STATES OF JERSEY

REGULATION OF CARE WORKERS' EMPLOYMENT STANDARDS

Lodged au Greffe on 20th April 2017
by Deputy G.P. Southern of St. Helier

STATES GREFFE

PROPOSITION

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

to request the Minister for Health and Social Services to –

(a) remove from the Approved Provider Framework ("APF") for home care, agencies whose employment practices fall significantly below the standards applied to staff delivering care services fully funded by his Department, such as rapid response and palliative care teams;

(b) ensure that any future applicants to join the APF at least meet the employment standards applying to staff delivering care services fully funded by his Department; and

(c) ensure that Regulations he plans to introduce under the Regulation of Care (Jersey) Law 2014 creating a framework for regulation of care services by the new Health and Social Care Commission include requirements for providers of personal and domestic care to apply employment standards at least equivalent to the standards applied currently to staff delivering care services fully funded by his Department.

DEPUTY G.P. SOUTHERN OF ST. HELIER

REPORT

Home care services involve the provision of personal and domestic care to people of all ages with physical, sensory, mental health and learning disabilities. These services play a vital part in ensuring that people are able to live in their own homes, with dignity. Care workers provide a very wide range of services, including washing, dressing, assisting with medication, dealing with incontinence and rehabilitative care (classified as personal care), and providing help with personal finances, housework, laundry, shopping and pension collection (classified as domestic care). Contrary to the widespread view that home care simply involves non-essential housework, as voiced on several occasions by the Minister for Health and Social Services, carers provide much of the support that is critical to allowing people to remain living at home. In many cases, home carers are the only people who have daily contact with vulnerable people, and in practice, these workers take on wider responsibility for the very well-being of those they look after.

On 23rd October 2012, the States agreed, in adopting P.82/2012 – Health and Social Services: A New Way Forward – as amended by P.82/2012 Amd., to develop the health and social care system to include integrated "out of hospital" services with a range of partner organisations. This direction was confirmed by the States' acceptance of P.27/2015 – Draft Strategic Plan 2015 – 2018. As a result of this policy change, the Minister for Health and Social Services ("HSS") removed the subsidy first from domestic care, and now from personal care from the previous sole provider of these services, the Family Nursing and Health Care Association ("FNHC"). In effect, the Minister has opened the market in personal care, as in the UK, to competition from private and not-for-profit organisations.

There are now some 23 recognised and accredited private and not-for-profit agencies, delivering these services. Each of these organisations has its own business model and employment practices, and its clients are funded largely through the new Long-Term Care ("LTC") Fund. The average charge for these services is between £19 and £22 per hour. Under the previous subsidy, FNHC were able to deliver this care for around £11 per hour. The Minister has extended the period in which FNHC clients who were receiving care in 2016 at the subsidised rate can continue to receive care at the same cost until the end of 2017.

Under the old system of subsidy, FNHC employed all of its staff on terms and conditions which mirrored those of the States. It could hardly have done otherwise with its nursing staff, if it wanted to recruit and retain its highly skilled and experienced staff, who are in short supply anyway. The same argument, however, does not apply to its less qualified, but equally skilled and experienced, staff, such as the care assistants, responsible for delivering personal care as part of a cohesive and co-ordinated team. FNHC management has stated that they wish to continue to deliver high-quality care packages in people's homes, but in order to compete with their private sector rivals, they have offered terms and conditions which are significantly reduced from those previously applied. These care assistants are faced with an ultimatum to agree new terms by the end of April or be made redundant. That is, some of them do. Those care assistants charged to deliver the services which remain fully funded and subject to a service level agreement, such as the rapid response and re-ablement, palliative care, District Nursing and Child and Family teams, remain on the original contracts.

Over 90 staff are faced with the choice of signing up for vastly inferior contracts or being made redundant by the end of April. The Minister has on several occasions said that he has no responsibility for the terms and conditions of the FNHC care assistants, nor indeed for that matter, any other employees of care agencies. This proposition requests him to have regard for those terms and conditions which may have a deleterious impact on the quality of service delivered, or on the ability of providers of these vital services to recruit and retain high-calibre dedicated staff, and to act to mitigate any detrimental impact that poor terms and conditions have on the ability of the Minister to maintain the high-quality personal services previously delivered by FNHC.

In blindly following the UK and opening up the personal care sector to market forces, the Council of Ministers and the Minister for HSS in particular, have encouraged a "race to the bottom" in the terms and conditions applied to care workers. This can be seen clearly in many UK studies, and is being demonstrated in the way FNHC care assistants are being treated now. While we are unlikely to witness the dire consequences of the lack of funding on the mainland for the delivery of care, thanks to the introduction of the LTC tax, the quality of care may well be at similar risk of failing to meet the standards we should justifiably expect.

The problem is that in attempting to drive down costs and overheads, many care companies in the UK have compromised standards to an unacceptable degree in their business models. In particular, the following factors, especially where they exist in combination, may render the delivery of quality care impossible to achieve, even for the most dedicated and skilled care workers –

- Low pay rates
- Zero-hours contracts
- No travel pay/mileage
- Flexible working hours
- Lack of proper holiday pay
- Absence of sick pay
- Un/paid training.

The data I quote below are taken largely from 2 documents –

- ***Time to care,*** a Unison report into homecare (2012)
- ***On the front line of care,*** (2003) a Unison sponsored report into home care service provision in Tower Hamlets; Jane Wills, Queen Mary University of London.

Local data is taken from Health and Social Security Scrutiny Panel research.

Although the Queen Mary University report is more than a decade old, it nonetheless contains excellent coverage of the issues facing care provision for us here in Jersey as we embark on a similar path to that taken in many parts of the UK.

From the Tower Hamlets document we learn that –

- Tower Hamlets Council has used outside contractors to provide some home care services since the 1980s. In addition to the in-house service, the Council now spot-purchases home care from 16 accredited providers, including the private and not-for-profit sectors. This situation is by no means atypical and approximately 60% of home care services in London are now provided by outside contractors.

- One of the main advantages of using the outside contractors is cost. The research identified that the main group of private contractors were charging the Council between £8.10 and £9.45 an hour for basic home care. This is cheaper than care that can be delivered in-house.

- The care staff working for these private contractors were paid between £5 and £6 an hour. Moreover, they were on zero-hour contracts, with no guaranteed hours, and no payment for training or for travel between clients.

Table 1: Summary of pay and employment conditions for in-house home care staff

Contract type	Basic pay*	Over-time	Shift premiums	Sick Pay?	Special benefits?	Holiday?	Pension?
'old' contract issued before 1995	£6.94 £7.19 after 1.04.03	1.5X week and Sats/ 2X Sundays	£2.96 paid after 8pm in the week and Sats £5.93 Sundays	1 month full pay and 2 months half pay for new starters rising to 6 months full pay and 6 months half pay	Enhanced maternity and adoption leave. A range of discretionary leave (paid and unpaid) inc. compassionate, dependency, childcare and extended leave	From 21 +8 bank holidays +4 concessionary days, rising to 26 +8 bhs +4 concessionary days after 5 years' service	Yes
'new' contract since 1995	As above	1.5X week and Sats/ 2X Sundays	none	As above	As above	As above	Yes

All carers were contracted to work a certain number of hours a week, although many did additional hours. Anything over 37 hours was paid as overtime. The range in contracted hours was from 22 to 37 a week, and workers had a variety of working patterns as they arranged to see their clients during the day. Some carers worked from 7 or 8 a.m. through to 2 p.m. each day, others did only evenings, from 4 to 10 p.m. or from 5 to 11 p.m. each day, while others worked split shifts, covering work in the morning and evening each day, with a break in the middle. A full summary of the pay and employment conditions of staff is outlined in Table 1. In contrast, pay and conditions for outside contractors are presented in Table 2.

Table 2: Summary of pay and employment conditions for home care staff working for outside contractors

Contractor	Contract type	Basic pay	Sick Pay?	Holiday?	Pension?
Private provider 1*	Zero hours: paid for work done and not travel time	£6 an hour Mon–Friday £7.50 Sats £10 Suns	none	20 days including bank holidays (but only 2 weeks at once)	None
Private provider 2*	Not known	£5 an hour Mon–Friday £6.38 weekends and bhs	Not known	Not known	Not known
Private provider 3	Zero hours: paid for work done and not travel time	£5.50 an hour Mon–Friday £6.60 Sats £7.50 Suns (N.B. one carer reported getting £5.75 an hour and £6.90 on Sats/ one new starter reported getting £5.25 an hour and £6.88 at weekends	None	20 days including bhs (but only 2 weeks at once)	None
Not for profit 1	Zero hours, paid for work done and travel and training	£6.40 an hour extra for unsocial hours, weekends and bhs	After 3 months service have 3 months full pay and then half	5 weeks, but after 5 years it increases by 1 day a year up to 30 days	Yes, after 6 months service with employer's contribution

Contractor	Contract type	Basic pay	Sick Pay?	Holiday?	Pension?
Not for profit 2	Employed, pay travel time	£5.64 an hour but £5.81 after 6 months evenings *1/3 Suns and bhs *2 More for overnights	None	20 days	Yes, Stake-holder scheme
Not for profit 3	Contracted, paid for work done and not travel time	£7.50 to £9.50 an hour overnight *1/3 bhs *2	None	20 days after 1 year	Yes, but no-one belongs
Not for profit 4	Paid for work done	£6.88 an hour £8.18 an hour after 8pm	Accrues with service, 1 month/ year	Not known	Yes, Stake-holder scheme

As can be seen from these 2 tables, the Tower Hamlets Council are full employees, with access to payment for travel time, enhanced overtime and anti-social hours payments, along with sickness and holiday pay, enhanced maternity leave and the local government pension scheme. All training, which was extensive in scope, was paid for by the Council and was undertaken during working hours.

It was noted in the report that likely eligibility criteria will mean that domestic care, such as housework and shopping, etc., will be stopped. That, of course, is what we have just seen in Jersey all these years later.

In contrast, the report examines the way in which the care workers' role has expanded. When they started work, some of the tasks they were doing now had been performed by qualified nursing staff –

> *"We were only just there for the domestic tasks. The nurses did the washing, dressing, medication and dressings. We have taken over a bit of the nursing. We do quite a bit for our money*."

Although the pay was not especially high, the employment conditions and the security provided by a position with the in-house home care team were valued, and they help to account for the low turnover and long service of staff.

Most staff saw about 7–9 clients a week. However, this varied from one carer who had only 3 clients, and was waiting for a new client, to one carer who saw 10 clients a week. There was plenty of evidence of very long-term relationships between staff and clients: continuous contact ranged from 3 years up to 23 years in one case. The 10 in-house care workers interviewed had 130 years of service between them. A testament to low turnover rates if ever there was one.

By comparison, care workers in the private sector were paid on average an hourly rate of around 12% less, with markedly lower rates for overtime and anti-social hours. In addition, 3 agencies used zero-hour contracts, and the majority paid only for contact time and not travel time. Four of the seven agencies did not pay sick pay. Holiday entitlement was reduced, and pension provision sporadic.

That was the situation in one London borough over a decade ago. What is the current provision in Jersey?

Agency	**Contract type**	**Basic pay**	**Sick Pay**	**Holiday**	**Pension**
FNHC old	Permanent FT/PT Fixed hours paid travel +mileage @55p	£13.14 hourly x 30% eve; x 40% Sat; x 60% Sun BH x 3	6 months FP + 6 months @50%	26 days + Bank hols	PECRS
FHNC new	Variable hours 07:00 to 23:00 No paid travel £1.25 per visit	£12 hourly £14 w/e + after 8 BH x 2	4 weeks Maternity 4 weeks FP 10 weeks @90%	20 days p.a.	PECRS end 08/17 Defined contrib. 5% employer/ employee
1	Mixed permanent/ Zero-hours £1.25 per visit if shift under 8 hours				
3	Zero-hours Travel 50p/mile or £5 per hour				
5	Paid travel time + 60p/mile if transport				

Agency	Contract type	Basic pay	Sick Pay	Holiday	Pension
6	Paid travel time + Mileage if transport				
7	Some zero-hours Paid travel time				
8	No mileage				
9	Mileage 20p/mile Between clients				
10	Mileage/ travel time incorporated in hourly rate				

The first factor to note in examining this table of local practice is the significant reductions proposed to the terms and conditions of FNHC care workers, which have left nothing untouched from basic hourly and antisocial hours' rates, through the removal of paid travel time, to reduced sickness and holiday provisions.

The data obtained on the private sector is far from complete, as the Scrutiny survey was largely concerned with a single issue, that of paid or unpaid travel time. However, it can be seen that there is some use of zero-hour contracts in the sector and wide variation in the treatment of travel time and mileage.

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.

The first thing to note is that the use of zero-hours contracts leads to a long-hours culture. In one particular case in Jersey, the care worker on one day worked through from 07:00 to 22:00, effectively a 15-hour day, for which she was paid for 12 hours' contact time, thereby reducing her hourly rate to £8. Examination of further timesheets showed some hourly rates falling below the minimum wage at that time.

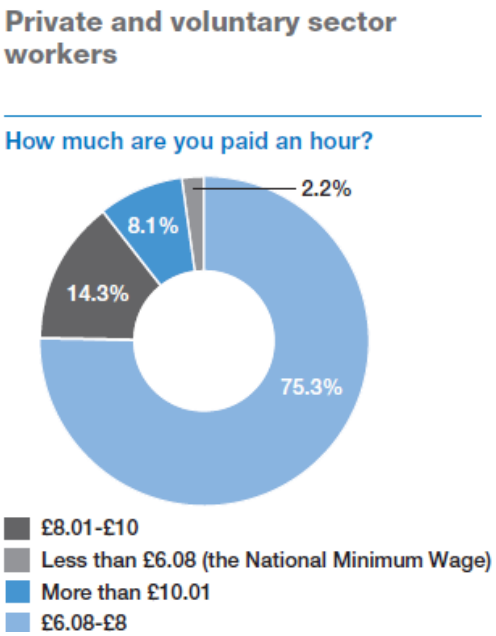
One has to ask what quality of care can be delivered at the end of a 15-hour day!

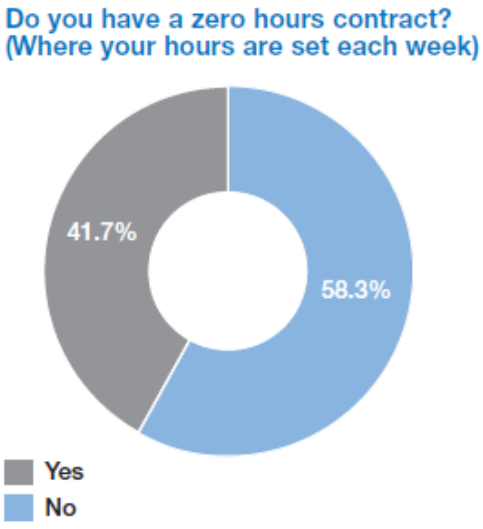
The 2 quotes here are taken from "Time to Care", the 2013 report of Unison, but reflect comments made by many care workers locally –

> *"**In order to earn a full time wage, the carers in our company usually start work at 7am and work until 9pm five/six days a week, with gaps throughout the day where we wait in the car until due at the next client. There is low morale amongst staff and a very high staff turnover which means clients often complain about the number of newly employed carers they meet."***

> *"**The amount of hours you have to work each month just to be able to bring home a half decent wage is getting worse. You see your family less and less each month because you need the money and you wear yourself out getting in as many shifts during the month to try and bring home a decent enough wage."***

The influence of the private sector on wage rates is illustrated here (from "Time to Care"), using 2012 UK data –

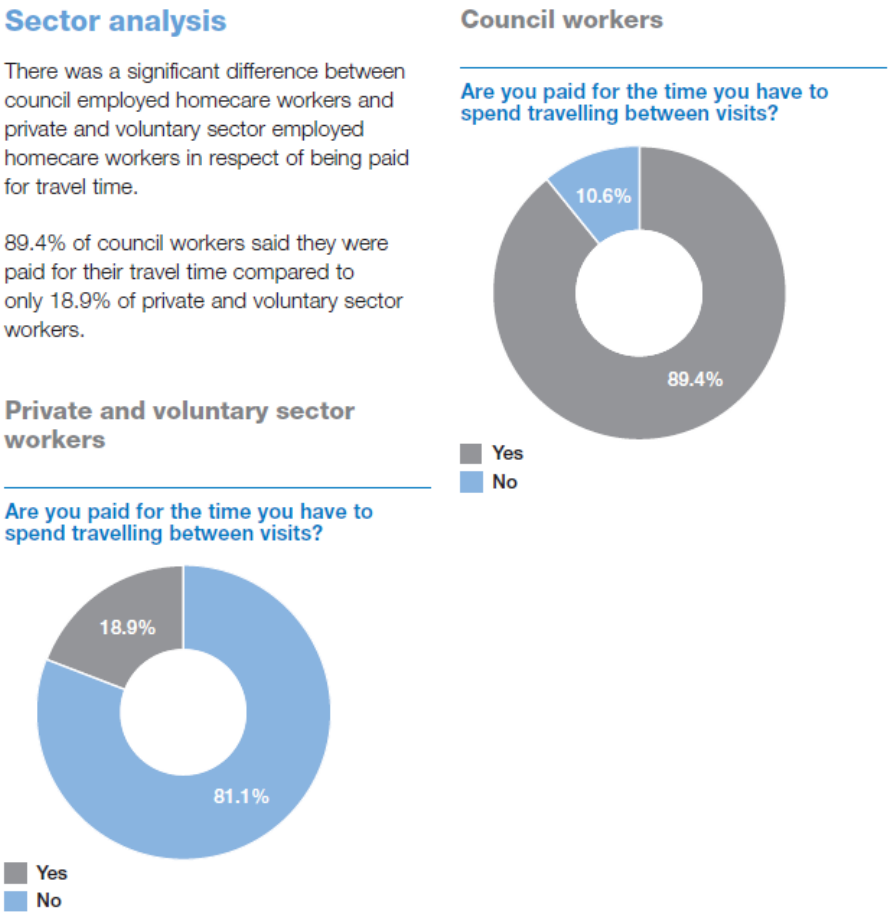




> *"**A zero-hour contract means that in practice I may receive my rota for the week just one day in advance, and sometimes less. This makes it impossible to plan my week and leaves me feeling anxious and stressed."***

*"**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.**"*

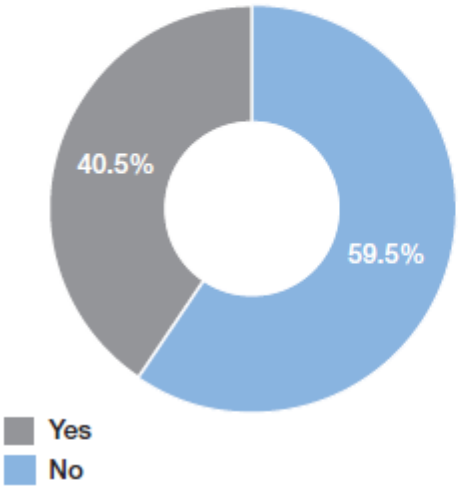
"Time to Care" showed that the private sector used twice as many zero-hour contracts (44%) than did council services (22%). There was also a vast difference between those who paid travel time and those who did not –



In addition to the poor terms and conditions that result from the uncertainty of zero-hour contracts, combined with payment for contact time and the requirement for flexible working, there are major concerns in area of sick pay. Once again, there was a marked difference between the private and public sectors in their treatment of sickness –

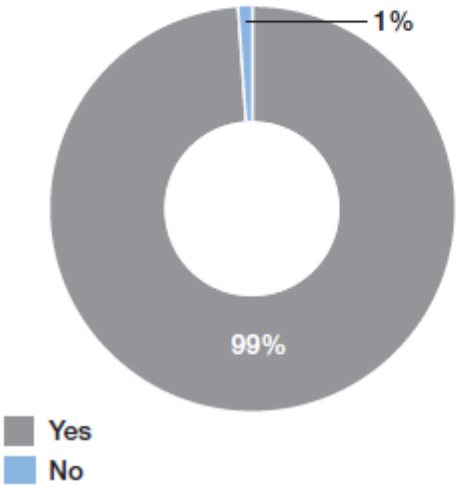
Private and voluntary sector workers

Do you get sick pay if you are ever ill and can't work?



Council workers

Do you get sick pay if you are ever ill and can't work?



99% of all council employed homecare workers received sick pay if they were ill and weren't able to work, whereas only 40.5% of homecare workers employed by private and voluntary providers received sick pay. This is a particular worry as we know that 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.

I believe that this proposition has demonstrated that the decision to introduce market forces into the social care market has led to a significant reduction in terms and conditions for those care workers who are charged with delivering care in the home. This is illustrated by the changes initiated by FNHC to the terms and conditions to be applied to some 90 staff in its workforce. This may lead, in turn, to reduced standards of care to its clients in the future, and certainly calls into question the standard of care delivered by private sector agencies who are reliant on poor terms and conditions for its employees as an intrinsic part of their business models. While standards may not have fallen to those which are to be found in parts of the UK, where 15-minute visits are commonplace, the Minister cannot wash his hands of the responsibility for the terms and conditions of workers employed to provide core services to people in need.

The Queen Mary University survey seems to confirm that reduced terms and conditions for the workforce were linked to reduced satisfaction on the part of clients, 70% of whom were frail and elderly, as follows –

Table 1: Satisfaction with the completion of tasks, comparing clients of the in-house and private contracted service

Task	In-house receiving %	In-house v. satisfied %	Private receiving %	Private v. satisfied %	Difference in satisfaction %
Collecting prescriptions	22	79	4	50	29
Paying bills	21	79	4	50	29
Shopping	42	70	9	50	20
Help washing/bathing	12	86	13	39	47
Help dressing	8	87	10	53	34
Assist to bed	2	100	5	67	33

The Unison Ethical Care Charter

As a means to delivering the objectives outlined in the thrust of this proposition, the Minister could commit his Department to signing up to Unison's Ethical Care Charter for the commissioning of homecare services, in part or in whole, over a prescribed timetable, say 3 years. The Charter is reproduced below in 3 such stages.

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.

Ethical Care Charter for the commissioning of homecare services

Stage 1

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.

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.

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

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.

Those homecare workers who are eligible must be paid statutory sick pay.

Stage 2

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

Zero-hour contracts will not be used in place of permanent contracts.

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

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).

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

Stage 3

All homecare workers will be paid at least the Living Wage (this would require the Living Wage to be in place, at whatever rate is seen as acceptable, by 2020). If HSS employed homecare workers paid above this rate are outsourced, it should be on the basis that the provider is required, and is funded, to maintain these pay levels throughout the contract.

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.

Financial and manpower implications

If adopted, this proposition will require some law drafting time to expand the remit of the Care Commission to encompass these new requirements. It may also require an additional administrator on the Commission to monitor and enforce the conditions.

Any financial costs involved in adopting these new conditions fall not on the HSS budget, but on the budgets of the care agencies involved in service delivery. This will be reflected in the business models adopted. Where this involves additional charges, these will be met from the Long-Term Care Fund, and not the HSS budget, which is already allocated to those services from FNHC which are subject to Service Level Agreements.