STATES OF JERSEY

JERSEY ETHICAL CARE CHARTER

Lodged au Greffe on 6th June 2017
by Deputy G.P. Southern of St. Helier

STATES GREFFE

PROPOSITION

THE STATES are asked to decide whether they are of opinion –

(a) to agree in principle that all providers of domestic care should meet the standards set out in the Jersey Ethical Care Charter ("the Charter"), as detailed below in paragraphs (i) to (xi) –

(i) The starting point for commissioning of visits will be client need, and not minutes or tasks. Workers will have the freedom to provide appropriate care, and will be given time to talk to their clients.

(ii) The time allocated to visits will match the needs of the clients. In general, 15-minute visits will not be used, as they undermine the dignity of the clients.

(iii) Homecare workers will be paid for their travel time, their travel costs, and other necessary expenses such as mobile phones.

(iv) Visits will be scheduled so that homecare workers are not forced to rush their time with clients or leave their clients early to get to the next one on time.

(v) All homecare workers will be covered by an occupational sick pay scheme to ensure that staff do not feel pressurised to work when they are ill, in order to protect the welfare of their vulnerable clients.

(vi) Clients will be allocated the same homecare worker(s) wherever possible.

(vii) Zero-hour contracts will not be used in place of permanent contracts. Holiday pay will not be "rolled up" in hourly rates.

(viii) Providers will have a clear and accountable procedure for following up staff concerns about their clients' well-being.

(ix) All homecare workers will be regularly trained to the necessary standard to provide a good service (at no cost to themselves, and in work time).

(x) Homecare workers will be given the opportunity to regularly meet co-workers to share best practice and limit their isolation.

(xi) All homecare workers will be paid at least the Jersey Living Wage (if and when the Jersey Living Wage is adopted by the States).

(b) to request the Minister for Health and Social Services to request all of the providers on the approved provider framework for homecare agencies to sign up to the Charter;

(c) to agree in principle that it should be a requirement under the Regulation of Care (Jersey) Law 2014 for care providers to sign up to the Charter; and

(d) to request the Minister for Health and Social Services to bring forward the necessary legislative changes to implement paragraph (c) above.

DEPUTY G.P. SOUTHERN OF ST. HELIER

REPORT

In the debate on my proposition, Regulation of care workers' employment standards, P.29/2017, I attempted to make the case that the States should not allow care providers to reduce standards, including employment terms and conditions, to fall below those in place for those services which were fully funded by the Health and Social Services Department ("HSSD"). It became apparent that Ministers, including the Minister for Health and Social Services, were not prepared to even consider changes to the Approved Provider Framework ("APF") or the Regulation of Care Act. The following comments make this abundantly clear –

> *"…. the Approved Provider Framework ("APF") does not make any reference to employment practices or standards in its provisions, and there is no intention for it specifically to do so."*
>
> *"Those Regulations do not relate to standards of employment because the Law does not provide the relevant powers."*.

The Minister for Health and Social Services maintained his "hands off" approach to market forces thus –

> *"Employers in the care sector set terms and conditions appropriate to the market in which they operate, and this is the proper comparator. In setting terms and conditions of employment, they take into account what they as private and third sector businesses can afford in order to recruit and retain staff. For their part, with a range of employers, employees can look for the best overall terms and conditions package and the working arrangements that suit them."*.

In the face of this determined opposition –

> *"In summary, Members are urged to reject the Proposition on the grounds that neither the Approved Provider Framework nor the Regulation of Care Law, which are intended to monitor and regulate standards of care, are appropriate vehicles for setting employment standards and practices."*.

The proposal was rejected by the narrow margin of 23 votes to 18.

There was, however significant support, not least from Ministers, for the potential of the Ethical Care Charter, produced by Unison in the UK, based on research undertaken in 2012, which was outlined in the report which accompanied P.29/2017 –

> **Senator Gorst:** *"It cannot be right simply to say no to Deputy Southern's proposition without having another approach that would help deliver some of those safeguards that he has right"*.

And elsewhere in his speech –

> *"I think that that at this point can be better undertaken through working together on the Unison Ethical Care Charter, a Jersey version of it,"*.
>
> **Senator Green:** "*the chairman of the Scrutiny Panel just asked would somebody from the Council of Ministers stand up and commit to the Ethical*

Care Charter. Well, I think the Chief Minister has already done that, but I align myself with that".

Senator Routier: *"There are 3 of us now who have stood up and given the assurance that the Ethical Care Charter is something we want to work to,".*

Deputy Pryke: *"….like him, (Deputy Southern) I want to achieve the best possible care in the community, but I could sign up to the Unison care charter".*

The Jersey Ethical Care Charter

This proposition seeks the agreement of the States on the 11 points of an ethical care charter for Jersey, derived from the Unison Charter, which has been a model for good practice since 2013.

I have deliberately chosen to include all 11 separate elements of the Charter in the proposition rather than in the report, to enable the widest possible range of debate, so that Members, including Ministers, where they see objection or improvement, can amend or oppose each element as they see fit, rather than oppose the entire Charter.

The over-riding objective behind the Charter is to establish a minimum baseline for the safety, quality and dignity of care by ensuring employment conditions which –

(a) do not routinely short-change clients; and

(b) ensure the recruitment and retention of a more stable workforce through more sustainable pay, conditions and training levels.

Rather than the Minister seeking to achieve savings by driving down the pay and conditions that have been the norm for staff in many areas in the UK, he should be using these as a benchmark against which to level up.

I am sure that all Members, Ministers and backbenchers alike, wish to avoid the poor practices that appear to have become the "norm" in the UK. We can and should set higher standards, but there is evidence that already these poor standards are taking root in Jersey. Zero-hour contracts are routinely used by some providers, along with the absence of payment for travel time. Worryingly, contact-time payments are proposed in the new terms for FNHC care workers.

To illustrate the cumulative impact of poor terms and conditions on the delivery of high-quality care, one only has to examine one example from current practice in Jersey. The company charges the going rate for its services of between £19 and £22 per hour. It pays its care assistants at the hourly rate of £10, but employs them on zero-hour contracts, with no travel time, and expects flexible working between the hours of 7 a.m. and 11 p.m. There is no sick pay; and holiday pay, as is common in Jersey, is rolled up in 4% on the hourly rate. This technical way round statutory holiday pay regulations means that many workers rarely get to take a well-deserved break. Furthermore, rotas are delivered by e-mail or text on a weekly basis, but additional hours may arise at shorter notice due to sickness or other factors. Many care workers feel obliged to take these extra shifts, either in order to improve their earnings or from fear of not being offered future work, as can be the case under zero-hour contracts.

Jersey starts with one enormous advantage over the UK. We have put in place a mechanism for funding care in the community: the Long-Term Care Fund. This has led to the opening-up of care services to the market. What we must protect against is the advance of poor practice in the delivery of services witnessed in many parts of the UK and evidenced in this report using the Unison survey of care workers. The ethical care charter seeks to avoid the worst excesses described here:

(a) Time to care

The written responses to (the Unison UK) survey paint a disturbing picture of a system in which the ability to provide some companionship and conversation to often lonely and isolated clients is being stripped away. Some recounted the shame of providing rushed and insufficient levels of care because of the terms and conditions of their job, whilst many detailed insufficient levels of training that they had been given to carry out the role. Others made the point that rushed visits are a false economy, leading to a greater likelihood of falls, medication errors and deterioration through loneliness.

79% of respondents reported that their work schedule is arranged in such a way that they either have to rush their work or leave a client early to get to their next visit on time. This practice of 'call cramming', where homecare workers are routinely given too many visits too close together, means clients can find themselves not getting the service they are entitled to. Homecare workers are often forced to rush their work or leave early.

This "time to care" lies at the heart of the charter, and is covered by ***statements (i), (ii), and (iv)***.

Those workers who refuse to leave early and stay to provide the level of care they believe is necessary, also lose out, as it means they end up working for free in their own time. This is especially the case when payment is restricted to contact time, and travel time is not paid.

(b) Travel time

58% of respondents (in the UK) were not paid for their travelling time between visits. As well as being potentially a breach of the minimum wage law, this practice eats away at homecare workers' already low pay. This has already become common practice here, in Jersey.

Payment for travel time would appear to many to be intrinsic to the work, and to the policy of moving care to a domestic setting, whenever possible, and is covered by ***statement (iii).***

(c) Continuity of care

37% of respondents reported that they were often allocated different clients, affecting care continuity and the ability of clients to form relationships with their care workers. This is crucial, especially for people with such conditions as dementia.

Continuity is seen as a vital element in the development of relationships based on trust and is covered by ***statement (vi)***.

Achieving continuity, however, requires the ability to recruit and retain high-quality staff, and this in turn leads to higher pay to keep turnover rates low.

56% of respondents (in the UK survey 2012) received between the national minimum wage of £6.08 an hour and £8 an hour at the time of the survey. The majority of respondents did not receive set wages, making it hard to plan and budget. Very low pay means a high level of staff turnover, as workers cannot afford to stay in the sector. Clients therefore have to suffer a succession of new care staff.

(d) Zero-hour contracts

The use of zero-hour contracts in the delivery of homecare is intrinsically bad practice. The absence of consistent weekly or monthly pay simply generates insecurity and a long-hours culture:

*"**A zero-hour contract means that in practice I may receive my rota for the week just one day in advance, and sometimes less. This makes it impossible to plan my week and leaves me feeling anxious and stressed."***

*"**I am on call from 7 in the morning until 10 at night I work 6 days on 4 off. With 30 hours in the 6 days I can't do anything else in case there is extra work. So I'm always available between these hours but we are only paid for the work we do not the standby time we have to spend by the phone.**"*

The use of zero-hour contracts is covered *by* ***statement (vii)*** of the Charter.

(e) Sick pay

In the Unison survey, only 40.5% of homecare workers employed by private and voluntary providers received sick pay. This is a particular worry as many homecare workers, due to the nature of their job, will often pick up problems like stomach-bugs. Given that they are dealing with vulnerable clients, it is vital that in order to protect their welfare, homecare workers do not feel under an obligation to come into work when they are ill, in order to earn their wage.

Many will consider that the protection of vulnerable clients in this way is crucial to safeguarding client health (*see* ***statement (v)***).

(f) Safeguarding/isolation

Whilst the vast majority of respondents (in the UK survey) had a clearly defined way of reporting concerns about their clients' well-being, 52% reported that these concerns were only sometimes acted on, highlighting a major potential safeguarding problem.

Only 44% of respondents see fellow homecare workers on a daily basis at work. This isolation is not good for morale and impacts on the ability to learn and develop in the role.

In any service delivered to clients in their home, the opportunity to share concerns and discuss best practice about client well-being is difficult. Careful consideration must be given to meeting these needs in the delivery of the service (***statements (viii) and (x)***).

(g) Training

In the UK survey, 41% of care workers were not given specialist training to deal with their clients' specific medical needs, such as dementia and stroke-related conditions.

Once again this may appear as a statement of the obvious, but the provision of high standards of training, at no cost in time or wages, to care workers must be a cornerstone of the service ***(statement (ix)***).

(h) Living Wage

Evidence from the UK indicates that the home care sector, despite the best efforts of some, has become a low-wage service with poor terms and conditions, leading to high turnover rates with associated poor standards of care. In the UK, the living wage has been established for some time as a mechanism to address poor wage rates. Local authorities can provide access to the living wage for its own and outsourced services to carers, as indicated here:

Milton Keynes has become the latest Council to sign up to UNISON's E*thical Care Charter*, part of the union's Save Care Now campaign.

Council leader Pete Marland said that signing the charter is "a huge step to improving the care our elderly or vulnerable people receive".

"It seeks to ensure that people are given the highest quality care by guaranteeing the people who provide it are well paid and have the time to care for people."

He added that: "we will pay the living wage, not use zero-hours contracts and not use 15 minute care visits", and signing the charter "will give those that need care confidence in their services".

Following the adoption by the Assembly of P.37/2013, "Living Wage for Jersey: investigation", by 35 votes to 7 (with 2 abstentions), the report by the Chief Minister and the Minister for Social Security into a living wage for Jersey, produced in 2015, opposed the adoption of a living wage, as follows –

> *"... the minimum wage rate already in use in Jersey (£6.78 from 1 April 2015) satisfies the living wage requirement"* and that *"As Jersey's existing minimum wage would satisfy the living wage requirement, there would be no savings to States expenditure".*

Nonetheless, the charitable body "Caritas" who campaign for the living wage estimate that the hourly rate for Jersey is currently £9.75. This is below the normal range of rates for care workers of between £10 and £13 an hour. I have included the provisional ***statement (xi)*** pending future developments in the living wage campaign.

Financial and manpower implications

There are no direct financial or manpower implications for the States arising from the 'in principle' adoption of an ethical care charter as described in this proposition and report.

Re-issue Note

This Projet is re-issued at the request of the proposer to replace the originally published version of the report accompanying his proposition.