Homecare Association

Voices of Homecare: Workforce

October 2025

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Executive summary

The Homecare Association regularly surveys its members to provide robust evidence on the state of the workforce and inform policy change. In 2025/26, the sector faces some of its most pressing challenges yet. Vacancies remain stubbornly high, pay and conditions lag behind competing sectors, commissioning and contracting practices continue to undermine providers' attempts to improve terms and conditions for their careworkers, and providers are being asked to take on new responsibilities with limited support. Without action, people who rely on homecare risk going without vital services, and providers risk closure.

This year, rather than duplicating new data collected by the Department of Health and Social Care[1], we focused our survey on four areas of immediate concern to providers: the closure of international recruitment routes, changes in the Employment Rights Bill, the expansion of delegated healthcare tasks, and the growth of unregulated care. These issues cut to the heart of workforce stability, safety, and the sustainability of homecare businesses.

Between 17 June and 22 July 2025, we collected 450 responses from homecare providers across the UK, serving over 186,000 clients and employing over 135,000 careworkers. The sample includes small, medium, and large providers, working with both self-funding clients and state commissioners.

Our report shows that:

- Commissioning drives workforce outcomes. The public sector funds 80% of homecare. Purchasers' reliance on lowest-price contracts fragments hours across many providers, increasing travel time, creating irregular schedules, and undermining job security. By contrast, locality-based commissioning with volumes of 1,000 to 2,000 hours per provider allows shift-based rotas, reduces turnover, cuts carbon emissions, and improves continuity of care.

- Fair funding and fair working practices are the foundations of sustainable services. It is within the Government's power to deliver these. A national contract setting a minimum fee rate, combined with sustainable funding and neighbourhood-based outcome-focused commissioning, would provide the foundation of a stable workforce.

- Ending international recruitment does not resolve exploitation issues and will exacerbate recruitment challenges. Hyper-fragmentation and zero-hours commissioning create instability, leaving workers underemployed and vulnerable. A key solution is for the NHS and local authorities to commission blocks of guaranteed hours within tight geographic zones. This gives providers the stability to offer secure,

[1] Homecare Association (2022) Findings of fourth Homecare Association member survey on workforce

legal contracts and makes it easier to distinguish responsible employers from those cutting corners.

- Addressing the funding shortfall is key. The Health Foundation has estimated the sector needs £8.7 billion to meet demand, cover rising costs, improve access, and boost pay in 2028/29. By 2034/35 this rises to £15.4bn. At a minimum, the sector needs £3.4 billion by 2028/29 to stop services from declining[2].

- Investment in homecare offers a compelling return for people, communities, and the NHS. The Health and Social Care Committee has recently identified in its inquiry into adult social care reform: the cost of inaction, every £1 invested in the sector would generate a £1.75 return to the wider economy.[3]

- With political will, change is both possible and urgent.

Uncompetitive wage rates, unsociable hours and insecure contracts, all shaped by commissioning styles, drive domestic workforce turnover.

A Fair Pay Agreement could help set a foundation for improvement, but it will only succeed if matched by sustainable funding for providers[4], reforms to commissioning and realistic local authority and NHS budgets. Without this, attempts to improve pay and conditions may push more careworkers into unregulated parts of the market and providers into further deficit.

Other reforms add to the complexity. Measures in the Employment Rights Bill on sick pay and zero-hours contracts will have a disproportionate impact on homecare, where part-time working is high and personalised care requires frequent rota changes. Delegated healthcare tasks are growing, yet NHS support and funding for training and oversight remain limited. Unregulated models of care also pose new risks, threatening both public safety and the viability of responsible providers.

Our message is simple. The Government must fund, plan for and include social care in reforms from the Fair Pay Agreement to employment rights, and from NHS integration to immigration. Local authority and NHS commissioning practices must evolve to support the Government and the sector's ambition for improved working conditions, sustainable services and high-quality care. Without this, the sector faces an erosion of employment standards, business sustainability, and quality of care driven by government policy decisions.

With proper support, homecare can provide rewarding careers and safe, high-quality support for the millions of people who depend on it.

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[2] Adult social care funding pressures: 2023–35 - The Health Foundation

[3] Health and Social Care Committee (2025) Adult Social Care Reform: the cost of inaction

[4] Fair Pay must mean fair funding: Homecare Association warns Government social care pledge falls short

Key findings at a glance

Pay, Terms and Conditions:

Half (51%) of respondents said the biggest barrier to recruitment and retention was low wages compared with other sectors. Over three-quarters (75%) of respondents said they have implemented strategies to increase wages. The most common pay rate (which covered 40% of respondents) was between £13-£13.99 per hour for careworker roles.

Sponsorship of international staff:

Barriers to international recruitment included that the recruit did not have access to a car (29%), that the process was unaffordable (22%) and that the processes were too slow (18%). Careworkers who did not have enough hours of work from their primary visa sponsor had contacted 89% of respondents in 2025 often (58%) or occasionally (31%).

Reasons for zero-hours contracts:

Most providers offer zero-hour contracts (78%). 40% of respondents said they change their careworkers' schedules on a weekly basis (24%) or more frequently. Reasons included hospital admissions, deaths of people being supported, sickness absence, traffic and travel disruption or unexpected changes in the condition of the person being supported.

It is easier for providers to pay staff for cancelled work if they have cancellation clauses that mean that purchasers pay for visits cancelled at short notice. However, we found that while 87% of those with supporting people who pay privately receive cancellation payments, only 43% of those with local authority clients and just 29% of those with NHS clients do.

Sick pay:

97% of respondents pay staff only Statutory Sick Pay (SSP) when they are off sick. 81% of respondents estimated that paying sick pay from day 1 would cost 10p – 30p extra per hour of care delivered.

Trade Unions:

12% of respondents report that there are unions active in their workplace. 6% had a formally recognised union operating.

Demand:

63% of respondents had met the demand for care in their area. 25% had too much capacity and too little demand, which meant they could not give careworkers sufficient hours.

37% had not met the demand for care in their area. 70% of those reported this is because they cannot recruit enough new careworkers. 36% had problems with their existing careworkers leaving, or with fee rates being too low.

Delegated healthcare tasks

70% of respondents have careworkers undertaking delegated healthcare tasks. Commissioners or purchasers pay only 15% of respondents more to undertake the tasks. 80% found it difficult to find registered NHS staff to sign off competency for tasks, and 65% felt they did not have the appropriate ongoing support from NHS staff for delegated tasks.

Recommendations

As soon as possible

- ✓ **Stabilise funding:** Ring-fence social care budgets and invest at least £1.6 billion in England (with equivalent sums in devolved nations) to address historic funding deficits.
- ✓ **Legislate for fair commissioning:** Introduce a statutory National Contract for Care, with sustainable fee rates calculated using an agreed methodology, and a legal requirement on commissioners to pay at least this rate.
- ✓ **Plan the workforce:** Develop a credible statutory workforce plan with the sector to ensure enough careworkers are available to meet the UK's ageing population.
- ✓ **Protect sponsored workers**: Establish a secure, independent reporting route for sponsored careworkers to raise concerns about exploitative employers without fear of destitution or deportation.
- ✓ **Support underemployed migrants:** Expand Regional Partnerships to cover sponsored workers with insufficient hours and other employment issues, not just those displaced by licence revocations.
- ✓ **Fund delegated health tasks**: Allocate dedicated funding for delegated healthcare tasks and require appropriate NHS clinical oversight.
- ✓ **Integrate homecare:** Embed homecare fully within Neighbourhood Health Services to support integrated community-based care.
- ✓ **Give providers certainty:** Require local authorities and NHS bodies to confirm fee rates for the coming year by the end of February, so providers can plan effectively.

By April 2026

- ✓ **Fix Regional Partnerships:** Reform Regional Partnerships to address persistent barriers in placing overseas workers, including access to driving tests, and strengthen links with community organisations so support reaches those who need it.
- ✓ **Fund Statutory Sick Pay changes:** Allocate ring-fenced funding to local authorities and the NHS so they can uplift homecare contracts in line with the additional costs of Statutory Sick Pay and other measures in the Employment Rights Bill. This should preferably be channelled via a National Contract.

By October 2026

- ✓ **Clarify union rights:** Publish clear guidance on how trade union access rights interact with data protection requirements.

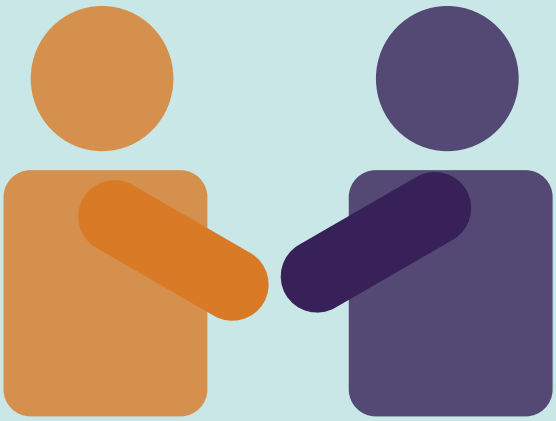
- ✓ **Guarantee fair pay parity:** Recognise that “fair pay” means funding a competitive wage rate at least on a par with the NHS. HM Treasury must announce adequate funding to support this ahead of Fair Pay Agreement negotiations.

By 2027

- ✓ **Reform commissioning practices:** Work with local authorities to develop a national plan for commissioning and funding that enables the shift away from zero-hours contracts required by the Employment Rights Bill. This must include:
    - Ending the “daily auction” of care packages to the lowest bidder.
    - Organising care geographically, with block contracts large enough to support efficient rotas and shift-based rather than minute-by-minute payment.
    - Requiring commissioners to pay for work cancelled at short notice and to fund providers to retain staff while clients are in hospital.

Medium-term

- ✓ **Regulate the unregulated:** Require registration of all careworkers, starting with unregulated and self-employed care workers providing personal care.
- ✓ **Give clear commissioning guidance:** Issue statutory directions to commissioners on when it is appropriate to commission, promote, or support unregulated care, to prevent unsafe practices and a two-tier system.



Recruitment and retention

Homecare Association Workforce Survey 2025

Recruitment and retention – findings

Domestic recruitment and retention

Over half (51%) of respondents said the biggest barrier to recruitment and retention was low wages in comparison to other sectors.

Recruitment has improved since the significant workforce pressures that we saw in late 2021 and early 2022. However, vacancy rates in homecare remain stubbornly high, with one in ten posts still vacant (Figure 1).

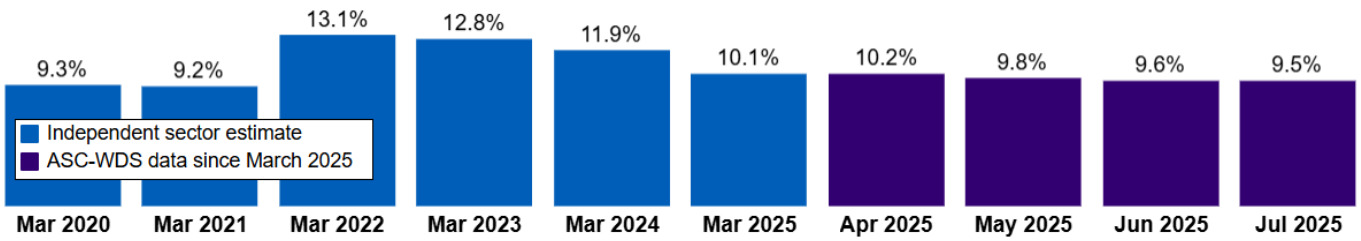


Figure 1: Skills for Care data on vacancy rates in Homecare Services[5]

We know some of the reasons why.

In April 2025, the Department of Health and Social Care[6] found 74% of homecare providers reported challenging recruitment. This was greater than residential and nursing care providers. The main recruitment challenges include:

- better pay outside of the care sector (28%)
- application did not meet job requirements (16%)
- better pay elsewhere within the care sector (11%)
- does not hold a valid UK driving licence (8%)

59% of homecare providers reported that retention was challenging. The top three reasons cited were:

- better pay outside of the care sector (35%)
- better pay elsewhere within the care sector (15%)
- better hours elsewhere within the care sector (8%)

46% of homecare providers reported that morale was low.

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[5] Skills for Care (2025) Recruitment and retention tracker (pictured as at 2 Sept 2025)

[6] Department of Health and Social Care (2025) Adult social care workforce survey

Skills for Care reports that the number of workers in the social care sector with a British nationality has decreased from 83% in 2020/21 to 73% in 2023/24. This means around 30,000 fewer posts filled by British workers in the last year (to 2023/24)[7]. With the closure of International Recruitment (a topic we will return to later); domestic recruitment issues will become even more pressing as providers will now need to recruit locally to fill all posts.

Our Workforce Survey explores the nuances of how this picture is playing out in homecare and how homecare providers are adapting to the significant challenges they are facing.

Stability of the current workforce

25% of providers say more of their careworkers were leaving compared to summer 2024

When asked whether more or fewer careworkers were leaving compared with the same time last year, 45% said the rate was about the same. However, one quarter (*19% 'more leaving'* and *6% 'many more leaving')* reported higher levels of staff leaving (Figure 2). As we come onto below, we know higher pay in other sectors continues to be a major driver of this.

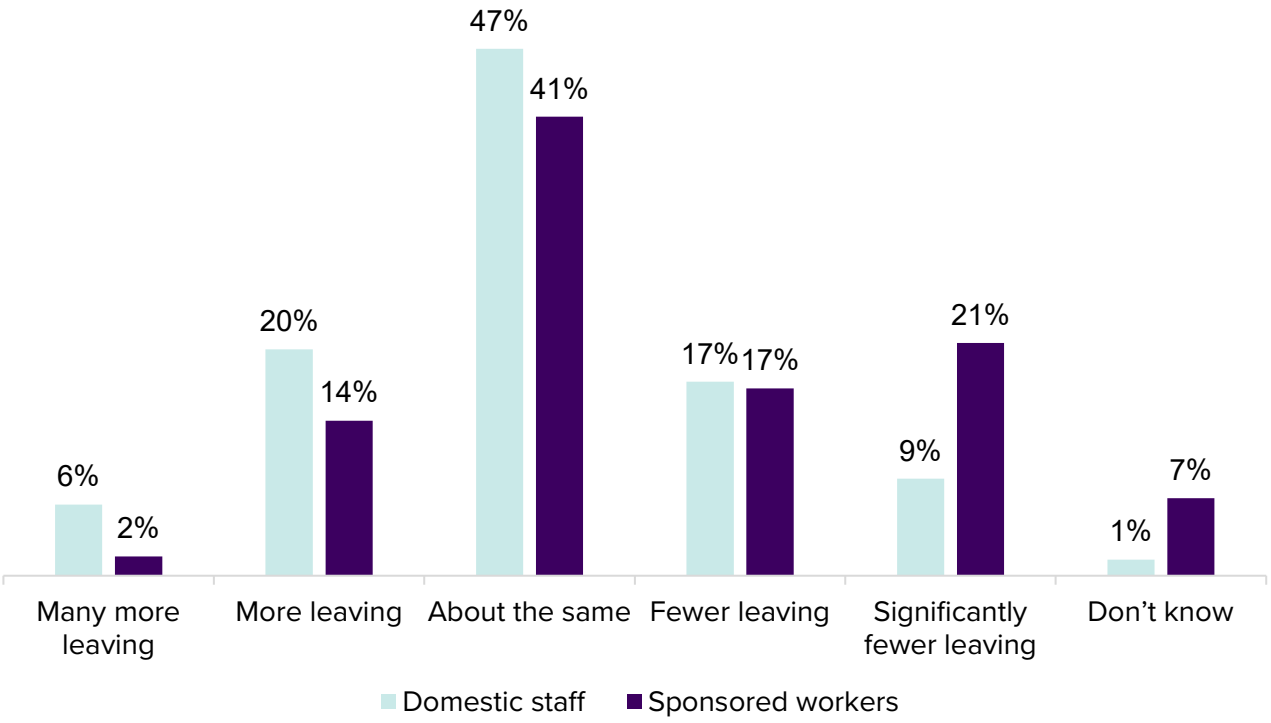

Figure 2: Are more or fewer careworkers leaving your employment than this time last year? (n=369)

[7] Skills for Care (2024) The state of the adult social care sector and workforce in England

In our 2024 Workforce Survey[8], only 16% reported higher leaver rates than in 2023, compared with 25% this year. This suggests that retention is getting worse.

Regional variation this year is notable: providers in the North East, North West and Yorkshire and Humber regions were more likely to report more staff leaving than last year, with Yorkshire the highest at 40%.

These patterns of staff turnover reveal the fragility of current employment models and highlight that the sector urgently needs targeted interventions. High turnover can reduce continuity of care, which is very important for most people being supported – they often want to build a relationship with the person supporting them. It can also increase training and business costs. Where staff leave the sector rather than a job, poor retention can threaten the ability of the sector to provide enough care for local communities across the UK.

Skills for Care data[9] shows that pay, sick pay, training, contracted hours, and use of sponsored staff all affect turnover, amongst other factors. We will examine these later in this report. High turnover can sometimes be driven by employer behaviour. At the Homecare Association, we champion best practice. There are also clear systemic issues affecting the whole sector in homecare. It's vital that we understand and address these – including low pay, which is ultimately driven by how much the public sector will pay providers for care[10].

Why we are losing careworkers

51% of care providers lose staff to other sectors with higher pay

Low pay remains the central challenge; over half of respondents (51%) said wages lower than other sectors have the greatest negative impact on their ability to recruit or retain careworkers. This reflects the sector's position in a highly competitive labour market where retail, hospitality, and other service industries frequently offer higher pay.

Skills for Care data show that sales and retail roles and cleaning roles may pay similar or higher wages for less responsible roles than care providers; and the NHS will pay more (Figure 3). The public sector purchases 80% of homecare[11], and how much the NHS and local authorities will pay for care limits homecare providers' ability to increase pay[12].

[8] Homecare Association (2024) Workforce Survey

[9] Skills for Care (2024) The state of the adult social care sector and workforce in England, section 9

[10] Homecare Association (2025) Fee rates for State Funded Homecare in 2025-26

[11] LaingBuisson (2024) Homecare and Supported Living UK Market

[12] Homecare Association (2025) Fee rates for State Funded Homecare in 2025-26

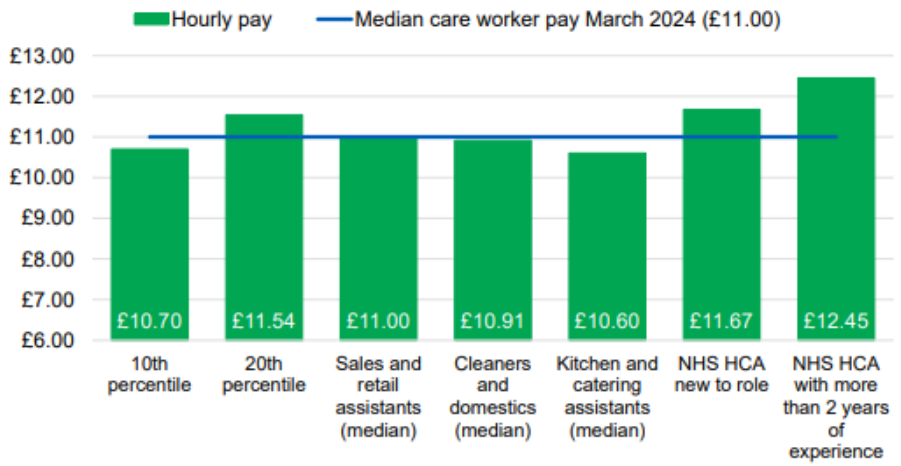

Figure 3: Skills for Care - Median careworker pay vs. pay in other sectors, The state of the adult social care sector and workforce in England, p.105.

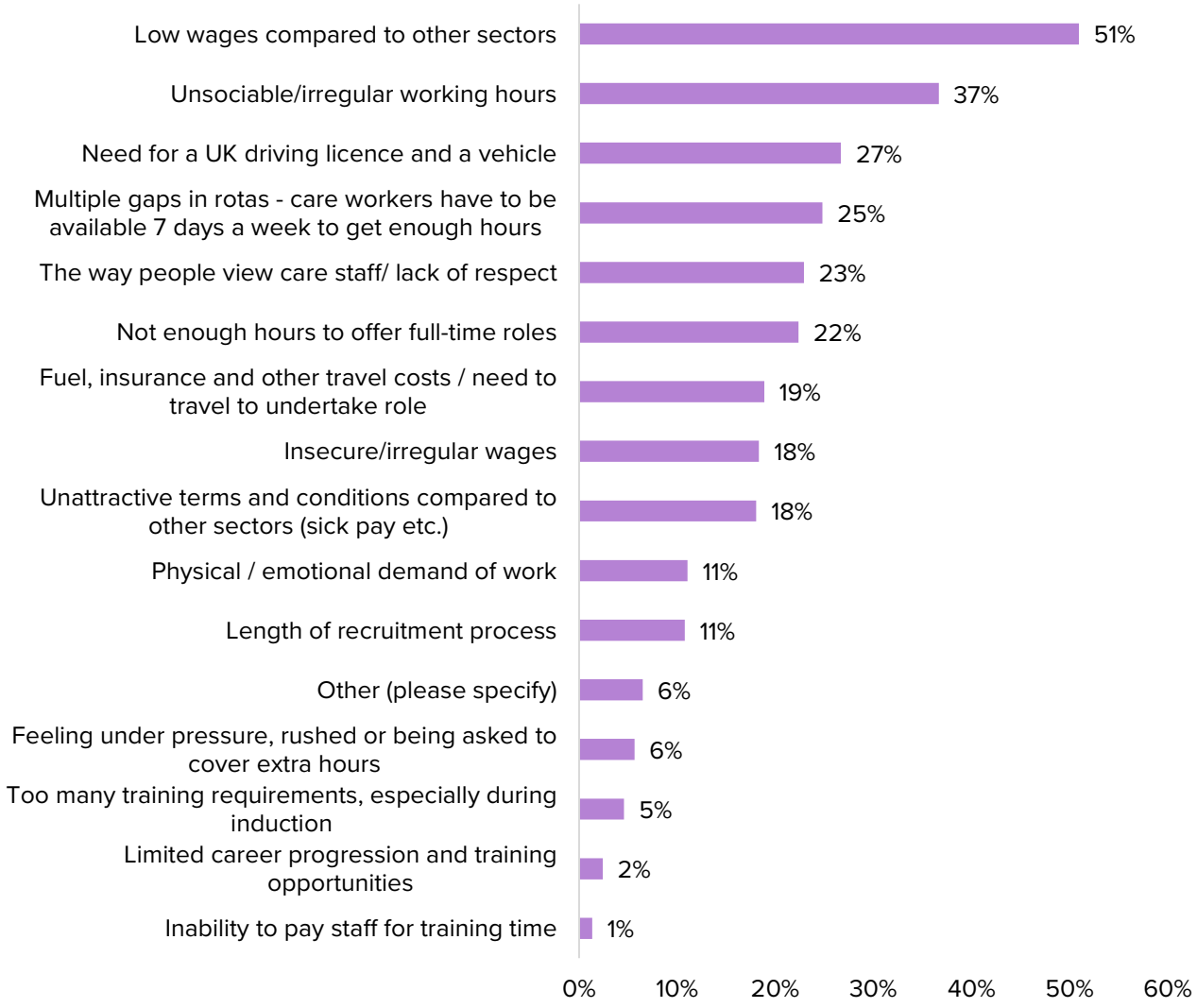

Figure 4: Which of the following do you think have the greatest negative effect on your ability to recruit or retain homecare workers at the moment? (n=371)

Beyond pay, 37% pointed to unsociable working hours, while 27% highlighted the requirement for a driving licence and vehicle access (Figure 4).

Homecare roles often involve early mornings, late evenings, weekends, and travel between clients, making it difficult to balance with other responsibilities. For people with care responsibilities, including childcare, these rarely match non-standard working hours.

As one provider told us:

> *"I offer salaries and make the role as attractive as possible, offering career progression, flexible working, rota in advance and still, we are unable to recruit domestically. The sector needs more marketing to re-educate people on the values of working in the care sector."*

Providers also raised delays in processing and acquiring DBS checks as an additional barrier to timely recruitment. This can mean that if a candidate has multiple job offers and one does not require a DBS check, they are more likely to take the alternative role in order to begin employment faster.

How providers address these challenges

76% of providers have increased wages and improved pay structures for their careworkers.

When asked what has the greatest positive effect on recruitment and retention, respondents emphasised workplace culture and values, a supportive team/positive organisation culture (71%), the personal values of staff or sense of vocation (57%) and a flexible working offer (56%) were the top factors cited (Figure 5).

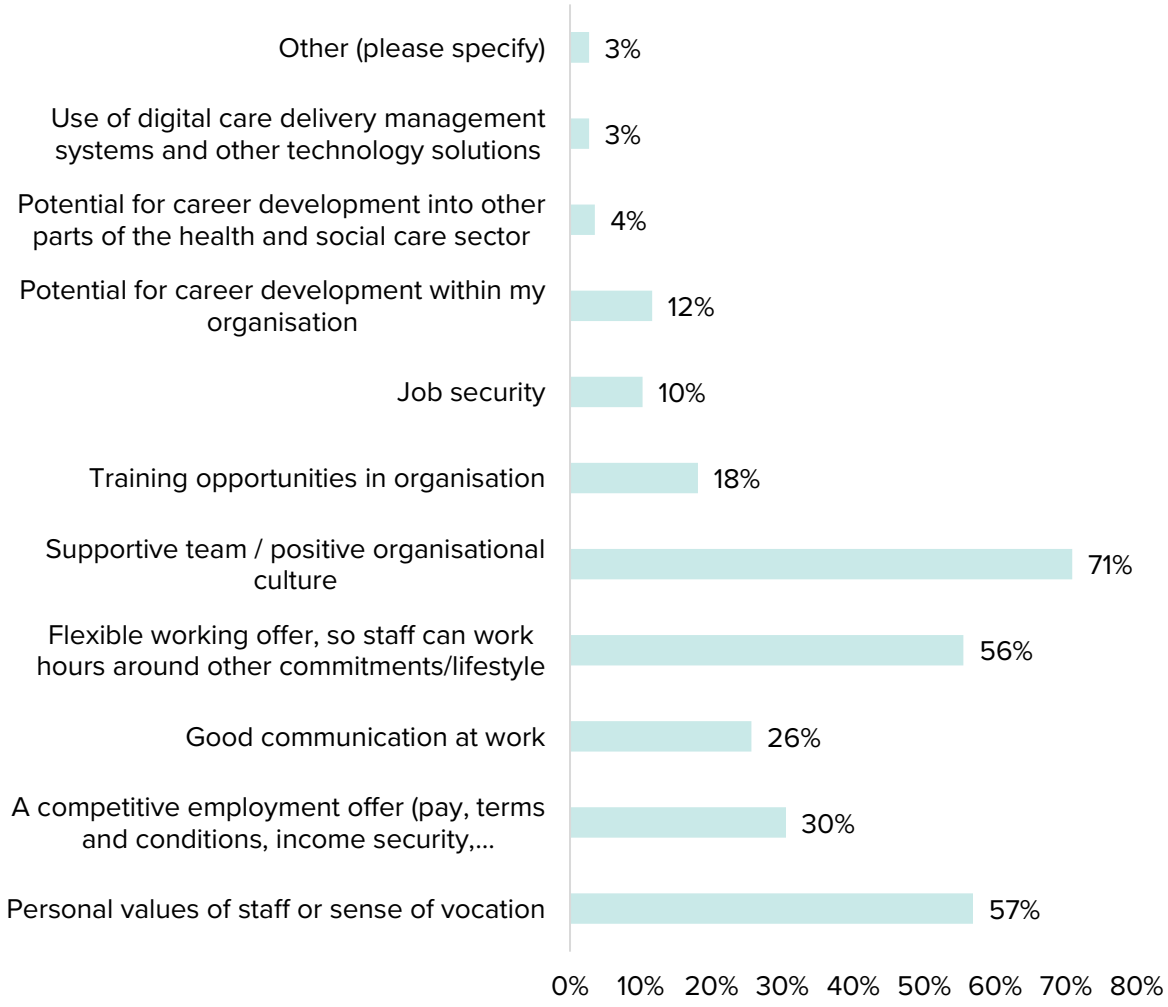

Figure 5: Which of the following do you think has the greatest positive effect on your ability to recruit or retain homecare workers at the moment? (Select three) (n=371)

Providers are not passive in addressing these challenges.

Over three-quarters (76%) said they have already increased wages and improved pay structures to aid recruitment and retention (Figure 6).

Other common strategies included improved support and supervision of care teams (61%), offering more flexible working patterns (60%) and enhancing training and development opportunities (56%).

Figure 6: What strategies has your organisation implemented to improve domestic recruitment and retention? (Select all that apply) (n=370)

Skills for Care's research[13] shows turnover is lower (28%) among careworkers with access to additional training compared to those without (35.4%).

> *"Investment in training, partnerships with employability organisations and values and culture alongside bonus incentives."*

> *"Treating staff as individuals and not a number."*

[13] Skills for Care (2024) State of the adult social care and sector and workforce in England

These findings are clear: improving pay, culture, flexibility and career development all strengthen recruitment and retention. Many providers are already making these changes. However, commissioning styles and fee rates limit providers' ability to improve things further. Government must work with the sector to deliver a credible statutory workforce plan and fair funding to ensure enough careworkers are available to support citizens.

Recruitment of sponsored workers

72% of respondents reported employees either raising a concern (38%) or considering leaving their job (13%) or the country (21%) in response to Government proposals to change settlement.

Visa applications by month (Home Office statistics)

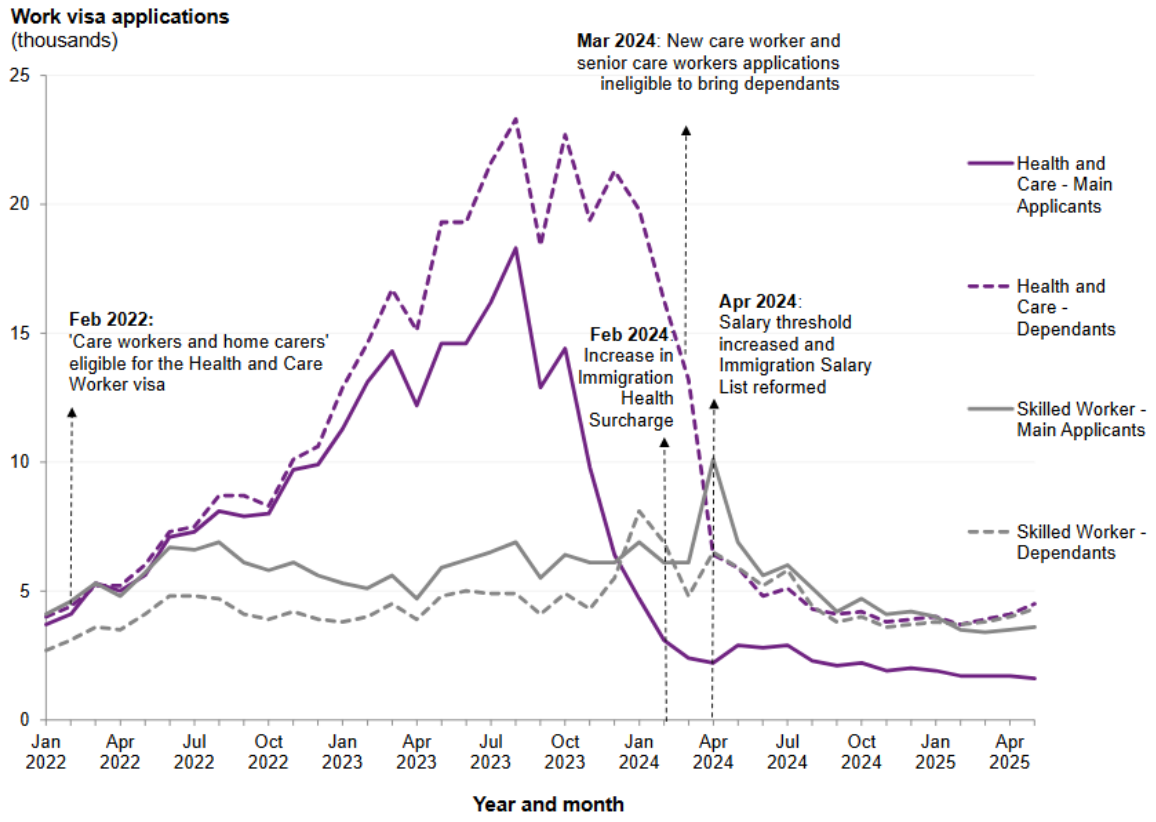

Figure 7: Home Office - Monthly entry clearance visa applications from January 2022–April 2025

When the Government added careworkers to the Shortage Occupation List in 2022, the number of visa applications rose dramatically (Figure 7). Legitimate employers in the sector were struggling for staff, and many turned to international recruitment. There was also significant exploitation of the route with reports showing[14] cases of fraudulent or fake

[14] Independent Chief Inspector of Borders and Immigration (2023) An inspection of the immigration system as it relates to the social care sector

employers - for example, the Home Office granted 275 Certificates of Sponsorship to a care home that did not exist.

As UK Visas and Immigration (UKVI) introduced more stringent tests for certificates of sponsorship over autumn 2023, the number of Health and Care Visas issued dropped dramatically from 18,300 in August 2023 to 2,400 in March 2024. While these tests helped to reduce fraudulent applications, they also made it difficult for legitimate employers to apply for visas (a topic we will return to).

In response to reports about exploitation, in March 2024 the Government introduced a requirement that only CQC-registered organisations in England could sponsor careworkers. The Government stopped careworkers from bringing dependants to the country with them. By March 2025, around 39,000 workers had lost their jobs because the Home Office had revoked their primary sponsor's licence. The Government further changed the immigration rules in April 2025, requiring care employers to prove that they had attempted to recruit from workers displaced by sponsorship licence revocations before being allowed to recruit from overseas.

In March 2025, the National Audit Office[15] published a report on the Skilled Worker Route, followed in July by the report of the Public Accounts Committee[16]. The reports highlight that the Home Office has made changes without understanding how the immigration routes operate or the impact or implications of changes. They highlighted a need for greater joined-up working to address exploitation and noted that the performance metrics only cover 'straightforward' cases; raising questions about customer service and length of wait for cases that are not straightforward.

By May 2025, applications for health and care visas had dropped further to 1,600 applications per month (including healthcare employee visas). However, on 12 May 2025, the Secretary of State for the Home Department issued a new White Paper: Restoring Control Over the Immigration System[17]. In it, the Government announced they would close international recruitment to care providers, though in-country recruitment of sponsored workers would continue for the time being, with some transitional arrangements. The closure of recruitment from abroad came into force on 22 July 2025. The Home Office made this change without proper consultation or impact analysis.

There has been widespread concern across the care sector that this could lead to renewed labour shortages as we saw in late 2021 and early 2022. The effect of the changes is unlikely to be immediate. There are also concerns that ending international recruitment does not address the issues of exploitation that are still active in the sector.

Skills for Care has previously noted that the distribution of international recruits across the country is regional. The closure of the route is therefore likely to impact some parts of the country more significantly than others.

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[15] National Audit Office (2025) Immigration: Skilled Worker Visas

[16] Public Accounts Committee (2025) Immigration: Skilled Worker Visas

[17] Home Office (2025) Restoring Control Over the Immigration System: White Paper

Data from Capacity Tracker (a Government platform used to collect data from social care providers) suggests that some local authorities (often in London and the South East) have almost half of the workforce composed of international recruits, where in other regions international recruits make up less than 5% of the workforce. Skills for Care data on new starters in 2023-24 illustrates this regional pattern (Figure 8).

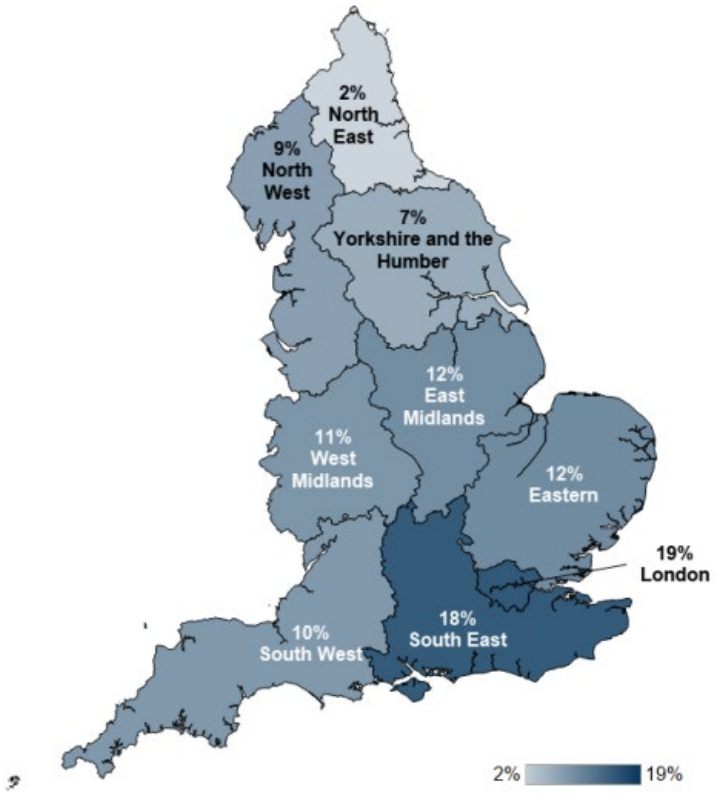

Figure 8: Skills for Care: estimated proportion of people recruited internationally starting careworker roles in adult social care in 2023/24 (The State of the Adult Social Care Sector and Workforce, p.129)

Reliance on sponsored workers

Our survey shows how widely overseas recruitment has become embedded in homecare. Overall, 59% of respondents said they employed some sponsored workers (Figure 9). By contrast, when the Government added careworkers to the shortage occupation list in 2022, 58% of providers told us they intended to focus on domestic recruitment[18].

[18] Homecare Association (2022) Continuing lack of homecare workers

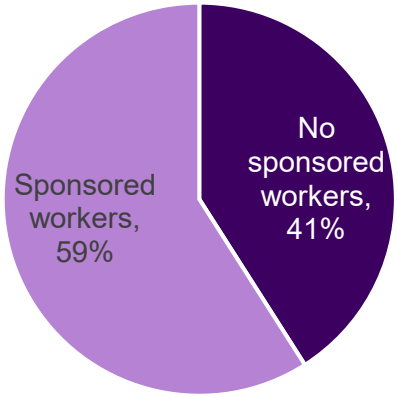

Figure 9: What percent of your workforce is made up by sponsored workers vs domestic workers? (n=359)

Reliance was higher among organisations working primarily in the public sector (where 78% of employers had sponsored staff) than among those serving people who paid privately (where 44% of employers did).

For most providers, sponsored workers make up only a small share of the workforce (Figure 10). In 83% of organisations employing sponsored workers, most of the staff were recruited domestically, and in around half of these organisations, sponsored workers represented less than 10% of their workforce.

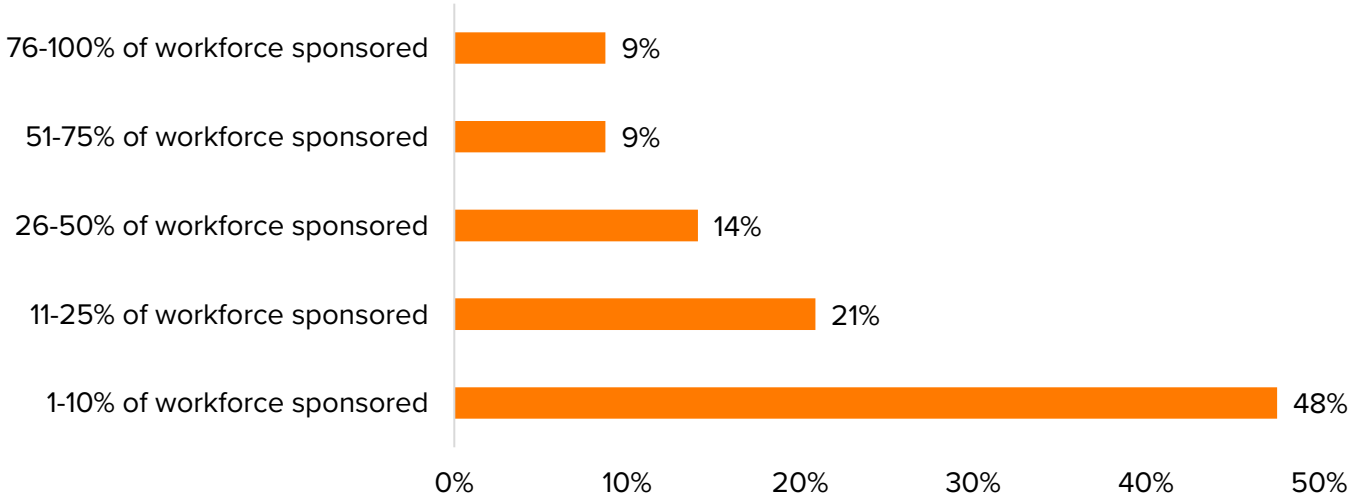

Figure 10: What percentage of your workforce is made up by sponsored workers? (n=359)

However, a minority of providers depend highly on sponsored staff at the moment. In 9% of organisations with sponsored workers, they accounted for 76-100% of the workforce. Such heavy reliance leaves these providers exposed to changes in immigration policy.

Practical challenges in overseas recruitment

We also asked providers about the difficulties they had faced in recruiting from overseas (Figure 11).

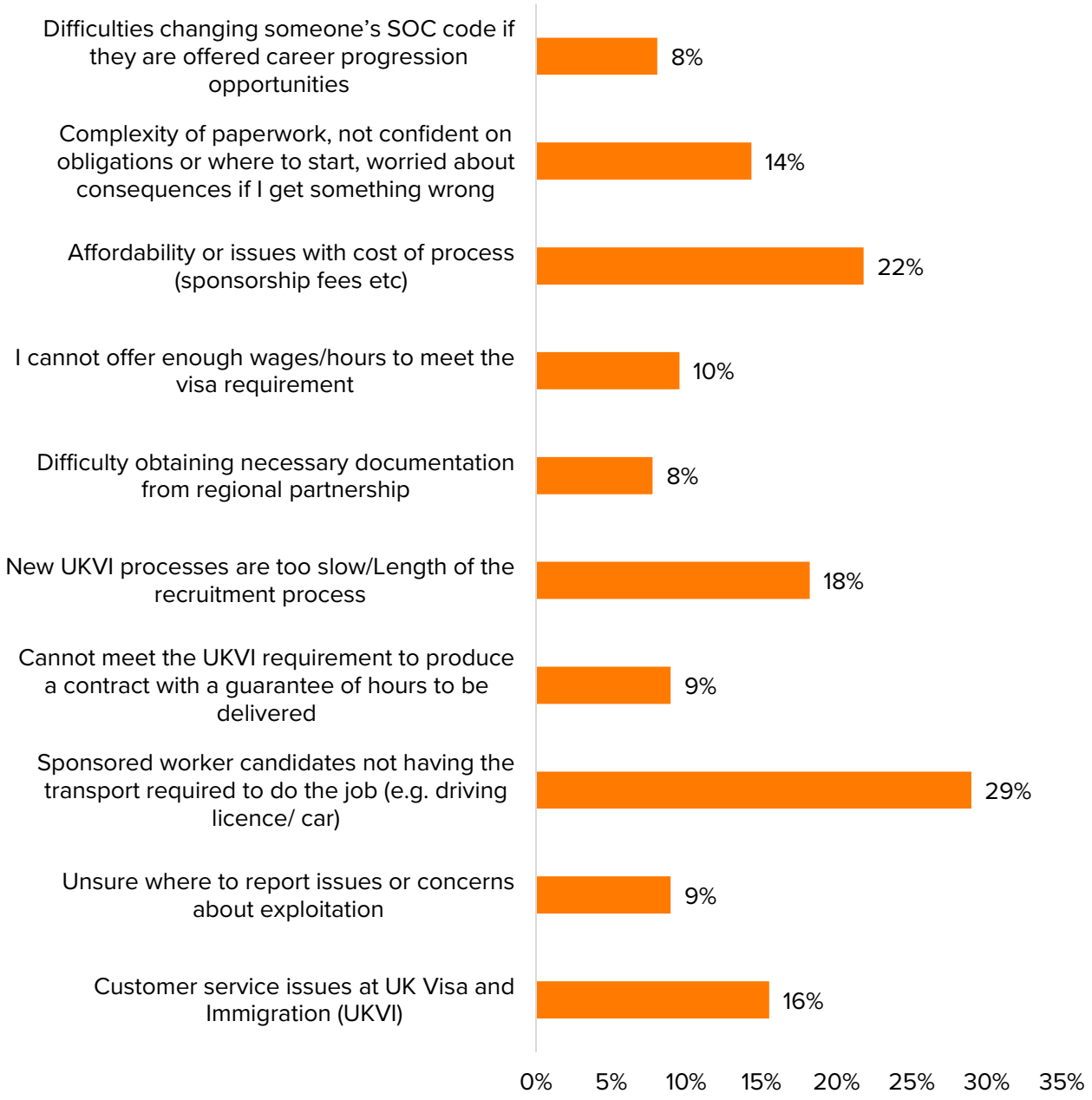

Figure 11: Have you experienced any of the following issues with overseas recruitment in the last year? (Tick all that apply) (n=355)

Issues included:

Workforce fit: recruits not having access to a car (29%) or providers struggling to give careworkers sufficient hours (10%).

Cost: the process becoming unaffordable (22%)

Delays and bureaucracy: slow processes (18%). Respondents also commented on extreme difficulties getting Defined Certificates of Sponsorship, difficulty getting references for displaced workers, and delays in Certificate of Sponsorship (CoS) processing that risked workers overstaying their visas.

System failures: providers commented that they had reported exploitation to multiple enforcement agencies without action, and that they had received incorrect advice from the Home Office business helpdesk.

Access to transport, the cost of the process and slow processes were also the top three responses to this question in our survey last year[19], suggesting they are consistent problems.

Even with a credible domestic workforce strategy, the scale of demand and persistent recruitment difficulties mean that in the medium to long-term the sector will most likely not be able to provide enough care for the ageing population without access to overseas workers.

Closing the route does not address the root causes of exploitation. Instead, it punishes legitimate providers and careworkers for failings in government policy design, oversight, and enforcement. Poorly planned changes to visa rules, a lack of coordination between agencies, and inadequate monitoring created the conditions in which abuse could occur.

Removing international recruitment altogether will not make those risks disappear, but it will reduce the supply of careworkers at a time when the system can least afford it. Providers, particularly in regions with a high proportion of international staff, face major risks to service continuity.

Settlement

Why settlement matters?

The ability to secure long-term residence is very important to many sponsored careworkers and to the providers who employ them. Certainty about settlement gives workers confidence to build their lives in the UK, while uncertainty undermines morale and increases the risk of staff turnover. After the Government published its Immigration White Paper, Restoring Control Over the Immigration System[20], many careworkers told us they felt anxious about whether they could stay in the country or ever qualify for settlement. Members reported that this uncertainty has had a visible negative impact on morale among existing staff.

Policy changes

The White Paper proposed introducing a new 'earned settlement scheme' that would extend the settlement period from five to ten years. It is suggested that some people might reduce the ten-year settlement period by gaining 'points' for contributing to society or the economy, though the White Paper provided no detail on how this would work.

At the time of writing, it remains unclear whether the new ten-year requirement would apply only to new arrivals or also to workers in the country. The Government has committed to consulting on the details of the scheme later in 2025.

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[19] Homecare Association (2024) Workforce Survey

[20] Home Office (2025) Restoring Control Over the Immigration System: White Paper

Adding to the confusion, the White Paper also announced that the Government would phase out international recruitment in social care by 2028 (with scope for an earlier end date if the Government believe exploitation is widespread). The Government has since clarified that:

> Existing sponsored careworkers who are working legally will be able to renew their visas and continue working until they reach the point where they can apply for settlement (whether this is five or ten years, and even if this is beyond 2028).
>
> There is a transition period from 2025 to 2028 (though the 2028 threshold is being kept under-review and could be earlier, if there is evidence of exploitation) during which new recruits can join the careworker visa route from other visa routes (for example, students).

While this clarification was welcome, uncertainty remains high.

Impact on overseas staff

We asked members how their sponsored staff had responded to the announcement on settlement (Figure 12). Out of 253 responses:

- 38% reported staff had raised concerns with them.
- 21% said staff were considering leaving the country.
- 13% of the staff were considering leaving their jobs.

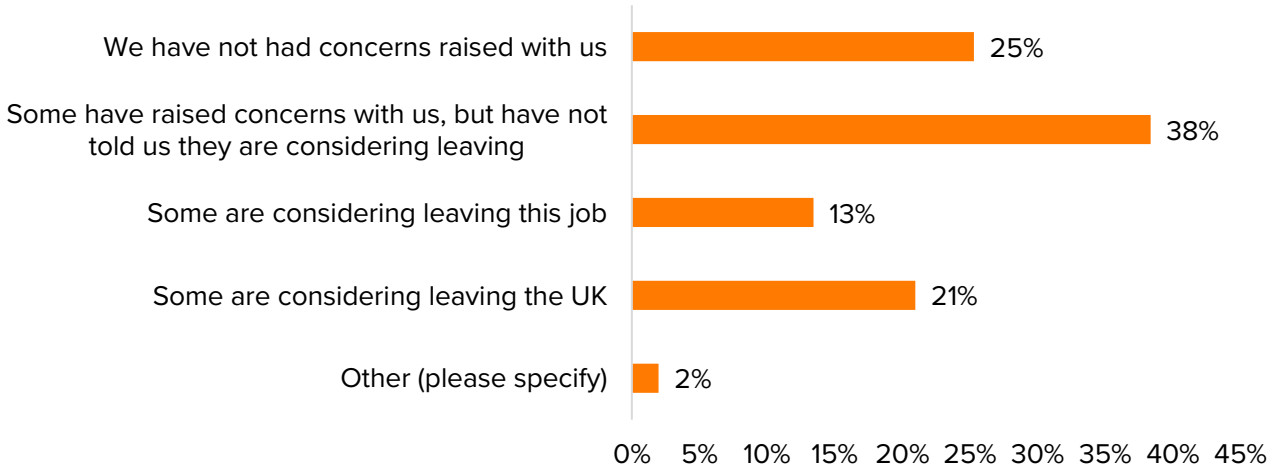


Figure 12: How have your sponsored staff responded to announcements about potential changes to the settlement period? (n=253)

Comments from respondents showed many staff feel anxious, concerned, scared or powerless to act while waiting for further details. Sometimes, employers that did not sponsor staff directly, but employed sponsored workers in second jobs, were also hearing concerns.

Regional Partnerships

Of those respondents that had tried to recruit from the regional partnerships, 52% had been unsuccessful.

In February 2023, the Government announced £15 million[21] in funding to support Adult Social Care with barriers to international recruitment, including administrative complexity and pastoral support. Local authorities organised regional partnerships to administer the funds and help providers recruit staff.

As visa applications surged and issues with exploitation became apparent, later funding rounds in 2024[22] and 2025[23] shifted focus. The Department of Health and Social Care asked regional partnerships to promote ethical recruitment and to support workers displaced by sponsorship licence revocations, matching them with responsible employers in their region who had job vacancies.

From April to July 2025[24], providers were required to prove that they had engaged with regional partnerships before being allowed to recruit internationally. Although that requirement ended with the July 2025 closure of overseas recruitment, providers are still being encouraged by the Government to engage with the regional partnerships to recruit displaced workers.

However, providers, and representatives of migrant workers have raised concerns about their effectiveness. Research by the Work Rights Centre found[25] that only 3.4% of careworkers signposted to regional partnerships found a job through that route.

Barriers included:

- Reluctance among sponsored workers to speak to government officials about their situation due to concerns about risks of immigration enforcement action or cultural issues where they are concerned about corruption.
- Careworkers who are still working for their original sponsor and are in exploitative situations who are afraid to leave or report their employer for fear of loss of income,

[21] Department of Health and Social Care (2023) International recruitment fund for the adult social care sector: guidance for local authorities

[22] Department of Health and Social Care (2024) International recruitment fund for the adult social care sector 2024 to 2025

[23] Department of Health and Social Care (2024) International recruitment regional fund for the adult social care sector 2025 to 2026: guidance for regional partnership

[24] Department of Health and Social Care (2025) Support offer to international ASC workers whose employer's sponsor licence has been revoked

[25] Work Rights Centre (2025) Less than 4% of exploited care workers reported to have found new work by government scheme, FOI data reveals

loss of sponsorship or enforcement action, particularly in a context where they have no recourse to public funds.

- Fraudulent and poorly managed sponsors did not give accurate information to recruits about what care roles would involve prior to their arrival or test their skills prior to their entering the country. Displaced careworkers in these situations may have unrealistic expectations or lack the skills to undertake care work.

Member experiences of Regional Partnerships

To understand how regional partnerships are working in practice, we asked members whether they had tried to recruit through them (Figure 13). Of the 273 responses, three-fifths had not engaged with the partnerships, while two-fifths had.

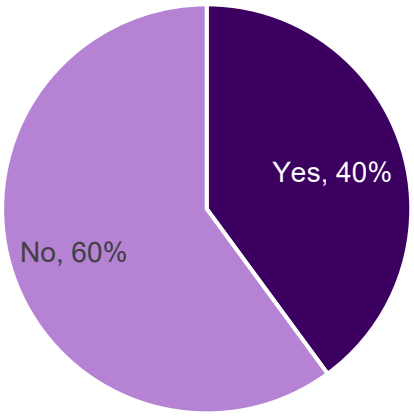


Figure 13: Have you tried to recruit from local regional partnerships for displaced workers? (n=273)

Among those who had, effectiveness was mixed (Figure 14). Out of 104 responses:

- 17% said they could always recruit (8%) or often (9%) recruit via the partnership.
- 31% had sometimes been able to recruit from the partnership.
- More than half (52%) had never been able to recruit via the partnership.

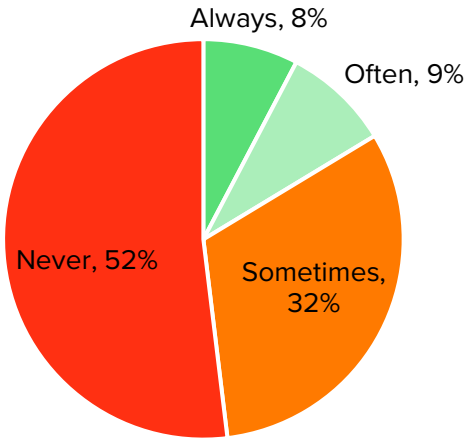


Figure 14: How frequently have you been able to recruit someone via the regional partnerships? (n=104 – only those that said yes to the previous question)

When asked about their experiences in more detail[26], around one-fifth described them as positive. The rest reported mixed or poor experiences. Concerns included:

Suitability of candidates: many lacked driving licences, had little or no training, were reluctant to deliver personal care, didn't share the values care employers were looking for, said they didn't want to work in domiciliary care, or their English was not good enough. Some respondents were providing driving lessons to candidates if the candidates otherwise met the company's needs.

Expectations and additional needs: some displaced workers had not worked in care because their original sponsor was fake, and they had unrealistic expectations of the role or did not want to provide personal care. Other workers were willing but needed significant emotional and pastoral support.

Location mismatch: available jobs did not always align with where displaced workers lived.

Gender balance: some companies need female staff for personal care roles where people have requested a female careworker to support them. The displaced workers' pool includes a lot of men.

Process and communication issues: delays, poor responsiveness, inaccurate information, and candidates not attending appointments were reported.

As our members said:

[26] We asked "What has your experience of regional partnerships been? We are interested in how easy the process is and whether the candidates are suitable for your caring roles." We received 92 responses.

Competition: there is significant competition with other employers when there are suitable candidates.

Other concerns were more systemic: some employers lacked a sponsorship licence, others could not afford salary requirements, and a small number of respondents were not even aware the partnerships existed. There were also questions about whether displaced workers themselves knew about the partnerships, or whether dependants and underemployed staff were being supported by the partnerships.

There did not appear to be a clear regional pattern in the data that suggested one partnership was performing particularly well compared to the others.

Overall, regional partnerships have provided some value, but evidence suggests they are far from an effective solution to workforce shortages. Uptake has been low, recruitment outcomes inconsistent, and systemic barriers remain unresolved. Without better resourcing, clearer processes, and stronger engagement with both providers and workers, regional partnerships cannot replace a properly regulated and well-planned international recruitment system.

Genuine Vacancy Test

In late 2023, before the current Government announced further changes to the visa system, the Home Office started to apply a more rigorous 'Genuine Vacancy Test' to applications for Certificates of Sponsorship. This caused a dramatic fall in the number of Certificates of Sponsorship being approved (see the graph at the start of the international recruitment section above).

The Genuine Vacancy Test required care employers to demonstrate that they had the hours of work available to employ a sponsored worker. In many cases, even large, legitimate employers with a high volume of work struggled to prove they had guaranteed hours available. This is because their contracts with the NHS and local government do not guarantee them any hours of work.

We believe this approach has not worked fairly and does not constitute effective enforcement because it has not effectively distinguished between legitimate employers and those that are exploitative. A care provider has challenged the use of the 'Genuine Vacancy Test' in this way successfully in court[27]. We are calling for greater alignment between how the Home Office assesses cases and how the public sector buys care via its commissioning practices. If guaranteed hours of work are required for recruitment, then the Government must purchase care in a way that guarantees hours of work to the provider.

In response to our concerns, the Home Office provided additional information[28] on how it assesses Certificates of Sponsorship, ran information webinars and introduced a new form of evidence that providers could use to support their application. This was a letter of support from Directors of Adult Social Services in their local area. The scheme that was established[29] allowed providers in England, whether or not they contract with local authorities, to ask a Director of Adult Social Services to support their application for Certificates of Sponsorship in order to recruit sponsored staff.

Our survey questions explored whether providers used supporting evidence and whether that made a difference.

Uptake of providers asking for a letter of support from their DASS

Only 16% of respondents said they had asked their Director of Adult Social Services (DASS) for a letter of support (Figure 15). Some explained that they worked primarily with the NHS or private pay market and assumed local authorities would not be able to help. Others were not aware of the scheme at all. A small number used external recruitment platforms instead, like Lifted Talent or Borderless, so didn't consider this themselves.

One respondent noted their DASS had never heard of the scheme and redirected them to the Commissioning Team to write the letter.

[27] Clarks Legal (2025) UK court rules Home Office's sponsorship requirement for care workers unlawful

[28] Department of Health and Social Care (2024) Applying for a Certificate of Sponsorship: help sheet for adult social care providers

[29] Home Office (2024) Directors of Adult Social Services supporting UKVI assessment of care sector CoS applications.

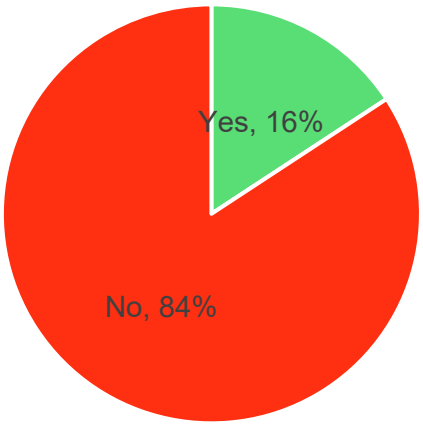


Figure 15: Have you asked your Director of Adult Social Services for a letter of support to aid your Certificate of Sponsorship application? (n=184)

Ease of access to DASSs for a letter of support

Of those who tried, the experience was mixed. More than a third said it was easy to get a letter, but 62% reported difficulties (Figure 16). Several described the process as long and bureaucratic. Others expressed mistrust, feeling that local authorities were too optimistic about domestic recruitment, or that DASSs were themselves engaging with disreputable providers.

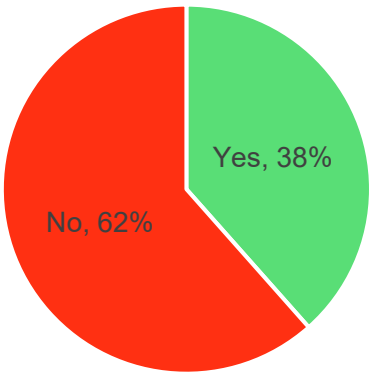


Figure 16: Has it been easy to obtain a letter? (n=39)

Effectiveness of letters of support from a DASS

Even when obtained, the letters often did not solve the problem. Around two-fifths felt the letter had helped with their application, while three-fifths said it had not (Figure 17). Many were unsure, as the Home Office did not explain whether they considered the letter in documented decisions.

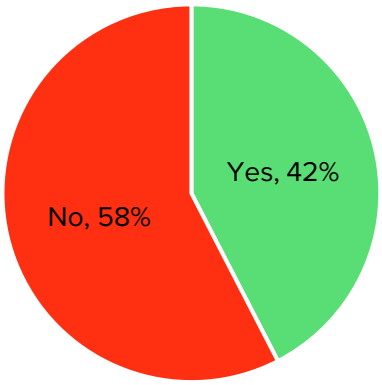


Figure 17: Did it help with your application? (n=33)

Reasons for not asking a DASS for a letter of support

Among those who had not sought a letter[30]:

- Two-fifths said that they had not needed it.
- One fifth of respondents did not know about the scheme.
- Around 1 in 10 assumed they were ineligible because they did not contract with the local authority.
- Around 1 in 10 said the process was long and bureaucratic.
- Around 1 in 20 expressed a lack of trust in local authorities.

Other respondents noted a range of additional barriers. Some said the Home Office had never suggested using a letter of support when refusing applications, while others had outsourced their sponsorship applications and were therefore less directly involved. The scheme was not formally available in the devolved administrations. Respondents had broader concerns about sponsorship itself and the treatment of sponsored workers. Finally, several providers explained they were not recruiting at all, as they were already struggling to provide sufficient hours for their existing employees.

Some members highlighted the unintended consequences of international recruitment on their existing workforce:

[30] Regarding asking for supporting letters from Directors of Adult Social Services we asked "If you have not asked, why not?"; we received 80 responses.

"I would have to take work OFF existing employees to try to fill as many hours as possible... Interestingly, I have had a series of people for interview recently who are experienced carers who are looking to leave their current care companies because they have lost hours (especially in non-peak times), because they have been given to Sponsored full-time carers. They are "only" being given work at peak hours (e.g. Mornings and being asked to work evenings and weekends)."

Although the Health and Care Visa route has now closed for overseas recruitment, the Genuine Vacancy Test is still required for those continuing to employ sponsored staff. The problems exposed by the Genuine Vacancy Test also remain highly relevant. They show how poorly designed immigration rules, combined with policymakers' lack of understanding of how local authorities and the NHS commission homecare, can block legitimate employers while failing to stop exploitation. Unless policymakers learn lessons, they could repeat the same mistakes in the future, leaving providers short of staff and careworkers vulnerable.

Exploitation of sponsored careworkers

In order to meet the legal conditions for a Health and Care Visa, sponsored careworkers must earn at least the salary set out in their Certificate of Sponsorship (£25,000 or £12.82 per hour, whichever is higher for 2025/26). Sponsored workers must not earn less than this. In homecare, where income depends on hours delivered, this means providers must give workers enough hours to meet that threshold.

How exploitation happens

We continue to hear concerns from providers approached by sponsored staff whose primary sponsor is not giving them enough hours of work to meet their visa conditions. These workers often look for second jobs to top-up their pay.

While the rules allow sponsored workers up to 20 hours of additional work from another employer, their primary sponsor must still provide enough hours to meet visa conditions.

Exploitation can take different forms:

Deliberate abuse: some sponsors deliberately restrict hours and push workers into other employment, even running fraudulent payroll schemes to make it look as though companies meet visa salary conditions. A BBC documentary[31] exposed how some companies pocketed

[31] BBC Africa Eye (2025) Stranded: Exposing the UK's immigration scammers

payments while leaving workers without legitimate care roles. The Government must address this kind of fraud urgently.

Structural shortfalls: other employers start with good intentions but lose work unexpectedly when commissioners or clients reduce or withdraw hours. Because public sector contracts rarely guarantee volume, even legitimate providers can find themselves unable to offer workers the hours they promised. If employers can't afford the salary agreed, then they may need to end the employment of the worker; they may not always do this promptly, which can also lead to visa compliance issues.

Why workers stay silent

Careworkers who are underemployed often feel trapped. Their visa status depends on their sponsor, and many fear that speaking up could lead to losing their jobs, income, and right to stay in the UK. Without recourse to public funds, the risk of destitution is high. This makes workers vulnerable to continuing exploitation, even when they know something is wrong.

Regional partnerships can sometimes support displaced workers, but provision is patchy. In many areas, partnerships prioritise only staff affected by licence revocations, leaving others with too few hours unable to access help.

What providers tell us

Our survey confirms the scale of the problem. Nearly nine in ten respondents (89%) said sponsored careworkers contacted them in 2025 seeking additional employment because their primary sponsor had not given them enough hours (Figure 18). This mirrors the pattern in 2024, suggesting no real improvement.

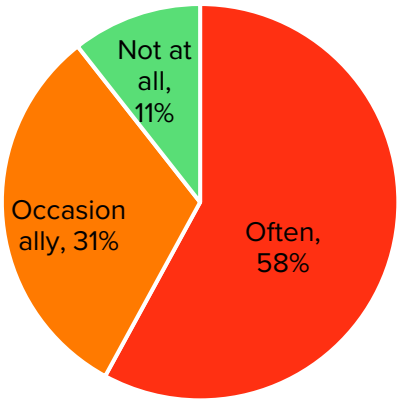


Figure 18: Have careworkers contacted you in 2025 seeking additional employment due to insufficient hours from their original visa sponsors? (n=283)

Inspections and enforcement remain limited. Only 6% of respondents reported an inspection in the past year, and just 1% had their licence suspended or experienced investigatory activity on illegal working (Figure 19).

A number of respondents raised concerns about the lack of Care Quality Commission oversight and about the risk of making accidental mistakes in complex sponsorship paperwork.

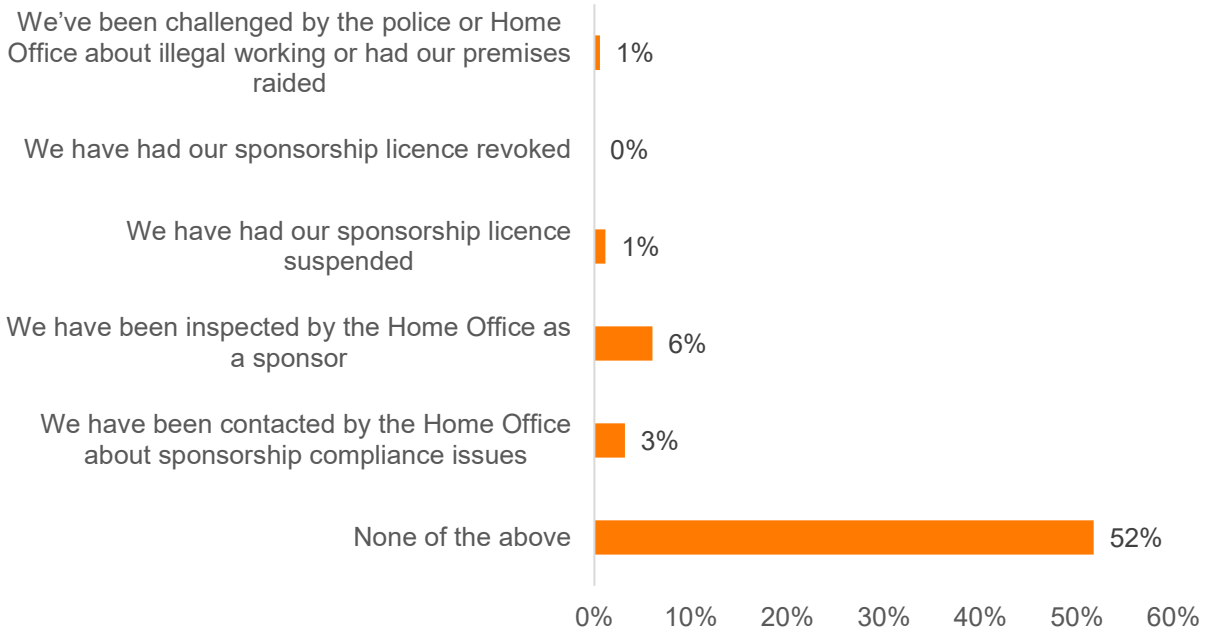


Figure 19: Have you experienced any Home Office inspection or enforcement activity in the past year? (select all that apply) (n=348)

Employment, pay, terms and conditions

Employment, pay, terms and conditions – findings

Pay rates for careworkers

99% of providers pay more than the National Minimum Wage to their careworkers

Low pay in the homecare sector is not a reflection of the value of the work or the skills required. It stems from chronic underfunding of social care and commissioning practices that prioritise lowest cost over quality. Local authorities and the NHS, the main purchasers of care, set fee rates that rarely cover the true cost of delivering services. With margins squeezed to the bone, providers have little room to invest in their workforce, resulting in pay that lags behind competing sectors like healthcare, retail and hospitality.

Against this backdrop, the Government's proposed Fair Pay Agreement (FPA) for adult social care has the potential to be transformative. Done well, it could set affordable minimum standards for pay and conditions across the sector, improve retention and begin to address long-standing workforce shortages. However, without sustainable funding and fair commissioning practices, the FPA risks becoming an unfunded mandate that care providers simply can't deliver and that current and future governments avoid addressing.

This risk was emphasised by the October 2024 Budget. The Chancellor of the Exchequer, Rt Hon Rachel Reeves MP[32], announced:

- A rise in the National Minimum Wage (NMW) to £12.21 per hour, from 1 April 2025.
- A rise in Employer National Insurance Contributions (NICs) from 13.8% to 15%.
- And a reduction in the 'Secondary Threshold' (the point at which employers pay NICs) from £9,100 to £5,000.

Together, we estimate these changes added between 10 and 12% to provider costs– equivalent to a £1.6 billion funding deficit for the homecare sector. The Government announced no immediate additional funding to offset this.

Against this backdrop, our survey asked providers what rates of pay they need to offer to attract applicants for careworker roles. The results are telling (Figure 20):

- 99% of respondents said they are already paying above the statutory minimum wage of £12.21 per hour for care services.
- The most common rate (selected by 40%) reported was needing to offer between £13-£13.99 per hour
- Only 3% are able to offer more than £16+ per hour.

[32] H.M. Treasury (2024) Autumn Budget

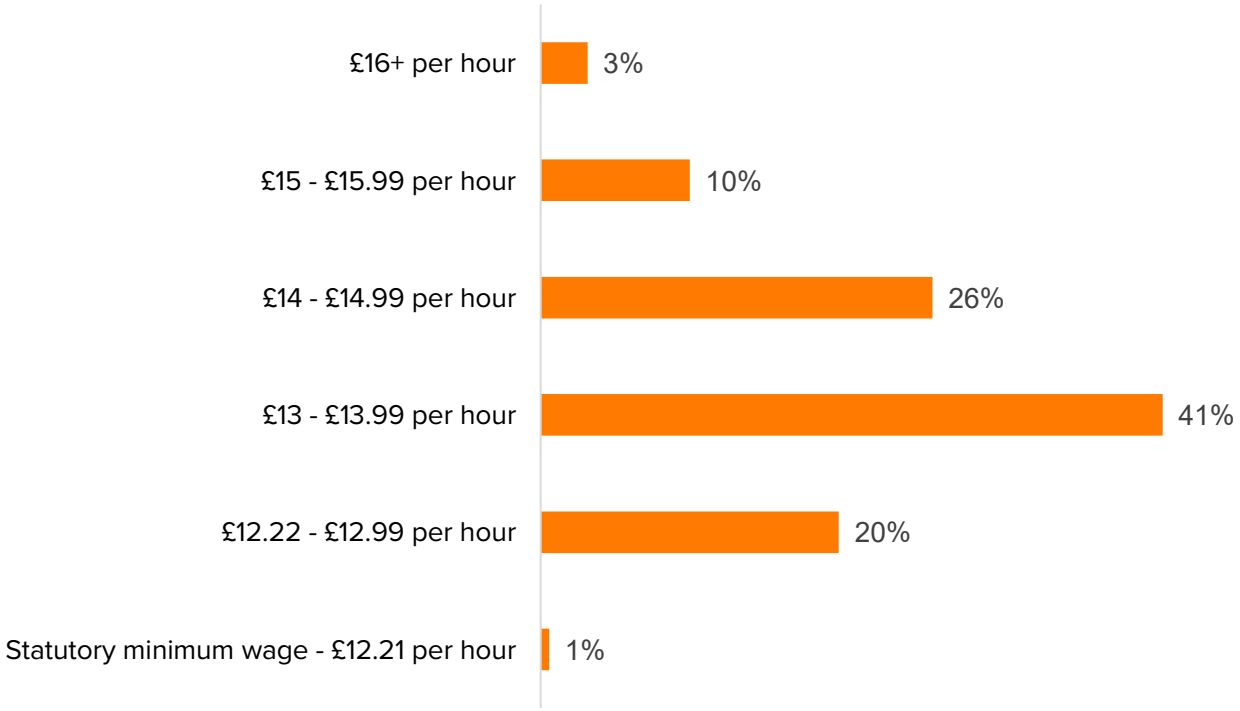


Figure 20: What pay are you finding you need to offer to attract applicants for careworker roles? (n=369)

These figures tell only part of the story. Headline pay rates (i.e. £14 per hour) often mask reality: while an advertised hourly pay rate may look competitive, it may include payment for travel or waiting time, reducing the effective hourly wage. It is this that the Homecare Association has consistently called on public commissioners and providers to account for to ensure careworkers receive full payment for the work they do.

Simply raising headline pay rates is not enough. Without fair funding and commissioning, providers cannot invest in training, sick pay, progression routes, or workforce stability. That is why we urgently need a National Contract for Care – setting sustainable fee rates using a transparent, sector-agreed methodology alongside the FPA.

A national contract would:

- ✓ Require commissioners to pay at least the minimum specified rate.
- ✓ Provide certainty for providers to invest in staff and services.
- ✓ Create a level playing field across regions, avoiding the “race to the bottom” on price.
- ✓ Help deliver the workforce needed to care for an ageing population.

If the Fair Pay Agreement is to succeed, the Government must back it with a statutory workforce plan and a sustainable funding settlement. Without this, pay improvements risk being unaffordable for providers, leaving the sector unable to deliver on the Government’s ambitions.

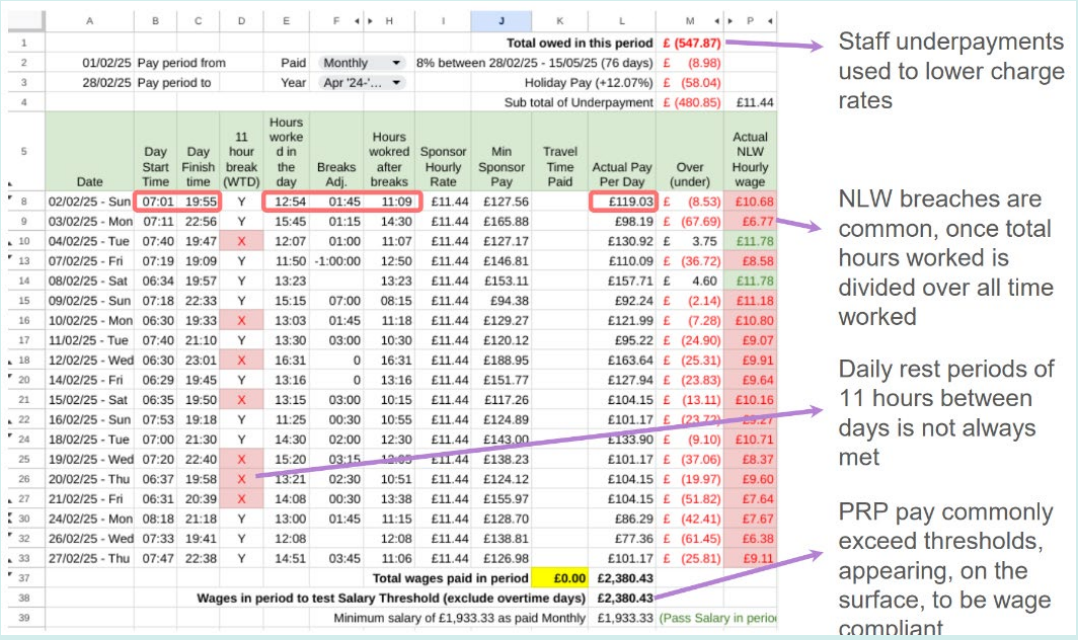
A note on headline pay rates

In some cases, headline pay rates are paid to careworkers based on the number of hours of care they deliver rather than the number of hours that they work. This can mean that careworkers can appear to receive an hourly rate that is significantly higher than the minimum wage; but this fails to account for travel and waiting time. This approach to pay can be legal if it is clear that this is what is happening, and the worker is still paid more than the minimum wage for all hours worked.

However, we are concerned that commissioners may incorrectly reward providers' who claim to have a high headline pay rate but pay by the hour of care delivered over providers who pay a lower pay rate but pay for all hours worked. Local authorities and NHS commissioners are not typically checking pay practices with the providers that they commission.

This kind of practice is often driven by zero-hour time-and-task commissioning. The provider is asked to cover piecemeal hours across a wide geographic area based on who can deliver the care for the lowest price. This impedes care providers ability to organise visits into viable 'runs' of calls or shifts.

Below is a redacted example of data on a careworker's pay (Figure 21). In this example, workers are expected to be available for up to 98 hours per week in order to deliver 39 hours of care. A higher headline pay rate increase will not significantly improve the terms and conditions for this worker because the issues are arising due to commissioning behaviour (zero-hours purchasing, scheduling, quality control) and lack of NMW enforcement.



	A	B	C	D	E	F	H	I	J	K	L	M	P
1									Total owed in this period		£ (547.87)		
2	01/02/25	Pay period from			Paid	Monthly		8% between 28/02/25 - 15/05/25 (76 days)			£ (8.98)		
3	28/02/25	Pay period to			Year	Apr '24-'...			Holiday Pay (+12.07%)		£ (58.04)		
4									Sub total of Underpayment		£ (480.85)	£11.44	
5	Date	Day Start Time	Day Finish time	11 hour break (WTD)	Hours worked in the day	Breaks Adj.	Hours wokred after breaks	Sponsor Hourly Rate	Min Sponsor Pay	Travel Time Paid	Actual Pay Per Day	Over (under)	Actual NLW Hourly wage
8	02/02/25 - Sun	07:01	19:55	Y	12:54	01:45	11:09	£11.44	£127.56		£119.03	£ (8.53)	£10.68
9	03/02/25 - Mon	07:11	22:56	Y	15:45	01:15	14:30	£11.44	£165.88		£98.19	£ (67.69)	£6.77
10	04/02/25 - Tue	07:40	19:47	X	12:07	01:00	11:07	£11.44	£127.17		£130.92	£ 3.75	£11.78
13	07/02/25 - Fri	07:19	19:09	Y	11:50	-1:00:00	12:50	£11.44	£146.81		£110.09	£ (36.72)	£8.58
14	08/02/25 - Sat	06:34	19:57	Y	13:23		13:23	£11.44	£153.11		£157.71	£ 4.60	£11.78
15	09/02/25 - Sun	07:18	22:33	Y	15:15	07:00	08:15	£11.44	£94.38		£92.24	£ (2.14)	£11.18
16	10/02/25 - Mon	06:30	19:33	X	13:03	01:45	11:18	£11.44	£129.27		£121.99	£ (7.28)	£10.80
17	11/02/25 - Tue	07:40	21:10	Y	13:30	03:00	10:30	£11.44	£120.12		£95.22	£ (24.90)	£9.07
18	12/02/25 - Wed	06:30	23:01	X	16:31	0	16:31	£11.44	£188.95		£163.64	£ (25.31)	£9.91
20	14/02/25 - Fri	06:29	19:45	Y	13:16	0	13:16	£11.44	£151.77		£127.94	£ (23.83)	£9.64
21	15/02/25 - Sat	06:35	19:50	X	13:15	03:00	10:15	£11.44	£117.26		£104.15	£ (13.11)	£10.16
22	16/02/25 - Sun	07:53	19:18	Y	11:25	00:30	10:55	£11.44	£124.89		£101.17	£ (23.72)	£9.27
24	18/02/25 - Tue	07:00	21:30	Y	14:30	02:00	12:30	£11.44	£143.00		£133.90	£ (9.10)	£10.71
25	19/02/25 - Wed	07:20	22:40	X	15:20	03:15	12:05	£11.44	£138.23		£101.17	£ (37.06)	£8.37
26	20/02/25 - Thu	06:37	19:58	X	13:21	02:30	10:51	£11.44	£124.12		£104.15	£ (19.97)	£9.60
27	21/02/25 - Fri	06:31	20:39	X	14:08	00:30	13:38	£11.44	£155.97		£104.15	£ (51.82)	£7.64
30	24/02/25 - Mon	08:18	21:18	Y	13:00	01:45	11:15	£11.44	£128.70		£86.29	£ (42.41)	£7.67
32	26/02/25 - Wed	07:33	19:41	Y	12:08		12:08	£11.44	£138.81		£77.36	£ (61.45)	£6.38
33	27/02/25 - Thu	07:47	22:38	Y	14:51	03:45	11:06	£11.44	£126.98		£101.17	£ (25.81)	£9.11
37							Total wages paid in period			£0.00	£2,380.43		
38							Wages in period to test Salary Threshold (exclude overtime days)				£2,380.43		
39							Minimum salary of £1,933.33 as paid Monthly				£1,933.33	(Pass Salary in perio	

Staff underpayments used to lower charge rates

NLW breaches are common, once total hours worked is divided over all time worked

Daily rest periods of 11 hours between days is not always met

PRP pay commonly exceed thresholds, appearing, on the surface, to be wage compliant

Figure 21: Example of headline pay not meeting minimum wage standards

A note on live-in care

Not all roles in the homecare sector are paid by the hour.

Many care providers also provide live-in care where the careworker lives with the person in their own home and provides support. This is usually on the basis that they are there for a few weeks and then have some time off on rotation.

We have not previously asked our members about pay-rates in live-in care, so this year, for the first time, we did. It's important to note that pay will depend on the amount of support being provided and skills involved in a particular placement. Much of this work is classified as 'unmeasured' for HMRC purposes.

It is vital that policy relating to careworkers recognises the important contribution of live-in careworkers and how their working lives are different from careworkers that do visiting calls or shifts.

The most common pay rates for live-in care (offered by 40% of respondents) were in the £800-899 per week range (Figure 22).

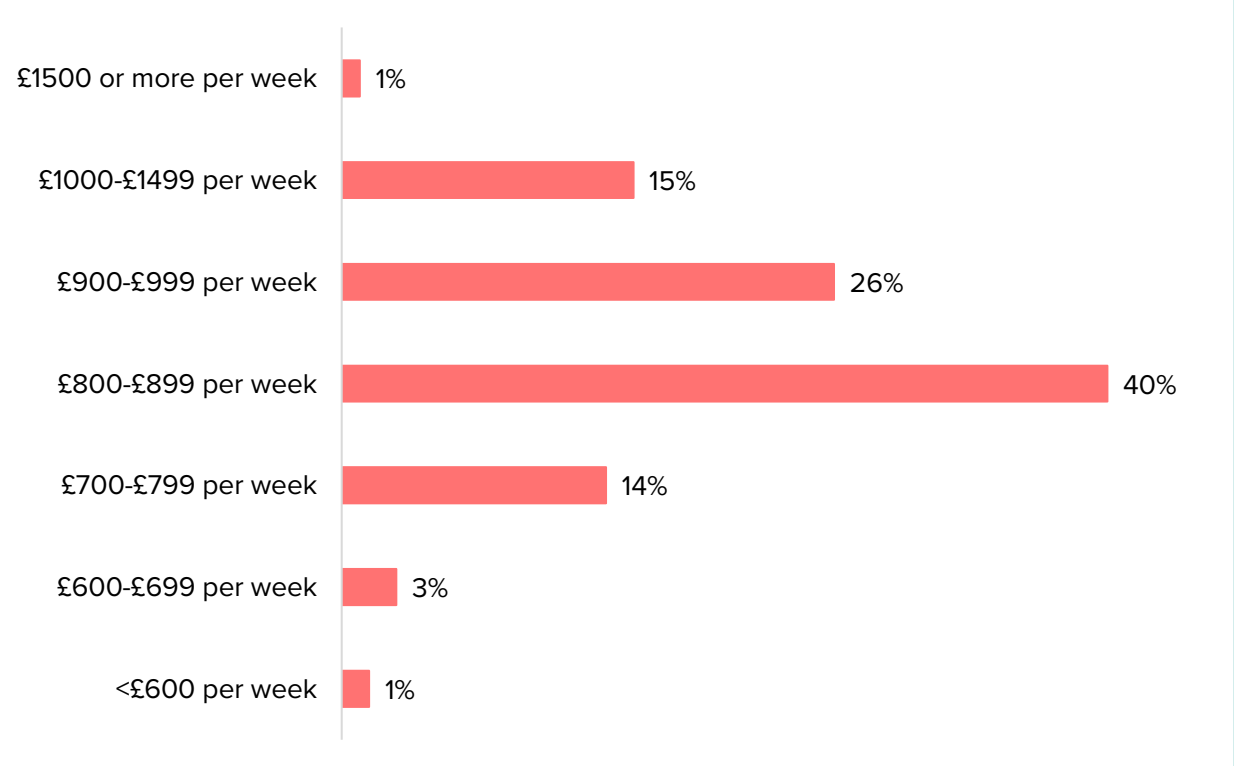


Figure 22: For live-in care roles, what pay are you finding you need to offer to attract applicants for careworker roles? (n=363).

Zero-hours contracts

Despite not being paid, 75% of providers absorb the cost of cancelled visits and pay their careworkers full pay

The use of zero-hours employment contracts in homecare is largely a consequence of the fact that public authorities commission and purchase care using zero-hour contracts. Social workers tailor care plans to the needs of the people supported in their own homes; this will involve a pattern of visits at different times of the day.

Councils and NHS commissioners purchase care by the minute or hour at low hourly rates, often below the cost of delivery of safe, quality, sustainable care. Private individuals typically pay fee rates that cover the costs of compliance.

Many public authority commissioners contract with large numbers of providers on framework agreements. This means local authorities and the NHS do not guarantee providers hours of work, and many providers have low volumes of hours.

When a larger provider has a reliable, higher volume of work in a locality, such as 2000+ hours per week, they can schedule efficient 'runs' of visits and guarantee careworkers' hours. In many regions, zero-hour commissioning practices coupled with hyper-fragmentation of hours make this impossible.

Start-ups, small providers and specialist providers do not always have the volume of work to guarantee hours. This can mean that a careworker's hours are very dependent on the specific needs of the people they are working with. If a person changes care provider, moves into a care home, goes to hospital or passes away, then a small or specialist care provider may not immediately have replacement work that matches that careworker's specialist skills and availability. This means it is challenging to offer guaranteed hours.

Care rotas for careworkers in the community can change at the last minute, even for large providers. This is because of factors including hospital admissions and discharges, deaths, colleagues being unwell, traffic and travel disruption, car breakdowns, needing to wait with ambulances or having to provide additional support when someone becomes unexpectedly unwell. Most providers have some staff available who can substitute in emergencies; however, some rota change is inevitable. Public commissioners rarely provide funding to account for these factors.

Inconsistent commissioning means many providers cannot confidently offer guaranteed hours contracts, even if they wish to. This needs to change.

The Employment Rights Bill will:

- Require employers to offer guaranteed hours contracts based on a reference period.
- Potentially require employers to offer work at regular times.
- Mandate compensation for cancelled or rescheduled shifts at short notice.

This represents a major shift for the homecare sector, moving towards a shift-based model that most current commissioning arrangements do not support. Without changes to the way local authorities and NHS bodies commission and contract with homecare providers, employers, especially smaller and specialist services, face significant cost increases and operational challenges.

To understand how providers are managing this balance between contractual security and flexibility, and what might need to change, we asked our members how frequently they use zero-hours contracts, why they use them and how often rotas change at short notice.

Most respondents (78%) said they offer zero-hour contracts, while two-thirds (66%) also offer guaranteed hours contracts – often using both side-by-side (Figure 23). Many explained that this mix reflects the diverse preferences of careworkers themselves. Some seek the security of a minimum guaranteed hours contract, while others prefer the flexibility of zero-hours arrangements.

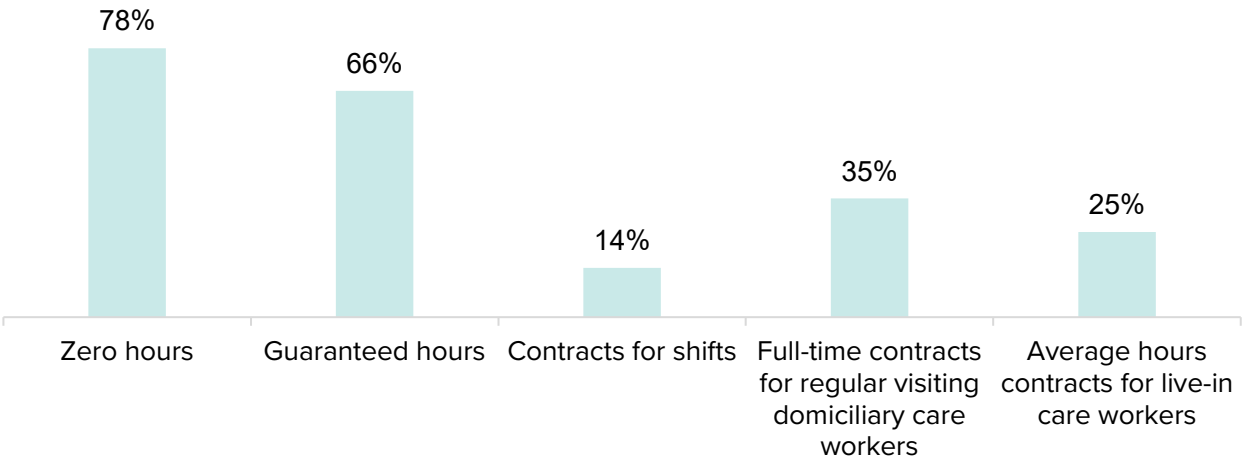


Figure 23: Which types of employment contract do you currently offer? (tick all that apply) (n=371)

As our members told us:

> *"We offer block contracts and contracted hours at 6 months based on hours worked over that period. We offer guaranteed hours contracts."*

"Guaranteed hours are not that popular with the team we have. Most want zero-hours contracts as they have control."

Where providers do offer guaranteed hours contracts, the minimum typically starts at 15-19 hours per week (20%), followed by 10-14 hours (17%) (Figure 24). A smaller share offer very low guarantees (1-6 hours per week), which again could reflect the demand for flexibility among some careworkers as well as business needs.

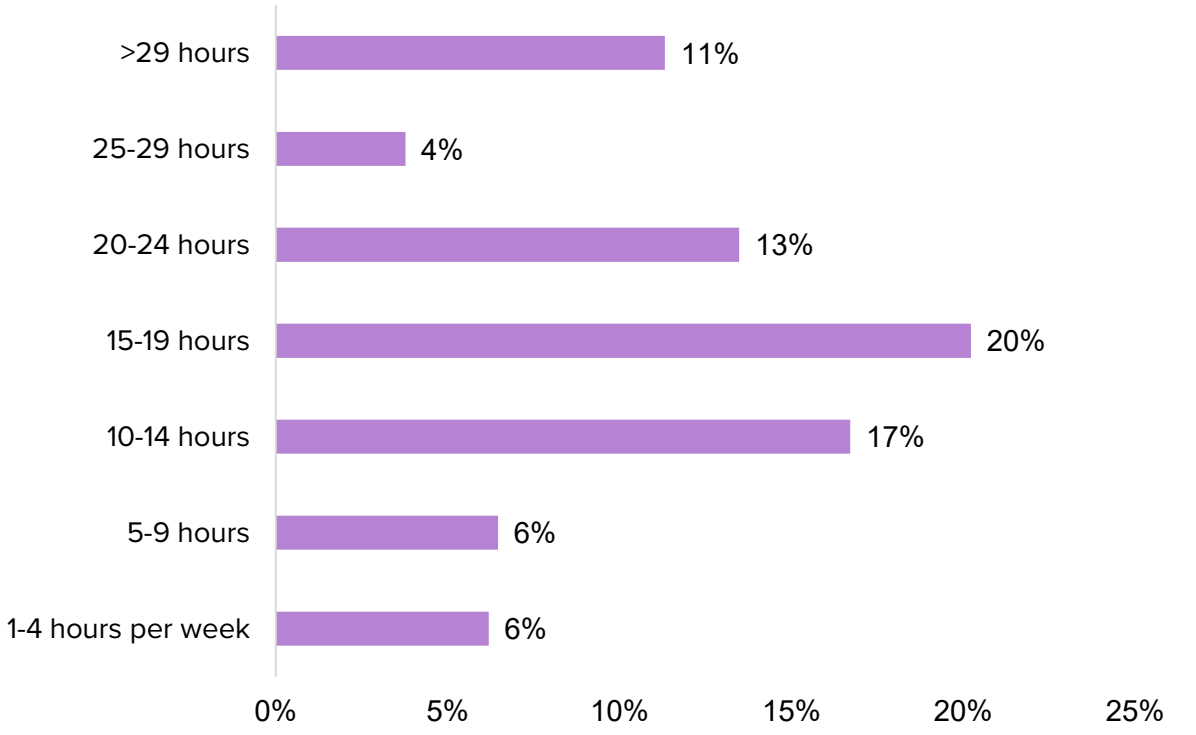


Figure 24: What is the minimum guaranteed hours contract you offer careworkers today? (n=371)

Scheduling also shows flexibility.

40% of providers reported changing careworkers' schedules on a weekly basis, with 12% doing so multiple times a week and 4% daily (Figure 25).

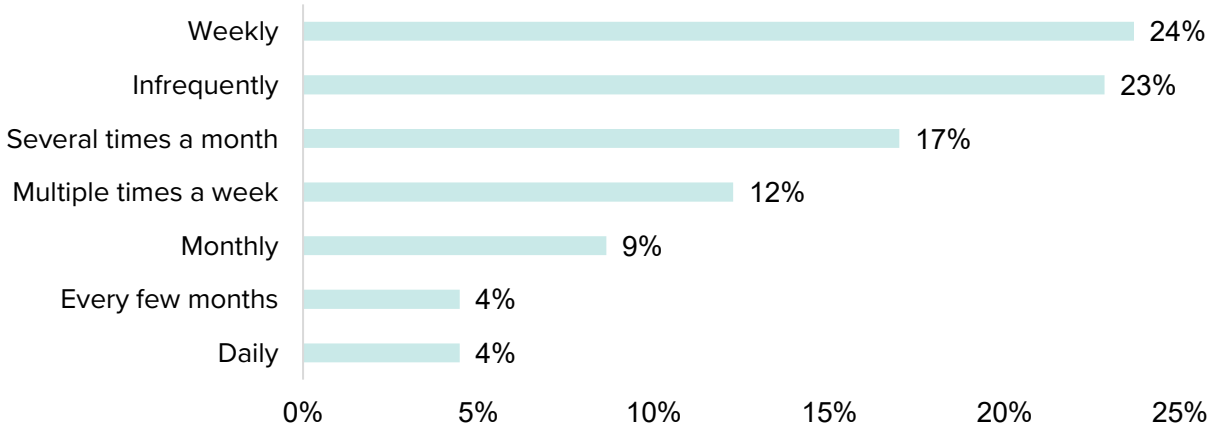


Figure 25: How frequently do you typically change a careworkers working hours at the moment? (n=359)

Hospital admissions were the most frequent cause of cancellations of careworker shifts, with 48% of providers reporting this happened ‘often’ or ‘very often’ (Figure 26). Other causes included deaths of clients, traffic and travel disruption or unexpected changes in a client’s condition. This reflects the very real nature of caring for people whose health needs are often complex and unpredictable.

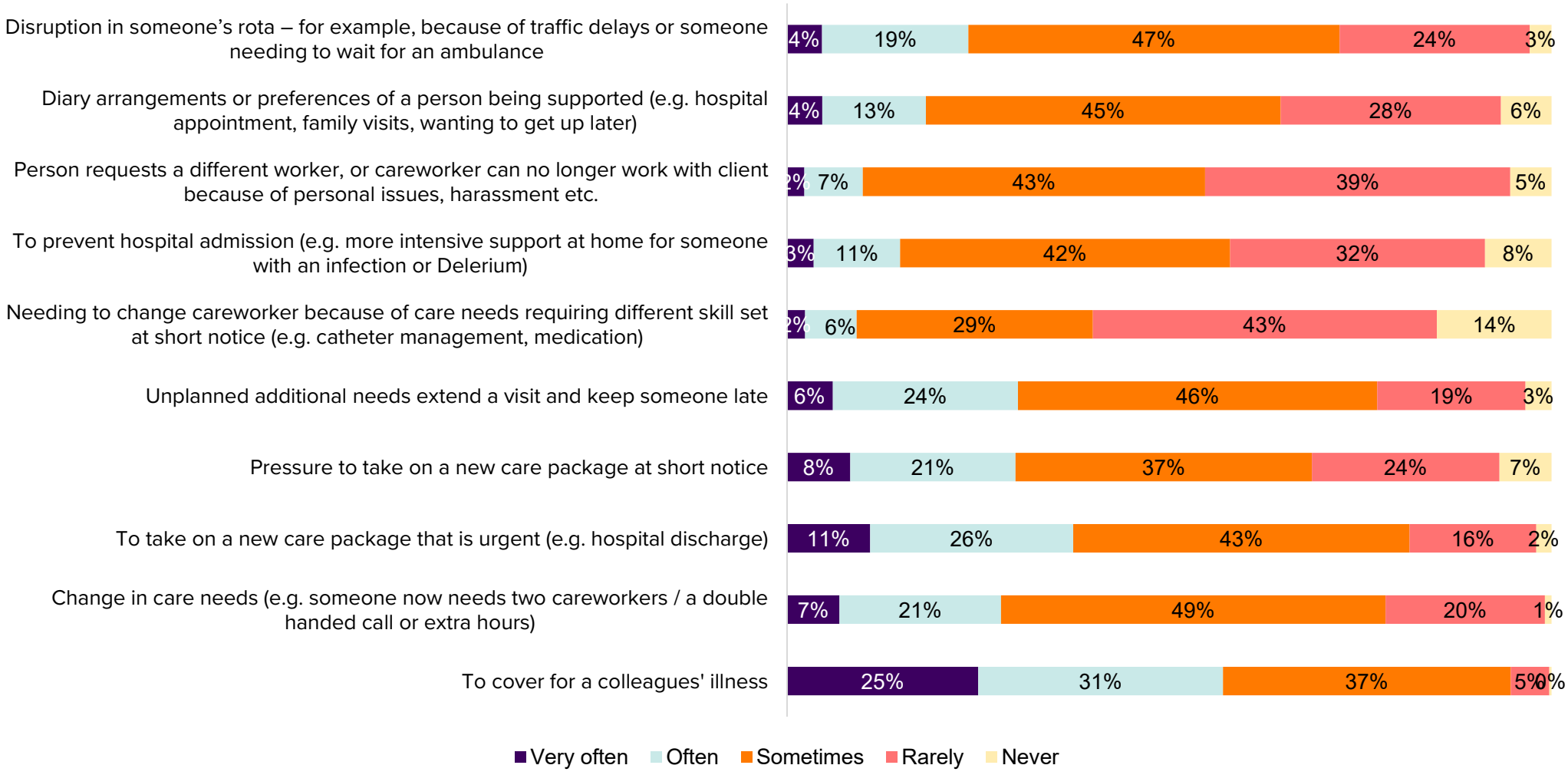


Figure 26: Thinking about changing careworkers' hours at short notice - how frequently do the following reasons apply? (n=369)

Payment practices for cancelled visits varied sharply depending on who funded the care. While 87% of providers said they received payment when visits are cancelled at short notice from people who pay privately, only 43% of those working with local authorities, and 29% with the NHS said the same (Figure 27).

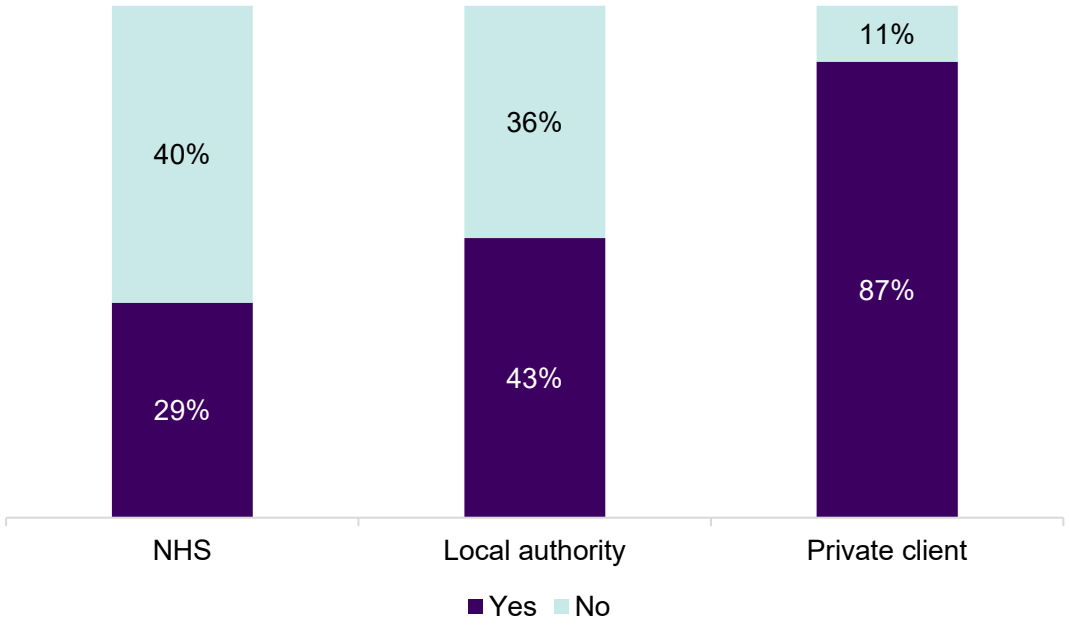


Figure 27: As a business, are you paid where the person cancels care calls at short notice? (n=364)

Despite this, 75% of providers told us they always pay their careworkers if a visit is cancelled, absorbing the financial risk on behalf of their staff (Figure 28). This difference will become increasingly important if the Government legislates for care companies to pay their staff for cancelled visits. In order to operate sustainably, it is vital that more public sector purchasers of care pay cancellation fees.

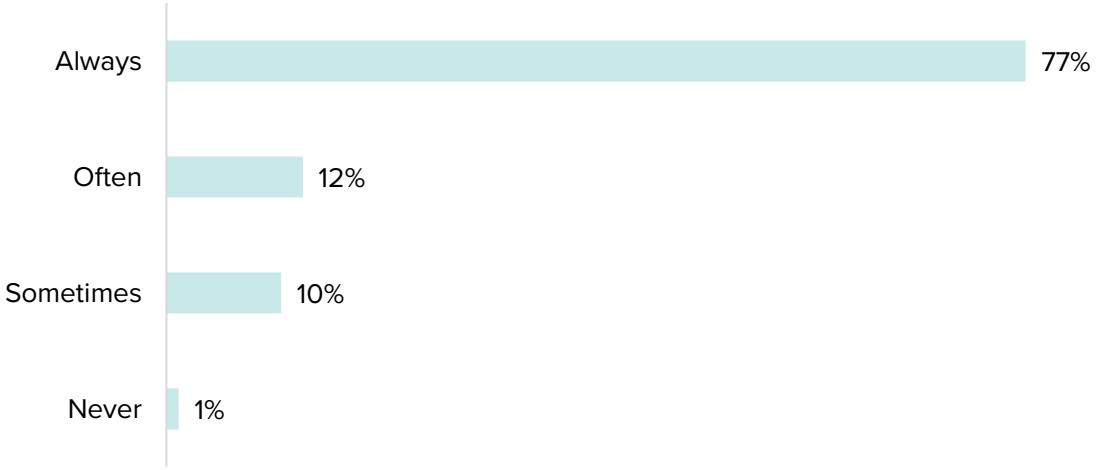


Figure 28: Do you currently pay your careworkers if a visit is cancelled at short notice? (n=371)

A similar pattern emerged with hospital admissions. Over half (57%) of providers delivering NHS-funded care said they receive no payment to hold a care package open when a client is in hospital (Figure 29). By contrast, people who pay for their care were far more likely to pay to reserve their care arrangements for a week or more.

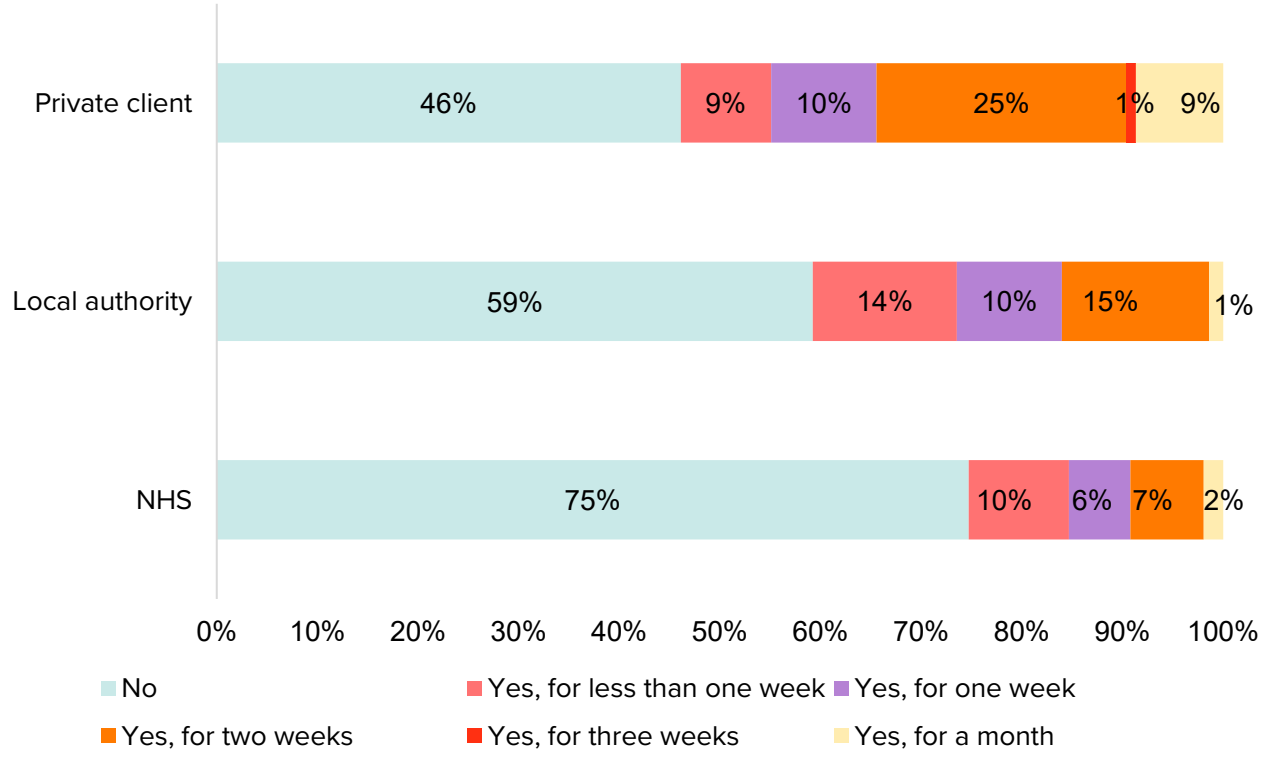


Figure 29: As a business, are you paid to hold someone's care arrangements open when someone is in hospital? (n=364)

We know from speaking to providers in other contexts that payment arrangements between commissioners and providers have a direct impact on frontline staff. When local authorities or the NHS refuse to pay for short-notice cancellations or to hold care packages open during hospital admissions, providers often cannot absorb the loss. This creates risks, including:

- **Income insecurity for staff.** Careworkers may find shifts cancelled at short notice, with fewer paid hours than expected.
- **Inconsistent rotas.** Frequent changes disrupt staff work-life balance, especially for those with caring responsibilities of their own.
- **Morale and retention.** Unpredictable pay and schedules make care roles less attractive compared to other sectors, contributing to high turnover.

Although many respondents pay staff even when commissioners do not reimburse them (see Figures 27 and 28), our work suggests[33] that fee rates in the sector are very low and

[33] Homecare Association (2025) Fee rates for State Funded Homecare in 2025-26

providers do not have the margins to absorb this in the long-term. Unless local authorities and the NHS reform payment practices, the burden of risk will continue to fall on both providers and their workforce. In most economic sectors, the business would have the power to negotiate cancellation fees or charge higher rates so that they have the margins to absorb cancellation costs, but care providers are struggling to negotiate either of these with public sector purchasers at present.

Sick pay

97% of respondents pay staff only Statutory Sick Pay (SSP) when they are off sick. 3% pay more than Statutory Sick Pay but not full pay. 1% pay full pay.

Why sick pay matters?

Sick pay is an important part of fair and safe employment. For careworkers, it not only provides financial security but also protects the people they support. Without proper cover, staff may feel forced to work while ill, risking the spread of infection and reducing the quality of care.

Government changes to sick pay

As part of the Employment Rights Bill, the Government has announced two key changes to Statutory Sick Pay, due to take effect in April 2026:

- Removal of the current four-day waiting period, so employers pay Statutory Sick Pay from the first day of absence.
- Removal of the Lower Earnings Limit (currently £125 per week), so people who are below this limit can claim 80% of their earnings, or the flat rate (currently £118.75), whichever is lower.

These changes will disproportionately affect the homecare sector because of the combination of low pay and high part-time working, both shaped by commissioning practices.

Public bodies frequently purchase homecare at rates below the actual cost of delivery. For example, in 2025 the average public sector fee rate for an hour of care rose by just 5.6%, while providers' costs increased by 10–12%. This left an average rate of £24.10 per hour, compared to our calculated minimum of £32.14 needed to meet all statutory and regulatory requirements[34]. With margins squeezed so tightly, most providers can only afford to pay staff the statutory minimum for sick pay.

The sector's workforce profile is important too. Skills for Care estimates that 46% of the homecare workforce employed by independent organisations work part-time[35], significantly

[34] Homecare Association (2023) Homecare Deficit

[35] Skills for Care (2024) The State of the Adult Social Care Sector and Workforce in England

higher than in care homes. This means the removal of the lower earnings limit will directly affect a larger proportion of careworkers, bringing more staff into scope for sick pay but also adding to provider costs.

Current practice

Our survey found that 97% of providers pay only Statutory Sick Pay. With just 3% offering more (Figure 30).

This was consistent across providers working mainly with councils/NHS and those serving self-funding clients. The reliance on SSP reflects financial constraints: most providers operate on contracts priced well below the true cost of care. In 2025, average public sector fee rates rose by 5.6% against cost increases of 10–12%, leaving providers unable to fund enhanced benefits.

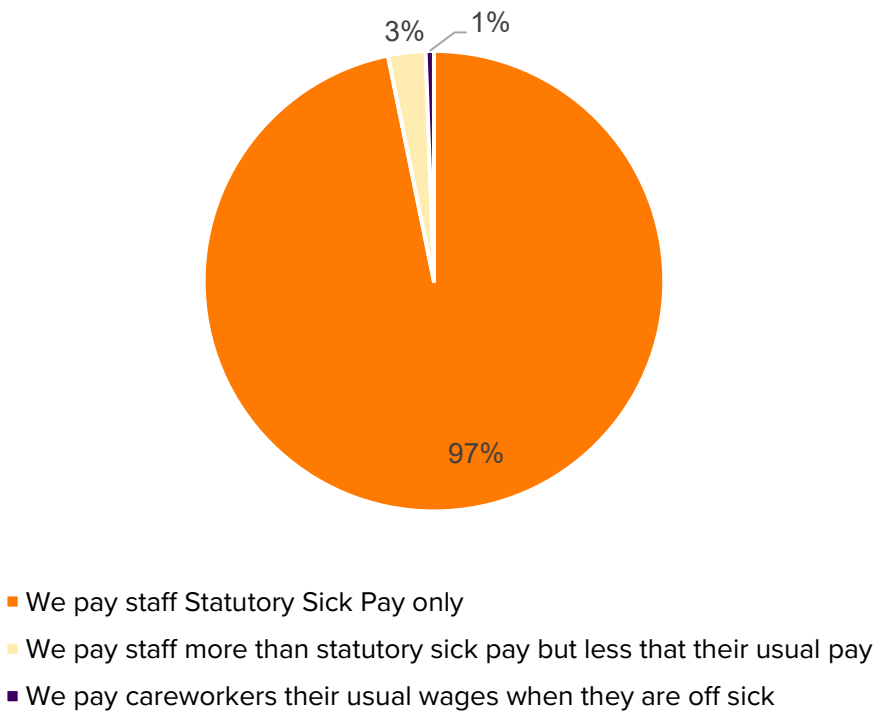


Figure 30: Do you pay staff only Statutory Sick Pay or do you have occupational sick pay? (n=244)

Cost impact of reforms to sick pay

When asked about the likely financial impact of SSP changes (Figure 31):

- A third of respondents estimated an additional cost of 26p more per hour of care delivered.
- Half expected the costs to rise by 10p-25p per hour.
- Only 16% expected a cost of 10p per hour or less.

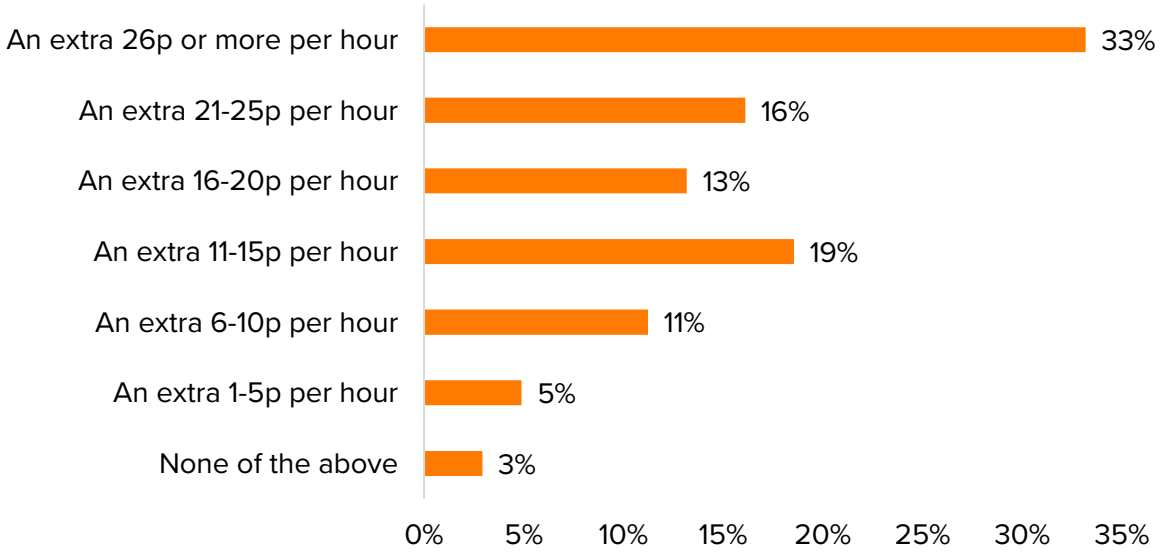


Figure 31: If careworkers were eligible to claim Statutory Sick Pay from day 1, what do you estimate would be the additional cost per hour of care delivered? (n=205)

If the Government removes the lower earnings limit, 28% of providers said more than 20% of their workforce would become newly eligible for SSP; a further 60% said eligibility would expand by 1–20% (Figure 32).

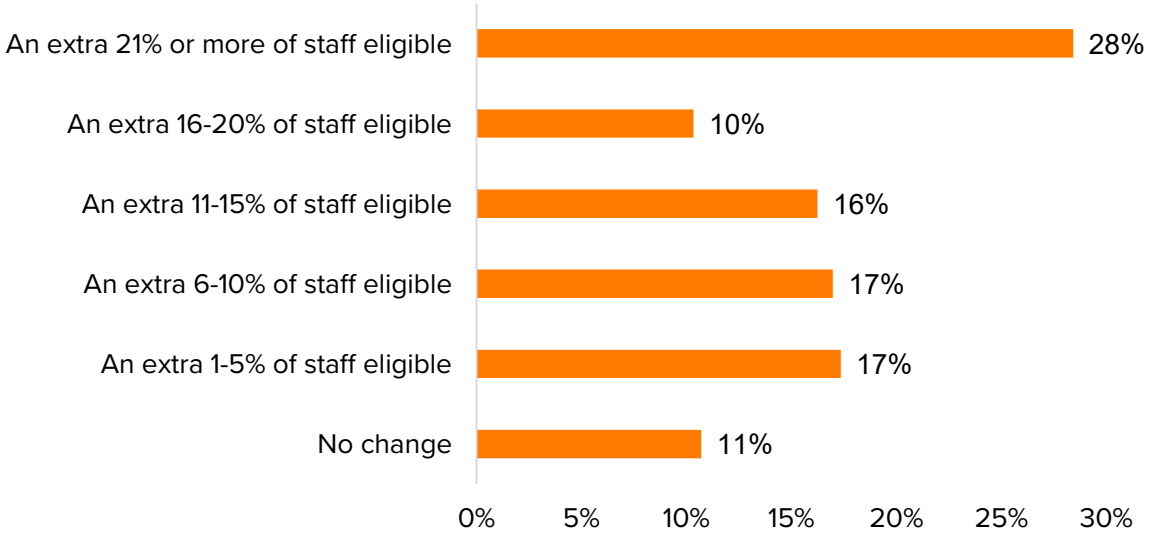


Figure 32: If the Government removes the requirement for an employee to earn at least £125 per week to be eligible for Statutory Sick Pay, what percentage of your careworkers would then be eligible to claim Statutory Sick Pay who were not eligible previously? (n=271)

Expected workforce effects

Most providers expect higher rates of sick leave once SSP is available from day one. Over half (52%) expect absence rates to rise by more than 10%, with only 9% expecting no change (Figure 33).

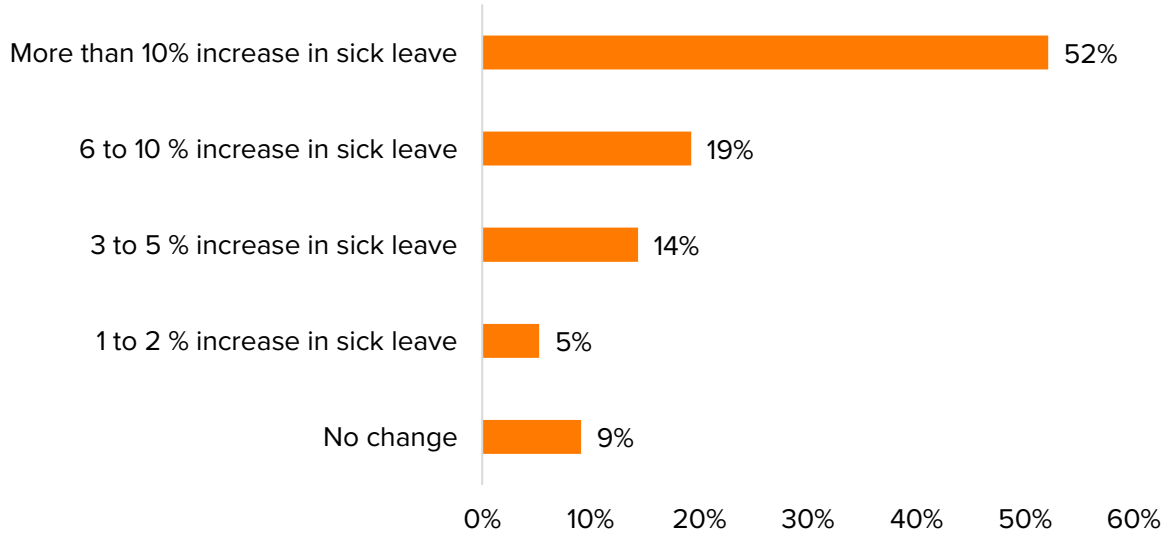


Figure 33: How much do you expect sick leave rates to change if careworkers have Statutory Sick Pay from day 1 and the lower earnings threshold is removed? (n=286)

Implications of changes to sick pay

These reforms are positive for workers' rights and for infection control, but they will bring significant extra costs to providers. Without matching increases in funding, most providers will continue to offer only the statutory minimum, and many will struggle to absorb the impact of higher absence rates.

Employers cannot deliver fair sick pay in isolation. To make these reforms sustainable, the Government must ensure commissioning covers the real cost of homecare, including proper sick pay, so that limited sick pay does not force staff to choose between their health and their income, and providers can offer safe, high-quality care.

Trade Unions

12% of respondents report that there are unions active in their workplace. 6% had a formally recognised union operating.

The Employment Rights Bill will bring major changes to how trade unions operate, including:

- Employers must inform employees of their right to join a trade union
- Unions will be able to request an access agreement in order to access premises or use electronic systems to facilitate meetings with staff, organise, represent and negotiate collective agreements.
- It will be easier for trade unions to become recognised (allowing them to represent workers in collective bargaining, among other things).
- There will be changes around the legislation relating to industrial action.

- There will be additional protection for union representatives.

Unions will also play a central role in the new Adult Social Care Negotiating Body, which will negotiate a Fair Pay Agreement. Yet union membership in social care is low: the Resolution Foundation[36] estimates just 15% of careworkers employed by private organisations are union members (20% including public sector workers). Our own survey suggests the figure may be even lower; however, it is possible that some careworkers are union members without their employer being aware of this.

Union presence today

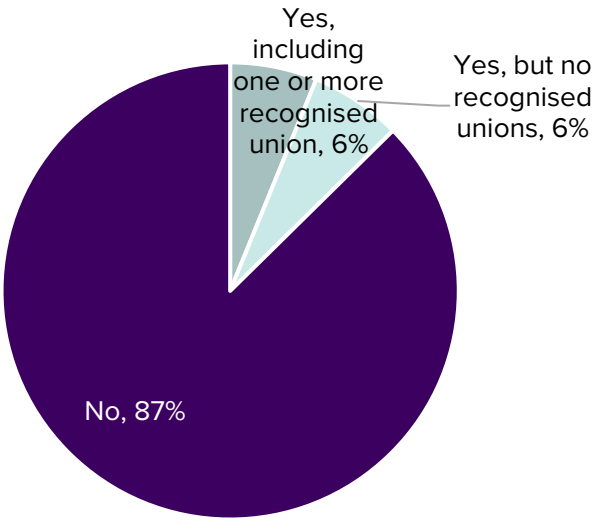


Figure 34: Are Unions currently active in your workplace? (n=309)

Only 12% of respondents said unions were active in their workplace, with half of these formally recognised (Figure 34).

Union activity was more common among organisations working mainly with public sector commissioners (19%) than those serving people self-funding their care (9%). We think this may be because of staff transfers under TUPE.

Employer experiences

We asked respondents about their experience of union activity in their workplaces[37]. For many providers, their only experience was of union representatives accompanying staff to disciplinary meetings. Some described positive relationships, while others found unions to be aggressive, threatening or overly focused on recruiting members. Experiences often depended on the individual representative.

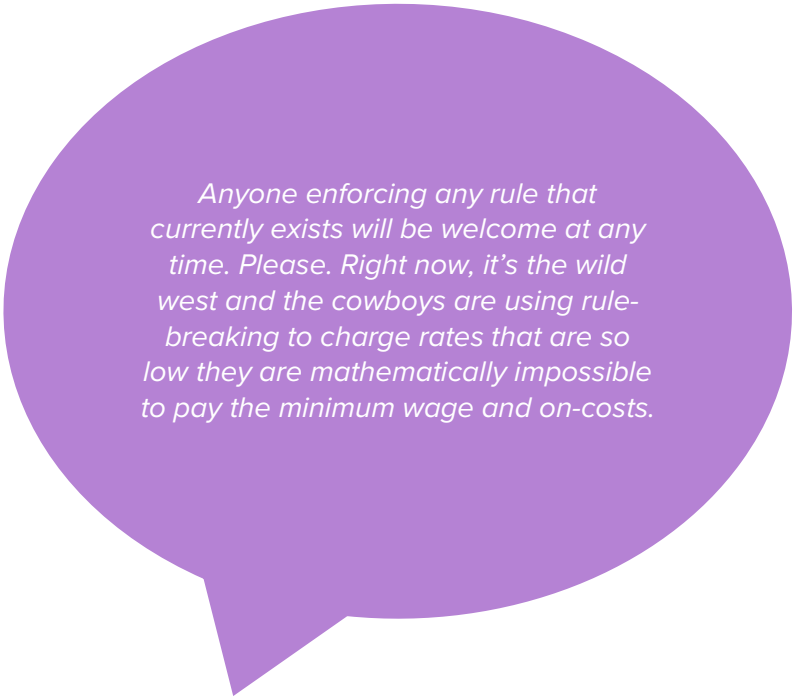
[36] Resolution Foundation (2023) Who cares?

[37] We asked: "Are unions currently active in your workplace? If yes, can you tell us about your experience?" We received 25 responses.

Respondents raised concerns that union officials did not always understand the funding, commissioning or business realities, though some had worked with unions to build that understanding. A couple noted unions were working with sponsored workers.

Attitudes to greater union access

Asked about the Bill's new access provisions[38], one third of respondents said they had no concerns and welcomed the change.



However, around half raised some concerns. The main issues were:

- Data protection and compliance if unions had access to premises or IT systems.
- Lack of HR capacity in small businesses to manage union engagement.
- Potential cost and time burdens, given already precarious finances. Fears that union involvement might disrupt workplace culture or reduce flexibility.
- Perceptions that their workforce had shown little interest in union membership.
- Concern that unions do not always understand commissioning or operational realities.

Some also pointed to wider policy tensions. In England, Unison's Ethical Care Charter was criticised for being awarded to councils that were not themselves acting ethically. In Wales,

[38] We asked "Do you have any thoughts or concerns about greater union access to your workforce?" We received 163 responses.

employers highlighted difficulties partnering with unions after the Trades Union Congress called for an end to commissioning for-profit providers in adult social care.

Collective agreements

Formal agreements are rare. Just 8% of respondents reported having a collective agreement in place, half of these as a legacy of TUPE transfers (Figure 35). A small number reported positive partnership agreements with specific unions.

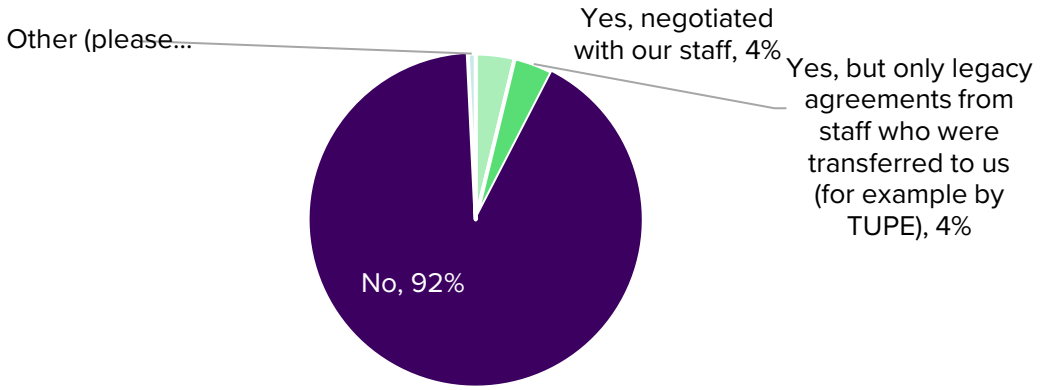
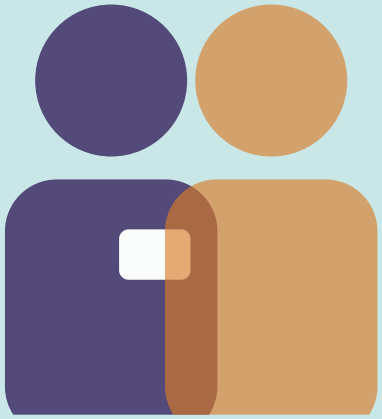


Figure 35: Do you currently have in place any collective agreements? (n=264)



Delivering services

Delivering services - findings

Demand

37% respondents said they had not met the demand for care in their area. 70% of those reported this is because they cannot recruit enough new careworkers.

Demand for care is about whether there are care services available when people want or need care. Availability of services depends on care providers having the staff and resources to take on more care.

If demand for care goes up and providers can't meet it, they may look to expand their business by recruiting staff. They are then able to meet demand. If they cannot expand their business (for example, due to staff shortages) and if this affects a whole area rather than a single business, this can be critical. It means that services cannot respond, and people go without support, families shoulder additional pressure, and the wider health and care system suffers. Delays in hospital discharge and increased emergency admissions are some of the visible consequences of this.

On the other hand, if demand for care goes down, then providers will find that they have staff who they do not have work for. Competition with other care providers will increase, and they may need to lower prices and reduce their business size, often by reducing staff numbers.

In our 2025 Workforce Survey, two-thirds of respondents said they were able to meet the demand for care, while just over a third could not. In 2024, only 52% reported being able to meet demand (Figure 36).

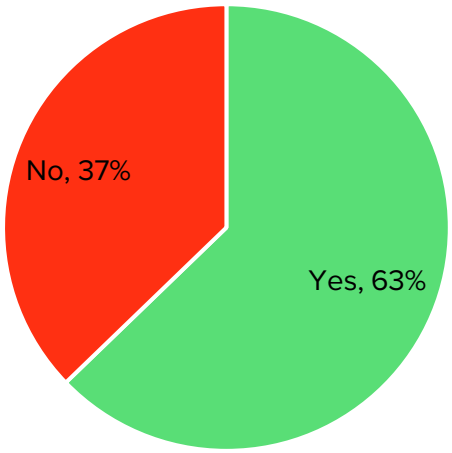


Figure 36: Have you been able to meet the demand for care? (n=352)

Capacity to meet demand varied depending on the balance of work:

- **Public sector providers (71%):** were most likely to say they could meet demand.
- **Private-pay providers (60%)** also reported a relatively high ability to meet demand.
- **Mixed providers (44%) -** working across both – were least likely to be able to meet demand.

While our survey responses do not give a full explanatory context for this, we are aware of some relevant factors from our other work, including:

- Some local authorities operating framework agreements opened those agreements to a large number of providers in 2022 during the last serious staff shortages. This has meant that providers working on framework agreement contracts in some parts of the country are seeing greater competition for work and local authorities and the NHS offer them fewer hours than they would like – effectively reducing demand for those who do a lot of public sector work.
- Local authorities have issued fewer direct payments in recent years, and they have reduced some direct payment rates (or at least not increased them to match inflation). This means that some predominantly private-pay providers have lost direct payment work, effectively reducing demand.
- Mixed providers are more likely to get enquiries about care from more sources, which may mean that they report higher demand.

Issues with too much capacity

Among those able to meet demand, around three-fifths said they had about the right level of capacity. However, around a quarter reported having too much capacity, meaning they struggled to give careworkers sufficient hours (Figure 37). This was particularly the case for public sector providers (29%) compared to private pay providers (22%).

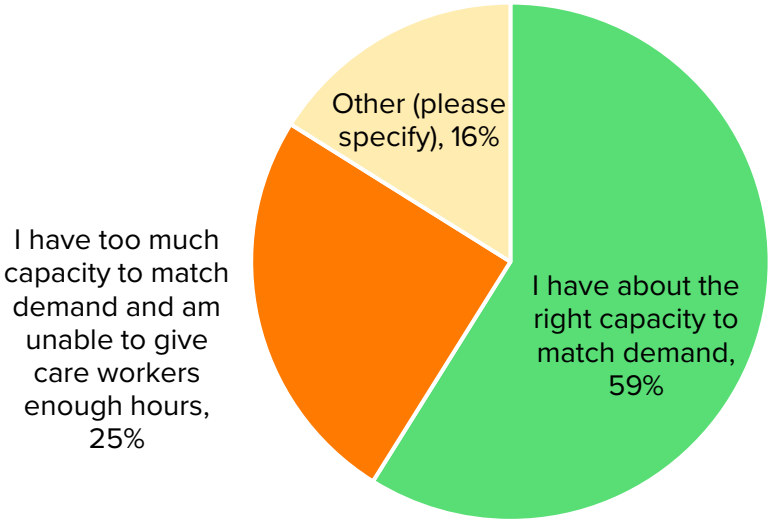


Figure 37: Have you been able to meet the demand for care? If yes: (n=251)

This reflects a fundamental reality in homecare: demand is rarely smooth. Providers often face peaks in the mornings, evenings and weekends, which do not align neatly with staff availability or careworker preferences. Some providers noted demand shifting to other models such as live-in care.

"Although I said NO above (because this is my biggest issue), please note that "I have too much capacity to match demand and am unable to give careworkers enough hours" is ALSO true: I have some carers who desperately want more hours. But I can't give them any because I am at full capacity of the availability of the team at peak hours (e.g. mornings/evenings/weekends) and this prevents me taking on more clients (which in turn might give us opportunities to fill gaps in rotas for those that want more work. This is a common problem I think, but one that it seems people away from the front line really struggle to understand. And none have a plausible solution to fix it."

Providers unable to meet demand

Among the 211 respondents unable to meet demand, the overwhelming reason was workforce shortages. 70% cited difficulty recruiting enough careworkers (Figure 38). Existing staff leaving and uncompetitive fee rates were the next most common reasons, echoing findings from last year. These were similar across all regions of England.

Figure 38: Have you been able to meet the demand for care? If no: (n=211)

Other barriers included:

- That some private pay clients were only willing to pay £20 per hour for care, or that direct payment rates had reduced, meaning demand was not financially viable.
- Lack of weekend staff or lack of car drivers or careworkers who are not able to work the hours required.
- Due to delays in CQC inspection.
- They anticipate they will not be able to meet demand when they can no longer recruit internationally.
- There are too many providers on the local authority framework agreement.
- That the visits being commissioned by local authorities and the NHS were too short.
- Difficulties with recruiting care coordinators.

A note on unregulated care

While not captured in this survey question, we are hearing increasing concerns from homecare providers about the unregulated care market and personal assistant roles.

Disabled people originally campaigned for access to personal budgets to become direct employers for choice and control reasons. It is important that choice and control is upheld and that people have the option to become direct employers if they want to.

However, this must be an informed decision and not pursued for cost saving reasons. Becoming an employer is a significant responsibility, one that takes time to understand.

We are concerned that some introductory services are advertising care services from 'self-employed' careworkers in order to offer lower costs. People purchasing services may not understand the difference between this and regulated services. They may also not understand that something advertised as 'self-employed' could, from a tax and employment law perspective, actually make them an employer.

Regulated care is becoming more expensive due to increased wage requirements, national insurance contributions and other costs. This will get worse with the Fair Pay Agreement and Employment Rights Bill. More people looking to purchase care may look to cheaper options; without necessarily knowing the consequences.

We have also heard of local authorities actively directing people towards this unregulated space as a way of meeting demand while reducing costs.

Self-employed personal assistants do not have the training, supervision or safeguarding support that employees have. They may not be paid Statutory Sick Pay or receive other support that would be available from an employer. People using unregulated services also have no recourse to raise concerns with a care regulator if something goes wrong and may struggle to arrange cover for sick leave, holidays etc.

There is a risk that this will create a two-tier system: regulated providers under financial and workforce pressure, and an expanding, unregulated market that places people and 'self-employed' careworkers at risk.

We believe that there is a need to:

1. Ensure that personal assistants are registered so that there is greater oversight of this sector.
2. Access to clear guidance for local authorities on appropriate use of personal assistants.
3. For the CQC to regulate agencies that introduce people to careworkers.
4. To ensure that the public understand the different types of care available and what regulated care offers that personal assistants do not so that they can make informed decisions.

Delegated Healthcare tasks

70% of respondents have careworkers undertaking delegated healthcare tasks.

Delegated healthcare tasks[39] are clinical tasks, such as checking someone's blood pressure, administering insulin or catheter care. A nurse would usually undertake these tasks but can delegate them to a careworker provided the careworker has their competency signed-off by a registered professional to perform that task for that specific person. This includes ensuring appropriate clinical oversight, so that if something does not seem quite right, the careworker knows who to contact. Done well, delegation can help people stay at home, reduce pressure on the NHS, and make best use of professional skills. But without proper training, support, and funding, it risks overloading careworkers, undermining safety, and creating hidden pressures in the system.

Policy context

In January 2025, the Secretary of State for Health and Social Care announced the establishment of the Casey Commission to recommend reforms to social care. In the same speech[40], he outlined immediate planned changes to improve social care over the next year, including supporting careworkers to undertake more delegated healthcare activities. The NHS 10-year plan[41] re-iterated this ambition, stating, "we will work with social care organisations to enable care professionals to carry out more healthcare activities".

The direction of travel is clear, but there are significant concerns that the Government is planning to intensify the responsibilities of careworkers without matched funding, training or clinical oversight.

What providers told us

Our 2025 Workforce Survey found that 70% of providers already support careworkers to undertake delegated healthcare tasks (Figure 39).

[39] Skills for Care (2025) Delegated Healthcare Activities

[40] Department of Health and Social Care (2025) New reforms and independent commission to transform social care

[41] Department of Health and Social Care (2025) Fit for the future: 10 Year Health Plan for England

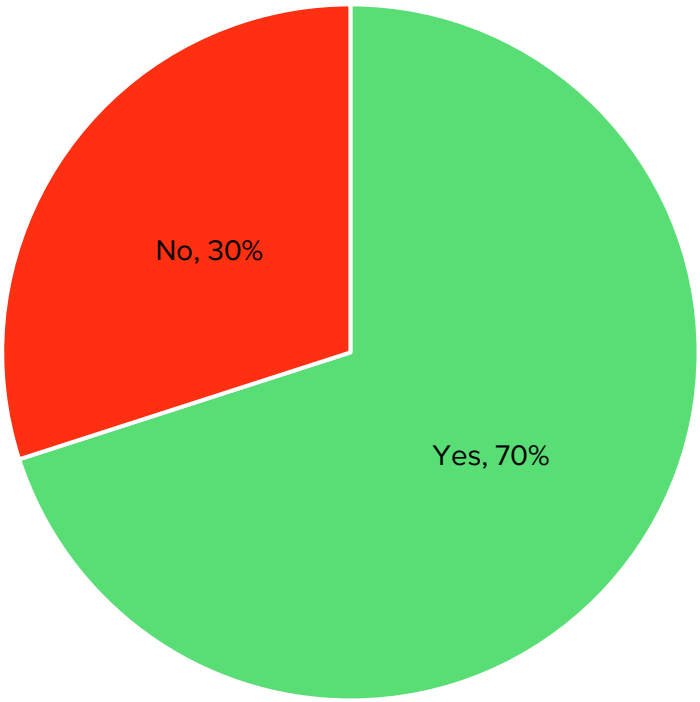


Figure 39: Do your staff undertake delegated healthcare tasks that would otherwise be carried out by a registered health professional (e.g. diabetes management, catheter care)? (n=327)

Yet the infrastructure around delegation is weak:

- **Lack of clinical support:** 65% of respondents said NHS staff do not provide appropriate ongoing support (Figure 40).
- **Difficulty securing sign-off:** 80% of respondents said it was not easy to find registered NHS staff to sign off staff competency for delegated healthcare tasks.
- **Limited in-house capacity:** 65% of respondents said they do not employ a nurse in-house or hold a Treatment of Disease, Disorder or Injury (TDDI) registration.
- **Pay and funding gap:** 59% of respondents said they do not pay careworkers more for delegated healthcare tasks, and 74% said their organisation is not paid more to deliver them. This means that only around one in eight (12%) care providers are paying workers more to undertake delegated healthcare tasks **despite not receiving any additional income themselves to cover this**.

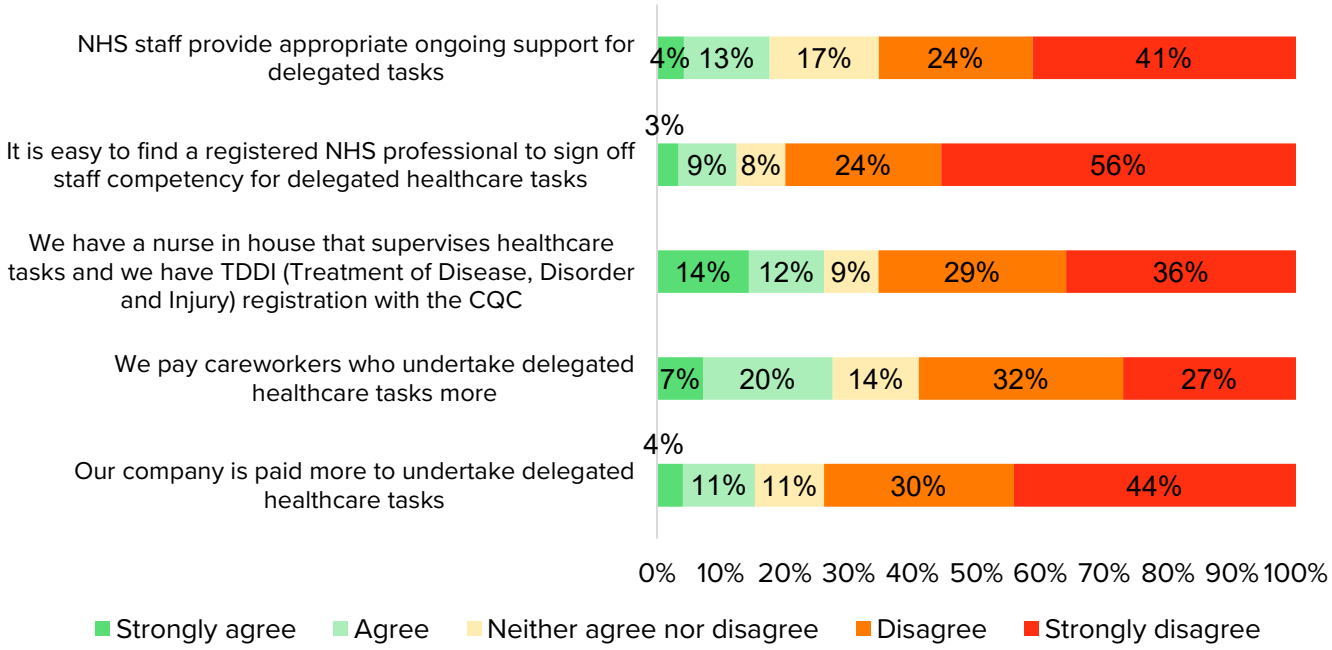


Figure 40: Which of the following statements do you agree with? (n=236)

Delegation can bring benefits for people with care and support needs and the wider health system, but at present it is happening at scale without the safeguards needed to make it safe or sustainable. Careworkers are being asked to take on tasks that are more complex and more stressful, often without fair pay, structured training, or clear accountability. The health service then leaves providers to absorb the risk, funding gap, and liability.

If the Government wants careworkers to play a bigger role in delivering healthcare, it must:

- Ensure consistent NHS support and clinical oversight.
- Provide funding that reflects the additional responsibilities.
- Recognise delegated healthcare tasks in pay and career development structures.

Unregulated care

8% of respondents provided unregulated personal care via introductory agencies (as well as regulated homecare)

Why it matters

Unregulated care is a growing concern for many of our members. Unlike CQC-registered providers, personal assistants (PAs) and introductory agencies often operate outside formal regulation. This creates multiple risks including that people may receive care without proper safeguards; people may struggle to get cover for care when their main careworker is off sick

or on holiday; workers may not have training, safety assessments or managerial support at work; and operating models with low compliance costs undercut responsible providers. Together, these factors could threaten both public safety and the sustainability of regulated services. Some introductory agencies advertise that they monitor and manage care delivery like a CQC-registered homecare provider. Whilst quality and safety may not be an issue in such cases, the regulations are clear that managed services require registration. Operating managed services without registration is unlawful, and when the CQC overlooks this, it creates an unfair advantage to companies that do not bear the costs of regulation. Some local authorities promoting unregulated care also oversee and manage delivery of care by individual workers, for example, finding sickness cover and coordinating complex care packages. Such activities require registration, and unlawful exploitation of legal loopholes to cut costs makes it hard for registered providers to compete.

Personal Assistants

Skills for Care[42] estimates there are 123,000 personal assistants working for people who receive Direct Payments, with an unknown number also employed privately. In most cases the supported person is the legal employer of their own personal assistants. However, we are aware of a rise in so-called 'self-employed' personal assistants. The legal tests for self-employment are difficult to meet in care, where people expect continuity of care and direct accountability. These leave workers and clients in a legally grey area, with risks around tax, employment rights and safeguarding.

Introductory agencies

Introductory agencies are organisations that help people to recruit a personal assistant. This is legal and in line with the original Direct Payment policy intention if the person recruiting goes on to directly employ the personal assistant. If there is ongoing management or supervision from the introductory agency, including support to arrange cover when there are absences, it means the agency is crossing the line into delivering homecare services, and the CQC should regulate them.

Market dynamics

While national data show the number of Direct Payment users[43] has decreased by 10,000 since prior to the pandemic, with many facing the same recruitment challenges as regulated providers, some councils are promoting unregulated models of care. In East Sussex[44], a council-promoted scheme organising self-employed personal assistants had to close after raising serious tax liability questions for people receiving support.

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[42] Skills for Care (2024) The State of the Adult Social Care Sector and Workforce in England

[43] Skills for Care (2024) The State of the Adult Social Care Sector and Workforce in England

[44] Homecare Association (2023) Unregulated Care – blog by Dr Jane Townson OBE

Survey findings

Only a small minority of respondents (8%) reported offering unregulated personal care through introductory agencies alongside their regulated services (Figure 41). Please note that organisations that only provide introductory services are not permitted to apply for Homecare Association membership, so this is not representative of the level of activity in the market in general. There is no register or official list of introductory or employment agencies.

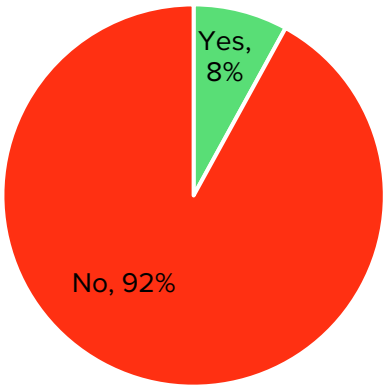

Figure 41: Do you offer unregulated personal care to people who need care and support via an introductory agency, in addition to CQC-registered (or devolved equivalent) personal care? (n=313)

Where respondents offered introductory services, they classified some staff as self-employed, potentially raising legal and safety questions (Figure 42).

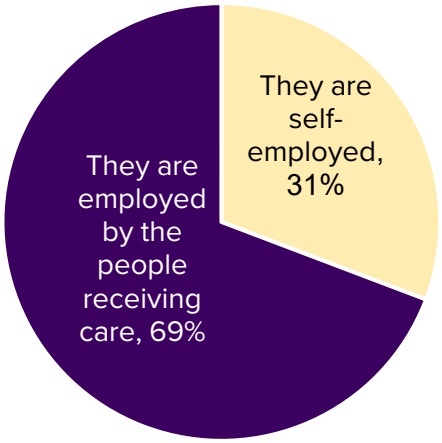

Figure 42: What is the employment status of the careworkers delivering unregulated personal care in your organisation? (n=13)

When asked why they had considered operating as an introductory agency, respondents cited:

- Needing additional revenue to stay in business.
- Being undercut by competitors already using the model.
- Meeting the demand from clients for lower-cost care.
- Offering flexibility to customers.

However, many providers rejected this model on principle, citing:

- Safety concerns and reputational risk.
- Uncertainty over the employment status of “self-employed” careworkers.
- Franchise rules preventing diversification.
- A belief that the Government should regulate all personal care, and providing unregulated care undermined this.

Implications

The evidence suggests that most responsible providers are reluctant to enter the unregulated market, even when financial pressures are severe. Yet they are being undercut by models that carry fewer safeguards and lower costs.

If Government and councils promote unregulated care as a cost-saving measure, they risk:

- Driving more services outside the regulatory framework.
- Exposing vulnerable people to higher safety risks.
- Undermining the viability of regulated providers.
- Undermining the employment status and rights of workers.

Policy must be clear: the Government and local authorities must not deregulate personal care by stealth, particularly when complexity of need is increasing and ministers want careworkers to perform more clinical tasks. Commissioners and regulators need to ensure a level playing field, so that all providers competing in the market meet consistent standards of safety, quality, and employment practice.

Conclusion

Homecare continues to face acute workforce pressures. Vacancies remain high at 9.5%[45], with wide variation in providers' ability to recruit and retain staff. For some, shortages are so severe they cannot meet demand. For others, mismatches between staff availability and peak-time demand leave hours unfilled and staff underemployed. These challenges go beyond numbers; they threaten continuity of care for people, and place additional pressure on families and the NHS.

International recruitment has been an essential lifeline in recent years, but members report widespread cases of sponsored careworkers not receiving enough hours to meet visa conditions. Closing the international recruitment route solves neither exploitation nor provides an alternative solution to workforce shortages. Instead, it risks leaving the regions most reliant on overseas staff, London and the South East, exposed to staff shortages and gaps in provision.

At the same time, uncompetitive wage rates, unsociable hours and insecure contracts drive domestic workforce turnover. A Fair Pay Agreement could help set a foundation for improvement, but it will only succeed if matched by sustainable funding for providers and realistic local authority budgets. Without this, attempts to improve pay and conditions may simply push more careworkers into unregulated parts of the market and providers into further deficit.

Other reforms add to the complexity. Measures in the Employment Rights Bill on sick pay and zero-hours contracts will have a disproportionate impact on homecare, where part-time working is high and personalised care requires frequent rota changes. Delegated healthcare tasks are growing, yet NHS support and funding for training and oversight remain limited. Unregulated models of care also pose new risks, threatening both public safety and the viability of responsible providers.

Our message is clear. The Government must fund, plan for and include social care in reforms from the Fair Pay Agreement to employment rights, and from NHS integration to immigration. Local authority and NHS commissioning practices must evolve to support the Government and the sector's ambition for improved working conditions, sustainable services and high-quality care. Without this, the sector faces an erosion of employment standards, business sustainability, and quality of care driven by government policy decisions. With proper support, homecare can provide rewarding careers and safe, high-quality support for the millions of people who depend on it.

[45] Skills for Care (2025) Monthly tracking – recruitment and retention [figure for July as estimated at 2 Sept 2025]

Appendix 1: Collection method and response rate

We collected responses through a self-selecting online survey of Homecare Association member organisations. The survey ran between 17 June and 22 July 2025. We received and accepted responses from 450 homecare providers across the United Kingdom. The sample related to services delivering care to around 186,674 clients, employing over 135,193 careworkers.

Respondents included small, medium, and large providers. Most businesses (88%) undertook a mix of work across NHS, local authority and private pay. 99% of respondents deliver at least some care to individuals privately purchasing care. We have included detailed data on respondents in Appendix 1.

Data labels on the graphs have usually been rounded to the nearest whole number. Where percentages have been, for example, added or subtracted in the text, we have used exact figures; hence, there may be occasional rounding differences from the graph labels.

With this robust sample, we uncovered several key trends in the homecare sector, starting with the current state of demand and supply.

Appendix 2: Data on respondents

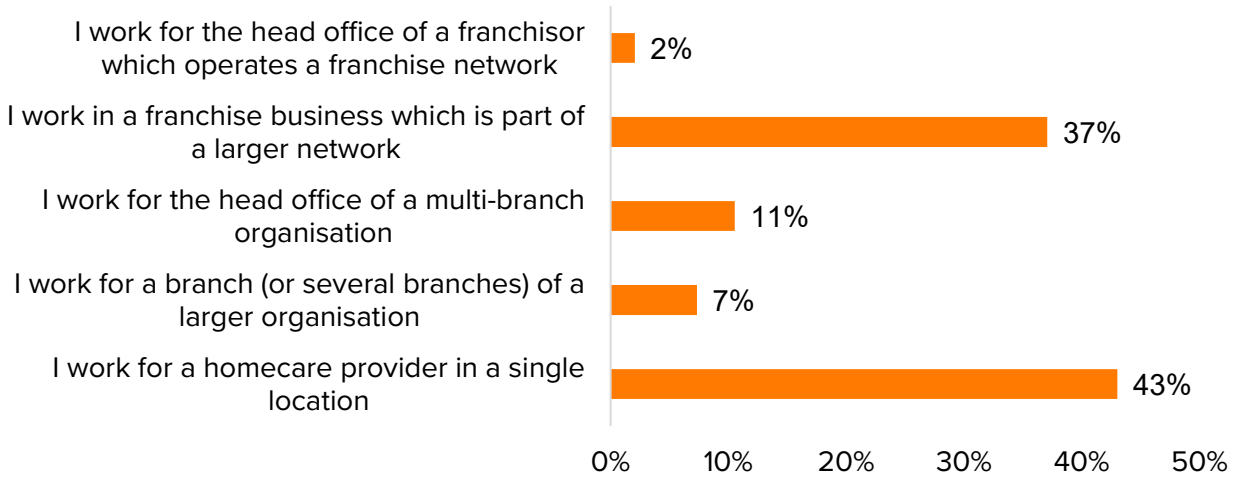

Figure 43: Which of the following best describes your role in the organisation you work for? (Select one) *(n=437)*

Most respondents either worked for a provider in a single location (43%) or for a franchise business (37%) (Figure 43).

A few respondents noted in the comments that they were owners or directors and not workers in their organisations.

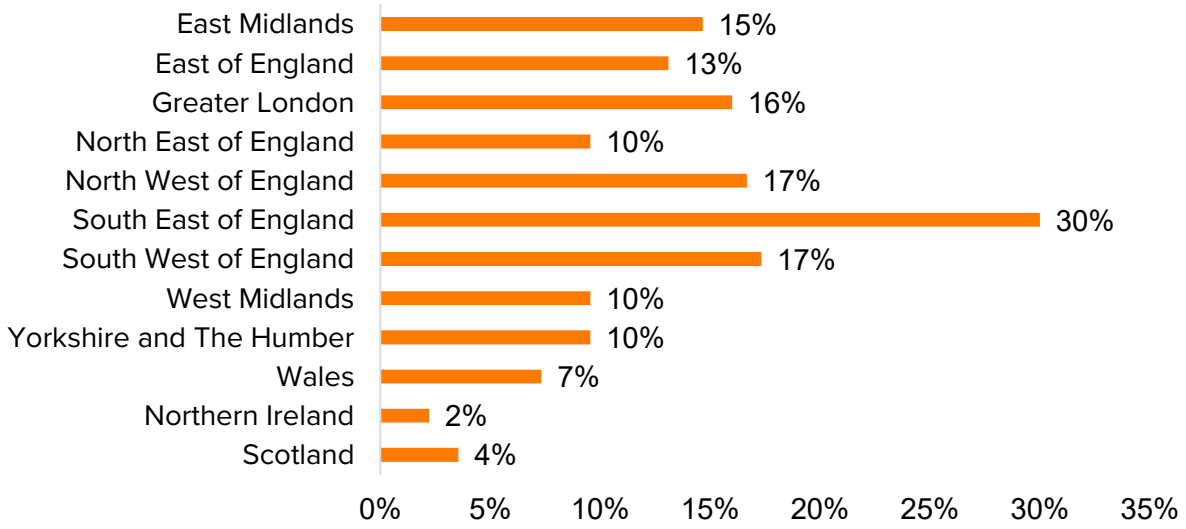

Figure 44: Which of the following best describes the location of the branches or franchises of the organisation that you are responsible for? (Tick all that apply) (n=450)

We received responses from all regions, with South East of England highest (30%) (Figure 44).

Respondents recorded 135,193 careworkers in total. The most common range was 20 to 49 careworkers (38% of respondents fell in this range) (Figure 45).

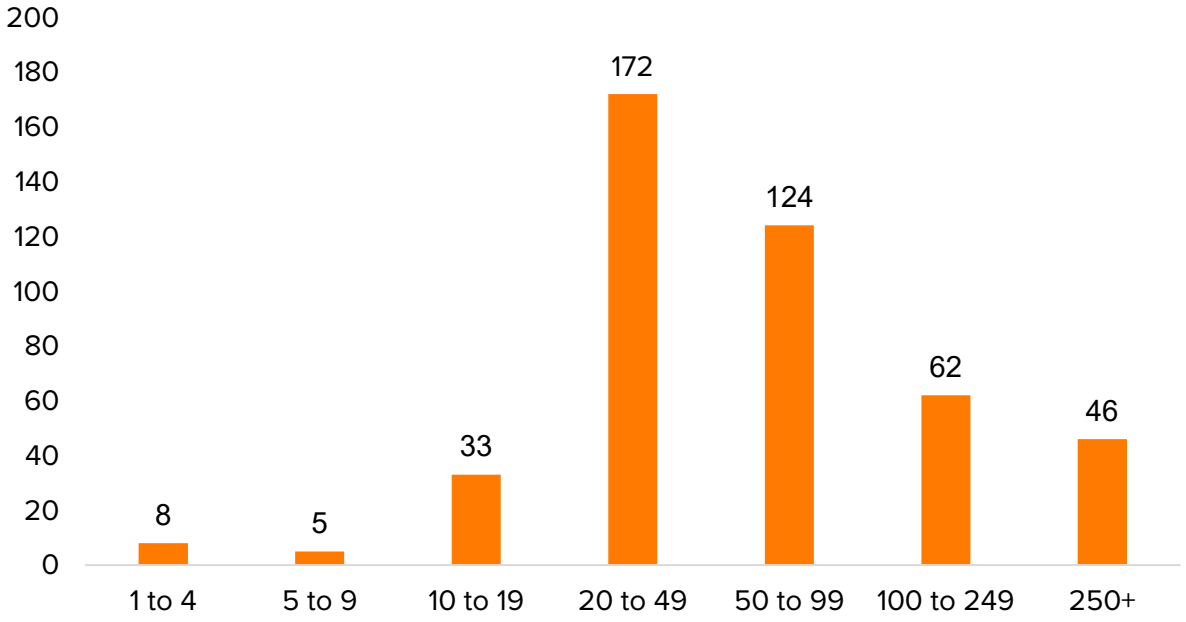

Figure 45: How many careworkers do you have? (n=450)

186,674 people were supported in total, with the 50-99 range being the most commonly selected (covering 32% of respondents) (Figure 46).

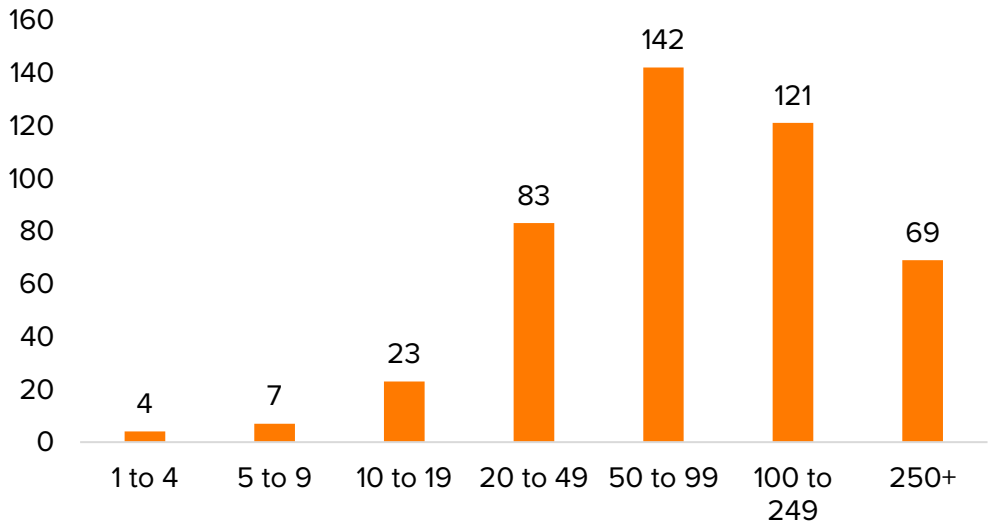

Figure 46: How many people do you support? (n=449)

Most businesses (87%) undertook a mix of work across NHS, local authority and private pay (Figure 47). 99% of respondents provided at least some privately paid work. Providers were more likely to work exclusively in the private pay sector than for public sector contracts. Most businesses combined local authority and private pay work for most of their workload. Only a minority took on a significant volume of work from the NHS (with only 4% of providers relying on the NHS for 40% or more of their work).

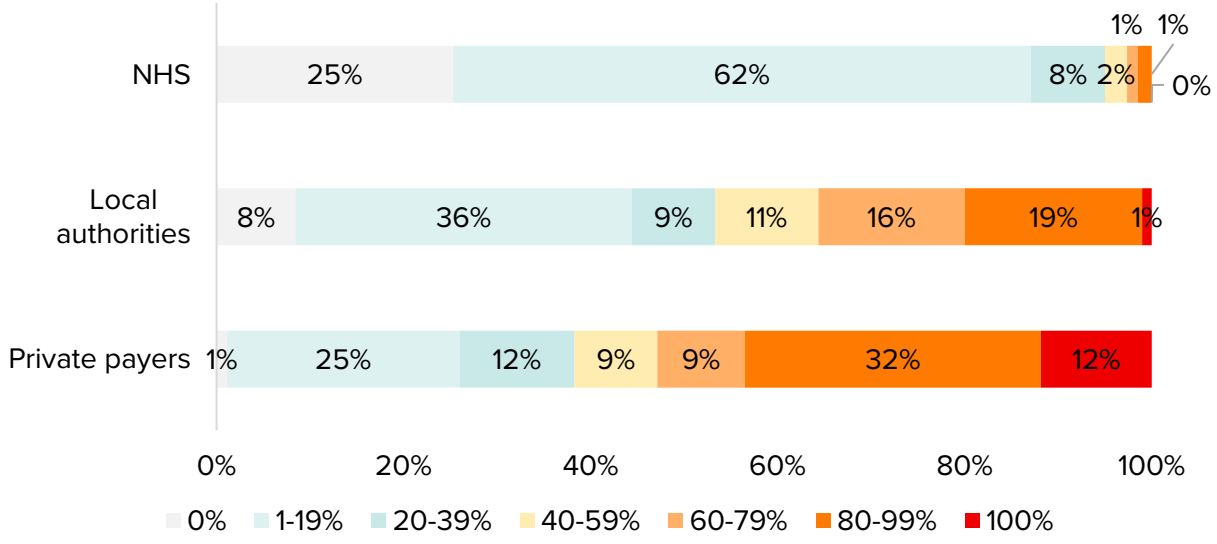

Figure 47: Thinking about the people you support, how much is funded by private-payers, local authorities or the NHS? (n= 441)

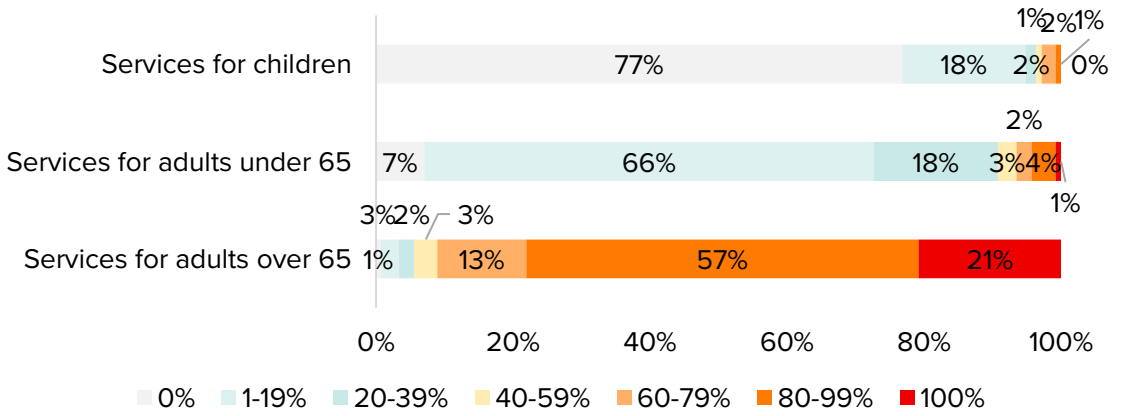

Figure 48: How much of your work is with children, adults or over 65s: (n=450)

Most respondents focused primarily on care for older adults, with 78% of providers delivering 80% or more of their care to over 65s. Many organisations undertook some care for adults under 65, and a few specialised in this. Most providers (77%) did not work with children, but a few specialised in this area (Figure 48).

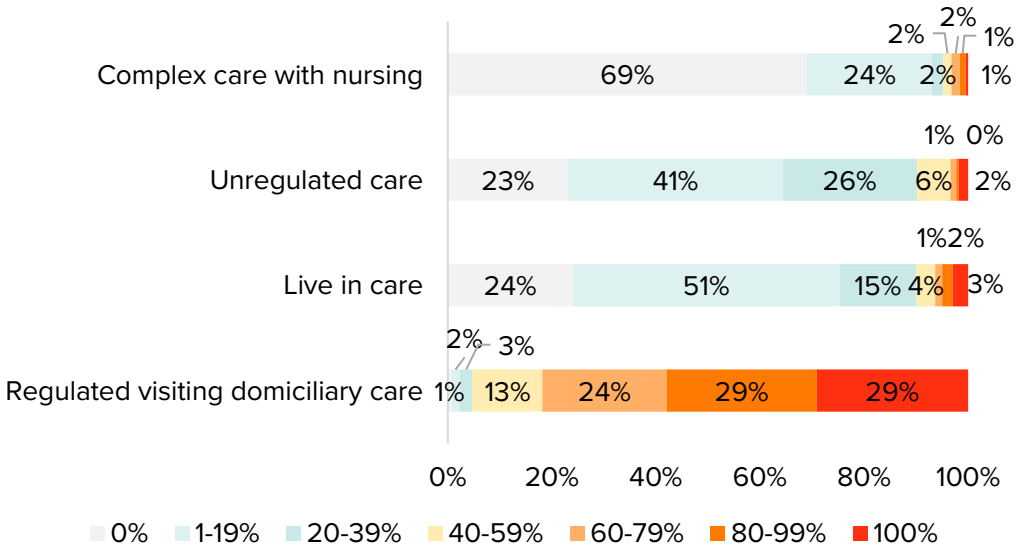

Figure 49: How much of your work is: (n=450)

Most respondents said that most of their work was regulated, visiting homecare (Figure 49). Often, providers combined this with some live-in or unregulated care provision.

Note that the answers on unregulated care in this question are different from the question on introductory agencies. In that question, 85% said they did not provide unregulated personal care via introductory agencies. In this question, 23% said they did not provide unregulated care. The CQC do not regulate some care activities, for example, cleaning or shopping, because they are not 'personal care' and so the category of 'unregulated care' in this question covers a broader range of care activities than 'unregulated personal care' as in the question on introductory agencies. This might explain why the responses appear to differ significantly.

Shaping homecare together

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