

Key to Care

Report of the Burstow Commission on the future of the home care workforce

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Time Sheet

Total number of Tasks: 13
Date: 14-Aug-2014

Client Name: Mrs Lena Mullarkey ID: 1014 Assist
33 Saturday 14-Aug-2014

Client Name: Mrs Vera Dudge ID: 1114 Personal Care - Private
33 Monday 16-Aug-2014

Client Name: Mrs Dorothy Lucas ID: 660 Bath / Shower - Private
Note: Take to the Fris
33 Monday 16-Aug-2014

Client Name: Mrs Jean Smith ID: 184 Personal Care - Private
Note: Take to the Fris
33 Monday 17-Aug-2014

Actual Start	Actual End	Task Time	Start Time	End Time	Visit Time	Signature
08:05	08:15	00:10	08:00	08:15	00:15	[Signature]
08:15	08:30	00:15	08:15	08:30	00:15	[Signature]
08:30	09:30	01:00	08:30	09:30	01:00	[Signature]
09:30	10:00	00:30	09:30	10:00	00:30	[Signature]
07:24	08:09	00:45	07:30	08:15	00:45	[Signature]
08:30	09:30	01:00	08:30	09:30	01:00	[Signature]
09:30	10:00	00:30	09:30	10:00	00:30	[Signature]

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MEARS



“Home care should be about empowering people to live independent lives near the people and places that are important to them.

It should be the way that we help people get back on their feet after a health or personal crisis”

Author

Ingrid Koehler, Senior
Policy Researcher, LGiU

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Forewords

WE EXPECT a lot from home care workers.

People who need support to continue living in their own homes have to place enormous trust in them relying on them, for help with the most personal and intimate tasks. Families entrust them to keep loved ones safe and treat them with the upmost dignity, respect, and genuine care. Councils expect them to help people to remain in their own home for as long as possible, avoiding more expensive residential care, while the NHS relies on them to keep people out of hospital.

This report paints a bleak picture of the state of home care. As a Commission we wanted to tell the story warts and all – and make a compelling case for urgent change.

As publicly funded care continues to be squeezed, the danger is that the good providers are driven out and those providers that make a profit by exploiting their workers thrive. The price in poor care is paid for by the most frail and vulnerable in our community, and by the care workers they rely on, who get a raw deal.

The Commission heard time and time again that care workers are grossly undervalued. It is a low pay, low skill and low status job – it is not yet seen as a career. This has to change if we want more people to take on these roles.

Home care is a vital part of our economic infrastructure. As our population ages and more families have to juggle work with childcare and care of the elderly, the quality and reliability of personal and household services will be key.

Making care work a career of esteem, where a living wage is paid, staff are trained and recognised as valued key workers who contribute a huge amount to society will inevitably come at a price, but the cost of doing nothing will be even greater.

The key to delivering great care is a great workforce and we need to get there urgently. There is already great care and there are thousands of dedicated staff, as the *Diary of a Home Care Worker* in this report demonstrates. There are providers that, against the odds, are delivering excellence and councils that have been smart and innovated their way out of crisis.

In *Key to Care* we challenge providers, local authorities and government to act on the evidence and best practice now so that care works for everybody.

Rt Hon Paul Burstow, MP
Chair of the Commission on Home Care,
Minister for Care Services, 2010-2012

MEARS entered the home care market in 2007. Our ambition was to shake up the sector.

We had three main goals:

- to integrate housing and care to provide better, more joined up services
- to move from services based on task and time to services that deliver positive outcomes for individuals and society
- to drive up the status, pay, terms and conditions of care workers.

We believe these three goals are fundamental to the delivery of consistently high quality care and support services. Unfortunately, it remains exceptional to see these principals reflected in the contracts that dictate provider practice.

Many care workers are currently delivering fantastic care in spite of the system. Surely we should redesign the system so that it rewards and incentivises care workers for providing high quality care, which promotes independence and values the knowledge and skills that care workers have. After all, it is care workers that are delivering day in, day out, often in challenging circumstances.

While we are quick to blame care workers when things go wrong, we do little to involve the very individuals who are at the forefront of care delivery in designing the solutions. One of the major strengths of this report is that it has listened to and reflected the views of front line care workers.

While Mears can and have realised positive change for care workers directly employed by us, we want to go much further.

All care workers should:

- be paid a living wage
- be freed from formulaic care plans so that they can be responsive to customer need
- and be recognised for the vital role that they play in our society.

This wholesale change needs commissioners, policy makers, providers and the wider sector to come together.

Much of the evidence heard by the Commission will solidify what sector professionals already know. For the sake of England's 685,000 care workers it is time to act.

Alan Long
Executive Director
Mears Group

Background to the Commission

If home care is not in crisis yet, it soon will be. More people need care and there is less money to pay for it and not enough people willing to do the work. It is not organised nearly as well as it could be and it appears designed to keep caring professional relationships from forming between workers and those they care for. We are probably lucky there has not been a major home care scandal yet. If things do not change, it may only be a matter of time. This Commission was formed with a sense of that urgency and a need to change.

There have already been a number of excellent reports this year about home care with a number of shocking findings. The Kingsmill Review particularly looked at exploitative employment practices.¹ The National Audit Office has highlighted the rise in need and the decline in support.² The International Longevity Centre estimated that we needed around one million more care workers over the next decade in an industry that already has trouble recruiting and serious trouble retaining staff.³ So why do we need another report and what is different about this one?

We could say that the facts and figures speak for themselves, but they do not. This Commission wanted to look at the broader picture of the home care workforce, what is working well and what is not and how we can do something about it.

It was initiated with the support of a care provider, Mears Group and the Rt Hon Paul

Burstow, MP, (the former Minister of State for Care and Support). Care providers do not come off very well in many of the reports that have been published so far and there are plenty of difficult messages for providers in this report, too.

But many of the providers that we have heard from are frustrated by the system. They want to provide good care with a great workforce. They want to stay in business, too. The current commissioning system which focuses on time and task care plans provides little security of revenue and no discretion for change.

Councils are also frustrated. They are faced with shrinking budgets and rising demand. They know that good care at home is about the broader network of friends, family and the community and its social and physical assets as well as direct care provision.

Through this Commission having a balance of providers and local authority commissioners, service user representatives, union and political representation who all agreed that things need to change and need to change urgently, we hope we are able to tell a broader story of how home care got to be where it is now and how we think things can change.

As part of the Inquiry we had an open call for evidence and we invited contributions from a range of people who work with care – academics, trade union representatives,

1 *The Kingsmill Review: Taking Care – An Independent Report into Working Conditions in the Care Sector*, Baroness Denise Kingsmill, CBE

2 *Adult Social Care in England: An Overview*, National Audit Office, March 2014

3 *The Future Care Workforce*, International Longevity Centre, February 2014

provider representatives, designers, care workers, people who are working in the forefront of integrating health and social care. Each and every one of them spoke across the range of complex issues that we cover in this report.

Licensing and regulation cannot change unless learning and development changes. Training and accreditation cannot change until employment practices and wages are reformed. Home care will not become a career of esteem until we start treating both service users and care workers with esteem – and that really means letting them work together to decide what the best care is in each individual case within an overarching framework of standards and performance measured outcomes.

That cannot happen until we radically change the way that councils commission services. Councils cannot fundamentally reform commissioning until they have the confidence that providers can be partners and that the workforce is sufficiently skilled, stable and compassionate enough to deliver the care we deserve.

This complexity and interdependency of problems and solutions is why we have chosen to set out our findings as a narrative and begin and end this report with the stories of care workers. In between these stories we look at what the conditions of care workers are really like, how the care system works and how it is commissioned.

We then think about how we might make caring a more esteemed profession, how we can use technology to support us in this and how this might improve the future of care.

This matters because the future of the care system affects all of us. We, or our loved ones, may one day rely on a home care worker to help us live independently, so finding solutions is the responsibility of all engaged and passionate citizens. These issues are complex, but we hope that this report is written in a way that is accessible to people without a background in social care and, of course, to care workers themselves.

The future of care work starts with sharing these stories as well as facts and with vision as well as recommendations.



The Commissioners



Rt Hon Paul Burstow, MP, has served as Liberal Democrat MP for Sutton and Cheam since 1997. He was Minister of State for Care Services in the Department of Health between 2010-2012 and subsequently served as Chair of the Joint Committee on the Draft Care and Support Bill. He has just finished Chairing a Commission on Residential Care with the think-tank Demos.



Alan Long is Executive Director of the Mears Group, a leading organisation in both the delivery of social housing repairs and maintenance and in the provision of care and support to vulnerable people. In the 10 years that he has worked for Mears he has held roles across Group Development as well as being Chief Executive of the Domiciliary Care division. He would love to see much greater parity of terms and conditions between those at Mears involved in repairing homes and those providing care to individuals. Prior to joining Mears, Alan has had senior roles with Britannia Building Society, Mars and Smith and Nephew.



Councillor Gwen Hassall is Stoke-on-Trent City Council's Deputy Leader and Cabinet Member for Social Care. Before retiring, Gwen worked with vulnerable adults and in housing for older people and became an elected member of the council in 2010. A committed member on the board of governors of a prominent city school Gwen also continues to keep abreast of changes and challenges affecting her portfolio and uses her extensive experience to inform policy and ensure that the most at risk members of our society are safeguarded, protected and looked after.



Sarah Newton, MP, grew up in her constituency of Truro and Falmouth, a part of Cornwall where she has family roots stretching back for generations. Before entering Parliament in 2010 Sarah was Director of American Express Europe, Age Concern England and the International Longevity Centre – UK. Since entering Parliament Sarah was elected onto the Science & Technology Select Committee and serves on the Board of the Parliamentary Office of Science & Technology and in 2013 was appointed Deputy Chairman of the Conservative Party.



Councillor John Pantall is an elected member at Stockport MBC and chairs the Health and Wellbeing Board. He worked from Manchester University on management and organisation development for the NHS over a period of 40 years in which he experienced 15 sets of organisational changes, large and small. John believes that while money helps, the challenge is for professionals to provide services for individual people, not as remote patients or clients.



Clare Pelham has been Chief Executive of Leonard Cheshire Disability since November 2010. Clare believes passionately in the manifesto of Leonard Cheshire Disability – to work for a society in which every person is equally valued, and for disabled people to have the freedom to live their lives the way they choose. Since October 2013 Clare has also been Chairman of the Voluntary Organisations Disability Group (VODG) – which represents over 80 leading voluntary sector disability organisations. VODG members support about a million disabled people throughout the UK, employ more than 75,000 staff and have a combined annual turnover in excess of £2 billion. Before joining Leonard Cheshire Disability, Clare was the inaugural Chief Executive of the Judicial Appointments Commission. She has also held senior civil service positions in the Cabinet Office, the Home Office and the Department of Constitutional Affairs. Clare has also worked in the private sector at IBM and was a member of the Executive Committee of Coca-Cola GB & Ireland.



Kevin Rowan was appointed Head of the Organisation and Services Department at the TUC in April 2013, heading up the TUC's work in public services, including rail and bus travel, the TUC's Organising Academy and the TUC's regional work. Prior to this, Kevin was the Regional Secretary of the Northern TUC, representing 54 trade unions and four hundred thousand trade union members in the Northern Region. He is chair of Equality North East, a member of the Regional Equality and Diversity Board, Northumberland LSC and the regional LSC Equality and Diversity Steering Group, the Regional Health at Work Group and Fresh NE; the campaign for a smoke free north east.

Summary of recommendations

Better and fairer commissioning

- **Minimum payments for contact hours:** councils should ensure that they are paying a sufficient rate for contact hours, which ensures that providers can pay care workers at least the minimum wage.
- **Moving away from time and task commissioning:** councils should be moving away from time and task commissioning and toward outcomes based commissioning.
- **Better oversight of existing contracts:** councils need to be more proactive in ensuring that their use of existing framework contracts is not contributing to the worst practices in home care, such as 15-minute care slots.

Valuing care and care workers

- **Key worker status for care workers:** the government should give immediate key worker status for those care workers employed directly by the public sector and should investigate how other care workers could be offered key worker status.
- **A living wage for care workers:** if we are truly to value our care workers they should receive a living wage. The United Kingdom Home Care Association calculates the hourly rate for the purposes of commissioning as £18.59 for compliance with the living wage and £21.33 for compliance with the London living wage.
- **A licence to practise:** the government should take immediate steps to put in place the suitability scheme proposed by the Health and Care Professions Council in the form of a statutory code with independent adjudication and a register. In the longer term, licensing would support the professional status of care workers and provide greater reassurance to care commissioners.
- **A training and career pathway for care workers:** care workers in both health and social care need minimum standards of training which can be developed into pathways of specialism. A more formalised career path would include apprenticeships alongside clear career pathways
- **Free influenza vaccinations for care workers:** care workers should be offered free flu jabs by the NHS to protect both their clients and themselves.
- **Working carer tax credits and care credits:** people with informal caring responsibilities should have support to continue in employment if desired.

Responsible and innovative providers

- **Enforcement of the minimum wage:** all commissioned care should follow open book accounting procedures. HMRC should change its procedures for how minimum wage investigations are triggered, allowing complaints from third parties.
- **Innovation and use of new technologies:** service design approaches and the use of technology can transform the way we deliver care in the community and liberate staff to spend more time on personal contact.

The full recommendations can be found on page 30 of the report.

Introduction

Home care should be about empowering people to live independent lives near the people and places that are important to them. It should be the way that we help people get back on their feet after a health or personal crisis. It should be the way that we save money by avoiding unnecessary hospitalisation and offering an alternative to residential care placements through support in a community setting.

But too often home care is not realising its potential. It is not working for older and disabled people who need help to live independently, and who often feel poorly served by an inflexible system that is defined by specific tasks and little continuity among care workers. It is not really working for councils, whose budgets are shrinking while needs are rising. It is increasingly not working for care providers who are competing on price and working from framework contracts that offer little predictability of work and revenue.

Perhaps most of all it is not working for the care workers themselves. They are the care sector's greatest asset and yet many are poorly paid, little respected, essentially unregulated and ill-trained. Under these conditions it is no wonder that home care has amongst the highest staff turnover rate in the economy at around 21% – about twice the national average¹. We are facing a recruitment crisis, with up to a million more

staff needed over the coming decades and, without better investment in the sector, little chance of finding them.

Yet through the course of our work, we have found examples of where home care works incredibly well. It is a lifeline to many people. Sometimes home care is managed well with small teams of people supporting clients.

Many home care workers are exactly the kind of people you would want looking after you in a crisis. They are genuinely caring and dedicated. When they are skilled and compassionate, well managed, well paid and well supported they are the key to high quality care. The recommendations we make in this report aim to make this the norm.

Without a properly functioning home care system, we will be leaving hundreds of thousands of people without the support they need. We will simply spend more money on hospitalisation and residential care instead. The system needs radical reform and it also needs more investment. With a rapidly increasing older population the need to make care a career of choice has never been greater.

The political and financial reality is that it will take time to make all the changes we would like to see, but there are things that can – and should – be done now to make home care work better for everyone.

¹ *National Minimum Data Set for Social Care: Briefing 12, Skills for Care, July 2010*

Diary of a Home Care Worker: a first hand account

Well, it was a struggle to get out of bed today, day 15 without a break. I have to work extra to be able to afford essential repairs to my car, without the car I am limited in the amount of work I can do and areas would need to be restricted meaning less money to live on. Yet there is no petrol allowance or consideration to the increase in my insurance.

My first call today is to assist a lady out of bed; it's a two-person call as she is very disabled. When I arrived there was an awful smell, I then noticed that her commode had not been emptied the night before and had been placed right next to her bed, how she managed to sleep is a wonder! We have one hour to assist but once she is safely seated I left the other carer to assist with her breakfast and tidying up, as my next call often takes much more time than is allocated.

Mrs M is fast asleep when I arrive. She likes a lie in but they regularly give her a gam call so that we are able to fit more people in. I offer her a drink to entice her to get up. This alone can take 20 mins but today I'm lucky, 10 minutes and she is ready to go into bathroom. Mrs M has difficulty with her bowels so I leave her alone to use the toilet. Fifteen minutes later she is ready to get washed. As this is a half hour call I am left with five minutes to get her washed, dressed, meds prompted and make her breakfast. I have reported my concerns but social services say this is an adequate time scale - I disagree! I would never leave a client because their time has elapsed so I carry out all tasks as required - if a little rushed and leave 20 minutes late.

Luckily my next client lives with a family member but as it is several miles away I arrive almost half an hour late. Today is her trip to the daycentre so her family have given

of working in care in the North East of England

her breakfast and started to get her dressed. As most of the work was carried out before I arrived I have condensed a 45-minute call into 20 minutes, giving me time to get to my next call a simple medication prompt which is only a 15-minute slot.

Mrs R has dementia and often requires more assistance than is currently in place. I offer her breakfast and a cup of tea and check the house is safe. She has no family nearby and suffers from agoraphobia so the three calls a day she receives are her only social contact. I make an effort to sit and chat while she has her breakfast. Reading through her file I notice that yesterday evening the carer was here for only 10 minutes.

As we are very short staffed in a different area I have been given some new calls to cover 15 miles away. This trip alone takes 25 minutes. So far today I have spent one hour travelling and it's only lunchtime. That's one hour of my day at work that I don't get paid for! I am running behind so after preparing a microwave meal and a cup of tea for the service user I run out without having time to have a conversation. It makes me feel so guilty but there is always someone else waiting.

By the time I arrive at my next call it is 1:45pm and the lady is very unhappy at my time keeping. I apologise and explain how far I have come but she is very angry with me. I can feel my head pounding knowing that I am going to be late for a sit I have to do next. I sit with the lady while her daughter goes shopping but as I am half an hour late she will come back half an hour later, which means I have childcare issues. Again! I phone around and get my 76-year old neighbour to agree to sit with my children so that my husband can go to work. It's nice to get home and see the kids - they were in bed when I left, but I haven't seen my husband at all.

Section 1: Life as a home care worker



What is it like working in home care? What are their wages, terms and conditions?

The care worker's story of a day in her working life on the previous spread is typical of many home care workers. (You can read about the rest of her week in *A Care Worker's Diary* on the LGiU website.)²

Her day is focused on rushing from place to place. Tasks are prescribed and sometimes there is not enough time to do the work she has been asked to do, never mind to the standard she knows her clients need. There certainly is not the time to provide the companionship she knows they need. On this day, the only 15-minute care slot she has is for a medication prompt, but she still feels harried and guilty when she cannot provide the human touch that care work should be about because call times are too short.

Most council-funded home care is delivered to people with complex and critical needs. She is dealing with people with serious issues such as dementia, where rushing can make care uncaring, but rush she must. Where she can, she gives extra time, but this extra time is unpaid or 'stolen' from other care recipients.

Although she is familiar with most of the people she sees and can provide continuity of care, some of her time is spent covering areas where the company she works for is

short staffed. This means that she is unlikely to have seen these people before and may never see them again. She becomes part of the parade of unfamiliar workers who may come into someone's bedroom and bathroom and take care of their intimate personal care needs. Some care recipients have reported having 50 different care workers in their home over a year.

Paying care workers the minimum wage

The impact on individuals as well as their care workers should be sufficient reason to look at how we deliver care. But to make matters worse, most care workers are not only not paid a living wage to look after the most vulnerable adults in our society, but in many cases they are not even paid the minimum wage.

It is estimated that somewhere between 160,000 and 220,000³ care workers are paid less than the minimum wage. HMRC's investigation of minimum wage compliance in the residential and home care sector⁴ between 2011 and 2013 found non-compliance in just under half of the cases they investigated in adult social care and that this was a worsening trend. The employment practices that can lead to non-

² *A Care Worker's Diary*, LGiU, May 2014

³ *Combining knowledge to estimate the percentage of care workers paid under the national minimum wage in the UK: a Bayesian approach*, Dr Sheereen Hussein, Social Care Workforce Periodical, Issue 16, Dec 2011

⁴ *National Minimum Wage in the Care Sector 2012/13*, HMRC, November 2013

payment of the minimum wage appear to be common practice among the industry's 17,000 providers.⁵

Care workers are not paid less than £6.50 an hour⁶ – the minimum wage at October 2014 – as their 'advertised' hourly rate. Their *nominal* wage will be at least the legal minimum. It is their 'effective' wage that can sometimes be less than the minimum legal requirement. Care workers are often only paid for contact time – the time they spend with individuals in their homes. Each different client is treated as the start and end of the paid working time; travel between homes often is not paid for.

This means that where there is significant travel time between appointments, particularly in relation to the amount of paid for contact time, care workers' 'effective' wage can be less than the minimum wage. This is illegal. To make matters worse, it is also common practice for compassionate care workers to give a little extra time to their clients when care slots seem inadequate. While this is the kind of person we would want to look after an aged parent, this puts their effective hourly wage further at risk. It is not illegal for employers not to pay them for this extra time, but this compounds the financial burden on care workers.

Minimum wage enforcement is not good enough. These cases are complex and rely on lengthy documentary analysis in a sector where HMRC has complained that the documentation is often poor. Even where it is clear there may be non-compliance it is not straightforward to calculate the level of arrears.

Proactive investigations have revealed non-payment, but investigations are usually

triggered by a complaint. The HMRC requires a named individual to make a complaint.

For an individual care worker on a zero-hours contract – meaning no guaranteed work – that is a daunting prospect. Third parties, such as trade unions, law centres and Citizens Advice Bureaux should be able to report a breach of the minimum wage law on behalf of someone else without having a named complainant. If the documentary evidence indicates a high likelihood of non-payment these complaints should lead to a formal investigation by HMRC officials.

Some reports already come via unions with a named complainant, but Unison has reported to the Commission that they are encouraged to informally settle the dispute with the employer. While this is often the very best outcome for an individual, it does not address the wider problem of employment practices that lead to non-payment of the legal minimum requirement or wider industry practices.

Expenses and other shoddy practices

Owing to the to non-payment of travel time, care workers are often paying to get to their clients out of their own pockets. They are required to have a means of transport to work – which usually means a car outside of dense metropolitan areas, but there is often no or inadequate recompense for travel expenses.

Care workers already on limited wages and zero-hours contracts have little predictability of income or future work, so it may be hard to budget ahead for the expense of getting

⁵ Including residential care

⁶ Some care workers are paid less than top rate of minimum wage if they fall under youth rates. Where workers have been found not to have been paid the correct wage, it was usually because employers failed to update wages quickly enough after someone's birthday or after the annual rate changes in October

to clients. In oral evidence submitted to the Commission by Helga Pile of Unison, one care provider is alleged to have charged £7 on advances of £20 for one week to allow care workers to fill their tanks to get to appointments – this equates to a 17,000% APR.

Care workers frequently have to pay for their own uniforms and for their own Disclosure and Barring Service (DBS) – the new form of Criminal Records Bureau checks – and they are often not paid for time they spend training, including induction training.

It is common practice to make prospective employees complete some of the training without pay as a condition of employment and this is not illegal – though good employers will reimburse staff after a period of employment. They also have to supply their own mobile phones and are often not recompensed for calls made in connection to their employment.

There are other examples of poor employment practice. Although care workers, as well as all health and social care workers, should be immunised against influenza⁷ through a work-placed programme as measure of personal, but more importantly patient and client protection, there is no way to monitor if this happens. The care client base is largely older people with complex care needs who are particularly vulnerable to winter flu which may lead to expensive hospitalisation and further care needs.

Care providers may encourage their workers to get a flu jab, but they will probably not pay for it. There is a strong case to be made for care workers receiving free flu jabs on the NHS as a preventative measure to protect care of older people.

The living wage

Care workers deserve a living wage. This is currently £9.15 an hour in London and £7.85 in the rest of the UK.⁸ Even where employers are paying a living wage or enhanced payments for experience, special care needs, overtime or weekend work, poor employment practice can erode the value of the wage.

Care workers who nominally earn a living wage could theoretically earn effectively less than the minimum wage if they suffered from some of the worst employment practices. So while the Commission supports a living wage for care workers, employers and commissioners need to ensure that they are receiving the living wage without the deductions, expenses and non-payment of travel time.

Submissions to the Commission discussed the interaction between the benefits system and low pay in this context. Ensuring care workers receive the living wage could draw many of them partially or entirely out of the benefits system: however, this would require more generous funding of social care in the first instance.

The United Kingdom Home Care Association (UKHCA), which represents home care providers, says that the hourly rate of pay required to allow payment of the living wage is £18.59 (and £21.33 for compliance with the London living wage) while, according to recent research, the average minimum rate of pay per hour is just £12.26.⁹

The Department of Health has said that local authorities should have evidence that their contracting does not compromise a provider's ability to pay the national minimum

7 Letter from Department of Health, Public Health England and NHS urging all health and social care workers to be vaccinated against influenza, September 2014

8 The living wage is based on UK and London cost of living and is calculated annually by the Living Wage Foundation

9 Councils in England 'pay too little for home care', BBC, 4 Feb 2014

wage and the same must apply to the living wage.¹⁰ Commissioners may specify the need to pay the living wage when contracting out these services, but with such low hourly rates these statements remain hollow.

According to the Health and Social Care Information Centre, the average hourly cost for home help provided by third party providers in England in 2013/14 was £15.50. Just over 170 million hours of help were provided by these organisations.¹¹

With this in mind, it would cost an indicative £529m for those hours to be paid at the UKHCA's living wage rate across England.¹² While this is a large sum of money, it pales in comparison with the budgets spent by the government on health in this time (around £110bn).¹³

Zero-hours contracts

Zero-hours contracts are employment contracts where there is an established relationship between employee and employer but there is no guarantee of work from day to day or week to week. It is estimated that around 60% of home care workers¹⁴ are on zero-hours contracts. They are attractive to care employers who, seeking to manage the uncertainty of cash flow in a framework contract, use them as a way of passing on their risk to the care worker on the front line.

There is a growing political consensus that the most exploitative zero-hours contracts – such as those which have an exclusivity clause meaning a worker cannot seek

employment elsewhere even if there is no work available with their primary employer – should be banned. But this would not remove all of the pernicious effects that these contracts can have. Workers who are on zero-hours contracts have little predictability of work and income – and this has a tremendously destabilising impact on people's personal and financial lives.

In some cases, workers prefer zero-hours contracts because of their own personal commitments, some of which may be equally unpredictable caring commitments. In these circumstances, the flexibility of a zero-hour contract can be helpful; however, in other cases, the lack of income predictability is keeping people who could work more on benefits.

Unsure if they would always have sufficient hours to qualify for working tax credit, they prefer to ensure that they stay below the 16 hours of employment that is the maximum for income support. Either way, the government is subsidising providers to pay care workers less than they could reasonably live on.

Perhaps the worst effect of zero-hours contracts is that they put workers in the position where they have little power to complain about poor working practices by employers or by their colleagues. It is simply too easy to cut someone's hours back.

Care workers should have the choice of a zero-hour contract, but the most exploitative examples of these contracts must be challenged.

10 DoH's *Response to the consultation on draft regulations and guidance for implementation of Part 1 of the Care Act 2014*

11 *Personal Social Services: Expenditure and Unit Costs, England – 2013-14, Provisional Release*, Health and Social Care Information Centre

12 Figure calculated by multiplying the difference between the average rate of £15.50 and the UKHCA's recommended living wage figure of £18.59 (£3.09) by the number of commissioned hours (171,198,715). The figure is £529,004,029.35

13 Department of Health Corporate Plan, 2013 to 2014

14 *The Future Care Workforce*, International Longevity Centre, February 2014

Why are care workers treated so badly?

There are many reasons why care workers are treated badly. We have traditionally undervalued the work of women and care work is by and large undertaken by women whether it is paid or unpaid – 80% of the employed care workforce is female.¹⁵

It may also be because, as a society, we often seem to undervalue the people that they work with – older people and those with a disability. But beyond larger cultural and societal issues that cannot easily be solved by a policy recommendation, care workers are treated badly and paid badly because it does not pay to treat them any better.

The UKHCA estimates that providers need to be paid £15.74¹⁶ per contact hour to pay care workers the minimum wage, including on-costs, overheads, travel time and enough of a return on investment to keep them in business. Few councils pay this rate.

A BBC investigation for *File on Four* found that only four in 101 councils approached paid at least this amount; the average payment was £12.26.¹⁷ This does not excuse failure to abide by the law. But when providers are commissioned by time and task and paid by contact hour and are not getting enough to cover the time between visits, they pass some of the shortfall on to the care workers themselves.

Councils also often rely on framework contracts that give little predictability of work

and revenue to care providers. Care is demand led, but more predictability in revenue would give care providers the security to have more care workers on fixed hours contracts or on variable hours contracts that include an agreed set of hours with the possibility of more work. In an increasingly volatile care market, many providers are going bust, or exiting the marketplace to focus on private clients.

Councils have a duty of care to social care clients and to the people who look after them. Councils should insist on open-book accounting with their providers to ensure that they can check that care workers are being paid *at least* the minimum wage and ideally a living wage. But if councils do not actually follow up or providers do not have clear records, there is little benefit to this approach.

Care workers deserve better

Care workers deserve better. They are the care sector's biggest asset, but this is rarely reflected in their pay and conditions. Paying a living wage to care workers has recently been the subject of debate in the sector with the report of the Demos Commission on Residential Care, which recommended that the sector become a living wage sector.¹⁸

That living wage should be a real one and not eroded by illegal and poor practices like non-payment of travel time or failure to cover basic expenses required to carry out one's job. Employers must do their part, but councils that commission services from care providers must also ensure that they do.

15 *The Future Care Workforce*, International Longevity Centre, February 2014

It should be noted that care providers who submitted evidence to the Commission did not recognise the £15.50 figure and stated that the majority of care contracts they saw tendered fell below the £13 per hour mark

16 *A Minimum Price for Homecare*, UK Home Care Association, Version 2.1, November 2014

17 Councils in England 'pay too little for home care': BBC, 4 Feb 2014

18 *A Vision of Care Fit for the 21st Century: the Commission on Residential Care (CORC)*, Demos, September 2014

Under no circumstances should care workers be paid less than the minimum wage. It is shocking to have to make a recommendation like this, but it must be made.

- HMRC must be more vigorous and consistent in its enforcement of the minimum wage and must make it easier for care workers to complain through a third party, such as a union, citizen's advice bureau or legal clinic.
- Councils must pay providers enough to cover *at least* the minimum wage. The UKHCA puts this at £15.74 an hour; however, if a council does not accept this figure it must provide an alternative model and be able to justify its decision. Councils should consider requiring Health and Wellbeing Board sign-off for any commissioning process that goes below the recommended rate.
- Health and Wellbeing Boards should take an oversight role in this matter, as good quality home care is key to health and social care integration and preventative care.
- Care providers must operate an open-book approach to their payment of care workers, including clear information about their profit

margins. Councils should inspect this as a matter of good practice.

- Councils should also be transparent about how their hourly rate is calculated.

In other matters, too, we must recognise the importance of care workers and their clients by providing for basic health protection. Care workers should get free influenza immunisation on the NHS and this should be routinely monitored and reported.

We must also value care workers more. These people are the key to care and they should be recognised as such by having key worker status.

This would help the care workforce have access to improved housing by giving them access to the HomeBuy scheme and in some areas assistance with rented accommodation. Even if this were a largely symbolic gesture in the first instance, it would be an important first step in demonstrating how much we value their work and contribution.

While this status is normally available only to public sector workers, we feel that serious consideration should be given to extending it beyond councils to those working for providers commissioned by these authorities.

Section 2: A profile of home care



How do people access home care? How does it work? Who does it? Who gets it and who pays for it? And what is the future demand of home care?

How home care works

Care at home or domiciliary care provides help for people to live at home. Home care can be a mix of services that help people live more independently. Care might include activities like help getting out of bed and dressing in the morning or the reverse at night. There might be help providing meals or reminding people to take medication. Home care often includes intimate personal care, such as help bathing or using the toilet.

Generally speaking, home care is not meant to include health care, but there may be help with changing dressings or some care that can also be offered in a clinical care setting. Increasingly, though, home care workers are being expected to carry out some 'clinical' assistance and, as there is a continued push for further health and social care integration, this will become more common.

Care is usually delivered in accordance with a care plan that is drawn up by an assessment team according to specific criteria. A care plan should take account of the support that individuals feel would help them live independently and with specific outcomes focused around an individual's aspirations. In practice, care plans focus on

contact hours and specific tasks that need to be undertaken – such as help with dressing or bathing with allotted times to complete those tasks. This is called time and task commissioning.

Getting help at home

Over a half million people in England receive some paid-for care at home. A small proportion of people pay for their own care (about 12%¹⁹) but this is probably an underestimate, as some people will be paying for cleaners, housekeepers and other domestic assistance that provide some of the support that home care can provide. Some people purchase care through the direct payments they receive from local authorities to help them live independently, but most home care is purchased through local authorities – for all adult social care managed by councils that is about £19bn a year.²⁰

If someone has social care needs and wants support from the local authority, they or their carer would contact their local authority for a social care assessment.²¹ Many councils undertake screening to help divert people away from an assessment if they are unlikely to qualify for assistance based on need or financial criteria.

19 *Adult Social Care in England: An Overview*, National Audit Office, March 2014

20 *ibid*

21 The same process applies for all care needs regardless of the package of support eventually offered

In recent years, threshold criteria have been narrowed by many councils, which means that fewer people are eligible for local authority funded care.

The Care Act 2014, Part One of which will be implemented in April 2015, clarifies the assessment and care planning process.²² Assessment must be undertaken for all people who appear to need care and support, regardless of their finances or whether the local authority thinks their needs will be eligible. Local authorities will also be required to give people advice and information about what support is available in the community.

The assessment will determine whether or not the person's needs meet the eligibility threshold and whether they have 'eligible needs' for care and support. From April 2015 there will be a national minimum eligibility threshold. This is intended to be broadly similar to the 'substantial' threshold currently used by most local authorities.

If a person has eligible needs, and wants the local authority's help to meet them, the authority will co-produce a care and support plan with them. For those entitled to financial support from the local authority, part of the plan will be a personal budget which sets out the costs of meeting their needs. Most people will be able, if they wish, to receive the personal budget as a direct payment, which they spend on their care and support, perhaps through employing personal assistants. If an individual is not eligible for financial support from the local authority they will be given an 'independent personal budget' which will show what the authority would pay for the care and support if it were meeting their needs.

Local authorities have a responsibility to review care and support plans to ensure

they continue to meet people's needs and outcomes. Under the Care Act, they are expected to carry out a review no later than every 12 months, with a 'light-touch' review recommended six to eight weeks after the care and support plan is implemented.

Some people will be eligible for intermediate care, a range of short-term services offered by the NHS and/or local authorities to help people recover their abilities after hospital discharge, or to prevent admission to hospital or care homes. Intermediate care services, such as reablement, are usually offered free for up to six weeks.

Some people will be eligible for NHS continuing healthcare, which is provided free by the NHS. To be eligible an individual must be assessed as having a 'primary health need' and have a complex medical condition and substantial and ongoing care needs. Continuing care can be hard to obtain and future funding for a wider range of care has been the subject of much interest; most recently from the Barker Review which recommended increased funding for chronic conditions such as dementia which are not usually eligible for continuing care,²³ but which are often associated with high care needs.

Who does home care?

There are about 685,000 home care workers in England. They are predominantly female – about 80%. Just over half of them (53%) are part time. They are diverse, just under 18% of staff are black or minority ethnic. They are older, with a slightly higher proportion of staff among older age groups (particularly ages 44-59) than the labour market as a whole.²⁴

'Informal' care

The vast majority of care is provided by 'informal' carers – such as spouses, relatives

22 *Care Act 2014, Statutory Guidance for Implementation*, Department of Health, October 2014

23 *The Commission on the Future of Health and Social Care*, King's Fund, September 2014

24 *The Future Care Workforce*, International Longevity Centre, February 2014



Sources:
NAO *Overview of Adult Social Care*, *The Kingsmill Review: Taking Care and The Future Care Workforce*

Care workers: the key facts

and friends. It is hard to know exactly what the value of that care is, but it has been estimated at £55bn a year.²⁵

Family, friends and neighbours have always played an important role in caring and they will continue to do so in even greater numbers. As our population ages, the gap between what can be provided by councils and demand for their services will grow. We need to acknowledge better the contribution that these carers make to our society and there are already some benefits for those who must give up work to care for loved ones. In 2013, the then Care Minister Paul Burstow, MP, commissioned a task and

finish group on carers and employment involving Employers for Carers and six UK government departments, including the Treasury and Work and Pensions.²⁶ It marked an important recognition by government of the value to the economy of personal and household services, including home care.

But we must also acknowledge the gap that they leave in our economy, particularly those who have dual caring responsibilities – for children and parents. We acknowledge that parents need help – there are working tax credits, childcare tax credits and salary sacrifice for childcare vouchers. There is

²⁵ *Adult Social Care in England: An Overview*, National Audit Office, March 2014

²⁶ *Supporting Working Carers: The Benefits to Families, Business and the Economy – The Final Report of the Carers in Work Task and Finish Group*, Department of Health, August 2013

evidence to suggest that working families tax credits have increased labour market participation.²⁷

The Department of Work and Pensions should investigate if a carer's tax credit, a care tax credit or a salary sacrifice scheme could have a similar impact on those with caring responsibilities, by giving them greater incentives and support to remain in work and help pay for formal care when they cannot be there. And, as many of the people in the care workforce also have caring responsibilities, many of them would benefit directly.

The care shortfall

The number of people who are over 85 is rising faster than any other segment of the population. This is the group of people who are most likely to need some sort of daily assistance to carry out 'normal' activities. They need care.

In spite of a growing need for care, less money has been spent on care each year since 2008/2009. In a time of widespread local government cuts, adult social care spending has fallen less than most other services (except children's services), but there has still been a reduction of about 7.5%. Most of these cuts have affected older adults, as services to working-age adults have only been reduced by about 0.2%.

This is likely to get worse. Cuts to adult social services now represent 52% of planned budget reductions according to the Audit Commission,²⁸ but adult social care already represents more than a third of 'upper tier' council spending.

During that time, in spite of initial enquiries to councils going up, fewer of those contacts are leading to assessments and fewer still of those are leading to a care package being offered to a new service user. Partly this is because thresholds have narrowed to the point that only those with the greatest care needs are offered support. The vast majority (87%) of over-65s live in areas that provide support only for substantial and critical care needs and 1% live in areas where only critical care needs are supported. The result is that 30% of women and 22% of men over the age of 65 who need help carrying out daily activities do not get that support and 43% of those over age 85 need help but are not getting it.³⁰

Rising eligibility criteria have seen many thousands of disabled and older people lose access to care and support. From April 2015, the Care Act will introduce a national minimum eligibility criteria. It will be set at the equivalent of the current 'substantial' level. Currently 19 councils still have a minimum threshold below this level, but the national criteria should prevent thresholds from being further tightened in most councils.

A 'moderate' eligibility criteria has been shown to have a positive economic impact among working age adults with moderate care needs.³¹ Some have argued that setting eligibility at the equivalent of 'moderate' and funding this appropriately would help to ensure that disabled and older people can access the support they need to live independently and ensure that their care needs do not escalate over the longer term. Further research needs to be undertaken to quantify these savings, particularly in terms

27 *The Effect of Working Families' Tax Credit on Labour Market Participation*, Institute for Fiscal Studies. Briefing Note 69, February 2006

28 *Tough times*, Audit Commission, 2013

29 *Adult Social Care in England: An Overview*, National Audit Office March, 2014

30 *ibid*

31 *Economic Impact of social care services. Assessment of the outcomes for disabled adults with moderate care needs*, Scope and Deloitte, 2013

of the savings for the NHS such as avoidable admissions.

There is simply not enough money in the current system to provide care to everyone who needs it. So inevitably the profile of care is shifting to more complex cases where individuals have a high level of multiple needs. Correspondingly, we should be ensuring the profile of the care workforce takes account of rising need, but there is little evidence of this.

Continuity of care is a necessity for those with complex needs, but there can be little continuity in an industry where there is a just over 20% annual turnover rate in staff. This is over twice the average across all industries. Turnover in social care is a matter of life and death.

The Care Quality Commission (CQC)³² found a statistical link between care homes with increased rates of staff turnover and notifications of death. It is reasonable to assume that high staff turnover impacts on care outcomes in home and community care.

Even if the impact was not that stark, care recipients tell us time and time again that they do not like having lots of different care

workers in their homes or performing intimate care.

Not only is there a high turnover, but providers and their representatives have told the Commission that there are recruitment difficulties in many areas of the country. Moreover, as complexity of need rises and there is further push to integrate health and social care, there is a greater need for care workers with sufficient skills.

Angeleça Silversides, who is working with the Royal Borough of Kensington and Chelsea, reported particular difficulties in London in obtaining staff with sufficient skills to undertake integrated care.

But even at current skills levels, there is likely to be a shortage of care workers. According to the International Longevity Centre,³³ if we continue to support current levels of need, with rising demand we will need an additional 765,000 care workers by 2025.

Dr Shereen Hussein, an expert in social care demography at King's College London, told the Commission that she was not optimistic about this demand being met unless there were significant changes in the way that social care was organised and care workers were recruited and retained.

Working carer tax credits and care credits

People with caring responsibilities should have help to contribute to the economy through employment. The Department for Work and Pensions should investigate tax credits for those with caring responsibilities in line with payments for working families to support those with children working outside the home. This should be part of a broader investigation into how care work is subsidised by the benefits system.

32 The 2013 Annual Report from the Care Quality Commission (CQC),

33 *The Future Care Workforce*, International Longevity Centre, UK, February 2014

Section 3: Commissioning care



How do councils commission care for adults? What are the key drawbacks of the current approach? What do councils need to do to commission care better?

The vast majority of home care, about 70%, is paid for by local authorities. Very little of that is provided directly by council staff. Many councils still retain their reablement services in-house, but the vast majority of home care services are commissioned to care providers. Care providers are given a care plan to fulfil and this is almost always a series of tasks with specific times to complete those tasks. In *Outcomes Matter*, the LGiU found that 90% of councils commission services this way.³⁴ This means that almost all the care that people receive in their own homes is regimented and prescribed.

Due to rising demands and shrinking funding, social care budgets have been under increasing pressure. This in turn, has put pressure on councils to find ways to save. While councils should be applauded for finding efficiencies in providing home care where this does not compromise quality and safety, methods such as reverse auctioning – getting providers to bid on care and choosing the lowest price to drive down the cost of care – are not an appropriate approach to lowering the cost of supporting people.

These methods have a profound effect on the quality of care that is delivered and on the quality of people's working lives. The

people who are working most closely with those who need care are care workers and their managers – the care providers. They can see the daily impact of care provision, but have no discretion to change or modify tasks or alter the contact time that someone needs – or even adjust it over the period of a week or a month. Like everyone, care recipients have good weeks and bad weeks, sometimes they need a little more help, sometimes a little less.

Care commissioning on a low-cost, time and task model also impacts on the market for care. Under the Care Act, local authorities have an explicit duty to shape care markets by working with a variety of care providers to make care services available whether they are paid for by the local authority or not.

However, some councils have reported to us that they are having increasing difficulty finding care providers that are willing to provide care. This is particularly a problem in rural areas where travel between appointments may be long and providers must either cut into meagre margins to pay travel time or find ways to give their workers short shifts.

Time and task commissioning also ignores the 'sociability' needs of home care recipients. We know that loneliness can be

³⁴ *Outcomes Matter: Effective Commissioning in Domiciliary Care*, LGiU, October 2012

just as strong a predictor of poor health³⁵ outcomes as smoking, obesity or lack of exercise, but our current model of care gives little time for care workers to provide that human touch.

More importantly, it gives little flexibility for care workers to reach out to neighbours or lapsed social connections such as clubs, friends and churches and to help clients get that vital human connection needed for good physical and mental health and quality independent living. Statutory guidance for the Care Act 2014³⁶ stresses the importance of maintaining significant relationships as part of an adult's wellbeing both in terms of assessing and meeting needs.

The care worker's story at the end of this report emphasises how she felt sociability was an important part of her job, but not one she could carry out under time and task approaches. The Commission would encourage routine monitoring and supporting of how care supports meeting the broader wellbeing needs outlined by the Care Act guidance.

Time and task commissioning can also lead to the some of the worst care practices, such as 15-minute care slots and call cramming – where appointments are scheduled so close together that care workers must either choose to cut one visit short or arrive late to the next one. The Department of Health has stated that, in addition to Care Act Guidance, these “very short home care visits are not normally appropriate”.³⁷

Providers compete fiercely on individual cases and they compete on cost per contact hour, not on the creativity of solutions, outcomes or the quality of their staff. Worst of all, there is little incentive for improvement

or change in the delivery of care once a client has been secured.

No one would have designed commissioning to achieve the state of care we have now, but incremental changes to drive down price and the need to be able to monitor care contracts has meant that the time and task commissioning is where we have ended up. We need to be able to reduce the overall costs of contracts, the overall costs of care of individuals, but there simply is no further room to reduce the cost of hourly contact. The current framework contracts with time and task care plans only incentivise the latter.

Much harder to do, but more rewarding, is outcome based commissioning which is focused on planning and choosing a set of measurable outcomes with the person who needs care (or in some cases, their families). Working with providers and care workers, tasks should follow outcomes and they should be decided by the people who are working most closely on a day-to-day basis with care workers. *Outcomes Matter* also found that most councils believe that outcome-based commissioning provides a brighter, better future for care – but it remains elusive.

A partnership approach with providers means that assessments can focus on outcomes for individuals. Some people who need care will get better, some will not. Some will need less care going forward, some will need more.

The current assessment system, with limited re-assessment, does not adequately take into account this very human pattern of care. Outcomes-based approaches, where councils work with providers, could focus on overall costs of care. If it costs a certain

35 *Rewarding Social Connections Promote Successful Aging*, John T Cacioppo, University of Chicago, February 2014

36 *Care Act 2014, Statutory Guidance for Implementation*, Department of Health, October 2014

37 *Department of Health Response to the consultation on draft regulations and guidance for implementation of Part 1 of the Care Act 2014*

amount to look after Mrs M this year, how can creative solutions designed by a team of care workers help reduce her care needs and care costs next year? If Mr R has a degenerative condition, how can we put care in place to prevent his costs rising significantly?

Through the further integration of health and social care we have much greater opportunity to take account of people's physical and social needs. There is a clear opportunity to provide a demonstrable model of the savings that home care can achieve by reducing re-admissions and avoiding or delaying unnecessary hospitalisation or residential care placements.

We need to develop a more thorough understanding of the preventative value of combined budgets. The Better Care Fund would be one way to do this, particularly modelling high-level outcomes such as reduced re-admissions to hospital.

A greater emphasis should also be placed on high quality accessible housing in an integrated local service. Without an adequate stock of adapted or adaptable homes we are missing an important part of the solution to better supported independent living. Again, investment in housing will reduce avoidable calls on acute services.

An officer at a London borough who has had responsibilities in both health and social care integration and care commissioning told the Commission:

“Better care at home might cost more per hour; but it costs less per person. Spending more in home care is paid for with savings in bed-based care: in hospitals and care homes. Person-for-person, those kinds of care are more expensive. Too often we use them when the quality of care at home isn't good enough. The direction of health policy is towards out-of-hospital care, in which more people with more acute and more complex needs will have their needs met at

home. So the question of funding investment in home care depends on what the local authority and the CCG are paying elsewhere in the health and care system for worse outcomes.”

It can be done. Some councils, such as Wiltshire Council, are already working to deliver outcomes-based commissioning. The story of the care worker from Wiltshire, whose account features at the end of this report, is a stark contrast to the care worker's diary at the beginning. She has the time to give the human touch. She and her colleagues are able to share information and plan for changing care needs. Anecdotally, their results are better.

More work needs to be done to assess the improved outcomes and potential savings of this approach and councils need to share their learning. There will be many different ways that this can be done, but councils need to consider in particular:

- a focus on individual outcomes
- supporting continuity and consistency of care
- a flexible approach based on changing needs, including reassessment and changing care plans
- specialist skills in assessment and care delivery to meet needs
- a diversity of service for all those needing care, including self-funders and those with personal budgets
- a well-trained, well-compensated workforce
- how many providers councils can have meaningful partnerships with
- organising contracts around geography or specialist need

- prevention of escalating need and avoiding costly interventions like residential care and hospitalisation where it is unnecessary
- information sharing between care workers and GPs, social workers and families
- monitoring and oversight by Health and Wellbeing Boards
- space for innovation and experimenting with new ways of working
- use of technology that supports relationships and information sharing between teams of care workers, care recipients, families and other professionals
- sharing good practice with other councils
- incorporating formal and informal feedback from care recipients and care workers to contract monitoring and market shaping.

Many councils are already locked into their current home care contracts, but those who are nearing the end of contracts must act boldly to move away from the time and task approach. Indeed, the guidance issued by the government in support of the Care Act 2014 throws down a clear challenge to commissioners to change.

We know that time and task simply is not working for care users, care workers, providers or councils in meeting their objectives.³⁸

Moving away from time and task commissioning

Councils should be moving away from time and task commissioning and toward outcomes-based commissioning. Although this is an approach still in development, councils need to work together to develop new approaches to person centred care and partnerships with providers. They should look at methods of making savings across the contract as a whole, rather than seeking to make efficiencies by driving down the hourly rate of pay. Councils should also be monitoring how well care plans and implementation are complying with Care Act guidance around wellbeing. The Care Quality Commission should undertake a thematic review of home care and compliance with this guidance.

Better oversight of existing contracts

Councils need to be more proactive in ensuring that their use of existing framework contracts is not contributing to the worst practices in home care, such as 15-minute care slots. In reviewing their contracts, councils should consider the impact of their commissioning approaches on the market and specifically whether framework contracts are creating fragmentation. Health and Wellbeing Boards should take an active oversight role concerning how care commissioning supports local objectives for preventative spending on care.

³⁸ The Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) have recently published *Commissioning for Better Outcomes – a Route Map*. This work has been funded by the Department of Health and was led by a team from the Health Services Management Centre at the Birmingham University

Section 4: A career of esteem: licensing, learning and development



How are care workers trained and regulated? How does current practice impact on the future of care and the workforce? What can we do to develop care work into a career of esteem?

Being a good care worker requires compassion, empathy and patience. Good care workers truly care about the people that they look after. There are many client management and practical skills needed to provide good care.

As eligibility thresholds are raised – meaning that people who do receive care have more complex needs – there are many technical and quasi-clinical skills that are also required. Ensuring that someone with, say dementia and perhaps a physical disability, receives adequate nutrition, proper medication and feels safe and secure and cared for may be described as basic care, but cannot be done well with a basic set of skills and some cursory training.

While it takes a lot to be a good care worker, it does not take much to join the workforce. All a prospective care worker needs is a means of transport, a means of contact and a criminal records check. There is an aspiration to pursue ‘values-based’ recruitment³⁹ – because in much care work the right attitude and kindness are more important than qualifications. This is not easy work, so people who want to care for others are considered less likely to move on quickly. But the reality of a high turnover, high demand but low paid recruitment

market means that values often cannot be recruited for.

Even if a care worker was found to be too unskilled or too uncaring to continue working with a company there is little to stop them from seeking work with another care provider. Treating all care workers the same in terms of pay or accreditation devalues the fantastic care and skill of the many very good care workers

The recruitment pool and indeed many of the workers are shared between domiciliary care and residential care. The residential care sector has seen a number of scandals in terms of poor treatment of residents – the Old Deanery and Oban House, for example, were exposed in stings. Although there are a number of systemic failings unique to care homes that can lead to patient abuse, poorly recruited and poorly trained staff is part of the problem.

If there has not been the level of scandal in the domiciliary care sector, it may be partly because care workers often work alone in the privacy of people’s homes. There is naturally less supervision and opportunity for oversight in someone’s home. Since most care visits are undertaken by a single worker, there is also less chance that dedicated care workers

³⁹ *Recruiting for Values in Adult Social Care*, The National Skills Academy

can see abuse by their colleagues and either complain to responsible management or blow the whistle.

The CQC regulates social care services, including care in the home. Home care providers as well as home care managers need to be registered with the CQC. The CQC published a review of home care⁴⁰ and expressed concern about the levels of care worker awareness of whistle-blowing and safeguarding procedures and the quality of monitoring care plans.

Confidential submissions to this Commission suggest that care workers' concerns about substandard care delivered by colleagues have been dismissed or, if on a zero-hours contract, they feel threatened with getting fewer hours if they are seen as 'troublemakers'.

The Equality and Human Rights Commission (EHRC) carried out a review of home care and found that the low pay and status of care workers, coupled with high workforce turnover rates, was a significant factor exacerbating threats to the human rights of older people.⁴¹ In a follow-up review of the recommendations,⁴² most councils said that they had taken some action to review commissioning practices to assess whether they were 'conducive to ensuring a well skilled and supportive care workforce'. However, the EHRC was not convinced that local authorities had been able to make significant improvements.

Regulation of care workers

Hairdressers are licensed. Child minders are licensed. Bouncers are licensed. And

although care providers are registered, care workers are not. While licensing and registration should not be seen as a panacea to the problems of the home care workforce, it could help promote care as work of esteem and quality.

Following events in Mid-Staffordshire, there has rightly been a focus on the quality of care rather than just the quality of clinical skill. The Francis Enquiry recommended a set of national standards for healthcare assistants – who are in some ways the NHS equivalent of care workers. Indeed, *The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings*⁴³ which followed the enquiry considered both roles and recommended a more joined up approach to the training of health care assistants and care workers.

The suitability scheme

These reviews also highlighted the need for registration of care workers. Both a voluntary system and a suitability scheme have been considered with government seeming to favour the suitability scheme as more effective. A suitability scheme would require adherence to a statutory code of conduct, which is currently being developed by Skills for Care. If someone violates this code of conduct, there would be procedures to add her or him to a list of people who are barred from working in adult social care. This would complement the existing DBS scheme, which does not incorporate care quality issues.

The Health and Care Professions Council (HCPC), which has responsibility for

40 *Not Just a Number: Review of Home Care Services*, Care Quality Commission, February 2013

41 *Close to Home: An inquiry into older people and human rights in home care*, Equalities and Human Rights Commission, November 2011

42 *Close to Home Recommendations Review*, Equalities and Human Rights Commission, October 2013

43 *The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings*, Department of Health, July 2013

licensing other health and social care professionals, has set out proposals⁴⁴ for how such a suitability scheme could work and how much it would cost (£3m to establish and £5-6m per annum to run) but has not been given the go-ahead.

This lack of a minimum regulatory regime for care professionals not otherwise licensed is unacceptable. A statutory code, with independent adjudication and a register must be the bare minimum in the sector and should be funded directly by government or by a levy on providers.

Comprehensive licensing

Many submissions to this Inquiry went a step further and called for individual licensing of care workers. This would establish a minimum level of training across the sector, leading to a licence to practise. This licence would recognise the skill, experience and dedication of care workers in the same way nurses and other health professionals are recognised and could be revoked in circumstances where care workers fail to provide appropriate standards of care.

A full licensing scheme would provide reassurance to council care commissioners that a provider with a licensed workforce would be able to undertake care that is not based on time and task. Under the current commissioning system, providers have little incentive to recruit more qualified care workers.

The time and task approach treats care workers like widgets and there are no

enhanced payments for a skilled care worker. Care workers themselves know that they are unlikely to be paid much, if any, more for seeking additional training and qualifications.⁴⁵ Licensing might give commissioners the confidence to let go of this highly-controlled approach to procuring services.

There are a number of reasons why licensing care workers individually is challenging. The care workforce is already underpaid and overburdened and the cost of individual licensing, when many care workers already have to pay for their own DBS costs,⁴⁶ could be an additional burden.

For example, the Ofsted registration for childminders costs £35, which is in addition to an enhanced DBS check of £44. And the fee of £35 does not represent the full cost of licensing, so there are additional costs to the taxpayer.

But perhaps the biggest barrier to individual registration is certification. Professional licensing relies on completion of accredited education or training and usually relies on accredited continuing professional development (CPD). So, in the childminding example, people have to complete accredited training and a first aid course before they can register.

There is no such required *and* accredited training for care assistants in adult social care. Once employed, care workers are required to be trained to the Common Induction Standards (CIS)⁴⁷ by their employers – whether they are new to the role or they have changed employers.⁴⁸

44 HCPC Proposal for regulating adult social care in England, updated November 2014

45 *The Kingsmill Review: Taking Care – An Independent Report into Working Conditions in the Care Sector*, Baroness Denise Kingsmill, CBE

46 It is common practice in other industries and in the voluntary sector to pay for DBS for employees or volunteers

47 *Common Induction Standards, Skills for Care*

48 Depending on other qualifications and previous completion, a care worker may not have to repeat all of the CIS on changing roles or employers

From Spring 2015, the CIS will be replaced by the Care Certificate. The Care Certificate is meant to be a more portable training, which would save money for providers but also reduce the burden of retraining on care workers who need to change employers.

However, the Care Certificate is still overseen by employers and there is no national registration system planned. Some providers have expressed concern that the Care Certificate will not be truly portable because they cannot be assured that the training will be delivered to acceptable standards. And because there will be no national register or accreditation, employers, regulators (such as the HCPC) and care workers themselves cannot use it as basic certification. This is a missed opportunity.

It is right that care workers should not have to bear the full burden of training and registration, but it is not right that people who look after some of our most vulnerable adults are unlicensed. In the long term, we would support further investigation into how a comprehensive licensing scheme might work in the care sector, without placing high barriers to entry.

One solution would be not to make licensing a requirement to start employment; instead care workers should be able to apply for a licence after a period of experience – say six months. The commissioning process could reflect the need for an experienced and skilled workforce by demanding a high proportion (70-80%) of licensed care workers in a provider's workforce and request licensed care workers for people with the most complex care needs.

Under the Care Act statutory guidance, councils should be supporting a market that includes a sufficiently skilled workforce.

Government should ask the HCPC and Skills for Care and Skills for Health to work together to develop a licensing and accredited certification system which

ensures that the people who look after adults with care needs are fit and proper people with the right skills to deal with complex care needs – including end-of-life care or dementia or learning disabilities.

In the meantime, we should press on with establishing a suitability register, based around a statutory code with independent adjudication. The government should take action to enact the suitability scheme proposed by the HCPC to provide additional safeguarding assurance without delay.

A career of esteem

Care work is a noble profession that many people would be unable or unwilling to do well. Good care workers are a lifeline to those for whom they care and a huge asset to the care system. But care workers often describe and sometimes see themselves as 'just care workers'. This is shameful, but understandable given the way that many are often underpaid, undertrained and undervalued.

However, entry-level care work and some basic care can be undertaken well by people with little formal skills or experience, but with the right values and personal characteristics. Some of those people end up leaving the profession because there is little chance for better pay or advancement.

People who already have 'informal' caring responsibilities – for their own children or for parents or spouses – and so have personal experience and the need for flexible work patterns can find that care work fits with their lives better than shift work or regular full-time work could do.

People who need the flexibility but have great caring skills and people who want to progress in their careers, both deserve to have career paths available to them within the caring professions that recognise the skills and experience they have gained as care workers.

Within home care work, the only real opportunity for advancement is to become a manager. There should be opportunities for specialism beyond the health and social care diplomas currently available. There should also be a path through to caring professions such as nursing or social work for those who want that – by taking account of care work in terms of required experience or pre-requisites for nursing or social work programmes.

Indeed, those programmes should consider care work rotations (in health or social care settings) as part of professional training.

Health care assistants already have some opportunity to have their experience credited and people in the social care sector should

have the same opportunities. As we move toward further integration between health and social care, training budgets and skills training should also be integrated.

This could also be an opportunity to develop apprenticeships in care work. This would help new entrants to the job market develop skills that could take them toward licensing, or qualifications that would help them enter other caring professions.

The fact that there is currently no such scheme reflects the lack of structure in the profession and the limited availability of career pathways. A more coherent programme of apprenticeships, as part of a clear career path, would support the status of care workers and cement the standing of care work as a career of choice.

A licence to practise

The government should take immediate steps to put in place the suitability scheme proposed by the Health and Care Professions Council in the form of a statutory code with independent adjudication and a register. In the longer term, licensing would support the professional status of care workers and provide greater reassurance to care commissioners. The government should investigate ways of implementing licensing for social care workers in the context of wider workplace learning and accredited training to ensure the new Care Certificate becomes a trusted and portable standard.

A training and career pathway for care workers

Care workers in both health and social care need minimum standards of training which can be developed into pathways of specialism or the basis for further training and entry into allied care professions such as nursing or social work. A more formalised career path would include apprenticeships alongside these clear career pathways.

Section 5: Design and technology in home care



How can design and technology help us improve care for the people who receive it and the people who deliver it? How can it help address the care shortfall?

If we set out, today, to design the kind of home care we would want for people who need care we would not end up with the system we have. The home care system has evolved over time from a well-intentioned home help system whereby recently widowed men might receive help with cooking the tea or washing up, to one which needs to provide complex care with, by-and-large, workers who are not much better trained.

It has changed from a system that was delivered largely by council employees, to one where services are procured, but decisions about care are being made by someone who is remote from delivering or receiving the care. We have largely ended up in this position because we have not really 'commissioned' home care.

One of the Commission's evidence sessions focused on design and home care and how technology can enable new approaches. Mat Hunter, Chief Design Officer at the Design Council, shared examples of how the design process starts with problems that need solving and works with users to understand the problems and develop solutions.

We heard from Paul Hodgkin, a former GP and the founder of PatientOpinion and CareOpinion, on the use of technology. He highlighted how feedback sites can provide a window into the quality of care and a lever for improvement. But his fundamental message was about the overlooked

opportunities for new technologies to help make connections around individuals.

There are already applications which can help family members who may be remote to help organise care for their loved ones. For example, RallyRound is an app which is already supported by some councils and CCGs. Other applications will be developed, but councils and care providers need to be a part of the conversation that is going on with and about care users and part of the design and development process.

Home care under time and task commissioning has struggled to integrate people's 'sociability' needs and the willingness of friends, family and neighbours to help. These wider conversations, assisted by digital technology, are a way that networks of support help people live not independently, but interdependently, at home.

Emma Gasson, lead Service Designer at FutureGov, a design and technology company working with local authorities primarily in areas of social care, talked about how their work has focused on establishing connections between professionals and communities. FutureGov's Casserole Club started from design principles and the need to find a more cost-effective and better way to do meals on wheels by supporting people with food and social connections. But feedback from the people who do the supporting indicates that they feel that they

have gained most from the programme as they feel a greater connection with their communities and have gained from the relationships they have established with the people they are helping. As a society, if we are to have any chance of bridging the care gap, we need to find more ways like this to create supportive connections.

A common objection to using mobile technology is that care workers do not have smart phones or might not be able to use them effectively. Recent research by Skills for Care⁴⁹ showed around 74% of surveyed staff had access to a smart phone, which is similar to the general population.

Perhaps more importantly, while only 52% of managers were confident in the digital skills of their staff, 90% of staff were confident in their own skills – perhaps because they are using digital skills elsewhere, just not as much at work.

Digital technologies do not have to revolutionise what we do to revolutionise impact and reach. Care workers already share information with colleagues about clients. This is usually done by hand writing notes in a book in someone's home. Recording those same notes electronically means that care managers can also see those notes and monitor care and conditions. It means that family members can also have oversight and can share information, too. Where technology has been used for home care, it has largely been used to monitor the time a worker has been in the home for contract monitoring purposes. This is a missed opportunity.

Design and technology can help care be organised better. Sebastian Nause-Blueml, an MA student in Service Design at the Royal College of Art, used design approaches to understand the problems facing care workers. He worked with a provider. He shadowed care workers. He highlighted succinctly their issues and worked with them to develop a design approach which covered income predictability, flexibility in rotas depending on need, sharing information between care workers and a team based approach to care.

This design solution is supported by digital technology, but the solution itself is about how a service can be redesigned around the needs of users aligned to better conditions for the people who work with them. The approach was impressive. The LGiU is now working with Sebastian and others to develop this approach further.

Mat Hunter, Chief Design Officer at the Design Council, has overseen projects looking at both product and service design to improve care. He told the Commission:

“My view is that there is plenty of potential ‘slack’ in the system, we have only scratched the surface of finding new ways to bring communities back into the heart of care and of maximising the empathy and capability of care worker. What we need is slack in the system to experiment, to try new things, even if we do not know yet what those new things will be exactly. My fear is that the biggest risk will be seen to be in trying new things, when we know the biggest risk to the system is in not doing enough to change it.”

Innovation and use of new technologies

Service design approaches and the use of technology can transform the way we deliver care in the community. The LGiU is working with designers and developers to develop design approaches with councils and care providers.

49 *Digital Capabilities in the Social Care Workforce*, Skills for Care, July 2014

Diary of a home care worker: a first hand account

I've been doing time and task, but working in the new way, focused on outcomes, has been much better. One lady I was working with, I'd never met her before but because she was in the outcomes scheme I'd already had information about her. I already knew what she liked and what she didn't like. I knew she liked her cup of tea and I knew she liked a bit of jewelry and to look nice.

When I first went in to see her she was still in bed and told me she didn't feel like getting up. I asked if I could sit on her bed and if we could have a little chat then. She said ok, but the whole time we were chatting she kept looking up at the clock and then she asked me "Don't you have to go?" I told her it was fine and asked if she'd like a cup of tea and when I brought it to her we chatted some more. She was a bit concerned that my half hour was up but I assured her it was ok. I asked her if she wanted another cup of tea and she said she'd love another. I told her that was ok, but now it was her turn to make a cup of tea for me. She decided she would get up and she got showered and washed her hair. I asked her if she wanted to put her jewelry on and she did. I was there for two hours and in that time she was washed, dressed and groomed. She looked very nice.

I think we achieved so much more in the two hours than if I'd visited her four times that week for half hour sessions. In fact, it turned her life around. She doesn't need us anymore and no longer receives care, but in the time we were working with her, I met her neighbours and helped her get back in touch with them. She looks after herself now, getting washed and dressed and out. That was something that was very rewarding for me and a big achievement.

Working in this way gives us a lot more flexibility to do different things for people. We give them information and help them find out about things like transport, in fact we've been working with Age UK to help people access different services. And using the time differently means that we can do things like sort their medication. It might have been all over the place, but we can help them get it organised and in one place. It saves a lot of stress for them knowing where their medication is and there isn't as much need to help them each time they need to take medication. We wouldn't normally be able to work like this, under the time and task approach - just do a quick medication prompt and that's your job, you're done. If we have a little bit more time we can gently push people in the right direction.

of working in care for Mears in Wiltshire

Sometimes I think when people have been ill or come out of hospital or if they've lost someone then even simple things can feel like they've hit a brick wall. But if you have the time and you're there to see what needs doing you can break down tasks and help people see that little by little they can cope and then they don't need you everyday. It gives them their confidence back. Long term it saves money.

You can't rush older people. That's when they have accidents. For example a leisurely shower a couple of times a week is so much better than a rushed daily shower. It becomes a comfortable and relaxing time for them.

There are only six of us working in a team. So it's always one of us seeing the client. Our manager shows them our picture, so they know it's one of us coming. It's not a surprise. It gives them confidence, they recognise us. It's not another stranger coming in. And when you think it about it, it has to be quite stressful to have a stranger show up at your house and then take you to the bathroom for a wash. It must feel like you're having to flash your bits to everyone, a different person every week, in your bathroom, washing you. You have to put yourself in their position. I wouldn't like that.

The six of us meet each week and talk about the people that we're working with. What's working and what's not. Who to push a little bit further and who needs a more relaxed approach. We share a lot of information in those meetings. We keep in touch during the week, too. We call or text each other. I'll even answer the phone on my days off, if I know it's one of my colleagues. If I can help them, I will. And they do that for me.

The clients notice that we're working together. They like that we share information and that the information is being used. They like that we're talking about how best to work with them and what they need and they know that the information they give us isn't just going to be sat on a shelf, but is going to be used by someone to help them. Working in the time and task way can be quite isolating, but this way I'm working with a team.

I've only been working this way for a few months, but already I can see a difference. I would really like it if this could continue, in fact go wider. Working in teams like we are now, with flexibility and some choice about what we do and I think we could achieve a lot more.

Section 6: The future of the home care workforce



What could home care look like? And what can we do to get there?

Unlike the care worker at the beginning of our report, the care worker whose first hand report appears on the previous page works for Mears in Wiltshire, where they are experimenting with new ways of delivering care.

The council works with providers in partnership and care is commissioned based on outcomes. This means that care providers are incentivised to help people live independently rather than maximise care hours and reduce cost per contact hour and care workers are given greater autonomy to make that happen.

The system is creaking. We need more people to take on caring roles to meet the needs of an ageing population and we need more people who are skilled and experienced enough to deal with complex care.

According to the International Longevity Centre we may need to almost double the current home care workforce of around 600,000 over the next decade. We are not likely to meet that demand without some significant changes.

Many care workers are paid badly, have little autonomy or chance of career progression and are part of an oft-maligned workforce. Recent scandals in residential care have highlighted negligence and abuse. It is absolutely right that poor and sometimes criminal practice should be exposed, but we do little to highlight or reward the often excellent care that many people provide

while working for low wages and with terms and conditions that few would willingly accept.

Health and social care should be more closely integrated through strategic planning and day-to-day practice, but this means asking care workers to deal with increasingly complex needs without a system for registration or widely recognised accredited training as care workers become more skilled and experienced. Bouncers and hairdressers and childminders are registered, care workers are not.

There is no getting around the money issue. In many parts of the country, and particularly in high-cost, high employment areas it is difficult to recruit and maintain a high-skilled workforce, never mind the higher-skilled workforce required for integrated care. Few councils are paying the recommended minimum hourly rate of £15.74 per contact hour – which is making it hard for home care providers to pay well, provide training and make enough profit to stay in business.

We could redesign the system so it is fit for purpose and does what we want home care to do – help people live dignified and independent lives for as long as they can in a place that is familiar to them. We must take that opportunity now.

Despite the fact that social care represents a huge proportion of council spend, there is not much room for change in terms of cash.

Local authorities are genuinely constrained by finance and competing priorities. The capacity for change is in thinking in new ways and organising care. This has to centre on that vital relationship between care worker and care recipient – only by addressing the needs of the workforce can we have the workforce we need.

The social care workforce of the future must reward and recognise care workers and give them certainty and a career path. Integration can save money through preventing

unnecessary hospitalisation and residential care, but a well-trained and sustainable sector will almost certainly require more money in care.

More importantly, though, there must be a will to change, in order to adapt to the needs of a changing society. With the right investment and support for the sector, this workforce of the future will be able to deliver better value for money, better outcomes and, critically, better services to those for whom they care.

Mrs. Carol Bamford
14 Crosby Street
Everley
Midshire
HG11 2HG

Employee Number: 17

Time Sheet

Total number of Tasks: 13
33 Saturday 14-Aug-2014

Date Range: Week 33 to 33 (Aug 14, 2014 to Aug 20, 2014)
Total Task Time: 16:15 Hrs

Client Name	ID	Service Provided	Actual Start	Actual End	Start Time	End Time	Verif	Signature	Tracked
33 Monday 16-Aug-2014 No of Tasks: 2									
Mrs Lena Mullarkey	1014	Assist to Bed - Private	08:30	09:30	08:30	09:30	1	[Signature]	10
Mrs Lena Mullarkey	1014	Assist to Bed	12:00	15:00	12:00	15:00	3	[Signature]	10
33 Tuesday 17-Aug-2014 No of Tasks: 4									
Mrs Dorothy Lucas	1114	Personal Care	07:30	08:15	07:30	08:15	0	[Signature]	15
Mrs Vera Dadge	660	Bath / Shower - Private	08:15	08:30	08:15	08:30	0	[Signature]	10
Mrs Jean Smith	184	Personal Care -	08:30	09:30	08:30	09:30	1	[Signature]	15
Mrs Anne Preece	1033	Personal Care	09:30	10:00	09:30	10:00	0	[Signature]	10
33 Wednesday 18-Aug-2014 No of Tasks: 4									
Mrs Dorothy Lucas	1114	Personal Care	07:30	08:15	07:30	08:15	0	[Signature]	15
Mrs Jean Smith	184	Personal Care	08:30	09:30	08:30	09:30	1	[Signature]	15
Mr Chris Adeyemo	1162	Check Call - Private	09:00	14:00	09:00	14:00	5	[Signature]	10
Mrs Anne Preece	1033	Personal Care - Private	09:30	19:45	09:30	19:45	15	[Signature]	10

I hereby certify that the details completed are a correct statement of those worked.

Employee's Signature: [Signature] Date: 18/8/14

Total Hours: 16 Total Trav: []

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The recommendations in full

Better and fairer commissioning

- **Minimum payments for contact hours:** councils should ensure that they are paying a sufficient rate for contact hours which ensures that providers can pay care workers at least the minimum wage. This is likely to be in line with the United Kingdom Home Care Association's minimum recommended payment of £15.74 an hour (and assumes 19% travel time per hour) for minimum wage compliance. Councils should consider requiring Health and Wellbeing Board sign-off for any commissioning process that goes below the recommended rate and should be transparent in their methods of pricing.
- **Moving away from time and task commissioning:** councils should be moving away from time and task commissioning and toward outcomes based commissioning. Councils need to work together to develop new approaches to person centred care and partnerships with providers. Where savings are required, they should look at methods of making these savings across the contract as a whole, rather than seeking to make efficiencies by driving down the hourly rate of pay.
- **Better oversight of existing contracts:** councils need to be more proactive in ensuring that their use of existing framework contracts is not contributing to the worst practices in home care, such as 15-minute care slots. In reviewing their contracts, councils should consider the impact of their commissioning approaches on the market, and specifically whether framework contracts are creating fragmentation. Health and Wellbeing Boards should take an active oversight role of how care commissioning is supporting local objectives for preventative spending on care.

Valuing care and care workers

- **Key worker status for care workers:** the government should give immediate key worker status for those care workers employed directly by the public sector and investigate into how other care workers could be offered key worker status. While key worker status is currently available only to public sector workers we believe that serious consideration should be given to extending it beyond councils to those working for providers commissioned by these authorities. Until then, the government will continue to subsidise the lowest paid in social care through the benefits system.
- **A living wage for care workers:** if we are truly to value our care workers they should receive a living wage. The UK Home Care Association calculates the hourly rate for the purposes of commissioning as £18.59 for compliance with the living wage and £21.33 for compliance with the London living wage.
- **A licence to practise:** the government should take immediate steps to put in place the suitability scheme proposed by the Health and Care Professions Council in the form of a statutory code with independent adjudication and a register. In the longer term, licensing



would support the professional status of care workers and provide greater reassurance to care commissioners. The government should investigate ways of implementing licensing for social care workers in the context of wider workplace learning and accredited training to ensure the new Care Certificate becomes a trusted and portable standard.

- **A training and career pathway for care workers:** care workers in both health and social care need minimum standards of training which can be developed into pathways of specialism or the basis for further training and entry into allied care professions such as nursing or social work. A more formalised career path would include apprenticeships alongside clear career pathways.
- **Free influenza vaccinations for care workers:** care workers should be offered free flu jabs by the NHS to protect both their clients and themselves.
- **Working carer tax credits and care credits:** people with informal caring responsibilities should have support to continue in employment if desired. The Department for Work and Pensions should investigate tax credits for those with caring responsibilities in line with payments for working families to support those with children working outside the home. This should be part of a broader investigation into how care work interacts with the benefits system.

Responsible and innovative providers

- **Enforcement of the minimum wage:** all commissioned care should follow open book accounting procedures (including their profit/surplus margins) and councils should take steps to ensure that care workers are earning at least the minimum wage. HMRC should change its procedures for how minimum wage investigations are triggered, allowing complaints from third parties.
- **Innovation and use of new technologies:** service design approaches and the use of technology can transform the way we deliver care in the community and liberate staff to spend more time on personal contact. The LGiU is working with designers and developers to develop design approaches with councils and care providers.

Comment: Jonathan Carr-West Chief Executive, LGiU



Most of us will need care at some point in our lives. All of us will have friends or family who do. Some of the most important care is that provided in the home. Yet we often do not get the quality of care we deserve and the people who provide that care do not enjoy the sort of career they deserve. This report sets out some of the reasons for this and suggests what we can do to improve the situation. The importance of that task is perhaps best captured by the comments of two of the parliamentarians who contributed to the Commission's work.

"Home care workers do one of the most difficult and sensitive jobs, providing a life-line of intimate care and personal support to some of our most vulnerable and fragile neighbours, enabling them, as they and we would wish, to remain in their own homes. Someone in your family at some time or another is likely to need their work and their kindness. Yet most home care workers do not get even the full minimum wage as their travel time between clients is not counted. Over half of them are on zero-hour contracts. They are not valued as they should be for the vital work they do. They need a living wage."

– Baroness Patricia Hollis

"The evidence gathered for this report and the recommendations will make a valuable contribution to an important national debate about how we can enable people with disabilities and people approaching the end of life to have the quality care that they need. The need for care provided by professional and family carers is something most of us will experience during our lifetimes. Developing sustainable, quality and affordable care and support for adults needs just as much attention from policy makers as for children and young people."

– Sarah Newton, MP

At the LGiU, we think this is a crucial issue for local government to get to grips with. We are tremendously grateful to all the Commissioners who put so much time and effort into this work and particularly to Paul Burstow, MP, who chaired the Commission with such energy and insight.

We are also grateful to Mears for supporting the work and especially to Alan Long and Abigail Lock.

This has been a challenging process for everyone involved. We have all had to face up to uncomfortable truths and make some bold decisions, but we believe the outcome is a set of robust recommendations that have real potential to improve the lives of care workers and those they care for. We look forward to working with local authorities and providers to help implement them.

Jonathan Carr-West
Chief Executive, LGiU

Contributions to the Commission

Colin Angel, Policy and Campaigns Director,
UK Home Care Association

Joan Beck, Former Director of Adult Social
Care at Doncaster MBC and ADASS
associate with responsibility for workforce
development.

Emma Gasson, Service Design Lead,
FutureGov

Paul Hodgkin, Founder of PatientOpinion

Mat Hunter, Chief Design Officer, Design
Council

Dr Shereen Hussein, King's College London,
demographer and founder of the Social Care
Workforce periodical.

Sebastian Nause-Blueml, Service designer,
developer of Lift: technology supported
service redesign for home care.

Helga Pile, National Officer for Social Care,
Unison

Angeleça Silversides, Healthwatch
Kensington and Chelsea

Written submissions list

Trades Union Congress

GMB

Unison

Mears Group

Bluebird Care

Surrey Care Association

Leonard Cheshire

ASH

Silver service carers, Ltd

Dr Malcolm J Fisk Co-Director of the Age
Research Centre, Health Design &
Technology Institute, Coventry University

Rochelle Monte, a care worker in the North
East of England

A care worker in the South East of England,
name supplied

Sandra Keatley, Chief Executive, Crossroads
Care Northwest

Registered manager, Omercares

Neil Eastwood, StickyPeople Ltd

Mike Frizzell, Everycare Ltd

Kate Price, Crossroads Care Rotherham

Morris Schwarz, Silverdale Care Ltd

Lorraine Williamson, Crossroads Care,
East Kent

Emma Aspinall, Director of Care Services,
Acorn

Kemi Eniade, Joint Commissioning and
Contracts Manager, London Borough of
Waltham Forest

London Borough of Harrow

Healthwatch Reading

Kirklees Council

Staffordshire County Council

Warwickshire County Council

A local authority officer working in
independent sector development, name
supplied

Alison Hudson, health care worker and
daughter of a home care client



For further information, please contact:

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The LGiU is a think tank and local authority membership organisation. Our mission is to strengthen local democracy to put citizens in control of their own lives, communities and local services. We work with local councils and other public services providers, along with a wider network of public, private and third sector organisations.

www.lgiu.org.uk

Mears is the leading social housing repairs and maintenance provider in the UK and a major presence in the domiciliary care market – bringing the highest standards of care to people and their homes.

Partnering with clients, 17,000 Mears Group employees maintain, repair and upgrade people’s homes, care for individuals and work in communities across the country – from inner city estates to remote rural villages.

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