Consultation impact assessment

Title: Fair pay agreement consultation impact assessment

Type of measure: Secondary legislation

Stage: Development/Options

Source of intervention: Domestic

Department or agency: Department of Health and Social Care

Other departments or agencies: N/A

IA number: DHSCDMA9687

RPC reference number: N/A

Contact for enquiries: FPAteam@dhsc.gov.uk

Date: October 2025

Summary: Intervention and Options

Illustrative cost of preferred (or more likely) option (base year = 2025/26, time = 10 years)

Total net present social value (in £m): £1.04 billion

Business net present value (in £m): -£26.2 million

Net cost to business per year (in £m): £2.9 million

What is the problem under consideration? Why is government action or intervention necessary?

The limited power of care workers within the labour market has led to a low equilibrium for pay, terms and conditions, security of income and employment and consequently retention and experience within the sector, with wider social consequences.

In the context of the market for care, where local authorities commission the majority of care services from thousands of competing independent providers, stakeholders describe a 'race to the bottom' in which providers attempt to deliver care at the lowest possible price by limiting pay levels and investment in the workforce. This had led to an increased reliance on staff with fewer economic opportunities outside the sector, including workers (predominantly women) who had previously left the labour market to care for children or family members with care needs and international workers from predominantly lower income countries.

Low levels of pay, progression and terms and conditions within the sector increase staff turnover and constrain productivity, which has negative consequences for the living standards of people with care needs and demand for NHS services. Low pay in the predominantly female workforce also contributes to pay inequality.

Providers have limited incentives to increase pay, as they do not directly bear these wider social costs. Commissioners of care may in turn be reluctant to increase fee levels given that this is not guaranteed to lead to increased pay or investment in the workforce and in the face of competing priorities for their constrained budgets. By contrast, government intervention which increased care workers' power to negotiate for better pay and conditions through collective bargaining with providers could support higher minimum levels of pay, terms and conditions and therefore productivity within the sector, if associated with increased funding.

What are the policy objectives of the action or intervention and the intended effects?

The objective of the fair pay agreement (FPA) policy is to ensure that workers in the adult social care (ASC) sector are recognised and rewarded for the work they do, by empowering trade unions and employer representatives to negotiate for pay and employment terms. This is expected to support the living standards of the care workforce and their households, helping to reduce inequalities. By making the sector more attractive, the FPA policy is expected to improve the retention of workers. This intervention will ensure that people can access quality care, which has many positive social outcomes including reduced pressure on the NHS. The FPA policy may also support wider government objectives, including supporting productivity and reducing economic inactivity and reliance on overseas recruitment.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

A fair pay agreement based on collective bargaining arrangements and supported by funding is preferred to alternatives such as using levers over, funding without centrally coordinated negotiation or enforcement, or a pay outcome that is determined by government or by a pay review body. These options would not meet the policy objective, as they would not ensure that workers and businesses are involved in determining an equitable outcome for pay and terms and conditions in the sector, and would be less likely to result in higher pay, efficiency and productivity.

The Employment Rights Bill allows the Secretary of State for Health and Social Care to establish a negotiating body and a process to enable fair pay agreements. We are currently consulting on the design of the FPA process in England. Views from the consultation will inform the design of the FPA process which will be finalised in secondary legislation. The consultation does not seek views on the outcome of an FPA but does cover the scope of negotiations and the negotiation process. The government has also announced that the FPA will be backed by £500 million of funding for local authorities in 2028/29.

In this IA, we have considered the potential impacts of a plausible outcome of the proposed FPA process given this funding envelope, but the terms of an FPA would ultimately be a matter for the ASC Negotiating Body to determine. We have compared this to a policy option in which there is no ASC Negotiating Body or enforcement and no associated funding (the 'do nothing' option).

Will the policy be reviewed? It will/will not be reviewed. If applicable, set review date: Month/Year				
Is this measure likely to impact on international trade and investment?		No		
Are any of these organisations in scope?	**Micro** Yes	**Small** Yes	**Medium** Yes	**Large** Yes
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)		**Traded:** N/A	**Non-traded**: N/A	

I have read the impact assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister: Stephen Kinnock Date: 16/10/2025

Summary: Analysis & Evidence

Policy Option 1 (Preferred)

Description:

Full economic assessment

Price Base Year 2025/26	**PV Base Year** 2025/26	**Time Period** 10 Years	**Net Benefit (Present Value (PV)) (£bn)**		
			Low: Optional	**High:** Optional	**Best Estimate:** £1.0bn

COSTS (£bn)	**Total Transition** (Constant Price) Years		**Average Annual** (excl. Transition) (Constant Price)	**Total Cost** (Present Value)
Low	Optional		Optional	Optional
High	Optional		Optional	Optional
Best Estimate	£10 million		£0.8 billion	£6.4 billion

Description and scale of key monetised costs by 'main affected groups'

- [Illustrative] Increased ASC labour costs to providers (businesses), which are passed through to commissioners/purchasers of care (Present Value £6.4 billion). In 2028/29, this consists of £500 million of local authority expenditure, £160 million of NHS expenditure, and £300 million of expenditure by households (in nominal, undiscounted terms). As increased pay represents a transfer, there is an equivalent benefit below. Both impacts are included in order to clarify the distributional impacts of the policy.
- Administrative costs to government for setting up and maintenance of the ASC Negotiating Body and enforcement of an FPA (Present Value £23 million).
- Business familiarisation costs including the time involved in understanding the FPA outcome each year and implementing changes to contracts (Present Value £26.1 million).

Other key non-monetised costs by 'main affected groups'

- Administrative costs to trade unions and employer representatives for engaging with the FPA negotiation process.

BENEFITS (£bn)	**Total Transition** (Constant Price) Years		**Average Annual** (excl. Transition) (Constant Price)	**Total Benefit** (Present Value)
Low	Optional		Optional	Optional
High	Optional		Optional	Optional
Best Estimate	£0 billion		£0.9 billion	£7.5 billion

Description and scale of key monetised benefits by 'main affected groups'

- [Illustrative] Increased income/consumption for the care workforce. This is a transfer with an equivalent cost above (Present Value £3.8 billion, illustratively).
- [Illustrative] Increased revenue from taxation and reduced expenditure on Universal Credit as a result of higher household income. As these effects are the result of a transfer (increased pay), they are likewise transfers and have equivalent costs above (Present Value £2.6 billion, illustratively).
- [Illustrative] Efficiency savings as a result of reduced recruitment and retraining costs. These provider level savings are expected to be passed through to local authorities , the NHS and households paying for their own care, given the competitive market for care (Present Value £1.1 billion, illustratively).

Other key non-monetised benefits by 'main affected groups'

- Wider improvements in the health and wellbeing of care workers as a result of higher pay and financial security.
- Productivity improvements in adult social care. Higher pay may result in more productive care workers who are retained for longer, with greater experience and skills, and more motivation and effort in their work.
- Increased quality of life for people who receive care as a result of any expansion in care activity in response to a funded increase in pay.
- NHS savings as a result of lower healthcare utilisation by people who receive care and unpaid carers as a result of any expansion in care activity.
- Increased quality of life and employment benefits for unpaid carers as a result of any expansion in care activity.

Distributional impacts

- The policy will have a positive impact on low-income groups. ASC is a low pay sector with 1 in 5 workers experiencing in-work poverty.
- The ASC workforce in England has a higher share of female workers and workers who are Black, African, Caribbean or Black British than the UK population. A policy that redistributes funds to the ASC workforce is likely to have significant positive impacts on people who share these characteristics and to enhance equality of opportunity.
- Benefits to unpaid carers may enhance equality of opportunity, as unpaid carers are more likely to be female, older, or disabled than the population as a whole.
- Increases in ASC pay, and terms and conditions are likely to increase the attractiveness of ASC relative to competing sectors. These sectors may experience greater challenges in attracting and retaining staff as a result.
- Demand for ASC, and especially public expenditure on ASC, tends to be concentrated in more deprived areas. An FPA could disproportionately impact on these areas, both in terms of benefits and risks.

Key assumptions/sensitivities/risks	**Discount rate**	3.5%

Assumptions

- The scope of a fair pay agreement outcome is subject to negotiation by the ASC Negotiating Body (ASCNB). However, for the purpose of the Impact assessment, we have considered illustrative costs of a potential fair pay agreement outcome.
- In subsequent years, we illustratively assume that pay increases in line with OBR earnings forecasts. However, the level of funding for fair pay agreements is a matter for future Spending Review negotiations, and the scope of future fair pay agreements depends on policy choices and negotiations by the ASC Negotiating Body.
- Providers pass increased labour costs through to local authorities , the NHS, and individuals who pay for their own care. The share of costs that fall to local authorities , the NHS, and households remains constant at levels based on LaingBuisson evidence on sources of expenditure in the sector.
- In 2028/29 and beyond, pay is assumed to increase in line with OBR earnings forecasts in the counterfactual.
- Demand for formal care follows projections produced by the Care Policy & Evaluation Centre (CPEC). The workforce is assumed to grow in line with CPEC demand projections.
- We will work with stakeholders to test our key assumptions.

Risks

- There is a risk that negotiations result in an FPA outcome that is not affordable to providers, or to local authorities and the NHS. The government is addressing this risk by setting out a remit letter for the ASCNB, which will include a funding envelope of £500 million grant funding for local authorities in 2028/29 as a condition that must be met. We therefore treat this quantum as a constraint. We also assume that the remit will require the ASCNB to have regard for affordability for purchasers of care including the NHS and self-funders, in addition to local authorities. The Secretary of State also has the power to ask the ASC Negotiating Body to reconsider, or to reject the FPA outcome.
- There is a risk that providers are not able to pass through costs to local authorities, the NHS, and self-funders. If businesses are unable to pass through all the costs associated with meeting the terms of an FPA, this could lead to a reduction in profits, reduced employment in the sector, and/or work intensification.
- Self-funders may not be able to afford the increase in the cost of care resulting from an FPA. In some cases, this may result in individuals delaying or reducing their use of formal care services. This may place additional pressure on unpaid carers and informal support networks.

Business assessment (Option 1)

Direct impact on business (Equivalent Annual) £m: -£3.0 m		
Costs: £26.1 million	**Benefits:** £0	**Net:** -£26.1 million

Contents

Evidence Base

Table 1: *Illustrative costs and benefits of preferred option, £ millions, 2025/26 prices (NB totals may not sum due to rounding)*

	2026/ 27	**2027/ 28**	**2028/ 29**	**2029/ 30**	**2030/ 31**	**2031/ 32**	**2032/ 33**	**2033/ 34**	**2034/ 35**	**2035/ 36**	**Discounted total (2025/26 base year)**
COSTS											
Increased labour costs*	-	-	900	930	960	990	1,010	1,040	1,060	1,090	6,370
Administrative costs to government	0.3	0.8	3.3	3.3	3.4	3.4	3.5	3.5	3.5	3.6	23.0
Familiarisation costs to business	-	9.4	2.5	2.5	2.6	2.7	2.8	2.8	2.9	2.9	26.1
Total costs	**-**	**10**	**910**	**940**	**960**	**990**	**1,020**	**1,040**	**1,070**	**1,090**	**6,420**
BENEFITS											
Recruitment efficiencies	-	-	158	162	165	169	173	177	181	184	1,090
Tax and benefit savings for government*	-	-	360	380	390	400	410	420	430	440	2,570
Increased income for care workforce *	-	-	540	560	570	590	610	620	630	650	3,810
Total benefits	**-**	**-**	**1,060**	**1,090**	**1,120**	**1,160**	**1,190**	**1,210**	**1,240**	**1,270**	**7,460**
Net Present Value											**1,040**

**These impacts include elements which are economic transfers and included on both the cost and benefit side. These are included to help clarify the distributional impacts of the policy.*

What is the problem under consideration?

Summary

As set out in the statutory guidance for the Care Act 2014[1], the core purpose of ASC is to 'help people to achieve the outcomes that matter to them in their life'. Access to ASC services for those who need it depends heavily on having a sufficiently sized, motivated and skilled workforce.

The ASC workforce is large, with 1.50 million people working in the sector in England in 2024/25 [2], equivalent to 5% of all adults in employment, making it comparable to the NHS, and larger in headcount terms than the construction, transport, or food and drink industries.

However, the sector has been characterised by comparatively high staff turnover, with growth in staff levels driven by international recruitment from predominantly lower-income countries in the last three years. Evidence presented in this impact assessment shows that low pay and poor terms and conditions are key factors affecting recruitment and retention, alongside factors such as limited career progression and limited access to learning and development. This in turn

[1] Care and support statutory guidance (www.gov.uk)

[2] The size and structure of the adult social care sector and workforce in England 2025 (skillsforcare.org.uk)

increases risks around access to high quality care for people in need. Furthermore, prevailing low pay and relatively poor terms and conditions in the sector have knock-on effects on living standards, health, and wellbeing for workers in the sector. Given the prevailing characteristics of the workforce, this gives rise to distributional, equality and equity concerns.

As local authorities commission the majority of ASC services, employment conditions in the sector are linked to local government finances. However, increasing local government funding would not, on its own, solve these issues. An FPA would create levers to make sure providers, as well as LA commissioners, create the right conditions for the workforce, supporting better care for both state and self-funders. Both local authorities, and the independent providers of ASC services they commission care from, have competing priorities for income, and neither party directly faces the wider social costs of low pay in ASC. These factors, combined with the significant market power of local authorities within the market for care and the limited market power of self-funders[3], have resulted in public fee levels and wider pay levels which reflect the statutory minima for pay, terms and conditions.

Fair pay agreement processes will help to resolve this by increasing the collective market power of workers within the sector, providing a means to negotiate for better pay and conditions in the ASC sector as a whole and creating levers to ensure the negotiated outcome is enforced. This point is substantiated in this impact assessment.

The adult social care sector has been characterised by high turnover

Staff turnover – the number of staff leaving a role during the year as a proportion of all staff – is a key indicator of workforce sustainability. Some movement between employers can be healthy as organisations compete to attract workers, or as people use care worker roles as a stepping stone to employment in other occupations, but high levels can be disruptive for workers, employers and consumers and are indicative of lower quality of work. High turnover rates limit investments in human capital and role-specific experience and increase recruitment and training costs for providers, constraining productivity growth and career progression. In adult social care, staff turnover reduces the continuity of care for people drawing on care services, with consequences for care quality[4] and can create risks around access to appropriate care.

Turnover rates in health and social care were higher than most industrial sectors and the UK average in 2022/23[5]. The staff turnover rate in adult social care was 23.7% in 2024/25. Turnover rates are higher for new starters, and for younger workers: care workers with less than one year of experience in the sector had a turnover rate of 40.9% in 2023/24, more double the turnover rate of care workers who had worked in the sector for ten years or more (20.0%). Turnover rates were 16.6 percentage points higher for workers aged under 25 compared to those 60 and above in 2023/24[6] [7]. On average, 1 in 10 workers leave adult social care each year to move to another industry, unemployment or inactivity[8]. Although this is low compared to some industries with comparable pay, the sector commonly cites competition from other sectors as contributing to workforce challenges[9]. Movement from the care sector into the health sector is more common than movement the other way[10]. The care sector also faces competition from

[3] Competition and Markets Authority (2017) Care homes market study – GOV.UK (www.gov.uk)

[4] See NICE (2018), People's experience in adult social care services: improving the experience of care and support for people using adult social care services and the supporting evidence

[5] CIPD (2024), Benchmarking employee turnover: What are the latest trends and insights?

[6] The State of the Adult social care Sector and Workforce 2024 (skillsforcare.org.uk)

[7] Social care also faces particular challenges in attracting younger staff. The adult social care workforce is skewed towards the older age bands, with 29% of workers aged 55 or over in 2022/23, compared to 21% of workers in the economically active population.

[8] DHSC estimate based on Skills for Care data

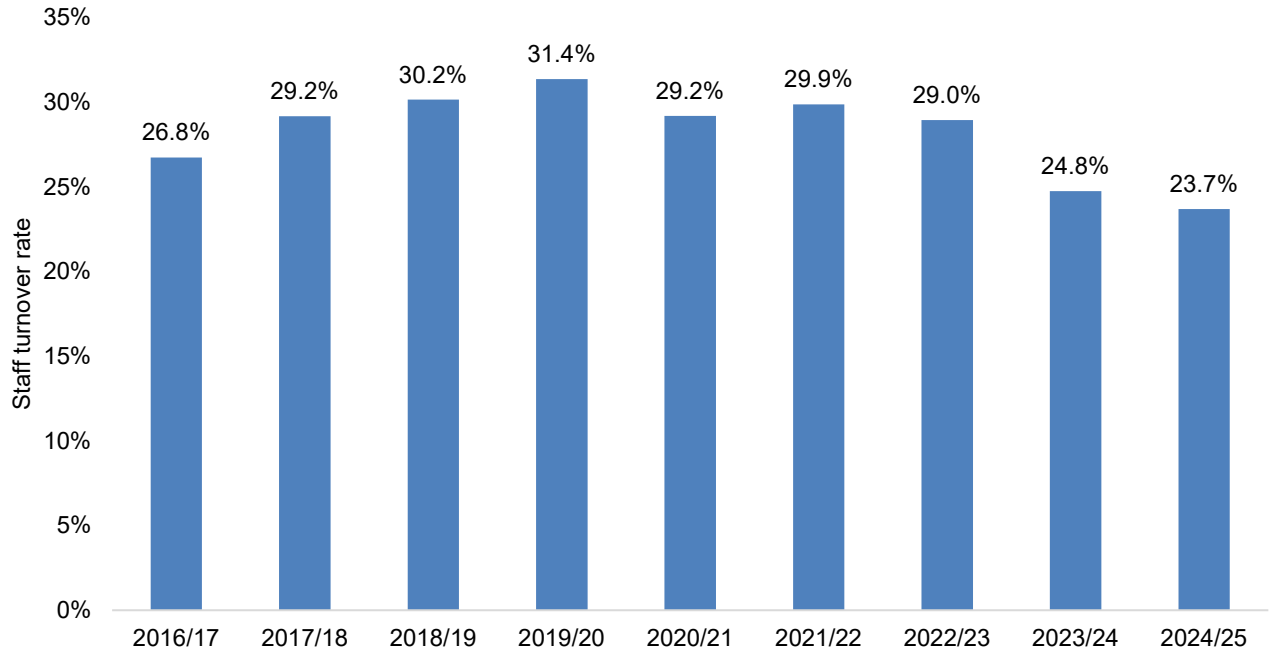
[9] For example - Hft-Sector-Pulse-Check-2023-Digital-Singles.pdf

[10] Health Foundation (2022) Lower paid NHS and social care staff turnover

hospitality, retail and cleaning sectors, and carers are drawn to these because they are seen as less demanding jobs for the same or better rates of pay[11].

As shown in Figure 1, turnover in the sector has improved since 2021/22, when the overall rate was 29.9%. However, most of this improvement is likely to have been driven by international recruitment using Skilled Worker Health and Care Worker Visa which are linked to work for a specific sponsor (i.e. employer), after care workers were added to the Shortage Occupation List in February 2022. Evidence suggests that international recruits are more likely to remain in post than new domestic recruits[12]. While international recruitment has reduced staff turnover and mitigated some of its impacts on capacity within the sector, it has also resulted in an increase in reports of unethical employment practices within the sector[13], including modern slavery and debt bondage[14]. Changes to Immigration Rules mean that workers applying for care workers and senior care worker roles from outside the UK are no longer eligible for the Skilled Worker Health and Care Worker Visa route as of July 2025.

***Figure 1**: Staff turnover rate, independent and LA sector, England, 2016/17-2024/25*



Source: Skills for Care, Trended data 2024/25

Partly as a result of high turnover, productivity growth in adult social care is constrained

As stated above, high turnover rates in an industry can constrain productivity growth by increasing the costs of training and development and reducing employers' incentives to invest, as well as reducing the average level of experience within a role.

The adult social sector has historically seen relatively low productivity growth, with available measures suggesting that productivity in ASC has declined over the last two decades (see Figure 2).

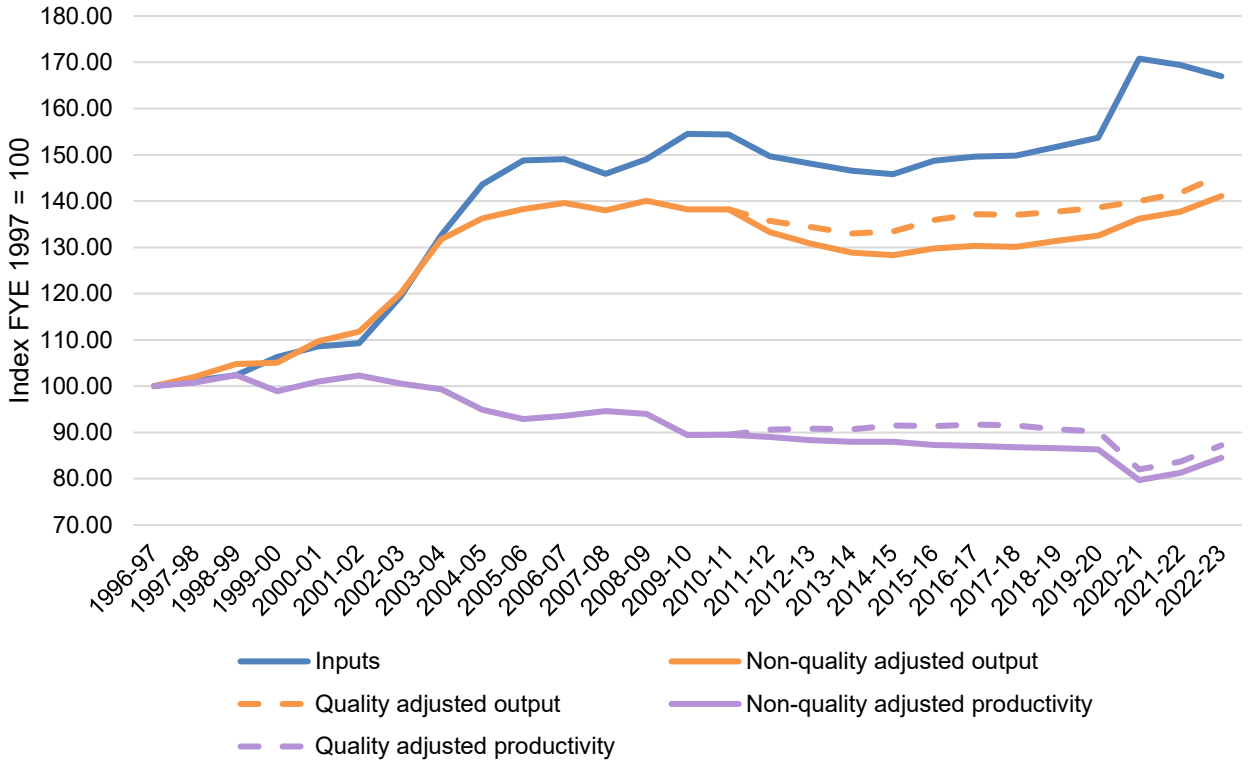
[11] Ekosgen (2019) The Implications of National and Local Labour Markets for the Social Care Workforce: Final Report for Scottish Government and COSLA.

[12] The State of the Adult social care Sector and Workforce 2024 (skillsforcare.org.uk)

[13] International recruitment fund for the adult social care sector 2024 to 2025: guidance for local authorities –

[14] Unseen (2023) Who cares? A review of reports of exploitation in the care sector (unseenuk.org)

***Figure 2**: Public sector productivity, adult social care, England*



Source: ONS, 2025, Public Sector Productivity, ASC, England

However, these measures of productivity do not capture the wider social impact of adult social care. While inputs to the sector are relatively clear, care outcomes are more difficult to measure and are not captured by National Accounts methodologies and metrics such as GDP. These outcomes include the quality-of-life benefits to care recipients and to unpaid carers (over and above those expressed in the market price for care packages), and reduced costs to the NHS.

Local authority leaders have reported concerns around the choice and quality of care and support that people can access[15]. The population of England is ageing as a result of rising life expectancy, and the number of people aged 75 and over is projected to increase by 917,000 (16%) by mid-2034[16]. Meanwhile, healthy and disability-free life expectancies have not increased at the same rate, driving need for adult social care alongside health services. In addition, care and support needs are becoming more complex and as a result, require more intensive support and therefore more hours of labour per cared for person. In combination, high waiting times and increasingly complex needs can cause unmet or under met needs. This may also result in family members or friends providing unpaid care unsustainably in the interim. The space for improvement in outcomes can be easily seen in the adult social care Outcome Framework (ASCOF)[17]. The measure for adjusted social-care related quality of life[18] stood at 0.417 in 2023/24 compared to a theoretical maximum of 1, and this has only improved slightly since it was first estimated (at 0.404) in 2016/17[19].

[15] ADASS (2025) Spring Survey

[16] ONS (2025), National population projections: Migration category variant, England summary

[17] Measures from the Adult social care Outcomes Framework, England, 2023-24 - NHS England Digital

[18] Social-care related quality of life is the average difference between expected and reported quality of life, which can be ascribed to LA-funded ASC services for long-term care users. It is an analogous concept to health-related quality of life and has been shown by contingent valuation studies to be valued in a similar way to individuals: 1 social-care related Quality Adjusted Life Year (QALY) is equivalent to 0.978 health-related QALYs (as estimated in Stevens, K.; Brazier, J. and Rowen, D. (2018) 'Estimating an exchange rate between the EQ-5D-3L and ASCOT.' European Journal of Health Economics, 19(5):653-661). Using the concept of Quality Adjusted Life Years (QALY) and the social value of £70,000 recommended in the HMT Green Book guidance, this suggests that the average user of LA-funded long-term experiences a benefit worth the equivalent of £29,000 per year.

[19] Measures from the Adult social care Outcomes Framework, England, 2023-24: Time series of aggregated outcomes measures – NHS England

Problems and delays in adult social care affects the flow to and from the NHS. Access to high-quality and timely social care improves health outcomes and reduces the reliance on more acute NHS services. ASC can also prevent hospital admissions and reduce pressure on hospital beds, by facilitating timely hospital discharge. It can also help to identify and address needs before they escalate, reducing demand for costly NHS healthcare services.

Gaughan et al. (2014)[20] and Fernandez and Forder (2008)[21] find that more care home beds could reduce length of stay in hospital by between 1% and 7%. Forder (2009)[22] examined the relationship between care home utilisation data (care home residents per capita) and hospital utilisation data (hospital episodes) in 2004/05 at the ward level. They estimated that an additional £1 spent on care home services results in a £0.35 reduction in hospital expenditure, though this is likely to be an underestimate for the wider impacts of ASC spending on the need for health services. Fernandez and Forder (2008) find that a 1% increase in residential social care services can reduce delayed discharge by 0.5%.[23]

The related issues of high turnover and low productivity in ASC mean that some of these social benefits are at risk. Individuals who are eligible for care are less likely to have access to the high-quality and timely care that they need under conditions of higher turnover and lower productivity, which could significantly impact on their quality of life. It could mean that they are more dependent on friends and family for support, which impacts on unpaid carers' economic activity and health outcomes. It could also mean that they have poorer health outcomes, including more preventable admissions, escalating conditions, or delays to hospital discharge.

Higher turnover and lower productivity growth and are functions of low pay and reward

Low pay: Adult social care has been defined as a low-paying industry by the Low Pay Commission (LPC) every year since the 'First Report of the Low Pay Commission' on the National Minimum Wage in 1998. Most care workers are paid on or just above the National Living Wage. The median hourly rate for a care worker in the independent sector was £11.00 as at March 2024, with nearly 70% paid within £1 of the 2023 NLW rate of £10.42.

ASC is in direct competition for staff with other low pay occupations. Median care worker pay was 67 pence lower than Healthcare Assistants (HCA) who were new to their role and £1.45 lower than HCAs with more than 2 years' experience. Median hourly care worker pay was 9 pence higher than cleaners and domestics and 40 pence higher than kitchen and catering assistants.

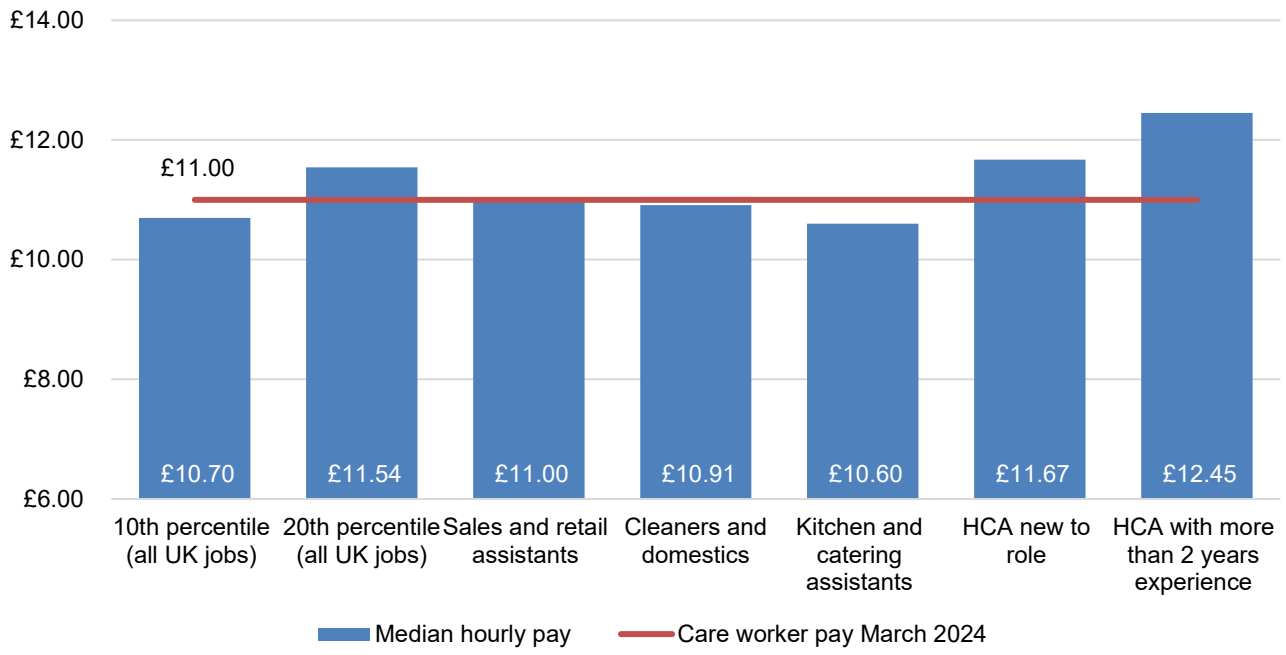
[20] Gaughan, J; Gravelle, H and Siciliani, L (2015) 'Testing the bed-blocking hypothesis: does nursing and care home supply reduce delayed hospital discharges?' Health Economics, 24(Supplement 1), 32-44

[21] Fernandez, J-L and Forder, J (2008) 'Consequences of local variations in social care on the performance of the acute health care sector.' Applied Economics, 40(12), 1503-1518

[22] Forder, J (2009) 'Long-term care and hospital utilisation by older people: an analysis of substitution rates.' Health Economics, 18(11), 1322-1338

[23] Fernandez & Forder (2008)

***Figure 3**: Median hourly pay, care workers and selected comparators as of March 2024*



Source: Skills for Care, The state of the adult social care workforce in England, 2023/24

Evidence shows that hourly pay is one of the most significant factors in determining variation in staff turnover between care providers. In focus groups conducted by the Resolution Foundation, low pay was at the centre of job dissatisfaction in care[24]. Similarly, 86% of ASC providers that responded to an Hft and Care England survey reported that the biggest barrier to recruitment and retention was the pay rates on offer to staff[25]. Skills for Care report that the hourly pay rate is one of the most important features in determining the probability of a worker leaving or staying in their role[26]. The strong relationship between pay in the sector and turnover has also been explored in research from the London School of Economics and the University of Kent[27]. The role of pay in determining the quantity of labour supplied to the sector was also highlighted by the Migration Advisory Committee in their 2022 review of international recruitment to the sector.[28]

Career progression: Pay differentials within the sector have also eroded over time. Pay differentials for experienced staff have been eroded from 33p per hour in March 2016 to 10p per hour in March 2024 for care workers with 5 years or more of experience relative to those with less than one year's experience.[29] At March 2024, the hourly rate difference between a top 10% earner (£12.16) and a bottom 10% earner (£10.42) was £1.74 per hour for care workers in the independent sector, reflecting a very flat pay structure with limited scope for progression[30]. Limited recognition of staff with more experience or skills can mean that there is reduced incentive for workers to progress or to stay in their roles.

[24] Who cares? • Resolution Foundation

[25] Hft-Sector-Pulse-Check-2023-Digital-Singles.pdf

[26] The state of the adult social care sector and workforce in England, 2024

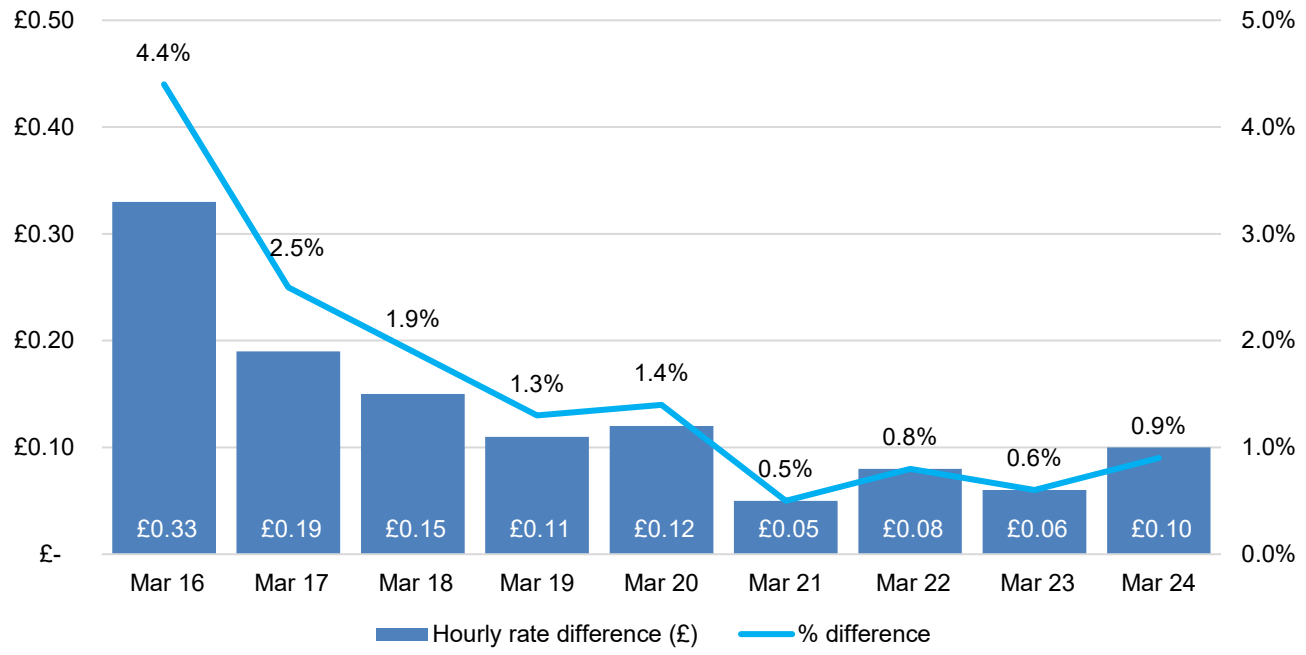
[27] Vadean, F.; Allan, S. and Teo, H. (2024) Wages and labour supply in the Adult social care sector. ASCRU working paper (Vadean-et-al-2024.pdf)

[28] Migration Advisory Committee (2022) Adult social care and immigration

[29] The state of the adult social care sector and workforce in England, 2024

[30] Pay in the adult social care sector in England as at December 2024

***Figure 4**: Mean care worker pay by experience in the sector, independent sector, March 2016 to March 2024*



Source: Skills for Care, The state of the adult social care workforce in England, 2023/24

Poor terms & conditions: Workers in social care are typically employed on statutory minimum terms and conditions, such as statutory sickness and annual leave entitlements. The sector reports that this has been caused by the constrained fees which local authorities consider they can afford to pay to providers of care[31] [32]. These have not kept pace with the rising cost of care, leading employers to bring down costs by 'squeezing out' workforce benefits to statutory minimum levels, and sometimes below. The Low Pay Commission 2023 report states that there are still 'significant non-compliance issues' in social care due to lack of payment for travel time. There is a commonly reported practice in domiciliary care where providers do not pay for travel time but pay at a higher rate for contact time[33].

Poor terms and conditions are associated with higher staff turnover. For example, the Skills for Care annual report[34] states that care workers were less likely to leave their posts if their employers paid above the 3% auto-enrolment rate for pensions, or if their employers paid more than Statutory Sick Pay if they cannot work due to illness.

Insecure employment: The ASC sector is also characterised by unstable employment, with 21% of workers in ASC in England on Zero Hours Contracts (ZHCs), including 30% of care workers, compared to 3.5% in the wider economy. This is even more pronounced for domiciliary care workers, where 43% were on ZHCs in 2023/24. The use of zero hours contracts is partly a response by employers to uncertainty in both care demand and labour supply (given high turnover). Some employers use ZHCs to constrain labour costs, by paying domiciliary workers for time spent on visits only, excluding breaks between visits. Although some workers benefit from the flexibility that ZHCs provide, generally employment uncertainty reduces labour supply. Furthermore, those on ZHCs have a higher turnover rate than other care workers (36.0% turnover rate in 2023/24 for care workers on a zero-hour contract compared to 29.7% for care workers with 35 or more contracted hours).

The Employment Rights Bill includes powers to end the exploitative use of ZHCs across all sectors including ASC, by giving workers on ZHCs or on 'low hours' contracts the ability to move to guaranteed hours contracts which reflect the hours they regularly work over a 12-week

[31] IfG Performance Tracker 2019

[32] Oral evidence to the Health and Social Care Select Committee, 5 March 2025 (parliament.uk)

[33] Resolution Foundation (2023) Who Cares? The experience of social care workers, and the enforcement of employment rights in the sector

[34] The State of the Adult social care Sector and Workforce 2024 (skillsforcare.org.uk)

reference period. The government will also ensure that workers get reasonable notice of any change in shifts or working time, with compensation for any shifts that are cancelled or curtailed at short notice[35]. These measures will also be consulted on over Autumn 2025[36]. Estimated impacts of these measures are set out in published impact assessments[37].

Low pay and reward also represent an unfair deal for workers

The prevailing low quality of work and pay within the sector is likely to have knock-on effects for workers' living standards, health, and wellbeing. Beyond these efficiency arguments, there are meaningful equity arguments for intervention.

The Health Foundation has estimated that 19.9% of residential care workers were living in poverty (less income than 60% of the median after housing costs) over the 2021-24 period, compared to 11.9% of all UK workers; and 13.4% of residential care workers lived in households in the bottom 20% of households for income, compared with 9.5% of all workers. Low household income in the sector has material consequences for care workers and their households: nearly 1 in 10 experienced food insecurity (12.3%, double the rate for all workers), and 12.2% of children living in a household with a residential care worker were 'materially deprived'[38]

Increasing pay in adult social care would not only tend to reduce income inequality between UK workers but promote equality of opportunity between groups who share protected characteristics. The ASC workforce in England has a higher share of women (79%) and people who are Black, African, Caribbean or Black British (18%) than people employed in the UK as a whole. Low pay in adult social care potentially partly reflects disadvantages experienced more often by people who share these characteristics within the labour market, and increasing pay in adult social care would potentially reduce differences in earnings between these groups and other workers.

Why is government action or intervention necessary?

There is strong evidence that addressing pay and terms and conditions can improve recruitment and retention for the ASC workforce. Research by the Policy Research Unit for adult social care has found that a 1% pay increase for all workers can improve labour supply in the sector by 1.8% through a combination of stronger recruitment and retention[39].

Most of adult social care is state-funded, predominantly through local authorities (LAs) – the ONS estimate 77% of people using community care services[40] and 63% of care home residents were state funded in 2022/23[41]. While services are predominantly delivered through independent providers who set pay rates independent of central government, those wage decisions are highly constrained by the fees paid by local authorities[42].

While some local authorities have adopted outcome-based or other commissioning strategies, including pay minima, which support better conditions, the sector describes prevailing terms and conditions as a 'race to the bottom' in which providers attempt to deliver care at the lowest possible price by limiting pay levels and investment in the workforce[43] [44] [45] [46]. This has led to an

[35] Next Steps to Make Work Pay (web accessible version) - GOV.UK

[36] Implementing the Employment Rights Bill - Our roadmap for delivering change

[37] Employment Rights Bill: impact assessments - GOV.UK

[38] Health Foundation (2025) Poverty, pay and the case for change in social care

[39] Vadean, F.; Allan, S. and Teo, H. (2024) Wages and labour supply in the Adult social care sector. ASCRU working paper (Vadean-et-al-2024.pdf)

[40] ONS (2023), Estimating the size of the self-funding population in the community, England: 2022 to 2023

[41] ONS (2023), Care homes and estimating the self-funding population, England: 2022 to 2023

[42] https://www.gov.uk/cma-cases/care-homes-market-study

[43] Adult social care Reform: the cost of inaction

[44] Adult social care Reform: The Cost of Inaction Inquiry | TUC

[45] Reform of adult social care – social workers say what's needed | BASW

[46] Adult social care – technical report for the research on productivity, Greater Manchester IPR, 2019

increased reliance on staff with fewer economic opportunities outside the sector, including workers (predominantly women) who had previously left the labour market to care for children or family members with care needs and international workers from predominantly lower income countries.

Low levels of pay, progression and terms and conditions within the sector increase staff turnover and constrain productivity, which has negative consequences for the living standards of people with care needs and demand for NHS services. Low pay in the predominantly female workforce also contributes to pay inequality.

However, providers have limited incentives to increase pay, as they do not directly bear these wider social costs. Current employees in the sector have limited market power relative to employers and may have limited other employment options, as evidenced by pay and other terms and conditions concentrating at statutory minimums. Trade union membership in the sector is low relative to other public services, partly because the workforce is fragmented between tens of thousands of employers who each determine pay, and terms and conditions. The information in pay advice and job adverts may not be sufficient to allow workers to compare these employment offers easily.

Commissioners of care may in turn be reluctant to increase fee levels in the face of competing priorities for their constrained budgets. Local government funding for ASC is not fully ringfenced. Therefore, additional funding intended for ASC wages might not be spent in this way. Local authorities have competing objectives and statutory responsibilities and are legally required to balance their budgets each year. While local authorities with care responsibilities spent 24% of their total service expenditure on adult social services in 2024/25[47], compared to 20% in 2014/15, with expenditure on adult social care rising by 26% in real terms over the period, it is not necessarily the case that their budgets reflect a level of care which maximises wider social benefits.

By contrast, government intervention which increases care workers' power to negotiate for better pay and conditions through collective bargaining with providers could support higher minimum levels of pay, terms and conditions and therefore productivity within the sector, if associated with increased funding.

Rationale and evidence to justify the level of analysis used in the IA

The level of analysis presented in this impact assessment is proportionate to the policy challenge under consideration. It reflects both the strategic importance of the intervention and the availability of evidence at this stage of policy development.

This impact assessment is intended to support responses to the public consultation on FPA policy. Responses to the consultation will inform secondary legislation. We will publish a regulatory impact assessment alongside secondary legislation to enable scrutiny of regulation.

The impacts outlined in this document are primarily derived from internal cost models developed by DHSC. These models have undergone extensive internal quality assurance and, alongside accompanying sensitivity analysis, represent the best available evidence to date.

However, the assessment is based on illustrative FPA outcomes, and final decisions on minimum standards for pay, terms and conditions, training, and career progression will be subject to negotiation by the ASC Negotiating Body and approved by government. We have included illustrative costs to demonstrate how the FPA negotiation framework may be used in order to inform responses to the consultation, but these should not be interpreted as actual policy costs. The uncertainty around these costs is described in the risks and assumptions section.

[47] Local authority revenue expenditure and financing England: 2024 to 2025 individual local authority data – outturn (Gov.uk)

Where direct evidence is limited—particularly around local variation in provider responses or behavioural impacts on workforce participation—assumptions have been informed by academic literature, sector reports, and expert judgement. These uncertainties are acknowledged, and their potential impact is explored through sensitivity analysis.

While the analysis is sensitive to underlying assumptions, these are explicitly stated throughout. Overall, the approach ensures the impact assessment is proportionate, transparent, and robust enough to support informed policy development and decision-making.

Policy objective

Objectives and intended outcomes

The overarching objective of the ASC FPA policy is to improve labour market and individual employee outcomes in the ASC sector by enabling employers and workers to negotiate industry minimum employment terms. This will ensure that workers in ASC in England are fairly recognised and rewarded for the work they do. This results in improved living standards for social care workers, improved retention, and higher productivity.

There are also secondary objectives:

- The policy reduces the risk that the output of the workforce is insufficient to meet care needs in the population.
- The policy reduces the risk of reliance on the immigration system and of exploitation of migrant workers.
- The policy improves the quality of care delivered in the ASC sector in England.
- Any reforms should be financially sustainable for central and local government, providers and self-funders.
- Any reforms should support the wider objectives for the care system, including supporting a sustainable social care market.

Success indicators

The success indicators depend to some extent on the scope of an FPA, but could include the following:

Objective	Key indicator of success
Primary objective	
The policy should improve labour market and individual employee outcomes in the ASC sector by enabling employers and workers to negotiate industry minimum employment terms. This will ensure that workers in ASC in England are fairly recognised for the work they do. This results in improved living standards for social care workers, improved retention, and higher productivity.	Increases in mean hourly pay rates for workers in scope (or relevant alternative depending on FPA outcome). Representatives of employers and workers are engaged in the negotiation process. Improvements in staff retention rates in ASC. Reductions in the incidence of relative poverty amongst workers in the ASC sector. An increase in subjective wellbeing for people who work in care.
Secondary objectives	
The policy reduces the risk that the output of the workforce is insufficient to meet care needs in the population.	Increases in the number of full-time equivalents employed within the sector, in line with expected increases in demand.

The policy reduces the risk of reliance on the immigration system and of exploitation of migrant workers.	Reductions in the number of workers recruited from overseas.
The policy improves the quality of care delivered in the ASC sector.	Improved quality of life reported by care users and unpaid carers. Reduced preventable emergency admissions to hospital amongst social care users.
Any reforms should be financially sustainable for local government, providers and self-funders.	The FPA outcome in any given year should be affordable for local authorities within the available funding (£500 million in 2028/29), and impacts on other parties must be considered.
Any reforms should support the wider objectives for the care system, including supporting a sustainable social care market.	Local authorities pay increased fee rates and support providers in implementing FPA terms. People with care needs can access care.

Monitoring and evaluation plans will be developed against these key indicators. In some cases, alternative metrics or proxy measures may be identified as evaluation plans progress.

Description of options considered

Option 0: Do nothing (the current system)

- This would leave the system as it currently is, with no adult social care fair pay agreement from 2028/29 onwards. The £500m funding in 2028/29 would not be available to local authorities.

- The minimum pay level would be the National Living Wage for all job roles, and minimum employment conditions would be statutory conditions including Statutory Sick Pay and standard annual leave entitlements. This would include any changes to statutory employment conditions implemented through the Employment Rights Bill.

- With low rates of unionisation, there would be limited means for workers to negotiate for better wages and terms in the sector.

- There would likely continue to be workforce challenges in ASC in England. ASC providers would be less willing and able to increase pay and conditions by more than employers in competing sectors and would therefore face challenges in attracting enough staff to the sector to meet care needs, given restrictions on international recruitment.

Option 1: Establish a fair pay agreements process in the adult social care sector

- Establishing a fair pay agreement in the adult social care sector is a manifesto pledge. The adult social care measures in the Employment Rights Bill will allow the Secretary of State for Health and Social Care to make regulations that will: establish the ASC Negotiating Body and set out how it operates, make provision about the remit of the ASC Negotiating Body, set out the process for dispute resolution, approve and implement negotiated agreement(s) and make provision for enforcing the final agreement(s).

- The public consultation seeks views on the remit and coverage of the ASC Negotiating Body, and the negotiation process, which will inform the design of the policy and be finalised in secondary legislation. The proposals include:

    - The Adult Social Care Negotiating Body (ASCNB) is established as an Advisory Non-Departmental Public Body, led by an independent chair, and supported by a secretariat comprising civil servants or an external delivery partner.

    - ASC workers are exclusively represented on the ASCNB by independent unions. ASC employers are represented on the ASCNB by a group of employer representatives, chosen by analysis on factors such as number of workers and number of service users. This process will be managed by the Care Provider Alliance. If any other members are appointed to the ASCNB, they are appointed as observers or advisers only.

    - Whilst the Secretary of State will determine the overall number of seats, each bargaining side will be responsible for determining how their own seats are shared and will submit membership proposals to the Secretary of State for review and approval.

    - Each annual round of negotiations will begin by the Secretary of State issuing a remit letter. This will set out a) any priority areas or parts of the workforce the ASCNB should consider, b) any conditions that the negotiated outcome should meet, including the total amount of funding available, c) timelines by which the ASCNB should submit an agreement to government.

    - For an outcome to be reached, a majority of members of all sides must be able to endorse it. Each bargaining side will be responsible for its own decision-making mechanism.

    - Care delivered by the self-employed or those working under informal care arrangements are not covered by the ASCNB. Care sector workers employed by local authorities and the NHS, agency workers and bank staff, however, are within coverage.

    - The ASCNB could negotiate on matters including: pay, terms and conditions, training, development, progression, people and culture policies, and additional benefits and financial incentives.

    - In cases where the ASCNB is unable to reach agreement, the chair will aim to resolve points of contention. If negotiations reach a genuine impasse, dispute resolution services will be provided by Acas as an independent third party. Formal dispute resolution must be triggered by the chair and agreed by a majority of ASCNB members.

    - DHSC and MHCLG Ministers review the proposed FPA and can ask the ASCNB to re-open negotiations or can choose to ratify the agreement. If negotiations have failed and all mechanisms have been tried, Ministers can make their own determination for minimum pay and conditions in the sector.

    - Guidance and communication on the implementation of the FPA will be published by DHSC and the ASCNB.

    - The remuneration terms of an FPA will be enforced by the Fair Work Agency.

    - Once negotiated and ratified, the terms of a fair pay agreement will apply to all workers covered by the agreement. As a majority of adult social care provision is funded by the state, the government will financially contribute to the costs of the fair pay agreement. The 2025 Spending Review allows for an increase of over £4 billion of funding specifically for adult social care in 2028/29, compared to 2025/26. As part of this, the first fair pay agreement will be backed by £500 million of grant funding to local authorities to implement the FPA in 2028/29. This funding will be paid to local authorities, to reflect the increase in the cost of care.

- The actual scope of any FPA is subject to negotiation by the ASCNB, though it is constrained by the LA funding envelope that is available to increase pay in the sector (£500m in 2028/29). In this impact assessment, we have considered the potential impacts of an average pay increase for all direct care staff and managers in ASC. However, the scope of an FPA is ultimately subject to secondary legislation and to negotiation by the ASCNB, and the impacts could vary for each option. The impact of these options will be explored further in the Regulatory Impact assessment that will be published alongside secondary legislation. The following options are not exhaustive, and combinations of these options are possible:

    - A global pay increase. This could take the form of a uniform percentage uplift to the wages of all workers that are in scope of an FPA.

    - A pay floor. Under this scenario, there could be a higher statutory minimum wage for adult social care workers. Workers in scope would receive hourly pay that is at least in line with this minimum pay rate. There may also be pay spillover effects, where workers who are paid above this rate also benefit from a pay increase, in order to maintain pay differentials.

    - A pay spine. There could be multiple minimum pay levels depending on experience, qualifications, or job role. A pay spine could have different impacts depending on the number of pay levels, the pay differential between these levels, and what factor is rewarded or incentivised by the pay structure.

    - Bonuses. An FPA may result in one-off payments or premia, where workers who are in scope must be paid an additional bonus or annual pay premium.

    - Other terms and conditions. An FPA may result in improved terms and conditions, including higher employer pension contributions, greater annual leave entitlements, or increases to sick pay beyond the reforms to Statutory Sick Pay.

    - Some employment conditions are likely to be of particular interest in ASC, including additional pay for travel time for domiciliary workers above the statutory level of the NLW, and payment for sleep-ins, where care workers stay overnight to be available to assist with care needs overnight.

Other options considered

<u>The same level of funding without an FPA</u>

- In this non-regulatory option, the powers outlined in the Employment Rights Bill would not be used to make secondary legislation, i.e. no ASC Negotiating Body would be set up, and no fair pay agreement would be determined.

- Instead, the equivalent funding would be allocated to local authorities but with no minimum requirements on pay and reward in the sector. Local authorities would continue to make their own choices about fee rates, and independent ASC providers would continue to make their own pay decisions.

- The intention would be that market pressures would lead local authorities to increase fees, and providers to increase pay and reward, so that ASC could attract and retain more workers as care needs in the population increased.

- However, this would be implemented differently in every local authority and provider and there would be no additional minimum terms at a national level in ASC beyond statutory minima. Any negotiation of pay and conditions between workers and employers could be at individual location or provider level, or even between each worker and their employer. Some ASC providers might increase pay for the lowest paid staff, some might increase pay for those with more experience, and some might choose to invest in other aspects of pay or reward.

- As there would be no national FPA or set of minimum terms beyond statutory employment conditions and the NLW, there would be no additional enforcement of any improved pay and conditions above statutory minima. Improvements in pay and conditions would be driven by market pressures alone. Workers themselves would need to challenge employers if they did not receive the pay and conditions outlined in their contracts.

- Moreover, local government funding for ASC is not fully ringfenced, and so additional funding intended for ASC wages might not be spent in this way. Local authorities have competing objectives and constrained budgets and may therefore place a lower value on adult social care outcomes than their total social value. Similarly, without legislation or enforcement, providers may not choose to spend uplifted fees on higher pay rates. Workers in the sector have limited market power relative to employers, with low union membership, and a fragmented market. Given the need for providers to compete for local authority contracts, there would still be barriers to providers investing in the workforce. As a result, it is likely that not all of the funding would be spent on increasing pay or reward in the sector.

- This option was discounted because it does not meet the primary objective of the policy, i.e. it does not enable employers and workers to negotiate industry minimum employment terms. Given the significant likelihood of leakage, this policy option would be less effective in improving the attractiveness of ASC jobs and reducing the risk that the output of the sector grows more slowly than care needs in the population.

<u>Establish a fair pay agreement process without allocated funding</u>

- In this option, the powers outlined in the Employment Rights Bill would be used to set up an ASC Negotiating Body. The process would be as outlined in Option 1, although the remit letter would not include a cost envelope. There would not be £500m of local authority funding available to LAs to contribute to the FPA outcome.

- This option was discounted because it does not meet the objective that the reform should be financially sustainable for local government, providers and self-funders. There is a significant risk that the negotiation would result in an FPA outcome that leads to unaffordable cost pressures for the sector. This could impact on provider viability if they are unable to pass these costs through to commissioners of care and care recipients. It could also impact on local authority finances and self-funders' spending on care and access to care if providers pass these increased costs through.

- As a result, implementing an FPA outcome without local authority funding could constrain access to care and quality of care. It could lead to increased reliance on unpaid carers, with a risk of negative impacts on their health, employment and wellbeing, and could place additional pressure on the NHS through delayed discharges and avoidable hospital admissions. It could also lead to weaker quality of life outcomes for care recipients. These risks are described in more detail in the risks and assumptions section.

How the policy will work in practice and meet its stated objectives

Implementation plan

Implementation of the fair pay agreement in ASC requires several stages:

- Autumn 2025 – public consultation (this impact assessment considers options outlined in the consultation).
- By Autumn 2026 – response to consultation published, secondary legislation laid that sets up the framework for the ASCNB.
- By Autumn 2027 – establish negotiating process and negotiations conclude on the first FPA.
- By April 2028 – the pay and terms and conditions elements of the FPA are ratified through regulations. Where parts of the FPA are not well placed to be in employment contracts, statutory guidance or codes of practice may be issued instead to bring those parts of the agreement into effect. This then means the first FPA comes into effect and is applied to workers' contracts.
- A new FPA is expected to be negotiated each year, to come into effect at the start of each financial year. This gives the ASCNB some scope for experimentation – e.g. the first FPA could be limited in scope, but subsequent negotiations may build on this over time, with the ASCNB using evaluation to understand the impacts so far and the scope to go further.
- Within the proposed annual cycle, consideration will be made to how much time to allow for negotiations, how to align timelines with local government and employer budget setting, and allowing enough time for implementation.

Summary of preferred option

This legislation will create the powers to set up a form of sectoral collective bargaining for adult social care. This can be defined as a process of negotiation between the representatives of employers and of workers to agree the terms of employment within the sector, based on a given funding envelope for local authorities.

The adult social care fair pay agreement would provide a means to negotiate for better wages and terms in the sector, which will be ratified through regulations as new statutory minimum terms for workers in ASC who are in scope of the FPA. Enforcement by the Fair Work Agency should help to ensure that increased funding is spent on improving pay and conditions for workers to comply with the terms of the FPA. This is the primary objective of the policy.

Increased wages will increase the incomes of households with at least one ASC worker, helping to improve living standards and wellbeing, reduce the incidence of relative poverty, and reduce inequality.

Increased wages in ASC will make it easier for providers to recruit and retain workers, not only helping to ensure that the ASC workforce can continue to grow to meet rising care needs in the population but also increasing sector stability. It will improve the recruitment and retention of UK workers, giving providers an alternative to overseas recruitment.

As pay in ASC increases, this is expected to lead to improvements in the quality of care, including via the efficiency wage hypothesis, where workers are incentivised to work harder to keep jobs which are better paid than their available alternatives. Higher pay also means that workers with role-specific knowledge, skills and experience are retained for longer, increasing productivity via human capital. Increased labour costs could also drive some businesses to invest in productivity improvements.

Theory of change

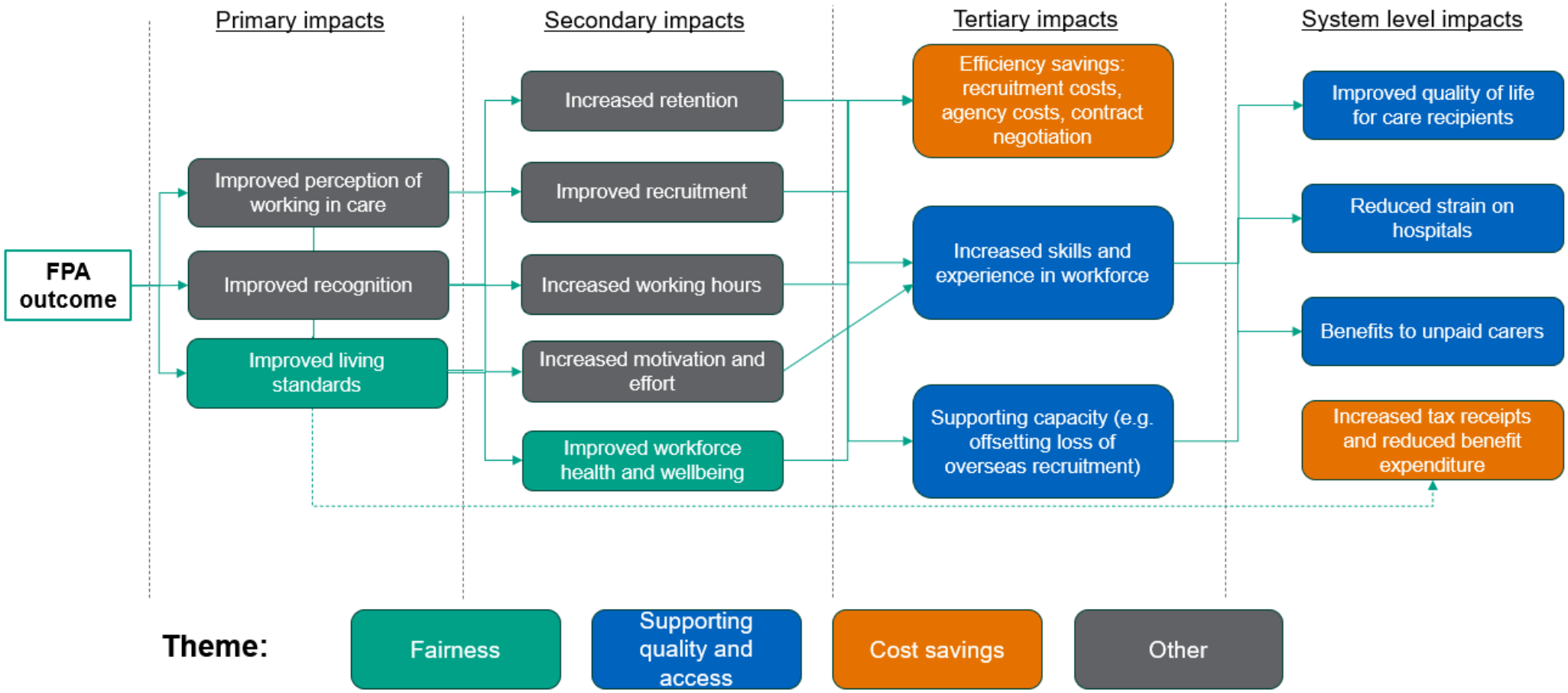
Input is the legislation – both primary and secondary, and then set-up of ASC Negotiating Body, including ongoing implementation costs associated with providing secretariat support to the body and enforcing each FPA outcome.

Output is a form of sectoral bargaining in ASC as outline above, in which worker and employer representatives negotiate the terms of an FPA according to a remit that is set by government, including a given cost envelope.

Outcomes is an annual FPA outcome that sets minimum terms for wages and/or other terms and conditions, for workers who are within scope within ASC.

Impact includes increased labour supply to the sector and improved productivity, with positive impacts for people who receive care, the NHS, and unpaid carers. The below provides a more detailed overview of the expected impacts of an ASC FPA policy.

Logic model of expected impacts of an FPA policy in ASC



Monetised and non-monetised costs & benefits of option 0

Impact appraisal of option 0 ("Do nothing")

Overview: Under the 'do nothing' proposal, there would be no planned additional government expenditure compared to the status quo. Costs would simply rise in line with rising care costs and demographic pressures.

Workforce implications: persistent issues such as low pay, limited progression opportunities, and poor employment conditions would continue to present challenges to recruitment and retention. Job satisfaction and morale would continue to be challenging, contributing to high turnover and reduced continuity of care. There is a greater risk that the sector may not be able to attract enough recruits to meet demand, particularly in the context of reduced overseas recruitment and significant competition from other low-wage sectors.

Distributional and equity considerations: this option would perpetuate existing inequalities within the workforce. A significant proportion of care workers—many of whom are women and from ethnic minority backgrounds—would remain in low-paid roles with limited financial security. There would be no improvements in the prevalence of poverty, with 1 in 5 residential care workers currently living in poverty in the UK.[48]

Systemic consequences: the lack of investment in the workforce under this option will likely have wider implications for the health and care system. The risk of workforce shortages would be higher, and this could constrain the quality and continuity of care available and increase reliance on unpaid carers. In turn, this could place additional pressure on the NHS through delayed discharges and avoidable hospital admissions, with broader opportunity costs for population health and wellbeing.

Costs and benefits of option 0

There are no costs or benefits associated with this option. This is the baseline against which other options are appraised.

Monetised and non-monetised costs & benefits of option 1

Costs of option 1 (fair pay agreement in ASC in England)

There are various costs that would result from the implementation of a fair pay agreement in adult social care, which include:

- Administrative costs to government for organising the ASC Negotiating Body.
- Familiarisation and transition costs to businesses for understanding and implementing the terms of the fair pay agreement.
- Increased labour costs which are passed through by providers to commissioners of care and people who fund their own care, as a result of higher pay and better employment conditions in the workforce.

Administrative costs

There are ongoing administrative costs to government for organising the ASC Negotiating Body. These include:

- Costs associated with the members of the ASC Negotiating Body such as fees for the Chair and travel expenses for all members.
- Costs associated with providing secretariat support to the ASC Negotiating Body, including a budget for research and evidence.

[48] UK care workforce twice as likely to live in poverty as average worker, The Health Foundation (2025)

- Costs associated with the negotiation process, including support for bargaining sides to engage in negotiation processes, and funding for dispute resolution.
- Costs associated with ongoing enforcement of the terms of the FPA by the Fair Work Agency.

To estimate the cost of the proposals outlined in the consultation, we have assumed that the secretariat would be staffed by a team of 6 full-time equivalent (FTE) staff, with the ASC Negotiating Body meeting 20 days per year. We have based staffing costs on assumptions from other non-departmental public bodies including pay review bodies. We have assumed that the ASC Negotiating Body is established from 2027/28, but there are some set-up costs in 2026/27 associated with preparing for negotiations.

We have assumed that enforcement activity covers 5% of the eligible workforce per year, and assumed that the costs to the Fair Work Agency are comparable to the costs of enforcing the NLW. We have assumed that enforcement costs start in 2028/29 with the first FPA and continue over the appraisal period.

Table 2: *Administrative costs to government for the ASC Negotiating Body and enforcement of an FPA*

£ m	**2026/27**	**2027/28**	**2028/29**	**2029/30**	**2030/31**	**2031/32**	**2032/33**	**2033/34**	**2034/35**	**2035/36**	**2026/27 + Total**
Total (real, undiscounted)	0.3	0.8	3.3	3.3	3.4	3.4	3.5	3.5	3.5	3.6	28.6
Total (discounted)	0.3	0.7	3.0	2.9	2.8	2.8	2.7	2.7	2.6	2.6	23.0

Familiarisation and transition costs

The FPA policy represents a new intervention in the ASC market, and it would take time for businesses to understand the terms of an FPA prior to each year that a new FPA outcome is introduced and to implement these changes. We have considered whether fair pay agreements would represent a new burden for local government under the new burdens doctrine. Our assessment is that, at this stage, there is no new burden. However, we will continue to monitor this as policy develops.

This could include the time spent reading guidance, making changes to contracts and payroll, and notifying staff. The time required is uncertain and likely varies with the complexity of an FPA outcome and the terms and conditions that are in scope. For example, a pay floor may not require any additional business time relative to the time that is already taken by businesses each year to understand and implement increases in the NLW. If an FPA outcome is more complex, and includes pay premia for some job roles, or a pay spine, or other terms and conditions, it may take businesses more time to understand and implement the changes.

We would be interested in any evidence on the potential impacts of the FPA on business administration, to inform appraisal of the FPA policy at secondary legislation stage.

For this consultation Impact assessment, we assume that for each independent business, it will take management or HR staff two full-time equivalent days prior to implementation of the first FPA outcome, and 0.5 full-time equivalent days in subsequent years to understand and implement subsequent FPA outcomes. This is additional relative to the time that is already spent on understanding and implementing increases to the NLW each financial year.

We use Skills for Care data on the hourly pay for senior managers, and assume this increases in line with OBR earnings forecasts over time. We apply assumptions about pension and employer National Insurance contributions to estimate the total cost to businesses per hour of senior manager time. We use the number of ASC businesses in 2023/24 as a baseline, and

assume that the number of managers who will need to be familiar with the terms of an FPA increases in line with CPEC demand projections over time.

Table 3: *Familiarisation costs to businesses arising as a result of an FPA*

	2026/27	**2027/28**	**2028/29**	**2029/30**	**2030/31**	**2031/32**	**2032/33**	**2033/34**	**2034/35**	**2035/36**	**2026/27+ Total**
Familiarisation costs (real terms, £m)	-	9.4	2.5	2.5	2.6	2.7	2.8	2.8	2.9	2.9	31.1
Familiarisation costs (real terms, discounted, £m)	-	8.8	2.2	2.2	2.2	2.2	2.2	2.1	2.1	2.1	26.1

Increased labour costs

As pay and employment conditions improve as a result of an FPA, the cost of employing a worker in ASC would increase. We assume that these increased costs would be passed through by providers to parties who commission or pay for adult social care, including local authorities, the NHS, and people who pay for their own care ('self-funders'), though how these costs would be shared is uncertain.

The actual scope of an FPA is subject to negotiation by the ASCNB. However, the remit letter will set out the financial envelope, which has been made available within the settlement for local authorities from the 2025 Spending Review, as a relevant factor for affordability, and any potential priorities or specific considerations for an agreement. The FPA will be backed by £500m of grant funding for local authorities in 2028/29. Given the mixed nature of funding in the sector, further costs associated with increased pay and reward would be expected to be passed through to households and to the NHS and these impacts should also be considered by the ASCNB when negotiating the terms of an FPA.

If self-funders are unable to afford increased fees, there may be a reduction in access for these recipients of care with a greater reliance on unpaid care, or providers may be forced to reduce profits to mitigate the impact on self-funders. These potential unintended consequences are discussed in more detail in the risks and assumptions section.

Current pay structure in adult social care

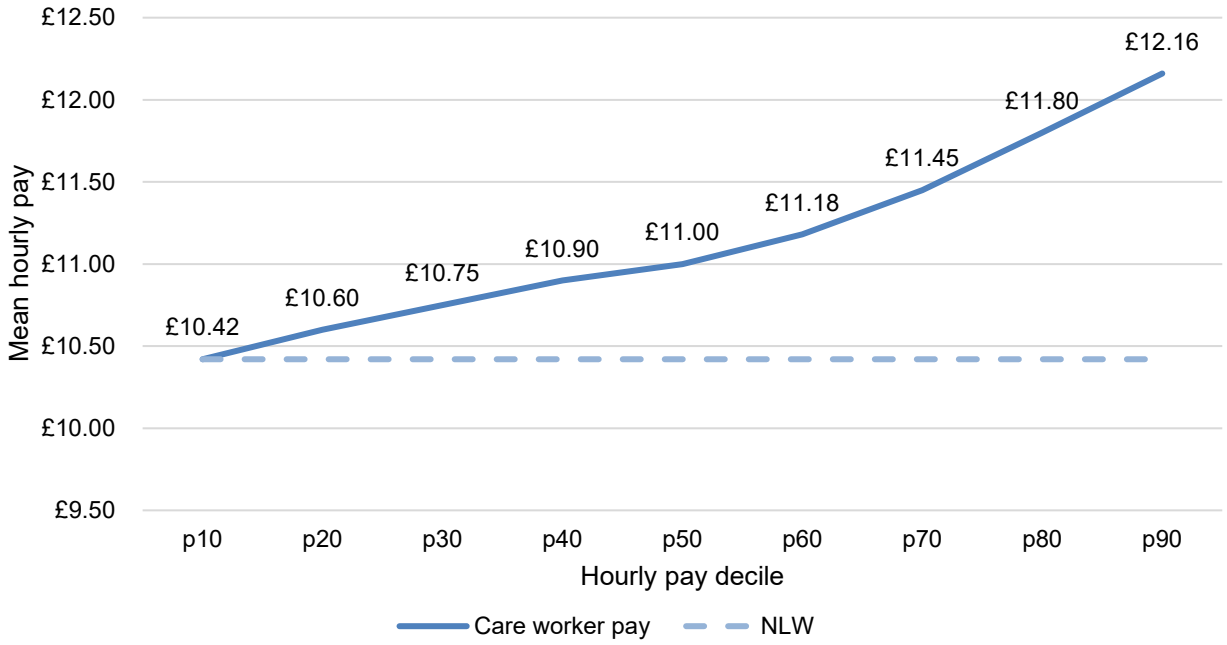
The majority of staff pay in ASC is determined by independent providers, who primarily rely on funding from contracts with LAs. Providers offer wages based on decisions surrounding what they can afford and local labour market conditions. However, due to financial constraints and competing service demands, LAs often limit the fees they pay to providers, using their significant market power as the largest buyer of care services to constrain fees. This, in turn, affects wage levels across the sector. A minority of providers do not accept LA-funded clients and are therefore not subject to the same constraints on fee income; however, their self-funded clients have limited market power to demand better staffing levels or conditions for the workforce. Consequently, pay in ASC varies between employers and localities, but overall remains low.

Most ASC staff are employed in the independent sector (1,345,000 filled posts in 2024/25), while smaller proportions work for LAs (119,900 filled posts in 2024/25) and the NHS (119,000 filled posts in 2024/25). Pay structures for LA and NHS staff differ from those in the independent sector, as they are governed by national frameworks: the National Joint Council (NJC) for LAs and the NHS Terms and Conditions of Service (Agenda for Change [AfC]) for NHS employees. The clauses in the Employment Rights Bill are broad, meaning that these workers could be in scope for an FPA, though they may be excluded from the FPA negotiation process via secondary legislation following consultation, or from an individual FPA outcome via the remit

letter to the ASC Negotiating Body. The interaction between the pay setting processes is discussed in more detail in the risks and assumptions section.

While worker pay in the NHS and, often, LAs tends to be higher than in independent providers, overall pay in the sector remains low. The sector has been defined by the LPC as a 'low paying industry' every year since the 'First Report of the Low Pay Commission' on the National Minimum Wage in 1998. The sector is heavily exposed to the NLW, with approximately 70% of care workers in the independent sector paid within £1 of the NLW[49].

***Figure 1**: Care worker hourly pay distribution (independent sector only), March 2024*



Source: Skills for Care, The state of the adult social care workforce in England, 2023/24

There is more variation for other job roles, with managerial roles (including registered managers and senior management) and regulated professionals (including social workers, occupational therapists and registered nurses) often paid much higher than the NLW.

***Table 4:** Full-time equivalent (FTE) posts, mean hourly pay, and estimated wage bill, by job role, adult social care in England, 2023/24*

Job role	FTE filled posts	Mean hourly pay	Estimated wage bill (excluding on-costs*)
All job roles	*1,170,000*	*£12.35*	*£27,880,000,000*
Senior management	12,500	£22.78	£549,000,000
Registered manager	25,000	£19.74	£952,000,000
Social worker	18,500	£20.95	£748,000,000
Occupational therapist	3,300	£20.11	£128,000,000
Registered nurse	27,000	£20.77	£1,082,000,000
Allied health professional	375	£23.27	£17,000,000
Senior care worker	72,000	£12.03	£1,671,000,000
Care worker	650,000	£11.25	£14,106,000,000
Support and outreach	44,000	£11.70	£993,000,000
Other managers	76,000	£16.28	£2,387,000,000
Other regulated professions	1,100	£17.28	£37,000,000
Other direct care	23,000	£12.97	£576,000,000

[49] The state of the adult social care sector and workforce in England, 2024

Other (all others)	153,000	£12.03	£3,550,000,000
Personal assistant	62,000	£11.76	£1,407,000,000

Source: Skills for Care estimates based on Adult social care Workforce Dataset, 2023/24
**On costs include other labour costs, such as National Insurance Contributions, pension contributions, costs of sickness absence, annual leave, parental leave etc.*

Pay growth in adult social care

As many workers in the sector are paid close to the NLW, pay growth in ASC is strongly influenced by increases in the NLW rate.

The impact of the NLW on the pay distribution in the wider labour market is well documented (Low Pay Commission 2024 Report; The impact of the National Living Wage on wages, employment and household incomes). At the bottom of the pay distribution, hourly pay is substantially influenced by the rising wage floor. People who are paid at the NLW in one year will normally receive pay increases in line with the NLW if they remain in that job. At the middle and top of the pay distribution, pay growth is not influenced by the rising NLW. For these workers, pay increases in line with average earnings.

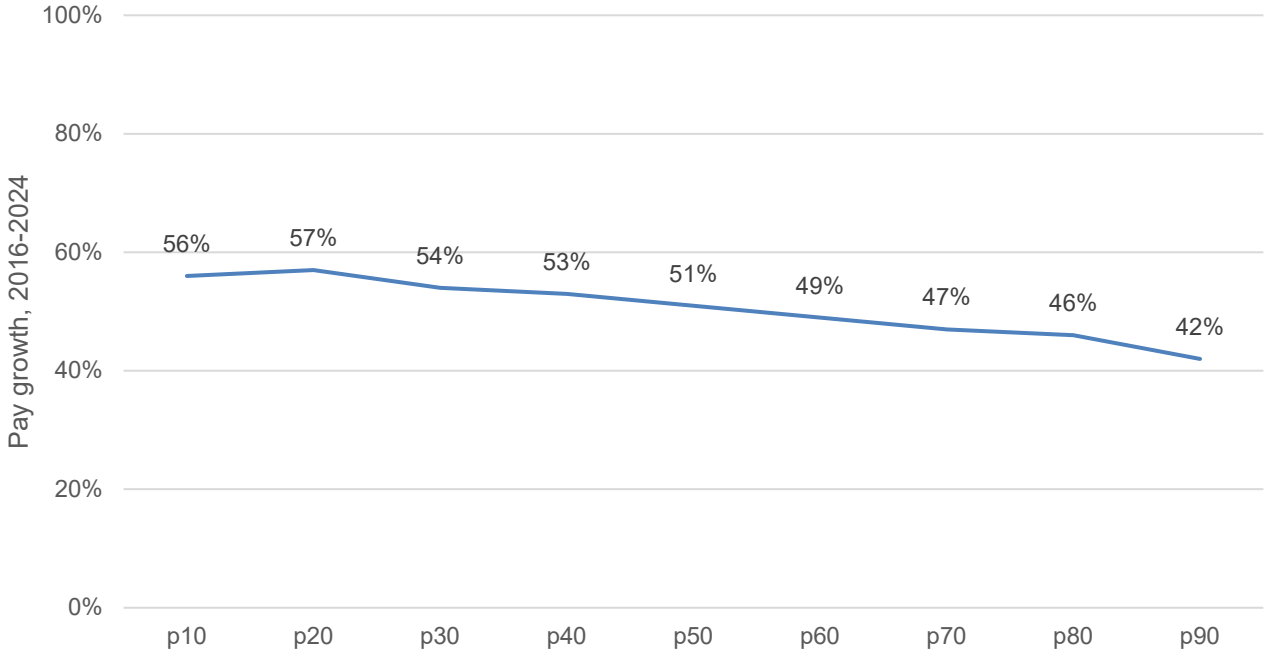
There are 'pay spillover effects' that extend above the NLW, which exist because employers try to maintain the existence of pay differentials for workers who are paid just above the pay floor, e.g. to reflect experience or seniority or local labour market conditions. Above the pay floor, pay growth is still influenced by increases in the NLW but to a lesser extent, reducing to average earnings growth for higher paid workers.

As the NLW increases, pay differentials for workers paid above the NLW are eroded across the whole labour market, because pay growth is strongest for those at the bottom of the pay distribution. Employers have responded in different ways to the erosion of pay differentials, including by removing some layers in their pay structures.

Pay growth in ASC has followed a similar pattern in adult social care to the wider labour market (see Figure 8, which shows pay growth for care workers in the independent sector from 2016 to 2024). The strongest pay growth has been for the bottom quintile of the pay distribution, who are largely paid at the NLW (18% of care workers in the independent sector were paid at the NLW in March 2024). Above this point, we see pay spillover effects, with strong pay growth that gradually declines for those workers who are further up the pay distribution.

As pay growth at the bottom of the pay distribution has been stronger than for higher earners, pay differentials have compressed, as they have in the wider labour market. Skills for Care have reported that care workers with five or more years of experience were paid 10 pence more per hour than new care workers in March 2024, compared to 33 pence in March 2016. However, it is important to note that pay differentials can reflect other factors, including skills, qualifications, geographical location and type of service, and providers may value some of these factors more when making pay decisions.

***Figure 2**: Growth in hourly pay by percentile for care workers in the independent sector, March 2016 to March 2024*



Source: Skills for Care estimates based on Adult social care Workforce Dataset, 2023/24

Workforce supply pressures

In a competitive labour market, ASC providers face market pressures to increase pay more quickly than other employers in order to attract a workforce that is sufficient to meet rising care needs in the population. This is already seen to some degree in the ASC sector. For example, the share of the care workforce paid at the NLW has gradually been falling over time, suggesting that providers seek to pay just above the NLW to attract and retain workers.

In the counterfactual, we therefore assume that there is some pay growth over and above the increases that we would expect to see based on the expected increases in the NLW alone, because providers operate in a competitive labour market and need to increase pay more quickly to attract a workforce that can meet growing care needs in the population. This assumption is described in more detail in the 'Risks and assumptions' section.

FPA illustrative scenario - average pay increase

For the purpose of the impact assessment, we considered an illustrative scenario in which there is an additional pay uplift for the following job roles: care workers, senior care workers, other direct care roles, personal assistants, managerial roles. This is intended to explore the potential impacts of an FPA, but it is not a policy position. The actual design of the FPA is subject to secondary legislation and to negotiation by the ASC Negotiating Body.

We use Skills for Care estimates for full-time equivalent posts and mean hourly pay in 2023/24, split by job role and sector. We assume that the workforce grows in line with CPEC projections for demand[50]. We also use Skills for Care data on pension and employer National Insurance contributions to estimate how these on-costs change as base hourly rate is increased.

We assume that all increases in labour costs are fully passed through by ASC providers to commissioners and consumers of care via increased prices. We assume that local authorities fund 52.3% of increased labour costs, the NHS covers 16.7% of increased labour costs, and households including self-funders pay for 31.1% of increased labour costs. This is based on a

[50] Projections of Adult social care Demand and Expenditure in England, 2022 to 2042, CPEC

LaingBuisson report on sources of expenditure in the independent sector[51]. However, there is substantial uncertainty in the share of costs that fall to different parties (see discussion of risks and uncertainties for more detail).

In 2028/29, we estimate that a 2.8% pay increase for these job roles is possible given the available £500m envelope for additional local authority expenditure as a result of the agreement, assuming further costs fall to the NHS and to households in line with the current split of expenditure in the sector. This is additional relative to the counterfactual, so is on top of the increases in labour costs needed to meet increases in the National Living Wage and pay pressures in a competitive labour market over 2025/26-2027/28. In total, care workers in the independent sector would receive a 5.1% pay uplift between 2027/28 and 2028/29 in this scenario.

In subsequent years, we have assumed that pay increases in line with OBR average earnings forecasts only. Over this period, we assume that the workforce continues to grow in line with CPEC projections for user numbers. We apply these steady state assumptions in 2029/30 and beyond given FPA policy uncertainty, the fact that the funding level has not yet been determined beyond the end of the current Spending Review period, and given other modelling assumptions are less likely to hold in the long-term.

This results in the following cost profile over a 10-year appraisal period.

Table 5: *Costs of increasing pay and reward in the sector to meet the terms of a fair pay agreement, passed through by providers via an increase in prices. Increased labour costs are presented in nominal terms for consistency with the £500m funding envelope for local authorities . Costs to other parties are highly uncertain*

£m	**2026/27**	**2027/28**	**2028/29**	**2029/30**	**2030/31**	**2031/32**	**2032/33**	**2033/34**	**2034/35**	**2035/36**	**2026/27 + Total**
Total labour costs (nominal, undiscounted)	-	-	960	1,000	1,050	1,110	1,160	1,220	1,280	1,340	9,120
Of which, costs to LAs	-	-	500	520	550	580	610	640	670	700	4,760
Of which, costs to NHS	-	-	160	170	180	180	190	200	210	220	1,520
Of which, costs to self-funders	-	-	300	310	330	340	360	380	400	420	2,830
Total labour costs (real, discounted)	-	-	820	810	810	800	800	790	780	770	6,370

Alternative FPA scenarios

The pay uplift discussed above is intended as purely illustrative, and other FPA outcomes could be affordable within the same envelope.

- **Pay floor.** The ASC Negotiating Body may recommend that a pay floor should be introduced in the sector. We estimate that it could be possible to introduce a pay floor for direct care workers only that is 68p above the expected NLW in 2028/29, within the £500m envelope for local authorities, assuming further costs fall to the NHS and to self-funders in line with the current split of expenditure in the sector. Note that this is subject to change in line with parameters such as average earnings, projections for the NLW, and workforce size.

[51] LaingBuisson adult social care market report

This is based on a model that uses the counterfactual ASC pay distribution and applies assumptions about the impact of an increasing wage floor on the pay distribution. We assume that pay for affected job roles increases to the new pay floor for those paid at the minimum, with spillover effects that extend up to £1 above the incoming pay floor. Workers who are paid above this threshold are assumed not to benefit from increases in the pay floor.

- **Pay spine.** Alternatively, the ASCNB could choose to negotiate a pay spine. A pay spine is a structured pay scale made up of a series of incremental pay points or bands. Each point on the spine corresponds to a specific salary level. A pay spine can be structured around various factors, such as job role, experience, or progression along the care workforce pathway.

  For example, within the £500m envelope in 2028/29 it could be possible to introduce a qualification-linked pay spine, where direct care staff with a relevant Level 2 qualification receive £1500 annual pay premium on their hourly pay rate, while workers with a relevant Level 3 qualification receive a total £3000 annual pay premium, assuming further costs fall to the NHS and to self-funders in line with the current split of expenditure in the sector. This assumes that there is no change in the expected uptake of qualifications as a result of the policy, which may be appropriate for a single year but is unlikely to hold in the longer term.

  The cost estimates are based on a model that compares the counterfactual pay distribution (based on Skills for Care data, adjusted to the appropriate year by applying wage inflation and workforce growth in line with demand) to a policy in which wages are increased for direct care staff with ASC-relevant qualifications.

  Note that there are significant risks of unintended consequences if a pay spine is designed in a way that does not reflect the actual value of the features that are being rewarded, for example by incentivising employers to recruit at lower levels or restrict access to training or qualifications. The scenario outlined here is illustrative; any pay spine would need to be designed based on strong evidence on the market value of the features that are rewarded.

- **Terms and conditions.** Other improvements to employment conditions may be considered as part of an FPA. These would be additional relative to the reforms to statutory minima in the Employment Rights Bill, including changes to Statutory Sick Pay and entitlements for workers on Zero Hours Contracts. We are seeking to build our evidence base on current practice and cost of employment conditions in the sector so that we can appraise the impacts of FPA outcomes that include a non-pay element.

Non-monetised costs

There are also likely to be administrative costs to trade unions and to employer representatives as they engage in negotiations. However, we do not have sufficient evidence on the potential impacts on these parties to monetise these costs. We will seek to build evidence on the potential impacts on trade unions and employer representatives through stakeholder engagement.

Benefits of option 1

Recruitment efficiencies

Improved pay and reward as a result of a fair pay agreement in ASC would lead to improvements in labour supply to the sector, through a combination of increased retention and increased ease of recruitment. Research has demonstrated that there is a wage elasticity of 1.8 in the sector, meaning that a 1% increase in pay should increase the number of people willing to work in the sector by 1.8%[52].

There are costs associated with high staff turnover, including recruitment costs, training costs, and the costs associated with having new staff who are less productive due to lack of experience in the job. It can also limit providers' ability to maintain reasonable staff workloads and stay motivated.

Care England estimates that there is a cost to providers of £6,000 per hire.[53] Skills for Care estimate costs of £3,600 per hire.[54] These cost estimates include the costs associated with advertising, staff time spent on the recruitment process, induction training, staff cover during the time taken to hire, and additional supervision or support during the induction period. We assume that each new recruit costs £4,800 in 2025/26 as the midpoint of these two estimates, and that this cost increases over time, in line with the GDP deflator.

We use the wage elasticity of labour supply to estimate the increase in retention that would be expected as a result of the illustrative FPA scenario. We assume that increased pay has an equal impact on recruitment and retention, in line with the assumptions in the wage elasticity research, so that the wage elasticity for retention is 0.9. We use Skills for Care data on staff retention rates in the sector and estimate how much this would change as a result of higher pay in the policy scenario compared to the counterfactual, by scaling by the assumed pay premium multiplied by the wage elasticity. As a result, we estimate that 30,000 fewer workers would leave their roles in 2028/29 as a result of the illustrative FPA scenario in that year, with the staff turnover rate falling to 20.8% (compared to 24.2% in 2023/24).

Based on the estimated cost for recruitment for new staff (£4,800), the total present value of this benefit over the 10-year appraisal period is £1.1 billion in 2025/26 prices.

While some local authorities have adopted outcome-based or other commissioning strategies, including pay minima, which support better conditions, many providers have not been able to raise prices thus far to achieve this benefit because their ability to do so is constrained by the monopsony power of local authorities and the challenges over service choice facing self-funders, which can result in a 'race to the bottom' between providers. As a result, care providers face financial pressures which prevent them from offering improvements upon pay or working conditions. Further detail is provided on page 18 under *'Why is government action or intervention necessary?'*. The scale of this saving, while significant, is still less than the increased labour costs that would be needed to achieve it, which is not feasible without increased income from local authorities given their significant market share.

While this is a direct saving to ASC providers, we expect that businesses would in practice pass most or all of this saving onto the commissioners of care (including local authorities and the NHS) and individuals who fund their own care. Based on current market outcomes, local authorities would potentially be able use their significant market power to capture most of the

[52] Wages and labour supply in the Adult social care sector, Vadean et al, 2024, Vadean-et-al-2024.pdf

[53] Solving the annual £3bn recruitment and retention cost to adult social care providers - Care England

[54] Our acceptance of low pay in social care costs us more than we think | Joseph Rowntree Foundation

efficiency savings made by providers by constraining increases in fees. Given local authorities have competing objectives within a constrained budget, they may have an incentive to seek to capture savings which could be reinvested in additional packages of care or in other service areas. While self-funders have less market power, they may also benefit to an extent as a result of competition between providers. Effectively, we expect this saving would offset some of the increases in the cost of providing care as a result of higher wages.

These benefits may vary depending on the design and scope of an FPA. For example, a global pay uplift assumes that every worker in scope benefits from an increase in pay. However, an FPA could be more targeted, for example as a pay floor that primarily benefits the lowest paid workers, or a pay uplift for certain workers (e.g. those with more experience, or with ASC-relevant qualifications). While we have estimated the impacts based on the average wage elasticity of labour supply, we would need to have more evidence on how this varies by hourly pay rate and job characteristics to be able to estimate the impact of different FPA scenarios.

Table 6: *Benefits associated with improved retention as a result of a fair pay agreement in ASC in England*

	2026/27	**2027/28**	**2028/29**	**2029/30**	**2030/31**	**2031/32**	**2032/33**	**2033/34**	**2034/35**	**2035/36**	**2026/27 + Total**
Reduction in churn	-	-	33,000	34,000	34,000	35,000	36,000	37,000	38,000	38,000	285,000
Total benefit (real terms, discounted, £m)	-	-	143	141	139	138	136	135	133	131	1,090

Tax and benefit savings

Increasing pay for the social care workforce would lead to reductions in Universal Credit expenditure, and increases in tax revenue for the Government. This is a transfer that is included on both the costs and benefits side when appraising the net present value of the policy, i.e. the total cost of the policy includes the cost of increasing gross pay, but a share of this is transferred back to the Exchequer via increased tax revenue. Including this transfer as both a cost and benefit helps to clarify the distributional impacts of the policy.

In order to estimate the scale of this impact, the Department for Work and Pensions (DWP) modelled the savings using their Policy Simulation Model (PSM). The PSM is built on a pooled sample of three waves (2019/20, 2021/22, and 2022/23) of the Family Resources Survey (FRS), an annual survey of UK private households that asks about the income of respondents.

The PSM then applies policy rules to estimate changes in entitlements to benefit payments, forms of tax liability and other useful quantities. It also uses OBR economic forecasts, as well as ONS population projection, to estimate how taxes and benefit payments will change over time.

In this analysis, ASC workers were identified using Standard Industry Classification (SIC) codes 87 (residential care activities) and 88 (social work activities without accommodation). The group is restricted to those in England who have a non-zero reported wage.

Individuals in the FRS who are defined to be an ASC worker have their net wages increased by 10% to estimate the impact of an increase in wages on income including tax and benefits.

The DWP analysis implies that for every £1 spent increasing gross earnings from 2024/25 to 2028/29, by either the government, or other parties, 35p returns to the state by higher income tax revenues, National Insurance Contributions, and reduced expenditure on Universal Credit.

We also consider the expected cost of increased employer National Insurance Contributions, which act as a transfer from the employer to the exchequer, using Skills for Care data on

employer National Insurance Contributions by hourly pay rate, uplifted to account for the changes to employer National Insurance Contributions in 2025/26.

Accounting for all of these transfers, the total present value of this saving to the Exchequer over the 10-year appraisal period is estimated to be £2.6 billion.

Table 7: *Benefits to the Exchequer associated with increased pay in ASC as a result of a fair pay agreement*

	2026/27	**2027/28**	**2028/29**	**2029/30**	**2030/31**	**2031/32**	**2032/33**	**2033/34**	**2034/35**	**2035/36**	**2026/27 + Total**
Total benefit (real terms, discounted, £m)	-	-	329	327	325	323	321	317	314	310	2,570

The DWP analysis is based on a scenario in which there is a higher pay increase than the increase outlined in illustrative Option 1. There are also other uncertainties around the representativeness of FRS for the ASC workforce, the accuracy of the modelled wage distribution, potential underreporting of benefit take-up, and forecasted pay growth, and this impact is sensitive to the design of a negotiated agreement. We hope to explore the potential saving further before publishing a regulatory impact assessment alongside secondary legislation.

Increased income for care workforce

Investment in pay in ASC would lead to improvements in the household income and the consumption of ASC workers.

A share of the increased labour costs can be treated as a direct transfer to the households of the care workforce – namely, net pay plus expected employer pension contributions. Effectively, we take the total labour costs and subtract the transfer to the Exchequer described above, and the remainder is a direct transfer to ASC workers and their households.

Overall, under these assumptions, this transfer has a present value of £3.8 billion over the appraisal period.

Table 8: *Increased income for care workforce as a result of a fair pay agreement in ASC*

	2026/27	**2027/28**	**2028/29**	**2029/30**	**2030/31**	**2031/32**	**2032/33**	**2033/34**	**2034/35**	**2035/36**	**2026/27 + Total**
Total benefit (real terms, discounted, £m)	-	-	490	480	480	480	480	470	470	460	3,810

Our expectation is that some of this pay increase would incentivise changes in behaviour that would also create costs to workers, such as increased effort or engagement, or increasing the number of hours worked. This will generally be the case for activities which support the wider benefits to people drawing on care and support, unpaid carers and the NHS described in the non-monetised benefits section below.

There is significant uncertainty around the share of increased pay that would result in increased output, and so we have not monetised these social benefits or resulting costs to ASC workers in this IA. There is also a counterargument that increased pay could result in reduced output, e.g. if workers can achieve the same income for fewer hours of work. We would welcome additional evidence on the likelihood of increased effort or hours in response to increased pay.

Non-monetised benefits

Improved quality of life for people receiving care

There is strong evidence that investment in the adult social care workforce generates significant wider benefits. For instance, increasing pay supports improved recruitment and retention, which in turn enhances continuity of care and strengthens workforce motivation and engagement. These improvements ultimately contribute to better outcomes and quality of life for people who draw on care.

Increased investment in ASC as a result of a fair pay agreement is likely to result in positive quality of life (QoL) outcomes for care recipients. The Adult Social Care Outcomes Tool (ASCOT)[55] allows for the measurement of outcomes for individuals receiving social care. As ASCOT is a preference weighted measure, social care quality adjusted life year (QALYs) estimates that are analogous to health QALYs.

Forder et al. (2018)[56] analysed the effects of community-based and care home services on the social care related QoL of service users. Working analysis reported in Forder (2018)[57] used these estimates to produce results about the impact of social care.

This analysis estimates that the marginal cost to achieve an aggregate gain of one ASCOT QALY is around £19,940, which is equivalent to £20,670 for one health QALY. The estimated increase in equivalised social care QALY, as measured by ASCOT, can then be valued at DHSC's social value of a QALY (£60k at the time of the study) to generate an estimated monetary value for the improvements in QoL because of formal ASC. This implies that an additional £1 spend on ASC will generate a Quality of Life increase worth £2.90 to care recipients.

If we assume that this applies to all of the expected LA investment in ASC as a result of an FPA, the total present value of this benefit over the 10-year appraisal period could be £9.7 billion in 2025/26 prices. The scale of the net benefit to ASC workers would reduce, as some of their increased income would incentivise increased effort or hours that result in improved outcomes for care recipients, but act as a cost to these workers. However, it's worth noting that this benefit is highly uncertain as existing evidence on quality-of-life improvements is largely based on the impact of increased local authority expenditure that results in increased access to care, and it is not yet clear how applicable this assumption is to FPA spend. Furthermore, the scale of social benefits depends on the extent to which ASC workers would increase effort or hours in response to higher pay, which is not well understood. This is an area we are actively exploring and will gather further evidence on through the consultation.

Table 9: *Potential Quality of Life benefits associated with investment in a fair pay agreement in ASC*

	2026/27	**2027/28**	**2028/29**	**2029/30**	**2030/31**	**2031/32**	**2032/33**	**2033/34**	**2034/35**	**2035/36**	**2026/27+ Total**
Total benefit (real terms, discounted, £m)	-	-	1,240	1,230	1,220	1,220	1,210	1,190	1,180	1,170	9,660

[55] Netten et al. (2012) '*Outcomes of social care for adults: developing a preference weighted measure.'*

[56] Forder, J., F. Vadean, S. Rand, and J. Malley. (2018) '*The impact of long-term care on quality of life*'. Health Economics, 27: e43-e58 doi: 10.1002/hec.3612

[57] Forder (2018) '*The impact and cost of adult social care: marginal effects of changes in funding'* QORU Discussion Paper, https://www.pssru.ac.uk/pub/5425.pdf.

NHS savings

Given the close integration of the health and care systems in England, any additional spending on the ASC system is likely to have beneficial impacts for the NHS due to a reduction in unnecessary GP consultations, ambulance call outs, A&E attendances and preventing the escalation of needs to the point where health interventions are required. In recent years, there has also been considerable focus on how ASC can reduce pressure on the NHS through reducing delayed discharges by investing in care home capacity as well as community care.

Forder (2009)[58] uses granular data to examine the relationship between care home utilisation (care home residents per capita) and hospital utilisation (hospital episodes) at the ward level. He estimates that an additional £1 spent on care home services results in a £0.35 reduction in hospital expenditure, and vice versa. This reflects hospital expenditure due to fewer admissions as well as reduced length of stay. It does not consider the impact this would have on quality of life outcomes if people use residential care rather than hospital care. Updated work from Forder (2018) in turn recommended a saving to health spending of £0.20 for every £1 spent on social care[59].

Gaughan et al (2014) who finds that higher long-term care supply and lower prices are associated with up to a 20-30% shorter hospital length stay for patients aged 65+ who had emergency admissions due to hip fracture or stroke and were discharged to a nursing or care home.[60] Fernandez and Forder (2008) find that a 1% increase in residential social care services can reduce delayed discharge by 0.5% or even more.[61]

Considering the range of evidence, we use a range of between £0.20 and £0.35 as our best estimate of the marginal effect of investment in ASC on hospital expenditure, with £0.28 as the midpoint.

If we assume that this applies to all of the expected LA investment in ASC as a result of an FPA, the total present value of the NHS savings over the 10-year appraisal period could be between £0.6 billion and £1.0 billion, with a central estimate of £0.9 billion in 2025/26 prices. The scale of the net benefit to ASC workers would reduce, as some of their increased income would incentivise increased effort or hours that result in NHS savings, acting as a cost to these workers. However, it's worth noting that this benefit is highly uncertain as existing evidence on NHS impacts is largely based on the impact of increased local authority expenditure that results in increased access to care, and it is not yet clear how applicable this assumption is to FPA spend. Furthermore, the scale of social benefits depends on the extent to which ASC workers would increase effort or hours in response to higher pay, which is not well understood. However, this is an area we are actively exploring and will gather further evidence on through the consultation.

Table 10: *Potential NHS benefits associated with investment in a fair pay agreement in ASC*

	2026/27	**2027/28**	**2028/29**	**2029/30**	**2030/31**	**2031/32**	**2032/33**	**2033/34**	**2034/35**	**2035/36**	**2026/27+ Total**

[58] Forder, J (2009) '*Long-term* care *and* hospital utilisation *by* older people*: an* analysis *of* substitution *rates.'* Health Economics, 18(11), 1322-1338

[59] Forder, J (2018) 'The impact and cost of adult social care: marginal effects of changes in funding'

[60] Gaughan et al. (2014) '*Testing the bed blocking hypothesis: Does higher supply of nursing and care homes reduce delayed hospital discharges.'*

[61] Fernandez, Forder (2008) - Consequences of Local Variations in Social Care on the Performance of the Acute Health Care Sector

Total benefit (real terms, discounted, £m)	-	-	120	120	120	120	110	110	110	110	920

Benefits to unpaid carers

Care for individuals is not only provided by directly employed care workers, but also by unpaid carers who may provide care for their spouses, relatives or friends and can include both personal (help with washing and dressing etc.) and practical care (help with mobility etc.). Unpaid carers perform a very important role, by allowing individuals to receive care in their own home thus delaying the need for formal care.[62]

An increase in investment in formal care spend via the FPA will help to alleviate pressures on high-intensity unpaid carers as unpaid and formal care are at least partial substitutes, and thus unpaid care reduces demand which otherwise would be placed upon the formal ASC sector[63]. As investment in an FPA supports access and improves the quality of care, it becomes a more valuable substitute for hours of unpaid care, with Nizalova (2023) finding that one extra hour of formal care would offset 17 minutes of informal care[64].

Approximating the opportunity cost of this reduction in informal care by assuming it is the same as the minimum wage (£9.50) at the time of the research, this translates into a £0.18 saving to informal carers for each £1 spend on formal care. This is very similar to the effect Saloniki et al (2024) find for the substitutability of formal domiciliary care and informal care provided from within the household (finding a benefit of £0.20).[65]

Forder (2018)[66] reports unpublished results of the QORU study of the impact of social care as regards the potential quality-adjusted life year (QALY) gain to carers, as measured by the adult social care outcomes tool (ASCOT), from an additional £1,000 of LA expenditure on ASC. The analysis should be considered as tentative but suggests that the marginal benefit to carers' well-being of an additional £1,000 spend on ASC ranges between 0.016 to 0.022 QALYs. This equates to between £0.96 and £1.32 in quality-of-life benefits for unpaid carers for each additional £1 of LA expenditure on ASC[67].

The total estimated impact on unpaid carers is estimated to range between £0.96 and (£1.32 + £0.18 =) £1.50, with £1.23 as the central estimate of the benefit to informal carers for each £1 of LA expenditure on formal care.

If we assume that this applies to all of the expected LA investment in ASC as a result of an FPA, the total present value of the savings to unpaid carers over the 10-year appraisal period could be between £2.8 billion and £4.4 billion, with a central estimate of £4.1 billion in 2025/26 prices. The scale of the net benefit to ASC workers would reduce in this scenario, as some of their increased income would incentivise increased effort or hours that result in savings to unpaid carers, acting as a cost to these workers. However, it's worth noting that this benefit is

[62] Nizalova, Forder (2023) Revisiting the Economic Case for Social Care Spending: Informal Care

[63] Lilly et al. (2007) 'Labor Market Work and Home Care's Unpaid Caregivers: A Systematic Review of Labor Force Participation Rates, Predictors of Labor Market Withdrawal, and Hours of Work'

[64] Nizalova, Forder (2023) Revisiting the Economic Case for Social Care Spending: Informal Care

[65] Saloniki, E.-C., Nizalova, O., Malisauskaite, G. and Forder, J. E. (2024) 'The impact of formal care provision on informal care receipt for people over 75 in England.

[66] Forder (2018) '*The impact and cost of adult social care: marginal effects of changes in funding'* QORU Discussion Paper, https://www.pssru.ac.uk/pub/5425.pdf

[67] Using DHSC's £60k social value of a QALY.

highly uncertain as existing evidence on unpaid carer impacts is largely based on the impact of increased local authority expenditure that results in increased access to care, and it is not yet clear how applicable this assumption is to FPA spend. Furthermore, the scale of the social benefits depends on the extent to which ASC workers would increase effort or hours in response to higher pay, which is not well understood. However, this is an area we are actively exploring and will gather further evidence on through the consultation.

Table 11: *Potential benefits to unpaid carers associated with investment in a fair pay agreement in ASC*

	2026/27	**2027/28**	**2028/29**	**2029/30**	**2030/31**	**2031/32**	**2032/33**	**2033/34**	**2034/35**	**2035/36**	**2026/27+ Total**
Total benefit (real terms, discounted, £m)	-	-	520	520	520	520	510	510	500	500	4,100

Improved worker health and wellbeing

There is a substantial evidence base demonstrating a positive link between minimum wage increases and overall well-being. With 70% of care workers in the independent sector earning within £1 of the NLW in 2023/24, there is sound reason to believe this wider evidence is applicable to the direct care workforce. This evidence demonstrates a 10% rise in minimum wages is associated with a 2.5% reduction in negative emotions such as stress and worry, a 0.79% improvement in self-reported health, and a 2.14% increase in satisfaction with standard of living[68].

A recent survey of the ASC workforce, 'The adult social care workforce and their work-related quality of life', found that around seven in ten (67%) of those surveyed said they were considering leaving because the income or salary is too low, and the same proportion (67%) state it is due to the impact of stress and burnout on their health and wellbeing. Seven in ten (68%) of the ASC workforce said they do not have enough, or they do not have any financial security, including 78% of those with an annual household income of less than £26,000. Respondents from Black ethnic backgrounds were less likely to say they have financial security (25% compared to 32% overall).[69]

The Health Foundation reported that 1 in 5 (19.9%) residential care workers lived in relative poverty from 2021/22 to 2023/24, based on analysis of Households Below Average Income and the Family Resources Survey.[70] This is higher than the incidence of relative poverty among all UK workers (11.9%) and health workers (8.2%). They estimate that 12.3% of residential care workers experienced food insecurity, and that workers in residential care were twice as likely to have used a food bank in the past year compared with other workers (2.9% of residential care workers compared with 1.5% of all workers).

Improvements in wages and household income are therefore likely to have meaningful impacts on wellbeing. Higher pay would increase household income and would be expected to reduce the incidence of relative poverty and deprivation in their households. This could reduce the incidence of stress related to financial difficulties.

However, we have not attempted to quantify these benefits, as a) they are especially sensitive to the design of the agreement which is negotiated and the distribution of additional pay between different groups of workers and b) the additionality of these benefits, relative to the benefit to care workers of increased consumption as a result of higher income, is uncertain.

[68] The impact of minimum wages on overall health and wellbeing, Sotirakopoulos et al.

[69] The Adult social care workforce and their work-related quality of life

[70] Poverty, pay and the case for change in social care

Productivity

Increasing pay could also increase productivity within the sector through a range of potential mechanisms.

One significant argument draws on the efficiency wage hypothesis: if wages were raised above the wages offered by other jobs available to care workers, those workers would be incentivised to work harder to reduce the risk of being fired and losing the additional income compared to their next best available option i.e. wages in competing occupations, including the NHS[5]. Workers' engagement and effort might also increase as a behavioural response to feeling happier and better valued at work.

Increases in income and especially in financial security could improve engagement and reduce sickness absence by improving mental health and wellbeing within the workforce. The size of this effect would depend more on consumer inflation and other drivers of household financial security and less directly on wages in competing occupations than that above; however, its overall size remains unclear.[71]

Increased retention at the firm-level, by reducing variation in reward between employers in the sector (under most but not all possible outcomes) and increasing pay relative to opportunities outside the sector, could increase productivity by increasing the average length of tenure and therefore the level of sector- and firm-specific knowledge and skills: newly recruited workers are potentially less productive while they are learning processes and ways of working. Depending on the design of an FPA, it could also incentivise investment in training and skills – for example, outcomes which included a pay spine based on assessed skills would strengthen the incentives for workers to seek training and development opportunities.

Increased unit costs for labour might incentivise providers to invest in technology and equipment as a substitute for labour at the margin. Increasing the stock of capital would in turn increase the productivity of the remaining labour force e.g. providing tablets for digital data capture reduces the proportion of staff time spent on less-productive administrative tasks compared to caring tasks. However, the financial capacity of the sector to invest is limited by low returns on capital – largely as a result of local authorities using their market power to constrain care fees.[72]

We assume that improvements in productivity within the sector are likely to lead to improvements in the quality of care received, with impacts on quality of life and health outcomes for people who receive care. This is partly because productivity in the sector generally, and effort in particular, is difficult to measure or observe, meaning that providers and commissioners would find it difficult to identify where productivity gains would support delivering the same quality of care using fewer resources. It also partly reflects the nature of many care activities: not all face-to-face care can be performed more quickly, even with extra effort or attention, without compromising the experience of the person drawing on care (for example, help with eating).

We have therefore not attempted to quantify this benefit, as we cannot determine the additionality of the quality-related benefits of investment in pay specifically compared to the

[71] Though Ipsos found some relationship, as might be expected, between financial security and mental wellbeing.

[72] This conclusion is supported by market intelligence and, in relation to at least care homes, by the Competition and Markets Authority: https://www.gov.uk/government/publications/care-homes-market-study-summary-of-final-report/care-homes-market-study-summary-of-final-report

quality-related benefits of ASC expenditure more generally which are quantified illustratively above.

Direct costs and benefits to business calculations

There were 18,500 businesses involved in providing or organising adult social care in 2023/24. This estimate does not include individuals employing their own care and support staff. 41% of social care organisations are residential services, or care homes. 59% provide non-residential services, including domiciliary or home care. A further 65,000 direct payment recipients were directly employing their own staff in 2023/24.

An FPA would be expected to increase labour costs in the sector. We have assumed that any additional labour costs as a result of an FPA are passed through by businesses to commissioners (including local authorities and the NHS), and self-funders via an increase in prices, supported by £500 million of funding for LAs in 2028/29. This is consistent with how the sector has operated historically as the National Living Wage has increased, where increases in the cost of care are passed onto commissioners of care and to individuals who fund their own care.

In a sector where labour costs make up c.70% of the factor inputs into the production of care, and profits are highly constrained, our expectation is that any increase in labour costs will be passed on to commissioners of care (including local authorities and the NHS) and self-funders.

However, there is significant uncertainty in this assumption (see discussion in risks and assumptions for more detail). Some businesses may be more able to contribute more to the costs of an FPA by reducing profits to absorb some of the increased labour costs, rather than passing them on to the commissioners of care or individuals who pay for their own care. This may be more likely in larger businesses or those that operate with more substantial profit margins.

There are also likely to be some familiarisation costs and administrative costs to businesses as a result of an FPA. This includes the time taken for businesses to become familiar with the terms of an FPA, to update contracts, and to ensure that records are compliant for the purposes of enforcement. These costs are uncertain and depend on the complexity of the policy. For example, a pay floor may require limited additional time to understand and implement, relative to time that care providers already spend implementing increases in the NLW.

As described in the section on costs, we assume that for each independent business, it will take management or HR staff two full-time equivalent days prior to the first FPA, and 0.5 full-time equivalent days in subsequent years to understand and implement subsequent FPAs. This is additional relative to the time that is already spent on understanding and implementing increases to the NLW each financial year.

We use Skills for Care data on the hourly pay for senior managers, and assume this increases in line with OBR earnings forecasts over time. We apply assumptions about pension and employer National Insurance contributions to estimate the total cost to businesses per hour of senior manager time. We use the number of businesses in 2023/24 as a baseline, and assume that the number of managers who will need to be familiar with the terms of an FPA increases in line with CPEC demand projections over time.

Table 12: *Costs to businesses arising as a result of an FPA*

	2026/27	**2027/28**	**2028/29**	**2029/30**	**2030/31**	**2031/32**	**2032/33**	**2033/34**	**2034/35**	**2035/36**	**2026/27+ Total**

Familiarisation costs (real terms, £m)	-	9.4	2.5	2.5	2.6	2.7	2.8	2.8	2.9	2.9	31.1
Familiarisation costs (real terms, discounted, £m)	-	8.8	2.2	2.2	2.2	2.2	2.2	2.1	2.1	2.1	26.1

Risks and assumptions

Assumptions and sensitivities

Negotiations by the ASC Negotiating Body

The analysis in this Impact assessment is illustrative, and is based on an assumption that the FPA process results in an average pay uplift for direct care staff and managerial staff, based on the pay uplift that is affordable given a £500 million envelope for local authorities, with further costs falling to the NHS and to self-funders.

However, the actual scope of an FPA is subject to negotiation by the ASC Negotiating Body. The impacts of the policy could depend on the job roles that are in scope (e.g. direct care roles, managerial roles, regulated professionals), as well as the design of the FPA outcome (e.g. whether it is a pay floor, pay spine, annual pay uplift, whether it includes other aspects of terms and conditions). This is fundamentally uncertain.

Furthermore, the £500 million envelope is part of a wider Local Government Finance Settlement and there are interactions with other pressures that are funded by local authorities. The ASC Negotiating Body may judge that given how pressures have changed between now and the first negotiations, that the amount of additional expenditure by local government which is affordable as a result of the agreement is smaller than this quantum. Some of these uncertainties and interactions are outlined below.

Demand for adult social care

The modelling assumes that demand for formal care and support grows according to the CPEC long-term demand modelling which projects social care demand from demographics trends, including the number of self-funders[73]. These projections are underpinned by ONS population projections alongside assumptions regarding prevalence of care and support need by age, gender, marital status and housing tenure.

We assume that projections of increases in demand are not affected by the implementation of a fair pay agreement. We assume that the number of full-time equivalent posts for each job role needs to grow in line with expected increases in demand, i.e. that there is no variation in staffing ratios or in which job roles deliver care over the period. We also assume that the workforce cannot grow by more than expected increases in demand in any one year.

We have not considered a sensitivity in which the demand projections are varied, as the costs (or the ambition of what is affordable within a given funding envelope) would simply scale under the modelling assumptions we have used. However, there are limitations to this. If demand increases substantially more quickly, then there is a greater risk that the pay increase that is affordable within the FPA envelope is not sufficient to attract a workforce that is large enough to meet need. Conversely, if demand does not increase as quickly as expected, then the benefits of FPA expenditure may be lower.

Wage growth in adult social care

[73] Projections of Adult social care Demand and Expenditure in England, 2022 to 2042, CPEC_DP_Projection_Final_22Feb25.pdf

As a minimum, we assume that average wages in ASC increase according to a weighted average of the expected NLW uplift and OBR earnings projections. We assume a weight of 62.5% for the expected NLW uplift and a weight of 37.5% for the OBR earnings forecast, in line with the assumption made by CPEC in their expenditure projections. [74]

We also estimate an additional component of pay pressure in ASC, as providers increase pay in response to market forces (the 'workforce supply pressure'). We use estimates of labour supply developed by the Adult social care Research Unit[75]. They find ASC labour supply to be elastic, with an overall value of 1.8. This would mean that a 1% increase in wages could increase labour supply in the sector by 1.8%, assuming that wages in the wider economy are constant.

We assume that if expected pay growth in ASC matches expected pay growth in competing occupations (using Migration Advisory Committee definition of competing occupations[76]), then workforce growth in the sector will grow in line with expected participation in the wider labour market. We estimate the additional pay growth in the sector generated by workforce supply pressures as the difference between CPEC projections for demand, and expected workforce growth based on NLW uplifts alone, divided by the wage elasticity.

This leads to the following assumptions for average pay growth in the counterfactual. From 2028/29 onwards, we assume that pay in the counterfactual grows in line with OBR forecasts for average earnings only, and that this is sufficient for the workforce to grow in line with demand.

Table 13: *Estimated annual pay growth in ASC without a fair pay agreement*

	2024/25	**2025/26**	**2026/27**	**2027/28**	**2028/29**
Counterfactual pay growth (nominal terms, year-on-year)	7.3%	5.2%	3.2%	3.3%	2.3%

However, there is significant uncertainty in pay growth in the sector. If pay growth is higher than expected in the years prior to 2028/29 (e.g. as a result of higher than expected increases in the NLW, or further reductions to the scale of overseas recruitment meaning that providers have to attract more of their workforce from the domestic labour market), then this could increase the cost of maintaining the baseline system as a larger share of the budget is needed to cover existing staff at higher pay rates. This could effectively reduce the size of the funding envelope that is available for FPAs, meaning that smaller pay increases are affordable.

There are also uncertainties in the estimate for the wage elasticity of labour supply in adult social care. This estimate is based on a single study which has some limitations, including relying on an assumption that a pay increase would have an equivalent impact on recruitment as on retention (i.e. a pay increase is equally likely to mean that a new person would consider working in the sector as to mean that an existing worker would continue to work in the sector). The estimate is also higher than wage elasticities of labour supply for comparable sectors or job roles (e.g. an estimated wage elasticity of labour supply of 0.06 to 0.07 for NHS nurses in Great Britain, implying that a 10% increase in wages would increase the supply of nurses by less than 1%[77], though the supply of nurses is more restricted and their employment is more dominated by a single employer in the NHS).

A lower wage elasticity of labour supply could mean that providers experience a pressure to give larger pay uplifts prior to the implementation of an FPA in order to attract and retain a workforce that is sufficient to meet demand, and could reduce the size of the benefits related to

[74] Projections of Adult social care Demand and Expenditure 2018 to 2038

[75] Vadean-et-al-2024.pdf

[76] Review of adult social care 2022 - GOV.UK

[77] The short-run elasticity of National Health Service nurses' labour supply in Great Britain, Crawford et al, IFS working paper, 2015

recruitment efficiencies. A lower wage elasticity would also increase the risk that the FPA envelope from 2028/29 onwards is not sufficient for the workforce to grow in line with expected increases in demand for care.

We are interested in further research related to labour supply in adult social care, including in the relationship between pay growth in competing sectors, and labour supply to adult social care. We will consider the impact of an FPA on labour supply, including as part of the FPA evaluation, and ongoing monitoring of workforce growth and staff turnover in the sector. The government will encourage the ASC Negotiating Body to consider the impact of the FPA on workforce outcomes when negotiating FPAs in subsequent years.

Pass through of costs

For the purposes of the Impact assessment, we assume that 100% of the increase in labour costs as a result of an FPA are passed through by businesses to commissioners of care and individuals who pay for their own care, via an increase in prices.

However, this is uncertain, and in some places, businesses may contribute to some of the costs by reducing profits. In the FPA consultation, the government states a belief that funding for adult social care should be targeted towards providers who are socially responsible and do not pass on costs to councils if they can cover these themselves[78]. This may be more feasible in businesses which have larger profit margins, or which are able to bank greater savings from recruitment efficiencies.

Providers may also be more exposed to increased labour costs in places where they are less able to pass on increased costs to households including self-funders. This could be because increases in the costs of care may be unaffordable for self-funders. This could result in reductions in demand for care, or could lead to self-funders depleting their assets more quickly and becoming eligible for LA support.

To reflect the uncertainty in the assumption around the pass through of costs, we have considered a sensitivity scenario in which businesses pass on 90% of the increase in labour costs as a result of an FPA, with the remaining 10% of costs falling to businesses themselves.

In this scenario, we have assumed that the total ambition of the policy remains the same, and that the level of funding from local authorities is the same as in the core policy scenario. We assume that businesses contribute to the costs of an FPA primarily via reduced profits or by banking efficiency savings from reduced churn, in order to reduce the cost increase for self-funders. The total costs, benefits and net present value remain the same as the core scenario in this sensitivity scenario, but the distribution of costs is different. Specifically, we assume that 52% of increased labour costs fall to local authorities, and 17% to the NHS as in the core scenario, but we assume that businesses contribute 10% of the costs, leaving households including self-funders to cover the remaining 21% of increased labour costs. We also assume that businesses are able to bank 10% of the savings related to recruitment efficiencies, i.e. these savings are not fully passed onto commissioners and consumers of care.

In this sensitivity scenario, the total net value of costs to businesses could be £560 million over the appraisal period, including £640 million of increased labour costs, and £100 million of retained recruitment efficiency savings. These net costs are significant but would scale according to providers' choices in trading off increases in prices versus reductions in profits. The extent to which providers may choose to absorb costs themselves is highly uncertain. However, providers would likely only be able to contribute to the cost of an FPA if they have large profit

[78] Fair pay agreement process in adult social care - consultation document - GOV.UK

margins, or if they have stronger negotiating power with local authorities to be able to retain more of the potential savings from recruitment efficiencies.

Table 14: *Illustrative costs and benefits associated with an FPA in a scenario where businesses contribute 10% of costs*

£m	**2026/27**	**2027/28**	**2028/29**	**2029/30**	**2030/31**	**2031/32**	**2032/33**	**2033/34**	**2034/35**	**2035/36**	**2026/27 + Total**
Labour costs (nominal, undiscounted)	-	-	960	1,000	1,050	1,110	1,160	1,220	1,280	1,340	9,120
Of which, costs to LAs	-	-	500	520	550	580	610	640	670	700	4,760
Of which, costs to NHS	-	-	160	170	180	180	190	200	210	220	1,520
Of which, costs to business	-	-	100	100	110	110	120	120	130	130	910
Of which, costs to self-funders	-	-	200	210	220	230	250	260	270	280	1,920
Total costs (real, discounted)	-	10	910	940	960	990	1,020	1,040	1,070	1,090	6,420
Total benefits (real, discounted)	-	-	1,060	1,090	1,120	1,160	1,190	1,210	1,240	1,270	7,460
Net present value											1,040

Table 15: *Net costs to businesses in scenario where businesses contribute 10% of increased labour costs associated with an FPA, and are able to retain 10% of the efficiency savings*

£m	**2026/27**	**2027/28**	**2028/29**	**2029/30**	**2030/31**	**2031/32**	**2032/33**	**2033/34**	**2034/35**	**2035/36**	**2026/27 + Total**
Total (real, discounted)	-	10	80	70	70	70	70	70	70	60	560
Of which, increased labour costs	-	-	90	80	80	80	80	80	80	70	640
Of which, familiarisation costs	-	9	2	2	2	2	2	2	2	2	26
Of which, efficiency savings	-	-	-14	-14	-14	-14	-14	-13	-13	-13	-110

Share of costs that are passed through to local authorities and the NHS

We assume that 52.3% of increased labour costs are passed through by businesses to LAs, that 16.7% of increased labour costs are passed through to the NHS, and that 31.1% of increased labour costs are passed through to self-funders. This is based on a LaingBuisson report on sources of overall expenditure in the independent sector[79].

However, there is uncertainty in the share of increased labour costs that are likely to be passed through by providers to different parties. There is very little published evidence on the breakdown of expenditure in the sector. The care market is highly fragmented, with different operating models, and data on the prices that individual businesses charge to individuals and commissioners of care can be market sensitive.

There is also uncertainty in the extent to which increased labour costs as a result of an FPA could be passed through to the NHS. The NHS also funds some adult social services, including via the Better Care Fund, Funded Nursing Care, and Continuing Healthcare. However, there is no published data on Continuing Healthcare expenditure, and Funded Nursing Care is only

[79] LaingBuisson adult social care market report

used to pay for the costs of delivering nursing care to some nursing residents. FNC costs may therefore only increase if registered nurses are in scope for an FPA.

The ONS estimate that from 1 March 2022 to 28 February 2023, 23.0% of people using community care services were self-funders, and 77.0% were state funded[80]. They also estimate that 37.0% of care home residents were self-funders, and 63.0% were state funded. However, this does not directly correspond to the share of expenditure as it does not account for top-up fees or for differences in prices charged to self-funders compared to those who are state funded. This publication also does not identify whether the care is majority funded by LAs or the NHS.

CPEC also publish estimates of expenditure by social services, user charges and private expenditure[81], which suggest that approximately 45% of this expenditure is by social services. However, this does not include expenditure by the NHS.

Finally, there are uncertainties in the extent to which costs associated with an FPA could be passed through to LAs or the NHS as a result of policy design or the outcome of negotiations. For example, an FPA outcome that excludes registered nurses would mean that there is unlikely to be a pressure on the cost of delivering Funded Nursing Care. Alternatively, the ASC Negotiating Body may agree a less ambitious FPA with the assumption that local authorities cover the majority or all additional labour costs, for example to minimise impacts on self-funders. Further work would be needed to explore how this could be delivered, including in providers that are not directly commissioned by local authorities or where local authority fees make up a minority of their income.

To reflect the uncertainty in the share of costs that are passed through by providers to local authorities, we have considered a sensitivity in which local authorities contribute 70% of the increased labour costs associated with an FPA, with 17% of increased labour costs falling to the NHS and 13% of costs to households. The distribution of administrative costs and familiarisation costs would be unchanged.

In this sensitivity scenario, the level of ambition of the FPA outcome would be more limited in 2028/29, as the envelope available to LAs for FPA costs is fixed at £500 million in 2028/29 in all scenarios, while the costs to households including self-funders are reduced. Within this envelope, a lower additional pay uplift of 2.1% would be affordable for direct care and managerial job roles, with individuals in these roles receiving a total pay uplift of 4.4% between 2027/28 and 2028/29.

While the present value of costs is reduced in this scenario (£4.8 billion compared to £6.4 billion in the core scenario), and the present value of benefits is also lower (£5.6 billion compared to £7.4 billion in the core scenario), leading to a lower net present social value (£770 million compared to £1.0 billion in the core scenario).

A less ambitious FPA may reduce the financial risks to providers and to self-funders, but may increase the risk that pay growth in the sector is insufficient to address workforce challenges and ensure that the ASC sector can meet rising care needs in the population. If access to care is constrained, there could be negative impacts on quality of life, the NHS and unpaid carers that partly offset these benefits.

Table 16: *Costs and benefits of an FPA in a scenario where local authorities cover 70% of the increased labour costs*

[80] Estimating the size of the self-funding population in the community, England - Office for National Statistics

[81] Projections of Adult social care Demand and Expenditure 2018 to 2038

£m	**2026/27**	**2027/28**	**2028/29**	**2029/30**	**2030/31**	**2031/32**	**2032/33**	**2033/34**	**2034/35**	**2035/36**	**2026/27+ Total**
Labour costs (nominal, undiscounted)	-	-	710	750	790	830	870	910	950	1,000	6,810
Of which, costs to LAs	-	-	500	520	550	580	610	640	670	700	4,770
Of which, costs to NHS	-	-	120	120	130	140	140	150	160	170	1,130
Of which, costs to self-funders	-	-	100	100	100	110	120	120	130	130	910
Total costs (real, discounted)	-	10	610	610	610	600	600	590	590	580	4,800
Total benefits (real, discounted)	-	-	720	710	710	700	700	690	680	670	5,570
Net present value											770

We will build on this analysis following the consultation, in the regulatory impact assessment that accompanies secondary legislation. We would welcome any evidence on the breakdown of expenditure in the sector, and any views on how the FPA policy could a) limit the additional costs to self-funders, and b) ensure that the views of self-funders are considered as part of negotiations.

Share of FPA envelope that is spent on pay

For the purposes of the IA, we have assumed that 100% of the funding envelope that is allocated for fair pay agreements is spent on increasing pay in the sector.

However, there is significant uncertainty in this, due to the complexity of the adult social care system and multiple bodies making choices at several stages of the process:

1. Decisions by the ASC Negotiating Body. The ASC Negotiating Body may choose to allocate a share of the envelope to other related employment matters, including sick pay (over and above entitlements to Statutory Sick Pay), annual leave, sleep-in payments or training. While these aspects of reward are likely to have positive social benefits, the evidence on the size of these benefits is more limited. We are seeking additional evidence on the preferences of workers, especially which aspects of reward matter most to workers and affect their decisions on whether to work in the sector.
2. Decisions by local authorities. Local authorities are required to fund a range of services and may value adult social care differently. Local authorities raise funds locally and are accountable to their local populations for spending and have discretion in setting fees for services. As a result, funding may be higher or lower than our assumptions, to reflect this uncertainty. To address this, the government is making an additional £500m available in 2028/29 for local authorities for the implementation of a fair pay agreement, and is consulting on a new ‘notional allocation’ that will set out the government’s expectation for how much local authorities should spend on adult social care, considering local authority expenditure, alongside income and funding available for adult social care.
3. Decisions by care providers. Most ASC providers are private businesses and make their own choices about how to spend increased fees from local authorities. While we expect that market pressures and enforcement of an FPA by the Fair Work Agency should lead care providers to substantially invest in pay and employment conditions, in line with the terms of an FPA, there is some uncertainty in this. For example, some providers may already be compliant with the terms of an FPA, or may not need to invest as much to be compliant (e.g. if they are operating in historically higher paying areas). Other providers may face severe pressures in other areas that are also a priority for spending (such as paying off debts or responding to surges in demand by recruiting additional staff or paying agency staff). There may be some non-compliance with the terms of a new FPA, either because of a lack of guidance, or because some businesses perceive that they are

unlikely to suffer the consequences of FPA enforcement. The extent to which this risk is realised therefore depends on the quality of guidance and enforcement.

If choices by the ASC Negotiating Body, local authorities and care providers mean that less of the funding envelope is invested in pay, this could reduce the scale of benefits of an FPA. Given the importance of investing in pay to increasing the number of people willing to work in the sector, this could increase the risk that the workforce is unable to grow in line with expected increases in demand.

As a sensitivity test, we have considered a scenario in which 80% of the local authority funding envelope is spent on pay, with the remaining 20% spent on other areas of spend. As we cannot predict how the remainder of the funding envelope would be spent and because of limited evidence on the benefits of expenditure on other aspects of reward, we have assumed that the social benefits of this spend are negligible.

In this illustrative scenario, the FPA could result in an additional pay uplift of 2.3% relative to the counterfactual for direct care staff and managerial staff. These workers would receive a total pay uplift of 4.6% between 2027/28 and 2028/29.

We estimate that the present value of costs in this scenario is £5.8 billion, and the present value of benefits is £6.0 billion. This results in a net present value of £160 million. However, this is uncertain, both because we do not have strong evidence on the benefits of other aspects of reward, and because there are greater risks that a less ambitious FPA may not be sufficient to attract enough workers to meet expected increases in demand. As in the previous scenario, if there are constraints on access to care, there could be social costs related to quality of life, NHS impacts and unpaid carer impacts that could partly offset the benefits outlined below.

Table 17: *Costs and benefits of an FPA in a scenario where 80% of the FPA envelope is spent on pay, with some of the funding spent on other workforce priorities*

£m	**2026/27**	**2027/28**	**2028/29**	**2029/30**	**2030/31**	**2031/32**	**2032/33**	**2033/34**	**2034/35**	**2035/36**	**2026/27+ Total**
Labour costs (nominal, undiscounted)	-	-	720	750	770	790	810	830	850	870	6,390
Of which, costs to LAs	-	-	380	390	400	410	420	430	440	450	3,320
Of which, costs to NHS	-	-	120	120	130	130	140	140	140	140	1,060
Of which, costs to self-funders	-	-	220	230	240	250	250	260	260	270	1,980
Non-pay FPA spend	-	-	100	100	110	120	120	130	130	140	950
Total costs (real, discounted)	-	10	740	740	740	730	730	720	710	700	5,820
Total benefits (real, discounted)	-	-	770	760	760	750	750	740	730	720	5,980
Net present value											160

Implementation risks

Affordability risks

There is a risk that the ASC Negotiating Body negotiates an outcome that is not affordable to the adult social care sector, and increases the likelihood of unintended consequences arising from increased labour costs as set out below. To mitigate this, the government will set out a remit letter for the ASCNB, which will include a funding envelope of £500 million grant funding for local authorities in 2028/29 as a condition that must be met. We therefore treat this quantum as a constraint. We also assume that the remit will require the ASCNB to have regard for affordability for purchasers of care including the NHS and self-funders, in addition to local authorities. The Employment Rights Bill also gives the Secretary of State the power to reject the negotiated

outcome and ask the ASC Negotiating Body to reconsider. DHSC and MHCLG Ministers will review the proposed FPA and can ask the ASCNB to re-open negotiations – for example, on the basis of affordability to LAs – or can choose to ratify the agreement.

There could also be a risk that an FPA outcome in one year reduces the flexibility for FPA negotiations in subsequent years, as improvements to pay or terms and conditions are usually persistent and could create cost pressures in subsequent years. This is partly mitigated by the fact that we would expect to see pay growth over time even in the counterfactual. For example, as pay for all job roles increases over time, it would eventually catch up with pay under the terms of an FPA outcome. This would give the ASC Negotiating Body some flexibility over time to vary the scope of an FPA, such as to target different job roles.

Unintended consequences for the ASC market

Increased prices to self-funders**:** the extent to which businesses are able to increase prices for self-funders varies across the sector depending on provider type and local market conditions. In areas where providers depend more on self-funders—such as affluent regions or where local authority (LA) rates are relatively low—there is a greater likelihood that higher labour costs resulting from the fair pay agreement (FPA) will lead to increased fees for self-funding clients. This reflects the broader cross-subsidy dynamic in adult social care, where self-funder payments help offset lower public funding. A 2017 study by the Competition and Markets Authority found that self-funders in 'larger providers' were charged 41% more, on average, than those with their places funded by local authorities and that this was threatening the financial sustainability of the sector – particularly in places with fewer self-funders and thus greater reliance on public funding.[82]

For self-funders, particularly those just above the means-test threshold, increased fees may reduce the affordability of care. In some cases, this may result in individuals delaying or reducing their use of formal care services, relying more heavily on unpaid care from family or friends in place. This may place additional pressure on unpaid carers and informal support networks, with associated social costs. Increased costs may also mean that self-funders deplete their assets more quickly and become eligible for LA support more often, or for a longer period. This would tend to increase the overall costs to local authorities of meeting their statutory duties.

Reduced profits**:** this risk is low but variable. According to data from the Care Quality Commission's (CQC) market oversight scheme, profit levels for care homes for older people were, as of March 2023, close to the lowest recorded since monitoring began in 2015.[83] If providers are unable to pass costs on, further reductions in profitability may limit providers' ability to invest in service improvements—such as adopting new technologies—or may result in continued reliance on minimum statutory pay and conditions. This, in turn, can contribute to workforce dissatisfaction and retention challenges. If profit margins fall significantly across the sector, there is a risk of provider exit and reduced incentives for new entrants, which could impact long-term market stability and capacity.

Unintended consequences for the ASC workforce

Reduction in employment or hours**:** there is risk that if providers are unable to fully pass on increased labour costs to commissioners and consumers of care via increased fees and prices, that there could be reductions in employment levels or working hours. Given that the workforce needs to grow to keep pace with growing demand for care, any contraction in the workforce risks reducing ASC capacity and, consequently, limiting access to care. This would have a negative impact on quality of life and health outcomes for those with care needs.

[82] IFS (2024), Adult social care in England: what next?

[83] NAO (2023), Reforming adult social care in England

Weakened terms and conditions outside the scope of an FPA: This presents a limited risk, though there is evidence of poor employment practices in parts of the sector. In particular, some providers offer minimal entitlements around sick pay, pensions, or guaranteed hours. There have also been instances of non-compliance with statutory minimum requirements, such as the National Minimum Wage, often linked to unpaid travel time in domiciliary care. There are interactions with changes to wider employment conditions in the Employment Rights Bill.

Reclassification of job roles or models of employment: There is a significant risk that ASC providers reclassify some workers to be out of scope of an FPA (given a lack of registration of some roles), in order to manage labour costs. This could include increased use of self-employment models in the sector. This could mean that these workers do not benefit from improved pay and conditions.

Work intensification**:** Social care is inherently labour intensive, and there is already evidence of unsustainable working patterns in the sector – particularly in domiciliary care. For example, domiciliary care workers spend an average of 12 minutes per hour of care time travelling between appointments. However, some providers do not pay at all for travel time, and some pay a lower rate for travel time than for time spent providing 'direct care'. In either case, this can often take care workers' overall pay below NLW rates, which is unlawful. Further, higher outgoings for providers in terms of constrained resources and NLW increases have led many providers to attempt to cut costs using practices such as 'call cramming', whereby rotas set do not account for travel time, which requires care workers to cut appointments short to travel between them or work additional, unpaid, hours. These practices not only negatively impact worker wellbeing due to factors such as stress and burnout but may also reduce the quality of care delivered.

There is a risk that FPAs, if not met by adequate funding or fee uplifts, may exacerbate work intensification. Higher wage costs without additional funding might lead providers to reduce staff or hours, increasing pressure on remaining workers. This would lead to tightly packed visits and high-intensity shifts.

These risks to the workforce, the market and households can be mitigated by ensuring that proposed FPA outcomes are affordable for the purchasers of care, including local authorities, the NHS and self-funders, and by the ASC Negotiating Body and government considering the impact on households and businesses, including by learning from evaluation of the FPA when setting the remit and negotiating FPA outcomes in subsequent years.

Impacts on other sectors

Interactions with other contracts: If ASC workers on National Joint Council (NJC) terms or Agenda for Change (AfC) terms are in scope for a fair pay agreement in ASC, there are risks around how the contractual terms interact, including whether those workers could end up on less generous terms as a result of a fair pay agreement, or whether workers in scope of both processes end up on more generous terms than those workers who are not. There is also a risk that job roles outside the scope of the FPA could seek pay increases as a consequence of the FPA outcome.

This has been mitigated through an amendment to the Employment Rights Bill that states that relevant workers will benefit from the most generous pay or terms and conditions (either in their current contract or what is set out by the ASC Negotiating Body). This would not affect the contracts of those workers within AfC or the NJC who are not covered by the ASC Negotiating Body.

Competition for labour: ASC is in direct competition with other sectors to attract and retain staff, including other publicly funded sectors. Increases in ASC pay, and terms and conditions are likely to increase the attractiveness of ASC relative to other competing sectors. These sectors

may choose to respond, which could increase costs to those organisations, and reduce the scale of benefits in ASC.

Around 10% of workers in ASC leave their roles entirely each year, either to move to economic inactivity or unemployment, or to start working in another sector. Health Foundation analysis[84] shows that low-paid workers in ASC who move to another occupation are most likely to move to health including nurses and nursing assistants. Other competing sectors include retail and hospitality.

A recent survey of the ASC workforce, 'The Adult social care workforce and their work-related quality of life', found that around seven in ten (67%) of those surveyed said they were considering leaving because the income or salary is too low[85]. Providers are also likely to report that better pay outside the social care sector is the main reason for staff leaving the sector[86]. Recent qualitative research[87] funded by NIHR found that some care workers were considering moving to the NHS because of better career opportunities and pay and benefits. Providers also reported that they wanted to have parity with the NHS and that recognising staff is very difficult when they are unable to pay on similar terms.

As the evidence suggests that these workers are likely to be responsive to pay increases, given an increase in pay and terms in ASC as a result of an FPA, we would expect some workers to move away from competing sectors including the NHS and early years, in order to work in ASC. As a result, there is some risk of reduced worker flows from ASC to the NHS, which the NHS currently benefits from, as well as potential draws from the NHS toward ASC, which could exacerbate NHS staffing shortages.

These sectors may therefore experience greater challenges in attracting and retaining staff as a result of an FPA in ASC, though the scale of the impact on any individual sector is likely to be small. It could lead to greater costs in those sectors if they introduce policies to remain competitive with the ASC offer.

We will mitigate this risk by considering the impact on other sectors as part of monitoring and evaluation of an FPA. This will be used to determine if the scope of the policy needs to be changed to reduce negative impacts on specific sectors.

Distributional impacts

Fairness is at the heart of Government's Make Work Pay agenda[88]. The Government's Plan to Make Work Pay aims to ensure that workers are recognised and fairly rewarded for the work they do.

An FPA policy redistributes funds to the ASC workforce who are more likely to live in lower income households. The Health Foundation reported that 1 in 5 residential care workers lived in relative poverty from 2021/22 to 2023/24, based on analysis of Households Below Average Income and the Family Resources Survey.[89] This is higher than the incidence of relative poverty among all UK workers (11.9%) and health workers (8.2%). They found that 12.2% of children in families containing residential care workers were materially deprived, compared with 4.2% for all UK workers. They estimate that workers in residential care were twice as likely to have used a

[84] Lower paid NHS and social care staff turnover - The Health Foundation

[85] The Adult social care workforce and their work-related quality of life

[86] Adult social care workforce survey: April 2025 report - GOV.UK

[87] Pay in Adult social care, Professor Carol Atkinson et al, 2025

[88] Next Steps to Make Work Pay (web accessible version) - GOV.UK

[89] Health Foundation (2025) Poverty, pay and the case for change in social care

food bank in the past year compared with other workers (2.9% of residential care workers compared with 1.5% of all workers).

Improved pay for the care workforce would increase household income and would be expected to reduce the incidence of relative poverty and deprivation in their households. The Health Foundation estimated that an increase in the minimum wage for residential care workers to £11.85 in 2022/23 would increase total household income by 6.6%. They estimate that the proportion of residential care workers in the lowest 20% of households for income would fall from 13.4% to 11.3% as a result, compared with 9.5% for all UK workers.

An FPA could also impact on people drawing on care and their households. There are two main potential effects here: 1) the increased costs to individuals who fund their own care as a result of increased labour costs in the sector, 2) changes to the quality or availability of care services as a result of higher pay in the workforce.

A fair pay agreement is likely to disproportionately impact on groups of people who share the following characteristics as a result of the composition of the workforce and the population in receipt of care and support:

- Sex
- Age
- Ethnicity
- Disability
- Sexual orientation
- Marital status
- Other characteristics – including maternity, religion or belief, gender reassignment

Sex

Women make up 79% of the adult social care workforce, compared to 51% of the population, making it a heavily female dominated sector.[90,91] As such, any pay increase is likely to have a disproportionately positive impact on women. Introducing a fair pay agreement would support gender equality by improving pay in a sector where women are overrepresented, helping to close the gender pay gap and strengthen women's economic independence.

Women in England are more likely than men to receive formal care: almost 6 in 10 (56.5%) of LA care users receiving long term support in a nursing or care home in England were female in 2023/24.[92] If the FPA results in any change to the quality or availability of care, this might therefore have a more significant impact on women. Increased costs of care are also more likely to impact on women.

Age

The age profile of ASC workers is skewed towards the older age bands. The average age of a worker in the adult social care sector was 44 in 2023/24, and 27%were over 55 years old. 8% of workers were under 25, compared to 11% of workers in employment (2023/24).[93] Long-term trends show that the proportion of the ASC workforce aged 55 and above has been rising steadily since 2016/2017, however, this is not exclusive to adult social care but mirrors trends amongst the economically active population.[4] The proposed policy is therefore more likely to positively impact older workers, while younger workers are less likely to benefit.

Older adults (65+) are more likely than younger adults (18-64) to have care needs and to access formal care: NHS Digital data shows that during 2022-23, 65.1% of LA care users

[90] Skills for Care, The state of the adult social care sector and workforce in England, 2023/24

[91] Population and household estimates, England and Wales - Office for National Statistics

[92] Adult social care Activity and Finance Report, England, 2023-24

[93] Skills for Care, The state of the adult social care sector and workforce in England, 2023/24

accessing long term support in a nursing home or care home in England were aged 65+[94]. If the FPA results in any change to the quality or availability of care, this may therefore have a disproportionate impact on older people. Increased costs of care to self-funders as a result of an FPA are also likely to have a greater impact on older people.

Ethnicity

The adult social care sector is more diverse than the population of England. In particular, there was a higher proportion of people with a Black/ African/ Caribbean/ Black British ethnicity in social care (18% in 2023/24) compared to the wider population (4.2%). The proportion of ASC workers with a white ethnicity was 68% compared to 81% of the population of England.[95] The proposed policy may therefore positively contribute towards closing ethnicity pay gaps.

81.5% of LA care users accessing long term support at the end of 2023/24 were white, 1.4% were Mixed/Multiple ethnic groups, 5.6% were Asian/Asian British, 4.9% were Black/African/Caribbean/Black British and 1.2% are other – the figures for England are 81%, 3%, 9.6%, 4.2% and 2.2% (respectively).[96] This suggests that no minority ethnic group is overrepresented in care users, however it should be noted that 5.3% of care users did not provide any data so these data sets may not be directly comparable.

Disability

Results of the 2021 UK census reveal that 17.7% of people in England were disabled at the time of question.[97] Within social care, the LFS (Labour Force Survey) identified 31% of workers as disabled in social care occupations according to the Disability Discrimination Act 1995 (DDA) definition. This is supported by the proportion of respondents to the ASC Workforce Survey in 2023/24 who reported having a disability (33%)[98]. The ASC-WDS showed a lower prevalence of disability amongst workers, at 2%, but this is likely an under-estimate that captures only the LFS equivalent of 'work-limiting disability'. Given the range of estimates, however, it is more challenging to estimate the impacts of the proposed FPA, but it is possible that disabled workers will be disproportionately likely to be positively impacted.

Individuals with disabilities (physical, and/or learning disability and/or mental health needs) have an increased probability of needing to use the social care system in their lifetime and therefore may be more likely to be affected if there are any changes to the quality or availability of care as a result of an FPA. The NHS Digital Activity and Finance Report shows that at the end of 2023/24, 54% of LA care users accessing long-term support in England were receiving care for physical support needs (as their primary support reason), while 23% received support related to learning disabilities and 12% for mental health support needs.

Sexual orientation

Sexual orientation was asked in the ASC Workforce Survey in 2023/24. Weighted responses suggest that 4% of the ASC workforce identify as gay or lesbian, 4% identify as bisexual and 1% identify with another orientation other than straight/heterosexual (5% of respondents chose not to answer this question)[99]. In the 2021 Census, of the population of England and Wales aged 16, 1.5% described themselves as gay or lesbian, 1.3% described themselves as bisexual and 0.3% selected "Other sexual orientation". This suggests that people who identify with any of these sexual orientations may be more likely to work in ASC than the population, though this is uncertain given smaller populations. People sharing these characteristics could be disproportionately likely to be positively impacted by the FPA.

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[94] Adult social care Activity and Finance Report, England, 2023-24

[95] Skills for Care, The state of the adult social care sector and workforce in England, 2023/24

[96] Adult social care Activity and Finance Report, England, 2023-24

[97] Disability, England and Wales - Office for National Statistics (ons.gov.uk)

[98] Adult social care workforce survey: April 2025 report - GOV.UK

[99] The adult social care workforce and their work-related quality of life

Marital status
Responses in the ASC Workforce Survey in 2023/24 suggest that the proportions of the ASC workforce who are married or in a civil partnership (45%) and divorced (9%) are comparable to proportions of all adults in England and Wales responding to the 2021 Census (47% and 9% respectively). The proportion of ASC workers who have never married or entered a civil partnership, and the proportion who have been widowed, are lower than the share of all adults (22% compared to 38% in the UK population). This potentially reflects the age distribution of the ASC workforce relative to the population: the average care worker is older than the average worker but younger than the average adult, and these marital statuses are notably more likely at the bottom and the top of the age distribution respectively. Impacts on groups sharing these characteristics may therefore be similar to those by age group.

Other characteristics – including maternity, religion or belief, gender reassignment
There is no published information currently available on pregnancy or maternity, religion or belief, or gender reassignment amongst ASC workers. We have no strong evidence to suggest that there are any differences between the workforce and wider population in this regard[100]. Similarly, we have no evidence to suggest that any groups of people who share these characteristics are more or less likely to draw on care services and therefore be affected by any changes to availability of care or quality of care services.

Other impacts

Regional impacts
The ASC workforce is distributed across England according to where there is demand for care. Partly due to older age groups having the highest care needs, and partly because access to publicly-funded social care is means tested, public demand for ASC tends to be more concentrated in coastal and post-industrial areas, with 9 of the 10 local authorities with the highest numbers of LA-funded care users per capita being in the bottom half of areas for deprivation.[101] If the FPA policy results in improved outcomes for LA-funded care users, this may therefore disproportionately affect households in more deprived areas.

Meanwhile, there tend to be higher proportions of self-funders in less deprived areas. 40% of community care service users in the local authorities in the least deprived decile of local authorities are self-funders, compared to 15% in the most deprived decile of local authorities[102]. Any impacts on self-funders as a result of an FPA (including increased costs, as well as any reduction in access or any improvements in quality of care) are therefore likely to disproportionately affect households in less deprived areas.

While the pay distribution in ASC is relatively narrow compared to the wider labour market, mean hourly pay in ASC tends to be higher in areas with higher prevailing wages, including London and the South East[103]. A policy that results in increased pay in the sector is likely to have differential impacts between local areas, but these impacts will depend on the scope and coverage of the FPA outcome. For example, a higher pay floor could have disproportionate impacts on areas where prevailing pay is lower. The costs of implementing the FPA outcome would be higher in local authorities that have lower prevailing wages, and the resulting increase in household income would be greater for workers in these areas. Improvements in recruitment efficiencies and productivity as a result of a higher wage floor could be greater in local areas

[100] The gender and age characteristics of the ASC workforce suggest that maternity and pregnancy could be more likely for workers in adult social care than for the population as a whole. On the other hand, Health Foundation analysis using the Family Resources Survey suggests that a similar proportion of residential care workers live in households containing children to the population as a whole: Health Foundation (2025) Poverty, pay and the case for change in social care

[101] Adult social care Activity and Finance Report, England, 2022-23 - NHS England Digital

[102] Estimating the size of the self-funding population in the community, England - Office for National Statistics

[103] Pay in the adult social care sector in England as at December 2024

with lower prevailing wages. Conversely, an FPA outcome that results in a uniform pay uplift to all workers would have greater costs in areas with higher prevailing wages.

Overall, the impacts of the FPA policy are likely to vary regionally, but the nature of this will depend on the scope and coverage of a negotiated FPA outcome. Impacts on the workforce, self-funders, and LA-funded care users are likely to vary according to the deprivation of the area. Impacts on the workforce could be greater in more or less deprived areas, depending on the nature of the FPA outcome. Benefits and risks to people drawing on LA-funded care are likely to be greater in more deprived areas, while benefits and risks to self-funders may be more significant in wealthier areas.

Economic growth

An FPA in adult social care is expected to improve pay and terms and conditions in the sector in England, which represents approximately 5% of employee jobs. This could have a limited positive impact on economic growth via improvements in labour supply and productivity. Higher pay in adult social care, a sector which employs a significant number of workers on low pay and with low household incomes, may also have distributive effects which have a small net positive impact on Real Household Disposable Income.

Higher pay in adult social care could increase labour supply by encouraging some economically inactive people to seek work, incentivising existing workers to seek additional hours, and via greater labour market participation of unpaid carers. Increasing pay could also improve productivity as workers are incentivised to work harder to keep jobs which are better paid than their available alternatives.

Higher pay could also mean that workers with role-specific knowledge, skills and experience are retained for longer. In addition, increased labour costs could drive some businesses to invest in productivity improvements.

Overall, there is limited empirical evidence demonstrating the impact of pay in adult social care on labour supply and productivity, and it is likely that the total impact on economic growth objectives is small.

Competition impacts

Almost by definition, the labour market faced by providers will become significantly less competitive if a negotiated fair pay agreement is introduced on the principle of collective bargaining, and given that unionisation in the sector is expected to increase. The potential impacts on businesses providing care and the market as a whole are identified in earlier sections.

With the possible exception of some specialist services, markets for care in England are highly competitive and characterised by relatively low barriers to entry, especially in domiciliary care. This is evidenced by constrained profitability[104], the relatively large number of firms, and significant growth (7.5%) in non-residential locations on the CQC register over 2024/25[105].

The net effect of an FPA on competition with the sector is uncertain: defining more attractive minimum terms and providing dedicated funding for the additional cost of publicly commissioned care might allow some providers who would otherwise consider exiting the market to remain. Likewise, it could reduce uncertainty around costs for prospective market entrants.

[104] LaingBuisson (2024) Adult social care in the UK Scale, Structure, Funding and Financial Performance of the Independent Sector

[105] The size and structure of the adult social care sector and workforce in England 2025 (skillsforcare.org.uk)

On the other hand, higher costs could incentivise amalgamation between firms if larger providers have an advantage in absorbing familiarisation and administration costs and/or passing increased costs onto purchasers via higher prices; or if increased standardisation and familiarity between providers reduces some of the costs of merging. Higher running costs might also mean that a greater level of operating capital is needed to successfully enter the market. Finally, higher pay for employees might also reduce the attractiveness of self-employment to care workers, which represents another form of competition and entry into the market for care.

An FPA is more likely to result in a marginal reduction in competition than an increase. There is a risk that this could result in further costs to self-funders and potentially to public commissioners of care, though the latter may be less exposed given their prevailing market power[106].

Justice system impacts

The Employment Rights Bill confers the powers to create additional enforcement mechanisms. However, at this stage, the adult social care FPA will not create new or amended offences, sanctions or penalties. We will consult on this in the future if we intend to create additional enforcement mechanisms.

The pay elements of a ratified FPA will be enforced by the Fair Work Agency in a similar way to how the National Minimum Wage is currently enforced by HMRC. The details of this will be subject to further consultation and regulations for the Fair Work Agency.

Tribunal impacts are expected to be minimal at this stage. The ASC FPA would not create any new protections (as social care workers are already protected via the Employment Tribunal and HMRC for minimum pay and terms), nor would it expand a protection to a new population of workers. Minimum standards in the sector are already enforced and any ASC FPA is expected to be agreed by both employers and employee representatives prior to implementation. Therefore, the overall impact post-implementation is expected to be low at this stage.

The adult social care FPA does not intend to create a new right to appeal, nor expand the existing jurisdiction of the United Kingdoms Tribunals system.

Environmental and sustainability impacts

We do not expect this policy to have any direct impact on the environment or sustainability.

Human rights

We do not expect this policy to have any direct impact on human rights.

A summary of the potential trade implications of measure

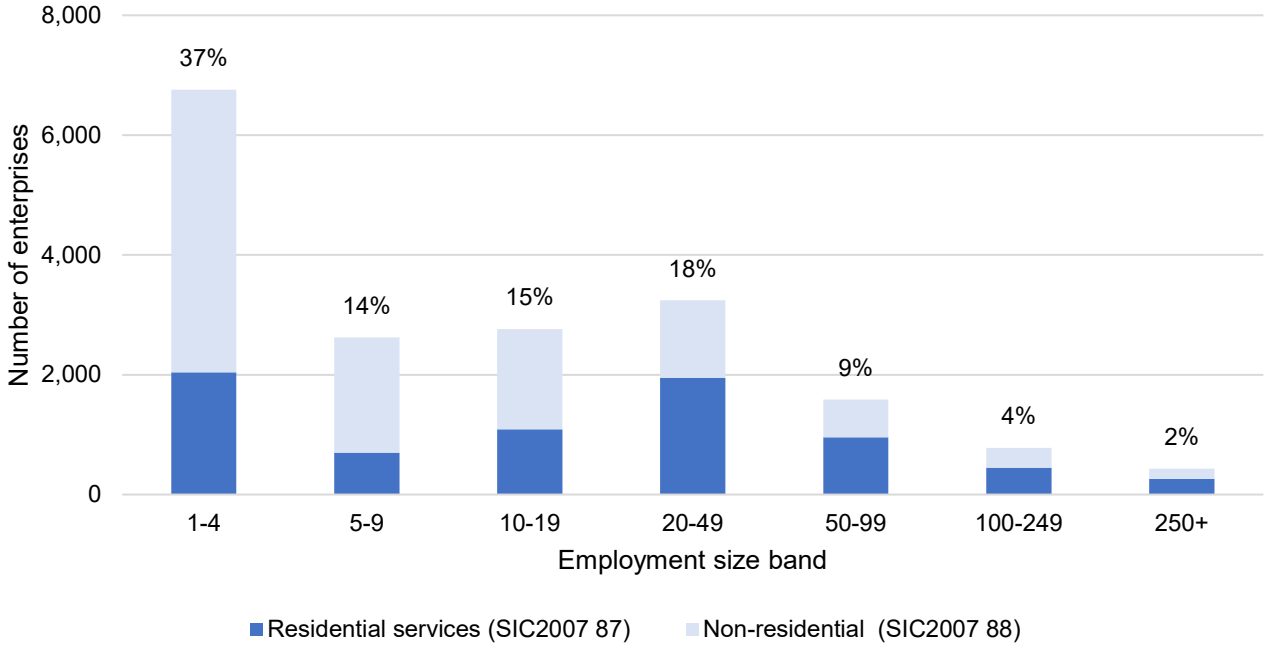
We do not expect this policy to have any direct impact on trade and investment.

Impact on small and micro businesses

Almost all ASC employers are small-to-medium sized enterprises (98%), 2% are large employees who employ almost half (47%) of the ASC workforce. Micro businesses account for 51% of employers by count, small businesses account for 33%, medium businesses account for 13%.

[106] Care homes market study - GOV.UK

***Figure 3**: Estimated number of adult social care organisations in England by number of employees, 2023/24*



Source: Skills for Care (2024), The state of the adult social care sector and workforce in England

Smaller businesses are likely to be more exposed to the costs associated with an FPA. They may have smaller profit margins and may be more constrained in their ability to raise prices. Lower reserves and lower levels of investment may mean there are barriers to investing in any productivity improvements that could help them to manage increased labour costs.

As a result, the smallest businesses may be more likely to experience some of the potential negative consequences of higher labour costs in ASC because of an FPA, including lower profitability, having to reduce the number of paid hours, and potentially, market exit.

The extent to which the costs of an FPA would be shared between public-sector commissioners and businesses is yet to be determined. However, an exemption for smaller enterprises would be inappropriate. The core objectives of the policy could not be achieved if small, micro, or medium enterprises were exempted from the application of the FPA process or its implementation, given the proportion of the workforce they collectively employ, and could create perverse incentives to break up larger enterprises in the sector.

Mitigations of the impact might include measures to ensure that the interests of smaller employers are represented appropriately during the co-design and negotiation of an FPA, for example by mitigating the costs of participating (such as staff time) where these might otherwise be disproportionate. Smaller enterprises are already able to access the public procurement of care and available public support with the costs of training workers, and we do not foresee a fair pay agreement creating additional barriers.

The complexity of the ASC sector is a key consideration in the design of the Adult social care fair pay agreement policy. There are different types of employers in the social care sector: the private provider, local authorities, and individuals. The Employment Rights Bill provides powers to reach a negotiated agreement in the ASC sector, but the detail and scope of the negotiation process (amongst other matters) will be established in secondary legislation.

Monitoring and Evaluation

DHSC have engaged the Evaluation Taskforce and HMT to ensure that a proportionate and robust monitoring and evaluation framework is planned concurrently to the FPA development. DHSC is commissioning an independent evaluation to examine the rollout and causal effects of an FPA in Adult social care. The evaluation will span the pre-implementation phase and

continue for up to two years after the FPA is introduced. The research will be commissioned through the NIHR (National Institute of Health and Social Care Research) Policy Research Programme. Alongside this, DHSC are scoping and improving existing data sources that will be valuable for monitoring and the evaluation.

Monitoring and data development

DHSC also intend to monitor trends in employment and pay in the sector, including:

- Skills for Care's Adult social care Workforce Dataset (ASC-WDS), which provides detailed breakdowns of full-time equivalent (FTE) numbers, hourly pay, job roles, qualification levels, and regional demographics.
- HMRC's Pay As You Earn Real Time Information (RTI) dataset, offering monthly payroll and headcount data at a regional level.

Previous work by the ONS has recommended the use of ASC-WDS over wider labour market sources such as the Labour Force Survey and the Annual Survey of Hours and Earnings given the relative risk of misidentifying or misclassifying workers who are likely to be in scope of the analysis. DHSC are working with Skills for Care in parallel to develop new questions to be added to ASC-WDS during 2025/26 to ensure that monitoring and evaluation can capture additional relevant information on terms and conditions in the adult social care sector, such as the payment of travel time.

Evaluation plans

The commissioned evaluation will span pre-implementation and up to two years after the introduction of the first FPA. The NIHR has launched a two-stage application process, concluding in April 2025, with final funding decisions expected by December 2025 to January 2026[107]. Bids will undergo rigorous scrutiny by an expert panel and will be judged on quality and value for money. While applicants have been invited to propose methodologies, the evaluation will likely be a phased approach.

Phase 1 Baseline assessment

This should involve research to baseline current practice on T&Cs in the sector. We would expect this research to explore the following questions:

- How do ASC providers make decisions about the T&Cs they offer?
- What factors influence these decisions?
- What impact do T&Cs have on the workforce?

This will likely involve mixed methods research to baseline current practice on reward in the sector, prior to the implementation of an FPA, to understand how providers make decisions about terms and conditions, and the impact they have on the workforce. This could involve analysis of ASC-WDS. This would build on previous and ongoing research into practices in the sector, including projects funded by the NIHR cited in the evidence base above.

Phase 2 Impact evaluation

This should involve an evaluation of the impact of the changes to statutory employment conditions, including statutory sick pay and zero hours contracts policy, which are due to be implemented from 2026/27 onwards. This phase should also include an FPA evaluation, which

[107] PRP (41-02) Evaluation of the fair pay agreement and the impact of employment rights in adult social care | NIHR

could involve both a process and impact evaluation. We would expect this phase to explore the following research questions:

- What impact have changes to statutory conditions (e.g. zero hours contract reform, statutory sick pay reform) had on workers and providers?
- What impact has the FPA had on its intended outcomes – i.e. improving pay for ASC workers?
- What impact has the FPA had on wider social care outcomes – e.g. a) staff retention, b) staff wellbeing, c) provider costs, d) care user quality of life[108]?
- What are the unintended consequences of an FPA?
- How does the structure and organisation of the FPA affect the impact of the FPA on its intended outcomes?

The FPA evaluation should consider the impact on workers, on providers, on local authorities, and on the wider social care system. It should involve both quantitative and qualitative research. The quantitative component could use methods such as a difference-in-difference analysis or regression discontinuity design to estimate the impact of a change in pay and reward policy on outcomes of interest. The qualitative component could involve a survey, interviews and/or focus groups with care workers, providers and sector representatives.

The research could also test whether there are unintended consequences for businesses or households. The before-and-after design could be used to test the impact on provider openings and closures (based on Care Quality Commission data) as a proxy for profitability or could use commercially available data on provider profits (such as LaingBuisson reports) and prices or similar data volunteered by individual providers. It could also test whether there is an impact on access to care, potentially using Client Level Data to explore the impact on activity. It will be important to consider business size as part of this, as well as impacts on self-funders specifically. To ensure robustness, the evaluation must isolate FPA effects from overlapping policy changes such as reforms to statutory sick pay, National Living Wage increases, and wider macroeconomic or immigration shifts.

Evaluation use

This evaluation will enable us to:

- Support future policy design work by demonstrating whether the FPA is achieving its intended outcomes. This could include determining whether changes to the FPA are needed over time, for example to introduce additional conditions into the framework.
- Justify current and future funding for the FPA and demonstrate value for money to HMT.
- Present the impact of the FPA and cross-economy employment changes more robustly to remain accountable to parliament and taxpayers.
- Understand which aspects of pay and reward matter to the workforce and to providers to support the sector in adopting best practice.

Findings from a first, baselining phase are more likely to be available during the implementation of the first FPA. This could impact on the remit letter that is produced by government (e.g. government may suggest a certain level of ambition or a focus on particular job roles in response to evidence), and the evidence could be considered by the ASC Negotiating Body when negotiating an FPA.

[108] An Adult social care Outcomes Toolkit (ASCOT) Workforce measure is detailed in the technical report available here: Adult social care workforce survey: April 2025 report - GOV.UK.

The evaluation currently being commissioned is primarily intended to understand the impact of the first FPA. However, we would expect that evaluation and monitoring, and the interpretation of previous findings, should become an ongoing part of the annual FPA negotiation process and have therefore assumed that the secretariat costs include a budget for commissioned research. This could follow a similar approach to the approach taken by the Low Pay Commission, which commissions multiple research projects each year, and where the findings inform subsequent recommendations for the NLW and NMW rates.