the workforce is already aged 55 or over, against just 7 per cent aged under 25, compared with 12 per cent under 25 across the wider economically active population.[10] At registered manager level, 32 per cent are 55 or over.[10] This is not a sector that primarily recruits school leavers; it is a sector that already runs substantially on people who arrived from somewhere else.

Retention data confirms career switchers are, if anything, the sector's more reliable workforce, not a compromise hire. Turnover among care workers aged under 25 is 38.0 per cent; it falls steadily with age, reaching a low of 20.3 per cent among those aged 50 to 59.[10] And adult social care apprenticeships, the sector's main formal entry route for people without a prior care qualification, are already overwhelmingly taken up by adults. Some 83 per cent of adult social care apprenticeship starters in 2024/25 were aged over 24, against 51 per cent for all apprenticeships nationally, a figure Skills for Care's own apprenticeships report contrasts with a much younger intake across the apprenticeship system as a whole.[48]

7.5 Connecting to the Government's Own Evidence on Economic Inactivity

The policy hook here is not a niche one. The independent Keep Britain Working Review, led by Sir Charlie Mayfield and published in November 2025, found that over one in five working-age adults are out of the workforce, with ill health now the single biggest driver of economic inactivity, at an estimated cost to the state of £212 billion a year.[49] ONS's most recent figures put economic inactivity among 50–64-year-olds across the UK at 25.5 per cent, against 20.9 per cent for the working-age population as a whole, a gap of 4.6 percentage points, driven substantially by long-term sickness.[50] We present this figure, like our NEET figure, as UK-wide context rather than a proven England-specific match to local care vacancies; we have not repeated the geographic-targeting error we corrected in Section 7.2 above.

A National Workforce Settlement should therefore treat career switchers explicitly as a second recruitment pool alongside NEETs, not an implicit by-product of general recruitment activity. That means recognising prior transferable experience, whether from other caring, service or frontline roles, within the Professional Levels framework set out in Section 02, and connecting the Care Workforce Pathway to existing DWP activity on extending working lives, rather than building a separate scheme from scratch.

7.6 A Third Pool Is Closing: International Recruitment and the Route to a Sustainable Domestic Workforce

NEETs and career switchers matter more now than they did five years ago because a third recruitment pool the sector had come to depend on is closing. International recruitment was, for several years, described by Skills for Care itself as the main driver of the sector's workforce growth, filling posts that domestic recruitment alone could not reach.[10] That route has narrowed sharply. The Health and Care Worker visa was closed to new overseas

applicants in the care worker and senior care worker occupation codes from 22 July 2025, as part of wider reform of the immigration system, following two years of documented abuse in parts of the sponsorship chain, including workers charged illegal recruitment fees overseas, arriving to find no genuine job waiting, or left stranded when a sponsor's licence was revoked.[51] Whatever view is taken of that reform, its consequence is not in dispute. A pool the sector had leaned on to fill tens of thousands of posts a year is no longer open to new arrivals from abroad.

This is not an argument for reopening that route, and this paper does not make one. It is an argument for treating the closure as the immediate, practical case for everything else in this section. NEETs and career switchers are not simply desirable additions to a healthy pipeline; with the international route closed to new entrants, they are what remains of the pipeline that grows the workforce at all. A National Workforce Settlement that recognises competence, pays for progression and gives entry roles a visible career, as this paper proposes throughout, is the mechanism by which a domestic workforce can be recruited and, critically, kept, rather than recruited once and lost to the same pay compression and lack of recognition described in Section 1.5. The sector cannot compensate for a closed international route with a domestic pipeline that leaks as quickly as this one currently does.

08

SECTION EIGHT

What Others Have Already Done

The other three UK nations already register their social care workforce. Canada shows a fragmented, multi-employer sector can become one recognised profession. None of them required a single national employer.

8.1 The Rest of the United Kingdom Already Does This

Before looking abroad, it is worth being clear that the nearest precedent is domestic. England is the only part of the United Kingdom without a body, mandated by and accountable to government, responsible for regulating and registering its social care workforce. Nuffield Trust's comparison of the four countries puts it without qualification: "England is the only country in the UK for which there is no professional body which is mandated by – and accountable to – government, that is responsible for the regulation of social care workers."[52] Skills for Care does outstanding work on workforce development, but it is a delivery partner, not a regulator, and it has never been given the powers of one.

NATION	BODY	REGISTRATION OF THE SOCIAL CARE WORKFORCE
Scotland	Scottish Social Services Council	Mandatory and qualifications-led. It is an offence to do social care work without being on the register.[52,53]
Wales	Social Care Wales	Mandatory and qualifications-based, with continuing professional development attached. Domiciliary care workers have been required to register since April 2020.[52,54]
Northern Ireland	Northern Ireland Social Care Council	Mandatory, though not qualifications-led. Linking registration to qualifications remains a longer-term aim.[52]
England	None	No mandatory registration and no workforce regulator. Social Work England registers social workers only, a fraction of the workforce described in Section 01.[52]

This matters for three reasons, and the CAA puts them in ascending order of importance. The first is simply that the argument has been won elsewhere on these islands, under the same labour market conditions, the same funding pressures and in two cases the same statutory framework for care regulation. The second is that Scotland and Wales both attach qualifications to registration, which is the specific link Section 02 asks England to build and which is routinely described here as impractical.

The third is the one we would put to the Independent Commission directly. A worker registered in Cardiff or Glasgow carries a recognised, verifiable professional status. The same worker doing the same job in Carlisle does not. That is not a difference in the work, the risk or the skill. It is a difference in whether the state has bothered to recognise it. Section 06 proposes that England close that gap by the route its neighbours took, beginning with the senior tier rather than attempting the whole workforce at once, and we note that neither Scotland nor Wales registered everyone on day one either.

8.2 Canada

Beyond the United Kingdom, Canada offers the closest comparator to England's position. Despite operating through multiple employers and regional systems, Canada has developed a National Occupational Standard for Personal Care Providers specifically to address the more than sixty different job titles and inconsistent provincial training requirements that existed before it.[55]

Ontario's Personal Support Worker Registry shows the "professional identity initiative" pathway working in practice, a voluntary public registry with a prescribed code of ethics, for a workforce with no single employer, and the province has since gone further, launching a new Health and Supportive Care Providers Oversight Authority in December 2024.[55] Independent health-policy analysis has specifically examined whether such standards-based approaches can substitute for full professional self-regulation, concluding they represent a credible alternative model.[56]

The primary lesson is not that England should copy Canada's structures wholesale, but that England does not need a single national employer to build a national profession. It needs what Canada built without one.

8.3 Nursing

Nursing evolved through professional standards, qualifications, registration and public recognition, not through a single reform programme delivered in one moment. The sociological account of how professions form describes exactly this evolutionary path,[43] and nursing's own experience is that public recognition remained an ongoing project for decades after registration was achieved, a useful caution against expecting recognition to follow immediately once a framework exists. Adult social care can follow a similar journey while maintaining its distinct, person-centred focus.

8.4 Construction and Technical Trades

The construction sector demonstrates how competency frameworks, credentials and licensing can create public confidence, career progression and workforce mobility across a highly diverse employer landscape. In the United States, industry bodies such as NCCER have built nationally portable credentials for a workforce at least as fragmented as adult social care's.[57] We note this as institutional and industry precedent rather than academic literature, because the trades-licensing evidence base is built by industry bodies, not peer-reviewed research, a distinction we think it important to be explicit about in a paper that asks government to weigh evidence carefully.

8.5 The OECD Comparative Picture

OECD analysis across member countries finds that fewer than half require personal care workers to hold any licence or certification at all, and that where countries have professionalised, through registration, training standards and career progression, it has been a deliberate policy strategy rather than an accident of a tidy employer structure.[58] England is not unusual in facing this problem. It would be unusual in continuing to leave it unaddressed.

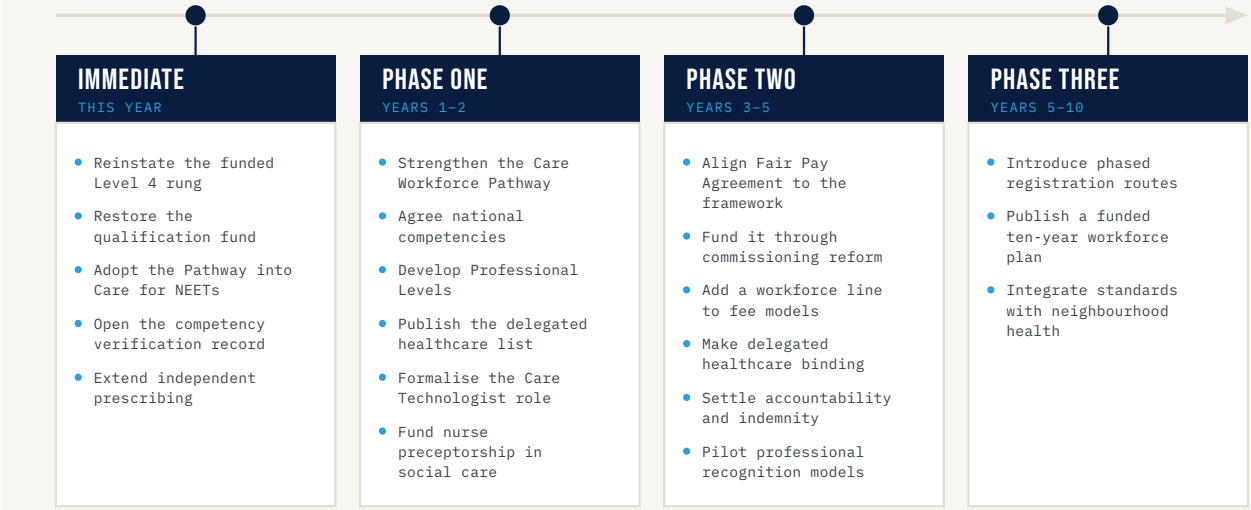
09

SECTION NINE

Implementation Roadmap and Conclusion

What must happen this year, then a ten-year plan, phased and funded, built on architecture the sector has already started.

A Phased Ten-Year Implementation Roadmap



9.1 Immediate (Within Twelve Months)

Five things cannot wait for a phased programme, because in each case a window is closing rather than opening.

The first is the Level 4 rung. Funding is withdrawn for new starts from 1 September 2026, and the social care T Level is being designed now for first teaching in 2028. A decision to reinstate the rung has to be taken while the qualification above it still exists and while the consultation on the qualification below it is still open, which means this year, not in year three.

The second is engagement with young people who are not in education, employment or training. There are close to a million of them, a number that passed one million in the first quarter of 2026, and the Youth Guarantee is being implemented now.[6,7,45] A care-sector pathway that arrives in year three arrives after the vehicle it was meant to travel in has left. The CAA's Pathway into Care programme, described in Section 7.3, exists and could be adopted within the current year. We therefore move this item forward from Phase Two, where an earlier draft of this paper placed it, into the immediate period. The steering group was right that its original placement did not match its urgency.

The third is the qualification fund. The proportion of the workforce holding a relevant qualification is falling, not rising, and each year at £10 million rather than the £53.9 million originally allocated widens a gap that later spending has to close at greater cost.[37,21]

The fourth is the competency verification record. Section 06 makes the case that registration should follow portability rather than precede it, and every year the record does not exist is a year in which 335,000 leavers carry competence that cannot travel with them. Building it on the Adult Social Care Workforce Data Set is a decision that can be taken this year.

The fifth is independent prescribing. The current pilot runs across 2026/27, and the design of whatever follows it will be settled while it runs. Extending it to 1,000 nurses, with backfill funded and providers at the table, has to be decided before the pilot reports if the next phase is to start without a gap.

Four of these are costed in Section 5.7, at £61 million to £76 million a year in total; the Pathway into Care needs adoption within the Youth Guarantee rather than new money.[13]

9.2 Phase One (Years 1–2)

Strengthen the Care Workforce Pathway; agree national competencies; develop Professional Levels; publish the national list of delegated healthcare activities set out in Section 4.3; formalise the Care Technologist framework the National Care Forum has piloted and Skills for Care has committed to support; establish the membership model; introduce a funded preceptorship route for newly qualified nurses entering social care; and adopt the Workforce Strategy the sector has already written.

9.3 Phase Two (Years 3–5)

Align Fair Pay Agreement activity with the framework and fund it through corresponding commissioning reform, taking the wider terms of employment described in Section 5.2 into the years two to ten agenda; introduce the workforce-development line and capability-linked uplift in fee models set out in Section 5.6; convert the delegated healthcare *Guiding Principles* into a binding framework with accountability and indemnity settled; and pilot professional recognition models.

9.4 Phase Three (Years 5–10)

Introduce professional registration routes, beginning with the phased approach set out in Section 06; publish a fully funded, long-term social care workforce plan, explicitly aligned with NHS workforce planning rather than produced separately from it; and integrate workforce standards with future neighbourhood health systems.

The precedent for what that alignment should look like already exists. The NHS itself has a Long Term Workforce Plan, running to 2036/37, that sets out training, recruitment and retention across the whole of the NHS workforce as a single, funded document.[59] Adult social care, a workforce of comparable scale as Section 1.1 sets out, has no equivalent. The two systems already share a boundary, in delegated healthcare, in delayed discharge, and increasingly in neighbourhood health, so planning for one without planning for the other in the same document is planning for half the workforce that actually delivers care. A social care workforce plan written to sit alongside the NHS plan, on a comparable time horizon and with a comparable level of government ownership, is the single change most likely to stop workforce policy for the two systems drifting further apart.

9.5 What We Ask of the Independent Commission

Two things can go wrong with a commission. Its recommendations can be ignored, or everything else can stop while it works. On workforce, the second is the live risk, and it is already happening. A funded rung is being withdrawn this September, the regulations that will set the Fair Pay Agreement's remit are being drafted, and a T Level is being designed, all while the sector is told that workforce is a matter for the Commission. Deferral is not neutrality. In a sector losing around 335,000 people a year, it is a decision with a cost.

So we draw a line across our own recommendations. The five immediate items in Section 9.1 need no commission, no primary legislation and no new institution. They need a decision, and several of them need it within weeks. Nothing in this paper asks the Commission to endorse them first.

Three things, though, are exactly what a commission is for, because they require an authority that no trade body or department alone can supply.

WHAT WE ASK THE COMMISSION TO ADOPT	WHY IT NEEDS THE COMMISSION
That the workforce settlement and the funding settlement are one settlement	Our first paper argued the money, this one argues the people, and the two have been considered separately for twenty years to the detriment of both. The Commission is the only body positioned to say that a funding settlement which does not carry a workforce settlement will not deliver better care, and to hold both halves in a single set of recommendations.
That a National Professional Framework, built on the Care Workforce Pathway, is the workforce architecture for whatever it recommends	The Pathway exists and the Workforce Strategy exists. What neither has is the standing that comes from a national commission naming them as the foundation rather than as sector initiatives government may or may not adopt, which is what has happened so far.
That England should register its social care workforce, by the route its neighbours took	Scotland, Wales and Northern Ireland have all done this, as Section 8.1 sets out. England is the outlier. A recommendation of this kind survives a change of minister, and a decade of sector advocacy has not produced one. Section 6.4 sets out the conditions we would attach, and our view that a badly designed register is worse than none.

We would add one point about the delegated healthcare boundary in Section 04, because it sits between the two categories. Publishing a national list of what counts as a delegated activity requires no commission and should happen now. Settling accountability and indemnity across the health and social care boundary probably does require the Commission's authority, because it touches the professional regulators, the insurance market and the NHS at once. Neighbourhood health cannot be delivered across a boundary nobody has defined.

A final note on how we are making this case. This paper is being published, and submitted to the Commission at publication rather than circulated privately in advance. Our arguments should be tested in the open, alongside everybody else's, and Appendix A.4 exists so that the parts of it built on our own arithmetic can be checked rather than taken on trust.

9.6 Conclusion

England does not require a single employer or a single workforce. It requires a single recognised profession. By building on the Skills for Care Care Workforce Pathway and creating a National Workforce Settlement, government has an opportunity to transform adult social care into a profession that attracts, develops and retains talented people, while providing the workforce foundation neighbourhood health, preventative care and sustainable public services all depend on.

We have tried, throughout this paper, to test our own arguments rather than simply assert them. Where the evidence supported us, on fragmentation, on pay compression, and on the scale of delegated healthcare already happening unrecognised, we say so with the original data behind us. Where it did not, as with the geography of NEET rates and care vacancies, we say that too, and adjust the recommendation accordingly. That is the standard we believe a paper submitted to Whitehall should be held to, and the standard we have tried to hold ourselves to here.

APPENDIX

Original Data: Methodology and Sources

This paper commissioned three original pieces of analysis, the third of them run three times on different data, built from primary public data rather than secondary summaries, so our own arguments could be tested rather than merely asserted. Full datasets, methodology notes and source PDFs are available on request. This appendix summarises each, then sets out the costing arithmetic behind Sections 5.7 and 5.8, a note on independent prescribing, and the full CQC provider count by local authority that underpins Section 1.4.

A.1 Regional Workforce Fragmentation and Vacancy Dataset

Combines Skills for Care's 2024/25 regional workforce tables (vacancy rate, turnover rate, filled posts, mean pay) with an original count of CQC-registered adult social care providers and locations by region and local authority, built by aggregating CQC's full public provider directory (18 February 2026 snapshot). The resulting national provider count of 18,199 independently corroborates Skills for Care's own "nearly 19,000 employers" figure using a different source and method. Sources: Skills for Care regional data workbook (skillsforcare.org.uk/Adult-Social-Care-Workforce-Data); CQC provider directory (cqc.org.uk/about-us/transparency/using-cqc-data).[18]

A.2 NEET Rate vs. Adult Social Care Vacancy Rate

Two passes, both retained here for transparency. The first combined Department for Education local-authority-level NEET/participation data with Skills for Care's vacancy figures aggregated to the nine English regions (r = -0.89, n = 9), on the mistaken understanding that region was the finest level at which vacancy data could be broken down; the split of Skills for Care's workbook we had filtered on (*all sectors – LA and independent*) is suppressed at local-authority level, which is what produced that impression. The second uses the correct split (*all sectors – LA, independent and direct-payment recipients*), which is populated for 149 of 152 English upper-tier authorities, matched to DfE's local-authority NEET rate for the 16–17 cohort. Brent, Doncaster and West Berkshire are excluded because their independent-sector figures are suppressed and no headline rate can be formed; Cornwall and the Isles of Scilly are combined, matching how Skills for Care reports them; City of London is retained despite a 16–17 cohort of 38, since dropping it moves the correlation from –0.24 to –0.26 and is not material. Pearson correlation across all 149 authorities, and separately excluding London's 32 boroughs. The two measures are not the same vintage or population: NEET is a snapshot of 16–17-year-olds; vacancies are 2024/25 whole-workforce returns. The Department for Education itself cautions against ranking authorities on these figures, which are local management information rather than survey data; we report the correlation, not a ranking. A null result is evidence against a simple geographic match, not proof no relationship of any kind exists, since deprivation, wages, transport and housing costs are uncontrolled in this comparison. Sources: DfE Explore Education Statistics, Participation in education, training and NEET age 16 to 17 by local authority, 2024/25 release (explore-education-statistics.service.gov.uk); Skills for Care, current year local area data download 2024/25 (skillsforcare.org.uk/Adult-Social-Care-Workforce-Data).[46]

A third pass, the Care Workforce Mismatch Index shown in Section 7.2, substitutes the ONS Claimant Count for the DfE NEET measure: the number of 16–24-year-olds claiming unemployment-related benefits in July 2026 (Nomis dataset NM_162_1, district level, aggregated to upper-tier authorities using the ONS lower-tier to upper-tier lookup) over ONS mid-2025 population estimates for the same age band, against Skills for Care's 2025/26 local authority vacancy rate. The claimant measure covers a wider age range (16–24 rather than 16–17), is monthly rather than annual, and captures registered benefit claims rather than education-participation status, so it is a genuinely independent check rather than a re-cut of the same data. It reaches the same conclusion: r = -0.04 across 152 authorities. The map score is the lower of an authority's two percentile ranks, so 90 means top tenth on both. The Isles of Scilly and the City of London are excluded as too

small for a meaningful rate. Boundaries are ONS Counties and Unitary Authorities (December 2023, BUC), simplified for print. The index, with every authority's figures, is published at bridgeheadcommunications.com/care-workforce-mismatch-index.[47]

A.3 Pay Compression, 2016–2025

Reconstructed directly from twelve editions of Skills for Care's "Pay in the Adult Social Care Sector in England" reports (March 2016 to December 2025), extracting the experience-based pay premium, the senior/frontline role differential, and the premium above the statutory minimum wage for each period. Cross-checked across overlapping report years for consistency. Source: Skills for Care topic reports (skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/workforceintelligence/resources/Reports/Topics).[5]

A.4 Costing the First Steps, and the Return

Every published input to the costing in Section 5.7 is listed below, followed by every step of arithmetic we performed on them. We separate the two deliberately, so that a reader who disagrees with an assumption can substitute their own without having to reconstruct the calculation. Two of the six lines are our own estimates rather than published figures, and are marked as such.

Published inputs. Apprenticeship funding bands: ST0007 Lead Practitioner in Adult Care (Level 4) £7,000, ST0006 Lead Adult Care Worker (Level 3) £4,000, both 18 months.[24] Current Level 4/5 apprenticeship supply into these occupations, 1,320 completions.[25] Original Level 2 Adult Social Care Certificate fund, £53.9 million for 37,000 staff; £115 million removed from planned 2024/25 training funding.[37] Learning and Development Support Scheme 2026/27, £10 million, within a £13.3 million total also covering the Assessed and Supported Year in Employment (£2.3 million) and the User-Led Organisation fund (£1 million).[21] Social Work England 2026–27 revenue budget £30 million, register above 100,000 with 103,287 renewals, annual renewal fee £122.[38] Nurse prescribing pilot, announced for 150 nurses across seven integrated care board areas, confirmed at £461,000 with six ICBs selected.[39] Registered nurse filled posts in adult social care 35,000; registered manager filled posts 26,400; filled posts overall 1.71 million; turnover 23.1 per cent, approximately 335,000 leavers; care worker turnover 21.0 per cent with a relevant qualification against 27.2 per cent without; 55 per cent of the workforce holding no relevant qualification on record; 53 per cent of starters recruited from within the sector, 7 per cent from the health sector.[10] Cost of replacing one worker, over £3,600 on Skills for Care's own template and over £6,000 on Care England's estimate.[40,41] Delayed discharge cost £2.7 billion a year on a £562 bed-day unit cost.[14] Fair Pay Agreement cost, £0.8 billion a year average.[9]

Our arithmetic. Level 4 reinstatement: 1,300 × £7,000 = £9.1 million; 2,000 × £7,000 = £14.0 million. Qualification fund restoration: £53.9 million less the £10 million now available = £43.9 million, rounded to £44 million; the implied unit cost of the original fund is £53.9 million ÷ 37,000 = £1,457. Independent prescribing: £461,000 ÷ the 150 nurses announced = £3,073 each, × 1,000 = £3.1 million, rounded to £3 million; 1,000 of 35,000 registered nurse posts is 2.9 per cent. 150 of 35,000 is 0.43 per cent. Social Work England cost per registrant: £30 million ÷ 106,000 = £283. Phased senior register: 30,000 × £283 = £8.5 million; 60,000 × £283 = £17.0 million, shown for the record and excluded from the immediate total for the sequencing reason given in Section 06. Immediate package total, four lines: £9.1 + 44 + 5 + 3 = £61 million; £14 + 44 + 15 + 3 = £76 million; per filled post, ÷ 1.71 million = £36 to £44; the current Learning and Development Support Scheme equivalent is £10 million ÷ 1.71 million = £5.85. Package as a share of the Fair Pay Agreement, £61–76 million ÷ £800 million = 7.6 to 9.5 per cent; as a share of delayed discharge cost, ÷ £2,700 million = 2.3 to 2.8 per cent. Sector replacement bill: 335,000 × £3,600 = £1.21 billion; × £6,000 = £2.01 billion. One percentage point of turnover: Skills for Care reports 23.1 per cent and approximately 335,000 leavers for directly employed staff, which implies a base of about 1.45 million posts, so one percentage point is 335,000 ÷ 23.1 = 14,502 leavers; × £3,600 = £52.2 million; × £6,000 = £87.0 million. We use the base implied by those two published figures rather than the 1.71 million total, because the 1.71 million includes staff the turnover rate is not calculated on. Prescribing break-even: £461,000 ÷ £562 = 820 bed days, ÷ the 150 nurses announced = 5.5 bed days per nurse.[13]

The two estimates, and why they are estimates. The national competency verification record has no published comparator, because nothing of its kind exists in this sector. We put it at £5 million to £15 million a year on the basis that it verifies and publishes competences already recorded in the Adult Social Care Workforce Data

Set rather than building a new register, and that it carries none of the fitness-to-practise, investigation and hearings functions that account for most of a professional regulator's cost. The upper bound of that range is a fifth of Social Work England's budget for a fifteenth as much statutory function. We invite government to test the figure; we would rather publish a bounded estimate with its reasoning exposed than omit the line. The size of the first registration tranche, at 30,000 to 60,000, is likewise an assumption: the 26,400 registered manager posts are known, but no published count exists of workers who would qualify as Advanced Practitioners or Delegated Healthcare Specialists, for the reason Section 4.1 gives, namely that the activity has never been nationally defined.

What we have not costed. We have not attempted to monetise improvements in quality or continuity of care, nor the value of avoided hospital admissions beyond the single prescribing break-even calculation above, nor any second-round effect on the Fair Pay Agreement's own cost. Each is real and each would improve the return. None is calculable to a standard we would be willing to put in front of the Treasury, so all are excluded.

A.5 Independent Prescribing for Social Care Nurses

The steering group that reviewed this paper raised independent prescribing as a specific and largely unexploited opportunity. The CAA's position on it is set out here rather than in the body of the paper because it turns on detail.

An independent prescriber is a registered professional who has completed a Nursing and Midwifery Council approved qualification allowing them to prescribe within their competence without a doctor's countersignature. The role is common in primary care and across the NHS and almost absent from adult social care. Its value in a care setting is specific: a resident whose condition changes in the evening can be treated by the nurse already present, rather than waiting for a general practice appointment, an out-of-hours visit or an ambulance. For people approaching the end of life, where anticipatory prescribing is often the difference between dying at home and dying in hospital, the effect is larger still.

Government has funded a pilot, and its short history is worth setting out precisely, because it is a case study in how a good intention fails to reach this sector. It was announced on 31 July 2025 as prescribing training for 150 nurses across seven integrated care board areas. At launch on 16 October 2025 the funding was confirmed at £461,000 and six ICBs had been selected, not seven. At that point, fifteen months after announcement, nurse enrolment was still only "likely to take place" the following year, with the pilot running across 2026/27.[39]

The CAA supports the intent and is candid about the design. Three things are wrong with it. First, scale: 150 nurses across the whole of England, against 35,000 registered nurse posts in adult social care, is four-tenths of one per cent, which is a level at which system effects are unlikely to be detectable however real they are. Second, the funding covers the qualification but not the backfill required to release a nurse from a rota that has no slack in it, which in practice determines whether an employer can participate at all. Third, the money was routed through integrated care boards, whose established reach is their own community nursing workforce rather than the independent providers who employ almost all of the sector's nurses. None of these three constraints is surprising, and all three would have been raised had the pilot been designed with the sector.

A FIGURE GOVERNMENT HAS NOT PUBLISHED

We are unable to say how far the pilot has actually reached, because no figure has been published for how many nurses enrolled, how many completed the qualification, or how many were employed by independent social care providers rather than by the NHS or a local authority. Providers in our membership report very little visibility of it. We say plainly that our impression of low uptake is anecdotal and that we cannot evidence it, which is itself the point: a pilot intended to inform a national rollout should be reporting these numbers as a matter of course. We ask the Department to publish enrolments, completions and the employer of each participant, broken down by the six selected ICBs, before any decision is taken on wider rollout.

The CAA therefore asks for three things. Extend the programme to at least 1,000 nurses, costed in Section 5.7 at £3 million, so the evaluation has a population capable of showing an effect. Fund backfill alongside the qualification, or the offer is open only to the largest providers. And design the next phase with provider representatives at the table, so that the practical

obstacles are identified before the money is committed rather than after the evaluation reports.

A.6 CQC-Registered Providers and Locations by Local Authority

The full count behind the 18,199 national provider figure in Section 1.4 and the regional analysis in A.1. CQC-registered adult social care providers and locations by local authority, ranked by provider count. Source: CQC public provider directory, 18 February 2026 snapshot; original CAA aggregation.

#	LOCAL AUTHORITY	REGION	PROVIDERS	LOCATIONS
1	Essex	East of England	671	899
2	Kent	South East	659	929
3	Hampshire	South East	589	858
4	Lancashire	North West	504	711
5	Birmingham	West Midlands	487	630
6	Surrey	South East	486	701
7	Hertfordshire	East of England	445	605
8	West Sussex	South East	419	583
9	Devon	South West	383	484
10	Nottinghamshire	East Midlands	365	496
11	Staffordshire	West Midlands	350	461
12	Norfolk	East of England	339	533
13	Leeds	Yorkshire and the Humber	318	408
14	Suffolk	East of England	308	430
15	Derbyshire	East Midlands	302	409
16	East Sussex	South East	291	403
17	Gloucestershire	South West	290	395
18	Lincolnshire	East Midlands	287	428
19	Leicestershire	East Midlands	267	341
20	Leicester	East Midlands	261	292
21	Croydon	London	252	311
22	North Yorkshire	Yorkshire and the Humber	247	373
23	Worcestershire	West Midlands	246	310
24	Oxfordshire	South East	245	332
25	West Northamptonshire	East Midlands	244	290
26	Cambridgeshire	East of England	230	297
27	Cornwall	South West	226	323
28	North Northamptonshire	East Midlands	224	275
29	Somerset	South West	224	316
30	Warwickshire	West Midlands	220	321
31	Milton Keynes	South East	217	240
32	Wiltshire	South West	217	318
33	Bournemouth, Christchurch and Poole	South West	215	265
34	Sheffield	Yorkshire and the Humber	215	260
35	Buckinghamshire	South East	208	281
36	Nottingham	East Midlands	206	230
37	Bradford	Yorkshire and the Humber	185	222
38	Wolverhampton	West Midlands	184	209
39	Redbridge	London	182	211
40	Coventry	West Midlands	182	223
41	Barking and Dagenham	London	180	184
42	Derby	East Midlands	179	201

#	LOCAL AUTHORITY	REGION	PROVIDERS	LOCATIONS
43	Liverpool	North West	178	208
44	Enfield	London	176	212
45	Manchester	North West	171	217
46	Havering	London	169	180
47	Sandwell	West Midlands	166	202
48	Barnet	London	164	193
49	Medway	South East	162	190
50	Dorset	South West	158	205
51	Cheshire East	North West	157	202
52	Shropshire	West Midlands	154	204
53	Peterborough	East of England	152	170
54	East Riding of Yorkshire	Yorkshire and the Humber	150	205
55	County Durham	North East	149	218
56	Ealing	London	148	160
57	Bristol, City of	South West	147	197
58	Southampton	South East	144	165
59	Kirklees	Yorkshire and the Humber	144	215
60	Harrow	London	143	157
61	Wakefield	Yorkshire and the Humber	143	182
62	Southend-on-Sea	East of England	140	167
63	Dudley	West Midlands	138	159
64	Walsall	West Midlands	138	160
65	Stoke-on-Trent	West Midlands	133	173
66	Sefton	North West	131	164
67	Wirral	North West	131	172
68	Bedford	East of England	129	169
69	Brent	London	129	157
70	Greenwich	London	128	152
71	Cheshire West and Chester	North West	127	170
72	South Gloucestershire	South West	127	166
73	Lewisham	London	125	143
74	Bromley	London	124	146
75	Stockport	North West	122	147
76	Hillingdon	London	121	144
77	Doncaster	Yorkshire and the Humber	120	157
78	Bolton	North West	119	136
79	Rotherham	Yorkshire and the Humber	117	146
80	Brighton and Hove	South East	116	159
81	Newham	London	115	123
82	Northumberland	North East	114	147
83	North Somerset	South West	112	139
84	Plymouth	South West	111	144
85	Trafford	North West	110	123
86	Kingston upon Hull, City of	Yorkshire and the Humber	110	142
87	Luton	East of England	109	120
88	Cumberland	North West	107	149
89	Sutton	London	104	127
90	Bexley	London	103	109

#	LOCAL AUTHORITY	REGION	PROVIDERS	LOCATIONS
91	Oldham	North West	103	115
92	Barnsley	Yorkshire and the Humber	103	128
93	Solihull	West Midlands	102	125
94	Rochdale	North West	101	119
95	Herefordshire, County of	West Midlands	101	137
96	Telford and Wrekin	West Midlands	99	115
97	Waltham Forest	London	98	108
98	Hounslow	London	97	113
99	Thurrock	East of England	96	109
100	Bury	North West	94	106
101	Central Bedfordshire	East of England	93	124
102	Salford	North West	93	107
103	Merton	London	92	104
104	Lambeth	London	90	98
105	Reading	South East	90	107
106	Torbay	South West	90	106
107	Newcastle upon Tyne	North East	88	125
108	Tower Hamlets	London	87	93
109	Swindon	South West	87	106
110	Warrington	North West	86	111
111	Portsmouth	South East	84	90
112	Blackpool	North West	83	97
113	Wigan	North West	82	116
114	Slough	South East	82	87
115	Sunderland	North East	81	140
116	Westmorland and Furness	North West	81	113
117	Haringey	London	80	95
118	Wokingham	South East	79	101
119	Kingston upon Thames	London	78	93
120	St. Helens	North West	77	89
121	Stockton-on-Tees	North East	76	103
122	York	Yorkshire and the Humber	75	86
123	Isle of Wight	South East	74	101
124	Calderdale	Yorkshire and the Humber	74	98
125	Gateshead	North East	73	102
126	North Tyneside	North East	73	90
127	Southwark	London	70	79
128	North East Lincolnshire	Yorkshire and the Humber	67	89
129	Middlesbrough	North East	65	82
130	Blackburn with Darwen	North West	65	76
131	West Berkshire	South East	65	90
132	Bath and North East Somerset	South West	65	85
133	Islington	London	61	71
134	Wandsworth	London	59	73
135	North Lincolnshire	Yorkshire and the Humber	57	76
136	Camden	London	54	64
137	Windsor and Maidenhead	South East	54	73
138	Richmond upon Thames	London	52	77

#	LOCAL AUTHORITY	REGION	PROVIDERS	LOCATIONS
139	Tameside	North West	52	71
140	Hackney	London	51	58
141	Hammersmith and Fulham	London	51	57
142	Redcar and Cleveland	North East	51	66
143	Knowsley	North West	46	66
144	Darlington	North East	45	55
145	South Tyneside	North East	43	56
146	Bracknell Forest	South East	43	47
147	Hartlepool	North East	35	40
148	Westminster	London	28	31
149	Halton	North West	27	42
150	Kensington and Chelsea	London	26	30
151	Rutland	East Midlands	21	24
152	City of London	London	13	13
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ABOUT

About the Care Association Alliance

The Care Association Alliance is the national membership body for local and regional care associations across England. Its member associations collectively represent thousands of independent and voluntary sector providers of residential, nursing and home care. It exists to support those providers in delivering high-quality, person-centred care, and to ensure that the voice of the sector, and of the workforce that delivers that care, is heard at every level of policy-making.

The Alliance engages with government, Parliament, regulators and commissioners on the issues that matter most to providers and to the people who work in adult social care, namely workforce recognition, funding, quality and sustainability. This paper is the second in a programme of reform the Alliance will continue to publish, building on *Adult Social Care Funding Reform*, its first paper, published in 2026.