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The forgotten third

MIGRANT CARE WORKERS' VIEWS ON IMPROVING CONDITIONS IN ENGLAND'S ADULT SOCIAL CARE SECTOR

VIOLATION TRACKER UK

WoRC
Work Rights Centre

About this series

Migrant workers play a crucial role in the UK economy and social fabric. Yet too often they are overrepresented in precarious work and excluded from employment justice. This series of publications seeks to document and expose these issues, making policy recommendations that can end migrant worker exploitation for good.

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About Work Rights Centre

Work Rights Centre is a registered charity dedicated to supporting migrants and disadvantaged British residents to access employment justice and improve their social mobility. We do this by providing free and confidential advice, and by publishing research which addresses the systemic causes of labour and social injustice.

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The views expressed in this report are those of the Work Rights Centre, and not necessarily those of reviewers. Any errors are our own.

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Executive summary

Working conditions in England's adult social care sector have long been in need of reform. Migrants in particular, who constitute as many as 32% of care workers, have been at the sharp end of exploitation, with recent evidence of fraudulent recruitment fees, wage theft, and modern slavery. And yet, despite facing well-documented risks of workplace abuse, migrant workers' voices are seldom represented in policy conversations on the future of the sector.

As the government prepares to embark on the most wide-ranging employment rights reform in a generation, including a Fair Pay Agreement for the adult social care sector, this report aims to plug the gap in migrant worker representation.

METHODS. We draw on 21 interviews and 71 survey responses from migrant care workers, as well as Violation Tracker UK's large-scale analysis of corporate regulatory infringements by 920 companies registered with the Care Quality Commission (CQC) - including 416 companies licensed by the Home Office to sponsor migrant workers.

FINDINGS. Overall, we find that migrant care workers are facing acute pressures across several areas. This includes:

- **Unsustainable working hours.** More than half (55%) of survey respondents were dissatisfied with their work schedules. Interviewees revealed a toxic dynamic whereby working hours were either all-consuming, with little time for family and self-care, or low and unpredictable, with barely enough hours to cover living costs.
- **Low levels of pay.** Three quarters (75%) of survey respondents were unhappy or very unhappy with levels of pay, and almost half (45%) of those who needed to drive between appointments were unpaid for travel time. Interviewees reported experiencing a demoralising cycle of financial insecurity, which failed to represent the complexity and social value of their work, and made it difficult to imagine staying in the sector long-term.
- **Persistent breaches of employment rights.** Nearly two thirds (65%) of survey respondents disclosed an alleged employment rights breach in the last 12 months, including health and safety breaches, bullying, and discrimination. More than a third (39%) of these respondents did not raise a complaint with their employer or make a report to an external agency, and interviewees reported that social pressure, mistrust of authorities, and fear of employer retaliation left them disempowered to raise grievances.
- **A punitive visa regime.** Research participants on the Health and Care Worker visa were particularly at risk. Interviewees feared that reporting their employers to authorities risked having their visa curtailed, and several carers described instances where employers used the threat of visa curtailment to silence grievances. Switching out of exploitative work situations was also problematic. While many workers (38) had tried to find a new sponsor, fewer than half (16) were successful.

Quantitative analysis of corporate infringements data by Violation Tracker UK uncovers that visa sponsor non-compliance is widespread. Cross referencing publicly available corporate violations data with the CQC and Home Office registers, the analysis finds that:

- A total of 177 companies with a licence to sponsor migrant care workers in August 2024 had a labour standards violations record, dated between 2020 and July 2024. This includes 42 companies that had more than one labour standards violation.
- Together, these companies lost a total of 225 Employment Tribunal cases during that time, for which they were ordered to pay more than £6million in compensation to workers.

RECOMMENDATIONS. To help raise employment standards for migrant care workers, we recommend that the government pursues two major strands of reform:

1. **Sector level reform.** This should start by including migrants' voices in the planned Negotiating Body responsible for the Fair Pay Agreement, and continuing with reforms that increase baseline levels of pay, invest in a career progression framework and training, and fix historic injustices relating to payment for travel time, sick pay and overtime pay, and the right to regular hours of work.

2. **Immigration reform.** This should ultimately address the power imbalance between employers and migrant visa workers, by empowering those workers to report non-compliance, leave exploitative roles, and take their labour to businesses that need and value them. The most effective way to achieve this would be by ending the sponsorship system that puts employers in charge of foreign workers' leave to remain. As a minimum, the Home Office should at least update policy to give visa workers more time to change sponsors, and ensure that those who suffered exploitation are given the unrestricted right to work to prevent re-exploitation and destitution.

The adult social care sector is at a pivotal moment. It is essential that the experiences and specific issues faced by migrant workers in the sector are addressed head on, rather than assumed to have been resolved through general reform measures. This report is the second in a series of publications, where the Work Rights Centre traces the risks of labour exploitation at the intersection of employment and immigration and unpacks the approaches needed to mitigate them.

1. Introduction

The adult social care sector is one of the largest in the UK labour market. As many as 1.59 million people were employed in the sector in England as at March 2024, according to Skills for Care, the strategic workforce development and planning body for adult social care in England.[1] By some estimates, more than 1 in 20 employed people in the UK work in care,[2] and the adult social care sector in England alone contributes over £68 billion to the economy - more than transportation, telecommunications, or food and beverage service activities.[3]

At its core, social care is what allows people in our communities to live safely and independently, irrespective of their physical and mental ailments. In 2023, care workers supported approximately 835,000 people in England who required long-term assistance,[4] and the sector is projected to grow substantially as the population of over 65s increases. In its latest report, Skills for Care estimates that 430,000 extra roles will be needed by 2035, if the workforce is to grow in line with these demographic changes.[5]

Despite its scale and importance, however, the care sector has historically suffered from significant issues. Low pay, unpredictable or all-consuming hours, and limited career development opportunities are three of the main issues affecting the workforce.[6] The end of free movement contributed to a significant crisis of staff retention and recruitment, which prompted a turn to international recruitment, primarily under the Health and Care Worker visa. In 2024, as many as 32% of care workers and senior care workers in England were non-British nationals.[7] Worryingly, shortly after the visa was introduced, reports of exploitation soared.[8]

The future of care is at stake. The newly elected Labour government has promised to create a new National Care Service, with the first step being establishing a Negotiating Body and Fair Pay Agreement for the sector.[9] Industry leaders have already started the hard yards of reform by publishing a workforce strategy for adult social care in England, which sets out recommendations for the sector to retain, train and transform the workforce.[10]

What has received far less attention is how any of these plans will be tailored to migrant workers, who constitute a sizeable proportion of the adult social care workforce, and experience significant additional risks. This includes the lack of unionisation, immigration restrictions that discourage migrant visa workers from reporting abuse and accessing their employment rights, as well as everyday racism.

This report aims to plug this gap. Drawing on primary research with migrant workers, both settled in the UK and working under the Health and Care Worker visa, and large-scale analysis of corporate infringements data, we aim to provide policymakers with a blueprint for inclusive reform that has both the capacity to respond to sector-wide challenges and the ability to address the acute and distinctive issues faced by migrant care workers today.

2. The adult social care sector

Adult social care encompasses residential care, which refers to the personal care provided to residents of care homes and nursing homes; domiciliary care, where professionals assist people in their homes to live independently; and live-in care, where support is provided around the clock. Other forms of social care can include community and day care services, which are focused on learning and social interaction.[11]

Although local authorities are responsible for commissioning publicly funded care services, the delivery of care is fragmented between as many as 18,500 organisations registered with the Care Quality Commission (CQC), England's independent regulator of health and adult social care.[12] In March 2024, of the 1,705,000 filled posts in the adult social care sector, the vast majority (79%) were for independent sector providers, with 58% in the private sector and 21% in the voluntary sector.[13] Local authorities, direct payment recipients, and the NHS each accounted for just 7% of filled posts.[14] The private sector currently plays the largest role in social care delivery.[15] Notably, this includes both organisations ranging from small businesses with a few employees to large national chains.

2.1. The social care workforce

The social care workforce is divided into several different job role groups. Direct care roles represent 76% (1,290,000) of all filled posts in adult social care in England. Of these roles, just over 70% are care worker roles (905,000), with the rest divided between personal assistants (123,000), senior care workers (82,000), and community support and outreach staff (56,000).[16] There are nuanced differences between these direct caring roles – for example, senior care workers tend to have more experience and more supervisory responsibilities than care workers. Community support and outreach staff tend to provide patients with support rather than direct personal care (e.g. they might help to organise day to day activities).

On the other end of the spectrum, 17% of filled posts in social care in England do not involve direct care giving activities. They are better described as administrative and ancillary posts that, nonetheless, include important activities like cleaning, catering, transport and maintenance roles. Managerial professionals, which make up a minority of the workforce (7%) and include registered managers and deputy managers, also play a crucial role in the sector by leading on the overall delivery of care and ensuring that staff are supported in their roles.[17]

The sector is heavily reliant on migrant workers. In March 2024, a total of 25% of the entire adult social care workforce were foreign nationals, with 6% being EU nationals, and another 19% being non-EU nationals.[18] The share of foreign nationals was even higher for direct care roles. Foreign nationals accounted for as many as 32% of care worker job roles, and 29% of senior care worker job roles (Fig. 1).

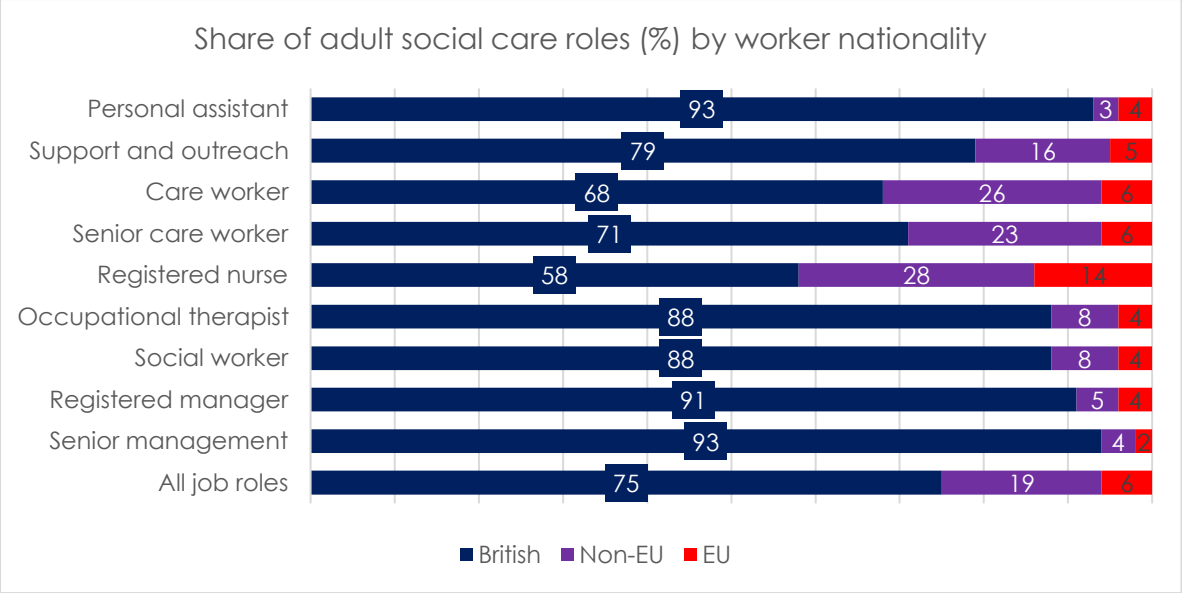

Figure 1 - Share of adult social care roles (%) by worker nationality. Source: 'The state of the adult social care sector and workforce in England', Skills for Care, 2024.

It is important that the figure for non-EU workers increased substantially as more British workers exited the workforce, and employers made strategic use of international recruitment on the Health and Care Worker visa (see Chapter 3). From 2021/22 to 2023/24, the number of posts filled by British nationals decreased by around 70,000.[19] Between February 2022 and April 2024, more than 111,000 care workers and 38,000 senior care workers received Health and Care Worker visas.[20] Overall, as many as 54% of large and 58% of medium-sized care providing organisations in England recorded using international recruitment to source care workers in 2023/24.[21]

The sector is highly feminised. Around 79% of the adult social care workforce in England is female - a figure that has remained relatively constant for at least a decade.[22] This makes the social care sector one of the most feminised sectors in the UK's low-pay economy. Looking at job roles defined by the Low Pay Commission as 'low-paid', the share of women is only higher in childcare roles (97%), hair and beauty roles (89%), and among public-sector nursing assistants (83%).[23] Many of the women who are professional carers are also mothers with dependent children (20%) - a higher share than in the rest of the labour market (14%).[24] This is an important statistic. As the Resolution Foundation notes, workers with parenting duties tend to require shifts at certain hours of the day, and may be more restricted to finding employment that is geographically closer to their home.[25]

Employee illness is common in the sector. According to Labour Force Survey data, an estimated 3.7% of care workers nationally experienced a recent work-related illness, compared with 2% across all jobs.[26] While the physical nature of the role likely plays a part in this statistic, inadequate employment conditions could also contribute to poor worker health. Care workers are 1.5 times more likely than the average worker to report stress, depression, or anxiety that is caused or made worse by their job.[27]

2.2. Work conditions

Despite the social significance of professional care and the economic importance of the sector, previous research with social care workers has identified several structural issues.

Low pay. In 2023/24, the median hourly rate of pay in the UK was £11.00 for care workers.[28] This was roughly 30% less than the median hourly rate of all workers in the UK (£15.88)[29] and, depending on geography, less than the Real Living Wage (RLW).[30] In March 2024, a majority of 63% of care workers in London were earning less than the London RLW of £11.95 per hour, and outside of London 36% of care workers earned less than the relevant RLW, which stood at £10.90 per hour.[31] Put into national context, wages in direct care provision were broadly comparable to those employed in elementary trades, sales and customer service, and housekeeping (Fig. 2).[32] At the peak of the cost of living crisis, some care providers reported having to support staff with access to basics, like food, fuel and toiletries.[33]

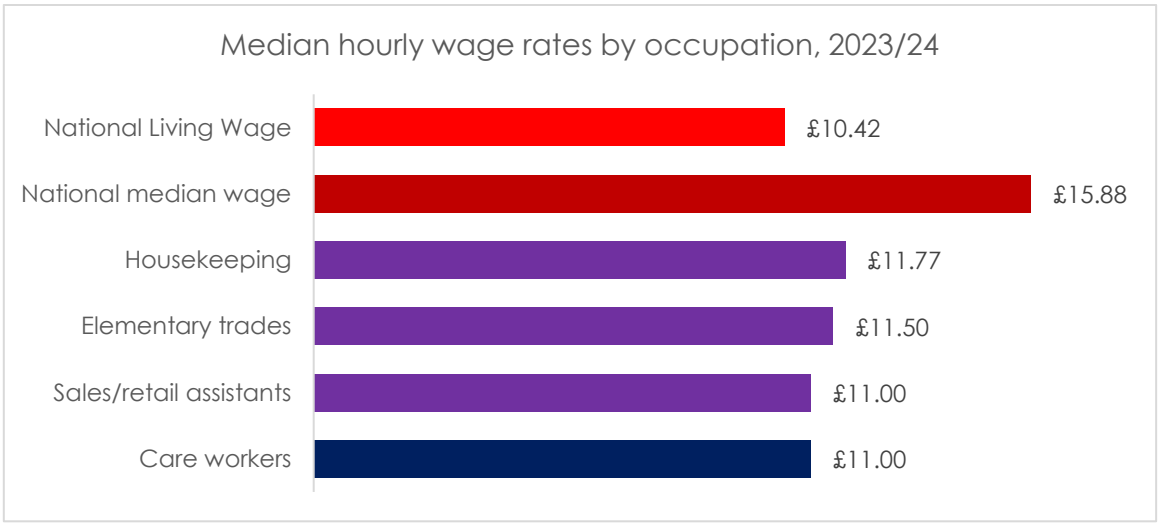

Figure 2 - Median hourly wage rates by occupation, 2023/24. Sources: Annual Survey of Hours and Earnings (Table 14.5a), April 2023 provisional data; 'The state of the adult social care sector and workforce in England', Skills for Care, 2024[i]

Minimal pay progression. Workers' ability to progress into better paid roles is also an issue, which has been exacerbated by recent economic downturns. On average, carers in England with five or more years of experience earn only around 10p more per hour than carers with less than a year's experience,[34] and the mean pay differential between care workers and senior care workers is around just £0.80 per hour.[35,36] This data is worrying, since progression into more senior roles is generally the only way to attain any pay rise. Changing employers while remaining in the same role has little bearing on pay progression, irrespective of tenure.[37]

[i] Annual Survey of Hours and Earnings is conducted at the start of 2023/24. Therefore, Skills for Care data, taken from the ASC-WDS survey, will include some in-year pay rises.

Pay rules do differ across the UK. Wales and Scotland have a slightly more generous system, where pay for social care staff is normally aligned with Real Living Wage rates. Both devolved nations also provided lump sum payments to carers in the height of the Covid-19 pandemic, in recognition of the high risk and social value inherent in the sector.[38] Despite this, no such agreements are yet applicable in England.

Zero hours contracts. The use of zero hours contracts that fail to guarantee a stable income is widespread. In 2023/24, as much as 21% of the care sector workforce in England were engaged on a zero hours basis.[39] Lower-paid workers were overrepresented on this type of contract, with just under one third of all care workers (29%) on zero hours, compared to 4% of senior management. Domiciliary care workers were particularly overrepresented, with 43% hired on a zero hours basis.[40] This is much higher than the average rate of zero hours contracts in the overall labour market, which sits at around 3.3% (Fig. 3).[41] While international recruitment has had a short-term impact in reducing the share of the care workforce on zero hours contracts by three percentage points since 2020/21 (as sponsored migrant workers must be provided with guaranteed hours),[42] overall the sector remains heavily reliant on a hyperflexible workforce.

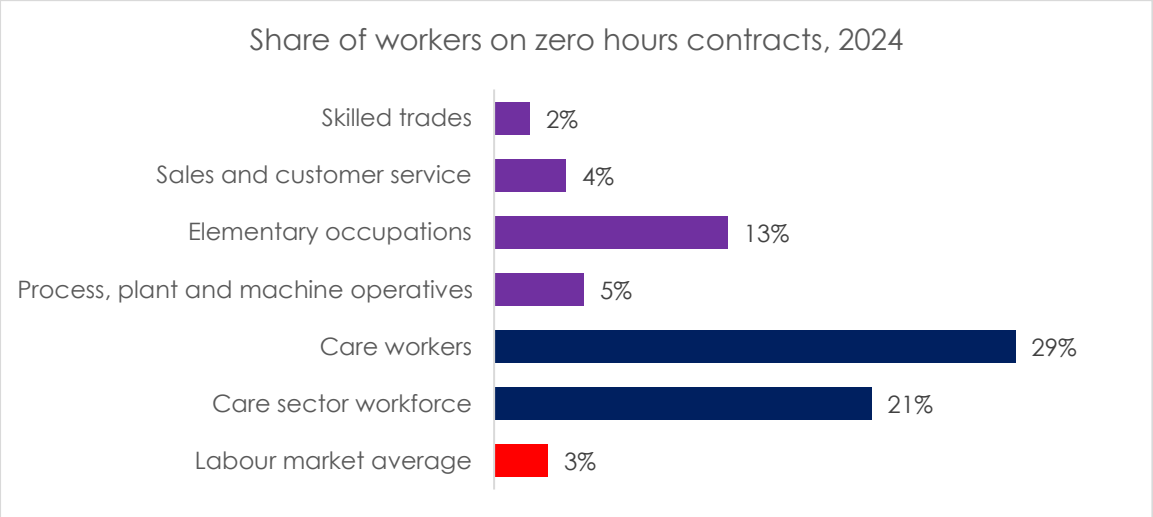

Figure 3 - Share of workers on zero hours contracts, 2024. Sources: 'The state of the adult social care sector and workforce in England', Skills for Care, 2024; EMP17: People in employment on zero hours contracts dataset (annual averages) (Table 7SOC20), ONS, August 2024

A missing professional development framework. Another significant issue stalling the retention of care workers has been the lack of meaningful training or development pathways. As at March 2024, more than half (56%) of all care workers had no qualification relevant to the social care sector.[43] While the CQC requires employers to provide basic levels of training, such as on manual handling of patients, health and safety, and fire safety,[44] the opportunities for training beyond this introductory level are limited. Previous research has noted that, in comparison with clinical staff working in the NHS, training for support staff who provide social care is "sparse and typically dependent on independent providers who are responsible for setting pay and

facilitating training opportunities".[45] Skills for Care, which helps social care employers provide education and development opportunities, has a budget[46] roughly 200 times smaller than the approximately £5billion budget of Health Education England.[47]

In 2015, Skills for Health, Skills for Care and NHS England launched a Care Certificate as an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sector.[48] However, issues with re-completion when changing jobs and a lack of external validation have meant that it has been seen "as of little value".[49] A new accredited and portable qualification, the Level 2 Certificate, was launched in June 2024, but it remains to be seen how successful this will ultimately be.[50]

2.3. A crisis of recruitment and retention

Given the range of workplace issues identified, it is perhaps not surprising that the adult social care sector is struggling to recruit and retain staff. This was exacerbated by a lack of long-term workforce planning by the government, the loss of staff coming from the EU after Brexit, as well as the knock-on effect of shortages on remaining staff, who were forced to work under increased pressure.[51] In a recent CQC survey of adult social care providers in England which included over 1,900 respondents, more than half (54%) said they were having challenges recruiting new staff, and 31% said they were having challenges in retaining them.[52]

In 2023/24, the vacancy rate in adult social care in England stood at 8.3%, the highest of any major industry and more than three times higher than the national average (Fig. 4).[53] Vacancy rates vary across job roles. Vacancy rates are much higher for care workers (9.9%) than senior care workers (5.4%), but are comparable to other social care occupations.[54] This suggests a struggle to recruit against the full spectrum of roles in the sector.

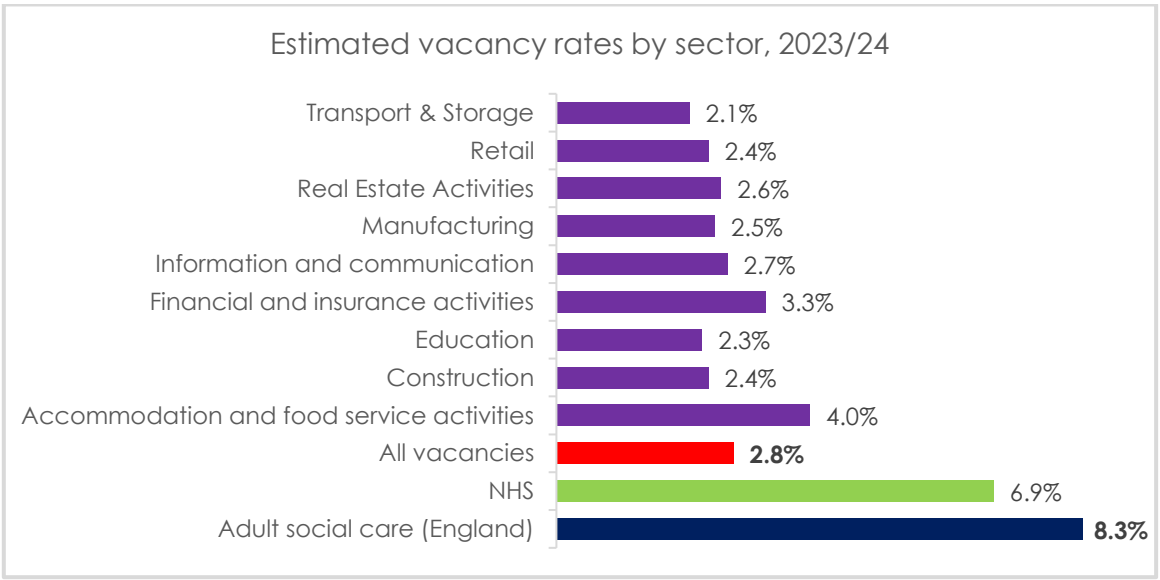

Figure 4 - Estimated vacancy rates by sector, 2023/24. Source: Skills for Care estimates, NHS digital, ONS Vacancies Survey (13 February 2024).

In some way, the workforce is being renewed. As many as 43% of new recruits come from outside of adult social care (and among them the majority are from outside the health and care sector entirely).[55] However, these new workers are poorly retained. At least 41% of people in care worker roles left their jobs before the end of their first year in the sector.[56] Although there is limited literature on turnover in the sector, a 2023 study commissioned by Skills for Care found that poor workplace culture (30%), burnout or stress (20%), lack of progression opportunities (19%), and pay (16%) were the most commonly cited reasons for leaving adult social care.[57] This points to a real risk of understaffing in the long term, as well concerns around the continuity of the provision of care.

2.4. Systemic roots of the workforce issue

The workforce crisis in England's adult social care sector and the erosion of work conditions did not happen in isolation. An underfunded budget for social care has led to intense price competition in the commissioning process across the country. The result of this competition has ultimately been passed onto workers who, in a fragmented system, have lacked the bargaining power to challenge poor conditions and secure better protections.

Cuts to local authorities have been devastating. Social care is the biggest area of council spending in England after education, accounting for 16.1% of local authorities' net current expenditure in 2022/23.[58] However, in the context of severe cuts to local authority budgets and an ageing population, spending per person on social care has fallen significantly in real terms. Analysis by the Health Foundation found that between 2009/10 and 2024/25, age-adjusted spending per person fell by 5% (although there has been a continuous recovery in spending since a trough in 2014/15).[59]

The combination of budget cuts and rising demand has left local authorities with little choice but to pass austerity measures of their own. The UK Homecare Association, a membership body dedicated to supporting homecare providers, reported in late 2023 that fee rates offered by local authorities to independent providers of homecare services were on average 25-35% lower than what was required to pay workers fairly and deliver high-quality, sustainable services.[60] Trends like this have meant that an increasing number of care providers are struggling to stay in business. In spring of 2024 the Association of Directors of Adult Social Services (ADASS) reported that 90% of directors of adult social care in England either had no confidence or were only partially confident that they could meet their statutory duties in 2024/25.[61] Furthermore, 65% of directors had reported that providers in their area had closed, ceased trading or handed back council contracts in the past 6 months.[62] This, in turn, has a knock-on effect on other services. As noted in the recent Lord Darzi review of the NHS in England, the pressures felt by social care impacts the entire health ecosystem, with as many as 13% of NHS beds occupied by people waiting for social care support or care in more appropriate settings.[63]

The privatisation of care has arguably turned the problem of budget cuts into a race to the bottom, according to analysis by the Institute for Public Policy Research (IPPR). As independent providers compete to secure increasingly less financially realistic care contracts from local authorities, workers often carry the load. For example, since the shift from largely public to private provision of care, the majority of savings in the cost of care have come from halving labour costs, rather than through greater efficiencies elsewhere.[64]

Poor bargaining power has made it harder for workers to challenge this trend. Previous analysis from the IPPR has suggested that around one in five care workers and senior care workers are members of a trade union or a staff association, compared with around four in five nurses who are members.[65] The latest statistics also suggest that around 17% of those involved in residential care activities are unionised, compared with 52% of those involved in human health activities.[66] There is also a discrepancy in workers' abilities to negotiate their pay. Most staff employed directly by local authorities in England are covered by the National Joint Council for Local Government Services, which determines pay and terms of conditions of employment for those workers.[67] Interestingly, while only 7% of care workers are directly employed by local authorities, they enjoy higher pay rates (around £1.20 extra per hour for care workers and £3.00 extra for senior care workers).[68] By contrast, the collective bargaining power of workers employed in the independent sector is significantly more limited.

Lack of general workforce planning. Despite being responsible for overseeing adult social care policy and workforce strategy, the Department of Health & Social Care has repeatedly failed to get a grip on the growing workforce crisis. In 2018, the National Audit Office (NAO) mentioned that the department had no "national strategy" to address workforce challenges in the sector.[69] By 2023, despite the announcement of various reform packages, the NAO's view was that the department still did not have "an overarching programme to coordinate its reforms" or a "theory of change" for how system reform measures contribute to long-term reform outcomes.[70]

3. The social care policy agenda

Successive governments have rightly worried about workforce trends in adult social care, not least due to their impact on the country's ability to cope with demand. Demand for care has increased substantially since 2016, and initial projections based on the growth of the over 65 population in England, suggest that the sector may need to fill an extra 430,000 posts by 2035, representing a 23% growth rate between 2023/24 and then.[71]

In this chapter, we examine some of the recent proposals to reform the sector put forward by successive Conservative governments, the use of the Health and Care Worker visa to plug labour shortages, and what the current Labour government needs to get right to address the risks for migrant workers.

3.1. Conservative proposals

Previous Conservative governments announced several proposals relating to care in the span of just a few years. On 1 December 2021, the Boris Johnson government outlined its ten-year vision to improve adult social care in The People at the Heart of Care white paper.[72] The paper outlined a long-term intention to fund training and development, new technology, and local authorities, to the tune of billions of pounds.[73] It included £3.6bn for changing the way that people pay for care (charging reform),[74] and £1.7bn for wider reforms to the system (system reform).[75] One example of the reform suggestions was at least £500million on training the workforce. Another initiative was to spend at least £300million to integrate housing into local health and care strategies, to increase the range of supported housing available.[76]

Cracks in the government's plans soon began to show. In 2022, it had to reprioritise some of the allocated funding to help ease immediate pressures, including delaying charging reform by two years to October 2025.[77] During the passage of the Health and Care Act 2022, the government also rebuffed, on three occasions, efforts to make it mandatory to produce independently verified assessments of current and future workforce numbers every two years.[78] In April 2023, the government produced a revised policy document that cut back or abandoned measures from its original white paper.[79] This included reducing the training allocation funding to £250million, and the housing integration plans to £102million.

On 10 January 2024, the Rishi Sunak government announced another set of reforms aimed at training and professional development, this time launching the Care Workforce Pathway, a national career structure for the adult social care workforce.[80] An Adult Social Care Training and Development Fund was also proposed to help support up to 37,000 individuals in direct care roles to enrol onto a new Level 2 Adult Social Care Certificate.[81]

Many of these policy announcements, however, were affected by the election of a Labour government in July 2024. The new government has already scrapped the Adult Social Care Training and Development Fund,[82] and it has similarly scrapped the

charging reforms due to be implemented in October 2025.[83] The most consistent Conservative legacy in the social care sector in recent years has arguably been using the immigration system to plug the significant workforce gaps through international recruitment. Namely, this is the adoption of the Health and Care Worker visa.

3.2. The Health and Care Worker visa

The Health and Care Worker visa was introduced in August 2020 as a subset of the Skilled Worker visa. It was designed to incentivise, by way of reduced fees and other aspects, health and care professionals to come to the UK to work with the NHS, an NHS supplier, or in adult social care.[84] In February 2021, the visa was expanded to add care workers, care assistants and home care workers under its remit.[85] Just one year later, in February 2022, the Home Office added care workers and home carers to the Shortage Occupation List, meaning both roles would benefit from a reduced salary requirement that made it cheaper for UK care providers to hire overseas workers.[86]

The visa works by making a migrant's permission to enter and remain in the UK contingent on, respectively, having a job offer from and thereafter being employed by a business licensed by the Home Office to sponsor them. At the time of writing, the application fee for the visa is either £284 per person or £551 per person, depending on whether the visa is valid for up to 3 years or longer, respectively. Migrants must also demonstrate to the Home Office that they have at least £1,270 in their bank account, to show that they can financially support themselves whilst in the UK (unless their employer certifies maintenance for them in the first month of their employment).[87] In terms of their rights under the visa, sponsored workers can only work full-time for the employer specified by their visa as their sponsor. They may take on additional work in eligible occupations (up to 20 hours a week), volunteer, and study – on the condition that they remain employed by their sponsor. The visa offers a path to permanent settlement, but visa holders cannot access public funds, and they cannot change sponsors unless they make an application to the Home Office (which carries an additional cost). Crucially, if they are dismissed, if they resign, or if their sponsor loses their licence through no fault of the workers, migrants on this route have up to just 60 days to find a new sponsor (from the date their visa is curtailed by the Home Office), make an application, and pay for a new visa.

The Health and Care Worker visa has been incredibly popular. Between Q1 2021 and Q2 2024, a total of 270,653 visas had been issued to main applicants under the route (Fig. 5), with Indian, Nigerian, Zimbabwean, Filipino and Ghanian individuals representing the top five nationalities. In the same period, 377,135 dependant visas were issued under the route. International recruitment into the care sector also occurred from within the UK. In the year ending June 2023, 26,200 students and graduates switched from the Study Route to the Health and Care Worker visa, as care and senior care workers.[88] However, a mix of stricter Home Office due diligence checks when licensing employers and government changes to the route (see after Fig. 6) have prompted a significant dip in numbers in 2024.[89,90]

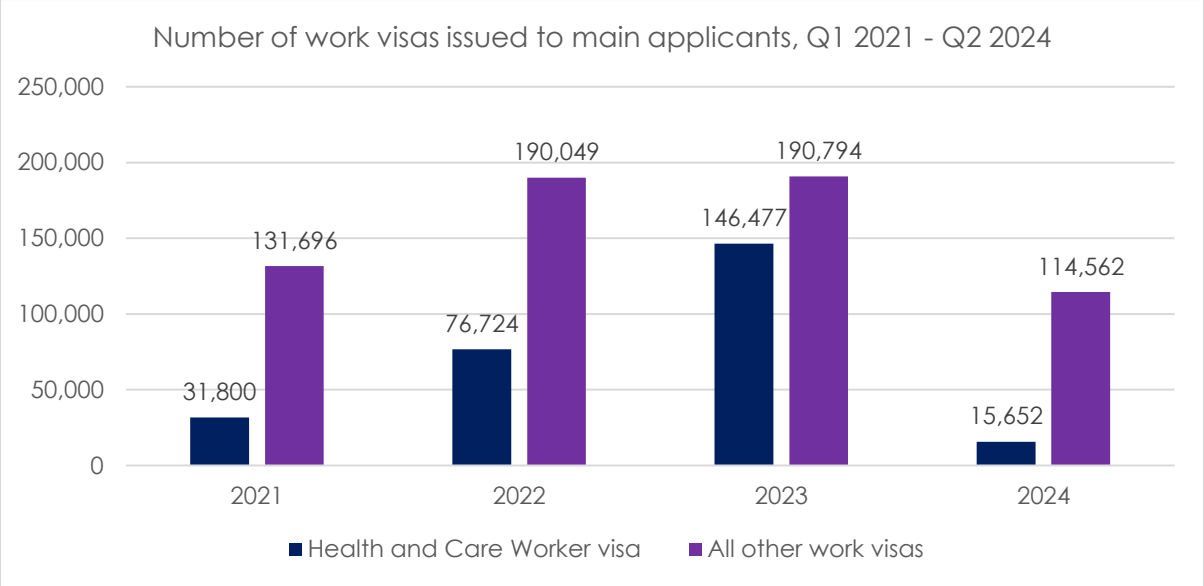

Figure 5 - Number of work visas issued to main applicants, Q1 2021 – Q2 2024. Source: Home Office Immigration system statistics quarterly release, Entry Clearance data tables, Q4 2023.

As of Q4 2023, care workers and home carers have accounted for most of the visas, with 109,100 visas issued (Fig. 5). That is more than 40,000 higher than the visas granted for nursing roles, the second most popular occupation, and over 70,000 higher than for senior care workers. Overall, the visa appears to be predominantly used to recruit migrant workers into the lowest paid positions.[91] Occupational data was not available from Q2 2024 onwards at the time of writing.

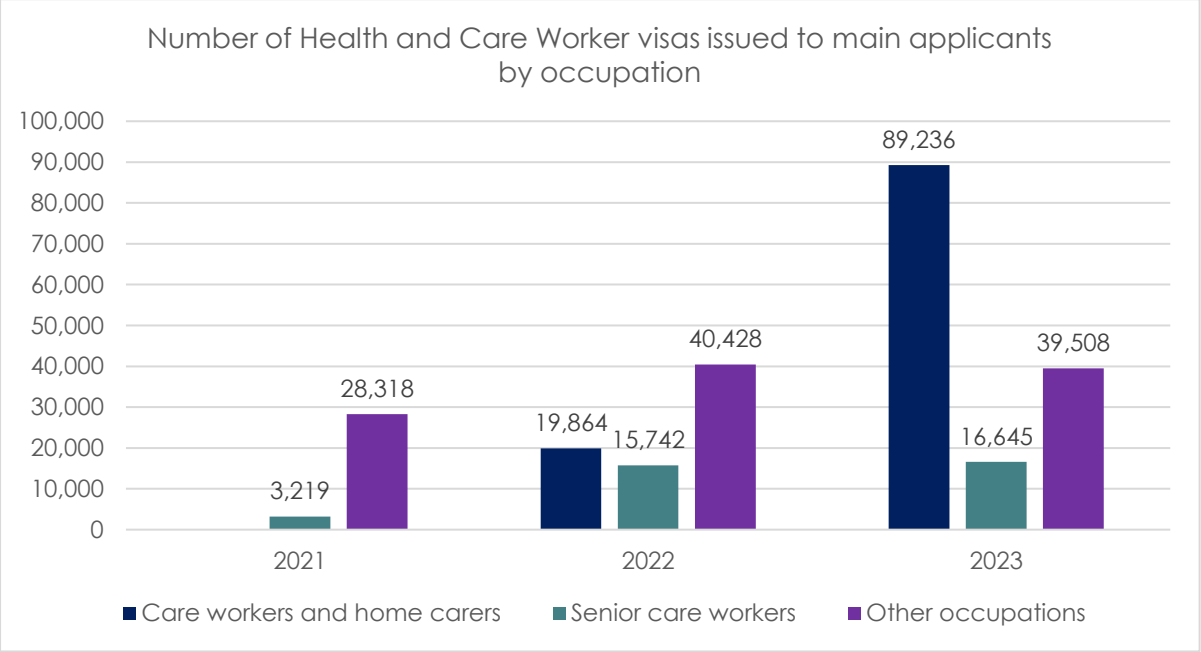

Figure 6 - Number of Health and Care Worker visas issued to main applicants by occupation, 31 December 2023. Source: Home Office Immigration system statistics quarterly release, Sponsored work visas by occupation and industry, Q4 2023.

The Conservative government's long-standing commitment to reduce net migration, even when it conflicted with economic interests, led to U-turns in policy. In December 2023, the Sunak government announced a raft of measures designed to bring net migration figures down rapidly.[92] In respect of the Health and Care Worker visa, the government announced that new applicants would no longer be able to bring overseas dependants with them to the UK, while care firms in England would have to be regulated by the CQC in order to sponsor workers moving forward. In January 2024, the then minister for Social Care Helen Whately also outlined that "international recruitment is not the long-term answer" for the UK's health and social care workforce needs, instead pointing to the government's workforce plan focused on "investing in training our home-grown healthcare workforce".[93]

The measures took care workers, businesses, and their advocates by surprise. Some policymakers warned that the changes would arbitrarily enforce a separation of care workers from their children and partners, while also increasing the risk of destitution and exploitation - as sponsored care workers would have just one income to rely on, and thus have less financial mobility.[94] Separately, Care England, a body that represents the main care chains in England, told the Health and Social Care Select Committee that operators were "annoyed" by the government's changes, which had been implemented without consultation with care homes and the Department of Health and Social Care.[95] Even the CQC noted that if the changes led to increased registrations with the CQC, it would raise concerns about its resources and capacity to respond to this.[96]

The changes have done little to stifle exploitation in the sector or to add avenues of redress for workers. Since 2022, there have been countless media reports and case studies from civil society organisations describing sponsored care workers who, among other issues, were charged tens of thousands of pounds in illegal recruitment fees[ii] to secure their visa, but were given only a fraction of their pay, or no pay at all.[97,98,99] Other reports included workers coerced into accepting substandard conditions of employment. The Independent Chief Inspector of Borders and Immigration (ICIBI) noted that the Home Office's control measures to mitigate these risks of exploitation had been "totally inadequate".[100] By the end of 2023, social care was the top sector for reported potential exploitation cases in the UK with 135 GLAA reports, a fourfold increase compared with reports made in 2022.[101] Similarly, in October 2024 the CQC noted that in 2023/24 it had made 106 referrals to partner agencies regarding modern slavery and labour exploitation concerns, three times higher than in the previous year.[102]

[ii] Under the Employment Agencies Act 1973, it is, generally speaking, unlawful for employment agencies in the UK to charge a fee for finding work, though there are some exceptions. Internationally, the position differs depending on the jurisdiction. However, overseas recruitment agencies licensed by the Gangmasters and Labour Abuse Authority are prohibited from imposing work-finding fees as part of its licensing standards. For more information, see here.

3.3. Labour plans for reform

The Labour Party promised fundamental reform of the adult social care sector.[103] In its manifesto document, Labour included an aim to create a National Care Service to deliver consistent standards across the UK, with a focus on supporting people to live independently for as long as possible. After the general election, Prime Minister Keir Starmer announced that his government was building a "10-year plan" for healthcare reform, which would include shifting care from hospitals to communities, and integrating health and social care. The plan is expected in spring 2025, following a period of consultation.[104]

The government also announced a raft of policy proposals aimed at the social care workforce, and at workers more generally. The much-anticipated Employment Rights Bill, published on 10 October 2024, paves the way for the creation of an Adult Social Care Negotiating Body, with a remit to negotiate terms and conditions of employment, pay and training standards across the adult social care sector.[105] The Negotiating Body is the first step towards the delivery of the manifesto promise of a Fair Pay Agreement for carers.[106] Other notable proposals in the bill include pledges to give zero-hours workers the right to guaranteed hours reflective of their usual schedules in a 12-week reference period; grant shift workers the right to receive notice and compensation for cancelled shifts; entitle workers to rights, such as parental leave, from the first day of work; and facilitate union representation. Notably, the bill also proposed unifying the complicated network of agencies involved in labour rights enforcement within a single Fair Work Agency, and establishing an Advisory Board of trade unions, employers, and independent experts to inform the government's labour market enforcement strategy.[107]

In many ways, these proposals constitute an important political recognition of the fact that the social care sector requires an urgent and fundamental rethink, including on its workforce. The Employment Rights Bill has been widely regarded as the biggest uplift in workers' rights in a generation.[108] The Negotiating Body it proposes could go some way to mitigate the power imbalance inherent in a fragmented and under-unionised workforce, and the Fair Work Agency could engender a culture of compliance. The extent to which these proposals achieve their intended outcomes, however, depends on the complex journey of delivery, and the inclusion of relevant stakeholders in their operationalisation.

Reflecting on the Labour government's plan for sector reform, sector experts at the Nuffield Trust,[109] Health Foundation,[110] and Community Care[111] raised the importance of detail (particularly regarding the proposal for a National Care Service),[112] a timetable for reform,[113] and adequate funding. Over four in ten adult social care providers closed parts of their organisation or handed back care contracts in 2023 because of cost pressures.[114] Another aspect of Labour's plan for social care that received considerably less attention is the need for a credible plan to address the urgency of migrant worker exploitation.

Labour's plans for sponsored migrant care workers

The Labour Manifesto included a pledge to reform the points-based immigration system (which underpins the system of employer-sponsorship behind the Health and Care Worker visa and most other work visas), so that it is "fair" and does "not tolerate employers or recruitment agencies abusing the system".[115] Separately, in June 2024 the then Shadow Home Secretary Yvette Cooper backed calls for a full investigation into the experience of people who say they have been left trapped in the UK with soaring debts, and little or none of the work they were promised.[116] At the time this report was published, we were yet to receive detail regarding the delivery of these two important proposals, beyond an announcement that businesses who break work visa rules would be banned from sponsoring migrant workers (which was already enshrined in existing rules).[117]

At an operational level, however, a few things are of note. Firstly, the Home Office has ramped up its enforcement action against sponsors in the form of licence suspensions and revocations. In the second quarter of 2024, 524 Skilled worker sponsors had their licence suspended, while 499 had their licence revoked. This is the highest number of suspensions and revocations in a quarter since records started in 2012.[118] Secondly, according to an answer from the Home Office to a written question by Olivia Blake MP in February 2024, the Home Office is working with local authorities to time the revocation of sponsor licences to delay the cancellation of workers' visas and to allow them the opportunity to find new sponsors.[119]

Additionally, the main approach to protect sponsored migrant workers appears to be the provision of £15million to regional partnerships to "support them to prevent and respond to unethical practices in the sector".[120] This "includes funding support for international recruits to understand their rights, and establishing operational processes with regional partnerships to support individuals to switch employers and remain working in the care sector when they have been impacted by their sponsor's licence being revoked". Details of how these processes can be accessed by sponsored migrant workers are yet to be revealed. Anecdotally, our contacts within regional partnerships have indicated that the "displaced worker rematching" service is still being piloted, as local authorities and their contractors grapple with (1) the complex problem of conducting due diligence on thousands of small employers, to ensure that workers are not exploited again; and (2) the separate issue of encouraging law-abiding, but risk averse, employers to recruit visa workers.

It is fair to acknowledge that the government has only been in post for a few months. While delivery is in its early stages, in this time ministers will have had the chance to understand both the acute crisis of sponsored care workers' exploitation, and the chronic issues experienced by the adult social care workforce as a whole. What is also important for the government to grasp is that sponsored workers are a major stakeholder on both levels. In the same way that foreign carers are not a temporary fix to the problem of recruitment, but have propped up the sector for years, their views on what it takes to make care work sustainable are not limited to the abuse by visa

sponsors, but are pertinent to conditions in the sector overall. With a 32% share of care worker roles in England, and a 20% share of the UK workforce as a whole, the voice of migrant workers is key to ensuring that the Negotiating Body delivers for the adult social care sector,[121] that the Employment Rights Bill is inclusive of the most vulnerable workers, and that the immigration system does not put employers in a dangerous position of power. It is this voice, that of workers themselves, that we seek to bring forward in this report.

4. Methods

This research report utilises a mixed-methods approach, combining interviews with migrant care workers and online survey data. Both pieces of primary research were carried out by the Work Rights Centre. Separate analysis of corporate regulatory infringements by Violation Tracker UK is included in the Appendix.

The geographic focus of this report is England, the region with the largest number of care homes and service users across the UK.[122] This research relies on purposive samples of migrant care workers. All but one research participant had been employed in the direct provision of care within the last three years, as either care workers or senior care workers, or in an analogous role (e.g. care assistant). Recruitment of survey participants took place via social media networks, while interview participants were also recruited through snowballing and Work Rights Centre's own service user base.

Interviews with care workers. Between April 2024 and May 2024, we interviewed 21 care workers. Questions ranged from their journey into the sector, to everyday work schedules, relationships with colleagues and management, experiences of employment breaches, and views on changes needed across the sector. Interviews lasted up to 60 minutes each, and participants were compensated with a £20 voucher for their time. Additional questions were asked of workers on the Health and Care Worker visa to capture experiences of recruitment and the visa regime, which are specific to sponsored workers.

All 21 interviewees were foreign-born. Nine of them held a Health and Care Worker visa, seven had obtained British nationality, two held status under the EU Settlement Scheme, and three had a different or undisclosed immigration status. By ethnicity, 16 participants identified as Black African, three were Eastern European, and one each were Asian and Black Caribbean. Our sample consisted of 11 female workers and 10 male workers. Workers had varying experience in the sector, ranging from under one year to seven years. A total of 18 respondents were still employed in the sector, while three respondents had previously worked in care.

Survey of care workers. Between 12 June 2024 and 2 July 2024 we carried out an online survey of care workers, with questions broadly mirroring the structure of the interview guide. The survey was carried out to triangulate interview findings. Unlike interviewees, survey respondents were not compensated.

We received 71 valid responses to our survey from foreign-born care workers. In terms of their immigration status in the UK, 54 respondents (76%) held a Health and Care Worker visa, seven were settled, five had a student or graduate visa, four held British citizenship, and one respondent did not specify their immigration status. A total of 53 respondents (75%) were born in Sub-Saharan Africa, with the most common countries of birth being Zimbabwe (29 respondents) and Nigeria (13 respondents). A further eight respondents were from South Asian countries, six from the EU, three from the Philippines, and one respondent did not specify their country of birth. Almost two thirds (68%) were between the ages of 35 and 49, a quarter (24%) were younger than 35, and the rest (8%) were between the ages of 50 and 65. In terms of gender, 53 respondents identified as female, and 18 as male, reflecting a 75%-to-25% split. For those respondents who received work from their employer (62 respondents), 44 had no more than two years' experience (71%), 11 had between two and five years' experience (18%), and seven had more than five years' experience (11%).

Limitations. The main limitation of this research is that the samples are non-random. Our survey data is not representative of all foreign-born workers employed in direct provision of care in England. For instance, due to the online nature of data collection, we may be under-representing workers not on Health and Care Worker visa, or those who are older. Nevertheless, given the lack of research specifically focused on migrant care workers, particularly those on an employer-sponsored visa, the data offers valuable insights into an at-risk and difficult to reach population. Furthermore, given the systemic nature of issues raised by respondents, it is reasonable to assume that these issues are not exclusive to our sample, and warrant serious consideration.

Our position and assumptions. As a charity dedicated to supporting migrants and disadvantaged Britons to access employment justice, our mission is not just to evidence labour exploitation, but to use evidence to advocate for policy changes that represent and support the people we interviewed and our beneficiaries. This also informs our assumptions. We assume that respondents accurately represent their experiences and that they are genuine care workers.[iii] We assume that migrant workers, whom we define as people born abroad, experience additional barriers to workplace justice. Perhaps, most importantly, we assume that their voices deserve better representation in policy conversations.

Ethics. All recommendations in this report were developed together with a dedicated Lived Experience Advisory Board. Comprised of four of our interviewees, our Board shared their experiences and views on what needs to change. Participation was voluntary, and interviewees were informed of their right to end the interview at any point, ask to see their data, or withdraw it. Throughout the report, pseudonyms are used to refer to interviewees.

[iii] Because primary research was conducted online, we introduced screening questions into the Expression of Interest form, and suspended an interview where we were not confident that the interviewee was a genuine care worker. We also did not provide a 'thank you' voucher to survey respondents, to ensure respondents had genuine interest in sharing their experience.

5. Findings

5.1. Journeys into care

Most of the care workers we interviewed expressed sincere passion for the act of caregiving. Asked about their journeys into the sector, they highlighted the altruistic elements of the profession and the ability to have a positive, tangible impact on other people's lives, a finding consistent with those from a 2023 report commissioned by Skills for Care.[123] Many also expressed great affection for their clients and colleagues, and the relationships they had developed on the job. Althea, a care worker from the Philippines, was one of 14 interviewees who described her professional history as driven by passion.

> *"I was a nurse. I came to work in the private hospital. Later, I got to switch to home care, to have an impact on people's lives. I thought it was interesting and was glad to be part of someone's life. I love creating a story, like people mentioning my name in a way that I was there for them. It's not all about the money, it's my passion. And caring for people, putting smiles on people's faces, makes me happy."*
>
> ***Althea, Filipina care worker***

Migrant workers on the Health and Care Worker visa echoed this sentiment. For many who had made a considerable investment in relocating, there was also an expectation that the UK would open the way to higher living standards, more secure wages and an overall better economic position compared to their country of origin. Emeka, a Nigerian care worker, described the joint pressures of social and economic instability which motivated him to look for work in the UK.

> *"The conditions back home at some point were not okay. In terms of security, in terms of [the economic situation]. Those were the two major reasons why I came back to the UK. First, the Naira was falling [in value]. Secondly, the security situation in parts of Nigeria was getting worse. There was no point in staying back."*
>
> ***Emeka, Nigerian care worker, Health and Care Worker visa***

Workers who arrived under the Health and Care Worker visa had made significant, life-changing efforts to come to the UK. They all had to pay a visa application fee. Before the government introduced a ban on sponsored care workers bringing dependants to the UK, a family of four would be paying more than £2,200 on application fees for a 4-year visa, and thousands more on flights. As Kudakwashe, a Zimbabwean care worker described, in this context some workers had to borrow money from friends and family to make up the cost, while others sold nearly everything they had – cars, property and other possessions – to facilitate a move to the UK.

"For someone coming from Africa it is really expensive. To complete the whole process, including my family moving in, we had to sell everything we had, we had to sell our car, we had to sell our property. We had to borrow money for the flights. When you're in the UK, you know, the amount seems small, like when you're told it's "only 270 pounds". It sounds like a small amount but when you're, you know, in Africa, that's really a lot. You have to save for so many months to be able to raise such a small amount in UK terms. So it was quite an expensive process."

Kudakwashe, Zimbabwean care worker,
Health and Care Worker visa

International recruitment fees. At the most extreme end, sponsored workers described paying thousands of pounds in recruitment fees to agents in countries of origin, who made a business of immigration consultancy, or directly to their employers. One worker we interviewed paid over £10,000 in agent fees, only to arrive in the UK to find that no work was available. Other workers reported having recruitment costs deducted directly from their wages, including one individual who was still experiencing this a year into their role. Survey data echoes these findings. Of 54 respondents on the Health and Care Worker visa, 20 (37%) had paid recruitment fees, including 11 who had paid £10,000 or more. Payment was reported by workers of diverse nationalities, including Bangladeshi, Burundian, Pakistani and Zambian.

The high prevalence of recruitment fees echoes the testimonies of Work Rights Centre clients and the numerous reports[124,125] on the risks inherent in the Health and Care Worker visa. Financial exploitation at the point of recruitment is a current and recurring problem for which, remarkably, there is virtually no remedy available in the UK - save for complex court claims which can take years of legal advice, and where enforcing judgments is still a major obstacle[126]. While many described the sacrifices they made to pay for the opportunity of working in care in the UK, there was generally a sense of resignation in our interviewees' accounts.

In many ways, the same sense of loss is reflected in the UK government's stance. While it is arguably the very limited accessibility of sponsorship under the Health and Care Worker visa that compels foreign workers to pay the fees, there is no official UK mechanism to compensate them. Labour enforcement agencies and the Home Office appear to treat the problem of recruitment fees as a phenomenon that happens abroad, beyond their jurisdiction. The UK lacks government-to-government agreements to regulate recruitment channels. In fact, many of our research participants came from designated red-list countries with severe shortages of healthcare workers.[127] In this context, most of the workers we interviewed felt they had only themselves to rely on - work hard, stay focused, and try to make up the fees with extra hours. As we uncover in the next section however, this came with a personal cost.

5.2. Working hours

Though some workers were happy with the hours they were given, there was a general sense of dissatisfaction with the nature of the work. At one end of the spectrum, research participants described their work volume as being so high, it left little time for family, leisure, or essential self-care. At the other end, workers were struggling to secure even the minimum number of hours to cover everyday living costs. Whether there was an excess or an absence of hours, across the sample there was a sense that something had to change. Less than half (45%) of survey respondents were content with their hours. Without prompting, 15 of 21 interviewees described how excessive or scarce hours affected their health, relationships, and ultimately the ability to get by.

The problem of overwork. Almost a third (32%) of survey respondents (19 people) reported working more than 48 hours per week, the maximum, average weekly hours permitted by Working Time Regulations 1998, unless the worker agrees to exceed this limit. This was echoed by interviewees, some of whom included working mothers who reported being unable to take care of their children because they were at work for extended periods of time. In one interview, a worker reported having about 60 hours of contact time with clients each week, but a total working time of close to 100 hours due to driving between clients' homes.

> *"You get to hear stories of other people who've come through and their companies don't have any work. The company I work for has quite a lot of hours. I work about 60 hours a week, which is only the contact time that I do with the clients […]. It's actually probably much more than the 60 hours, because I have to travel around in between. So sometimes it can get up to 90. Probably 100. And sometimes you don't really get much of a social life because you're mostly at work."*
>
> ***Kudakwashe, Zimbabwean care worker, Health and Care Worker visa***

Long hours are demanding in and of themselves, but in the care sector labour is particularly intense, with workers complaining about the impact on their physical and mental health. Zuzanna, another interviewee, recounted doing 55-hour weeks which felt like "carnage to the system". She had left her role as a care worker long before our interview, but had since remained active in the sector in other capacities. The parallels between her experience and what other workers were still encountering years later throw light on the obstinate culture of overwork.

> *"I would say it was around 55 hours of work a week [that I was working]. It was a long time ago, but it was a lot of hours. It was a mixture of days and nights. And I think if you ask any medical professional, they will tell you that that is just a carnage to your system when you just mix being up all night with all-day shifts."*
>
> ***Zuzanna, Polish, former care worker***

Some workers described how a culture of presenteeism and long-shifts prevented them from taking sick leave. Even when employers did offer enhanced sick pay, managers applied pressure on a personal level to discourage extended periods of sick leave. This took a toll on workers' health. As one survey respondent put it, they could "avoid becoming exhausted physically and mentally", if they were able to "afford more frequent and longer breaks".

The prevalence of under-employment. At the other end of the spectrum, 27 survey respondents (45%) expressed a desire for more working hours, representing the prevalence of underemployment. This includes all 12 respondents who were working less than 35 hours per week.

The prevalence of variable hours contracts and an ever-changing work schedule meant that some workers were living in a generalised state of social and financial insecurity. When hours were not guaranteed or thinly dispersed over the course of a working week, workers described being permanently 'on call', compelled to accept work whenever it was available, even if they were suffering from an illness or had other obligations. For domiciliary care workers, this phenomenon was made worse by last-minute cancellations and illnesses from other staff members. This led to a chaotic atmosphere where workers could have their shift cancelled despite being en-route to a home, or being asked to cover shifts at the very last minute.

> *"I would have loved to know what I'm doing for a month. Every day. I have five hours [per day] and it's for example, Monday to Friday. Then I have the weekend off. And you know [I'd] have the whole week to give [my] 100%. But in my company, it's a bit difficult. We have some fixed days off but because of cancellations or maybe some of my colleagues are sick or they can't make it... we have to cover shifts. So it's very chaotic, it is not stable. I would love a very stable, structured, well-managed rota. That helps me plan and keep my mental health in check."*
>
> ***Aderonke, Nigerian care worker, Health and Care Worker visa***

Visa workers were most at risk. The problem of under-employment was particularly acute for workers on the Health and Care Worker visa, and indicates the prevalence of sponsor non-compliance. While legally businesses with a licence to sponsor cannot employ migrant workers on a zero hours contract and must notify the Home Office of any changes to the workers' schedule, in practice the rules were often broken.

Visa workers who had no or insufficient hours of work struggled to find employment elsewhere to make up a minimum liveable income. Though the visa permits workers to carry out up to 20 hours of supplementary employment (in certain occupations) without updating the Home Office, the variability of hours provided by their sponsor made it difficult to make themselves available to a second employer. Several interviewees described feeling trapped, in a sense of limbo. As Matilda, a Zimbabwean care worker recalled, it felt as if the days were being "wasted".

"It's 37.5 [hours] in the contract, which was signed, but there are some weeks that you may not get the contracted hours, you get less than the contracted hours. And the main thing is that those 37 hours will be spread across the whole week. In a week, I wake up at seven o'clock in the morning. You started at seven every day. But on some of those days, you work like three hours for the whole day. Imagine, from 7am to 9pm, you work only three hours for that day. The day is wasted. [...] You're waiting for work. You're waiting. You do maybe thirty minutes, then you have to wait for like two hours for them to give me a call [to work] for 30 minutes."

Matilda, Zimbabwean care worker, Health and Care Worker visa

Finding supplementary employment permitted by the visa was particularly important for those not provided with any work by their sponsor. Survey data recorded 11 cases where workers were provided with no hours by their sponsor. Just one of them had been able to find supplementary employment. More often, respondents mentioned getting by through work in the irregular economy (six respondents), help from a food bank (six respondents), and help from family or friends (four respondents). This echoes Work Rights Centre casework data. Between January 2023 and October 2024, the Work Rights Centre advice team was approached by 102 people on the Health and Care Worker visa. The majority of those who spoke to an employment adviser were provided with no work, and a majority of them struggled to secure supplementary employment or switch sponsors.

Work hours take a toll on physical and mental health. The stress associated with the volume or, on the contrary, the shortage of work hours was independently referenced by just under half of our interviewees. Some of them mentioned that their health had suffered significantly while being in their jobs. Chidera, a Nigerian worker, recounted a period of debilitating depression.

"I had depression. So on the basis of that, I thought I had a brain tumour. I felt dizzy and I was not able to carry out the services that I was supposed to do. So, I had to contact my agency. When you are highly stressed out and no one is even looking after you, all you [can do] is to come to work, do the services."

Chidera, Nigerian care worker

This stress was particularly high for the research participants who had not been given any work by their visa sponsor at all. While the failure to provide work is a clear breach of contract by the employer, it was ultimately workers who suffered the consequences. Unable to work and to earn, and unsure whether the non-provision of hours pushed them outside the conditions of their visa, they were not only living in a state of financial and social insecurity, but were also fearful of immigration enforcement.

In a moving intervention, one of the survey respondents, a qualified nurse from Pakistan, described the indignity of being tied to an abusive sponsor, unable to find alternative employment, and made to depend on cash in hand work and charity.

> *"I requested him to give me job. He said, if I pressure him for work, he will terminate my employment, and I will lose my visa. I am a single mother with a six year old daughter. I was a nurse back home. I worked for a government hospital as a nurse in Pakistan. I left my job, sold my properties and borrowed money from relatives to come to this country for a better future. Now I rely on a food bank, cash in hand job, and relatives support. What a painful situation is it which I cannot explain! Sometimes I feel myself as a beggar when I go to food bank for food or ask relatives for help although I have a degree in nursing and work experience as a nurse."*
>
> ***Pakistani care worker (survey respondent), Health and Care Worker visa***

The very same sponsor referenced in her intervention had been rated 'good' by the CQC, pointing to the futility of the last government's attempt to delegate compliance to the sector.

> *"I tried to convince my employer that I have good skills and work experience. He didn't listen to anything and said straightforward that he has no job for me. This company is rated 'Good' by CQC and it is one of the companies which is listed among the database of care companies that was built by campaigners recently."*
>
> ***Pakistani care worker (survey respondent), Health and Care Worker visa***

It is worth pointing out that the CQC's historical inspection and ratings process for social care providers has been subject to criticism. A recent review of the operational effectiveness of the CQC found many issues with the regulator's practices in this area, including outdated ratings being publicly advertised on its database, overall ratings being calculated by aggregating inspection outcomes over several years, and one in five inspectable locations not being subject to any rating whatsoever.[128] More critically, for workers, the CQC's focus is on the quality of care services. While poor employment practice may be taken into account for CQC registration or rating, the current rules would not allow the CQC to "deregister somebody because they do not pay travel or because they exploit their workforce". In summary, the existing regulations simply do not adequately protect workers.[129]

Workers call for certainty. From the sample of survey respondents who were employed on zero hours or minimum hours contracts (29 people), a majority of 69% (20 people) said they would prefer a consistent work schedule. This was reflected in the responses of interviewees, almost all of whom would have preferred a fixed or set number of

hours each week, with a rota agreed in advance. Workers reported that this would alleviate some of the pressures on their mental health and lives in general. Only two interviewees suggested that they were happy with their current arrangement, and one person said that they would prefer to be on a zero hours contract that would allow them the flexibility to make their own work-life balance arrangements.

> *"To be honest, there were problems with that job because there was a zero hours contract and it was up to them when they were giving me shifts and when they were not. And sometimes I [wanted] to work, but they said 'this week you're having off'. They were not actually consulting with you, there was not much communication."*
>
> ***Maryana, Ukrainian care worker***

The lack of a predictable and manageable rota disproportionately affected those with responsibilities outside of their workplace, such as caring and raising children, as well as those who work in domiciliary care and must travel to and between clients' homes. Rotas appeared to be often set with limited consideration for where workers lived relative to clients, where clients were in relation to one another, or whether workers had access to private transportation.

5.3. Pay

As many as 75% of survey respondents (45 people) reported being either unhappy or very unhappy with their wage rate. This was an expected finding given pay for care worker roles is normally at the relevant minimum wage or marginally higher. Many interviewees reported wages being too low to cover essential living costs, making them rely instead on partners' incomes or additional employment. Financial insecurity was exacerbated by a culture of unpaid overtime and unpaid driving. While in our view, the prevalence of paid sick pay was a welcome silver lining, overall there was a sense among workers that overall remuneration hardly reflected the complexity and social value of their work.

Wages are unsustainably low. The workers we interviewed echoed the general sense of dissatisfaction with levels of pay expressed by survey respondents. Once rent and bills were accounted for, workers reported having very little left at the end of the month or, in some cases, entering their overdraft. A few interviewees described taking on additional work to get by, including shopkeeping and pet breeding. Others were only getting by with the help of partners who were also in work and were able to support with the costs of childcare, food and other essential expenses. Mudiwa, a worker from Zimbabwe who had an undergraduate degree and had been working in the UK on a Health and Care Worker visa since 2022, captured the uncomfortable feeling of knowing that, were it not for her husband's income, she and her daughter would not have been able to get by.

"I feel for all the single mothers here. The amount we got paid last month, a single person cannot pay bills and rent. But my husband working helps with childcare and paying bills, for food… my husband can also work anywhere as he is not limited [in his right to work]."

Mudiwa, Zimbabwean care worker, Health and Care Worker visa

Other research participants made similar comments. If the wages from being a professional carer could just about cover the costs of living alone in rented accommodation, it was hardly enough to cover the costs of childcare. Workers on the Health and Care Worker visa were especially affected, as they have no recourse to public funds and cannot claim benefits. Notably, even the minority of interviewees who did not express dissatisfaction with their pay explicitly, described it only as "manageable", or sufficient under the current circumstances.

"If you're living alone then it's probably fine. But if you have kids, you have to send them to school, pay their bills, and also feed them every day. I think it simply wouldn't be enough."

Althea, Filipina care worker

Periods of sickness were enough to disturb the precarious balance of 'just enough' income. After the first three days of sick leave, which are unpaid, workers on Statutory Sick Pay (SSP) are generally entitled to receive £116.75 a week for up to 28 weeks. However, interviewees noted that due to the low level of pay in the sector generally and the barely liveable level of SSP, being sick for too long was simply not an option.

A culture of overtime. The negative effects of low hourly pay were compounded by the lack of remuneration for working overtime. Employers do not have to pay workers for overtime, but their average pay for total hours worked must not fall below the National Minimum Wage. A majority of 67% of workers (40 people) who completed our survey reported working beyond their agreed hours at least once in the past 12 months. For a significant minority of 28% of survey respondents (11 people) who reported working overtime, this was unpaid or paid at less than the contractual wage rate.

Interviewees illustrated the ways in which some employers created a culture of voluntary overtime, where workers' professional ethics and dedication to patients was turned against them. One interviewee reported an incident where they had been deceived into working overtime to cover a colleague on leave, on the expectation of an increased rate of pay which never materialised. Others reported needing to work overtime when a client would have a medical emergency or fall into a critical state. Given the importance of continuity of care, workers felt they were left with no choice but to stay and work for free, often for hours. Their work ethic was taken for granted, while their time remained unpaid.

"That is another motivation why I quit. I was working as an employee for this care company, and my manager asked me if I could take the shifts of a person who was on holiday. They would pay four [pounds per hour] more. So, I made the calculation. It was 500-600 more in one month [that I would earn]. If I was doing this overtime they were asking me to do, I'd be doing double the shifts. […] At the end of the month, they paid me normal hours, no overtime. As if I didn't work it."

Mihaela, Romanian, former care worker

Unpaid driving. As many as 67% of domiciliary care workers (22 people) who filled out our survey reported having to drive between appointments on the same day. By its very nature, this type of care work is conducted in people's own residences, requiring workers to spend a considerable amount of time travelling between clients' homes. According to previous research, driving can take up as much as a fifth of their working day.[130] A total of 15 survey respondents spent an average of 10 hours travelling between residences each week, while the other seven workers spent at least 20 hours per week. Worryingly, 10 out of 22 respondents told us this time was unpaid. They were neither paid for the time they spent driving, nor by mile, having instead to fully absorb the costs of driving between appointments.

"[I would like] to be paid for time spent driving and miles, because fuelling a car is way too expensive, one is left with nothing at all to save. [I would like] to be paid 12 hours or 10 hours per day, as some companies are paying 7 or 8 hours for time worked with a client, yet one has left home as early as 6am to be with client by 7am and got back home at 10pm as the last client is 9pm. So the carer is spending days seated in the car the whole day only to be paid for time with client."

Kenyan care worker (survey respondent),
Health and Care Worker visa

The time that domiciliary care workers spend driving between clients' homes as part of their shift is classified as working time under minimum wage regulations, so not being paid for this time at all is unlawful. The situation in relation to mileage is slightly different. HMRC's rules on Mileage Allowance Payments do permit employers to pay their employees up to 45p per mile for business journeys without having to report this (25p per mile after 10,000 miles have been reached in the tax year), but payments are ultimately discretionary. Interviews revealed that even where a worker was paid appropriate mileage allowance, the low rate meant that workers were still receiving a small amount in wages, despite working all day. This was because domiciliary work was fragmented between several short appointments, and carers were only paid for client contact time. One interviewee noted they could get as little as £30 on a "bad day".

It is unlawful for carers' overall daily pay, including travel while on a shift, to fall below the national minimum wage level. And yet, this is precisely what we found to be happening. Our findings chime with recent research from Unison, which suggested that around 75% of domiciliary care workers across England are not being paid for the time that it takes to travel between appointments.[131]

> *"They pay [by] the mile, 20p per mile. But that's not enough, you're maintaining your vehicle, incurring charges, paying business insurance, you're doing all of that, and then 20p/mile. And that time is not paid.*
>
> *And if it's 1 hour 30 minutes between [shifts], nobody pays for that. You just get paid for the mile. Some workers who walk or take the bus, they don't pay for your bus pass. I tried to ask about it, but no - they don't do it. The minimum wage was £10.42 for an hour. The calls are 30 minutes, that's 5 pounds. Then you have to get on the bus. £1,70. Then go back, another £1,70. That's all you earned gone. But you have to keep doing it."*
>
> ***Emeka, Nigerian care worker, Health and Care Worker visa***

Care workers deserve better pay. Across many of the interviews we conducted, research participants felt that the low levels of pay were reflective neither of the social value of the work they were doing, nor the skills required for the role. Some workers felt disillusioned that employers failed to recognise the responsibilities and skills involved in looking after several vulnerable clients in one shift, all of whom required check-ups nearly every hour, including during overnight shifts. Others believed they would earn more doing similar roles within a similar band in the NHS, than by working for an independent care provider. Overall, there was a real sense that for this work to be sustainable, something had to change. A minority of workers, all of whom were British or settled in the UK, had taken the issue of under-payment to their management.

> *"I've complained about pay. [...] The complaint was about an increase in wages. At the moment, things are tough, communities are being hit by the cost of living. And basically, it is likely my wages are decreasing, and it's becoming challenging to afford amenities and other stuff. This discourages me, so I complained because I need an increase in wages. If there's no increase, I am wasting my energy and putting in more effort for nothing."*
>
> ***Jonathan, British care worker***

Many other workers who felt unable to voice their concerns, or who were simply unhappy with the outcome, were ready to exit. Mihaela, a Romanian woman, was one of three interviewees who had stopped working in care by the time she took part in our research. Pay, she explained, was a deciding factor in her decision to quit.

"The pay is very low. Yeah, this was the motivation behind why I quit my job. For the responsibility that you have - because sometimes you can have 20 people on your hand to manage and to keep them alive [on a night], and you have to check on them every hour. And you are signing that they are alive and they are fine during your shift. And so on that 12 hour shift, you have to keep them alive."

Mihaela, Romanian, former care worker

In the triad of exit, loyalty, and voice,[132] it is important to note that exit is not a viable option for all workers. Quitting carries risks, and is particularly difficult for visa workers who would have just 60 days from the date of curtailment to find a new sponsor and pay for a new visa if they wanted to remain in the UK. And yet, while the Health and Care Worker visa route forces sponsored workers into tolerating low pay, unpaid overtime, and hours of underpaid driving in the short term, this cannot be the long-term solution. To build a future for the adult social care sector that addresses the severe issues of staff recruitment and retention, levels of pay need a fundamental rethink.

5.4. Employment rights breaches and reporting

In addition to systemic issues related to work hours and low pay, research participants recorded a range of apparent employment rights breaches. A majority of 65% of survey respondents (46 people) believed they had experienced a violation of their rights in the last 12 months, and wanted to formally complain about it. Among them, 43% (20 people) mentioned they had encountered an issue related to potentially incorrect payment of wages – a finding echoed by interviewees, who described struggling to keep up with the ever-changing hours and wages.

In another 35% of cases (16 people), survey respondents reported health and safety breaches. This was contextualised by interview participants, who described the intense physical nature of their work, as well as the Labour Force Survey, which indicates that the rate of work-related illness in the care sector is almost twice the national average.[133] Finally, 59% of respondents reporting a breach of their rights (27 people) stated they had experienced workplace discrimination, and another 37% (17 people) mentioned bullying or harassment. In the context of these apparent employment rights breaches, it is revealing that many workers did not feel able to raise a complaint. This is what we explore next.

Discrimination was an everyday occurrence for migrant workers. As many as 59% of survey respondents (27 people) and 12 interviewees reported experiencing discrimination in the workplace. Some of the workers we spoke to believed they were treated less favourably than their British counterparts. For example, Zuzanna, who had left the sector, described that migrant care workers were expected to work night shifts and on weekends, while British workers were relieved of these shifts. Another interviewee believed that British workers had greater autonomy over their work

patterns and could choose their shifts freely, while migrant care workers were denied access to part-time opportunities, even where they had legitimate reasons for requesting this (e.g. part-time studies).

> *"We had different contracts, [the migrant and British workers]. One of my colleagues, who was British actually, started crying about that, because she felt overwhelmed by the fact that we pointed it out to her but no, it was never [formally] spoken about. And when they paid [us], we had to calculate it very carefully because there was not one month when they wouldn't make a mistake. So they didn't even pay attention to be sure to pay us the full amount. They were basically recruiting migrant workers from Eastern European countries in bulk, like ordering a pack of 10 water bottles. I don't think I ever felt on equal terms."*
>
> ***Zuzanna, Polish former care worker***

Four workers reported that they had experienced racism at work, either from fellow colleagues and managers or, more frequently, from clients themselves. Interviewees described upsetting incidents where they had experienced name-calling and verbal abuse. Other micro-aggressions recounted were exclusion from operational conversations about the delivery of care, shunning from staff social groups, and relegation to less desirable tasks. Edouard, a Black British worker, was one of those who described feeling like he was part of a toxic work environment where racist insults were common.

> *"They deal with you like you're a nobody. They give tasks that are dishonourable. You feel shameful of your job. They call you names, and you're not feeling well-to-do with your job. These are things that happen, but we are paid for it. The only thing we can do is [quit] that particular job."*
>
> ***Edouard, British care worker***

Alice, a South African with over four years of professional experience as a care worker, reflected bitterly on how some clients saw her only through a racist lens.

> *"You don't have to talk down on me, based on my skin colour, based on my race. And make certain presumptions and stuff like that. [...] Over time, this has the ability to affect our mental health."*
>
> ***Alice, South African care worker, Health and Care Worker visa***

Breaches appear to remain unreported, and unresolved. Despite the prevalence of labour rights breaches, 39% of survey respondents (18 people) who told us they had experienced a workplace issue in the past 12 months also said they did not report their complaints to their employer or externally. Interview data revealed the many layers of social pressure, mistrust, and fear of retaliation that underscored this trend. Some workers suggested that they did not want to actively land other colleagues in trouble with management. For others, a poor relationship with managers meant that there was not a conducive environment in which to report complaints or give feedback, even where management had attempted to facilitate this on an anonymous basis. One person described how within some small care companies, this dynamic was exacerbated where nepotism arose from familial connections within the business.

> *"Many people who are working there are close relatives to the owners of the company. So they get enough hours, they get flexible working patterns, they can get nice clients."*
>
> ***Matilda, Zimbabwean care worker, Health and Care Worker visa***

A third group of interviewees said they felt pressured by their peers to keep their complaints private and distance themselves from the everyday frictions of the job. During times of turmoil, many of these workers thought about their motivations for working (e.g. supporting family members) as a way of building internal resilience and avoiding confrontation.

> *"The relationship between us care workers and the bosses does not encourage complaints. So there was a time that there was this app and it was installed onto our mobile devices. It was basically to help with our relationship with the bosses but it did not go very well because any message or comment that you leave can be traced back to you, there was too much fear about how safe that could be."*
>
> ***Yolanda, Ghanaian care worker, Health and Care Worker visa***

Yolanda, a Ghanaian care worker, also lamented how there are no mechanisms for her to securely report rights breaches to government bodies, where an internal grievance is ineffective or simply not an option. Workers must disclose their identity in order to prompt any meaningful action, so many fear that a report could be traced back to them, and they would face retribution from their employer.

"Hopefully you get the point about my visa and my permission, that puts me at risk of losing my job and losing my residence here and being deported, that's something I don't want. I am neck deep into this and you have to pass [information] on to people who are not really going to support you and help you to fight for your rights. They can also turn against you and put you out there, straight into the hands of people you are running away from. You want that assurance that if I do take that first step, I want someone that is going to have my back, so that I am not thrown back into the same cycle. But there is nothing like that."

Yolanda, Ghanian care worker, Health and Care Worker visa

The sponsorship system disincentivises reporting. The fear that raising a grievance or reporting externally would prompt employers to retaliate was particularly acute for workers on a Health and Care Worker visa. Several of them described how employers used the threat of visa curtailment to silence grievances, and deflect any attempts to negotiate more favourable conditions. Interestingly, one worker suggested that intimidation was not always explicit, but rather took the form of 'reminders' that the visa could be curtailed at any point. Not only did this contribute to a feeling of entrapment, but it suggests that sponsors themselves are aware of the precarity that workers face and are towing a fine line – being just threatening enough to ensure worker compliance, but not threatening enough to provoke an external complaint.

The system of sponsorship fundamentally disincentivises sponsored migrant workers from reporting exploitation to external authorities. Even if they could demonstrate that employers were clearly breaching employment law, workers were all too aware that if any action were taken against their employer, their immigration status would be at risk. Emeka, a care worker from Nigeria, found himself working in supervisory roles despite being employed as a care worker. Despite this being a breach of his visa conditions, he could not raise the issue with his employer or externally.

"Some of [sponsors] will make you do jobs that are beyond your responsibilities as a care worker. You find yourself working maybe as a deputy manager, or as a care supervisor, or as a senior carer or whatever else that is beyond your role. [...] Actually, that is what happened to me. I asked them - please let the Home Office know that I'm doing another role now. They employed me actually for a supervisory role, but ended up giving me a CoS for a care worker.

I kept asking them to notify the Home Office, but at some point they just said that's what it'll be and if I'm not happy with the actual role, they will give me 5 days and then sack me. And the advice from [a support organisation] was to accept it, but send an email to show that you are not complicit in this - I will continue in this role, but when a care worker role is available or when they are ready to notify the

Home Office, to please give me that role. Since I've done it, the aggression they've been doing since then.... But I cannot complain. What can I do, because they're still my sponsors."

Emeka, Nigerian care worker, Health and Care Worker visa

The government response to migrant exploitation remains inadequate. While the ways in which the work visa system encourages abuse and inhibits reporting has been extensively documented, the government response has been underwhelming.[134] According to the Home Office, UKVI Compliance Command works with local authorities and the Association of Adult Social Care Directors in the timing of revocations, potentially delaying visa curtailment to allow workers the opportunity to find new sponsors.[135] It is not clear how well this system is currently working. Similarly, despite ours and other warnings[136] that the register of licensed sponsors is poorly suited to support sponsored workers to find businesses by sector, no amendments to the register structure have been made by the Home Office. As many as 70% of survey respondents on a Health and Care Worker visa (38 people) noted that they had tried to switch sponsors, but just 42% had succeeded (16 people). Of those successful, only two respondents had managed to find another sponsor within the 60-day window they would have after receiving notice of their visa curtailment, and seven respondents took more than 4 months.

Switching sponsors is an uphill battle. Interviewees described in detail the frustrating process of repeatedly trying, and failing, to obtain another job. Bureaucratic difficulties, the costs of sponsorship, and the attitude of some employers who perceived sponsored workers as being risky candidates were all highlighted as issues complicating the process. For example, some workers had successfully obtained offers of employment or had done well in interview stages, only to be told they could not be hired because the prospective employer did not have the requisite Home Office licence. Consequently, the process of getting a new sponsor was reported as being protracted, with one worker mentioning searching for nearly a year before being able to switch employers.

"I've had a couple of interviews. I've even had some NHS interviews as well. They usually go with the candidate that doesn't require visa sponsorship. So that has been the challenge. A lot of people want to hire me, but they don't have a sponsorship licence, they cannot [provide me with] a visa."

Aderonke, Nigerian care worker, Health and Care Worker visa

A few respondents were prevented from finding other sponsors by the fact that their current employers did not want to provide references, or in some cases had given bad references. It is worth noting that while employers are not obliged to provide a

worker reference, if they do it must be fair and accurate. Workers can theoretically challenge a 'bad reference' in the Employment Tribunal, but the procedural and substantive hurdles make it a difficult option. As a result, this is another area where sponsored workers are effectively left without redress for the loss that they have suffered.

> *"I was looking around and I actually got a few offers. But when I go through all the processes and then when it comes to references, my employer was not really keen on giving them anywhere."*
>
> ***Kudakwashe, Zimbabwean care worker, Health and Care Worker visa***

5.5. The future of the sector

The major issue of staff retention which was recognised by policymakers and industry leaders, was reflected clearly in our research with care workers. Asked where they saw themselves working in five years' time, less than half of survey respondents (47%) said care. A third (32%) of respondents told us they wished to work in a different sector entirely, while another 20% were undecided. Interview data added depth to this finding. While all workers expressed great respect for the act of caring, the intensely physical nature of the work, the lack of promotion options into more supervisory roles, and the minimal level of pension support made it hard for many to imagine a future in direct provision of care.

An intensely physical role. Two in three interviewees described the everyday nature of their work as tough and physically demanding. Many cited the physical acts of lifting and hoisting clients, helping them to get dressed and providing support with other daily mobility activities as having taken a toll on their health in recent years. We heard accounts of weight loss, sciatica, rheumatological issues, and other illnesses and injuries that required workers to take time off and seek medical treatment. Mental health was cited too. Dealing with difficult and often temperamental clients on a regular basis was emotionally exhausting and, some workers believed, poor mental health hindered their physical recovery.

> *"I have gotten ill while working. I go through a lot of personal [procedures] while working. And when I get back home, I may have pains all over me. It's quite physical work.*
>
> *Sometimes, I just have to rest up. Sometimes, I have to take medication for pain relief. Sometimes, I just have hope that when I rest and wake up, I'll be able to keep going."*
>
> ***Edouard, British care worker***

Limited promotion opportunities. For the minority of interviewees who wanted to stay in the sector, getting a promotion to an office-based or managerial role was regarded as one of the few plausible ways to get to retirement age sustainably. However, at the same time workers noted that it was very difficult to get a formal promotion. Many did not know whether promotion was possible, what the criteria were, and in some cases were actively prevented from career development opportunities. In one case, a worker wanted to pursue a free National Vocational Qualification (NVQ) through the care home they were working at, but were refused. Other respondents recognised that promotion was possible, but that it was informal in nature, and often involved taking on additional responsibilities without additional remuneration. As Matilda put, the absence of a career progression framework left many workers feeling stuck. The only way to advance was to change roles, or leave the social care sector entirely.

> *A sector-wide career progression framework is a good idea. If you actually manage to secure better qualifications and progress more, you can get better opportunities, better working conditions. But for us, we are stuck at the same company. I am not progressing.*
>
> ***Matilda, Zimbabwean Care worker, Health and Care Worker visa***

Half of the workers were looking to exit the sector. In the context of an intensely demanding role where pay was low, hours were all consuming, and many workers experienced issues ranging from misunderstandings over wages to blatant racism, it is perhaps unsurprising that just 47% of survey respondents saw themselves as remaining in the sector in the next five years. Interviewees added depth to this finding. Some of them were determined to use their experience in adult social care as a stepping stone into other roles related to healthcare, including jobs in nursing, counselling and pharmacy. Some interviewees portrayed the NHS as a higher standard, both in terms of pay, opportunities for career progression, and pensions. This is consistent with analysis presented by the Institute for Fiscal Studies (IFS).[137] The NHS has historically benefited from one of the most generous pension schemes in the UK, offering substantial retirement and life assurance benefits. By contrast, the care sector is made up of a myriad providers with different pension models, many which offer little more than the minimum statutory requirement.

> *"I'm really hoping that in five years' time, I would have gotten additional skills. I don't intend to work in the care sector my whole life. I would want to just work in the care sector for a few years and in the process upgrade my skills, if possible, take a professional role in a specific area. [...] I do enjoy working in the care sector, but I believe there's a lot more that I can do. Things that would improve my personal and professional life. I look forward to working elsewhere within the healthcare sector."*
>
> ***Kudakwashe, Zimbabwean care worker, Health and Care Worker visa***

6. Conclusion and recommendations

This report has demonstrated that systemic issues of low pay, all-consuming hours, a pervasiveness of employment rights breaches, and the absence of a career progression framework heavily impact migrant workers' health, relationships, finances, and ultimately retention. Visa workers face significant additional challenges, compounded by a punitive immigration regime and lack of safe reporting mechanisms. Given their pivotal contribution to the sector and to the lives of millions of people around the country, we urge the government to heed the accounts of migrant workers in this report and tackle exploitation.

To address the problems identified by migrant workers, we make two sets of recommendations: (1) sector-level changes that will benefit all workers; and (2) changes to immigration rules and processes that will address the disadvantage experienced by migrant workers on the Health and Care Worker visa. All recommendations below stem from our research participants' interventions, and were refined in consultation with a Lived Experience Advisory Board.

In making these recommendations, we recognise that social care is an incredibly complex policy area, not least due to the multitude and heterogeneity of public and private actors involved in the provision of care. The solutions proposed below are therefore non-exhaustive and they exclude other well-documented matters such as pay levels for sleep-in shifts and recent changes banning new Health and Care Worker visa applicants from bringing dependants to the UK.

We also recognise the challenge of financing a comprehensive reform package. Ensuring that local authorities have the money to pay for the delivery of care is a crucial consideration, but a new financial settlement for care must also ensure that workers share in the benefits. This will help retention of workers in the sector, and it will also improve the quality of care provision. These recommendations are designed to provide a direction for change that can make England's adult social care sector a better place to work for all.

6.1. Sector-level changes

The government needs a long-term strategy for the care workforce that not only recognises the urgency of retention and recruitment, but is also informed by migrant workers' voices. At a minimum, this should include measures to give workers a better pay offer, turn care into a viable, attractive career, and protect worker welfare.

A better pay offer

Increase baseline pay. The low level of pay in social care is one of the primary concerns raised by workers in our study, and sector leaders elsewhere. To reduce the incidence of in-work poverty and cultivate staff retention, we recommend bringing pay in line with the Real Living Wage as a starting point. Other stakeholders have previously recommended different reform packages. For example, the Trades Union

Congress recommended a sectoral minimum wage of £15 an hour,[138] while the Health and Social Care Committee proposed paying care workers the same rate as equivalent NHS Band 3 roles (currently £11.67 per hour for entry level roles).[139]

The care commissioning process should be leveraged to ensure compliance with higher pay. For example, the Scottish government previously delivered living wage rates in its social care sector by making additional money for local authorities conditional on them successfully negotiating a pay rise for workers.[140] The new Labour government could impose similar conditions as part of its Fair Pay Agreement for the sector as a whole. As IPPR has previously identified, local authorities can leverage the care commissioning process to ensure compliance with collective bargaining agreements (or, in this case, the Fair Pay Agreement), by requiring providers to demonstrate that they comply with its terms and pay workers at the appropriate level.[141] Indeed, this is already partly the case, with around 25% of local authorities in England requiring some or all care providers to pay the Real Living Wage.[142]

Introduce defined pay scales. This will allow workers to earn more based on their experience and their promotion into more senior roles. Implementation will require the development of a formal career progression pathway (see below) but could be operationalised through the new government's Fair Pay Agreement for the sector. This idea is reflected in Skills for Care's workforce strategy in England,[143] and in a 2018 IPPR report.[144]

Mandate pay for travel costs. The discretion that employers currently have to not pay for travel costs like mileage has helped to perpetuate a system where workers, particularly those in domiciliary care, are only paid for 'contact time' with service users (rather than including driving time and associated costs). This is particularly important in the context of the new government's plan to encourage care at home. We recommend that the government makes payment for travel costs mandatory, in line with the maximum allowance stipulated by HMRC's Mileage Allowance rules. New guidance should also be issued to allow workers to claim travel expenses related to traffic and delays, as well as to compensate workers who use public transport to travel to appointments. In line with previous recommendations by the Health and Social Care Committee, new rules should make it a requirement for the time allocated for travel to be clearly set out in the contracts of workers.[145] Payments for travel time should also feature separately on workers' payslips to allow for transparency and make it easier for workers to enforce their existing rights and challenge incorrect payments.

Mandate compensation for overtime work. Despite it being highly prevalent in the care sector, overtime pay is discretionary for employers. This is not just unfair for workers, but makes little sense in a sector struggling to retain staff. We recommend making it a mandatory requirement for employers in the sector to compensate staff for work beyond normal hours, in line with uprated general pay levels we have recommended above.

Making care a viable career

Implement a career progression framework. To incentivise the retention of staff, the government must create a career progression framework that allows those in the sector to accede to more senior and better paid roles. While a Care Workforce Pathway[146] published in early 2024 outlined four new role categories, each requiring different levels of knowledge and skills, this was silent on the topic of pay. A new framework must include adequate pay scales to cultivate retention and ensure the highest standard of care for patients. This should be revised annually to reflect cost of living changes, with appropriate geographical weightings (e.g. Greater London).[147] The NHS Agenda for Change pay scale is an example of how this could be operationalised.[148]

Invest in training. The government helped to introduce the Care Certificate into the sector, but this remains at the discretion of providers. To support staff retention and career progression, as well as better care for patients, we endorse the call to extend the rollout of the Care Certificate qualification.[149] Specifically, the government should continue the rollout of the Care Certificate qualification to support new starters in the sector to achieve a level 2 qualification within three years. Over time, an increasing proportion of new entrants should be encouraged to obtain certificates to move towards a greater level of standardisation in the sector.

Protect worker welfare

Give workers the right to regular hours. The financial precarity and stress derived from working unpredictable hours was one of the central concerns flagged by participants to our study. We welcome the Employment Rights Bill's provisions to give workers on zero hours contracts the rights to receive guaranteed hours, and to give shift workers the right to receive notice of shifts. However, significant details of implementation are yet to be hashed out, including how minimum hours and agency workers will be included in the guaranteed hours provision, how much notice workers will be given for their shifts, or how much compensation they will be entitled to for cancelations. To ensure that the bill supports the most vulnerable, migrant workers should be included in the next stages of implementation, alongside trade union representatives and other stakeholders.

Increase sick pay. If we fail to look after our social care workforce, there will be fewer people to look after all of us. Poor health related to overwork, a culture of presenteeism, and an inability to financially afford taking time off were some of the central concerns raised by workers in our study, and have previously been found to affect happiness and performance.[150] Though the government has already announced plans to remove waiting days and extend SSP to those earning below the lower earnings limit,[151] it must also substantially increase the rate of SSP to protect worker welfare and public health. At a minimum, in the interim we recommend that the government mandates occupational sick pay in the adult social care sector. Previous research has found that care workers are less likely to leave their workplace if they have enhanced sick pay included in their contracts of employment.[152]

Recognise the value of social care work. A longer-term goal of the government should be to ensure that the value of social care work is as publicly recognisable as that of the work conducted in the NHS. The sector has historically been locked in a vicious cycle, where perceptions about care work have contributed to low pay,[153] and vice-versa. It may be the case that a National Care Service, which the government committed to developing, would provide this through a single, recognisable identity that ensures workers have "parity of esteem"[154] with the NHS, and the public at large feel a sense of ownership of social care. Recognition is also about incentives and benefits. Aside from the reforms mentioned above, the government should consider how to ensure that workers are offered comprehensive benefits packages, including pension packages. For example, we know that care providers who contribute more than the minimum 3% contribution into workplace pensions experience lower staff turnover rates.[155]

6.2. Immigration reform

Tackling sectoral issues will only go so far in resolving the wider issues that migrant workers face. As was clear throughout our research, migrant worker exploitation is also an outcome of a work-migration visa system that reinforces poor standards. Too often, migrants on the Health and Care Worker visa have to choose between staying silent in exploitative conditions, or reporting their employer and risking their immigration status. To tackle these issues at source, the government needs to reform the work-migration system itself.

End employer sponsorship. The most effective way to address the power imbalance in the employer-migrant worker relationship would be to end employers' direct control of workers' immigration status, and give international workers the ability to more easily change jobs and take their skills where they are valued. As we argued in the past,[156] this could be implemented by adopting a system where migrants obtain visas on the basis of their experience, qualifications, and levels of English, removing the need to be employed by a particular entity. Such a system would improve worker welfare by making it simpler to leave abusive workplaces, but also cut sponsorship costs for law-abiding care providers, and ease pressures on care regulators. Alternatively, the government could move sponsorship away from an individual employer and to a regulated consortium of employers – such as the National Care Service.

While ending the employer sponsorship system is likely the most impactful way of addressing the risks inherent in the Health and Care Worker visa, the government can also adopt mitigation measures in the interim.

Give sponsored migrant workers more time to change sponsors. Our study found that the process for migrant visa workers to change sponsors is fraught with issues, not least because the current 60-day time limit to change jobs simply is not long enough. Ensuring sponsored migrant workers have more time to switch sponsors reduces the chances of workers becoming undocumented and at risk of re-exploitation. The government has tacitly accepted that the existing timescale is not working. In May

2024, the international recruitment fund for the adult social care sector (worth around £15million) was repurposed to facilitate in-country switching of sponsored migrant workers who had lost their jobs because of unethical practices or the revocation of their employers' sponsorship licences.[157] In short, the government is paying millions of pounds to resolve a problem that it has created by not giving workers the time and means to find alternative employment themselves. The 60-day time limit should be significantly increased, in line with more generous time limits (6 months) imposed by the UK's international partners, such as Australia[158] and the Republic of Ireland.[159]

Vary the conditions of leave of workers until they change sponsors. To mitigate the risk of re-exploitation during the time that exploited workers are looking for a new sponsor (bearing in mind that this process can be fraught with difficulties, and workers do not have access to public funds), the Home Secretary should exercise her power under Section 4(1) of the Immigration Act 1971 to unilaterally vary the conditions of leave for sponsored migrant workers who receive a curtailment notice or a notification that their sponsor has lost their licence. This variation should allow the unrestricted right to work during the time that workers are permitted to remain in the UK to look for a new visa sponsor.

Empower migrant workers to report exploitative employers. Workers who are afraid of losing their immigration status or who have already become undocumented, including through no fault of their own, are struck in a cycle of precarity and re-exploitation. To alleviate this risk, we urge the government to:

- Institute safe reporting, ensuring that data regarding an exploited person's immigration status is not shared with immigration enforcement authorities.[160] In addition, labour market enforcement agencies should end the practice of simultaneous and coordinated raids with immigration authorities, while guidance should be introduced to prevent labour enforcement agencies and local authorities from actively enquiring about workers' immigration status. A similar policy is already in place in other countries.[161]

- Introduce a special status for exploited, sponsored migrant workers, to enable them to continue their stay in the UK lawfully, take up work without restriction, and access remedy. Bringing a claim against an exploitative employer can take many months or even years.[162] This status would give workers the ability to support themselves and to meaningfully engage in litigation over a longer period of time. Other countries operating various iterations of this policy include Australia,[163] New Zealand,[164] Canada,[165] the Republic of Ireland[166] and Finland.[167]

Improve due diligence when granting sponsor licences. While the Home Office has stepped up its enforcement action on sponsors in 2024,[168] it must also make sure that workers are not prejudiced as a result of these actions (by implementing the policy changes we have referred to above), and ensure that this is not a one-time exercise. We recommend that compliance with employment obligations and employers'

previous history of labour violations is taken into account more strictly when granting licences to employers. The Home Office must not outsource the responsibility that it has to audit employers properly.

End the use of financially punitive repayment clauses. The government must ensure that sponsored migrant workers are not financially trapped in exploitative working conditions through the inclusion of onerous repayment clauses in employment contracts. Though the use of these clauses is not specific to the care sector and can have legitimate aims, our research participants and previous work found it has been deployed to extort money from low-paid, sponsored migrant workers.[169] Existing guidance confirms that any repayment clause must abide by the four principles relating to transparency, proportionality, timing and flexibility, but the fact that this is not on statutory footing means that workers can be uncertain as to the fairness and lawfulness of the clause being used against them.[170] We recommend that the government legislates to restrict the use of repayment clauses in the sector to reduce the incidence of financial exploitation through extortion or other means.

These recommendations provide some direction on the measures urgently needed to address the issues facing migrant workers in the adult social care sector. However, migrant care workers do not exist in a vacuum. Their work touches on the lives of millions of service users and their families. A failure to address their issues is likely to have a knock-on impact on the quality of care, which ultimately impacts us all. Any hopes of improving standards and conditions will inevitably depend on other policies that are not necessarily sector-specific. For example, a well-functioning labour enforcement system whose work isn't as dependent on workers raising grievances themselves will be crucial. We hope that the proposed Fair Work Agency will take more proactive enforcement action in this regard, separately from immigration enforcement. Similarly, although many of the workers we interviewed were resilient in the face of persistent non-compliance, they also need to be empowered to access their rights in practice, which often cannot be done if they lack access to good legal advice and representation. The government should therefore reconsider the provision of legal aid (e.g. for employment claims) and its geographical availability, to ensure that workers in more rural and hard to reach areas are not prejudiced. Ultimately, it is this holistic combination of policy solutions that will be required to turn the sector around.

Appendix: Labour violations by CQC-registered and Home Office licensed companies

About this Appendix

Violation Tracker UK is the UK's first wide-ranging database of corporate regulatory infringements, dating back to 2010. The database is compiled by pooling records of enforcement outcomes made publicly available by over 80 government authorities, including Employment Tribunals and the HMRC National Minimum Wage Team. The compiled records are analysed and coded by year, company name, company industry (where known), and type of violation. This results in a broad database of companies found to have committed a violation.

For this exercise, we looked at companies with a violation recorded between January 2020 - July 2024. We cross-referenced the names of companies in this database with the list of providers registered with the Care Quality Commission (CQC), the regulator for health and social care providers in England. This resulted in a total of **920 CQC-registered companies with a recent violation record**. Next, we cross-referenced these companies with the Home Office register of employers with a licence to sponsor foreign workers. This resulted in **416 CQC-registered and Home Office licensed companies, with a recent violation record.** This appendix looks at the type of violations committed.

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About Violation Tracker UK

Violation Tracker UK is produced by the Corporate Research Project of Good Jobs First (GJF), a Washington, DC-based non-governmental organisation, focused on corporate and government accountability. GJF's Corporate Research Project provides tools to assist campaigners, public officials, journalists, academics and others in analysing the conduct of companies and industries.

1. Violations by CQC-registered companies

The Violation Tracker UK database of corporate regulatory infringements includes 920 companies that were registered with the CQC and had at least one violation record between January 2020 and July 2024. Together, they committed close to 2,000 violations (Table 1).

Just over half of the infringements recorded were care quality violations. This includes notices issued by the Care Inspectorate Wales, prosecutions and fixed penalty notices issued by the CQC, as well as compensation orders by the Local Government and Social Care Ombudsman. A total of £13 million has been recorded, in a climate where healthcare breaches rarely result in a monetary penalty.

When it comes to labour market enforcement, 280 CQC-registered companies had a labour market violation record. Together, these companies lost a combined total of 345 Employment Tribunal cases, and were ordered to pay £7.6m in compensation to workers. Within the same period, 26 companies were named and shamed by the HMRC for failure to pay minimum wage, and many others were flagged for workplace safety offences. The Health and Safety Executive (HSE)also issued 68 notices and successfully convicted in 12 cases for health and safety breaches, including deaths and serious injuries to workers and patients caused by company or organisational negligence.

Type of violation	**Violations by CQC-registered companies**	**Violations by CQC-registered and Home Office licensed companies**
Care quality	1,013	509
Labour standards - Employment Tribunal cases lost	345	225
Labour standards – NMW breaches	27	17
Labour standards – other (BEIS. EHRC and ECNI)	17	8
Workplace health and safety (HSE and HSENI)	81	67
Other violations	479	228
Total violations	*1,962*	*1,054*

Table 1 – Number of violations committed by CQC-registered companies, 2020-July 2024.

2. Violations committed by CQC-registered and Home Office licensed companies

Within the same database of companies with a recent violations record (January 2020 - July 2024), a total of 416 companies were both registered with the CQC and licensed by the Home Office to sponsor migrant workers. Together, they committed over 1,000 violations (Table 1). In terms of labour standards violations, the database includes 250 labour violations, committed by 177 CQC-registered companies with a licence to sponsor migrant workers.

Over the course of 4.5 years, these companies lost a combined total of 225 Employment Tribunal cases, and were ordered to pay more than £6million to workers in compensation. In addition, 17 companies were named and shamed for failure to pay the minimum wage, and many others were flagged for workplace safety offences. A total of 58 notices were sent by the HSE to 36 employers for workplace safety offences, and the agency convicted in an additional 8 cases (Table 1).

3. Discussion

These findings are concerning, especially given the low-level of enforcement action taken by UK regulators. The infringements recorded in the Violation Tracker UK database are likely only the tip of the iceberg. Non-compliance with employment law is bound to be much higher, as only a small fraction of employment disputes make it to an Employment Tribunal (many breaches remain unreported, or disputes are settled before a judgment is made).

The fact that almost two thirds (64%) of labour violations committed by a CQC-registered employer were attributable to a company with a licence to sponsor is also cause for concern. When a person comes to the UK to work, they should be able to expect that the government has conducted appropriate scrutiny of the employers they are licensing to provide that work. From an immigration perspective, this is even more important when the Home Office's own guidance for sponsors states that:

> *"The ability to sponsor workers to work in the UK is a privilege that must be earned. When a sponsor is granted a licence, significant trust is placed in them. With that trust comes a responsibility for sponsors to act in accordance with our immigration law, all parts of the Worker and Temporary Worker sponsor guidance, wider UK law (such as employment law) and the wider public good. UKVI has a duty to ensure all sponsors discharge these responsibilities, and that a sponsor's actions (or omissions) do not create a risk to immigration control or are not conducive to the public good".*[171]

Despite the harsh words, it appears that obtaining the privilege of sponsorship has been a relatively easy task for many care providers with a recent history of violations.

4. Method and limitations

The Violation Tracker UK database is compiled by pooling all records of enforcement outcomes made publicly available by government authorities, with over 80 regulatory agencies tracked. The compiled records are then analysed and coded, which enables us to extract data by year, company name, company industry (where known), and type of violation. This results in a broad database of companies found to have committed a violation.

For this exercise we intersected three data sources: the Violation Tracker UK database of companies with a violation recorded between January 2020 - July 2024, the Care Quality Commission (CQC) register of regulated care providers,[iv] and the Home Office register of employers with a license to sponsor migrant workers.

It is important to understand that unlike the violations data, which is fixed in time and would remain the same regardless of when it is accessed, the CQC and Home Office registers are dynamic. These datasets change every day as the authorities add, or remove, companies to the list (not least as part of enforcement action). Consequently, the time the data is accessed matters, and the effect is that our results most likely under-state the true scale of non-compliance.

We used the CQC register of companies available in September 2024. This leaves out any companies that committed a violation during our Jan 2020 – July 2024 reference period, but were removed from the CQC before September 2024, when we accessed the register. It also excludes companies that may have changed their name or restructured to register subsidiaries rather than the original parent company. In some cases, a violation is registered under the name of the care home rather than the care provider, meaning these too may have been missed, although efforts were made to manually connect these to the relevant provider.

For Home Office data, we used the register of licensed employers from August 2024. This leaves out companies that committed a violation during our Jan 2020 – July 2024 reference period, but have lost their licence on or before the date we downloaded the register. Indeed, the Home Office stripped hundreds of employers of their licence in 2024.[172] Similarly, it is important to note that companies can link subsidiaries and connected entities onto the same licence, and these will not be separately recorded in the Home Office register. For example, 'Bupa' has a license to sponsor workers, however Bupa group deliver care services and are registered with the CQC via a number of different subsidiaries e.g. Bupa Care Homes (CFH Care) Limited and Bupa Care Homes (ANS) Limited, which are presumably linked under the same licence.

In most cases we have not presumed that the subsidiary is named on the licence, which has excluded a number of prominent companies such as Mitie Care and Custody, Minster Care Management Limited, and Hallmark Care Home subsidiaries with track records on Violation Tracker UK which are registered with the CQC but

[iv] A wide range of healthcare providers are registered with the CQC. In addition to care homes there are dentists, hospitals, hospices and other providers of treatment.

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[13] Skills for Care, 21.

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