Audit of the impact of work permit restrictions on the Adult Social Care Workforce

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July 2008
Audit of the impact of work permit restrictions on the Adult Social Care Workforce: Report to the Department of Health

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Summary

• This Department of Health funded project aimed to look at the impact of work permit restrictions on the adult social care workforce. It focused on the position of senior care workers in the context of the implementation of Tier 2 of the points based immigration system (PBS) in autumn 2008 which envisages that few senior care workers currently holding work permits will meet the criteria for entry, or renewal of visas, under the new system.

• The project data was drawn from secondary analysis of the National Minimum Data Set for Social Care (NMDS-SC) and from interviews with 49 informants from the care sector who were either providing care services or who were representing the sector. Fieldwork took place between February-May 2008.

• Compared with their counterparts recruited in the UK, senior care workers recruited from abroad were more likely to be younger, to be better qualified, to have had less time off sick and to be working full time.

• The introduction of the minimum £7.02 per hour limit for senior care workers with work permits has caused problems within the sector and created anomalies between workers on different sorts of visa.

• Employers taking part in the interviews set difficulties in recruiting senior care workers from the UK-born workforce within the wider context of recruitment and retention problems within the sector as a whole.

• Their key concern was that experienced senior care workers might be replaced by less experienced staff. Particular concerns were expressed by providers of services to people with dementia who argued that quality of care might be affected if experienced staff who had established personal relationships with service users and acquired the skills needed to work with people with dementia were replaced by less experienced staff.

• It appeared that services located in more rural areas would appear to be at greater risk of being affected by changes to the system. This is because their isolated geographical position and the smaller pool of workers on whom to draw made it harder for them to recruit staff from the local population of UK citizens.

• There are possible issues for compliance raised by the increased use of workers on student visas and the need to ensure that all parts of the care sector are fully aware of the changes.
Main report

Background

There are longstanding problems with recruitment and retention in social care. The Commission for Social Care Inspection (CSCI), the body responsible for regulating and inspecting adult social care services, has described these difficulties as ‘chronic’ (Commission for Social Care Inspection, 2006, p7) while Eborall and Griffiths (2008) have calculated that vacancy rates in social care are around 4-5 per cent, compared with a national average of 2.7 per cent. This is double that for all types of industrial, commercial, and public employment (Learning and Skills Council, 2006b) and compares with less than one per cent for secondary school teachers and qualified nurses (Department of Health/Department for Education and Skills, 2006, p17).

While recruiting workers from abroad to work in social care is not a new way of dealing with labour shortages (Wanless, 2006), the use of international recruitment has increased sharply over the past 10 years. Between 2003-2004, 24,473 work permits were granted to senior carers, workers who were deemed to have three years relevant social care experience and/or the equivalent of a NVQ3 qualification. The majority of these workers came from India (n=7,110) and the Philippines (4,847) with substantial numbers also coming from South Africa (2,446) and China (1,765) (Dobson & Salt, 2006, p45).

Although the low status of social care among the general public and historically poor rates of pay (Platt, 2007) have always acted as a barrier to employment in the sector, the key explanations behind this increase lie in the government’s agenda for expanding and modernising public services, demographic changes - especially the increase in the proportion of people aged 85 and over (Office for National Statistics, 2007) – and rising consumer expectations about services (Salt & Millar, 2006). Current unpublished estimates suggest that there are now altogether around 30,000 senior care workers holding work permits and they are thought to represent between 25-30 per cent of senior care workers in the adult social care workforce.

With the accession of the A8 group of countries to the EU in May 2004, there was a decline in the overall number of work permits issued, although it is not known how many A8 nationals took up senior carer posts that would otherwise have required a work permit (Salt & Millar, 2006). The Worker Registration Scheme (WRS) provides some information on the number of A8 nationals (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and
Slovenia) working as care workers\(^1\). This shows that between 2004-2006, there were 14,090 registrations for care workers and care assistants out of a total of 364,240 registrations in the ‘Top Twenty Occupations’ (Blanchflower \textit{et al.}, 2007, p43). However, it is important to note that this represents a comparatively small proportion when compared with the numbers working in factories, warehouses, agriculture, or hospitality. Even more importantly, the WRS only records \textit{entry} into the sector, and not exit (Bauere \textit{et al.}, 2007; Markova & Black, 2008). This means that the number of registrations does not represent the actual number of employees from A8 states within the social care workforce.

In 2006 the government announced that the existing work permit system would be replaced by a points based system (PBS) as part of its managed migration policy. These changes were intended to attract migrants with the knowledge and skills to benefit the UK, to reduce the bureaucracies that had developed since the consolidation of the last Immigration Rules in 1994, and to improve public confidence in the immigration system (Secretary of State for the Home Department, 2006). These changes have been phased in, with applications for Tier 2, ‘Skilled workers with a job offer’, opening in autumn 2008.

In August 2007, the UK Border Agency (Home Office UK Border Agency, 2007) issued updated guidance suggesting that senior care worker positions meeting the current work permit skills criteria of the equivalent of a NVQ level 3 qualification and/or three years experience were ‘extremely rare’. As a transitional measure, the guidance stated that the skills criteria would be waived for in-country extension applications but employers would be expected to pay them a minimum salary of £7.02 per hour. Further changes were made in January 2008 (Home Office UK Border Agency, 2008a). These allowed applications for changes of employer and granted an exceptional 12 months extension for senior care workers whose work permits had been approved before December 2003. These changes have been opposed by voices within both the care industry (Samuel, 2007; 2008b) and trade unions (UNISON, 2007). In particular, concerns have been expressed that they will worsen existing staff shortages and reduce continuity of care.

This system will cease to operate in autumn 2008 with the introduction of the Tier 2 points based system. Employers wishing to bring workers to the UK will need a licence which will be approved by the UK Border Agency. Those found to be disobeying

\[^1\] The figures do not differentiate between care workers and senior care workers.
the rules or employing workers illegally, will be subject to on the spot fines and risk losing their licence. Applicants wishing to come to the UK will also need prior entry clearance, for which they will not be allowed to apply without a Certificate of Sponsorship from their prospective employer (Home Office UK Border Agency, 2008c, p8). They will also need at least 70 points to qualify. This score will be derived from the following:

- a job offer that meets the Resident Labour Market Test, where an employer has advertised a job but been unable to fill it from the local labour market (30 points) or intra company transfer (30 points);
- a job offer in a shortage occupation (50 points). Social care is not currently on this list²;
- an ability to demonstrate English language proficiency (10 points);
- sufficient funds to be able to maintain themselves (10 points);
- their qualifications level, ranging from no qualifications (0 points), NVQ Level 3 (5 points) to PhD (15 points); and
- prospective earnings of at least £17,000 per annum (5 points), ranging to £24,000 and over (20 points).

(Home Office UK Border Agency, 2008c, p9)

These rules will also apply to existing work permit holders seeking to extend their stay in the UK. The effect of these changes is that the UK Border Agency anticipates that few senior care workers will be sufficiently qualified or earn enough to meet the 70 points limit:

Senior care worker positions that meet the requirements of the tier 2 (skilled) category will be extremely rare. The Migration Advisory Committee³ will advise Government on where migration can sensibly fill gaps in the United Kingdom economy, including whether any special provision is required for the social care sector.

(Home Office UK Border Agency, 2008a)

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² The list of shortage occupations can be found at: http://www.workpermit.com/uk/work_permit/occupations.htm.

³ The Migration Advisory Committee (MAC) ‘exists to provide independent, transparent and evidence-based advice to government on where labour market shortages exist that can sensibly be filled by migration’ http://www.ukba.homeoffice.gov.uk/aboutus/workingwithus/indbodies/mac/.
The impact assessment of the introduction of the Tier 2 points based system (Home Office UK Border Agency, 2008b) acknowledged that there were a number of lower paid jobs currently catered for by the work permit system that would no longer qualify under Tier 2. However, it suggested that some of these occupations might be placed on the shortage occupation list, subject to a recommendation from the Migration Advisory Committee and subsequent government agreement. It also stated that employers could choose to raise wages so that jobs complied with the new points based criteria or that they could offer vacancies to workers from other EU countries (p7).

Responding to concerns expressed by the sector, the Department of Health commissioned the Social Care Workforce Research Unit at King’s College London to undertake an audit of the impact of changes to the work permit system for senior care workers on the adult social care workforce. The project was funded under the Unit’s responsive programme, designed for small scale projects that could be completed within a short space of time.

**Aims**

In consultation with the Department of Health, the agreed aims of this project were to examine:

1. What are the implications of these changes for recruitment and retention rates in Adult Social Care Services?
2. Will the changes affect the quality of care provided if experienced non EU workers are replaced by less experienced staff?

**Methods**

The data presented in this report is drawn from two sources. Firstly, it uses information from interviews with 49 informants, comprising owners and managers of care homes and home care agencies (n=43), three representatives of large care home and home care providers, and three representatives from organisations representing the care sector. Excluding this latter group, over 80 per cent of informants (n=37/46) were employed in the private sector. With one exception, the remainder were employed by voluntary organisations. They were selected using maximum variation sampling (Patton, 2002), where the intention is to include as many phenomena that potentially differ from each other as possible. Interviews were completed over the telephone using verbatim notes completed at the time. A small number were completed face to face and audio recorded for quality purposes.

The report also draws on secondary analyses of data from the National Minimum Data Set for Social Care (NMDS-SC), which is
maintained by Skills for Care (Skills for Care, 2007a). This dataset is currently under development but is eventually expected to encompass the whole adult social care workforce in England, including those employed in the private and voluntary sectors about whom it was previously difficult to obtain comprehensive information. This dataset is not publicly available and so we were privileged to have been given access to it.

The NMDS-SC does not currently collect information on citizenship status, although this is likely to change in the future. However, using an approach developed by Hussein and colleagues (2008) in a project funded under the Department of Health's Social Care Workforce Research Initiative, we identified a subset of senior care workers who had been recorded as 'recruited from abroad'. It is essential to emphasise that this category will also include other workers, such as citizens of other EU countries who do not need work permits, dependants of work permit holders, and those holding student visas. In the same way, work permit holders may also be included among the categories of people recruited in the UK if they have changed employers.

**Sampling strategy**

It is estimated that there are 35,000 establishments employing social care workers in England, of which 22,300 are care homes (Eborall & Griffiths, 2008). Care homes are registered by CSCI to provide personal care, nursing care, or both. The majority are registered to care for older people. However, they also include care homes for people with a learning difficulty, mental health problems, palliative care, and specialist services such as those for people with a brain injury. Although the private sector owns the majority of care homes, they are also run by voluntary organisations and local councils. There are differences in the fees charged by different types of provider (Curtis, 2007) and in the rates of pay that are received by workers in different settings (Eborall & Griffiths, 2008). Table 1 shows that we achieved interviews with different types of provider, although clearly in a project this size it would have been impossible to achieve a representative sample.

Given that one of the aims of the project was also to look at the impact of work permit changes on quality of care, Table 1 also records the rating given to each service by the CSCI. This rates services as being either: three stars (excellent), two stars (good), one star (adequate), or zero stars (poor). The ‘not yet rated’ category covers homes that have not yet been rated for 2008.

One report has suggested that only around two thirds of homes are ‘good’ or ‘excellent’ (Samuel, 2008a) whereas 86 per cent (n=26) of
the homes taking part in this project who had been rated came into these categories. Not every establishment approached agreed to be interviewed; on average, for every successful interview, two providers declined to take part. Homes rated as ‘poor’ or ‘adequate’ may possibly have been less willing to share their experiences.

We also aimed to achieve a geographical spread of interviews. Thus, care providers came from seven of the nine regions of England (with the exception of the North East and East Midlands) and Wales[^4]. Wales (four per cent) and the North East (six per cent) contain the smallest proportions of social care workers who were born abroad while London (68 per cent) and the South East (22 per cent) have the highest share (Experian, 2007).[^5]

### Table 1: Type of care service and CSCI ratings

<table>
<thead>
<tr>
<th>Type of home</th>
<th>CSCI rating</th>
<th>Not yet rated[^6]</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>*</td>
<td>**</td>
<td>***</td>
</tr>
<tr>
<td>Care home – older people</td>
<td>1</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Care home – learning difficulty</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Care home – mental health</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Care home – dementia</td>
<td>1</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Care with nursing - older people</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Care with nursing – younger people with physical disability</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Home care</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>4</td>
<td>22</td>
<td>4</td>
</tr>
</tbody>
</table>

[^4]: This was at the request of the Welsh member of the project stakeholder group.

[^5]: This study used data from the Labour Force Survey. It only reported on country of birth, not citizenship, and so does not indicate how many of these were work permit holders and how many were British citizens.

[^6]: This means that CSCI have not yet carried out a key inspection this year.
Ethical permission for the project was obtained from the College ethics committee and participants gave their informed consent.

Limitations of the data

The timing and scale of this project mean that it is not possible to provide generalisable data on the impact of the changes. The people interviewed represent only a small sector of those working in adult social care. Similarly, the limitations of current data sources for examining the full impact of migration are well known (House of Lords Select Committee on Economic Affairs, 2008). This means that there is currently no existing publicly available data source allowing social care workers holding work permits to be identified. The NMDS-SC dataset used in this study represents an incomplete dataset and so is subject to change. For these reasons, the results presented here should only be viewed as indicative, and further work would be required to examine the situation in more detail.

Results

Size of workforce and recruitment source

Eborall and Griffiths (2008) estimate that there are around 569,000 care workers in the adult social care workforce in England but these figures do not allow for differentiation between care workers and senior care workers. Using NMDS-SC data, Table 2 suggests that senior care workers comprise around 10 per cent of the adult social care workforce, although it must be acknowledged that this proportion may change as the NMDS-SC rolls out to include all employers.

Table 2 also compares the proportion of workers ‘recruited from abroad’ in different care occupations. As mentioned earlier, this category will include EU citizens and people with a different immigration status, such as student or dependants’ visas, not just people with work permits. Table 2 shows that proportionally more workers recruited from abroad were working as senior care workers and registered nurses but that they were under represented in other occupations, suggesting that they had been recruited specifically because it had proved to be difficult to fill these posts from within the UK.
Table 2: Numbers of adult social care workers in different NMDS-SC job roles compared with those ‘recruited from abroad’ (NMDS-SC December 2007 dataset)

<table>
<thead>
<tr>
<th>Main job role</th>
<th>All workers</th>
<th></th>
<th>Recruited from abroad</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Registered manager</td>
<td>2,601</td>
<td>2</td>
<td>10</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Senior care worker</td>
<td>9,260</td>
<td>8</td>
<td>503</td>
<td>24</td>
</tr>
<tr>
<td>Care worker</td>
<td>60,907</td>
<td>55</td>
<td>1,066</td>
<td>51</td>
</tr>
<tr>
<td>Registered nurse</td>
<td>6,423</td>
<td>6</td>
<td>287</td>
<td>14</td>
</tr>
<tr>
<td>All other care providing roles</td>
<td>8,196</td>
<td>8</td>
<td>38</td>
<td>2</td>
</tr>
<tr>
<td>Other managerial and professional roles</td>
<td>4,344</td>
<td>4</td>
<td>18</td>
<td>1</td>
</tr>
<tr>
<td>Ancillary staff – not care providing</td>
<td>13,458</td>
<td>12</td>
<td>153</td>
<td>7</td>
</tr>
<tr>
<td>Other non care providing roles</td>
<td>4,667</td>
<td>4</td>
<td>25</td>
<td>1</td>
</tr>
<tr>
<td>Total valid n</td>
<td>109,856</td>
<td></td>
<td>2,100</td>
<td></td>
</tr>
</tbody>
</table>

Percentages may not total 100 per cent due to rounding. There are 27 different job roles recorded in the NMDS-SC. Registered managers, registered nurses, care workers and senior care workers comprise the majority of the direct care workforce in adult social care. Other roles have been combined in this table because they are not the focus of this study.

Demographics

Unsurprisingly, given the gendered nature of social care, 88 per cent (n=7,989) of those employed as senior care workers were women. Eighty per cent (n=7,441) were ‘white’. By contrast, just 16 per cent (n=77) per cent of senior care workers recruited from abroad were white (Φ=-0.452, p<0.001). This is in keeping with the data cited earlier on work permit holders main countries of origin.

A more detailed question on ethnicity which subdivided the main categories into more detailed groupings (e.g. White UK versus any other white backgrounds) produced high proportions of missing values (19 per cent, n=1,735) compared with the broader ethnic grouping question (four per cent, n=385). While this means that caution should be taken in interpreting this data, it was striking that just four per cent (n=311) of senior care workers were recorded as

Although the Race Relations (Amendment) Act 2000 places a duty on public bodies to monitor their employees’ ethnicity, the overwhelming majority of social care employers are not in the public sector. The NMDS-SC is completed by employers and they may have felt less willing to make assumptions about their employees’ ethnicity in the detailed question.
being from ‘Other White Backgrounds’, the census category in which people from A8 accession states are most likely to be categorised. This was exactly the same proportion as that found across the dataset as a whole so the explanation is not that people from ‘Other White Backgrounds’ were more likely to be employed in other positions. This picture is certainly consistent with the WRS data cited earlier which suggested that the majority of people from A8 states have chosen to work in sectors other than social care.

As will be discussed later, this finding also accords with the views of informants, the majority of whom felt that the A8 states did not, or could no longer, provide a substantial source of potential employees when compared with countries outside the European Economic Area (EEA).

With a mean age of 36 (SD 7.5), senior care workers recruited from abroad were significantly younger ($F=108.415$, $p<0.001$) than their counterparts recruited in the UK whose mean age was 43 (SD 11.4). This is consistent with the wider migration literature which shows that migrants tend to be younger in comparison to the native born population (Robinson, 2002).

Overall, 99 per cent (n=8,216) of senior care workers were recorded by their employers as not having a disability. Senior care workers recruited from abroad were slightly less likely to be classified by their employer as having a disability ($\Phi=0.22$, $p=0.05$). However, many people with a disability are reluctant to disclose their status to employers so it is possible that the NMDS-SC underestimates people with a disability in the workforce. Certainly, where social care workers have been able to disclose their health status in confidence, far higher prevalence rates have been found (McLean, 2001; 2003).

Pay

Research examining the overall impact of internationally recruited workers on the pay of local workers, particularly those working in less well paid occupations, has drawn different conclusions (Coats, 2008; Coleman & Rowthorn, 2004; Dustmann et al., 2003). Social care is the third largest low-paying sector in the UK economy, with over a million jobs being paid at or around the level of the minimum wage (Low Pay Commission, 2008). While the majority of those working at this level are employed as care workers, it has been pointed out that, based on average hourly rates of £5.54 per hour for care workers and £6 per hour for senior care workers working in care homes with nursing, the differential between the average hourly rates is less than 50 pence per hour (Skills for Care, 2007b).
Information on pay was available for two-thirds of the senior care workers in the NMDS-SC dataset. Once more, the high proportion of missing values means that the data must be interpreted with caution. Across the dataset as a whole, the mean hourly rate was £6.50 per hour for senior care workers; the median hourly rate was £6.20, while the modal rate (rate paid most frequently) was £6.

Wages in social care vary by region because they are influenced by local market rates (Darton et al., 2003). Table 3 shows the mean, five per cent trimmed mean, and median hourly rates by region. The five per cent trimmed mean is the mean hourly rate after the five per cent lowest and highest hourly rates have been excluded. This is a more accurate figure than the arithmetic mean as it is less susceptible to the effects of extremes. In a dataset of this size, extreme values are likely to be the result of input errors. Using the trimmed mean, Table 3 shows that only in London did senior care workers receive an average hourly rate of over £7 per hour.

Table 3: Hourly rates of pay for senior care workers in adult social care by region (NMDS-SC December 2007 dataset)

<table>
<thead>
<tr>
<th>Region</th>
<th>Mean</th>
<th>95% confidence interval</th>
<th>5% trimmed mean</th>
<th>Median</th>
<th>Valid N*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Lower</td>
<td>Upper</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North East</td>
<td>6.04</td>
<td>5.96</td>
<td>6.13</td>
<td>5.96</td>
<td>5.95</td>
</tr>
<tr>
<td>Yorkshire &amp; the Humber</td>
<td>6.16</td>
<td>6.10</td>
<td>6.21</td>
<td>6.11</td>
<td>6.05</td>
</tr>
<tr>
<td>East Midlands</td>
<td>6.31</td>
<td>6.24</td>
<td>6.37</td>
<td>6.19</td>
<td>6.0</td>
</tr>
<tr>
<td>North West**</td>
<td>7.67</td>
<td>6.07</td>
<td>9.27</td>
<td>6.27</td>
<td>6.10</td>
</tr>
<tr>
<td>West Midlands</td>
<td>6.40</td>
<td>6.32</td>
<td>6.48</td>
<td>6.30</td>
<td>6.17</td>
</tr>
<tr>
<td>Eastern</td>
<td>6.56</td>
<td>6.52</td>
<td>6.61</td>
<td>6.47</td>
<td>6.38</td>
</tr>
<tr>
<td>South East</td>
<td>6.67</td>
<td>6.52</td>
<td>6.81</td>
<td>6.59</td>
<td>6.23</td>
</tr>
<tr>
<td>South West</td>
<td>6.75</td>
<td>6.67</td>
<td>6.84</td>
<td>6.60</td>
<td>6.23</td>
</tr>
<tr>
<td>London</td>
<td>7.47</td>
<td>7.17</td>
<td>7.78</td>
<td>7.46</td>
<td>7.0</td>
</tr>
</tbody>
</table>

* Employers have completed the NMDS-SC in stages, which accounts for the variation in the numbers of workers in each region. ** Three cases, possibly the result of input errors, seem to be inflating this figure.

The sampling strategy for the interviews specifically aimed to identify homes with experience of employing senior care workers with work permits and so it was unsurprising that reported hourly rates of pay for senior care workers in the establishments taking part in the interviews were higher than those shown in Table 3. They ranged from £5.80 to £10.45 and the mean rate of pay was £7.14 (SD 1.21). However, they should not be seen as
representative of the sector as a whole. Rather, the interviews revealed some of the geographical and local labour market factors impacting on pay rates within and between regions.

Two homes, one located in Wales and the other in London, provided the most extreme examples of this. The home in Wales was located three miles from the nearest village which was not served by any public transport. Despite advertising vacancies in the local press and job centre and in nursing magazines, recruitment had been extremely difficult. The home’s care workers came from Poland, the Philippines, Bulgaria, and Russia as well as other parts of the UK. The senior care workers had been recruited from India and Africa by an agency. They were paid £10.45 per hour in addition to being provided with accommodation. The manager reported that she was ‘very, very pleased’ to have them because otherwise the home would have had to close due to their being unable to recruit local staff prepared to work in such a geographically isolated position.

By contrast, the London care home was situated in a deprived borough with high levels of local unemployment and an ethnically diverse local population. Senior care workers here, all of whom were UK citizens or people with indefinite leave to remain, were paid between £6-7 per hour. In the past, the home had used international recruitment but now this was unnecessary as:

We can get staff ourselves...Almost every day, we turn down five or six applicants...Job vacancies are generally filled by word of mouth as the home has a good reputation.

(Care home, London, two stars, 37)

These issues are discussed in more detail in the later section covering recruitment and retention.

Another theme that emerged from the interviews was the anomalies that had arisen from the £7.02 limit. This had affected different providers in differing ways. Thus, representatives from large companies argued that the decision had had serious repercussions for the overall size of their company’s payroll because, in the interests of equality, they had offered this rate to all their senior care workers, irrespective of whether they were on a work permit. By contrast, smaller enterprises were more likely to report that they had implemented a two tier pay structure whereby senior care workers with work permits were paid £7.02 per hour but those who were UK citizens or had indefinite leave to remain were not. Unsurprisingly, this was reported to have caused resentments if workers became aware of what was happening. A third inconsistency arose from the difference between rates of pay for work permit holders and those for workers on other types of visa.
People with work permits and their dependants often work in the same occupations (Home Office UK Border Agency, 2008b). This led to one example whereby two family members working in the same establishment received different rates of pay. The work permit holder received £7.02 per hour. Her dependant received less. In this instance, the home owner considered that the difference could be justified on grounds of experience but not all providers offer increments for experience or length of service.

Working hours and sickness

Data from the NMDS-SC suggested that senior care workers recruited from abroad were also more likely to be in full time paid employment. Ninety seven per cent were working full time compared with just two thirds of those who were recruited from within the UK (Cramer’s V = 0.151, \( p<0.001 \)).

The high proportion of part time working among staff providing direct care is a feature of the social care sector (Eborall & Griffiths, 2008) and is largely attributable to the high proportion of women combining paid work with family responsibilities (Cameron & Moss, 2007).

Participants generally identified some benefits to having a high proportion of staff working part time or flexible hours. One informant suggested that part time contracts made it easier to cover for annual leave and sickness without recourse to agency staff, as there was a larger pool of people on whom to draw. Another explained that the nature of care work meant that it was company policy to employ people for a maximum of 30 hours per week ‘as this is about as much as someone can take’. Her argument was that this helped improve retention in the long term. It was also, as a different informant pointed out, consistent with government policies on flexible working and work life balance (Department for Business Enterprise and Regulatory Reform, 2008).

Set against these advantages was the sheer number of people required to staff an establishment when only a minority of staff are contracted to work full time. For example, within the care homes included in this study, the ratio of numbers of staff employed to numbers of residents ranged from 0.6 to 1.8, with a mean ratio of 1:1 (SD 0.28). One of the reasons given for recruiting senior care

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8 This is based neither on whole time whole time equivalents nor on staff: resident ratios in terms of the actual number of staff on duty at any one time. It simply refers to the actual number of staff employed in each home at the time of the interview in comparison to the number of residents.
workers and care workers from abroad was the need to find staff who would be prepared to work full time:

Most of the workers we employ locally...do not want to work long hours because some are on benefits and are not able to work longer than 16 hours per week.

(Care home with nursing, London, two stars, 35)

As well as being more likely to work full time, workers recruited from abroad were also more likely to work unsocial hours. This is consistent with research undertaken in the US (Presser, 2003) and UK (Evans et al., 2005) across different sectors of the economy. Thus, the need to find staff prepared to work unsocial hours or cover sickness was offered as further explanation for the use of international recruitment:

Non-EU staff work up to 48 hours and live in as they cover for shifts. Our overseas staff tend to be relied on to do last minute back ups and to cover sickness. Two care workers from overseas live on site.

(Care home with dementia, South West, two stars, 21)

Furthermore, sickness itself occurred less frequently among workers recruited from abroad. Based on NMDS-SC data, senior care workers recruited from abroad had taken an average of just two days sick leave (SD 4.5) in the past year compared with their counterparts recruited in the UK who had an average of seven days (SD 21) ($F=23.6, p<0.001$).

Phrases such as ‘covering shifts’ and ‘last minute back ups’ also demonstrated the importance of senior care workers recruited from abroad in contributing to the overall levels of experience and commitment within the workforce:

We have got people on work permits who have been here 10-12 years and...got leave to remain. They are very flexible and very loyal. They feel we have have given them an opportunity and they become a more stable workforce.

(Large company, 44)

Workforce stability is an important issue in a sector where vacancy and turnover rates are high. Eborall and Griffiths (Eborall & Griffiths, 2008) have calculated that vacancy and turnover rates for care workers are 4.5 and 22.2 per cent respectively. This is around twice as high as those found among senior care workers as a whole where the equivalent rates are 2.4 and 10.9 per cent (p70). In this context, senior care workers were contributing to continuity and stability:
There is a core group of staff who are going nowhere and the home relies on these people. Others last for less time.

(Care home with nursing, Eastern, not yet rated, 33)

**Qualifications**

Information on qualifications was available for about two-thirds of the NMDS-SC dataset. This showed that senior care workers recruited from abroad were better qualified than their counterparts recruited in the UK and that this difference was statistically significant. Seventy two per cent of senior care workers recruited from abroad held qualifications at NVQ level 3 or above compared with 48 per cent of those recruited within the UK ($\Phi=-0.110, p<0.001$).

The interviews showed that the levels of qualifications and experience required among senior care workers differed according to whether they worked in a care home or in a care home providing nursing. A representative from the care sector pointed out that homes providing nursing care recruited people with overseas nursing qualifications but who had not undertaken an adaptation programme that would enable them to register with the Nursing and Midwifery Council (NMC) as senior care workers. Their role was essentially to provide technical support to NMC-registered nurses. By contrast, care homes and home care agencies employed senior care workers to supervise care workers and act as a ‘shift leader’.

While a minority of informants insisted that all senior care workers, including British citizens and those with leave to remain, held NVQ level 3 qualifications, the majority thought that experience was more important. In these instances:

Seniors tend come up through the ranks and are almost always internal appointments.

(Care home with nursing, South East, two stars, 36)

Opportunities for career progression for existing staff were seen as a way of improving both quality of care and staff retention. They could even be a stepping stone to acquiring a professional qualification:

The SCWs [senior care workers] from abroad already had qualifications equivalent to NVQ 3. Some of the British born SCW’s have risen through the ranks and become SCW’s after gaining their NVQ Stage 3. Some of the British born SCW’s have left to go on to study as RGNs [Registered General Nurses].

(Care home with nursing, South East, three stars, 39)
Recruitment and retention

Informants did not identify issues in recruitment and retention as simply being concerned with the supply of senior care workers. Rather, they were viewed as part of a wider difficulty that affected the sector, and sometimes the UK economy, as a whole.

Attitudes to work within the UK population

A topic that is receiving increasing attention is why, when there are still relatively high levels of unemployment among some parts of the UK labour market and a rise in the number of jobs that do not demand high levels of qualifications, there is increasing demand for foreign-born migrant workers in the UK to work in low paying sectors such as care work, hospitality and cleaning (May et al., 2007).

A report for the Department for Work and Pensions (DWP) on the impact of migration from A8 accession states on the UK-born workforce has suggested that:

The generally poor labour market outcomes of low-skilled natives in the UK do not reflect either a lack of available jobs, structural factors in the labour market, or a lack of formal qualifications – since A8 migrants find it relatively easy to find employment – but rather issues around basic employability skills, incentives and motivation.

(Lemos & Portes, 2008, p4)

Similar conclusions were reached in research funded by the Learning and Skills Council with a range of employers, including those providing social care (Learning and Skills Council, 2006a). While one group of employers (termed ‘advocates’) preferred to employ workers born abroad and another (termed ‘reluctants’) had negative perceptions of them, the majority of employers were described as ‘pragmatists’. For them, migrant workers compensated for gaps in the workforce and their chief advantage was that they had a better work ethic than their counterparts who were UK citizens.

The majority of participants taking part in this study also reported that they had employed workers from outside the UK for pragmatic reasons because they were unable to employ sufficient UK born staff with the right qualities:

Overseas staff have come here to work. UK staff come along because the job centre has sent them and they have to show they have gone to a number of interviews. They aren’t committed.

(Care home, London, one star, 28)
In this country, care doesn’t have the status it should have...Staff from overseas work hard and have a good attitude and work ethic. Local staff don’t tend to stay and prefer to claim benefits and benefits seem to be preferred over work, whether in supermarkets or care homes.

(Care home, South West, two stars, 20)

Another informant spoke even more frankly:

We feel it necessary to recruit foreign workers because we find the local workers too lazy to work.

(Care home with nursing, South West, two stars, 31)

Level of pay and recruitment

In addition to the low status attached to care work and the attitudes to work that they thought characterised some sectors of the UK population, informants also acknowledged that rates of pay made the work unattractive:

We have exhausted the supply of local care workers because few people these days are willing to do the sort of work they do for so little money.

(Care home, Eastern, not yet rated, 27)

Funding arrangements

However, informants also felt that the option suggested in the impact assessment document (Home Office UK Border Agency, 2008b) of attracting more people to work in the sector, by increasing rates of pay was constrained by the limits set by local authorities on the fees that they would pay to support residents needing care. Representatives of the care home industry and large companies were particularly concerned with this issue. It was pointed out that some local authorities had chosen not to increase the level of fees that they would pay in the 2008-2009 financial year, despite rises in the levels of the minimum wage and the introduction of the £7.02 level for senior care workers. It has been shown that fees in care homes are more sensitive to increases in labour costs than price inflation (Netten et al., 2003) because labour costs make up between a half and two thirds of the costs of providing care (Wanless, 2006), so where the increase in fees is not commensurate with increases in labour costs, this can have a significant impact (Darton et al., 2003).

Although some providers are unaffected by the fees set by local authorities because they choose not to provide a service to people supported by local authorities, they are in the minority. Currently only around a third of people living in care homes are fully funding their own care (Wright, 2003) and even smaller numbers receive
fully funded NHS funded nursing care. While there are government plans to reform the system for funding long term care (HM Government, 2008), any changes will not provide solutions in the short term.

Other factors influencing recruitment and retention

The supply of care providers in different parts of the UK is not simply based upon consumer demand or the demographic characteristics of the population. Specifically, London (Robinson & Banks, 2005) and green belt areas (Knibb, 2006) are seen as unattractive to providers because of the high cost of land and local wage markets in which the demand for care workers outstrips supply. This affects providers in different ways. One home paid senior care workers £9 per hour but:

Staff retention is a problem as we are an affluent county with high living costs...When staff leave it is usually to go to other care homes in the area with better conditions.

(Care home with dementia, South East, two stars, 38)

At £5.80 per hour, wages in a home in a different part of the South East were far less but, in this instance, competition from other providers meant that:

If work permits were restricted, it would be virtually impossible to employ local people because the area is so full of care homes – even my own staff often have jobs in other homes in the area.

(Care home, South East, two stars, 25)

Reputation was also seen as an important factor influencing recruitment and retention. One informant from a two-star (good) rated care home owned by a housing association in the East of England reported that they paid senior care workers £9.43 per hour. Despite there being quite intensive local competition from other care homes, they had never needed to use international recruitment, relying on the local job centre and their ‘reputation as a good employer’. However, even this was not always felt to be sufficient:

We’re a small company who pays well [£7.20 per hour] so people stay...[but] we’d have problems if we couldn’t recruit overseas staff.

(Care home, South West, two stars, 29)

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9 Estimated to be 20,000 in the government’s response to the Select Committee on Health’s report on continuing care (Secretary of State for Health, 2005).
Workers from A8 accession states and students

Firm evidence on the impact of migration from workers from the A8 accession states will take some time to emerge but there is some evidence that the number of migrants varies in different parts of the UK (Gilpin et al., 2006) and that labour shortages alone do not entirely explain the distribution of migrant workers throughout the country (Coombes et al., 2007). Many of these workers are concentrated in occupations deemed to be low skilled that are not commensurate with the educational qualifications so it is possible that with time they will acquire the language skills and knowledge of the local labour market that will allow them to move onto other jobs (Saleheen & Shadforth, 2006). It has also been suggested that many of these workers only intended to work in the UK for a short time and may have already returned to their home countries (Pollard et al., 2008).

Evidence from the interviews was consistent with all these studies. Homes in the South West, and to a lesser extent the South East, appeared to be more likely to have employed workers from A8 states. One home in the South West reported that they had 20 staff from various A8 accession states, meaning that they comprised the majority of employees. However, while London and the East of England are areas of high inward migration from A8 citizens, this did not seem to be reflected in the ethnic composition of staff employed by providers in these areas.

Three informants, two representing large companies and the other the owner of a large home care agency, reported that they had considerable experience of recruiting workers from A8 accession states. Their view was that the situation had changed, two of them independently using the phrase ‘the cupboard is bare’, although one thought that workers from Bulgaria and Romania might potentially be employed in the sector. Another was less convinced by this possibility. His experience was that workers from A8 states either chose not to work in the sector, or if they were recruited, then they quickly moved on into other sectors such as hospitality. Another informant suggested that changes in exchange rates and improved employment in their home countries had meant that people were more inclined to return home:

There was a ready supply of workers from the new EU countries [but] it’s becoming very difficult. They are now finding that pay rates are not as great as they used to be [because of sterling exchange rate]. We have lost several Polish workers recently.

(Large company, 44)

The number of student visas issued each year is thought to be more than double the number of work permits (House of Commons
Debate, 2008) and it appeared that some providers had responded to difficulties in recruitment and retention by employing people on student visas, particularly in homes in the South East and London.

**Impact of work permit restrictions on quality of care**

Research undertaken within (McGregor, 2007) and outside the UK (Man, 2004) has suggested that deskilling can occur when workers move to countries where their qualifications are not recognised. From the perspective of some informants, the employment of senior care workers with work permits had improved the overall skills level within their workforce:

The staff from overseas usually have a background in nursing. [Staff from Commonwealth countries] make very good care workers because usually the nursing training they have had is based on British nursing requirements.

(Care home, West Midlands, one star, 32)

However, not every informant agreed with this viewpoint:

Most foreign workers come from a nursing background and find the concept of personal choice, which is practised in the care home, sometimes difficult after the institutionalised routines they are used to.

(Care home, South East, two stars, 23)

Overseas jobs and professional qualifications are taken with a pinch of salt. Language has been a big issue and can mean more training required, especially around written reports. It is the responsibility of senior care workers to carry out assessments and to write them up as reports and if their written English isn’t up to scratch they can’t do the job.

(Care home with dementia, South East, two stars, 20)

Language can sometimes be an issue beyond just accents and most of our staff will be going to English classes. Written English is very important to care work [so if they have difficulties] we encourage them to go to classes.

(Care home with nursing, South East, three stars, 34)

For these reasons, the majority of informants preferred to employ senior care workers who were already living in the UK. This had an additional advantage in that it was easier to check on the veracity of references.

Informants put forward two main reasons why they wished to be able to continue to employ senior care workers. The first related to the good relationships that they had built up with people using services:

If visas for care staff from overseas were [to be] tightened up, the whole sector would suffer and our hardworking team would suffer. Vulnerable people need to have people they know looking after them.

(Care home with nursing, South East, three stars, 34)
[Internationally recruited staff] are very hardworking and the residents love them. [Restrictions] would have a direct impact on us as we could not get the same quality of workers locally. We [are based] in a small village, five miles from the nearest town and we've exhausted our supply of local people who want to work here.

(Care home, North West, two stars, 26)

CSCI estimates that 28 per cent of care home places are for people with dementia (Commission for Social Care Inspection, 2008) but over half (Macdonald & Cooper, 2007) of all care home residents are thought to have some form of dementia. Homes providing places for people with dementia, or other mental health problems, were particularly concerned about the potential impact of replacing experienced senior care workers with work permits with others who were less experienced. In particular, they pointed out that senior care workers with work permits had acquired additional skills and experiences:

They are prepared to put in lots of hours and we have invested a lot of money in their training [to work with older people with mental health problems]. We need continuity of staff because our residents [mainly people with dementia] cannot cope with frequent changes.

(Care home, Eastern, not yet rated, 27)

In their own country, they have been trained as general nurses and don’t have much experience of looking after the elderly mentally ill so they will often treat residents as children or act in a condescending way...[However] they are there like a shot in an emergency and because of their work ethic they adapt to new ideas very quickly once they have been taught them.

(Care home, South East, two stars, 25)

Other informants thought it would create instability within the sector:

Non-EU staff provide technical care at a level of competence that’s difficult to find in England and they’re willing workers. When other homes local to me have had numbers of overseas staff who have to go back home at or around the same time for whatever reason, this has had a knock on effect of destabilising the staff in all the homes in the whole area. This is because some staff have used the opportunity provided by vacancies to move around and/or ask for extra money.

(Care home, South West, two stars, 18)

However, an important point to recognise is that not all informants appeared to be equally aware of the full extent of the changes to the work permit system, particularly the new responsibilities for employers sponsoring applicants under the points based system. It was noticeable that informants working for large enterprises and representatives of the care sector spoke in great detail about immigration policy and its impact on the sector but owner managers of small homes seemed to be less aware of these changes. As
mentioned earlier, there are estimated to be 35,000 establishments employing social care workers (Eborall & Griffiths, 2008) and enforcement will always be more difficult in a disparate sector such as social care.

Conclusions

This study has highlighted some of the longstanding recruitment problems in social care that have led to the employment of senior care workers, and other internationally recruited workers, in social care. It has discussed some of the implications of the current restrictions on work permits and the planned move to the Tier 2 points based system.

Evidence from the NMDS-SC, which currently includes some 10,000 records of senior care workers, suggests that senior care workers recruited from abroad were younger, had higher qualifications, better sickness records, and were more likely to work full time than their counterparts recruited inside the UK.

In the context of high turnover and vacancy rates within the sector, interviews with 49 employers and representatives of the care sector suggested that senior care workers holding work permits played an important role in contributing to stability and continuity within the workforce. This was also shown in the number of former work permit holders who had acquired leave to remain in the UK and had made a long term commitment to working in the care sector.

Informants emphasised the importance of the quality of the relationships that some senior care workers had built up with service users. While senior care workers recruited from abroad were better qualified than their British counterparts, employers pointed to the investments they had made in training them to work within the UK care system and in improving their written and spoken fluency in English. They particularly stressed the way in which current work permit holders had developed skills in working with people with dementia who make up a considerable proportion of people using care services (Commission for Social Care Inspection, 2008; Knapp et al., 2007; Livingston et al., 1997). There was some evidence that the employers most likely to be affected were those based in more rural areas, where geographical isolation and a smaller pool of people on whom to draw made it difficult for them to attract staff. The use of the CSCI quality ratings (for the first time in a research project so far as we know) showed that even homes with ‘good’ or ‘excellent’ ratings reported difficulties in recruitment. While factors such as a good local reputation or providing good terms and conditions for staff were
thought to improve recruitment and retention, this was not always enough to ensure that all vacancies were filled.

There were indications that restrictions on work permit holders had led to the greater use of people with student visas. The implications of this were beyond the remit of this study but it potentially might lead to a reduction in quality of care, greater illegal working if students outstay their visa or work for more than the permitted hours per week. There was also some evidence that some parts of the sector may be less aware of the changes to the responsibilities of employers than others and this may have implications for those parts of the UK Border Agency responsible for ensuring compliance.

The evidence on the use of EEA citizens was more equivocal. Although homes in certain parts of the country had recruited workers from the A8 accession states, few employers were of the view that this would provide a source of new recruits once the current system for renewing work permits has been changed. In particular, there were some suggestions that there was greater circulatory migration (workers coming back and forth from their home countries)(Constant & Massey, 2002; Gozzini, 2006) or using social care as a transition industry before moving into another sector (Saleheen & Shadforth, 2006) among these workers when compared with workers from outside the EEA but further work would be required to confirm, or contradict, this picture.

The introduction of the £7.02 limit was seen to be problematic by the majority of informants who were not already paying all their senior care workers in excess of this amount. Social care historically has low rates of pay (Low Pay Commission, 2007; 2008), partly because of its low status and the gender bias within the workforce (Grimshaw & Rubery, 2007) and partly because current funding arrangements have meant that many employers operate on tight profit margins (Darton et al., 2003). Evidence from the NMDS-SC showed that this average hourly rate was only found in London. In some circumstances, there were local factors that meant that wages were either higher or lower than the regional average, showing the difficulties in establishing a rate for senior care workers that could be applied throughout the sector.

While this study suggested that there would be risks to the quality of care provided to service users and stability within the workforce should it prove to be impossible to recruit or retain senior care workers from outside the EEA, there are questions about the reliance upon migrant labour in the long term. There was some evidence of ethnic segregation in some homes and communication difficulties were mentioned by employers as being of concern to service users and their families. There are also wider debates about
the extent to reliance on workers from abroad contributes to economic polarisation (Kaplanis, 2007) and creates inequalities (May et al., 2006; 2007). However, these are questions beyond the remit of this study which strongly suggests that the changes to restrictions on work permits for senior care workers will create further difficulties in a sector that already experiences problems in recruitment and where improving the quality of care is seen as an important government priority (Department of Health/Department for Education and Skills, 2006; HM Government, 2007).
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