

Kent Academic Repository

Full text document (pdf)

Citation for published version

Hussein, Shereen (2014) Evidence and Reflections for The Kingsmill review of exploitation in the care sector. Discussion paper. King's College London

DOI

Link to record in KAR

<https://kar.kent.ac.uk/68324/>

Document Version

Publisher pdf

Copyright & reuse

Content in the Kent Academic Repository is made available for research purposes. Unless otherwise stated all content is protected by copyright and in the absence of an open licence (eg Creative Commons), permissions for further reuse of content should be sought from the publisher, author or other copyright holder.

Versions of research

The version in the Kent Academic Repository may differ from the final published version.

Users are advised to check <http://kar.kent.ac.uk> for the status of the paper. **Users should always cite the published version of record.**

Enquiries

For any further enquiries regarding the licence status of this document, please contact:

researchsupport@kent.ac.uk

If you believe this document infringes copyright then please contact the KAR admin team with the take-down information provided at <http://kar.kent.ac.uk/contact.html>

Evidence and Reflections for The Kingsmill review of exploitation in the care sector

Dr Shereen Hussein

Senior Research Fellow
Social Care Workforce Research Unit
King's College London

Shereen.hussein@kcl.ac.uk

0207 848 1669

February 2014

First Roundtable on Working Conditions in the Care Sector 20th February 2014 House of Lords

Opening remarks

By Dr Shereen Hussein

There are an estimated 2 million social care jobs in the UK, which is expected to increase substantially over the coming few decades. Care workers are the backbone of this workforce. They provide crucial, intimate and personal care for the most vulnerable of our society. Their work is both socially and economically important, reducing considerable costs on hospitals and other professional staff while enabling many to live with dignity, contribute to the society and maintain their autonomy for as long as possible.

The sector has been identified year on year by the Low Pay Commission as one of the least paying sectors in the UK; recent very conservative estimates indicate that at least from 10 to 13 per cent are paid under the National Minimum Wage (NMW) (affecting some 200 thousand workers); and recent evaluation by the HM Revenue & Custom (HMRC) highlights the widespread of non payment of NMW with 48 per cent of their sample of employers found to be non-compliant.

The real issue is not how many are paid under the NMW but the chronic low wages across all care workers who are on the majority paid on or around the NMW, with very narrow wage distributions. With budget cuts; commissioning processes aiming to meet such cuts it is very easy for more and more care workers to be effectively paid under the legal minimum. Fragmented work, shorter visits, widespread practice of zero-hour contracts all increase the risk of non-payment of work time, and

increased workers' levels of stress and burnout can directly affect the quality of care provided.

Care workers in the majority are attracted to the sector because they want to make a difference; they value the reward of helping someone else over the poor wages and hard working conditions. A typical British care worker is a woman in her late 40s, usually with caring responsibilities of her own; she is looking for a job that is flexible and which she can do and feel rewarded. However, with the continued changes in the commissioning of care leading to a highly fragmented care market, with very limited time to spend 'caring', care workers are deprived from their main reward: 'feeling they are doing a good job'. With counted minutes to visit a person in need of their care, they either spend more unpaid time to fulfil their job or they are forced to leave to start another shift feeling guilty or worse.

Another important group in the sector are migrant workers. There is no surprise that the sector has relied and will continue to rely heavily on migrants who may have their own reasons to accept its secondary labour position. It is estimated that at least 20 per cent of the workforce are migrants, reaching 40 or 50 per cent in large cities and the capital. However, the profile of migrants has been changing dramatically over the past decade due to clear changes in immigration policies. The most important issue to stress within these changes is the power and choice shift that is also occurring. While both groups of migrants (from within or outside the EEA) face a number of restrictions in relation to access to benefits, residency and employment vulnerability - those from outside the EEA, particularly those used to be on work permits are the most vulnerable and reliant on continuous employment with a specific employer. The selection criteria are considerably different when employing EEA nationals already in the UK or recruiting non-EU migrants to the sector.

Employers are moving away from an ability to choose, select and state prerequisites such as levels of language proficiency, qualifications and previous experience from migrants who are not otherwise able to migrate, into a relatively free labour market where migrants from an expanding EU able to move and choose available jobs given they meet the minimum requirements. For social care, there are very little requirements and with employers pressed to fill vacancies, even English language is not a must let alone relevant vocational training or experience. This calls for a clear induction and training programme for migrants and indeed all care workers, we know that induction and training is very variable across the sector.

There is a clear need to understand and stress the economic value of this workforce and to take measures to ensure it is valued and provided with fair pay, clear opportunities to progress and appreciation to their work.

Shereen Hussain

During the roundtable discussion a number of issues were raised and I would like to provide further information on some different aspects of the workforce.

1- The Workforce

It is estimated that the independent sector (including private and voluntary) employs around 75 per cent, Councils employ 16 per cent, and recipients of direct payments estimated to employ eight per cent of the total social care workforce¹. However, due to the personalisation agenda, the latter group is growing substantially. The majority of formal care for older people and others with long-term care needs is provided by 'direct care' workers, working in care homes, people's own homes (home care) or in settings such as day centres. The sector's workforce also includes professionally qualified staff, such as registered nurses (not working in health settings such as hospitals), social workers and occupational therapists; managers and supervisors, and an array of ancillary staff providing non-direct care services, such as cleaning, driving and catering. It is estimated that over 2 million people work in this sector in the United Kingdom (UK), constituting around 7 per cent of the estimated 29 million total labour market in the UK.

Direct care workers are the backbone of the social care workforce, constituting 72 per cent of the workforce, which is equivalent to an estimated 1.2 million workers in England alone. Social care workers are employed for an estimated 49,700 providers in England alone². An increasing number of workers are employed directly by service users through personal budgets³. Pay rates are among the lowest in the UK; these rates are considerably lower within the private sector, where around 60 per cent of the workforce is employed. There are clear indications of further fragmentation of work through commissioning increasing numbers of small providers who are in the majority are for-profit private organisations.

2- Turnover rates

Using longitudinal data records of nearly 3000 employers, panel analysis indicates that the overall turnover rate remained almost unchanged for the period 2008-2010. Mean turnover rate was 22.5 per cent in 2008 (median=14.29) and 22.9 per cent in 2010 (median=14.29). This means that on average around a quarter (24 per cent) of the care workforce changed their jobs within the previous 12 months prior to the beginning of 2008, with similar workforce traffic 18 months later. A turnover rate of 22 to 23 per cent is considerably higher than that of other work sectors in the UK, standing at an average of 15.7 per cent, however, it is considerably lower than the 34 per cent turnover rate observed in the catering and leisure industry⁴.

¹ Hussein S., Stevens M., Moriarty, J. and Manthorpe J. (2010) *Longitudinal Care Study (LoCS)* Interim report to the Department of Health. Social Care Workforce Research Unit, King's College London.

² Skills for Care (2012) *The State of the Adult Social Care Sector and Workforce in England, 2012*.

³ Estimated at 178,000 in the adult care sector in 2012 in England alone.

⁴ Hussein, S. and Manthorpe, J. (2011) *Longitudinal changes in care worker turnover and vacancy rates and reasons for job leaving in England (2008-2010)*. Longitudinal analysis of the National

The panel analysis indicates that turnover rates remained the same for over half of care providers, while 26.7 per cent of them experienced an increase in care worker turnover rate. An almost equal proportion of providers experienced an improvement (decline) in their care workers' turnover rate. The longitudinal analysis shows that voluntary providers are more likely to be found within the groups of providers with stable turnover rates when compared to those with improved or worsening turnover rates. Changes (positive or negative) are significantly more likely to occur within the private sector. Small organisations are significantly over-represented within providers with decreased (improved) turnover rate during the period of this study, while medium size organisations are over-represented among the group with increased (worse) turnover rates.

The longitudinal analysis examined changes in employers' perceived reasons for staff leaving their jobs. A comparative analysis of reasons and changes over time was conducted among three main groups of providers: 1) Those who did not experience any change in their turnover rate from 2008 to 2010; 2) Those who experienced an improvement (decline) in their turnover rates; and 3) Those who saw care workers turnover rates increase over time. For organisations with no change in turnover rates, the distribution of perceived reasons for leaving remained almost unchanged from 2008 to 2010, with the exception of 'personal reasons' and 'reasons unknown'. For providers with increases in care worker turnover rates the relative importance of 'unknown reasons' and 'dismissals' has increased. There were no changes in levels of redundancy or end of contracts. For providers that experienced an improvement in turnover rates, the importance of pay as a reason for leaving was significantly reduced from 2008 to 2010. Other significant but small changes in magnitude are: an increase in the relative importance of personal reasons; a decline in the importance of 'nature of work' and a decline in 'unknown reasons'. These changes suggest that providers with improved turnover rates over time were able to issues of pay and attracting workers who recognise the nature of the work involved in social care.

3- Gender and Age

The social care workforce is predominantly female – around 83 per cent overall, rising to 85 to 90 per cent of those undertaking direct care-providing jobs. Men account for up to a quarter of the workforce in certain areas, notably day care, support roles and management. The ratio of 4:1 in favour of women is consistent across the UK. However, men remain over-represented in senior management; accounting for more than 30 per cent of this group. Recent analysis of data on men indicated both vertical and horizontal segregation of male workers within the sector indicating important interactions between race/migration, socio-economic status, nationality and gender⁵. While around 17 per cent the workforce are men, much higher percentages are observed in jobs that are traditionally masculine in nature,

Minimum Data Set for Social Care (NMDS-SC), Analysis report 1. Social Care Workforce Research Unit, King's College London.

⁵ Hussein, S., Manthorpe, J. and Ismail, M. (in press) Male workers in the female-dominated long-term care sector: evidence from England. *Journal of Gender Studies*.

such as technicians, or managerial roles. The over-representation of men in managerial roles may suggest the advantageous positions of men in the sector benefiting from their minority status. However, not all men seem to be in this position, migrant men are more concentrated within traditionally female jobs such as hands-on care work and less in managerial roles. The proportion of men among the migrant workers is higher than the average; ranging from 19 per cent among A8 migrants to 26 and 27 per cent among non-EEA and A2 (Bulgaria and Romania) migrants⁶.

The mean age of the workforce 42 years, men are slightly younger than women but migrant workers are considerably younger, migrants from A8⁷ countries are the youngest with a mean age of 34 years.

4- Contribution of British BME workers

Recent analysis of the contribution of British Black and Minority Ethnic groups (BME) to the sector showed it to be much lower than previously believed, constituting only 7.5 per cent of the workforce. There are variations in nature of work and indications of higher levels of job insecurity among different ethnic groups⁸. Nearly 40 per cent of British BME workers were identified by employers to be of black or black British ethnicity and 22 per cent as being Asian or Asian British, with a considerable proportion of 30 per cent being identified as belonging to “other” ethnic groups. Such a distribution does not reflect the overall ethnic distribution of England and Wales where the largest ethnic group is other white (5.3 per cent) then Asian or Asian British (4 per cent) followed by black or black British at 2.3 per cent and mixed ethnicities at 1.8 per cent. Research has also revealed that younger workers (18-25 years) in the sector are less ethnically diverse than their older counterparts⁹.

5- Migrants and the Social Care Sector

The social care sector has always relied heavily on migrants, and will continue to do so. Analysis of NMDS-SC in 2011 indicates that employers identified migrants to constitute 15 to 20 per cent of the workforce; reaching 40 to 50 per cent in large cities and the Capital. These figures are likely to have underestimated the real contribution of migrants to the sector due to the fact that employers were the ones identifying migrants and in many cases migrants can be invisible to the employers especially if they did not require a work permit. The vast majority of migrant workers

⁶ Hussein S. (2011) The contributions of migrants to the English care sector. *Social Care Workforce Periodical*, Issue 11: February 2011, London.

⁷ Countries joined the European Union in May 2004, with low-income levels. They include the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia. While both Malta and Cyprus have joined the EU during the same time (2004) they are not identified as ‘A8’.

⁸ Hussein, S., Manthorpe, J. and Ismail, M. (2014) Ethnicity at work: the case of British minority workers in the long-term care sector. *Equality, Diversity and Inclusion: An International Journal*. 33 (2): 177-192.

⁹ Hussein, S. and Manthorpe, J. (2010) Attracting young adults (18-25) to work in social care in England, how secondary data analysis may assist policy makers and providers. *Diversity in Health and Care*. 7(4): 229-239.

in social care are from non-EEA countries, with over a quarter of them arriving from just two countries: the Philippines and India. Other main sending countries include Poland, Zimbabwe, Nigeria and South Africa¹⁰. More recent data (end of 2013) indicate that employers completing the NMDS-SC identified British workers in 64 per cent of the workforce, with 14 per cent identified as 'unknown nationality'¹¹. Migrant workers are more prevalent within adult residential and domiciliary settings than community care or day care; they are also more likely to work for private providers in these settings. On the other hand, migrant workers are proportionally less likely to hold managerial and supervisory roles. Proportionally more migrant workers are reported within establishments providing services for people with dementia (16 per cent), other older people with mental health problems (15 per cent) and adults with physical disabilities (15 per cent); while least among those providing services to adults who misuse alcohol/drugs (11 per cent).

It is clear that migrants from non-EEA countries continue to form the majority of migrants joining the sector year on year; however, the contribution of migrants from A8 and A2 countries is becoming more evident. Looking at the length of time that has elapsed between joining the UK and entering the English care sector, as well as current main jobs, the analyses reveal that A8 and A2 nationals have the fastest pace of joining both the care sector and their current jobs after arriving to the UK. This suggests that they have either secured their care jobs while in their home country or actively sought employment in the sector on arrival. For other EEA nationals the picture was different, on average, migrants from this group waited over three years after arrival to the UK before joining the care sector and four years prior to their current job. These figures may suggest different initial migration motivations and may reflect that many of EEA (non A8/A2) may have accompanied other family members to the UK and perhaps, after a while, they have considered work in this sector¹².

There are indications that since 2010 employers have tended to recruit migrants already in the UK rather than recruiting directly from abroad. In 2009-2010, research estimates around half of migrants to be recruited directly from their home countries¹³. With changing immigration policies, it is becoming virtually impossible for employers to secure new work permits for (senior) care workers. However, many workers remain on their previously issued work permits prior to the introduction of the non-EEA immigration cap in 2012.

Regression analysis examining the specific profile of migrant workers confirms that they are more likely to be young, but there is more of an equal gender balance, with

¹⁰ Hussein S. (2011) The contributions of migrants to the English care sector. *Social Care Workforce Periodical*, Issue 11: February 2011, London: ISSN 2047-9638.

¹¹ Authors' own analysis using NMDS-SC end of October 2013 returns.

¹² Hussein S. (2011) Migrant workers in long term care: evidence from England on trends, pay and profile. *Social Care Workforce Periodical*, Issue 12: March 2011, London: ISSN 2047-9638.

¹³ Hussein, S., Stevens, M. and Manthorpe, J. (2011) What drives the recruitment of migrant workers to work in social care in England? *Social Policy and Society*, 10(3): 285-298.

significantly less reported disabilities among migrants working in the care sector compared to UK staff. In addition, the model highlights a number of important findings that may have direct implications on the quality and continuity of care provided by migrant workers in the care sector. The use of migrant workers is positively and significantly associated with both turnover and vacancy rates within organisations. This implies that employers may resort to employing migrant workers when both recruitment and retention are most difficult.

While working in the care sector offered many positive and enriching experiences for migrant workers, their colleagues and service users, qualitative research indicates that some migrant workers experience different forms of racism and discrimination¹⁴. Accounts were given of discriminatory behaviour exhibited in the workplace by employers and colleagues, although racist comments and behaviour from service users, including refusing to receive services from particular migrant workers, were reported more often. Participants indicated that visible social markers such as dress code, skin colour, and English accent/proficiency are used to classify workers; skin colour was the strongest indicator for incidences of discrimination and racism, suffered particularly by migrant workers identifying as black African.

6- Wages and Pay in the Social Care Sector

Evidence of low pay in the sector, particularly among direct care workers, is abundant, with the Low Pay Commission highlighting the care sector as one of most vulnerable sectors in terms of its workers being paid on or under National Minimum Wage (NMW) thresholds. The NMW came into effect in the UK during the last nine months of the 20th century (April, 1999), with the care sector arguably one of the main beneficiaries of the introduction of NMW. Nonetheless, it was, and remains, one of the lowest paying sectors in the UK.

Hussein (2011) used very conservative adjustment factors of unpaid time (22.7 min/week on average) and unpaid travel time (4.8 min/week on average) were derived from data obtained from care workers responding to a large survey (LoCS¹⁵ study; n=1,205). On average, our conservative estimate of unpaid time resulted in an average reduction of hourly pay rates by a fraction of 0.01 (1 per cent). This is a very conservative adjustment and it is likely that pay rates are affected by a higher percentage of unpaid time. A Bayesian hierarchical model considering prior knowledge reported by the LPC and ONS and using the 'new' adjust pay distribution as described, produced 'posterior' distributions of the probability of direct care workers being paid under the NMW. The results indicate that between 9.2 per cent

¹⁴ Stevens, M., Hussein, S. and Manthorpe, J., (2012), Experiences of racism and discrimination among migrant care workers in England: findings from a mixed-methods research project, *Ethnicity and Racial Studies*. 35(2): 259-280.

¹⁵ Longitudinal Care work Study, conducted by the Social Care Workforce Research Unit and funded by the Department of Health.
<http://www.kcl.ac.uk/sspp/kpi/scwru/res/capacity/locs.aspx>

and 12.9 per cent, translating to 156,673 and 219,241 jobs, are likely to be paid under the NMW¹⁶.

Pay analysis reflects a two tier system, with very low pay among the majority of workers in the direct care work and ancillary work (drivers, cook etc.) categories and a relatively higher, with wider range, pay levels among professional staff and managers. Hierarchical modelling techniques indicate the considerable effect of sector of employment and possible structural variations related to ethnicity and gender. Those in low-skilled jobs working in the public sector earn significantly more than their counterparts in the private and voluntary (not-for-profit) sectors. For care workers the analysis indicates that 55 per cent of variance in wages related to employers (or providers); followed by 11 per cent determined by region of employment, and a further 4 per cent relating to employment sector within a particular region. The variable with the numerically largest effect was sector. Direct care workers employed in the private and voluntary sectors earned considerably less than their counterparts in local authorities; with those working in the private sector earning the least amount¹⁷.

Many migrant workers in the care sector earn less than British workers. However, when specific job role is controlled for, these variations are not significant. The latter may relate to factors not captured by the NMDS-SC such as patterns of shifts, for example, night or weekend shifts, as well as individual personal and professional experiences. Overall the distributions of hourly pay rates were narrower among migrant workers, suggesting less variability in their pay and wages¹⁸.

7- Induction and Training

The majority of direct care workers, including domiciliary care workers, start working in the English social care sector with no formal training. Induction and training are key elements in preparing care workers to conduct their duties to service users safely and in an acceptable quality. Additionally, training and gaining qualifications can be regarded as the main non-financial incentives for care workers, especially with well-documented very low wages in the sector¹⁹.

¹⁶ Hussein, S. (2011) 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 London: King's College London.

<http://www.kcl.ac.uk/sspp/kpi/scwru/pubs/periodical/2011/issue16.aspx>

¹⁷ Hussein, S. and Manthorpe J. (2014) Structural marginalisation among the long-term care workforce in England: evidence from mixed-effect models of national pay data. *Ageing and Society*. 34(1): 21-41.

¹⁸ Hussein S. (2011) Migrant workers in long term care: evidence from England on trends, pay and profile. *Social Care Workforce Periodical*, Issue 12: March 2011, London: ISSN 2047-9638.

¹⁹ Hussein, S. (2011) 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 London: King's College London.

<http://www.kcl.ac.uk/sspp/kpi/scwru/pubs/periodical/2011/issue16.aspx>

Skills for Care estimates²⁰, in 2012, just over three quarters of adult domiciliary workers have completed some form of induction (Skills for Care, 2012). These figures are based on information provided by employers and relate to any general induction. They are not specifically related to the Common Induction Standards (CIS). The Care Quality Commission (CQC) states that all staff should receive a comprehensive induction that takes account of recognised standards within the sector and is relevant to their workplace and their role. The relevant induction in this context means the Common Induction Standards (CIS).

The following information in relation to induction and training of domiciliary care workers is derived from the Longitudinal Care Work Study (LoCS) conducted by King's College London. As part of the LoCS, two rounds of surveys collected information from a total of 1,342 workers in the social care sector in England at two time points (2009/10 and 2011/12). A total of 332 responses were received from domiciliary care workers. The vast majority of participating care workers indicated that they have received some form of induction, with only 6 per cent in 2009/10 and 4 per cent in 2011/12 indicating they received no induction at all. However, type of induction was variable with only 68 per cent indicating they received some 'formal' induction (24 per cent at a formal training centre and the rest at their workplace); a quarter (24 per cent) received informal induction from co-workers; and 4 per cent received their induction through online training material or other form of written documents.

Based on 332 responses from domiciliary care workers, only 41 per cent indicated they have ever heard of CIS, this percentage declined to 33 per cent in 2011/12²¹ (this percentage is based on small numbers and should be treated with caution). There were some indications of a reduced level of other forms of training over time; in 2009/10, 37 per cent indicated that level of training offered to them has increased a little or a lot in comparison to the year before, the same percentage dropped to 17 per cent in 2011/12.

Focusing on specific topics of induction and training, the majority of workers were given training in 'Health and Safety' (88 per cent) and 'Moving and Handling' (86 per cent). However, relatively fewer workers were trained in areas such as 'Dementia Awareness' and 'Mental Capacity Issues' with a quarter or more never receiving any training in these areas with their current or previous employers. Other areas where training was not widespread includes 'Communication Skills' and 'Welfare benefits' (29 per cent and 55 per cent respectively received no training).

These findings indicate that the majority of domiciliary care workers receive some form of induction, however, only 68 per cent had 'formal' induction and less than half have ever heard of Common Induction Standards. Furthermore, type and context of induction is variable. While the data indicate a slight increase in receiving 'any' induction over time there are some indications of reduction in the quantity of

²⁰ Skills for Care (2012) *The State of the Adult Social Care Sector and Workforce in England, 2012.*

²¹ Based on 48 cases

training over time. Training in some care related topics appears to be relatively limited, with at least a quarter of workers not receiving any. This is particularly the case for mental capacity issues, dementia awareness and communication skills.

Reflections and Recommendations

How can local authorities address concerns over care workers' payments and work conditions?

Social care policy directions are increasingly shifting care for older people and adults with long term care needs to their own homes. Providing opportunities to increase their involvement and engagements in their communities. Home care, care provided in people's own home, becomes the backbone of the social care structure to maintain people's independence and quality of life. While the importance of care work to our society is indisputable, the pay and status of the job are not. By law, all adults over the age of 21 are entitled to a minimum wage (£6.31 an hour from October 2013); however, fragmented short shifts, under (or non) payment of travel time combined with zero hours contracts increase the risk of payment under the national minimum wage significantly.

The price of care services is greatly influenced by local government budget cuts and economic austerities with increasingly tighter budgets to commission social care. A recent opinion poll by Ipsos MORI²² found that over eight in ten (84 per cent) public sector leaders believe that their organisation has been affected a great deal or fair amount by cuts in public spending. Recent Equality and Human Rights commission report into home care²³ indicates systematic failure in the quality of elder care with links to poorly paid service, inadequate pay to care workers, poor working conditions and lack of continuity of care.

The vast majority of home care is provided through the private sector, with incidences of zero hours contracts and very low wages significantly higher than that in the voluntary sector or those run by local authorities. While zero hours contracts might be considered as a form of flexible working patterns offering workers the opportunity to have a variety of shifts at a short notice, they increase the risk of unpaid between-client travel time and cost as well as unpaid 'on-call' time. A recent UNISON survey²⁴ shows the commissioning processes of many councils may fuel the use of zero hours contracts. By operating a tendering process where the unit price of

²² Ipsos MORI (2013) *Public Sector Leaders: Views on public services and economy*.
<http://www.ipsos-mori.com/researchpublications/researcharchive/3156/Public-Sector-Leaders.aspx>

²³ Equality and Human Rights Commission (2013) *Close to home: An inquiry into older people and human rights in home care*.
http://www.equalityhumanrights.com/uploaded_files/homecareFI/home_care_report.pdf

²⁴ UNISON (2013) *Rise in zero hours contracts shame councils and hit elderly and vulnerable*. 1/8/2013 <http://unison.org.uk/news/rise-in-zero-hours-contracts-shame-councils-and-hit-elderly-and-vulnerable>

care is set to a considerably low level (in some cases £8.98 per hours inclusive of wages, travel and overhead) and fragmenting care work to a huge number of providers with no guaranteed work volume, some local authorities might be seen to fuel the use of zero hours contracts. Furthermore, contracts with local authorities usually do not explicitly specify the legality of paying workers at least the national minimum wage.

While funding pressures on local authorities are to be acknowledged, there are several opportunities to adopt good practice when commissioning social care. One of the main recommendations is the urgent need for detailed conversations about pay and working conditions in the care sector. Such dialogue needs to take place in the light of the growing need for long-term care, the increasing emphasis on direct payments and personalisation and thus the shift of employment responsibilities to the individuals.

Some local authorities have taken steps to improve the commissioning process despite financial pressures by prioritising social care. Some recommendations for local authorities to consider:

- Local authorities should ensure their commissioning process reflect the actual cost of care in their locality. Being transparent of how they assessed the minimum care unit price in their local setting.
- Local authorities should ensure in their contracting process that at least the national minimum wage is paid for all workers involved, including payment of travel time and cost (avoiding the use of enhanced pay rates as they can mask underpayment).
- Visit length should be commissioned based on client needs.
- Avoid, as much as possible, commissioning very short visits (15 minutes) as they are in the majority not sufficient to ensure high quality care and place both workers and people receiving care at risk. They can be used for monitoring purposes for example.
- Ensure that providers arrange work schedules in a way that avoids high level of travel time between clients.

Disclaimer and Acknowledgment

I would like to acknowledge the Department of Health for funding many of the studies cited in this short report, either through its core funding to the Social Care Workforce Research Unit or through separate competitive tendering processes. The views expressed here are solely of my own and do not necessarily represent that of the funder.

Dr Shereen Hussein
February 2014