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Quality of jobs and services in the Personal care and Household Services sector in the United Kingdom

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INTRODUCTORY NOTE

This report has been prepared, reviewed and finalised through the research of its authors, the contributions and suggestions of the project partners, the suggestions and remarks made by the participants-members of partners' organisations at the regional seminars (Rome / Brighton / Vienna 2015) and by the Advisory Board members (AGE Platform, Eurofound). The authors wish to thank warmly all these persons for their time and contribution. The report presents the personal care and household services sector in the country at stake and in the framework of the For quality! project objectives, following the methodological grid validated by the consortium, without being exhaustive. Authors have tried to incorporate corrections and comments that were reported to them during this process. However, the content does not necessarily reflect the vision of the project partners who are not responsible for the information contained in this report.

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1. NATIONAL OR LOCAL REGULATION AND POLICIES

1.1. Policy and legal backgrounds

We will try to separate as far as possible elements for the UK and elements regarding countries (England, Wales, Scotland, and Northern Ireland). At the difference of other European countries, **until today only very little attention has been paid to the personal and household service sector in the UK.** Not only has the sector not been legally defined, but this sector is also neither the subject of regular statistical exercises nor are there any public policies explicitly targeting this sector of activity. Consequently, there is very little data and research available on the personal and household service sector in the UK. While the care sector is well regulated at national level, the sector of domestic personal services has not been the object of any specific public regulation. There is no specific policy aiming at developing this sector as it can be the case in other countries like Belgium, France or Sweden for instance.

There are no specific policies in place to foster this sector and that households hiring employees are treated as any other employment relationship (in contrast to other countries where employers of domestic staff might be able to take advantage of measures such as tax reductions). Neither are employees working in the personal and household sector treated in a specific way. For example, as long as an employee who occasionally works for a private household earns less than GBP 110 per week, this does not have to be declared for tax purposes by the private household. The current fiscal and social systems in the UK incentivise households and private employers to employ domestic staff occasionally rather than regularly, as this avoids any administrative burden. This therefore fosters informality in this sector. Nevertheless there also exists a formal sector – largely private – providing care and housework services to dependent people. There is a very large offer of private housework services.

1.1.1. England

General overview of care policy

The number of people in England requiring both health and social care is increasing. In the next 20 years the percentage of people over 85 will double. This means there will be more people with ‘complex health needs’ (that is, more than one health problem including long-term conditions) who require a combination of health and social care services.

The government’s ambition is for everybody who uses both health and social care services to have integrated care; services that work together to give the best outcome based on enabling a person to lead as full a life as they can.

In 2012 the Department of Health defined social care, of which domiciliary care is a significant proportion, as:

“Care and support enables people to do the everyday things that most of us take for granted: things like getting out of bed, dressed and into work; cooking meals; seeing friends; caring for our families; and being part of our communities. It might include emotional support at a time of difficulty or stress, or helping people who are caring for a family member or friend. It can mean support from community groups and networks: for example, giving others a lift to a social event. It might also include state-funded support, such as information and advice, support for carers, housing support, disability benefits and adult social care.”¹

The government’s adult social care policy objectives are to enhance adults’ quality of life, delay and reduce the need for care, ensure positive care experiences, and safeguard adults from harm. This is to be achieved through the government’s core principles: to prevent, postpone and minimise people’s need for formal care and support, a system should be built around promoting a person’s independence and wellbeing and that people should be in control of their own care and support.

Publicly funded care makes up only a minority of the total value of care, and this proportion is decreasing. Most care and support is provided unpaid by family, friends and neighbours (informal care), while many adults pay for some or all of their formal care services. Local authorities provide a range of universal and preventative services, many of which are available without assessment of need. Local authorities typically only pay for individual packages of care for adults assessed as having high needs and limited means. They commission most care from the private and voluntary sectors, with home care and care homes the most common services.

Legislative and other changes are increasing adults’ role in shaping their own care and support, diversifying the types of care available and changing how adults access it. The Care Act 2014 rationalises local authorities’ obligations, introduces new duties based on individual wellbeing and to mitigate pressures on self-funders and carers. The act has changed how local authorities assess and fund adults’ care needs and from April 2016, it will introduce a limit on an individual’s contributions to meeting their eligible care needs.

Additionally, the government is pursuing the NHS ‘Five Year Forward View’² which sets out the challenges facing the health and care system over the next 5 years and the aims of increasing integration and new models of social and health care. Also the *Cities and Local Government Devolution Bill* will see the devolution of health and social care budgets to emerging city regions.

Care Act 2014

The Act commenced in England in April 2015 and will have an impact on how services are delivered and who delivers them. Under the Care Act, local authorities will take on new functions. This is to make sure

¹ Caring for our future: reforming care and support. DH (2012)

² Five Year Forward View (2014) NHS England

that people who live in their areas:

- receive services that prevent their care needs from becoming more serious, or delay the impact of their needs;
- can get the information and advice they need to make good decisions about care and support;
- have a range of providers offering a choice of high quality, appropriate services.

Furthermore the Act requires local authorities to help develop a market that delivers a wide range of sustainable high-quality care and support services that will be available to their communities.

When buying and arranging services, local authorities must consider how they might affect an individual's wellbeing. This makes it clear that local authorities should think about whether their approaches to buying and arranging services support and promote the wellbeing of people receiving those services.

A quasi-market model completed by personal payments for individuals

According to the Livindhome report (national report on England), English home care services suffer from **chronic structural under-funding**.³ There is a substantial market for privately purchased care and heavy reliance on informal care.

Care services are publicly funded. They offer in-home services to recipients. Help with domestic tasks, psychological/emotional support and help to participate in social activities outside the home are rarely covered, particularly for older people, although this may change in future as older people receive personal budgets.⁴

From a policy point of view, the main approach in England over the past 20 years has been the development of **quasi-markets, that is a purchaser-provider model**, with local authorities increasingly contracting with external, private (charitable and for-profit) providers rather than relying on their own, in-house services. Local authorities select the providers which then provide in-kind services. For any individual older or disabled person, a **care manager** would conduct an assessment and then purchase home care services from one (rarely more) of the provider organisations with which the local authority had contracts; this was expected to offer greater choice and flexibility for service users (a model that has recently been developed to a certain extent in Sweden as well for example).

³ Caroline Glendinning & Alison Wilde, "Home Care in England", Living independently at home. Reforms in home care in 9 European countries, LIVINDHOME Report, 2011, <http://www.sfi.dk/Files/Filer/SFI/LIVINDHOME/LIVINDHOME.pdf>

⁴ Livindhome report, op. cit.

More recently another mechanism has been introduced, that is the introduction of **personal budgets (PB) or individual budgets (IB)**. This is another mechanism (**in-cash rather than in-kind services**).

In the NHS in England, personal health budgets were introduced in 2009 and were meant to offer a similar service along the lines of the social care model and were introduced for those with long term conditions. In 2014 the right to have a personal health budget was extended for adults eligible for NHS continuing health care and children in receipt of continuing care. In 2015 in England Personal health budgets were extended again. The aim of these changes is to offer personal health budgets or integrated personal budgets across health and social care, for those with learning difficulties.

Personal budgets can be held in different ways: as cash payment held and managed by the service user; by the care manager and used to purchase home care and other services from local authority-contracted providers; or by a home care service provider, to be used to pay for care as and when desired.

Personal budgets can be used to purchase a wider range of services and tasks than previously available through care manager-purchased home care or direct payments. The evaluation of the IB pilot projects found that IBs were used to fund help with domestic tasks, gardening, leisure activities and outings, although the low levels of IBs received by older people meant that high proportions of their budgets were typically used for essential personal care

In 2010, 14% of workers in the field of personal services to dependent people were paid through these direct payments. However, take-up of the direct payment option remained low; in 2007/08 direct payments still constituted only one to six per cent of local authorities' gross expenditure on adult social care.

As a result of this development of personal payments, **the risk is that of a polarisation of the care market with on the one hand a quasi-market regulated by the Care Quality Commission, and on the other a care market less regulated and with poorer working conditions based on the use of these personal budgets.**⁵

Allowances to people and carers

People needing substantial, repeated or regular personal care and/or supervision can claim a *social security cash benefit*, the Attendance Allowance (or Disability Living Allowance for working age disabled people, replaced in 2013 by the Personal Independence Payment). As mentioned in the French France Stratégie report, job creation is not the main objective of these cash-for-care schemes, as they may

⁵ Degavre F. et Nyssens M. (2012), *Care regimes on the move. Comparing home care for dependent older people in Belgium, England, Germany and Italy*, op. cit.

be used to pay informal carers.⁶

People whose needs are not high enough to qualify for local authority funded home care services are likely to use the allowances to pay for a range of informal support and commercial services

England also has a cash income-replacement benefit *for family carers* called *Carers Allowance*, although its level is very low; a national strategy setting out the responsibilities of local authority social services and NHS services to support carers (HM Government, 2010); and a highly effective carers' lobbying organisation (www.carersuk.org). England is one of the rare countries to have developed a real support policy in direction of the carers.

Eligibility

As explained in the Livindhome report, eligibility thresholds vary from one local authority to another. **However, because of budgetary pressure, most local authorities restrict eligibility to those who have only minimal assets or savings** (thus often excluding home owners whose house is included in estimates of assets); low incomes; and high levels of care needs. Indeed, because of the current very tight restrictions on public spending, most local authorities are **raising their needs-related eligibility criteria to the highest levels**. As a result, many people purchase some or all of their home care services from their own private resources. This also creates a greater reliance on informal carers but also unmet needs for some of the people. The number of households receiving authority-funded home care services has decreased from over 500,000 in 1992 to 350,000 in 2005; however the mean time funded by authorities has passed from 3.2 hours per week to 10 hours over the same period⁷.

Integration of Health and Social Services

Although Northern Ireland has had an integrated model for over 20 years, there is now a drive in England for Integration between both health and social services. Social services are under the remit of Local Authorities, Health the NHS. There are a number of models developing such as the Vanguard models or a city wide approach, such as the proposed 'Devo-Manc' model in Greater Manchester, which proposes to have city wide control on all public services, including, health social care, housing, education and transport, for instance under one elected authority.

⁶ France Stratégie, H. Garner, N. Leutheureau-Morel, Gouvernance et organisation des services à la personne en Europe, 2014, December.

⁷ Livindhome report, op. cit.

Workforce

In 2010 the estimated size of the domiciliary care workforce in England was 351,470, including; 267,180 in independent sector, 48,130 in the voluntary sector and 36,160 in local authorities.⁸

81% of publicly funded homecare is now provided by the independent sector, compared to 5% in 1993.⁹

The main purchasers of homecare are local authorities who are estimated to buy 80% of the hours of care provided by the independent sector.

1.1.2. Scotland¹⁰

As with England and Wales, the majority of people in receipt of homecare in Scotland receive it **through local social services**, which assess need for help according to certain eligibility criteria. A small majority of homecare continues to be delivered by the councils' in-house services, and the proportion of statutory funded care delivered by the independent sector is growing.

Since July 2002 people aged 65 and over have been eligible for free personal care and can no longer be charged by local authorities for such services in their own homes, although they can be charged for domestic services. The policy has contributed to a **shift from use of residential care to homecare**. However there is a debate about the sustainability of the policy in the long term and current funding shortfalls have led to some local authorities operating "waiting lists" for the free services. As in England and Wales, the independent sector has also found that contract prices offered by local authorities often fail to keep pace with inflation and other statutory burdens on employers.

The majority of service users receive homecare provided by in-house teams but the use of the **independent sector is growing**, particularly for more intensive packages of care. In 2010 27% of publicly funded homecare was provided solely by the independent sector, with 7% a combination of service from local authority and the independent sector. The remainder, 66% was provided solely by local authorities.

The Scottish Government publishes an annual report on the numbers of people accessing social services. The latest report contains the following points:

- In March 2014 there were 61,740 clients receiving care at home services in Scotland.
- Approximately 680,000 hours of care at home were recorded over the census week, a figure which

⁸ UKHCA (UK Home carers association). An overview of the UK domiciliary care sector, Summary Paper January 2012.

⁹ UKHCA, op cit.

¹⁰ We draw here on UKHCA report and elements provided by SSSC.

has increased every year since 2011.

- Councils are increasingly purchasing services from the private and voluntary sector. In 2014 51% of care at home clients received a service solely from their local authority, compared to 73% in 2007.
- The number of people in receipt of Direct Payments has continued to increase. Approximately 6,010 people were in receipt of a Direct Payment in 2013/14.

In addition, there are an estimated 759,000 informal carers aged 16 or over in Scotland. This figure represents 17% of the 16+ adult population in Scotland.

The Public Bodies (Joint Working) (Scotland) Act 2014 established a framework for integrating health and social care in Scotland. The Scottish Government has also developed a series of National Health and Wellbeing outcomes which set out what health and social care partners are attempting to achieve through this agenda. For example, Outcome two is about making sure that “people, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community”¹¹

Scotland like England is also considering developing integrated health and social services, but as at 2015, had not moved as far forward as England in this respect.

1.1.3. Northern Ireland

Domiciliary care is defined as the range of services put in place to support an individual in their own home. Services may involve routine household tasks within or outside the home, personal care of the client and other associated domestic services necessary to maintain an individual in an acceptable level of health, hygiene, dignity, safety and ease in their home.

‘People First’ is the DHSSPS’s (Department of Health and social policy) vision for community care. It was published in 1993 with six core objectives, including the development of domiciliary care services to enable more people to continue to live in their own homes. The DHSSPS publish an annual report on Domiciliary Care Services for Adults in Northern Ireland. The key findings of the 2014 are as follows:

- In September 2014 domiciliary care services were provided to 24,189 clients

¹¹ Scottish Government, National Health and Wellbeing Outcomes: <http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes>

- In September 2014 intensive domiciliary care services¹² were provided to 8,177 clients
- An estimated 250,798 contract hours of domiciliary care were provided during the survey week
- The statutory sector (Health and Social Care Trusts) provided 32% of domiciliary care contact hours, with 68% provided by the independent sector
- Four fifths (80%) of all clients receiving domiciliary care services received 6 or more visits. The number of clients receiving 6 or more visits has steadily increased from 2010
- During the survey week four fifths (80%) of clients receiving domiciliary care services were in the elderly client group, one in nine (11%) had a physical disability, one in twenty (5%) had a learning disability and one in twenty five (4%) had mental health needs. A small proportion (<1%) had no material handicap.

In December 2011, the DHSSPS published “Transforming Your Care: A Review of Health and Social Care in Northern Ireland”¹³. It made 99 proposals for change across the range of health and social care services. It also identified 12 major principles for change which would underpin the future model of health and social care in Northern Ireland.

1. Placing the individual at the centre of the model by promoting a better outcome for the service user, carer, and their family
2. Using outcomes and quality evidence to shape services
3. Providing the right care in the right place at the right time
4. Population-based planning of services
5. A focus on prevention and tackling inequalities
6. Integrated care – working together
7. Promoting independence and personalisation of care
8. Safeguarding the most vulnerable
9. Ensuring sustainability of service provision
10. Realising value for money
11. Maximising the use of technology
12. Incentivising innovation at a local level

A review of domiciliary care that sits in the wider Transforming Your Care (TYC) change programme started in 2014 and will report in 2015. At the centre of the review is the TYC core objective of ‘putting the individual at the centre of service delivery and enabling people to live independently at home for as long as possible’

¹² Intensive domiciliary care service is defined as 6 or more visits and more than 10 contact hours during the survey week

¹³ DHSSPS, 2011. <http://bit.ly/1OqKtVf>

1.1.4. Wales¹⁴

The majority of people in receipt of homecare in Wales receive it through local social services operated by the 22 local authorities in Wales, which assess need for help according to certain eligibility criteria. Most councils contract out services to the independent sector, which now provides just over half of publicly funded homecare and there has been a continued policy emphasis on helping people remain at home.

Much less data is available in Wales on the independent homecare sector, but anecdotal evidence provided to UKHCA suggests the picture is similar to England with the independent sector finding that contract prices offered by local authorities often fail to keep pace with inflation and other statutory burdens on employers.

There are 968 providers in respect of establishments and agencies in Wales, of which 22 are local authorities. There are a total of 1,780 regulated social care and support settings in Wales which fall within the scope of the current regulatory regime. Of the 1,780 settings, 1,562 are owned by the independent sector and 218 are owned by local authorities.

In Wales during 2015, discussions continue about health and social care integration, this being carried out at National level.

2. WORK AND EMPLOYMENT QUALITY

2.1. Career and employment security

2.1.1. Overall approach

While the sector in the UK is characterised by strong gender segregation and part-time employment, it is difficult to find useful data on working conditions in this sector. This is partly due to the high prevalence of undeclared working arrangements, which not only make it difficult to measure the actual extent of the sector but also risk having an adverse effect on working conditions in this area (a fact that has been discussed in connection with migrant domestic workers working in the UK). The high prevalence of informal employment in this sector might furthermore deter workers initially interested in engaging in this sector of activity. In addition to this, informal working arrangements will inevitably result in a loss of revenue for the state through forgone taxation and benefits. For the workers this also

¹⁴ We draw here on the presentation made by UKHCA (UK Home carers association).

means that they miss out on their entitlement to public benefits and insurance provisions such as the statutory pension scheme or statutory sick pay.

England

The number of adult domiciliary social care jobs in England as at 2013 was estimated at 630,000. 475,000 of these jobs were in Care Quality Commission (CQC) regulated locations. This included 425,000 jobs in locations offering the CQC regulated service 'domiciliary care', 100,000 in locations offering 'supported living services', 35,000 in locations offering 'extra care housing services', 20,000 in locations operated by local authorities and 25,000 in locations operating a nursing agency.¹⁵ Around 10,000 jobs were in non-CQC regulated services such as domestic services, home-help and meals on wheels services and around 145,000 were jobs for direct payment recipients.

Around 214,000 adults, older people and carers received direct payments from councils. It is estimated that, as at 2013, approximately 70,000 (33%) of these individuals were directly employing their own care and support staff. However, these figures should be treated with caution as, despite advances in this area, there is still a shortage of data about individual employers and their workforce. It is estimated that the true proportion of direct payment recipients employing staff is likely to be between 25% and 40% (55,000 to 85,000).

Some personal budget holders (including those receiving direct payments) choose to have their care and support provided by self-employed personal assistants (as opposed to directly employing a personal assistant or purchasing care from an agency). There is currently not enough information available about these self-employed personal assistants.

There is also very little information available about the number of individuals directly employing care and support staff via other funding streams or as self-funders (non-direct payment recipients), or the use of self-employed personal assistants.

Scotland

As of 2013 there are approximately 1,900 active housing support / care at home services registered with the Care Inspectorate. This figure has remained relatively stable during the past three years.

The SSSC publishes an annual data report on the Scottish social services sector. A summary of the key workforce statistics for the housing support / care at home sub-sector from that report follows. All figures are correct as of 2013:

- The sub-sector employs approximately 62,000 workers in Scotland. The total number of workers has remained relatively stable during the past three years.
- Approximately 46% of housing support / care at home workers are employed by the voluntary sector. A further 28% are employed by the private sector.
- Approximately 81% of the housing support / care at home workforce is female. The equivalent figure for the wider social services workforce is 85%.
- The majority of staff in this sub-sector (88%) is employed in frontline care roles. A further 11% are working in auxiliary or managerial roles.
- Approximately 75% of all housing support / care at home staff are on permanent contracts
- The median weekly hours for housing support and care at home staff is 30. There are significant proportions of staff working full-time or part-time within these sub-sectors.
- There are believed to be approximately 100 nurses working in this sub-sector. The majority are based in the

¹⁵ CQC regulated locations can offer more than one service therefore individual services may sum to more than the total.

private sector.

A number of individuals use their direct payment to employ a Personal Assistant (PA). There appears to have been a steady decline in the number of packages which include a PA contract. In 2007 approximately 63% of packages included a PA package. That figure had fallen to 42% by March 2013. The SSSC has developed an estimated figure which suggests that there were approximately 4,700 PAs as of March 2012.

Wales

In 2011-12, a total of 11,916,648 hours of publicly funded domiciliary care was provided to clients in Wales. Of these, 3,594,021 (30%) were provided by 5,109 domiciliary care workers and 359 senior domiciliary care workers employed by Welsh local authorities. It can be estimated that the remaining 8,322,627 (70%) hours of domiciliary care were provided by an estimated 11,831 domiciliary care workers and 831 senior domiciliary care workers employed by the independent sector.

Up to an estimated 14% (1,773) of domiciliary care workers, not employed by local authorities, could be self-employed as personal assistants to individuals in receipt of direct payments.

In October 2013, there were 2,855 residential care home care workers providing publicly funded care to adults employed by local authorities in Wales. In October 2013, local authority social care workers provided care up to a maximum of 2,786 residents, who resided in 120 local authority residential care homes. Local authority care homes can provide up to 10% of places available for adults who require residential care.

In October 2013, the independent sector provided social care for up to a maximum 24,172 residents, who resided in 1,012 independent residential care homes. Assuming that the independent sector employs the same proportion of staff to residents as local authorities, their terms and conditions are equal and that they have the same level of absence as local authority staff, it can be estimated that the independent sector employs an estimated 24,771 residential home care workers. Thus, the estimated total of adult residential home care workers is 27,626.

Northern Ireland

The Carers Trust reports that there are 213,980 carers in Northern Ireland and that 30,000 carers in Northern Ireland are young carers.¹⁶

There are 305 domiciliary care services¹⁷ registered with RQIA¹⁸, this figure includes organisations in both the statutory and independent sectors with more than one registered service. It is estimated by the NISCC that approximately 11,929 of staff employed are domiciliary care workers in these organisations. Currently 2500 domiciliary and day care staff are registered with the NISCC on a voluntary basis and, with the roll out of full registration in Northern Ireland for all of the social care workforce, the NISCC estimates an additional 11,500 domiciliary care staff will be registered from September 2015 – December 2016.

Terms and conditions for home care workers vary from secure permanent contracts to zero hour casual contract. It is estimated that up to 40% of the workforce have permanent contracts.

The number of people who use self-directed support or direct payments to employ their own home care worker is rising in Northern Ireland, although it is still a relatively small part of the sector compared to other parts of the UK.

¹⁶ Carers Trust Website – Key Facts About Carers

¹⁷ http://www.rqia.org.uk/what_we_do/registration__inspection_and_reviews/service_provider_directory.cfm

¹⁸ The Regulation and Quality Improvement Authority (RQIA) is Northern Ireland's independent health and social care regulator

In March 2014 2,900 direct payments were made.

Access to home care is not means tested as a result very few people pay directly for their own care.

Employment arrangements in this sector are further characterised by a **high level of part-time jobs**, which seems to be increasing. According to data from the Annual Population Survey 2008, the prevalence of part-time employment is considerably higher among those engaging in personal and household services, at 55 per cent, compared to 26 per cent of the total workforce. Moreover, data from this survey shows significant differences concerning contractual provisions between workers in this sector compared to the overall workforce. While 57 per cent of workers in this sector are **self-employed** and only 38 per cent working under **permanent contracts**, this compares to 13 per cent of the overall workforce in self-employment and 82 per cent of permanent jobs.

In England, the workforce is predominantly made of **female part-time workers**. The latest data puts homecare at a turnover rate of 18.1%. Using updated figures from December 2008 – February 2009, the average hourly pay for a homecare worker was £6.80. This figure should be used with caution given geographical variations. Workforce information has been provided by homecare providers as part of a “National Minimum Dataset” project co-ordinated by workforce body Skills for Care.

Importance of occasional employment in UK

The introduction of direct payments and the extension of cash-based personal budgets may gradually lead to a more diverse, flexible and less regulated workforce. In 2009-10, 9.6 per cent of people aged 65-plus receiving local authority funded community based services were receiving personal budgets (Age UK, 2010). Assuming an average of 2.3 personal assistants (PAs) employed per recipient (Skills for Care, 2010)¹⁹, this gives an estimate of over 200,000 people working as personal assistants for older people. **As more people receive personal budgets instead of directly provided services, the numbers of people working directly for service users is likely to increase further.**

Personal budgets therefore encourage informality and occasional employment and more generally bad working conditions. There are **no requirements for personal budget holders to provide contracts or formal conditions of employment** to the personal assistants they employ, or for such workers to have any minimum qualifications. Only 34 per cent of PAs had been given a job description; personal budget-holding employers gave low priority to previous experience or job training, and only a minority supported compulsory registration (Skills for Care, 2008). Local authorities are beginning to develop systems to help prevent abuse of people who direct their own support ‘but the evidence indicates that no council yet

¹⁹ SKILLS FOR CARE (2010), The state of the adult social care workforce in England 2010, London, Skills for Care, mentioned in LIVINDHOME report.

has a systematic approach in place. Information and support to people funding their own care was also variable between councils'²⁰.

Household employing housework staff is submitted to the same rules than any other private employer. In **England** there is **no obligation to declare occasional workers** under a certain threshold and there are social exemptions for occasional workers paid less than £111 per week i.e. around 140 Euros, this being the threshold for liability to social security contributions.²¹ This peculiarity of the British model conduces many households to recruit for very short working times, without neither administrative duty to undertake nor social contributions to pay.

Some voices have been expressed to try to better regulate this system. In the framework of the public consultation on the topic of employment potential of the personal and household service undertaken by the European Commission in 2012, **the UK Trades Union Congress (TUC) highlighted that any growth of employment in this sector needs to take place in the formal and not the informal economy**. The TUC emphasises that informal employment in personal and household services is not only difficult to monitor but more generally has negative effects on both the quality of services delivered as well as working conditions for the workers involved. Further, the TUC states that informal workers will not be entitled to contributory benefits, which will leave them without any entitlement to statutory sickness pay, maternity leave or state pensions. Furthermore, the TUC highlights that informal employment in this sector will ultimately have a negative impact mainly in three areas:

- A lack of social security coverage might deterrent those that initially were interested in working in this sector.
- Informal working arrangements risk workers being exploited by their employers.
- Informal employment will inevitably result in a loss of revenue for the state through both taxation but also through the provision of benefits provided.

By emphasising the **benefits of working for an agency** (for example, training opportunities, guaranteed hours of work, sickness and holiday entitlements), some managers of home care agencies hope to deter significant numbers of their employees from moving to work for individual personal budget-holding employers. The latter may, therefore, be more likely to recruit helpers from their own informal local networks, leading to an overall increase in the size of the home care workforce, albeit potentially under less formal or regulated arrangements. In addition, provider organisations may also begin recruiting unqualified staff to provide the 'companionship' and domestic help demanded by some personal budget holders. However, any impacts on the overall volume and range of home care service options that result from users being able to purchase services directly instead of through a care manager are likely to take some time to become apparent. Moreover, any such changes may be of less significance than the

²⁰ CSCI (2008), The State of Social Care in England 2006-07, London, Commission for Social Care Inspection

²¹ Wages comprised between 111£ (lower earnings limit) and 153£ (primary threshold) are not liable to social tax contributions, however workers are nevertheless entitled to social rights (unemployment and pension), as if these contributions would have been actually paid.

increasing constraints on local authority funding and wider difficulties in recruiting and retaining home care staff and personal assistants.

The issue of forgone National Insurance (UK social insurance) payments and the entitlements linked to this in the case of informal working has also been picked up in other studies which highlight the **longer-term impact of undeclared work**. One study for example emphasises the fact that it is predominately women who are employed in domestic services, and they are already more likely to be affected by poverty and old-age poverty in particular (Jones 2004). Not participating in the UK national pension scheme might therefore have an even more serious impact on these women.

Existence of a collective agreement

Collective agreements are only likely to be found where the work is carried out by directly employed staff of Local Authorities or the NHS.

Migrant work

Migrant work is of particular importance in the UK. Every year around 17,000 non-EU residents enter the UK as domestic workers accompanying their employers (Gallotti 2009). However, it is also believed that due to the country's restrictive eligibility requirements, a large number of migrant domestic workers enter the UK through irregular entry channels. The issue of migrant domestic workers is therefore closely related to that of the informal employment of foreign workers.

Since 1998 non-EU workers wishing to accompany their employer to the UK can obtain a temporary work visa under UK immigration law (Gallotti 2009). These provisions allow employers to bring their domestic staff to the UK, typically performing a wide range of tasks including housekeeping or care work. In April 2012 the immigration rules for domestic workers in the UK changed, and now only allow domestic workers to accompany their employers for a maximum of six months²². Moreover, it is only possible to apply for a domestic worker's visa if an individual has been working for the same employer for at least one year. This visa is non-renewable and domestic workers are not allowed to bring along family members. In addition, once in the UK, domestic workers are not allowed to change employers, as they were previously able to do²³. This change in legislation, resulting in a non-renewable temporary work permit for a maximum of six months and without the option of changing employers was initially proposed in 2006 but only came into force in 2012.

²² See more details on current UK immigration policies for domestic workers working in private households: <http://www.ukba.homeoffice.gov.uk/visas-immigration/working/othercategories/domesticworkers/>

²³ Following a review of legislation, in 2000 the criterion of allowing domestic workers to change employers freely was added to UK immigration rules.

Organisations concerned with domestic and migrant worker rights as well as trade union organisations harshly criticised this move as a step back in terms of migrant workers' rights.

Studies among migrant domestic workers have reported cases of both psychological and physical abuse, including sexual abuse (Oxfam and Kalayaan 2008). In the context of the new legislation migrant workers would be unable to change employer if they were unhappy with their working conditions. Kalayaan (2009) has also reported on the growing phenomenon of migrant workers who provide care to elderly people in their own homes. While this report states that migrant workers play an unrecognised role in providing care to people in their own homes, the number of migrants who perform these sorts of tasks is increasing. Kalayaan argues that there should be more support, including training, for migrants who find themselves in these often challenging roles.

However, in 2011, the UK Government was among two EU governments which did not vote in favour of ILO Convention 189 on Domestic Workers mainly because the UK government argued that domestic workers share the same protection as other employees in the UK and therefore there was no need to adapt UK law to the requirements of the ILO Convention. This decision has been strongly criticised by the TUC in its submission to the European Commission's 2012 consultation on this sector.

2.1.2. Income and wages

According to the Livindhome report, social care is one of the sectors of the UK economy where **low pay** is common (Low Pay Commission, 2005), notwithstanding the fact that direct care workers were one of the groups to benefit most from the introduction of the National Minimum Wage in 1999 and social care employers were amongst those most concerned about its impact.

The Low Pay Commission (LPC) has expressed **concerns about non-compliance with the National Minimum Wage (NMW)** in this sector: "The evidence suggests that some groups are at greater risk than others of not receiving their entitlement to the NMW. Of particular concern is social care: HMRC's report on their recent investigations supported other evidence which had indicated that NMW non-compliance in this sector was higher than average." (Low Pay Commission, 2014)

A recent report by the Resolution Foundation highlights the potential scale of **underpayment** in the UK social care sector. There are around 160,000 care workers (out of 1.4 million) who are less than the NMW "when all working time" is considered. The average loss for these workers is around £815 per year (Gardiner, 2015)

The LPC has also expressed concerns about **non-payment for travel time**. This issue can lead to non-compliance of the NMW for care at home workers. The UK Government has published a number of reports which 'name and shame' services which have failed to comply with the NMW. A number of care providers have been included on this list.

The Living Wage (LW) is an hourly rate that is set independently and calculated annually. The current rate is £7.85 per hour.²⁴ There have been a number of economic and social arguments made in favour of the living wage. For example, the LW has been shown to improve psychological health and wellbeing among employees and increase life expectancy (Public Health England, 2014). The Low Pay Commission has indicated that employers should (where possible) aim to pay the LW.

In *England*, the mean hourly pay rate for a senior care worker in adult domiciliary care is £8.36 and for a care worker the rate is £7.36. The national minimum wage is £6.50. There are wide spread concerns that through practices such as not paying for travel time, travel expenses, training or uniforms; some employers are in effect paying less than the national minimum wage. It is estimated that 49% (excluding direct payment recipients) of adult domiciliary care workers are on a zero hour work contract, which gives an indication of the precariousness of work in this sector.

In *Scotland*, there are a number of initiatives which promote the Living Wage. For example, the Scottish Government funds the Living Wage Accreditation scheme. Employers can be fully accredited when their entire workforce is paid a minimum of the living wage. They can also attain partial accreditation if they are working towards this objective. As of May 2015 there are more than 200 accredited living wage employers in Scotland. A number of these employers are working in the care at home sector.

The Scottish Government's Vision and Strategy for social services highlights the needs to address the perceptions about this sector: "action to address low pay would enable a more positive narrative to emerge about the sector and encourage people to see it as a good career choice" (Scottish Government, 2015).

2.1.3. Worker's rights

If care workers are employed by local authorities, the NHS, national charities or some of the larger Care home providers they will be covered by collective bargaining arrangements, whether nationally or locally. However outside of these it is unlikely whether there will be collective bargaining even if there is a trade union presence within the workforce.

In *England*, in 2012 the government introduced new pensions legislation. One of the requirements of this legislation is that all employers automatically enrol certain employees into a workplace pension. People who are Individual Employers employing Personal Assistants will have to consider whether their Personal Assistants qualify to be automatically enrolled into a workplace pension. Each employer will have a staging date which is the date that the new duties first apply to them and these begin coming into effect on 1 June 2015.

²⁴ Rate correct as of May 2015. In London the living wage rate is £9.15 per hour.

2.2. Skills development and professionalisation²⁵

2.2.1. Skills and qualifications

The skill levels of the homecare workforce are generally low. However, employing agencies are now required to have specified levels of qualified staff. **National Care Standard 20**, relating to the competency and training of staff, specified that by 1 April 2008 **50 per cent of all personal care was to be delivered by workers with National Vocational Qualifications (NVQ) or equivalent.**

Skills and qualification levels are therefore slowly increasing, with most staff having or working towards NVQ qualifications acquired through on-the-job learning and assessment. Newly appointed home care workers without relevant qualifications must register for NVQ training within six months of starting employment. However, up to the end of March 2007, between a fifth and a quarter of registered home care agencies had not met this qualifications standard. In 2008, only 32 per cent of care assistants or home care workers had gained NVQ level 2 and a further 27 per cent level 3 (the two lowest levels) or above. Perhaps influenced by the difficulty in implementing Care Standard 20, the Care Quality Commission (the English national health and social care regulatory body) has recommended that the 50 per cent target figure should be dropped and replaced by a requirement that employers ensure they have ‘sufficient’ numbers of suitably qualified, skilled and experienced staff. From January 2011, NVQs will be incorporated into a new Qualifications and Credit Framework (QCF) that will enable people to gain qualifications at their own pace along flexible routes and allow a ‘mix and match’ approach to meeting the different development needs of the workforce (www.skillsforcare.org.uk/qualifications_and-training).

There are few workers in domiciliary care with professional (e.g. nursing) qualifications. Three-quarters of the domiciliary care workforce work as care/senior care workers providing direct, hands-on personal care and only three per cent have professional roles (the rest being managerial or supervisory positions). Direct, ‘hands-on’ care is provided primarily by women – 79 per cent of all those working in private domiciliary care agencies are women, as are 94 per cent of those providing local authority domiciliary care (Skills for Care, 2010). Eighty-two per cent of women working in domiciliary care do so on a part-time basis (compared to 56 per cent of men). A Care Certificate has been introduced into this sector in England during 2014.

Situation in England

72% of the adult domiciliary care workforce had completed a formal induction process, 8% of this workforce were in the process of completing their induction, while for the remaining 20% it was not applicable. 45% of all adult social care staff involved in direct care has no formal qualifications. The highest qualification level of the adult social care workforce involved in providing direct care is 30% have attained a level 2 qualification, 15% level 3, 4% level 4 or above, and 6% any other qualifications.

Skills for Care, in partnership with the Department of Health, actively promote social care. In 2012/13 there were

²⁵ We draw here on the Livindhome national report for England and partners’ submissions.

73,100 social care apprentices.

The Care Certificate developed, as part of the Cavendish Review work, jointly by Skills for Care, Health Education England and Skills for Health was designed with the non-regulated workforce in mind. Introduced from April 2015, it gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. The Care Certificate builds on and replaces the Common Induction Standards (CIS) and National Minimum Training Standards (NMTS) and is one part of the induction for staff who are employed as Health Care Assistants, Assistant Practitioners, Care Support Workers and those giving support to clinical roles in the NHS where there is any direct contact with patients.

Situation in Scotland

The Scottish Social Services Council's register was setup under the Regulation of Care (Scotland) Act 2001 to regulate social service workers and to promote their education and training. Registration is a major part of the drive for higher standards in social services and is bringing the social service workforce in line with other professional colleagues. Nursing, medicine and teaching are all regulated professions and workers have to register with their own regulatory bodies to be able to work in their field. Social service workers have to do the same. To register with the SSSC a worker must satisfy the criteria for registration. This includes holding, or agreeing to work towards, the appropriate qualifications for the job they do. The registration agenda for care at home services is as follows

- managers of care at home services must register within six months of taking up employment in this role. Managers must complete 15 days or 90 hours post registration training and learning (PRTL) during their three year registration period.
- supervisors in a care at home services must be registered by 30 June 2017. Workers new into their role after 30 June 2014 should achieve registration within six months of taking up employment in this role. Supervisors must complete 10 days or 60 hours of PRTL during their five year registration period.
- workers in a care at home will be required to register in due course. The Scottish Government have yet to announce the dates for registering this workforce. The SSSC's website notes that the anticipated date for opening the register is 1 January 2017. The anticipated date when workers must be registered by is 1 January 2020.

Situation in Northern Ireland

The Northern Ireland Labour Market Information (LMI) Stage 2 Report – Domiciliary Care report March 2011 noted that there are a number of employees who are reluctant to undertake training. Many do not consider that they have the educational ability to access training or may have had a negative experience at school. Lack of confidence is a major factor. Some employees have other commitments on their time and training is not a priority for them. A lack of funding for NVQ26 training has been identified as a barrier for undertaking training.

The increasing cost of training and sometimes poor quality of training is concerning for employers. The level of access to training very much depends on the financial stability of an organisation at present. Many employers are reducing their funding for qualifications in the year ahead. Some employers have in-house trainers to deliver all training to employees. An advantage of in-house training means that training deficits can be identified and dealt with earlier.

The NISCC 2014 report on the Qualification Profile of the Social care workforce in the Independent and Voluntary

²⁶ From 2011/12 the relevant qualifications are those on the Qualification Credit Framework (QCF)

Sectors in Northern Ireland found that 48% of care staff in domiciliary care and 56% in supported living²⁷ hold a relevant Health and Social Care qualification.

The roll out of registration for domiciliary care staff during 2015 and 2016 and the PRTL requirements that goes with registration will ensure standards continue to be raised.

2.2.2. Recruitment and staff shortages

Home care provider agencies report significant problems in recruiting and retaining staff and turnover is high. Turnover problems are not unrelated to levels of pay, which have remained relatively low because of the purchasing power of local authorities in keeping down the prices they pay for services. The vacancy rate in social care is nearly double that for all types of industrial, commercial and public employment (Eborall and Griffiths, 2008). Many of the vacancies are described as ‘hard to fill’ because of a shortage of suitably qualified candidates (rather than an overall shortage of applicants) (Moriarty, 2008). Patterns of demand for services, with peaks in the morning and evening, also reduce the attractiveness of work in the sector, particularly where there are alternative low skilled employment opportunities in the local retail and catering sectors.

In *England*, an estimated 41.8% of directly employed staff working in adult domiciliary care services started their role in the last 12 months, this is 185,000 people. It is unsurprising to see the largest number of new starters in this area because this is the area of the sector that has seen the most growth in the past year. Adult domiciliary care services also have the lowest staff stability, highest turnover rate (30.6%) and a vacancy rate of 7.7%,

2.2.3. Professionalisation

In *England*, professional roles accounted for 6% of all jobs in adult social care jobs in England. This group includes several rather different jobs, which have in common the requirement for a professional qualification. The jobs included in this category are social workers, occupational therapists, registered nurses, allied health professionals and teachers.

It is estimated that the number of registered nurses working in domiciliary services is 6,800 or 13% of all nurses working in adult social care in England. There is evidence that employers may be filling (either now or in the recent past) a skills shortage of registered nurses in England by recruiting from abroad.

In *Northern Ireland*, the NISCC 2014 report on the Qualification Profile of the Social Care Workforce in the Independent and Voluntary Sectors in Northern Ireland showed that 5.6% of staff in conventional

²⁷ Supported Living Services are registered with RQIA as domiciliary care agencies

domiciliary services holds a social work, nursing or allied health professional qualification. In supported living services the number was 28% however it should be noted this percentage includes a large organisation which provides specialised services and employs 69 social workers (this might account for the significant difference in the two service areas).

2.3. Health and well-being

2.3.1. Work organisation

In *England*, the average number of days sick per worker in the past 12 months was 4.5 days, the private sector (at 3.7 days) and voluntary sector (at 4 days) are similar. However, the statutory local authority sector has higher sickness at an average of 10.2 days per worker. With an estimated workforce of 1,297,000 and an average of 4.5 sickness days that is a total of at least 5,840,000 days lost to sickness every year.

However, it should be noted that sickness rates in the NMDS-SC may be under-recorded in the private and voluntary sector, which could make them appear lower than the reality, especially when compared to the statutory local authority sector.

2.3.2. Risk exposure and health problems

In *England*, increasingly, care is provided within people's homes by Personal Assistants (PAs), care agency staff or local authority homecare services. The Health and Safety at Work Act 1974 (HSWA) does not apply to activities classed exclusively as 'domestic services' carried out in 'private households' Personal care provided within someone's own home may be 'domestic service' and therefore may fall within this dis-application.

However, an employee will only be a domestic servant if their job roles and responsibilities are exclusively domestic in nature. Employees whose role extends beyond domestic duties are not considered to be employed exclusively as domestic servants and this dis-application is not likely to apply. Examples include:

- if the carers work for the NHS, Local Authorities or employment agencies then they are unlikely to be employed exclusively as domestic workers and HSWA may apply,
- if the care involves complex healthcare activities (such as operation of life support or palliative care equipment) then HSWA is likely to apply, and,
- if delivery of the care requires specialist training (for example, people handling and dealing with challenging behaviour) then HSWA is likely to apply.

3. SERVICE QUALITY

3.1. England

The Care Quality Commission (CQC) regulates a range of care providers across England who are involved in delivering personal care. This includes residential care, nursing homes and care agencies. The CQC expect all regulated providers to comply with their new Fundamental Standards (which replaced the earlier Essential Standards on 01 April 2015). The CQC will then regularly inspect providers to ensure the service they deliver is safe, effective, caring, responsive to people's needs and well-led.

The number of adult domiciliary social care jobs in England as at 2013 was estimated at 630,000. 475,000 of these jobs were in CQC regulated locations.

In order to register, a home care service provider must complete an application form and provide appropriate financial references, a statement of purpose, a business plan, and a set of written policies and procedures making clear how the organisation intends to comply with the Domiciliary Care Regulations 2002 and the National Minimum Standards.²⁸ Providers must also nominate a 'responsible individual', a senior member of the organisation responsible for supervising the management of the service. Although the responsible individual is not registered, they represent the organisation and must be able to show that both they and the organisation meet the fitness requirements for registration. In addition, upon registration, domiciliary care agencies are required to provide an outline of the **training programme** for the next six months for all staff, including managers. We have seen above that a target was fixed to professionalise workers (50% of care was to be delivered by workers with National Vocational Qualifications (NVQ) or equivalent) but that this objective was questioned.

In addition, regular **inspections** (announced and unannounced) of each provider organisation encourage compliance with a set of National Minimum Standards (NMS). There are three types of inspection: key inspection, and random and thematic inspections. A key inspection is a major assessment of the quality of the service and any risk it might present and is usually unannounced. Newly-established agencies have a key inspection in the first six months. Shorter inspections focus on specific issues and supplement the key inspection. They may follow up a previous concern or complaint, a change of manager, or a change in the service. Thematic inspections focus on a theme, for example how staff manages users' medication.

The NMS cover all aspects of management and care practice, but have been criticised for having an undue focus on processes and paperwork, rather than on outcomes and practice. Homecare providers met or exceeded 82% of the former National Minimum Standards in 2007.

According to France Stratégie report, registration of providers is not really constraining. Providers just engage in respecting norms in the field of health or hygiene for instance. Control would be rather weak.

²⁸ We draw here on the Livindhome national report for England.

There is for instance no norm regarding the ratio of managers by employees.

3.2. Scotland²⁹

The Care Inspectorate is the independent scrutiny and improvement body for care services in Scotland. The Care Inspectorate makes sure that people receive high quality care and ensure that services promote and protect their rights. In 2013 the Care Inspectorate published a report highlighting the quality of care at home services in Scotland. The report contained the following points:

- Over 80% of all services receive good, very good or excellent for all themes
- 50.1% of voluntary sector services gained all very good or excellent grades
- 29% of private sector services gained all very good of excellent grades
- 23.2% of local authority run services gained all very good or excellent grades
- 2.2% of all services gained all unsatisfactory or weak grades

Until 2013 the Care Inspectorate used a six point scale to grade services. The Inspectorate has now moved to a five point scale.

3.3. Northern Ireland

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services. Their role is to ensure that health and social care services in Northern Ireland are accessible, well managed and meet the required standards.

RQIA also has a role in assuring the quality of services provided by Health and Social Care (HSC) Board, HSC trusts and agencies, to ensure that every aspect of care reaches the standards laid down by the Department of Health, Social Services and Public Safety and expected by the public.

²⁹ Drawn on UKHCA

3.4. Wales³⁰

Providers in Wales are regulated by the Care and Social Services Inspectorate Wales against certain standards. In 2008-2009 CSSIW found that there had been significant improvements in the quality of homecare services and that homecare providers were performing well in a number of areas, including care planning, quality assurance and medication.

³⁰ Drawn on UKHCA

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