Stakeholder perspectives on domiciliary elderly care in the UK

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June 2011, Revised Report

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Introduction

The aim of this report is to provide an overview of stakeholders’ perspectives of work quality in domiciliary elderly care in the UK, which employs approximately 675,000 persons, nearly twenty-five percent of the 2.7 million employed in the health and social care sector (Office for National Statistics, 2010; Skills for Care, 2010). Domiciliary elderly care involves the provision of personal care (e.g., preparing meals, bathing, dressing) to older adults in their own homes and is a growing area within the health and social care sector. A key change within this sector over the last twenty years has been the movement from publically funded care being provided in-house by local authorities, to local authorities being responsible for contracting out the work to private and not-for-profit organisations, i.e., the independent sector. Five stakeholders were invited to discuss employment conditions and trends within the domiciliary elderly care sector, including a local authority, an employers’ association, the regulatory body concerned with standards of care provision, the sector skills council that is responsible for skill provision in the social care sector, and a trade union.

1 Economic and employment development in the sector

Key organisational and employment characteristics of the UK domiciliary elderly care sector are summarised below.

1.1 Structure and size

The domiciliary elderly care sector in the UK consists of four main types of supplier: private organisations; voluntary organisations; local authority organisations (i.e., state provision), and personal employers, i.e., a care service user directly employing a personal assistant. All organisational providers are legally required to be registered with the care regulator. Between 2008 and 2009, there were 6,078 registered providers of domiciliary care, of which 76% were private, 12% were voluntary and 12% were local authority; approximately two-thirds of these were small organisations of less than fifty employees. The total number of people in England in receipt of care by registered providers was estimated to be 582,000 (UKHCA, 2011). The number of personal assistants is not known, as they do not have to be registered with the care regulator.

The exact expenditure on domiciliary elderly care in the UK is not known. But a recent report suggests that there was £3.9 billion of public expenditure on domiciliary elderly care (UKHCA, 2011). This is likely to account for most of the expenditure on domiciliary elderly care, as most funding in the UK is public, and most private sector income originates from public sources (an estimated 75% to 100% for each private sector organisation). However, the level of private funding is increasing, as between 1998 and 2008 it was estimated that whilst real expenditure had grown by 57%, the amount of public funding had only grown by 48% (House of Commons, 2010). Local authorities control most public funding and commission services from various registered providers. They utilise their own
specialist elderly care commissioning teams to do this. Local authorities also have a requirement to ensure a reliable supply of providers and to promote competition between providers.

The total number of persons employed in domiciliary elderly care has been estimated to be 675,000 (Skills for Care, 2010). Approximately 80% work in the private sector. Most employees are female, aged over 35 years and on part-time contracts. A large proportion of employees are also migrants; recent data suggests that across England as a whole, 31% of adult social carers are non-UK born, but in the London area, 66% are non-UK born. Almost half of employees stay with an employer for less than three years and the level of turnover has been recently estimated to be at 22% per year (Skills for Care, 2011).

1.2 Employment trends

The domiciliary elderly care workforce has expanded by 25% since 2006 and is expected to increase further in response to growing demand. Some estimates put the size of the future domiciliary care workforce at 2.3 million in 2025, an increase of around 350% (Skills for Care, 2011). However, there is less clarity about the extent to which this workforce will consist of employees of organisational providers or of personal employers. This is because of another anticipated employment trend, the increased use of personal assistants who are employed directly by service users. This trend is likely to occur partly in response to a general decrease in state support for domiciliary elderly care, meaning that users will have to contribute more directly to their care costs, but largely because of the UK government’s current personalisation agenda. Personalisation refers to the tailoring of social service provision to meet the unique needs and preferences of individuals and the empowerment of individual service users to achieve this (Dickinson & Glasby, 2010; Her Majesty’s Government Policy Review, 2007). This agenda represents a significant transformation of adult social care provision to enable it to “put people first” (Social Care Institute for Excellence, 2010) and involves moving away from public sector-run care and decision-making, towards individual service users taking more responsibility and making choices for themselves. An important aspect of the personalisation agenda is that service users will be able to decide how to spend their personal budgets¹ and, as a result of this, may choose to employ their own personal assistants. These employees are expected to provide the same care services as those working within local authority or independent agencies.

1.3 Pay and conditions

The level of pay for domiciliary elderly care workers in the UK is very low, with a median rate of £6.50 per hour in England, and with most employees paid no more than one pound

¹ Personal budgets refer to the allocation of money to individuals who are receiving social care, and may take the form of direct cash payments made to these individuals, or be held and managed by the local authority on their behalf (The Association of Directors of Adult Social Services, 2009; Social Care Institute for Excellence, 2010; UNISON, 2010).
above the national minimum wage of £5.93 (Skills for Care, 2011). The level of pay is higher in local authorities than in the private and voluntary sectors by as much as 13% (Skills for Care, 2010). This is due in part to the fact that local authorities tend to provide more specialist services and their highly unionised workforce has historically been able to negotiate better terms and conditions.

Although care work often involves working overtime to cope with unexpected demand, as well as evening work and night work, domiciliary elderly care workers do not always receive compensation for this. For example, a survey of care workers found that 68% did not receive additional pay for working nights (TNS, 2007). Furthermore, although 22% of a domiciliary elderly care worker’s time is spent travelling between clients (Skills for Care, 2011), only 52% received payment for travelling time and only 54% received payments for fuel costs.

With regard to training, UK employers are legally obliged to provide health and safety training. Although a majority of social care employees received this type of training, there is no exact data for domiciliary elderly care workers (TNS, 2007). In addition, evidence suggests that induction training is not given to all employees, and that little additional training to increase skill levels is provided (Francis & Netton, 2004; TNS, 2007). Until recently a further requirement for registered care providers was that all care staff had to obtain a National Vocational Qualification at Level 2 in social care, although this was removed in 2008 and is currently being replaced with another qualification. The typically flat organisational hierarchies and the small size of organisations further limit development and career advancement opportunities for employees. Jobs are also characterised by relatively low levels of engagement and representation. For example, 64% of domiciliary elderly care workers reported having an annual performance review, compared to 86% of care home staff (TNS, 2007), and there were few collective agreements, particularly in private providers.

Finally, work is typically organised within short, time-restricted visits where the care worker is required to conduct contractually specified tasks. In addition to the demands of the pace and timing of work, employees are exposed to other demands including physical demands, interaction demands and having high levels of responsibility. Job resources, such as the provision of direct social support from managers and co-workers can be low, as employees typically work in isolation. The job discretion of domiciliary elderly care workers is limited by the set working time and tasks, but employees do have a high degree of discretion over how they organise and manage their tasks and how they interact with the service users.

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2 As noted by the employers’ association, however, where travel time is included in the overall hourly pay rate it will not be paid separately: employers are legally required to ensure that work and travel time together are paid at or above the national minimum wage.
2 General background on the stakeholders

Five stakeholder organisations were involved in this study. Two of the key stakeholders in this sector are local authorities who commission care services and employers who provide care services. In this study, the perspective of local authorities was gathered from a local authority care commissioning department, and an employer perspective was gained from an employers' association. The three other stakeholders included representatives from the regulatory body concerned with standards of care provision, the sector skills council that is responsible for skill provision in social care sector, and a trade union.

The local authority

The local authority involved is based in the northwest of England with a jurisdiction covering a predominantly urban population of approximately 214,400. We informally interviewed three members of its care commissioning team who had over forty years combined experience in the sector.

The employers’ association

The employers’ association is a not-for-profit organisation for domiciliary care providers across the public, private and voluntary sectors, and is part-funded by membership fees. It does not have a legal statutory basis but its main roles are: to provide help and advice to its 1,900 member organisations; to promote higher standards of care; and to represent employers' interests to policymakers and regulatory bodies. The interviewee was a senior employee who has held the post for 6 years and who was responsible for providing sectoral representation to policymakers and the media, interpreting policy and communicating this to its members, and offering guidance on best-practice.

The care regulator

The care regulator is an independent organisation, largely funded by registration fees, that operates to protect the service user and to ensure that health and care providers in England comply with essential standards of quality and safety. The regulator covers all care services provided by the NHS, local authorities, voluntary and private organisations. Core functions include licensing care organisations, monitoring compliance with standards and enforcing this compliance. The interviewee was a manager working at national level who had a remit to examine current and future regulation policies and to develop strategies for policy implementation.

The sector skills council

The sector skills council is a government-funded, employer-led body concerned with the training standards and development needs of employees in the social care sector in

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3 Following the devolvement of the UK government, the care regulator operates in England alongside organisations undertaking similar roles in Scotland, Northern Ireland and Wales.
England. Its objective is to develop a qualifications framework and establish standards that promote the best social care provision. The sector skills council is involved in workforce development activities, conducts sector research and provides a voice on behalf of the sector to policymakers. The sector skills council interviewee was a national advisor involved with engagement with the government and other stakeholders and with policy development and implementation.

The trade union

The trade union is one of the largest in the UK, representing approximately 1.3 million employees, mainly from the public sector. The main functions of the union are to organise and represent employees on work-related issues through the provision of direct support and campaigning. The union is organised at three levels, locally, regionally and nationally: the local operation provides organisational stewards and representatives for employee issues; the regional operation focuses on policy development and associated actions; the national operation develops policy and selects issues on which to campaign. The union interviewee is a senior officer working at national level with a remit to represent the 300,000 members who work in social care (including domiciliary care), which she did through sitting on national and European committees and through lobbying government.

3 Historical background

The initial focus is on the extent to which employees in the health and social care sector have been represented historically. The two key changes in domiciliary elderly care in the recent past have been: (1) the increased demand for care services, and; (2) the transition from public-funding and public sector provision to publically funded independent (private and voluntary sector) provision. The increased demand for care is a reflection of the growing elderly population in the UK: people are living longer, and, due to better health care, are living with more serious conditions. These put pressure on care funders and providers in terms of increased demands and expectations. The trend towards local authorities being the commissioner of services has been advanced by both Conservative and Labour governments and is based on the assumption that a competitive market in care provision will provide a more efficient means of providing services. In England, for example, more domiciliary care is now being bought by the local authorities than is being provided by them (Laing & Buisson, 2000; Matosevic, Knapp, Kendall, Forder, Ware & Hardy, 2001), with the most recent figures indicating that 81% of domiciliary care was provided by the independent sector in 2008, compared to just 51% in 1999 (Community Care Statistics, 2008; UKHCA, 2011).

This backdrop provides the context within which to understand the role of the stakeholders in this sector and their relative capacity to represent the interests of employers.

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4 As with the care regulator, the employers association operates solely in England, but alongside similar organisations elsewhere in the UK. Note that a separate sector skills council exists for health care providers.
employees and the elderly. As noted, the role of local authorities has changed from being providers to commissioners of care, whilst the number of independent providers has increased dramatically. Although some local authorities, including the one in this study, still provide a limited amount of specialised domiciliary elderly care, it is private organisations that now employ most workers in this subsector and, as a result, their capacity to influence has increased greatly. This has increased the profile and organising capacity of the employers’ association since its conception 21 years ago, although it has no legal basis and thus cannot be involved in collective bargaining. Collective bargaining and agreements are the responsibility of the trade unions, the main unions in this sector being relatively recent amalgamations of much older unions. The move away from local authority care provision that is largely unionised, to private care provision that is largely non-unionised, has, however, decreased the power of the unions to influence practices in this sector and to organise workers.

Sector skills councils were set up by the previous labour government to increase employee skill levels, one of which is the skills council for social care that has been in operation for 12 years. Skills councils are publically funded but largely employer-led, and can therefore be seen to mainly represent employers’ interests.

The interests of the elderly are considered to be largely the concern of the care regulator that has responsibility for regulating care standards in all health and social care organisations and for dealing with complaints from service users and their relatives. The care regulator was set up in 2009 as the single regulator of care in response to increased concerns about standards of care in the public and private sectors, and the fact that multiple agencies were monitoring care standards in a relatively uncoordinated manner.

Overall, it is evident that employers’ interests are promoted by increasingly powerful employers, the employers’ association and the skills council, whilst the capacity of the elderly and their relatives to protect their interests has been enhanced by the creation of the care regulator. But at the same time, the capacity of trade unions to represent employee interests has decreased, even though the sector has many employees who might be classed as vulnerable.

The sector attracts at least three types of worker that might be classed as vulnerable: (1) females; (2) migrants, and; (3) low-skilled. The disproportionate representation of women is likely to be because they have traditionally adopted caring roles, may have had experience caring for children and other family members, and may seek flexible and part-time working hours to fit around other roles. Anecdotal evidence suggests that women may be disadvantaged, “there is a gender pay gap, enforced because men are not going to work for that kind of money” (trade union).

The high percentage of migrants working within the sector was noted by all the stakeholders. Low barriers to entry and a willingness to work on very low pay were seen to be reasons for this. The sector, which suffers from high turnover and has difficulties recruiting, may also deliberately target migrants for their skills and attitudes, “the sector will talk in very positive terms about migrant workers… some of this is based on culture… they’ll be employing workers from countries that have a caring culture” (skills council), or
for economic reasons, “you’ll be aware that there is a business efficiency in terms of employing migrant workers at low wages” (skills council). Communication difficulties have enabled some care organisations to take advantage of migrants, with discrepancies in pay and abuses of employment rights not uncommon, “they don’t respect their workers” (trade union). According to the skills council and care regulator, the employment of illegal workers has grown, creating a hidden, unrepresented workforce, likely to be exposed to the poorest working conditions.

The low-entry level for employment in social care is not problematic given that basic training is a legal requirement. However, this training may be brief (in some cases less than one day) or inadequate for some aspects of the role. With poor training provision, employees may eventually become trapped in dead-end jobs, having “little chance of promotion, very few opportunities, and little diversity” (employers’ association).

4 Current developments and trends

In this section we discuss the situation in terms of current and predicted employment trends, the nature of workers’ jobs and roles, and the influence of key stakeholders. The interviews with the stakeholders highlighted one current and one predicted employment trend. The current trend is the increased use of personal assistants by care services users which, as noted, has been driven by reduced state support for care costs and the previous and current government’s personalisation agenda. The use of personal assistants, described as a growing “army of unregulated workforce” (trade union) who are “completely out of scope of regulation” (care regulator), has been identified as problematic because users can employ anybody (e.g., family members, friends) with no assurances that they will be trained or qualified to undertake such a role, and with no legal requirement to have them undergo Criminal Record Bureau background checks, thus presenting potentially serious safeguarding issues for both users and the personal assistants themselves. In addition, it is not clear how personal assistants will be represented, “who will be teaching [them] what their rights are? If they have a grievance, where do they go?” (trade union). The lack of regulation and representation may enhance the vulnerability of such employees. Moreover because personal budgets cannot be spent on public sector care, this, according to the trade union, also affects the sub-contracted workforce, who are “losing out on terms and conditions, low pay, the consequence being very high turnover in the private sector…”

Stakeholders further predict that the current barriers existing between health and social care provision will eventually be broken down, because “it’s seen as providing efficiencies and cost reductions” (sector skills council). On a practical level this would involve the upskilling of the current social care workforce and enable them to take on basic health care duties such as administering medicine to service users. But those currently working in the health care sector, which has better terms and conditions, see this as a potential means of lowering pay and the quality of employment conditions.
4.1 Work and employment characteristics

Domiciliary elderly care work was assessed to determine its quality. Stakeholders perceived work and employment to be characterised by:

— Very low pay
— Low skills and qualification requirements
— Poor training provision
— Low discretion
— High workload
— Exposure to the risks of working alone, e.g., isolation, violence
— Zero-hour contracts

The low level of pay was seen to be a key issue in this sector, which had a particular effect on recruiting and retaining staff. One interviewee noted that “from what I know, people get paid more working at Tesco\(^5\) to be quite frank, which is obviously problematic in terms of drawing in people, a workforce of good quality, that stays motivated, a stable workforce” (care regulator). This issue was compounded further by the fact that some employees were not paid for the time moving from one client to another and that they were expected to pay for their transport between work locations, uniforms and mobile phone use. The low level of pay was seen to be one of the key factors affecting the quality of care, with private providers criticised for offering poorer terms and conditions and lower pay than their public sector counterparts. However, the low pay of workers is partly a result of the contracts offered by local authorities: “so much care is purchased by the state, the price it is sold for has a huge impact on employment conditions and wages” (employers association). Indeed, the low level of fees paid by local authorities to independent care providers have been linked with, for example, difficulties in meeting increases in the national minimum wage (Low Pay Commission, 2011).

Domiciliary care workers were seen to have a very low-level of qualifications, with “70% of care workers not holding any qualifications at all” (trade union). As noted earlier, the requirement to complete a National Vocational Qualification at Level 2 had been removed in 2008, but it was suggested that the new modular qualifications system being introduced to replace this, the Qualifications Credit Framework, was better able to meet the needs of employers as it enables “bite-sized opportunities focusing on skills rather than long qualifications” (sector skills council) and because it requires less time off needed for training. Training was also seen to be limited, with the minimum requirement being cited as, “just one hour, and they might follow someone about for a morning” (trade union), and this being typically focused on health and safety issues. The low level of training was seen to be partly a result of employers not being incentivised to do so.

Domiciliary workers’ tasks were typically arranged within 15 to 30 minute time periods, with employees having little discretion over the nature and timing of tasks. It was

\(^5\) Tesco is a UK supermarket chain.
suggested that this enhanced the pressure for employees who struggled to achieve what they needed to in this time. Moreover, the lack of training meant that employees were sometimes not able to cope with novel situations. A further aspect of the role discussed more generally was employees’ exposure to risk, which was a feature of working alone. It was considered that risk could be minimised through providing good channels of communication, support and training.

The domiciliary elderly care sector extensively uses zero-hour contracts extensively, which involve employees being expected to be available to work as and when they are required. The flexibility they offered was seen by some stakeholders to be a benefit for employers and employees.

Overall, work and employment conditions in the local authorities were considered the best, followed by the voluntary sector and then the private sector. What separated local authority care work in particular was that employees tended to work full-time (i.e., 35 to 38 hour per week), had better pay (i.e., up to £4 more per hour) and better conditions (e.g., holiday pay; sick pay; pension schemes; union representation), and also had higher levels of training.

4.2 Stakeholder influence

Stakeholders were questioned about the extent of their influence on work and employment conditions in the sector and the role of other stakeholders. Most stakeholders perceived little general capability to improve work and employment conditions in domiciliary elderly care jobs, with the main area of influence being training and skills. Furthermore, most stakeholders, except trade unions, did not view improving work and employment conditions of employees as central to their objectives, even though a link between the quality of work and the quality of care was recognised.

The local authority saw their main responsibilities as ensuring the provision of the best quality care for the lowest possible price, while the employers association saw their role as steering the sector towards good practice in the delivery of social care as well as promoting dialogue on what they perceived to be problematic local authority commissioning practices. But as an organisation with limited resources, the employers’ association was finding it increasingly challenging to work with the growing number of decentralised government bodies and to reach out to the numerous micro-providers, “I’m quite surprised and a little alarmed at the number of social care providers that don’t belong to any type of business support services”. The sector skills council perceived their greatest influence to be on the skills of the domiciliary elderly care workforce, but faced difficulties in aligning the needs of employers with a sometimes contrary government agenda: “it’s expected that we implement or lead on some government initiatives or policy, but at the same time we’re supposed to be employer-led”. The care regulator noted that their main focus was on care outcomes. As a means to ensure that good outcomes were achieved, the care regulator was able to evaluate recruitment practices and take enforcement action if necessary (e.g., when employers had failed to take references or carry out background checks on potential employees). The care regulator further
considered itself as working in tandem with the sector skills council to improve workforce skills. However, like other stakeholders, the care regulator had no remit to regulate personal assistants or to assess local authority commissioning and therefore had limited influence on these areas.

The trade unions recognised their limited influence on the work and employment conditions of domiciliary elderly care workers because of the low level of unionisation and lack of national collective agreements or national bargaining forums. The move towards private sector care delivery and a more fragmented workforce was perceived by the trade union to have contributed to “falling membership, declining standards, and a race to the bottom on pay and conditions”. Privatisation was noted as a particular barrier, “some private providers are hostile to union involvement despite the benefits it can bring them”. Nonetheless, the unions sought to gain influence by organising the full range of care workers, by achieving more recognition agreements with private employers, by maintaining a social dialogue with key stakeholders, and by campaigning and negotiating to influence policies and practices in social care. The current coalition government was not considered to be as “sympathetic” to trade unions as the previous government, “we’re beginning to feel that the government is not supporting our dialogue to improve or even maintain the terms and conditions of low paid domiciliary care workers”. One example given was the recent decision, made without consultation with the unions, to revoke the Two-Tier Code, effectively removing the rights of new starter employees contracted to local authorities to receive the same terms, conditions and pensions as transferred employees. The unions saw this as particularly problematic, with the unprotected elderly care workforce facing an inevitable “downgrading” of their pay and conditions.

5 Collective bargaining and social dialogue

The domiciliary elderly care sector in the UK is characterised by a lack of coordination between different stakeholders and there are no national forums for different stakeholders to discuss employee related issues, although formal relationship do exist between the sector skills council and the trade union. Nor was there much evidence that stakeholders regularly worked together on shared initiatives or campaigns relating to employment conditions. The sector skills council showed an interest in campaigning in this area but felt that there would be a conflict of interests in light of the fact that they were funded by central government. There was also a perception by some stakeholders that their aims were in conflict with other stakeholders. For example, the employers association described their relationships with trade unions as “cordial” but found that the unions had an agenda that was not favourable to their member organisations on, for example, the use of zero-hour contracts, and that unions had a perception that the “statutory sector equals good and independent sector equals bad” (employers association).

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6 Since 2010 there has been Conservative-Liberal Democrat coalition government in power in the UK. Prior to this, the Labour party had been in control since 1997. Trade unions have traditionally been affiliated with the Labour party.
As well as there being no national forum for the discussion of employee-related issues, most stakeholders did not see improving employees' work and employment conditions in the domiciliary elderly care sector as a central part of their agenda, the only exception for this being the trade unions. In contrast, the aims of the employer association were to provide guidance to employers on best practice. The legal remit of the care regulator was to promote care outcomes which they recognised also reflected the quality of employees’ work, but considered this area to be more the responsibility of the sector skills council. One of the main goals of the sector skills council was to improve the qualification and skills system to increase the flexibility of the social care workforce in anticipation of the integration of health and social care provision. Despite this, the sector skills council did not, surprisingly, acknowledge their role in improving conditions, “in some ways [in] improving conditions, there’s little we directly do”.

At a national level, the trade union’s main objective was to influence policy affecting the sector, e.g., by trying to shape UK employment law on issues such as the national minimum wage and health and safety, by promoting equal pay legislation and engaging in research and collaborations to examine broader sectoral issues such as the personalisation process and its effects in the US and Norway. But it was at the regional and local level where the trade union was more directly involved with improving employment conditions which it did through negotiation with employers and trying to ensure employees come under a national agreement that supported, for example, fair and equal pay, and also seeking to provide legal representation for those involved in disciplinarians and grievances. Collective agreements in this sector were mainly confined to local authority care providers. As a result of the uncoordinated and fragmented nature of employment and contractual relationships between care providers, commissioners and union representatives, and because “British employers are fairly resistant to unionisation” (employers association), local agreements were in place with just a minority of private providers. These recognition agreements were limited in that they only covered certain localities or organisations and focused on issues such as uniforms and travel. Of the “thousands” of local agreements in force, most were not subject to revision but were reviewed on an annual basis. Although the trade union played a significant role in the public sector, it was clear that the majority of care providers in the private sector were outside of their remit and could not benefit from their partnership approach to employment.

6 Relationships with other actors and institutions

A number of other stakeholders were cited as being active in the sector, including other trade unions, charities, and a regulatory body for social workers, an employer association for residential care, and a parallel sector skills council for health care providers. However, their influence over employment conditions was difficult to establish. Stakeholders collaborated with these organisations and each other in a number of ways such as attending periodic meetings, membership of committees, networking, and conducting joint research activities. Working relationships tended to be informal, and stakeholders
regarded each other neutrally, “we may be at the same meetings as [other stakeholders] are” (employers association); “I have on occasions done some work with [other stakeholders] on various bits and pieces” (sector skills council). The sector skills council further discussed how they had a more difficult relationship with a separate government-run body that promoted organisational best practice, “we sometimes struggle with our mutual boundaries… we do sometimes work together, but it’s about competitive survival at the end of the day”. There was little evidence of collaboration on shared initiatives or campaigns that directly related to improving employment conditions.

7 Future perspectives

Stakeholders were invited to share their perspectives on what they saw as the important forthcoming issues, debates and challenges within the sector. The following issues were raised:

— Future funding
— Employee recruitment
— Changing needs of service users
— Restructuring and deregulation

The funding of adult care provision was a concern raised by all stakeholders and described as a “crisis” by the trade union. The current system has been criticised for being unfair, complex and completely unsustainable with respect to the growing demand and changing needs that are forecast (Poole, 2009). Stakeholders discussed how they expected the transition from public sector responsibility for funding care towards individual responsibility to be and how this might affect service users, “people are going to have to pay [more] for their own care” (care regulator).

Difficulties were also anticipated in attracting and recruiting a larger workforce that is needed to cope with the increased number of elderly needing care, and from a population of workers who might not be attracted to low paid work that typically uses zero-hour contracts. Many also stated that a larger, trained workforce is needed to cope with the growing elderly population with more complex needs and also because local authorities “are only funding people with critical or severe needs” (care regulator). The domiciliary sector was thought to be very unprepared to cope with the “time-bomb issue” (sector skills council).

Allied to this, reduced government spending and the changing needs of service users implied sectoral efficiencies and diversification. The employers association predicted the reduced government spending would lead to a consolidation of care provision leading to larger organisations, which was problematic for them because of reduced membership levels. Conversely, the personalisation agenda would mean an increase in the number of micro-organisations and personal assistants, triggering concerns about their lack of regulation from the regulatory body and potential vulnerability from the trade union.
8 Conclusions

We have examined stakeholder perspectives on the quality of work and employment conditions in the health and social care sector, and specifically in relation to domiciliary elderly care. Growing demand for care services combined with the privatisation of the sector has resulted in a rapid expansion of private organisations competing for contracts over recent years. The need for providers to be highly efficient and economical with limited public resources has resulted in poor working conditions marked by extremely low pay, a lack of investment in employee training and development, unfavourable zero-hour contracts, and, with the increase in private providers, an associated decrease in union recognition and representation. The current personalisation agenda is further set to create a new potentially hidden workforce of personal assistants who are outside the scope of regulation. Compounded by a lack of social dialogue, no one specific stakeholder can be considered as particularly active or successful at improving the quality of work and employment conditions in domiciliary elderly work, although the promotion of skills and qualifications remained a central concern for most. The trade unions, key advocates of employee interests, were working hard to retain and expand their membership in an increasingly difficult environment.
References


Annex: Table of acronyms

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<thead>
<tr>
<th>Description</th>
<th>NHS</th>
<th>UK</th>
<th>WALQING</th>
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<tr>
<td>National Health Service</td>
<td>NHS</td>
<td>UK</td>
<td>Work and Life Quality in New and Growing Jobs</td>
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