Written evidence submitted by GMB Union (ASC0112)

Adult Social Care Reform: The Cost of Inaction

GMB Trade Union

GMB is a trade union which represents over 500,000 members throughout the UK in both the private and public sectors. GMB has members in a wide range of areas including being prominent worker representatives in social care, the NHS, and local government.
GMB is proud to be the lead campaigning union in social care. Care is part of our society's foundations and is a national asset, it is part of the fabric of our communities, and ensuring its sustainability is one of the greatest challenges that we face.

Question 1:

How much is inaction on adult social care reform costing the NHS and local authorities, and what impact does this have on patients and the public?

Summary

- **The current social care structure of majority privatised provision devalues the roles of local authorities in their responsibility to ensure care which is fit for use in their areas – markets rule, not the needs of the user.**
- **As a workforce of over 1 million of the lowest paid workers in the UK, care work is linked to poverty within our communities.**

The path that led to the current crisis needs to be described if we are to understand the problems facing the care sector. This is about both values as well as solutions. Modern old age and adult disability care was once part of the same programme that created the NHS and the vision of a safety net from cradle to grave.

Social care and NHS workers once had parity in pay and terms and conditions. GMB believes that care should be restored to its place as an integral and valued part of the welfare state. Both the creation of the modern care sector and the swift disaster of outsourcing and fragmentation in the early 1990s proved that the Government the status quo is not inevitable – the Government can change the care sector both for worse, and for better.

Social care was not meant to become the fragmented and low-paid sector that it has become. Care, alongside the NHS, was a part of the Attlee Government's vision of a new world that would end the iniquities of the old. The modern social care system was created by 1948 National Assistance Act which swept away the last remnants of the hated Poor Law. Instead, the law required local authorities to provide funded placements and care packages for those who required assistance. Residential were supposed to accommodate no more than 25 to 30 residents. Fees were supposed to be around 80 per cent of the old age pension, in order to provide for individual independence. The post-war Labour Government also insisted that domiciliary care charges must not exceed the cost of delivery. Services were mostly delivered by local authorities and care workers were paid

under local authority terms and conditions. Local authorities then had much more direct role in the planning of both health and care services. It followed that there was much closer integration between the NHS and social care. As late as the end of the 1970s, pay negotiations took place in tandem – and the NHS employers' pay offers were made after those in local government, in recognition of the fact that differences in pay structures inevitably led to recruitment and retention pressures.

The current care system was not inevitable. The fragmented, privatised market model for care is relatively new: the public sector directly met provided between eight and nine out of ten beds until the early 1990s. But, in one Margaret Thatcher's last acts as Prime Minister, local authorities were forced to promote 'competition.' Under John Major, 80 per cent of state subsidies were required to be spent on private providers. One of the most dramatic privatisations of a public service followed.

In England, 93 per cent of publicly-funded residential placements were in local authority run homes the start of the 1990s. The figure had fallen to just 21 per cent ten years later. Today, 95 per cent of residents are cared for in private or voluntary sector homes. It has been said that the fragmentation of care was '*arguably the most extensive outsourcing of a public service yet undertaken in the UK.'* As a report for private investors commented years later:

'The transformation of publicly funded social care service delivery which has taken place in Britain, from predominantly in-house to an outsourcing model … would have been unthinkable in the NHS. The fundamental difference is that social care is largely staffed by low paid workers.'

Many of the new private providers were backed by private equity firms. The 'dominant feature' of these early deals was to 'get the labour costs down by 30 per cent,' in large part by reducing staffing levels and wages, according to a former private equity partner.

The consequences of this fragmentation for care workers have been severe. Most care workers are no longer covered by adequate, nationally bargained pay rates and terms and conditions. The failure to preserve parity with the NHS has let to severe shortages in comparable roles, such as registered nurses. Pay is too low in all parts of the care sector, but average care worker pay is still 12 per cent lower in private providers than it is direct local authority provision. We do not hesitate to criticise public sector employers, but on average the remaining local authority-operated homes have better retention on average, and much lower levels of employment on zero hours contracts.

Within our negotiations with recognised employers, the cost of care and local authority commissioning continuously raised as a reason for employers not paying better or providing contractual benefits such as sick pay. However the procurement and commissioning process is a locked process in many cases. GMB has offered in many instances to be involved in the commissioning processes, but has only secured this in Sheffield, who, through signing up to the GMB's domiciliary care charter, are developing a new system for block commissioning – which discourages race to the bottom procurement and encourages companies to recognise trade unions. They are not there yet – but significant moves have been made to reduce the 'task and finish' pay model and they have successfully found alternative and ethical ways of funding care in their city.

The overriding priorities for current and future governments must be the securing of the sector's finances and a reversal of the fragmentation of care service and employment standards. The Conservative Party came to office with a soon dropped pledge to enact a reforms that 'stands the test of time.' The Labour Party is committed to building a National Care Service and a Fair Pay Agreement in Adult Social Care, the first steps have been made, however significant investment

needs to be made in the process of setting up collective bargaining and a continued commitment to the policy of sectoral bargaining needs to be made.

Part of those reforms should include backing for local authorities to rebuild their direct provision as part of a wider policy to stabilise the sector and drive-up employment standards and in absence of that, move towards ensuring ethical care is commissioned in their areas.

The inaction for reform, ensures that public money moves into the pockets of private companies and shareholders and does not ensure good value for money for the public, or secure fair, ethical and good work for care sector workers.

Question 2:

What NHS and local authority service reforms are not happening as a result of adult social care pressures, and what benefits are patients and the public missing out on?

Summary

- **Poor planning and funding cycles impact the level of care which workers can provide**

GMB believes that much closer integration between NHS, care services and the trade unions is an essential requirement for social care reform.

Today, the role of Integrated Care Boards excludes both the voice of workers and the voice of care providers. When local decisions are made relating to funding, the NHS takes the precedent as the only voice in the room. This reduces the capacity for local authorities to plan effectively for social care needs, as the inevitable funding distribution within the local NHS may focus on directives, such as waiting times and bed clearance, which result in social care pressures beyond the capacity to meet them.

Equally, the absence of worker voice creates a black hole where distributed funding is a postcode lottery within regions, with ICB's dictating to employers where and how funding should be spent.

In 2023, the ICB's distributed a winter retention bonus. Some ICB's allowed employers to distribute this evenly, while others allowed only for care giving workers to receive it – this created a two tier system which devalued and demoralised the workforce.

The inability to plan appropriately, leads to long waiting lists for social care arrangements and commissioners offering only care funding packages which boarder financially the means they can meet on the funding levels available.

This in turn has a knock on impact as service need overrides all else, which in turn, leads to short term care visits so users do not receive the care package they are paying for, or is being funded for them, residents being placed in unsuitable care packages due to bed availability, over the nursing care they require and family members feeling they have to fight for basic needs of their loved one.

This impacts staff who are not paid for the hours they are at work and are often far beyond the capacity they are able to meet within a shift. They are – as the regular face, more often than not at the end of abuse from service users and families, upset they are unable to provide the level of care they want to provide and the result is the question – is this really worth it?

Everything is reactionary and short term.

Care staff turnover is significant. Unsupported and underpaid the staffing crisis in social care is underpinned by poor pay levels and terms and conditions. The turnover fuels the demand and the miscommunication ensure the cycle persists.

Question 3:

What is the cost of inaction to individuals and how might people's lives change with action on adult social care reform?

Summary

- **The current structure focuses on mainstream methods of care, but loses focus on those who provide care for free in their own homes**

A reduction in community services and support, secures isolation for those with disabilities and reduces the support which their unpaid carers receive. Workers such as Shared Lives carers who go over and above by giving their people a secure and stable place to live outside of institutions by moving them into their own home, report to the GMB that their bills are not covered by the local authority fees they receive, if they become ill and have to go to hospital, they have to pay for respite while simultaneously having their fees deducted from the local authority. Equally, all carers, young and old currently cannot afford temporary respite care for the relatives they look after and support in their own homes.

Further charges apply to these carers which brings down their pay further, for example, unpaid carers are often inadvertently disadvantaged by above average parking at the hospital and other NHS facilities in comparison to the general population. As disabled blue badge holders are not entitled to free parking, the fees can amount to hundreds of pounds a month to support those they care for, in favour of private companies who run the car parking contracts.

The world of work is also difficult for unpaid carers. Inflexible working conditions and no access to emergency family leave for kinship carers often result in carers leaving their full time employment to care for their family members.

As a nation we should better support and recognise those who find themselves in this position and provide them with what they need to carry out this valuable role.

It is people like Shared Lives and unpaid carers that hold up the care system but are conveniently forgotten. The recent benefit review for unpaid carers will certainly be an improvement for those individuals, it does not go far enough to expand eligibility criteria to include widows and individuals on the state pension – however if we aspire for a national care service which encompasses all aspects of care, then this needs to be planned for now so those who provide care in their own homes and the unregulated carers – such as personal assistants, are not forgotten through reform in the future.

There is an urgent need for a new funding settlement in social care that retains more money within the system and addresses chronic underfunding. Significant sums could be saved within the existing system – including the £1.5 billion that is extracted from the sector each year through disguised profits. But additional money needs to be raised too. All efforts should be made to find a funding

model that raises revenue fairly, which precludes regressive taxation measures that hit the poorest the hardest.

Question 4:

Where in the system is the cost of inaction on adult social care reform being borne the most?
Summary

- **A national strategy is urgently needed which puts workers at the centre of plans. By driving up pay and terms and conditions and setting high standards for health and safety and workers voice, the care sector can move to the place it needs to be to function effectively.**

- **Staffing**

The fight for £15 an hour is a fight for the future of the care sector, for those who care and those who need it.

More than nine in ten of members responding to GMB's Care Survey believe that low wages put people off working in care (93.8 per cent). Without proper recognition and reward the sector will not be able to attract new starters.

The clock is ticking. GMB's own analysis of ONS UK population estimates predict that there will be another roughly 20 percent increase in the number of those aged 65 and over between 2020 and 2030, with the number of those aged 80 and over increasing by over 33 percent in that time.
Skills for Care has estimated that in England alone up to 650,000 extra social care staff would be needed to improve services and meet demand by 2030.

GMB has long made clear that the capacity shortfall in care cannot be met without resolving the understaffing crisis, which in turn means resolving recruitment and retention.

Properly recognising and rewarding the social care workforce will benefit both carers and those being cared for. Making this the bedrock of how future care is delivered in the UK will help ensure safe staffing levels through attracting new starters and retaining experienced colleagues. This will allow staff to provide the good quality of care that they wish to and those in care deserve.

This is a claim informed by our members experiences everyday and one indicated through wider studies of the social care sector. One study of over 2,500 care homes in England over three years found that better wages and training for care workers, more person-centred care and proper staffing levels in homes were linked to higher CQC ratings.

In turn, these better CQC ratings were found to be linked with the higher quality of life among the residents who needed most help. On staff wages alone, a 10 per cent rise in care worker average hourly wage was found to increase the likelihood of a care home being rated 'good' or 'outstanding' by 7 per cent.

"If the job … had decent pay and respect then vacancies would be filled and there would be enough carers to look after people in their own homes, enabling them to be out of hospital and free up beds in the NHS."
Support worker

- **Money**

‘I struggle to pay rent & bills & feed us let alone have any money left to pay for extras or to enjoy life.’ Care Team Shift Leader

“I am using savings to make ends meet but this will not see me through the coming year and as I am not in line for a pay increase I do not know what I am going to do.” Administrator

“My employer provides a draw down service – this gives me the option to borrow from my wages before pay day for a small admin fee. It seemed great at first, but now I’m in a cycle of debt to myself – every month borrowing money from my wages to get through the month and paying for the privilege. No matter what they put in place – pay just isn’t enough to cover my basics.”

Chronically low pay has left many care workers unable to afford basic necessities. Charities report a significant increase in the number of care workers who are seeking support to afford grocery and energy bills. Several GMB members told us that they were using food banks to get by. The crisis in wages long preceded the crisis in prices. According to the Health Foundation, even before the cost of living crisis hit, more than a quarter of residential care workers lived ’in or on the brink of poverty.

The relentless drive to reduce costs, due to a combination of profit maximisation and low local authority fees, has led to a race to the bottom on non-pay terms and conditions. A third of direct care workers are employed on zero hours in England, rising to 46 per cent of domiciliary care workers and more than half of all direct care workers in London.

Care workers are typically not paid for travel time or sleeping time when on duty.

The Supreme Court ruled in 2021 that staff who are required to sleep at work are not entitled to the National Minimum Wage for that time. This is in spite of the disruption to regular sleeping patterns that our members report in unfamiliar beds or buildings, or as a result of always being on-call. The Supreme Court’s judgement rested on an early Low Pay Commission report, and the Low Pay Commission must now urgently revisit the issue. **The sleep-in shifts judgement has exposed a fundamental weakness in the National Minimum Wage Regulations which must be addressed.**

Most care workers are entitled to Statutory Sick Pay (SSP) only – or no sick pay at all. Workers in care are more likely to be reliant on SSP than in any other sector.22 One 2020 study found that 77 per cent of care homes offered SSP only.23 The UK has one of the lowest rates for sick pay entitlement in Europe at less than a fifth of average wage, and many workers are excluded from it. 80% of care sector workers who responded to a GMB survey said that they might be forced return to work before they are ready if they were on SSP. **It is essential that Statutory Sick Pay is raised and reformed so that no-one is forced to attend work when they are ill.**

“With me being on a zero hours contract, I don’t always get work. If I become ill I don’t get paid. If I get a cold or flu related illness I’m expected to stay at home without pay because I may pass the illness to our service users … It is a very very stressful life.” Carer

Stress

68% of GMB members advise they have poor mental health through working in the care sector. Low pay, high level pressure both puts a stress within an outside the workplace. We have seen examples where stress kills, and over 1.8 million people are on waiting lists for mental health treatment.

When taking time away from work isn’t an option due to lack of sick pay provision, or flexible working isn’t available to give people the opportunities to fit work in around their lives, or there is no end in sight to the cycle of working 70 hours a week while only being paid for 30 – is there any wonder that staff leave the sector?

Increasing terms and conditions and setting minimum staffing levels, which do not count nurses and office based staff – as they currently do, will help to relieve some of the stress within the workforce, however more funding into local mental health services will also support those in crisis get the help and support they need quicker.

Violence

"I am attacked on a fairly regular basis. The worst being an injury to my forehead that required 18 stitches." Team Leader

GMB has obtained shocking statistics from the Health and Safety Executive under the Freedom of Information Act. The figures reveal that serious injuries to care workers are much more likely to be as a result of violence than they are for workers in the wider economy. Nearly four in ten (39 per cent) of reports for serious injuries in residential care settings were caused by violence in 2021/22 – compared to 9 per cent for all workers. The rate rose to half or more in some regions.
Similarly, in the NHS violence and aggression is just accepted. This is a community wide issue. The public need to have awareness raised and provisions must be made to strive for violence free workplaces.
To do this there has to be a funding supply dedicated to workers health and safety to ensure security measures are put in place, in consultation with the staff that experience violence in the workplace, we also believe that expectations should be put in place for local authorities care health and safety boards, which include workers voices, should measure incidents and be referred to in procurement processes, the health and safety executive should also take a more visible role in reducing the level of violence for care sector staff.
When questioned by GMB on their remit, they advised their funding does not stretch far enough, GMB is leading on a plan with Social Care Wales, HSE and joint trade unions on behalf of the Welsh Government Partnership group to improve reporting and incidents of violence in the sector.

- **Professionalisation and improving regulations**

The regulation of social care varies by nation and setting. In England, the main regulator is the Care Quality Commission (CQC), which is responsible for monitoring patient standards. The CQC has been criticised for failing to predict or prevent the failure of major providers, such as Southern Cross and Four Seasons. As one industry expert put it, regulation has been reduced to 'a spectator at the accident rather than a preventative measure.'72 Our members are twice as likely to say that the CQC is not improving care standards as those who say that it is. As discussed above, there are also serious gaps in the coverage of regulation – domiciliary care firms that provide 'introductions' are currently unregulated. We call for the strengthening of regulation in order to close these loopholes and establish a regulatory function that can proactively investigate the finances of overly indebted providers.

There is a disincentive to do this because there is little guidance or imagination for a different kind of system. Until commissioning is taken seriously enough to cover the cost of care, contracts awarded to companies who can guarantee workers voice and high standards through procurement – we can not drive these standards up.

A national strategy is needed to encompass the journey to the National Care Service.

This strategy needs to encompass local and national aims:

1. A national structure for commissioners and Directors of ASC which focuses on the standards of fair work, quality of care and questions to employers during procurement around how workers voice plays a part in their business.
2. In procurement, points are earned for trade union recognition and access, proof of paying sick pay, proof of policies for action on health and safety. To align all commissioning to national standards.
3. Worker voice representation on local authority commissioning boards and ICB's
4. Funding allocation for care worker registration in England, which also includes personal assistants, to close any loopholes so bad actors can not move their exploitative practices into different sections of the market to save money.
5. Establish a national negotiating body for social care which brings unions, as the worker representatives and employer representatives to negotiate the Fair Pay Agreement on an annual basis.

Question 5:

What contribution does adult social care make to the economy and HM Treasury and how might this change with action on reform?

We feel we have identified many factors through the above questions, but would like to highlight the position of the workforce and the benefits of reform.

- **Universal Credit.**
  Low Pay fuels poverty and in work benefits. Many care sector members claim universal credit as a top up for their wages for low pay hourly rates, or mismanagement of their pay (such as being advised it is a RLW paid job, but only being paid the RLW for 15 minute commissioned time limits)
  If workers had better pay and protections, the need for UC usage would fall and more money would be spent in the local economy on essentials which currently can not be afforded.

- **Raising pensions**

The law sets a minimum level of contributions to be paid. All staff must receive minimum pension contributions of 8%. The total contribution is 5% of the workers earnings, with at least 3% coming from you, the employer.

The current retirement age (as of Jan 2024) is 66 and is expected to raise in future years.

The workforce is made up of 81% women and the average age of a carer is 44.6 years old, 29% of workers are aged over 55.

We know that the care industry is a heavy task focused job. We know that the care sector has a high turnover rate and staff are likely to move around in the sector, it is imperative that care sector workers have access to their pension at the end of their working lives, a solution would be to group pension pots together for a care worker pension scheme – again with worker voice and trade unions central to the pension board for its protection. Employers should also be moved to pay at least 5% employer fees as a measure to support those in long service to create an affordable retirement.

Question 6:

To what extent are the costs of inaction on adult social care reform considered by the Government when evaluating policies, including within the Budget and Spending Reviews? How should these costs be assessed and evaluated?

- **Private equity is rife in the sector and depletes publics funds into the pockets of shareholders through tax heavens. This public money is lost to the system and not reinvested through workers pay and improvements to terms and conditions.**

For as long as we have had members in the social care sector, GMB has made it clear that the ownership model is broken. When we assess the annual accounts of employers, we are met often with a labyrinth of group structures, with no clear operational purposes, and can see money being filtered up and on occasion out of the UK to tax havens.

The Centre for Health and the Public Interest (CHPI) refers to money leaving the sector not through tax, wages, or actual running costs, as 'leakage'.
Its research estimated in 2019 that £1.5 billion a year is taken out of the care system in profits disguised as rent payments and management fees. This equates to 10 per cent of the total money which goes into the sector annually, which when used as an alternative measure of profitability shows that the care sector returned nearly the same rate of profits as did all UK companies in 2019, which was 10.7 per cent according to ONS figures.
This 'leakage' is so out of control that even Jeremy Hunt suggested that the finances of private ownership needed to be investigated:

'It's the Wild West out there. We need the Competition and Market authority to make sure that market is operating in the interest of consumers, particularly the very vulnerable people who need that sector.'

Owners of failing care homes have paid themselves enormous salaries and dividends, to the cost of the taxpayer, fee-paying residents and their families, and at the expense of the workforce's pay packet. As reported in the Guardian, one care home operator owner paid himself over £20 million despite multiple breaches of health and safety standards.

There has been a mass transfer of care assets from the public to the private sectors. Research by Centre for International Corporate Tax Accountability and Research (CICTAR) estimates that the value of privately owned care home assets is now £245 billion. A considerable portion of the assets are the hands of landlords – homes transferred through 'sale and lease back' arrangements.

This is infrastructure that is vital to the health and wellbeing of our communities. The maintenance of this infrastructure is currently left to the decision-making of property developers, rather than strategic planning of local authorities or national government. As the demand for residential care grows, more of this wealth could continue to be concentrated in the hands of very few.

Care is judged on its quality of service – how well people are cared for should be the fundamental marker of success. The myth that the transfer of services to the private sector will lead to superior quality is undermined by the finding that 84 per cent of care homes run by local authorities were rated good or outstanding, compared with 77 per cent of for-profit homes, according to analysis of regulatory reporting.

Seven out of the ten largest providers in the residential care market – who account for a fifth of the overall market - are run on a for-profit basis:

Private equity has a large stake in our social care system, which can be described as 'capitalism in high gear'. As we have seen, private equity models have been responsible for much of the running-down of pay and terms and conditions in the sector. Classic private equity models do not seek to build and maintain essential services in our society – instead, they extract as much wealth as possible in as short of time as possible. These types of ownership are the antithesis to what society would consider 'caring'; while there has been little political will to challenge this type of exploitation directly, we must at least have greater transparency on the financial strategies of companies within the care sector.

Significant patterns emerge when we look into private equity funding. Controlling companies within groups are often registered as far away as the Cayman Islands, but also much closer to home, in Jersey.

There are different registered companies who the operations of care homes. While trade unions might negotiate across all these entities on behalf of our bargaining groups, the assets are split, and under this model there is the potential to spread money across lots of different legal entities.

These extremely complicated structures obscure the flows of money – much of it derived from taxpayers' fees. Every employee of a care provider should be able to readily understand where the money is going. It is clear that current UK company law is failing to ensure that public money is being spent in a transparent way. **GMB calls for new transparency standards and a public inquiry into the financial engineering of the care sector.**

There has been an increase in private equity takeovers across the economy in recent years. Across the economy, GMB is often confronted by cutthroat business management approaches following these takeovers. Private equity is difficult to fully define, but one of the most important concerns with its involvement in the sector is that debt is normally laden on the businesses that are taken over. This makes the focus of the financial structuring and management of care companies entirely about realising returns on the investment and managing the debt.

These firms often have short term approach to their investments. Typically, a private equity fund will tell investors that they will have a full return within a defined period – such as 5 or 7 years – which sets the clock ticking for short term cuts within the business, and it raises the chance of future TUPE transfers.

Care homes are now often sold and leased back. This has meant that assets have been transferred into the hands of landlords and care home companies are then required to pay rent on the properties they might have once owned.

This has proved to be a highly lucrative business for landlords. CICTAR research estimates that the care home property portfolio in the UK is worth £245bn. Annually, they assert that £1.5bn is paid in rent to landlords from care home companies.

Landlords are able to calculate profits bed by bed, and this is a standard industry measurement. CICTAR research found that '£3,181 was the profit per bed per year (£61 per week) made by landlords from the rent paid by all for-profit homes (at 85% occupancy)' and that £1.3bn was paid as rent to landlords by all for-profit homes garnering them an estimated £515m profit.

Landlords are able to raise rents when they like. The burden is felt throughout the care home operators. Wages are suppressed, resources are cut down on, and the cost to the service users goes up.

In contrast GMB members have told us that successive years of under inflation pay rises have left them struggling.

In 2021 it emerged that a care home company in Northern Ireland was effectively selling individual rooms within their care homes to investors.

This approach is not unique. Investment companies advertise that 'typical leases are up to 25 years with 10% net income.' They also state that their 'chosen developers work closely with the NHS trusts and local authorities to identify areas of significant demand and buy care homes in most under-supplied parts of the country – ensuring a buoyant market.'

While this model might furnish the care home with some up front capital to spend on the running of services, it further increases the debts from that home to yet another entity that will play no active role in the service of care.

While much of our membership lies in residential elderly care, we have an increasing number of members who work in domiciliary care. It is a hugely self-funded part of the sector. According to LaingBuisson the value of the homecare and supported living market in England is now £11.5 billion.

""I struggle to pay my priority bills due to being on a low income but working full time, I am finding that I am having to borrow money and take out loans to be able to afford food, gas and electricity. I live alone and walk too and from work yet still can't afford to live comfortably for the month." Senior Carer

Welsh Government saw the tentacles of private equity and the impact it was having on value for money for in children's social care and have taken the bold step through their policy 'taking profiteering out of social care' which aims to put measures in place through commissioning to allocate contracts away from profiteering companies, who do not meet the standards of Fair Pay. Meaningful efforts are made in Wales to in still workers voice and much can be learnt from their processes and policies.

Conclusion:

Commissioning work needs to take place during the formation of the Fair Pay Agreement Negotiating body – so that the principles of fair work and fair pay, are already agreed and embedded in the commissioning process.

Workers voice is essential to the process, the deliberate action over decades to reduce trade union influence in social care has played a huge role in the underfunding of this vital service.

Employers should expect that collective bargaining is the norm and worker voice should be central to their procurement bids and transparency for care sector employer accounts also results in local authority commissioners being able to make a decision on whether or not an employer is good value for the public funding.

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December 2024