

Resolution Foundation

Does it pay to care?

Under-payment of the National Minimum Wage in the social care sector

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Executive Summary

The National Minimum Wage (NMW) is a right, not a privilege. And yet estimates suggest that between 160,000 and 220,000 direct care workers are likely to be being paid less than the legal minimum. This is nothing less than a national scandal, not only because it compounds an already poor employment situation for a significant minority of care workers but because NMW under-payment on this scale has an impact on the quality and dignity of care provided to older and disabled people who depend on social care services.

Social care remains a low status occupation and one that society appears content to see poorly remunerated. It is one of the lowest paid sectors in the economy, reliant on an overwhelmingly female workforce, many of whom lack formal qualifications and a growing proportion of whom are migrants. Combined with limited career opportunities and inadequate representation it's an increasingly unattractive proposition for many UK workers.

What transforms domiciliary care from an occupation often defined by poor employment conditions and low rates of hourly pay into one in which there are significant rates of NMW under-payment is the irregular nature of the service provided. Care in people's homes is not required on a consistent nine-to-five basis but in small chunks of time at different times of the day: in the morning to get someone up, washed and dressed; at lunch time to ensure that they are fed; and in the evening to help them back to bed. This creates fragmented and irregular patterns of work in which workers spend significant amounts of time travelling between clients.

With pressure on care budgets, workers are increasingly being paid only for the 'contact time' that they spent with clients and do not receive discrete payments for the time spent travelling between them. Of course, not every domiciliary care worker who does not receive an additional, discrete payment for travel time between clients will be being paid less than the NMW. Some will receive hourly rates of pay that are sufficiently high to ensure that the time they spend travelling between clients does not reduce their hourly pay below £6.19 per hour. Yet in a sector marked by ubiquitous rates of low hourly pay, there is little room to absorb the additional costs of travel between clients and many domiciliary care workers regularly find themselves working schedules that mean that their actual pay is less than the legal minimum.

The law on travel time is relatively clear: unless genuinely self-employed, a worker travelling for the purposes of duties carried out in the course of his or her work will be required to be paid at least the minimum wage, excluding the first and last journeys of the day and travel to and from breaks. And despite the fact that the irregular nature of domiciliary care delivery often makes it difficult to know precisely how the law should be applied, there is nevertheless a fair amount of legal clarity. How then are hundreds of thousands of workers denied the pay to which they are entitled?

At root, NMW non-payment stems from the growing gap between rising demand for care services in an ageing population and the funding made available to meet that demand. The failure of successive governments to ensure that funding for social care keeps pace with rising demand has put pressure on local authorities as the commissioners of care, many of whom have responded by not only restricting access to care but by driving down the price they are willing to pay for it – with the ending of discrete payment for travel time being one means of doing so. In turn, the independent care providers that now dominate the sector have responded by enhancing the flexibility of their workforces and seeking to drive down expenditure on wages (the bulk of care costs) by paying only for contact time and by monitoring staff more

closely to ensure that not a minute more than the time actually spent with clients is remunerated. In this environment, and given the deficiencies of the current NMW enforcement regime, it is easy to see how, whether deliberately or inadvertently, a substantial number of providers are operating pay systems that place a disproportionate amount of the risk of an underfunded social care system on individual domiciliary care workers.

In the medium term, a more sustainable funding settlement for social care is essential to resolving this problem. But the search for such a settlement must not delay action to end illegal NMW non-compliance in the care sector and ensure that the hundreds of thousands of domiciliary care workers currently being paid less than the legal minimum are given what they are entitled to by right. What then, can be done to drastically reduce the scale of NMW under-payment in the short-term?

First, local authorities must take steps to ensure that they are commissioning care in such a way as to better protect those who deliver it. This means ensuring that commissioning policies reflect the *actual* costs of care in any given locality, including the need to pay care workers at least the NMW. Local authorities should be required to be transparent about these figures and how their estimations have been arrived at. In addition, statutory guidance should be published requiring all local authorities to stipulate in contracts entered into with independent care providers that hourly rates for working time must be sufficient to cover payment of travel time and ensure that these contractual provisions are properly monitored and enforced. If these measures fail to reduce NMW non-compliance in social care, legislation should be considered that would make local authorities and independent care providers joint and severally liable for non-payment of the NMW.

Second, independent care providers must also be doing everything possible to ensure that their statutory obligations in regards to payment of the NMW are met. A statutory code of practice should be introduced to drive up standards among providers. The code would stipulate that a realistic component for travel time is included in the prices tendered to local authorities, that payslips are made more transparent and remuneration structures rendered less complex, and that work schedules which cram together short care slots that are difficult to deliver within the allocated time are phased out.

Third, the NMW enforcement regime must become a more effective deterrent to providers operating pay systems that leave domiciliary care workers with hourly rates less than the national minimum. Ultimately, the law on travel time is reasonably clear and must be properly enforced. First and foremost that requires an enforcement regime that is properly resourced. For this reason the government should end the current freeze on the minimum wage enforcement budget and designate NMW enforcement as 'essential expenditure' to render it exempt from the current freeze on public sector marketing. In addition, as befits its status as a 'high risk' sector, Her Majesty's Revenue and Customs (HMRC) should look to target more resources on social care, distributing sector-specific information and guidance and undertaking visible, pro-active interventions to identify and prosecute more employers in the sector that consistently break the law. Penalties for NMW non-compliance should also be increased and the regime's reliance on pro-active self-reporting by individual workers reduced by having HMRC work more closely with other organisations to identify and target employers likely to be breaching the law. Lastly, more needs to be done to ensure that workers who successfully win a claim for unlawful deduction of wages receive the pay they are owed. A government fund should be created that would immediately reimburse low-paid workers who have been victims of unlawful deductions and make government, rather than vulnerable individuals, responsible for recovering funds from employers.

Introduction

The National Minimum Wage (NMW)¹ is a right, not a privilege. All UK workers are entitled to it unless they are covered by a specific exemption. The vast majority, working for employers that faithfully adhere to the law, are paid at or above hourly NMW rates.

Yet a minority of workers still regularly do not receive their full NMW entitlement. Under-payment of the NMW – whether as an intentional act or as a result of ignorance or error – occurs across a broad range of industrial sectors and takes many forms. These include:

- Under-payment by means of inaccurate recording of actual hours worked;
- Under-payment by means of deducting for uniforms and/or other equipment;
- Under-payment on the basis of falsely designating work as piece rate (i.e. as ‘output only’ rather than ‘time work’ when the employer has control over a worker’s time);
- Under-payment by means of deducting for accommodation that does not form part of an employment contract or by means of artificial separation of the employer/landlord in cases where they are actually the same entity;
- Under-payment as a result of non-payment for travel time undertaken for the purpose of work

The last of these is a particular problem for domiciliary care workers in the UK’s Health and Social Work sector.² Pay in the sector is already among the lowest in the UK with the median hourly wage only 15 per cent above the NMW.³ Lower hourly rates and narrower pay distributions are more prevalent among the independent care providers⁴ who now dominate the care market.⁵ For a small but significant minority of domiciliary care workers the combination of low (and shifting) hourly rates of pay and non-payment for travel times between clients results in hourly pay rates that not only frequently fail to reflect actual time worked, but often fall below the current legal minimum of £6.19 an hour.

The fact that a significant number of domiciliary care workers regularly receive less than the NMW for their labour should be a cause for serious concern. This is not only because the law is reasonably clear about the fact that time spent travelling between clients should be regarded as time worked for the purposes of the NMW, but because NMW under-payment has a direct impact on those who receive care. This is not to question the professionalism of domiciliary care workers, most of whom deliver excellent services against formidable odds. But it remains the case that insecure, under-valued and poorly paid care workers delivering care in short and intensive time slots often struggle to provide clients with the dignified care they both deserve and require. And with the UK’s social care workforce projected to expand rapidly in future years as a result of increased life expectancy and medical advances that will leave more people living longer in ill health,

¹ Currently £6.19 per hour (rising to £6.31 from 1 October 2013) for adults, £4.98 for those aged 18 to 20, £3.68 for those aged under 18 and £2.65 for apprentices

² Human Health and Social Work Activities, sector Q under SIC 2007 classifications

³ See L. Besse., C. Forde., S. Moore., M. Stuart, *The National Minimum Wage, earnings and hours in the domiciliary care sector*, University of Leeds (2013)

⁴ S. Hussein, ‘Modelling pay in adult care using linear mixed-effects models,’ *Social Care Workforce Periodical* (2010), see <http://www.kcl.ac.uk/sspp/kpi/scwru/pubs/periodical/issues/scwp7.pdf>

⁵ The shift towards independent sector provision in residential care accoutred in the 1990s but the outsourcing of domiciliary care only became commonplace in the 2000s, see J.Hughes., H. Chester., D. Challis, ‘Recruitment and Retention of a Social Care Workforce for Older People,’ *PSSRU Discussion Paper M193-2*

the price of continuing inaction will only grow. Put simply, if we care about enforcing a legal minimum wage and improving domiciliary care we need to start investing in the workforce that provides it.

Given the existence of a legal right to remuneration for the time spent travelling between clients,⁶ the problem of NMW under-payment among domiciliary care workers is not *primarily* one of inadequate legal provision (although, as we will see, the law in this area is disjointed and provides employers with loopholes that can be easily exploited) but rather, why the law continues to be contravened *despite* being reasonably clear.

The answer requires an appreciation of:

1. The ***underlying factors that shape the market*** in which independent care providers bid for care jobs, particularly the funding arrangements underpinning the UK's system of publicly-funded social care provision.
2. The ***response of independent care providers*** to those market conditions and the means by which many – consciously or not – operate pay systems that do not remunerate at NMW rates for all hours for which those rates should be paid. This includes the trend toward payment for contact time only, the decline of enhanced payments for shorter visits, enhanced monitoring of working time, and the rise of more flexible and atypical forms of employment such as zero-hours contracts.
3. The ***lack of effective deterrents*** that might dissuade individual care providers from operating pay systems that do not remunerate at NMW rates for all hours for which those rates should be paid. This includes deficiencies in the current NMW enforcement regime but also the barriers to effective redress that face workers who seek to press claims for unlawful deduction from pay.

This report will explore each of these in turn as a means of understanding why a significant number of domiciliary care workers are paid less than the NMW and determining what measures are required to reduce the incidence of NMW under-payment in the sector.

The report is structured as follows:

- Section 1 examines the profile of the UK's domiciliary care workforce.
- Section 2 sets out the NMW under-payment problem in the social care sector, exploring precisely how domiciliary care workers are paid less than the NMW as a result of non-payment for travel time, the likely scale of the problem and the legal position in respect of the NMW and payment for travel time.
- Section 3 explores the range of contributory factors that help explain why, despite a reasonable degree of clarity as to its illegality, a small but significant number of domiciliary care workers are paid less than the NMW. It explores the underlying factors that shape the market for domiciliary care, the constraints and pressures influencing the employment strategies of independent care providers, and the lack of effective deterrents that might prevent non-compliance with the NMW.

⁶ Excluding travel to or from the worker's home, see Section 2

- Section 4 pulls together this analysis and sets out a series of proposals to begin to reduce the incidence of NMW under-payment in the care sector.

Terminology

The social care sector is complex and continues to change rapidly. In order to retain a degree of consistency throughout we have:

- Used the term 'direct care worker' when describing all those providing hands on care in any setting including residential, domiciliary and day care workers.
- Used the term 'domiciliary care worker' to describe those who provide care in the home rather than 'homecare worker' so as to avoid confusion with the term 'care home'.
- Used the term 'client' for those who receive care in the home rather than 'service user'.
- Used the term 'worker' rather than 'employee' when describing those who are not directly-employed at a particular establishment. This includes those employed as agency, bank, pool, voluntary workers and the self-employed.
- Defined the independent sectors as the sum of the private and voluntary (third) sectors

Section 1

The profile of the direct care workforce

Imbalances of power within the employer-worker relationship are crucial to understanding why certain forms of atypical and non-standard work are more precarious than others. In order to understand why a significant number of domiciliary care workers are regularly paid less than the minimum wage it is necessary to begin by understanding the profile of the direct care workforce in the UK.

A root cause of many of the problems in social care is the fact that it remains a low status occupation and one that society appears content to see poorly remunerated. Low levels of pay, coupled with the low status, gendered assumptions about the nature of the work, unfavourable employment conditions, and a lack of career opportunities have made care an unattractive proposition for many UK workers. It's partly for this reason that the sector suffers acute recruitment and retention issues. Average vacancy rates in England in social care are far higher than for all other types of industrial, commercial and public employment,⁷ even if there is some evidence to suggest that vacancy rates have declined over recent years in the wake of the economic crisis.⁸ Turnover varies across the social care sector but is also higher than in most other occupations. There are significant problems, particularly in domiciliary care, among providers of all types in attracting and retaining a trained workforce.⁹ The sector is therefore reliant on a workforce that is:

- **One that has low levels of formal qualifications.** 37 per cent of adult direct care workers hold no qualifications and 61 per cent only hold Level 2 qualifications or below.¹⁰
- **Heavily gendered.** This reflects the fact that the image and perception of care still bears the imprint of work that was historically carried out informally by women within the family and, as such, remains low-status. 84 per cent of domiciliary care workers are women¹¹ and many are motivated by job satisfaction and the emotional rewards of care work rather than financial gain.
- **Increasingly reliant on migrant workers.** Evidence indicates that foreign-born workers make up a growing proportion of the social care workforce.¹² This reflects the fact that care is viewed as an increasingly unattractive occupation to a range of groups of potential workers in the UK¹³ and migrant workers have stepped in to fill the gap. Data from the Labour Force Survey on care workers employed in occupations classified under 'care assistants and home carers' indicate that between 2001 and 2009 the proportion of foreign-born care workers more than doubled – from about 7 per cent in 2001 to 18 per cent in 2009.¹⁴ In the same period the overall proportion of foreign-born

⁷ Skills for Care, *The State of the Adult Social Care Workforce in England*, Leeds (2010)

⁸ S.Hussein., J. Manthorpe, *Longitudinal changes in care workers turnover and vacancy rates and reasons for job leaving in England* (2011)

⁹ J. Rubery, G. Hebson, D. Grimshaw, M.Carroll, L. Marchington, L.Smith and S. Ugarte, *The recruitment and retention of a care workforce for older people*, Manchester Department of Health Social Care Workforce Initiative (2011), see <http://www.kcl.ac.uk/sspp/kpi/scwru/dhinitiative/projects/ruberyetal2011recruitmentfinal.pdf>

¹⁰ Skills for Care, *The State of the Adult Social Care Sector and Workforce in England*, Leeds (2012).

¹¹ L. Besse., C. Forde., S. Moore., M. Stuart, *The National Minimum Wage, earnings and hours in the domiciliary care sector*, University of Leeds (2013)

¹² A. Cangiano., I. Shutes, S. Spencer, and G. Leeson, 'Migrant Care Workers in Ageing Societies: Research Finding in the UK,' Centre on Migration, Policy and Society, University of Oxford, Oxford (2009)

¹³ J. Moriarty, 'Competing with Myths: Migrant Labour in Social Care,' In *Who Needs Migrant Workers? Labour Shortages, Immigration and Public Policy*, edited by M. Ruhs, and B. Anderson. Oxford (2010).

¹⁴ A. Cangiano., I. Shutes, 'Ageing, Demand for Care and the Role of Migrant Care Workers in the UK,' *Journal of Population Ageing* 3 (2010): 1-2

workers in employment in the UK increased from 8.4 per cent to 12.9 per cent. And while the majority of domiciliary care workers remain UK nationals (80 per cent), this headline figure masks some interesting regional variations. In London, for example, non-UK nationals make up the majority of domiciliary care workers in London (53 per cent). As is the case for the social care workforce overall, the majority of foreign-born care workers are women (76 per cent compared with 87 per cent of UK-born care workers, according to LFS estimates).¹⁵ Foreign-born workers appear to be concentrated in the lowest paid care jobs, within a sector marked by low levels of pay overall.

- **One that has limited bargaining power and a particularly weak collective voice.** This is exacerbated by the frequent physical separation from colleagues that is a distinct feature of the irregular and fragmented service they provide. Union membership among domiciliary care workers and support workers stands at 24 per cent, far lower than that of care managers (58 per cent) and qualified social workers (88 per cent), according to the Social Care Workforce Research Unit at King's College London.¹⁶

¹⁵ A. Cangiano., I. Shutes, S. Spencer, and G. Leeson, 'Migrant Care Workers in Ageing Societies: Research Finding in the UK,' Centre on Migration, Policy and Society, University of Oxford, Oxford (2009)

¹⁶ See <http://www.communitycare.co.uk/articles/28/04/2011/116735/alarm-over-lack-of-union-membership-among-care-workers.htm>

Section 2

How are domiciliary care workers frequently paid less than the National Minimum Wage?

Under-payment of the NMW among care workers is complex and it is therefore important to understand, on a very practical level, the means by which a significant minority of domiciliary care workers are paid less than the NMW.

At the heart of the issue of NMW under-payment among direct care workers is the ubiquity of low pay in the sector. As successive reports of the Low Pay Commission have made clear, pay in the social care sector is among the lowest in the UK with median hourly wages among domiciliary care workers only 15 per cent above the NMW.¹⁷ Moreover, hourly pay rates are lower and pay distributions narrower among the independent care providers who now dominate the care market.¹⁸

However, other industrial sectors combine a high incidence of low-paid work without significant rates of NMW under-payment. What transforms domiciliary care from an occupation that is merely poorly remunerated into one in which there are significant rates of NMW under-payment is the irregular and fragmented nature of the service provided. People do not require care in their home on a standard 9 to 5 basis. As a result, the working patterns of those who provide domiciliary care have always been somewhat variable. However, in recent years large numbers of domiciliary care workers have found themselves only being paid for the (increasingly short) periods of time that they are with clients without any discrete payment for the time they spend travelling between care jobs.

Of course, not every domiciliary care worker who does not receive an additional, discrete payment for travel time between clients will be paid less than the NMW. Some will receive hourly rates of pay that are sufficiently high to ensure that the time they spend travelling between clients does not reduce their hourly pay below £6.19 per hour. Yet in a sector marked by low hourly rates of pay, many domiciliary care workers do regularly find themselves being paid less than the legal minimum wage.

To illustrate precisely how the non-payment of travel time often leaves individual domiciliary care workers with actual hourly pay rates below the national minimum it is useful to examine three real-life 'work diaries' that illustrate the typical working patterns of many domiciliary care workers in the UK. The following case studies are taken from a series of qualitative interviews with domiciliary care workers from around the UK which we conducted for the purposes of this report. In each diary entry the call 'contact times' in brackets reflect the approximate times each job was undertaken rather than the time that job was scheduled, reflecting the reality of delivering care in which overruns and delays are a frequent occurrence. Such overruns and/or delays have not been factored into our estimates of actual hourly wages. The names of the individuals involved have been changed to protect their identities.

¹⁷ L. Besse., C. Forde., S. Moore., M. Stuart, The National Minimum Wage, earnings and hours in the domiciliary care sector, University of Leeds (2013)

¹⁸ Low Pay Commission annual reports 2009, 2010 and 2011

Sharon's story

"I've been a domiciliary care worker in County Durham for 11 years. I'm currently on £6.50 an hour but it's a flat rate so I get £3.25 for a 30 minute call and £1.63 for a 15-minute call. I don't receive any allowance to cover the costs of petrol so it comes out of my own pocket. In a typical fortnight I work 11 days on and 3 days off, including 2 evenings. Today, as usual, my day started before 6am. My first call (6.45am – 7.15am) is a 30 minute visit helping Ms P to get out of bed, bathed, dressed and seated safely before providing her with breakfast.

I leave Ms P and drive for 6 minutes to my next 30 minute call (7.21am – 7.51am) with Mrs. M. This also entails getting her out of bed and fed. She's fast asleep when I arrive and it takes me some time to get her up. As this is a 30 minute call I'm a little rushed – and running slightly late – by the time I leave.

I leave Mrs. M and drive for 5 minutes to my next 30 minute call (7.56am – 8.26am) with Mr. P, another breakfast, and then from there a longer 20 minute drive to my next call (8.46am – 9.01am) which is just a 15-minute slot. This one is always a push to get done in the time I have and I'm already about 25 minutes behind schedule so I try to be as efficient as possible. I then have another long 23 minute drive to my next 30 minute call (9.24am – 9.54am) which is my final morning visit of the day. My next call is scheduled for 11am so I head home for a tea break.

My first client after lunch, Mr. J, lives quite a distance away so it takes me a while to get there from my home. It's a 30 minute call (11.00 – 11.30am) to provide him with his dinner. I always think it is too early for him to eat but he's always scheduled in for this time so I get on with it. I then drive 6 minutes to my next client, Ms. T, another 30 minute dinner call (11.36 – 12.06). My next client (12.12 – 12.57pm) needs some personal care as well as his dinner so it's a 45-minute call and it takes me another 6 minute drive to reach him.

I finish up and set out for another long 20-23 minute drive to my next client, a woman who pays extra for 2 hours of care (1.20 – 3.20pm) so I can have a proper chat with her. I really enjoy seeing her but the return drive is another 20 or so minutes so my next call with Mrs. B starts late (3.45 – 4.15pm). It's a 30 minute care slot to make her tea and when I'm done I set off on a 6 minute drive to my next client, Mrs. E, who has 30 minutes of care (4.21 – 4.51pm). My next client is several miles away so it takes me 11 minutes to drive there (6.02pm – 6.32pm). My last job, making Mr. E his tea, lasts for another 30 minutes but it's close by so it only takes me three minutes to arrive (6.25 – 6.55pm). I finish up and head home exhausted having, as always, run a good few hours over what is down on my paper schedule".

Contact time paid for: 8 hours at £6.50 = £52

Travelling time between clients (excluding first and last journey of the day and a break period 10.10 – 11am): 2 hours and 6 minutes

Total actual working time: 10 hours and 6 minutes

Expenses not covered: £10 in petrol

Actual hourly wage: £5.13 (£4.14 if petrol expenses are deducted)

Miranda's story

"I've been a domiciliary care worker in South London for the last two years. My current hourly rate is £6.78 but I get £3.80 for shorter visits of 30 minutes. I don't receive any allowance to cover the costs of travelling by bus between journeys so I have to pay for my weekly Oyster pass myself. In a typical week I work six days on and have one day off.

My first call today (7.30am – 8.15am) was a 45 minute visit. It's a double-up helping Ms. J to get out of bed, assisting her with continence (commode and pad), a strip wash and getting dressed afterward. We then have to get her to take her medication, eat something and get her comfortable before we leave. We're a little rushed and I run out as the next call is down for 8.15am on my rota.

It takes me 15 minutes on the bus to get to my next call, a 30 minute visit (8.30am – 9am) with Mrs. B. This is a simple call that requires me to wash and dress Mrs. B and encourage her to pop up the shops to get a pint of milk. I leave Mrs. B and have a 30 minute bus ride from Dulwich to another 30 minute call in Peckham (9.30am – 10.00am). I'm already 30 minutes behind my paper work schedule but that's normal as they're never realistic. The call is with Mr. M who needs help getting up, washed, dressed and fed. He also has problems with his sight so I need to set him up properly for the day to make sure he doesn't have a fall. I leave Mr. M and travel 15 minutes (sometimes it can take 20 if the bus is delayed) to my next 30 minute call with Mrs. V (10.15am – 10.45am). Mrs. V is a lovely woman who needs help preparing breakfast and getting ready. I have to make sure she is wearing her pendant alarm as she's very frail.

Another 15 minute bus ride to my next call (11.00am – 12.00pm). This one lasts for an hour because Mr. W needs a bit more personal care including looking after his arm (he fell recently and it's in a sling). I leave Mr. W to go to my next call, a 30 minute visit which is another 30 minutes away by bus (12.30pm – 1.00pm). This involves helping Mr. A with preparing a meal and drink and helping him practice negotiating his stairs so he can use the bathroom. I leave Mr. A and travel 30 minutes on the bus to my next call (1.30pm – 2.15pm), a 45 minute call involving getting Mr. J some lunch but also preparing sandwiches for his evening meal and making sure he knows where they are.

After Mr. J I have a gap until 3.30pm which I won't get paid for. I get myself some lunch and have a sit in the park close to where my next call will be to kill some time. My next client is Ms. G (3.30pm – 4.00pm), a 30 minute call helping her use the toilet, changing her pad and helping her back to bed. I leave feeling guilty – it must be awful to spend the bulk of your day sitting in bed. I ask Ms. G if she wants me to make her a hot drink before I leave but she doesn't want anything. After I leave Ms. G at 4.00pm I have another gap until 5.30pm. I pop to the shops as it makes no sense for me to try to get home. After what seems like an age I arrive at my next call (5.30pm – 6.00pm), a 30 minute visit with Mrs. W helping her with personal care, changing into her night gown, popping up the shops to get her some essentials and chopping up her food so she can manage it.

I leave Mrs. W and travel 15 minutes to my next 30 minute call with Ms. M (6.15pm – 6.45pm), a simple medication check and help to bed. From there it's a short 5 minute walk to my last call of the day (6.50pm – 7.20pm), getting Ms. S ready for bed".

Contact time paid for: 6 hours and 30 minutes (£6.78 per hour with an enhanced payment of £3.80 for each 30 minute slot) = £47.35

Travelling time between clients (excluding first and last journey of the day and travel to and from break periods): 2 hours and 35 minutes

Total actual working time: 9 hours and 05 minutes

Expenses not covered: weekly Oyster card to cover journeys by bus £19.60

Actual hourly wage: £5.21 (without accounting for the costs of bus fare)

Janice's story

"I've been a domiciliary care worker in Newcastle for 20 years, eight employed directly by a local authority and the last 12 with a series of private companies. I've been with my current employer for 9 months. My current hourly wage is £6.25 but it's a standard rate so roughly £3.13 for a 30 minute call and £2.08 for a 20-minute call. I class myself as one of the lucky ones. As a homecare worker, I get paid 15 pence per mile, which in no way covers the cost of my petrol or the wear and tear on my car but certainly helps.

I work 12 days on and 2 off, although if I have a quiet week I often find myself working my days off to try and make up some money. This month I have only had 1 day off. Some days can be spent working from 7am – 10pm but due to the nature of the work I may often work an hour or two with multiple gaps when I just have to go home for perhaps an hour or so.

Today, as usual, I was up and preparing to go to work for 7.30am when I was interrupted by a frantic call from the on-call staff. Someone called in sick and they needed to change my rota. My first call ends up being an hour and a half visit (7am – 8.30am) with another carer at the home of a middle aged man, Mr. L, who is paralysed from the neck down. I haven't been to this call before and soon find out why we have an hour and a half to get him showered and dressed. Company policy states that I must read care plans before starting work with a client but he is desperate to get up. The other carer has been here a couple of times so we jump straight in, taking a lot of guidance from the gentleman. Before we know it the call has overrun. I was supposed to be at my next client at 8.30am. Yet by the time all tasks have been completed and he is comfortably seated it is 8.50.

I leave Mr. L and travel to my next client, Mrs. G, at breakneck speed and manage to get there in only 10 minutes of travel. I try to gain entry for 5 minutes before I ring on-call but I have to leave a message and wait for them to ring me back. 10 minutes later I'm told that she died last week. No one had informed me. I rush on to my next call rather distraught – a 5 minute journey by car. My next call (9.20am – 9.50am) is in a block of flats and takes me at least 10 minutes just to get inside. The client, Mrs. Y, is fast asleep when I walk in. I have 30 minutes to administer her medication and provide breakfast and a hot drink. I leave in reasonable time logging out as I go. The next client is a 45 minute call (10.00am – 10.45am) on the floor above in the same block of flats which means it is only a couple of minutes' walk. On arriving at my next call I'm perplexed as reading the care plan I am supposed to support Mr. B to shower and dress but he is dressed and sitting with a cup of tea. It turns out that he has dressed improperly without showering and that his toilet and sink are smeared with faeces. I clean the area and administer his medication. My phone rings while I'm doing this - on call asking me to hurry up. My next client has been on the phone to see why I haven't arrived yet. This

call has taken the full 45 minutes yet I haven't done what I was initially supposed to do. Luckily my area today is quite condensed so it only takes me 10 minutes from leaving Mr B to arriving at my next 15-minute call with Mrs. A (10.55am – 11.10am). Mrs. A merely requires medication and a cup of tea. After this call I have a small space so I will be able to make up some time.

My next lady is a 5 minute drive away. She requires me to administer her medication, again in a 15-minute call (11.15am – 11.30am). Her call was written up as 10.45 – 11.00 but I'm running behind schedule. She is a lovely lady and doesn't mind that I'm late. After she takes her tablets she offers to make me a cup of tea, I feel dreadfully guilty as I refuse. She only wanted a chat but I need to move on to the next client.

Luckily I had a call to say that my 11.00 call had been cancelled, probably because I'm late. It does mean I've lost an hour's pay as they pay privately but not to worry, at least I can make up some time. So after a 10 minute journey on to my first 30-minute lunch call (11.40am – 12.10pm) I arrive at Mr J and help him make a meal himself. When I arrive he is very upset as he has been incontinent. Mr J has a shower call twice a week and today is not one of them. He begs me to assist him, and I just can't say no. Mr J even suggests I don't help him make lunch in place of the shower but I can't let him starve. After I help him shower and change clothes he is much happier to cook. Pretty rushed through but we did it all in 40 minutes. Although I only get paid for the 30 allocated.

It's another 10 minute drive to my next client, Mrs. T. I assumed given the time (12.30 – 12.45pm) this was a lunch call but it is actually a medication prompt. It could have been a nice easy call, but it turns out the last carer was late so she didn't take morning medication until 11am. I have to remove some of her meds and refuse to give them as the time frame is too short and could put her at risk of overdose. I again call the on-call team to inform them of the situation (a call I make from my mobile phone for which I pay the bill). Mrs. T's was supposed to be a 15 minute call but what with reading the care plan and discussing with the on-call team it takes 25 minutes, 10 of which I won't get paid for.

A 5 minute drive and I'm back to Mrs. Y for another 30-minute slot (1pm- 1.30pm). She is up so lets me straight in, but still doesn't want to get dressed. I have to prepare a meal and prompt her to take her medication. She appears to be quite depressed so I sit and chat while the microwave heats her lunch. I made her smile – that made my day. Sometime it's those simple things that remind me why I love my job so much. I leave Mrs. Y a much happier lady at 1.30pm. Only a 10 minute drive to my last lunch call which is 15 minutes with Mrs. A (1.40 – 1.55pm).

I pop home for a break before I start on my next set of calls between 4pm and 6pm. I'll then have an hour's break before I start again at 7pm putting people to bed. Usually I collapse into my own bed about 10.30 unless I'm running late – which comes with the territory!"

Contact time paid for: 4 hours and 45 minutes at £6.25 = £29.70

Travelling time between clients (excluding first and last journey of the day and break periods): 1 hour and 2 minutes

Total actual working time: 5 hours and 47 minutes

Actual hourly wage: £5.13

The scale of NMW under-payment among direct care workers

Social care is often described (with good reason) as a 'data desert'. As such, estimating the precise scale of NMW under-payment in the care sector is extremely difficult and the main data sources¹⁹ under-report the scale of low-paid work and the size of the sector in general.

There are also a number of particular complexities surrounding the calculation of hourly pay rates among domiciliary care workers given the irregular and fragmented nature of their work. Domiciliary care workers, like others in direct care occupations, often work several shifts a day with the possibility of breaks of varying duration in between. A significant proportion of long-term care is provided on the basis of an 'hour-glass' time schedule in which, for example, a care worker may attend a shift in the morning to get a client fed and dressed and return in the evening to assist them to bed. This raises a variety of practical and legal questions about what constitutes working time, what constitutes travel time and what constitutes a break. For example, should a domiciliary care worker with 30 minutes between appointments but only a 20 minute journey have the additional ten minutes designated as a break (despite the fact that they are hardly able to undertake non-work related tasks) or should it be designated as work?

The issue of whether the time and costs of travelling between clients should be remunerated is perhaps the most pressing of these complexities. It's a particularly important issue because we know that a substantial proportion of direct care workers whose work involves travelling are not given discrete payments for the time they travel. Skills for Care's 2007 National Survey of Care Workers, for example, found that nearly half (45 per cent) of direct care workers did not have their travel costs met by their employer²⁰ and funding pressures on providers are likely to mean that proportion has risen. Of course not every direct care worker who does not have their travel costs met will be being paid less than the NMW. However, the prevalence of low hourly wages across the sector means that the lack of discrete payments for travel time in many cases places domiciliary and other direct care workers below or at risk of falling below the legal minimum.

Accounting for unremunerated travel time is therefore essential in assessing the scale of NMW under-payment among domiciliary care workers. However, most standard estimates of NMW under-payment among care workers do not account for the additional 'stressors' that increase the risk of NMW non-compliance – non-payment for travel time being perhaps the most ubiquitous. As a result, it is highly probable that the estimates of NMW under-payment cited in many standard accounts (broadly in the range of 1 to 6 per cent)²¹ are extreme lower bound estimates that are highly unlikely to accurately reflect the true scale of the problem.

Perhaps the most accurate estimate of NMW under-payment among care workers, and the only one that properly accounts for non-payment for travel time, is a 2011 study carried out by Dr. Shereen Hussein.²² In taking account of additional 'stressors'. Dr. Hussein's analysis of the numbers of direct-care workers²³ paid

¹⁹ The Annual Survey of Hours and Earnings (ASHE) and the Labour Force Survey (LFS)

²⁰ Skills for Care, *National Survey of Care Workers*, November 2007 see, http://www.skillsforcare.org.uk/research/latest_research_reports/national_survey_of_care_workers_2007.aspx

²¹ For examples see, National Minimum Wage: Low Pay Commission Report (2012) http://www.lowpay.gov.uk/lowpay/report/pdf/8990-BIS-Low%20Pay_Tagged.pdf, L. Besse., C. Forde., S. Moore., M. Stuart, The National Minimum Wage, earnings and hours in the domiciliary care sector, University of Leeds (2013) http://www.lowpay.gov.uk/lowpay/research/pdf/LPC_-_Final_Leeds_University_Report_-_26_February_2013SM2.pdf and Skills for Care/IFF Research, *Employment aspects and workforce implications of direct payments* (2007) http://www.skillsforcare.org.uk/research/latest_research_reports/Direct_Payments_research.aspx

²² <http://www.kcl.ac.uk/sspp/kpi/scwru/pubs/periodical/2011/issue16.aspx>

²³ Direct care worker encompasses all those providing hands on care in any settings including residential, domiciliary and day care

less than the NMW gives us a far more accurate glimpse at the true scale of the problem. The analysis draws on sector-specific data from the National Minimum Data Set for Social Care (NMDS-SC)²⁴ and adjusts the pay rates from that survey using data drawn from the Longitudinal Care Workforce Study (LoCS).

On the premise of extremely conservative estimates of average travel times among direct care workers (an average of four minutes per hour) Dr. Hussein concludes that there is between a 9 and 12 per cent probability that a direct care worker in the UK is paid less than the NMW. Placing the overall direct care workforce in the UK at around 2 million Hussein estimates that this would mean that between **156,673** and **219,241** direct care jobs in the UK are jobs in which the worker is paid below the NMW.²⁵ While NMW underpayment on this scale still only represents a small proportion of the total number of care jobs in the UK it nonetheless suggests an extremely high level of NMW non-compliance within the care sector particularly given that average travel times of four minutes per hour significantly underestimate the journey times of many domiciliary care workers.

²⁴ <https://www.nmds-sc-online.org.uk/default.aspx>

²⁵ Dr. Shereen Hussein has estimated that the total UK social care workforce is around 2 million, see 'Estimating probabilities and numbers of direct care workers paid under the National Minimum Wage in the UK: A Bayesian approach', Social Care Workforce Periodical, Issue 16: December 2011 see, <http://www.kcl.ac.uk/sspp/kpi/scwru/pubs/periodical/2011/issue16.aspx>

What does the law say?

The legal issues surrounding the application of the National Minimum Wage Regulations (henceforth “NMWR”)²⁶ in social care are complex and are made more challenging by the irregular nature of domiciliary care.²⁷ However, when it comes to the question of whether time spent travelling between calls should count as working time for which the NMW should be paid the law is reasonably clear:

Unless genuinely self-employed²⁸ a worker travelling for the purposes of duties carried out in the course of his or her work will be required to be paid at least the minimum wage (excluding the first and last journeys during any particular period of duty).

‘Travelling’ is defined in Regulation 7 of the NMWR as:

- In the course of a journey by mode of transport or on foot;
- Waiting at a place of departure to begin a journey by mode of transport;
- Where the journey is broken, waiting at a place of departure for the journey to recommence; and
- Waiting at the end of a journey for the purpose of carrying out duties (excluding any time spent – if any – on a rest break).

As such, it seems clear that individual domiciliary care workers should be paid an hourly rate equal to or above the applicable NMW rate when divided by the time spent in the client’s home and appropriate travel time (excluding the first and last journeys during any particular period of duty). This appears to have been the view adopted by the Compliance and Technical Officers of the NMW Enforcement Agency and, importantly, would also appear to hold irrespective of the precise type of work undertaken, of which there are four types as defined under the NMRW²⁹:

- “Salaried hours work” is work where the worker is entitled to no payment (e.g. overtime) beyond an annual salary (except a performance bonus).
- “Time work” is work paid for by reference to the time worked that is not salaried hours work.
- “Output work” is work paid for by reference to output rather than time worked.
- “Unmeasured work” is any other type of work, and, in particular, work where there are no specified hours and the worker is required to be available when needed or work is available.

What does this mean in practical terms for individual domiciliary care workers? It means that a domiciliary care worker who spends a total of 25 hours per week working with clients and a total of 4 hours travelling between clients must be paid at least the NMW for 29 hours per week.

²⁶ http://www.legislation.gov.uk/ukdsi/2009/9780111480397/pdfs/ukdsi_9780111480397_en.pdf

²⁷ Domiciliary care raises a number of specific issues in regards to the application of the NMWR that extend beyond whether time spent travelling between calls should count as working time in respect of which the NMW should be paid. These include whether time spent performing duties beyond contracted hours should count as working time during which the NMW should be paid where there is a requirement to complete a defined number of calls in a day and whether enhanced shift-premia payable, for example, in respect of weekend or evening working should be included in the remuneration assessed for the purpose of compliance with the NMWR, both of which are outside the scope of this report.

²⁸ Determining whether someone is genuinely or falsely self-employed is, again, a legal question. Workers may be considered to be genuinely self-employed if they have the freedom to work for others, can refuse work, have control over their own hours, incur their own expenses and deal with their own losses

²⁹ See National Minimum Wage Regulations 7 and 15 to 18.

However, despite the apparent legal clarity on this issue the application of the law to specific cases can be a complex and somewhat disjointed undertaking. To illustrate let's take two common examples:

1. A domiciliary care worker might be given a schedule with four different 15-minute care slots within an hour with no time for travel built into the schedule thereby forcing them to leave their client early (which if visits are monitored electronically can result in pay being reduced) or go over their slots and travel on their own time.
2. A domiciliary care worker might be given a schedule with extremely long gaps between clients so that they are forced to go home in between visits.

The first is clearly unlawful and is therefore a clear question of properly enforcing the NMWR. However, the application of the NMWR in the second case is less straightforward. It raises challenging questions about what constitutes working time and what constitutes rest (workers not being entitled to the NMW during lunch and rest breaks). It shows how the work schedules of many care workers can complicate enforcement and how they often increase the likelihood, whether by error or negligence if not conscious exploitation, that care workers will be placed at risk of NMW under-payment – in this particular case, by leaving the worker open to the charge that the travel time to and from home was undertaken for purposes other than work.

If anything the growth in personal budgets and the continued expansion of self-directed support through employment of Personal Assistants will make it even easier for the NMW to be contravened. This is because domiciliary care workers will find themselves travelling between two clients who, because they will have contracted them via personal budgets, are, in effect, two separate employers. As currently constituted, the law does not recognise travel time between different employers as working time and, therefore, it is not covered by the NMWR. This problem is often laid at the door of personalisation itself but it seems equally valid to argue that the law for workers not employed by an agency and who work predominantly for individual personal budget holders needs to be updated to ensure they are adequately protected.

Section 3

The underlying factors that shape the market for care

We have seen that under-payment of the NMW is likely to affect a significant number of the UK's domiciliary care workers and that the legal position in regards to payment for travel time undertaken for the purposes of work is reasonably clear: unless genuinely self-employed a domiciliary care worker travelling for the purposes of duties carried out in the course of his or her work will be required to be paid at least the minimum wage (excluding the first and last journeys during any particular period of duty). Why then do a significant number of domiciliary care workers still receive hourly wages that are less than the legal minimum?

The dynamics of publicly-funded social care provision in the UK

The funding of social care in England still largely reflects the settlement arrived at in the immediate aftermath of the Second World War. That settlement saw the creation of a National Health Service (NHS) charged with responsibility for centrally-directed services but left responsibility for personal social services largely to local government. If anything, that split has become starker over the course of the past 30 years as further responsibility for the provision of publicly-funded social care has been shifted toward local authority commissioning and means-tested provision.

As a result the funding of social care in the UK is now inextricably tied to financial settlements between central and local government. Those financial settlements are based on the allocation of funding from the Department of Communities and Local Government (DCLG) to local authorities on the basis of a 'formula spending share' calculation that takes into account differences in demography and other factors such as local labour costs. Social care funding flows down to local authorities as a component of formula grant and is not ring-fenced. Indeed, there is no targeted funding allocation for social care other than a number of smaller specific grants allocated by the Department of Health (DH). The result is that care provision in any given locality is subject to a variety of competing local pressures and, as such, represents the localised products of commissioning decisions made by each local authority.

The context in which those commissioning decisions are made would be far less challenging were it not for the fact that funding from central government has largely failed to keep pace with the complex and rising needs of the UK population. Demographic pressures are such that despite enjoying more than 15 years of real-terms growth (an average annual increase of 5.1 per cent since 1994)³⁰ funding for adult social care budgets has been largely absorbed by rising demand. The result has been the emergence of a sizable gap between rising needs and available resources.

The government is well aware of the consequences of this funding gap and the pressure it is placing on local government. It was for this reason that additional resources were identified in the 2010 Spending Review and an independent review commissioned to recommend a more sustainable means of funding care for the future. Over the period 2010/11 – 2014/15 social care will see a four year real-terms increase in grant funding equating to around £875 million a year on average provided through the DH's Personal Social Services grant, which will be merged into the local government formula grant. A further £1 billion a year by 2014/15 will be set aside from the NHS budget for partnership working between the NHS and social care to encourage collaboration between local government and NHS staff to offset rising pressure on services.

³⁰ R. Humphries, *Social care funding and the NHS: an impending crisis?* The King's Fund (2011)

However, while undoubtedly welcome, this transfer of resources into adult social care has been offset to a considerable extent by extremely tough spending settlements for local government and moves to encourage the freezing of council tax budgets.³¹ As expenditure on adult social care is not ring-fenced, reductions to local authority formula grant leave the additional resources allocated for care provision vulnerable to competing local priorities – in effect shifting the risk downward from central to local government.³² And while local authorities have attempted to offset reductions by means of efficiency savings, the level of savings required are unprecedented. If they are not found through efficiencies then a funding gap of at least £1.2 billion could open up by 2014.³³

Local authority commissioning practice

The failure of successive governments to allocate sufficient resources to adult social care to keep pace with the complex and rising needs of our population places pressure on local authorities as the primary commissioners of publicly-funded care provision. Many have responded to constrained budgets by both tightening access to care (85 per cent of councils now restrict publicly-funded care to those with substantial and/or critical needs)³⁴ and using the considerable leverage many have as a result of their monopsony purchasing power to drive down its cost. The UK Home Care Association estimates that as of 2011 58 per cent of councils were reducing the price they were willing to pay for care.³⁵ Evidence gathered by the Association of Directors of Adult Social Services (ADASS) bears this out, highlighting the fact that local government spending reductions between 2010 and 2012 included around £1.89 billion in spending reductions on adult social care – reductions that ADASS deemed unsustainable.³⁶

There are a number of other ways in which local authorities have pushed down the price they pay for care. Some local authorities have simply turned to fixing a maximum price – to cover wages and provider overheads.³⁷ UKHCA's survey found that 53 per cent of providers reported that the council they traded with had stated a maximum price they would pay for domiciliary care, sometimes at worryingly low levels.

Another way that many have pushed down the price they pay for care is to commission it on the basis of shortened visit lengths. The UKHCA survey³⁸ found that as of 2012 almost three quarters of domiciliary care visits commissioned by local authorities in England were for periods of 30 minutes or less, with one in ten visits commissioned for 15 minutes or less. Indeed, many local authorities have moved away from payment for care by the hour. A survey by the Local Government Information Unit found that just over one in ten local

³¹ If extended to 2015-16 a number of departments, including the Department for Communities and Local Government (DCLG), will have seen funding reductions of around 30 per cent since 2010.

³² The phrase "shifting of risk" is one used by the team at Manchester Business School who have written extensively about time as a contested terrain in the management and experience of domiciliary care work see, J. Rubery, D. Grimshaw, G. Hebson, "Exploring the limits to local authority social care commissioning: competing pressures, variable practices and unresponsive providers." *Public Administration* 91(2):419-347 (2013) and J. Rubery and P. Urwin, "Bringing the employer back in: why social care needs a standard employment relationship," *Human Resource Management Journal* 21, no. 2, pp. 122-137 (2011)

³³ Richard Humphries, *Social care funding and the NHS: an impending crisis?* The King's Fund (March 2011)

³⁴ Association of Directors of Adult Social Services (2012). ADASS Budget Survey 2012. London: ADASS. Available at: www.adass.org.uk/images/stories/Press12/ADASS_BudgetSurvey2012Summary.pdf

³⁵ UKHCA Commissioning Survey (2011) see, <http://www.ukhca.co.uk/pdfs/UKHCACommissioningSurvey2011.pdf>

³⁶ Association of Directors of Adult Social Services (2012). ADASS Budget Survey 2012. London: ADASS. Available at: www.adass.org.uk/images/stories/Press12/ADASS_BudgetSurvey2012Summary.pdf

³⁷ All costs including wages

³⁸ UKHCA Commissioning Survey 2012, *Care is not a Commodity* (2102) see, <http://www.ukhca.co.uk/pdfs/UKHCACommissioningSurvey2012.pdf>

authorities paid domiciliary care providers by the minute; 24 per cent by the quarter hour, another 30 per cent by the half hour and just over a quarter by the hour.³⁹

Many local authorities have also ceased to pay enhanced payments for certain types of care such as shorter visits or those in unsocial hours (evenings and weekends). For those on high hourly rates the move away from enhanced payments and toward a single charge rate might come as a welcome simplification but the loss of enhanced payments can be used to reduce price because they are an important way of recognising the costs of travel time for care workers on low hourly rates who do not receive a discrete travel allowances. Nationally, as of 2012, just over a quarter (28 per cent) of providers are now paid a higher rate by local authorities for undertaking visits of less than an hour.⁴⁰

There has also been a marked trend among local authorities away from commissioning care on the basis of guaranteed volume, block contracts with discounted prices and toward spot or 'framework agreements'⁴¹ in which a variety of providers are registered and are then asked to tender for small 'care packages' of work on the basis of the lowest price.⁴² The UK Home Care Association's (UKHCA) survey⁴³ found that as of 2012 the majority of councils' contracting arrangements offered no guarantee of volume, with less than a quarter (24 per cent) of providers holding contracts with any guarantee of purchase. There is also evidence of some local authorities commissioning these small care packages on the basis of reverse e-auctions where providers place online bids for contracts in real time, competing to offer the lowest price compatible with service specifications. Proponents claim that this process aids competition and helps to achieve rapid price cuts but there are concerns that bidding on this basis promotes a focus on reducing costs at the expense of quality.⁴⁴

The move away from guaranteed volume block contracting may also be linked to moves among some local authorities to commission from a larger pool of providers. Freedom of Information requests submitted by UNISON show that more than 50 per cent of councils commission homecare from 20 plus providers, more than 20 councils commission care from more than 50 providers, with nine buying in services from more than 100 private and voluntary sector organisations.⁴⁵ Many local authorities have moved towards commissioning from a variety of providers in order to deliberately diversify care provision but there is a risk that commissioning care from such a multiplicity of providers reduces the amount of oversight available to ensure providers are complying with their statutory responsibilities.

The growth of self-directed support and personal budgets has been one of the drivers of the move away from block contracts, as money has been freed up from existing contracts to facilitate individual choice and control. Under the 2013 Draft Care and Support Bill, all users of social care services will be entitled to a personal budget in place of commissioned services.⁴⁶ Where individuals choose to take their personal budget as a direct payment, they become an employer and have to fulfil employment obligations, including ensuring

³⁹ LGiU, *Outcomes Matter: effective commissioning in domiciliary care*, 2012

⁴⁰ UKHCA Commissioning Survey, *Care is not a Commodity* (2012) see, <http://www.ukhca.co.uk/pdfs/UKHCACommissioningSurvey2012.pdf>

⁴¹ A framework agreement is a general term for agreements with a provider, or providers, which set out terms and conditions under which specific purchases can be made for the duration of the term of agreement. They are designed to facilitate the tendering of services/works required on a repeated basis, but where the precise quantities needed are unknown. Once established the process for awarding individual purchases is faster and less costly than would be the case if procured separately.

⁴² UKHCA (2011). *UKHCA response to consultation on the National Minimum Wage* see, <http://www.ukhca.co.uk/pdfs/ResponsetoLPC2012.pdf>

⁴³ UKHCA Commissioning Survey 2012, *Care is not a Commodity* (2102) see, <http://www.ukhca.co.uk/pdfs/UKHCACommissioningSurvey2012.pdf>

⁴⁴ Equality and Human Rights Commission, *Close to home: An inquiry into older people and human rights in home care* (2011)

⁴⁵ <http://unison.org.uk/news/rise-in-zero-hours-contracts-shame-councils-and-hit-elderly-and-vulnerable>

⁴⁶ Secretary of State for Health (2012) Draft Care and Support Bill, London: The Stationery Office.

that workers are paid the NMW. Direct payment support services exist to support individuals with their employer obligations and can overcome many of the employment issues raised by the growth of personalisation. However, the provision of support has varied considerably across the country.⁴⁷ Furthermore, with local authorities under growing financial pressure, more are expecting individual budget holders to pay for their own support services from within their personal budget rather than commissioning support centrally.⁴⁸

Given the financial constraints that many local authorities are now operating within it is not difficult to see why many have taken measures to reduce the costs of care and now commission care almost exclusively on the basis of cost rather than quality.⁴⁹ Many local authority Adult Social Care Directors would, of course, argue that it is providers who are responsible for ensuring that the statutory rights of care workers are upheld, including payment of an hourly rate which is at least at the level of the NMW. In strictly legal terms they are correct.

However, it is disputable whether local authorities are doing enough to genuinely or correctly assess the actual cost to the provider of delivering the required care and, in cases where they are, making sure that providers pay their workers at least the NMW after the contract has been awarded. While it is difficult not to conclude that the very dynamics of commissioning in the context of rising demand and shrinking budgets are at fault, there are clearly steps that local authorities can take to ensure they are commissioning care in such a way as to better protect those who deliver and receive it.

⁴⁷ M. Routledge., and J. Lewis, *Taking stock, moving forward*, London: Think Local Act Personal (2012)

⁴⁸ S. Bennett., S. Stockton *Best Practice in Direct Payments Support: A guide for commissioners*, London: Think Local Act Personal (2012)

⁴⁹ In their review of local authority commissioning policies under the UK procurement policy of 'best value,' Rubery, Grimshaw and Hebson found that cost factors predominated and quality criteria became merely additional requirements for providers to meet within the costs envelope, see J.Rubery, D.Grimshaw, G.Hebson, "Exploring the limits to local authority social care commissioning: competing pressures, variable practices and unresponsive providers." *Public Administration* 91(2):419-347 (2013)

How independent care providers have adapted to the market

The dynamics of publicly-funded social care and the commissioning practices of local authorities shape the market in which independent care providers operate. That market is an extremely fragmented and competitive one, comprising over 3,000 private and voluntary organisations, many of whom operate on the basis of extremely tight margins. In the face of on-going reductions in the unit price that many local authorities are willing to pay for care and the trend away from guaranteed volume block contracts with discounted prices, many independent care providers have felt compelled to alter their employment strategies in order to compete.

They have done so by seeking ways to enhance the flexibility of their workforce so that they are better tailored to respond to fluctuations in demand and, more importantly, by adopting various strategies to reduce expenditure on the wages that form the bulk of care costs. It is in the operation of these business models that some independent care providers – whether intentionally or unknowingly – will be operating pay systems that leave domiciliary care workers with hourly rates that are less than the legal minimum. An appreciation of the different mechanisms which drive those business models is therefore crucial to understanding why under-payment of the NMW is a significant issue in the social care sector.

Payment for contact time only

Despite commissioning care on the basis of increasingly shortened visits lengths,⁵⁰ the overwhelming majority of local authorities still expect providers to cover travel time out of the hourly rate paid for the time spent in a client's home. Only a handful of local authorities make any discrete payment towards the travel time of domiciliary care workers. As a result many providers have chosen to no longer pay their care workers a discrete payment for time spent travelling between clients but to pay only for the "contact" time that care workers are with a client.

Of course, not every care worker who does not have their travel costs met in the form of a discrete payment will be being paid less than the NMW. Yet many on low hourly rates will be. And the risk is particularly acute where providers arrange work schedules so that domiciliary care workers are required to carry out too many short visits too close together (known colloquially as "call cramming") thereby forcing workers to leave clients early or travel on more their own time. A survey carried out by UNISON in 2012 found that eight out of ten respondents reported having their work arranged in a way that made it difficult to carry out their duties without rushing or leaving a client before time.⁵¹

The trend away from enhanced payments for shorter visits

Local authorities are increasingly phasing out enhanced payments for certain types of care and many are moving toward single hourly charge rates (pro-rata) for all categories of care. Nationally, as of 2012, just over a quarter (28 per cent) of providers are paid a higher rate by local authorities for undertaking visits of less than an hour.⁵² This means that providers have to meet the increased costs involved in travelling between multiple care jobs from that hourly rate. Domiciliary care workers employed by providers who do not provide a discrete travel allowance and who are not able or willing to cover the costs of more frequent travel are thus at heightened risk of being paid less than the national minimum.

⁵⁰ Laing and Buisson, *Care of Elderly People UK Market Survey 2010-11*

⁵¹ UNISON, *Time to Care: a UNISON report into homecare*, 2012

⁵² UKHCA Commissioning Survey 2012, *Care is not a Commodity* (2102) see, <http://www.ukhca.co.uk/pdfs/UKHCACommissioningSurvey2012.pdf>

Enhanced monitoring

The ability of providers to arrange and operate work schedules that only pay for contact time has been facilitated by technological developments that have made it far easier to monitor fragmented and irregular working arrangements. Enhanced monitoring obviously has its benefits in terms of protecting care workers from accusations that they did not attend a client or have spent insufficient time with them but it also facilitates payment by the minute and a remuneration structure that places many care workers at risk of NMW under-payment. In the interviews we conducted for this report we heard evidence of care workers having to log the actual length of their visits with clients through timesheets and, increasingly, via electronic monitoring systems. This trend was also supported by a UKHCA survey⁵³ which also found evidence of councils employing time-consuming authorisation procedures before agreeing to pay for care that lasted longer than the commissioned time.

Increased use of atypical and non-standard forms of work

In order to adapt to the trend among local authorities to commission care on the basis of spot or 'framework agreements' where no block volume of care is guaranteed, many care providers have sought to make their workforces more flexible in order that they can match care workers to constantly shifting volumes of commissioned care. As a result, a growing number of independent care providers are moving all or a proportion of their domiciliary care workforce onto atypical or non-standard forms of work such as zero-hours contracts in which workers are not guaranteed any set number of weekly hours.

As of 2011-12 56 per cent of domiciliary care workers were employed on zero-hours contracts with a higher concentration (8 in 10) among those working for private providers.⁵⁴ A recent written reply to the House of Commons from Care Minister Norman Lamb cited Skills for Care research, drawing on the NMDS-SC, to the effect that there are around 307,000 domiciliary care staff in England on zero-hours contracts.⁵⁵ Flexible working arrangements facilitate the operation of pay systems in which only contact time is paid for and travel time is not explicitly reimbursed.

All of these measures can be seen as a direct response to the extremely competitive market in which providers tender for care. It is undoubtedly the case that reductions in the unit price of care and the nature of local authority commissioning in many parts of the country have placed many providers under great strain. However, it is also the case that some providers are managing their workforces in ways that place individual domiciliary care workers at risk of NMW under-payment. Ultimately, independent care providers have a responsibility to meet their statutory obligations to pay at least the NMW obligations more needs to be done to ensure they are doing so.

⁵³ UKHCA Commissioning Survey 2012, Care is not a Commodity (2102) see, <http://www.ukhca.co.uk/pdfs/UKHCACommissioningSurvey2012.pdf>

⁵⁴ L. Besse., C. Forde., S. Moore., M. Stuart, The National Minimum Wage, earnings and hours in the domiciliary care sector, University of Leeds (2013)

⁵⁵ See, <http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm130701/text/130701w0004.htm#1307021001880>

The lack of effective deterrents that might prevent non-compliance with the NMW

We have seen how the dynamics of publicly-funded social care in the UK and the commissioning practices of local authorities shape a market in which many independent care providers are compelled to seek ways to reduce expenditure on the wages they pay their domiciliary care staff. Yet there is still a question about how, despite the law being reasonably clear in regards to travel time, many independent care providers are able to operate pay systems that see care workers paid less than the national minimum without facing adverse consequences.

Part of the answer lies, as we have seen, in the legal complexities surrounding the application of NMW Regulations to domiciliary care. However, the lack of effective deterrents that might prevent providers from under-paying the NMW is also a contributory factor. There is now widespread acceptance of the NMW across the political spectrum and a large measure of agreement that more effective enforcement of the NMW is required. Yet little has been done to detail what elements of the enforcement regime are inadequate and how that system might be bolstered.

The Department for Business Innovation & Skills (BIS) is the government department responsible for the NMW and maintains its commitment to robust enforcement through the implementation of its 2010 NMW Compliance Strategy.⁵⁶ BIS has a service level agreement with Her Majesty's Revenue and Customs (HMRC) to enforce compliance with the NMW. HMRC employs 17 regional teams comprising 153 Compliance Officers and a central team of 20 staff to carry out their work. HMRC spends just over £8 million each year on its NMW enforcement work.

Inadequate information and guidance

The vast majority of employers and employees are aware of the NMW. Yet knowledge of the specific detail of the NMW regulations is less widespread. That makes it all the more important, particularly in a sector where work patterns are often irregular and the potential for confusion and ambiguity with regard to the application of the NMW high, that accessible and clear information and guidance is made available to employers and workers alike.

In March 2012 BIS issued specific guidance on travel time that stated that the NMW must be paid for time when the worker is "required to travel in connection with their work" and that "any rest breaks taken during the time the worker is travelling count as time worked". Current guidance on the new government website www.gov.uk is similarly unambiguous: the "time spent travelling in connection with work, including travelling from one work assignment to another" is working time that must be remunerated. However, more explicit sector-specific guidance would help make sure that more care providers were aware of their obligations and more domiciliary care workers of their rights.

Deficiencies in the current enforcement framework

It has been clear for some time that the enforcement powers available to HMRC to ensure employers pay at least the NMW are inadequate to the task required. It is arguable that the HMRC NMW Compliance Unit has been underfunded since its inception but its ability to carry out its statutory enforcement role has become increasingly challenging in recent years following a budget freeze (an effective real terms decline).

⁵⁶ Department for Business, Innovation and Skills, *National Minimum Wage: compliance strategy* (2010) see, <http://www.bis.gov.uk/assets/biscore/employment-matters/docs/10-678-nmw-compliance-strategy.pdf>

As a result the compliance and enforcement teams able to investigate employers who may not be complying with the NMW – the bedrock of enforcement – remain woefully small. For example, in 2011 Birmingham's NMW compliance team, responsible for investigating violations in a city of over 1 million people, comprised of just eight officers including a manager.⁵⁷ The resources available in other towns and cities were no larger at the time this information was released and are unlikely to have increased in the period since.

NMW enforcement in the UK is also weighed heavily toward pro-active self-reporting on the part of workers. Reactive investigations, initiated by workers, ex-workers or third parties on their behalf, make up about 60 per cent of HMRC's total investigative caseload.⁵⁸ Proactive enforcement of employers about whom no complaints have been made – identified through a cyclical and sectoral risk-profiling process⁵⁹ – makes up only 40 per cent of HMRC's total investigative caseload.⁶⁰ Yet with many low-paid workers at risk of NMW under-payment unaware of their rights or unwilling to report their employer this reliance on self-reporting by individual workers mitigates against effective enforcement of the law.

What's more, the sanctions for non-compliance in cases where under-payment of the NMW has been firmly established are set at levels which fail to act as an effective deterrent. The Employment Act 2008 strengthened the penalties that could be levied against employers found to have paid under the national minimum wage but the penalty charge is capped at £5,000 and is halved if an employer complies fully with a notice of underpayment within 14 days of service.⁶¹ Employers also receive other signals that suggest enforcement is not a priority. It still remains the case, for example, that nothing can legally be done about job adverts that advertise work paying below the national minimum wage. With little chance of being captured by thinly spread compliance officers and unlikely to face more than minimal punishment the current enforcement framework does little to deter employers paying less than the NMW whether intentionally or through error or oversight.

The ability to publicly name and shame employers who are not complying with the NMW, introduced by the Coalition government in 1 January 2011, has the potential to become an effective deterrent that might go some way to compensating for inadequate resourcing. Yet the stringent criteria⁶² on which it has been based have largely hampered its effectiveness. To date, only one small business from Leicester having been publicly named and shamed for non-compliance with the NMW.⁶³ The government has recognised this and recently announced that as of October this year it will strip back these restrictions so that any employer who breaks

⁵⁷ House of Commons, Written Answers, 12 July 2011 (Column 288W) see,

<http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm110712/text/110712w0003.htm#1107131001279>

⁵⁸ Department for Business, Innovation and Skills, *Delivering Results: National Minimum Wage compliance report 2010/11* (2011) see, <http://www.bis.gov.uk/assets/biscore/employment-matters/docs/n/11-280-national-minimum-wage-annual-report-2011.pdf>

⁵⁹ Trade Union Congress, Commission on Vulnerable Employment (2007) see, http://www.vulnerableworkers.org.uk/files/CoVE_full_report.pdf

⁶⁰ Trade Union Congress, *Enforcing the National Minimum Wage: a practical guide* (2008) see, <http://www.tuc.org.uk/extras/nmwenforcement.pdf>

⁶¹ Section 85 of the Legal Aid, Sentencing & Punishment of Offenders Act 2012, which received Royal Assent in May, looks set to allow magistrates to impose unlimited fines on corporations and/or their directors and officers which may mean that the £5,000 limit will be rendered void.

⁶² To name and shame an employer requires evidence of either deliberately failing to comply with their NMW obligations, ignoring HMRC advice on how to become compliant, failing to keep or preserve NMW records, delaying or obstructing an HMRC officer, refusing or neglecting to answer questions put to them by an HMRC officer, refusing or neglecting to provide relevant information or produce relevant documents to an HMRC officer, or refusing or neglecting to pay arrears under a Notice of Underpayment. Moreover, HMRC only refers to BIS for naming purposes cases where the total arrears owed are at least £2,000 and the average arrears per worker at least £500

⁶³ See <http://www.independent.co.uk/news/uk/politics/scandal-of-firms-that-dodge-paying-the-minimum-wage-8580941.html>

minimum wage law can be named. These changes have the potential, if set to work alongside other reforms, to make NMW enforcement more robust.

Inadequate means of redress for individual care workers

NMW enforcement officers have the power to take enforcement action in cases of NMW non-compliance, including by means of imposing a financial penalty or by taking a claim to an employment tribunal on behalf of the worker for unlawful deductions from wages. A claim for unlawful deduction of wages can be brought before an Employment Tribunal (ET) or civil court within 3 months less one day of the deduction or the last deduction in a series of deductions and a claim for unpaid wages through the civil courts can be brought within 6 years in England and Wales (5 in Scotland).

Yet there are clearly significant barriers that confront any individual taking a case of unlawful deduction to an ET or through the civil courts. First, the process is highly stressful and many workers are deterred by the fear that they will face difficulties finding employment subsequently. Second, taking a dispute to tribunal is financially costly both in terms of lost income (a particular barrier for low-paid workers considering initiating a grievance) and legal costs. As a result of the introduction of fees for employment tribunal claims and appeals to the Employment Appeal Tribunal (EAT) from 29 July 2013, these legal costs will become a bigger barrier. And of course, even if an individual dispute is successfully settled out of court or by means of an ET, this would not prevent further abuses from occurring to other workers.

And what of the workers who successfully establish a claim for unlawful deduction of wages? Available figures show that it regularly takes upwards of 100 days to close complaints about under-payment of wages, and these figures have risen since last year. For example, in Stockport in 2011 it took an average of 162.38 days to close a case and in Portsmouth in the same year an average of 198.60 days.⁶⁴ Of course, the process of investigation, civil penalty notice, allowance of appeal makes it difficult to close even the simplest case in a very short period of time but the NMW Compliance Unit's lack of resources cannot help the situation. Perhaps most worryingly, HMRC does not keep statistics on the amount of arrears that have been paid or not paid back to workers, leaving the actual process of retrieval to individuals. In 2012/13 HMRC identified 736 employers who had failed to pay the National Minimum Wage and £3.9m in unpaid wages for over 26,500 workers, yet neither BIS nor HMRC actually have a role in making sure that all of this £3.9m in identified arrears has actually repaid to those workers from whom it was unlawfully deducted.

⁶⁴ House of Commons, Written Answers, 12 July 2011 (Column 287W) see, <http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm110712/text/110712w0003.htm#1107131001279>

Section 4

What can be done?

As we have seen, the problem of significant levels of NMW under-payment among care workers is a complex one with a range of causes. At its core the problem stems from the way in which social care in the UK is funded and the pressures which a widening gap between rising needs and available resources places on the different components of our publicly-funded system of care provision.

A national debate is already underway about the best means of funding a fairer, more sustainable system of social care. In the short term, more funds might be made available from the NHS. Yet it is clear that even accounting for an increase in productivity from existing social care services, any system of social care which is adequately funded in the medium to long-term will require increased public spending. Whether that extra public spending can be met from within current state support to older people or whether it requires some form of higher taxation⁶⁵ is an issue which lies outside the scope of this report. However, in the absence of a comprehensive funding solution what can be done to ensure the law is upheld and the problem of NMW under-payment among domiciliary care workers addressed? In the section below we outline a series of proposals designed to address the problem in the short-term.

Reform local authority care commissioning

It is clear that the way in which many local authorities commission care contributes to NMW under-payment among frontline domiciliary care workers both by actively driving down the price paid for care and by failing to stipulate or monitor compliance with the NMWR as part of the process of contracting care from independent care providers. Given the financial constraints that many local authorities are operating within and the financial pressures they face it is easy to see why such a situation has developed yet it is also clear that it needs to change.

Despite the structural financial pressures bearing down on them, some local authorities are taking steps to improve their commissioning practices. The London Borough of Islington, for example, looks set to be the first local authority nationally to have required, as of March 2014 when £6 million worth of contracts are re-tendered, all domiciliary care workers working for contracted providers to be paid at least the London Living Wage. Similarly, the London Borough of Southwark, for example, is working with UNISON on an Ethical Home Care Charter which includes steps to ensure that providers that win contracts begin to phase out the use of zero-hours contracts and pay at least the London Living Wage.⁶⁶ Thus, while we should not expect localised improvements in local authority commissioning to fully resolve the problem of NMW under-payment across the sector, there is clearly scope for individual local authorities to do more to ensure that domiciliary care workers are paid at least the NMW. We recommend the following steps be taken:

First, as the LPC has consistently recommended, local authorities must ensure that their commissioning policies reflect the *actual* cost of care in their locality, including the need to pay care workers at least the NMW. This assessment take full account of care costs including an annual uprating to reflect increases in the NMW each October. Local authorities should be required to be transparent about how they have assessed

⁶⁵ A. Charlesworth and R. Thorlby, *Reforming Social Care: options for funding*, The Nuffield Trust (2012)

⁶⁶ Currently £8.55 per hour

the cost of care in their locality and the minimum unit price required to facilitate providers meeting their statutory obligations by publishing a full breakdown of the key components of care costs in their localities.

Second, statutory guidance should require all local authorities to stipulate that hourly rates for working time must be sufficient to cover payment of travel time in contracts entered into with independent care providers. This echoes calls made by the Cavendish Review that payment for travel time become a contract condition for domiciliary care providers.⁶⁷ It is no longer sufficient to argue that it is solely the responsibility of providers to ensure that statutory rights, including payment of an hourly rate which is at least at the level of the NMW, are enforced. New ways need to be found to extend commissioners' leverage over providers, for example by use of the Social Value Act (2012), to ensure that contracts stipulate the need to account for paid travel time and these contractual stipulations should be properly monitored and enforced. If this fails to reduce NMW non-compliance in domiciliary care legislation should be considered that would make local authorities and independent care providers joint and severally liable for non-payment of NMW.

Third, to ensure that providers are not incentivised to arrange work schedules in ways that increase total travel time between clients, local authorities should move away from commissioning care in care slots of less than 30 minutes. We therefore recommend that 15 minute slots be phased out except for the purposes of monitoring.

These changes should form part of a wider shift in the culture of care commissioning from one geared to time and task, towards one in which price is increasingly linked to outcome. The concept of outcome-based commissioning has been a feature of the adult social care landscape for some time, but progress has been patchy.⁶⁸ The shift toward outcome-based commissioning, perhaps aided by the opportunities provided by the Social Value Act, needs to gather pace to ensure improved outcomes for clients and promote sustainable business models that invest in the care workforce.

Take steps to ensure independent care providers meet their statutory obligations

Independent care providers operate in an under-funded and extremely competitive market and it is understandable that many have responded by altering their employment strategies to enhance the flexibility of their workforce and to reduce expenditure on wages. However, in doing so many have ensured that domiciliary care workers are being paid less than the hourly NMW rate and that many more are at similar risk. While local authorities should take steps to improve their commissioning practices and ensure that the price they pay for care is sufficient, there is a need for measures to ensure that care providers are doing everything they can to ensure that their statutory obligations are met.

In addition to considering legislation to make local authorities and independent care providers joint and severally liable for non-payment of NMW, the scale of NMW under-payment in this sector requires government to consider establishing a statutory code of practice to drive up standards among providers. The code would require independent care providers to:

- Ensure that a realistic component for travel time is included in the prices tendered to local authorities commissioners

⁶⁷ The Cavendish Review: an independent review into healthcare assistants and support workers in the NHS and social care settings (July 2013)

⁶⁸ L. Lucas and J. Carr-West, *Outcomes Matter: Effective Commissioning in Domiciliary Care* (2012)

- Detail clearly on staff payslips what paid hourly rates comprise in terms of working time and specifically whether travel time is included, and whether there are enhanced rates for short visit lengths. Average hourly pay rates including reasonable allowance for travel time should be clearly marked at the head of weekly or monthly payslips so that domiciliary care workers are clear what rates they are being paid and for what working time.
- Phase out work schedules in which care slots are crammed into time periods that make it difficult for domiciliary care workers to carry out their duties without rushing, leaving a client before time or travelling in their own time.

Construct a more effective system of enforcement and redress

The HMRC Compliance Unit is doing what it can within a constrained budget to enforce the NMW. In recent years the Unit has sought to maximise the use of its resources by placing greater emphasis on intelligence and risk.⁶⁹ But NMW enforcement needs to become a much more effective deterrent to providers operating pay systems which do not ensure that all domiciliary care workers are being paid the national minimum. Ultimately, the law is the law and must be properly enforced. We recommend the following steps be taken:

First, the government must make sure that HMRC's Compliance Unit is properly resourced. Despite increases in funding for HMRC's NMW enforcement work of £2.9 million each year from 2007 to 2011, the financial resources allocated to enforcement remain inadequate. Ensuring that the resources dedicated to NMW enforcement match the scale of the problem is therefore an urgent priority. We recommend that the government end the freeze it has applied to the minimum wage enforcement budget and designate publicity on NMW enforcement as 'essential expenditure' exempt from the current freeze on public sector marketing.

Second, with social care widely acknowledged as a 'high-risk' sector more must be done to make sure resources follow accordingly. HMRC should look to target resources on distributing sector-specific information and guidance and undertaking visible, pro-active interventions to identify and prosecute more employers in the sector that consistently break the law. If necessary that should mean freeing HMRC from the current strict rules on confidentiality which prevent it from reporting on challenges to employers who break the law.

Third, the relevant information and guidance on NMW compliance should be improved. In its 2012 report the LPC recommended that "the Government puts in place, and maintains, effective, clear and accessible guidance on all aspects of the minimum wage particularly where there is significant evidence of ignorance or infringing practice." This has not happened in the case of social care despite widespread awareness about NMW under-payment among domiciliary care workers and those with knowledge about the sector. There remains a pressing need for more explicit sector-specific guidance on www.gov.uk, including a series of worked examples illustrating precisely how travel time between clients should be remunerated, so that more employers are aware of their obligations and workers of their rights.

Fourth, the reliance of the enforcement system on pro-active self-reporting should be reconsidered. There are a range of other organisations that collect information and intelligence that could help identify employers who fail to comply with NMW Regulations. HMRC should begin to work more closely with other

⁶⁹ National Minimum Wage: Low Pay Commission Report (2012) http://www.lowpay.gov.uk/lowpay/report/pdf/8990-BIS-Low%20Pay_Tagged.pdf

organisations to identify and target employers likely to be breaching the law. As Andy Hull⁷⁰ argues in a forthcoming paper, there is a strong case, on the grounds of subsidiarity, for devolving primary responsibility for NMW enforcement to local authorities. Local authorities already have extensive contact with local businesses through the collection of Business Rates, Planning, Licensing, Environmental Health, Food Safety, Pollution and Health and Safety and many of these roles include an enforcement element. While any devolution of NMW enforcement will require the transfer of adequate powers, skills and resources, local authorities are well placed to identify employers who might not be NMW compliant and to shift the enforcement system toward proactive identification rather than relying on workers themselves reporting abuses.

Fifth, the penalties for NMW non-compliance should be increased. While it is important to strike the right balance between civil penalties and criminal sanctions it's clear that the current sanctions regime does not strike it correctly. A full review into arrears and penalty provisions should be carried out and allowance made for increased fines, which may require the use of criminal law, beyond £5,000.

Lastly, more needs to be done to ensure that workers who successfully win a claim for unlawful deduction of wages receive the pay they are owed. As has been noted, workers who have been the victims of unlawful deductions from their wages must pursue repayments through local county courts by means of paying for a High Court Enforcement Officer - similar to a bailiff - to demand payment from the employer. All of this takes time and, in the case of the later, an upfront payment of £60 (recovered from the employer when they pay). What's more, a worker that does not receive arrears owed has to be prepared to report the non-payment, confronting once again the barriers originally faced in proactively reporting an abuse. For many low-paid workers the pursuit of deducted wages in this manner is fraught with difficulties and can be a huge burden. A government fund should be created that would immediately reimburse low-paid workers who have been victims of unlawful deductions and make government, rather than vulnerable individuals, responsible for recovering funds from individual employers. This would also aid HMRC in the process of beginning to keep statistics on the amount of arrears that have been paid or not paid back to workers who have been the victims of unlawful deductions from their wages.

⁷⁰ A. Hull (forthcoming), *Settle for Nothing Less: enhancing NMW compliance and enforcement*, Centre for London

Conclusion

Domiciliary care workers across the UK continue to deliver excellent services despite the fact that many face extremely tough working conditions. The low status and low rates of pay associated with their occupation combined with the irregular and fragmented nature of the service they provide often means that work is precarious for many. Yet receiving an hourly wage at or above the national minimum remains their right, not a privilege dependent on the generosity of their employer.

It amounts to nothing less than a national scandal that hundreds of thousands of domiciliary care workers are at risk of routinely being paid less than the legal minimum of £6.19 an hour. This is not just because the law is reasonably clear about the fact that time spent travelling between clients should be regarded as time worked for the purposes of the NMW, but because a poorly paid and undervalued workforce will struggle to provide clients with the dignified care they both deserve and require. If we care about improving home care services for people we need to make sure we start investing in the workforce that provides it.

With the UK's social care workforce projected to expand rapidly in future years as a result of increased life expectancy and medical advances that will leave more people living longer in ill health and in need of day-to-day care the price of inaction will only grow. There is therefore a need to take urgent measures to address the significant levels of NMW under-payment among domiciliary care workers in the UK.

A comprehensive solution requires us to address the way in which social care in the UK is funded and the pressures which a widening gap between rising need and available resources places on the different components of our publicly-funded system of care provision. But the absence of a comprehensive funding solution should not stand in the way of ensuring that all domiciliary care workers receive at least the minimum wage.

Ensuring that the prevalence of NMW under-payment in the social care sector is drastically reduced will be a huge challenge requiring action across a number of fronts including measures to reform local authority care commissioning, to ensure that independent care providers meet their statutory obligations and that an effective system of enforcement and redress is in place to prevent non-compliance. But doing nothing is not an option if we care about the living standards of hundreds of thousands of low-paid care workers and their ability to provide the dignified care that their clients need and deserve.

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