

KBS Covid-19 Research Impact Papers, No. 1

Fair care work

A post Covid-19 agenda for integrated employment relations in health and social care

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The Covid-19 crisis has caused enormous distress around the world and demands urgent research to interrogate how it has impacted upon, and how it will continue to reshape, multiple features of economy and society. We hope that this series of KBS Covid-19 Research Impact Papers will provoke new debate among our UK and international partners in business, civil society and government. We look forward to building new ideas for policy and practice that foster a more inclusive, sustainable and responsible future.

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Abstract

The distinctive contribution, in terms of bravery and sacrifice, made by the healthcare and social workforce to tackling Covid-19 has been reflected in the Thursday night round of applause reserved for this part of the workforce. However, if this applause is to be more than a well-meaning gesture, serious consideration must be given by policy makers and practitioners to whether and how these sentiments can be captured in the fair treatment at work of these health and social care employees.

This paper is designed to kick start debate on how this might be achieved. It traces the challenges exposed by Covid-19 and maps the way forward along key dimensions of employment relations in health and social care: migrant workers; pay determination; learning and development; and the nature and consequences of outsourcing. It sets out a model of fair care work based on four essential principles: integration, aligning the treatment of workers in health and social care; parity of esteem for workers employed by different types of service provider and across the occupational hierarchy; compliance to ensure the effective implementation of fair care work; and collective employee voice to guarantee employee interests are meaningfully aggregated and articulated.

1. Introduction

The distinctive contribution made by the healthcare and social workforce to tackling Covid-19 has been reflected in the Thursday night round of applause reserved for this part of the workforce. Sitting alongside other ‘key workers’ in their essential contribution to societal functioning in a period of acute crisis, the 2.2 million, largely female,¹ employees in health and social care² are nonetheless distinguishable by their relentless and intense frontline engagement with the virus, and the high level of risk and uncertainty to which they are consequently exposed. The ritual clapping represented a collective display of respect and gratitude. However, if it is to be more than a well-meaning gesture, serious consideration must be given by policy makers and practitioners to whether and how these sentiments can be captured in the fair treatment at work of these health and social care employees.

This paper contributes to deliberations on fair care work, presenting policy options designed to address the challenges to employment relations (ER) in health and social care highlighted by the Covid-19 pandemic. In doing so, we acknowledge that the form and viability of our suggestions are intimately related to broader, underpinning policy developments on the shape and funding of health and social care delivery, which likely beckon in the wake of the virus. Based on many years of research into and engagement with ER in the public services, our purpose here is to present an informed set of ER possibilities for discussion, available for (re-) evaluation and detailed interrogation if and when a more radical re-structuring of health and social care is forthcoming.

In scoping the paper, we have also been mindful of the current, understandable preoccupation with the health and safety of the sector’s workers as largely articulated by the trade unions and professional associations.³ It is a preoccupation likely to stimulate debate on the current and future physical and mental health of care employees, including, for example, how more robust arrangements for occupational health might be developed and how employee voice on such issues through, for example, the network of workplace health and safety representatives might be bolstered.

We touch upon employee well-being throughout the paper but with this topic already attracting significant attention, our main focus is on the following key dimensions of employment relations in health and social care:

- migrant workers
- pay determination
- learning and development
- the nature and consequences of outsourcing.

These dimensions overlap to some degree. Outsourcing is, after all, a process of delivering health and social care, inevitably touching on the other three dimensions which relate to substantive aspects of employment. More specifically, our chosen dimensions raise several cross-cutting issues:

The government as a model employer

The model employer approach has a long history.⁴ It dates back to the early twentieth century, when the government as an exemplar for the rest of the economy adopted a ‘good’ practice Whitely approach to the management of its own employees, based on effective union representation and regular consultation. Over the succeeding century, the interpretation and application of this approach has been subject to debate and change, driven not least by public policy shifts in what constitutes ‘good’ ER practice.⁵

The meaning of the model employer approach has also been somewhat dissipated by the emergence over of the years of a mixed economy for the delivery health and social care, apparent in the provision of services from across the public, private and voluntary sectors. From being the main employer of workers in health and social care, with the capacity to pursue a common approach to ER, the state now sits alongside a multitude of other service providers from these various sectors. In healthcare, 233 employer Trusts in NHS England are complemented by around 850 private and voluntary sector organisations providing care for NHS patients.⁶ In adult social care, local authorities with responsibility for services,⁷ principally rely on the delivery of care through some 18,500 commissioned provider organisations from the private and voluntary sectors.⁸

In the public sector the model employer approach continues to be drawn upon by policy makers as a feature of employment relations,⁹ although mainly in the context of equal opportunities.¹⁰ The Covid-19 crisis presents an opportunity to refresh the model employer approach in the public sector. In part this involves re-visiting the notion of ‘fairness’, and what it means in both procedural and substantive terms to call for ‘fair care work’. It also provides a chance to extend a model approach across health and social care, embracing not only the state as employer but employers from the private and voluntary sector employers as well.

Effective implementation

If a new, shared model employer approach is to develop across both health and social care, questions inevitably arise as to how it can be given meaningful effect. Certainly, the exponential proliferation of employers within the mixed care economy attenuates the relationship between the state and the health and social care workforce. However, the government continues to fund, if not deliver, most health and social care services and retains considerable regulatory power over the general performance of these providers.¹¹ This power is exercised through a variety of arms-length bodies and mechanisms – for example the Care Quality Commission and the NHS Standard Service Contract – and includes a degree of workforce accountability and scrutiny. The monitoring of workforce management remains, however, fragmented and light-touch. In this paper, we argue the need for a much sharper and tighter monitoring framework, with these regulatory bodies and mechanisms more fully leveraged to secure compliance.

The effective implementation of a shared approach to employment relations can also be tied to the ongoing development of more integrated forms of health and social care delivery. As implied, a detailed consideration of service (re-) configuration lies beyond the scope of this paper. However, it is worth noting that the current steps towards service integration through Sustainability and Transformation Partnerships (STP) and, in their more mature form, Integrated Care Systems (ICS),¹² provide the basis for a shared workforce agenda.¹³ Most STPs/ICSs have a workforce stream of activity, and while progress in taking this work stream forward remains, at best, patchy, there are examples of emerging shared policy and practice. The new registered nursing associate role, for instance, is designed for various care settings, with health and social care providers working in partnership through their STP/ICS to: draft a common job description for role; jointly procure the necessary training; and agree a common trainee rate of pay.¹⁴ We argue that the Covid-19 crisis provides added impetus for STPs/ICSs to develop a more integrated workforce agenda. Indeed, we view STPs/ICSs as providing an important potential space for the development and effective implementation of a new ER approach across health and social care.

Collective employee voice

For many years, collective employee voice was an essential feature of the government's model employer approach,¹⁵ with union membership seen as an important source of industrial citizenships and an essential feature of a modern pluralist liberal democracy. The legacy of public policy support for collective employee voice is reflected in the continued relatively high levels of union density in the public sector, at well over half of the workforce.¹⁶ Indeed, in the context of the Covid-19 crisis, the ongoing contribution of trade unions and professional associations, particularly in the NHS, is reflected in a statement on employment relations during the pandemic produced by the union-management National Social Partnership Forum.¹⁷ While recognising the ongoing need for transparency and consultation, this statement commits NHS unions and employers to 'pausing or varying (their) typical employment relations activity' as a means of minimising disruption during the crisis.

As more 'typical' employment relations resume, collective employee voice is likely to be louder in health and social care: attention has been drawn to increasing union and professional association membership, especially in social care, as workers seek to both articulate and protect against the concerns and uncertainties generated by the virus.¹⁸ It is a presence which generates challenges for the respective partners. For the unions and professional associations, the challenge lies in building the capacity of traditionally fragile workplace organisation to participate in more dynamic forms of employment relations at this level. For healthcare and social care employers, the challenge centres on their willingness to meaningfully engage with the unions as services are re-opened and perhaps redesigned in the wake of the crisis.

Notwithstanding these overlapping and cross cutting issues, we consider each of our four dimensions in turn, by exploring:

- context and current arrangements
- challenges as exposed by Covid-19
- the way forward: mapping possible policy responses.

2. Migrant workers

Context: migrant workers in health and social prior to Covid-19

Migrant workers have been a long-standing component of the health and social care workforce, but their contribution has been largely unrecognised and undervalued. The Covid-19 crisis has highlighted the critical role that this highly feminised and ethnically diverse migrant workforce has played in supporting the most vulnerable members of society in this time of acute need.

The NHS has a long-history of employing migrant health workers and encouraged nurses and doctors to come to the UK in the 1950s and 1960s to train and remain in its workforce. Many other migrants found work in the NHS as cleaners and porters in the rapidly expanding health sector workforce.¹⁹

In 2018, migrants, foreign nationals comprised 12 per cent of the healthcare workforce – equally split between EU and non-EU nationals. The proportion of non-British nationals has remained broadly stable since 2012, but numbers have increased from 155,000 to 227,000 reflecting some growth in the NHS workforce with EU nationals accounting for the majority of this growth. The overall uplift in the EU workforce since 2012 conceals a more recent *decrease* in the number of EU 15 nurses employed in the NHS since the June 2016 Brexit vote, alongside an increase in Asian nurses, especially nationals of the Philippines. Overall, most healthcare workers in England with an EU nationality were from EU15 countries and most non-EU nationals were from South Asia.²⁰

The migrant workforce is not evenly distributed by occupation or location. Of those working in healthcare roles in NHS hospitals, higher proportions of doctors and nurses are non-British nationals in comparison to other staff groups – 29 per cent and 18 per cent respectively. Moreover, the proportion of the healthcare workforce that are non-British nationals varies across the UK. London has the highest proportion with almost a quarter of the workforce comprising non-British nationals, reflecting the greater diversity of the population in this catchment area.²¹

The preponderance of migrants in the health professions stems from supply and demand side factors. Successive governments have expressed an ambition to develop a 'self-sufficient' healthcare workforce. These statements have been especially prominent when there have been well-publicised shortages of healthcare professionals, a heightened public sensitivity to immigration and high-profile criticism that NHS employers have actively recruited scarce overseas health professions. In practice, historical under-provision of state funded training places for doctors and relatively poor pay for nurses combined with inadequate workforce planning, have reinforced a systemic reliance on overseas health workers, especially doctors and nurses, to a far greater extent than most other OECD countries.²²

Social care is also heavily reliant on a non-British national workforce and this dependence has increased in the last decade. 8 per cent (115,000 jobs) of the adult social care workforce were of an EU nationality and 9 per cent (134,000 jobs) were of a non-EU nationality. A third of non-British born workers have arrived in the UK since 2011 and within this non-British component it is Romania (13 per cent) and Poland (11 per cent) that comprise the most sizeable nationalities, indicating the impact of EU accession on the make-up of the workforce, followed by Nigeria and the Philippines (both 8 per cent). Non-British nationals therefore comprise around 17 per cent of the social care workforce in England – and around 40 per cent of the workforce in London. It is amongst registered nurse (37 per cent) and care worker (20 per cent) roles that non-British nationals are most prevalent.²³

This dependence is related to features of work in social care in which, like other low-wage sectors, demand for migrant labour persists as an integral component of employer workforce strategies. Social care is a predominantly minimum wage sector (see below pay and outsourcing sections) with employers using labour market flexibility to employ a quarter of the adult social care workforce on zero – hour contracts. Turnover in the sector is high and even more elevated for those on this type of contract.²⁴

Jobs that are unattractive to native-born workers are often filled by migrants, who are less influenced by social status and more concerned with a basic level of economic security. This orientation encourages a greater willingness to accept low wages on a 'temporary' basis because of restricted labour market opportunities. It is not only low pay, however, that explains these workforce patterns. As Piore noted, migrant labour has specific advantages for employers that arise primarily from the attributes of jobs that migrants fill, rather than solely the wages that they are paid.²⁵

Alongside low pay, social care work is unappealing given demanding working conditions and few opportunities for advancement. The stigma attached to care work was captured by interviews with Zimbabwean care workers who described themselves as working for the BBC (the British Bottom cleaners).²⁶ Although these migrant workers found aspects of their work satisfying, they suffered the indignity of working in jobs far below their qualification levels, precluding or at best delaying opportunities to move into better paid, more senior, registered nursing roles. Even when migrant workers are able to access higher paid nursing roles, they are often stereotyped and channelled into performing generic caring rather than more specialist technical tasks.²⁷

Migrants are especially vulnerable in economic terms given their unfamiliarity with the labour market, employment rights and language barriers. If an individual is working without authorisation, workers jeopardise their employment rights and access to benefits. For many workers the fear of being reported to the immigration authorities ensures compliance, enabling unscrupulous employers to exploit vulnerable workers. In general, the informality and lack of transparency about pay rates, deductions made for housing and transport, long working hours and unpaid hours are commonly reported

difficulties. These problems have been reinforced in an era of hyper-flexibility, especially in homecare environments (see, also, the outsourcing section). Moore and colleagues have reported the use of unpaid availability in which workers were sent home if there was no work, workers had to wait around between visits and there was no guarantee that travel time between visits was paid to ensure compliance with national minimum wage rates.²⁸

The impact of Covid-19

Migrant workers are especially at risk in terms of health and safety. In part this derives from their disproportionate representation in high risk care occupations. It also reflects the fact that the migrant workforce comprises many black, Asian, and minority ethnic (BAME) workers. Covid-19 has exacted a heavy toll in terms of higher death rates amongst BAME groups in society.²⁹ Both BAME men and women, particularly working in caring personal services in residential and home care, have significantly higher death rates related to Covid-19 than the general population at 26.3 and 12.7 deaths per 100,000 respectively.³⁰ Elevated death rates amongst BAME care workers did not apply to all health professions, such as doctors or nurses, suggestive of differences in assessing and managing risk between healthcare occupations.

Amongst migrant workers, particular nationalities have been especially hard hit with approximately 13 per cent of the estimated 173 frontline healthcare staff that have died of Covid-19 comprising nationals from the Philippines. Although the precise reasons for this elevated death rate are unknown, one Filipino respiratory nurse commented:

‘I have learned to speak out and lead a team, but some Filipinos who haven’t been here for very long are still very much in the Filipino culture of keeping quiet and being extremely hardworking. It may be putting them at risk by not questioning or whistleblowing, whether that’s about PPE or additional hours.’³¹

Such views reflect a broader set of concerns about workplace safety in the context Covid-19, expressed by care workers³² and can be seen to derive from more general policy shortcomings in the management of the virus in care home settings: for example, the accelerated discharge of patients from hospital to care homes without a testing regime in place,³³ the shortages of PPE and muddled guidance on its use.^{34,35} However, forming such a numerically significant part of the care home workforce, these shortcomings have impacted on migrant workers with particular force.

Widespread public unease about the treatment of migrant workers risking their lives at the frontline of Covid-19 health and social care, has recently prompted a shift in government policy. This has been apparent in two developments. The first is a suspension of the NHS surcharge levied on migrant workers from outside of European Economic Area, currently standing at £400 and scheduled to rise in October, 2020, to £624. Even with this change it may well take time to build trust and ensure that migrants feel confident to access the NHS given the legacy of charges and anxiety about

immigration checks.³⁶ The second development is a change in the bereavement scheme allowing relatives of foreign national NHS staff who die from Covid-19, leave to indefinite stay in the country. The scheme has now been extended from doctors and nurses to cover migrant NHS support and social care workers.³⁷

Mapping a way forward

Migrant workers perform an essential role for caring for some of the most vulnerable in society. Employers and those that regulate health and social care, notably the Care Quality Commission, have a responsibility to maintain minimum standards and have a duty of care to the workforce that should be underpinned by proper risk assessment. The workforce, especially those who are most at risk, need to be reassured that they will not suffer any detriment as a consequence of the Covid-19 crisis and that appropriate protection is provided for these workers and those they look after. The provision of PPE is a necessary but not a sufficient step because protection also requires appropriate training, managerial oversight and scope for employee voice and independent workplace representation. Barriers need to be removed that limit migrant workers access to healthcare provision not only in terms of charges but also building trust, engagement and signposting provision so that vulnerable groups feel confident to access health services.

The pay and employment conditions of migrant workers in health and social care brings into sharp focus deep seated employment relations problems. A new deal is required for the migrant workforce that can draw together existing good practice and public policy proposals. This deal might include:

- Trade union and professional association guidance that has been developed for overseas recruited nurses that publicises employment and immigration rights and outlines good practice in terms of recruitment, induction and supervision.³⁸ This guidance provides a platform for current campaigns that focus on protecting the health, pay, employment and families of care workers.³⁹
- Employer and regulator guidance. The components of a new deal are evident from existing research evidence. Skills for Care investigated adult social care providers that had labour turnover of less than 10 per cent and found a pattern of employment practices including attracting appropriate applicants, focusing on selecting on values and behaviour, providing realistic pre-job information, such as using ‘taster shifts’ as well addressing matters of pay and training. In the round these measures had a positive impact on turnover.⁴⁰

Finally, the position of migrant workers is shaped by the interaction and double jeopardy of poor employment conditions combined with an immigration regime characterised as ‘a hostile environment’ – an umbrella term for successive government clampdowns on unauthorised migrant workers.⁴¹ The government is currently piloting its Immigration Bill through Parliament that will preclude low-earning immigrants, also characterised as low skilled, being able to access the UK labour market because they will not meet the salary threshold of £25,600 and qualifications criteria necessary to gain the requisite points. The exclusion of lower-

earners, such as those working in social care, is justified by government because it is argued that reliance on a migrant workforce provides no incentive for employers to improve low pay and low productivity and that millions of suitable workers are already available in the UK labour market.

This analysis, is one dimensional because it fails to recognise the vital contribution of migrant workers and assumes that low pay and productivity can be remedied in the short term. Improvements to pay and productivity are essential but this needs to proceed alongside the recognition, retention and recruitment of an essential workforce that includes a significant proportion of migrant workers. Low pay is not the only reason deterring British workers from working in health and social care and rather than substituting for British workers, migrants are making a vital contribution that is complementing a variety of other regulated professions such as social workers and doctors.⁴²

The characterisation of migrant (and indeed other) workers in health and social care jobs as low-skilled is also unsophisticated. Whilst skill has a hierarchical component in terms of increased complexity, skill is related to proficiency, competence and discretion. The same skills are viewed very differently in specific contexts and roles. For senior managers and graduates 'emotional intelligence' is prized but when these behaviours are exhibited by care workers they are disregarded and viewed as innate. Similarly, qualifications are only rewarded when formalised and credentialised; the upshot is that migrants often possess qualifications and a degree of professionalism that are not recognised at the workplace.⁴³ Immigration policy needs to have regard for these wider considerations and employers' organisation, professional associations and voluntary organisations representing migrant workers have documented the problems that migrant workers are facing.⁴⁴ They have made the case to include health and social care workforce visa extension arrangements for existing migrant workers and to establish a specific social care visa that would be similar to the existing NHS visa.⁴⁵

Pay and the health and social care workforce

The Covid-19 crisis is forcing a fundamental re-assessment of the socio-economic value traditionally placed on health and social care work, with implications for how the employees delivering it should be rewarded. As these workers take risks and, in some cases, sacrifice their lives, the undervaluing of care work, long associated with the feminised nature of the workforce,⁴⁶ is challenged. Indeed, as the myriad occupational groups, spanning care assistants, cleaners, porters, nurses, doctors and other registered professionals, share these risks and sacrifices, and jointly contribute to care delivery, the distinction between low and high skilled work, a key driver of pay determination, begins to erode. As Bergfeld and Farris⁴⁷ note: 'The (Covid-19) crisis is interrogating the legitimacy of that skills-hierarchy that places at the bottom all those skills and jobs that are necessary for the reproduction of life and society.'

While calls have been made to address the pay of health and social workers in the context of the current crisis,⁴⁸ the workers themselves have been more concerned with their well-being and safety as the basis for effective care delivery.⁴⁹ However, in the medium and longer term, and as clinical control over the virus increases, the thoughts of these workers and their representatives will legitimately turn to the search for a fairer effort-reward bargain.

Context: pay determination before Covid-19 crisis

With public sector pay bill costs constituting around a quarter (22 per cent) of total public expenditure, and closer to a half of total expenditure in healthcare,⁵⁰ pay determination in the public services has long been sensitive to, as well as a driver of, macro-economic well-being. As a consequence, post-war governments of all party-political complexions have sought, with varying degrees of formality and precision, to regulate pay in the sector. In procedural terms, this has been reflected in a permissive and durable system of collective bargaining in the public sector, gradually, albeit unevenly, being overlaid by more mechanistic and notionally independent forms of pay determination. This has produced a patchwork of arrangements within and between different parts of the public services, at times interfacing uneasily with one another.

In the NHS, the Agenda for Change agreement, collectively bargained in 2004–5, continues to operate alongside an arms-length review body, typically recommending annual pay rises. In contrast, pay determination for local authority social care workers is subsumed under the Local Authority Services National Joint Council, covering a diverse range of municipal employees, and reaching collectively bargained agreements codified in the Green Book. At the same time, the pay of health and social care workers in the private and independent sectors continues to be determined in an unregulated way and, in the absence of significant collective employee representation, usually at the discretion of employers seeking to depress labour costs in delivering commissioned services. This has led to the development

of social care, in particular, as a low pay sector, with the Resolution Foundation⁵¹ reporting that over half of social care workers are paid below the real living wage (see, also, section on outsourcing). This low pay regime⁵² extends to the estimated 100,000 workers in private sector organisations delivering ancillary services in the NHS – cleaner, porters, catering and security staff – many whom are paid the national minimum wage.⁵³ Indeed, perceived pay inequities are particularly sharp in the NHS. The uneven use of private sector contractors by healthcare providers can lead to workers performing very similar support roles in different Trusts, and sometimes even in the same Trust, receiving different pay rates: for NHS in-house employees, pay rates are set out in Agenda for Change, while for outsourced staff pay rates are typically lower and unilaterally set by the private sector employer (see, also, section on outsourcing).⁵⁴

In substantive terms, governments have shifted their preferred criteria for pay determination in the public sector, in large part reflecting politically driven attempts to legitimise pay increases to the tax-paying public, in different ways.⁵⁵ A post 1945 emphasis on pay comparability with the private sector, gave way in the 1980s and 1990s to a narrower reliance on affordability and individual employee performance. In more recent years affordability has been superseded by labour market need, and the capacity of pay to ensure the requisite recruitment, retention and motivation of staff.

In a more direct sense, governments have also sought to regulate substantive pay during periodic incomes policies, applied with particular rigour to its own employees in the public sector. Most recently, this has been apparent in the public sector pay constraint accompanying the government's post-2010 austerity programme. In 2011–12, the Conservative-led coalition government imposed a two year pay freeze, followed by a 1 per cent pay cap on the public sector pay bill until 2015–16. Indicative of how this policy impacted the pay of workers health and social care is the case of the Agenda for Change pay band 5 registered nurse, who, according to the IPPR,⁵⁶ saw their real pay fall by £3,241 or 10.1 per cent over this period of constraint. In the last couple of years, public sector workers have seen increases in excess of 1 per cent, with average earnings rising by around 2 per cent in real terms since 2017. However, the IFS note public sector earnings are still 2.5 per cent lower on average in real terms than at the start of 2010.⁵⁷ It is little surprise, therefore, that over this period barely a third of respondents to the NHS staff survey have been satisfied with their pay.⁵⁸

The nature of employment in parts of the health and social care has deepened the pay pressures faced by segments of the workforce. Thus, a relatively high proportion of workers in adult social care (40 per cent) are part time, with their earnings potential, particularly in domiciliary care, further depressed by a pay system which fails to pay them for travelling time to service users.⁵⁹ The increasing use of zero-hours contracts, now covering around a quarter of the adult social care workforce,⁶⁰ has introduced an additional source of pay irregularity (see, also, section on outsourcing). Indeed, in the context of Covid-19, workers in adult social care with

symptoms are self-isolating on a maximum Statutory Sick Pay of just £96 a week.⁶¹

Challenges: the impact of Covid-19

The combination of relatively low pay rates, declining living standards and, for some workers, irregular earnings has exacerbated longstanding recruitment and retention pressures in health and social care. There have been well publicised shortages in a range of healthcare professions.⁶² However, at the frontline of care delivery, they have been particularly notable amongst registered nurses, where the suggested shortfall is now around 40,000.⁶³ The level of staff turnover has also been striking, particularly in social care where the annual turnover rate for directly employed care workers has been well over a third. Even in healthcare turnover now stands at around 10 per cent.⁶⁴

The Covid-19 crisis has exposed the problematic relationship between pay and workforce capacity across the health and social care workforce in two important respects. The first relates in a very practical sense to the quality of care a stretched workforce has been able to deliver during the crisis. While the hard work and dedication of employees cannot be doubted, staff shortages, particularly amongst the registered professions, have put pressure on skill mix and safe staffing levels in key clinical areas. This has been starkly illustrated in the case of Intensive Care Units during the current crisis, with the traditional one-to-one nurse-patient ratio being diluted as a single nurse takes on as many as six patients.⁶⁵

Questions might also be asked about the level of nursing capacity especially in residential care homes, and about whether if registered nurse numbers had been higher the virus might have been better managed in this setting. Thus, it is striking that the Health Foundation note a 20 per cent reduction in registered nurse jobs in adult social care since 2012.⁶⁶ Indeed, it might be argued that depleted, or at the very least tight staffing levels in care homes, have forced employers to bring in agency employees to cover for their own self isolating members of staff. As a recent report by Public Health England notes, such agency staff coming into homes, might well have contributed to the spreading of the virus.⁶⁷

Second, and in a more general sense, Covid-19 prompts consideration of the foundational principles of pay in the sector and in particular what constitutes fair pay. The crisis serves to renew the legitimacy of national, standard rates of pay for health and social care workers. The bravery and sacrifice displayed have not varied by occupational status: these qualities have been apparent in equal measure across the occupational hierarchy. In such circumstances, should any worker in health and social care be low paid? The most recent collectively bargained changes to Agenda for Change and the Green Book have sought to address low pay by removing the lowest grades and uplifting pay at the bottom-end of the pay structure to above the national minimum wage. But as already indicated, low pay remains endemic for workers in the social care sector employed in private and voluntary sector organisations (see section on Outsourcing).

Similarly, the bravery and sacrifice displayed have not varied by geographical region, reminding us that the jobs performed by these workers are the same throughout the country. Such a reminder should drive out the periodic preoccupation of policy makers and commentators with real or statistically contrived local labour market conditions and the pay adjustments they require.⁶⁸ Care work has intrinsic societal value wherever it is performed. Indeed, given the shared experienced and contributions of workers, a case can be made for addressing the patchwork and misaligned arrangements for pay determination in the health and the social care sectors and amongst public, independent and private sector providers.

Mapping a way forward

Debate and speculation on the pay of healthcare workers has already begun to stir, although signals from policy makers on this issue have been decidedly mixed. The Secretary of State for Health and Social Care has expressed 'sympathy' with those calling for a rise in nurse pay.⁶⁹ This sits uneasily with reports that the government is considering a public sector pay freeze to help cope with the financial fall-out of the virus,⁷⁰ although these reports were almost immediately denied by the government.⁷¹ In Scotland meaningful steps have already been taken, with social care workers directly employed in local government given an immediate pay rise to reflect the pressures associated with the virus, and social care providers given 'greater flexibility' with their funding arrangements to increase pay.⁷² Going forward a more considered approach is required, unpacking systematically the different elements of pay determination.

Three elements of pay determination need to be addressed:

1. A one-off reward

The first centres on the scope to pay health and social care workers for the immediate pressures faced and the contribution made in dealing with the crisis: in short, a single special payment to recognise and reward their current efforts. Various suggestions have been made for this type of payment, for example, in the form of a non-consolidated bonus⁷³ or 'hazard premium'.⁷⁴ However, while merited and to be welcomed, clearly this is a short-term response, which risks obscuring the need for more fundamental and sustainable solutions.

2. Reviewing and lifting pay rates

The second element relates to current pay rates for health and social care workers, and, more specifically, would take the form of a one-off, dedicated exercise to establish fair pay rates for such workers. This begs questions about the nature and procedural determination of fairness, including how to overturn the continuing undervaluation of feminised caring roles. Various responses are available:

- The issue of fair pay rates might be returned to a domain of informed collective bargaining, perhaps with the support independent pay experts. This would involve the NHS Staff Council and the NJC for Local Authority Services working together on this exercise, perhaps even as a prelude to developing more permanent collective bargaining arrangements cutting-across the health and social care workforce. There are precedents for public sector bargaining partners – unions and employers – commissioning remuneration experts to review pay issues, then feeding these expert views back into the bargaining process: see, for example the Local Government Pay Commission set up by the Local Government Services NJC in 2003, to further attempts to implement single status pay in the sector.⁷⁵
- Another option would be for the current NHS Pay Review Body to carry out this dedicated one-off review to establish fair pay rates. Given the cross-cutting nature of the proposed review, this would involve extending the remit of the NHS Pay Review Body to cover social care, again with a view to retaining an NHS and Social Care Pay Review Body to monitor and assess future pay movements.
- A final option would be the appointment of a dedicated one-off, special commission with precise terms of reference to review and establish fair pay rates in health and social care. This might be the most inclusive option, with commission members including not only independent pay experts, as with the pay review body option, but also union, employer, government and even service user representatives.

3. Sustaining fair pay: uprating

Following the establishment of fair pay rates, the third element of any new pay arrangements is a mechanism to ensure that these rates are fully embedded and sustainable. The process of regular pay uprating might be returned to the realm of collective bargaining or be left with the independent pay review body, although, as suggested above, in both cases we would argue for more integrated models covering both the health and social care sectors.

There are, however, other procedural options available. For example, there are public sector precedents for pay indexing. From the late 1970s firefighter pay was linked to the upper quartile of 'manual workers' average earnings.⁷⁶ A more viable formula, given occupational diversity in care work, might see annual pay rises above the cost of living ('inflation-plus' increases). This would guarantee health and social workers rising living standards for the foreseeable future. Alternatively, comparability might be reinstated as a means of periodically ensuring that pay in health and social care remained aligned to pay rates amongst like occupations in the rest of the economy. Again there are precedents for regular comparability reviews in parts of the public sector: for example the Civil Service Pay Research Unit operated on this basis for some 30 years from the mid-1950s, while the Clegg Comparability Commission in the late 1970s to early 1980s undertook comparability reviews for key groups of public sector workers, including registered nurses and midwives.⁷⁷

4. Building integrated capacity and capability: a new deal for health and social care workforce learning

Workforce management is the biggest challenge the NHS and social care face. Meeting this challenge not only means ensuring that both sectors have the right numbers of staff employed, but also that those staff have the right knowledge, attitudes and skills to safely and effectively deliver care, wherever they work. For some time, policy makers and practitioners have appreciated the importance of developing staff capability and capacity in the context of a growing and ageing population (Health Foundation, 2019; and NHS England, 2019). However, Covid-19 has reinforced and deepened the need for both to be developed further and strengthened.

Context: one workforce

To meet these challenges, we need to re-imagine how employee education and development in health and social care is organised, accessed and delivered to create the optimal conditions in care organisations for all staff to learn. This includes the 1.5 million staff employed in unregistered support roles: that is those employees working alongside, often assisting health and social registered professionals, and typically positioned in healthcare at Agenda or Change pay bands 1 to 4.⁷⁸ Many of these support workers have been at the forefront in battling Covid-19, reflected in list of healthcare assistants, porters and cleaners to be found amongst those who have sacrificed their lives in combating the virus.⁷⁹

This re-imagining will require not only a fundamental change in the way access to education and training is organised, but also how learning is valued and delivered. In short, it requires treating the NHS and social care workforce as one, whether they are employed in unregistered roles or not, whether they work in care homes or hospital or in the community, whether they are trained by a further education college or university, or recruited from a local or a national labour market. It will mean treating the learning needs of a receptionist, porter, healthcare assistant or care worker as seriously as a doctor, social worker, nurse or midwife, so that all staff who provide care directly or indirectly to a patient or client are able to acquire the skills and knowledge they need.

Too often the workforce is not treated as one. Too often those who provide support to the most vulnerable in our society struggle to access the learning they need and to progress their careers. Data from Skills for Care, for example, show that just 49 per cent of workers who provide direct care have a level 2 qualification or above, whilst 40 per cent of new care workers have not engaged with the Care Certificate (2019).⁸⁰ In the NHS it has been estimated that the 40 per cent of the workforce employed in support roles access below 5 per cent of the sector's spending on learning (Cavendish, 2013). Indeed, the NHS Staff Survey shows that nursing support workers are less likely to report that they have been able to attend the training that they need than their registered

nursing colleagues (NHS Survey Coordination Centre, 2020). As recently as 2019, unfair access to training was reflected in the fact that a £150 million increase in NHS funding for Continuing Professional Development was not made available to unregistered healthcare and social care staff.

The uneven distribution of learning has several causes including: the disproportionate use of finite training budgets to meet the high training costs of registered professional; the absence of whole workforce planning;⁸¹ the questionable capacity of health and social care providers to mentor and supervise unregistered support workers in training; and the limited availability of career pathways for such support staff. Uneven access to learning has a range of consequences, for example, contributing to high-turnover, (running at a third in the social care independent sector according to Skills for Care (2019)), and prompting the feeling amongst support staff that, in the words of Lord Willis, they are ‘undervalued and overlooked’ (HEE, 2015:36). These outcomes undermine what Skills for Care (2019) rightly views as the benefits of a formally qualified, highly skilled and competent social care workforce: ‘high quality care and support’, with improved safety and value for money. In summary, uneven learning opportunities have negative outcomes for support staff and their employers and for service users. Indeed, with many of these staff recruited from local labour markets, these shortcoming in training have likely depleted the human capital to be found in local economies, hindering their ability to rebuild in the wake of Covid-19 (CLES, 2020).

Missed opportunities

We are not the first to call for wide ranging changes in the way the NHS and social care organise the learning of their staff. There have been previous opportunities to address the under investment in the development of over half of the health and social care workforce. In 2006 Robert Fryer’s *Learning for a Change in Healthcare* (DH, 2006) review warned that the NHS did not take the learning needs of their lower graded staff seriously enough, with many struggling to access necessary learning including functional (literacy and numeracy) skills. Following the care failures at Mid-Staffordshire hospital,⁸² Camilla Cavendish’s (2013) review of health and social care support worker education and development, described such workers as being too often the ‘invisible workforce’.⁸³ Her recommendations focused on: identifying what was common in learning in health and social care; increasing access to learning; creating career pathways; and driving up the quality of vocational education. She also shone a light on the divide between health and social care as far as workforce planning was concerned but also on the unevenness of this process within the NHS:

‘The NHS operates in siloes and social care is seen as a distant land occupied by a different tribe...The NHS has tended to treat HCAs and the registered nurses who supervise them as separate workforces.’ (Cavendish, 2013)

Lord Willis’ *Raising the Bar* review of Registered Nurses and Care Assistants education and training in 2015, reiterated

the need to value care assistants along with the importance of themes such as standardisation, transferability and bridging the gap with social care.

All three reviews made a wide range of recommendations including addressing functional skills, introducing a portable skills passport, joint training for health and social care staff, common titles and guaranteed learning entitlements. However, just two of the recommendations made were formally implemented: Cavendish’s call for a Care Certificate and Willis’ suggested need for a new nursing associate role.

There are examples of good practice and guidance in individual employers and sectors, in particular HEE’s (2014) *Talent for Care* strategic framework for the training and development of NHS support workers. For too many, however, the story remains the same: a lack of access to high quality learning, particularly formal qualifications; underutilisation of skills; lack of standardisation and transferability; inconsistent job titles and job descriptions; and frustration at the lack of opportunities to progress their careers.

Vocational education and training (VET) policy and practice

Learning in health and social care does not exist in isolation and many of the issues raised above, such as unequal access to and investment in learning, are reflected in the wider UK economy. They are long-standing issues inherent in national VET policy (CEDEFOP, 2020), and these are partly playing themselves out in health and social care as elsewhere. As a consequence, some of the barriers to effective learning support workers face, such as the need for greater flexibility in the delivery of apprenticeships or increased investment in further education, need to be resolved via wider policy reform. These issues are beyond the scope of this paper, but there are welcome signs that the importance of VET is being reassessed, for example through the creation of a new National Skills Fund (Financial Times, 2020). To complement this development, we would also suggest that the apprenticeship levy (Richards, 2012), introduced in April 2017, be re-designated and re-purposed as a training levy. This would provide greater flexibility to meet employee and employer training needs in the wider economy. It would prove particularly useful in the NHS where all 230 or so Trusts meet the threshold to pay the levy (an annual pay bill of more than £3million), allowing them to spend levy funds on a more diverse array of training programmes and a broader range of associated costs.

VET is also located within the context of wider organisation human resource policy and practices, such as job design, appraisals, opportunities for flexible working and trade union recognition. These combine to generate and are underpinned by very different workplace learning cultures. Fuller and Unwin (2011) have contrasted ‘expansive’ with the ‘restrictive’ workplace learning environments. The former have been characterised as encouraging the acquisition, transfer and retention of learning by, for instance, distributing skills widely throughout the workforce, protecting time-off for learning, articulating a clear vision for learning, the development of communities of practice and sharing of learning across

jobs, work and agency boundaries. The latter, 'restrictive' environment has been seen as degraded along these different dimensions. It is open debate whether and to what the extent the NHS and social care sectors, in general can be said to have a 'expansive' rather than 'restrictive' learning culture. There is likely organisational variation within and between these sectors. Certainly, for many support workers across the sectors a 'restrictive' rather than 'expansive' learning environment is more likely to be the norm. To take one example – the evidence for the distribution of workforce learning opportunities in health and social care could be said to be polarised, as the example of 2019 CPD funding allocation described above or the high proportion of social care staff without formal qualifications illustrates.

Mapping a way forward

The following proposals for a new approach to workforce learning in health and social care are based on the two key principles outlined above:

- 1 The development of a 'one workforce approach' to learning covering both parts of the care sector and embracing the different segments of its workforce; and
- 2 The creation of an 'expansive' learning culture in health and social care.

In short, our proposals are designed to ensure that all staff have access to high quality training and education to develop the knowledge, skills, behaviours and competencies they require and progress their careers:

Integrated workforce planning

We have mentioned above the need for greater flexibility in the availability of workforce development opportunities and the importance of refreshing national policy on VET. We would add that to ensure the health and social care workforce challenge is met, both sectors must be treated as one in terms of workforce planning. Care is frequently delivered across settings, by multi-disciplinary teams and by different agencies. From a patient or client's perspective, there is little apparent value in addressing the development needs of the care workforce in this siloed way.

New leadership

The proposed increased role of STPs/ICS in workforce planning (NHS England 2019) is welcome. Their 'footprints' are for many staff the optimal level to plan, not least because they afford the opportunity to engage with local labour markets and skill eco-systems such as local colleges and employment agencies. This approach will result in more joint learning, but clearer and more robust leadership responsibility at all levels of the system.

Parity of esteem

There needs to be parity of esteem for workforce development needs across care pathways. Service users with their distinctive health and social care needs and circumstances must be confident that they are being cared for by a well-trained and qualified workforce. There is also a case for parity of esteem in relation to different types of qualification – for

example, BTECs, apprenticeships and university degrees. The lack of such parity in this respect has been a longstanding issue in VET and a barrier to widening participation into healthcare degrees.

Common frameworks

This approach should be completed by the development of common education and competency frameworks in key areas and portable skills passports which will enable consistent and transferrable learning.

Minimum entitlements

Staff should be given a minimum learning entitlement throughout their careers. There should also be a guarantee that all staff be supported to obtain a minimum level of functional and digital skills.

Accessibility

One response to Covid-19 has been the move to more learning on-line. One issue that needs to be considered is that not all staff will have access to the ICT they require or the space needed to learn on-line. This, and indeed the range of proposals presented in this part of our report, also requires account be taken of the distinctive, often frequent training challenges faced by key groups of workers: those working, for instance part-time or on shifts, with domestic caring responsibilities or a disability. Learning must be accessible to all and all must be given the opportunity to participate in full.

Career progression route: advice and guidance

NHS and social care staff are frequently frustrated by the lack of career development opportunities and unclear about progression routes. This contributes to high turnover and means that workers are often unable to work to their full potential. We propose the creation of a new National Care Career Service (NCCS) that would include the appointment of local Career Coaches and Advisors. The NCCS would provide careers information, advice and guidance including for those nearing retirement. The NCCS would help staff navigate their careers including between occupations and agencies, but also support new models of care and ways of working, for example by identifying the competences required to work in multi-disciplinary teams. The NCCS would also support line managers who have a key part to play in creating expansive workplace learning cultures, for example, by championing learning and carrying out effective appraisals.

A stronger employee voice on learning

We believe that professional bodies and trade unions and locally Union Learning Representatives have a crucial role in helping to shape, guide and deliver learning strategy. This role ranges from national strategy, to representation of STP/ICS boards and in individual employers promoting, encouraging and supporting participation in learning for all.

A vision and a new national body

Finally, the Department of Health and Social Care, with partners, should create a clear and inclusive national vision for learning in health and social care. The development and implementation of such vision should become the

responsibility of the HEE reconstituted to include social care in its remit. HEE's workforce transformation agenda already interfaces with attempts to construct more integrated care services and many HEE staff are working to support with STPs/ICSs in pursuing this objective. The creation of Health *and Social Care* Education England would help facilitate the pursuit of these and other initiatives and secure the drafting a new one workforce, expansive training and development vision.

5. Outsourcing health and social care

Context: the nature and consequences of outsourcing

It is significant that when the British government devised its policy response to Covid-19, it called upon a wide range of private sector firms. Among the more visible examples, it contracted Deloitte to manage testing centres, Serco to run call centres to support vulnerable people in self isolation, Oxford Nanopore Technologies and Sitel to support the government's testing programme and ISS to clean the newly constructed Nightingale Hospital. By early May 2020, a total of 141 contracts had been awarded to the private sector and formed a key plank of the Covid-19 response.⁸⁴

The extensive engagement of private sector firms is significant for four reasons:

An unregulated public-private model

Covid-19 outsourcing contracts with private sector companies deepen a longstanding British government commitment to a mixed model of public services. For almost four decades, both Labour and Conservative governments have obliged or incentivised all parts of the public sector to outsource provision to the private sector, from IT and logistics to hospital cleaning and adult social care. This was massively accelerated with the controversial 2012 Health and Social Care Act. While often billed as a means to win efficiencies through market competition, including by accessing new technologies, skill-sets and innovative management practices, the hallmark of many outsourcing contracts has been their potential to minimise costs.⁸⁵ The highly visible role of private companies during the pandemic thus calls for renewed questioning about the comparative advantage of an unregulated, public-private model.

Fragmented supply chains

At a time of heightened risk in the delivery of health and social care, it is more important than ever that lines of management responsibility and accountability are clearly drawn. If a hospital treating Covid-19 patients has outsourced its cleaning to a private sector company, which in turn relies on a temporary employment agency to supply workers, then worker safety may be compromised by confused communications, blurred hierarchies and ineffective teamworking – for example between cleaners and healthcare support workers on a hospital ward.⁸⁶ Who takes responsibility for health and safety in this situation? Also, if outsourcing contracts are signed for short periods, say 24 months, and then passed from one company to another, feelings of job insecurity are amplified and companies are unlikely to commit to skills investment, such as Covid-19 training.

Clash of values

The media has highlighted the conflict between loyalty to shareholders or to the public among private companies that depend on government contracts. Many commentators have called for shareholder dividends and executive bonuses to be cancelled during Covid-19.⁸⁷ This brings to the surface a so far insurmountable problem that a sizeable portion of UK

government spending, financed by tax and national insurance, is not supporting the physical and human infrastructure of the public sector but is instead siphoned off to feed equity fund partners, shareholders (often offshore) and high paid executives. At this time of collective crisis, should there be limits on executive pay at companies reliant on government contracts?⁸⁸ Is it time to wind down the financialisation of UK care homes?

Two-tier employment

Covid-19 has exposed the inequality of employment conditions. The general tendency is for outsourced hospital workers and adult social care workers, including those subcontracted by an agency, to have worse pay, sickness benefits and leave entitlements than their colleagues directly employed by the NHS or the local authority. Moreover, it is women who account for the majority of the outsourced health and social care workforce and so the two-tier inequality has a strong gender inequality dimension. This has always seemed unjust but is particularly so now when these key workers – male and female, inhouse and outsourced – suffer the same high risks of Covid-19 exposure. Under pressures of austerity since 2010, the Treasury and public sector managers carry some of the blame for signing outsourcing contracts that impose unfair terms and conditions on workers. But we must also question the social purpose of private sector businesses. Can they commit to a model of fair care work which upgrades to the standards of the public sector – benefitting skill investment, worker wellbeing, staff retention and higher quality care? Is there a role for trade unions as a social partner in negotiating equality into outsourcing contracts?

These issues are coming to a head as the Covid-19 crisis drags on. From one week to the next, we are witnessing the accumulated institutional and organisational weaknesses of Britain's fragmented public-private model for delivering health and social care. The case of outsourced adult social care sheds valuable light on the current challenges for outsourced workers:

Challenges: outsourced adult social care and Covid-19

It is now clear, as an editorial in the *BMJ* puts it, that government support for adult social care 'came too late' and unnecessarily exposed many care workers to the risk of illness and even death.⁸⁹

The slow response is in part explained by the privatised and fragmented character of adult social care which exacerbated what Martin Green, Chief Executive of Care England, described as the government's 'abandonment' of the care sector in the early stages of the crisis⁹⁰. Adult social care is procured separately by over 100 local authorities and delivered by tens of thousands of private for-profit companies, voluntary bodies and public sector organisations.⁹¹ Importantly, unlike the NHS, the private sector is the main actor. It employs three fifths of all adult social care workers.⁹² This means private companies must also answer questions about their slow response to protecting care workers during Covid-19.

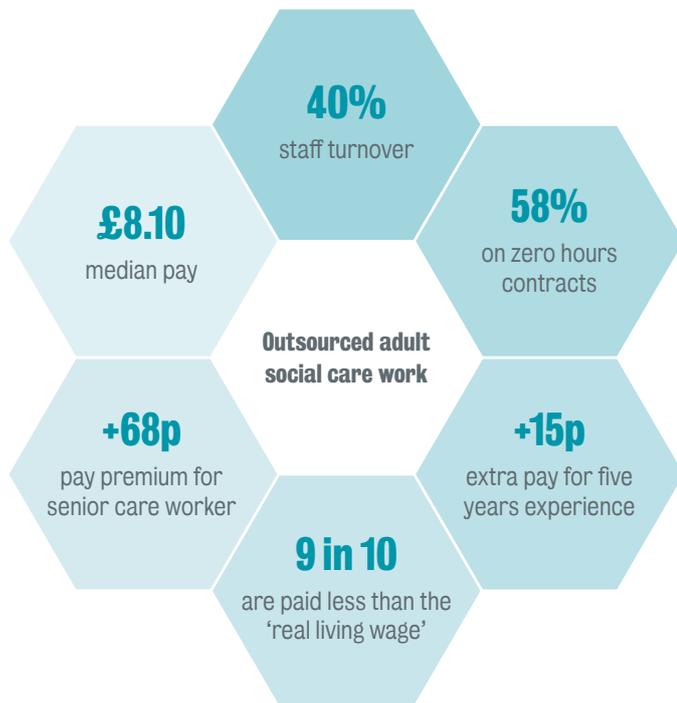
The largely privatised model might matter less if the private businesses concerned had a clear social purpose, but the big players are instead world leaders in extracting profit. Three of the four largest care home chains – Care UK, Four Seasons (still alive despite crashing into administration last year) and HC-One – are controlled by powerful private equity firms that demand high returns on their debt financing regardless of the consequences for care workers or patients.⁹³ Because they are not publicly listed, there is no way of knowing the details of how private equity funds make their enormous profits or who should be liable for business failure.⁹⁴

Unsurprisingly, financialisation worsens employment conditions. It creates an atmosphere of anxiety, especially over job insecurity, and because it draws out so much profit it limits opportunities for care workers to train and progress (see training section).⁹⁵ This drags down conditions of work for women, and also restricts progress for BAME workers who account for one in four care workers. Overall, the last three decades of outsourcing adult social care has produced poor working conditions in the for-profit, adult social care sector (figure 1). Some local authorities have paid higher fees to companies in an effort to improve matters, but research shows the fees do not translate into better working conditions – although the results are more positive for voluntary sector providers.⁹⁶

During the Covid-19 crisis, we have seen how poor work compromises workers' safety and diminishes the quality of care:

- Very high rates of staff turnover in private companies (three times the rate for local authority care workers) exacerbate problems of Covid-19 sickness absence and damages continuity of care.
- Three out of five domiciliary care workers have a zero-hours contract, which means they may be less resilient to cope with a health crisis at work – their working hours may conflict with family responsibilities and their earnings uncertain.
- Outsourced adult social care work is one of the lowest paid occupations in the country. In 2018/19 median hourly pay was £8.10, lower than for cleaners at £8.20. Benefits, such as paid sickness absence and annual leave, are also considerably worse than in the NHS.

Figure 1. Poor work in the outsourced, private for-profit adult social care sector⁹⁷



Mapping a way forward

The UK has a long way to go in establishing a greater sense of fair work among the hundreds of thousands of outsourced workers who contribute to meeting the country's health and social care needs. In light of the research evidence, as well as the challenges faced during Covid-19, we call for a new regulatory approach that can improve the quality of outsourcing arrangements, sustain fair employment, deliver quality care and support workers' wellbeing.

There are already several good initiatives which provide valuable evidence of good policy and practice and demonstrate that many stakeholders are ahead of government in innovating to combat unfair outsourcing in the health and social care sector:

- Wales introduced a voluntary Code of Practice in 2017 for all recipients of public money to adhere to 'Ethical employment in supply chains'. Last year, the *Fair Work Wales Commission* called for it to be made mandatory and deepen the substantive conditions regarding 'fair work'.⁹⁸
- Unison, the UK's largest public services trade union, is encouraging all local authorities to sign up to its 'Ethical Care Charter'; 45 had signed up by May 2020. Recommended by the Communities and Local Government Select Committee in its 2017 report, the Ethical Care Charter sets clear ethical criteria for outsourced care workers concerning zero hours contracts, the real living wage, occupational sick pay and paid travel time, among others.⁹⁹
- The Living Wage Foundation requires members not only to pay employees a real living wage, but also to have a plan for their subcontractors to pay a living wage. The Foundation also signs up 'Recognised Service Providers' who commit to submitting Living Wage bids alongside usual market rate bids to clients.¹⁰⁰
- The last Labour government applied a 'Two Tier Code' to outsourcing contracts in the NHS and local government in order to close a loophole in the TUPE Regulations.¹⁰¹ In effect, it required all subcontractors to offer employment conditions 'no less favourable' than public sector conditions. This was abolished in 2010 but was widely viewed as successful, especially for outsourced hospital cleaners, porters and others under PFI (Private Finance Initiative) contracts.¹⁰²

While extremely valuable, there is a need to consolidate these initiatives to avoid the risk of a patchwork of good and bad outsourcing practices and in light of evidence that voluntary efforts rarely scale up. So, a new UK-wide mandatory approach is needed. The precise details will need to be worked out through detailed negotiation between public sector bodies, trade unions, regulators and representatives of voluntary and private sector subcontractors. But the overall objective should be the following: to mandate all commissioning public sector organisations and all current and potential private and voluntary sector provider organisations to sign up to a new Social Purpose License.

This means that the market for health and social care provision would revolve around public sector organisations, voluntary bodies and private for-profit companies that each adhere to a Social Purpose License. The License would impose new ethical obligations on the public sector body (as commissioner), the service provider (whether private, voluntary or public) and a newly appointed independent regulator, as follows:

The public sector commissioner must ensure the safety, quality and dignity of outsourced workers by agreeing to:

- 1 long-term outsourcing agreements of at least five years
- 2 a fee level that is adequate to cover the costs of fair work (specified below)
- 3 clearly defined high quality services
- 4 oversight of training and skills of outsourced workers.

The provider (whether private, voluntary or public) must adhere to the following strict criteria:

- 1 all pay and non-pay terms and conditions (including sick pay and pensions) are at least as favourable as those set by the NHS Pay Review Body and as codified in the Agenda for Change agreement
- 2 terms and conditions are extended to temporary agency staff
- 3 no staff are on zero hours contracts
- 4 all establishments have a trade union recognition agreement
- 5 the expected annual rate of return on capital invested is less than 5 per cent
- 6 the controlling parent company and/or shareholders are domiciled in the UK for tax purposes
- 7 no aspect of the governance structure is managed or controlled by a private equity fund.

The newly formulated regulatory body must ensure the minimum stated criteria are adhered to

If any one or more conditions are not upheld then the Social Purpose License must be revoked. The body must also recommend new criteria in light of peer reviewed research evidence where necessary.

6. Summary and conclusion

As the Covid-19 crisis continues to play out, there remains considerable uncertainty as to the socio-economic consequences of the pandemic, and how national governments and the international community will respond to them. One of the few certainties, centres on our past, present and future reliance on the health and social workforce to combat the virus. As the protracted nature of the battle against the Covid-19 becomes clear, and as the Thursday night applause begins to fade, it is important not to lose sight of this certainty or take it for granted. In this paper we have sought to 'place a stake in the ground', to kick-start discussion on the establishment of fair care work. We acknowledge that the viability and plausibility of our proposals is contingent on the development of future policy on a broad range of foundational issues, not least the shape and funding of care delivery, revealed in the current context as flawed in numerous and various ways. However, our proposals should be seen as a point of departure for further debate, a means of setting the parameters for an agenda, variously labelled in our paper as a new deal or a refreshed model employer approach to employment relations in health and social care.

In general, the Covid-19 crisis has revealed the vulnerability of many workers in modern labour markets adding weight to recent calls for action in dealing with the precarious nature of employment in the 'Gig Economy' (Taylor, 2017; Wood 2020). In this paper we have argued that the well-publicised organisational difficulties faced in dealing with the virus, expose a related but distinctive set of challenges for the management of health and social care workforce.

We have considered these challenges along four dimensions of employment relations:

Migrant workers

As a key part of the frontline health and social care workforce, migrant workers have been seen to face a disproportionate level of risk in engaging with the virus. However, based on their fragile and uncertain status, migrant care workers have often been forced into insecure, low paying work roles and viewed as 'outsiders', a designation then used to penalise them further in terms of wider socio-economic support.

Pay

The traditional and ongoing undervaluation of largely feminised care work and the more recent decline in living standards during a recent period of austerity-driven pay restraint, have been presented as sitting uneasily with the major contribution made by employees across the occupational hierarchy in dealing with the Covid-19. Indeed, the fragmented nature of pay determination, producing uneven treatment across the health and social care workforce, has hardly been conducive to addressing shortcomings in pay systems and structures.

Learning and development

The capacity of the workforce to deal with Covid-19 has been seen as hampered by the siloed and distorted nature of the learning and employee development agenda in health and social care. Funding for training has been unevenly distributed between different occupational groups, with the learning of frontline support workers, such as healthcare assistants, chronically under-resourced.

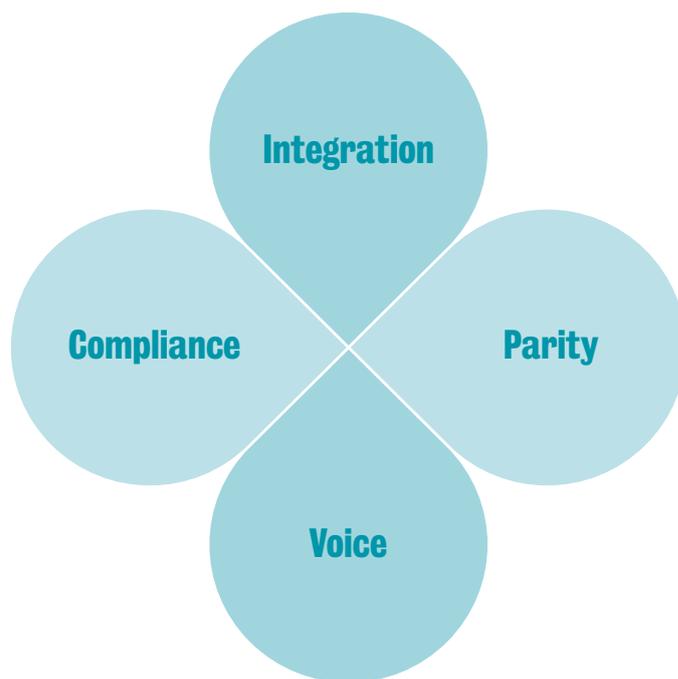
Outsourcing

The contracting-out of health and social care services, deepening during the Covid-19 crisis, has generated a fractured model of services provision with major gaps in the treatment of outsourced cleaners, hospital porters, care workers and security guards among others. At the extreme end, this has been driven by the need for maximum short-term gain by large corporations and equity funds, often at the expense of care quality. It is a model of care delivery revealed as tragically ill-suited and poorly-prepared to combat the pandemic, particularly in adult social care. More specifically, this fractured care delivery model has rested on, and fostered, forms of employment characterised by low pay, irregular earnings, job insecurity and few development opportunities.

At the core of our paper has been the call for fair care work in health and social care as a response to these challenges, inevitably begging questions about how we characterise fair care work. In discussing the four dimensions of employment relations, we have raised a variety of substantive and procedural features which might be seen to underpin fair care work. These features connect to the cross-cutting themes presented at the outset of the paper, although it is worth refining and elaborating on them as a means of characterising fair work in health and social care.

Figure 2 below summarises the four main features of fair care work, and each, in turn, is discussed below.

Figure 2. The component parts of fair care work



Fair care work is integrated

The fragmentation of service delivery has been mirrored in the fractured nature of employment relations both within and between the health and social care sectors. This fracturing has led to the uneven treatment of employees, with consequences for the capacity of the workforce to deliver services in a connected way, in turn, with implications for care quality. In response we have argued for the greater integration of employment relations. In part, this integration centres on the alignment of employment practices between public, private and voluntary sector service providers. The suggested Social Purpose Licence, a requirement for all private and voluntary sector service providers, is designed to ensure a shared approach based high minimum standards of employment within the mix economy of care delivery.

In addition, integration relates to the synchronisation of employment relations practice between health and social care sectors. In employment relations terms, social care delivered through local government, has long been seen itself as 'the poor relation' of healthcare, and we have drawn attention to the separate and very different systems of pay determination and learning in the respective sectors. We have suggested various moves towards greater integration, for example, by: developing and using a skills passport; introducing a common training framework; extending the remit of the NHS pay review body to social care; and including adherence to NHS pay review body recommendations as a requirement of the Social Purpose Licence covering private and voluntary sector employers.

Fair care work ensures parity of status and treatment

As workers from across the occupational spectrum make a shared contribution to dealing with Covid-19, so the crude distinction between low and high skilled workers begins to crumble (Bergfeld and Farris, 2020), with implications for how health and social care workers are viewed and managed. In general terms, the erosion of the high-low skill distinction encourages a re-evaluation of employee job roles, in particular their socio-economic worth relative to other occupations in economy, with consequences for how these roles are paid. Indeed, we have argued not only for pay rates which reflect a revised assessment of job worth, but for mechanisms ensuring that the value of pay is maintained, if not increased, in real terms.

For migrant workers, often concentrated in 'low skilled' health and social care jobs, the breakdown of crude skill distinctions brings to the fore their significant positive contribution and value to the community, and in so doing undermines the legitimacy of egregious attempts to present them as 'outsiders'. For workers in the lower echelons of the occupational hierarchy, also often viewed as 'low skilled', such as care assistants and support workers, the uneven distribution of resources for training and development becomes much less justifiable and sustainable.

Fair care work requires employer compliance

Fair care work cannot be an optional extra. Throughout the paper we have argued that the right to fair care work reflects the enduring debt the community owes to the health and social care workforce for its bravery and sacrifice in dealing with Covid-19. More prosaically, the importance of fair care work lies in ensuring future care quality as the population ages and the incidence of chronic disease increases. Time and again we have drawn attention to how poor employment practice in health and social care has negatively impacted the recruitment and retention of staff, with detrimental consequences for care outcomes. In short, fair care work underpins good health and care outcomes.

If fair care work is to be more than an 'optional extra' employers must comply with suggested employment standards and 'good practice'. At the outset we noted the challenge of implementing a common approach to ER within the mixed economy of service provisions, and given the incremental delegation of employer responsibilities to NHS trusts. However, with the government continuing to fund the delivery of most health and social care, levers to support the implementation of fair care work remain and might be further developed. These levers include:

New regulatory bodies and mechanisms

Given the myriad arms-length regulatory bodies, we hesitate to suggest the creation of new ones. However, our Social Purpose Licence would mandate private and voluntary sector adult social care providers to meet clear employment and governance standards, with an associated regulatory body to ensure compliance. We have also suggested the establishment of a new National Career Care Service

to support workforce development across and within health and social care.

Existing regulatory bodies

A variety of existing bodies play a role in supporting and overseeing workforce management in health and social care, but with scope to perhaps sharpen and strengthen their focus and responsibilities in this respect. For example, CQC inspections cover aspects of workforce management. However, CQC Regulation 18, dealing with staffing, is quite narrowly drawn, concentrating almost exclusively on employee training and development. CQC regulations might be revised to embrace a wider range of workforce issues: the scope for employee voice; the management of equal opportunities; the capacity to recruit and retains staff.

The remit and coverage of other arms-length bodies might also be refined to support say the integration agenda. We have suggested the creation of Health and Social Care Education England and or the NHS and Social Care Pay Review Body.

Commissioned research and evaluation

A variety of bodies commission research on aspects of workplace management in health and social care. They might be encouraged to monitor and track progress on the implementation of a fair care work agenda. These commissioning bodies include: the Migration Advisory Committee; the Office of Manpower Economics, servicing the NHS and other pay review bodies; and the DHSC funded Health and Social Care Workforce Research, based at the King's College, London.

Fair care work provides employees with a collective voice

At the outset, we presented the encouragement of and a willingness to listen to a collective employee voice, particularly as articulated through trade unions and professional associations, as central to the government's model employer approach. While union density remains relatively high in the public sector at around half the workforce, this still represents a marked decline over recent decades, with density in the 1970s and indeed well into the 1980s sitting at around 80 per cent (Beaumont, 1992). Clearly there are a variety of reasons for this fall, although the progressive erosion of support from national policy makers for union membership, both in general and amongst its own employees, is likely to be a contributory factor. Within adult social care we have noted that union presence is even weaker amongst private and voluntary employers, encouraging us to suggest the Social Purpose Licence includes a requirement for employers to recognise trade unions.

The importance of collective employee voice, particularly at the workplace level has emerged across our dimensions of employment relations: in supporting migrant workers isolated and weakly positioned in unstable labour markets; in protecting the health and safety of workers, not least in the context of the Covid-19 crisis; and in taking forward and elevating the learning and development agenda. Networks of union learning and health and safety representatives exist, but they are patchy and fragile. Naturally unions are keen

to support and resource these representatives; employers need also to encourage and meaningfully engage with them.

As the terror of this pandemic begins to subside, it feels like the right moment to start talking about how to rebuild and re-regulate our health and social care system. It had many flaws before Covid-19, in the level of financial resources, the fractured governance across the thousands of organisations and, as we have highlighted in this paper, its broken model of employment relations. We have witnessed enormous sacrifices of workers of all grades and occupations these last months. But we have also seen the real problems of organisation and governance that have come to light in response to the pandemic. This is why we are urgently calling for a new deal for fair care work in health and social care. It will require multiple rounds of dialogue with the main stakeholders, innovative thinking, long-term commitment and, most importantly, the courage to imagine a brighter future for health and social care workers. After all, these are the workers who are arguably at the heart of efforts to improve livelihoods for all in 21st-century Britain. We hope therefore that our four-dimensional model of fair care work will contribute to this collective effort.

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Endnotes

- 1 Over three quarters (77 per cent) of the NHS England workforce are women ([https://www.nhsemployers.org/~media/Employers/Publications/Gender%20in%20the%20NHS.PDF](https://www.nhsemployers.org/~/media/Employers/Publications/Gender%20in%20the%20NHS.PDF)) 83 per cent of the adult social care workforce are women (<https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/State-of-Report-2019.pdf>).
- 2 This 2.2 million is full time equivalent figure, evenly split between 1.1 million employees in NHS England (<https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/february-2020>) and 1.1 million in adult social care (<https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/State-of-Report-2019.pdf>). The total employee headcount figure for health and social care is 2.8 million with 1.3 million employees in NHS England and 1.5 million employees in adult social care.
- 3 For example: Unison, 2020.
- 4 Fredman and Morris, 1988.
- 5 Coffey and Thornley, 2009; Bach and Kessler, 2012.
- 6 <https://www.nhsconfed.org/resources/key-statistics-on-the-nhs>
- 7 <https://www.adass.org.uk/regions2>
- 8 <https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/State-of-Report-2019.pdf>
- 9 See for example: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/536961/civil_service_workforce_strategy_final.pdf
- 10 NHS Improvement, 2019.
- 11 Moran, 2003.
- 12 House of Commons Health and Social Care Select Committee, 2018.
- 13 Close to 50 STPs were established in 2015, designed to develop an integrated system of health and social care within a given geographical catchment area (often roughly aligned with counties). They delivered their strategic plans at the end of 2016. There are currently 18 ICS seen as based on 'a closer collaboration' between health and social care providers and commissioners (<https://www.england.nhs.uk/integratedcare/integrated-care-systems/>).
- 14 Traverse, 2018.
- 15 Beaumont, 1992.
- 16 Department for Business, Energy and Industrial Strategy, 2019.
- 17 <https://www.socialpartnershipforum.org/media/166314/SPF-Covid-19-statement-final-and-formatted.pdf>
- 18 Wilson 2020.
- 19 Bach (2010a).
- 20 ONS (2019).
- 21 Ibid.
- 22 OECD (2019), See Health at a Glance, Figure 8.20.
- 23 Ibid.
- 24 Skills for Care (2019).
- 25 Piore (1979).
- 26 McGregor (1997).
- 27 Bach (2010b).
- 28 Moore (2017).
- 29 ONS (2020a).
- 30 ONS (2020b).
- 31 <https://rcni.com/nursing-standard/newsroom/news/a-culture-of-keeping-quiet-and-working-hard-costing-philipino-nurses-their-lives-160221>
- 32 See, for example, study by Hayes et al. (2017) of 2,600 care workers in the North West of England which indicated major concerns about worker and care user safety in the context of Covid-19. It reported that a large majority of respondents indicated that too little was being done by employers to keep staff safe (69 per cent of learning disability support workers, 60 per cent of home care workers, 52 per cent of residential care).
- 33 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/880288/COVID-19_hospital_discharge_service_requirements.pdf
- 34 Public Health England (2020a).
- 35 Public Health England (2020b).
- 36 Home Affairs Committee (2020a).
- 37 <https://www.theguardian.com/world/2020/may/20/nhs-coronavirus-bereavement-scheme-extended-to-low-paid-workers>
<https://www.gov.uk/government/news/home-office-extends-bereavement-scheme-to-nhs-support-staff-and-social-care-workers>

- 38 RCN (2017), Unison (2015).
- 39 Unison (2020). https://www.unisonnw.org/care_workers_vs_covid_19
- 40 Skills for Care (2017).
- 41 House of Lords (2018).
- 42 Alderwick and Allen (2019).
- 43 Hayes et al (2019).
- 44 Home Affairs Committee (2020b).
- 45 Royal College of Physicians (2020).
- 46 England, 2005.
- 47 Bergfeld and Farris, 2020.
- 48 Institute of Public Policy Research (IPPR), 2020.
- 49 Unison, 2020.
- 50 Institute of Fiscal Studies (IFS), 2019.
- 51 Cominetti, Gardiner & Kelly, 2020.
- 52 The pay protection available to workers in NHS and other contacted out public services was significantly weakened by the Coalition government's withdrawal of the Code of Practice on Workforce Matters in Public Service Contracts. This Code had been designed to guard against the development of a two-tier workforce in relations to pay and other terms and conditions in the context of outsourcing (with some employees protected TUPE and others not). In 2010, the Code was replaced by a document entitled *Principles of Good Employment Practice*. Designed to inform the procurement process, the application of these principles was, however, voluntary. Moreover, the principles were worded so vaguely, they became virtually meaningless. Thus, new entrants, supplying public services, were encouraged to provide 'fair and reasonable pay, terms and conditions' without any clarity on how 'fair and reasonable' should be interpreted. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/62089/principles-good-employment.pdf
- 53 <https://www.theguardian.com/society/2019/apr/07/second-class-nhs-workers-struggle-as-pay-gap-widens>
- 54 <https://southeast.unison.org.uk/news/article/2019/06/system-second-class-nhs-workers-must-end/>
- 55 Hutton, 2011.
- 56 Dromey and Stirling, 2017.
- 57 IFS, 2019.
- 58 <https://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2019/>
- 59 Rubery et al, 2015.
- 60 <https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/State-of-Report-2019.pdf>
- 61 Hayes et al. (2017).
- 62 Buchan et al 2019.
- 63 Buchan et al 2019.
- 64 Skills for Care, 2019.
- 65 <https://www.nursingtimes.net/news/workforce/covid-19-places-critical-care-nurses-front-and-centre-as-leaders-30-03-2020/>
- 66 Buchan et al, 2019.
- 67 *Daily Telegraph* 19/5/20.
- 68 Wolf 2010.
- 69 <https://www.nursingtimes.net/news/workforce/hancock-asked-if-nurses-should-be-paid-more-after-covid-19-crisis-06-04-2020/>
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- 75 Kessler and Dickens, 2008.
- 76 Siefert and Sibley, 2005.
- 77 Standing Commission on Pay Comparability, 1980.
- 78 Although a new registered band 4 role, the nursing associate, was introduced in early 2019.
- 79 <https://www.hsj.co.uk/coronavirus/healthcare-assistants-hit-by-high-covid-19-death-rates/7027759.article>

- 80 The Care Certificate was introduced in April 2015, one of the key recommendations of the Cavendish Review of the training and management of support workers in health and social care. The Care Certificate is taken by all new patient/user facing workers in support roles, and requires these workers to meet fifteen health and social care standards before they can begin delivering care.
- 81 National Audit Office, 2016; Addicott, 2015.
- 82 Francis, 2013.
- 83 A term in turn borrowed from Thornley, 1997.
- 84 Tussell (2020) *Factsheet #2: Covid19 and UK public procurement*, May (tussell.com/uploads/).
- 85 By exploiting gaps in pay and trade union influence between public and private sectors, outsourcing has enabled public sector managers to cut wages and long-term labour costs such as pensions (Berlinksi 2008). Evidence of poor outsourcing practices in the commissioning of adult social care has been reported in reports by the Communities and Local Government Select Committee (e.g. House of Commons 2017).
- 86 These kinds of contradictions and tensions are identified in management research on supply chains (Rubery et al. 2010).
- 87 *Financial Times* (<https://www.ft.com/content/5aed1aa4-d720-43b1-b799-1dad8c506413>).
- 88 There are no legal limits on executive pay in the UK. For example, at the big four accountancy and consultancy firms (three of which have been awarded Covid-19 contracts – E&Y, PwC and Deloitte), partners earned an average of £720,000 in 2019. (*Financial Times*, 7/4/2020, <https://www.ft.com/content/65d8e851-5e33-4a2d-a814-a4c27f949dd3>).
- 89 The full quote is: ‘Government support for social care came too late. A Covid-19 “action plan” for social care was published on 15 April – nearly a month after country-wide social distancing measures had been introduced.’ Editorial, *British Medical Journal*, 10-05-2020 (<https://www.bmj.com/content/369/bmj.m1937>). ONS data show a ‘significantly elevated rate of death’ among both male and female social care workers up to mid-April; data for England and Wales up to 20/04/2020, <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/>
- 90 *The Times* (<https://www.thetimes.co.uk/article/coronavirus-care-home-staff-feel-abandoned-as-more-residents-fall-prey-to-covid-19-lvnqv67ld>). Indicative of this abandonment were: the accelerated discharge of patients from hospital settings back to care homes without a testing regime in place; the inflated price of personal protective equipment (PPE) to care homes; shortages of PPE; and muddled guidance, particularly on the use of PPE.
- 91 There are an estimated 24,000 providers of adult social care in England alone.
- 92 Data from the National Minimum Dataset for Social Care suggest 59 per cent of all jobs were in private sector establishments, 19 per cent in voluntary sector organisations and the remainder in local authorities (Skills for Care 2019).
- 93 Financialisation in the UK care homes sector is widespread. Four Seasons, recently the second largest provider of care homes in the UK, was first acquired by the private equity firm Terra Firma and then, in 2017, when it could not pay a £27m debt interest charge, was taken over by H/2 Capital. Directors at Terra Firma paid themselves up to £1.6m in 2016 and expect 12–14 per cent annual returns on care home investments (*Financial Times*, 9/2/2020, <https://www.ft.com/content/952317a6-36c1-11ea-a6d3-9a26f8c3cba4>).
- 94 In general, Freedom of Information applies to public organisations but not always to private companies companies (<https://www.open-contracting.org/>).
- 95 See, for example, the case-study evidence in Appelbaum et al. (2013), as well as evidence that financialisation is fuelled by the discriminatory undervaluation of women’s care work in Horton (2019).
- 96 Statistical analysis of data for 102 adult social care providers found that each additional pound in higher fees increased hourly pay of care workers by 14p (homes) and 18p (domiciliary) (Grimshaw et al. 2015).
- 97 2018–19 data cited in Skills for Care (2019). Two figures refer to independent sector domiciliary care workers only, namely for zero hours contracts and for the pay premium for senior care workers.
- 98 Fair Work Wales (2019).
- 99 Unison (2016).
- 100 See details at the Living Wage Foundation website, <https://www.livingwage.org.uk/become-recognised-service-provider>
- 101 The Transfer of Undertakings (Protection of Employment) Regulations (1981), known as TUPE, has major loopholes. It protects the terms and conditions of employees who transfer from the public sector to the outsourcing organisation, but not new recruits and not subsequent changes after the point of transfer. Trade unions brought the issue of ‘the two-tier workforce’ to public attention in the 1990s and the then government responded with the ‘Two Tier Code’. It had far greater success in the NHS (especially in PFI agreements) than in local government where there were few if any examples of its application, for example to social care.
- 102 Grimshaw (2009).

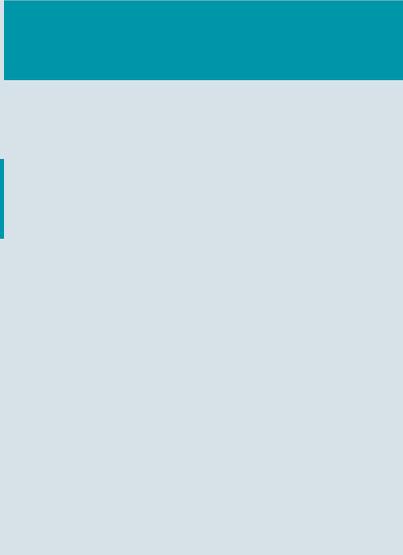
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Being in the heart of London, our students and academics have unlimited opportunities for collaboration, research, and developing their career prospects. From bold new startups to multinational conglomerates, businesses inform our teaching and benefit from our work.

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