

The Kingsmill Review: Taking Care

An independent report
into working conditions
in the Care Sector

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Foreword

Care matters. People receiving care need support to live comfortably and independently. Older and disabled people might need extra help to prepare meals and bathe, they might need a prompt to take vital medication, and they might need support with conditions such as Dementia and Alzheimer's.

Care Work is in crisis. People who may be vulnerable are not being treated with the care and attention they deserve. All too often, their only source of support, Care Workers, are exhausted, unable to plan their own lives through insecure contracts, and unable to spend enough quality time with the person in receipt of care.

The role that Care plays in our society is vital. Care Workers deliver the support needed to people nearing the end of their lives, to disabled people, and to people with chronic illnesses. It enables them to live comfortably and in a dignified way. Care Workers need to be treated properly so that they can treat Care Recipients Users properly.

All too often during the course of this review, I've heard the words 'I'm just a Care Worker'. How unfair it sounds. Care Workers often have to deal with complex feeding methods, use hoists for moving clients, dress wounds, administer medication, and provide vital emotional and domestic support for Care Recipients. It's not a job for the faint-hearted and it's certainly not 'just a job'.

Care Workers are under-valued, under-paid and under-trained. They don't have the status of Nurses. They don't have the status of Child-Minders. The sector is subject to weak regulation. We don't know who they are, we don't know what qualifications they hold and they are not registered with any professional body. This workforce of 1.8 million people in England is almost invisible.

The working conditions of Care Workers are among the worst of any in England. Their wages tend to be either National Minimum Wage or no more than 15% above that minimum. Frequently, even the National Minimum Wage is ignored, with employers unlawfully refusing to pay Domiciliary Workers for the time to travel in between their clients. Many Care Workers don't even know what hours they'll be working from week to week – exploitative 'Zero Hours Contracts' play a huge role in the sector and destabilise workers' lives.

Qualifications are patchy. The Care Quality Commission's oversight of workforce issues is weak and the provision of training and education relies on a fragmented independent sector. Training varies considerably, with no real enforcement of a common framework for Care Workers. The workforce tends to be older women or migrant workers, who have few other employment options. Younger people are reluctant to enter the industry, as there is no career progression.

The low status of Care Work and poor treatment of workers has led to a vicious downward spiral into one of the most difficult sectors for workers, with widespread exploitation. Turnover rates range from 20% to 30% per annum, a sign of difficult conditions and instability in the sector.

In this review we hope to highlight the low pay, poor status, inconsistent training, and weak regulation in the sector, the reasons for these conditions, and what can practically be achieved to improve standards for Care Workers. This is worthwhile and important work – too many caring and compassionate people are being forced out of the sector because of low wages, bad contracts, and a lack of training. We want real change for Care Workers.

When Care goes wrong, it can go badly wrong. The serious case of poor care and neglect last year at Orchid View shows that we need to value Care in the same way that we value Health. Workers need to be properly treated, trained and regulated.

Care for elderly and disabled people is a major issue for the mid-21st Century. We are all likely to live longer and a large number of us will require care in our final years. We would all wish to be cared for by staff who are valued, qualified, committed and

treated properly by their employers and the State. The public purse, however, is tight – and increases in taxation are deeply unpopular.

As a result, the recommendations in this review fall into two categories: immediate changes that could be implemented within existing budget constraints, and long-term objectives that will require investment and extra funding. The most likely source of these additional monies would be the integration of the Health and Social Care budgets. Improving conditions for Care Workers and Care Recipients is a journey: we need to act now, but we need long-term change and to truly value Care as essential to the wellbeing of some of the most vulnerable people in society.

Baroness Denise Kingsmill CBE

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Please note: all photos are stock images to protect identities

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A. Summary

Care Workers carry out some of the most important work in society, caring for the sick, elderly and the disabled. Yet the Care Sector is in crisis. As well as the work being physically and emotionally demanding and often undertaken in unsocial hours, there is evidence of widespread exploitation of workers. For example:

- Studies suggest that between 160,000 and 220,000 Care Workers are unlawfully paid less than the National Minimum Wage.¹ A HMRC investigation into 80 Care Providers found that almost half (47%) were not compliant with National Minimum Wage regulations
- An estimated 307,000 Care Workers, or a fifth of the Adult Social Care Workforce, are on 'Zero Hours Contracts', meaning they do not have stable hours each week or a stable income
- A fifth of Health and Social Care Apprentices receive no training at all. Nearly a third of Care Workers receive no regular ongoing training
- Over 41% of Care Workers do not receive specialised training to help deal with their client's specific medical needs, such as dementia and stroke-related conditions

Exploitative working conditions for Care Workers mean that there is a risk that they will only be able to deliver a rushed, poor quality service. The pressure that 15 minute care slots places on them means they are unable to give the human interaction that Care Recipients desperately need. Excessive time pressures and low levels of training lead to mistakes and, in a minority of regrettable cases, abuse. Meanwhile low

pay and exploitative working practices make it harder to attract, motivate or retain the workforce: turnover is 19% a year in Residential Care and 30% in Domiciliary Care, and a third of staff that leave do so within 12 months. The sector also struggles to attract young people: nearly half (45.6%) of employees are aged 46 or older.

These conditions make it difficult to attract ambitious and compassionate young people to the sector and have created a high dependence on low skilled, female and migrant workers who are particularly vulnerable to exploitation, due to their limited employment options.

In September 2013, Ed Miliband asked me to conduct a review into exploitation in the Care Sector. I was asked to examine what could be done to tackle exploitative working practices, and so improve the quality of care, within the existing care budget.

At the root of the immediate crisis is a crisis in funding, particularly since the deep cuts Local Authorities have had to absorb since 2010 and the context of increasing demand due to an ageing society. We have included long-term objectives which will require greater funding for the Care Sector. If we truly valued Care and Care Workers, we would help older and disabled people to reduce the need for potentially distressing hospital admissions.

However not all of the changes required in Care are about funding. We have evidence of a weak and fragmented regulatory environment, irresponsible procurement practices by Local Authorities, and poor workforce planning and management skills within Care Providers. The recommendations set out here focus on these issues, which could be addressed at little or no cost. Improvements could be possible in the sector through safeguards to support both employers and employees to better coordinate and protect them from an unsustainable race to the bottom in wages and skills.

¹ Hussein, S., *Estimating Probabilities and Numbers of Direct Care Workers Paid under the National Minimum Wage in the UK: A Bayesian Approach*, Social Care Workforce Periodical, issue 16 (December 2011)

Policy recommendations

1. Introduce a Licence to Practice for Care Managers

- Care Workers need a stronger voice and greater status. The people who perform this essential task must receive fair compensation, reward and training for their efforts, and have their rights protected. Registration and legal training requirements for Care Workers are effective ways to raise standards in care and protect user rights. As a first step, Care Managers must be registered and have a Licence to Practice with a requirement to have a Level 5 Diploma in Leadership for Health and Social Care.
- The Health and Care Professions Council (HCPC) currently operates a licensing system for Social Workers and a number of other professions. The licensing system includes Standards of Proficiency and a commitment to continuous professional development. We recommend the remit of the HCPC should be extended to Care Workers to protect them from exploitation. We believe that, eventually, all Care Workers should be registered and have a Licence to Practice. Care Workers are paid from the public purse; we need to know who they are and that they are properly qualified. The Care Quality Commission (CQC) should have the power to prosecute providers who employ Care Managers/Workers without a licence.

2. Enforce the National Minimum Wage

- The National Minimum Wage (NMW) must be a floor, not a ceiling. The CQC should be required to monitor evidence of non-payment of the NMW. It should have an absolute requirement to refer cases where workers are being paid less than the legal minimum to the HMRC for investigation. The law should be changed to enable better information-sharing and joint-working between the HMRC and the CQC, as well as other relevant authorities. HMRC should be required to take a more proactive approach to enforcing the NMW.

- Local Authorities must be required to perform due diligence to ensure that Care Workers are not being paid less than the National Minimum Wage. If evidence is found of non-payment of the NMW and Local Authorities are found not to have performed appropriate due diligence, they would be jointly-liable.

3. Ban exploitative 'Zero Hours Contracts'

- An estimated 307,000 Care Workers are on 'Zero Hours Contracts'. Many are on a compulsory basis and in some cases they are prevented from working for other employers. An independent review for the Labour Party recently set out new legal rights for employees on Zero Hours Contracts to ban employers from being able to force them to be available at all hours, insist they cannot work for anyone else, or cancel shifts at short notice without compensation. It also called for employees on 'Zero Hours Contracts' to be able to demand a fixed hours contract when they have worked regular hours over six months with the same employer, and to receive a fixed hours contract automatically when they have worked regular hours over a year – unless they decide to opt out.
- If employers require a worker to be available for work but with no guarantee of providing work, I recommend that they should have to pay for this standby time. Good working relationships require reciprocity. Standby Contracts allow flexibility for employers and certainty for workers. This would remedy the uncertainty of 'Zero Hours Contracts' for workers, allowing them to plan and budget with a Standby Contract.

4. End 15 minute Care slots and introduce a Care Charter

- The CQC should set standards for Local Authority procurement processes through a new Care Charter. This would ensure that commissioners drive best practice and hold Care Providers to the conditions they must meet to secure a contract. The goal should be to ensure that irresponsible procurement practices do not put pressure on providers to

exploit workers and break the law. The CQC should be made responsible for ensuring that Local Authorities follow the principles of the Care Charter. Above all, this must include an end to 15 minute slots, which are associated with non-payment of the minimum wage and poor quality of care.

5. Improve training standards and progression

- The Care Sector is suffering from weak and inconsistent training. Young people are not attracted to the industry, which is a concern for recruiting the next generation of Care Workers. The average age for a new starter is 35 years old. Skills for Care sets training standards for the Care Sector but adherence to these standards is voluntary and employers in the Care Sector lack the tools to ensure a level playing field. To tackle this problem Skills for Care should be reformed to strengthen the representation of employers and employees on its board. It should be given an explicit remit to tackle poor standards and raise levels of training, and particularly apprenticeships, in the sector.
- A more strategic approach to skills funding would enable the sector to meet the new training standards within existing budgets. Labour has pledged to offer a 'something-for-something deal' to employers.² This will give employers, working collectively at sector level, more control over skills standards and the £1.5 billion apprenticeship budget, and in return ask that they work to increase the number of high quality apprenticeships in their sectors and supply chains. Skills for Care should negotiate with central government for more high quality apprentices in the Care Sector. The organisation should also look to:
 - Set a common training levy for employers to pool money that they each spend individually on care and give workers consistent training
 - Use the extra funding to invest in Group Training Associations in each area,

providing tailored and high quality training provision for Care Providers

- Licence training providers and identify poor training providers in the sector
- Create example models for career progression from Care Worker to manager, with links to qualifications and pay

6. Improve oversight and regulation of working conditions

- Oversight and enforcement of Care Providers needs to be improved to tackle exploitative work practices. The Care Quality Commission (CQC) is responsible for the regulation of all Health and Adult Social Care Providers in the UK. The CQC currently inspects most Care Homes and Domiciliary Care services at least once a year³, and has the power to enter premises and remove records⁴. This puts the CQC in a strong position to identify and monitor exploitation of Care Workers. Poor working conditions often go hand in hand with poor quality of care and abuse of Care Recipients. The remit of the CQC should be extended to protect Care Workers from exploitation, as well as their existing remit to ensure providers meet appropriate standards for care users.

² The Labour Party, *A revolution in apprenticeships: a something-for-something deal with employers* (Labour's Policy Review, 2013)

³ CQC, *Preparing for CQC Inspection*: http://www.cqc.org.uk/sites/default/files/media/documents/cqc_preparing_for_inspection_-_cpa_version_-_final_0.pdf

⁴ The CQC was given these powers under sections 62 and 63 of the Health and Social Care Act 2008

A long term view for the sector

The ultimate objective is the professionalization of Care Work. We believe that long-term changes in the sector are needed to improve the status of Care Workers, create opportunities for pay and progression, and raise standards across the sector. Some of these would involve financial investment, and are therefore dependent on improvements in the current funding situation.

into a specialist role or degree study, such as Nursing.

Conclusion

The time is now for real change in the Care Sector. We need good quality care. We need Care Workers who are treated properly, paid fairly and adequately trained. The opportunity to make those changes is now.

Tackle low wages

- Local Authorities should use the tendering of procurement contracts to encourage employers to pay the Living Wage. The experiences of Southwark and Islington Council show that this can be done by reducing waste elsewhere, at no extra cost to central government.

A Licence to Practice for all Care Workers

- All Care Workers should be registered and required to hold a Licence to Practice – with a particular focus on those contracted through personal budgets given the low levels of oversight of these workers. The register and Licence would be maintained by the HCPC; its role would also include sharing knowledge, promoting the status of Care Workers and protecting the public from unqualified workers. This should be completed within five years.

Create opportunities for progression

- We believe the Care Workforce need to be more professionalised. In order to achieve this, significant improvements will be needed in the registration and training of Care Workers, with progression opportunities that are linked to qualifications and pay. National Minimum Training Standards and QCF Level 2 Diploma should be made compulsory for all Care Workers.
- Skills for Care should develop higher-level apprenticeships linked to QCF levels 7 and 8, and Care Workers should be able to fast track

B. Conclusions and recommendations

This review was prompted by growing concerns about the treatment of Care Workers and their capacity to deliver quality care to some of the most vulnerable people in our society. Poor conditions for workers often lead to poor quality of service for clients – mostly elderly and disabled people. When care goes badly wrong, the results can be devastating, as with the case at Orchid View last year.

I was asked to focus on ways to improve working conditions in the Care Sector without increasing funding. Our team set out to establish practical recommendations of ways to improve working conditions for Care Workers. We have drawn on the expertise of policy experts, academics, large and small service providers, Local Authorities and Care Workers themselves. We have consulted with a variety of contributors on an individual level for both a deeper understanding of the industry and a critical analysis of our recommendations and their possible effectiveness in improving working conditions.

The call for greater funding in care has been overwhelming. The pressure of austerity measures on Local Authorities has led to years of under-funding and chronically poor conditions for Care Workers and Care Recipients alike. Under-funding the Care Sector is a false economy; if we truly valued care, fewer people would need to go to hospital. This would avoid the trauma and uncertainty of a hospital visit, and be a benefit to the public purse. The line drawn between Health and Care is artificial; the work on integration and Sir John Oldham's review for the Labour Party of 'Whole Person Care' has gone some way to address this. We would like to build on this. We need to build a continuum of pay, training and conditions across Health and Social Care so that a Care Worker or a Health Worker could have the same opportunities. Care is the entry point for many into the system of Health and Social Care.

Our recommendations seek to improve pay, status, training and progression, and regulation and oversight in the Care Sector. These are set out into two sections – short term and long term. The short term recommendations are important and immediate changes that we can put into place to improve the Care Sector within the existing budget. The long term objectives will require investment but are essential to the future success of the sector and a move towards a professional and high quality care service.

Tackling Workforce Exploitation in Care

The strain on finance is not the only issue in the Care Sector. We strongly recommend greater funding for the Care Sector and a better understanding of its value to society as well as potential savings for the NHS. However the problems of poor working conditions and low professional standards are exacerbated by the weak regulatory environment, commissioning practices that fragment service provision and poor workforce planning. We believe that addressing these problems will result in significant improvements even within existing funding constraints, leading to a radical reduction in widespread use of exploitative 'Zero Hour Contracts', the end of systematic non-payment of the National Minimum Wage, and progressive improvements in the training and professionalism in the sector.

1. A Licence to Practice for Care Managers

Care Workers need a stronger voice and greater status. The people who perform this essential job

must receive fair compensation for their efforts, be able to input into practices and policies that affect them most, and have their rights protected. Care Workers are paid from public funds, whether through an independent Service Provider or directly by the Local Authority, and it is essential that taxpayers know where this money is being spent. The development of a registration system for Care Workers is an effective way of regulating standards in care and protecting workers' and users' rights.

The registering body would issue a Licence to Practice, which gives credibility to the profession, promotes the status of the workers and provides important benefits to the members, while also protecting the public from unqualified, incompetent or unfit practitioners. The Patients Association and other groups called for formal registration to ensure "appropriate feedback and a consistency in recruitment, training and professional development"⁵. The benefits are numerous: protection and legal representation, advice and support for workers, the ability to share best practice, network, a greater sense of status and a symbol of a professional workforce.⁶

The Health and Care Professionals Council should have its remit expanded to include the issuing of Licences to Practice for Care Workers. Full registration and licensing would require additional funding. Therefore, as a first step, we would recommend that all Care Managers must be registered, have a Licence to Practice, and be qualified to at least a Level 5 Diploma in Leadership for Health and Social Care.

The role of a Care Manager is vital in ensuring that Care Workers have sufficient time to complete tasks, are properly trained for their activities and have the support needed to complete their duties. In Scotland, Care Home Managers and Supervisors, Domiciliary Care Managers and Social Workers are all registered by the Scottish Social Services Council. This ensures that managers have relevant qualifications, work to a Code of Practice, and work with the Sector's Skills Council on Workforce Development and Planning. From September 2015, all Care Workers in Scotland will be registered. England should use this example and set up its own Licence to Practice, firstly for Managers, then for all Care Workers. In England, the

Health and Care Professions Council already operates a licence to practice for Social Workers. This could be easily extended to cover Care Managers as well.

Full registration and licensing would require additional funding. Therefore, as a first step, we recommend that all Care Managers must be registered, have a licence to practice and be qualified to at least QCF Level 4 Diploma with opportunities for existing Care Workers to progress. This will help to attract more young people to the sector.

2. Vigorously enforce the National Minimum Wage

There are between 160,000 and 220,000 direct Care Workers paid less than the legal National Minimum Wage out of an estimated workforce of 1.85 million people.⁷ One reason Domiciliary Care Workers are not being paid the National Minimum Wage is non-payment of travel time; this is the time it takes for Domiciliary Care Workers to travel from one Care Recipient's home to another. For Residential Care Workers, the National Minimum Wage is often ignored for night shifts, overtime or 'sleepover' time when employers calculate the average amount of time that Care Recipients are awake. **The National Minimum Wage must be vigorously enforced.**

The report by HMRC 'National Minimum Wage Compliance in the Social Care Sector' has found high levels of non-compliance within the Care Sector in particular. In 2012/13, HMRC identified 736 employers out of 17,000 organisations who had failed to pay the National Minimum Wage to staff, a total sum of £3.9 million in unpaid wages for 26,500 workers. In 2011, Birmingham's compliance team, in a city of over 1 million people, had just eight officers and a manager.⁸ HMRC tends to be reactive and rely on workers to initiate proceedings; these are 60% of the caseload.⁹ Further resource is needed to support HMRC and the freeze applied to its expenditure should be lifted. Non-enforcement of the National Minimum Wage is a false economy; ensuring that people are properly rewarded for their hard work will have a beneficial impact on the economy as a whole

⁵ Cavendish, C., *The Cavendish Review* (2013), 34

⁶ While not completely identical, the Royal College of Nursing is analogous. Details available at – <http://www.rcn.org.uk/membership/benefits>

⁷ Philpott, J., *Rewarding work for low-paid workers* (Joseph Rowntree Foundation, 2014)

⁸ HM Revenue & Customs, *National Minimum Wage Compliance in the Social Care Sector*

⁹ HM Revenue & Customs, *National Minimum Wage Compliance in the Social Care Sector*

and prevent unscrupulous providers operating in the Care Sector.

To ensure the NMW is fully enforced, the CQC, as part of its new remit, should be required to monitor potential evidence of non-payment of minimum wage. It should have an absolute requirement to refer cases where workers are being paid less than the legal minimum to the HMRC for investigation. The law should be changed to enable better information-sharing and joint-working between the HMRC and the CQC, as well as other relevant authorities.

3. Ban the use of exploitative 'Zero Hours Contracts'

The use of 'Zero Hours Contracts' in Care is widespread and is a practice that has mushroomed in recent years.¹⁰ These contracts cause instability for workers, for Care Recipients and for the care that is delivered. Not knowing how many hours you will be working in a given week or even how much money you are likely to earn leads to unstable and exploitative conditions for Care Workers. Workers are often penalised for not being able to work certain hours or, worse, can have their hours reduced for whistleblowing or complaining – clearly a risk in the Care Sector where peoples' lives are at stake.¹¹

For a small minority of Care Workers who voluntarily enter into 'Zero Hours Contracts', employees have the ability to choose the number of hours they work and negotiate; there is mutuality. Working mothers or people who care for elderly relatives may benefit from the flexibility of these contracts. This, however, only applies to a small minority of cases. For the overwhelming majority in the Care Sector, 'Zero Hours Contracts' are compulsory. Not only does this lead to financial instability, but it also means that workers are fearful of questioning practices or whistleblowing in case the Service Provider 'zeroes down' a staff member's working hours. Employees on 'Zero Hours Contracts' are often obliged to be exclusively available to the employer, who does not have a matching obligation to provide work.

An independent review into for the Labour Party by HR expert Norman Pickavance¹² recently recommended new legal rights for employees on 'Zero Hour Contracts' to be able to demand a fixed hours contract when they have worked regular hours over six months and to receive a fixed hours contract automatically when they have worked regular hours over a year, unless they decide to opt out. The review also recommended banning employers from forcing workers on 'Zero Hours Contracts' to be available at all hours, insisting they can not work for anyone else, or cancelling shifts at short notice without compensation.

We recognise and commend the result of this report, and would like to suggest another way of doing this. We recommend that employers in the Care Sector who wish to require employees to be available without guarantee of work must use Standby Contracts. These would not guarantee hours, but companies would pay for time spent by employees on standby. If an employee is not on standby, he or she would be entitled to work for another company or in a different role. The insistence on Standby Contracts instead of 'Zero Hours Contracts' will encourage providers to plan care more effectively and allow the Care Worker to work elsewhere instead of being at the beck and call of their employer at all times.

4. Local Authorities must commission for the National Minimum Wage for suppliers' staff and monitor abuse

The vast majority of Care is procured by Local Authorities in contracts with the independent sector. Payment of the National Minimum Wage by Service Providers should be explicit in the procurement process, to ensure that Service Providers can be held to account and understand the law on payment for travel time for Domiciliary Care Workers. The UKHCA's research has suggested that the minimum price of delivery for a Service Provider to be able to pay the National Minimum Wage to staff is £15.19 per hour. A number of Local Authorities are paying rates that are below this figure, causing significant

¹⁰ Alakeson, V. and D'Arcy, C., *Zeroing In* (The Resolution Foundation, 2014), 20

¹¹ Alakeson, V. and D'Arcy, C., *Zeroing In*, 8

¹² Pickavance, N., *Zeroed Out: The place of zero-hours contracts in a fair and productive economy* (2014)

problems for Service Providers.¹³ Local Authorities must be transparent with the pay rates given to providers and include payment of the National Minimum Wage as standard.

Local Authorities should also be required to perform due diligence to ensure that workers in the Care Sector are not being paid less than the National Minimum Wage, for example due to unlawful non-payment of travel time. If evidence is found of non-payment of the minimum wage and Local Authorities are found not to have performed appropriate due diligence, they would be jointly liable with the Care Provider.

5. Local Authorities must sign a compulsory Care Charter

There is poor monitoring of the contracts used by Local Authorities to procure the services of Independent Sector Care Providers. The consultation response 'Oversight in Adult Social Care' from the Department of Health arising out of the failure of Southern Cross Healthcare demonstrates greater political will to ensure the financial stability of Care Providers and manage failures in the private Care Sector.¹⁴ Consequently, the time is ripe to rethink monitoring of Adult Social Care and ensure that Local Authorities improve their commissioning and procurement practices.

Care does not take place in a vacuum. Local Authorities are part of a wider procurement process from central government to the older or disabled person in receipt of care. The funding chain emanates from central government to 152 different Local Authorities. The Local Authorities then procure the vast majority of Care from the independent sector. Reducing expenditure levels in Care, as a result of austerity measures and increasing demand from an ageing population, is putting Local Authorities under unbearable pressure. This reduction in spending is a false economy; increased, targeted spending on Care should be a priority. Local Authorities must work more constructively with Service Providers, Care Workers, Trade Unions and Care Recipients.

To ensure this is the case, the CQC should set standards for Local Authority procurement processes through a new Care Charter, setting out the key conditions that providers must meet in order to receive a contract. The objective must be to ensure that irresponsible procurement practices do not put pressure on providers to exploit workers and break the law. The CQC should be made responsible for ensuring that Local Authorities follow the principles of the Care Charter.

The Care Charter should be developed by the CQC in consultation with key stakeholders, but the principles below suggest some important issues that seek to stop exploitation of Care Workers and improve quality of care through better workforce planning to ensure continuity of care and a more flexible service.

The Care Charter

The aim of the Care Charter is to ensure quality and dignity in care provision for Care Recipients through a high standard of working conditions. A motivated, sympathetic and consistent workforce will allow for a quality experience for Care Recipients. Local Authorities must all agree to the following principles, including when procuring services from the independent sector:

- **An end to 15 Minute Time Slots.** Only when a Care Recipient receives multiple slots of care in a day, or explicitly requests shorter times will 15 minute care be used
- **No minute-by-minute task-based commissioning or provision;** visits should allow for sufficient flexibility to recognise that care takes place in the context of relationships built up between Care Workers and Care Recipients
- **Domiciliary Workers will be paid for their travel time** between visits and Councils will ensure that Care Providers pay staff at least the National Minimum Wage, including for travel time
- Local Authorities and Service Providers will be **transparent in their price setting**, which will include pay and conditions, including paid training, for Care Staff
- **Exploitative 'Zero Hours Contracts' will not be used.** Local Authorities will specifically disallow Service Providers to use 'Zero Hours Contracts' that require workers to be on call without guarantee of work. Instead, Service Providers may use Standby Contracts where, if a provider requires a Care Worker to be available for work and prevents them from working elsewhere, this will be termed standby time and there will be a wage
- Local Authorities will more **extensively monitor Care** provided by Service Providers, including the working conditions for staff
- Care Recipients will be allocated **the same Domiciliary**

¹³ Francis, J., *An overview of the UK domiciliary Care Sector* (2013)

¹⁴ Department of Health, *Market Oversight in Adult Social Care* (2014)

Worker when possible, to ensure continuity of relationships with Care Recipients

6. 15 Minute Care is careless. End 15 Minute Care Slots.

Care requires time. Some clients might require help with food preparation, washing or bathing, or a simple medical prompt. Most clients will require a combination of different care services. Personal support and human contact are fundamental to care. When Care Workers do not have sufficient time or are rushed, however, care can go badly wrong. The Equality and Human Rights Commission has reported that some Care Recipients' Human Rights are being breached: hair is not being washed and people are often left without a meal due to lack of time.¹⁵ Strict restrictions on time mean that people are not being treated with dignity, their needs are being ignored, and Care Workers can not do a satisfactory job. In 2012, almost three quarters of Domiciliary Care visits commissioned by Local Authorities in England were for periods of 30 minutes or less. Shockingly, one in ten visits was for 15 minutes or less.¹⁶ Elderly, sick and disabled people in nearly two-thirds of areas are facing 15 minute visits and there has been a 15% increase in the proportion of visits lasting just 15 minutes over the last five years.¹⁷

Good care can not be provided within 15 minutes. It puts an unfair burden on the Care Worker and jeopardises the quality of care given. The Low Pay Commission reported a possible link between 15 minute Domiciliary Care appointments and Care Workers being paid below the National Minimum Wage.¹⁸ If travel time is not paid and staff regularly complete 15 minute care slots, they risk being paid a measly £1.63 for 15 minutes of very intimate and vital care.¹⁹ This not only affects the Care Recipient, through the inability of Care Workers to attend to the users' needs fully, but also the Care Worker – with wages so low, it is difficult to recruit and retain a compassionate workforce. Recruitment of a new staff member costs around £3,500, thus losing and replacing staff represents a significant cost for employers, as well as interruption for Care

Recipients.²⁰ The Care Charter, set by the CQC and compulsory for all Local Authorities, should ensure that 15 Minute Care Slots are ended.

7. Improving training standards and progression

The Care Sector desperately needs stronger coordination and leadership to tackle low levels of training, poor workplace standards and the lack of high quality apprenticeships in the sector. Moreover, opportunities for career progression remain very limited and it can be difficult for workers to understand how qualifications relate to job titles and pay rates. Tackling these problems will require a stronger sectoral body, capable of driving through improvements across the sector, with responsibility for overseeing reforms to improve standards, training and productivity over time.

Skills for Care already sets recommended training standards for the Care Sector, yet adherence to these standards is voluntary. Skills for Care should be given an explicit remit to tackle poor performance and standards in the sector, with a core focus on raising training levels. Giving Skills for Care a stronger role in standardising training would also enable the CQC to focus on exploitative practices and abuse.

Skills for Care already has good employer representation on its board, but does not have employee or Care Recipient representation. More should be done to improve this, whether through individuals, trade unions or professional bodies. To ensure a joined up approach with other relevant bodies and draw on existing best practice, the Health and Care Professions Council and the Social Care Institute for Excellence should also sit on the board of Skills for Care, and the case for stronger NHS representation should be examined.

Problems with poor quality training and a lack of high quality apprenticeships are not unique to the Care Sector, but are more pronounced. Labour's independent Skills Taskforce, led by the director of the Institute of Education Chris Husbands, called for this to be tackled through a 'something-for-something deal' with employers.²¹ This will give employers, working collectively at sector level, more

¹⁵ Equality and Human Rights Commission, *Close to Home: An Inquiry into older people and human rights in home care* (2011), 70

¹⁶ Angel, C., *Care is not a commodity* (London: United Kingdom Homecare Association, 2012)

¹⁷ Leonard Cheshire Disability (2013) *Ending 15-minute care*

¹⁸ LPC (2012) in Unison, *Time to Care* (London: The Unison Centre), 6

¹⁹ Unison, *Time to Care*, 12

²⁰ Care England submission to the Kingsmill Review, 3

²¹ The Labour Party, *A revolution in apprenticeships: a something-for-something deal with employers*

control over skills standards and the £1.5 billion apprenticeship budget. In return, employers will be asked to work to increase the number of high quality apprenticeships in the sector. Labour will also give employer-led sector bodies the powers they need to raise standards and increase apprenticeships in their sectors and supply chains, such as the power to set training levies and licences to practice.

Skills for Care should negotiate with central government to gain control over a proportion of the apprenticeships budget in return for a clear goal to boost the number of high quality apprenticeships in the sector.

The organisation should also look to:

- Set a common training levy for employers to pool money that they each spend individually on Care and give Care Workers consistent training
- Use the extra funding to invest in Group Training Associations in each area, providing tailored and high quality training provision for Care Providers
- Create example models for career progression from Care Worker to manager, with links to qualifications and pay

8. Introduce a rating system for training providers in the Care Sector

There is currently poor regulation of training providers and no enforcement of a standardized system for qualifications in the Care Sector, causing many employers to question the quality of qualifications. The existence of poor training providers is bad for employers who often have to retrain staff coming from other employers within the sector, and bad for employees who have to perform tasks for which they are insufficiently trained. **We need to weed out poor training providers that operate in the sector.** Labour's Skills Taskforce recommended a licensing system for FE colleges and other training providers that wish to deliver apprenticeships and Labour's proposed 'Technical

Baccalaureate'.²² This provides an opportunity to raise the standards among training providers in the Care Sector, and could be extended to all training providers in the Care Sector, not just those delivering apprenticeships.

We also recommend that Skills for Care should be made responsible for enforcing a Quality Assurance mechanism. The introduction of a rating system for training providers will help employers distinguish between varying levels of training quality. Skills for Health provide a Health Quality Mark for training providers with superior training and learning standards.²³ Skills for Care could introduce a similar rating system for providers in the Care Sector. The combination of more proactive regulation and rating system would help ensure that employers are not wasting their money on training that is inadequate, and would contribute to restoring faith in the sector qualifications. A centralised system co-ordinated by employers would reduce the waste of separate and varying levels of training run by each provider, and ensure quality throughout the sector.

9. Improve oversight and regulation of working conditions

Since April 2009 the Care Quality Commission (CQC) has been responsible for the regulation of all health and Adult Social Care Providers in the UK. All providers are legally required to register with CQC in order to provide services, and must demonstrate how they are meeting essential standards of quality and safety. The CQC currently inspects most Care Homes and Domiciliary Care services at least once a year²⁴, and has the power to enter premises and remove records²⁵. It is an offence for a provider to carry on a regulated activity without registering with the CQC, punishable by a fine or imprisonment.

This puts the CQC in a strong position to identify and monitor exploitation of Care Workers. Yet it has no remit to look at these issues, despite the fact that poor working conditions often go hand in hand with poor quality of care and abuse of Care Recipients.

²² The Labour Party, *A revolution in apprenticeships: a something-for-something deal with employers*
²³ Skills for Health, *The Quality Provider Network*, 2014 (online), available:
<http://www.nsahealth.org.uk/the-quality-provider-network>

²⁴ CQC, *Preparing for CQC Inspection*:
http://www.cqc.org.uk/sites/default/files/media/documents/cqc_preparing_for_inspection_-_cpa_version_-_final_0.pdf

²⁵ The CQC was given these powers under sections 62 and 63 of the Health and Social Care Act 2008

The remit of the CQC should be extended to protect Care Workers from exploitation, as well as their existing remit to ensure providers meet appropriate standards for care users. As a

condition of their licence, Care Providers would have to provide evidence that they meet legal standards for workers, and an active, intelligence-led inspection regime, combined with the threat of fines, should serve to check that this is the case. To operate effectively within existing resources, the CQC should concentrate resources on parts of the sector that are associated with abuse and exploitation, based on intelligence.

Care as a Profession: The Long Term View

In order to ensure that care changes in the long term, it is important to ensure that there are long-term improvements in the sector. This would involve financial investment in the sector and should follow the following principles:

- Valuing the role of the Care Worker
- Paying Care Workers a fair wage and giving them good working terms and conditions
- Training Care Workers to a good standard and recognising training
- Regulating the industry, in particular the terms and conditions for Care Workers

Long Term Objective 1: Good Pay and Progression for Care Workers

1. Care is skilled work. Employers must push the Living Wage

Care is a skilled sector, and the National Minimum Wage should most certainly not be the maximum wage. Southwark and Islington Councils are leading the way in becoming Living Wage Councils – including Care Workers who are employed through independent sector organisations. People need to be able to earn a decent living from the hard work that they put into Care. The Living Wage is good for employers: higher rates of retention, lower sickness and better staff morale. It also benefits employees, who can quit second jobs, spend time with family and friends, and spend more in the local economy.

Analysis published by IPPR shows that if low-paid employees were moved on to a Living Wage, their gross annual pay would rise by an average of £1,376. If every low-paid worker was moved on to a Living Wage, the government would save on average £232 in lower social security spending and £445 in higher tax receipts.²⁶ **Through tax credits, the government is subsidising the bad employers who pay low wages.** In the Care Sector, some of the costs for this

are likely to be met by the government, as the industry is largely state-funded. This report recommends that there should be a focus on at least enforcing the National Minimum Wage, but Local Authorities should also look to use procurement to promote the Living Wage across the Care Sector.

Through improved planning and organisation, Southwark and Islington have introduced Living Wage contracts in the Care Sector. They have absorbed the costs by reducing waste elsewhere, without any increase to central government funding. It should be noted that statutory hourly rates and/or living hourly wage rates may be ineffectual without guaranteed weekly hours and can accommodate unpaid working time.

Case Study: Islington Borough Council

Islington Council spends £6.3m every year on approximately 500,000 hours of Domiciliary Care delivered by 4 Care Providers. Despite being one of the most deprived boroughs in the UK, and in the midst of an economic crisis, the council was one of the first to receive the London Living Wage (LLW) accreditation in 2012. The move to the LLW was calculated as amounting to less than 0.05% of the council's total pay budget. For Domiciliary Care, the move to the LLW has seen an increase in commissioning rates from £12.70 per hour to £14 per hour. Funding for the LLW in Domiciliary Care is taken from a £600k corporate contingency set aside for this purpose – a move the council made despite a £27m in budget cuts from the government. The LLW was a "moral obligation we felt we should not duck", given that the Cost of Living Crisis has hit the residents of Islington hard.

2. Skills for Care should create models for career progression from Care Worker to Manager, with links to qualifications and pay

Standards must be raised across the board and at all levels in the Care Sector. The qualifications landscape is fragmented, and it can be difficult for workers to understand how qualifications relate to job titles and pay rates. The sector is losing staff partly due to the lack of opportunities for workers wishing to progress to higher levels. Many Care Workers that we have spoken to report that promotion does not always

26 Reed (2013), 'The Cost of Low Pay, Juncture' available: <http://www.ippr.org/juncture/the-cost-of-low-pay>

result in much of a pay increase. It is striking that the median difference in pay for Care Workers and Senior Care Workers is a mere £0.50 extra pay per hour.²⁷ Better opportunities for career progression must be introduced if the sector is going to be able to attract the levels of staff needed to cope with future challenges.

Opportunities for progression must be very clearly linked with qualifications and pay increases. Care Workers should have the opportunity open to them to progress to levels of higher pay and obtain senior positions within the sector, such as a Care Managers, Social Workers or Nurses. A model for career progression would enable workers to review their available options and plan their careers more effectively. Opportunities for progression should be part of the induction programme with advisory information about career routes.

Long Term Objective 2: High Status for all Care Workers

1. All Care Workers must have a Licence to Practice

In the previous section, we recommended that, in the short term, all Care Managers must have a Licence to Practice that is administered by a registration body, such as the Healthcare Professions Council. **In the long term, all Care Workers should have a Licence to Practice and be registered with the HCPC.** A dual system of full registration and provisional registration would be in operation. Provisional registration should be for Care Workers who are in the process of attaining the minimum levels of qualification required for registration and completing background checks (most importantly the CRB check). Full registration should be available to those who have completed minimum training and qualifications, as well as the CRB check. The cost should be shared between the employer and the employee.

Regulators with large volumes of registrants, such as the Nursing and Midwifery Council (NMC) are able to spread the costs of core infrastructure across a larger number of people, whereas registrants of smaller

bodies such as the General Chiropractic Council (GCC) share a larger proportion of these costs²⁸. The NMC register 670,000 nurses and midwives and has an annual registration fee of £100²⁹. Given that the size of the care workforce is estimated to be around 1.85 million³⁰, the regulator would benefit from economies of scale and could minimise registration costs.

In Scotland, the Scottish Social Services Council is responsible for registering key groups of workers in the Care Sector. A compulsory system of registration for all Care Workers is due to be in place from September 2015. Care Managers pay a registration fee of £30 and Care Support Workers pay £15 per year. The Care Inspectorate registers and regulates Care Services in Scotland, including the registration status of Care Workers. In the long term, England should use this model and ensure that all Care Workers have a reasonable Licence to Practice to ensure certain standards and improve workers' rights.

Long Term Objective 3: Quality Training and Development

The Care Sector is suffering from inconsistent, and in many cases poor quality, training. Many qualifications are not being recognised by employers. Employers often lack faith in the sector's training providers, who deliver qualifications at varying standards. As a result, employers often resort to developing their own in-house training, leading to duplication of training and wasted resources. There is a crucial need to fill skills gaps and to guarantee the quality of training and education in the sector. Care Workers should have the opportunity to progress, increase pay, and obtain senior or specialist positions within the sector, whether it is as a Care Manager, Care Supervisor, District Nurse, Occupational Therapist or Social Worker. Not investing in training and progression is a false economy. Where extensive training is invested in and career pathways are open to all workers, employers benefit from improved quality of service, improved worker satisfaction and performance, and reduced costs due to lower turnover rates.³¹

²⁷ Skills for Care, *National Key Statistics Report*: February 2014, Table 18

²⁸ Department of Health, *Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers* (London: The Stationary Office Limited, 2011), 10

²⁹ Nursing and Midwifery Council (online), available: <http://www.nmc-uk.org/registration/>

³⁰ Pennycook, M., *Does it pay to care* (The Resolution Foundation, 2013), 17

³¹ Devins, D. et al., *Improving progression in low-paid, low-skilled retail, catering and care jobs* (York: Joseph Rowntree Foundation, 2014), 42-43

1. The National Minimum Training Standard and QCF Level 2 Diploma must be compulsory for all Care Workers

Care Workers lack consistent minimum standards for levels of training. Skills for Care have worked with Skills for Health to develop a code of conduct and a National Minimum Training Standard for Healthcare Assistants and Care Workers.^{32,33} Following the Cavendish Review, Skills for Care are working alongside Health Education England (HEE) and others to develop the Care Certificate, to be introduced in 2015. The Certificate will build on the existing Common Induction Standard, as well as the National Minimum Training Standard, and will help bridge the gap between health and care, as it will be transferable from sector to sector.³⁴ Completion of the Care Certificate before working unsupervised, as well as completion of the QCF Level 2 Diploma within two years, should be required of all Care Workers, and enforced through the registration process. This would also allow Care Workers to change between employers without needing to be re-trained.

Many new Care Workers receive only 1-2 days of shadowing before they are expected to work unsupervised. All new Care Workers should receive a two-week shadowing period before they can work unsupervised. Skills for Care should widen the Workforce Development Fund (WDF) to include funding for induction shadowing, in order to help employers meet the minimum requirements. The estimated cost of training the proportion of Care Workers who do not currently hold a QCF Level 2 Diploma is £600 million.³⁵

The integration of the Health and Care workforce will provide opportunities for this to be gradually implemented, as well as funding from various different stakeholders.

2. Skills for Care should work to bridge academic and vocational learning by developing higher-level apprenticeships, linked to QCF Levels 7-8

The independent Skills Taskforce Review has highlighted a damaging divide between vocational and academic learning: “we need to stop viewing vocational and academic learning in two different silos – both are improved when they are planned and developed in complementary ways, with opportunities for young people to access both and switch between them”.³⁶ Skills for Care recently introduced a Higher Apprenticeship (HA) in Social Care that relates to the QCF Level 5 Diploma in Leadership for Health and Social Care.³⁷ The apprenticeship is available at two different pathways: The HA General Adult Social Care Pathway (80 credits) and The Specialist Adult Social Care Pathway (120 credits). The specialist pathway enables apprentices to transfer credits and undertake specialist modules at university to gain a university qualification at Level 5. Moreover, they can then use the credits gained to progress onto other university qualifications at degree and graduate level.³⁸

The introduction of the Higher Apprenticeship is a big development, and will enable workers in the Care Sector with little or no formal qualifications to gain university degrees in Health and Social Care. Skills for Care should continue working with Higher Education (HE) bodies to bridge vocational and academic qualifications. The organisation should develop apprenticeships at higher levels within the Care Sector, linked with QCFs at Levels 7 and 8.

³² Skills for Care and Skills for Health, *National Minimum Training Standards for healthcare support workers and adult social Care Workers in England* (2013)

³³ Skills for Care and Skills for Health, *Code of Conduct for healthcare support workers and adult social Care Workers in England* (2013)

³⁴ Health Education England, Skills for Care and Skills for Health, *Care Certificate Framework, Technical Document* (2014), 2

³⁵ House of Lords Library

³⁶ The Labour Party, *Skills Taskforce Interim Report: Talent Matters – why England needs a new approach to skills* (Labour's Policy Review, 2013), 4

³⁷ Skills for Care, *New routes into university for people working in adult social care* (2013)

³⁸ Skills for Care, *New routes into university for people working in adult social care*, 16

3. Care Workers must be able to fast track into a specialist role or degree study

At a time when the UK is moving towards more integration of care services, new opportunities for progression from Care to Health, and vice versa, are becoming available. The introduction of the Care Certificate in 2015 will certainly help bridge the gap between Healthcare Assistants and Care Workers. However, there needs to be a greater focus on allowing Care Workers to progress into Nursing, Social Work, Occupational Therapy and service management within the sector. Many Care Workers lack the Further Education (FE) qualifications to gain entry onto the university degrees that are often needed for such occupations. With the development of a new Nursing Apprenticeship announced by the Department of Health in March 2014, experienced Healthcare Assistants and Care Workers will in the future be able to pursue a nursing degree on the job.³⁹

The announcement of a nursing apprenticeship is a big improvement and will certainly help to widen the access to nursing for people within the Care Sector. However, there is a worry that the apprenticeship will be more readily available to Healthcare Assistants with closer ties to hospitals, rather than Care Workers operating in the field. Domiciliary Care Workers are often very isolated from other staff and do not receive the supervision necessary to determine that they are delivering the high levels of care required for entry to a nursing apprenticeship.

We believe that more can be done to enable progression from Care into other professional jobs within the sector, such as Nursing, Occupational Therapy and Social Work, and to recognise the skills already attained by experienced Care Workers. One way of improving progression from Care to Health, and vice versa, would be to introduce a fast track for Care Workers onto university degrees for professional jobs in the sector, such as Nursing, Social Work or Occupational Therapy. Skills for Care and Skills for Health should cooperate with Higher Education (HE) bodies to investigate opportunities for enabling experienced Care Workers to gain entry

straight into the first or second year of a degree in Nursing, Occupational Therapy or Social Work. The existence of a university fast track for Care Workers will attract new people into the Care Sector.

Moreover, it will help recognise Care Work as a professional job with good opportunities for career progression. For a fast track to be possible, QCF course content should be updated in order for it to be more in line with the curriculum for the relevant degrees.

Conclusion: Why do we need change?

The Care Sector could be excellent. The integration of Health and Care marks a leap forward in our approach to promoting wellbeing. Being cared for at home is much better for a client than being rushed to A&E and treated in hospital. The CQC has concluded 'Good health status is likely to be a longstanding outcome of various factors, although a greater focus on improving public health, for example with enhanced primary healthcare, might reduce the burden on secondary care services and ensure people are cared for in the most appropriate environment.'⁴⁰ Indeed, an estimated 12.5% of admissions to A&E could have been dealt with through care at home and 40% of continued stay patients in a hospital could be cared for at home or in a Care Home.⁴¹ Investing in Care and Care Workers means that Care Recipients can receive care in their own homes, and not in hospitals. The example of the success at Torbay Council shows how Health and Care can work together and reduce the need for people to be admitted into hospital.⁴² **Care is the key to the new spectrum of integrated Health and Care**, thus good working conditions for Care Workers will have far-reaching and widespread benefits.⁴³

Improving conditions for Care Workers would be a great benefit to employers. It currently costs £3,500 to recruit and train a single worker in the Care Sector.⁴⁴ For many SMEs in the Care Sector, the cost of recruiting staff can be a heavy burden – in

³⁹ Department of Health, New nursing apprenticeships for those who have proven they can care, 2014 (online), available: <https://www.gov.uk/government/news/new-nursing-apprenticeships-for-those-who-have-proven-they-can-care>

⁴⁰ Care Quality Commission, *The State of Healthcare and Adult Social Care in England* (London: The Stationary Office, 2012), 3

⁴¹ Dr Chai Patel / HC One Submission to the Kingsmill Review, 4

⁴² Thistlethwaite, P., *Integrating Health and Social Care in Torbay* (London: The King's Fund, 2011)

⁴³ Centre for Workforce Intelligence, *Think integration, think workforce: three steps to workforce integration* (Centre for Workforce Intelligence/Institute of Public Care Oxford Brookes University, 2014)

⁴⁴ Care England Submission to the Kingsmill Review, 3

particular when the turnover rate is 19% a year in Care Homes and 30% a year in Domiciliary Care.⁴⁵

Without good quality care, more workers may be forced out of the job market. In 2010, 12% of people aged 16 or over in England were looking after or giving special help to a sick, disabled or elderly person in 2010, representing 5 million adults in England.⁴⁶ Without a steady workforce able to provide Care to disabled and elderly people, increasing numbers of economically active people will be forced out of the job market – this is another false economy.

Crucially, improved working conditions mean better experience for Care Recipients. The experiences of patients generally improve when staff have a good work climate, co-work support, job satisfaction, organisational support, low emotional exhaustion and supervisor support. In particular in the NHS, if patient experience and staff wellbeing are monitored, resources can be more effectively distributed and good practices can be shared.⁴⁷

THE LARGEST RESOURCE IN THE CARE SECTOR IS THE WORKERS; IF WE ARE TO DELIVER GOOD QUALITY CARE, IT IS VITAL THAT WORKERS HAVE GOOD QUALITY CONDITIONS.

⁴⁵ Cavendish, C., The Cavendish Review, 6

⁴⁶ Laing and Buisson, *Domiciliary Care UK Market Report* (London: Laing and Buisson, 2013), 5

⁴⁷ Maben, J. et al., *Exploring the Relationship between Patients' Experiences of Care and the Influence of Staff Motivation* (National Institute for Health Research Service Delivery and Organisation Programme, 2012), 4

C. The Care Work Crisis

A toxic combination of conditions in Care is leading to high turnover, low job satisfaction, and sub-optimum quality of service for Care Recipients. The lack of good wages, career pathways and cramming of calls for Care Workers is pushing a large number of people to leave the sector.

With recruitment costs as high as £3,500 per staff member⁴⁸, there is a high cost for time wasted on constantly training new employees who leave soon after starting work.

‘Social Care is in a state of emergency, and the cracks are now visible and beginning to gape’

Unite Submission to Kingsmill Review

Poor wages, ‘Zero Hours Contracts’, and a media that blames the Care Worker when things go wrong, means that workers are put off from entering the sector. Without sustained change in the sector, Care risks losing compassionate and experienced staff, as well as failing to attract the next generation of workers.

This chapter looks at the nature of the care workforce and sets out the evidence of the exploitative working practices, the lack of training and progression opportunities, and the poor status associated with the Care Sector.

The State of the Industry

The number of workers in Adult Social Care is estimated to be 1.85 million⁴⁹ with projections suggesting that the number of jobs will increase to 2.6 million by 2025. The majority of Care Workers are employed in Residential (40%) and Domiciliary Care (42%); others are in Community Care (14%) and Day Care (4%).⁵⁰ The past fifteen years has seen a growth in the independent sector, as Local Authorities have sought to outsource Care. The workforce has reflected this shift, with 1.2 million people employed in the independent sector, and only 151,000 people employed directly by Local Authority.⁵¹ Three-quarters of Care Workers are female⁵², and a relatively high proportion are from Black and Minority Ethnic groups, at 29%.⁵³

Care Workers carry out some of the most important work in society, caring for the sick, elderly and the disabled. The range of tasks completed by Care Workers can vary considerably: from assisting in the preparation of meals to administering medication and changing a dressing. The line between work completed by a Care Worker and a Nurse is often blurred, and Care Homes often have people with multiple medical conditions. Tasks that used to be completed by District Nurses are now often completed by Care Workers, all too often without the relevant training. The UKHCA reported that its helpline was ‘inundated with workers asking whether they are allowed to do invasive procedures, giving insulin or assisting with medication.’⁵⁴

The work completed by Care Workers fits under three categories:

- Supporting people to live well in the community: for example taking people to the shops or visiting friends and relatives
- Preventing people with significant health or care needs from having to use residential or nursing care and hospital: this involves care through re-ablement and crisis response services
- Helping people with care needs maintain themselves in the community: this includes personal care, domestic cleaning and home repair.

The Care Industry is made up of a wide range of different operators and a small number of large organisations. The four largest companies hold 21.4% of market capacity: Four Seasons Health Care (5.2%), Bupa Care Homes (4.8%), HC-One Limited

⁴⁹ Philpott, J., *Rewarding work for low-paid workers*

⁵⁰ Skills for Care, *The size and structure of the adult social Care Sector and workforce in England* (Skills for Care, 2013), 1

⁵¹ Skills for Care, *The size and structure of the adult social Care Sector and workforce in England*, 5

⁵² Skills for Care, *National Key Statistics Report: February 2014*, Table 8

⁵³ Cavendish, C., *The Cavendish Review*, 5

⁵⁴ Francis, J., *An overview of the UK domiciliary Care Sector* (2013)

⁴⁸ Care England Submission to the Kingsmill Review

(2.9%), and Barchester Healthcare (2.7%). Laing and Buisson have identified the four different segments of funding and provision: Private funding and independent sector supply (40.6%), Public funding and independent sector supply (52.9%), Private funding and public sector supply (small percentage), and Public funding and public sector supply (6.5%).⁵⁵ Local Authorities remain the largest single source of funding for older and physically disabled people, thus placing them in a position of monopsony. In the Independent Sector, Local Authorities financially supported 199,000 or 43.4% of residents. The NHS supported 7.2% (ie 29,000) and the rest (43.4%) was made up of self-payers.⁵⁶

Low Wages

The vast majority of workers in the Care Sector are paid between £6.08 and £8 per hour, which puts their salary at somewhere between the National Minimum Wage and the Living Wage.⁵⁷ According to the Low Pay Commission, the Care Workforce is already one of the least well remunerated in the country, where evasion of the National Minimum Wage is also rife.⁵⁸

‘We would never consider paying teachers at the level we currently reward Care Workers’¹

Dr Chai Patel, Chairman, HC-One

Evasion of the National Minimum Wage comes in many forms. Officially, the majority of Care Workers are paid a basic rate within 15% of their legal entitlement.⁵⁹ Hourly rates for Domiciliary Workers, however, are often depressed when the lack of payment for travel time in between visiting different clients is taken into account. In addition to this, Domiciliary Care Workers are often not paid for training time and are obliged to pay for their uniform.⁶⁰ Residential Care Workers suffer similar non-payment for training time, charges for uniform, extended hours that are not paid for, and can be charged excessive rates for accommodation. Night shift workers are vulnerable to being on call, but only paid for time spent with a client.⁶¹ As well as only

being paid by the minute for client time, Care Workers are at risk of ‘call cramming’, a process of packing in many visits too close together to be physically possible and not allowing sufficient time to travel in between clients. With basic rates of pay within 15% of the National Minimum Wage, any failure to pay travel time can take workers below their legal entitlement.⁶²

Dr Shereen Hussein has analysed the National Minimum Data Set for Social Care (NMDS-SC) and concluded that between 9% and 12% of direct Care Workers are paid less than the National Minimum Wage. This equates to between 160,000 and 220,000 direct Care Workers who are being paid less than their legal entitlement.⁶³ A report by HMRC called ‘National Minimum Wage Compliance in the Social Care Sector’ has found high levels of non-compliance. 183 investigations were completed between 1 April 2011 and 31 March 2013, in where 47% were found to not comply with the NMW. The result was £338,845 in arrears for 2443 workers. The highest value arrears owed to any single worker was £11,223.⁶⁴

The law is clear about payment for travel time. It claims that, unless a person is genuinely self-employed, travel for the purposes of duties carried out in the course of work will be required to be paid at least the Minimum Wage (excluding the first and last journeys during any particular period of duty).⁶⁵ Care Work is not regular, nine-to-five work. Care is required at various times of the day: in the morning, to help someone get out of bed, at lunchtime for a meal, and in the evening for a meal and to go to bed. Thus Care Workers have irregular working patterns, and spend a significant amount of time travelling in between different clients. Non-payment of travel time means that large parts of the working day are unpaid.⁶⁶ As a result, Care Workers are being exploited – their weak bargaining power should not mean that they are not even paid the Minimum Wage.

⁵⁵ Laing and Buisson, *Laing’s Healthcare Market Review 2012-2013* (London: Laing and Buisson, 2013), 42

⁵⁶ Laing and Buisson, *Laing’s Healthcare Market Review 2012-2013*, 39

⁵⁷ Unison, *Time to Care*, 12

⁵⁸ Hull, A., *Settle for Nothing Less*, (London: Centre for London, 2013), 45

⁵⁹ Hull, A., *Settle for Nothing Less*, 47

⁶⁰ Unison Focus Group on 6 March 2014

⁶¹ HM Revenue & Customs, *National Minimum Wage Compliance in the Social Care Sector* (2013), 3

⁶² Hull, A., *Settle for Nothing Less*, 47

⁶³ Pennycook, M., *Does it pay to care*, 17

⁶⁴ HM Revenue & Customs, *National Minimum Wage Compliance in the Social Care Sector*, 3

⁶⁵ Pennycook, M., *Does it pay to care*, 18

⁶⁶ Pennycook, M., *Does it pay to care*, 3

The Legal Perspective:

Travelling time is work time. The 2013 Employment Appeal Tribunal decision in the case of *Whittlestone v BJP Home Support* found that Travelling time is time work, for which a worker should be remunerated at the NMW, except where (a) incidental to the duties being carried out and the time work is not assignment work or (b) it is between their work and home (Reg 15(2) of the NMW Regs 1999).

According to the HMRC report, in the tax year 2012-13, 188 penalties were issued for a total of £112,786. Bindmans LLP note that this would appear to be a low figure, and there may be a risk that unscrupulous employers see the low prospect of enforcement proceedings as an acceptable cost of business when set against the potential benefit of keeping employment costs to a minimum.

Widespread use of exploitative 'Zero Hours Contracts'

The use of 'Zero Hours Contracts' has mushroomed in recent years. According to the Office for National Statistics, the number of people reporting that they are employed on 'Zero Hours Contracts' rose from 168,000 in 2010 to nearly 600,000 in 2014⁶⁷, and one survey of employers suggests that up to a million people could be employed on contracts that do not guarantee any hours or income.⁶⁸ Care Workers are particularly affected by the use of 'Zero Hours Contracts'. Skills for Care estimates that 307,000 people, or a fifth of the adult social care workforce, are contracted on these terms⁶⁹, and almost 42% of respondents in Unison's 'Time to Care' reported that they are employed on a 'Zero Hours Contract'.⁷⁰

Pamela

"People like us make people in care feel valued"

Length of time in the Care Sector: 25 years

Qualifications: I received training from the Local Authority 25 years ago. Now the industry is almost completely run by the private sector, comprehensive training doesn't exist

Aspirations: I want to give good quality care to vulnerable people who deserve care

Desires from the industry: "People like us make people in care feel valued"

Experience of work in Care: The authorities are not monitoring contracts and outcomes, for example, we are not being paid for travel time between visits

How would you improve working conditions? We are carrying out clinical tasks, like PEG feeding, with no training. We need standards of training and more advanced courses.

Pamela
55 years old,
South East, Senior
Care Worker,
Domiciliary Care



⁶⁷ Analysis by the ONS (2014) estimates the numbers to be between 522,000 and 645,000. Some of the increase may be due to greater awareness among employees of what constitutes a zero-hours contract. See: <http://www.ons.gov.uk/ons/search/index.html?newquery=zero+hours+contract>

⁶⁸ Stevens, M., *One million workers on zero hours contracts*, CIPD, 2013 (online), available: <http://www.cipd.co.uk/pm/peoplemanagement/b/weblog/archive/2013/08/05/one-million-workers-on-zero-hours-contracts-finds-cipd-study.aspx>

⁶⁹ Skills for Care, *The State of the Adult Social Care Sector and Workforce in England* (Skills for Care, 2012)

⁷⁰ Unison, *Time to Care*, 16

'I can't plan my life, not knowing when exactly I am going to be working, I can't plan things, what seems to have happened invariably is because we have lost a few Care Recipients, some of them they've gone into hospital, is that I have gappy rotas, periods when I am not working, odd half hours, I take a book with me, I know that I am not getting paid, sometimes it's really depressing, one of my colleagues said she was going out from 3pm to about 7pm and actually there was only two payable hours in that whole period...'

Male Care Worker, Sheffield, large provider

'Zero Hours Contracts' are, if used appropriately, not necessarily a problem. Some employees prefer the flexibility and ability to choose the hours they work on a daily, weekly or monthly basis. In particular, single parents may choose to work during school term time and not during holiday time, and a person in a couple may work to wish alternative hours to their partner to ensure sufficient childcare. 'Zero Hours Contracts', however, are being used extensively and excessively in Care, and are often the only type of contract available to an employee; limiting their ability to plan work, monthly finances and a social life. 'Zero Hours Contracts' mean episodic and unpredictable working time with employees available to the employer, but not paid. Some Care Companies may even insist that employees only work for the company, and not for other providers; this means they are at the beck and call of their employer – and unable to work elsewhere even if the employer gives them no hours.

The impact of a 'Zero Hours Contract' on an employee should not be under-estimated. Lacking a stable number of hours each week and a stable income means that workers have a great uncertainty in forecasting their finances or planning ahead. In particular, those on 'Zero Hours Contracts' tend to work fewer hours on average (21 hours per week) than those who are not (31 hours per week).⁷¹ People who are on 'Zero Hours Contracts' are vulnerable to their employers, who can reduce their number of hours at any given moment. One employee claimed:

"We are being forced this month to move over to zero hour contracts or face dismissal"⁷²

As a result, workers are often reluctant to report non-payment of the National Minimum Wage, issues of quality with care provided, and some are fearful of joining trade unions and having their hours reduced by their employer. People also have difficulty in managing household expenditure, balancing with family commitments, and claiming tax credits and other benefits. One employee, quoted in the submission to this review from Unison, pointed out: "Staff are really scared they will lose their job. ZHCs mean they have us over a barrel."⁷³

The Legal Perspective:

Bindmans LLP sees the two most common problematic contractual terms pertaining to ZHCs appear as:

- exclusivity clauses, preventing workers from 'topping up' their salary with work from two or more contractors; and
- the short term notice of available hours, which results in a lack of financial security.

These clauses working together cause the most instability for workers and create a dependence on employers, by preventing them from working elsewhere, while potentially only generating a small salary.

These exclusivity clauses cause the most instability for workers and create a dependence on employers, by preventing them from working elsewhere. A recent independent review for the Labour Party set out recommendations to introduce new legal rights for employees on 'Zero Hour Contracts' that included banning the use of exclusivity clauses for employees on 'Zero Hour Contracts' and providing them with financial compensation when shifts are cancelled at short notice.⁷⁴

The use of 'Zero Hours Contracts' and non-payment for travel time which reduces the salary to below the National Minimum Wage is making jobs in Care increasingly unattractive. One of the key reasons for people leaving the sector is cited as competition from other employers, 6.5% of leavers citing this as

⁷¹ Pennycook, M., Cory, G. and Alakeson, V., *A Matter of Time* (Resolution Foundation, 2013), 3

⁷² Unite Submission to the Kingsmill Review, 7

⁷³ Unison Focus Group 6 March 2014

⁷⁴ Pickavance, *Zeroed Out: The place of zero-hours contracts in a fair and productive economy*

the main reason.⁷⁵ Often workers in the sector refer to the promise of more consistent hours at the local supermarket, with a relatively similar wage. As the economic situation improves, employers will find it increasingly difficult to find staff willing to work with such uncertain conditions and poor pay levels.

There has also been a sharp increase in the number of women in self-employment in recent years. The Care Sector has witnessed some of the fastest growth, where self-employment has come to replace employment for many female Care Workers.⁷⁶ For sectors such as Care, the move from employment to self-employment is often associated with loss of job security and pay. The Women's Budget Group found that much of the increase in female self-employment was effectively in precarious work or 'Zero Hour Contracts', rather than the creation of new businesses.

Low levels of training

The Social Care Sector has combined low qualification requirements with low wages.⁷⁷ Overall, training is neither sufficiently consistent, nor sufficiently well supervised, to guarantee the safety of all patients and users in health and care⁷⁸. There are no minimum educational requirements to begin working in Care. Even literacy and numeracy are not

always tested⁷⁹.

There are Common Induction Standards (CIS), which were developed by Skills for Care, and are supposed to be completed by all adult social care practitioners within 12 weeks of starting a job⁸⁰. However, only 72% of UK workers are reported to have completed any induction, not necessarily CIS.⁸¹ Induction training is also relatively low level, usually lasting no more than a few days. One survey found that over 41% of Care Workers do not receive specialised training to help deal with their client's specific medical needs, such as dementia and stroke-related conditions, and nearly a third receive no regular ongoing training.⁸² Cultural training is vital, since today's multi-cultural Britain means that carers may often encounter clients from different cultures, and yet this is not standard practice either.

The CIS were designed to be completed before Care Workers can work unsupervised, in order to enable workers to demonstrate their understanding of how to provide high quality care and support, and managers have a duty to ensure that new staff know enough to meet the required outcomes in each knowledge area. As of February 2014, however, just 66% of Care Workers have completed CIS, with 11% currently in the process.⁸³ Only 39% of Care Workers have completed QCF Level 2 diploma or higher,

Sally

"I am not a number, but I can't fix it on my own"

Length of time in the Care Sector: 2 years; has now left the Care Sector

Qualifications: No formal training – I completed one day of work shadowing, but was then left to work by myself. The unions offered training, but we weren't allowed the time off away from our clients

Aspirations: I want to work in Care after I looked after my husband at the end of his life. Care is something that I'm passionate about.

Desires from the industry: I needed a job to be honest, and care seemed an interesting route

Experience of work in Care: I feel guilty for stealing time from people – but how else can we see everyone on our schedule?

How would you improve working conditions?

Get rid of Zero Hours Contracts – we are all scared of rocking the boat and not having any hours next week



Sally
63 years old,
North East, Care
Worker,
Domiciliary Care

⁷⁵ Kelly, D., *Personnel Statistics Report* (The National Care Forum, 2013), 12

⁷⁶ Fisher, L., *Many 'self-employed' women get by on less than £10,000 a year*, The Guardian, 2014 (online), available: <http://www.theguardian.com/society/2014/mar/08/women-self-employed-gender-pay-gap-jobs>

⁷⁷ Jones, K., *The road less travelled* (The Work Foundation, 2013), 22

⁷⁸ Cavendish, C., *The Cavendish Review*, 36

⁷⁹ Cavendish, C., *The Cavendish Review*, 36

⁸⁰ Skills for Care, *Common Induction Standards* (online), available: <http://www.skillsforcare.org.uk/Standards/Common-Induction-Standards/Common-Induction-Standards.aspx>

⁸¹ Independent Age submission to the Kingsmill Review, 5

⁸² Unison, *Time to Care*

⁸³ Skills for Care, *National Key Statistics Report: February 2014*, Table 22

whilst 5% are in the process.⁸⁴ The two most commonly cited reasons by Care Managers for failing to meet the QCF Level 2 diploma were staff turnover and training-related problems.⁸⁵ 58.6% of all providers said they required no extra qualifications for Care Workers performing intermediate care.⁸⁶ The Health and Social Care Sector as a whole spends a significant amount on training, at over £5.4 billion per year, and yet skills gaps occur at all levels of the Care Sector.⁸⁷

There is no overarching standard for training and qualifications in the sector that employers will accept and some accrediting bodies are recognised as being better than others. Care Workers often comment that education and training is too theoretical and class-based, and value training that they can put into practice.⁸⁸ Lack of faith in qualifications, as well as the companies that deliver them, has led many Care Providers to develop their own in-house training⁸⁹, but this can lead to duplication of training, leading employers to retrain new staff irrespective of what they have learned elsewhere.⁹⁰ In-house training is rarely accredited and leaves workers unable to prove what they have learned to clients or new employers. Care Workers note that the training courses on offer are too numerous to fully grasp.⁹¹

“It needs to be recognised as a profession. Care work is not glorified housework. I always tell people: do not say you are just a carer!”

Co-Ordinator at DoCare Limited

A cost-effective integration of Health and Care is being undermined by a lack of professional structure for ‘new role’ carers.⁹² In particular, there is a need for more clinical relevance for QCF Level 3 course content.⁹³ There exists concerns that the QCF Level 3 diploma might not be recognised in the future – undermining universal confidence in, and currency for, these qualifications.⁹⁴ If the Integrated Care Agenda is to be successful, district nurses need more knowledge and understanding regarding the Care Sector.⁹⁵ There needs to be better understanding of the link between inter-professional training and effective integration.⁹⁶

Aisha

Length of time in care: 12 years

Qualifications: NVQ Level 3

Aspirations: To provide quality care for vulnerable people

Desires from the industry: To give people a quality service in the final years of their lives

Experience of work in Care: We are constantly treading on egg shells with Zero Hours contracts. We want to report poor care or risks, but can't for fear of losing our hours

How would you improve working conditions: The Local Authorities need to give everyone training – NVQs and Diplomas should be the standard for everyone

“We’re treading on egg shells”

Aisha
35 years old,
Central London,
Senior Care
Worker,
Residential Care



⁸⁴ Skills for Care, *National Key Statistics Report: February 2014*, Table 24

⁸⁵ Rubery, J. et al., *The Recruitment and Retention of a care workforce for older people* (European Work and Employment Centre/University of Manchester, 2011), 180

⁸⁶ Rubery, J. et al., *The Recruitment and Retention of a care workforce for older people*, 182

⁸⁷ Davis, B. et al., *UK Commission's Employer Skills Survey 2011: UK results* (UKCES 2012) 126

⁸⁸ Rubery, J. et al., *The Recruitment and Retention of a care workforce for older people* 339

⁸⁹ Cavendish, C., *The Cavendish Review*, 41

⁹⁰ Cavendish, C., *The Cavendish Review*, 41

⁹¹ Rubery, J. et al., *The Recruitment and Retention of a care workforce for older people*, 182

⁹² Wild, D., Szczepura, A. and Nelson, S., *Residential Care Home workforce development* (Joseph Rowntree Foundation, 2010), 4

⁹³ Wild, D., Szczepura, A. and Nelson, S., *Residential Care Home workforce development*, 30

⁹⁴ Wild, D., Szczepura, A. and Nelson, S., *Residential Care Home workforce development*, 42

⁹⁵ Skills for Care, *Evidence Review: Integrated Health and Social Care* (Institute of Public Care/Oxford Brookes University/Skills for Care, 2013), 20

⁹⁶ Skills for Care, *Evidence Review: Integrated Health and Social Care*, p vii

Case Study: Good Practice: Training and Career Progression at DoCare Ltd

DoCare is a small to medium family-run Domiciliary Care Provider based in Gloucestershire with 130 employees. DoCare provides its staff with extensive training, as well as a clear career structure and opportunities for progression. DoCare Workers are paid for training time, uniforms, travel time, travel mileage, and personal protective equipment. Workers can apply for a company car after six months, as well as motoring training should they wish to improve their driving skills.

"You can't fault DoCare when it comes to training" (Care Worker, DoCare Limited)

"We had one girl that was shadowing for 4 months. Some people take longer than others to learn the basics" (Care Worker, DoCare Limited)

"If our staff are being continually trained, they feel valued and invested in and are more likely to stay" (Manager, DoCare Limited)

Any promotion at DoCare reflects competence and experience in the Care Sector and comes with a pay increase. All new Care Workers start at C1 Level, where they are put on probation for six months and undertake two weeks of training, followed by a minimum two-week shadowing period. Upon completing the probation period, Care Workers are immediately promoted to C2, where they train for the QCF Level 2 Diploma, paid for by DoCare. The C3 tier is for Care Workers who have completed the diploma, whilst the C4 tier is for Senior Care Workers with more responsibilities. Team Leaders follow a similar career route as Care Workers, and are split into tiers ranging from T1 to T4. The T3 tier is for Team Leaders who have completed the QCF Level 3 Diploma, whilst the T4 tier is for Team Leaders with demonstrable experience in the sector and specialisation in a particular field, such as dementia or end of life care.

Problems attracting and retaining staff

Care is not seen as a career, in particular for the next generation of younger people.⁹⁷ Since 2005, the number of young workers in the sector has declined and Care Work appears almost entirely absent from consideration as a career option for school leavers and jobseekers.^{98,99} This is particularly worrying given that nearly half (45.6%) of employees are aged 46 or older.¹⁰⁰ Analysis by the National Care Forum shows that the age of the population of Care Workers has increased steadily over the last three years, whereas the number of staff aged 35 and under has seen a 1.5% decrease in the same period.¹⁰¹ As a result, there is a need for younger people to enter the industry.

A key problem is the lack of high quality training routes into the sector for young people. Employers perceive poor returns for their investment in apprenticeships due to a lack of engagement by young people, high turnover rates, and the loss of trained staff to other organisations.¹⁰² Some employers are dissatisfied with the quality of training and learning outcomes for apprentices.¹⁰³ Lack of employer involvement in the design and delivery of apprenticeships also contribute to the lack of recognition for such schemes.¹⁰⁴ Only 34% of Health and Social Care apprentices receive both on- and off-the job training, and one fifth receiving no training at all.¹⁰⁵ Training in the sector has tended to be narrowly focused on job-specific tasks and often fails to provide apprentices with theoretical knowledge necessary to innovate and adapt to changing conditions and care needs.¹⁰⁶

97 Centre for Workforce Intelligence, *Growing apprenticeships in social care*, (Centre for Workforce Intelligence, 2013), 5

98 Hussein, S. And Manthorpe, J., *Attracting young adults (18-25 years) to work in social care in England*, Diversity in Health & Care, Vol. 7, No. 7, 2010, 236

99 Vector Research, *Men into Care*, (Skills for Care West Midlands, 2010), 1

100 King's College London, *Will an ageing nursing workforce work*, Policy Plus, Issue 2, 2007, 1

101 National Care Forum, *NCF Annual Staff Survey*, 2014 (online), available:

http://www.nationalcareforum.org.uk/viewNews.asp?news_id=213

102 Centre for Workforce Intelligence, *Growing apprenticeships in social care*, (Centre for Workforce Intelligence, 2013), 5

103 Centre for Workforce Intelligence, *Growing apprenticeships in social care*, 5

104 Jones, K., *The Road Less Travelled* (London: The Work Foundation, 2013), 21

105 Jones, K., *The Road Less Travelled*, 21

106 Jones, K., *The Road Less Travelled*, 21

'There are common medical conditions that we deal with on a daily basis and an awareness of what those medical conditions can present...is essential for the Carer to find correct care or deal with acute situations that may arise...We deal with Diabetes, Strokes, Parkinson's Disease and Dementia'

Domiciliary Care Worker, Major Care Provider,
South-East England

Only around 1/3 of apprentices in the Social Care Sector were aged between 16-24 and almost 90% of Social Care apprentices had already worked for their current employer prior to starting the apprenticeship.¹⁰⁷ Barchester Healthcare, who run 240 Care Homes in the UK, offers apprenticeships specifically targeting unemployed young people. The scheme is unpaid, but apprentices continue to receive Jobseeker's Allowance for the duration of the apprenticeship. Out of the 450 youth apprenticeships available, the company was able to recruit 72 under 25s.¹⁰⁸

Opportunities for progression are also limited, as a result of the fragmented nature of the sector and its Training Providers. There is a lack of clear and simple career ladders and aligned training opportunities that can support the progression from Care Worker to higher levels within the sector.¹⁰⁹ Only 1% of workers in the sector are recruited as a result of internal promotions, transfer or career development.¹¹⁰ One survey found that the main motivation for workers pursuing training at QCF Level 2 and above is personal and professional growth (95% of respondents). Increase in pay is also viewed as an incentive for further learning (58% of respondents),

although this is not always available.¹¹¹ Many Care Workers may not pursue opportunities for career progression, as they feel the financial reward for a senior position involving more responsibilities and stress is too limited.¹¹² The median hourly pay rate for Care Workers is £6.83, whilst for Senior Care Workers it is £7.35.¹¹³ It is striking that the financial reward for obtaining a QCF Level 3 diploma, the standard for Senior Care Workers, is a mere 50 pence extra pay per hour. Senior positions often involve taking workers away from the job of caring – factors that attracted many workers to the sector in the first place. Moreover, family responsibilities and the lack of senior part-time positions limit the opportunities for progression within this sector.

A lack of career progression is a significant factor in the difficulty the sector has retaining staff. Turnover rates are high, standing at 19% a year in Care Homes and 30% a year in Domiciliary Care.¹¹⁴ Dr Shereen Hussein points out that the turnover rate for social care is 'considerably higher than that of other work sectors in the UK, standing at an average of 15.7%'.¹¹⁵ Research by the National Care Forum demonstrates the reasons for leaving; most significant are 'Personal Reasons', 'Resignation', 'Dismissal' and 'Competition from other employers'.¹¹⁶ Deteriorating working conditions, poor training, as well as limited opportunities for progression, is encouraging workers to change between Care Providers, or leave the sector altogether.

High dependence on low skilled and migrant labour

Low pay and exploitative working conditions mean that the Care Sector is highly dependent on low skilled, and in some areas largely migrant workforce. The number of foreign-born Care Workers more than doubled from about 7% in 2001 to 18% in 2009¹¹⁷ and in London, the number of non-UK nationals makes up the majority of Domiciliary Care Workers, at 53%.¹¹⁸

107 Jones, K., *The Road Less Travelled*, 18

108 Peacock, L., *Barchester Healthcare dismayed by the lack of youths wanting care jobs*, The Telegraph, 2012 (online), available:

<http://www.telegraph.co.uk/finance/newsbysector/supportservices/9607690/Barchester-Healthcare-dismayed-by-lack-of-youths-wanting-care-jobs.html>

109 Devins, D. et al., *Improving progression in low-paid, low-skilled retail, catering and care jobs*, 34

110 Skills for Care, *National Key Statistics Report: February 2014*, Table 19

111 Wild, D., Szczepura, A. and Nelson, S. *Residential Care Home workforce development*, Joseph Rowntree Foundation

112 Wild, D., Szczepura, A. and Nelson, S. *Residential Care Home workforce development*, Joseph Rowntree Foundation

113 Skills for Care *National Key Statistics Report: February 2014*

114 Cavendish, C., *The Cavendish Review*, 6

115 Hussein, S. and Manthorpe, J., *Longitudinal changes in care work turnover and vacancy rates and reasons for job leaving in England* (Social Care Workforce Research Unit King's College London, 2011)

116 Kelly, D., *Personnel Statistics Report*, 11

117 Pennycook, M., *Does it pay to care*, 9

118 Pennycook, M., *Does it pay to care*, 10

Migrants are particularly vulnerable to exploitation due to a lack of awareness about their workplace rights, and in some cases working visas that tie them to particular employers, which restricts their ability to leave and can make it difficult for them to raise concerns about treatment. In the course of this review we spoke to a group of five Filipino Care Workers whose working visas were tied to one Care Home in the southeast. Taking advantage of this situation, the Care Home was deducting large amounts of money from the workers' pay for housing, uniforms and training – almost certainly illegally. Historically most migrants working in the Care Sector have come from the Philippines and India. Other main nationalities include Zimbabwe, Nigeria and South Africa, and in recent years the sector has seen an increasing number of workers from Poland and the other Eastern European countries that joined the EU in 2004.¹¹⁹

'I would use the analogy of filling a bucket which contains a hole at the bottom. Homecare agencies fill the bucket with staff until the bucket starts to empty. Then they fill it with new staff. Over and over again'

Warren Wright, Domiciliary Worker,
Hampshire

Low levels of union membership and weak employee voice in the sector exacerbate the difficulty some Care Workers have in exercising their rights. Trade union membership levels average 24% of workers, far lower than Care Managers, which reach 58%.¹²⁰ Employees are also isolated from their colleagues, leading to low levels of collegiate support. Indeed, 43.7% of workers say that they hardly ever saw their colleagues at work, and often worked in physical isolation from other staff members.¹²¹

Gender and the low status of Care Work

At 84%, the workforce is also overwhelmingly female. The average age for a new starter is 35 years old, reflecting the fact that many join after a period of caring for an older relative or a young child. On the traditional male-breadwinner model, men and women were expected to perform different roles within society. Men would work outside the home to provide a sustainable income for the whole family, whilst women performed unpaid labour within the home, such as carrying out domestic duties and caring for children and the elderly. Care was organised and carried out within the parameters of a family home. With the decline of the male-breadwinner model and the rise of female employment, welfare states began making alternative care arrangements. However, the current Care Crisis suggests that the restructuring of Care Work has not adequately addressed the issues faced by the decline of the male-breadwinner family structure and the erosion of traditional gender roles.¹²²

The lack of public understanding and respect towards the sector is associated with the perceived feminine nature of Care Work. Low pay, limited career opportunities and general poor working conditions in the sector reflect a historical undervaluing of women's work and a high degree of gendered occupational segregation.¹²³ Care Work is, ironically, both idealised and poorly valued at the same time. On one hand, Care Workers are often seen as self-sacrificing, compassionate and generous, whilst on the other, the sector is poorly resourced; carries low esteem, and Care Workers are often taken for granted.¹²⁴ Some men reject Care Work as a result of outright sexism.¹²⁵ For the few men that join the sector, they often struggle with the public perception of Care Work being 'women's work'. Men may experience a challenge to their masculinity, both by working alongside women and by job performing roles that were traditionally undertaken by women.¹²⁶ Some respond to such challenges by emphasizing the professional aspects of the job, whilst suppressing

119 Hussein, S., The Contributions of Migrants to the English Care Sector, The Social Care Workforce Periodical, Issue 11 (2011), 3

120 Drinkwater, M., The impact of competitive tendering on social services and service users, Community Care, 2014 (online), available: <http://www.communitycare.co.uk/2011/04/27/alarm-over-lack-of-union-membership-among-care-workers/>

121 Unison, Time to Care, 31

122 Mahon, R., *Child Care Policy at the Crossroads* (New York: Routledge, 2002), 2

123 Hussein, S. and Manthorpe, J., *Structural marginalisation among the long-term care workforce in England*, Ageing and Society, Vol. 34, No. 1, 23

124 Bigo, V., *The care paradox*, International Journal of Green Economics, Vol 4, No. 2, 2010, 117

124 Vector Research, *Men into care*, 1

125 Vector Research, *Men into care*, 1

126 Lupton, B., *Explaining men's entry into female-concentrated occupations*, Gender, Work and Organization, Vol. 13, No. 2, 2006, 106

those aspects of the job that they feel carry female connotations, and by demonstrating a greater desire to progress in their careers.¹²⁷

‘I’m angry for all the women out there who have got no voice!’

Deb Claridge, former Domiciliary Care Worker,
Midlands

There is considerable evidence that men who enter female-concentrated occupations, so-called ‘feminised work’, benefit from their minority status.¹²⁸ Men ride the ‘glass escalator’ and progress quicker than women into senior positions. The same trends can be witnessed in the Care Sector, where men tend to be concentrated in positions of authority.¹²⁹ Men are more likely to work as Senior Managers, Middle Managers and Managers in care-related roles (1.5% compared to 0.9%), and are significantly more likely to hold Managerial or Supervisory roles (14.2% compared to 10.5%).¹³⁰ Men account for 72% of all technician jobs within the Care Sector.¹³¹ Moreover, men occupying certain senior positions within the Care Sector can expect to earn up to £1 per hour more than women doing the same jobs. The mean hourly pay rate for women in Manager/Supervisor positions is £11.75, whilst for men the rate is £12.82.¹³² For Professional jobs, the mean hourly pay rate is £12.06 for women and £12.57 for men. Varying job roles, different leave periods, as well as family commitments outside of work, limit women’s access to training and promotion, which in turn affect pay levels.¹³³ Not all men in the sector benefit from the existence of a glass escalator, and migrant men are more likely to be lower-paid occupations within the Care Sector hierarchy, such as Direct Care Work.¹³⁴

Whilst men, according to one survey, are almost twice as likely as women to want to progress in the sector (77.7% compared to 41.7%), the overrepresentation of men within senior positions

cannot be explained by gender differences in motivation alone.¹³⁵ Using the statistics for motivation for career progression, as well as worker demographics by Skills for Care, we can calculate that there will be approximately 246,537 women who want to progress, compared to 107,755 men.¹³⁶ Given the fact that the Care Sector workforce is largely dominated by women, employers are likely to have more than twice as many female employees wishing to progress in their careers.

127 Lupton, B., *Explaining men’s entry into female-concentrated occupations*, Gender, Work and Organization, 106

128 Lupton, B., *Explaining men’s entry into female-concentrated occupations*, Gender, Work and Organization, 105

129 Hussein, S., *Men in the English Care Sector*, (Social Care Workforce Research Unit, 2011), 6

130 Hussein, S., Manthorpe, J. and Ismael, M., *Male workers in the female dominated long-term Care Sector*, Journal of Gender Studies (in press), 6

131 Hussein, S., Manthorpe, J. and Ismael, M., *Male workers in the female dominated long-term Care Sector*, 6

132 Hussein, S., *Pay in adult social care in England*, Social Care Workforce Periodical, Issue 6, 2010, 25

133 Hussein, S. and Manthorpe, J., *Structural marginalisation among the long-term care workforce in England*, 37

134 Hussein, S. and Christensen, K., *Migrant men in women’s work* (under review), 3

135 Rubery, J. et al., *The recruitment and retention of a care workforce for older people*, 340

136 Skills for Care, *National Key Statistics Report: February 2014*, Table 8

D. The Causes behind the Crisis

There is a race to the bottom in the Care Sector, with wages, skills and conditions. This makes it difficult to attract, develop or retain a motivated and professional workforce and as a result has a serious negative impact on quality of care. This chapter looks at the toxic combination of factors causing this crisis in the Care Sector.

Cuts to funding

Funding for Care Services is largely provided by Local Authorities, who support 51% of independent sector Care Home residents.¹³⁷ The level of funding that Local Authorities receive is calculated by central government using a formula spending share calculation, and is distributed alongside funding for other locally provided services such as Children's Services and Waste Services. In 2012-13, Authorities received £77 billion for these services, with discretion on expenditure.¹³⁸ Budgetary pressure from the 2010 Comprehensive Spending Review has had a significant impact on Care.

The budget for Adult Social Care commissioned by Local Authorities is £19.1 billion per year, in comparison to £102.3 billion spent per annum on the National Health Service.¹³⁹ As part of Local Authority spending, Adult Social Care has not been ring-fenced against the current government's austerity measures. Instead, total spending fell by 8% between 2010-2011 and 2012-2013.¹⁴⁰

The lack of investment in Care needs to be established in its wider context. Currently, Local Authorities and the NHS are working in silos. While

care services are locally-commissioned, NHS spending is centrally managed, resulting in a disjointed health and care system. The example of Torbay Council shows that greater investment in Care, in particular training for Care Workers in medical tasks, can have a positive effect on NHS expenditure.¹⁴¹ The trauma for an older or disabled person (or indeed, any person) from entering hospital is prevented by increased expenditure on Domiciliary Care.

The integration of Health and Social Care would go some way towards alleviating the problems this causes, and it will be important for Local Authorities and the NHS to work in a joined-up way. The Department of Health and Department for Communities and Local Government have established the £3.8 billion Better Care Fund, the Integrated Pioneers Initiative and the Public Service Transformation Network, to integrate Health and Social Care. But funding in Care is still an issue; until the value of Care is truly realised, funding will remain an issue.

Increased demand due to an ageing population

Cuts are being made in the context of increased demand due to an ageing society, further stretching the limited resources of Local Authorities. The proportion of people aged 65 years or over is increasing, with 10.8 million people aged over 65 in the UK in 2013.¹⁴² The 'old age dependency ratio' (the number of people over the state pension age for every 1,000 people of working age) is likely to increase. In 2009, there were 314 people over the state pension age per every 1000 people of working age. In 2032, this projected to rise to 349 people over the state pension age.¹⁴³ Not only are older people

¹³⁷ Laing and Buisson, *Care of Elderly people* (2013)

¹³⁸ National Audit Office, *Adult social care in England* (2013)

¹³⁹ National Audit Office, *Adult Social Care in England* (National Audit Office, 2013), 13

¹⁴⁰ National Audit Office, *Adult Social Care in England*, 7

¹⁴¹ Thistlethwaite, P., *Integrating Health and Social Care in Torbay*

¹⁴² Age UK, *Later in Life in the United Kingdom* (Age UK, 2014), 3

¹⁴³ The Kings Fund, *Ageing Population*, 2014 (online), available: <http://www.kingsfund.org.uk/time-to-think-differently/trends/demography/ageing-population>

more likely to use Health and Care services, but projections suggest that a higher proportion of older people in the future will be living on their own and will be likely to require formal care, with the number of older people with care needs likely to rise by more than 60% in the next 20 years.¹⁴⁴ Of people who are currently aged 65 years old, around a fifth of men (19%) and a third of women (34%) will require Residential Care at some point in their lives. Under half of men (48%) and over half of women (51%) will need Domiciliary Care only.¹⁴⁵

‘We need to work in partnership with the providers who are struggling, rather than penalize them. Leeds Council designed a quality framework for providers linked to a cost-strategy.’

Tim O’Shea, Leeds City Council

Jocelyn

Length of time in care: 3 years

Qualifications: Previously qualified as a Midwife in the Philippines, but now in Care Work

Aspirations: Better life in the UK with a secure job and future for children. I’m currently working six days a week for my daughter to be able to visit prospective universities

Desires from the industry: Secure Care Work. We are in a dangerous situation – if we upset our employer or complain, we will be sent back home

Experience of work in Care: Our employers charges us for everything – training, uniform, and rent: our hands are tied

How would you improve working conditions? We need security and want the same rights as non-migrant workers

“Our hands are tied by our employers”

Jocelyn
32 years old,
West Midlands,
Care Worker,
Residential Care



Irresponsible commissioning practices

Many Local Authorities see the value of good working conditions for staff and for the quality of service received by the Care Recipient. However, the pressures on Local Authority budgets are in some cases leading to irresponsible commissioning practices that exacerbate the cost pressures on providers, Care Workers and Care Recipients.

Local Authorities invite Care Providers to tender for contract with the Council to provide care. Providers often compete for the lowest tenders in reverse auctions to the Council. In recent years, there has been a move towards shorter visits and billing per minute. As a result of the Council’s monopsony position, some providers are obliged to accept the Local Authority’s price, often with an impact on working conditions, and often with a view to squeezing competition out of the market and charging higher prices in the future.¹⁴⁶

An issue, however, is that some providers see their future in terms of providing services for self-funded

¹⁴⁴ The Kings Fund, *Ageing Population*

¹⁴⁵ Care Quality Commission, *The State of Health Care and Adult Social Care in England*, 84

¹⁴⁶ Institute of Public Care, *Where the Heart is* (Institute of Public Care/Oxford Brookes University, 2012), 29

clients due to pressures on resources for state-funded clients. Yet this may mean that poorer areas where Care Recipients cannot afford to pay will be left with services based upon low pay and inferior conditions for workers – reinforcing two tier services.

The weighted average charge paid by councils in the UK for one hour of weekday, daytime Home Care in the UK is estimated at £12.87. However, rates as low as £9.55 and £10.04 were reported by providers in Wales, the West Midlands, the North West and Northern Ireland.¹⁴⁷ Most recent data suggests that Local Authorities pay an average of £15.00 per hour for Independent Sector Home Care, with a range between £8 and £31.00.¹⁴⁸ Some authorities are even fixing a maximum price to cover wages and fixed costs, sometimes at worryingly low levels.¹⁴⁹ In 2011-12 the average unit cost of “in house” Local Authority Home Care had risen to £35.50, while the average unit cost of Home Care to authorities from using independent providers was £14.70. Effectively the Independent Sector is operating at less than half the cost of the statutory sector.¹⁵⁰

Local Authorities have moved away from commissioning through block contracts to Framework Agreements. Whereas a Block Contract would guarantee payment for a certain number of clients and a certain amount of time, Framework Agreements provide greater flexibility for Local Authorities. Once a company signs a Framework Agreement, it is still not guaranteed any work and must wait for the Local Authority to instruct it to provide care for the stated Care Recipient.¹⁵¹ As a result, companies have an uncertain number of hours on the contract; this uncertainty is often passed on to employees through ‘Zero Hour Contracts’.

Case Study: Good Practice: Outcomes-based Commissioning at Wiltshire Council

Wiltshire Council has replaced its Domiciliary Care Services with a system of integrated care and support called Help to Live at Home.

The Council set outcomes in conjunction with Service Providers and has established commercial initiatives. Not only does this commissioning based on outcomes promote independence and better quality for Care Recipients, but there is also an emphasis on Care Workers: ‘We began with the idea that the notorious problems of quality in care originate in the employment conditions of Care Workers’. Providers are guaranteed business in their geographical areas, which provides ‘predictable revenues and confidence to invest’. The Service Providers are also allowed the space to innovate and make use of technology to achieve outcomes.

Wiltshire Council claims ‘our providers will not achieve good outcomes without a better workforce with better terms and conditions of employment’.

As a result of financial pressures from central government, Local Authorities have been forced to pass on uncertainty, shorter visits and squeezed funding to Care Providers and their employees – putting Care Recipients and quality of care at risk. Local Authorities have reduced the amount of state-funded care and increased the threshold for eligibility. 85% of adults over 65 now live in Local Authorities that arrange services for adults with substantial or critical needs only.¹⁵² 1% of adults now live in authorities which provide for critical needs only.¹⁵³ Another way of reducing costs is to commission shorter visits. In 2012, almost three quarters of Domiciliary Care slots were for periods of 30 minutes or less, with one in ten for 15 minutes or less.¹⁵⁴ A Worker claimed 15 minutes is ‘Insufficient time to do anything properly, cannot talk – which many people need more than other help in some ways’.¹⁵⁵

In addition, the use of direct payments risks weakening the position of Care Workers. Direct payments are a new approach to give more choice to the Care Recipient through ‘personal budgets’. The user is paid directly by the Council based on their care needs and allowed to use the funds at their

¹⁴⁷ Angel, C., *Care is not a commodity*, 24

¹⁴⁸ Institute of Public Care, *Where the Heart is*, 19

¹⁴⁹ Pennycook, M., *Does it pay to care*

¹⁵⁰ Francis, J., *An overview of the UK domiciliary Care Sector*, (Sutton: United Kingdom Homecare Association, 2013), 7

¹⁵¹ Institute of Public Care, *Where the Heart is*, 20

¹⁵² National Audit Office, *Adult Social Care in England*, 9

¹⁵³ National Audit Office, *Adult Social Care in England*, 7

¹⁵⁴ Angel, C., *Care is not a commodity*

¹⁵⁵ Leonard Cheshire Disability, *Ending 15-Minutes Care* (Leonard Cheshire Disability, 2013), 9

choice. Direct Payments has led to a growth in the number of Care Workers employed as 'Personal Assistants'. The average pay received by Personal Assistants is £7.60 per hour, which is considerably less expensive than workers from the Domiciliary Care Sector, but the amount received by the Care Worker is higher than the rate paid by companies. Workers are at risk, however, as in some cases they are being employed by the Care Recipient under less favourable working conditions and statutory rights than if they were employed by an organisation. While personal budgets can have benefits for Care Recipients, enabling them to better tailor the service to their needs, care must be taken that this does not further weaken the rights of an already vulnerable workforce.

visibility of services is at risk from budget cuts, which can lead to continuously changing service providers as they constantly seek to undercut each other in an effort to gain unregulated contracts¹⁵⁷. It is clear that greater cohesion is required between Local Authorities, the regulator and representatives, and also Care Workers themselves, so that solutions can be reached that ensure the care recipient, often the most vulnerable person, and the Care Workers, are not marginalised in pursuit of economic benefits.

Stephen

Length of time in care: 10 years

Qualifications: Previously worked in a different sector, and was sought by recruiters for management ability

Aspirations: Managing an effective residential Care Home that treats both service users and employees fairly

Desires from the industry: More funding in the industry: at the moment privately funded individuals are subsidising Local Authority clients who pay less for services

Experience of work in Care: We're losing good people to shelf stacking in supermarkets because of low pay and a lack of career progression

How would you improve working conditions?

Local Authorities are on a race to the bottom – we need to focus on quality and service for clients, not just price

"There's a race to the bottom"

Stephen
45 years old,
Yorkshire, Care
Home Assistant
Manager,
Residential Care



Competitive tendering has had a significant impact on Social Services and Care Recipients and has led to significant criticism from the industry. As Mark Drinkwater notes, while Local Authorities are trying to cut costs, sourcing the cheapest Social Care Provider does not necessarily result in the best value for Care Recipients¹⁵⁶. Ruth Cartwright, manager of the British Association of Social Workers in England, says continuity is important for those with learning disabilities as they find it hard to understand and adjust to change. She feels that the quality and

Weak regulatory environment

The race to the bottom in the Care Sector is taking place against the backdrop of a weak regulatory environment that does little to prevent good Care Providers from being undercut by those competing on low skills, low wages and low standards. There is no regulation of Care Workers and oversight of Care Providers is weak, with responsibility for raising and verifying standards in the sector spread across

¹⁵⁶ Drinkwater, M., *The impact of competitive tendering on social services and service users*

¹⁵⁷ Drinkwater, M., *The impact of competitive tendering on social services and service users*

numerous bodies with poor coordination and no real 'teeth' to enforce improvements.

Since April 2009 the Care Quality Commission (CQC) has been responsible for the regulation of all Health and Adult Social Care providers in England. The CQC regulate the treatment, care and support services for adults in Care Homes, in people's own homes, (both personal and nursing care), and other regulated settings¹⁵⁸. They take into account the 'Essential Standards of Quality and Safety' and monitor providers to make sure they continue to comply with the requirements. The CQC focuses on outcomes for people who use services and has some enforcement powers, including fines and public warnings, and it can close a service down if patients are at risk. However, providers are not legally bound to adhere to the outcomes the CQC sets and assessment is largely based on self-reporting by providers. Not all activities are covered by the CQC, notably personal care organised by the care user, and the CQC has no remit to monitor or tackle exploitative working practices that risk good patient care.

In addition to the CQC there are three other bodies with some form of remit to examine standards in the Care Sector:

- The Sector Skills Council for the sector, Skills for Care, helps to identify skills needs in the sector and to develop training standards, but it lacks the power or resources to solve the chronic lack of investment in training and apprenticeships, which is exacerbated by high turnover and fear of 'poaching' by rival providers.
- The Social Care Institute for Excellence also gathers best practice and evidence about what works in care, but again has no resources or powers to enforce this.
- Finally, the Health and Care Professions Council regulates Social Workers but has no remit to oversee Care Workers, leaving the workforce completely unregulated. This is in contrast to arguably similar roles such as teaching assistants, social workers and child-minders, which are characterised by

registration and legal training requirements that ensure workers have the skills they need to work with potentially vulnerable people.

Case Study: Good Practice: Child Care Workers

Child Minders and Child Carers are regulated by Ofsted. These professionals are required to meet certain standards before they are permitted to register with Ofsted and commence work. This includes committing to strict ratios of childminder to child, detailed training prerequisites, including educational attainment and first aid proficiency, procedures for dealing with complaints, strict record keeping requirements and provision of information to the regulator. Such rigorous standards have been met with widespread approval; Andreas Schleicher of the OECD articulated that "staff qualifications are one of the strongest predictors of the quality of early childhood education and care". If such extensive provisions and protections are afforded to young members of our society, it is logical that similar measures are taken to safeguard the older and disabled people.

None of these organisations work together in a coordinated way, and they are not joined up with other bodies with an interest in workplace standards such as the HMRC minimum wage compliance unit or the Health and Safety Executive.

The people who are being failed are both the Care Recipients, who are often in a vulnerable position, and the Care Workers, who are isolated and treated poorly.

¹⁵⁸ Care Quality Commission, *Services we regulate*, 2014 (online), available: <http://www.cqc.org.uk/public/about-us/services-we-regulate>

Appendices:

The Call for Evidence

Baroness Kingsmill CBE will be consulting widely with businesses, employees, trade unions, Local Authorities, think tanks and charities to investigate evidence of poor working conditions in the Care Sector and the impact on quality of care, particularly non-payment of the minimum wage, high use of zero hour contracts, low levels of training and the factors associated with poor English language ability. We also welcome Care Workers to submit case studies or testimonies from their own experiences.

The review will seek to understand the dynamics of the sector and the factors behind poor working conditions, including the funding and relationships between Local Authorities, agencies and private service providers. The Kingsmill Review will make policy recommendations to tackle these issues, with a specific focus on how to improve working conditions without raising the cost or reducing the availability of care.

Specific areas of interest include:

1. The structure of the industry and the workforce
 - a. What are the different types of care work, and how do roles in the sector vary across home-care and residential care services, and those commissioned through personal budgets?
 - b. What kinds of people are involved in care work, and how does this vary in different parts of the country? What role does migration and migrants play in the care workforce, and how has this changed over time?
 - c. What is the nature of funding and how is funding likely to change?
2. Evidence on the scale and nature of poor working conditions in the Care Sector::
 - a. How is working time structured and calculated for Care Workers and what impact does this have on pay and working conditions? How are travel costs, uniforms and training covered?
 - b. What is the nature of contracts in the sector and how does this vary across domiciliary, residential and privately commissioned workers?
 - c. What are the different commissioning models used in the Care Sector and what impact does this have on working conditions, including non-payment of the minimum wage and the use of zero hour contracts?
 - d. What is the impact of this on Care Workers?
3. Professional Standards and Progression
 - a. How easy is it to recruit and retain staff?
 - b. What are the language proficiency levels among Care Workers?
 - c. How are Care Workers trained?
 - d. What opportunities are there for workforce development and career progression?
 - e. What impact do these issues have on service users and quality of care?

4. Policy recommendations

- a. How can we tackle high levels non-payment of the National Minimum Wage and zero hour contracts in the Care Sector?
- b. How can we promote both efficiency and decent working conditions through better workforce planning?
- c. Which models of commissioning, ownership and workforce organisation promote better working conditions and quality of care and how can we encourage these across different parts of the sector?
- d. How can we make better use of existing resources to improve workforce development and support?

If you would like to make a submission to the Kingsmill Review, please email yourbritain@labour.org.uk, with the subject heading 'Submission to the Kingsmill Review'.

Submissions to the Call for Evidence

Care England

Citizens UK

Debra Claridge

Dr. Shereen Hussein

Dr. Sian Moore

Do Care

Independent Age

HC-One

National Care Association

National Care Forum

Royal College of Nursing

UNISON

Unite

Warren Wright

Organisations and Individuals Consulted

Aileen Buckton

Lewisham Council

Alice Mitchell-Pye

Leonard Cheshire

Andrew Kaye

Independent Age

Andrew McKechnie

PricewaterhouseCoopers

Andy Burnham

Member of Parliament for Leigh

Andy Hull

Islington Council

Barry Quirk

Chief Executive, Lewisham Council

Baroness Greengross**Baroness Pitkeathly****Brendan O'Driscoll**

PricewaterhouseCoopers

Camilla Cavendish

The Times

Caroline Robinson

FLEX

Caroline Waters

Equality and Human Rights Commission

Chris Benson

Leigh Day Solicitors

Claire Falconer

FLEX

Clare McNeil

Institute for Public Policy Research

Colin Angel

UK Homecare Association Ltd

David Croisdale-Appleby

Skills for Care

David Norgrove

Low Pay Commission

Debbie Sorkin

Chief Executive, National Skills Academy for Care

Debra Claridge

Former Care Worker

Dee Carlin

Lewisham Council

Des Kelly

National Care Forum

Dr. Chai Patel

HC-One

Dr. Rhidian Hughes

Centre for Workplace Intelligence

Dr. Shereen Hussein

Kings College London

Dr. Sian Moore

University of West England

Eleni Giatsi

Laing Buisson

Emily Holzhausen

Carers UK

Guy Collis

UNISON

Helga Pile

UNISON

Isabel Shuts

Compass

James Lazou

Unite

Jane Ashcroft

Care England

Jane Carter

Leonard Cheshire Disability Trust

Janet Burgess

Islington Council

John Kennedy

Joseph Rowntree Foundation

Jonathan Lillistone

Southwark Council

Justin Bowden
GMB

Justine Cawley
Elizabeth Care

Karen Diovich
Royal College of Nursing

Kate Egerton
Leigh Day Solicitors

Katy Jones
The Workforce Foundation

Lizzie Dowd
The Royal College of Nursing

Liz Taylor
National Dignity Council

Lucianne Sawyer
UK Homecare Association

Lynne Smith
Leigh Day Solicitors

Marc Jones
Profiles4Care

Martin Day
Leigh Day Solicitors

Matthew Bolton
Citizens UK

Matthew Percival
Confederation of British Industry

Matthew Pennycook
The Resolution Foundation

Michelle Atkinson
Leeds City Council

Mike Falvey
Four Seasons Health Care Ltd

Nick Fry
Bindmans LLP

Nicky Marcus
Unite

Paul Broadbent
Gangmasters' Licensing Authority

Peter Daly
Bindmans LLP

Phil Pegler
Carewatch Care Services Ltd

Prof. Jill Manthorpe
Kings College London

Rachel Dodgson
Care Quality Commission

Rakesh Kotecha
West Midlands Care Association

Ray James
Association of Directors of Adult Social Services

Richard Bowden
BUPA

Richard Exell
Trade Union Congress

Robert Padron-Stephenson
Penrose Care

Ruth Grove-White
Migrant's Rights Network

Sandra Stark
BUPA

Sarah Newman
Profiles4Care

Sean McLoughlin
Islington Council

Sian Moore
University of the West of England

Sir John Oldham
Labour Review into Health and Social Care

Sue Rogers
Liverpool City Council

Tim O'Shea
Leeds City Council

Una Mills
Do Care Ltd

Vidhya Alakeson
Resolution Foundation

Yasmin Alibhai-Brown
The Independent

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