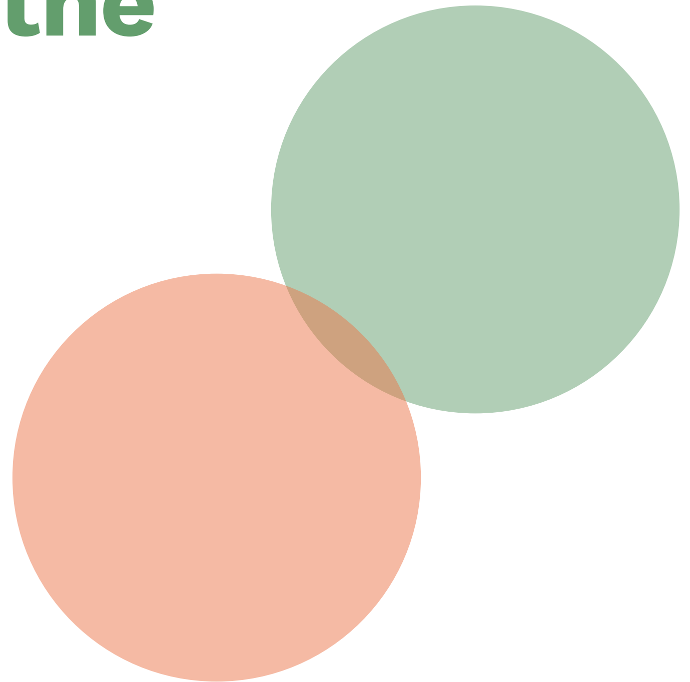
TOPIC 2: The role of pay and contracted conditions in sustaining the health and adult social care workforce for the long term



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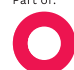

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The Health Foundation
REAL Centre

REAL Supply

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REAL Supply

Plain English summary

Context

The health and social care workforce is crucial for delivering care to those in need. However, both sectors face ongoing challenges in recruiting and retaining staff. With increasing demand and an aging population, the NHS and social care sectors must expand significantly in the coming years. The ability to meet this demand depends on effective policies around pay and working conditions. This study examines how wages, contracts, and job conditions affect the supply of health and social care workers.

Knowledge gap

While workforce shortages are well-documented, there is limited research on how pay and conditions influence staff decisions to join, stay, or leave the sector in the U.K. Most studies focus on doctors and nurses, leaving major gaps in understanding the social care workforce. Existing research also overlooks how to measure the value of job conditions – such as shift patterns, job security, and career development – and how this might impact recruitment, retention and hours of work. Additionally, centralised pay structures may not account for regional workforce challenges, and more needs to be understood about how local pay flexibility could improve staffing levels.

Value

By exploring how financial and non-financial incentives affect workforce supply, this research can provide policymakers with evidence-based recommendations. Understanding and measuring the true drivers of staff recruitment and retention will help determine whether simply increasing wages is enough or if broader changes – such as more flexible pay models, improved working conditions, or better career development opportunities – are needed to sustain the workforce.

Impact

The findings will support better workforce planning and help decision-makers design policies that attract, retain and increase the hours of work of health and social care workers. By addressing workforce shortages effectively, the research will contribute to a more stable and sustainable care system, ensuring that services remain accessible to those who need them most.

Introduction

The health and adult social care workforce is a key component in providing the care and support to those in need of health and social care. Ensuring the supply of that workforce is a critical element in sustaining the NHS and social care sector in the long-term. Concerns around workforce capacity are not new. But with changing demographics and increasing demand, the need to take a more long term view of the workforce has been recognised with the publishing of the NHS Long Term Workforce Plan[1] and the Workforce Strategy for Adult Social Care in England developed by Skills for Care[2]. The ability to meet these demands for staffing requires a clear understanding of the policy instruments that need be utilised to provide the necessary workforce.

This pathfinder provides an overview of the role of contracted pay and conditions, that make up the total reward package for employment, in the supply of the health and social care workforce and identifies areas of research that will support policy makers to deliver the required workforce capacity in the long run.

Background

Current workforce

The health and social care sectors employ a large number of workers with a substantial share of overall resources being spent on the pay bill. Both the NHS and the adult social care sector employ around 1.7 million people each with the combined health and adult social care sectors employing a substantial proportion of the total workforce, at around 10% of the total workforce in England[3]. The workforce is predominantly female[4] [5] with variations of gender balance across different occupational groups, and with these occupational groups representing a diversity of skills. These elements are important as they have particular relevance to a better understanding of the labour supply decisions of the workforce.

1 **https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/**

2 **https://www.skillsforcare.org.uk/Workforce-Strategy/Home.aspx**

3 Reported figures vary depending on what element of the NHS family of organisations are included and are only estimated for private providers of care either providing care in the private or public sector independently for the public sector. Figures do not include unpaid carers. See for example **https://www.nuffieldtrust.org.uk/resource/the-nhs-workforce-in-numbers** and **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**

4 **https://www.nhsemployers.org/-/media/Employers/Documents/Plan/DIVERSITY-AND-INCLUSION/EQW19/Gender-in-the-NHS-infographic.pdf**

5 and **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**

Future workforce projections

Workforce requirements are projected to increase in the future. The NHS Long Term Workforce Plan suggests an increase of FTEs is required from 1.5m to 2.3m in 2036/7, representing over a 50% increase in just 15 years. This equates to an increase of around 3% in the workforce size each year compared to a historical average workforce growth of around 1.1% (Warner and Zaranko 2023). The Skills for Care Workforce Strategy reports an anticipated need for an increase of 29% in the adult social care workforce over a similar period. In the absence of an equivalent increase in the total working population, this would represent an increase in the proportion of the total workforce dedicated to health and social care (see '**The consequences of non-marginal changes in recruitment into healthcare training**' pathfinder).

It should also be noted that as with any workforce planning, assumptions on both demand and supply are built into the projections and this will impact on our understanding of not just how many more workers are required, but what type of workers. This is considered further in a separate pathfinder ('**Skill-mix and the production function**').

Attainability

The projected increase in the required numbers of health and social care workers needs to be considered in a historical context, where the associated labour markets have exhibited persistently high vacancy rates. Skills for Care report vacancy rates over the last 7 years ranging from 7% to over 10%.[6] Within the healthcare sector, NHS digital figures[7] indicate average vacancy rates of around 8%. Such vacancy figures are higher than those found elsewhere in the economy.[8] Turnover rates of social care workers are also high indicating a poor retention of such workers. Skills for Care figures report turnover rates over the last 7 years at around 30% and figures for NHS although lower at around 10% are still substantial.

Turnover and vacancy rates also differ by occupational group and indeed there may be substantial variation within occupational groupings such as specific nursing or medical specialties. Similarly, there are also marked regional variations across England and, within regions, differences can be seen across remote, rural, coastal and urban areas. Differences in these key labour market indicators across the dimensions referred to above will in turn have implications for equality of care.

6 Recruitment and Retention Tab 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

7 https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---june-2024-experimental-statistics

8 Average rates for the UK over the same period are around 3% but some care is required to compare vacancy rate metrics; see https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/jobsandvacanciesintheuk/previousreleases?page=7

Thus, with current supply targets not being met, an increase in the workforce will need more resolute actions than the "more of the same" policy measures. Increasing the relative pay of the health and social care workforce is the obvious solution, but budget constraints may make this difficult politically. It is, furthermore, also important to note that any increase in pay, without understanding the variations in staffing levels that already exist, could lead to a growth in the workforce that perpetuates existing inequalities in the supply of care.

"With current supply targets not being met, an increase in the workforce will need more resolute actions than the "more of the same" policy measures."

This pathfinder explores the role that pay and contract conditions play in incentivising the behaviour of the workforce including their recruitment, retention and hours of work supplied and considers the evidence available to find the most cost-effective levers to increase labour supply to their forecasted required levels.

Relevance

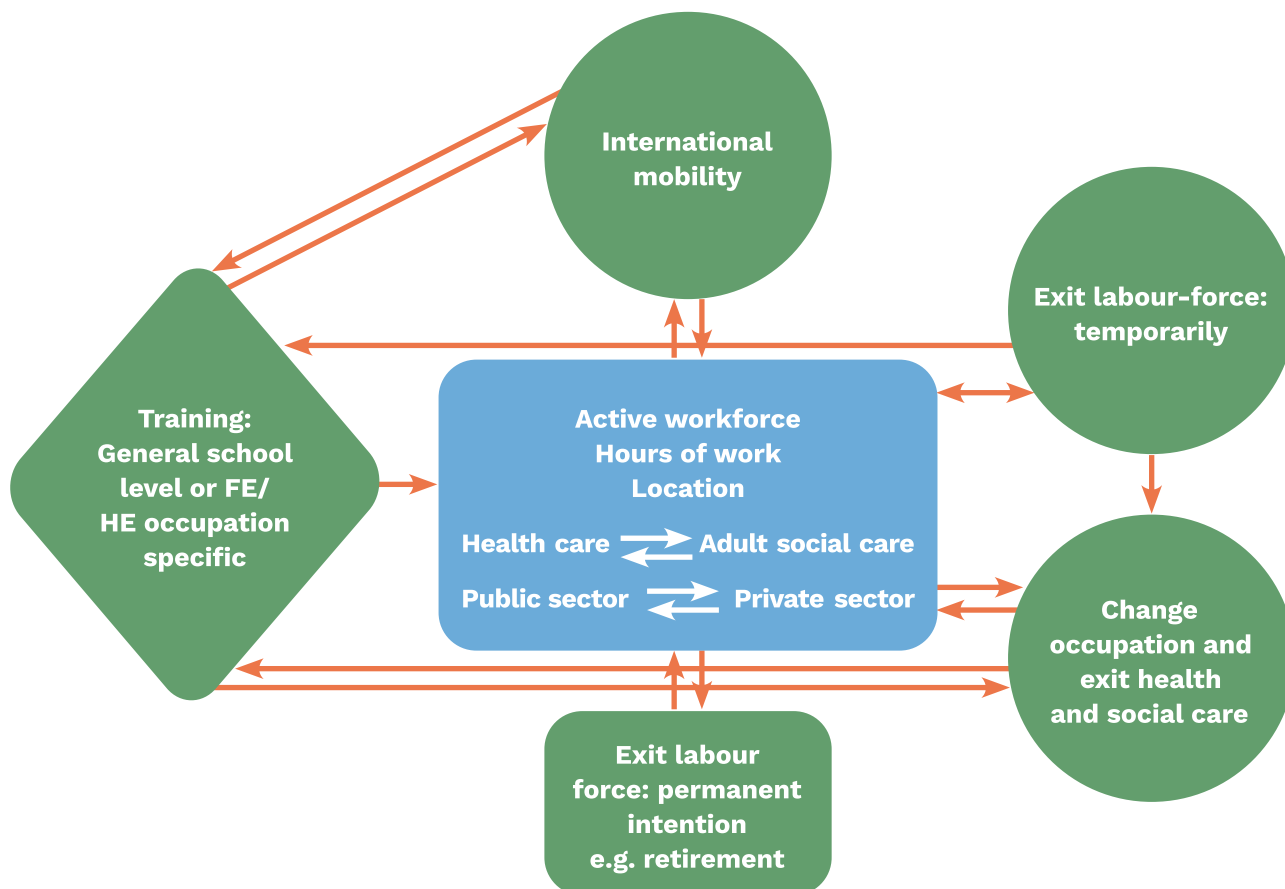
The importance of long-term planning around the health and care workforce and achieving an increase in their workforce numbers has been identified in our engagement with stakeholders. They also suggested that to support the aspirations being realised, further evidence was required to assist in formulating the best ways to incentivise the increase in the workforce. In particular, the achievability of the growth of the workforce within the anticipated future budget constraints was highlighted. This is reflected in the pathfinder topic which considers both the role of pay and also contracted conditions in driving the labour market behaviour of the health and social care workforce.

Workforce stocks and flows

To understand the role of pay and contract conditions on the stock of the health and social care workforce, the flow of workers needs to be understood. There are multiple entry and exit points for the health and social care workforce (see Figure 1). Entry points include the gateways directly from training, whether this is from school level qualifications or through occupation specific training at further or higher education level including graduate entry schemes. Entry or re-entry from alternative occupations outside the health and social care sector may be direct or require training, for example return to practice schemes where regulatory licensing has lapsed. Entry points from abroad are also possible (see pathfinder '**International Migration**') and reflect the global nature of the health and social care labour market. This global market, however, also provides an exit point for the health and social care labour force. Exit points to alternative occupations also exist as do exits from the labour force altogether. These might be temporary as part of usual life-cycle behaviour such as career breaks or can be more permanent such as retirement although re-entry is still possible.

The entry and exit flows influence the stock of the active health and social care workforce available at any one time. But there are also internal flows of workers within the health and social care workforce which will determine the distribution of that available stock of workers across the health and social care sectors, across the private and public sector provisions of both health and social care and across geographic locations. And finally, the total amount of labour that the stock of workers supplies will be determined by the hours of work that are worked. This may be in terms of the fraction of full-time or the propensity to increase hours over contracted hours and work over-time.

Figure 1: Stocks and flows impacting on the active health and social care workforce



Relevant economic frameworks

The decision to enter or exit the health and social care workforce, the distributional effects arising from the internal mobility of workers within it, along with the decision on how much to work within it, fundamentally comes down to an individual's analysis of the costs and benefits of the job relative to the alternative option on offer. Given the nature of the different jobs and the characteristics of individuals, it naturally follows that costs and benefits will vary substantially across the spectrum of the workforce.

Several rigorous economic frameworks exist to analyse the various behavioural decisions by members of the workforce, which in turn can lead to the labour market supply effects mentioned above. Such analysis can yield several policy recommendations that can advise and support policymakers in enhancing the effective supply of labour. These frameworks include the neo-classical model of labour supply which utilises a labour-leisure trade-off to frame the decision to work or not and, if working, how many hours to supply. Elements within this framework are traditionally of particular importance for female labour supply decisions. Occupational choice models provide a further framework to understand how decisions are made across competing occupations. Decisions to undergo training are framed within a human capital framework where investment through the accumulation of skills are made in relation to the expected returns on that investment.

At the heart of these models and driving behaviour is the reward received in return for the supply of labour services. The most important element of that reward is pay. Pay in a competitive market is

determined by a number of factors relating to the characteristics of the job. Such an understanding dates back to Adam Smith in the Wealth of Nations who first developed the theory of net advantages to explain the variation in pay across different jobs (Smith 1776). Smith describes how pay would reflect the "whole of the advantages and disadvantages" of a job where these characteristics included features relating to the "agreeableness" such as the "ease or hardship, the cleanliness or dirtiness" of the job, the "easiness and cheapness, or the difficulty and expense" of learning the skills required for the job, the "constancy or inconstancy of employment" reflecting job security, the trust and confidence required of those undertaking the job and the probability of succeeding in the profession. This theory was refined further by Rosen in the theory of equalizing differences where trade-offs between pay and job characteristics take into consideration preferences and productivity and are reflected in labour supply and labour demand decisions (Rosen 1986).

Whereas the models of Smith and Rosen above largely rely on competitive labour markets, the health and social care labour market in the UK is far from being fully competitive. Instead, the labour market in the health and care sector is characterised by centralised wage-setting or market-based wage setting but constrained by budgets determined by centralised funding formulae. This will result in constraints on pay, where pay is not able to adjust fully to reflect the jobs "net advantages". This will then impact on the health and social care sector's ability to attract workers, retain them or encourage them to supply more hours.

However, remuneration extends to more dimensions than pay. Pay is just one element within the reward package for work. Though the wage received by workers may be the main reward, other pecuniary and non-pecuniary rewards are available to incentivise labour market behaviours. So, whilst wage adjustment might be constrained and not fully flexible, the role of non-pay rewards becomes of more importance to understand as this can provide an additional lever for policy makers to influence an enhanced supply of labour.

"Though the wage received by workers may be the main reward, other pecuniary and non-pecuniary rewards are available to incentivise labour market behaviours."

Contracted pay and conditions

The pay framework and conditions of employment within the health and social care sector are set by a variety of contracts. Those between employer and employee within the NHS include national structures[9] such as Agenda for Change, which outlines the terms and conditions for all non-medical staff[10], contracts for medical staff including consultants[11], specialty and specialist doctors[12] and contracts for doctors in training[13]. Pay within these salaried frameworks are set by the relevant governments, supported by independent recommendations provided by the Office for the Pay Review Bodies[14], and specifically the NHS Pay Review Body (NHSPRB) and the Review Body on Doctors and Dentists Remuneration (DDRB). Some scope exists for pay variability through supplements such as high-cost area supplements and

9 These are set nationally for England, Scotland, Wales and Northern Ireland with variations between the devolved contracts
10 https://www.nhsemployers.org/topics/pay-pensions-and-reward/nhs-terms-and-conditions-service-agenda-change
11 https://www.nhsemployers.org/articles/consultant-contract-2003
12 https://www.nhsemployers.org/articles/terms-and-conditions-and-resources-sas-contract-2021
13 https://www.nhsemployers.org/publications/doctors-and-dentists-training-terms-and-conditions-england-2016
14 https://www.gov.uk/government/organisations/office-for-the-pay-review-bodies

recruitment and retention premia. Outside these national frameworks for the public sector healthcare workforce, there are contracts that will be locally based[15]. Other contracts define agreements for independent contractors who operate as businesses such as pharmacists, General Practitioners and Dentists where fees and service expectations are defined. Here pay is not set specifically. Instead, income will be determined as a consequence of the fees[16]. These businesses may themselves employ workers on local contracts, though standardised model contracts are also available (British Medical Association 2020). The adult social care sector is not currently covered by any national framework although this may change with the suggestion of an Adult Social Care negotiating Body being included within future employment legislation (Department of Business and Trade 2024). Where the private sector provides adult social care for the public sector, wages are set by providers within the constraints of funding formulae that allocates resources. While these formulae may incorporate variation reflecting local labour market conditions, the absolute value of the funding means a large proportion of the workforce is operating at the national level of the minimum living wage.

For those operating under employment contracts, the reward package will consist of pecuniary and non-pecuniary element. The pecuniary element is normally a salary set by an hourly rate or annually. Such a pecuniary element will operate in conjunction with the associated standard working hours, including shift patterns, breaks, overtime arrangements and on-call working. Future pay, or deferred incentive payment structures, may also be outlined in the form of pay progression. Other pecuniary benefits may include employer contributions to pension schemes which can be regarded as a delayed pecuniary reward, sick pay, maternity and paternity pay over and above the statutory requirements. Contracts may also include indemnity or insurance coverage that might be required for professional licensing. Non-pecuniary aspects will include annual leave entitlement, may also include study or training leave entitlements[17] and flexible working opportunities which can also be formalised within contract conditions. These may include variations to standard working hours such as part-time work, compressed hours, annualised hours and other modifications to a standard contract including remote working and job sharing[18].

For those operating as independent contractors, contract conditions will include less explicit rewards, such as flexible working, but with the pecuniary elements related to the fees for services. Independent contracting is by nature more flexible, and it is typically for the independent contractor to determine how they might deliver that service. However, independent contractors may also face obligations for provisions that may restrict flexibility, such as the requirement for Extended Hours and Enhanced Access in the new GP contract[19].

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15 There is some connection between NHS contracts and private sector work within schedule 6 of the 2003 consultant contract referring to extra programmed activities and spare professional capacity.

16 The DDRB do not determine fees for non-salaried dentists or GPs but they do make recommendations on target incomes to support negotiations for the specific provider contracts.

17 Conditions of contracts may also refer to competency requirements related to professional standards and licensing for which study and training leave are intended to support.

18 See this within the NHS context: **https://www.england.nhs.uk/wp-content/uploads/2022/02/B0395-flexible-working-raising-the-standards-for-the-NHS.pdf**

19 **https://www.england.nhs.uk/gp/investment/gp-contract/network-contract-directed-enhanced-service-des/enhanced-access-faqs/**

Which conditions

At this point it is important to draw a distinction between working conditions that are an inherent characteristic of a job, and working conditions resulting from labour market staff shortages. The theory of equalising differentials is one that describes a long-run equilibrium for the labour market where pay and other non-pay rewards will adjust to bring into alignment labour demand and supply. Thus, unpleasant aspects of a job such as mental effort or uncleanliness should be reflected in the reward. This is quite explicit within the Agenda for Change job evaluation framework where roles are placed on the pay spine depending on 16 elements relating to skills, responsibilities, physical, mental and emotional effort and other working conditions such as environmental conditions, hazards and behaviours of patients[20]. But where the market is not competitive and operates under constraint, equilibrium may not be achieved, and shortages may occur. This will then impose further unpleasant aspects for those workers in the labour force related to overwork. These are not an inherent characteristic of the job but one that is a result of the shortages. They will however still impact on the stock and flow of the active workforce as described in figure 1. Ensuring pay and contracted working conditions, including non-pay rewards, reflect the inherent net advantages of a job should allow the market to reach equilibrium and in doing so remove these symptoms of disequilibrium.

"Ensuring pay and contracted working conditions, including non-pay rewards, reflect the inherent net advantages of a job should allow the market to reach equilibrium."

What we know

There are only limited studies that consider the role of economic drivers on the recruitment, retention and hours of work supplied of the health workforce in the UK. This, for the large part, may be due to the limited variability in pay and conditions, given the national pay-setting framework that dominates the UK health care labour market. Of the studies that do exist, these tend to concentrate on doctors and nurses. Even less research has been undertaken on the adult social care workforce. This overview focuses on research on the UK health and social care workforce. While other evidence exists from other health and social care systems, it is not clear if it would directly translate into supporting policy instruments appropriate for the English health and social care system. Further work should explore what evidence from the U.S., Australia and Norway, could be used to support evidence-based policy in England.

Retention

A recent system review of "the relationship between labour force satisfaction, wages and retention within the UK National Health Service" noted the role of job satisfaction on retention and that while pay influences satisfaction, any increase in pay would have little overall impact on retention (Bimpong et al. 2020). One study that looked at actual quitting behaviour of nurses comments that given destination wages were lower than in the NHS "*higher average hourly wages in the NHS are insufficient compensation for the disagreeable non-pecuniary working conditions experienced there*" (Frijters, Shields, and Price

20 https://www.nhsemployers.org/publications/nhs-job-evaluation-handbook

2007: 71). Another study of NHS nurses found that job satisfaction was the most influential driver of intentions to quit where elements of the working environment were driving job satisfaction (Shields and Ward 2001). These included shift patterns, unpaid overtime, autonomy over hours and opportunities to undertake further training. However, it is important to note that this relates to intentions and not actual quitting behaviour. Another study that considered nurses within primary care and the community noted the influence of pension considerations on retention although these were not specified (Storey et al. 2009). A study on doctors, nurses and midwives within hospital settings found that retention was negatively impacted by fixed term contracts (Moscelli et al. 2024). The role of part-time work differed depending on occupation and had a positive effect on retention for nurses but a negative one for doctors. A study on Allied Health Professionals (AHPs) that considered those who stayed, left or returned to either NHS or non-NHS employment found differences in the role of pensions as opposed to pay on behaviour for NHS versus non-NHS AHPs (Loan-Clarke et al. 2010). A study on the retirement decision of doctors estimated the relative importance of job characteristics on their willingness to delay retirement and the number of extra years that they might be willing to work (Cleland et al. 2022). Job intensity was of particular importance to GPs, whereas working hours and on-call were more important for hospital doctors. This research used a stated preference technique and so is not based on actual behaviour. However, it does provide a way to introduce variation in job characteristics to measure their impact on decision making where there is little to observe due to centralised pay and conditions.

Recruitment in to training

There is little evidence on the role of pay and conditions as an incentive to enter formal training for either nurses or doctors in the UK. This may reflect the traditional tendency of excess demand for training places. Research on UK doctors instead focuses on how selection mechanisms operate, with a body of literature considering how best to encourage particular types of applicants in terms of their socioeconomic background, through measures such as widening access activities. Recent research has focused on doctors' behaviours through the medical training pathway including time taken out of training or exiting training through emigration decisions. Research on choice of specialty within the training pathway tends to focus on specific specialties such as general practice which has traditionally been a shortage specialty. For UK nurses, there is a recognition of a high attrition rate from training but little research considering the flow of nurses from the completion of training into the nurse workforce.

Hours of work

Studies that concentrate on the effect of pay on hours of work for the UK health care workforce are also limited and again are concentrated on nurse and doctor labour market decisions. Evidence specifically on nurse labour supply models can be found within the Health Foundation Report on "Nurse supply model: a review of economic factors affecting nurse supply" (Derbyshire et al. 2021) where relatively inelastic wage elasticity of supply for studies of UK nurses are reported indicating that an increase in wages would only lead to small increases in labour supply. The role of non-pecuniary aspects is instead highlighted as important drivers of labour supply decisions (Eberth, Elliott, and Skåtun 2016). A model of labour supply for doctors in the UK also finds inelastic wage elasticity of supply and notes that the results were "*sensitive to the exclusion of job quality, suggesting the important role of non-pecuniary job attributes in labour supply decisions*" (Ikenwilo and Scott 2007: 1303).

Distributional

The impact of centralised wage setting on the geographic distribution of the health care workforce in England has been considered in relation to the nursing workforce. Here, the varying competitiveness of pay that results from centralised wage setting has been found to impact on the ability to recruit and retain the nursing workforce as measured through vacancy rates (Elliott et al. 2007). Just as disagreeable jobs require compensation, so do disagreeable locations. Another study considered the role of competitive pay as reflected by local labour market conditions on nurses and doctors (Elliott et al. 2010). The study found doctors' labour supply behaviour was less affected by the competitiveness of their current pay compared to that found for nurses. It was suggested that doctor labour supply behaviour was more related to future pay and promotion possibilities and positive job characteristics related to teaching hospitals. These results were linked to the construction of the staff market forces element within the funding formulae that distributes funding across the health care system in England. The staff market forces factor adjusts funding to reflect the additional costs faced by providers from their specific local labour markets. However, it should be noted that this does not automatically feed through to pay adjustments. Another study considered the responses of hospital trusts to cost of living differences through pay supplements where possible, promotions and additional hours but found that "*existing national pay system does not provide trusts with sufficient flexibility to retain staff in the face of cost-of-living increases*" (Propper, Stockton, and Stoye 2021: 33). Consequences for patients were explicitly considered by one study that looked at mortality rates for emergency heart attacks where the use of agency staff is related to local labour shortages (Propper and Van Reenen 2010).

Adult social care

Less research has been done on the economic drivers of labour supply behaviour for the social care workforce. This paucity has, however, recently been partially addressed with research funded by the Health Foundation study "Retention and Sustainability of Social Care Workforce (RESSCW) project". Within this a study looked at recruitment and retention in Adult Social Care and found that retention was related to permanency of the contract, non-standard hours of work and presence of job-related training (Forth and Bryson 2022). The role of pay was low relative to other job characteristics. The research found that retention rates varied across local labour markets but there was no clear evidence as to why this might be the case. The study also found lower retention rates within adult social care than the equivalent health care occupational group of health care assistants and found evidence that this may be related to job characteristics such as career progression possibilities. Research on wage elasticity within the adult social care sector finds high wage elasticity for the supply of labour and finds differences across geographies (Vadean, Allen, and Teo 2024).

Evidence gaps and opportunities

There is only limited evidence of the role of pay and conditions on the labour supply decisions of the health and social care workforce in the U.K. Most of that evidence is centred around nurses and doctors. Some of the evidence that does exist is dated. This is relevant since relative pay and conditions may have altered since the research was completed. Thus, conclusions based on the impact of absolute pay or conditions on recruitment, retention and hours of work, may no longer be appropriate. Relative contracted conditions for the health and social care workforce have also altered over time. For instance, the use of flexible working including hybrid/home working is a relatively new standard feature within contracts for the general workforce. However, this type of working may not be suitable for the health and social care sector particularly for frontline staff. This may alter the relationship between competing occupations within and out with the health and social care sectors.

Where studies find job characteristics other than pay drive labour supply decisions, little is said about the relative effects of these characteristics or the compensation that might be required to counter them. It is also important to address the often-neglected effects of wages being constrained, whether by centralised pay-setting or by constraints on budget allocations. If pay does not compensate for negative characteristics of a job, then jobs require either to be redesigned to mitigate these negative job characteristics, other forms of compensation need to be in place or pay must increase. This requires an understanding of the value of these job characteristics to individuals along with the cost of mitigating them. However, with pay and conditions being relatively rigid across the sector, finding the variation in the data to explore these valuations is difficult. Thus, the further use of stated choice techniques such as Discrete Choice Experiments may be one way to complement revealed preference data. Using the emerging larger private sector could be another source of data to explore the behaviour of the health and social care workforce in a more flexible, competitive market setting.

Finally, the health and social care sector is characterised by pay that is nationally set for the health care workforce and for large parts of the social care workforce, in effect nationally set at living wage rates. Where pay in the health care sector can vary using local recruitment and retention premia or other area supplements, there is no evidence as to the costs and effectiveness of these schemes. Fundamentally, if the workforce is to grow in proportion to the general workforce, pay relative to the general workforce will need to increase. Consideration should be made as to whether this should be under the current pay-setting framework or if this should change. For the health care sector in particular this should include consideration of whether national pay setting is still appropriate and what might be gained by introducing a more regional flexible pay setting arrangement. Similarly, the proposed Adult Social Care National Negotiating body may increase negotiating power on pay but may also have implications for flexibility of wages.

Conclusion

This pathfinder provides a broad overview of the areas of research that would support the sustainable supply of the health and social care workforce. It identifies a need to better understand the instruments of pay and conditions as a solution to a wide range of issues that impact on the supply of the health and social care workforce. This includes the relative importance of pay and conditions along with the associated costs of implementing any changes. It also considers whether pay should simply rise relative to the general workforce to achieve the increase of supply that is required, or whether pay needs to be more flexible with a move away from the nationally set pay framework.

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