

New forms of employment Casual work, UK

Case study 47: Local government contracting of social care

A home care services provider under contract to a UK local authority has been using zero hours contracts for all its home support assistants on a continuous basis. Zero hours contracts provide an efficient way of matching paid hours of work across the workforce to the number of hours required by the contracting body.

Introduction

The use of zero hours contracts has increased in the UK, particularly since 2010. These contracts, which have no specific legal status, have always been possible in the UK and have not developed out of any new initiative, or new employment or benefit regulations. One area where their use is widespread and established is in private or voluntary sector organisations providing social care services under contract to a local authority.

In this case study, the use of zero hours contracts arises largely out of the procurement practices of the local authority concerned. This case study discusses the practices of the organisations involved:

- the local authority as a public sector commissioning body;
- a private, voluntary and independent (PVI) sector provider of home care services (under contract to the local authority);
- a recently established local authority trading company (LATC) which provides specialist adult social care services (under contract to the local authority);
- the local branch of the trade union, Unison.

Interviews were conducted with key actors within the council, the new trading company and the contracted service provider, and with two employees currently working on zero hours contracts. Supplementary data were drawn from publicly available financial and workforce data for 2013–2014.

Local government in the UK has a long tradition of contracting out non-core services. Compulsory competitive tendering adopted during the 1980s forced councils to open up large parts of their service delivery to private sector providers to eliminate ‘producer capture’ and achieve significant cost savings (Rhodes, 1994; Colling, 1999). The transfer of services to the private sector has been found to progressively dilute pay and conditions, particularly as new staff are introduced on different terms of employment (Foster and Scott, 1998).

In the late 1990s, local government was allowed to include criteria other than price in its contracting decisions under the principle of best value but was not allowed to favour bids from the public sector. It is during this period that the main push for outsourcing domiciliary social care services came about. Social care services make up as much as 50% of local authority spending, but are largely provided under contract by a multitude of private and not-for-profit providers (Audit Commission, 2011; Hughes et al, 2009; Rubery et al, 2011). Much of the transfer of services occurred before the 2008 financial crisis and

the post-2010 austerity policies. However, the severe squeeze on local government funding since 2010, particularly in the most deprived areas where social care is often an even higher share of the budget, has further intensified pressure on local government to take costs out of the social care budget through even tighter commissioning of social care.

General characteristics

Local authority

The local authority in this case study is a large metropolitan district council in the north of England, with statutory responsibility for the provision of social care services to vulnerable adults and young people, either directly or through contracting arrangements. Its total budget for 2013–2014 was around €854 million (an exchange rate of €1 = GBP 0.82 is used throughout this report), approximately 50% of which is spent on direct staffing costs; the other 50% is spent on contracting and other organisational running costs. The council employs around 6,000 staff (excluding schools), but in response to budget cuts totalling €122 million since 2010, it council has lost over 2,000 (mostly permanent) staff across its whole field of operations through voluntary redundancy and early retirement. It has also merged and restructured to reduce its ‘directorates’ from seven to five.

Despite this significant downsizing and restructuring, the human resources (HR) vision for the council is still centred on a good employer model (Fredman and Morris, 1989), which involves trying to do ‘the best for workforce’. This is manifested in the protection of existing terms and conditions, and a public commitment to a ‘no compulsory redundancy’ policy, supported by the internal redeployment of staff displaced by service redesign. The council has a centralised corporate HR function of around 30 staff, which supports the whole organisation.

The local authority has responsibility for assessing care needs of its citizens and for commissioning that care, including for those who are required to pay the local authority for services on the basis of means testing. If requested, it also assesses citizens for personal budgets to enable them to purchase care directly. This policy of personal budgets was piloted in the late 2000s and is now available as an option to those eligible for government-funded care as an alternative to directly commissioned care services.

Provider

The provider referred to in this case study began operating as an unincorporated association in 1994 before registering as a charity in 1998 which, in the UK, confers additional rights and responsibilities, such as various forms of tax relief and the protection of assets from misappropriation by individual members. Published accounts show that its annual turnover for 2013–2014 was €1.65 million; these accounts describe the organisation as being ‘in a stable financial position with comfortable reserves’ even though it only about broke even for the last few years.

The provider employs 115 staff, including nine office-based management and administrative staff and 106 home support assistants, including the two interviewees for this report. Only five men are employed and ages range from 22 to 76 years-old. The office staff have been employed for 4.5–20 years, whereas the home support assistants typically have shorter tenures; just under 50% have been employed for less than five years.

The provider offers personal care, companionship and domestic support to individuals in their own homes. It delivers around 2,400 hours of care to around 370 individual clients, about 50% of which (1,200 hours) is under contract to the local authority. This represents around 5% of total care hours commissioned by the case study local authority. The other 50% is delivered under individual private contracts with clients who may be using their own private income or savings, or who may be in receipt of local authority funded personal budgets to purchase their care. The provider occasionally delivers a small number of hours under a spot contract agreement with a neighbouring local authority.

There are currently no trade union members within the case study provider: a small number of staff who transferred over to the organisation on its formation in 1994 were trade union members, but over time they have been gradually replaced by non-union staff. Although the general manager was personally fully supportive of trade union membership, it appears that there has not been a strong tradition of unionisation: employees do not show any particular interest in becoming unionised and local union branches have not made efforts to recruit and organise care workers. There is no formal channel of collective staff representation although, in common with many charities, the provider has a voluntary management committee made up of around 12 trustees who meet bi-monthly with the general manager to discuss operational and workforce issues. A staff representative used to sit on this committee but it was decided, by agreement with the staff, that it would be more efficient for staff to communicate issues directly to the general manager, who would refer them where necessary to the committee.

Context of social care procurement

As discussed above, the financial constraints placed on the public sector have significantly increased the demands on resources and one strategy adopted has been to increase integration of services. The council has brought together adult and children's social care commissioners under a single senior manager and implemented standardised practices wherever possible. Although this was expected to result in operational efficiencies by removing duplicated effort, in the view of the lead commissioner for adult services, the creation of this 'People Directorate' represented a shift back to the original unified 'social services' departmental model, which most councils dismantled in the late 1990s. However, it also represented an opportunity to move towards holistic 'outcomes based' commissioning (for example, 'supporting older people to live independently'), with a greater focus on quality (rather than quantitative) 'outputs'. The previous devolved procurement arrangements had created duplication and variable standards, which could be made more coherent under a single strategic approach.

No adult social care services are provided in-house; all are provided under contract by either the PVI sector or through the new LATC established in December 2013. The trading company is currently still under the governance of the council but has a discrete management structure, and the new managing director is responsible for its operational performance and a total annual budget of €40 million. Faced with the major cuts in budget post-2010, the council leadership preferred the trading company option as a means of reducing costs to the alternative of wholesale privatisation. This option allows the organisation to offer 'traded' services directly to citizens and other local authorities, which the council is not allowed to do. Following a three-year transition period, during which funding is provided primarily by the council, the trading company will become fully independent. This means it will have to bid for local authority contracts and private referrals in the same way as any other private sector provider, although the ambition is to develop the organisation along the lines of a cooperative with shares owned by employees rather than investors.

The trading company currently delivers the following services under contract to the council:

- the universal 'reablement' service – supporting clients to live independently following periods in hospital or other residential care away from the home;
- a 'telecare' service – where sensors are installed in the home to act as a warning system for both the client and staff should daily routines be missed or safety problems detected;
- residential care, support services and day care for people with physical and learning disabilities.

The local authority only began to make significant use of external commissioning for domiciliary social care in the mid to late 2000s, that is, at a relatively late stage compared with most local authorities (Rubery et al, 2011). The private sector's involvement in residential care, nursing care and day care is of much longer standing, dating from the late 1990s and early 2000s.

In anticipation of its 2011 procurement exercise for home care, and once severe budget cuts had been made, the council undertook an extensive reconfiguration of in-house services and redeployment of staff to other care services. This prevented the transfer to successful bidders of directly employed staff under

the Transfer of Undertakings Regulations (TUPE), as required by Directive 2001/23/EC on transfers of undertakings. The last remaining directly employed adult social care workers were TUPE transferred to the LATC in December 2013.

This move to even more comprehensive outsourcing of domiciliary care services sought to reduce costs. However, the council decided against the other main means of reducing costs, namely, changing the eligibility criteria for receiving local authority funded care. Instead of restricting access to services to only those whose needs were at either 'critical' or 'substantial' levels, as defined by the Fair Access to Care Services (FACS) criteria (SCIE, 2013), it continued to service all levels of needs including those deemed to be 'moderate' or 'low'. This decision to continue servicing all four FACS levels of needs is highly unusual across local government, and restricting referrals for funded services to critical and substantial levels would have reduced the number of clients by around 40%. Although this possibility has been discussed in budget setting meetings, there does not appear to be any appetite to revise the eligibility criteria. This position is perhaps surprising as, according to the lead commissioner, there is a growing demand for more complex and resource intensive palliative care in the critical or substantial end of the spectrum, adding further to budget pressures.

The demand for services is generally stable at somewhere between 20,000 and 25,000 hours per week across the local authority area. There are some fluctuations, but these are not necessarily related to seasons and so are unpredictable.

Procurement approach

The integrated commissioning function designs the overall service specifications for a particular population or client group, along with the anticipated outcome and quality measures. The corporate procurement unit supports commissioners as required through the bid, evaluation and contract award stages, as well as providing support and challenges throughout the life of the contract to ensure value for money, compliance and quality. The procurement process is important in shaping the use of zero hours contracts in the private sector due to the tight budget and time specifications, as discussed below.

The last procurement exercise resulted in 10 home care providers being listed under a four-year framework contract due to end in 2015, worth around €12 million a year. The city is divided into five zones, with two providers per zone for local authority commissioned services. New referrals are allocated to each of the two providers on an alternate basis subject to capacity and staffing; a further 15 home care providers are used on a spot purchase basis, where clients use their personal budgets. Most of the 10 preferred providers are for-profit businesses. From the providers' perspective, the zoning helped to stabilise allocated hours to each provider, in contrast with previous city-wide contracts, where providers had no 'exclusivity rights' to operate in a particular area and had to compete with all providers for each care package. Over the course of the contract, a broadly stable number of hours could be expected from week to week. The council had considered reducing the framework providers to just five to increase the capacity of individual organisations, but there were concerns about the resulting dominance of the remaining five providers.

Fees

Fees paid for domiciliary home care are generally low in the UK and are decreasing in nominal as well as real terms. The case study local authority pays a flat rate of €13.90 per hour fixed from 2011 to 2015. Under the procurement arrangements before 2011, the fee was €14.27 per hour and some enhancements were paid for unsocial hours; these enhancements were abolished in 2011. There were internal discussions whether to reduce the rate further because of overall cost pressures and comparisons with the rates paid by other local authorities. According to the lead commissioner, this could have created problems in attracting potential bidders and also damaged relationships with existing providers; the decision may also have been influenced by the experience of other councils in the area which were being taken to a tribunal for cutting fees significantly.

The €13.90 hourly fee is below average: 2013 data collected by the BBC under Freedom of Information procedures found the average hourly fee for home care to providers in the UK to be €14.95. Significantly, only four out of 101 councils paid the €18.50 rate calculated by the UK Home Care Association as being necessary to properly reflect wages, training and travel costs (BBC, 2014). The case study council felt that, without a significant increase in funding available for home care services, the €18.50 minimum hourly fee was absolutely out of the question.

A fixed fee was stipulated in the tender to avoid ‘a price war’ and to award contracts based on quality scores alone. However, by pitching the fee at €13.90 per hour, it may have precluded bids from providers who might wish to build in allowances for guaranteed hours, retainer payments and travel allowances. There was no shortage of bidders at €13.90 per hour and only one provider at the invitation-to-tender (ITT) stage argued that the council was wholly unrealistic to expect quality care at that price. The case study provider had been contracted with the council in the past and was willing to bid for work at the new rate of €13.90 per hour. Despite the tightness of margins (even for a charity), the fixed fee was seen as advantageous as they had lost out to large providers when tendering for other contracts where competition on price was involved.

Regulating working conditions

The local authority has a history of relatively stable industrial relations, with three trade unions recognised for the purposes of negotiation and consultation over workforce issues. Unison is the largest trade union in the city with around 6,000 members, followed by the general union GMB and then Unite. All three unions have a good working relationship with the council, and despite the recent upheavals, were broadly positive about the efforts of its HR department to protect job opportunities for existing staff through the use of an internal jobs market and a formal ‘no compulsory redundancy’ policy.

The most significant channel of formal consultation and negotiation is the Joint Consultative Committee at corporate level, where council-wide workforce issues such as large outsourcing decisions, staffing numbers and pay and conditions are discussed by council officers and trade union representatives. Directorate-level consultative committees deal with staffing levels and restructuring within a particular service area or affecting a group of staff and not the whole council.

Regarding the joint regulation of working conditions for outsourced staff, the Unison branch argued that the position of the trade unions locally was compromised (or at least affected by) a number of issues. Significant factors included:

- a lack of meaningful consultation at early stages of the commissioning process;
- faltering political support for in-house models in the face of sustained budget cuts;
- the financial pressures on commissioners resulting in cost considerations taking precedence over quality – in reality if not in rhetoric;
- the fragmentation of service provision leading to existing members being increasingly dispersed and difficult to organise;
- trade unions’ limited penetration in the PVI sector making it difficult to extend collective bargaining and pay settlements – except in the LATC during its ‘transition’ phase;
- the few mechanisms used in procurement to set or enforce HR standards among contractors beyond basic training and safeguarding provisions.

The lead commissioner noted that the council had not had any real contact with trade unions over commissioning plans, particularly where contracts were relatively well-established and the private sector was already a significant provider of services.

Unison felt that the council had attempted to include the unions in consultations around the implementation of contracts and TUPE transfer of staff, but to a lesser extent when the decision to procure was made. Despite the council’s historical commitment to keeping services in-house wherever

possible, political leaders were increasingly turning to PVI providers to maintain or take over the running of council services.

The establishment of the new trading company in December 2013 and the subsequent TUPE transfer of around 800 council staff did lead to a major consultation exercise at corporate level – notably, initially, among politicians and senior management about several options. The trade unions’ main concern was the likelihood that the recruitment of new staff to the trading company who were not covered by TUPE regulations would lead to a gradual dilution of terms and conditions (Foster and Scott, 1998). So far, changes primarily relate to new pension provisions and have not involved major changes in working time arrangements; as a result, no use has been made of zero hours contracts within the new trading company to date. The company has a contract with the council for three years, with a broad commitment to maintaining existing working conditions. After that it will have to ‘compete with the market’ and the search for efficiencies could lead to a review of working practices for the 1,200 staff now in post.

The approach to terms and conditions adopted by the council in the fully outsourced services, according to both the council’s HR staff and the lead commissioner, is much more ‘hands off’. Although the council did aspire to promote HR best practice across the city, it was not considered either feasible or cost-effective to insert specific working conditions or clauses into contracts – particularly where the reason for outsourcing was to lower unit costs driven by less favourable pay and conditions.

In terms of HR practices within care services, the council currently monitors safeguarding procedures and background checks on new recruits, along with training and development plans for staff. However, it does not make any explicit recommendations or requirements on pay and working conditions. The council expects providers to comply with statutory provisions on pay and conditions, but it does not specify minimum pay rates, which are seen as entirely a decision for individual providers as employers.

As discussed earlier, the relatively low fixed hourly fee does not offer significant margins for providers to set wages above the national minimum wage (NMW) or even to respond to changes in the NMW (which is now €0.28 higher than 2011 when the procurement exercise was completed). The NMW increased by €0.23 in October 2014, placing yet more pressure on the financial viability of some providers, particularly as the council has no plans to increase the fees. The lead commissioner recognised that, although payment practices between providers vary – for example, some providers pay for travel time and some might pay a higher hourly rate but no travel time, – there was no evidence that providers paying higher wages were any better in terms of quality ratings or reputation. Moreover, most staff were paid close to the NMW.

Recruitment and training procedures are audited by council officers and improvement plans are put in place as required, for example, where paperwork is incomplete or where issues of poor care have been highlighted. Contracts have been suspended in the past while providers attend to quality issues, but home care is not felt to be an ongoing concern in respect of staffing or service standards.

In the case study provider, operational and day-to-day HR management is overseen by the general manager, although the provider contracts a business services specialist to help prepare HR policies and recruitment packs (the same company is used by several home care providers in the area).

Design and implementation process

No directly employed local authority staff are engaged on zero hours contracts. Instead, most employees are on permanent or fixed-term contracts with guaranteed part-time or full-time hours, though the council does use what are termed permanent variable hours (PVH) contracts. These confer the same employment rights as a standard part- or full-time contract (including statutory notice period, pro rata holiday pay consolidated into wages, sickness and maternity entitlements) but with no guarantee of hours from week to week. These PVH contracts typically applied to ‘sessional’ and seasonal roles such as events and sports staff, but were increasingly used in place of completely ‘casual’ contracts (where the employer and employee have no mutual obligations regarding working hours) to provide some guarantee of capacity where demand was sufficient.

Employees on PVH contracts are expected to be available for work when required and persistent refusal to accept the hours of work offered can be dealt with through council disciplinary procedures, such as formal warnings, leading eventually to dismissal. As of summer 2013, these contracts constituted 7.5% of the council employees, with a further 7% on fixed-term, casual and temporary contracts. The PVH staff were 64% female and 45% were in the prime working age category of 30–50 years-old, so this type of contract was not associated with younger workers. Most occupations of the PVH staff were in sports and leisure services in seasonal and ‘sessional’ roles such as events staff and sports coaches. These contracts could be regarded as similar to zero hours contracts, in that no guarantees are made about working hours, but with less ambiguity regarding employment rights.

The LATC employs staff on regular guaranteed hours contracts of 16, 25, 32 and 37 hours a week, depending on the service area, and allows part-time staff to work additional hours up to a maximum of 37 hours, beyond which time off ‘in lieu’ of pay or overtime enhancements of ‘time and a 1/5’ is applied. The company also uses PVH contracts rather than zero hours contracts, but primarily for staff who are already on a guaranteed part-time hours contract, to increase their hours of work up to and over 37 hours a week without incurring any overtime payments for the employer; for example, staff could elect to work on their day off if desired but this would be paid at the standard rate. This was a valuable source of additional income to some staff, and it meant that the employer could secure additional capacity without any binding commitment to extra hours or the payment of overtime rates to full-time staff.

Thus, the council had two types of contracts that served similar purposes to zero hours contracts:

- in the main council, to meet seasonal demand;
- the LATC, to provide cover at low cost from staff who are known to the organisation (directly employed staff).

This arrangement avoided agency fees, payment of overtime and problems of casual workers who have no knowledge of the organisation. The treatment of these PVH contracts as distinct from zero hours contracts also explains part of the confusion over the extent of the use of zero hour contracts in the UK (see case study 48 in this project for an analysis of zero-hours contracts in the UK – Eurofound, 2015).

In contrast, in PVI home care, zero hours contracts were used and regarded by the council and the provider as a widespread and generally ‘accepted’ feature of employment in the sector. The council lead commissioner regarded the use of these contracts to be a key reason why in-house services could not compete with PVI providers on unit costs, as payment for ‘downtime’ was a substantial addition to the overall running costs of council services. This suggests an important difference between the council’s PVH contracts and these zero hours contracts: the former may be used to provide seasonal flexibility and variable cover, but they do not involve the fragmentation of the working day as used in home care (described below).

Permanent zero hours contracts have always been used by the provider in this case study for all employees and for all areas of work, with the exception of a small number of salaried office staff including the general manager. This is primarily because the contract with the local authority only pays for the working time spent with clients. Zero hours contracts were part of the founding business model and were felt to be a necessary arrangement to align with the commissioning practices of the local authority.

The importance of local authority contracts meant that guaranteed hours contracts were not considered a feasible business model for many PVI providers and particularly those operating on only a local scale only. The commissioner noted that new companies not contracted with the local authority were planning to operate on guaranteed hours, but considered this may be part of a short-term strategy to ‘poach’ staff and clients (clients wishing to maintain their relationship with individual carers would be able to transfer their direct payments to the new provider) rather than a long-term business model. Anecdotally, the provider suggested that some local home care providers had experienced significant financial and operational issues as a result of moving from zero to guaranteed hours contracts, with some going out of business.

Neither the commissioner nor the provider identified any particular problems in recruiting for zero hours contracts. In fact, it was perceived as increasingly common for employers in many low-paying sectors such as retail and hospitality to offer zero hours contracts. The council had recently asked a private provider to pilot an overnight service, which it was able to make operational in less than two weeks. Here, existing staff volunteered for the night shift, and the private provider was easily able to recruit externally on zero hours contracts to backfill the day shift. The commissioner noted that there seemed to be a stable supply of recruits who wanted to work in the industry, irrespective of zero hours contracts, and providers rarely refused work owing to a lack of capacity. These conditions may reflect the high unemployment in this locality. Although staff turnover could be high, most leavers stayed within the sector, perhaps moving between providers to access clients in a different geographical area. Some staff moved from home care to residential care for more guaranteed hours, but may have found that pay rates were slightly lower, equivalent to the NMW. Residential homes made greater use of agency staff to fill temporary gaps in capacity, but some in the area were building up their own pool of bank (casual) staff to reduce spending on agency staff rather than increasing the number of guaranteed hours contracts.

The use of zero hours contracts was not regarded by the commissioner as having created any persistent quality problems. The provider acknowledged that use of zero hours contracts did impact on staff retention over the long term, but it did not appear to significantly affect recruitment in the local labour market where workers may often have limited alternative choices. Zero hours contracts did dissuade some applicants who were in receipt of welfare benefits as payments are linked with recorded working hours, meaning frequent recalculations and occasional delays. Nonetheless, school leavers were increasingly applying for care work jobs as the range of alternative jobs decreased and the government reduced young people's access to unemployment benefits. However, while younger recruits might be willing to accept a zero hours contract, they might lack the interpersonal skills required for the job and underestimate the full range of physical and emotional demands. This was leading to a mutually reinforcing 'low commitment' model of employment. Employers structure entry-level jobs in such a way as to require only minimal qualifications in order to suit school leavers, but they are then concerned that the 'quality' of recruits is low in terms of skills and experience. They recruit from a pool of labour that have come to accept zero hours contracts as a 'reality' of the employment landscape, but they offer few incentives for workers to commit to one employer when marginally better working conditions are on offer elsewhere.

While a zero hours contract carries a degree of implicit flexibility to match worker preferences with the variable demand for hours, both the employee's and employer's preference was for a stable volume of work across the week. Zero hours contracts were a cost-driven solution, and although the provider expressed a strong desire to offer guaranteed hours, for as long as only contact hours were paid for by the council it was said to be simply not feasible.

Working method, processes and procedures

As discussed earlier, all home support assistants at the case study provider were engaged on zero hours contracts. Both of the employees interviewed were home support assistants who had worked for the case study provider for a number of years (nine years and eight-and-a-half years, respectively) and who had always been engaged on a zero hours contract. Both were aware of the type of contract when they applied for the job, but did not report that it significantly affected their decision to accept. One employee had worked on a guaranteed hours contract for four years in residential care prior to joining the current employer, whereas this was the first job for the other employee. It was the sole job for both employees. Neither of them was in receipt of in-work benefits (that is, working tax credits paid to those in low income employment working at least 16 hours a week and subject to household means-testing), although they were aware of colleagues who often had to submit evidence of working hours in order for welfare payments to be adjusted. Neither employee reported any problems in qualifying for statutory sick pay as both were earning more than €135 per week.

All staff on zero hours contracts are treated as 'employees' in the sense that they have a formal written permanent contract of employment. They have redundancy rights on a sliding scale based on the length of

time employed (for example:, under one month = no notice of termination; one to three months = one week's notice; three months to three years = two weeks' notice; and over three years = one week per year up to a maximum of 12 weeks). However, redundancy payments would not normally apply as staff are simply not allocated any paid hours when demand is low (rather than being made redundant), although there are small reserves held for redundancy payments should the entire organisation become insolvent. Statutory maternity leave in the UK is 52 weeks and maternity pay is due for 39 weeks as long as employees (but not 'workers') have been employed continuously for 26 weeks. At the case study provider, maternity pay for all employees is calculated based on individual average earnings over the last eight weeks and in accordance with the statutory schedule (90% of earnings for six weeks and then the lower of 90% of earnings or €168.50 for the next 33 weeks). Holiday entitlements are calculated on the basis of average weekly hours over the preceding 12-week period which for both employees, neither of whom had children, meant that additional hours could be gained over the summer holidays when other staff with children were on holiday and then taken as a higher paid holiday entitlement in September.

Retainer payments (at 50% of the hourly wage rate) used to be paid by the council and the provider for up to two weeks when clients went into hospital or residential care to offset some of the lost earnings when contact hours were not available. However, these were removed by the council about eight years ago due to cost. Although retainers are still in place for clients with learning disabilities (where the relationship between the care team and client is typically more static and hospital stays are less common), a loss of payment associated with a break in care was seen as 'standard practice' in the home care sector. As payment is for contact time only, care workers record visits which are countersigned by the client and then billed to the council. The council opted not to introduce electronic monitoring for visits as it was not deemed compatible with the move towards focusing on achieving positive outcomes for care users rather than focusing only on the inputs, such as minutes of care. Although the commissioner noted there were potential cost savings attached to electronic monitoring, home care work was already heavily 'time and task' focused, which would have been intensified by electronic monitoring.

Home care visits are typically 60 or 30 minutes, but can be as short as 15 minutes. The provider reported that 15-minute visits have become more common as budgets are squeezed. These short visits might involve support for a narrow range of tasks such as assisting a client to get ready to leave the house, or helping to prepare hot drinks and medication. In some cases, employees would stay beyond the recorded 15-minute allocation and therefore forgo payment, but where staff raised concerns about the length of visits, the provider could request that the client's care package be reassessed by the local authority. Unison at a national level has expressed concerns about the feasibility of providing quality care in 15-minute visits (Unison, 2012). Linking payments to predetermined visit times reduces the need for the provider to supervise staff to ensure work is completed on time, passing the risk on to the staff in terms of having to provide more time, or to the user if the staff are unable to complete all tasks.

The provider suggested that a zero hours contract would suit some employees who required flexible hours outside of a typical full-time working pattern, but in fact the ideal candidate would be middle-aged or older with no children or other commitments limiting the number of hours available for work. Both interviewed employees suggested that, in reality, zero hours contracts suited the needs of very few employees, that is:

- workers without children who did not have a particular need for flexible hours and could be available to work full time on a traditional '9 to 5 Monday to Friday' basis;
- workers with younger children who might find that client visits would clash with childcare routines – in their opinion, it would be difficult to make a 07.30 breakfast visit and take children to school for 08.30.

Work schedules for all staff on zero hours contracts are drawn up on a weekly basis and are issued on a Thursday to commence the following Monday, covering either a five- or seven-day period; staff essentially work a rolling 12-day pattern followed by a two-day rest period. The published rota contains the scheduled visits for each staff member over the coming week and reflects the care packages of known

clients – the times and days when visits are expected for the clients currently engaged by the provider. Visits to any clients who have been admitted to hospital or residential care are removed and any suitable new clients are added (see above for a discussion of issues around allocation of new clients). Visits can be cancelled by clients at only a few minutes’ notice and it can be difficult for the provider to bring subsequent visits forward to smooth out the worker’s routine. Despite the enhanced rates of pay, there is typically an undersupply of staff at weekends, so all staff are expected to work alternate weekends rather than asking for volunteers. New clients can be added to rotas and staff can be asked to cover for each other when unavailable at a couple of hours’ notice. Nonetheless, with the general reduction in average hours owing to a slowdown in new referrals, the likelihood of being offered new clients is decreasing and cover for absent staff is only typically required during holiday periods or absence through illness. The allocation of clients and working rotas take into account the home location of staff and their mode of transport. Although there are no definitive rules, employees are typically offered visits that are within 20 minutes travelling time from their home and ordered in such a way as to reduce the likelihood of multiple trips to and from the same area across the day.

HR policies

From the provider’s perspective, there are relatively few formal training or qualification requirements for new recruits into home support assistant roles, as training is performed on-the-job. All staff attend a formal one-day induction course, which is unpaid, followed by one-and-a-half days of paid training. They are then expected to complete the workbook training of Skills for Care, the independent strategic body that oversees the UK health and social care workforce, in their own time over a 12-week probationary period. Employees are allowed to use resources and facilities at the employer’s premises to complete the workbook during breaks, holidays or days off; this mainly involves reflective assessments of what they have learnt and experienced at work, so there is no formal training time involved. On-the-job training is provided through three days of job ‘shadowing’.

New recruits who have not obtained the expected but not compulsory vocational qualification, National Vocational Qualification (NVQ) level 2 standard in social care – the professional qualification recognised by Skills for Care, are expected by the provider to register to train within six months of employment. New recruits are required to undergo a criminal record check and, at the case study provider, they are now required to pay the €55 fee charged by the Disclosure and Barring Service (DBS), which the employer only reimburses after six months of employment. The DBS check must be completed before an employee is allowed contact with clients. Delays in processing applications have meant that potential recruits could leave before having actually started work, resulting in significant upfront cost implications for the provider. This was why the system of asking new recruits to fund the costs of the check was introduced.

Hourly entry rates at the case study provider are set at the 2013 NMW figure of €7.70, with a €0.02 increase after 12 weeks and another €0.27 increase following the completion of the NVQ care qualification (Table 1). Only 15% of adult women are paid under a low-pay threshold of the minimum wage plus 10% (Grimshaw, 2014), which indicates how low the pay is in private sector social care. The hourly premium rate for weekends is an additional €1.19 for staff who have completed the 12-week probation and an additional €1.12 for NVQ qualified staff. This is a relatively high premium according to a survey of 52 home care providers (Rubery et al, 2011). There are no further pay points for staff to move into and both of the employees interviewed reported receiving only a small number of very marginal pay rises during their time working for the provider. Recent uplifts in the NMW (€0.46 in the last three years) had steadily eroded differentials between the starting rate and post-probation rate, and although the provider reported a desire to give a pay rise this year, it may only apply to unqualified staff who would be earning less than the 2014 NMW of €7.93.

Table 1: Hourly rates at case study provider (€)

Hourly pay	Monday to Friday	Saturday and Sunday
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Hourly pay	Monday to Friday	Saturday and Sunday
Unqualified starting rate (12-week probation)	7.70	7.80
Unqualified full rate (after 12-week probation)	7.72	8.91
NVQ qualified rate	8.00	9.12

Source: General manager of case study provider

Travel time is paid at a flat rate of €0.41 and is attached to every individual visit, regardless of the length of the visit or the travel time/distance. This would theoretically benefit those with a larger number of short visits (more 15-minute visits across the day would accrue more flat rate travel payments), but the employees interviewed suggested that it did not amount to a significant extra payment. One of the interviewed employees travelled to visits on foot and reported that some journeys could take 25 minutes in each direction, sometimes for only a 15- or 30-minute visit. Even on the basis of a 30-minute visit, this would only pay €4.41 (30 minutes' pay at €4.00 plus €0.41 travel allowance) for a total of 1 hour and 20 minutes of time. Unpaid travel time is an increasing concern across the home care sector, as in many cases total pay for all hours of 'work-related time' is below the equivalent hourly NMW (Bessa et al, 2013), particularly when clients' homes are dispersed across a wide area. Even for the other employee, who travels by car, journeys could be 20 minutes across the city (sometimes several times a day), for which only €0.41 would be paid. The provider used to pay a petrol allowance, but this practice was ended a number of years ago owing to costs and employees are now encouraged to claim tax relief from HM Revenue and Customs (HMRC) for business mileage instead. The manager considered consolidating travel payments into the hourly rate, but when it became apparent that some staff would lose out, it was decided not to proceed.

Decisions around working practices, pay and conditions are generally taken by the management committee and communicated directly to staff by the general manager, often using memos in staff wage slips. There are no collective forums for staff representation, and issues or grievances are typically resolved on an individual basis. Despite this lack of formal social dialogue, employment relations appeared to be stable and reasonably cooperative. Both of the employees interviewed were broadly positive about the provider as an employer:

- there was a sense of a commitment to staff training and development – to NVQ level 2 standard;
- there was a degree of flexibility around unpaid leave and short-term unavailability for work, such as for appointments;
- staff receive a Christmas bonus;
- staff are supplied with contract mobile phones, though this also enables the employer to reach employees at any time.

External support

No specific external support is provided by the local authority to the provider with respect to work scheduling and zero hours contracts. The local authority's position is that the contractual arrangements for staff are a matter solely for the provider. The provider uses an external consultancy service for some HR advice and guidance, but not specifically related to zero hours contracts.

Outcomes and effects

While the use of zero hours contracts appears to fit the model of commissioning and service delivery under study, these arrangements have consequences for society, employers and care workers. The particular case reported here was not experiencing significant problems in recruiting and retaining staff,

but this could be considered a consequence of the severe impact of the recession and austerity in this region. In a much larger survey involving 52 PVI domiciliary care providers across 14 areas in 2008 and 2009, significant problems were encountered in recruiting and retaining a stable workforce; the average annual labour turnover rate was 31% and 77% of providers reported a labour shortage, 70% for covering care during unsocial hours. The consequences of these shortages and turnover rates were often unmet care needs and lack of continuity of care, which significantly reduce the recipient's experience of care (Rubery et al, 2011).

The use of zero hours systems and the associated fragmentation of the working day was a major reason why providers often face difficulties in recruiting sufficient staff, as these arrangements made it difficult to recruit outside the local area where care had to be provided. Such arrangements also limited recruitment to those willing to accept the often long as well as unsocial hours and the lack of guaranteed earnings.

There are three main issues identified by the employees interviewed in respect of zero hours contracts:

- lack of certainty over hours across the week or month – too few or too many;
- lack of certainty over minimum hours during the day – so that employees have to make themselves available for long working days in order to achieve a set number of paid hours;
- lack of certainty over work schedules and minimum work periods – resulting in variable unpaid breaks between visits and awkward travel schedules.

The two interviewees had contrasting reactions to the experience of being engaged on zero hours contracts. For one employee, the average hours from week to week were not enough to guarantee a sufficient level of income, whereas for the other employee, the average hours were too high to allow for rest and recreation. The employees explained that a zero hours contract was not necessarily a problem if the supply of new clients across a particular area was relatively constant; this had been the case up until recently, when competition from other providers for private referrals meant that the rate of new business had slowed significantly. The zoned framework contract was designed to 'protect' a defined area of potential clients, but the private purchase of care directly by clients along with flexible spot purchasing by the council meant that there were greater overlaps between geographical areas and more providers competing for the same business.

The former employee had previously worked an average of around 30 hours a week on a five-day rota (from 06.30 to 18.00) and around 40 hours a week on a seven-day rota. However, in the last year or so, this had dropped to as low as 12 hours when existing clients had gone into hospital and had not been replaced by new clients. This meant that the payment of fixed outgoings such as rent, food and utilities was a pressing concern, particularly as a single earner, and the employee reported having to keep a close eye on personal spending as her bank balance was going 'down and down'. In contrast, the primary issue for the other employee was that there was no limit to the hours staff could be asked to work. So although earnings would almost always be at least equivalent to full-time hours, there was no real work-life balance. This employee was on duty during the day shift (07:00 to 18.00) and the evening shift (18.00 to 21.30), and worked up to 45 hours on a five-day rota and up to 65 hours on a seven-day rota. The lack of guaranteed minimum hours was the main reason for the former employee seeking alternative employment – with the local authority trading company. But while the latter employee was grateful to have at least a full-time wage in practice, she was not entirely comfortable with the long hours, which meant lack of rest and recuperation and time with her partner.

In both cases, paid working hours were not reflective of the actual 'working day'; allowing for breaks between visits and travel time, the hours for which an employee was available for work could be double what was paid for. Visits were concentrated around mealtimes (07.00 to 08.00, 12.00 to 13.00, and 16.00 to 17.00), with some additional contact time in between – usually in the late morning to help with domestic duties and escorted trips to the supermarket or doctors' appointments. This resulted in a relatively large amount of unpaid 'downtime' in between paid visits, adding to the length of the working day but not reflected in overall earnings. The interviewed employee who worked evening shifts reported

typically being 'on duty' for 15 hours a day, of which only seven or seven-and-a-half hours were actually paid for. On the one hand, this reflects the hours for which the employer can legitimately invoice clients, but it also means that to achieve anything close to full-time hours, an employee might have to be available for over 70 hours across the week.

Furthermore, the spacing of visits and the amount of time required to travel to and from clients' homes meant that unpaid breaks were typically insufficient for rest or social interaction, either at home or with colleagues, friends and family. Both respondents described a frequent experience of browsing in local shops and visiting cafés in between visits, as the break was neither short enough to warrant travelling straight to the next client nor long enough to allow for a trip home. In fact, it was common to bump into other colleagues with similar breaks between clients at nearby shops.

While it was relatively rare for hours to fluctuate from full-time hours one week to no hours the next, the fluctuating client base due to clients being admitted to hospital or residential facilities meant that individual care workers did not have a consistent number of clients. Although clients were charged a flat minimum rate if a visit was not cancelled in advance (either paid by them directly or by the council), when a client was away from their home no chargeable hours were available for their care worker and therefore the provider could not pay them for the 'lost' hours as they did not receive fees from the local authority. Although the total number of hours delivered by the provider was relatively stable, new clients could be located in different geographical locations from previous clients, with different support needs at different times of the day. This created potential scheduling clashes with existing visits, problems in integrating new visits into existing travel routes, and difficulties in ensuring that staff had specific training and experience to perform certain tasks such as using equipment/home modifications. New referrals were therefore associated with these practical considerations in mind and could not necessarily compensate for lost clients.

Sensitivities around the personal and intimate nature of many tasks meant that continuity of care was a priority, wherever possible, in order to foster a trusting relationship between the home support assistant and their client. Once this relationship has been established it can be problematic to reassign another employee with whom the client is unfamiliar in order to bridge a gap in hours. Similarly, the physical location of existing clients and associated travel routines made it difficult on a practical level to reassign work. For example, it would be difficult to reassign work between the two interviewed employees as their clients are based in different areas and one of the employees does not drive.

Aside from the inconvenience of inefficient travel, 'wasted time' between visits and the limited opportunities to in-fill hours on an ad hoc basis, both respondents reported that inconsistent patterns of working time were compounded by a relative lack of flexibility to make alternative arrangements when work was not available. Both reported feeling as if they were on '24/7 standby', with few opportunities to use downtime for other purposes; unexpected downtime was not generally used for spontaneous activities, trips or breaks, as new clients could be allocated at any time. One of the employees reported that, when one of her clients (a morning visit) went into hospital, the gap until the next visit at 15.00 presented an opportunity to rest, but she subsequently received numerous phone calls asking her to work, which she agreed to.

In contrast to casual work, where there are no mutual obligations on either party to offer or accept work, zero hours contracts are asymmetrical in that employers offer no guarantee of work but employees will generally have to accept the work if it is available – or suffer disciplinary procedures/loss of future hours. There was no formal policy which denied hours to those who had refused them during a previous work period, but the employees interviewed did not think it would be viewed favourably by management when setting the next rotas. One employee reported that a zero hours contract meant she was able to take unpaid leave of around five weeks a year, in addition to paid holidays of four weeks, but this would not be possible at short notice; staff would be expected to be available for work even if there were gaps in the published rota. Thus, workers were somewhat trapped in a system of long 'hours of availability', which were insufficient to guarantee earnings and not flexible enough to allow the employees to pursue other commitments and interests. Exclusivity clauses were not in place, meaning that the staff could

theoretically work for more than one provider on zero hours contracts, but it would be unusual for staff to work elsewhere.

The relative lack of certainty over total earnings and total free time was a major issue for both employees in terms of their future career and job choices; neither wanted to work on a zero hours contract in the future and had considered looking elsewhere, within the care sector, for jobs offering fixed hours. One employee stated that the low average hours worked on a zero hours contract was a central factor in applying for alternative employment at the LATC and that the number of hours was instrumental in her choice of service area at the new employer;(she declined posts in two service areas of 30 and 32 weekly hours in preference for a service area offering 37 hours a week. The other employee suggested that a guaranteed number of hours of no more than 37 hours a week was the primary consideration. In general, however, so many posts in domiciliary social care are organised on a zero hours contract basis that there are few routes away from zero hours, apart from moves to residential homes or to office-based jobs coordinating care.

Strengths and weaknesses

Table 2 summarises the advantages and disadvantages of the system described in this case study.

Table 2: Impact of commissioning and employment practices on providers and workers

Commissioning instrument	Local authority's objective	Provider impact	Worker impact
Framework contract based around geographical 'zones'	To guarantee a service level for clients and to protect against dominance of a small number of companies	<p><i>Advantages</i></p> <p>Broadly stable hours</p> <p>Protection from competition within the 'zone'</p> <p><i>Disadvantages</i></p> <p>No guaranteed new clients in the 'zone'</p> <p>Geographical inflexibility across 'zones'</p> <p>New providers competing for clients outside of framework</p>	<p><i>Advantages</i></p> <p>Defined area of work: clients, visits and routes may fit in with personal circumstances and home location</p> <p><i>Disadvantages</i></p> <p>Fluctuating individual hours due to client turnover</p> <p>New companies competing for private work reduces supply of new clients</p> <p>Geographical restrictions and need for continuity of care means few opportunities to pick up other hours, unless other staff are on holiday</p>
Fixed fees	To prevent undercutting and to award contracts based on quality measures	<p><i>Advantages</i></p> <p>Stops undercutting by larger firms</p> <p>Gives a chance to emphasise quality dimensions</p> <p><i>Disadvantages</i></p> <p>Low hourly fee (€13.90) limits funds for training and other staff investment, and creates problems of labour</p>	<p><i>Advantages</i></p> <p>Less likelihood that companies will exert a downward pressure on wages (where above NMW)</p> <p><i>Disadvantages</i></p> <p>No chance for high cost/high quality providers to enter the market paying higher rates</p> <p>Hourly pay is not enough to meet the 'cost of living' (€8.00 versus €9.22 UK living wage)</p>

		shortage (but not at the time of the study due to the recession) Does not reflect the range of tasks undertaken	Hourly pay is insufficient to offset non-working periods
Paying for contact hours only	To ensure close matching of cost and output	<p><i>Advantages</i></p> <p>Not expected by local authority to pay staff for 'downtime' or periods of low demand</p> <p>Limits requirement for supervision</p> <p><i>Disadvantages</i></p> <p>Time and task oriented nature of the work</p> <p>Need to manage numerous short visits</p> <p>Relatively fixed schedules limit scope to share hours</p> <p>Risk of staff turnover due to zero hours contracts</p>	<p><i>Advantages</i></p> <p>May be able to use time between work for other commitments, rest or leisure</p> <p>Relative autonomy to organise work and travel routine</p> <p><i>Disadvantages</i></p> <p>No petrol allowance or bus fare</p> <p>Fixed travel allowance favours high volume of shorter visits</p> <p>Minimum work period of 15 minutes</p> <p>Variable earnings and schedules</p> <p>Long working day with short but unpaid breaks not suitable for other activities</p> <p>No retainer payments</p> <p>Holiday pay based on average hours</p> <p>Frequent recalculation of in-work benefits based on changing average hours</p>

Source: Case study interviews

Future plans

There are no plans for any change in the use of zero hours contracts by the provider and no plans for any improvement in commissioning arrangements by the local authority. As other local authorities have cut fees further, it is possible that conditions could even deteriorate further at the next procurement exercise, or at least that the cost increases over the past four years and the rise in the NMW will not be fully compensated for in the fee setting. It is also possible that the newly established LATC, once it is free to set its own terms and conditions after three years, may make more extensive use of zero hours contracts to compete with PVI providers.

Commentary

The use of zero hours contracts appears to reflect both the model of commissioning and employment across the home care sector in this local authority area. The way in which services are paid for and the way in which work is structured leads towards a flexible form of contracting, where employees are only paid for the contact time they have with clients and there are few incentives and opportunities to increase investment in the workforce.

All jobs are offered on a zero hours basis (except for the small number of salaried office staff), and there are few apparent incentives or facilitators enabling a move towards more stable or binding contract arrangements with staff (even with a small number of weekly hours). The relatively low hourly fee

offered by the council, the lack of enhancements and retainers, along with the growing pressure on entry rates brought about by relatively sharp rises in the NMW result in little reserve funding to pay for downtime between visits or for off-rota gaps when contact hours are not available.

Zero hours contracts provide the means to match paid hours of work across the workforce to the number of hours required by the contracting body – in this case, the local authority and private clients. In this sense, zero hours contracts are a central component of the provider's business model and appear likely to remain so.

In the context of the local authority and the specific provider in this case study, the high unemployment and limited alternative employment opportunities have allowed both the commissioning body and the employing organisation to use zero hours contracts without major problems in terms of recruitment and retention of staff or quality of care. As already mentioned, this situation does not apply in all labour markets, although zero hours contracts are indeed the norm in social care not only in high but also in low unemployment areas (Rubery et al, 2011). In areas of low unemployment, the outcome is high staff turnover and a labour shortage for the provision of care. In this particular case study, the main losers from zero hours contracts are the staff themselves, who face not only uncertainty over hours and earnings but also extended work involvement relative to the number of paid hours, as they are either waiting for the next client appointment or available at home to be called in for new client work.

The area studied is one of the most deprived in the UK and has been hit hard by budget cuts. The outcome is that zero hours contracts are becoming more widespread post-recession in the local labour market, although they have been used in the PVI sector for home care for a long time and have always been a core part of the business model for PVI providers tendering to supply home care services for the council.

The generalisation of zero hours contracts to entry-level jobs in other service sectors will reduce pressure to change the arrangements in home care. The minimum change that would be required for a move away from zero hours contracts is better procurement practices, including a much higher fee level. However, even then, this might not be translated into either higher hourly pay or guaranteed hours unless there was some expectation that this was a permanent policy shift. Data from across the social care sector suggest that revenue from higher charges is not necessarily passed on to staff in the form of higher hourly wage rates (Rubery et al, 2013) or guaranteed hours.

There are few grounds for recommending these practices to other sectors or countries. The only reason why these arrangements are not leading to problems of service supply or quality is because of the depressed nature of the local labour market. This has enabled the provider to secure service staff for relatively long periods on low pay and no guaranteed hours. The local authority has taken advantage of these conditions by cutting and fixing the fees payable, removing supplements for unsocial hours and, at an earlier stage, cancelling retainer payments when clients are temporarily hospitalised. The local authority has thus passed the risk and the lower resources first on to the providers, but in the clear understanding that this will also be passed on to the employees within the contracted out services – that is, through the use of zero hours contracts and by restricting paid hours to face-to-face contact time.

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