Nottingham Trent University

NTU Work Futures Observatory

Social Care Commissioning in Sheffield: The role of trade unions

Helen Woods, Tom Vickers and Linda Kemp

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Executive Summary

This report examines Sheffield City Council's recent reform of their adult Home Care commissioning, which took place in the context of the wider national crisis in social care consisting of rising demand, high vacancies and long-term underfunding. Traditional local authority commissioning models have been criticised for inefficiency and poor workforce conditions, resulting in low quality care to vulnerable adults. Sheffield redesigned its approach to commissioning in an attempt to address these challenges following the expiry of their existing provider contracts.

A distinctive feature of this renewed model was the involvement of trade unions, including the GMB, who were included in the design and consultation as partners. They participated in evaluation panels and helped ensure workers were consulted about the changes and played a key role in a large-scale TUPE transfer. This report considers the benefits of trade union involvement for improving workforce standards and confidence in this process.

Key elements of the renewed commissioning model include the introduction of a patch-based model for home care delivery, reducing travel time for home care staff, aligning with NHS Primary Care Networks to smooth the implementation of care packages. This replaces care providers biddings for individual care packages. Interviews with commissioners suggest the new model has successfully reduced waiting lists, led to improved care coordination, and improved workforce stability through reduced travel time, an improved training offer and clearer career progression.

Introduction

This report outlines the challenges faced by local authorities (LA's) in commissioning and delivering adult home care services in recent years, and explains how one authority, Sheffield City Council (SCC), sought to address this via changes to their commissioning process. Representatives from SCC were spoken to regarding their revised commissioning model at the recommendation of the GMB Union, who had been involved in the new commissioning process alongside other trade unions. One Home Care service manager was also interviewed about their experience of providing care under the new model. It is hoped this example can be utilised as a step toward addressing the widespread crisis in care commissioning, including the benefits of direct trade union involvement in commissioning processes.

Context

Demand for adult social care among people aged 18–64 has risen sharply, with new requests increasing by 18% between 2014–15 and 2022–23—well above the growth rate of that age group's population. This rise, combined with more disability benefit claims, is placing growing strain on services for younger adults, adding to long-standing pressures linked to an ageing population (Bancalari and Zaranko, 2024). Although the number of older adults has increased, a smaller proportion now receive state-funded care: there has been a 10% drop since 2014–15, largely due to stricter eligibility rules. Over the same period, public spending has not kept pace with demographic change. Forecasts from the Office for Budget Responsibility indicate that social care funding would need to rise by around 3.1% per year in real terms over the next decade just to meet demand and cost pressures (Bancalari and Zaranko, IFS, 2024).

Meanwhile, more than four in ten care workers in England are paid below the real living wage despite these being highly skilled and essential jobs (Skills for Care, 2024). Three in ten are on zero hours contracts, nine times the average for all workers (Dromey and Cooper, 2025).

LA's have legal responsibilities for the provision of adult social care, but the vast majority is delivered by independent providers (Skills for Care, 2023). 79% of care workers in England are employed by the private sector, despite many of these being publicly funded through LA adult care budgets. This mean there is a disconnect between LA commissioners who do not have direct control over the pay and working conditions of care workers employed by the private sector (Bancalari and Zaranko, IFS, 2024).

In terms of workforce retention, providers have also been struggling. The care sector has a higher vacancy rate that the national average (Skills for Care 2016, in Bancalari and Zaranko, IFS, 2024), with one estimate suggesting that the sector could face a shortfall of more than 1 million care workers by 2037 (Independent Age 2015). It has also been noted that the projected growth of the over-65s population alone has led Skills for Care to estimate that the adult social care system in England will need approximately 440,000 paid care workers by 2035, which is a growth of 25% from current numbers (Fenton et al., 2023).

Previous research has consistently identified deep-seated problems with the current commissioning process, negatively affecting both the quality of service and working conditions. For example, Hudson (2019) reviews current commissioning arrangements for adult social care in England, and identifies widespread dissatisfaction with funding, the range and quality of provision, and workforce conditions. He recommends that this should be addressed by shifting to an approach that commissions 'small and local,' holistically, personally, and with more weight given to the ethics of providers.

While the problems in social care partly concern funding, calling for national solutions, the need for more collaboration at a local level has also been consistently highlighted. For example, Cameron et al. (2018) interviewed 92 participants involved in commissioning health and social care services in England. They highlight the value of different stakeholders coming together, with benefits often framed in terms of some combination of efficiency, prevention, and empowerment. Extending to other parts of the UK, Scott et al (2024) reviewed 47 publications on co-production in social care and found that although co-

production was an aspiration for many commissioners, aiming to share power with service users and communities, commissioning processes frequently acted as a barrier to its fulfilment. The complexity of the commissioning process was a consistent finding, and the authors call for more flexible funding models, longer-term pilot projects, an increased emphasis on social value, and steps to increase capacity in strong leadership in commissioning.

These are factors which the Sheffield commissioning model has sought to address and improve via working alongside customers, providers, and trade unions to provide a streamlined, patch-based model which sought to consult with stakeholders at every stage.

Data Sources

In preparing this report we spoke to the lead and former lead of home care commissioning in Sheffield City Council, referred to here as CC1 and CC2. We also spoke to the manager for one of the newly commissioned care providers, shown here as CM1, which was directly attracted to Sheffield by the new commissioning model, having been consulted for their experience delivering a community wellbeing model in the nearby city of Leeds. This sample is small in size, but deep in the expertise of these individuals due to their critical strategic role in the commissioning process. Understanding of the consequences of this model could be considerably enriched by further research to gather the experiences of home care recipients and care staff on the ground.

Findings

Below is a thematic overview of findings that outline the benefits of union involvement in this process, among other factors.

1. Drivers for Change and Context of the Old System

The primary driver for commissioning reform was described as the expiry of long-extended contracts: “We had come to the end of the contract life… it was a huge endeavour.” (CC1).

CC1 emphasises the enormous scale of home care in Sheffield, with 35 providers, 1200 workers, 2500 service users weekly, and over 1.1 million annual home-care visits. Under the old system waiting lists were long, reprovision was common and a “fastest finger” model sent each care package to all providers, leading to inefficiency and chaotic travel patterns that were typified in CC2’s words as, “eight care workers turn up on the same street at the same time”. So, with previous contracts coming to an end Sheffield researched what had worked elsewhere. and designed a new system involving fixed geographic patches sized for provider sustainability (each comprising roughly 1,500–2,500 hours per week).

2. Collaboration as a Response to Challenges

CC1 identified the need for commissioning and delivery to "be a lot smarter" given the lack of funding, which CC2 described as leaving providers "working in shoe strings".

CC1 repeatedly stressed the need to avoid adversarial dynamics and prioritising collaboration as "the key to all this," including collaboration between providers and trade unions as well as the council, and this was echoed by CC2.

3. New Contracting Model and System Transformation: Benefits to Customers and the Workforce.

The new model reorganised the city into 16 geographic patches, sized to include around 1,500–2,500 contracted care hours per week, each with an exclusive contract provider. This removed competitive bidding for every package of care and reduced unnecessary travel for home care workers. CC1 explained that under the new system:

> "Care coordination is far more efficient… you've got happy services, happy carers, [and] happy providers."

The alignment of patches with Primary Care Networks improved collaboration with health services and increased the speed at which packages could be put in place, which was described as also avoiding delays in hospital discharge. Awarding 16 locality contracts was reported to have reduced waiting lists significantly (often to fewer than half a dozen people at any time) and improved integration with community networks.

In terms of wider staff support, CC1 highlighted that the new approach also introduced a "transformational contract", which included a Care Academy for training and progression, and efforts to encourage younger entrants. Although formal choice of provider was narrower within the Council-arranged service, the benefits—in flow, continuity, and joint innovation—were judged to outweigh this, and alternative providers remained available for those who prefer them.

> "Providers… work in collaboration, not competition… we're doing a lot of work with technology enabled care and optimised care." — CC2.

As defined by Sheffield City Council, "optimised care" empowers the service user to do what they can for themselves, provides personalised care and also allows family or informal carers to deliver care if they wish.

Sheffield's model was described by CM1 from a provider's perspective as unusually open to innovation and technology, with CM1 commenting that the city has been "one of the biggest proponents of change". They highlighted an upcoming digital monitoring pilot that would allow providers to access data on service users' routines and changes, something she welcomed after an initial pilot in which providers had little visibility. CM1 argued that this approach supported more "preventative and proactive care", shifting the sector beyond task-based delivery. For example, new technology installed in people's homes was able to

monitor how often someone uses the toilet, which allowed care staff to monitor for things like urinary tract infections, which in turn could reduce worsening illness and hospital admissions.

CM1 also expressed strong support for Sheffield's Optimised Care Model, in part as it challenged risk-averse assumptions about a need for two-carer visits. This aspect was also referenced by CC2, who stated that their increased use of technology, including AI, allowed them to reduce staff from two to one on a number of visits. CM1 said the model had been "fun to work with" and was valued by both care workers and service users, contributing to greater independence and better, more efficient use of the workforce. There are questions about how the increase in the use of new technologies will impact on how staff are utilised, though SCC have stated it has not led to reductions in staffing. The long-term impact remains to be seen.

Early feedback according to the commissioners—especially from workers in social enterprises—suggests better pay, far less travel, stronger continuity with regular clients, and expanded access to training via the Care Academy (e.g., dementia and dignity in care). Given the large number of international recruits, the Council also delivered citywide training on British culture, communication and meal preparation to reduce complaints and improve satisfaction. Plans were also said to be underway to strengthen workers' direct voice with the Council, independent of employers through mechanisms such as workers group meetings. SCC also introduced longer contract durations as part of the new model (7 years + 3 optional), addressing providers' concerns about stability of the workforce and care provision.

Further developments included:

- A shift "from competition to collaboration", with mandated sharing of learning across care providers.
- Establishment of a "care and well-being service improvement board", to support ongoing quality development.

4. Role and Impact of Trade Unions

CC1 attributes improvements as centrally arising from the entire collaborative model, of which trade unions were an integral part:

> "It's not one particular element… it's that wider collaboration, everybody working together to one end."

Union involvement (primarily the GMB Union and UNISON, also Unite) formed a core component of the transformation. The involvement of unions in the tender process was described by interviewees as contributing to lifting workforce standards across providers and appears to have improved retention and satisfaction, though fuller evidence is still being developed by SCC. CC1 emphasised the commissioning team's belief that:

> "If we created the right working environment for care workers… that would support retention… and deliver the best possible care."

Unions participated as “meaningful partners” (CC1), in procurement panels and workforce forums. Unions were involved early in engagement and co-production, helped shape the specification and tender questions, and sat on the evaluation panel. During the large-scale TUPE transfer—from 36 providers down to 14, with nine incumbent, involving approximately 2,500 service users and 1,300 care workers in a single day—the Council worked closely with unions to run drop-in sessions and support staff. This appears to have minimised workforce loss and to have improved worker confidence during the transition.

> “It was absolutely beneficial having GMB and the others involved… their expertise … allowed us to be a lot more robust in our selection.” — CC2.

Council leadership strongly backed the approach, while some providers were said to have initially felt anxious. However, selecting unions with “the right attitudes… very collaborative in their approach” helped build trust. CC1 states unions were central partners because they represented the majority of home care workers.

CC1 and CC2 attributed several improvements following the new commissioning model and union involvement:

- A “more sustainable marketplace”, with better staff retention with workers feeling “more valued”.
- Smaller patches allowed non-drivers to become home-care workers: “people on foot can now benefit… you don’t need a car”, increasing inclusion and reducing costs for care workers

These benefits of the patch-based model were echoed by CM1, who also described this as enhancing integration with local services, enabling providers to build relationships with “GPs, district nurses, social work teams, and voluntary-sector organisations”, and to support better signposting and holistic care. CC1 notes that further workforce satisfaction data will come from ongoing surveys led by colleagues. They also offered personal stories illustrating workforce empowerment—for instance, a care worker promoted to coordinator after 30 years in the care role, reportedly describing the changes as “the best thing that happened”.

Previous research (e.g. Ruffini, 2024) has provided evidence of an association between improved conditions for workers and improved care quality. In Sheffield, the new model is felt to have improved continuity—one of the biggest concerns previously. CC1 highlights:

> “We’ve seen better continuity of care, which is important.”

Further evidence will emerge from ongoing service-user surveys.

The model has gained national attention, including The *Home Care Association* which has endorsed it as an example of best practice, and *Skills for Care* which plans to publish associated resources from this model.

CC1 describes the development process as fundamentally based on “learning from others… having the big ears and small mouth”—actively listening to other local authorities, and stakeholders and incorporating external ideas.

CM1 described the new model, with its smaller cohort of providers and greater commissioner oversight, as having helped staff feel more confident that their rights were respected. CM1 was keen to stress that her organisation already upheld high standards—including signing the Unison Ethical Care Charter in Leeds. Despite improvements however, CM1 argued that union involvement and contractual expectations cannot overcome structural underfunding, noting that that "without proper funding coming into local authorities, you're limited in how far you can go with pay". CM1 therefore repeatedly cited the need for national reform, stating that social care must be treated as "an equal partner to the NHS", and that care workers should be recognised as "skilled professionals" with a corresponding investment in the sector.

Conclusion

In conclusion, it does appear that Sheffield City Council's new commissioning model can claim a number of successes in terms of the quality of care delivery and improvements in the treatment of staff on the ground. There appears to be genuine ongoing efforts to co-produce alongside key stakeholders and SCC continue to review the effectiveness of the model. Trade union involvement was actively sought, and SCC insisted that providers be open to union involvement as part of their contract. This model appears to be an example that demonstrates the promotion of worker rights can be a positive part of the commissioning process and does not need to viewed down a narrow lens of equating worker rights with increased cost to employers. This model has taken a pragmatic approach in adopting a patch-based system aligned to NHS primary care delivery, which in itself allows for greater streamlining with NHS partners and may have a positive impact on 'bed blocking'. While this report is drawn from limited data, it is hoped that this may be built on in exploring possibilities for changes to commissioning which are beneficial to commissioning authorities, the workforce and those in need of care.

About the Work Futures Observatory

The Work Futures Observatory exists to strengthen collaboration between trade unions and academic researchers. Following a pilot co-funded by the GMB Union, the Observatory offers a bespoke research, knowledge and education resource to benefit workers, trade union practices and associated areas of public policy. We welcome contact from any trade union or associated body to discuss how we can support your work.

Contact the Directors - Dr Tom Vickers (tom.vickers@ntu.ac.uk) and Professor Nadia K Kougiannou (nadia.kougiannou@ntu.ac.uk). For further information see: https://www.ntu.ac.uk/research/groups-and-centres/projects/work-futures-observatory

References

Bancalari, A, Zaranko, B (2024). Adult social care in England: What next? IFS Report, No. R338, Institute for Fiscal Studies (IFS), London, https://ifs.org.uk/publications/adult-social-care-england-what-next

Cameron A, Brangan E, Gabbay J, Klein JH, Pope CJ, Wye L. Discourses of joint commissioning. Health Soc Care Community. 2018;26:65–71. https://doi.org/10.1111/hsc.12462

Dromey, J. and Cooper, B. (2025) Seizing the Opportunity: The Fair Pay Agreement in Social Care. The Fabian Society.

Fenton, W. Polzin, G. Fleming, N. Fozzard, T. Price, R. Davison, S. Holloway, M. Liu, H. O'Gara, A. (2023) The state of the adult social care sector and workforce in England. Skills for Care. Accessed April 2026. Available at: www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/workforceintelligence/resources/Reports/National/The-state-of-the-adult-social-care-sector-and-workforce-in-England-2025.pdf.

Hudson, B. (2019). Commissioning for change: A new model for commissioning adult social care in England. Critical Social Policy, 39(3), 413-433. https://doi.org/10.1177/0261018318818960

Ruffini, K. (2024) Worker earnings, service quality, and firm profit- ability: Evidence from nursing homes and minimum wage reforms. *Review of Economics and Statistics*. 106 (6): 1477–1494.

Scott RJ, Mathie E, Newman HJH, Almack K, Brady L-M. Commissioning and co-production in health and care services in the United Kingdom and Ireland: an exploratory literature review. Health Expect. 2024;27:e14053. https://doi.org/10.1111/hex.14053

Skills for Care (2024) The state of the adult social care sector and workforce in England, 2024.