IMPACT OF THE NATIONAL LIVING WAGE (NLW) POLICY ON LOW PAY JOBS IN THE PRIVATE ADULT SOCIAL CARE SECTOR IN ENGLAND

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A thesis submitted in partial fulfilment of the requirements of University of Sunderland for the degree of Doctor of Philosophy

October 2024

Abstract

Current literature suggests that the National Living Wage has exacerbated issues in the care sector such as an increase in zero-hour contracts, underpayments in wages, maintaining pay differentials and competition from other sectors. Nevertheless, there is limited research on how these challenges have impacted the professional and personal lives of workers. This research addressed a gap by using hermeneutic phenomenology to explore the private adult social care sector's lived experiences of the National Living Wage policy in England, contextual factors that influence the living standards of care workers under the policy and by recommending ways to address challenges.

Purposive sampling was used to obtain written interviews of 23 care workers and eight care managers. The findings question the appropriateness of the National Living Wage for the care profession considering the training, role, and workload, suggesting the need for a national care wage. Care workers questioned whether the additional responsibilities of a promotion are worth compared to the minimal pay increase. Thus, care providers need to ensure that senior roles satisfy a care worker's emotional needs (satisfaction that they are improving the care experiences of service users) and financial needs (living comfortably, minimising overtime and better work life balance). Additionally, more learning and development opportunities need to be provided to break the "glass ceiling" which could prevent women from progressing to senior roles.

The findings also reveal the need for Local Authorities to reconsider the elements of its relationship with care providers considering the challenges put forward by the National Living Wage. Local Authorities need to consider the struggles of competing with corporate businesses in the cleaning and retail sectors and the pressures of maintaining wage differentials. The solution is a fair cost of care based on service specifications rather than the current rates established under extreme austerity. This research demonstrates how care providers have adjusted to the increases in National Living Wage rates with the limited funding available adding to the current short-term analysis in the sector. The insights from this research highlight challenges that policy makers must address to improve worker experiences in the sector. This research would be of interest to organisations such as the Low Pay Commission, HMRC, Department of Health and Social Care and trade unions.

Acknowledgements

I am eternally grateful to almighty God for strengthening me throughout the period of this research work. I would like to dedicate a few lines to thank all the people that have contributed to the accomplishment of this work.

First, I am especially grateful to my supervisor Dr Julia Janfeshar Nobari. I would like to thank her for her suggestions and cooperation in making this piece of work successful. She has shown exceptional patience in every phase of this journey by providing all the assistance and time that I needed. Without her this would not have been possible. I am grateful to my supervisor Dr Hamid Seddighi for his very helpful suggestions and guidance.

I would also like to acknowledge the assistance of Dr Paul-Alan Armstrong, Dr Augustus E. Osseo-Asare, Dr Mark Proctor and my faculty and the University of Sunderland who have provided all the support I needed to complete this research.

My sincere thanks to all the participants who shared their views and experiences. Without their input this work could not have been completed. I am grateful to all the ENRICH (Enabling Research in Care Homes) clinical research networks who disseminated my research to participating care homes. I applaud their work in supporting and delivering research in care home settings.

I would like to convey my appreciation to my mother, brother, sister and family for their support and encouragement. Their understanding and love has been the backbone of my success, and I could not have reached this milestone without them. I would like to thank them for always believing in me, for having the utmost patience during the challenging times, and for celebrating every small victory along the way. This achievement is as much theirs as it is mine, and I am forever grateful to have them by my side.

Finally, I would like to thank everyone who have directly and indirectly provided their support and thoughtful comments on this project.

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Chapter 1. Introduction

1.1 Introduction

Many workers in low pay jobs are deterred from securing employment due to the possibility of being removed from benefits (Moore et al., 2017).To shift away from the culture of having benefits as a primary source of income, the government introduced the National Living Wage at £7.20 per hour in April 2016 (current rate: £10.42 per hour from April 2023) which were to be paid to all workers aged 25 and above. This amounted to a significant annual pay increase of 10.8% in nominal terms when average earnings were rising by 3% at that point of time (Low Pay Commission, 2018).

This research explores the process of engaging with and fulfilling the National Living Wage policy by the private adult social care sector in England. It examines their experience of adapting to the policy concerning rising care costs and decreased funding that intensifies the impact of the policy. Data would be collected from care workers and managers through a pilot study and written interviews. Documentary analysis would be used for triangulation. Findings from this research could be used by organisations such as the Low Pay Commission, HMRC, Department of Health and Social Care and trade unions to identify how they can further support the sector.

1.2 Background to the Research Problem

Significance of the National Living Wage Policy

In April 2024, the Low Pay Commission recommended a 10% increase to the National Living Wage rate bringing the National Living Wage to £11.44. This increase is the third largest annual increase in its history and 30% higher than the adult minimum wage rate in 2015 (Low Pay Commission, 2024). The Department for Business and Trade (2024) estimates that this increase will boost the wages of around three million low paid workers.

This also marked a significant milestone achieving the government's long-standing target for the bite (the National Minimum Wage expressed as a percentage of the relevant median hourly pay) of the National Living Wage to reach two-thirds (66%) of median earnings (Department for Business and Trade, 2024). When the National Living Wage was

implemented in 2016, the bite was estimated to be 55.8% (Low Pay Commission, 2016). Brown (2017) argues that this national figure conceal the disproportionate impact of the National Living Wage in different sectors and regions. Six regions had bites already over 60% by the end of 2016. The bite was over 70% in very small firms and around 90% in low paying sectors. Hence, the National Living Wage policy could pose significant challenges to sectors such as social care where labour costs make up around half the expenditure (Bottery, 2020; Competition and Markets Authority, 2017).

Current quantitative studies on the National Living Wage conclude that the National Living Wage in general has no adverse impact on employee retention and hours worked whilst significantly increasing the wages of low paid workers (Aitken, Dolton and Riley, 2019; Capuano et al., 2019; Capuano, Cockett and Gray, 2018; Lee et al., 2022) . However, when comparing subsets, there is some evidence that larger increases in National Living Wage might negatively impact on employee retention (Capuano et al., 2019) and hours worked (Lee et al., 2022) for women who worked part time.

As Capuano et al. (2019) and Lee et al. (2022) suggested that a negative impact of the National Living Wage was found more profoundly in particular subgroups such as women working part time, it would be interesting to explore the private adult social care sector with a workforce consisting mainly of women (81%), and 48% of the workforce working part time (Skills for care, 2023).

Significance of National Living Wage on the Private Social Care Sector

The social care sector has a long-standing experience of poor pay and precarious working conditions. It has been argued that the National Living Wage rate does not reflect the actual amount being paid to care workers and, in some instances, have amplified the poor working conditions already prominent in the sector (Hardy, 2016; Hussein, 2017a; Moore et al., 2017). Austerity and the funding crisis in the sector have led to local authorities implementing cost cutting measures on care contracts which in turn is passed onto workers (Hudson, 2019). Cap on care home fees by Local authorities (Machin, Manning and Rahman, 2003; Machin and Wilson, 2004) and the strict monitoring procedures imposed on care homes by the Care Quality Commission (Vadean and Allan, 2020) makes the sector more vulnerable to consequent upratings of the National Living Wage.

Despite some quantitative research showing that the National Living Wage has had a positive effect on wages and number of hours worked in the social care sector (Gardiner, 2016; Giuponni et al., 2016; Vadean and Allan, 2020) with no statistically significant effect on employment (Giuponni et al., 2016; Vadean and Allan, 2020), there is evidence that suggest that the National Living Wage has exacerbated a number of workforce issues in the social care sector such as an increase in the usage of zero-hour contracts (Vadean and Allan, 2020) which makes it easier for employers to amend terms and conditions to increase labour efficiency (Moore et al., 2017), underpayments in wages (UNISON, 2020), maintaining pay differentials and competition from retail and hospitality sectors offering similar paid less demanding jobs (Moriarty, Manthorpe and Harris, 2018; Skills for Care, 2023).

Increase in Zero-Hours Contracts

Vadean and Allan (2020) found evidence of increased usage of zero-hours contracts by providers to increase labour efficiency to offset the costs of the National Living Wage. This is an unwelcome trend as non-standard contracts such as zero-hours makes it easier for employers to amend terms and conditions and increases worker dependency on the employer for the choice and hours for work (Moore et al., 2017).

Underpayments in National Living Wage

The highly fragmented nature of care work makes the sector highly vulnerable to wage underpayments with confusion regarding travel time. Insufficient time allocated for travel not accounting to traffic and other unforeseen circumstances could significantly increase the unpaid working time of care workers (Moore and Hayes, 2018). In 2020, the tribunal ruled that three contractors appointed by Haringey Council in North London had paid some care staff less than half the minimum wage because of unpaid travel time. They were ordered to pay more than £100,000 in back pay to the ten-homecare staff involved (UNISON, 2020).

Maintaining Pay Differentials and Competition from Other Sectors

In research done by the Social Care Workforce Research Unit at King's College London, Moriarty, Manthorpe and Harris (2018) identified some of the difficulties faced by the adult social care sector in relation to the introduction of the National Living Wage. One of the main

problems was the skilful and demanding nature of social care work compared to similar paid occupations in retail and hospitality. For the same wage, workers could get a less demanding job in another industry as all industries are paying the National Living Wage despite the responsibilities of the job. Another challenge of the consequent uprating of the National Living Wage was maintaining differentials across the pay structure between less and more experienced staff. Participants reported that experienced care professionals often moved to work in the NHS (National Health Service). According to Skills for Care (2023), before March 2017, a care worker with over 5 years of experience in the adult social care could expect an hourly rate which was 33 pence higher than a care worker with less than a year of experience. This gap has been reducing, and as of March 2023, the difference is only six pence.

1.3 Justification and Contributions of the Research

As labour costs make up around half the expenses in social care (Bottery, 2020; Competition and Markets Authority, 2017), and 63% of care workers in the independent sector being paid below the upcoming National Living Wage in March 2023 (Skills for Care, 2023), the social care sector is highly vulnerable to the consequent upratings of the National Living Wage. Furthermore, Machin and Wilson (2004) and Machin, Manning and Rahman (2003) highlight that as care home fees are paid by local authorities or social services and the fact that these fees are capped and does not increase with wage laws have the potential to intensify the effects of a minimum wage in this sector.

The aged 65 and above population is estimated to increase from 10.5 million to 13.8 million people in England between 2020-2035. If the adult social care workforce is to increase proportionally, an additional 440,000 jobs (25% growth) would be required by (Skills for Care, 2023). Good quality social care would be needed for the ageing population in the UK to be independent and improve their overall wellbeing, reducing demands for GP and hospital services. Atkinson and Crozier (2020) expressed concerns that an increase in stress levels by care workers could decrease care quality and suggested that this could be detrimental to the effective functioning of the UK health care systems.

According to the National Audit Office (2016), an inadequate workforce in health and social care organisations are causing delays to discharge older patients from the hospital who no longer need acute care costing the NHS an additional annual cost of £820 million. If these

people were to be cared for in another appropriate setting it would cost an additional £180 million annually, a significantly less amount in comparison to in-hospital care.

Existing research highlights some of the challenges of the National Living Wage policy on the sector. The National Living Wage has exacerbated issues in the care sector such as an increase in Zero-Hour Contracts (Vadean and Allan, 2020), underpayments in wages (UNISON, 2020), difficulty in maintaining pay differentials and competition from other sectors (Moriarty, Manthorpe and Harris, 2018; Skills for Care, 2022). However, scant attention is given to worker experiences, the adaptation strategies used by workers in response to these challenges and how their day-to-day life has been affected as a result. This research would address this gap by exploring the experiences of the National Living Wage policy by care workers and care organisations in their professional and personal lives and how they have addressed any challenges, and factors influencing their standards of living.

Adilov (2008) states that the negative effects of minimum wage could be stronger in the long run since demand elasticity is higher in the long run than in the short run. Giuponni et al., (2016) also emphasised the importance of further research on the effects of National Living Wage in care homes stating that although most care homes have so far adapted to the National Living Wage more data is needed to add to the current short-term analysis also looking at the medium and longer-term. Machin and Wilson (2004) support this view:

"Many commenters believe that more serious impacts of minimum wages can take some time to work through" (Machin and Wilson, 2004, p.2).

Vadean and Allan (2020) further confirmed this view claiming that how care providers will adjust to austerity measures and the planned increases in National Living Wage rates is an important question for future research, especially due to the sector already dealing with low retention rates and issues with labour supply. Hence, the present study will address these concerns by adding to the short-term analysis on the impact of National Living Wage in the sector by providing a detailed analysis on how care workers and care providers have adjusted to austerity measures and the annual increases in National Living Wage rates. In addition, this study will also explore if the National Living Wage has changed the way low pay workers interact with the tax and benefits system and whether their standard of living has improved.

As the focus of this research is on capturing care worker and care manager experiences of working under the challenges imposed by the policy, these findings could guide policy makers to structure further ways to support the care workforce and care organisations. Findings from this research could be used by organisations such as the Low Pay Commission, HMRC, Department of Health and Social Care and trade unions to deliver improvements in the private adult social care sector.

1.4 Research Aim and Objectives

The overall aim of this research is to explore the experience of engaging with and fulfilling the National Living Wage policy by the private adult social care sector in England and to capture care worker and care manager experiences of working under the conditions imposed by the policy. The title of the research is Impact of the National Living Wage (NLW) policy on low pay jobs in the private adult social care sector in England. The following three research objectives have been identified to achieve the research aim.

1. Explore the private adult social care sector's views and experiences of the National Living Wage policy including benefits and challenges.
2. To identify factors that influence the living standards of workers under the National Living Wage policy within the private adult social care sector.
3. Identify ways in which the sector can address challenges imposed by the National Living wage policy.

The first objective is important as to improve the sector's experience of complying with the National Living Wage policy, it is necessary to understand how the private adult social care sector's workers and organisations are currently appraising and responding to the National Living Wage policy and how it has affected the relationship between care organisations and Local Authorities. It would be difficult to identify best practices without knowing the benefits and challenges posed by the policy and the adaptation strategies used in response to these challenges. Objective two of this study will assist to examine the reasons for the persistent low pay and poor working conditions in the sector. It is hoped that expanding the research in these directions would deepen the understanding of the impact of the National Living Wage policy in the adult social care sector whilst also providing a stronger foundation for developing effective, evidence-based solutions that address the needs of workers, service providers, and

the individuals they care for. The final objective is to provide recommendations on how the sector can address the challenges imposed by the National Living Wage policy.

1.5 Research Approach

Hermeneutic phenomenology (Alsaigh and Coyne, 2021) facilitates this research's drive to probe deeply into the lived experiences of engaging with and fulfilling National Living Wage policy by the private adult social care sector in England. Self-completion written interviews is the main data collection method. In addition, a pilot study and documentary evidence will assist with triangulation to increase the rigour of the research (Bowen, 2009). Documentary analysis will consist of documents derived from the state such as Acts of Parliament, House of Commons meeting minutes and official reports related to the National Living Wage. In addition, reports from Non- Governmental Organisations (NGOs) such as the Living Wage Foundation and Resolution Foundation will also be gathered. The purpose of the pilot study is to confirm whether care workers and care managers are the most appropriate stakeholders to address the research objectives, advertise the main research and establish suitable mediums for data collection.

Purposive sampling (Bryman, 2016) will be used to recruit participants through Face Book Groups which have been specifically targeted for care workers, and through the 15 ENRICH clinical research networks with a combined registration of 578 care homes (NIHR School for Social Care Research, no date).The criteria for managers to participate in the study is for them to be involved in the application and compliance of the National Living Wage policy in their organisation. The criteria for care workers to participate in the study is that they receive the National Living Wage as an hourly rate. A care worker not receiving the National Living Wage or care managers whose staff are paid above the National Living Wage could not provide the necessary perspectives to achieve this research's aim to explore the experience of engaging with and fulfilling the National Living Wage policy by the private adult social care sector. Participants will also be asked to recommend other participants who might be willing to provide further insights to the research (Bryman, 2016).

An open-ended approach to coding known as initial coding (Saldana, 2015) will be done manually using a thematic framework. Post manual coding, the software NVivo will be used

for accuracy and further investigating of the data to compare findings amongst care workers and care managers for further contextualisation.

1.6 Structure of Thesis

The remaining chapters of the thesis are structured as follows.

Chapter Two: The Private Adult Social Care Sector Workforce

A brief introduction of the adult social care sector is given with an overview of the rapid privatisation in the sector. Furthermore, matters related to funding versus demand for services are examined in detail. Issues such as pay improvement in real terms, recruitment, migrant care worker population and gender inequality are further explored to gain a deeper understanding of the sector. Finally, factors influencing the standards of living amongst the care sector workforce are discussed as well as the impact of the coronavirus pandemic.

Chapter Three: National Living Wage: Legislative Impacts, Stakeholder Dynamics and Emerging Questions

This chapter provides an analysis of National Living Wage concept, how the concept is oriented both within the private adult social care sector and wider UK. The relationship of the government and the private social care sector is discussed within the context of UK legislation leading to the identification of the statutory duties of contractors (NHS and Local Authorities) and care providers to address the needs of a wide range of stakeholders. The concept of stakeholder management is applied to explore the relationship between care providers and care workers. The final section of the chapter provides a summary of the questions arising from existing literature.

Chapter Four: Methodology

This chapter discusses and provides justification for the philosophy of the research design (social constructionism) and adoption of the hermeneutic phenomenology methodology to study the lived experiences of National Living Wage in the private adult social care sector in England. The adoption of virtue ethics in solving ethical dilemmas is discussed. The suitability of the chosen research methods (documentary analysis, pilot study and written interviews) is clarified as well as the avenues used for participant recruitment (Face Book

groups, through Clinical Research Networks and snowballing from previous contacts). The reason for choosing purposive sampling and how the concept of information power guided the sample size is explored in detail. The thematic framework approach to data analysis is discussed along with the role of the software NVivo. A brief section on researcher reflection is included describing the learning process experienced by the researcher.

Chapter Five: Findings and Discussion

Section One: Results of the Pilot Study

The first section of the chapter presents the analysis of the pilot study conducted for a period of four weeks from 3 April 2022 to 1 May 2022. Participant recruitment procedures are provided along with the respondent characteristics to increase validity. The pilot study focuses on the research gaps arising from the literature review. Insights are provided into subject areas such as how care workers viewed the National Living Wage policy, how the National Living Wage have impacted career plans of care workers and their workload, care worker interaction with the benefits system, issues with wage discussion, causes of gender inequality, and the implication of the National Living Wage policy on the relationship between Local Authorities and care providers. Overall opinion amongst participants are identified for each question, from which conclusions are drawn. These conclusions are linked with the literature review and research objectives to identify topics (research gaps) that need to be explored in the main study (interviews).

Section Two: Description, Analysis and Synthesis of Interviews

The second section of the chapter presents the findings from interviews conducted with both care workers and care managers. The characteristics of participants from both groups are compared with data obtained from the Adult Social Care Workforce Data Set (ASC-WDS), to ensure that participant characteristics are not biased. Initially, the interviews with care workers are described and analysed in detail, highlighting key themes and insights. These findings are then contrasted with the results from interviews with care managers, allowing for a comparative analysis between the two groups. The outcomes of these interviews are subsequently synthesised with the literature review and pilot study findings to draw broader conclusions. The section concludes with a comprehensive summary of all findings.

Chapter Six: Conclusions and Recommendations

This chapter presents a summary of findings for the individual research objectives. How these findings have contributed to knowledge and practice are highlighted. A brief section is included describing the lessons learnt by conducting the pilot study. Furthermore, the challenges encountered during the research process and how these have been addressed are outlined. Suggestions are made for possible avenues for further research. Finally, an overall conclusion for the thesis is provided.

1.7 Chapter Summary

This chapter provided background information on the concept of National Living Wage and its challenges on the private adult social care sector. The discussion of current research on the subject helped to identify research gaps providing a rationale for the need to conduct further research. The anticipated output and application of findings were highlighted, followed by the overall research aim with justification for each of the individual research objectives. The research methodology was outlined, and the final section provided an outline of how the remaining chapters of the thesis are structured.

Chapter 2. The Private Adult Social Care Sector Workforce

2.1 Introduction

This chapter puts forward an analysis of rapid privatisation in the sector and how rising care costs and decreased funding over the years has presented challenges to care providers. Care providers have responded to these challenges by employing workers on zero-hour contracts with inferior terms and conditions and unpaid travel time (Moore et al., 2017; Vadean and Allan, 2020). This chapter further analyses pay improvements over the years, and how the care sector has been challenged and benefitted by the National Living Wage. Finally, low paid care sector workers standards of living are discussed as well as the implications of the coronavirus pandemic.

2.2 The Private Adult Social Care Sector in England

The past thirty years saw significant changes in social care delivery from being publicly provided by Local Authorities to being provided by private care providers. In 1993, 95% of domiciliary care services were provided through the public sector. However, by 2012 this figure has dropped to just 12% (Hudson, 2019). Private care providers act as agents providing care on behalf of the government. The government commissions the provision of care, to care providers. This key service is provided to service users by care workers with guidance from their managers (Weissert, Chernew and Hirth, 2003). Local Authorities and the Care Quality Commission enforces stringent regulations to ensure that care providers perform to the standards obliged by the Care Act 2014 towards stakeholders such as the service users, service user families and the Local Authority itself.

In the year 2022/2023, the adult social care sector had around 18,000 organisations with 39,000 care providing locations and a workforce of around 1.64 million. Around 88% of adult social care workers were employed on permanent contracts, with 52% working full time and 48% working part-time. The majority of the workforce consisted of women (81%) (Skills for Care, 2023).

The sector was estimated to contribute £55.7 billion per annum to the economy in England. The wages calculated using the ASC-WDS (Adult Social Care Workforce Data Set) amounted to around half of this amount at £26.6 billion in the year 2022/2023 (Skills for

Care, 2023). Already contributing a significant proportion of expenses towards wage bills, the planned increases in the National Living Wage rates (GOV.UK, 2019) poses a significant challenge to private providers strapped of resources due to limited funding (Burchardt, Obolenskaya and Hughes, 2020). Unsurprisingly, the adult social care sector was reported to be one of the *"most vocal"* (Low Pay Commission, 2016, p. xviii) in expressing concerns regarding the introduction of the National Living Wage.

2.3 Privatisation of Social Care Sector in UK

In the early 1980's state provided services were criticised for lacking choice and influencing too much control over services provided (Hudson, 2019). This control was considered as an impediment to user empowerment (Hudson, 2019). As a result, the NHS and Community Care Act 1990 was implemented with the aim of improving cost and efficiency of public services while widening available choices for service users through substantial involvement of the private sector. The Act redefined the role of Local Authorities as a hiring service as opposed to agents providing care services. Funding for this role came with the stipulation that 85% of it should be spent on purchasing care services from private providers (Filinson, 1997; Hudson, 2019).

This resulted in the rapid privatisation of social care. In 1979, 64% of residential and nursing home beds were provided through the public sector, whereas in 2012 this figure has dropped to just 6%. Until 1993, 95% of domiciliary care services were provided by the public sector. This figure quickly plummeted down to 11% by 2012 (Hudson, 2019). This rapid privatisation has translated to significant changes in service delivery and workforce pay, recruitment and training (Hudson, 2019).

This shift towards privatisation, accompanied by a growing reliance on for-profit providers, have raised concerns about the implications for the quality and accessibility of care. Some scholars argue that the focus on profit-making in private care homes may conflict with the goal of delivering high-quality, person-centered care, as financial pressures may lead to cost-cutting measures that negatively impact service delivery (Foster and Harker, 2022; Hudson, 2016; Institute for Government and The Chartered Institute of Public Finance and Accountancy, 2023).

Training has also become privatised in the process. Traditional full-time degrees are being increasingly replaced with the government funded fast track frontline programme. The first five weeks is spent in a summer institute, followed by a year in a local authority placement. The second year is spent working as a qualified social worker, while studying for a master's degree and completing a leadership programme (Community Care, 2016).

Academics have questioned the ability of fast tracking students through a programme where a range of complex skills need to be covered and expressed concerns that this move away from traditional university taught courses will have an impact on the amount of social care research completed and reduction in number of academics with social work practice experiences and research qualifications (Community Care, 2016; Hudson, 2019; Thoburn, 2017). Thoburn (2017) argued whether the distortion in the balance between students entering social care via mainstream and fast-tracked specialist programmes due to unequal funding levels is really in the interest of the profession and those who are receiving care.

Care home closure is also an ever-prevailing risk. Although 37% of care home fees are funded by local authorities, it has been reported that self-funders often pay higher and bridge the gap for the low fees paid by local authorities which is essential for care home survival (Baxter, Heavey and Birks, 2020; Hudson, 2019). A few large providers cover significant proportions of the market in some areas and their concerns of viability poses as serious threat to the market (Scourfield, 2012). The first catastrophic event occurred in 2011 with the collapse of Southern Cross with 9% of the market nationally. The effects on some areas such as the North East were worse as the company accounted for up to 30% of care in some parts of the North East (Hudson, 2019). Reasons for collapse were stated as decrease in funding over the years causing a 36% drop in income levels. This in turn led to a series of event which spiralled out of control. Drop in income levels led to a lack of property maintenance, which led to lower occupancy and loans attracting higher interest rates, thus, a fall in share price, poor management and quality of care which led to negative inspection reports and a further drop in occupancy levels (Scourfield, 2012).

The company which took over (Four Seasons) itself has fallen into hardship and having suffered large financial losses have closed three of its Birmingham care homes (BBC, 2016). Hudson (2016) proposed the following options to reform the care sector from privatisation;

Improve contracting practices: Incorporate greater social value, Living Wage and ethical codes of practice in contracting procedures.

National actions on pay, security and status of care work: A sector specific pay and career progression structure imposed by the government, improving work security by having the right to a fixed hour contract and stronger protections for zero-hour contracts with the status of care work elevated by making care work a regulated profession under the Health and Care Professionals Council.

Adequate funding to achieve duties imposed by Care Act 2014: Care Act 2014 by law obligates local authorities to shape the market by ensuring that service users have a variety of high-quality care choices to choose from. However, there is no strategic framework or a guide to local authorities to inform what this means in practice. Local authorities need to be provided with the necessary funding and tools to outsource services towards a strategic direction as imposed by the Care Act 2014.

Stricter market regulation: Enforce stricter rules to regulate the market which includes greater transparency on how resources are allocated with no commercial confidentiality, requirement of being subject to UK taxation laws, greater accountability on reaching outcomes and workforce standards instead of the one 'fit and proper' text by the Care Quality Commission.

Phasing the market towards a mixed economy: Replacing the market gradually through resumption of the statutory and third sector role, with a strategic medium-term goal to have a mixed economy sector with a more balanced number of public, voluntary and private organisations. A first step would be to prioritise organisations with a social purpose for future contracts.

The quality of care in the private adult social care sector has been a central concern, particularly given the reliance on for-profit providers. The Care Quality Commission (CQC) is the independent regulator responsible for monitoring and inspecting social care services in England, ensuring that providers meet national standards of care. However, the quality of care varies significantly across the sector, with some providers consistently delivering high-quality services, while others have been found to fall short of expected standards (Care Quality Commission, 2022a).

Despite these challenges, there are examples of good practice within the sector, with some providers adopting innovative and digital approaches to care delivery. Care providers are using digital technology to enhance the range of services available, offering individuals greater independence and control over their care while also supporting their overall well-being. These technologies can reduce the administrative burden on care workers, allowing them to spend more time on direct, face-to-face care. Additionally, they enable care providers to operate more efficiently, allowing them to better support both the people they care for and their staff (Skills for Care, 2024). However, ensuring that high-quality care is consistently delivered across the sector remains a key challenge for regulators and policymakers.

Demand for Social Care

Good quality social care would be needed for the ageing population in the UK to be independent and improve their overall wellbeing, reducing demands for GP and hospital services. According to National Audit Office (2016), workforce capacity issues in health and social care organisations are making it difficult to discharge older patients from the hospital who no longer need acute care costing the NHS an additional annual cost of £820 million. If these people were to be cared for in another appropriate setting it would cost an extra £180 million annually, a significantly less amount compared to in-hospital care.

The population aged 65 and over is estimated to increase from 10.5 million to 13.8 million people in England between 2020-2035 (Skills for Care, 2023). Table 1 below projects how the required number of adult social care jobs might increase based on the number of people in the population aged 65 and over. If the adult social care workforce is to increase proportionally, an additional 440,000 jobs (25% growth) would be required by 2035. Based on current statistics, one adult social care job is required for every six people aged 65 and over (Skills for Care, 2023).

Model	2022/2023	2025	2030	2035	% Increase in posts 2021/22 to 2035
65+ model	1,790,000	1,870,000	2,060,000	2,230,000	27%

Table 1: Adult social care job forecast based on the population aged 65 and over (Skills for Care, 2023, p.169, table.12)

2.4 Funding for Adult Social Care

The relationship between the government and the care sector involves the government contracting out the provision of care and the care provider performing the duty of care (Department of Health and Social Care, 2017). In England, Local Authorities individually decide their budget on social care. Revenue for social care comes from grant funding from the central government, increase in council tax through adult social care precept, pooled funding and spending by the NHS and cross subsidization of costs by service users (Foster and Harker, 2022). Issues in the sector can be partly attributed to rising care costs and inadequate funding over the years.

The gross current expenditure in the year 2021/2022 for adult social care by Local Authorities increased to £22 billion, which is £0.7 billion (3.4%) higher than it was in the previous year. The average hourly rate for commissioned home care also increased by 2.9% to £18.88. Despite this, it was still below the £21.43 minimum rate proposed by United Kingdom Homecare Association with wide variations in average purchase costs amongst different regions in England. The Care Quality Commission have reported that in March 2022, care home profits were at its lowest level since their market oversight regime began in 2015 (Care Quality Commission, 2022b).

Options to increase funding for social care include taxation, mandatory insurance, voluntary insurance and user charges (Lu et al., 2021). Lu et al., (2021) conducted a UK wide study to analyse the UK public preferences on social care funding. Their results indicated that the public would like social care funding to be raised as a collective approach in the same way as

NHS funding. The results were consistent amongst all age, gender, socioeconomic groups, and countries.

In April 2022, the government introduced the Health and Social Care Levy which is a 1.25% tax on earnings. The main objective of this tax was to fund the government's plan for health and social care set out in the policy paper, Build Back Better: Our plan for health and social care published in September 2021 (Seely and Foster, 2021). £5.4 billion of revenue from the levy were to be used to support adult social care reform in England from 2022-2025. Details of how this revenue would be allocated was set out in the white paper published in December 2021, People at the Heart of Care: adult social care reform (Foster and Harker, 2022).

At least £500 million was included to solve the workforce issues in the social care sector which includes initiatives such as developing a universal knowledge and skills framework to support career progression, portable care certification, occupational and mental health support, a digital hub where workers can access support and advice and implementing best practice recruitment. It also included £70 million to strengthen market shaping and commissioning and £3.6 billion to reform the social care charging system (Department of Health and Social Care, 2021d).

Currently, self-funders pay a higher rate to subsidise the low rates paid by the local authorities ensuring care home survival (Baxter, Heavey and Birks, 2020; Hudson, 2019). Reforming the social care charging system would be necessary to implement the Health and Care Act 2022 where self-funders can request their respective local authority to arrange care at the same rate paid by the Local Authority. It is only through paying a fair rate to providers that this change would be feasible (Department of Health and Social Care, 2021d; East Sussex County Council, 2022; Local Government Association, 2021).

However, in November 2022 the government announced the cancellation of the Health and Social Care levy with a promise to maintain the same level of funding for social care, with the exception social care charging reforms which has been delayed until October 2025 and funds diverted (HM Treasury, 2022). The government also announced funding of up to £2.8 billion in 2023/24 and £4.7 billion in 2024/25. This funding would comprise of new government grants, redirected funding from the adult social care charging reform which has been delayed, and allowing Local Authorities to increase both the council tax to 3% and

social care precept to 2% (an increase of 1% for each) (HM Treasury, 2022). The Local Government Association (2023) has argued that this funding is unlikely to drive service improvements considering the additional workforce costs, inflation, demographic pressures, and the fact that the amount to be raised from council tax and the adult social care precept is an estimated figure rather than guaranteed income.

Figure 1 below estimates that after accounting for these cost pressures, only £800 million of this extra funding is left (Institute for Government and The Chartered Institute of Public Finance and Accountancy, 2023). This amount would probably be insufficient to address the objectives the government targets to achieve using this funding such as stabilising provider market, reducing delayed discharge, reducing unmet needs and expanding the workforce (Institute for Government and The Chartered Institute of Public Finance and Accountancy, 2023).

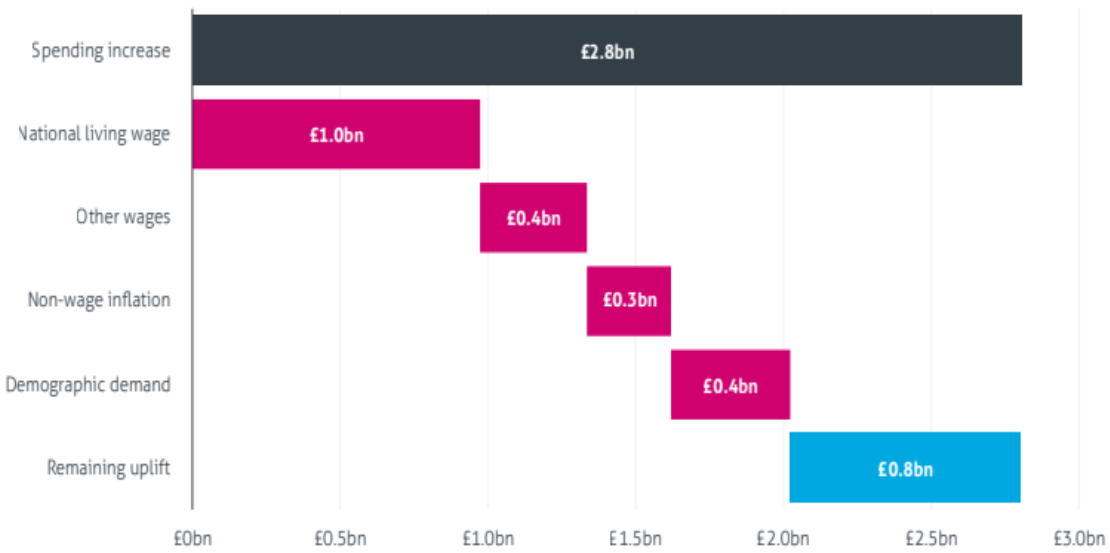


Figure 1: Cost pressures on the 2023/2024 uplift in spending on adult social care (Institute for Government and The Chartered Institute of Public Finance and Accountancy, 2023, p. 122, figure.3.3)

The Local Government Association (2023) has called for £13 billion in funding to meet these ongoing pressures and for Local Authorities to fulfil their statutory duties imposed by the Care Act 2014. This figure also includes £3 billion to increase care worker pay to address recruitment and retention issues (Local Government Association, 2023).

The policy on social care funding has shifted from central government grants to being increasingly dependent on locally raised revenue such as the social care precept resulting in inequalities with the most deprived areas being disadvantaged. Between 2010/11 and 2017/18, 30 Local Authorities with highest levels of deprivation reduced services by 17% per person compared to 3% per person by the 30 least deprived areas (Bottery and Babalola, 2020). The limited additional government funding available has been impromptu and short-term making authorities hesitant to make long term improvements such as pay rises, improved care worker terms and conditions and increasing provider fees (Burchardt, Obolenskaya and Hughes, 2020). At present a high proportion of social care is obtained through paying for it privately and unpaid care through family and friends unlike NHS care (Lu, Burge and Sussex, 2021).

2.5 The National Living Wage Policy in the Social Care Sector in England

The social care sector has a long-standing experience of poor pay and precarious working conditions. It has been argued that the National Living Wage rate does not reflect the actual amount being paid to care workers and, in some instances, have amplified the poor working conditions already prominent in the sector (Hardy, 2016; Hussein, 2017a; Moore et al., 2017).

Pay Improvement in Real Terms

To further understand care sector workers standards of living it is important to further analyse pay improvement in real terms over the years and how the care sector has been benefited and challenged by the introduction of National Living Wage.

Figure 2 below looks at the care worker hourly pay trend in both nominal and real terms over the past ten years. Nominal pay shows the actual pay rate on that particular year whereas real term rates are adjusted to inflation. The nominal median care worker hourly rate increased from £7.28 in March 2016 to £10.11 in March 2023. This resulted in a 39% increase in wages. Nevertheless, in real terms, the average care worker is 74 pence per hour (8%) better off in March 2023 than they were in March 2016 (Skills for Care, 2023). Between September 2012 and March 2016, the nominal median hourly rate increased by an average of 13 pence per year (Skills for Care, 2022). After the National Living Wage, this rate surged to an average of 40 pence per year, demonstrating the influence of the National Living wage increases on the sector (Skills for Care, 2023).

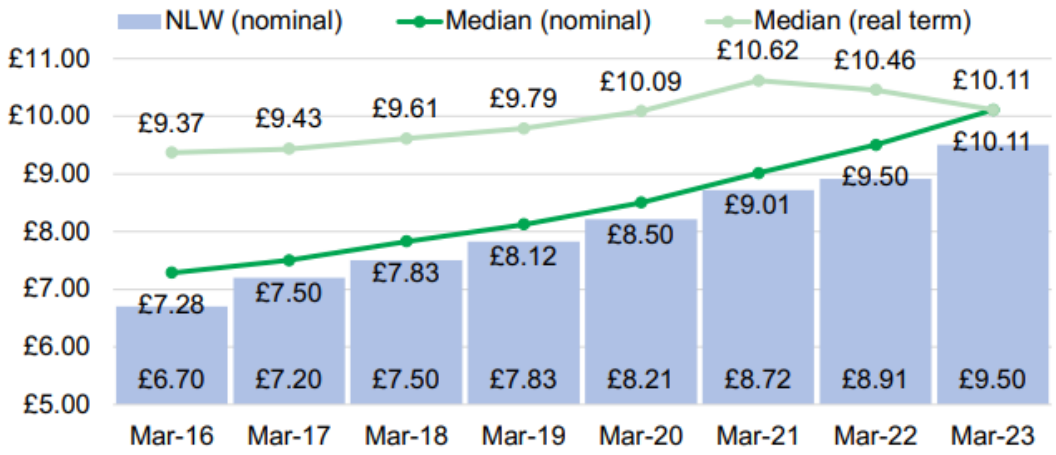


Figure 2: Care worker nominal and real term median hourly rate trend (Skills for Care, 2023, p.133, chart.79)

However, this would also mean that less skilled jobs in other low paying sectors (as defined by the Low Pay Commission) are having significant increases in their nominal median hourly rate. With the implementation of National Living Wage, pay in the retail sector and cleaning sector have been increasing faster than the social care sector. The less demanding nature of these sectors might make the social care sector less attractive for future and existing talent (Moriarty, Manthorpe and Harris, 2018). Another challenge of the consequent updating of the National Living Wage has been maintaining differentials across the pay structure between less and more experienced staff.

Figure 3 below shows hourly rate pay differences between workers with less than one year experience versus five years or more experience. In March 2016, care workers having a sector experience of greater than five years earned 33 pence (4.4%) more per hour on average than a care worker with less than one year of experience. Nevertheless, by March 2023, the experience pay gap had dwindled to just six pence (or 0.6%) per hour. Research conducted by Moriarty, Manthorpe and Harris (2018) for the Social Care Workforce Research Unit at King's College revealed that experienced care staff are leaving the sector to work in the NHS due to the decreasing pay gap between new and more experienced staff..

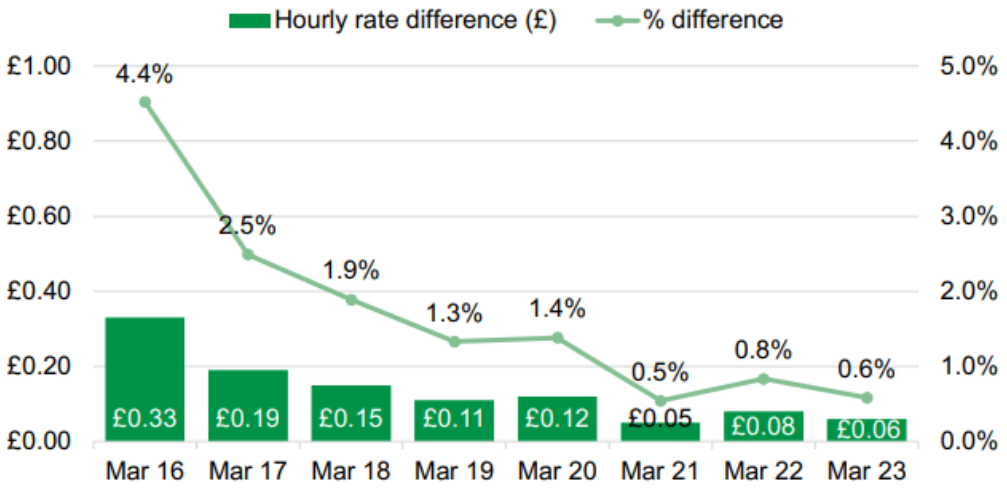


Figure 3: Hourly rate difference between workers with less than one year experience versus five years or more (Skills for Care, 2023, p.138, chart.84)

Recruitment and Retention

The social care sector is highly labour intensive. Therefore, recruitment and retention play a significant role. However, the social care sector in the UK has faced longstanding recruitment and retention issues with high staff turnover and vacancy rates (Moriarty, Manthorpe and Harris, 2018; Skills for Care, 2022). This poses serious issues for people providing care and the vulnerable people on the receiving end. Allan and Vadean (2021) examined the relationship between workforce retention and the quality-of-care homes. Their analysis suggested strong correlations between quality and the staff retention and vacancy levels in both residential and nursing homes. They concluded that a relatively small change

in staffing levels could impact the quality of the average care home (Allan and Vadean, 2021).

Moriarty, Manthorpe and Harris (2018) conducted research in partnership with the Department of Health and identified the existing recruitment challenges as following: low levels of pay and status, lack of leadership, competitions within and outside the sector which has been intensified by the National Living Wage, workload intensification and zero-hours contracts.

Migrant Care Worker Population

To address the recruitment and retention problems in the sector, care providers have made an impulsive decision to recruit a high number of international workers willing to accept the subpar working conditions in the sector. Care providers believe that international workers are more hard-working, committed and willing to accept the mediocre working conditions of the sector (Manthorpe et al., 2010).

Although the care worker occupation was not qualified under the skilled worker route initially, it was added to the Health and Care Worker visa and Shortage Occupation List in February 2022 due to recommendations by the Migration Advisory Committee. As a result, people arriving in the UK to take up social care jobs have been increasing. The proportion of the social care workforce with a non-EU nationality have increased from 10% in the year 2021/22 to 14% in the year 2022/23. The figure for EU nationality has remained constant at 7% for the same period. Figure 4 below depicts the impact of care workers being added to the Shortage Occupation List. Between March 2022 and March 2023, approximately 70,000 people arrived in the UK to provide direct care providing roles. This figure is significantly higher compared to the previous year of 2021/2022 where 20,000 people arrived to provide direct care providing roles. With high vacancy and turnover rates, this supply of international workforce is a significant lifeline support for the sector.

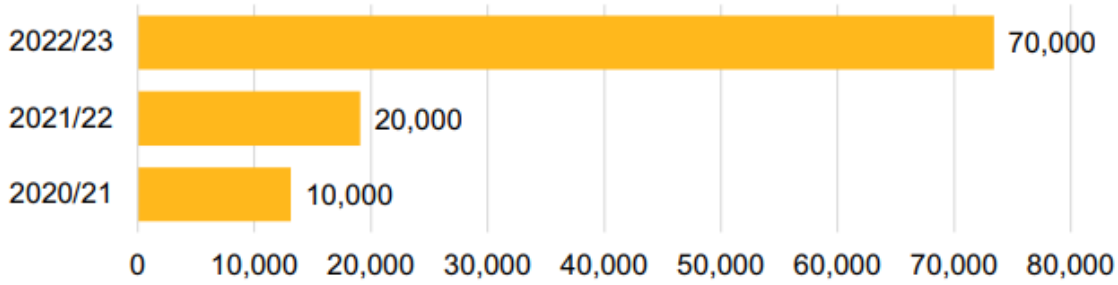


Figure 4: Number of people starting direct care providing roles that arrived in the UK within the year (Skills for Care, 2023, p.116, chart.62)

Characteristics of international employees such as workers being dependent on their employer for accommodation and residence rights makes them vulnerable to modern slavery working practices and highly reluctant to raise any issues in working practices such as the quality of care being provided (Manthorpe et al., 2010). Emberson and Trautrims, (2020) identified modern slavery risks in English adult social care procurement to be debt bondage, recruitment risks due to the complexity of international labour supply chains, remuneration risks such as illegal deductions and occupational risks such as excessive overtime.

The Migration Advisory Committee in their April 2022 review cited that migration is not the appropriate response and that a low paid workforce constrained to their job by visa conditions would lead to serious exploitation of the workers. Instead, they urged the government to improve funding with better pay and conditions for workers to make the sector more sustainable (Migration Advisory Committee, 2022). The gendered history of care work could be partly attributed to the persistent poor employment conditions in the sector which has been analysed in more detail below.

Gender Inequality

While the majority of the sector's workforce consists of women (81%) (Skills for Care, 2023), in proportion they are considerably under-represented in managerial and supervisory roles which have better pay and conditions (Hussein, 2017a; Moore and Hayes, 2018; Müller, 2019). Skills for Care (2023)'s report on the state of the adult social care sector in England highlighted that women were less likely to be in senior management roles (69%) compared to being a direct care worker (82%). Müller (2019) analysed data from 20 EU member states

and found a negative relationship between the proportion of female workers in the health and social care sector and the average relative income and this applied to highly skilled and lower skilled occupations as well.

The main reason for the historically prevalent roots of low pay in the social care sector has been defined as the gendered history of home care where care is performed by woman for free and the skills required to perform the job are considered to occur naturally to woman (Grimshaw and Rubery, 2007; Moore and Hayes, 2018). *"The perceptions of the role of women in society"* (Nobari and Armstrong, 2020, p.76) assume that women have a caring and helping character instilled into them by nature to perform their roles as mothers and carers (Moore and Hayes, 2018). Thus, the intricate skills required to provide good quality health and social care are often undervalued and not recognised. It was only from the 1970s that the home care profession was recognised as formal employment with written contracts, fixed hours and training (Moore and Hayes, 2018).

Hussein (2017b) conducted significant research to identify the perceived reasons behind the persistent poor wages in the feminised long-term care sector in the UK with 1342 survey questionnaires and 300 interviews with relevant stakeholders. She concluded that the long-term care sector has a strong perception that acceptance of poor pay is a prerequisite for working in the sector and workers who challenge the pay or working conditions are not suitable to work in the sector. Other reasons include the value society places on care where being a carer is not recognised as a career and low funding levels and marketisation of care (Hussein, 2017a). These views were expressed by employers and workers were hesitant to discuss about pay as if there was an "implied level of unacceptability of discussing wages within the context of care work" (Hussein, 2017b: 1822).

This stigma regarding wage discussion is concerning as there is a clear link between productivity and financial wellbeing (Armstrong and Brown, 2019; CIPD, 2023; Martono, Khoiruddin and Wulansari, 2018). Financial distress has a negative impact on the physical and mental health of employees resulting in higher levels of absenteeism and presenteeism (being at work but underperforming) (CIPD, 2021). In the case of the care sector, this could mean a decline in the care quality provided, thus negatively impacting the health of vulnerable service users accessing care.

In order to find a solution to the low pay associated with female dominated sectors, Müller (2019) surveyed 20 unions from 16 different countries who represented workers from the health and social care sector. The results revealed short term measures such as legal pursuits to deal with immediate wage discrimination and collective bargaining strategies. Long term measures included proposing changes to existing pay and grading schemes to reflect the pay and grading used in similar male dominated sectors and challenging the value society places on care work in general. Further suggestions included pursuing initiatives addressed to the state such as increasing the minimum wage and ending austerity policies.

The coronavirus pandemic has put social care on the forth of attention and some of the strategies suggested by Müller (2019) are being initiated by relevant organisations representing social care in the UK (Department of Health and Social Care, 2020b; UK Parliament, 2020). On 8 September 2020, in the Health and Social Care Committee meeting held at the House of Commons, president of the Association of Directors of Adult Social Services (ADASS) James Bullion called for a national care wage of £10.90 an hour, linked to a band 3 NHS healthcare assistant as a way of starting the journey (UK Parliament, 2020). Meanwhile, the Social Care Sector COVID-19 Support Taskforce commissioned by the government found evidence from the taskforce review that to ensure the resilience of the sector and workforce the government should initiate a review of the employment terms and conditions in the sector. The taskforce recommended that this be a long-term plan of action in consistent with the NHS people plan (Department of Health and Social Care, 2020b). However, these initiatives are yet to be put into any sort of action.

Austerity and Standards of Living in the Care Sector

Austerity and weak economic growth contribute to the obstacles front onto low paid workers to bring themselves and their families to a socially acceptable living standard (Swaffield et al., 2018). Many workers in low pay jobs struggle to pay bills and many are in receipt of working tax credits or some type of income support. However, they are deterred from securing additional hours or higher paid jobs due to the possibility of having their own or their partner’s benefits removed (Moore et al., 2017). The government replaced the Working Tax Credit with five other benefits and credits to introduce greater fairness and simplicity to the welfare system while ensuring that people are better off in work than on benefits. Claimants must sign before being given access to the scheme, requiring them to meet certain

work search, preparation and training requirements to reach the required income thresholds (Department for Work and Pensions, 2014).

The Universal credit system has come under criticism for its in-built six or more weeks of waiting for time, tough conditions and tight stance for sanctions (Sainsbury, 2014). There have been instances when the system has pushed low-income earners towards further hardship leading to rent arrears, debt and in some cases homelessness (Gardiner and Finch, 2020). Hartfree (2014) argues that this is related to how low-income households manage their income. Many low-income households receive pay on a weekly or fortnightly basis, budgeting expenses the same way. They do not have the skills to manage a single larger payment leading to mismanagement resulting in significant arrears and a long time without money until the receipt of next payment (Department for Work and Pensions, 2020). Thus, a more informed approach was needed to help workers in low pay jobs to become independent. The government introduced the National Living Wage as a solution.

The introduction of National Living Wage happened at a time when low paid workers were experiencing immense challenges due to austerity. Whilst the government announced that it expected the nationwide wage bill to increase by £4.5 billion due to the National Living Wage, the government placed several measures to reduce working age benefits by £13 billion many of which were focused on the bottom half of the lower paid (D'Arcy, Corlett and Gardiner, 2015). Hence, the National Living Wage has provided only partial financial relief from welfare cuts faced by the most disadvantaged.

Working in the care sector brings its own unique challenges to benefit from tax relief, minimum wage, pension auto enrolment and in work benefits (Low Incomes Tax Reform Group, 2018). Care work characteristics such as non-payment of travel time and zero-hour contracts make them vulnerable to confusions relating to minimum wage laws, tax credits and mileage allowances. The amount that an employer pays to employees for using their own vehicle to work is labelled as mileage allowance payments by HMRC (HMRC, 2019b). Some employers roll up travel costs in the care worker's pay making the reimbursement taxable in the first instance and the care worker having to claim it back. In instances when employers do reimburse for actual costs, rates per business mile is often less than the amounts allocated by HMRC (Low Incomes Tax Reform Group, 2018). Hence, the worker is left to claim the difference with HMRC to claim tax relief (GOV.UK, No Date). This is

possible as an employer is not legally required to pay travel expenses as long as the employee's total pay minus the cost is above the minimum wage (ACAS, No Date).

Furthermore, travelling from home and an employee's normal workplace is not covered by both minimum wage (ACAS, No Date) and income tax legislations (HMRC, 2021a). However, if the workplace is not permanent and temporary, which often happens in care work when covering for colleagues, a deduction is due under the Income Tax (Earnings and Pensions) Act 2003 (HMRC, 2021a), but the worker is not entitled to minimum wage for that time (ACAS, No Date). This differing treatment of home to work expenses under minimum wage and tax legislations may create confusion and care workers may miss valuable tax relief.

After understanding the complicated differing minimum wage and tax legislation, workers are required to fill in the P87 form which has its own challenges. The form is placed in the Personal Tax Account requiring users to prove their identity through Government Gateway or GOV.UK which is notorious for asking hard to pass questions (HMRC, 2019a). There is an option to send the form by post, however, the form needs to be filled out online before you can print it completely excluding the digitally challenged. You can only claim by phone if you have claimed expenses in a previous year and your expenses are less than £1000 or £2500 for professional fees and subscriptions (HMRC, 2019a). Moreover, there is no option to save a partly completed form. Although the HMRC provides a few examples of information you may require (HMRC, 2019a), it is not possible to navigate to different sections in advance to check exactly what information is needed.

The travel component of care work also poses challenges to claiming Working Tax Credit (WTC). Eligibility for certain benefits such as WTC requires a minimum number of working hours (GOV.UK, No Date) Care workers spend a high proportion of their working day travelling between clients and often this time is unpaid (Atkinson and Crozier, 2020; Moore, 2017; Moore and Hayes, 2018). Due to the higher rate paid for client contact time, employers can satisfy minimum wage requirements (Low Incomes Tax Reform Group, 2018). Nevertheless, as many care workers are not directly paid for travel time, this affects their eligibility to claim WTC as a significant amount of their working day is not counted as remunerative work. Furthermore, zero-hour contracts make working hours variable often

taking working hours above and below the thresholds of claiming WTC leading to frequent starting and stopping of claims or overpayments (Low Incomes Tax Reform Group, 2018).

The labour Force Survey suggests that 19.8% of care staff were on zero hours contracts compared to 3.2% for the economy as a whole in the year 2022 (Office for National Statistics, 2023). The sector specific report produced by Skills for Care (2022) estimates this figure to be higher indicating that almost a quarter of the workforce (24%) were on zero-hours contracts in the year 2021/22. Hence, the National Living Wage should be considered as only one element of an anti-poverty strategy and should be complemented by availability of jobs, better working conditions and standards of living (Cooke and Lawton, 2008; Emmerson, Johnson and Miller, 2014; Gardiner and Millar, 2006; Swaffield et al., 2018).

In addition, care workers also face long term financial concerns such as meeting the Lower Earnings Limit (LEL) to build a national insurance record for state pension. The LEL for 2021 to 2022 is £120 per week (HMRC, 2021b). Zero-hours contracts mean that workers may work regularly, and hours may fluctuate occasionally (Low Incomes Tax Reform Group, 2018). Moreover, each job qualifies for the LEL separately and not based on the worker's average earnings for the week. So, workers do not pay national insurance contributions if their weekly wages for each job is below the LEL, although their aggregate weekly earnings for both jobs combined exceed more than the LEL (Department for Work and Pensions, 2013).

In addition to difficulties in claiming tax relief and benefits, the unpredictable nature of care work has been known to cause work related stress, in turn affecting the overall worker quality of life and living standards (Hussein, 2017b). Local Authorities often use electronic monitoring systems to make payments to providers on a minute-by-minute basis, thus penalising the worker if visits run late due to an emergency faced by a service user, unrealistic number of scheduled visits to increase productivity or insufficient time allocated for travel not accounting to traffic and other unforeseen circumstances (Moore and Hayes, 2018). At times, councils also commission 15- minute visits which is notorious for being unrealistic and stressful for both service users and care workers (Moore and Hayes, 2018). Furthermore, research by the Living Wage Foundation (2020) imply that low paid workers experience adverse effects on their physical and mental health due to everyday stresses that come with the struggle to afford food and general household bills.

To resolve some of the workforce issues in the sector, the trade union Unison introduced the Ethical Care Charter Scheme which involved paying the Real Living Wage, sick pay and by providing proper training in work time (Moore, 2017). The statutory National Living Wage is different to the Real Living Wage which is voluntary and solely based on the costs of living and worker's needs, whereas the National Living Wage is a legal requirement and also focuses on employer affordability and the rate's impact on employment levels (Brown, 2017). While the National Living Wage is at £10.42 per hour, the UK Living Wage for outside London is £10.90 per hour and the London Living Wage is £11.95 per hour for the 2023/2024 tax year (Living Wage Foundation, 2023). Authorities who signed up for the Ethical Care Charter scheme has reported improvements in recruitment and retention figures and the overall quality of care. Care workers who were part of the scheme felt their lives have been improved and their contribution recognised (Moore, 2017). The Scottish and Welsh governments have already committed to providing the Real Living Wage for care workers (Gov.Scot, 2023; Welsh Government, 2022).

Gardiner and Hussein (2015) argued that although the cost implications to implement a living wage for all frontline care jobs in the UK would be significant, 47 percent of the costs would be refunded to the public purse in the form of income tax and a reduction in benefit spending. They further suggested that raising pay could lead to improved service delivery leading to further cost savings in terms of wider social and economic benefits. The coronavirus pandemic has played an important role to highlight the contributions of care workers and the need for sector level reforms.

2.6 Covid-19's Impact on the Workforce

Covid-19 has magnified longstanding issues of low pay, working conditions and staffing levels in the sector, prompting renewed calls for funding and reform (Shembavnekar, Allen and Idriss, 2021; Wild and Szczepura, 2021). The government injected £3.7 billion of emergency grant funding in the sector to combat pandemic related pressures and had invested over £1.1 billion through the Infection Control Fund to reduce the virus transmission rates (Department of Health and Social Care, 2020a). However, Local Authorities reported the additional funding as insufficient to cover all pandemic related costs (Dunn et al., 2020).

During the pandemic, it was criticised that compared to their colleagues working in the NHS, staff in the social care sector were often undervalued and forgotten. Issues with quality of care and the disconnection between the health sector and social care sector was brought to the forefront (Foster, 2020; Pautz, Gibb and Riddell, 2020). Meanwhile, the rates of death involving Covid-19 amongst men and woman in the social care sector were significantly higher than the rates of death involving other healthcare professionals (Office for National Statistics, 2021b).

Providing care often involves close physical proximity increasing the risk of contracting the virus. The proportion of staff working in the sector are more ethnically diverse and older than the general working population and current figures suggest that the risk of infection and death rates are higher amongst people of ethnic minorities and older people (Office for National Statistics, 2021a; Shembavnekar, Allen and Idriss, 2021).The social care sector in England is highly complex and fragmented with around 18,200 organisations providing care across 38,000 locations (Skills for Care, 2020b), causing practical and logistical challenges in implementing crucial responses to control infection rates such as sharing real time data, coordinating support, distribution of sufficient Personal Protective Equipment (PPE), and provision of sufficient testing for staff and service users (Dunn et al., 2020; Shembavnekar, Allen and Idriss, 2021).

In February 2019, prior to the start of the pandemic, the percentage of days lost to sickness amounted to 2.6%. As of June 2021, this figure stood at 5%, an increase of 97% (Skills for Care, 2021a). Many workers were only entitled to receiving the Statutory Sick Pay (SSP) during time off sick related to Covid-19 reasons. Hence, a care worker on National Living Wage working a 37-hour week would lose two-thirds of their income if they tested positive or had to self-isolate (Griffin, 2020). Furthermore, workers reported of increasing workloads due to covering for colleagues self-isolating or training new volunteers (Department of Health and Social Care, 2021b; Shembavnekar, Allen and Idriss, 2021).

This increase in workload, limited access to PPE, unclear work expectations and everchanging PPE guidance has taken a toll on worker's mental and physical wellbeing (Aughterson et al., 2021; McFadden et al., 2021). Evidence suggest that frontline and social

care workers experienced high levels of stress, anxiety and depression due to demands placed by the pandemic (Aughterson et al., 2021; Greene et al., 2021; McFadden et al., 2021). Despite these challenges, workers also reported positive factors such as increased unity where everyone is collaborating together over a common cause (Aughterson et al., 2021). There has been an increase in digital innovations and a move towards virtual appointments and meetings to share best practice. Examples of digital innovations include total digital triage system freeing up clinical time, remote and video consultations which could save time and costs to patients, working without waiting rooms and maximising the use of face-to-face consultations (NHS England and NHS Improvement, 2020a). In March 2020, just 28% of primary care appointments occurred via telephone. By April 2020, 48% of appointments took place via telephone (NHS Digital, 2020), showing the rapid pace at which NHS is adopting digital technology. Although this uptake in technology would alter the functions of social care jobs as a form of greater assistance to employees, this would not help to ease the labour demand and workforce issues due to the high level of human interaction required to provide care (Druckman and Mair, 2019).

Also, compassionate, and inclusive leadership styles have proven to be useful. Establishment of local system enablers and escalation routes helped with rapid decision making. Emergency and clinical teams were able to self-govern and implement the necessary changes to meet patient needs. Leaders learnt how to collaborate valuable experience and knowledge amongst their teams to formulate solutions to the unfolding situation. Team members met regularly to share important lessons and innovative responses to the crisis in order to recover together (Bailey and West, 2020).

It has been evidenced that project-based teams pooled together from different care organisations facilitate knowledge sharing that leads to the innovation of better services and operating guidelines (Harris and Sarwar, 2022; Sarwar, Harris and South, 2017). This would mean minimising costs through robust information systems to share knowledge and risk sharing by having common goals and making collective decisions. A more flexible workforce across systems could be considered as a new way of working for the future.

2.7 Chapter Summary

In summary, the relationship between the government and care providers have been affected due to lack of funding to enable care providers to perform the required tasks. Although the social care sector entered the pandemic with more resources in real terms than it was in 2010/2011 (The King's Fund, 2021), this was offset by the rising costs of social care services, National Living Wage, and rising demands. Pay improvements in real terms have been low for care workers until the introduction of National Living Wage. However, post the introduction of National Living Wage, pay in low paid sectors with less demanding jobs have been increasing at a faster rate and consequent upratings of the National Living Wage has created difficulties in maintaining pay differentials.

Combination of factors such as rapid privatisation, decreased funding, increasing demand, rising workforce costs due to National Living Wage and low levels of pay and status have caused severe recruitment and retention problems in the sector. The fact that acceptance of low pay is a conceived prerequisite for working in the sector due to its gendered history further puts workers at a disadvantage.

Furthermore, care work characteristics such as zero-hours contracts and unpaid travel time have posed significant challenges for workers to interact with the tax and benefits system impacting standards of living. The Covid-19 pandemic has worsened existing challenges in the sector further affecting worker's mental and physical wellbeing. As challenges in the care sector are directly correlated with quality in standards of living for both people receiving and workers providing care, care worker compensation and their impact are issues worthy of further research.

Chapter 3. National Living Wage: Legislative Impacts, Stakeholder Dynamics and Emerging Questions

3.1 Introduction

This literature review examines the concept of National Living Wage by exploring how the concept is oriented in the UK, especially within the private adult social care sector. Being the main funding body of the social care sector, the relationship of the government and social care sector is explored within the context of UK legislation. The relationship between care providers and care workers are explored through the concept of stakeholder management and the care commissioning process is discussed in detail.

The reason for studying the aforementioned areas is to provide a meaningful discussion and analysis of the National Living Wage in a structured way, to facilitate a critical understanding of the concept in the private social care sector. The aim is to provide a clear focus with justification for empirical research of the National Living Wage concept within the context of the private adult social care sector.

3.2 National Living Wage

To discourage dependence on the government for the topping up of wages through the benefits system, the government implemented the National Living Wage on 1st April 2016 applicable to the working population aged 25 and above, with some exemptions (Department for Business, Energy and Industrial Strategy, 2016). Workers were to be paid £7.20 per hour in the fiscal year April 2016-March 2017 (Department for Business, Energy and Industrial Strategy, 2016) resulting in an annual pay rise of 10.8% for the lowest-paid when average earnings were rising by 3% at that point of time (Low Pay Commission, 2018).

Since then, the Low Pay Commission have been recommending the pathway of National Living Wage increases to reach the ambitious targets set by the government, considering economic conditions and research evidence (Low Pay Commission, 2023). In April 2020, the annual increases adviced by the Low pay Commission brought the National Living Wage to £8.72 reaching the government's 2015 target for the national living wage to be 60% of median UK earnings by 2020 (Low Pay Commission, 2020). The Low Pay Commission

recommended a 9.7% increase in April 2023 bringing the National Living Wage to £10.42 to deliver the government's new target of 66% (2/3) of median earnings by April 2024. The coverage of workers to receive the National Living Wage increased to aged 23 and over from the year 2021 and are due to increase to those aged 21 and over from April 2024 (Low Pay Commission, 2023).

The policy context that leads to the introduction of the National Living Wage dates as far back as 1351 when the statute of labourers set maximum wage rates (Prowse and Fells, 2016). The chronology of wage milestones in the UK as shown in Appendix 1 demonstrates the evolution of the concept indicating that the policies related to wage are a process in continuous amendment. Hence, it would be interesting to identify the difficulties and opportunities that this continuous amendment brings to organisations and how organisations adjust and sustain to the continuous change in wage-related policies.

Several studies have been conducted to identify the impact of National Living wage on the UK labour market (Adascalitei et al., 2019; Aitken, Dolton and Riley, 2019; Capuano et al., 2019; Capuano, Cockett and Gray, 2018; Giuponni et al., 2016; Heffernan et al., 2021; Lee et al., 2022; Moore et al., 2017; Walmsley et al., 2019). Due to the potential for differences across occupations, industries, geographical regions, contract types and demographics, these differences have also been explored to an extent, especially among industries with a high proportion of low paid workers since they are much more likely to be affected. The extent of the effects of the National Living Wage is different across various subgroups.

Current quantitative analyses to examine the effects of National Living Wage uprating's using data from Annual Survey of Hours and Earnings (ASHE) concludes that regardless of their age, the National Living Wage has increased wages for low paid workers with a generally little negative effect on employee retention and hours worked (Aitken, Dolton and Riley, 2019; Capuano et al., 2019; Capuano, Cockett and Gray, 2018; Lee et al., 2022). The Annual Survey of Hours and Earnings is based on a 1% sample of employees registered with Her Majesty Revenue and Customs (HMRC). It provides information on the levels, distribution and make-up of earnings and paid hours worked for employees in all industries and occupations. The data can be further categorized by region, occupation, industry, age group and public or private sector (Office for National Statistics, 2022a).

However, when comparing subsets, there is some evidence that larger increases in National Living Wage might negatively impact on employee retention (Capuano et al., 2019) and hours worked (Lee et al., 2022) for women who worked part time. In terms of future policy implications for the Low Pay Commission, Capuano et al. (2019, p.3) concludes that:

> *"The fact that the larger increase for employees aged 25 or more did result in a reduction in employee retention for part-time employees (and most clearly for women who worked part-time) suggests that caution should be exercised in considering any future rises of a similar magnitude"* (Capuano et al.,2019, p.3).

These findings support two contrasting theoretical models of wages and labour markets. According to neoclassical models, the price of labour is determined at the equilibrium of labour supply and demand where full employment is possible. Introducing a minimum wage interferes with this equilibrium resulting in reduced demand for labour (Adams, 2019). This explains the reduction in employment retention for women who worked part time following the introduction of National Living Wage in April 2016 (Capuano et al., 2019), and reduction in hours for 23- and 24-year-old women who worked part time when the age entitlement of National Living Wage was reduced from 25 to 23 (Lee et al., 2022).

However, these effects were not observed in any other sub groups supporting the monopsony models such as Card and Krueger's (1994) studies of fast-food restaurants stating that a higher minimum wage has slightly positive (or zero) effects on employment and does not reduce non-wage benefits while labour costs are often passed on to customers. Adilov (2008) states that even the critics of Card and Krueger (1994) find it difficult to argue that small increases in the minimum wage would significantly decrease employment which lead to 650 economists signing a letter in 2006 stating that a modest increase in the minimum wage would not have a strong negative effect on employment.

However, the Card and Krueger's (1994) model could not completely be applied to the private social care sector as care home fees are paid by local authorities or social services and the fact that these fees are capped and does not increase with wage laws have the potential to intensify the effects of the minimum wage in this sector (Machin, Manning and Rahman, 2003; Machin and Wilson, 2004; Vadean and Allan, 2020). The dual labour market theory seeks to explain different market structures causing wage differentials. The theory contends

that the labour market is made up of primary market which includes sectors where jobs are highly creative, productive, difficult to measure and capital intensive and the secondary market which consists of labour intensive, routine and disciplined jobs characterized by poor working conditions and lower wages (Bulow and Summers, 1986). Brown (2017) argues that the national figures conceal the disproportionate impact of the National Living Wage in different sectors and regions. Six regions had bites already over 60% by the end of 2016. The bite was over 70% in very small firms and around 90% in low paying sectors.

The efficiency wage model also accounts for wage differentials assuming that wage is positively related to the productivity of labour. Hence, organisations may set up higher wages than the market rate expecting that it would increase productivity and profit, workers will invest more effort and reduce turnover as finding a new job would cost more to the worker (Kwon, 2014). Walmsley *et al.*, (2019) reported that with consequent uprating of the National Living Wage, employers expect increased effort from workers.

Walmsley *et al.*, (2019) explored reactions to the National Living Wage and its implications for the status of Employee Relations by conducting 12 semi-structured interviews with senior industry representatives of the hospitality sector. Their key findings highlighted concerns on the ability of smaller and more labour-intensive businesses to deal with increases in the National Living Wage. Business reactions to the National Living Wage include *"price increases, increasing unit sales, cutting costs elsewhere including staff reductions/recruitment freezes as well as subsequent increases in productivity"* (Walmsley et al., 2019, p.263). Employees are expected to do more and a perfect job in exchange for the National Living Wage that allows employees and their families to just get by. Moreover, annual increases in the National Living Wage has caused a decrease in pay differentials and staff questioned whether the minor pay difference is worth the extra responsibility (Heffernan et al., 2021, 2022; Walmsley et al., 2019).

Moore *et al.*, (2017) explored the relationship between non-standard employment contracts and the payment of the National Living Wage, creating a set of worker case studies using qualitative data collection from six low paying industry sectors. Their research indicated that organisations brought amendments to employment terms and conditions in response to the National Living Wage, mainly through reducing working hours, increasing unpaid components in the working time, and increasing the use of younger workers.

Whilst most workers were paid above the National Living Wage, this did not reflect the full working time given to the employee and the increase in workload brought by employers by reducing staff numbers. These findings are supported by Adascalitei et al. (2019) in their study of the retail and hospitality industry in two English cities by using 41 interviews and 55 questionnaire surveys of senior managers and owners further revealing that the reasons for these drastic actions are due to increasing pressures of low economic growth, pension auto-enrolment and VAT thresholds in addition to the National Living Wage.

In summary, quantitative analyses on the subject did not find any negative impact of the National Living Wage policy apart from the decrease in employment retention (Capuano et al., 2019) and hours (Lee et al., 2022) in part time workers, especially women. This was only observed following the National Living Wage implementation in April 2016 (Capuano et al., 2019), and when the age entitlement of National Living Wage was reduced from 25 to 23 (Lee et al., 2022). However, the conduct of qualitative studies on the subject revealed some experiences which could not be identified in quantitative studies. Employers expected workers to be more productive and introduced measures such as price increases, cost cutting initiatives, recruitment freezes, increasing unpaid components in working time and a general increase in workload. Decrease in pay differentials has caused staff to question the fairness of extra responsibilities for a minimal pay difference. It would be interesting to explore the experience of social care sector within this context as many strategies employed by other sectors to minimise the negative impact of National Living Wage could not be employed in the social care sector due to existing contracts with Local Authorities and strict quality standards imposed by the Care Quality Commission (Machin, Manning and Rahman, 2003; Machin and Wilson, 2004; Vadean and Allan, 2020).

3.3 The Adult Social Care Sector in England

The social care sector has completely changed over the last three decades from a public ownership model to a quasi-market model (Hudson, 2019). In a quasi-market model private companies provide services, and the services are purchased by the public sector (Barron and West, 2017; Filinson, 1997; Hudson, 2019).

The adult social care sector was privatised with the aim of significant improvements in service delivery and choice for service users. However, with the funding reductions over the

past decade (The King's Fund, 2021), the significant area for cost cutting for providers (Hudson, 2019) is the labour costs that make up around half the expenses in social care (Skills for Care, 2023). As a result, the current social care market is classified as low paid and incompetent to cater to complex needs of service users. The quality of social care and the employment terms and conditions has declined leading to recruitment and retention problems in the sector (Hudson, 2019).

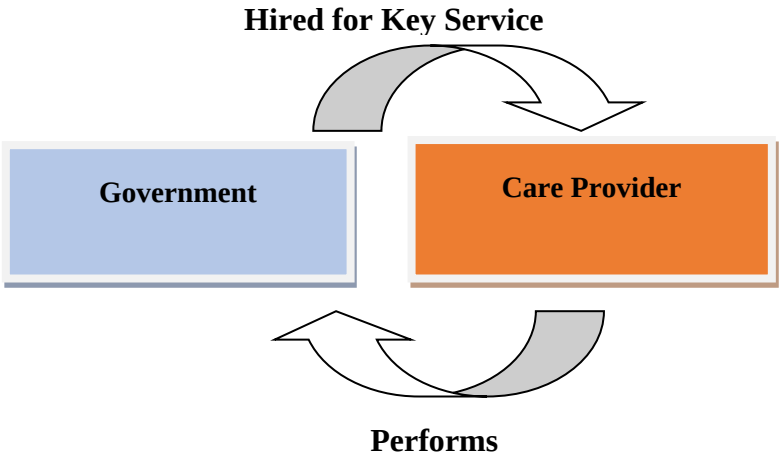


Figure 5: The relationship between the government and the private social care sector (based on Weissert, Chernew and Hirth, 2003)

Figure 5 above summarises the overall relationship with the government and the private social care sector. Provision of care, which is the key service that the government contracts out to care providers forms the basis of the relationship. This key task is performed by care workers with guidance from their managers (Weissert, Chernew and Hirth, 2003). As per this framework, wages paid, and their impact is an important issue worthy of further exploration.

The care commissioning process in the UK obligates the NHS (National Health Service) and Local Authorities to adapt to several legislations involving a wide range of stakeholders (Care Quality Commission, No Date). Some of the most important legislations covering the delivery of care include the Equality Act 2010, Care Act 2014 and the Health and Care Act 2022. Service users are to be treated equally while respecting their rights as an individual as governed by the Equality Act 2010, Care Act 2014 and the Health and Care Act 2022.

The Equality Act 2010

The Equality act 2010 ensures that everyone is entitled to an equal opportunity, and nobody is discriminated unfairly due to their age, disability, gender, marital status, religious beliefs, or sexual orientation. The Act covers equal opportunities regarding employment, workplace appointment, harassment, enquiries about disability and health in recruitment, non-discrimination rules in occupational pension schemes, gender discrimination, pregnancy and maternity equality, disclosure of information related to the gender pay gap, enforcement procedures related to employment tribunals, unenforceable terms in contracts and making reasonable adjustments to ensure that a person is not disadvantaged because of a disability (*Equality Act*, 2010).

The Care Act 2014

The Care Act 2014 brings care and support legislation together into a single act with a new wellbeing principle at its heart. It aims to make care and support clearer and to put people's wellbeing at the centre of decisions and include and develop personalisation. The Care Act 2014 addresses a wide range of stakeholders in the care commissioning process including Local Authorities, care providers, employees working in the care sector, care recipients and carers (*Care Act*, 2014).

Care recipients: The Care Act starts by stating that the general duty of a Local Authority is to promote the individual's wellbeing. With the care recipient at the heart of the legislation, the Act requires to consider the individual's views, wishes, feelings and beliefs and the individual's participation as fully as possible related to care with information and support necessary to enable the individual to participate. The Local Authority must meet the care and support needs of its residents and provide continuity of care and support when the adult moves or in case of provider failure. For the first time, a legal framework is created so key organisations and individuals with responsibilities for adult safeguarding can agree on how they must work together and what roles they must play to keep adults at risk safe.

Carers: For the first time, carers have been recognised in the law in the same way as those they care for. Carers have a legal right for an assessment of their needs for support and the agreement of a support plan with the relevant authority which sets out how the carer's needs will be met which may include the provision of care and support to the adult needing care or

some other way which would depend on the outcomes the carer wishes to achieve in day-to-day life.

Care sector workers: Section 97 of the Care Act states that it is a duty on providers of health services to support the system of education and training for health care workers and that there is a duty on NHS commissioning boards to support this system.

Local Authorities: A legal requirement for the Care Quality Commission and care providers to provide detailed information regarding the quality of care being provided to assist the Local Authority to carry out its function. The Care Quality Commission must conduct reviews of the regulated care activities by service providers, assess the performance of service providers following each review and publish a report of the assessment. The Act also encourages the integration of care and support within health services and instructions for pooling arrangements for optimum use of expertise and resources.

Care Providers: The care Act details the rights of appeal procedures about Care Quality Commission decisions. It is a duty on the Care Quality Commission to assess the financial sustainability of certain care providers. Where there is a risk to financial sustainability, the Care Quality Commission would assist the provider to develop a plan to minimise or eliminate the risk and arrange for or require the provider to arrange for appropriate professional expertise to carry out an independent review of the business.

The Health and Care Act 2022

The Health and Care Act 2022 is based on the proposals set out in the NHS Long Term Plan published in January 2019 and the white paper "Integration and Innovation: working together to improve health and social care for all" published in February 2021 (Department of Health and Social Care, 2021; Local Government Association, 2022; The King's Fund, 2022b). The main purpose of the act is to establish a shift from the old legislation which encouraged competition between health care organisations (Local Government Association, 2022). For the first time, Integrated Care Systems have gained a statutory footing which would formally stipulate collaboration amongst NHS and various health care organisations and hold them accountable. Each Integrated Care System is accountable to NHS England for their operational and financial performance. The Care Quality Commission is the body responsible to independently review and rate the Integrated Care Systems (The King's Fund, 2022a).

The Health and Care Act 2022 has brought a number of wider reforms to public health, social care delivery, quality, and safeguarding. For the purpose of this research, the key changes in social care governance imposed by the act have been highlighted below (*Health and Care Act*, 2022).

Integrated Care System (ICS): The main function of an ICS is to form key partnerships that bring together providers and commissioners in order to plan, co-ordinate and commission health and care services. The Health and Care Act 2022 provides discretion and flexibility on how individual ICSs work so that their functions can be personalised to the local population needs. Each ICS consists of an Integrated Care Board (ICB) and an Integrated Care Partnership (ICP). Many organisations will work across more than one level to achieve healthcare objectives.

Integrated Care Board (ICB): ICBs will replace the former Clinical Commissioning Groups (CCGs) and will be accountable to NHS England for operational and financial performance of health services. Each ICB will consist of an independent chair, chief executive officer, representatives from NHS trusts and NHS foundation trusts, General Practice, Local Authorities and an individual with expertise and knowledge of mental illness. Together with its partners, the ICB is responsible to produce a five-year plan for health services with regards to their partner ICP's integrated care strategy. Based on the five-year plan, the ICP's integrated care strategy, the joint strategic needs assessments and the joint health and wellbeing strategies produced by the local Health and Wellbeing Boards, the ICB will be responsible for allocating the NHS budget and commissioning services. The ICB will have flexibility to delegate funding to support the joint planning of some NHS and council-led services.

Integrated Care Partnership: Each ICB and its partner local authorities will be required to establish an integrated care partnership (ICP), consisting of representatives from the ICB, the local authorities within their area and other partners such as NHS providers, public health, social care, local healthwatch, and voluntary, community and social enterprise (VCSE) organisations. The ICP is responsible for publishing an integrated care strategy which details the arrangements to be made to meet the needs of the local population. In doing so, the ICP should consider the joint strategic needs assessments, and the joint health and wellbeing strategies produced by the local Health and Wellbeing Boards.

Whenever the ICP receives a new joint strategic needs assessment from a health and wellbeing board, it must consider whether the integrated care strategy needs to be revised. In preparing the strategy, the ICP should also involve the local healthwatch organisations and the people who live or work in the area. The main function of the ICP is to meet the wider public health and social care needs through the integrated care strategy but the ICP does not have individual authority to commission services.

CQC Assessment of Local Authority social care services: The Health and Care Act 2022 has introduced a new duty for the CQC to appraise the performance of local authorities in delivering its adult social care duties imposed by the Care Act 2014. The CQC has the authority to conduct inspections as part of its reviews. The CQC must publish a report of its assessment specifying any aspects in which the CQC considers the local authority is failing and provide appropriate recommendations. If necessary, the secretary of state may give enforceable directions to the local authority that the secretary of state considers appropriate for the purpose of addressing the failure.

Improved data sharing and standardisation: The Health and Care Act 2022 gives new powers to all health and social care bodies, the secretary of state and NHS digital to require health and social care bodies to provide information (other than personal information) on all activities related to their health services and adult social care. The secretary of state has the power to impose financial penalties on private social care providers who fails to provide the required information to the required information standard or if the information provided is false or misleading.

If the relationship of the government and the social care sector is explored within the context of UK legislation, there are statutory duties on the contractors of care (NHS and Local Authorities) and care providers to address the needs of a wide range of stakeholders such as care recipients, carers, families of care recipients and employees (*Care Act*, 2014; *Equality Act*, 2010; *Health and Care Act*, 2022).

Nevertheless, decrease in funding over the years have put care homes at risk for closure (Hudson, 2019). It has been reported that self-funders often pay higher and bridge the gap for the low fees paid by local authorities which is essential for care home survival (Baxter, Heavey and Birks, 2020; Hudson, 2019).This is concerning as a few large providers cover

significant areas in some of the markets (Scourfield, 2012). This poses a threat of market failure (Scourfield, 2012), which could lead to serious consequences for service users and for services (Social Care Institute for Excellence, 2012). Inadequate care may cause individuals to need acute care or hospitalisation for longer, which is significantly more costly than social care (National Audit Office, 2016; Social Care Institute for Excellence, 2012).

The original idea about privatisation such as more efficient care and better choice for service users has not been fruitful. (Hudson, 2019). Hudson (2016) proposed that for the care sector to reform from privatisation greater social value needs to be incorporated into contracting practices with national actions on pay, security, and status of care work. He further states the need for adequate funding to achieve duties imposed by the Care Act 2014, transparency on resource allocation, and phasing the market towards a mixed economy.

3.4 Mapping Stakeholder Theory to Social Care

Stakeholder theory emerged as a critique of shareholder primacy, which posits that the main responsibility of a business is to maximise returns for its shareholders (Freeman, 2010). Freeman (2010) argued that businesses operate within a network of relationships and are impacted by, and impact, various stakeholder groups. In sectors like private adult social care, which are driven by complex human needs and relationships, the theory offers a framework for understanding and balancing competing demands (Donaldson and Preston, 1995). The sector's stakeholders, such as care recipients, families, care staff, Local Authorities and care providers, have different, sometimes conflicting, priorities (Skills for Care, 2023). Stakeholder theory emphasises the importance of identifying these groups, understanding their interests, and addressing them through inclusive and transparent decision-making processes.

The sector faces significant challenges, including funding shortfalls, recruitment difficulties, and regulatory pressures such as the National Living Wage (Skills for Care, 2023). The coronavirus pandemic further exposed vulnerabilities in the sector, particularly around staffing, infection control, and resource allocation (Dunn et al., 2020; Shembavnekar, Allen and Idriss, 2021). Given these complexities, a stakeholder approach that emphasises collaboration, transparency, and ethical decision-making can help address the sector's

challenges and improve outcomes for all involved. By adopting stakeholder theory, private adult social care providers can reap several key benefits:

Improved Care Quality: Shared decision making involving service users, families, and staff helps to ensure that care services are responsive to individual needs and are delivered with compassion and understanding (Bendtsen Kronkvist et al., 2023; NHS England, 2017). Therefore, stakeholder engagement could lead to more personalised care plans, better communication, and stronger relationships between care providers and recipients.

Staff Retention and Well-being: Actively involving employees in decisions about their work environment and professional development leads to higher job satisfaction and lower turnover (Skills for Care, 2023), which in turn could lead to improved care continuity for service users. This approach also fosters a positive workplace culture where staff feel valued and heard (Harrison, Bosse and Phillips, 2010).

Sustainability and Profitability: By balancing the needs of investors with those of service users and staff, care providers can achieve a sustainable model of care provision that aligns ethical practices with long-term financial success. Care providers could get an upper hand in negotiations by providing a better service and a higher level of service user satisfaction. This could be done by investing a higher share of the profits to address the service user's needs and increasing CSR scores. (Fedele and Miniaci, 2017) studied 7488 companies operating in the care sector in Italy from 2005-2013. They concluded that the leverage of mature for-profit companies is significantly higher than non-profit companies due to the non-distribution nature and cost of debt is lower for non-profit companies and companies with high Corporate Social Responsibility (CSR) scores. This indicates that care providers could decrease their leverage and get better debt terms by investing a higher share of profits to improve service user satisfaction.

Donaldson and Preston (1995) presented three different features of the stakeholder theory that are interconnected to fit within each other. The most external layer of the theory consists of its descriptive feature where the theory is used to describe specific characteristics and behaviours of the firm and how corporations are managed in the real world. The descriptive feature supports the next layer where the theory is classified as instrumental. That is the theory can be used as a link and guidance towards achieving success or organisational

objectives. The central core of the theory is normative where the firms have a moral obligation in treating all its stakeholder's interests of equal value and that firms need to device suitable approaches to deal with each of its stakeholders.

Descriptive Aspect

The formal relationship between care providers and care workers start with an induction, which includes a care certificate if previously not completed. It also includes the necessary training to perform their role such as health and safety, safeguarding, first aid, moving and handling. Depending on the role, the training can be specific such as communication skills to support people with autism or dementia.

Care providers collaborate with care workers to evaluate the needs of service users and develop plans on how service users can achieve these needs. They support care workers in delivering care plans for service users and finally reviewing the outcomes (Think Local Act Personal, No Date). These processes are governed by the Care Act 2014 and Health and Care Act 2022.

Instrumental Aspect

Harrison, Bosse and Phillips (2010) argue that firms could use the process of stakeholder management as a competitive advantage suggesting that when trusting relationships are developed with stakeholders, they tend to share meaningful information about their utility functions so that firms can allocate resources to processes which are the most important to satisfy the needs of stakeholders. They gave examples where employees are willing to take a pay cut or share information that would improve the processes of the organisation. This process of knowledge transfers of new ways of producing or delivering could open doors for innovation.

Figure *6* below illustrates how this process could be potentially used in the social care sector to gain a competitive advantage. (Harrson et al., 2010, p. 62, fig. 1).

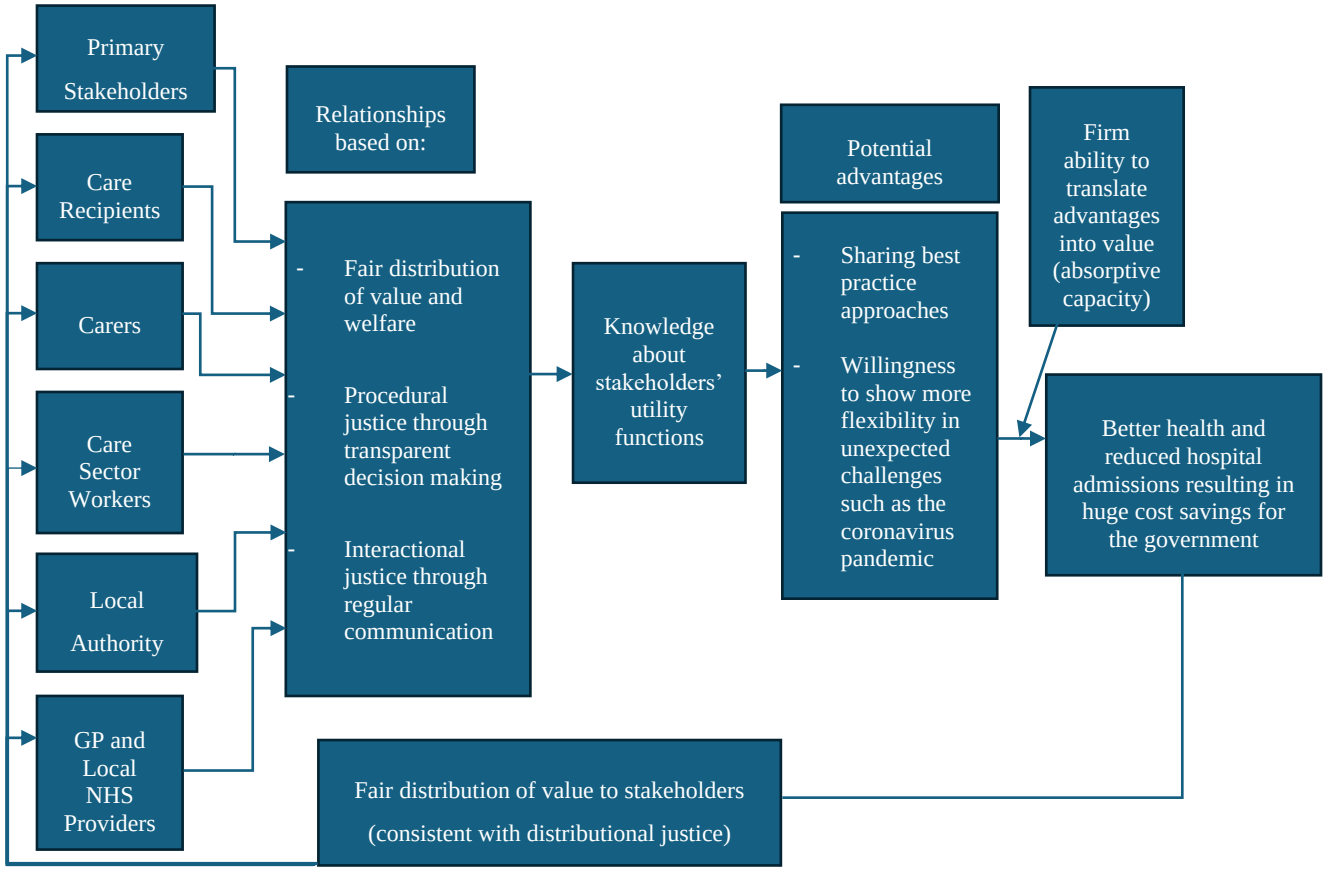


Figure 6: Managing for stakeholders and value creation in the social care sector (Based on Harrison et al., 2010, p. 62, fig. 1)

As demonstrated in

Figure 6 shown above, care providers need to establish procedural and interactional justice by spending time listening to care workers through meetings and other forms of communication. This process should be reciprocal where care providers share with care workers the process of their decision making and actions which could affect the welfare of the care workers. Procedural justice refers to how fair care workers believe the decision-making process is while interactional justice refers to how fair care workers are treated in different proceedings. This process, in turn, would lead to care workers sharing valuable information such as service shortcomings and best practices trusting that they would not be exploited, and their views and interests would be considered in the future (Harrison et al., 2010). In the social care sector, sharing of best practice approaches or innovative ideas may lead to better health or even reduced hospital admissions for the persons involved resulting in huge cost savings for the government (Deeny, Gardner, Al-Zaidy, Barker and Steventon, 2017).

Normative Aspect

Care providers should build trusting relationships and communication systems with care workers to assess the quality of the services being provided. Effective communication is an integral part of managing relationships (Mio et al., 2020) leading to increased productivity and performance (Linder and Foss, 2015).

Care workers should be provided with the necessary training and support as governed by the Care Act 2014. Section 97 of the Care Act states that it is a duty on providers of health services to support the system of education and training for health care workers. Care providers with higher levels of learning and development have lower staff turnover and higher CQC ratings (Skills for Care, 2022).

3.5 The Care Commissioning Process

The Local Authority or NHS forms a strategic relationship with local care providers through the care commissioning process, which is designed to ensure that services are tailored to meet the specific needs of the local population. This process involves the four key stages of analysing, planning, implementing, and reviewing. The first stage, analysing, requires an assessment of population needs to identify gaps in care provision. This is followed by the

planning stage, where a detailed strategy is developed to address these gaps. The implementation stage then focuses on supporting care providers to deliver services that meet these needs effectively. Finally, the reviewing stage ensures that the outcomes of the care services are evaluated, allowing for improvements and adjustments where necessary (Think Local Act Personal, No Date).

Each of these stages plays a vital role in ensuring that services are both efficient and of high quality, meeting the diverse needs of the population. The care commissioning process is governed by key legislation, including the Care Act 2014 and the Health and Care Act 2022, which set out the legal framework for ensuring that care services are person-centered, sustainable, and responsive to changing population demands. Flexible contracting arrangements are made to accommodate the changing needs of the service users and the duration of the contract could vary from anywhere between 1-30 years (Jefferson et al., 2017; South of England Procurement Services, 2022).

The contractor and care providers share the overall goals of the contract which is to help the service user achieve their desired outcomes. This eliminates the problem of conflicting goals (Cowden et al., 2020). There is elaborative monitoring, policing and incentive mechanisms established to further align the interests of the service providers and contractors (Hackney Council, 2013; Richmond and Wandsworth Safeguarding Adults Board, 2018; The Royal Borough of Kingston upon Thames, 2020; West Sussex County Council, 2020).

The final stage of the commissioning process (reviewing) involves evaluating the outcomes of the commissioned services and assessing whether they are meeting the needs of the population. This stage is critical for ensuring accountability and driving continuous improvement in service delivery (The Royal Borough of Kingston upon Thames, 2020; Think Local Act Personal, No Date). Reviewing involves collecting feedback from service users, carers, and providers, as well as analysing performance data to assess the effectiveness of services (Birmingham City Council, No Date).

The Care Quality Commission plays an important role in this stage, as it is responsible for inspecting and regulating adult social care services in England. CQC inspections provide valuable information for commissioners about the quality of services and whether they are meeting national standards (Care Quality Commission, 2022a). Additionally, local authorities

are required to review their commissioning strategies regularly to ensure they remain aligned with the changing needs of the population (Care Quality Commission, No Date).

The stringent standards imposed during the reviewing process prevents care providers from acting out of self-interest and engaging in self-serving behaviour given the opportunity (Pouryousefi and Frooman, 2017; Shankman, 1999). However, there have been recorded cases of care providers not keeping or recording adequate information (moral hazard) and below par service due to staffing issues (adverse selection) as reported by the Quality Assurance Management Board of West Sussex County Council (2014). Moral hazard refers to when the agent does not put the effort to perform the agreed-upon tasks. That is, the agent is shirking. Adverse selection refers to when the agent misrepresents their skills or abilities to complete the given task to the satisfaction requirement (Eisenhardt, 1989).

Optimal Contract Type

Several individuals and organisations may be involved in a person's care (Department of Health and Social Care, 2022). Hence, the achievement of outcomes would depend on the optimum performance of all individuals and organisations involved in the person's care. If agency theory is applied to the commissioning process of social care between the government and care providers as demonstrated in Appendix 2, it could be argued that the optimal contract for this situation is behaviour-based although most care providing contracts contain an outcome-based component (Bristol City Council, 2008; Monitor and NHS England, 2015). In turn care providers should be transparent with record-keeping preventing moral hazard and fully disclose their capabilities especially related to staffing to prevent adverse selection (Cowden et al., 2020; Pouryousefi and Frooman, 2017).

Although a preferred choice amongst organisations, outcome based reward systems disadvantaged care providers by offering them compensation for outcomes they did not fully control (Bosse and Phillips, 2016). It could be argued that the contract between care providers and the government introduced areas with fear or an inability to manage risk because:

- Factors that are not in the control of care providers may make the achievement of outcomes more difficult. For example, government policies and legislation imposing

more responsibilities and conditions on care providers (*Care Act*, 2014; *Health and Care Act*, 2022), economic issues (cost pressures due to the rise in National Living Wage or rent inflation), competition and technological changes.

- Several individuals and organisations may be involved in a person's care (Department of Health and Social Care, 2022). Hence, the achievement of outcomes would depend on the optimum performance of all individuals and organisations involved in the person's care. For example, the GP, family members, carer and any community organisations or health care providers involved must complete their assigned tasks to a satisfactory level. The effort of the social care provider alone would not help to achieve the outcomes to the highest level.

In a research initiated by The King's Fund, Robertson and Ewbank (2020) described the benefits of using completely behaviour-based contracts for commissioning for care using the Bradford district and Craven with a population of 632, 780 using fixed income contracts and South Tyneside covering a small population of 157,204 using block contracts. Their findings reported providers having more transparent conversations with commissioners about the issues they were facing enabling the system to find solutions. Staff found their roles shifting away from monitoring and spending more time discussing development pathways and quality improvement. This has also led to improved relationships which encourage innovation. For example, the two acute trusts delivering care in the Bradford district and Craven area have a collaboration Programme that enables them to support each other rather than compete for patients (Robertson and Ewbank, 2020). Effective management of professional expertise and the encouragement of political accommodations amongst organisations can lead towards more integrated care (Sarwar, Harris and South, 2017).

Local Authorities believe that increase in prices would not necessarily benefit the service users and the increased amount would mainly be used to increase provider profits (Jefferson et al., 2017). This may explain the elaborative monitoring, policing and incentive mechanisms established to align the interests of the service providers and local councils. However, councils have tried to reduce these risks to the providers to provide better care to service users through establishing support systems for providers. These include (NHS England, 2019a);

- Increased support from NHS for healthcare and other activities.
- Addressing the training needs required by provider staff.
- Establish learning initiatives to share best practice, such as the 50 vanguards which developed preventative approaches to care which saw significant reductions in emergency admissions.

With already strict monitoring mechanisms in place and the fact that the outcomes of care are not fully controlled by the care provider makes a behaviour-based contract ideal for the situation (Eisenhardt, 1989). Now that the relationship between the government and care providers have been discussed, it would be important to discuss the impact of the National Living Wage policy in the sector.

3.6 Impact of the National Living Wage Policy on Social Care

One of the earliest research on the impact of National Living Wage on the social care sector was done by Giuponni *et al.* (2016) by sending questionnaires to all care homes in England obtaining 1410 responses for the pre-National Living Wage survey and 629 responses in the post-National Living Wage survey. Their research concluded that the National Living Wage has strongly affected wages in the care home industry as before April 2016, 25% carers aged over 25 were paid at or below the National Minimum Wage. After the introduction of the National Living Wage, this percentage dropped to zero as per the law. Surprisingly, the percentage of workers aged 25 and underpaid at or below the National Minimum Wage fall by almost 30%, while that paid at the National Living Wage exceeds 30%. Hence, firms have voluntarily increased the wages of workers aged under 25.

Giuponni *et al.* (2016) also found some evidence of a negative impact on employment (albeit modest and statistically insignificant) and a positive impact on the number of hours worked. This study supports the evidence found in earlier studies of Minimum Wage in the care home sector (Machin, Manning and Rahman, 2003; Machin and Wilson, 2004) of the before and after effects of the introduction of Minimum Wage in April 1999 and its subsequent increase in October 2001.

Studies conducted using data from NMDS-SC (National Minimum Data Set for Social Care) concluded similar results (Gardiner, 2016; Vadean and Allan, 2020).The results confirmed a

positive spill-over effect (Gardiner, 2016; Vadean and Allan, 2020) and a positive impact on the number of hours worked (Gardiner, 2016). Although the study by Gardiner (2016) did not address employment rates, Vadean and Allan (2020) confirmed the findings of previous studies that there has been no statistically significant effect on employment. They suggested that due to austerity measures care providers would have been making optimal usage of their staff and any further reduction could not be feasible due to the standards imposed on the providers by the Care Quality Commission. However, they did find an increasing usage of zero-hours contracts by providers to increase labour efficiency.

This is not a very welcoming effect as research done by Moore et al., (2017a) indicated that with the introduction of National Living Wage employers are making the use of non-standard contracts such as zero-hours which makes it easier for employers to amend terms and conditions as these types of contracts puts the worker in a vulnerable position due to their dependence on the employer for the choice and hours for work.

In quantitative terms, the National Living Wage has had a positively significant effect on wages and number of hours worked in the social care sector with no statistically significant effect on employment. There is also evidence of positive spillover effects on workers aged under 25. However, researchers have suggested that the National Living Wage has exacerbated a number of workforce issues in the social care sector such as an increase in the usage of zero-hour contracts which makes it easier for employers to amend terms and conditions to increase labour efficiency, maintaining pay differentials and competition from retail and hospitality sectors offering similar paid less demanding jobs (Moriarty, Manthorpe and Harris, 2018). In addition, some care workers are not paid for the time spent on travelling between service users increasing their vulnerability to wage underpayments (Moore and Hayes, 2018).

3.7 Questions from Existing Literature

Table 2 below shows the summary of the mind map created to identify research gaps. Yorks (2008) argued that the core of any research process is defined by three elements. The mind map helped to address the first two elements (what we need to know and why we need to know it). This was achieved by discovering questions from the literature review, which could be researched to identify further ways to support the care workforce.

Possible topics to be critiqued were identified based on the research aim and objectives, following which the main findings of the literature review were jotted down. Next, the findings were analysed to identify possible research gaps (what we need to know)- the first element of Yorks (2008) heart of the research process. The identified research gaps were then examined for any links to the research objectives (why we need to know it). Research gaps with no links to the research questions were decided to be unsuitable for this research. A further column was added to identify which stakeholder could best answer the relative research gap. The third and final element put forward by Yorks (2008) is to justify the validity of the research. The reasons for choosing the research methods have been explained in detail in the Methodology chapter (Chapter four) whilst addressing concerns of reliability and validity.

What we know	**What we need to know**	**Question answered by**
As labour costs make up over half the expenses in social care (Bottery, 2020; Competition and Markets Authority, 2017), and 46% of care workers in the independent sector being paid below the upcoming National Living Wage in March 2022 (Skills for Care, 2022), the social care sector is highly vulnerable to the consequent upratings of the National Living Wage.	How does the private adult social care sector's workers and care organisations appraise the National Living Wage policy (including benefits and challenges)?	care workers, care managers
Increase in working hours as a result of the National Living Wage policy (Gardiner, 2016; Giuponni et al., 2016).	Worker's feelings regarding working longer hours. Positive or negative? What workplace issues need to be addressed to cope with the increase in working hours?	care workers
Competition from other sectors. With the introduction of National Living Wage, pay in the retail and cleaning sectors have been increasing faster than the social care sector (Skills for Care, 2020). The less demanding nature of these sectors might make the social care sector less attractive for future and existing talent (Moriarty, Manthorpe and Harris, 2018).	What are the motives for staying in the sector despite other sectors offering more convenient job opportunities with less responsibility for the same pay or even more?	care workers

Decreasing wage differentials: Prior to March 2016, care workers with greater than five years of sector experience earned an hourly rate of 26 pence to 37 pence higher on average than a care worker with less than one year of experience. However, the experience pay gap have decreased since the introduction of the National Living Wage to just seven pence per hour by March 2022 (Skills for Care, 2022).	Are there any demotivation factors for junior care workers to progress in their career due to the need to take on additional responsibility for minimal pay increases? (Avoiding of stressful situations due to increased workloads that comes with additional responsibility).	care workers
The Care Act 2014 places statutory duties on care contractors and care providers to assist each other to support resident needs (Care Act, 2014). As challenges faced by care providers are directly correlated with quality of care provided (Allan and Vadean, 2021b), it is a legal obligation on the Local Authorities to support care organisations to manage the challenges caused by the continuous uprating of the National Living Wage.	Are these duties fulfilled? For example, Does the Local Authority provide the required support (financial or other types of support) to manage the National Living Wage increments? What additional support is required?	Care mangers
Care providers held different types of contracts with Local Authorities (Bristol City Council, 2008; Monitor and NHS England, 2015).	What type of contact is ideal for care commissioning based on the current circumstances (for example, yearly increases of the National Living Wage rates)? And their reasons?	Care managers
Low paid workers in the care sector face even more hurdles to bring themselves and their families to a socially acceptable living standard, such as challenges in claiming in work benefits(Low Incomes Tax Reform Group, 2018). As many care workers are not directly paid for travel time, this affects their eligibility to claim Working Tax Credit as a significant amount of their working day is not counted as remunerative work. Furthermore, Zero-Hour Contracts make working hours variable often taking working hours above and below the thresholds of claiming Working Tax Credit leading to frequent starting	Does features of care work such as Zero-Hour Contracts and travel time present the same obstacles when claiming Universal Credit (as opposed to Working Tax Credit)?	care workers

and stopping of claims or overpayments (Low Incomes Tax Reform Group, 2018). The government has now replaced the Working Tax Credit and five other benefits with Universal Credit (Department of Work and Pensions, 2014).		
Unacceptability of discussing wages (Hussein, 2017a).	Why is it not acceptable to discuss wages? Consequences of discussing wages? (Disclosure of information and transparency which is linked to stakeholder theory).	care workers, care managers
The main reason for the historically prevalent roots of low pay in the social care sector has been defined as the gendered history of home care where care is performed by woman for free and the skills required to perform the job are considered to occur naturally to woman (Grimshaw and Rubery, 2007; Moore and Hayes, 2018). Skills for Care (2022)'s most recent report on the state of the adult social care sector in England highlighted that women were less likely to be in senior management roles (68%) compared to direct care providing roles (83%).	Skills for Care (2022) could not identify the exact cause of this difference using the Adult Social Care Workforce Dataset alone. Therefore, to shed some light on these figures, career progression goals of care workers and how their employers can help to achieve them needs to be identified.	care workers, care managers

Table 2: Summary of mind map to identify research gaps

Analysis of the main findings (what we know) of the literature review to identify possible research gaps (what we need to know) as put forth by Yorks (2008).

3.8 Chapter Summary

Cap on care home fees by Local authorities and the strict monitoring procedures imposed on care homes makes the sector more vulnerable to consequent upratings of the National Living Wage. If the relationship of the government and the social care sector is explored within the context of UK legislation, there are statutory duties on care contractors (NHS and Local Authorities) and care providers to address the needs of a wide range of stakeholders such as care recipients, carers, families of care recipients and employees (Care Act, 2014; Equality Act, 2010; Health and Care Act, 2022). As challenges faced by care providers are directly correlated with quality of care provided (Allan and Vadean, 2021b), it is a legal obligation on the Local Authorities to support care organisations to manage the challenges caused by the continuous uprating of the National Living Wage. This research will attempt to find out if Local Authorities are providing the required support (financial or other types of support) to manage the National Living Wage increments and what additional support are required by care organisations. Care providers held different types of contracts with Local Authorities (Bristol City Council, 2008; Monitor and NHS England, 2015). It will also be important to understand the type of contract that would be ideal for care commissioning considering the challenges put forward by the continuous increases of the National Living Wage rate.

Despite some quantitative research showing that the National Living Wage has had a positive effect on wages and number of hours worked in the social care sector with no statistically significant effect on employment, there is evidence that suggest that the National Living Wage has magnified several workforce issues in the social care sector. There has been an increase in the usage of zero-hour contracts which makes it easier for employers to amend terms and conditions to increase labour efficiency, unpaid travel time, maintaining pay differentials and competition from retail and hospitality sectors offering similar paid less demanding jobs. Nevertheless, there is limited research on how these challenges have impacted the professional and personal lives of workers. This research would address this gap by exploring the private adult social care sector's views and experiences of the National Living Wage policy in England, factors that influence the living standards of care workers under the policy and by recommending ways to address challenges. The next stage of this research will detail the research methods to be used to capture the empirical data, including details of the research philosophy to be adopted, data collection techniques and sample selection.

Chapter 4. Methodology

4.1 Introduction

The literature review (Gardiner, 2016; Giuponni et al., 2016; Moriarty, Manthorpe and Harris, 2018; Vadean and Allan, 2020) addressed the challenges of National Living Wage policy on the sector, however, scant attention is given to worker experiences, the adaptation strategies used by workers in response to these challenges and how their day-to-day life has been affected as a result. Therefore, the aim of this research is to explore the experience of engaging with and fulfilling the National Living Wage policy by the private adult social care sector in England and to capture care worker and care manager experiences of working under the conditions imposed by the policy. The following three research objectives have been identified to achieve the research aim.

1. Explore the private adult social care sector's views and experiences of the National Living Wage policy including benefits and challenges.
2. To identify factors that influence the living standards of workers under the National Living Wage policy within the private adult social care sector.
3. Identify ways in which the sector can address challenges imposed by the National Living wage policy.

Hermeneutic phenomenology (Alsaigh and Coyne, 2021) defines the rationale for how this research will study the process of engaging with and fulfilling the National Living Wage policy in the sector, conduct data analysis and understand the derived findings. This chapter details the philosophical assumptions, ethical guidelines and key features of hermeneutic phenomenology whilst justifying the suitability of the approach to the current research. Furthermore, the use of a pilot study, documentary evidence, and interviews to collect data are justified as well as the choices made for sampling, participant recruitment and data analysis. In addition, a small section is provided on researcher reflection which highlights the learning process the researcher experienced from the data collection and analysis and how this has influenced the researcher's view on the topic.

4.2 Stakeholders of the Adult Social Care Sector

Identification of stakeholders is crucial to understand the complex processes, relationships, contributions and competing demands involved in an institution (Bettinazzi and Feldman, 2021; Steurer, 2006). The exploratory nature of this research makes this understanding of processes and relationships a prerequisite, to identify which key player would be most helpful to address the research objectives. Therefore, a list of stakeholders were drawn (as shown below in Figure 7) to understand the key units (Nobari, 2015) which comprises of the whole adult social care sector. The stakeholders in Figure 7 have been derived from the analysis of the Health and Care Act 2022 (*Health and Care Act*, 2022), Care Act 2014 (*Care Act*, 2014), and official government documents related to social care (Department of Health and Social Care, 2021a; NHS England, 2017, 2019a, 2020, No Date; NHS England and NHS Improvement, 2020b).

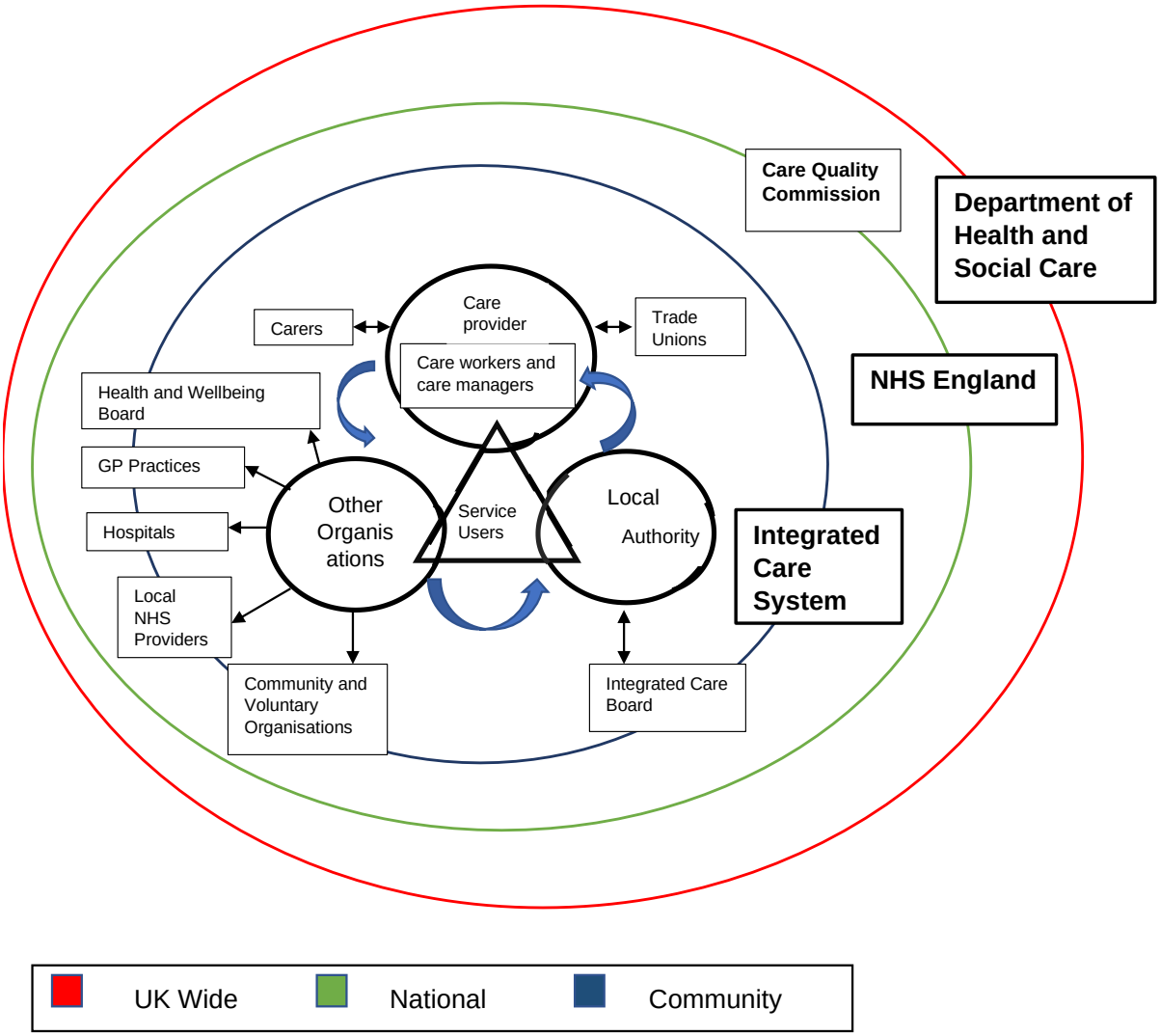


Figure 7: The stakeholder map of the adult social care sector (Based on Nobari, 2015, p.135, fig.12)

Three levels of social care delivery (UK wide, national and community) has been identified based on the NHS England's overview of Integrated Care Systems, their priorities for the NHS long term plan published in January 2019 (NHS England, 2019b), and the Health and Care Act 2022. The Department of Health and Social Care is responsible for all government policy on health and adult social care in the UK (Department of Health and Social Care, No Date). The NHS England manages the implementation of these policies at the national level in England by developing and supporting Integrated Care Systems (NHS England, 2019b) whilst the Care Quality Commission rates and independently reviews these systems (Care

Quality Commission, 2022a). Integrated Care Systems work at the community level where the Integrated Care Board, together with its partner Local Authorities and all other organisations involved in the service user's care (for example community and voluntary organisations, local NHS providers, hospital, GP practice and Health and Wellbeing Board) are involved in the commissioning of care to the care provider and delivery of the care and support plans for service users. The service user is at the centre of the social care sector where all stakeholders work together with the aim of helping the service user achieve their desired outcomes (Birmingham City Council, No Date; Department of Health and Social Care, 2021a).

As this research focuses on the impact of National Living Wage on the private adult social care sector, a simplified version of the stakeholder map is produced below in Figure 8 that involves the key stakeholders within private social care sector affected by the National Living Wage policy in England. To achieve the proposed research objectives, the focus of this research would be on two main stakeholders: the care workers (receiving the National Living Wage) and private care providers (managers involved in applying of the National Living Wage policy). In selecting these stakeholders, the four principles of source criticism as suggested by Alvesson and Sköldberg (2018) has been applied.

1. **Criticism of authenticity:** Care workers who are directly impacted by the National Living Wage in their professional and personal lives would be highly motivated to share their genuine lived experiences to drive improvements in the care sector.
2. **Criticism of bias:** Alvesson and Sköldberg (2018) suggested that researchers should complement information with counter-information representing the opposite bias. They gave examples of management literature where glossy statements about companies by managers are complemented with shopfloor workers with a counter bias. Therefore, it was decided that care managers would be interviewed along with care workers to represent counterweight views.
3. **Criticism of distance (time and space):** Care workers who receive the National Living Wage are closest to the phenomenon and hence, are better able to convey the impact of the National Living Wage in their professional and personal lives. Care managers also experience the National Living Wage in their professional lives. However, this phenomenon does not impact their personal lives as they do not receive

the National Living Wage. The National Living Wage takes effect from the 1st of April each year. The pilot study data was collected as soon as the National Living Wage came into effect from 3 April 2022 to 1 May 2022. This was soon followed by data collection of the main study from 3rd August 2022 to 31st October 2022. The gap of four months from the National Living Wage implementation date to data collection was to allow ample time for the participants to adjust to the changes and better understand their lived experience.

4. **Criticism of dependence:** This principle governs that the greater the number of intermediaries from the original information source, the less valuable is the source. The criticism of dependence does not apply to care workers and care managers as both sources are presenting their own lived experiences with no intermediaries involved.

The stakeholder analysis was a helpful activity to apprehend the processes and relationships involved in the social care sector (Bettinazzi and Feldman, 2021; Kujala et al., 2022). Identification of stakeholders was important to understand the environment in which the adult social care sector operates (Steurer, 2006; Xiao, 2023), so that the researcher would have the appropriate knowledge and understanding to make accurate interpretations of the data (Fuller and Loogma, 2009).

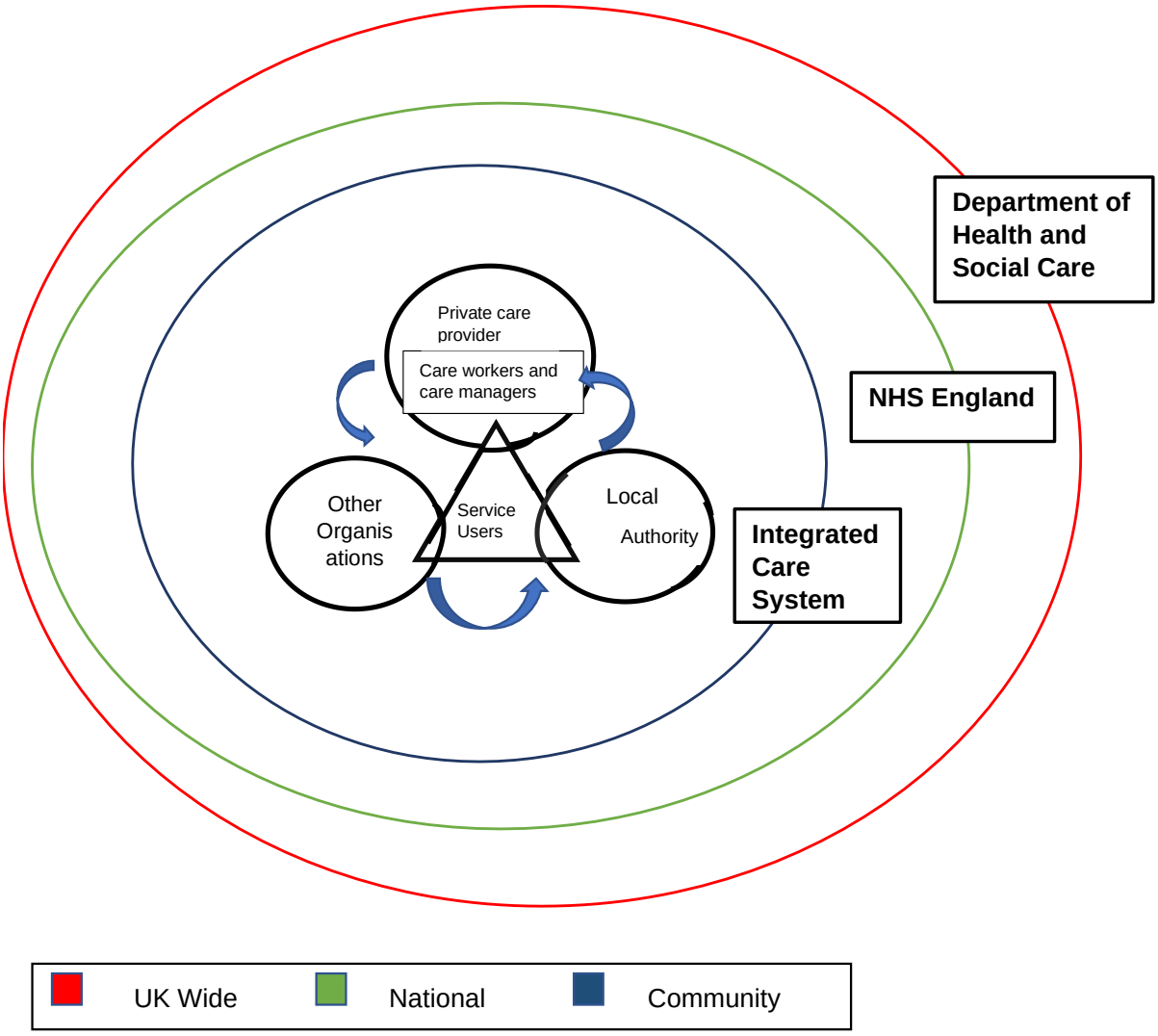


Figure 8:The stakeholder map of the adult social care sector summary (Based on Nobari, 2015, p.137, fig.13)

4.3 Philosophy of the Research Design

The previous research projects authored by the researcher have been dedicated to post positivist views (Athif, 2010, 2015). Nevertheless, it was decided that the epistemological stance should be inspired by the commitment to achieve the research aim rather than the cognitive bias of the researcher (Alvesson and Sköldberg, 2018). In this instance, the philosophical assumptions have been inspired by reflecting on how to construct and interpret data that would answer the research gaps rather than being *"stuck in a particular paradigm"* (Alvesson and Sköldberg, 2018, p.375).

The aim of this research is to explore the experience of engaging with and fulfilling the National Living Wage policy by the private adult social care sector in England and to capture care worker and care manager experiences of working under the conditions imposed by the policy. To achieve this research aim, care workers and care managers have been viewed as social constructions whose experiences are influenced by their individual circumstances. This involved identifying the external social factors (such as the stigma of wage discussion, gender inequality, interaction with the tax and benefits system) that influence low paid worker's standards of living (Morgan, 2014).

Figure 9 below depicts a summary of the philosophical assumptions (Creswell, 2007) that have guided this research in making decisions on finalising the research objectives, data collection methods, data analysis procedures and writing-up the findings. The consequent sub-sections justify the adoption of each stance to address the research objectives.

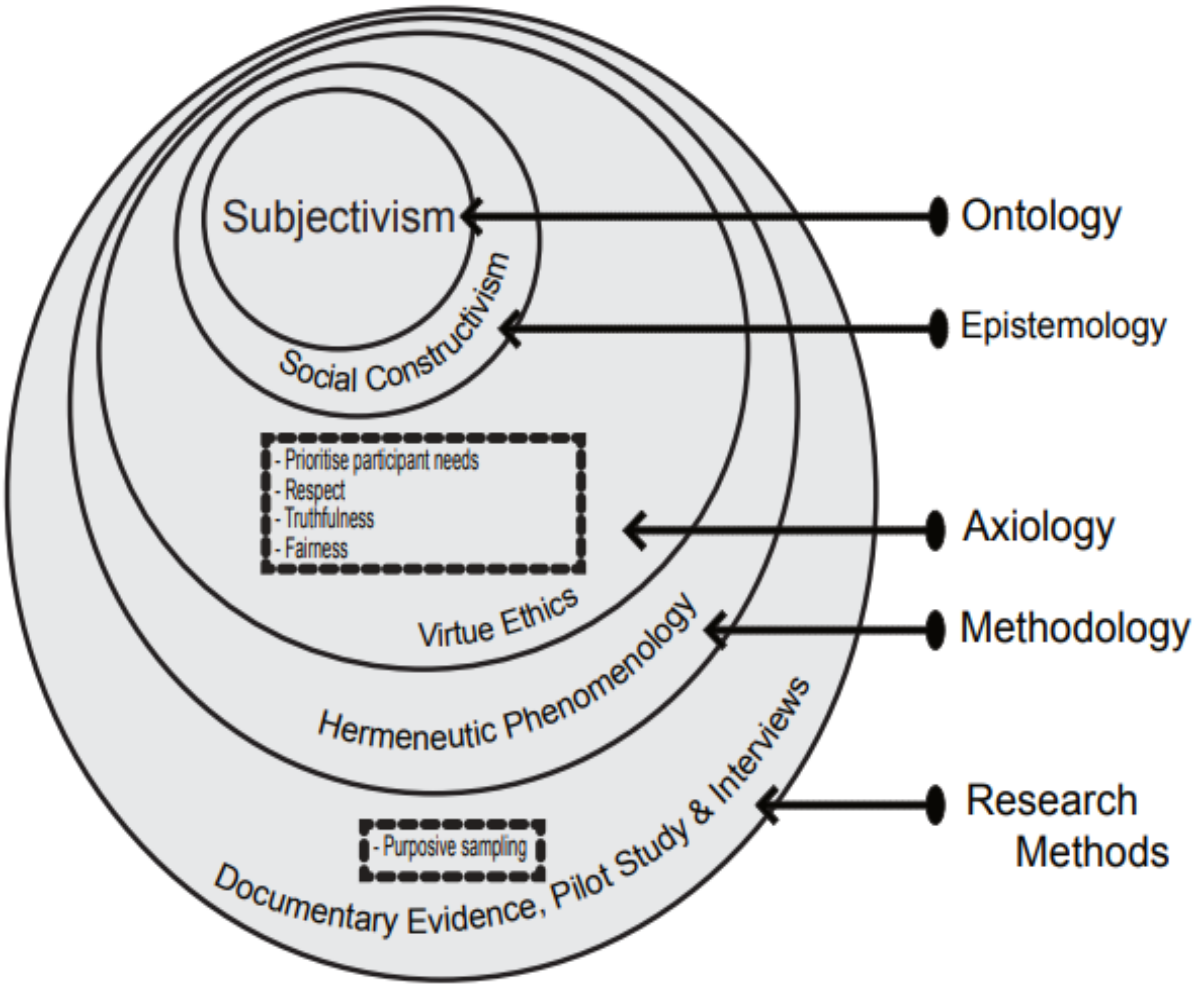


Figure 9: Philosophical assumptions and Research Design (based on Creswell, 2007)

Social Constructionism through the lens of Subjectivism

This research adopts the epistemological stance of social constructionism where knowledge has been constructed based on the researcher understandings of how participants have experienced the challenges imposed by the National Living Wage policy. In this type of social constructivist research, knowledge involves subjective meanings of social actions requiring the researcher to interpret knowledge from the people's point of view and the researcher interprets this knowledge to concepts and theories (Bryman, 2016). The social constructivist position assumed by this research would assist the transferability of these findings to similar populations within the same context (Bryman, 2016; Green and Thorogood, 2018).

The application of social constructionism approach in applied research have been useful in qualitative studies using self-completion written questionnaires (Adamson et al., 2004; Ataro, 2020; Pitura, 2023), as this epistemological stance allows the researcher and participants to collaborate and co-create knowledge. Participants are viewed as social constructions directly influenced by their experiences (Kamble, 2022).

Understanding the various experiences as presented by the participants correspond to the ontological view of subjectivism which involves interpreting their subjective realities of working under the conditions imposed by the National Living Wage policy. The emphasis is on understanding the individual rather than a universal theory (Kivunja and Kuyini, 2017).

For this research, ontology provides answers on the essence of reality (Creswell, 2007) of the National Living Wage phenomenon in the social care sector. This research assumes that the concept of National Living Wage has multiple realities, and those realities have been explored through written interviews. Open-ended questions have been asked so that participants can construct their own realities as opposed to their subjects of thoughts being confined to a close ended question. This research assumes that reality is not there to be discovered but socially constructed by participants who convey an interpretation of their experiences to the researcher (Kivunja and Kuyini, 2017). Interviews were analysed with the intent of reporting these subjective and multiple realities. These multiple realities have been evidenced using verbatim quotes to report on the different perceptions, beliefs and experiences presented by the participants.

Research adopting an ontological assumption of subjectivism often employ thematic analysis where themes are drawn from participant quotes and analysed to report on subjective individual experiences. For example, a subjectivist ontological stance employing thematic analysis have been used by researchers to pursue similar research on the National Living Wage, such as the influence of National Living Wage on employee relations in the UK hospitality sector (Walmsley et al., 2019) and the lived experiences of National Living Wage for workers on non-standard contracts (Moore et al., 2017).

Ethical Dilemmas and Axiological Approach

This section focuses on the ethical dilemmas that emerged and the core values that guided this decision-making process. Axiology is the *"philosophical approach to making decisions of value or the right decisions"* (Kivunja and Kuyini, 2017, p.28). It involves the steps taken to ensure that all actions taken in the research are considered morally and ethically correct (Biedenbach and Jacobsson, 2016). This research faced ethical dilemmas such as how to ensure that the participants are properly informed and if their consent is voluntary, what are the appropriate steps to maintain anonymity and confidentiality and evaluating on the necessary steps required to minimise any harm to participants (Halai, 2006). Such ethical dilemmas can be guided by three main ethical theories: utilitarian, deontological and virtue ethics (Guevara-López, Altamirano-Bustamante and Viesca-Treviño, 2015; Morris and Morris, 2016). The utilitarian researcher evaluates decisions in terms of the number of people that would be satisfied with the decision. A decision is considered ethical if it results in an outcome that will benefit the most people (Fisher and Lovell, 2008). Deontological researchers base their decisions on the action itself and are guided by regulations imposed by their research institution and specific country legislations (Morris and Morris, 2016).

This research is guided by the virtue ethics theory arguing that making moral decisions is not just a matter of calculation or principle-based duties (Hartman, 1998; Hillman, 1996). Instead, virtue ethics states that researchers should consider their intrinsic moral values and on what they believe is an ethical researcher (Morris and Morris, 2016). One of the purposes of this research is to guide policy makers to structure further ways to support the care workforce and care organisations. Hence, the ethical decisions in this research are guided by the search for the good of the participants (Guevara-López, Altamirano-Bustamante and Viesca-Treviño, 2015). The value statement that guided all ethical decisions is "to benefit the

participants without any potential harm." Virtue ethics allowed a degree of flexibility to always prioritise the needs and wishes of the participants (Morris and Morris, 2016). Whilst universal ethical principles required a justification that the benefit of the research outweighs any potential harm to participants (Arifin, 2018), the decisions in this research were made with a view to eliminating all potential harm to participants. To achieve this, the virtues adopted in the research included being truthful about the nature of the research, fairness in adhering to participant's legal rights and interests whilst maintaining institutional guidelines, respecting participant wishes, participant right to make choices, and privacy (Kivunja and Kuyini, 2017).

As suggested by Meho (2006) and Fritz and Vandermause (2018), participants were provided with a consent form and information sheet (Appendix 8) detailing information about the research and participant rights, the anticipated amount of time needed, what participating in the research would involve, and potential benefits and risks of participating in the study. A detailed explanation of all aspects of the research ensures that participants could make an informed decision on whether participating in the research would be beneficial for them (Halai, 2006). Participants were also advised that participation is voluntary and, on their right to withdraw from the study without any reasoning. Attention was given to follow all UK General Data Protection Regulation guidelines (Information Commissioner's Office, 2021) when handling data.

Data was collected anonymously using the software Qualtrics to prevent any direct or indirect identification. As some of the participants have provided e-mail addresses, all responses were stored in a password protected device to ensure that data remained confidential. Any breach of confidentiality leading to the identification of the participant might result in the participant being treated differently in their workplace due to their honest or extreme views provided for the research (Turcotte-Tremblay and Mc Sween-Cadieux, 2018). For example, if an organisation were to discover that a care worker has disclosed measures taken by them to combat the pressures of the National Living Wage which could negatively impact the organisational image, the care worker may face disciplinary action. This could even impact their future job opportunities, career advancements or they could become a social outcast in their work environment. If a care manager revealing the failures

of a Local Authority to support them is identified, it may damage the reputation of the Local Authority and may lead to legal repercussions and severance of relationships.

Hence, it was important to remain cautious during and after data collection to prevent any potential harm to participants. In addition, participants were asked to contact the NHS on https://www.nhs.uk/conditions/stress-anxiety-depression/ and MIND on https://www.mind.org.uk/ in the unlikely event that any of the questions cause distress. Ethical approval was obtained from the University of Sunderland's research ethics group (Reference Number: 006427.)

Hermeneutic Phenomenology Methodology

Researchers have described phenomenology as a qualitative methodology aimed at presenting how participants relate to a phenomenon within the context of a lived experience (Alsaigh and Coyne, 2021; Bynum et al., 2021; Kivunja and Kuyini, 2017). Therefore, phenomenology is a suitable methodology to guide this research process to present the lived experiences of the National Living Wage phenomenon in the private adult social care sector in England. Neubauer, Witkop and Varpio (2019, p.90) defines phenomenology as:

> *"An approach to research that seeks to describe the essence of a phenomenon by exploring it from the perspective of those who have experienced it"* (Neubauer, Witkop and Varpio, 2019, p.90).

The criteria for managers to participate in the study was for them to be involved in the application and compliance of the National Living Wage policy in their organisation. The criteria for care workers to participate in the study was that they receive the National Living Wage as an hourly rate. The belief was that a care worker not receiving the National Living Wage or care managers whose staff are paid above the National Living Wage has not experienced the phenomenon, thus, could not provide the necessary perspectives to achieve the research aim.

The branch of phenomenology adopted in this research is hermeneutic rather than descriptive. The reason is that this research aims to provide more than a description of the National Living Wage phenomenon by interpreting how individual contexts have impacted

their experience and how this influences the decisions made by participants (Neubauer, Witkop and Varpio, 2019; Rodriguez and Smith, 2018). In this research, care workers and care managers have described how they have experienced the National Living Wage, how this experience have challenged them, and the decisions made to adapt to the challenges that they experienced. The focus is to contribute to the understanding of the phenomenon in a particular context in contrast to descriptive phenomenology which involves identifying universal features of a phenomenon to produce generalisable descriptions (Neubauer, Witkop and Varpio, 2019). Another aspect that differentiates this research from descriptive phenomenology is that instead of bracketing off previous understandings and past knowledge, the inquiry of this research is an extension of the literature review, documentary analysis and pilot study results (Neubauer, Witkop and Varpio, 2019; Rodriguez and Smith, 2018).

Purposive Sampling and Participant Recruitment

Purposive sampling strategy was used to ensure that those who have valuable knowledge and experience are targeted (Bryman, 2016). Participants were recruited into the research by distributing links to the interview along with an informative flyer (Appendix 4) in six Facebook (FB) groups (details in Appendix 5) which care sector staff are members, through the 15 ENRICH (Enabling Research in Care Homes) clinical research networks (Appendix 6) with a combined registration of 578 care homes (NIHR School for Social Care Research, no date) and snowballing from previous contacts (Bryman, 2016). The criteria for managers to participate in the study was for them to be involved in the application and compliance of the National Living Wage policy in the organisation. The criteria for care workers to participate in the study was that they receive the National Living Wage as an hourly rate.

In Qualitative research, people, settings or data are sampled to understand a particular problem rather than to statistically represent a wider population (Given, 2008). As research employing an interpretivist position whilst viewing reality as social constructions, this research does not seek to obtain samples to generalise or to produce statistically representative findings (Bryman, 2016). The aim of this research is to represent a range of experiences and it is up to the reader to decide on its applicability to a particular situation (Biggam, 2018; Bryman, 2016; Given, 2008; Green and Thorogood, 2018; Seale and Silverman, 1997).

To ensure that the sample represented a diverse range of backgrounds, sociodemographic data collected included gender, age, ethnicity, employment type, location, service type, sector experience, experience in current role, employment status and whether the participant was on a Zero-Hours Contract (ZHC). In addition, as the literature explained the disproportionate impact of the National Living Wage in different sectors and regions (Brown, 2017), it would be interesting to identify how location, personal characteristics and circumstances influenced participant views and experiences of the National Living Wage policy.

Participant sociodemographic data were compared with the Adult Social Care Workforce Data Set (ASC-WDS) to increase validity (comparisons provided in Chapter five: Findings and Discussion). The ASC-WDS had 47% coverage of all Care Quality Commission (CQC) regulated private social care establishments in March 2022, with around 447,000 worker records. As most employers have had their data updated in the past 12 months, this sample would be adequate to represent the sector (Skills for Care, 2022).

The sample size of this study was guided by the concept of information power proposed by Malterud, Siersma and Guassora (2016). Information power implies that the more information the sample holds in relation to achieving the research objectives, the lower the number of participants needed. The concept of saturation is also used in qualitative studies where the researcher recruits participants until new themes and ideas stop arising from data analysis (Coleman, 2019). However, although a large sample size might provide all the variances of the National Living Wage concept in private adult social care, it would be difficult to seize the emerging patterns and shared experiences (Malterud *et al.*, 2016). Therefore, the concept of information power is preferred over the concept of saturation to provide rich in-depth descriptions of data (Patton, 2015).

Data collection took place from 3rd August 2022 to 31st October 2022. The interview questions have been reproduced in Appendix 7.

Table *3* below presents the composition of responses. 72% of the responses submitted by care workers were deemed as qualified responses suitable for analysis. This figure was 47% for the care managers.

Response category	**Number of responses**	**Qualified responses**	**Percentage of qualified responses**
Care Workers	32	23	72%
Care Managers	17	8	47%
Total	49	31	-

Table 3: Composition of Responses

The table above illustrates the total number of responses received from each participant category and the percentage of qualified responses from the total.

Figure 10 below describes how a response was selected as a qualified response to be included in the data analysis.

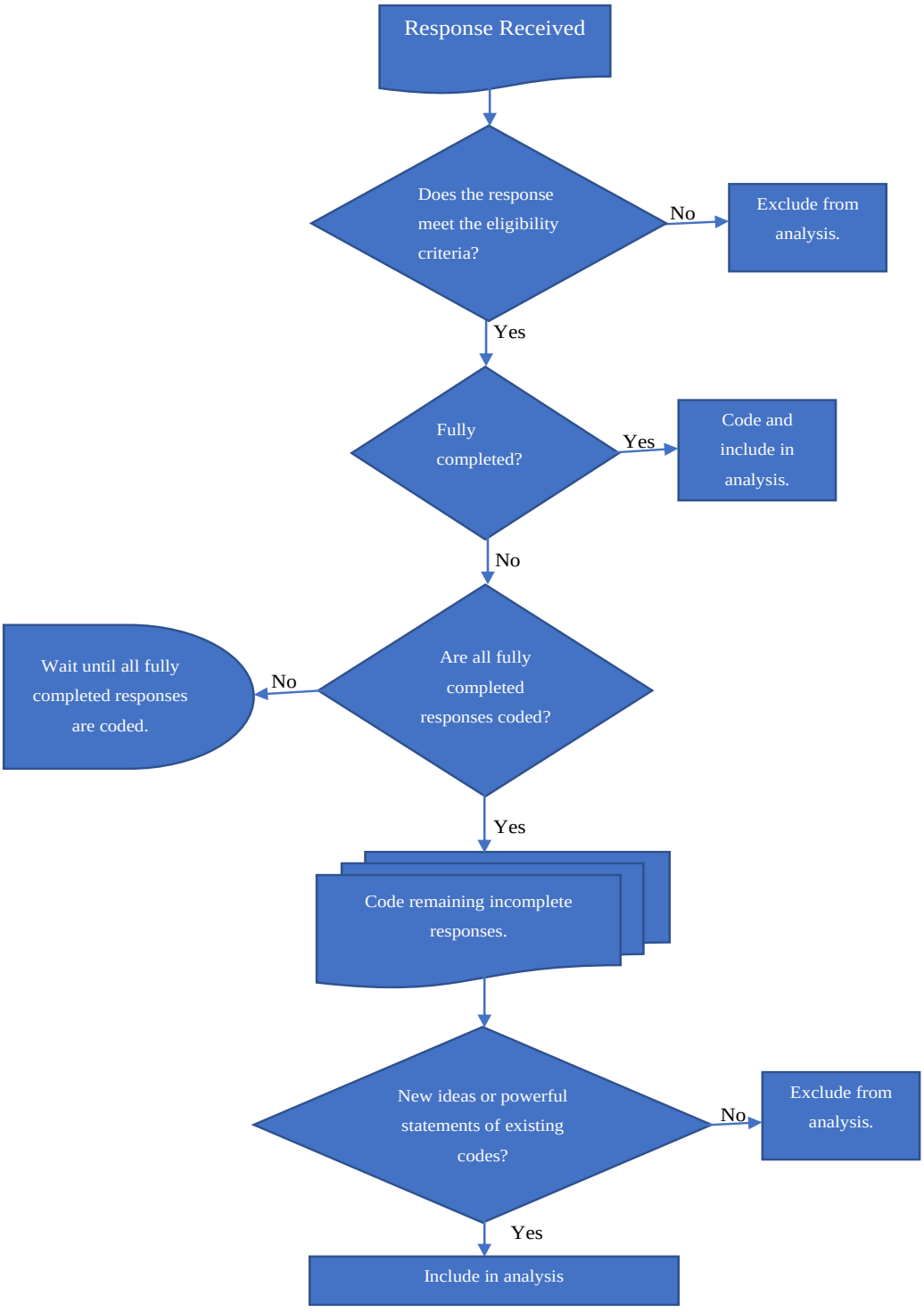


Figure 10: Response selection for data analysis

The main aim of this research is to explore the experience of engaging with and fulfilling the National Living Wage policy by the private adult social care sector in England and to capture care worker and care manager experiences of working under the conditions imposed by the policy. Hence, any care workers not receiving the National Living Wage or care managers whose staff are paid above the National Living Wage could not provide the necessary perspectives, beliefs, and experiences relevant to achieve this research aim. Therefore, it was necessary to exempt any responses from participants not meeting these conditions. Three care manager responses were excluded when they mentioned that their staff were actually paid above the National Living Wage. One care worker response was excluded as well when she mentioned that her actual wage was £10.30 per hour instead of the National Living Wage rate of £9.50 per hour (the National Living Wage rate from April 2022 to March 2023).

All responses meeting the eligibility criteria where 100% of the questions were completed were deemed as qualified responses. Incomplete responses meeting the eligibility criteria were included based on the information power of the given answers. Malterud, Siersma and Guassora (2016) coined the concept of information power by proposing that the sample of the study should depend on the amount of information the sample holds relevant to the aim of the study. For the purpose of this research, an incomplete response is deemed to have information power if the response reveals new ideas or contains powerful statements related to existing codes derived from the fully completed responses. Malterud, Siersma and Guassora (2016, p.1758) explained that the application of information power eliminates responses that is not relevant to the aim of the study or lack quality data that could present a sufficient analysis.

"By initial and consecutive assessment of information power, the researcher may avoid waste of time and resources for collection of unnecessary data, elaboration of information that is not relevant for the aim of the study, and lack of overview needed for a thorough analysis" (Malterud, Siersma and Guassora, 2016).

After all the fully completed responses were coded, the concept of information power (Malterud, Siersma and Guassora, 2016) was applied to each incomplete transcript by checking carefully for new ideas or articulate examples of existing codes. Table 4 below presents the percentage and number of questions answered by each care worker included in the data analysis. 20 care workers completed 100% of the questions. One care worker

completed 97% (32 out of 33 questions) and two care workers completed 79% (26 out of 33 questions) of the given questions.

Interview Number	% Of answers completed	Number of questions answered
CW1	100%	33
CW2	100%	33
CW3	97%	32
CW4	79%	26
CW5	100%	33
CW6	100%	33
CW7	100%	33
CW8	100%	33
CW9	100%	33
CW10	100%	33
CW11	100%	33
CW12	100%	33
CW13	100%	33
CW14	100%	33
CW15	100%	33
CW16	100%	33
CW17	100%	33
CW18	100%	33
CW19	100%	33
CW20	100%	33
CW21	100%	33
CW22	79%	26
CW23	100%	33

Table 4: Percentage of answers completed by individual care workers

Percentage and number of questions completed by each care worker included in the data analysis.

Table 5 below presents the percentage and number of questions answered by each care manager included in the data analysis. Most care managers (five care managers) completed 100% of the questions and three care managers completed above 50% of the given questions.

Interview Number	% of answers completed	Number of questions answered
CM1	100%	24
CM2	100%	24
CM3	100%	24
CM4	100%	24
CM5	100%	24
CM6	54%	13
CM7	58%	14
CM8	58%	14

Table 5: Percentage of answers completed by individual care managers

Percentage and number of questions completed by each care manager included in the data analysis.

Research Methods (Documentary Evidence, Pilot Study, and Interviews)

This research employed multiple data collection instruments including a pilot study, interviews, and documentary evidence to achieve triangulation. Triangulation has been defined as a *"research strategy to test validity through the convergence of information from different sources* (Carter et al., 2014)*".* The strategy involves the use of multiple methods to collect data in relation to a single research aim (Noble and Heale, 2019).The use of multiple methods would help to avoid biases associated with each research method, resulting in a more in-depth covering of the National Wage phenomenon from different aspects. It is hoped that multiple instruments of data collection will increase the validity of the research and present the study from a variety of perspectives (Bryman, 2016; Carter et al., 2014; Noble and Heale, 2019).

Documentary Evidence

Documentary evidence in this research was used as a supporting data collection procedure along with the pilot study and interviews in support of triangulation to increase the rigour of the research (Bowen, 2009). Potential documents were first analysed for quality using the four criteria described by Scott (1990) prior to selection. First the documents were checked for authenticity by verifying the legitimacy and origin of the document. Secondly, credibility was confirmed by weighing the accuracy and soundness of the document. The document was then checked for representativeness by ensuring that the evidence is typical of similar documents in nature and the final criteria of meaning was achieved by ensuring that the information in the document was clear and comprehensible. The documents selected and the data analysed are presented in Appendix 3.

Throughout the research, a comprehensive collection of official documents was amassed, including Acts of Parliament, House of Commons meeting minutes, and various official reports related to the National Living Wage. These documents provided critical legislative, and governmental perspectives on the policy's development, implementation, and intended impact. In addition, reports from Non-Governmental Organisations (NGOs) such as the Living Wage Foundation and the Resolution Foundation were also gathered throughout the course of the research. These reports offered further viewpoints and on-the-ground insights into how the National Living Wage has affected workers, employers, and the broader

economy. By analysing these diverse sources, the research was able to construct a rich contextual background that illuminated the complex social, political, and economic factors surrounding the National Living Wage. This comprehensive document analysis not only deepened the understanding of the policy's broader implications but also identified key themes and issues that could be further explored in the pilot study and interviews (Bowen, 2009).

Pilot Study

A pilot study can be useful to identify the appropriateness of data collection procedures, the management and conducting of the study and whether the methods used are eliciting the appropriate content to address the research objectives (Malmqvist et al., 2019; van Teijlingen and Hundley, 2002). The pilot study was implemented with the following purposes in mind.

1. To identify initial insights into the research gaps, so that the questions for the main study could be altered to address the research objectives more effectively.
2. To confirm whether the philosophical assumptions made were appropriate to assist in achieving the research aim and objectives.
3. To determine whether the key stakeholders (care workers and care managers) identified in the stakeholder analysis in section 3.5 are the most appropriate groups to address the research objectives.
4. To establish whether the chosen Facebook groups (details in Appendix 5) were suitable mediums to approach the key stakeholders.
5. Advertise the main research and establish an initial connection with the key stakeholders to generate an interest in the research.

Hence, to achieve the above purposes, it was more important to gain more responses despite shorter answers rather than fewer responses with detailed answers. Despite this research using a qualitative approach, short questionnaire surveys with multiple choice questions were used instead of detailed interviews for the purpose of the pilot study to gain more responses in the relatively short time frame allocated for the pilot study. Time and funding constraints did not allow to conduct interviews for the pilot study which would have taken the participants longer to complete which might have hindered the response rate.

Questionnaires (care workers: 26 responses, care managers: 3 responses) took approximately five minutes to complete and were created using the online tool Qualtrics. A poster advertising the pilot study along with links to the questionnaire and participant information sheet were distributed in Facebook (FB) groups (details in Appendix 5) which were targeted at care sector employees. Data was collected for a period of four weeks from 3 April 2022 to 1 May 2022.

The criteria for managers to participate in the study was for them to be involved in the application and compliance of the National Living Wage policy in their organisation. The criteria for care workers to participate in the study was that they receive the National Living Wage as an hourly rate. Care workers and care home managers were administered a different set of questions as both are unique stakeholders with differing abilities to answer certain research gaps.

The pilot study focused on how the National Living Wage (NLW) have affected the care sector by touching on how care workers and care managers viewed the National Living Wage policy, how the NLW have impacted career plans of care workers (Moriarty, Manthorpe and Harris, 2018; Skills for Care, 2020b) and their workload (Giuponni et al., 2016; Moore et al., 2017; Vadean and Allan, 2020). It also explored care worker interaction with the benefits system (Low Incomes Tax Reform Group, 2018), the thorny issue of wage discussion in the sector (Hussein, 2017a), causes of gender inequality (Moore and Hayes, 2018) as well as the implication on the relationship between Local Authorities and care providers (Monitor and NHS England, 2015; Weissert, Chernew and Hirth, 2003).

Quantitative data on the study population such as age, gender, type of the organisation, location, and type of contract were also collected. Participant characteristics were compared with data from the Adult Social Care Workforce Data Set (ASC-WDS) that provides national statistics covering the adult social care workforce in England (Skills for Care, 2022). This was done to increase validity, ensuring that the pilot study data was not biased, and participants represented a wide range of backgrounds and characteristics.

Percentages of the responses to each question were calculated using excel and presented in tables and graphs (Boslaugh, 2012). These visuals diagrams were useful to find insights from the data by identifying the common thoughts and differences amongst care workers and care

managers (Scagnoli and Verdinelli, 2017). Nelson and Chatfield (2022) argued that visualisations such as graphs which emphasise colour could be thoughtfully incorporated to qualitative research to present snapshots of the data in the form of an easily understood summary. These visualisations representing graphical conclusions of the findings could aid as a data comprehension tool for both readers and researchers who are more visually oriented (Cristancho, Watling and Lingard, 2021).

The use of visualisations to advance reader comprehension is often underutilised in qualitative research (Nelson and Chatfield, 2022; Scagnoli and Verdinelli, 2017). Visual representations of the findings allowed for the data to be presented in an additional form, which would allow readers to view the results from the researcher's perspective so that they can validate researcher interpretations (Verdinelli and Scagnoli, 2013).

Overall opinion amongst participants were identified for each question. Any differences or similarities in opinions were explored for the questions that were identical amongst the care worker and care home manager questionnaires. Next, conclusions were drawn from the meaning of these opinions. These conclusions were linked with the literature review for possible explanations in participant views and to identify further research gaps. Finally, these conclusions along with possible explanations from the literature review were linked with the research objectives to identify topics that needed to be explored in the main study (interviews). This helped to identify how the meaning of the data from the pilot study could contribute towards achieving the research objectives.

Ismail, Kinchin and Edwards (2018) emphasised that there are two important decisions that a researcher needs to address when conducting a pilot study in qualitative research. That is, whether the main study interviews should be conducted with the same participants and whether to include the pilot study results in the main findings. In this research, the interview questions in the main study were an extension of the pilot study questions and were presented differently. Hence, the issue of *"semantic satiation"* (Ismail, Kinchin and Edwards, 2018, p.5) causing participants to lose interest in the study is unlikely. Consequently, there was no requirement for participants that they could not participate in the main study if they have contributed to the pilot study. Moreover, the anonymous nature of the Qualtrics software makes it impossible to impose this requirement as there is no way to identify if any of the main study participants have contributed to the pilot study as well.

For the same reasons, as the main study questions were different and served as an extension of the pilot study, the pilot study results were not reported as part of the main findings. Instead, the main study findings were compared against the pilot study findings along with the literature review to identify similarities and to explore reasons for any differences.

Key Implications of the Pilot Study

Malmqvist et al., (2019) explained how analysing the procedures and results from their pilot study helped to identify weaknesses in their research procedures and instruments. They went on to conclude that:

"A carefully organised and managed pilot study has the potential to increase the quality of the research as results from such studies can inform subsequent parts of the research process" (Malmqvist et al., 2019, p.1).

Short questionnaire surveys could be used to achieve this aim in qualitative research in contexts where time and funding constraints limit researchers from adopting qualitative methods for pilot studies. Qualitative research methods such as interviews are often more time consuming and expensive to conduct in comparison to questionnaires (Bryman, 2016). Despite the qualitative nature of this research, the pilot study questionnaires provided initial insights into the research gaps which refined the questions for the main study. This helped to address the research objectives more effectively. As the pilot study already elicited further topics of interest to be explored in the main study (interviews), it was decided that further questionnaires would not be administered as part of the main study.

In addition, it also confirmed that care workers and care managers were the most appropriate groups to address the research objectives and provided confirmation that the chosen Facebook groups were suitable mediums to approach these stakeholders (Malmqvist et al., 2019; van Teijlingen and Hundley, 2002). The pilot study was a useful tool to advertise the main research and establish an initial connection with the key stakeholders to generate an interest in the research.

Conducting the pilot study was a learning experience which helped to nurture research skills such as reflexive thinking, conforming to ethical guidelines and critical thinking (Ismail,

Kinchin and Edwards, 2018). The pilot study emphasised possible ethical concerns that need to be addressed when conducting a study of this nature.

As suggested by Meho (2006) and Fritz and Vandermause (2018), participants were provided with a consent form and information sheet detailing information about the research and participant rights, the anticipated amount of time needed, what participating in the research would involve, and potential benefits and risks of participating in the study. Participants were also advised that participation is voluntary and, on their right to withdraw from the study without any reasoning. Attention was given to follow all UK General Data Protection Regulation guidelines (Information Commissioner's Office, 2021) when handling data. Conforming to these ethical guidelines early in the pilot study led to a habit of being cautious and conforming to the same ethical research practices in the main study.

The pilot study encouraged to appreciate how personal positions might influence the research. The researcher developed the belief that the National Living Wage is inadequate in comparison to the cost of living and that more should be done to improve the standards of living of low paid workers. This raised questions on the ability of the researcher to distance herself from the conception to be able to interpret the findings fairly. For example, although most of the participants in the pilot study rated the National Living Wage as "somewhat helpful" (38% care workers and 67% care managers), the overall view amongst care workers was mixed. 50% of care workers rated the National Living Wage as either "somewhat helpful" or "extremely helpful", and the same percentage rated the National Living Wage as either "not very helpful" or "not helpful at all".

These results were unexpected and different from the view that the researcher held. This situation encouraged the researcher to reflect on the power dynamics of interpreting research results. The pilot study highlighted the importance of continuously reflecting on how personal biases and positions could impact the interpretation of findings.

Furthermore, the pilot study helped to identify questions that needed to be amended for the main study to elicit appropriate responses. When analysing participant contract types, it was realised that multiple options might apply to one participant. For example, a participant might work full-time hours on a zero-hours contract. Therefore, in the main study, participants were asked whether they work full time hours or part time hours in addition to a

separate question asking them whether they work on any zero-hours contracts. In addition, what defines full-time hours and part-time hours are subjective. Therefore, participants were informed the ADS-WDS (Adult Social Care Workforce Data Set) standard of full-time hours being 37 or more hours per week and 36 or less hours per week will be considered as part time hours (Skills for Care, 2021b).

In summary, this pilot study was a valuable pathway in working towards achieving the research objectives by helping to highlight some of the views, behaviour, and experiences of the sector with regards to the National Living Wage. The analysis of the pilot study results identified ways to modify the questions for the main study in a way that would more effectively answer the research objectives. Hence, the findings of the pilot study have helped to inform the subsequent interview questions for the main study (Malmqvist et al., 2019; van Teijlingen and Hundley, 2002). The pilot study assisted to narrow down the areas of interest to explore which was useful to maintain a clear focus of the study (Ismail, Kinchin and Edwards, 2018). The main study focused on collecting more insightful data on the reasons for the aforementioned views and explanations on positive and negative experiences put forward by the pilot study.

The pilot study also benefitted the researcher from a professional perspective by encouraging to adopt best practices in data collection and analysis such as conforming to ethical guidelines and reflecting on personal positions and biases whilst interpreting data (Ismail, Kinchin and Edwards, 2018). It helped the researcher to be more flexible, in understanding that findings can be unexpected and quite contrasting than that of the views held by the researcher. Insights from this pilot study suggest that the use of short questionnaire surveys in pilot studies could prove valuable regardless of the epistemological position of the research.

Interviews

Gray (2017, p.378) suggested that *"the interview maybe considered the most logical research technique where the objective of the research is largely exploratory"* (Gray, 2017, p.378). An interview schedule was derived to enable an in-depth analysis of topics of interest and unexpected ideas discovered from the pilot study responses. The software Qualtrics was used to conduct anonymous written interviews online. Participants could access the interview via the link provided and the information sheet and consent form were embedded in the

interview. Participants were informed that they were free to use capitals for emphasis, that detailed answers are preferred, that there are no wrong or right answers and that they should not worry about spellings or grammatical errors (Meho, 2006).

The Covid-19 pandemic has resulted in researchers appreciating the unique advantages of virtual research methods in future research contexts beyond the pandemic (Keen, Lomeli-Rodriguez and Joffe, 2022). A significant advantage of using written interviews for this study population is that it allowed participants to complete the interview at their own convenience in a sector where workers have intense workloads with various shift schedule times (Fritz and Vandermause, 2018; Ratislavová and Ratislav, 2014). Participants solely control the amount of time spent in the interview and could easily discontinue the study without hesitation as the researcher is not physically present offering an ethical advantage (Hawkins, 2018).

It also eliminated the potential of data loss or misinterpretation during transcription (Meho, 2006) and significantly less time was required to format the data for analysis (Fritz and Vandermause, 2018). In addition, online written interviews reduced travel and time costs normally associated with traditional qualitative research. Furthermore, this method enabled a greater geographic access within the limited time of three months allocated for data collection (Keen, Lomeli-Rodriguez and Joffe, 2022). The responses covered at least one care worker from each region of England and care managers representing three regions. The time and financial costs required to travel to each region of England would have made it almost impossible to adopt traditional face-to-face interviews for this research.

A major drawback of written interviews is the inability to observe verbal or visual cues (Heath et al., 2018). However, the anonymous environment of the Qualtrics written interviews encouraged confession, thus capturing more extreme views and experiences (Bryman, 2016). Written interviews could eliminate some of the biases resulting from face to face interviews such as age, gender, ethnicity, class, and hierarchical status (Coleman, 2019; Heath et al., 2018).

4.4 Data Analysis

Figure 11 below depicts the framework for data analysis used in this research.

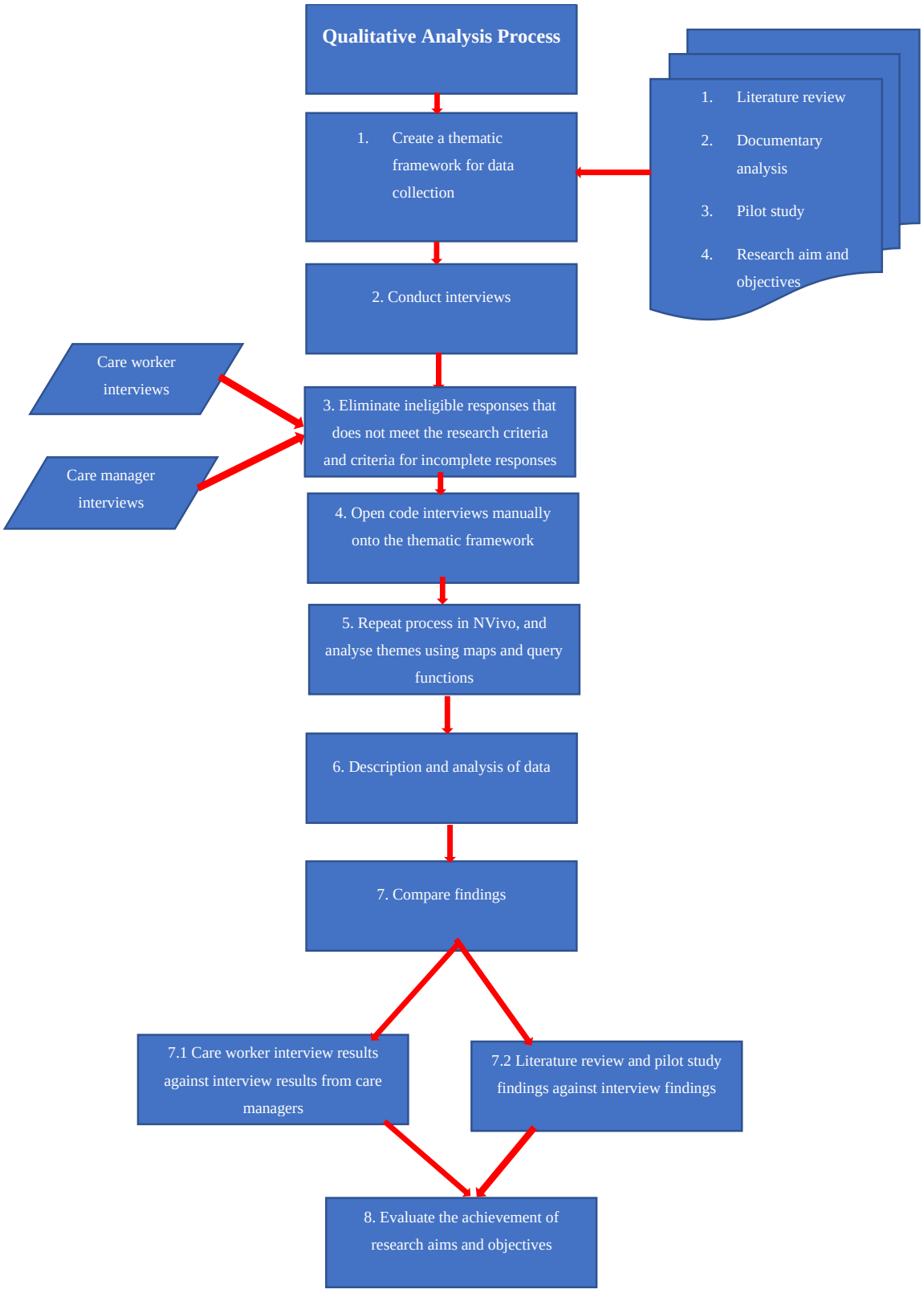


Figure 11: Qualitative data analysis process

A thematic framework analysis for data collection helped to identify common patterns, as well as similarities and differences within the data (Braun and Clarke, 2021b). Thematic framework was developed by the National Centre for Social Research in the UK in an effort to help manage unstructured qualitative data and make the analysis process transparent (Bryman, 2016). Each transcript was printed out and read twice to allow for familiarisation of data. Next, any views, behaviours or perceptions related to the research objectives were highlighted and a short phrase that captures the essence of the content (a code) was allocated next to the text. This type of detailed and open-ended approach to coding is labelled as initial coding by Saldana (2015).

This process was repeated using the software NVivo to ensure accuracy and to conduct a further detailed analysis of the data. NVivo allowed for easier management and structuring of the data and allowed transparency in the data analysis process. NVivo also helped to run queries to identify if participant characteristics and circumstances influenced their experience. In addition to presenting the voice of the participants using quotes, interview findings are also presented using visual diagrams and quantified tables.

Visual Diagrams

Once the coding process was completed in NVivo, the project map feature provided a visual representation of the themes and codes. Presenting visual diagrams with the help of the project map feature of NVivo would help readers to identify similarities and differences in viewpoints amongst care workers and care managers within a particular theme (Scagnoli and Verdinelli, 2017). With the project maps identifying all the common and differing codes within a theme amongst the two groups, visually oriented readers could get an insight of the big picture with a quick glance (Cristancho, Watling and Lingard, 2021). The project maps also increases the trustworthiness of the research by providing a glimpse of how the researcher has analysed the raw data (codes) to reach the given conclusions (Verdinelli and Scagnoli, 2013).

Tables

Cloutier and Ravasi (2021) argues that tables are epistemologically and ontologically neutral tools that helps qualitative researchers to increase transparency about data collection and analysis. For example, table 14 presents the opinions of care manager participants regarding the optimal contract type for care commissioning with their reasons which clearly shows the similarities in opinions amongst participants in one snapshot. These types of concept-evidence tables increases the trustworthiness of the data analysis process by providing evidence that the researcher has consciously engaged with the data prior to reaching conclusions (Cloutier and Ravasi, 2021).

Table 12 presents raw data on the communication tools used to discuss pay and benefits by the private adult social care sector so that readers can be ensured that the research conclusions are backed up by robust data. Similarly, table 13 represents how the researcher evaluated whether the suggested strategies by participants to improve wage discussion could be implemented through these communication tools increasing transparency on how empirical evidence has been interpreted. This would increase trustworthiness by allowing readers to independently assess whether the researcher has been *"honest in how the research has been carried out and reasonable in the conclusions they make"* (Pratt, Kaplan and Whittington, 2019, p2).

A more detailed description of the framework for data analysis has been provided in Chapter five: Findings and Discussion.

4.5 Research Steps

The methodology adopted in this research (hermeneutic phenomenology) does not pinpoint to a specific guideline of steps to follow. Instead, researchers delve deeply into the philosophical values, knowledge and characteristics of this methodology to adopt this approach in their reading, writing and reflections (Alsaigh and Coyne, 2021; Neubauer, Witkop and Varpio, 2019; Van Manen, 2016). Consequently, Alsaigh and Coyne (2021) have prescribed a framework to conduct a hermeneutic phenomenology study whilst adhering to the main concepts of this methodology which consists of pre-understandings, fusion of horizons and the hermeneutic circle. Their framework is a combination of the stages recommended by Ajjawi and Higgs (2007) and Fleming, Gaidys and Robb (2003) which they

argued were clear to follow and widely used in research studies. This research was guided by Alsaigh and Coyne (2021)'s framework as described below.

Step One: Choosing Appropriate Research Questions

To achieve the hermeneutic aim of gaining a deeper understating of the phenomenon (Van Manen, 2016), participants were presented with open-ended questions which encouraged them to elaborate on their experiences. Questions on the benefits and challenges of National Living Wage were presented in several ways for participants to consider these topics in different contexts to gain a deeper understanding. To ensure that the questions were relevant to advance a deeper understanding (Alsaigh and Coyne, 2021), they were based on research objectives, research gaps arising from the literature review, and the views, behaviours and experiences put forward by the pilot study.

Step Two: Identification of Pre-Understandings

Identification of pre-understandings is one of the main concepts of hermeneutic phenomenology (Alsaigh and Coyne, 2021). Reflecting on subconscious prejudices assisted in exploring the phenomenon without limiting the horizon of understanding (Fleming, Gaidys and Robb, 2003). This step highlighted the need to be aware of how the pre-understandings put forward by the pilot study might impact upon the interpretation of the final study. Hence, extra vigilance was given to objectively interpret the interviews of the main study separately and the findings of the main study would be compared with the pilot study. The researcher further reflected on personal positions, positions held of the participants and on how the research context might influence the research process. This reflective process has been detailed in the next section of this chapter (Researcher Positionality and Reflections).

Step Three: Gaining Understanding through Dialogue with Participants (eg: interviews and diaries)

Understandings were sought using Qualtrics written interviews. The anonymous environment encouraged confession, thus capturing more extreme views and experiences.

Step Four: Transcribing/ Iterative Reading/ Preliminary Interpretation of Texts to Facilitate Coding/ Identifying First Order (participant's horizon) Constructs

Each transcript was printed out and read twice to allow for familiarisation of data. Next, each sentence was examined for any views, behaviours, and perceptions (participant's horizon) related to the research objectives. These were highlighted and a short phrase that captured the essence of the participant's horizon (a code) was allocated next to the text. This open-ended approach to coding (Saldana, 2015) ensured that all aspects of the phenomenon have been captured.

Step Five: Identifying Second Order (the researcher's horizon) Constructs =Integration

The software NVivo was used to organise the codes and formulate second order constructs (the researcher's horizon). Each transcript was carefully read again, and the coding framework applied accordingly in NVivo. Visual representations were created using the project map feature of NVivo. This helped to revise the name of the codes and any codes with the same meanings were merged together. It also helped to ensure that all codes were matched with the correct theme, and necessary interchanges were made. These revised set of codes (second order constructs) represented an integration of participant horizons (first order constructs) and the researcher's horizon generated based on theoretical and personal knowledge.

Step Six: Meshing the Horizons/ Themes are Developed and Challenged by the Researcher = Aggregation

The codes derived from the care worker interviews were then described in detail, whilst attempting to analyse the meaning of the findings representing the theme. The movement from the codes to the meaning of the whole theme is known as aggregation (Alsaigh and Coyne, 2021). Findings were challenged for alternative conclusions that can be drawn other than those initially formed. Next, codes derived for the theme from care managers were discussed and then compared against findings from care workers. Matrix coding queries were run using NVivo to identify if participant characteristics and circumstances influenced their experience.

Step Seven: Linking the Literature to the Themes Identified

The findings representing the themes were then synthesised with the findings from the literature review and pilot study (parts), in doing so achieving the research aim (whole). This step of developing and understanding of how the data (parts) contribute to the understanding of the National Living Wage experience (the whole) is considered as completing the hermeneutic circle.

Step Eight: Critique of the Themes/ Reporting Final Interpretation at this Point in Time (fusion of horizons)

A final interpretation and critical analysis of the findings in relation to each of the research objectives are presented in Chapter six: Conclusions and Recommendations. Contributions of the research are highlighted as well as implications for policy makers.

Step Nine: Establishing Trustworthiness

Steps were taken before, during and after data collection to establish credibility and trustworthiness of the findings. Table 6 below depicts suggestions proposed by Aslaigh and Coyne (2021) that have been followed in this research.

Step Nine: Establishing Trustworthiness as proposed by Aslaigh and Coyne (2021)		
Before Data Collection	During Data Collection	After Data Collection
*Alsaigh and Coyne's (2021) framework applied throughout the research process when deciding on research questions, data collection and analysis to achieve methodological coherence. *Decision made to employ multiple data collection methods (pilot study, documentary evidence and interviews) to improve validity. *Reflecting on researcher positionality to ensure that findings truly emerge from the data whilst limiting the influence of researcher background and preferences.	*Views sought from two stakeholders (care managers and care workers) to place the study in a wider context whilst minimising bias and misinformation. *Clear and detailed interview questions, presenting the same question multiple times in different contexts to minimise errors in recollection. .	*All analytical decisions have been documented in Chapter five: Findings and Discussion, creating an audit trail to improve transparency. *Coding and data analysis repeated in NVivo to minimise human error. *Use of verbatim quotes to present findings allowing the reader to validate researcher interpretations. *Contextual data about research participants provided along with rich descriptions of their experiences to allow readers to make judgements on transferability.

Table 6: Step nine: Establishing Trustworthiness as put forward by Aslaigh and Coyne (2021)

Steps taken to establish trustworthiness before, during and after data collection based on the suggestions proposed by Alsaigh and Coyne (2021).

4.6 Researcher Positionality and Reflections

The epistemological position and adoption of the hermeneutic phenomenology methodology requires adopting a reflexive stance when conducting the research. According to von Unger (2021, p.187), reflexivity is *" based on constructivist epistemologies that require reflexivity as a methodological consequence".*

Hermeneutic phenomenology stimulates reflection by encouraging researchers to acknowledge their pre-understandings and reflect on how this shape their interpretation of data (Neubauer, Witkop and Varpio, 2019). The fusion of horizons which is an important step in hermeneutic phenomenology involves meshing the researcher's horizon of understanding (pre-understandings) with the text (participant's horizon of understanding), in the process broadening the researcher's horizon and creating new understandings about the phenomenon (Alsaigh and Coyne, 2021). The process of reflexivity involves understanding the surrounding circumstances of the research situation, including the researcher's influence on the research process, analysis and findings (von Unger, 2021). The main aim incorporating reflexivity in this research was to create a transparent research process and to maintain a log of subjectivities that had occurred in the research process which could influence the interpretations of research outcomes (Cassell, 2005), increasing the reliability of research (Finlay, 2002). To approach reflexivity, the three principles as described by Savin-Baden and Major (2012) was applied to identify researcher positionality.

The first step was to analyse any personal positions that might influence the research. Having researched on the topic of low pay in the Maldives before, and now pursuing a PhD on the subject, the researcher had developed the belief that the National Living Wage is inadequate in comparison to the cost of living. The researcher's personal belief that more should be done to improve the standards of living of low paid workers may increase the chance of being biased towards a particular view. This raises questions on the ability of the researcher to distance herself from the conception to be able to interpret the findings fairly. Holmes (2020) argued that novice researchers were more vulnerable to making assumptions about other's perspectives and limit interpretations based on their own misconceptions. This served as a reminder of how the researcher's negative perception of the National Living Wage might impact the interpretation of the findings. This situation also encouraged the researcher to reflect on the power dynamics of interpreting the interview results. Consequently, data was

filtered through the four levels of interpretation as suggested by Alvesson and Sköldberg (2018).

Level One: Interaction with Empirical Material

The transcripts were investigated for various aspects of the phenomenon. Any views, behaviours and perceptions related to the research objectives were highlighted. Each sentence was scanned for any surprising concepts or views, in addition to the dominant and expected views highlighted in the literature and pilot study.

Level Two: Interpretation

An open-ended approach to coding (Saldana, 2015) was adopted to ensure that all aspects of the phenomenon have been captured. By being aware of how any pre-understandings might impact upon the interpretation of the transcripts, the researcher ensured that there is no prioritisation towards certain interpretations. Thus, a balanced view is taken by considering any unexpected views when interpreting the data.

Level Three: Critical Interpretation

Whilst analysing the overall findings for each theme, cases of disagreements are highlighted, and explanations provide for why these views stand out. In addition, the reasons for why certain views are dominant are discussed in detail.

Level Four: Reflection on Text Production and Language Use

This level highlighted the need to reflect on the power dynamics when presenting the findings. Hence, the researcher was attentive to ensure that conclusions are drawn solely from the data and not influenced by the personal position (the belief that the National Living Wage is inadequate in comparison to the cost of living and more should be done to improve the standards of living of low paid workers) held by the researcher. Findings were re-examined for alternative conclusions that can be drawn other than those initially formed. Findings were also discussed with supervisors, fellow researchers and in faculty conferences to ensure that alternative explanations have not been overlooked.

Although the dominant views of the research conformed to the views of the researcher, extra vigilance was given to highlight cases of disagreements. These contrasting views challenged the researcher's and fellow research participants lines of thinking (Alvesson and Sköldberg, 2018). Wider reflection and further reading prompted the researcher to wonder why these views stand out. This was a valuable lesson underlining the insights that can be gained by looking at the wider social context of each individual. This reinforced the social constructionist stance of this research revealing the uniqueness of each social entity.

The second step was to consider the position that the researcher held of the participants in the project. As someone who is not from the social care profession or the social care sector, it can be assumed that the researcher assumes an outsider position in this regard. Therefore, does not have access to the culture being studied or might not have enough background knowledge to ask more meaningful questions (Holmes, 2020). Therefore, a pilot study was conducted to establish an initial connection and gain priori knowledge to identify initial insights. Consequently, this led to a fuller appreciation of how pilot studies could enhance research.

The third step involved reflecting on how the research context might influence the research process. During the final study, the researcher aimed to conduct a few face-to-face interviews. However, it seemed that in this case, the care workers were less willing to reveal sensitive information to an outsider (Holmes, 2020; Hussey et al., 2004). Consequently, all interviews were conducted anonymously through Qualtrics. This was an important realisation of how the sensitive context of the research made face-to-face interviews an inappropriate tool for data collection. The reason being that participants were uncomfortable disclosing personal information about their financial and workplace situations in a face-to-face environment.

The purpose of the first step was to limit the opportunity of biased interpretations by making the readers aware of the researcher's initial negative perception of the National Living Wage. It is hoped that this crucial step will increase the reliability and transparency of the research. The reflections in the second step prompted the researcher to consider her position in relation to the participants. This step highlighted the importance of conducting the initial pilot study to connect with the participants and gain initial insights so that the questions in the final study could be more meaningful. The third step reinforced that anonymous written interviews

through Qualtrics was an optimum medium to conduct the study as opposed to face-to-face interviews. The process of reflexivity directly influenced the decision making in both the methodological and analytical stages of the research process, thus directly impacting the conclusions reached regarding the private adult social care sector's experiences of the National Living Wage.

4.7 Chapter Summary

This research adopted a hermeneutic phenomenology methodology which generates in-depth understandings of lived experiences, adopting an epistemological orientation of social constructivism with an ontological orientation of subjectivism viewing that realities are a result of social factors that are in constant change. Purposive sampling was used to seek care workers employed on the National Living Wage and managers who were involved in the application and compliance of the National Living Wage. Snowball sampling was also used when participants were asked to recommend other suitable participants. Data was gathered using a pilot study, documentary evidence, and interviews to achieve the research objectives. These methods have been chosen to address the reliability and validity threats and to overcome any data access limitations. The instruments of multiple collection helped the research achieve triangulation that presented the study from a variety of perspectives (Noble and Heale, 2019).

The pilot study questionnaires were analysed using charts and tables to identify overall opinions. Conclusions were drawn from the meaning of these opinions whilst linking these conclusions to the literature review and research objectives. Interviews were coded manually onto a thematic framework using an open-ended approach. The data was then imported to software NVivo for accuracy and to perform a more detailed analysis. Ethical guidelines were followed throughout the research process to ensure that the benefit of the research outweighs any potential harm to participants. Conducting this research was a learning process which conveyed the importance of pilot studies and encouraged to reflect on the power dynamics of interpreting the interview results.

Chapter 5. Findings and Discussion

Section One. Results of the Pilot Study

1.1 Section Introduction

Prior to the implementation of the main study, a pilot study was launched using a questionnaire for care workers and care home managers. This section of the chapter presents the analysis of the pilot study conducted for a period of four weeks from 3 April 2022 to 1 May 2022. It is hoped that the pilot study would prove as a steppingstone in working towards achieving the research objectives.

The pilot study provides initial insights into the questions arising from the literature review by touching on how care workers viewed the National Living Wage policy, how the NLW have impacted career plans of care workers (Moriarty, Manthorpe and Harris, 2018; Skills for Care, 2020b) and their workload (Giuponni et al., 2016; Moore et al., 2017; Vadean and Allan, 2020). It also explores care worker interaction with the benefits system (Low Incomes Tax Reform Group, 2018), the thorny issue of wage discussion in the sector (Hussein, 2017a), causes of gender inequality (Moore and Hayes, 2018) as well as the implication on the relationship between Local Authorities and care providers (Monitor and NHS England, 2015; Weissert, Chernew and Hirth, 2003).

Overall opinion amongst participants is identified for each question. Any differences or similarities in opinions are explored for the questions that were identical amongst the care worker and care home manager questionnaires. Next, conclusions are drawn from the meaning of these opinions. Finally, these conclusions along with possible explanations from the literature review are linked with the research objectives to identify topics (research gaps) that need to be explored in the main study (interviews).

1.2 Survey Implementation and Respondent Characteristics

Participants were recruited into the pilot study by distributing links to the questionnaire along with the participant information sheet in Facebook (FB) groups. Care workers and care home managers were administered a diverse set of questions as both are unique stakeholders with differing abilities to answer certain research gaps. The criteria for managers to participate in the study was for them to be involved in the implementation of the National Living Wage in

the organisation. The criteria for care workers to participate in the study was that they receive the minimum wage pay as an hourly rate. Data was collected for a period of four weeks from 3 April 2022 to 1 May 2022. A total of 26 responses were collected from care workers and three responses from care home managers.

In Qualitative research, people, settings or data are sampled to understand a particular problem rather than to statistically represent a wider population (Given, 2008). This has been done by ensuring that the study population includes participants with a wide range of characteristics where possible, including type of the organisation, location and type of contract held to ensure a wide range of perspectives and experiences.

To ensure that participant characteristics were not biased and represented a wide range of backgrounds from the care sector, a comparison of the participant characteristics were made with data from the Adult Social Care Workforce Data Set (ASC-WDS). The ASC-WDS is an online data collection system for organisations in the adult social care sector, managed by Skills for Care on behalf of the Department of Health and Social Care. In 2021, the ASC-WDS had 46% coverage of all Care Quality Commission (CQC) regulated social care organisations with around 482,000 worker records. With most employers having updated their data in the past 12 months, a sample of this size would be a solid basis to represent the whole sector at a fairly accurate level (Skills for Care, 2018).

When compared with the ASC-WDS, the survey represented a wide range of backgrounds from the care sector. As shown in Figure 12 below, 85% of care workers who took the survey were female, which was similar to the 84% reported for the care worker occupation in the sector by the ASC-WDS. The ASC-WDS reported that 16% of care workers in the sector were male. In the survey, 11% of care workers identified as male and 4% as non-binary/ third gender. All the care managers who participated in the survey were female.

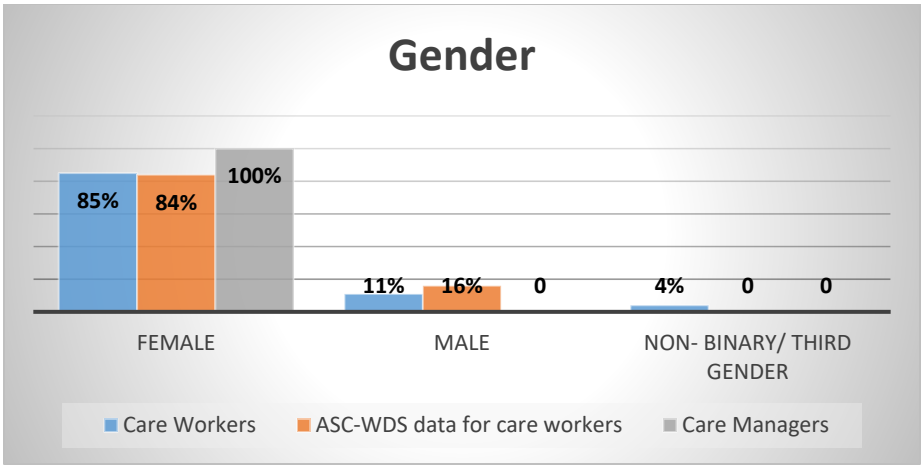


Figure 12: Gender comparison amongst care worker survey, care manager survey and ASC-WDS data for care workers

88% of the care workers who took the survey reported as 23 years and over, and surprisingly the ADS-WDS reported that 88% of care workers working in the sector were 25 years and over. Two of the care managers reported that they were 23 years and over whilst one participant preferred not to say.

Figure 13 below displays the similarity in type of service amongst participants in the care worker survey and ADC-WDS. 58% of care workers worked in adult residential care and 42% worked in adult domiciliary care. Similarly, the ASC-WDS reported that 51% of adult social care establishments provided residential care and 49% domiciliary care.

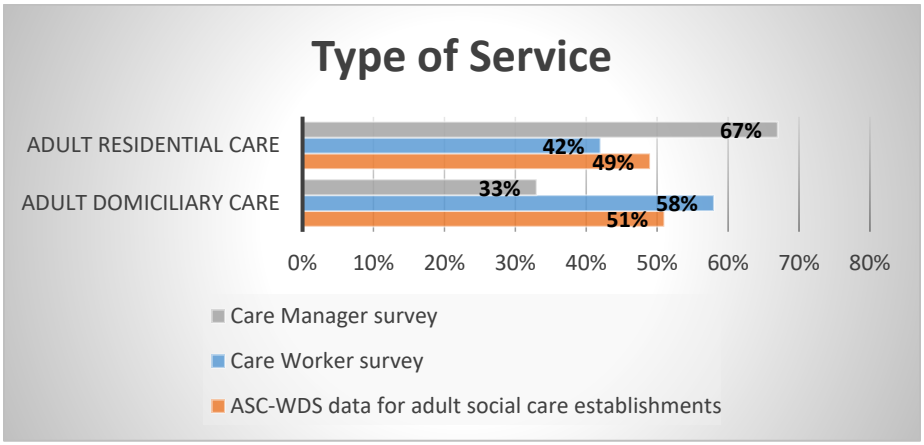


Figure 13: Type of Service comparison amongst care worker survey, care manager survey and ASC-WDS data for social care establishments

As shown in Figure 14 below, participants represented different regions from England. Out of nine regions, the survey was able to capture participant views from seven regions throughout England.

Figure 14: Location (Care worker and care manager survey)

All care managers were on full-time contracts. The Majority of the care workers (69%) were working full time and 23% part-time. The remaining 8% reported that they were on a zero-hours contract. The ADS-WDS reported that 49% of care workers were working full time and 51% part time. Out of this, 35% of care workers were on zero-hours contracts. When analysing participant contract types, it was realised that multiple options might apply to one participant. For example, a participant might work full-time hours on a zero-hours contract. Therefore, in the main study participants were asked whether they were working full-time or part-time hours. A separate question was included to ask whether they work based on zero-hours contracts. In addition, what is defined as full-time hours and part-time hours are subjective. Therefore, participants were informed that the ADS-WDS standard of full-time hours being 37 or more hours per week and 36 or less hours per week will be considered as part time hours.

1.3 Views and Response to the NLW Policy

The social care sector is highly labour intensive and labour costs make up over half the expenses (Skills for Care, 2020b). Skills for Care (2020b) estimated that 35% of the adult social care sector workforce (485,000 workers) were being paid below the new National

Living Wage rates in 2020 and bringing the pay of these workers to the statutory minimum would cost the sector an extra £115 million. The actual cost is estimated to be even more if employers were to maintain pay differentials between lower level and senior staff.

With limited ability to compromise on quality due to standards imposed by the Care Quality Commission (Care Quality Commission, No Date) or increase fees due to fixed contracts with Local Authorities (Machin, Manning and Rahman, 2003; Machin and Wilson, 2004), the sector is highly vulnerable to the consequent upratings of the National Living Wage. In this regard, it would be interesting to find out how the sector perceives the National Living Wage.

Figure 15 below displays the views on the National Living Wage policy by the care workers and care home managers. Although most of the participants rated the National Living Wage as "somewhat helpful" (38% care workers and 67% care managers), the overall view amongst care workers were mixed. 50% of care workers rated the National Living Wage as either "somewhat helpful" or "extremely helpful", and the same percentage rated the National Living Wage as either "not very helpful" or "not helpful at all".

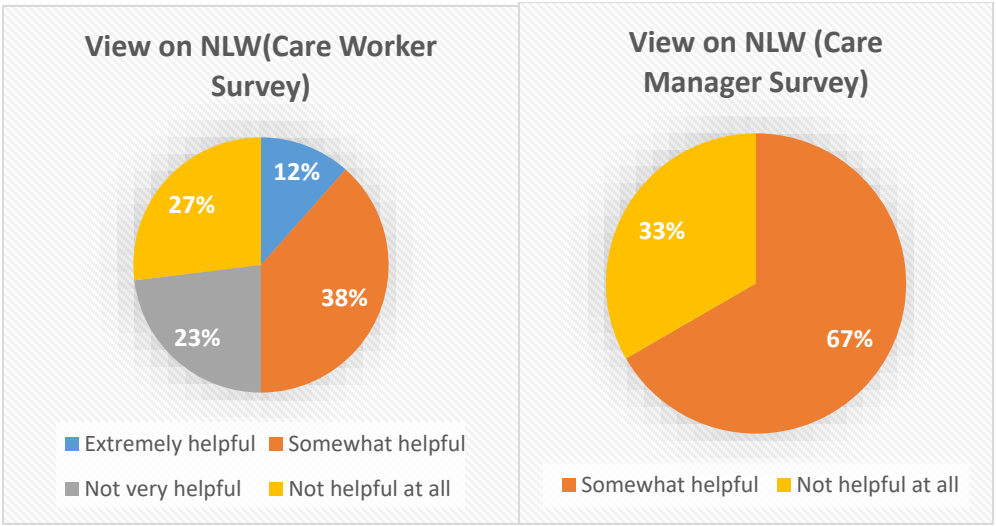


Figure 15: View on NLW (care workers and care managers)

Despite the scale of the increases, just 12% of care workers thought that the National Living Wage was extremely helpful whilst care workers who thought that the National Living Wage was not helpful at all was more than double this figure at 27%. Research suggesting that the National Living Wage has exacerbated a number of workforce issues in the sector such as an

increase in the usage of zero-hour contracts and workload (Moore et al., 2017; Vadean and Allan, 2020) might have contributed to these figures. However, more data is needed to shed light on why such a high percentage of care workers rated the National Living Wage negatively. Therefore, text box questions were added in the main study asking participants to explain the benefits and challenges brought by the National Living Wage to their work and life. This specifically helped with the objective one of this study by highlighting the sector's views on the National Living Wage including benefits and challenges.

Career Plans

With the introduction of National Living Wage, pay in the retail and cleaning sectors have been increasing faster than the social care sector (Skills for Care, 2020b). The less demanding nature of these sectors might make the social care less attractive for future and existing talent (Moriarty, Manthorpe and Harris, 2018). Care workers were asked to rate their likelihood of staying in the sector despite other sectors offering easier job opportunities for the same pay. The results are presented below in Figure 16.

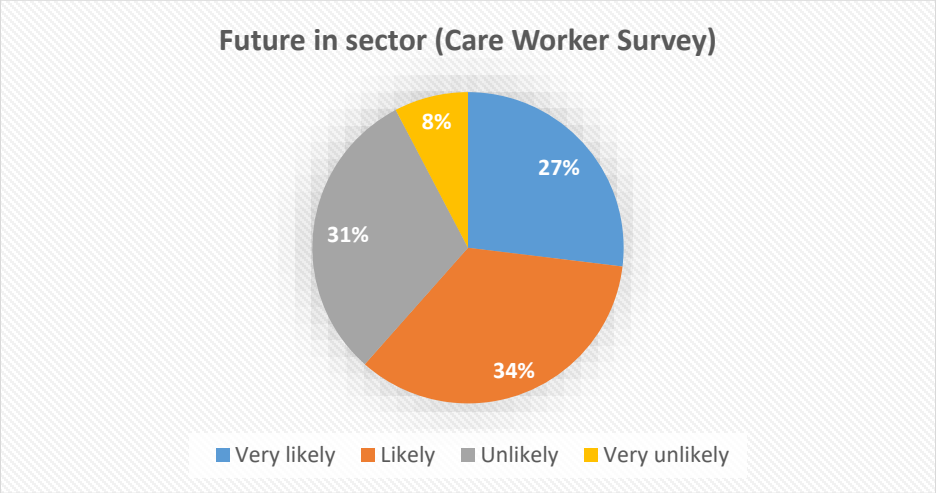


Figure 16: Future in the sector (care worker survey).

Interestingly, the greater part of participants (61%) favoured towards staying in the sector with 27% claiming that they were "very likely" to stay in the sector and 34% claiming that they are "likely" to stay. Although 31% rated that they were "unlikely" to stay in the sector, only 8% confidently claimed that it was "very unlikely" for them to stay in the sector. This was expected due to the existing high turnover and vacancy rates in the sector (Skills for

Care, 2020b). It would be interesting to find out the motives for staying in the sector despite other sectors offering easier job opportunities for the same pay.

The National Living Wage policy is causing a decrease in wage differentials between junior and more experienced staff. Before March 2016, care workers with greater than five years of sector experience earned an hourly rate of 26 pence to 37 pence higher, on average than a care worker with less than one year of experience. However, the experience pay gap had more than halved to just 12 pence per hour by March 2020 (Skills for Care, 2020a). The care worker survey attempted to explore whether the National Living Wage policy might demotivate junior care workers to progress in their career due to the need to take on additional responsibility for minimal pay increases.

Figure 17 below concludes that the most popular opinion amongst care workers were that they were unlikely to accept a promotion and take additional responsibilities (38%). Care workers might be avoiding stressful situations that come with additional responsibility due to the decrease in wage differentials. 27% of the participants rated that they were likely to accept a promotion, and the same percentage of participants rated that they were very likely to accept a promotion.

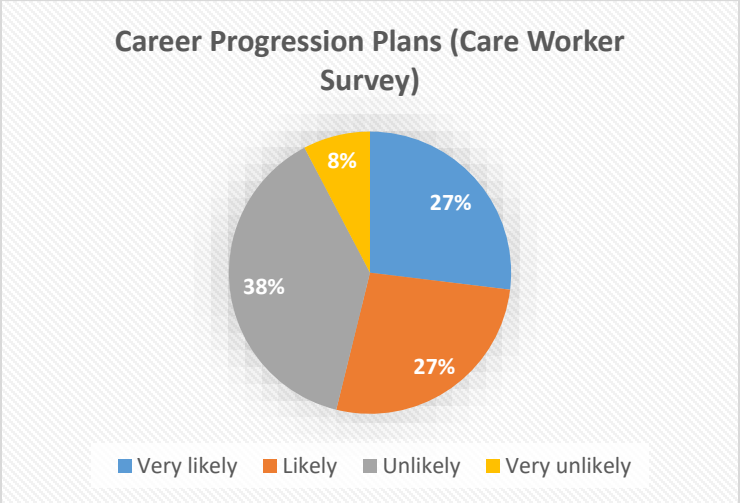


Figure 17:Career progression plans (care worker survey)

Workload

Quantitative research on the sector suggests that the National Living Wage policy positively impacts the number of hours worked (Gardiner, 2016; Giuponni et al., 2016). Participants were asked their thoughts if their organisation increased the number of hours they worked. As presented in Figure 18 below, significant percentage of participants (58%) rated that they would feel negative if their working hours increased whilst 31% rated that they would feel neutral about the situation. Only 11% rated that they would feel positive if their working hours increased. This might be due to the fact that care workers are already managing a high workload under stressful situations (Moore et al., 2017).

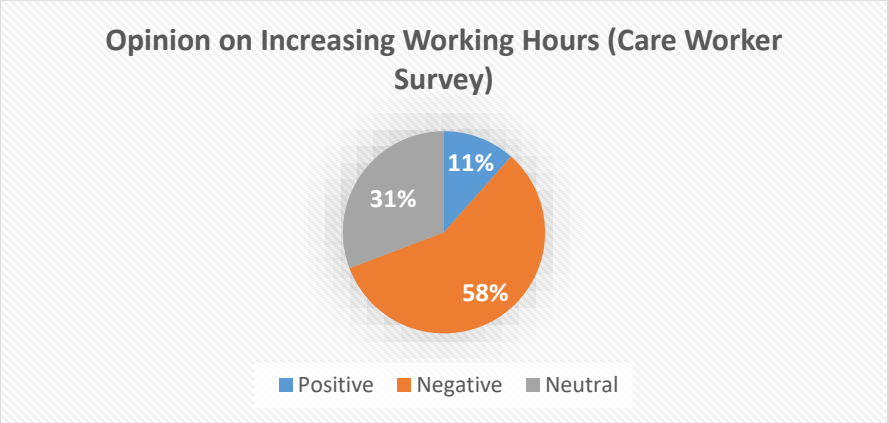


Figure 18: Opinion on increasing working hours (care worker survey)

Following this, participants were asked about the support provided to manage their current workload. Figure 19 below presents the mixed opinions amongst the care workers. 46% rated that they were satisfied with the support received whilst the same percentage of care workers rated the level of support received as either "slightly dissatisfied" or "not satisfied at all" (27% and 19% respectively). Just 8% of care workers were "very satisfied" with the level of support they received. In the care manager survey, two of the managers were slightly dissatisfied with the support provided to care workers whilst one manager was very satisfied.

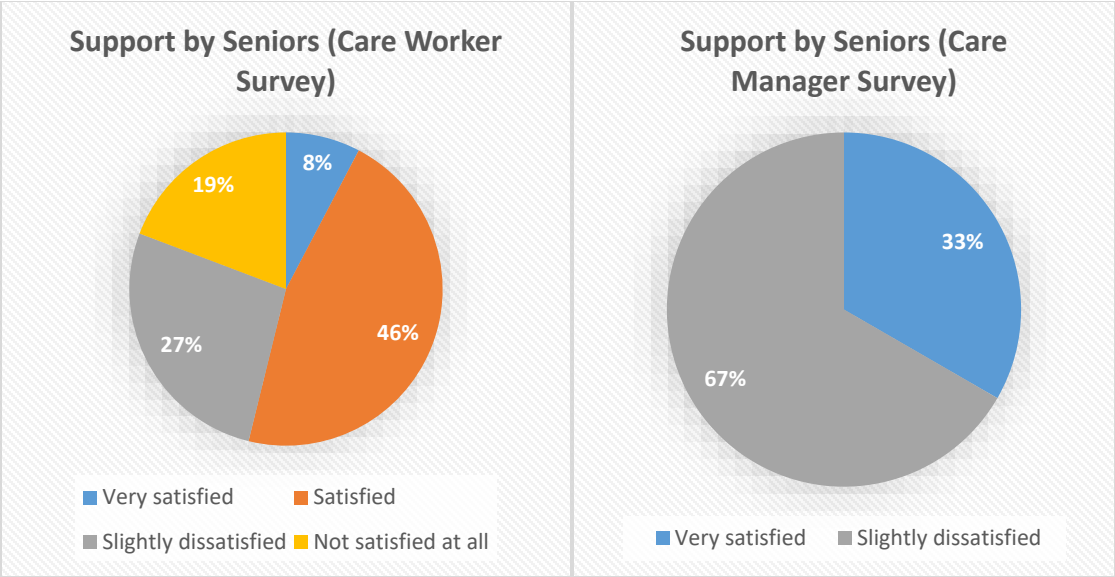


Figure 19: Support by seniors (care worker and care manager survey)

1.4 Standards of Living in the Care Sector

Many workers in low pay jobs struggle to pay bills and many are in receipt of working tax credits or some type of income support (Moore et al., 2017). It has been established that workers in the care sector face even more hurdles to bring themselves and their families to a socially acceptable living standard due to intricate features of care work (Low Incomes Tax Reform Group, 2018).

Eligibility for certain benefits such as Working Tax Credit (WTC) requires a minimum number of working hours (GOV.UK, No Date). As many care workers are not directly paid for travel time, this affects their eligibility to claim WTC as a significant amount of their working day is not counted as remunerative work. Furthermore, zero-hour contracts make working hours variable often taking working hours above and below the thresholds of claiming WTC leading to frequent starting and stopping of claims or overpayments (Low Incomes Tax Reform Group, 2018).

The government has now replaced the Working Tax Credit and five other benefits with Universal Credit to introduce greater fairness and simplicity. Instead of the number of hours worked per week, claimants need to meet certain work search, preparation, and training requirements (Department of Work and Pensions, 2014). Hence, the care worker survey attempted to uncover whether the intricate features of care work such as zero-hour contracts

and travel time present the same obstacles when claiming Universal Credit (as compared to Working Tax Credit).

Of the 26 participants who participated in the care worker survey, just five of the workers claimed that they were on Universal Credit. Of the five participants, the majority (three participants) disagreed that care work features make it difficult to claim Universal Credit. One participant selected the "Agree" option and another selected the "Strongly agree" option. None of the participants selected the strongly disagreed option. For these participants (who selected the "agree" and "strongly agree" options), it would be interesting to find out how features of care work made it more challenging for them to claim Universal Credit. This is an important aspect of the study linked to objective two to identify factors that influence standards of living amongst low-paid care workers.

Wage Discussion

Research by Hussein (2017b) concluded that one of the major reasons for the persistent poor wages in the long-term care sector is the perception that acceptance of poor pay is a prerequisite for working in the sector and workers who challenge the pay or working conditions are not suitable to work in the sector. These views were expressed by employers and workers were hesitant to discuss about pay as if there was an "implied level of unacceptability of discussing wages within the context of care work" (Hussein, 2017b: 1822). The aim of this research's survey was to find out if although workers were uncomfortable to discuss wages, do the care workers and care managers think that it would be helpful to shift to a culture where wages are discussed with seniors.

When care workers were asked about their comfortable level in discussing wages with seniors, the results were mixed as shown in Figure 20 below. Whilst 39% (10 care workers) rated that they would be extremely comfortable to discuss wages with their seniors, similarly 31% (8 care workers) felt that they were not very comfortable to discuss wages with their seniors. 15% (4 care workers) rated that they were somewhat comfortable, and the same percentage rated that they were not comfortable at all. In overall, the care home managers felt that care workers, in general, are not comfortable with discussing wages. None of the care managers thought that care workers were extremely comfortable about discussing wages.

Two of the care managers rated that care workers were not very comfortable and one rated that they were somewhat comfortable.

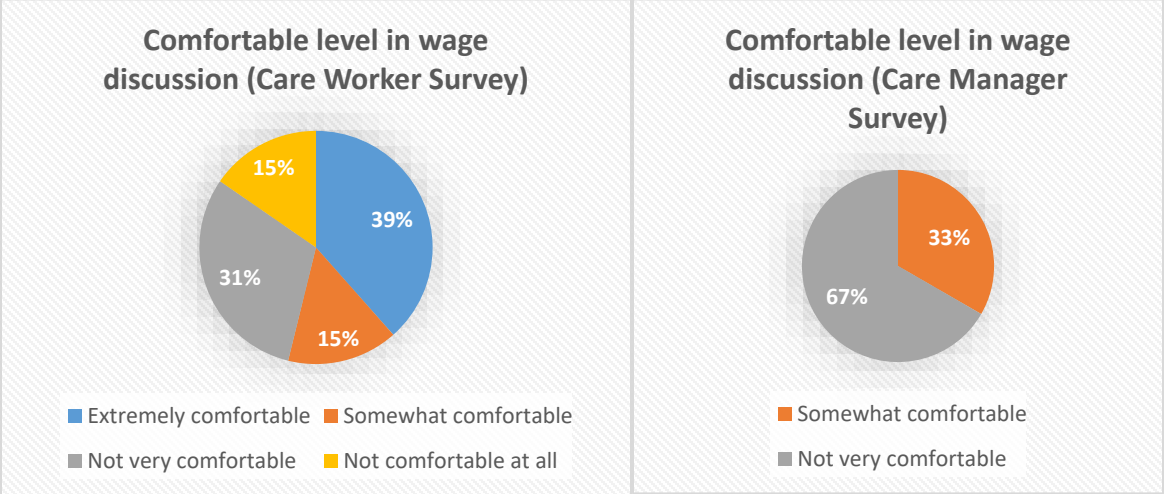


Figure 20: Comfortable level in wage discussion (care worker and care manager survey)

Despite the mixed results regarding the comfortability in discussing wages, Figure 21 below shows that a significant 73% rated that it would be either "extremely helpful" or "somewhat helpful" to discuss wages with seniors (38% and 35% respectively). 19% rated that it would not be very helpful and only 8% rated that it would be not helpful at all. All three care managers thought that it would be somewhat helpful for care workers to discuss wages with their seniors. Hence, the care sector needs to find ways to shift to a culture where the topic of wages can be openly discussed with seniors.

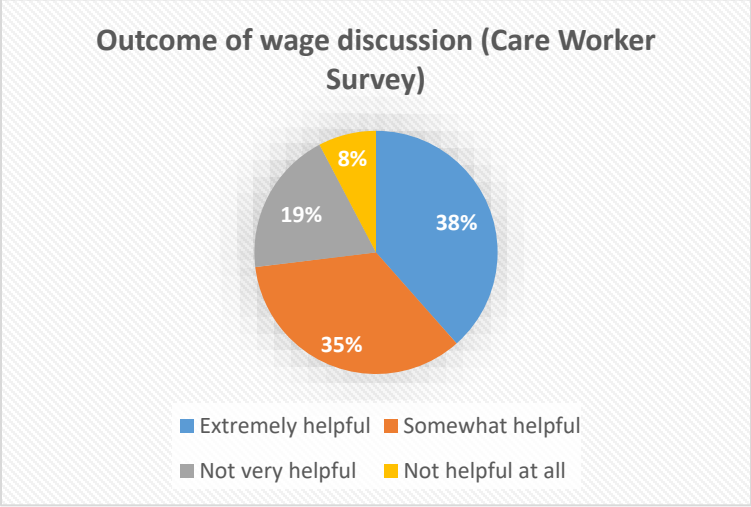


Figure 21: Outcome of wage discussion (care worker survey)

Reasons for Gender Inequality

Skills for Care (2020) highlighted that women were less likely to be in senior management roles (67%) compared to direct care providing roles (83%). To figure out the reasons for these figures, participants were given the following reasons for gender inequality mentioned in the literature.

1. Stereotyping about women's capabilities and skills (Grimshaw and Rubery, 2007; Moore and Hayes, 2018).
2. Lack of flexible working (Chung, 2019).
3. Gender differences in qualifications and experience (Maries, Whitcomb and Singh, 2022; Voigt and Spies, 2020).

Participants were allowed to select multiple options as they felt suitable. They were also given a text box to list down any other reasons not mentioned in the list. None of the participants used the text box. As represented in

Figure *22* below, most participants believed that the major reasons for gender inequality in the sector attributed to lack of flexible working and stereotyping about women's capabilities and skills. 50% of care workers selected lack of flexible working as a reason and 34% of care workers believed stereotyping to be a reason. Just 16% of care workers thought that it was due to gender differences in qualifications and experience. Similarly, two of the care home managers believed that gender inequalities existed due to stereotyping about women's capabilities and skills whilst one manager believed that it was due to lack of flexible working options.

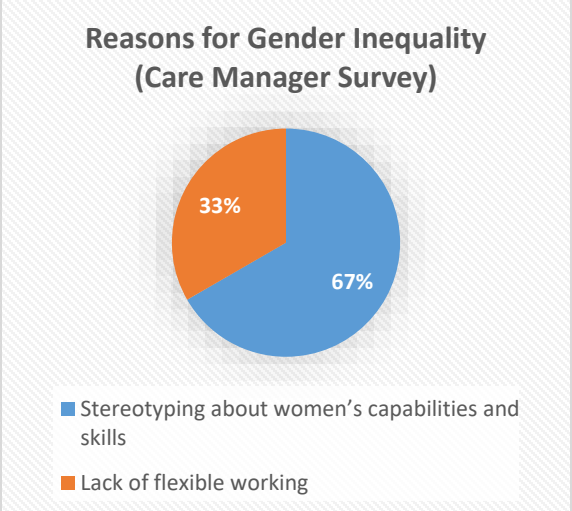


Figure 22: Reasons for gender inequality (care worker and care home manager survey)

Research in the sector highlights the issue of gender stereotyping where care giving is considered more suitable for women and the skills required to perform the job are considered to occur naturally to women (Grimshaw and Rubery, 2007; Moore and Hayes, 2018). However, it did not highlight the issue that most participants believed contributed to gender inequality in the sector, which was the lack of flexible working options in the sector. Further research needs to be conducted on how flexible working could help care workers progress in their career to more senior management roles.

National Living Wage Challenges and Support by Local Authorities

The relationship between the government and the care sector involves the government contracting out the provision of care and the care provider performing the duty of care (Department of Health and Social Care, 2017). The Care Act 2014 places statutory duties on Local Authorities and care providing organisations to assist each other to support resident needs. As challenges faced by care providers are directly correlated with quality of care provided (Allan and Vadean, 2021b), it is a legal obligation on the Local Authorities to support care organisations to manage the challenges caused by the continuous uprating of the National Living Wage. In turn care providers should be transparent with the challenges they face due to the National Living Wage (moral hazard) to assist the Local Authority to carry out its functions (Cowden et al., 2020; Pouryousefi and Frooman, 2017).

Care home managers were asked to rate the difficulty their organisation has faced in managing the continuous uprating of the National Living Wage. Two of the managers rated it as somewhat challenging and one manager rated it as not very challenging. None of the managers rated the consequences of National Living Wage as extremely challenging. These findings support Giuponni et al.'s (2016, p.6) conclusion that *"most care homes seem to have so far adapted to the NLW introduction".*

When asked about the support provided by Local Authorities,

Table *7* below shows that two of the managers found the support given by their Local Authority to manage the continuous upratings of the National Living Wage satisfactory. However, one care home manager, despite rating the difficulty of their organisation in

managing the National Living Wage as only “somewhat challenging” (instead of extremely challenging) rated that they were not satisfied at all with the support provided by the Local Authority. It would be interesting to find out what type of support works well for the care organisations and what additional support the Local Authority could provide to better manage the challenges put forth by the National Living Wage. Objective three of this study highlights the importance of identifying appropriate strategies to alleviate challenging aspects of National Living wage.

Very satisfied	0
Satisfied	2
Slightly dissatisfied	0
Not satisfied at all	1

Table 7: Support by Local Authority to manage NLW challenges

Optimal Contract Type

Care homes hold different types of contracts with Local Authorities, and each type of contract has its own challenges (Bristol City Council, 2008; Monitor and NHS England, 2015).Two of the care home managers stated that they had block contracts with the Local Authority and one of the managers stated that their contract consisted of two components: a fixed advance and payment based on outcomes.

If agency theory is applied to the commissioning process of social care, it could be argued that the optimal contract (Eisenhardt, 1989) for this situation is behaviour-based (block contract). The reason being that several individuals are involved in a person’s care (Department of Health and Social Care, 2022) and the achievement of outcomes would depend on the optimum performance of all individuals involved. While rewarding care providers based on the outcomes achieved was a common incentive alignment mechanism, it would disadvantage risk-averse care providers by offering them compensation for outcomes they did not fully control (Bosse and Phillips, 2016). All care home managers who

participated in the survey agreed with this view by selecting block contract as the most suitable contract type for care commissioning. More data is needed to discover the reasons why a particular contract type is more suitable for care commissioning based on the current circumstances.

1.5 Section Summary

Participants had mixed views on the helpfulness of the National Living Wage. Interestingly, the greater part of care workers favoured towards staying in the sector despite other sectors offering easier job opportunities for the same pay. Despite this, the most popular opinion amongst care workers were that they were unlikely to accept a promotion and take additional responsibilities. Care workers might be avoiding stressful situations that comes with additional responsibility due to the decrease in wage differentials caused by the National Living Wage.

Furthermore, a significant percentage of care workers rated that they would feel negative if their working hours increased. This is worrying as quantitative research on the sector suggests that the National Living Wage policy positively impacts the number of hours worked (Gardiner, 2016; Giuponni et al., 2016). This might be due to the fact that care workers are already managing a high workload under stressful situations (Moore et al., 2017). The survey received mixed opinions on the support provided for care workers to manage their current workload.

Unlike the Working Tax Credit, it is unlikely that the intricate features of care work such as zero-hour contracts and travel time would present obstacles when claiming Universal Credit. Despite the mixed results regarding the comfortability in discussing wages, the care sector expressed interest to shift to a culture where the topic of wages can be openly discussed with seniors. Most participants believed that the major reasons for gender inequality in the sector attributed to lack of flexible working and stereotyping about women's capabilities and skills. Research in the sector highlights the issue of gender stereotyping (Grimshaw and Rubery, 2007; Moore and Hayes, 2018). Further research needs to be conducted on the type of support that is needed to help care workers progress in their career.

Although the findings support Giuponni et al.'s (2016, p.6) conclusion that *"most care homes seem to have so far adapted to the NLW introduction",* it would be important to find out in

the main study what type of support works well for care organisations to address the challenges imposed by the National Living Wage policy. This would help to address objective three which is to identify ways in which the sector can address challenges imposed by the National Living wage policy.

Local Authorities need to reconsider the elements of its relationship with care providers considering the challenges put forward by the National Living Wage. While rewarding care providers based on the outcomes achieved was a common incentive alignment mechanism, it would disadvantage risk-averse care providers by offering them compensation for outcomes or factors such as the National Living Wage that they did not fully control (Bosse and Phillips, 2016). All care home managers who participated in the survey agreed with this view by selecting block contract as the most suitable contract type for care commissioning. More data is needed to discover the reasons why a particular contract type is more suitable for care commissioning based on the current circumstances.

In summary, this pilot study was a valuable pathway in working towards achieving the research objectives by helping to highlight some of the views, behaviour, and experiences of the sector with regard to the National Living Wage. The analysis of the pilot study results has helped to identify ways to modify the questionnaire questions for the main study in a way that would more effectively answer the research objectives. Hence, the findings of the pilot study have helped to inform the subsequent interview questions for the main study (Malmqvist et al., 2019; van Teijlingen and Hundley, 2002).The main study focused on collecting more insightful data on the reasons for the aforementioned views and explanations on positive and negative experiences put forward by the pilot study.

Section Two. Description, Analysis and Synthesis of Interviews

2.1 Section Introduction

This section of the chapter reveals the results of interviews described in Chapter four: Methodology. The research concentrates on two groups of stakeholders: care workers who received the National Living Wage as an hourly rate and care managers who were involved in the implementation of National Living Wage. To increase data validity, participant characteristics of both groups are compared with data from the Adult Social Care Workforce Data Set (ASC-WDS).

First, care worker interviews are described and analysed, and then cross referenced against care manager interviews. Each theme is discussed in detail using quotations as evidence of the conclusions. These conclusions from the interview results are then compared against the literature review and pilot study findings. This section concludes with a summary of lived experiences of the National Living Wage in the context of the private adult social care in England.

2.2 Participant Characteristics

The objective of sampling in qualitative research is to represent a wide range of people, settings or data to achieve the research aim rather than statistical representation (Given, 2008). To ensure that participant characteristics were not biased, sociodemographic data collected included gender, age, ethnicity, employment type, location, service type, sector experience, experience in current role, employment status and whether the participant was on a Zero-Hours Contract (ZHC).

Also, to increase data validity, a comparison of the participant characteristics and consequent findings in this section were made with data from the Adult Social Care Workforce Data Set (ASC-WDS) (Skills for Care, 2022). The ASC-WDS is an online data collection system covering the adult social care sector workforce, managed by Skills for Care on behalf of the Department of Health and Social Care. In March 2022, the ASC-WDS had 47% coverage of all Care Quality Commission (CQC) regulated social care establishments in the independent sector with around 447,000 worker records. With most employers having updated their data in the past 12 months, a sample of this size would be fairly accurate to

represent the whole sector (Skills for Care, 2022). Table 8 below shows a breakdown of the sociodemographic characteristics of participants.

Gender	Care Workers	Care Managers
Female	22	6
Male	1	1
Prefer not to say	0	1
Age	**Care Workers**	**Care Managers**
Under 25 years	1	0
25-54 years	19	7
55 years and over	3	0
Prefer not to say	0	1
Employment Type	**Care Workers**	**Care Managers**
Employee	20	8
Worker (e.g., casual or agency worker)	2	0
Self-employed	1	0
Ethnicity	**Care Workers**	**Care Managers**
White	22	7
Black, Asian and minority ethnic groups	1	1
Location	**Care Workers**	**Care Managers**
South East	7	0
London	1	0
North West	5	6
East of England	1	0
West Midlands	1	1
South West	3	1
Yorkshire and Humber	2	0
East Midlands	2	0
North East	1	0
Service Type	**Care Workers**	**Care Managers**
Adult domiciliary care	8	0
Adult residential care	15	8
Sector Experience	**Care Workers**	**Care Managers**
Less than 3 years	2	1
3-9 years	8	4
10 years or more	13	3
Experience in Current Role	**Care Workers**	**Care Managers**
Less than 3 years	12	3
3-9 years	10	4
10 years or more	1	1
Employment Status	**Care Workers**	**Care Managers**
Full time	19	Not Applicable
Part time	4	Not Applicable
Zero-Hours Contract (ZHC)	**Care Workers**	**Care Managers**
Number employees on ZHC	6	Not Applicable

Table 8: Participant characteristics

Sociodemographic of care workers and care managers who participated in this research.

As presented in Table 8 above, participants represented a diverse background of characteristics being inclusive of different genders, age groups, employment types, ethnicity, locations, experience in the sector, experience in current role, service type and employment status. The research covers at least one care worker from each region of England and care managers representing three regions to ensure a wide range of experiences and views from throughout England.

However, despite best efforts, the care manager participants represented only one age group (25-54 years) and one service type (adult residential care). This representation is limited in comparison to the ASC-WDS which reported that 68% of the registered care managers were aged 25-54 years and 32% were aged 55 years and over. With regards to the service type, 40% of adult social care organisations were providing residential services and 60% were providing non-residential services (Skills for Care, 2022). Nevertheless, care managers represented broad sociodemographic diversity based on other factors such as gender, ethnicity, locations, experience in the sector, and experience in current role. The research also has limited representation of minority ethnic groups and male participants amongst care workers. Ethnicity and gender composition of participants are presented in more detail in Figure 23 and Figure 24 below.

Figure 23 below shows a gender comparison amongst participants and ASC-WDS data. The ASC-WDS reported that 16% of care workers in the sector were male, whilst the percentage shown for male care workers in this research was comparatively lower at 4%. Despite the effort, there was limited male care worker representation compared with the ASC-WDS data. This was not the case with the care manager interviews. The research shows 12% for male care manager participation, which was similar to the 16% reported for the care manager occupation in the sector by the ASC-WDS.

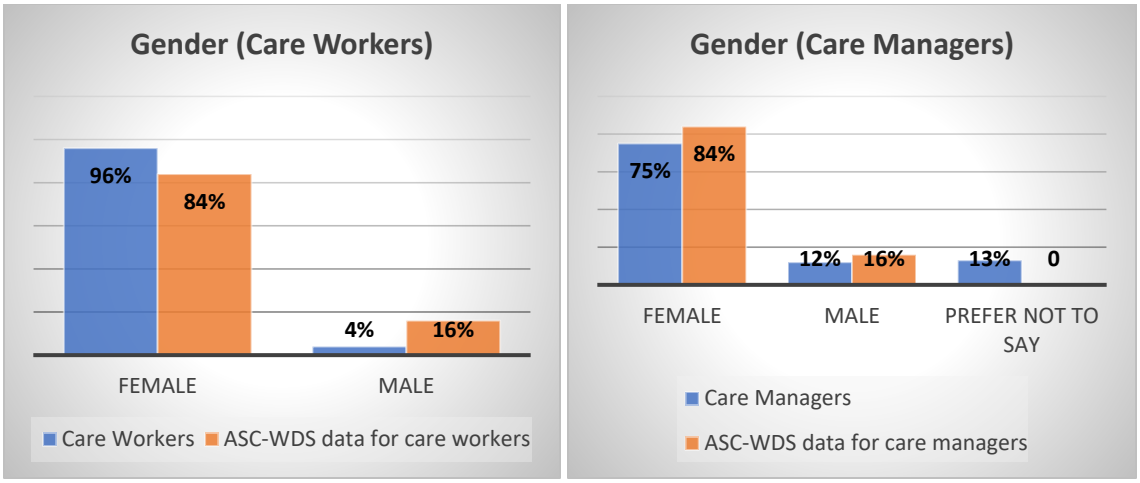
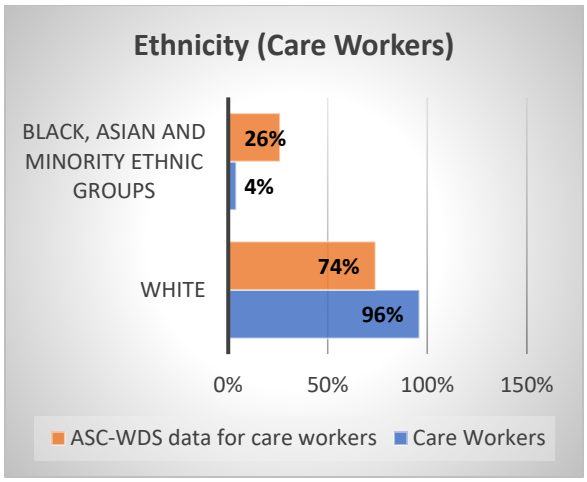


Figure 23: Gender comparison amongst participants and ASC-WDS data

The fact that such a significant percentage of care workers were female (22 female, 1 male) could help towards objective two of this research, which is to identify factors that influence the living standards of workers under the National Living Wage policy within the private adult social care sector. Skills for Care (2022) highlighted that women were less likely to be in senior management roles (68%) compared to direct care providing roles (83%). This research attempted to identify some of the barriers that might hinder care worker progression to senior roles. Since 96% of participants were female, it is likely that these findings are transferable to the female care worker population providing a plausible explanation for the above-mentioned figures by Skills for Care (2022).

The ADS-WDS reported that 26% of care workers in the sector belonged to black, Asian and minority ethnic groups, whilst the figure stands at 4% for care workers in this research. The adult social care workforce is more diverse than the working population in England which consisted of 14% black, Asian and minority ethnic groups in the year 2021/2022 (Skills for Care, 2022). Although the representation of minority ethnic groups amongst care worker participants is limited in this study, care workers represented broad sociodemographic diversity based on other factors such as age groups, employment types, locations, experience in the sector, experience in current role, service type and employment status. The percentage of black, Asian and minority ethnic group participation amongst care manager participants was 13%, which was close to the 17% reported for the care manager occupation in the sector by the ASC-WDS as presented in Figure 24 below.



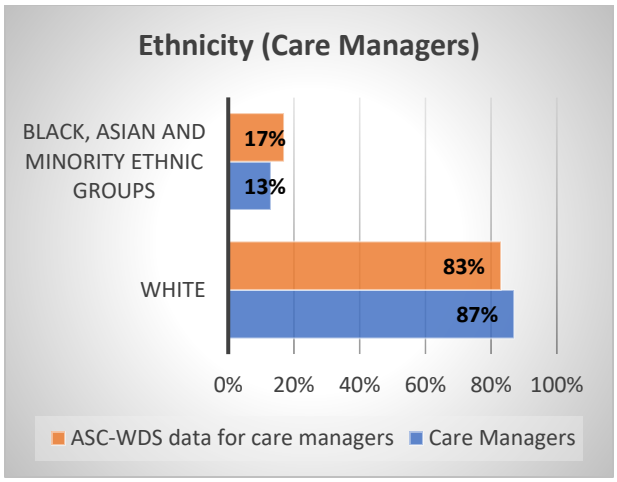


Figure 24: Ethnicity comparison amongst participants and ASC-WDS data

The research consisted of views from care workers on ZHCs. Skills for Care (2022) estimated that around a quarter (24%) of the adult social care workforce was employed on a ZHC. Similarly, 26% of the care workers in this research were employed on a ZHC as described in Figure 25 below. These figures are surprisingly high compared to the 3.4% estimated by the Labour Force Survey for the wider economy (Office for National Statistics, 2022c).

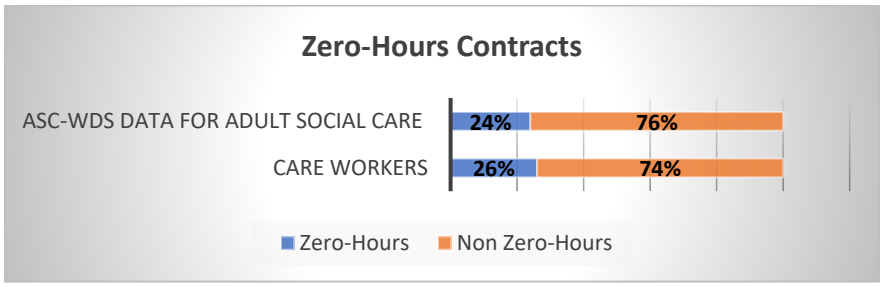


Figure 25: Comparison of zero-hours contract status amongst care workers and ASC-WDS

It is also inclusive of participants from various employment types (Employee, casual or agency and self-employed) as evident in

Figure *26* below. 87% of the care worker participants reported being an employee, and interestingly the ADS-WDS recorded that 86% of care workers working in the sector were employees. 9% of care workers in this research identified as being a casual or agency worker and 4% as self-employed. Similarly, the ASC-WDS concluded that 12% of care workers in the sector were casual or agency workers and 2% consisted of other employment types such as being self-employed. 100% of the care manager participants were employees, which is not

surprising as the ASC-WDS figure for care managers in the sector working as employees amounted to 98%.

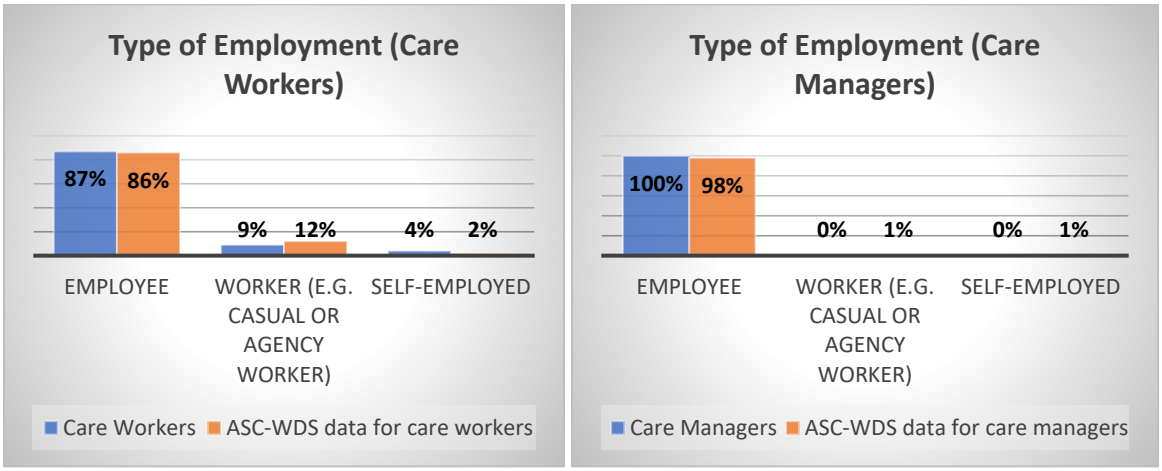


Figure 26: Comparison of employment types amongst participants and ASC-WDS data

The findings in this section of the chapter are based on interview data obtained from 31 participants (23 care workers and eight care managers) and does not aim to have statistical representation. Nevertheless, great importance was given to ensure that participants represented a wide range of backgrounds and characteristics. In this regard, it is likely that the findings are transferable to care worker and care manager populations experiencing the National Living Wage.

2.3 Data Analysis Process

This section describes the framework for data analysis as shown in Figure 27 below to ensure transparency of the data analysis process.

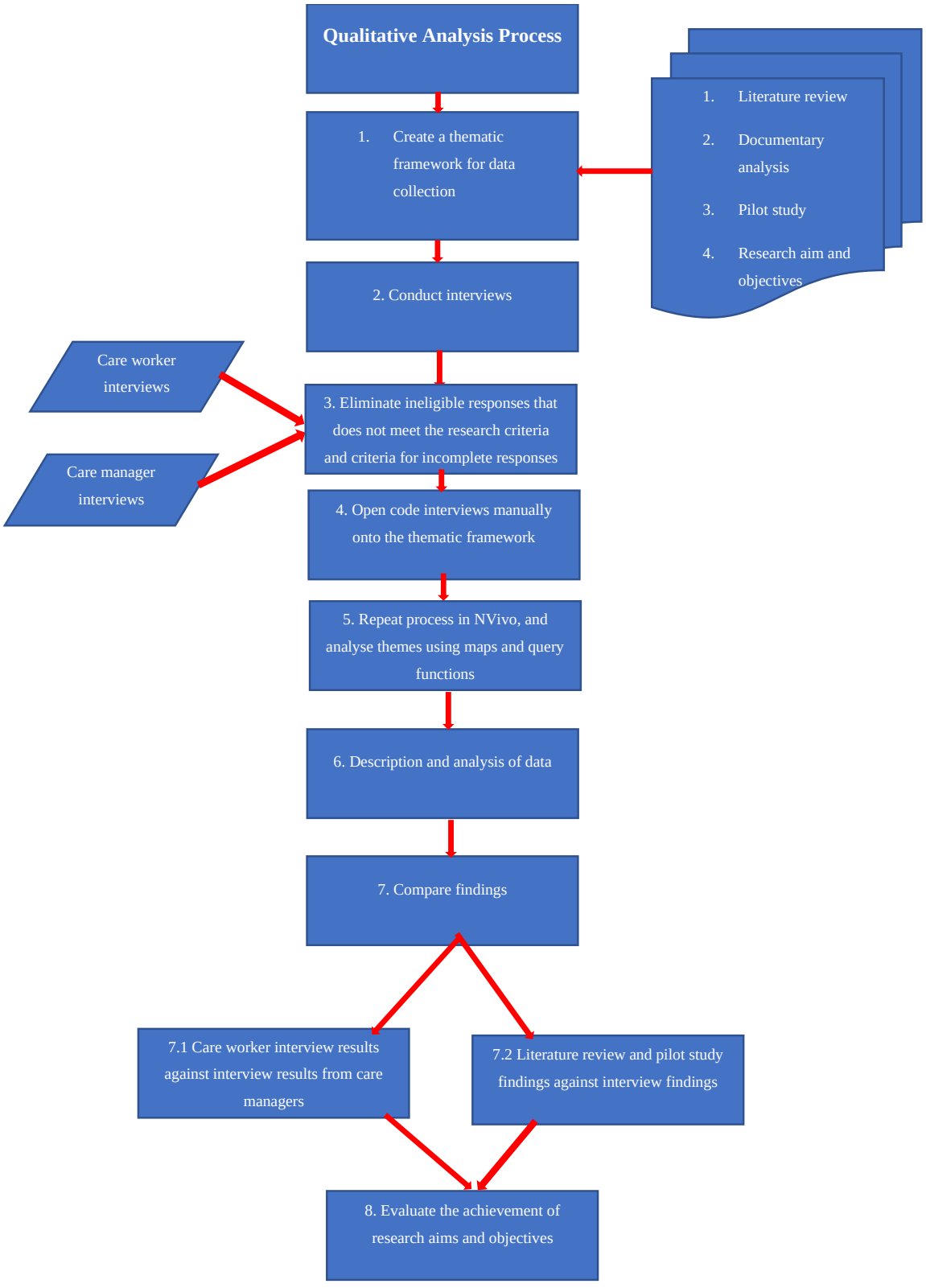


Figure 27: Qualitative data analysis process

To ensure that the data collected from the interviews would lead to the achievement of research objectives and to guide the data analysis process, a thematic framework was developed for data collection (Biggam, 2018). Themes were based on research objectives, research gaps arising from the literature review, and the views, behaviours and experiences put forward by the pilot study.

Braun and Clarke (2014, p.26152) argue that the developing and analysis of themes is a useful approach *"for those doing more applied research… or when doing research that steps outside of academia, such as into the policy or practice arenas"*. Thus, the use of themes for data analysis have been a common approach adopted by researchers in qualitative studies to research the National Living Wage policy (Adascalitei et al., 2019; Moore et al., 2017; Moriarty, Manthorpe and Harris, 2018; Walmsley et al., 2019). The exploratory nature of the research topic allows the views and experiences of the participants to be analysed into themes in relation to the research aim (Ozuem, Willis and Howell, 2022).

In this research, the views and experiences of the participants have been coded and summarised into themes within the context of the research objectives. Analysis of these themes acted as a tool to achieve the research objectives by highlighting common patterns, similarities and differences on how the National Living Wage policy have impacted the professional and personal lives of workers (Braun and Clarke, 2021a). The thematic framework helped to develop an understanding of the lived experiences of the National Living Wage policy in the social care sector by structuring the data and making the analysis process more transparent (Nowell et al., 2017).

Figure 28 below shows a mind map of the themes developed for care worker interviews.

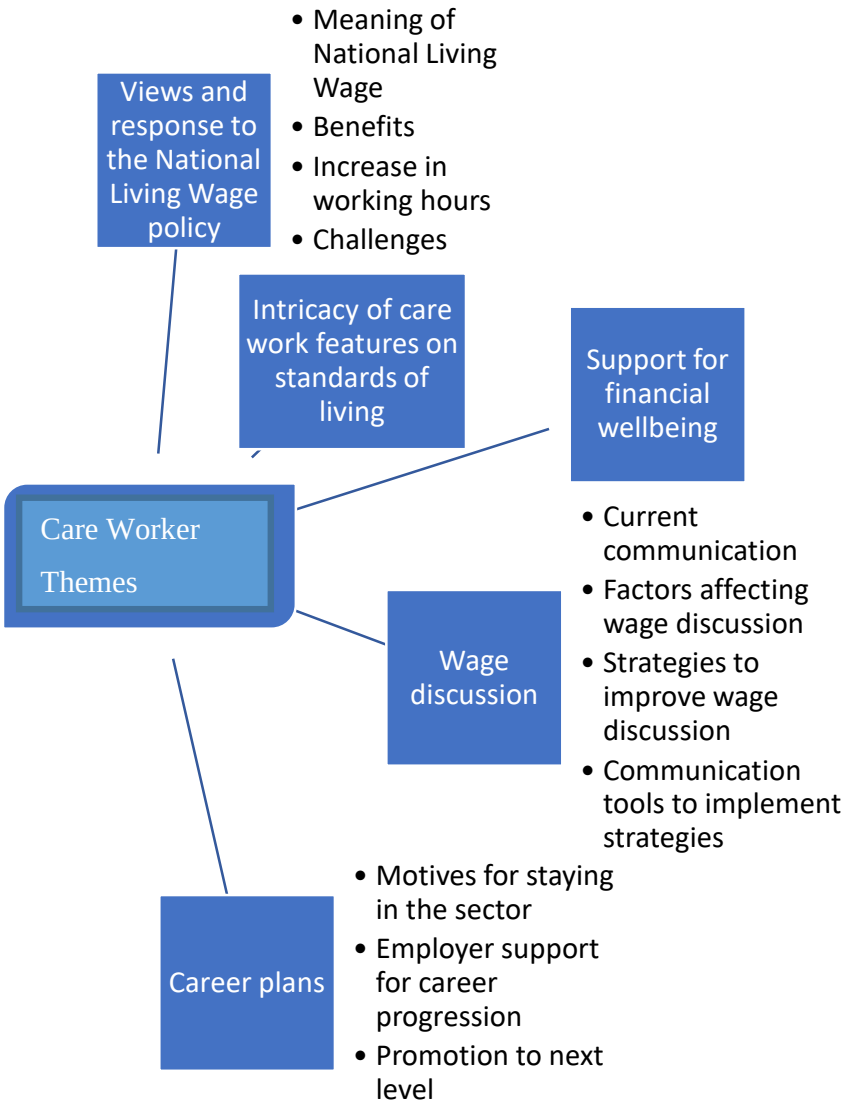


Figure 28: Mind map of themes for care workers

The first theme included questions attempting to identify how care workers perceive the National Living Wage and the benefits and challenges brought by the National Living Wage to their work and life. This theme also discussed sector specific workplace issues that need to be addressed so that care workers could cope with the increase in working hours brought by the National Living Wage policy. The second theme explored whether the intricate features of care work such as zero-hour contracts and travel time contribute to underpayments in the National Living Wage or impact care worker interaction with benefits. The third theme investigated the available employer support for financial wellbeing. The fourth theme probed into aspects of wage discussion with employers including factors that might encourage or prevent employees from discussing wages, possible strategies to improve wage discussion and whether these strategies can be implemented via the current mediums used to discuss pay and benefits. The questions in the final theme captured important elements related to career plans of care workers. This theme covered subjects such as motives for staying in the sector, career progression goals, employer support for career progression and promotion to next level.

Figure 29 below shows a mind map of the themes developed for care manager interviews. The first theme analysed the perceived meaning, benefits, and challenges of National Living Wage from a care manager's perspective. In addition, managers were also questioned about the strategies that they have employed to overcome the challenges brought by the National Living Wage, current support from Local Authorities and additional support that Local Authorities could provide to manage National Living Wage upratings. The second theme examined the prevalent contract types in the sector, and managers were asked about the most suitable contract type based on current circumstances. The third theme explored the support for financial wellbeing available to staff. Finally, the fourth theme, explored the concept of wage discussion in terms of current communication taking place in the workplace, communication regarding changes, strategies to improve wage discussion and whether these strategies can be implemented through the current mediums used to discuss pay and benefits.

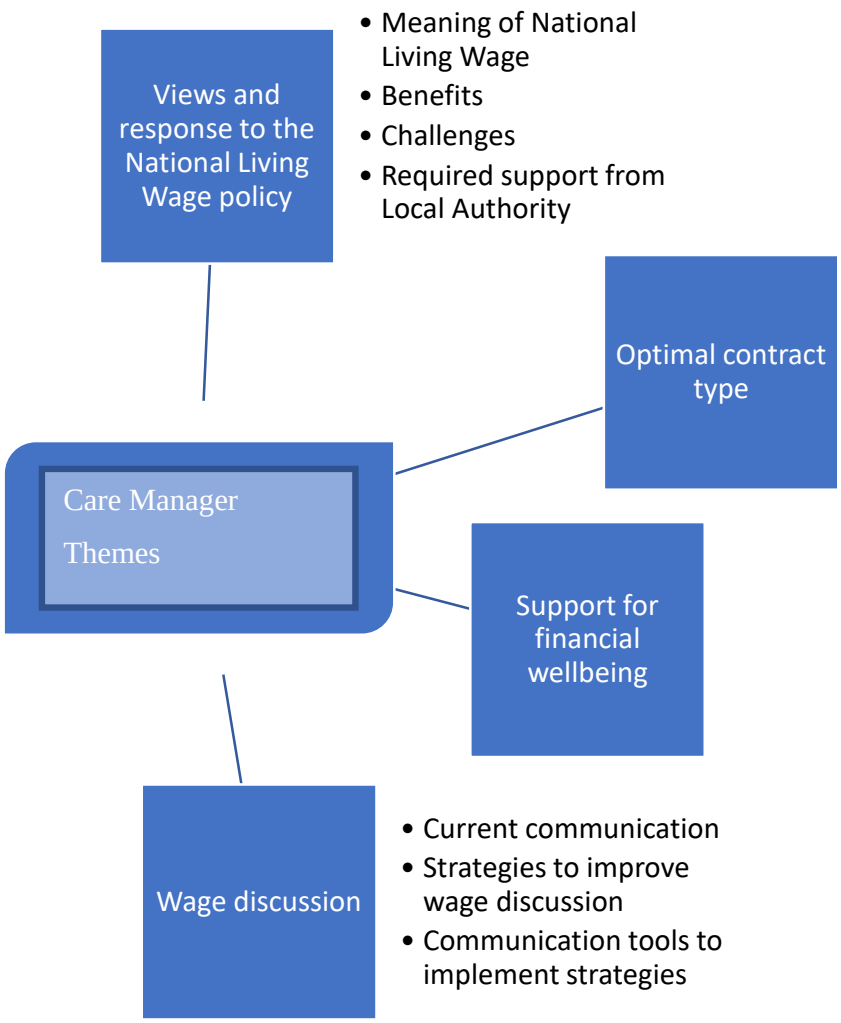


Figure 29: Mind map of themes for care managers

After data were collected according to the themes and ineligible responses eliminated, the first three transcripts were coded generating a list of codes. Braun and Clarke (2013, p.207) defines a code as

"a word or brief phrase that captures the essence of why you think a particular bit of data may be useful" (Braun and Clarke, 2013, p.207).

Coding was undertaken with paper copies of the transcripts, highlighting important sections of text, and allocating a word or short phrase that captures its overall meaning (Bryman, 2016). Every single sentence was not coded, but only sentences and important points focusing on participant's perceptions, experiences, observations, and assumptions that would help answer the research gaps. This open-ended approach to coding is known as initial coding (Saldana, 2015).

As shown in

Table *9* below, a table was created for each of the themes. The list of codes generated by the first three transcripts were entered. A short definition for the code was entered in the next column to ensure that meanings of the codes could be verified and evaluated before allocating any data to the code (Saldana, 2015). Further transcripts were read, and relevant statements were highlighted and allocated to the existing codes. In instances where important statements were not captured by existing codes, a new code was created, and its definition entered into the table (Saldana, 2015). After the coding of each interview, the answers were re-read to ensure that all data valuable to the research objectives have been highlighted and coded. Whilst analysing each answer, the specific code representing the answer was identified in the excel table and the interview number entered next to the code description. The code was further examined to ensure that name of the code reflect the actual data.

Once all the transcripts were coded manually, all transcripts were imported, and the relevant themes and codes were created in NVivo. Each transcript was carefully read again, and the coding framework applied accordingly in NVivo. Repeating the coding process in NVivo assisted to further revise the names of the codes to ensure that the codes reflected the overall meanings and concepts elicited by the data. Any codes with the same meanings were merged together (Miles, Huberman and Saldana, 2019). Analysing the themes and codes using the

project map feature in NVivo helped to ensure that all codes were matched with the correct theme, and necessary interchanges were made (Braun and Clarke, 2021a).

NVivo was used to search for segments of data which represented codes within themes. NVivo rapidly searches through all transcripts to display all the extracts that have been linked to a particular code on the screen (Bryman, 2016). Having all the quotes related to the relevant code compiled in one place allowed for detailed focusing on each of the codes individually. The main objective was to interpret and make sense of the codes to identify the most articulate and powerful examples representing the code. These examples of data were entered as quotations in the last column as shown in

Table 9 under “memorable quotes”. The interview number and page number of the transcript is mentioned next to the quotation to indicate from where the extract comes from. Where applicable, the word “Email” replaces the page number indicating that the quotation was extracted from an email sent by the participant post interview to explain their answers in more detail. These tables helped to identify the patterns and discrepancies between interviews across the codes within the theme.

2. Challenges of NLW policy for Private social care sector			
Abbreviations: CM= Care Manager, P= Page Number, NLW= National Living Wage			
Code	**Code Description**	**Interview Number**	**Memorable Quote**
4. Funding Vs Wages	Funding provided by Local Authorities not covering the NLW increments	CM1, CM4	"Rates paid by local authorities for care do not support adequate staffing levels…staff renumeration costs higher but funding not supporting." (CM1, P2)
14. NLW covered by Local Authority	The Local Authority uplifts the fees to exactly cover the NLW increment costs	CM2	"The uplift almost exactly covers the NLW on cost, so no impact." (CM2, P2)
24. Difficulty to maintain wage differentials	A challenge to maintain the pay difference between junior and senior level staff	CM5, CM3	"Almost seems out of reach, we struggle to ensure everyone has the best wage possible, but we also need to be mindful that the increment must be shown in other staff wages i.e., Junior staff on Living wage, Team Leader should have an increased incentive / reward." (CM5, P2) "We have agreed with the local authority to commit to pay staff at least the Real Living Wage (currently £9.70) by April 2023, this was implemented from October 1st ,2021. The local authority has incrementally increased their payments to us. However, this doesn't cover the full cost of the wage increases when ALL staff

			wages have to increase not just those currently on minimum wage in order to remain fair and reflecting the different roles and responsibilities of staff within the Home." (CM3, Email)

Table 9: Brief extract of codes derived from interviews.

An example of how the interviews have been open coded to each theme. A brief description is provided next to each code to ensure that meanings of the codes could be verified before allocating any data (Saldana, 2015). This is followed by the interview numbers and the most powerful examples representing the code.

The codes derived from the care worker interviews were then described in detail, whilst attempting to analyse the overall findings representing the theme. Codes derived for the theme from care managers were then discussed and then compared against findings from care workers. The following matrix coding queries were run using NVivo to identify if participant characteristics and circumstances influenced their experience.

1. All care workers who mentioned that their earnings improved were compared against location, working hours, whether they were paid travel time and their codes about financial wellbeing offered by employers.
2. The code "a lot of overtime" was compared with workers who were paid and not paid travel time. The purpose was to identify if people were working overtime to compensate for the fact that they were not paid travel time.
3. All the codes that came under "challenges of the National Living Wage policy" were compared with care workers who were paid and not paid travel time. The purpose was to analyse whether workers who were not paid travel time faced more challenges as opposed to workers who were paid travel time.
4. Travel time (paid, unpaid, and not applicable) was compared with location, working hours, and whether they were claiming Universal Credit to identify any patterns.
5. Universal Credit (claiming or not claiming) was compared with location, working hours, whether they were paid travel time to identify any patterns.
6. All the codes that came under "challenges of the National Living Wage policy" were compared with location, working hours, whether they were paid travel time, and whether the care worker was claiming universal credit to check if any group with a particular characteristic was disadvantaged.

These findings were then synthesised with the findings from the literature review and pilot study, in doing so addressing the research objectives (Biggam, 2018).

2.4 Implications of Using NVivo to Enhance Data Analysis

When coupled with traditional mediums of data analysis such as coloured highlighters, papers and sticky notes, NVivo is a useful tool for data management which provides

triangulation by acting as an additional method of data interaction (Maher et al., 2018). NVivo enhanced the transparency of the data analysis process by creating an audit trail of the decisions made. The accurate and quick data retrieval process of the software allowed for visualisation of the data (using the project map feature) and ask questions from the data in the form of queries building confidence in the conclusions drawn (Houghton et al., 2017).

The matrix coding function helped to analyse the viewpoints of specific groups in open ended responses which aided to understand why the responses of certain groups were distinctive (Feng and Behar-Horenstein, 2019). For example, as opposed to the majority, some care workers did agree that the National Living Wage have increased their weekly earning and their affordability has improved, albeit slightly. Upon running a matrix coding query using NVivo, it was identified that these specific care workers were paid for travel time where applicable, worked full time on fixed hours and described their employer support for financial wellbeing positively. Table 10 below describes how NVivo has improved and contributed to the data analysis process in this research.

The role of NVivo functions in enhancing data analysis	
NVivo Function	**Contribution to Data Analysis in this Research**
Case Classifications	In NVivo, case classifications are a set of attributes (for example, gender, location, employment status) allocated to each participant. Case classifications were used to analyse individual attributes of participants by running queries to understand whether a particular characteristic of the participant, for example location, influenced their experience of the National Living Wage policy.
Nodes	A node is a reference given to sections of coded text. Whilst allocating a node, a description was written for each node which helped to maintain consistency in data allocation. With a simple click on the node, NVivo presented all the extracts which have been allocated to that node. Next, all the extracts were read and contrasted against its allocated node to ensure that the data reflected the description of the node. Having all the extracts in one place allowed a deeper understanding of the nodes and this feature was used to select the most articulate and powerful examples representing the node for the write-up. Nodes were eventually organised into themes.
Project Map	Visual representations of all the codes allocated to each group (care workers and care managers) for a particular theme were created using the project map feature. When writing up the findings, these visual representations (figures 18 to 19 and figures 25 to 28) were used to identify similarities and differences in viewpoints between the two groups. The visual representations were also used to

	identify if all the codes reflected the theme they were allocated to. Necessary interchanges were made when required.
Matrix Coding Query	Queries were used to confirm if participant characteristics and circumstances influenced their experience of the National Living Wage policy. When a query was run in NVivo, it displayed all the data that met the criteria of the query. The matrix coding function was used to question the data to compare nodes with participant attributes and different attributes amongst participants. For example, all the nodes that came under "challenges of the National Living Wage policy" were compared with location, working hours, whether they were paid travel time, and whether the care worker was claiming universal credit to check if any group with a particular characteristic was disadvantaged.

Table 10: The role of NVivo functions in enhancing data analysis.

This table lists the specific functions of NVivo that aided the data analysis process in this research. A brief explanation is provided next to each function on how it has been applied in the data analysis process to improve rigour.

2.5 Views and Response to the NLW Policy

As labour costs make up over half the expenses in social care (Bottery, 2020; Competition and Markets Authority, 2017), and around a half (46%) of care workers in the independent sector being paid below the National Living Wage in March 2022 (Skills for Care, 2022), the social care sector is highly vulnerable to the consequent upratings of the National Living Wage. Unsurprisingly, the adult social care sector was described as one of the *"most vocal"* in expressing concerns regarding the introduction of the National Living Wage (Low Pay Commission, 2016, p. xviii). In this regard, it is crucial to bring forward the lived experiences of the sector in fulfilling the National Living Wage policy.

This section presents the benefits and challenges the participant's experienced working under the conditions imposed by the policy and strategies employed to overcome these challenges. The section also covers the current support provided by Local Authorities to care organisations and how this could be improved.

Meaning of National Living Wage

Despite the scale of the increases, a high percentage of care workers rated the National Living Wage negatively in the pilot study. The pilot study identified the need to explore why such a high percentage of participants held a negative view regarding a policy designed to support them. Therefore, participants were asked to describe the meaning they ascribed to the policy by responding to the question "What does the National Living Wage mean to you?".

Many care workers described their view on the National Living Wage in context to the struggles they faced in acquiring 'necessities'. Care workers expressed worries about their capacity to pay bills, always having to work overtime which consequently impacted their ability to have a social life. This is worrying as research by the Living Wage Foundation (2020) imply that low paid workers experience adverse effects on their physical and mental health due to everyday stresses that come with the struggle to afford food and general household bills.

"Still struggling to pay bills, don't really have a life outside of work always need to do extra hours to cover bills" (CW18)

"You get a national minimum wage in what kind of you job you do and what age you are, but it isn't enough to live on" (CW1)

Whilst some care workers raised concerns regarding the affordability of necessities with the National Living Wage, other care workers described the National Living Wage as a wage which allows you to afford necessities. Care managers echoed this view of care workers when asked what the National Living Wage meant to them. Care managers noted that the National Living Wage should conform to an acceptable standard where people can cover basic living expenses.

"A wage you can live on a reasonable standard…can pay bills and stop adding to debt" (CW9)

One care worker even indicated that she was able to put away some savings after covering the cost of essentials. The difference in opinions amongst care workers might be due to the difference in individual circumstances such as the cost of living in their location (Brown, 2017) or other factors such as having dependents (Office for National Statistics, 2022d).

"Being able to afford basic necessities and the ability to put some money away each month." (CW14)

Instead of describing the National Living Wage in a positive or negative light, some care workers questioned the suitability of the National Living Wage for the work they do. When asked what the National Living Wage meant to her, one care worker curtly responded:

"Least wages for people who do not have a qualification" (CW5)

Clearly for this care worker, the National Living Wage should be an amount allocated to the lowest job roles which requires no training or qualifications. Care workers expressed dissatisfaction with the lack of recognition for the specialised training and skills required to become a care worker.

"I don't think we are recognised enough and [people] think that anyone can do our jobs. We are in training all the time and still have to know a lot of things about the body etc and nurses trying and get us to do their jobs in the field which we recognise but not allowed to do. Due to this [and] with ongoing training I think we should be paid more and for our milage too" (CW16)

One care worker highlighted the mentally and physically demanding situations a care worker could face when caring for vulnerable adults.

"...but the tough job I do should be paid more, as I have been bitten, kicked, smacked on several occasions" (CW17)

Like care workers, care managers criticised the approach of the National Living Wage being a one size fits all figure. They expressed concerns towards the assumption that the National Living Wage would be suitable to all types of workers.

"The NLW is a one size fits all figure plucked from thin air..."(CM2)

"That care staff are still not paid what they are worth." (CM6)

Figure 30 below depicts the meanings of National Living Wage as summarised by care workers and care managers. Whilst care workers conveyed mixed opinions regarding the suitability of the National Living Wage to afford basic living essentials, care managers suggested that the National Living Wage meant a decent wage that should cover general living expenses. It has been shown that the struggle to afford food and general household bills impacts negatively on the physical and mental health of low paid workers (Living Wage Foundation, 2020). The difference in opinions amongst care workers might be due to the difference in individual circumstances such as the cost of living in their location (Brown, 2017) or other factors such as having dependents (Office for National Statistics, 2022d). Nevertheless, both groups questioned the appropriateness of the National Living Wage to care workers considering their training, role, and workload.

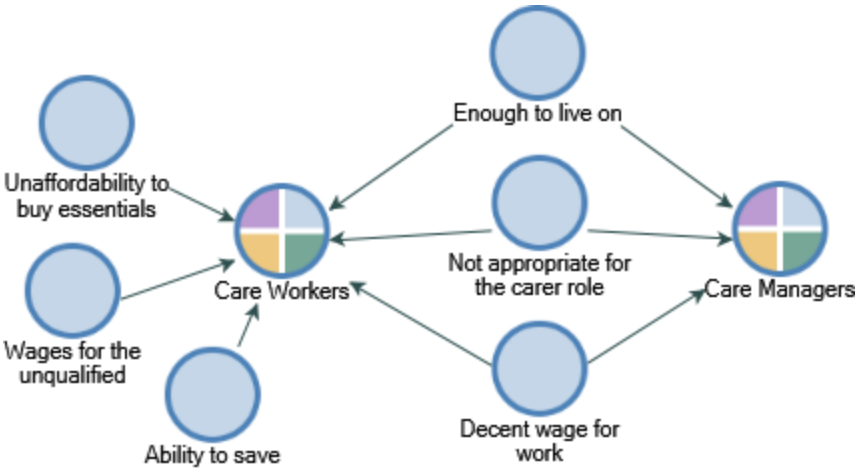


Figure 30: Meaning of National Living Wage as summarised by care workers and care managers

A better pay than the National Living Wage is necessary to reflect the skilled and demanding nature of care work. It is also important to make the sector more sustainable and attractive to new workers. These views have been reflected in the most recent yearly statistics published by Skills for care (2022). The number of vacancies has been skyrocketing but there are fewer people to replace them. Employers have not been able to recruit and retain staff, resulting in the number of vacancies to increase by 52% in the year 2021/2022 (55,000 to 165,000 vacant posts). The starter rate has also fallen from 37.3% in 2018/19 to 30.8% in 2021/22.

Müller (2019) suggested proposing changes to existing pay and grading schemes to reflect the pay and grading used in similar male dominated sectors and challenging the value society places on care work in general to address the low pay associated with female dominated sectors. The coronavirus pandemic has put social care on the forth of attention and some of the strategies suggested by Müller (2019) are being initiated by relevant organisations representing social care in the UK (Department of Health and Social Care, 2020b; UK Parliament, 2020). On 8 September 2020, in the Health and Social Care Committee meeting held at the House of Commons, president of the Association of Directors of Adult Social Services (ADASS) James Bullion called for a national care wage of £10.90 an hour, linked to a band 3 NHS healthcare assistant (UK Parliament, 2020). However, these initiatives are yet to be put into any sort of action. Gardiner and Hussein (2015) argued that although the cost implications to increase wages for all frontline care jobs in the UK would be significant, 47

percent of the costs would be refunded to the public purse in the form of income tax and a reduction in benefit spending. They further suggested that raising pay could lead to improved service delivery leading to further cost savings in terms of wider social and economic benefits.

Benefits of NLW policy for the private adult social care sector

The conservative government introduced the National Living Wage on 1st April 2016 to economically benefit low paid workers with the aim of reducing the dependence on benefits for the topping up of wages, and ensuring that work pays (Department for Business, Energy and Industrial Strategy, 2016). However, care workers reported not experiencing any benefits from the National Living Wage due to the amount being insufficient to fulfil a basic standard of living where workers can afford essentials.

"Still struggle to afford since everything is going up in price. They are no benefits as I don't think it is enough." (CW1)

Unlike the assumptions of the government which positioned the National Living Wage at the forefront to all solutions related to low wage and high welfare (Department for Business, Energy and Industrial Strategy, 2016), many care workers who took part in this study highlighted the constant need to rely on family and benefits to top up wages despite the upratings of the National Living Wage.

"No, I have to rely on benefits to top my wages" (CW6)

The inadequacy of the National Living Wage was often attributed to the increase in cost of living making the increases in National living Wage less prominent. The median hourly rate for care workers decreased in real terms by 1.5% between March 2021 and March 2022 (Skills for Care, 2022). This decrease was a result of the global energy crisis and unexpected recovery in demand following the coronavirus pandemic (CNN, 2022) which sent inflation levels rising through the roof from 0.7% in March 2021 to a staggering 7% in March 2022 (Office for National Statistics, 2022b). By October 2022, the inflation level has increased to 11.1% which is the highest ever recorded since the national statistic series began in 1997. Unsurprisingly, gas and electricity prices made the largest contribution to this figure

followed by rising food prices (Office for National Statistics, 2022b). The impact of these statistics has been reflected in the experiences described by care workers.

No benefit for me due to the high impact of the household bills going up...sometimes not having the money to fill the car up due to the challenges we have with petrol going up and also house bills (CW16)

Nevertheless, some care workers did agree that the National Living Wage have increased their weekly earning, and their affordability has improved albeit slightly. Upon running a matrix coding query using NVivo, it was identified that these specific care workers were paid for travel time where applicable, worked full time on fixed hours and described their employer support for financial wellbeing positively, thus further indicating that personal circumstances influenced their view on the National Living Wage (Brown, 2017; Office for National Statistics, 2022d).

"There is only a slight benefit in that we can afford a bit more however still not enough to run a home especially with the cost of living going up" (CW13)

The continuous uprating's in National Living Wage might devalue the skilled care worker role, as care workers who were earning above the National Living Wage due to their skilled role are now paid the same rate as the National Living Wage. When asked how the National Living Wage has benefitted her, one care worker replied:

"No, my pay already met the NLW, so my pay did not alter." (CW19)

Care managers described the benefits of National Living Wage from a corporate point of view in contrast to care workers who expressed their views from a personal point. Most care managers did not experience any particular benefit of the National Living Wage as all competitors (from both within and outside the sector) were paying the National Living Wage as well to comply with the government legislation. In some instances, the National Living Wage tend to be particularly helpful depending on the geography of the care home. In urban regions the costs of living, especially housing tends to be higher than rural areas. Brown (2017) argues that the national figures conceal the disproportionate impact of the National Living Wage in different sectors and regions. Six regions had bites already over 60% by the

end of 2016. The bite was over 70% in very small firms and around 90% in low paying sectors. Hence, a care worker earning the National Living Wage in rural areas usually have a higher spending power than a care worker earning the National Living Wage in an urban area. Here, a care manager from the least densely populated region of Southwest England (Office for National Statistics, 2022e) describes how the National Living Wage is considered a good example in their location and motivates people to work.

"Good example to set in our location and also better incentive for people to work here." (CM5)

Figure 31 below portrays the care sector's views on the benefits of the National Living Wage. In theory, the National Living Wage has improved the weekly earnings of care workers, thus, should improve their affordability to buy essentials. However, the benefits of National Living Wage has been overshadowed by crippling inflation aggravated by the global energy crisis (CNN, 2022; Office for National Statistics, 2022b). Many care workers have had to rely on other means to top up their wages such as depending on family or benefits. This contrasts with the government's main aim of introducing the National Living Wage which is to reduce the reliance on the benefits system to top up wages whilst ensuring that work pays (Department for Business, Energy and Industrial Strategy, 2016). Care workers who were previously paid above the National Living Wage due to the skilled nature of their role are now being paid the lowest rate that is legally possible.

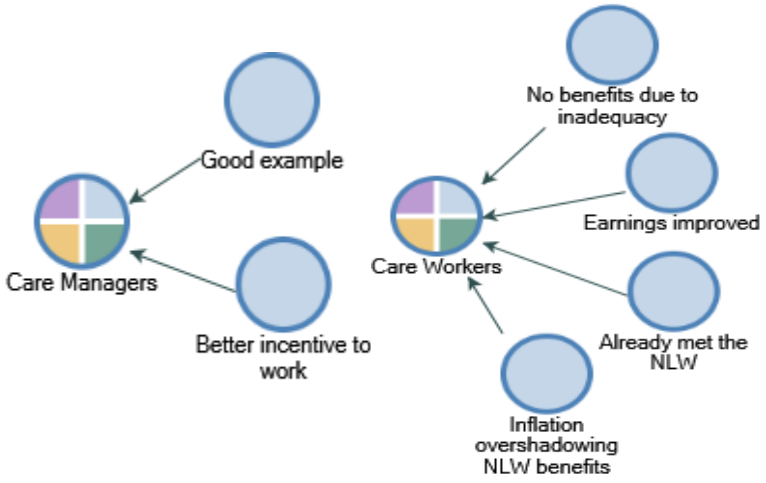


Figure 31: Perceptions on benefits of the National Living Wage by the social care sector

From a corporate point of view, care managers expressed a similar concern that the National Living Wage on its own does not provide a competitive advantage as competitors from within and outside the sector are paying the same rate. Nevertheless, the National Living Wage tends to hold more value in less densely populated areas such as the Southwest of England where cost of living is cheaper (Brown, 2017; Office for National Statistics, 2022e). This variation has been identified in the literature which explains the disproportionate impact of the National Living Wage in different sectors and regions (Brown, 2017).

Increase in Working Hours

Quantitative research on the sector suggest that the National Living Wage policy positively impacts the number of hours worked (Gardiner, 2016; Giuponni et al., 2016). This is worrying as in the pilot study, the majority of care workers rated that they would feel negative if their working hours increased. This might be due to the fact that care workers are already managing a high workload under stressful situations (Moore et al., 2017). Therefore, care workers were asked about the biggest challenges in their workplace. The aim was to identify workplace issues that the sector must address so that care workers could cope with the increase in working hours brought by the National Living Wage.

The biggest work-related obstacle for care workers was managing without enough staff, consequently leading to increase in workloads. National Living Wage has prompted an increase in the usage of zero-hour contracts which makes it easier for employers to amend employment terms to increase labour efficiency and workload (Moore et al., 2017; Vadean and Allan, 2020). Care workers complained that although workload expectations have increased, they are not paid for performing extra tasks to cover up for the staff shortage.

"Crisis in Staffing levels. More jobs to do despite not be paid for them" (CW3)

Demands in workload could take various forms. For example, care workers reported an increase in the paperwork that needed to be completed, frequent role changes, dealing with challenging service users and their partners without proper support, and having to work too much over time. The situation is made worse when there is limited assistance from colleagues and managers.

"Increased workloads and less help. Even manager doesn't want to help out" (CW19)

Care workers scrambled to complete all the tasks for each client, but still may end up being short-changed for time. Local Authorities often do not take the unique situations a care worker could face into consideration such as visits might run late due to an emergency faced by a service user, and not accounting to traffic and other unforeseen circumstances (Moore and Hayes, 2018). At times, councils also commission 15- minute visits which is notorious for being unrealistic and stressful for both service users and care workers. There has been cases of unrealistic number of scheduled visits to increase productivity or insufficient time allocated for travel (Moore and Hayes, 2018).

"Trying to fit all the clients in and not having enough time" (CW16)

Although quantitative research on the sector suggest that the National Living Wage policy positively impacts the number of hours worked (Gardiner, 2016; Giuponni et al., 2016), the majority of care workers in the pilot study rated that they would feel negative if their working hours increased. Sector specific workplace issues need to be addressed so that care workers could cope with the increase in working hours brought by the National Living Wage. Figure 32 below conveys the biggest challenges faced by care workers in their workplace.

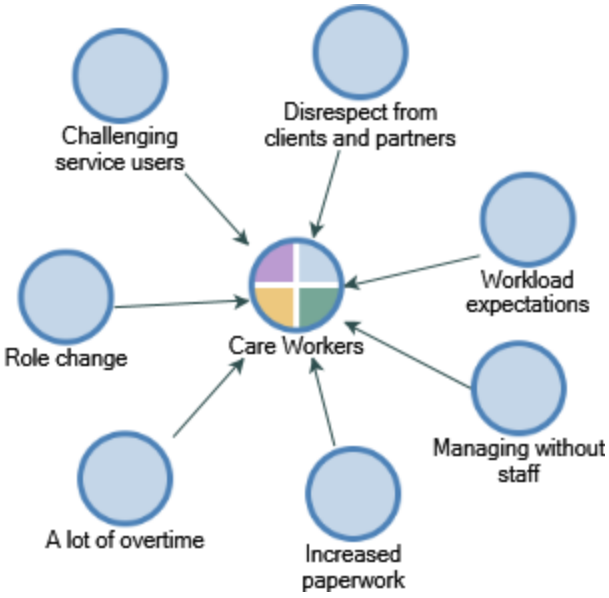


Figure 32:Biggest challenges in the workplace as described by care workers

Care workers reported the biggest workplace challenge as crisis in staffing levels leading to increased workloads. The situation has been exacerbated by the National Living Wage which has prompted an increase in the usage of zero-hour contracts which makes it easier for employers to amend employment terms to increase labour efficiency and workload (Moore et al., 2017; Vadean and Allan, 2020). Care workers described how they were expected to take on the extra workload to cover up for the staff shortage despite not being paid for them. They detailed various ways on how their workload has increased which they need to complete with limited assistance from colleagues and managers.

Care workers felt rushed to complete all the tasks for each client, but still may end up being short-changed for time. In addition, care workers could face unforeseen circumstances such as visits running late due to an emergency faced by a service user and traffic (Moore and Hayes, 2018). There has been cases of unrealistic number of scheduled visits such as 15-minute visits to increase productivity or insufficient time allocated for travel (Moore and Hayes, 2018). Thus, Local Authorities and care providers need to consider the unpredictable nature of care work when allocating staff workloads.

Challenges of NLW Policy for the Private Adult Social Care Sector

National Living Wage policy in the context of the care sector poses distinct challenges for care workers and care providers. It has been argued that the National Living Wage rate does not reflect the actual amount being paid to care workers and, in some instances, have amplified the poor working conditions already prominent in the sector (Hardy, 2016; Hussein, 2017a; Moore et al., 2017). The literature underlined the need for further research on how the sector will adjust to the austerity measures and the planned increases in National Living Wage (Giuponni et al., 2016; Vadean and Allan, 2020). Participants described the challenges they experienced, which helped to identify the adaptation strategies used by them in response to these challenges and how this impacted their day-to-day life.

When asked if they had faced any challenges due to the National Living Wage, care workers expressed disappointment in not being able to have any savings with the current National Living Wage.

"Hardly taking home enough money to have extra money" (CW10)

As evidenced by government statistics (Office for National Statistics, 2022d), the struggles of managing finances with the National Living Wage was particularly evident in care workers with dependents.

"Almost assumes you can live on that wage which is difficult with dependents" (CW2)

As outlined in the previous section, care workers had to manage these struggles by depending on family or benefits.

"I couldn't live working in a home doing 37 hours a week. I had a son at school... my mum gave him his dinner money and bus fare ... bought his uniform etc and paid for school trips because after bills I had no money left." (CW22)

One of the strategies to overcome these financial difficulties is controlling and budgeting of finances in a way that they can afford essentials. Spending had to be minimised in all areas and sometimes this could mean cutting back on essentials such as food, gas, and electric usage.

"Have to control my money then I can afford things such as gas, electric, food etc" (CW1)

Another strategy is to take on overtime to have an acceptable living standard. Working excessive hours by picking up overtime too frequently has disrupted the work-life balance of many care workers. Care workers reported feelings of exhaustion and not having any time for family or friends. They described how they were not benefitting despite working so many hours as their pay is spent towards paying bills and they were not able to enjoy life.

"Having to pick up overtime up to 5-6 shifts weekly just to pay the bills. Nothing positive I'm afraid…NO family /social life, exhaustion. Not receiving any benefits. Taxed very highly of overtime." (CW12)

Care managers were faced with a distinct set of challenges compared to care workers. Some Local Authorities provided increments in their payments with the increases in National

Living Wage. However, these increments often did not cover adequate staffing levels let alone the increases in National Living Wage.

"Rates paid by local authorities for care do not support adequate staffing levels…staff renumeration costs higher but funding not supporting." (CM1)

Only one care manager felt that they were not challenged by the National Living Wage as the uplift in their payment was the exact cost which they incurred due to the National Living Wage.

"The uplift almost exactly covers the NLW on cost, so no impact." (CM2)

Another challenge that care managers faced was to maintain the pay difference between junior and senior level staff. Walmsley *et al.,* (2019) highlighted concerns on the ability of smaller and more labour-intensive businesses to accommodate increases in the National Living Wage. Sudden changes to pay differentials were regarded as unfair, decreased employee morale, negatively impacted productivity (Walmsley et al., 2019) and there have been instances where experienced care staff moved to work in the NHS due to the decreasing pay gap (Moriarty, Manthorpe and Harris, 2018). In March 2016, care workers having a sector experience of greater than five years earned 33 pence (4.4%) more per hour on average than a care worker with less than one year of experience. Nevertheless, by March 2023, the experience pay gap had dwindled to just six pence (or 0.6%) per hour.

As the previous quotation indicated, although some Local Authorities provided increments reflecting the National Living Wage, these increments often did not fully cover the costs incurred or exactly covered the costs to increase all staff wages to the National Living Wage. There seemed to be a level of frustration in care managers with their inability to maintain a wage hierarchy reflecting the different responsibilities in job roles. Local Authorities need to take into consideration that increasing the wages of the lowest paid staff has a direct ripple effect on all other roles in the job hierarchy.

"Almost seems out of reach, we struggle to ensure everyone has the best wage possible but we also need to be mindful that the increment must be shown in other staff wages ie Junior staff on Living wage, Team Leader should have an increased incentive / reward." (CM5)

"We have agreed with the local authority to commit to pay staff at least the Real Living Wage (currently £9.70) by April 2023, this was implemented from October 1st, 2021. The local authority has incrementally increased their payments to us. However, this doesn't cover the full cost of the wage increases when ALL staff wages have to increase not just those currently on minimum wage in order to remain fair and reflecting the different roles and responsibilities of staff within the Home." (CM3)

Furthermore, care managers felt that the National Living Wage undermined and undervalued work in the care sector creating competition from within and outside the sector. The Covid-19 put some of these issues to the forefront prompting renewed calls for funding and reform (Shembavnekar, Allen and Idriss, 2021; Wild and Szczepura, 2021). Despite Covid-19 related deaths being significantly higher in the sector compared to other healthcare professionals (Office for National Statistics, 2021b), social care staff were often undervalued compared to NHS colleagues (Foster, 2020).

This feedback is reflected in the statistics by Skills for Care (2022) which concludes that, in general, when there are more jobs available in other sectors, fewer adult social care posts get filled. With the introduction of National Living Wage, pay in the retail sector and cleaning sector have been increasing faster than the social care sector. The less demanding nature of these sectors might make the social care sector less attractive for future and existing talent (Moriarty, Manthorpe and Harris, 2018; Skills for Care, 2020b). These are unwelcome trends as a relatively small change in staffing levels could impact the quality of the average care home impacting the health and standards of living amongst service users (Allan and Vadean, 2021a).

Care managers described the struggles they faced in dealing with competition from within the sector where all homes were paying the same pay to comply with regulation and especially from outside the sector where the pay is sometimes more than the National Living Wage.

"None - when supermarkets pay more for less work how can we compete?" (CM6)

They were worried that some of their most brilliant and amazing care staff were considering their career options in other sectors. Care managers wished that they could offer competitive wages at the same level as big corporate businesses with wider profit margins so that social care would be seen as a viable career to develop and progress. There was a feeling of helplessness of not being able to do anything as in the current economic climate care workers need to base their decisions on financial terms.

"There are no clear benefits as all homes (competitors) in the area also pay this rate, you can still earn more stacking shelves in Aldi than in a care home. The heart-breaking part is that some absolutely amazing care staff are now considering their career options when rates of pay are significantly higher in, for example, the hospitality and retail sector. Staff are no longer seeing Social Care as a career with opportunity to develop and progress. At the end of the day there isn't much I can say or do to when as an independent business we simply cannot compete with the wages offered by corporate companies and in the current climate personal decisions are based on financial terms." (CM3)

The monopsony wage models such as Card and Krueger's (1994) studies of fast-food restaurants suggest that a higher minimum wage has slightly positive (or zero) effects on employment and does not reduce non-wage benefits while labour costs are often passed on to customers. However, research in the social care sector suggest that the Card and Krueger's (1994) model could not completely be applied to the private social care sector as care home fees are paid by local authorities or social services and the fact that these fees are capped and does not increase with wage laws have the potential to intensify the effects of the minimum wage in this sector (Machin, Manning and Rahman, 2003; Machin and Wilson, 2004; Vadean and Allan, 2020).

Whilst this may be true to some extent, the care managers who participated in this research have responded to the National Living Wage challenges by increasing service user fees where possible and pushing for more private funded residents. Self-funders often paid a higher rate to subsidise the low rates paid by Local Authorities cushioning the negative financial impacts caused by the National Living Wage. Although not covered by the research on National Living Wage, wider literature on the sector report that that self-funders often

bridge the gap for the low fees paid by local authorities which is essential for care home survival (Baxter, Heavey and Birks, 2020; Hudson, 2019).

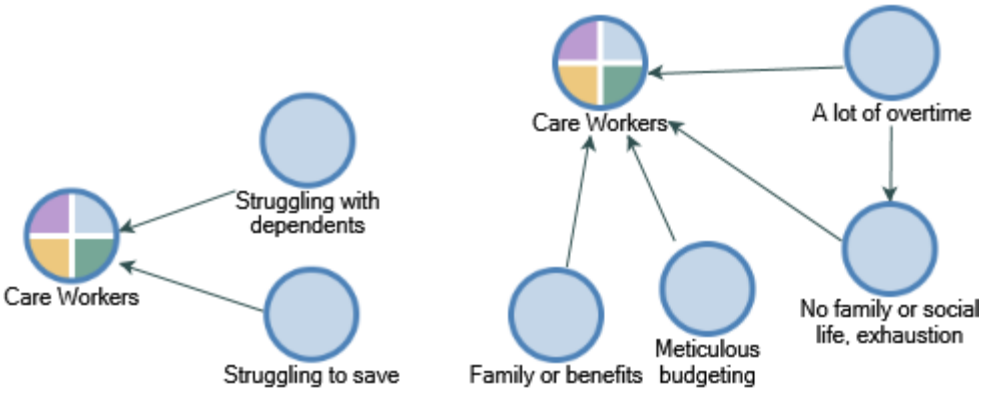
"Fee increases not meeting the wage rises. Top up fees have had to be introduced and self-funded residents paying more." (CM4)

All the codes that came under "challenges of the National Living Wage policy" were compared with location, working hours, whether they were paid travel time, and whether the care worker was claiming universal credit to check if any group with a particular characteristic was disadvantaged. No such patterns could be identified upon running a matrix coding query using NVivo.

Further research was needed to identify the care sector's adaptation to the austerity measures and the planned increases in National Living Wage (Giuponni et al., 2016; Vadean and Allan, 2020). Participants description of the challenges they experienced as described in

Figure *33* below, helped to identify the adaptation strategies used by them in response to these challenges and how this impacted their day-to-day life.

Care workers struggled with managing finances especially with dependents (Office for National Statistics, 2022d) and expressed disappointment in not being able to save with the current National Living Wage. Many care workers depended on family or benefits to top up their wages. Finances had to be meticulously budgeted and sometimes this could mean cutting back on essentials such as food, gas, and electric usage. A significant number of care workers worked overtime to compensate resulting in exhaustion from working excessive hours and disruption in work life balance.

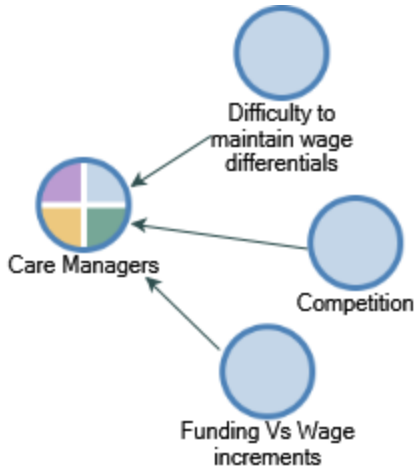


Challenges for Care Workers How Care Workers overcome challenges

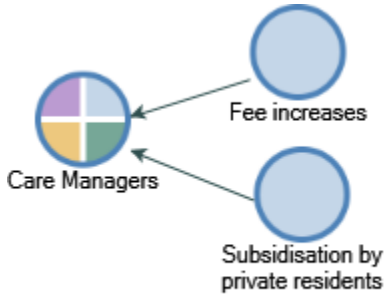
Figure 33: Challenges and overcoming them as conveyed by care workers

In contrast to care workers, care managers were presented with a unique set of challenges in their professional life rather than personal life.

Figure 34 below describes these challenges and the strategies used by care managers to overcome them. In instances where Local Authorities provided increments in their payments due to the National Living Wage, these increments often did not fully cover the costs incurred or exactly covered the costs to increase all staff wages to the National Living Wage. This left managers in a critical position where they struggled to maintain a wage hierarchy when the limited additional funding only covered the lowest paid staff. The sudden decrease in pay differentials which were regarded as unfair decreased employee morale, negatively impacted productivity (Walmsley et al., 2019) and there have been instances where experienced care staff moved to work in the NHS due to the decreasing pay gap (Moriarty, Manthorpe and Harris, 2018).



Challenges for Care Managers



How Care Managers overcome challenges

Figure 34: Challenges and overcoming them as conveyed by care managers

The Monopsony wage models such as Card and Krueger's (1994) imply that a higher minimum wage does not reduce non-wage benefits and additional labour costs are often passed on to customers. Although the literature concerned with studying the impact of the National Living Wage on the sector suggest that this could not completely be applied to the private social care sector (Machin, Manning and Rahman, 2003; Machin and Wilson, 2004; Vadean and Allan, 2020), care managers in this research have responded by increasing service user fees where possible and recruiting more private funded residents who subsidised the low rates paid by Local Authorities. Although not covered by the research on National Living Wage, wider literature on the sector report that that self-funders often bridge the gap for the low fees paid by local authorities (Baxter, Heavey and Birks, 2020; Hudson, 2019).

Local Authorities need to take into consideration that increasing the wages of the lowest paid staff has a direct ripple effect on all other roles in the job hierarchy. With the introduction of National Living Wage, pay in the retail sector and cleaning sector have been increasing faster than the social care sector (Moriarty, Manthorpe and Harris, 2018; Skills for Care, 2020b). The inability of care organisations to compete with corporate businesses having wider profit margins have left care workers wondering whether social care is a viable career option with opportunities to progress. For the sector to be more sustainable, better pay and conditions are

needed to attract the local workforce. As challenges in the care sector are directly correlated with the quality of the services provided (Allan and Vadean, 2021a), it is important to identify the required support from Local Authorities whilst considering the adaptation strategies that are already employed by the sector in light of the National Living Wage.

Required support from Local Authority

The National Living Wage has presented the social care sector with challenges such as difficulty in maintaining pay differentials and competition from retail and hospitality sectors offering similar paid less demanding jobs (Moriarty, Manthorpe and Harris, 2018; Skills for Care, 2020b). Hence, it would be important to find out what type of support works well for the care organisations and what additional support the Local Authority could provide to better manage the challenges put forth by the National Living Wage.

The Care Act 2014 places statutory duties on Local Authorities and care providing organisations to assist each other to support resident needs (*Care Act*, 2014). As challenges faced by care providers are directly correlated with quality of care provided (Allan and Vadean, 2021b), it is a legal obligation on the Local Authorities to support care organisations to manage the challenges caused by the continuous uprating of the National Living Wage. Nevertheless, many care managers felt abandoned and unsupported by their Local Authorities to manage the National Living Wage increments.

"None as far as I can see. The weekly fee paid by local authority wouldn't even pay our staff wages." (CM5)

Some of the managers reported an uplift in fees by their Local Authorities. It should be noted that this uplift may or may not cover the increase in National Living Wage and does not consider the additional cost required to maintain wage differentials.

"One LA has additional fees, but apart from that, zero support from any." (CM2)

Managers were asked for suggestions on additional support that their Local Authority could provide that would help them to overcome the challenges presented by the National Living

Wage. Most of the managers suggested a fair cost of care that would enable quality and sustainable care provision whilst allowing the provider to make reasonable profits.

"Pay a realistic fee rate that covers the cost of care." (CM4)

"A fair cost for care- and not the way they are currently going about it." (CM2)

Issues in the sector can be partly attributed to rising care costs and decreased funding over the years (Bottery and Babalola, 2020). The rising costs in social care services are caused by the increase in demand, demographic trends, and workforce costs (The King's Fund, 2019).

In April 2022, the government introduced the Health and Social Care Levy of which £5.4 billion were to be used to support adult social care reform in England from 2022-2025. This included £70 million to strengthen market shaping and commissioning and £3.6 billion to reform the social care charging system (Department of Health and Social Care, 2021d). Currently, self-funders pay a higher rate to subsidise the low rates paid by the local authorities ensuring care home survival (Baxter, Heavey and Birks, 2020; Hudson, 2019).

Reforming the social care charging system would be necessary to implement the Health and Care Act 2022 where self-funders can request their respective local authority to arrange care at the same rate paid by the local authority (*Health and Care Act*, 2022). It is only through paying a fair rate to providers that this change would be feasible (Department of Health and Social Care, 2021d; East Sussex County Council, 2022; Local Government Association, 2021). As a result, Local Authorities have been requesting providers for historic figures of care costs to capture the median cost of care provided in their location. It has been questioned whether the current cost of care provided under the current funding levels is necessarily the cost of good provision of care. Care managers criticised the one size fits all approach not reflecting the unique care needs of different service users.

"Increase funding one size does not fit all, a resident that needs full support of 2 staff and support with all aspects of adl should be funded higher than the resident with low level needs." (CM1)

Care managers suggested the median cost of care be based on specific service specifications instead of the historic cost of care provided.

"As usual, the local authorities want level 6 whilst funding at level 4. The fair cost for care could mitigate some of the impact, however in reality the way the government are assessing a fair cost for care is based off the median costs of the current provision of care- not the provision of good care. Providers have not been asked to put forward a required figure against a service spec, they have just been asked for historic figures. The confidence sector wide is near zero." (CM2)

Despite the Care Act 2014 placing a legal obligation on the Local Authorities to support care organisations, there was a lack of support by Local Authorities to manage the National Living Wage increments. Figure 35 describes the current support provided by Local Authorities as opposed to the required support by care providers. In some instances, support was provided in the form of an uplift in provider fees. Nevertheless, this uplift often did not cover the increase in National Living Wage and does not consider the additional cost required to maintain wage differentials. Managers suggested a fair cost of care could mitigate the financial burden imposed by the National Living Wage.

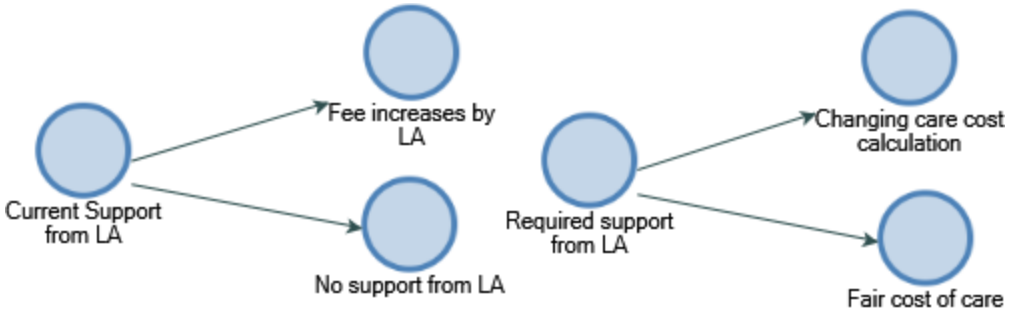


Figure 35: Current support provided by Local Authorities in comparison to the required support

To comply with the Health and Care Act 2022, the social care charging system needs to be reformed so that self-funders can request for care arrangements at the same rate paid by Local Authorities. £3.6 billion of the Health and Social Care Levy was allocated to reform the social care charging system (Department of Health and Social Care, 2021d). Consequently, Local Authorities have been requesting providers for historic figures of care

costs to capture the median cost of care provided in their location. However, Local Authorities need to change their current approach of assessing a fair cost of care based on the median cost of the current provision of care. A fair cost of care should reflect the unique care needs of different service users, by basing the median cost of care on specific service specifications instead of the historic cost of care provided.

2.6 Intricacy of Care Work Features on Standards of Living

It has been established that low paid workers in the care sector face even more hurdles to bring themselves and their families to a socially acceptable living standard due to intricate features of care work (Low Incomes Tax Reform Group, 2018). Care work characteristics such as non-payment of travel time and zero-hour contracts makes them vulnerable to confusions relating to minimum wage laws.

Eligibility for certain benefits such as Working Tax Credit (WTC) requires a minimum number of working hours (GOV.UK, No Date). As many care workers are not directly paid for travel time, this affects their eligibility to claim WTC as a significant amount of their working day is not counted as remunerative work. Furthermore, zero-hour contracts make working hours variable often taking working hours above and below the thresholds of claiming WTC leading to frequent starting and stopping of claims or overpayments (Low Incomes Tax Reform Group, 2018).

The government has now replaced the Working Tax Credit and five other benefits with Universal Credit to introduce greater fairness and simplicity. Instead of number of hours worked per week, claimants need to meet certain work search, preparation, and training requirements (Department of Work and Pensions, 2014). The Universal Credit account remains open even if you have surplus earnings from work and the claim will only be closed after six months of no Universal Credit payments (GOV.UK, No Date). Hence, this research attempted to understand whether the intricate features of care work such as zero-hour contracts and travel time present the same obstacles when claiming Universal Credit (as compared to Working Tax Credit).

Of the care workers who had experience in claiming Universal Credit, none of the care workers thought that care work features such as zero-hour contracts and travel time make it

more difficult to claim universal credit. These care workers were also compared with location, working hours, and whether they were paid travel time to identify any links between participant characteristics and claiming Universal Credit. No patterns could be identified upon running a matrix coding query using NVivo.

Care workers who received Universal Credit were diverse on whether they were on zero-hour contracts or paid travel time. Hence, the sub sample of care workers receiving Universal Credit were in a position to suggest if these particular features impacted a care worker's ability to claim Universal Credit. Table 11 below presents the composition of the work characteristics of the care workers who had experience in claiming Universal Credit.

Care Worker (CW) Interview Number	Zero-Hours Contract	Paid Travel Time	Type of Service
CW4	No	No	Domiciliary
CW6	Yes	Yes	Domiciliary
CW11	No	Not Applicable	Residential

Table 11: Work characteristics of the care workers receiving Universal Credit

A breakdown of the contract characteristics of care workers that were claiming Universal Credit. That is, whether they were on a zero-hours contract or received payment for travel time, and the type of care service they were providing. The diversity of these characteristics meant that these care workers were able to suggest if zero-hour contracts and travel time make it more difficult to claim universal credit.

The literature raised concerns that whilst most workers were paid above the National Living Wage, this did not reflect the full working time given to the employee and the increase in workload brought by employers by reducing staff numbers (Adascalitei et al., 2019; Moore et al., 2017). All care workers who participated in the research agreed that they were receiving the National Living Wage as an hourly rate. However, 63% (5 care workers) of the domiciliary care workers reported that they were not paid for the time spent on travelling between service user homes to provide care. Only 37% (3 care workers) reported that they were paid for the travel time.

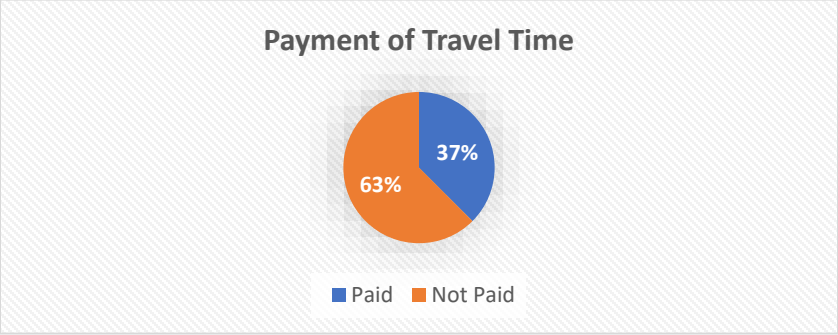


Figure 36: Payment of travel time amongst domiciliary care workers

It appears that the National Living Wage does not reflect the actual amount being paid to care workers. As a result of the non-payment for travel time, many domiciliary care workers are earning below the National Living Wage. Insufficient time allocated for travel not accounting to traffic and other unforeseen circumstances could significantly increase the unpaid working time of care workers (Moore and Hayes, 2018). In 2020, the tribunal ruled that three contractors appointed by Haringey Council in North London had paid some care staff less than half the minimum wage because of unpaid travel time. They were ordered to pay more than £100,000 in back pay to the ten-homecare staff involved (UNISON, 2020). The quotation below describes how unpayment of travel time could lead to excessive working hours for little pay.

"Worked 60 hours a week for 4 weeks. .... i ended up with £37 extra for an extra 139 hours!!! ...it's disgusting" (CW22)

The software NVivo was used to run the below matrix coding queries to analyse whether unpaid travel time caused any other detriments to care workers.

1. The code “a lot of overtime” was compared with workers who were paid and not paid travel time. The purpose was to identify if care workers who were not paid travel time were more likely to work overtime to compensate. No evidence of this was found.
2. All the codes that came under “challenges of the National Living Wage policy” were compared with care workers who were paid and not paid travel time. The purpose was to analyse whether workers who were not paid travel time faced more challenges as opposed to workers who were paid travel time. No evidence of this was found.
3. Travel time (paid, unpaid, and not applicable) was compared with location, working hours, and whether they were claiming Universal Credit to identify any patterns. No links could be identified between participant characteristics and travel time.

Unlike the benefits that were replaced by Universal Credit, care work features such as zero-hour contracts and travel time does not make it more difficult to claim universal credit. This is because in contrast to benefits such as the Working Tax Credit, Universal Credit does not depend on the number of hours worked and the Universal Credit account remains open until after six months of no Universal Credit payments (GOV.UK, No Date). Application of the number of hours worked as a condition of claiming is problematic to care workers as they spent a great deal of their working hours travelling which is often not counted as remunerative work. In addition, Zero-Hour Contracts could make working hours variable taking working hours above and below the thresholds of claiming certain benefits.

Although non-payment of travel time does not make it more difficult to claim Universal Credit, it makes care workers highly vulnerable to underpayments in National Living Wage. If a lot of their working hours are spent on time travelling between service user homes, care workers could end up working excessive hours which are paid well below the National Living Wage (Moore et al., 2017; UNISON, 2020). Insufficient time allocated for travel not accounting to traffic and other unforeseen circumstances could make the situation worse (Moore and Hayes, 2018). Hence, the National Living Wage should be considered as only one element of an anti-poverty strategy and should be complemented by better working

conditions and standards of living (Cooke and Lawton, 2008; Emmerson, Johnson and Miller, 2014; Gardiner and Millar, 2006; Swaffield et al., 2018).

2.7 Support for Financial Wellbeing

The literature indicated that many low paid workers are in receipt of working tax credits or some type of income support as they struggle to pay bills (Moore *et al.*, 2017b; Low Incomes Tax Reform Group, 2018). However, it was unclear if care workers were provided any support for financial wellbeing by their employers. Participants were asked to describe their employer's support for financial wellbeing. Many care workers reported that there was no support for financial wellbeing provided by their employers. One care worker depicted her experience of consistent miscalculations and being paid late by her employer.

"Crap I was always chasing my money. it was always wrong, or it was late" (CW22)

In some instances, employers provided subsidised meals or a travel bonus where the travel allowance was increased due to the increase in fuel prices. This is an appreciated relief for care workers as the global energy crisis and unexpected recovery in demand following the coronavirus pandemic has led to fuel prices soaring (CNN, 2022). Nevertheless, the increases in travel allowance still did not cover the actual increase in fuel prices. Some employers include travel costs in the pay making the reimbursement taxable. If reimbursed for actual costs, rates per business mile is often less than the amounts allocated by HMRC (Low Incomes Tax Reform Group, 2018) and the worker is left to claim the difference with HMRC to claim tax relief (GOV.UK, No Date). However, they are hindered from doing so due to the complexity of the process and the requirement to keep detailed records of all mileage and expenses.

"Employer is aware of travel pay and had up it due to the petrol increase but still doesn't cover what we pay out. We can claim back from the government but have never done so as it takes a lot of [effort] effect. as you have to get all the milage you have done in the last year, and then you are not guaranteed you we [will] get it back." (CW16)

If the workplace is temporary, which often happens in care work when covering for colleagues, a deduction is due under the Income Tax Act 2003 (HMRC, 2021a), but the

worker is not entitled to minimum wage for that time (ACAS, No Date). This differing treatment of home to work expenses under minimum wage and tax legislations may create confusions. In addition, the filling of the required P87 form requires identity verification through Government Gateway, to be filled online and there is no option to save a partly completed form. It is also not possible to navigate to different sections in advance to check exactly what information is needed (HMRC, 2019a).

A suitable solution would be to make it a legal requirement for all employers to cover travel expenses separately so that this amount would not be taxable in the first place. In cases where rates per business mile offered are less than the amounts allocated by HMRC, the employer should claim the difference with HMRC on behalf of employees. This would ensure that the digitally challenged or employees confused due to the complexity of the process would not be excluded from this valuable tax relief.

Some care workers felt the need to defend their employers by giving reasons on why their employer was not able to provide them financial support. They stressed that their employers were not able to offer financial support due to factors beyond their control whilst being critical on the care rates paid to the provider. The £7.5 billion funding announced by the government in November 2022 has been criticised as inadequate to meet the ongoing pressures faced by the sector. The Local Government Association has called for £13 billion and estimates that approximately £3 billion will be required to increase care worker pay (Local Government Association, 2023). Concerns were raised on their employer's ability to improve pay and working conditions on the current rates.

"They can't do anything because they can't with the pay. It needs rising."(CW1)

Managers seemed to have agreed with this view. When asked about the support for staff financial wellbeing, one manager firmly replied as follows.

"As good as it can be on LA rates." (CM2)

Care workers argued that care providers were providing any support they were capable of with the resources they have. They often referred to the size of the company to demonstrate that the firms do not have the capacity or resources to offer more support.

"They pay what they can sometimes they give an advance...The NLW is a joke. Don't consider with cost of living. My company a small company so can't afford to up the wages" (CW6)

Managers echoed this view as demonstrated by the below quotation.

"The owner is doing all he can by offering extra increases in wages where possible, he wishes he could do more." (CM3)

Only one care manager was satisfied with the financial support provided to staff.

"Pretty good, provide wellbeing package from Westfield health, allows for counselling on phone & in person plus cash repayments for dental, optical, consultant, complimentary therapies etc. Held Mindfulness training sessions." (CM5)

Despite having limited resources, employers had used some creative strategies to provide some sort of financial relief for their staff. Care workers had the option to work overtime if they wanted to earn more. In certain cases, the employer provided an advance amount repaid through the salary. However, care workers questioned the affordability of these salary loans as deductions from wages whilst already suffering financial hardships could lead to more arrears of essential expenses.

"We don't get it. we can [have] the option if we need to borrow from wage, but then if we do that then we would [not] have a wage left when it comes to pay day" (CW15)

Figure 37 below describes the various forms of financial support offered by care sector employers.

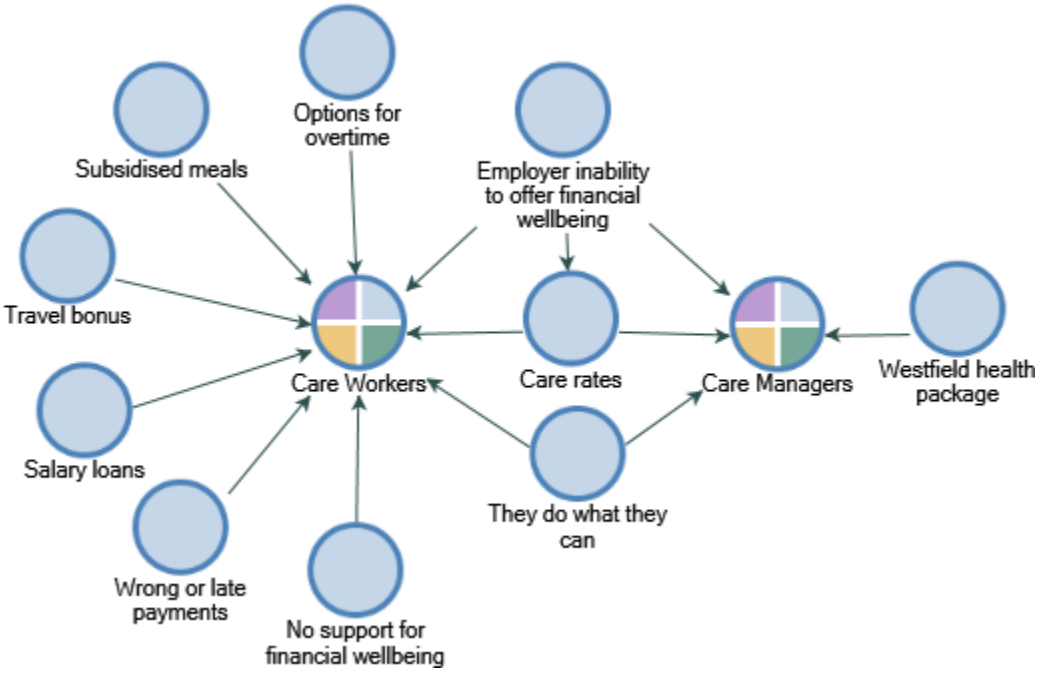


Figure 37: Forms of financial wellbeing support offered by care sector employers

Many care workers did not receive support for financial wellbeing by their employers. In some instances, employers provided subsidised meals or a travel bonus due to the increase in fuel prices. The increases in travel allowance still did not cover the actual increase in fuel prices. The literature highlighted similar concerns that some employers include travel costs in the pay making the reimbursement taxable. If reimbursed for actual costs, rates per business mile is often less than the amounts allocated by HMRC (Low Incomes Tax Reform Group, 2018) and the worker is left to claim the difference with HMRC to claim tax relief (GOV.UK, No Date).

Care workers reported being hesitant to claim travel expenses back from the government due to the complexity of the process and the requirement to keep detailed records. The differing treatment of home to work expenses under minimum wage and tax legislations may create

unnecessary confusions (HMRC, 2021a) and filling of the P87 form requires digital skills (HMRC, 2019a). A suitable solution would be to make it a legal requirement for all employers to cover travel expenses separately so that this amount would not be taxable in the first place. In cases where rates per business mile offered is less than the amounts allocated by HMRC, the employer should claim the difference with HMRC on behalf of employees. This would ensure that the digitally challenged or employees confused due to the complexity of the process would not be excluded from this valuable tax relief.

Expectations of support to financial wellbeing were low amongst care workers as they demonstrated an awareness of the low rates paid to the care providers. Care workers empathised with the capacity and resources of the small companies they work for. Despite limited resources, employers had used creative strategies such as the option to work overtime and salary loans. Nevertheless, deductions from wages whilst already suffering financial hardships could lead to further arrears and debt.

2.8 Wage Discussion

There is a strong perception that acceptance of poor pay is a prerequisite for working in the sector and workers who challenge the pay or working conditions are not suitable to work in the sector. These views were expressed by employers and workers were hesitant to discuss about pay as if there was an "implied level of unacceptability of discussing wages within the context of care work" (Hussein, 2017b: 1822).

Despite the stigma of wage discussion in the sector, the pilot study revealed that the care sector has a clear interest to shift to a culture where the topic of wages can be openly discussed with seniors. A significant 73% rated that it would be either "extremely helpful" or "somewhat helpful" to discuss wages with seniors (38% and 35% respectively). All care managers thought that it would be somewhat helpful for care workers to discuss wages with their seniors.

To bring this paradigm shift, clear strategies to improve wage discussion needs to be implemented. This research provides care workers and care managers perspectives on the current communication taking place regarding financial wellbeing and participants were asked to suggest strategies to improve communication around financial wellbeing.

Current Communication

Effective communication is important to build financial understanding amongst employees and for organisations to identify ways to support employee wellbeing (Armstrong and Brown, 2019). Communicating the impact of the financial crisis on both the employees and the business likewise could encourage employees to raise concerns and breakdown the stigma associated with financial problems (CIPD, 2023). Communication regarding financial wellbeing is vital as there is a clear link between productivity and financial wellbeing (Armstrong and Brown, 2019; CIPD, 2023; Martono, Khoiruddin and Wulansari, 2018). Financial distress has a negative impact on the physical and mental health of employees resulting in higher levels of absenteeism and presenteeism (being at work but underperforming) (CIPD, 2021). In the case of the care sector, this could mean a decline in the care quality provided, thus negatively impacting the health of vulnerable service users accessing care.

Participants were asked to narrate their perspectives on the current communication taking place regarding financial wellbeing. Care workers reported feeling frustrated when no communication was taking in the workplace regarding pay and benefits. For example, one care worker describes below how her employer was refusing to reciprocate communication efforts initiated by employees by being "cold and cut off".

"One sided. Staff trying to advocate for better pay but chief executive is cold and cut off with the same answer of "we did give a pay rise back in...."" (CW10)

Other care workers questioned the honesty and transparency of communication regarding pay. In the extract below, the care worker explained that informal talks took place amongst staff and that she and her fellow care worker colleagues were concerned about the level of honesty by the employer regarding budgets and the financial position of the company.

"Informal talks between staff mostly. Confusing communication between owners and staff. e.g., they seem to be able to afford house refurbishment when i cannot even afford a full food shop. … Explain the reasons for not being able to pay us more. If people understand

where the income is going, then they may be more understanding of the pay they are receiving" (CW19)

Only one care worker reported that there was a current ongoing discussion about pay increases taking place at work.

"Currently increase in pay being discussed" (CW2)

The notion of current communication regarding pay differed between care managers and care workers. In contrast to the previous quotations presented by care workers, care managers described the current communication taking place as honest and transparent. Managers reported conveying sincere and clear information about organisational circumstances.

"Discussed but honest with staff about budgets." (CM1)

They informed that any changes to pay and benefits will be communicated with staff throughout the change management process in both pre and post transition phases. The quotation below represents the practice of a manager in communicating changes to pay.

"Early and consistent communication." (M2)

Figure 38 below presents the sector's perspectives on the current communication taking place regarding financial wellbeing. Although care managers described the current communication taking place as honest and transparent, care workers reported feeling frustrated with the current communication levels. Whilst some care workers questioned the honesty and transparency of communication regarding pay, others criticised employers for refusing to reciprocate communication efforts initiated by employees. Dissatisfaction with current communication combined with financial distress can impact the quality of care provided (productivity) (Armstrong and Brown, 2019; CIPD, 2021, 2023; Martono, Khoiruddin and Wulansari, 2018) which could have negative consequences for vulnerable service users**.**

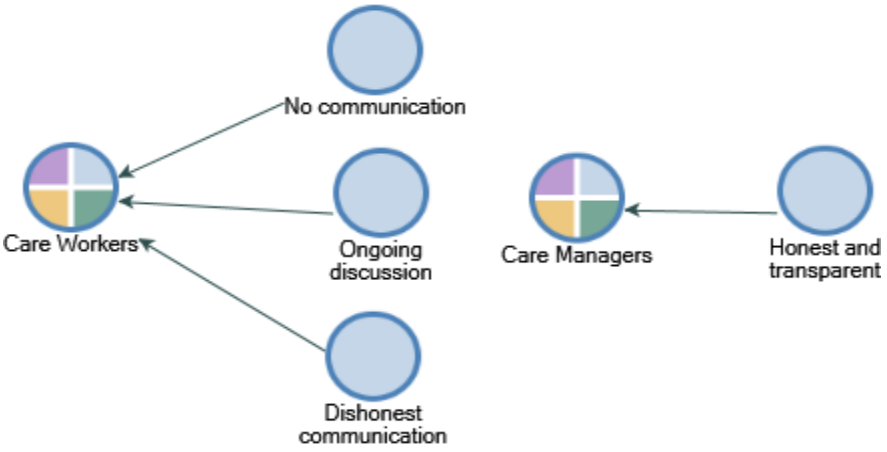


Figure 38: Perspectives on the current communication taking place regarding financial wellbeing

Factors Affecting Wage Discussion

Effective communication is essential to promote financial wellbeing and improving worker absenteeism rates (CIPD, 2023; Martono, Khoiruddin and Wulansari, 2018). Care workers perform the important task of provisioning care on behalf of care providers. Encouraging disclosure of information and transparency can prevent problems such as opportunistic behaviour by care workers linked to moral hazard (Eisenhardt, 1989). Moral hazard refers to when workers do not put the agreed effort to perform tasks. That is, the worker is shirking. Thus, effective communication (transparency and disclosure of information) is an integral part of managing this relationship (Mio et al., 2020) leading to increased productivity and performance (Linder and Foss, 2015).

Care workers were asked if they were comfortable about discussing wages with their employer and explain the reasoning behind their answer. They offered examples of circumstances that encourage communication around pay, as well as highlighting situations that make them uncomfortable to discuss wages.

The most cited reason for comfortability in discussing wages was a good quality employer-employee relationship. Words such as “approachable” and “understanding” were used

frequently when describing how their relationship with managers encourage and make wage discussion comfortable.

"Have a good relationship with line manager" (CW2)

The value that the employer placed on financial wellbeing also created a sense of comfortability to discuss wages. One care worker described how her employer was receptive to changes in the external environment such as the recent increase in fuel prices. It showed her that her employer valued and initiated financial incentives prior to concerns being raised by staff.

"Because they are receptive and usually implement things before, they are asked for-e.g. a travel bonus when fuel started to increase" (CW9)

Others were just frustrated with workload expectations and wanted to advocate for what they believe is the right pay. Care workers complained of travelling long distances without any compensation for travel time or being expected to do unpaid overtime.

"I mention a lot that when I do overtime, I don't get paid for it due to being salaried" (CW18)

The belief that discussions are the only way to change and keep management informed on the current situation on low pay also encouraged care workers to raise the issue of wages with seniors.

"As they need to know where to improve as management is very poor"(CW20)

When explaining the reasons on why they are uncomfortable to discuss wages, care workers portrayed the issue of low pay on care rates paid to the providers rather than their employers. They felt that it was not fair to discuss wages as employers were not to be blamed for the funding issues in the sector.

"It is very difficult as the whole sector is under-funded and under-staffed, so I don't feel able to ask for more money or to do less hours. I mostly work 6/7 days a week but if I don't do it, they will struggle to find someone else." (CW23)

Constant feedback by employers that wages are fixed and that they are doing the best they can also discouraged care workers from raising the topic of wages. Care workers were given a clear message that there are set wage rates for each job role and there is no possibility to get pay raises.

"I don't see the point in ask about wages to employer as all the answer would be is well you knew the wage when u applied for the job" (CW15)

As depicted in Figure 39 below, care workers illustrated circumstances that encourage communication around pay, as well as highlighting situations that make them uncomfortable to discuss wages.

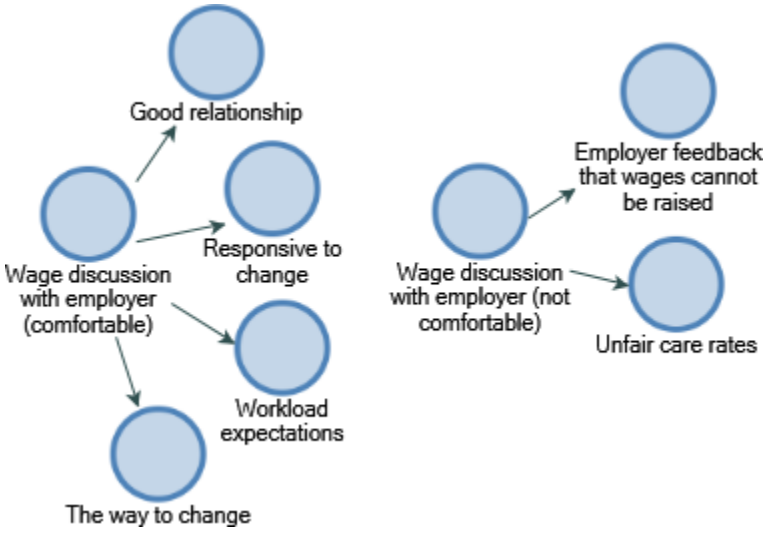


Figure 39: Factors that encourage and hinder wage discussion

They emphasised on the importance of a good quality employer-employee relationship, where the employer is approachable and understanding. Care workers felt comfortable to discuss wages when employers valued and initiated financial incentives prior to concerns being raised by staff. Such transparency and disclosure of information is an integral part of managing the stakeholder relationship leading to increased productivity and performance (Linder and Foss, 2015). They were more likely to raise the issue of pay when they believed that discussions are the only way to change and keep management informed on current situations such as travelling long distances without any compensation for travel time or being expected to do unpaid overtime.

Behaviours that may discourage wage discussions include assertion by employers that wages are fixed for each job role and constant feedback that they are doing the best they can. Some care workers felt that it was not fair to discuss wages as employers were not to be blamed for the funding issues in the sector. Hence, a fair rate of care by Local Authorities could encourage more care workers to raise their voice.

Strategies to Improve Wage Discussion

Transparent decision making and regular communication with stakeholders could lead to sharing best practice approaches and flexibility in unexpected challenges (Harrison, Bosse and Phillips, 2010). Interestingly, participants proposed strategies of transparent decision making and open communication which could be employed to shift to a culture where the topic of wages can be openly discussed with seniors.

One of the suggestions included having individual discussions with named person and time so that personalised information could be provided to each care worker regarding the roles of different individuals involved with their pay. This made sense as not all care workers would be comfortable to put forward their thoughts in front of their colleagues or ask questions to clarify doubts.

"Named person and time to discuss. Openness on everyone's role" (CW2)

Care workers insisted on the importance of creating an open culture where workers are encouraged to have healthy discussions regarding pay. In the below quotation, the care worker adviced that employers must be willing to listen and be open to feedback or any constructive criticisms presented to them.

"Be willing to take feedback/constructive criticism." (CW14)

Similarly, the below care worker highlights the needs to have a welcoming environment for wage discussions where staff get the sense that the organisation is happy to listen to their concerns.

“Discuss pay more [and] not just be fobbed off each time.” (CW18)

Managers seemed to agree with this view.

“Nothing, we operate a very open culture” (CM3)

Some care workers believed that the communication process would start once employers start taking active steps to increase wages.

“Put things into action and increase wages” (CW1)

Whatever the strategies used to encourage communication around pay, care workers emphasised the importance of being transparent and giving consistent updates on the situation. They believed that employers needed to be honest on their current financial situation and financial priorities for the future. One care worker recommended sending emails and signposting staff to any recent updates in pay related information.

"Email updates about what is going on with these things. Signposting. Talking openly about it." (CW23)

As highlighted before, some care workers mentioned again that their employers were offering support which they are capable of with the resources they have. Care workers believed that initiatives needed to be taken at the government level first to improve communication around topics such as low pay and improving job quality.

"Contact the local social but it comes down to the government not protecting the care workers and having us treated as valued workers" (CW21)

Care managers agreed with this view that the communication around wages needs to be extended from the local organisational level to the Local Authorities. However, managers had experienced difficulties in communicating with Local Authorities regarding the persistent low pay in the sector and claimed that any form of negotiation can be difficult due to the competitive nature of the market.

“We have a sector wide tapestry of small providers working in competition with each other. It is a 'public sector market', which means our bargaining power is minimal.” (CM2)

"Our company is very open but when dealing with external authorities that is difficult." (CM4)

Figure 40 below presents the recommended strategies by participants to remove the stigma around wage discussion.

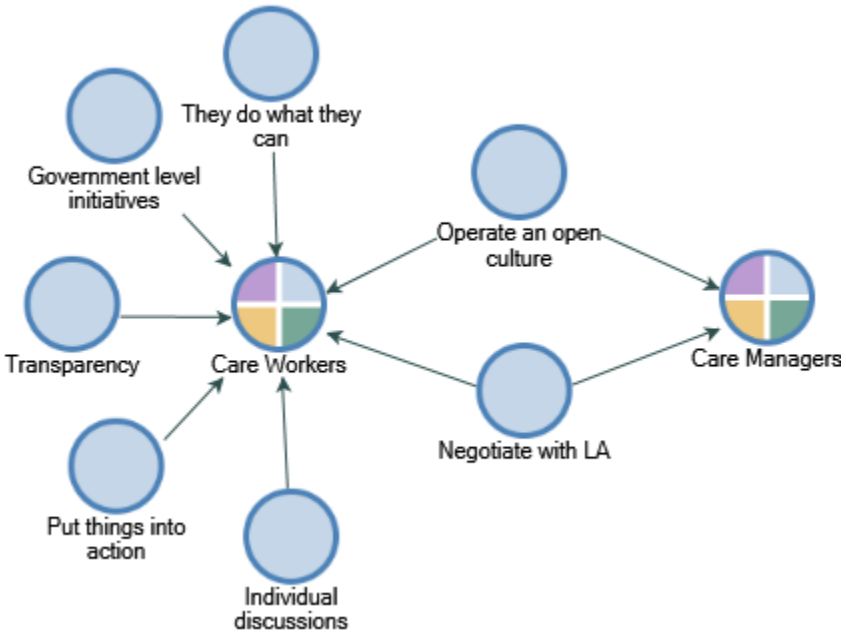


Figure 40: Suggested strategies to improve wage discussion

One of the suggestions included having individual discussions with named person and time. This was to provide opportunity for care workers who are not comfortable to put forward their thoughts in front of their colleagues and provide personalised information. Both care workers and care managers insisted on the importance of creating an open culture where employers were willing to listen and have open discussions with staff. They suggested that the environment should be welcoming enough that the staff feels the organisation is happy to listen to their concerns.

Some care workers believed that the communication process would start once employers start taking active steps to increase wages. Whatever the strategies used, care workers thought it was important to be transparent and give consistent updates. They adviced that employers need to be honest on their current financial situation and financial priorities for the future. One care worker recommended sending emails and signposting staff to any recent

updates in pay related information. Transparent decision making and regular communication with stakeholders could lead to sharing best practice approaches and flexibility in unexpected challenges (Harrison, Bosse and Phillips, 2010)

Care workers and care managers agreed that the communication around wages needs to be extended from the local organisational level to the Local Authorities. However, managers had experienced difficulties in communicating with Local Authorities claiming that any form of negotiation can be difficult due to the competitive nature of the market. For wage discussion to be more effective, it needs to be a joint effort between care workers, care managers and the Local Authorities.

Communication Tools to Implement Strategies

In the previous section, participants suggested strategies to improve wage discussion such as individual discussions, creating an open culture where employers are willing to listen and have open discussions with staff, transparency, and consistent updates on the situation, and extending the communication around wages from the local organisational level to the Local Authorities. Participants were asked regarding the current communication methods used, to evaluate whether these strategies can be implemented using the current mediums used for discussion or whether new forms of communication need to be identified.

Table *12* below represents the participant's responses. Although employers had used a variety of mediums, they generally used face to face and email to communicate on pay and benefits.

Communication tools used to discuss pay and benefits		
Medium	**No. of Care Workers**	**No. of Care Managers**
Face to face	13	4
Letters	1	_
Email	10	3
Staff forums	1	1
Text	1	_
Phone calls	1	_
WhatsApp	2	_
Staff meetings	1	_
Wage slip	1	_

Table 12: Communication tools used to discuss pay and benefits

This table presents the diverse mediums that the private adult social care sector employs to communicate about pay and benefits.

Each strategy was carefully evaluated to check whether they can be implemented through email or face to face discussions as presented in Table 13 below. After evaluation, it can be concluded that employers could use their current mediums such as face to face conversations and emails to implement these new strategies and there is no need for new forms of communication.

Evaluation of strategies with the current communication tools		
Strategies	**Can the strategy be implemented through face-to-face communication?**	**Can the strategy be implemented through email?**
Individual discussions	Yes	No
Open culture where employers are willing to listen and have open discussions	Yes	Yes
Transparency and consistent updates	Yes	Yes
Extending the communication to Local Authorities	Yes	Yes

Table 13: Evaluation of strategies with the current communication tools

This table presents an evaluation of whether the suggested strategies by participants to improve wage discussion could be implemented through face-to-face communication and email. Employers generally used face to face and email to communicate on pay and benefits. It seems that these strategies can be implemented using the current mediums.

2.9 Career Plans

The population aged 65 and over is estimated to increase from 10.5 to 13.8 million in England between 2020-2035. If the adult social care workforce is to increase proportionally, an additional 480,000 jobs (27% growth) would be required by 2035 (Skills for Care, 2022). However, the sector has faced longstanding recruitment and retention issues which has been linked to low levels of pay and status (Moriarty, Manthorpe and Harris, 2018; Skills for Care, 2022). The National Living Wage has presented new challenges such as decreasing pay differentials and competition from other sectors offering easier jobs for the same pay (Skills for Care, 2022). The pilot study indicated that although care workers generally favoured towards staying in the sector, the National Living Wage policy is demotivating care workers to accept a promotion and take on additional responsibilities.

Registered managers had a high vacancy rate of 12.8%, in comparison to 10.7% for the sector and 4.3% for UK. It is important for care workers to progress to senior roles as services without a registered manager had lower CQC ratings (Skills for Care, 2022). Therefore, participants were asked to describe their motives for staying in the sector, career aspirations, and employer support required to reach these goals. This section also attempts to capture the decision-making process of care workers in terms of accepting a promotion, thus, informing employers of factors that encourage and hinder care workers to accept a promotion.

Motives for Staying in the Sector

With the introduction of National Living Wage, pay in the retail and cleaning sectors have been increasing faster than the social care sector resulting in easier job opportunities for the same pay (Skills for Care, 2020a). Moriarty, Manthorpe and Harris (2018) in their research on recruitment issues in the adult social care sector expressed concerns that the less demanding nature of these sectors might make the social care sector less attractive for future and existing talent. Interestingly, the pilot study revealed that the greater part of care workers favoured towards staying in the sector despite other sectors offering easier job opportunities for the same pay. Hence, care workers were asked to describe the reasons behind this decision.

A few care workers reported flexibilities such as working hours and workplace proximity as reasons for working in the sector.

"Close to home, don't want to let employer down, like flexible hours" (CW2)

However, the root cause that the care workers frequently set forth was loyalty towards their sector, employer, service users and the act of caring itself. They believed that they are making a difference by ensuring that the needs of service users are met in every possible way. Care workers were worried that leaving might cause further disrepair to the sector. The below quotation illustrates how loyalty affected a care worker's decision making in terms of staying in the sector.

"I have seriously considered leaving care. But if everyone keeps leaving the situation will only become worse…I would like to find a way to attract more people into care so that the job becomes less stressful and more enjoyable and rewarding again."(CW23)

Similarly, the following care worker (CW13) conveys her decision to stay in the sector in relation to her positive sentiments towards the people she cares for and sense of responsibility towards the family members of service users.

Question: With the introduction of National Living Wage, other sectors (such as retail and cleaning) have been offering easier job opportunities for the same pay. What are your motives for staying in the sector despite this?

Response: I love my Job. I do it because I care for people rather than the money.

Question: What difference are you making in your job?

Response: To leave a resident feeling happy and their family's to be reassured we are looking after their relative

The quote below depicts an illustration of how the act of caring itself creates a rewarding experience for the care worker that is valuable than any other factor that would entice the care worker to leave her job. The care worker described caring as a job that she looks forward to and is enthusiastic about. She outlined rewarding aspects of caring such as being

the reason for someone to smile, calming down service users when they are afraid and just "being there" for service users who are away from loved ones and family.

"Why do a job that you hate and don't look forward to going to work. I love my job and knowing I am going to make someone's day is all that counts for me… Making someone smile every day. Holding someone's hand when they are afraid and frightened, being there when loved ones are not around " (CW16)

The pilot study revealed that the greater part of care workers favoured towards staying in the sector despite other sectors offering easier job opportunities for the same pay (Moriarty, Manthorpe and Harris, 2018; Skills for Care, 2020a). Although care workers valued flexibilities such as working hours and workplace proximity as shown in Figure 41 below, the principal ground for staying in the sector was loyalty towards their sector, employer, service users and the act of caring itself.

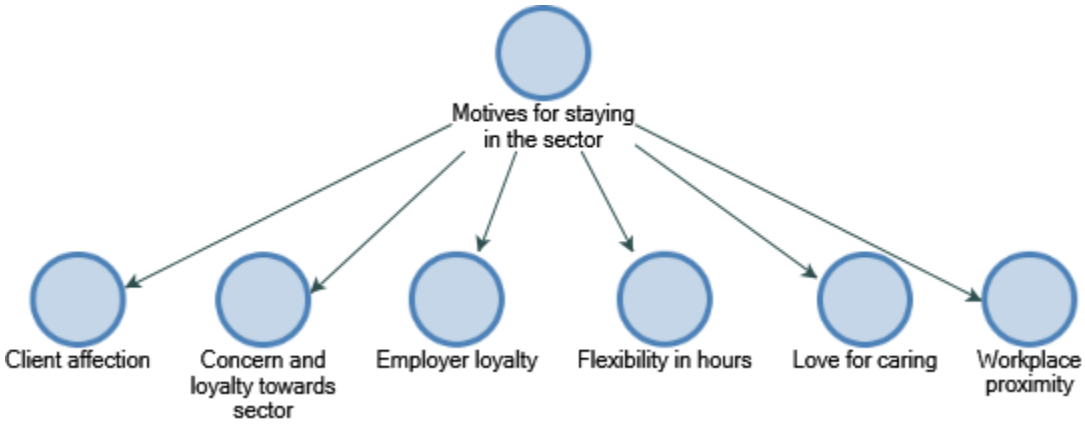


Figure 41: Motives for staying in the sector

They believed that they are making a difference by ensuring that the needs of service users are met in every possible way. Care workers were worried that leaving might cause further harm to a sector that is already struggling. The act of caring itself created a rewarding experience that was valuable than financial incentives. Care workers were enthusiastic about rewarding aspects of caring such as working with service users through times of worry, sorrow, happiness and just "being there" for service users who are away from loved ones and family.

Employer Support for Career Progression

While the majority of the sector's workforce consists of women (82%) (Skills for Care, 2022), in proportion they are considerably under-represented in managerial and supervisory roles which have better pay and conditions (Hussein, 2017a; Moore and Hayes, 2018; Müller, 2019). It is important for the biggest demographic of the workforce to take on more senior management roles as registered managers had a vacancy rate of 12.8%, which is higher compared to the 10.7% for the sector and 4.3% for the whole nation (Skills for Care, 2022). Furthermore, statistical analysis reveals that services without a registered manager received lower CQC ratings (Skills for Care, 2022), impacting the care experiences of vulnerable service users.

Skills for Care (2022)'s most recent report on the state of the adult social care sector in England highlighted that women were less likely to be in senior management roles (68%) compared to direct care providing roles (83%). Skills for Care (2022) could not identify the exact cause of this difference using the Adult Social Care Workforce Dataset alone. Therefore, to shed some light on these figures, care workers were asked about their career progression goals and how their employers can help to achieve them. Since 96% of participants were female (22 out of 23), it is likely that these findings are transferable to the female care worker population providing a probable explanation for the above-mentioned figures by Skills for Care (2022).

Whilst some care workers have not yet decided on any career progression goals, other care workers had a range of career aspirations such as further training and education, becoming an educator, and promotion to senior levels. Some care workers had already started on working towards their goals.

"Get more training…currently studying" (CW5)

Whatever the career aspirations, the underlying motive is to improve the care experience for service users. The following care worker explains her belief on how she could contribute to improving care standards by becoming a teacher or examiner. She indicates the importance of imparting peace and dignity towards service users in a caring role. She aspires to train

junior care workers to perform this important role by teaching the required “knowledge and compassion” with her experience.

"I want to become a teacher of health and social care or an assessor for h&sc nvq…I hope I can bring peace to the people in my care, provide them with dignity for their final years. I hope I can pass my knowledge and compassion to younger members of staff" (CW19)

Likewise, the below care worker illustrates on how being promoted to an operations manager could help her have a direct influence on the care services provided. She trusts that the position would enable her to “do more to help” the service users.

"To become an operations manager so I can have more effect on the people we support...I want to develop my skills and do more to help the people we care for." (CW23)

Care workers were asked to suggest ways on how employers can assist them to achieve their career progression goals. The most frequent advice was to support them to complete more training courses or in acquiring additional qualifications. Interestingly, care workers gave a diverse range of suggestions on how employers can provide this support. Employers were recommended to support learning and development through paying for courses, providing flexibility to attend university, in house training to perform senior roles, and providing access and training to use the relevant softwares. These findings are not surprising as data from Skills for Care (2022) clearly shows that employers with higher levels of learning and development had lower staff turnover and higher CQC ratings. Care workers that received some form of training had a turnover rate of 31.7% compared to 41.2% for those who did not. In addition to employee satisfaction, it should be noted that learning and development is essential for care workers to support the increasingly complex needs of service users (Skills for Care, 2022). Moreover, it is a legal obligation on care providers to support the system of education and training of care workers, and there is a duty on NHS commissioning boards to support this system as per section 97 of the Care Act 2014.

In the following quotation, the care worker describes her struggles to move up the career ladder as “glass ceiling progress”. The glass ceiling is a metaphor that describes an invisible barrier that prohibits certain individuals from being promoted to senior positions. The phrase

is usually used to portray barriers that women and minorities encounter when attempting to advance in a male-dominated business hierarchy (Kulik and Rae, 2019).

"Providing further training and support...Glass ceiling progress. You can see that from support worker to assistant manager is available, but interviews are met with the feedback of "You lack managerial experience" "You do not have knowledge of the computer systems we use" - of which we have no access to so would not have this knowledge" (CW10)

Here, the participant depicted her failures to overcome the invisible barriers that women face in the context of the care sector. Although there is opportunity to progress in theory, her attempts to progress were prevented by interviewer expectations which was not possible to achieve. Not only was she criticised for not having the experience that she did not have the opportunity to achieve, nor which was an actual requirement of the job, but also not having the knowledge of computer systems that she did not have access to. Clearly, in house training to perform senior roles and providing access and training to use the relevant softwares by employers could prevent these situations where care workers feel trapped behind a “glass ceiling”.

Some care workers suggested that it would help if their employer created a progression pathway for their career aspirations. For example, a clear career pathway for each employee to move along the job hierarchies, get the necessary training or any other career goals.

Question: What career progression goals do you have?

Response: Getting an NVQ.

Question: How can your employer help to achieve your career progression goals?

Response: After 6 months they'll put me through level 2 NVQ.

Another recommendation put forward was to advertise jobs to internal employees first before advertising externally.

"They do promote people in house and advertise it to the carers before it goes out to the public" (CW16)

Figure 42 below describes the career progression goals of care workers and the required support to achieve these goals.

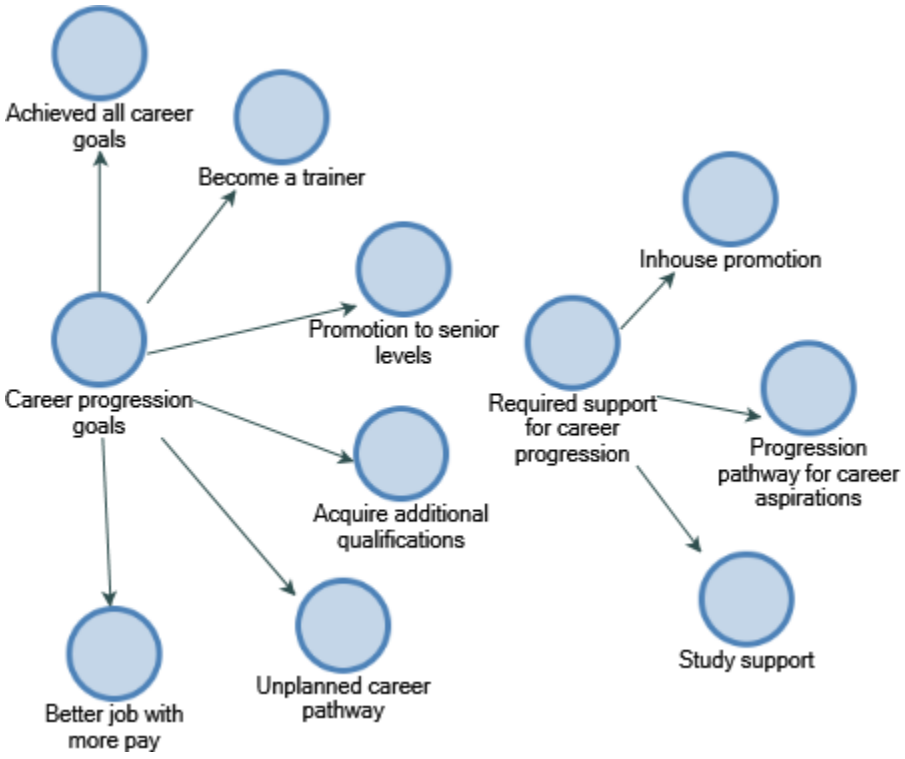


Figure 42: Care worker career progression goals and the required support to achieve them

Whilst some care workers had an unplanned career pathway, other care workers had a range of career aspirations such as further training and education, becoming an educator, and promotion to senior levels. The underlying motive behind each career aspiration was to improve the care experience for service users by training self or others to perform higher standards of care or through having a direct influence on the services provided. Care workers sought for employers to support them to acquire additional training and qualifications. Employers were recommended to support learning and development through paying for

courses, providing flexibility to attend university, in house training to perform senior roles, and providing access and training to use the relevant softwares.

These findings support data from Skills for Care (2022) indicating that employers with higher levels of learning and development had lower staff turnover and higher CQC ratings. Section 97 of the Care Act 2014 obligates care providers and NHS commissioning boards to support the learning and development essential for care workers to support the increasingly complex needs of service users (Skills for Care, 2022). The lack of learning and development opportunities have left care workers feeling trapped behind a "glass ceiling" in their struggles to get promoted. Other recommendations put forward include creating a progression pathway for individual career aspirations and internal job promotions.

Promotion to Next Level

The National Living Wage policy is causing a decrease in wage differentials between junior and more experienced staff. In March 2016, care workers having a sector experience of greater than five years earned 33 pence (4.4%) more per hour on average than a care worker with less than one year of experience. Nevertheless, by March 2023, the experience pay gap had dwindled to just six pence (or 0.6%) per hour. The pilot study found some evidence that the National Living Wage policy is demotivating junior care workers to accept a promotion and take on additional responsibilities. To expand on the reasons for this result, care workers were asked to state the reasons why they might accept or reject a promotion. This could lead to identifying factors that encourage care workers to progress in their roles and caution employers of factors that might discourage care workers to progress across the job hierarchy.

It is important for care workers to progress to senior roles as registered managers had the highest vacancy level at 12.8% after registered nurses (14.6%). This figure is worrying in comparison to the 10.7% vacancy rate estimated for the whole sector and 4.3% for the wider UK economy (Skills for Care, 2022). These are unwelcome trends as the Skills for Care (2022) analysis of CQC ratings depict that services without a registered manager at the time of inspection were less likely to achieve a "good" or "outstanding" rating. Since the absence of registered managers has a direct impact on the vulnerable people using care services, it is

important to identify factors that encourage and hinder career progression amongst care workers.

The underlying motive behind accepting a promotion for some care workers were their positive sentiments and sense of responsibility towards service users. They expressed their desire to make a positive impact on the delivery of care services.

"I [would] like to make a difference and if I can put my knowledge to good use then this is the way forward" (CW16)

Care workers believed that the increased responsibilities with the promotion would help them to learn new things, develop their skills and gain new knowledge on more effective ways to deliver care.

"To broaden my knowledge and to prove i can have responsibilities and for the extra pay" (CW19)

The view on financial benefits of a promotion differed between participants. For some care workers a promotion meant that they would be able to live more comfortably and minimising overtime leading to a better work-life balance.

"Previous high-pressured role with better pay, no need to work overtime" (CW12)

Some care workers appreciated the extra pay that comes with the promotion, even when the pay difference is minimal.

"Because a little extra help" (CW21)

Other care workers were more wary of accepting increased responsibilities and workload for a minimal pay difference. They pointed out that they already have a high enough workload and would like to avoid stressful situations that comes with additional responsibility. They did not believe that progression in role would have any better outcomes as the additional responsibility did not reflect in the pay difference. In the extract below, the care worker describes her decision on why she would not accept a promotion. The promotion presented additional responsibilities and workload (costs), especially in terms of the required

paperwork which resulted in less time for actual care work. These costs when weighed against the financial benefits was not worth for the participant.

"Not worth it too much extra paperwork less time for caring for not much more money" (CW8)

The pilot study found evidence that the National Living Wage policy is demotivating junior care workers to accept a promotion and take on additional responsibilities due to the decreasing wage difference. The high vacancy level of registered managers and lower CQC ratings of services without a registered manager (Skills for Care, 2022) highlights the importance of identifying factors that encourage and hinder career progression amongst care workers which is summarised below in Figure 43.

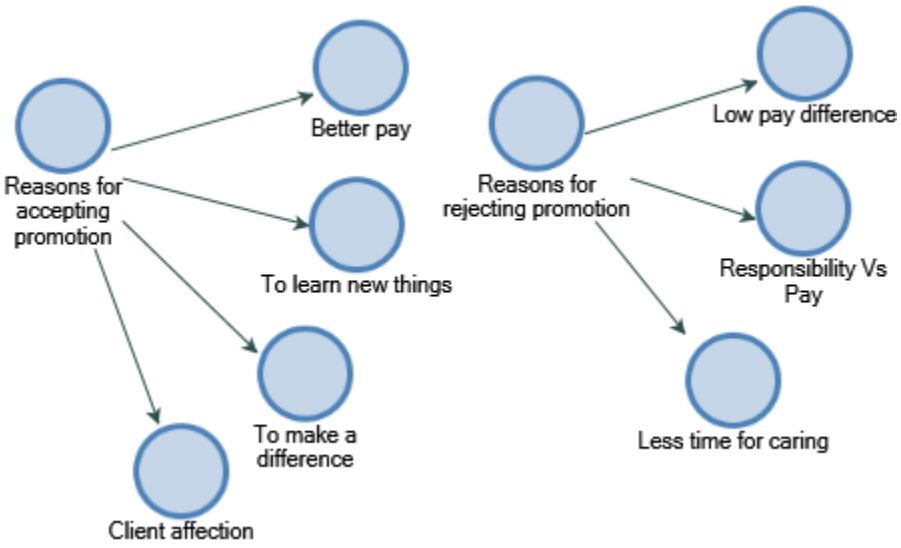


Figure 43: Factors that encourage and hinder career progression amongst care workers

When accepting a promotion, care workers focused on the influence they could have on the delivery of care services. Care workers described how learning and development that comes with the job role would equip them with the required set of skills to implement effective ways on delivering care. The view on financial benefits of a promotion differed between participants. For some care workers, the extra pay (even in cases when the difference is minimal) meant that they would be able to live more comfortably and minimise overtime leading to a better work-life balance. For other care workers, the promotion presented

additional responsibilities and workload (costs), when weighed against the financial benefits was not worth for the participant. Care workers considered the extra pressures of managerial work in their decision-making process, especially in terms of the required paperwork which resulted in less time for actual care work.

Managerial roles offered to care workers should include learning and development opportunities to acquire new skills that could satisfy their desire to have a positive impact on care delivery. Managerial roles should be incorporated with elements that could satisfy a care worker's emotional needs (satisfaction that they are improving the care experiences of service users) and financial needs (living comfortably, minimising overtime and better work life balance). Care workers decision making process to accept a promotion should be construed in terms of their desires for emotional and financial satisfaction and their perception of additional responsibility and workload as costs. It should be borne in mind that the increased responsibility and workload, such as the additional burden of documenting reports, form and letters should be reflected in the pay.

2.10 Optimal Contract Type

If agency theory is applied to the commissioning process of social care, it could be argued that the optimal contract (Eisenhardt, 1989) for this situation is behaviour-based (block contract). While rewarding based on the outcomes achieved was a common incentive alignment mechanism, it would disadvantage care providers by offering them compensation for outcomes they did not fully control (Bosse and Phillips, 2016). For example, government policies and legislation imposing more responsibilities and conditions on care providers (Care Act 2014, Health, and Social Care Act 2022), economic issues (cost pressures due to the rise in National Living Wage or rent inflation), competition and technological changes.

Furthermore, the achievement of outcomes would depend on the optimum performance of all individuals and organisations involved in the person's care, not the social care provider alone (Department of Health and Social Care, 2022). For example, the GP, family members, carer and any community organisations involved must jointly perform their required responsibilities to achieve the optimum health levels for service users.

With already strict monitoring mechanisms in place and the fact that the outcomes of care are not fully controlled by the care provider makes a behaviour-based contract ideal for the situation (Eisenhardt, 1989). All care home managers who participated in the pilot study agreed with this view by selecting block contract as the most suitable contract type for care commissioning. Hence, care managers were asked to explain the reasons on why a particular contract type is more suitable for care commissioning based on the current circumstances. Examining the reasons amongst care managers for the preference of a particular contract type could assist to eliminate some difficulties with current commissioning practices.

Table *14* below presents the opinions of care managers on the most suitable contract type for care commissioning and their reasoning. As evidenced by the literature, care homes held different types of contracts with Local Authorities (Bristol City Council, 2008; Monitor and NHS England, 2015). Care managers generally preferred a block contract over others. In block contracts, commissioners agree with providers for the provision of care needs of a population in a particular area for a fixed period. This type of contract differs from a fixed income contract where providers are offered a fixed rate per individual to access a range of services (Social Care Institute for Excellence, No Date).

Optimal contract type			
Care manager	**Current contract type**	**Preferred contract type**	**Reasons**
CM1	Fixed income contract	Two Components: A fixed advance and payment based on outcomes	Flexibility
CM2	On framework residential	Block contract	More sustainable for providers but can create unrealistic expectations from commissioners in terms of 'we pay for the bed, you MUST meet this very complex person's needs because we have assessed them as suitable'.
CM3	Individually contracted per resident	Block contract	Security of income
CM4	Fixed income contract	Block contract	Guaranteed income and ability to plan
CM5	Fixed income contract	Block contract	Guaranteed income but would need to be at a better rate than the one offered currently

Table 14: Optimal contract type

The opinion of care managers regarding the optimal contract type for care commissioning and their reasoning.

Their opinion was based on positive characteristics of the block contract such as security of income which would aid them to better plan the delivery of services. Care managers reported that block contracts are a more sustainable option for providers, however, implied that a fair cost of care needs to be established first to enable quality care provision. They also expressed concerns that it could create unrealistic service expectations from commissioners which could extend beyond the capacity and expertise of the provider. Therefore, clear service expectations need to be set beforehand based on the capacity and expertise of the provider. Only one care manager stated preference to shift from a fixed income contract to a contract comprising a fixed advance and payment based on outcomes. The care manager believed that this type of contract offered more flexibility as rather than being paid a fixed amount, the provider has a chance to get incentivized more based on the outcomes achieved.

In research done by The King's Fund, Robertson and Ewbank (2020) described the benefits of using completely behaviour-based contracts for care commissioning. Their findings reported providers having more transparent conversations with commissioners about the issues they were facing enabling the system to find solutions. Staff found their roles shifting away from monitoring and spending more time discussing development pathways and quality improvement. The Covid-19 pandemic emphasised how shared learning and collective intelligence of experience helped the sector develop appropriate responses to the crisis (Aughterson et al., 2021). This would mean minimising costs through information and goal sharing (Tumbat and Grayson, 2016).

In support of the literature review and pilot study, care managers generally preferred a block contract. The Care Act 2014 imposes legislative duties on the Care Quality Commission and Local Authorities to strictly monitor care services and the fact that the outcomes of care are not fully dependent on the care provider (Department of Health and Social Care, 2022) makes a behaviour-based contract ideal (Eisenhardt, 1989). Care managers reported that block contracts offered security of income, therefore a more sustainable option for providers. They stated that this would help them to better plan enabling quality care provision. However, care managers implied that a fair cost of care needs to be established first. They also adviced that to avoid conflict, clear service expectations need to be set beforehand based on the capacity and expertise of the provider. Robertson and Ewbank (2020) argued that

behaviour-based contracts amongst providers encouraged transparency where the focus was on working together to identify pathways towards quality improvement rather than monitoring. The Covid-19 taught the social care sector important lessons on collaborating and working together to recover from a crisis (Aughterson et al., 2021). This would mean minimising costs through robust information systems to share knowledge and risk sharing by having common goals and making collective decisions (Tumbat and Grayson, 2016).

2.11 Section Summary

This section of the chapter reported findings of the care sector's experiences of the National Living Wage in England, giving insight into the benefits, as well as highlighting challenges. Care workers and care managers questioned the appropriateness of National Living Wage in comparison to a care worker's training, role, and workload. Although it has improved the weekly earnings of care workers in theory, this have been overshadowed by steep inflation contributed by the global energy crisis (CNN, 2022; Office for National Statistics, 2022b). As a result, care workers have had to depend on family or benefits to top up their wages.

Although care work features such as non-payment of travel time does not make it more difficult to claim Universal Credit benefit, it makes care workers highly vulnerable to underpayments in National Living Wage. If a lot of their working hours are spent on time travelling between service user homes, care workers could end up working excessive hours which are paid well below the National Living Wage (Moore et al., 2017; UNISON, 2020). Care workers managed these challenges by budgeting comprehensively, which sometimes involves cutting back on essentials such as food, gas, and electricity. They often worked excessive hours to compensate causing exhaustion and disruption to work life balance. Issues such as staff shortage and increased workloads need to be addressed so that care workers could cope with the increase in working hours brought by the National Living Wage. (Gardiner, 2016; Giuponni et al., 2016). Care workers described how they were expected to take on the extra workload to cover up for the staff shortage despite not being paid for them.

On the other hand, managers were struggling to maintain a maintain a wage hierarchy when the limited additional funding only covered the lowest paid staff. Sudden changes to pay differentials that are regarded as unfair negatively affected staff morale, decreased

productivity (Walmsley et al., 2019) and there have been instances where experienced care staff moved to work in the NHS (Moriarty, Manthorpe and Harris, 2018). The Covid-19 helped to put these issues to the forefront prompting renewed calls for funding and reform (Shembavnekar, Allen and Idriss, 2021; Wild and Szczepura, 2021). Although Covid-19 related death rates were significantly higher in the sector compared to other healthcare professionals (Office for National Statistics, 2021b), social care staff were often undervalued and forgotten compared to NHS colleagues (Foster, 2020). Care organisations have been unable to compete with corporate businesses with wider profit margins. Hence, Local Authorities need to take into consideration that increasing the wages of the lowest paid staff has a direct impact on all other roles in the job hierarchy.

Care managers have responded to these challenges by increasing service user fees and recruiting more private funded residents to subsidise the Local Authority rates. They suggested a fair cost of care, which is unsurprising as effective reward systems are essential for care providers to perform (Tumbat and Grayson, 2016). To comply with the Health and Care Act 2022, Local Authorities have been requesting providers for historic figures of care costs. However, Local Authorities need to change their current approach of assessing a fair cost of care based on the median cost of the current provision of care. A fair cost of care should reflect the unique care needs of different service users, by basing the median cost of care on specific service specifications instead of the historic cost of care provided under extreme austerity measures.

Expectations of support to financial wellbeing were low amongst care workers as they demonstrated an awareness of the low rates paid to the care providers. Despite limited resources, employers had used creative strategies such as the option to work overtime and salary loans. However, deductions from wages during hardships could lead to further arrears and debt. In some instances, employers provided subsidised meals or a travel bonus due to the increase in fuel prices. Care workers reported being hesitant to claim travel expenses back from the government due to the complexity of the process and the requirement to keep detailed records. A suitable solution would be to make it a legal requirement for all employers to cover travel expenses separately so that this amount would not be taxable in the

first place. In cases where rates per business mile offered is less than the amounts allocated by HMRC, the employer should claim the difference with HMRC on behalf of employees.

Despite care managers describing the current communication on pay as honest and transparent, care workers questioned this whilst condemning employers for not reciprocating to employee-initiated communication efforts. Dissatisfaction with current communication combined with financial distress can impact the quality of care provided (productivity) (Armstrong and Brown, 2019; CIPD, 2021, 2023; Martono, Khoiruddin and Wulansari, 2018) which could have negative consequences for vulnerable service users**.** A good quality employer-employee relationship is crucial, where the employer is approachable and understanding. Care workers felt comfortable to discuss wages when employers valued and initiated financial incentives prior to concerns being raised. Employers should avoid asserting that wages are fixed according to job roles and avoid behaviours which suppresses wage discussion such as constant feedback that they are doing the best they can. Transparency and disclosure of information is an integral part of managing the stakeholder relationship leading to increased productivity and performance (Linder and Foss, 2015). Transparent decision making and regular communication with stakeholders could lead to sharing best practice approaches and flexibility in unexpected challenges (Harrison, Bosse and Phillips, 2010).

Participants agreed with this view as suggested strategies to improve wage discussion included individual discussions, creating an open culture where employers are willing to listen and have open discussions with staff, transparency, and consistent updates on the situation, and extending the communication around wages from the local organisational level to the Local Authorities. Managers reported difficulties negotiating with Local Authorities due to the competitive nature of the market. For wage discussion to be more effective, it needs to be a joint effort between care workers, care managers and the Local Authorities.

The pilot study revealed that the greater part of care workers favoured towards staying in the sector despite other sectors offering easier job opportunities for the same pay (Moriarty, Manthorpe and Harris, 2018; Skills for Care, 2020a). Despite care workers valuing flexibilities such as working hours and workplace proximity, the main reason for staying in

the sector was loyalty towards their sector, employer, service users and the act of caring itself. The experience of providing care was more rewarding than financial incentives.

Care workers had a range of career aspirations such as further training and education, becoming an educator, and promotion to senior levels. They suggested employers to support learning and development through paying for courses, providing flexibility to attend university, in house training to perform senior roles, and providing access and training to use the relevant softwares. These findings support data from Skills for Care (2022) indicating that employers with higher levels of learning and development had lower staff turnover and higher CQC ratings. Furthermore, section 97 of the Care Act 2014 obligates care providers and NHS commissioning boards to support the learning and development essential for care workers to support the increasingly complex needs of service users (Skills for Care, 2022).

The lack of learning and development opportunities have left care workers feeling trapped behind a "glass ceiling" in their struggles to get promoted. The glass ceiling is a metaphor that describes an invisible barrier that women and minorities encounter when attempting career advancement (Kulik and Rae, 2019). Skills for Care (2022)'s most recent report on the state of the adult social care sector in England highlighted that women were less likely to be in senior management roles (68%) compared to direct care providing roles (83%). It is important for the biggest demographic of the workforce to take on more senior management roles as registered managers had a vacancy rate of 12.8%, which is higher compared to the 10.7% for the sector and 4.3% for the whole nation (Skills for Care, 2022).

Other recommendations put forward include creating a progression pathway for individual career aspirations and internal job promotions. The decision making of care workers in terms of accepting a promotion include weighing costs against benefits. Senior roles should satisfy a care worker's emotional needs (satisfaction that they are improving the care experiences of service users) and financial needs (living comfortably, minimising overtime and better work life balance). The increased responsibility and workload, such as the additional documenting of reports, form and letters should be reflected in the pay.

The elements of the relationship between care providers and Local Authorities needs to be reconsidered as per the challenges put forward by the National Living Wage. While

rewarding care providers based on the outcomes achieved was common, it would disadvantage care providers by offering them compensation for factors such as the National Living Wage that they did not fully control (Bosse and Phillips, 2016). Robertson and Ewbank (2020) argued that behaviour-based contracts amongst providers encouraged transparency where the focus was on working together to identify pathways towards quality improvement rather than monitoring. The Covid-19 pandemic highlighted the importance of increased unity where everyone is collaborating for a common cause (Aughterson et al., 2021). Staff met to share learning, develop innovative responses to the crisis with a common goal of recovering together (Bailey and West, 2020). This would mean minimising costs through information and goal sharing (Tumbat and Grayson, 2016).

Care managers suggested that block contracts were more sustainable due to the security of income. They believed that the guaranteed income would enable providers to establish plans for better quality care provision. Nevertheless, for block contracts to be successful, a fair cost of care needs to be established first and clear service expectations need to be set beforehand based on the capacity and expertise of the provider. The next chapter concludes this thesis by identifying research limitations, contributions, and implications of these findings to better support the social care sector.

Chapter 6. Conclusions and Recommendations

6.1 Introduction

Existing research highlighted some of the challenges imposed by the National Living Wage policy on the social care workforce (Moriarty, Manthorpe and Harris, 2018; Skills for Care, 2022; Vadean and Allan, 2020). Thus, the overall aim of this research was to explore the experience of engaging with and fulfilling the National Living Wage policy by the private adult social care sector in England and to capture care worker and care manager experiences of working under the conditions imposed by the policy. This was addressed through the following three specific research objectives:

1. Explore the private adult social care sector's views and experiences of the National Living Wage policy including benefits and challenges.
2. To identify factors that influence the living standards of workers under the National Living Wage policy within the private adult social care sector.
3. Identify ways in which the sector can address challenges imposed by the National Living wage policy.

This chapter will present a summary of findings in relation to the above research objectives. Contributions of this research are highlighted as well as implications for policy makers. Additionally, strengths and limitations of the research are outlined and possible avenues for further research are discussed.

6.2 Research Approach

This research adopted a hermeneutic phenomenology methodology (Alsaigh and Coyne, 2021) with the philosophical approach of social constructionism used as a rationale for data collection, analysis and interpretation of findings (Saunders, Lewis and Thornhill, 2016). Conforming to social constructionism, care workers and care managers were viewed as social entities whose experiences of the National Living Wage policy are a result of individual circumstances and are influenced by social factors.

The research employed purposive sampling (Bryman, 2016). The criteria for managers to participate in the study was for them to be involved in the application and compliance with the National Living Wage policy in the organisation. The criteria for care workers to participate in the study is that they receive the National Living Wage as an hourly rate. A care worker not receiving the National Living Wage or care managers whose staff are paid above the National Living Wage could not provide the necessary perspectives to achieve this research's aim to explore the experience of engaging with and fulfilling the National Living Wage policy by the private adult social care sector. Snowballing sampling was used when participants were asked to recommend other participants who might be willing to provide further insights to the research (Bryman, 2016). Participants were recruited through Facebook (FB) groups which care sector staff are members, through the 15 ENRICH (Enabling Research in Care Homes) clinical research networks with a combined registration of 578 care homes (NIHR School for Social Care Research, no date) and snowballing from previous contacts (Bryman, 2016).

A thematic framework was developed for data collection based on research objectives, research gaps arising from the literature review and the views, behaviours and experiences put forward by the pilot study. Qualitative written interviews were used to probe deeply into worker's lived experiences of the National Living Wage. Qualitative written interviews with open ended questions is often employed in applied research work with a social constructivist epistemology (Adamson et al., 2004; Ataro, 2020; Pitura, 2023). The anonymous environment of the Qualtrics software encouraged participants to elicit sensitive data without any filters, enabling the capture of extreme views and experiences (Bryman, 2016). An open-ended approach to coding known as initial coding (Saldana, 2015) was done manually. Data was then imported and analysed using the software NVivo for accuracy and to run queries for a more detailed analysis of the responses (Bryman, 2016).

6.3 Summary of Findings

Research Objective 1: Views and Experiences of the National Living Wage Policy

Since labour costs account for over half of the expenses in social care (Bottery, 2020; Competition and Markets Authority, 2017), and approximately 46% of care workers in the

independent sector were earning below the National Living Wage as of March 2022 (Skills for Care, 2022), the social care sector is particularly susceptible to the impacts of increases in the National Living Wage. Therefore, it is essential to highlight the lived experiences within the sector regarding the implementation of the National Living Wage policy. This study offers perspectives and strategies for adhering to the policy, shedding light on the benefits and challenges from the viewpoint of the private adult social care sector in England.

The challenge of affording food and household bills impacts both the physical and mental health of low-paid workers (Living Wage Foundation, 2020). While care workers expressed varied opinions on whether the National Living Wage is sufficient to cover necessities, care managers believed it should provide a decent income for general living expenses. Opinions among care workers differed, influenced by factors such as their location and personal circumstances (such as having dependents) (Brown, 2017; Office for National Statistics, 2022d).

Care workers who reported that the National Living Wage had slightly improved their weekly earnings and affordability were primarily from rural areas of England, such as the South-East and Yorkshire and Humber, where the cost of living is lower. This variation is supported by literature that highlights the uneven impact of the National Living Wage across different sectors and regions (Brown, 2017). These workers were compensated for travel time when applicable, worked full-time with fixed hours, and viewed their employer's support for financial wellbeing positively. Care workers' experiences of the policy are not uniform and are informed by their location and individual circumstances. Nevertheless, both care workers and care managers questioned the appropriateness of the National Living Wage considering a care worker's training, role, and workload.

The National Living Wage has prompted an increase in the usage of zero-hour contracts which makes it easier for employers to amend employment terms to increase labour efficiency and workload (Moore et al., 2017; Vadean and Allan, 2020). According to the findings of this study, care workers were expected to take on extra workload to cover for staff shortages despite not being paid for them. There was an increase in paperwork that needed to be completed, frequent role changes, dealing with challenging service users and

their partners without proper support, and having to work too much overtime. The situation was made worse with limited assistance from colleagues and managers.

The literature identified that care workers could face unforeseen circumstances such as visits running late due to an emergency faced by a service user and traffic (Moore and Hayes, 2018). There has been cases of unrealistic number of scheduled visits such as 15- minute visits to increase productivity or insufficient time allocated for travel (Moore and Hayes, 2018). Thus, Local Authorities and care providers need to consider the unpredictable nature of care work when allocating staff workloads. In addition, issues such as staff shortage and increased workloads need to be addressed so that care workers could cope with the increase in working hours brought by the National Living Wage (Gardiner, 2016; Giuponni et al., 2016).

Although the National Living Wage has increased the weekly earnings of care workers in theory, the findings of the present study suggest that it had not improved their affordability to buy basic necessities. Care worker participants implied that the benefits of National Living Wage has been dimmed by staggering inflation contributed by the global energy crisis (CNN, 2022; Office for National Statistics, 2022b). They struggled with managing finances, especially with dependents (Office for National Statistics, 2022d), requiring them to rely on other means to top up their wages such as depending on family or benefits. Care workers managed these challenges by budgeting meticulously, which sometimes involves cutting back on essentials such as food, gas, and electricity. They often worked excessive hours to compensate causing exhaustion and disruption to work life balance.

In contrast to care workers, the challenges presented to care manager participants were limited to their professional rather than personal life. Care managers raised concerns that the limited additional funding by Local Authorities only made up for the lowest paid staff and they have been faced with the challenging task of maintaining an appropriate wage hierarchy. Previous research revealed that decreasing of wage differentials are considered as unfair impacting negatively on staff morale and productivity (Walmsley et al., 2019). The pilot study found evidence that the National Living Wage policy is demotivating junior care workers to accept a promotion and take on additional responsibilities due to the decreasing

wage difference. In the main study, the decision making of care workers in terms of accepting a promotion included weighing costs (increased responsibility and workload) against benefits (making an active difference towards improving care experiences, living comfortably, minimising overtime and better work life balance). Hence, Local Authorities need to take into consideration that increasing the wages of the lowest paid staff has a direct ripple effect on all other roles in the job hierarchy.

Furthermore, pay in the retail and cleaning sectors have been increasing at a faster rate than the social care sector since the introduction of the National Living Wage (Moriarty, Manthorpe and Harris, 2018; Skills for Care, 2020b). When queried, care manager participants expressed frustrations on how they found it impossible to compete with corporate businesses with wider profit margins. Despite these challenges, the pilot study revealed that the greater part of care workers favoured towards staying in the sector despite other sectors offering easier job opportunities for the same pay (Moriarty, Manthorpe and Harris, 2018; Skills for Care, 2020a). Although care worker participants valued flexibility such as working hours and workplace proximity, the main reason for staying in the sector was loyalty towards their sector, employer, service users and the act of caring itself. Care workers were conscious that leaving might create further struggles in the sector. The reward from the experience of providing care was greater than any financial incentives.

The literature indicates that monopsony wage models does not completely apply to the private social care sector because additional labour costs cannot be passed on to customers due to existing contracts with Local Authorities and regulations from the Care Quality Commission (Machin, Manning, and Rahman, 2003; Machin and Wilson, 2004; Vadean and Allan, 2020). Despite this, care managers in this study responded to the challenges of the National Living Wage policy by raising service user fees where possible and recruiting more privately funded residents to subsidise Local Authority rates.

With the implementation of the Health and Care Act 2022, self-funders can request care arrangements at the same rate paid by Local Authorities. Local Authorities have been requesting providers for historic figures of care costs to establish a median cost for care. Care managers who participated in this study criticised this approach of basing a fair cost of care

on the median cost of the current provision of care provided under extreme austerity measures. They insisted that a fair cost of care should be determined by service specifications reflecting the unique needs of different service users.

Given these findings, there is a need to review the current elements in the relationship between care providers and Local Authorities. Outcome based contracts put care providers at a disadvantage as compensation are based on outcomes that they do not fully control (Bosse and Phillips, 2016). Care manager participants preferred block contracts which offered security of income and sustainability. They insisted that with guaranteed income comes the ability to plan strategies to enable quality care provision. However, care managers implied that a fair cost of care needs to be established first. They also advised that to avoid conflict in block contracts, clear service expectations need to be set beforehand based on the capacity and expertise of the provider.

Research Objective 2: Factors that Influence Standards of Living

Unlike the benefits replaced by Universal Credit, aspects of care work like zero-hour contracts and travel time did not make it harder to claim Universal Credit. However, many domiciliary care workers in this study earn less than the National Living Wage due to unpaid travel time. This finding aligns with previous research showing that care workers often spend a significant portion of their working hours traveling, which causes their hourly wage to drop below the National Living Wage (Moore et al., 2017; UNISON, 2020). Failing to account for traffic or emergencies can worsen the situation (Moore and Hayes, 2018). Therefore, the National Living Wage should be seen as just one part of an anti-poverty strategy and should be supplemented by improved working conditions and living standards (Cooke and Lawton, 2008; Emmerson, Johnson, and Miller, 2014; Gardiner and Millar, 2006; Swaffield et al., 2018).

Care workers in this study empathised with the low rates paid to care providers and had modest expectations for financial wellbeing support. Similarly, the £7.5 billion in funding announced by the government in November 2022 has been criticised as insufficient. The Local Government Association has requested £13 billion in funding to address ongoing pressures and to enable Local Authorities to meet their statutory obligations under the Care

Act 2014. This amount also includes £3 billion to raise care worker pay to help with recruitment and retention challenges (Local Government Association, 2023).

This study found that employers used creative strategies like offering overtime and salary loans with their limited resources. However, wage deductions during tough times could lead to further financial difficulties. In some cases, employers offered subsidised meals or travel bonuses to offset rising fuel prices. When the employer-provided mileage rate was lower than the HMRC rate, care workers had to claim the difference from the government. Unfortunately, many care workers missed out on this tax relief due to the complicated process. A better solution would be for employers to claim the difference on behalf of employees or legally require that travel expenses be covered separately, making them non-taxable.

Care managers in this study characterised their communication on pay as honest and transparent. However, care workers reported instances where employers had failed to respond to their communication efforts. This dissatisfaction with communication, coupled with financial stress can negatively impact the quality of care provided (Armstrong and Brown, 2019; CIPD, 2021, 2023; Martono, Khoiruddin, and Wulansari, 2018).

Care worker participants felt most at ease discussing wages when they had a positive employer-employee relationship, characterised by approachability and understanding. They appreciated employers who valued their work and took the initiative to offer financial incentives. Frequent feedback about doing their best and the implication of fixed wages discouraged wage discussion.

Participants recommended strategies to enhance wage discussions, including individual conversations, fostering an open culture where employers are receptive to staff input, ensuring transparency, providing regular updates, and extending wage-related communication beyond the organisational level to involve Local Authorities. Managers reported challenges in negotiating with Local Authorities due to the competitive market. To make wage discussions more effective, a collaborative approach involving care workers, care managers, and Local Authorities is essential.

Care workers in this study expressed various career aspirations, including pursuing further training and education, becoming educators, and advancing to senior positions. They recommended that employers facilitate learning and development by covering course costs, offering flexibility for university attendance, providing in-house training for senior roles, and ensuring access to relevant software and training. These findings align with Skills for Care (2022) data, which shows that employers who invest in learning and development tend to have lower staff turnover and higher CQC ratings. Additionally, Section 97 of the Care Act 2014 mandates that care providers and NHS commissioning boards support the necessary learning and development for care workers to meet the increasingly complex needs of service users (Skills for Care, 2022).

Care worker participants have experienced feeling trapped behind a "glass ceiling" when attempting to get promotions. The reason was blamed on the lack of learning and development opportunities The glass ceiling is a metaphor that describes an invisible barrier that women and minorities encounter when attempting career advancement (Kulik and Rae, 2019). Women were less likely to be in senior management roles (68%) compared to direct care providing roles (83%) (Skills for Care, 2022) despite being the biggest demographic of the workforce. These are worrying trends as registered managers had a vacancy rate of 12.8%, which is higher compared to the 10.7% for the sector and 4.3% for the whole nation. Furthermore, services without registered managers had lower CQC ratings (Skills for Care, 2022). Since 96% of participants in this research were female (22 out of 23), it is likely that these findings are transferable to the female care worker population providing a probable explanation for the above-mentioned figures by Skills for Care (2022). Other recommendations to encourage career progression include creating a progression pathway for individual career aspirations and internal job promotions.

Research Objective 3: Recommendations to address challenges imposed by the National Living Wage Policy

Addressing Low Pay in the Sector

In terms of social care provision and contribution to practice, there are clear implications of this research's findings for addressing the challenges faced by care workers and care

managers. The construction of the National Living Wage as a one size fits all approach must be challenged as care workers experiences of the policy are not uniform and are informed by their location and individual circumstances.

Moreover, the appropriateness of the National Living Wage to care-workers considering their training, role, and workload must be questioned. Care workers are expected to take on extra workload to cover up staff shortages. There was an increase in paperwork that needed to be completed, frequent role changes, dealing with challenging service users and their partners without proper support, and having to work too much overtime. In addition, the literature highlighted that they could face unforeseen circumstances such as visits running late due to an emergency faced by a service user or traffic (Moore and Hayes, 2018).

Existing pay and grading schemes need to be amended to reflect similar male dominated sectors (Müller, 2019). A national care wage linked to a band 3 NHS healthcare assistant needs to be implemented as suggested by the president of the Association of Directors of Adult Social Services (ADASS) in the Health and Social Care Committee meeting held at the House of Commons on September 2020 (UK Parliament, 2020). The Scottish and Welsh governments have implemented the Real Living Wage for care workers (Gov.Scot, 2023; Welsh Government, 2022). Gardiner and Hussein (2015) have argued that although the cost implications to increase wages for all frontline care jobs in the UK would be significant, 47 percent of the costs would be refunded to the public purse in the form of income tax and a reduction in benefit spending.They further suggested that raising pay could lead to improved service delivery leading to further cost savings in terms of wider social and economic benefits.

Required Support by Local Authorities

Care manager participants raised concerns that funding by Local Authorities only made up for the lowest paid staff. Furthermore, pay in the retail and cleaning sectors have been increasing at a faster rate than the social care sector since the introduction of the National Living Wage (Moriarty, Manthorpe and Harris, 2018; Skills for Care, 2020b). Care managers in this study found it impossible to compete with corporate businesses whilst also struggling to maintain pay differentials. Care workers questioned whether the additional responsibilities

of a promotion are worth compared to the minimal pay increase. Thus, Local Authorities need to take into consideration that increasing the wages of the lowest paid staff has a direct ripple effect on all other roles in the job hierarchy.

Care manager participants emphasised the need to implement a fair cost for care and highlighted the incompetency of the current approach used by Local Authorities. A fair cost of care should be based on unique service specifications of service users rather than the median cost of the current care provision under extreme austerity measures.

Optimal Contract Type for Care Commissioning

The current relationship between care providers and Local Authorities needs to be reconsidered based on the challenges imposed by the National Living Wage. Effective reward systems are a key component for the effective functioning of this relationship between care providers and Local Authorities. (Tumbat and Grayson, 2016). As outcomes of care are not fully controlled by care providers, outcome based contracts can put them at an unfair disadvantage (Bosse and Phillips, 2016). Care managers who participated in this research agreed with this view by suggesting that block contracts offered them security of income and sustainability. They argued that with guaranteed income comes the ability to plan strategies to enable quality care provision. However, care manager participants emphasised the importance of establishing a fair cost of care first. They also advised that to avoid conflict in block contracts, clear service expectations need to be set beforehand based on the capacity and expertise of the provider.

Behaviour-based contracts encourage team work to identify solutions towards quality improvement rather than monitoring (Robertson and Ewbank, 2020). Effective management of professional expertise and the encouragement of political accommodations amongst organisations can lead towards more integrated care (Sarwar, Harris and South, 2017).The Covid-19 pandemic highlighted the importance of sharing information and having common goals to minimise costs (Aughterson et al., 2021; Tumbat and Grayson, 2016). Staff met to share learning, develop innovative responses to the crisis with a common goal of recovering together (Bailey and West, 2020).

Addressing Vulnerabilities Concerning Unpaid Travel

As a result of the non-payment for travel time, many domiciliary care workers who participated in this research are earning below the National Living Wage. The literature identified that not accounting for traffic or a service user emergency when allocating travel time could make the situation worse (Moore and Hayes, 2018). Furthermore, where travel costs have been taxed beforehand or less than the rate published by the government, care workers have to deal with the cumbersome task of claiming back travel expenses. Many care workers miss out on this important tax relief due to the process being too complicated (Low Incomes Tax Reform Group, 2018). Therefore, it should be a legal requirement that travel expenses and travel time need to be covered separately. Where the employer provided rate is less than the government, a suitable solution would be for the employer to claim the difference on behalf of employees.

Strategies to Improve Wage Discussion

Dissatisfaction with current communication combined with financial distress can impact the quality of care provided (productivity) (Armstrong and Brown, 2019; CIPD, 2021, 2023; Martono, Khoiruddin and Wulansari, 2018). The findings revealed that good employer-employee relationships need to be established. Employers need to be approachable and understanding when communicating. Initiating financial incentives without being prompted could show that employers value financial wellbeing. Employers should be conscious and avoid implying that they are doing the best they can and that wages are fixed based on job roles.

Suggested strategies by participants to improve wage discussion include individual discussions, creating an open culture where employers are willing to listen and have open discussions with staff, transparency, and consistent updates on the situation, and extending the communication around wages from the local organisational level to the Local Authorities. Local Authorities need to open mediums to have discussions between care workers, care managers and the Local Authorities. Transparency and disclosure of information is an integral part of managing the stakeholder relationship leading to increased productivity and performance (Linder and Foss, 2015). Transparent decision making and regular

communication with stakeholders could lead to sharing best practice approaches and flexibility in unexpected challenges (Harrison, Bosse and Phillips, 2010).

Supporting Career Progression

Despite a significant 82% of the care sector workforce consisting of women, they were less likely to be in management roles compared to direct care providing roles (Skills for Care, 2022). The findings reveal that lack of learning and development opportunities have left care worker participants feeling trapped behind a "glass ceiling" when attempting to get promotions. It has been suggested by participants that care providers need to support learning and development through paying for courses, providing flexibility to attend university, in house training to perform senior roles, and providing access and training to use the relevant softwares. Employers with higher levels of learning and development had lower staff turnover and higher CQC ratings (Skills for Care, 2022). This would also assist providers to comply with section 97 of the Care Act 2014 requiring care providers and NHS commissioning boards to support learning and development essential for service user needs (Skills for Care, 2022).

In addition, the decision making of care worker participants in terms of accepting a promotion included weighing costs against benefits. Senior roles should satisfy a care worker's emotional needs (satisfaction that they are improving the care experiences of service users) and financial needs (living comfortably, minimising overtime and better work life balance). Managerial roles offered to care workers should include learning and development opportunities to acquire new skills that could satisfy their desire to have a positive impact on care delivery. The increased responsibility and workload, such as the additional documenting of reports, forms and letters should be reflected in the pay. Employers should also create progression pathways for individual career aspirations and promote jobs internally.

6.4 Contribution to Knowledge

Existing research highlights the challenges imposed by the National Living Wage policy on the private adult social care sector such as an increase in Zero-Hour Contracts (Vadean and Allan, 2020), underpayments in wages (UNISON, 2020), difficulty in maintaining pay differentials and competition from other sectors (Moriarty, Manthorpe and Harris, 2018; Skills for Care, 2022). This research contributes to the existing literature by delving deeper

into how workers have adapted to these adversities and how their daily lives have been transformed as a result. By understanding their coping strategies and the adjustments they have made in response to the National Living Wage policy, this research have identified best practices that have emerged from these adaptations. Such insights are crucial not only for improving the working conditions within the sector but also for making social care a more attractive field for prospective employees (Manthorpe et al., 2010).

It also analysed how care providers have adjusted to the increases in National Living Wage rates with the limited funding available adding to the current short-term analysis on the impact of National Living Wage in the sector. Researchers (Giuponni et al., 2016; Vadean and Allan, 2020) have emphasised the importance of further research on the effects of National Living Wage on care providers claiming that how care providers will adjust to austerity measures and the planned increases in National Living Wage rates is an important question for future research, especially due to the sector already dealing with low retention rates and issues with labour supply. Ultimately, this research sheds light on the resilience of the sector and the innovative approaches they employ to navigate the complexities of the current landscape.

In addition, the study has also captured factors that negatively influence the living standards of workers under the National Living Wage policy. The study identified that low financial expectations due to the low rates paid to care providers, employers being hostile towards employee-initiated communication on wage discussions and lack of learning and development opportunities creating a “glass ceiling” when attempting to get promotions contribute to the persistent low pay and poor working conditions in the sector. It is of paramount importance to identify these factors so that care providers and policy makers can proactively implement strategies to eliminate these issues.

Given the focus of this research upon the experiences of National Living Wage in the adult social care context, the study captured key challenges faced by care workers and care managers. The focus was to explore their perceptions on the benefits and challenges presented by the policy, with the aim of providing recommendations to address challenges imposed by the National Living Wage policy (objective three). This would be helpful for

policy makers to drive improvements in the care sector. This research would be of interest to organisations such as the Low Pay Commission, HMRC, Department of Health and Social Care and trade unions. These findings have practical implications for policy makers which have been discussed in the previous section (Research Objective 3: Recommendations to address challenges imposed by the National Living Wage Policy). The researcher has already been contacted by the Association of Directors for the Adult Social Services for a copy of the research for them to present the findings to the Low Pay Commission.

6.5 Limitations of Theoretical and Methodological Choices

Criticisms of Stakeholder Theory

This research maps stakeholder theory to the private adult social care sector, exploring the formal relationship between care providers and care workers. Some researchers have questioned the practical feasibility of stakeholder theory and argued that certain groups are often overlooked in stakeholder research (Kujala et al., 2022; Xiao, 2023). Likewise, the recommendations in this thesis arising from the application of stakeholder theory are not feasible without additional funding. Furthermore, there are other important stakeholders, such as the Local Authorities, whose views have not been included in this research. Time and funding constraints did not permit for the scope of this research to be extended to include the views of Local Authorities. Future research could build upon the findings of this thesis by presenting the views of Local Authorities regarding the challenges of the National Living Wage policy in the sector. Nevertheless, the findings of this research support the view held by Xiao (2023, p.26) that stakeholder theory can reduce the exploitation of low paid adult social care workers *"both in theory and practice, and contribute to the long-term success and sustainable development (Xiao, 2023, p.26)"* of the private adult social care sector.

Generalisability

As the experiences of National Living Wage is a sensitive topic requiring in-depth data to sufficiently capture participant views, a qualitative approach was chosen for data collection. It has been argued that qualitative research cannot be generalised to a wider population, hence, does not contribute to wider knowledge (Biggam, 2018). The reason being that

qualitative research involves the study of a small group or individuals sharing certain characteristics (Bryman, 2016). However, seeking a representative sample of individuals in a qualitative study and analysing the vast amount of data generated would prove difficult to capture the shared experiences amongst participants (Malterud, Siersma and Guassora, 2016).

This study provides a rich in-depth picture of the experiences and perceptions of National Living Wage within the context of the private adult social care sector (Patton, 2015). The aim is to provide the reader with enough information to make judgements about the transferability of findings to other situations and settings (Biggam, 2018; Bryman, 2016; Given, 2008; Seale and Silverman, 1997). This research employed multiple data collection methods to achieve triangulation that would present the research from a variety of perspectives (Noble and Heale, 2019). Multiple instruments including a pilot study, interviews and documentary evidence were used to collect data.

Minimising Researcher Bias

When analysing qualitative data, the researcher assumes an interpretative role in the data analysis process. The interview relationship consists of a major power imbalance where the interviewer has the sole authority of interpreting data generated (Bryman, 2016; Coleman, 2019)**.** To increase reliability and trustworthiness, all analytical decisions that lead to the formulation of codes and themes have been documented in Chapter five: Findings and Discussion, forming an audit trail of the data analysis process. The use of the pilot study and interviews for data collection has been described in detail. The coding process and data analysis were further repeated using the software NVivo to increase transparency and minimise human error.

Minimising Participant Bias

Furthermore, it should be acknowledged that interview answers maybe be biased and exhibit errors in recollection (Coleman, 2019). This was dealt with by collecting data from two key stakeholders, instead of just one source. Views were collected using the same questions from care workers and care managers ensuring that findings were not limited to one group. Views

from care managers assisted in placing the views from care workers in a wider context minimising bias and misinformation. Moreover, consideration was given to ensure that the interview questions were clear and detailed, presenting the same question multiple times using different wordings. For example, questions on the benefits and challenges of National Living Wage have been presented in several ways to for care workers to consider these topics in different contexts providing them the opportunity to reconsider their views. It is hoped that this would minimise any bias and errors in recollection.

Ethical Concerns

Finally, consideration was given to addressing ethical challenges throughout the research process (Sanjari et al., 2014). The ethical challenges faced included how to ensure that consent is voluntary and informed, deciding on the necessary measures to maintain anonymity, confidentiality and minimising harm to participants (Halai, 2006). Ethical decision making was guided by the virtue ethics theory where researchers apply their own moral values and make decisions on ethical dilemmas based on what they believe is an ethical researcher (Morris and Morris, 2016). The value statement that guided all ethical decisions is "to benefit the participants without any potential harm." The virtues adopted in the research included being truthful about the nature of the research, fairness in adhering to participant's legal rights and interests whilst maintaining institutional guidelines, respecting participant wishes, participant right to make choices, and privacy (Kivunja and Kuyini, 2017). The steps taken to address each of the ethical challenges have been detailed in Chapter four: Methodology.

6.6 Recommendations for Further Research

There is considerable potential for further research on this subject, particularly by building upon the findings of this study. One fruitful direction for future research could involve replicating the study with an expanded scope that includes the perspectives of Local Authorities. As key stakeholders in the adult social care sector, Local Authorities play a critical role in implementing the National Living Wage policy, often grappling with its financial and operational implications. By gathering and analysing the views of Local Authorities, researchers could gain deeper insights into the multifaceted challenges posed by

the policy. This additional perspective might reveal new challenges or opportunities, such as how budgetary pressures and funding allocations affect the quality of care, the sustainability of care services, and the ability of Local Authorities to maintain a stable workforce. These insights could significantly enhance the current understanding of the policy's impact and offer a more nuanced picture of the sector's response to wage regulations.

Furthermore, conducting similar research in Wales and Scotland, where care workers are entitled to at least the Real Living Wage, could provide valuable comparative data. Such research would allow for a cross-regional analysis of how different wage policies influence the adult social care sector, including their effects on worker satisfaction. By comparing the outcomes in Wales and Scotland with those in England, researchers could identify best practices and policy lessons that could inform future wage-setting decisions across the UK. This comparative approach could also shed light on the broader implications of adopting a Real Living Wage in England, potentially providing a stronger case for its implementation.

In addition to broadening the geographical and stakeholder scope, the findings of this study could be further refined and validated by developing specific hypotheses based on the qualitative data. These hypotheses could then be tested using quantitative methods, such as surveys or statistical modelling, to ensure that the results are statistically representative. This approach would enable researchers to confirm the robustness of the initial findings and provide more concrete evidence of the relationships between wage policies and worker experiences in the private adult social care sector in England. By employing a mixed-methods approach that combines qualitative insights with quantitative rigor, future research could contribute to a more comprehensive and reliable body of knowledge on the impact of wage policies in the adult social care sector. This, in turn, would equip policymakers, care providers, and other stakeholders with the evidence they need to make informed decisions that promote both the well-being of care workers and the sustainability of the sector.

6.7 Journey as a Researcher

Whilst studying for her MBA in 2010, the researcher completed a 17,000 words dissertation on the principles of ethical decision making in businesses and its impact on the market place

by using Primark (a global clothing retailer) as a case study, interviewing 15 customers of Primark chosen at random from three Primark stores at different locations in the UK.

After that, the researcher took the opportunity to carry out research for the Civil Service Commission as a full-time consultant to review the Maldives Civil Service grading and pay system for three months. The aim was to evaluate the provided pay and benefits of the Civil Service in comparison with other government entities for the past 5 years from July 2015. This was done by identifying differences in pay and benefits between employees working in the capital and atolls and exploring the state of the economy. Changes in the cost of living and government's fiscal position were identified within the past 5 years and recommendations provided based on research evidence.

After much persuasion, in February 2018, the Civil Service Commission was able to convince the government to increase the salaries of more than 23,000 employees working in the Civil Service based on her report. Since then, the topic of low pay has been very close to the researcher’s heart as it confirmed that research is an important component to drive improvements in pay. While reading on the subject matter, she found out that the British social care sector is a low paying industry consisting mainly of woman (92%) and as of March 2016, 40% of care workers were paid below the National Living Wage according to Skills for Care (2016). Hence, the National Living Wage is likely to have a high impact on this sector.

The researcher decided to conduct PhD research in this topic as like for the low paid employees in the Civil Service of Maldives, she wanted to bring out new information that might help to identify the issues and difficulties faced by workers servicing some of the most vulnerable people in the British population that would assist in improving the planning and quality of social care in order to provide a better service for the people using it.

The researcher found a gap in literature by identifying that there is limited research on how challenges presented by the National Living Wage policy have impacted the professional and personal lives of low paid workers in the private adult social care sector. This PhD research addressed a gap by exploring the private adult social care sector’s views and experiences of the National Living Wage policy in England, factors that influence the living standards of

care workers under the policy and by recommending ways to address challenges. The researcher believes that it is necessary to understand how the private adult social care sector's workers and organisations are currently appraising and responding to the policy to identify best practices and to improve the sector's experience of complying with the National Living Wage policy. The previous research projects authored by the researcher have been dedicated to post positivist views (Athif, 2010, 2015). Nevertheless, the researcher was conscious of being cognitively biased (Alvesson and Sköldberg, 2018) and it was decided that a constructivist epistemological stance was necessary to achieve the research aim.

6.8 Chapter Summary

The findings of this research question the one size fits all approach of the National Living Wage, arguing for the implementation of a national care wage. Local Authorities need to consider the sector's struggle of competing with corporate businesses in the cleaning and retail sectors and the pressures of maintaining wage differentials. The solution is a fair cost of care based on service specifications rather than the current rates established under extreme austerity. The current elements in the relationship, especially contracts with care providers, needs to be reviewed based on the challenges imposed by the National Living Wage.

Open cultures encouraging transparent communication need to be cultivated between care workers, care managers and Local Authorities. More learning and development opportunities need to be provided to break the "glass ceiling" preventing more women from progressing to senior management roles. Senior roles should satisfy a care worker's emotional needs (satisfaction that they are improving the care experiences of service users) and financial needs (living comfortably, minimising overtime and better work life balance).

These findings add to the current short-term analysis on the impact of National Living Wage in the sector and opened possible avenues for further research. Conducting this research was a learning process which conveyed the importance of pilot studies and encouraged to reflect on the power dynamics of interpreting the interview results. This led to a greater appreciation of the insights that can be gained by looking at the wider social context of each individual.

Appendix 1: Chronology of Wage Milestones in the UK

The below table containing the chronology of wage milestones in the UK provide a structured overview of significant changes and developments in wage policies and rates over time. This includes key legislative acts, the introduction of minimum wage laws, adjustments to the National Living Wage, and other critical events that have shaped the wage landscape in the UK. The table illustrates the evolution of wage standards, highlighting how economic, political, and social factors have influenced workers' earnings across different periods.

Chronology of Wage Milestones in the UK	
1351	Statute of labourers which set maximum rather than minimum rates.
1891	Fair wages resolution sought to prevent government contractors from paying unfairly low wages to employees.
1909	Tripartite Trade Boards (later called wages councils) for selected industries where low wage employment was concentrated.
1928	International Labour organization held its minimum wage-fixing machinery convention.
1970	Equal Pay Act.
1975	Schedule 11 of the Employment Protection Act.
1993	Abolition of wage councils (Trade Union Reform and Employment Rights Act 1993) except for Agricultural Wages Council which was abolished in 2013.

1997	Formation of the Low Pay Commission (LPC).
1999	LPC's first recommendation of £3.60 for adults raised the pay of 1.7 million workers.
2000	LPC gained cross-party support following the Conservative Party announcing its adoption of the principle of NMW.
2001	The Living Wage campaign was launched in East London by the East London Communities Organisation (now Citizens UK) by organizing a series of public demonstrations.
2005	Greater London Authority developed its calculations for a London Living Wage.
2008	Establishment of the Living Wage Foundation.
2012	The Scottish Parliament adopted the Living Wage. Labour leader David Miliband launched the Living Wage Week in November 2012 subsequently sending a letter to Labour Councils requesting they consider adoption of the Living Wage.
2015	National Living Wage for workers aged 25 and over with a target of achieving a level of 60% of the median hourly rate by 2020.
(Prowse and Fells, 2016)	
2019	Chancellor of the Exchequer pledged to increase the National Living Wage towards a new target of 66% (2/3) of median earnings by April 2024.

	Plans to increase the coverage of workers from aged 23 and over from the year 2021, and to those aged 21 and over within five years (GOV.UK, 2019).
2020	Government's 2015 target for the national living wage to be 60 percent of median UK earnings reached (Department for Business, Energy and Industrial Strategy, 2016).

Appendix 2: Optimal Contract Alternative Based on Eisenhardt's (1989) Propositions

The table below presents the optimal contract alternative based on Eisenhardt's (1989) propositions. The table utilises Eisenhardt's (1989) propositions as a framework for selecting the most appropriate contract type within the context of the adult social care sector. Eisenhardt (1989) emphasises the importance of aligning the goals of principals (e.g., care commissioners) and agents (e.g., care providers) while considering factors like the efficiency of established information systems, the level of control and certainty level to achieve the required outcomes, risk tolerance, task programmability, performance measurability and length of the contract. Eisenhardt (1989) argues that these propositions guide the structuring of contracts to ensure high-quality service provision and proper incentive alignment.

Optimal Contract Alternative Based on Eisenhardt's (1989) Propositions

Proposition	The situation in the social care sector	Optimum type of contract
Information systems are positively related to behaviour-based contracts and negatively related to outcome-based contracts.	The care contractor has a strong evidence base, including the type and cost of social care required for their specific population as well as the capacity and range of providers. The care contractor shares data and intelligence with relevant organisations through Integrated Care Partnerships (ICP) to facilitate innovations and improve services. This is complemented with robust monitoring systems using data from the care	Behaviour-based contract

	provider's monitoring processes, Care Quality Commission, feedback from the local Healthwatch group, customer feedback from the citizens and the contractor's own observation and assessment of Key Performance Indicators and service standards.	
Outcome uncertainty is positively related to behaviour-based contracts and negatively related to outcome-based contracts.	Factors such as government policies and legislations imposing more responsibilities and conditions on care providers (Care Act 2014), economic issues (cost pressures due to the rise in National Living Wage or rent inflation), competition and technological changes may cause uncontrollable variations in outcomes. Furthermore, the achievement of outcomes would depend on the optimum performance of all individuals and organisations involved in the person's care. The effort of the social care provider alone would not help to achieve the outcomes to the highest level.	Behaviour-based contract
The risk aversion of the agent is positively related to behaviour-based contracts and negatively related to outcome-based contracts	The care provider is usually more risk-averse than the care contractor due to limited sources of finance and workforce availability.	Behaviour-based contract

The risk aversion of the principal is negatively related to behaviour-based contracts and positively related to outcome-based contracts.	The care contractor, on the other hand, has a diverse range of support through partnerships and integrated care systems where NHS organisations, in partnership with local councils, community and voluntary organisations and other health care providers take collective responsibility for managing resources. Resources such as finance, workforce and estates are pooled to reduce duplication and achieve efficiencies.	Behaviour-based contract
The goal conflict between principal and agent is negatively related to behaviour-based contracts and positively related to out-come-based contracts.	The care contractor and care provider share the overall goals of the contract which is to help the service user achieve their desired outcomes.	Behaviour-based contract
Task programmability is positively related to behaviour-based contracts and negatively related to outcome-based contracts.	Although outcomes could be uncertain and difficult to measure due to the involvement of a joined team effort, the tasks performed by care workers are highly programmable which could include help with personal care such as dressing or showering or monitoring individuals' conditions by taking their temperature, pulse, respiration, and weight, and possibly helping with medication. Care workers have strict policies and procedures to follow when performing all tasks.	Behaviour-based contract

Outcome measurability is negatively related to behaviour-based contracts and positively related to outcome-based contracts.	Many of the specified outcomes in care plans could be easily measured, but as mentioned before requires a joint team effort. Hence, it is difficult to measure the contribution of the care provider in achieving the particular outcome.	Behaviour-based contract
The length of the agency relationship is positively related to behaviour-based contracts and negatively related to outcome-based contracts.	The duration of the contract could vary from anywhere between 1-30 years	Inconclusive

Appendix 3: List of Documentary Evidence Used

This table presents a summary of the sources and types of documents collected during the research. It includes official documents such as Acts of Parliament, House of Commons meeting minutes, and reports related to the National Living Wage. Additionally, reports from Non-Governmental Organisations (NGOs) such as the Living Wage Foundation and the Resolution Foundation were also gathered. The analysis of these documents provided a comprehensive contextual background, offering insights into the social, political, and economic factors associated with the National Living Wage and identifying further areas for exploration in the pilot study and interviews.

Documents Selected	**Data Analysed**
Adăscăliței, D., Crockett, G., Heyes, J., Newsome, K. and Yates, E. (2019) *The Impact of the National Living Wage on Businesses.* Sheffield: Sheffield University Management School	The impact of National Living Wage on wages, profits, staffing levels, employments practices, prices, and quality of services.
Aitken, A., Bolton, P. and Riley, R. (2018) *The impact of the introduction of the National Living Wage on employment, hours, and wages*. London: National Institute of Economic and Social Research.	Findings examining the effects on employment

	and hours worked of the introduction and first uprating of the National Living Wage.
Capuano, S., Cockett, J. and Gray, H. (2018) *The impact of the minimum wage on employment and hours*. Brighton: Institute for Employment Studies.	Impact of National Living Wage on employment and hours worked based on employee characteristics such as age and whether the employee worked full time or part time.
Capuano, S., Cockett, J., Gray, H. and Papoutsaki, D. (2019) *The impact of the minimum wage on employment and hours.* Brighton: Institute for Employment Studies.	Impact of National Living Wage in 2016 and further up ratings on employment and hours worked based

	on age, gender, part time and full-time employees, employee contract and organisation type.
Care Act 2014, c. 23. Available at: https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted (Accessed: 2 August 2020).	The rights of stakeholders in the care commissioning process including Local Authorities, care providers, employees working in the care sector, care recipients and carers.
D'Arcy, C., Corlett, A. and Gardiner, L. (2015) *Higher ground: who gains from the National Living Wage? • Resolution Foundation*. London: Resolution Foundation. Available at: https://www.resolutionfoundation.org/publications/higher-ground-who-gains-from-the-national-living-wage/ (Accessed: 30 May 2021).	Challenges and opportunities associated

	with National Living Wage.
Department for Business, Energy and Industrial Strategy (2016) *Policy Paper National living wage (NLW)*. Available at: https://www.gov.uk/government/publications/national-living-wage-nlw/national-living-wage-nlw (Accessed: 20 March 2020).	Government plans and motivations behind the introduction of National Living Wage.
Department of Health and Social Care (2021a) *Integration and innovation: working together to improve health and social care for all (HTML version), GOV.UK*. Available at: https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version (Accessed: 31 August 2022).	Legislative proposals for a Health and Care Bill that aim to make it easier for health and care organisations to deliver joined-up care for people who rely on multiple different services, building on earlier recommendations by NHS England and

	NHS Improvement.
Department of Health and Social Care (2021b) *People at the Heart of Care: adult social care reform white paper*, *GOV.UK*. Available at: https://www.gov.uk/government/publications/people-at-the-heart-of-care-adult-social-care-reform-white-paper (Accessed: 16 August 2022).	This white paper sets out a 10-year vision for adult social care and provides information on funded proposals that will be implemented over the next 3 years.
Equality Act 2010, c.15. Available at: https://www.legislation.gov.uk/ukpga/2010/15/contents (Accessed: 2 August 2020).	Legislation covering both care workers and care recipients ensuring equal opportunity for everyone and nobody is discriminated unfairly due to their age, disability, gender,

	marital status, religious beliefs, or sexual orientation.
Foster, D., Sandford, M. and Harker, R. (2021) 'Adult Social Care Funding (England)'. Available at: https://commonslibrary.parliament.uk/research-briefings/cbp-7903/ (Accessed: 29 May 2021).	Key funding pressures facing adult social care services in England and their impacts.
Gardiner, L. (2016) *Rising to the challenge: early evidence on the introduction of the National Living Wage in the social care sector*. London: Resolution Foundation. Available at: https://www.resolutionfoundation.org/publications/rising-to-the-challenge/ (Accessed: 25 October 2020).	Impact of National Living Wage on working hours and employment in the social care sector and how funding might impact the ability of providers to keep up with further up ratings.
Gardiner, L. and Finch, D. (2020) *The long and winding road: The introduction and impact of Universal Credit in Liverpool City Region and the UK*. London: Resolution Foundation. Available at:	Effectiveness of the Universal

https://www.resolutionfoundation.org/app/uploads/2020/01/The-Long-and-Winding-Road.pdf (Accessed: 20 March 2020).	Credit policy and barriers for people moving into Universal Credit.
Giupponi, G., Lindner, A., Machin, S. and Manning, A. (2016) *The impact of the national living wage on English care homes.* London: London School of Economics.	The impact of National Living Wage on English care homes in terms of wages, employment, hours, prices, and productivity.
Health and Care Act 2022, c. 31. Available at: https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted (Accessed: 23 January 2023).	Legislation on wider reforms to public health, social care delivery, quality, and safeguarding.
Heffernan, K., Mulkearn, K., Rickard, C., Conlon, G., Sutton, K., Withers, L. and Woolacott, Z. (2022) *Influence of the NLW on pay setting, differentials, and progression: A report for the Low Pay Commission*. London: Incomes Data Research. Available at: https://www.gov.uk/government/publications/low-pay-commission-research-2022 (Accessed: 16 May 2023).	The effect of National Living Wage on pay setting, maintaining pay

	differentials and opportunities for pay progression.
Heffernan, K., Mulkearn, K., Rickard, C., Withers, L. and Woolacott, Z. (2021) *Impact of future targets for the NLW: A report for the Low Pay Commission*. London: Incomes Data Research. Available at: https://www.gov.uk/government/publications/low-pay-commission-research-2021 (Accessed: 16 May 2023).	Impact pf National Living Wage on pay structures, wage differentials, employment terms and conditions, and planned measures by organisations to offset future wage increases.
Home Office and UK Visas and Immigration (2020) *Policy paper UK points-based immigration system: further details statement.* Available at: https://www.gov.uk/government/publications/uk-points-based-immigration-system-further-details-statement/uk-points-based-immigration-system-further-details-statement (Accessed: 19 November 2020).	Routes to employing international workers into the main professions in the social care sector based on the new points-based

	immigration system.
Lee, S.-M., Manly, L., Patrignani, P. and Conlon, G. (2022) *Assessing the impacts of the reduction in the age of entitlement to the National Living Wage from age 25 to age 23*. London: London Economics. Available at: https://www.gov.uk/government/publications/low-pay-commission-research-2022 (Accessed: 16 May 2023).	Impact of National Living Wage on employment, hours worked, and hourly earnings of 23-and 24-year-olds who were newly eligible in April 2021.
Low Pay Commission (2018) *National Minimum Wage: Low Pay Commission Report 2018* (CM 9717). Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/759271/National_Minimum_Wage_-_Low_Pay_Commission_2018_Report.pdf (Accessed: 6 February 2019).	Overall impact of National Living Wage, economic pressures across low paying industries and stakeholder views.
Migration Advisory Committee (2020) *Review of the Shortage Occupation List: 2020.* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/927352/SOL_2020_Report_Final.pdf (Accessed: 19 November 2020).	Recommendations by the Migration Advisory Committee

Migration Advisory Committee (2022) *Adult social care and immigration (accessible), GOV.UK*. Available at: https://www.gov.uk/government/publications/review-of-adult-social-care-2022/adult-social-care-and-immigration-accessible (Accessed: 15 August 2022).	for the social care sector including stakeholder evidence.
Moore, S., Antunes, B., White, G., Tailby, S. and Newsome, K. (2017) *Non-Standard Contracts and the National Living Wage: A Report for the Low Pay Commission.* Project Report. The University of Greenwich	The relationship between contractual agreements and the payment of the National Living Wage.
Skills for Care (2022) *The state of the adult social care sector and workforce in England*. Available at: https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx (Accessed: 5 November 2022)	Comprehensive analysis of the adult social care workforce in England. Topics covered include recent trends in workforce supply and demand, employment information, recruitment and retention,

	demographics, pay, qualification rates and future workforce forecasts.
UK Parliament (2020) *Health and Social Care Committee, Oral evidence: Social care: funding and workforce, HC 206*. Available at: https://committees.parliament.uk//oralevidence/817/html (Accessed: 27 February 2021).	Oral evidence given by the Health and Social Care committee at the House of Commons on the funding and workforce issues in the social care sector.

Appendix 4: Care Manager and Care Worker Posters

Dear Care Managers,

A BIG THANK YOU FOR THE GREAT JOB YOU ARE DOING!!!

A PhD student needs your help in researching the "***Impact of the National Living Wage (NLW) policy on low pay jobs in the private adult social care sector in England".*** Are you;

- 18 years or over
- Working in the private adult social care sector in England
- A **care manager** involved in the implementation of National Living Wage.

What: By participating, you will be contributing your valuable knowledge and experience to help us recommend further ways to support the care workforce. Please feel free to use capitals for emphasis and detailed answers are preferred.

Time: The interview can be completed at your own convenience and pace. It should take around 20 minutes to complete.

Confidentiality: Responses are collected on an anonymous basis and are confidential.

To take part, simply copy and paste the below link in your browser:

https://sunduni.eu.qualtrics.com/jfe/form/SV_0pMobugWL76G1xQ

Contact: If you have any questions, please contact either me (Fathimath Athif) at bh66sf@research.sunderland.ac.uk or Dr. Julia J. Nobari at the Faculty of Business, Law and Tourism at the University of Sunderland: julia.j.nobari@sunderland.ac.uk

Dear Care Workers,

Share your valuable knowledge and experience! Help us recommend better ways to support the care workforce by becoming a part in researching the "Impact of the National Living Wage (NLW) policy on low pay jobs in the private adult social care sector in England".

Are you –

- Over 18

- Working in the private adult social care sector in England

- A **care worker** receiving the National Living Wage

Become a part of change today!

- Takes Around 30 mins

- Confidentiality protected

- Complete at own convenience

To participate please copy the link below in your browser

https://sunduni.eu.qualtrics.com/jfe/form/SV_5A83grWcQUDTFMG

If any questions, please contact

Fathimath Ibthihaj Athif
Bh66sf@research.sunderland.ac.uk

Dr Julia J. Nobari
Julia.j.nobari@sunderland.ac.uk

Faculty of Business, Law and Tourism at the University of Sunderland

Appendix 5: Details of Care Sector Worker Facebook Groups

Care workers use Facebook groups to build a sense of community, share resources, and provide mutual support within the caregiving profession. These groups serve as platforms for care workers to exchange information, discuss challenges, and share best practices, helping them stay informed about the latest developments in the field. Additionally, Facebook groups offer a space for emotional support and camaraderie, allowing care workers to connect with others who understand the unique demands of their role.

GROUP NAME	PURPOSE	NUMBER OF MEMBERS
Private Sector Healthcare Workers Association Group	One Collective Voice, the place for Association Members to share advice, discuss experiences / challenges and inspire change. To be positive, not negative.	6600
Home care support workers	I have created this group for care support workers only. You can have your say on any good or bad situations. Funny or sad. If you care to rant, then rant. We may be able to help each other.	2000
National Association of Care and Support Workers (NACAS) Member Community Group	This is a community group for NACAS members, where they are able to meet and discuss issues. It will also be a noticeboard for any NACAS updates, events or any information related to their membership, or care working in general.	505
Group for UK Care Workers and Support Workers	This group is primarily a support network for carers in the United Kingdom. The more carers we can get to join the more we can help each other.	39700
Support Group for Social Care Workers UK	We aim to provide a place where you can share your feelings and experiences relating to work in a safe, non-judgmental environment with others may have been in similar situations and are in a position to offer advice to support you in your role as a social care worker.	6300

Group for Care and Support Workers	Group for care workers and support workers to share problems etc.	1200

Appendix 6: List of ENRICH (Enabling Research in Care Homes) Clinical Research Networks.

ENRICH (Enabling Research in Care Homes) Clinical Research Networks are a UK-based initiative designed to support and facilitate research within care home settings. These networks bring together care home staff, residents, researchers, and other stakeholders to create a collaborative environment that encourages high-quality, ethically sound research. The goal of ENRICH is to improve the quality of life and care for residents by promoting evidence-based practices and ensuring that care homes have access to the latest research findings. By bridging the gap between academic research and practical care delivery, ENRICH helps integrate research into everyday care, fostering innovation and continuous improvement in care homes.

1. North East and North Cumbria
2. North West Coast
3. Yorkshire and Humber
4. Greater Manchester
5. East Midlands
6. West Midlands
7. West of England
8. Thames Valley and South Midlands
9. East of England
10. Kent, Surrey, and Sussex
11. Wessex
12. South West Peninsula
13. North Thames
14. South London
15. North West London

Appendix 7: Care Manager and Care Worker Interviews

Care Manager Interview

Dear **Care Managers**,

I am conducting PhD research on the Impact of the National Living Wage (NLW) policy on low pay jobs in the private adult social care sector in England. Are you;

- 18 years or over
- Working in the private adult social care sector in England
- A care manager involved in the implementation of National Living Wage.

If so, could you please help me by completing some interview questions? The interview can be completed at your own convenience and pace. It should take around 20 minutes to complete. By participating, you will be contributing your valuable knowledge and experience to help us recommend further ways to support the care workforce. Please find in the attached file the information sheet and consent form for further details.

To take part, simply click next page to start the interview. If you change your mind at any time and no longer wish to take part, just close the window and your answers will not be saved. Please feel free to use capitals for emphasis and detailed answers are preferred. There are no wrong or right answers, and you should not worry about spellings or grammatical errors.

This is an independent research project and has been approved by the University Research Ethics Team. Responses are being collected on an anonymous basis and are totally confidential. If you have any questions, please contact either me (Fathimath Athif) at bh66sf@research.sunderland.ac.uk or Dr. Julia J. Nobari at the Faculty of Business, Law and Tourism at the University of Sunderland: julia.j.nobari@sunderland.ac.uk

Many thanks, Fathimath Athif

Information sheet and consent form

You may now consent and proceed to answer the questions that follow.

I certify that I am 18 years and over and working in the private adult social care sector in England.

- ○ Yes
- ○ No

Skip To: End of Survey If You may now consent and proceed to answer the questions that follow. I certify that I am 18 years... = No

I agree to take part.

- ○ Yes
- ○ No

Skip To: End of Survey If I agree to take part. = No

Please confirm that you are a care manager involved in the implementation of National Living Wage.

- ○ Yes
- ○ No

Skip To: End of Survey If Please confirm that you are a care manager involved in the implementation of National Living Wage. = No

1.How would you describe your gender?

- ○ Male
- ○ Female
- ○ Non-binary/ third gender
- ○ Prefer not to say

2.What is your age?

- ○ Under 25 years
- ○ 25-54 years
- ○ 55 years and over
- ○ Prefer not to say

3. What is your ethnic group?

- ○ White
- ○ Mixed / Multiple ethnic groups
- ○ Asian / Asian British
- ○ Black / African / Caribbean / Black British
- ○ Other ethnic group

4. Tick the type of service that you provide.

- ○ Adult residential care
- ○ Adult domiciliary care

5. What is your employment type?

- ○ Employee
- ○ Worker (e.g., casual or agency worker)
- ○ Self-employed

6. Where in England are you located in?

- ○ South East
- ○ London
- ○ North West
- ○ East of England
- ○ West Midlands
- ○ South West
- ○ Yorkshire and Humber
- ○ East Midlands

○ North East

7. What is your work experience as a care manager?

○ Less than 3 years

○ 3-9 years

○ 10 years or more

8. How many years have you been working with your current organisation?

○ Less than 3 years

○ 3-9 years

○ 10 years or more

9. What is your professional and educational background?

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10. Could you please provide a brief overview of your job role?

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11. What does the National Living Wage mean to you?

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12. What are the benefits of National Living Wage for your organisation?

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13. What challenges has the continuous uprating of the National Living Wage brought to your organisation? Please provide details on how you have managed these challenges.

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14. What were your strategies to implement the National Living Wage? Please provide details on how these strategies have benefitted and presented challenges to your organisation.

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15. What support has the Local Authority provided to manage the implementation and uprating of National Living Wage?

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16. What additional support could the Local Authority provide for you to better overcome the challenges presented by the continuous uprating of the National Living Wage?

17. What type of contract does your organisation hold with the Local Authority?

- ○ Fixed income contract
- ○ Block contract
- ○ Two components: A fixed advance and payment based on outcomes
- ○ Other. Please mention the type of contract

_____

Q45 18. Based on current circumstances, what do you think is the most suitable contract type for care commissioning?

- ○ Fixed income contract
- ○ Block contract
- ○ Two components: A fixed advance and payment based on outcomes
- ○ Other _____

19. What are your reasons for selecting ${Q45/ChoiceGroup/SelectedChoices} in your previous answer? Click on the "back" button to change your previous answer.

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20.How would you describe your organisation's support for the financial wellbeing of your staff?

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21. How would you describe the current communication taking place in your workplace regarding pay and benefits? e.g., clear, honest, transparent, informal talks, verbal communication

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22. Which tools are mainly used by your organisation to discuss pay and benefits? e.g., Email, face to face, one to one conversation, large group discussion, WhatsApp group, WhatsApp one to one etc.

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_____

_____

_____

_____

23.If your Local Authority contract is revised which includes changes to care worker pay and benefits, in which stages of the process would you communicate with your care workers regarding these changes to pay and benefits? i.e., pre-transition phase, post-transition phase, both pre and post transition phases etc.

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24.What can your organisation do to improve communication around topics such as low pay and improving job quality?

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If the researcher has any confusions regarding any of your answers, would you be willing to explain or clarify them? If yes, please write down an email address below. If No, please click next.

_____

Thank you very much for taking the time to give us your views. Your contribution to this research will help us to recommend further ways to support the care workforce. Please do share the interview link to any suitable participants.

If you have any further queries or would like a summary report of the findings, please email me at bh66sf@research.sunderland.ac.uk. If you would like to share/ explain anything or if you have any comments, please feel free to share in the below text box.

Care Worker Interview

Dear **Care Workers**,

I am conducting PhD research on the Impact of the National Living Wage (NLW) policy on low pay jobs in the private adult social care sector in England. Are you;

- 18 years or over
- Working in the private adult social care sector in England
- A care worker receiving the National Living Wage

If so, could you please help me by completing some interview questions? The interview can be completed at your own convenience and pace. It should take around 30-35 minutes to complete. By participating, you will be contributing your valuable knowledge and experience to help us recommend further ways to support the care workforce. Please find in the attached file the information sheet and consent form for further details.

To take part, simply click next page to start the interview. If you change your mind at any time and no longer wish to take part, just close the window and your answers will not be saved. Please feel free to use capitals for emphasis and detailed answers are preferred. There are no wrong or right answers, and you should not worry about spellings or grammatical errors.

This is an independent research project and has been approved by the University Research Ethics Team. Responses are being collected on an anonymous basis and are totally confidential. If you have any questions, please contact either me (Fathimath Athif) at bh66sf@research.sunderland.ac.uk or Dr. Julia J. Nobari at the Faculty of Business, Law and Tourism at the University of Sunderland: julia.j.nobari@sunderland.ac.uk

Many thanks,
Fathimath Athif

Information and consent form

You may now consent and proceed to answer the questions that follow.

I certify that I am 18 years and over and working in the private adult social care sector in England.

- ○ Yes (1)
- ○ No (2)

Skip To: End of Survey If You may now consent and proceed to answer the questions that follow. I certify that I am 18 years... = No

I agree to take part.

- ○ Yes (1)
- ○ No (2)

Skip To: End of Survey If I agree to take part. = No

Please confirm that you are a care worker receiving the National Living Wage.

- ○ Yes (1)
- ○ No (2)

Skip To: End of Survey If Please confirm that you are a care worker receiving the National Living Wage. = No

1.How would you describe your gender?

- ○ Male
- ○ Female
- ○ Non-binary/ third gender
- ○ Prefer not to say

2.What is your age?

- ○ Under 25 years
- ○ 25-54 years
- ○ 55 years and over
- ○ Prefer not to say

3. What is your ethnic group?

- ○ White
- ○ Mixed / Multiple ethnic groups
- ○ Asian / Asian British
- ○ Black / African / Caribbean / Black British
- ○ Other ethnic group

4. Tick the type of service that you provide.

- ○ Adult residential care
- ○ Adult domiciliary care

5. What is your employment type?

- ○ Employee
- ○ Worker (e.g. casual or agency worker)
- ○ Self-employed

6. Where in England are you located in?

- ○ South East
- ○ London

- ○ North West
- ○ East of England
- ○ West Midlands
- ○ South West
- ○ Yorkshire and Humber
- ○ East Midlands
- ○ North East

7. What is your work experience as a care worker?

- ○ Less than 3 years
- ○ 3-9 years
- ○ 10 years or more

8. How many years have you been working with your current employer?

- ○ Less than 3 years
- ○ 3-9 years
- ○ 10 years or more

9. What is your professional and educational background?

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10. Could you please provide a brief overview of your job role?

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11. What does the National Living Wage mean to you?

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12. Has the National Living Wage improved your financial wellbeing? What are the benefits of National Living Wage for you?

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13. Are there any challenges brought by the NLW to your work/ life? Please provide details on how you have managed these challenges?

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14. How are these challenges (that you described in your previous answer) impacting your living standard such as weekly earning, Tax, benefits entitlement etc.?

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15. What is your employment status?

- ○ Working full time hours (37 or more hours per week)
- ○ Working part time hours (36 or less hours per week)

16. Do you work based on zero-hours contacts?

- ○ Yes
- ○ No

17. Do you get paid for travel time? Select not applicable if your job does not require you to travel after the start of your working hours/shift.

- ○ Yes
- ○ No
- ○ Not applicable

18. Are you on universal credit?

- ○ Yes
- ○ No

19. Please name any other benefits that you are claiming

_____

20. Is there any difficulty to claim universal credit because of your job features, i.e., zero hours contract, travel time?

- ○ Yes
- ○ No
- ○ Not applicable

Skip To: End of Block If 20. Is there any difficulty to claim universal credit because of your job features, i.e., zero ho... = No

Skip To: End of Block If 20. Is there any difficulty to claim universal credit because of your job features, i.e., zero ho... = Not applicable

21. Could you explain how care work features such as zero-hour contracts and travel time make it more difficult to claim universal credit?

_____

_____

_____

_____

_____

22. How would you describe your employer support for your financial wellbeing?

_____

_____

_____

_____

_____

23. Are you comfortable about discussing workload/ wages with your employer?

- ○ Yes
- ○ No

24. What are your reasons for selecting ${Q36/ChoiceGroup/SelectedChoices} in your previous answer? Click on the "back" button to check your previous answer.

_____

_____

_____

_____

_____

25. How would you describe the current communication taking place in your workplace regarding pay and benefits? e.g., clear, honest, transparent, informal talks, verbal communication

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_____

26. Which tools are mainly used by your workplace to discuss pay and benefits? e.g., Email, face to face, one to one conversation, large group discussion, WhatsApp group, WhatsApp one to one etc.

_____

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_____

27. What can your employer do to improve communication around topics such as low pay and improving job quality?

_____

_____

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_____

28. With the introduction of National Living Wage, other sectors (such as retail and cleaning) have been offering easier job opportunities for the same pay. What are your motives for staying in the sector despite this?

_____

_____

_____

_____

_____

29. What difference are you hoping to make/ you are making in your job?

_____

_____

_____

_____

_____

30. What has been the biggest challenge in your current job? i.e., increased workloads etc.

_____

_____

_____

_____

_____

31. What career progression goals do you have?

_____

_____

_____

_____

_____

32. How can your employer help to achieve your career progression goals?

_____

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_____

_____

33. National Living Wage often decreases the pay difference between job levels. Would you accept a promotion to the next job level/ role and take on additional responsibilities?

- ○ Yes
- ○ No

34. What are your reasons for selecting ${Q49/ChoiceGroup/SelectedChoices} in your previous answer? Click on the "back" button to check your previous answer.

_____

_____

_____

_____

_____

If the researcher has any confusions regarding any of your answers, would you be willing to explain or clarify them? If yes, please write down an email address below. If No, please click next.

_____

Thank you very much for taking the time to give us your views. Your contribution to this research will help us to recommend further ways to support the care workforce. Please do share the interview link to any suitable participants.

If you have any further queries or would like a summary report of the findings, please email me at bh66sf@research.sunderland.ac.uk. If you would like to share/ explain anything or if you have any comments, please feel free to share in the below text box.

Appendix 8: Information Sheets and Consent Forms

PARTICIPANT INFORMATION SHEET CARE WORKERS

We invite you to participate in research that explores worker experiences of the National Living Wage, the adaptation strategies used by workers in response to these challenges and how their day-to-day life has been affected as a result. The interview covers key issues on pay and standards of living, such as your experiences of the National Living Wage, communication regarding pay and career progression plans.

We would be grateful if you could complete the interview questions. Please feel free to use capitals for emphasis and detailed answers are preferred. There are no wrong or right answers, and you should not worry about spellings or grammatical errors. Your responses will help us highlight key findings and make recommendations to alleviate challenging aspects of the National Living Wage policy on the sector.

If you have any queries about this research, please contact the research team: Fathimath Athif at bh66sf@research.sunderland.ac.uk or Dr. Julia J. Nobari at the Faculty of Business, Law and Tourism at the University of Sunderland: julia.j.nobari@sunderland.ac.uk.

Study Title:

Impact of the National Living Wage (NLW) policy on low pay jobs in the private adult social care sector in England

What is the purpose of the study?

To explore the process of engaging with and fulfilling the National Living Wage policy by the private adult social care sector in England and examine their experience during and after a time of implementation of the policy.

Who can take part in the study?

In order to take part in the study you must be.

- 18 years or over
- Working in the private adult social care sector in England
- A **care worker** receiving the National Living Wage as the hourly rate

Do I have to take part?

Participation is entirely voluntary. If you change your mind about taking part in the study, you can withdraw at any point during the session without giving a reason and without penalty. Unfortunately, you will be unable to withdraw the information you provide once you have submitted the survey as data will be anonymised.

What will happen to me if I take part?

If you decide to take part, you will be asked to complete some online interview questions. This should take you around 30-35 minutes. You will be asked to answer background questions covering your experiences of the National Living Wage, standards of living, communication regarding pay and career progression plans.

What are the possible disadvantages and risks of taking part?

There are no risks anticipated in taking part in this research. In the unlikely event that any of the questions cause you distress, please contact the NHS on https://www.nhs.uk/conditions/stress-anxiety-depression/ and MIND on https://www.mind.org.uk/.

What are the possible benefits of taking part?

Your responses will help us highlight key findings and make recommendations to alleviate challenging aspects of the National Living Wage policy on the sector. You will be

contributing your valuable knowledge and experience to help us understand the situation in the sector better.

Will my taking part in this study be kept confidential?

All information will be treated with the strictest confidence throughout the study. No information which may lead to your identification, such as your name, will be requested as participation in this survey is anonymous. Your IP address will not be stored. We will take all reasonable measures to ensure that data remain confidential. The responses you provide will be stored in an encrypted and password protected storage device. Access to this information will only be allowed to the research team. The stored information will be kept for 5 years before careful disposal. You can access the General Data Protection regulations at: https://www.gov.uk/government/publications/guide-to-the-general-data-protection-regulation for further information on your right to the data.

What will happen to the results of the research study?

Data collected in this study will be analysed and used as part of my PhD. The study will be presented to both academic and non-academic audiences through presentations at conferences or academic journals, but these would only report general trends/responses and no identifying information would be released.

Who is organising and funding the research?

The research is conducted and self-funded by Fathimath Athif as part of her PhD, with supervision from Dr. Julia J. Nobari and Dr. Hamid Seddighi of the University of Sunderland.

Who has reviewed the study?

This study has been reviewed and approved by the Research Ethics Committee of the University of Sunderland. Ethical issues of confidentiality, anonymity, voluntary participation, safety, beneficence, and fairness were considered before giving approval.

What if something goes wrong?

If you have any questions or require more information about this study before or during your participation, you can contact the researcher, Fathimath Athif, at bh66sf@research.sunderland.ac.uk or Dr. Julia J. Nobari at the Faculty of Business, Law and Tourism at the University of Sunderland: julia.j.nobari@sunderland.ac.uk, and we will respond to your query within 10 working days and give you an indication of how it will be dealt with. If you remain unhappy or wish to make a formal complaint, please contact the Chair of the Research Ethics Committee at the University of Sunderland who will seek to resolve the matter as soon as possible:

Dr John Fulton (Chair of University of Sunderland Research Ethics Committee): john.fulton@sunderland.ac.uk

You also have the right to submit a complaint to the Information Commissioner's Office https://ico.org.uk

INFORMED CONSENT FORM CARE WORKERS

Please read the following items and withdraw from the study if you do not agree to any of the following.

1) I have read the information sheet in full; I understand the purpose of this research is to explore the process of engaging with and fulfilling the National Living Wage policy by the private adult social care sector in England and examine their experience during and after a time of implementation of the policy.

2) Any questions I had have been answered, and I understand I may ask further questions at any time by contacting the researchers using the email addresses provided.

3) I understand what is involved in participating, that it is voluntary, and that I may withdraw at any stage during the research. I will be unable to withdraw the information I provide once the analysis of data starts.

4) I understand the research results will be shared with the University of Sunderland as a summary report and my identity will not be disclosed.

5) I understand the results will be used for publications in reports and academic publications, such as journal articles.

6) I agree to take part in this study under the conditions set out above.

PARTICIPANT INFORMATION SHEET CARE MANAGER

We invite you to participate in research that explores worker experiences of the National Living Wage, the adaptation strategies used by workers in response to these challenges and how their day-to-day life has been affected as a result. The interview covers key issues on pay, such as your experiences of the National Living Wage, Local Authority support, the agency relationship between the government and the social care sector, and communication around pay.

We would be grateful if you could complete the interview questions. Please feel free to use capitals for emphasis and detailed answers are preferred. There are no wrong or right answers, and you should not worry about spellings or grammatical errors. Your responses will help us highlight key findings and make recommendations to alleviate challenging aspects of the National Living Wage policy on the sector.

If you have any queries about this research, please contact the research team: Fathimath Athif at bh66sf@research.sunderland.ac.uk or Dr. Julia J. Nobari at the Faculty of Business, Law and Tourism at the University of Sunderland: julia.j.nobari@sunderland.ac.uk.

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What is the purpose of the study?

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Who can take part in the study?

In order to take part in the study you must be.

- 18 years or over
- Working in a private adult social care sector organisation in England
- A **care manager** involved in the implementation of National Living Wage.

Do I have to take part?

Participation is entirely voluntary. If you change your mind about taking part in the study, you can withdraw at any point during the session without giving a reason and without penalty. Unfortunately, you will be unable to withdraw the information you provide once you have submitted the survey as data will be anonymised.

What will happen to me if I take part?

If you decide to take part, you will be asked to complete some online interview questions. This should take you around 20 minutes. You will be asked to answer background questions covering your experiences of the National Living Wage, Local Authority support, the agency relationship between the government and the social care sector, and communication around pay.

What are the possible disadvantages and risks of taking part?

There are no risks anticipated in taking part in this research. In the unlikely event that any of the questions cause you distress, please contact the NHS on https://www.nhs.uk/conditions/stress-anxiety-depression/ and MIND on https://www.mind.org.uk/.

What are the possible benefits of taking part?

Your responses will help us highlight key findings and make recommendations to alleviate challenging aspects of the National Living Wage policy on the sector. You will be

contributing your valuable knowledge and experience to help us understand the situation in the sector better.

Will my taking part in this study be kept confidential?

All information will be treated with the strictest confidence throughout the study. No information which may lead to your identification, such as your name, will be requested as participation in this survey is anonymous. Your IP address will not be stored. We will take all reasonable measures to ensure that data remain confidential. The responses you provide will be stored in an encrypted and password protected storage device. Access to this information will only be allowed to the research team. The stored information will be kept for 5 years before careful disposal. You can access the General Data Protection regulations at: https://www.gov.uk/government/publications/guide-to-the-general-data-protection-regulation for further information on your right to the data.

What will happen to the results of the research study?

Data collected in this study will be analysed and used as part of my PhD. The study will be presented to both academic and non-academic audiences through presentations at conferences or academic journals, but these would only report general trends/responses and no identifying information would be released.

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If you have any questions or require more information about this study before or during your participation, you can contact the researcher, Fathimath Athif, at bh66sf@research.sunderland.ac.uk or Dr. Julia J. Nobari at the Faculty of Business, Law and Tourism at the University of Sunderland: julia.j.nobari@sunderland.ac.uk, and we will respond to your query within 10 working days and give you an indication of how it will be dealt with. If you remain unhappy or wish to make a formal complaint, please contact the Chair of the Research Ethics Committee at the University of Sunderland who will seek to resolve the matter as soon as possible:

Dr John Fulton (Chair of University of Sunderland Research Ethics Committee): john.fulton@sunderland.ac.uk

You also have the right to submit a complaint to the Information Commissioner's Office https://ico.org.uk

INFORMED CONSENT FORM CARE MANAGERS

Please read the following items and withdraw from the study if you do not agree to any of the following.

1) I have read the information sheet in full; I understand the purpose of this research is to explore the process of engaging with and fulfilling the National Living Wage policy by the private adult social care sector in England and examine their experience during and after a time of implementation of the policy.

2) Any questions I had have been answered, and I understand I may ask further questions at any time by contacting the researchers using the email addresses provided.

3) I understand what is involved in participating, that it is voluntary, and that I may withdraw at any stage during the research. I will be unable to withdraw the information I provide once the analysis of data starts.

4) I understand the research results will be shared with the University of Sunderland as a summary report and my identity will not be disclosed.

5) I understand the results will be used for publications in reports and academic publications, such as journal articles.

6) I agree to take part in this study under the conditions set out above.

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