An Evaluation of UNISON's Ethical Care Charter

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Foreword

UNISON Local Government is very pleased to be able to release this positive assessment of our Ethical Care Charter, launched five years ago. The current crisis in social care is universally acknowledged. With average cuts to council budgets of 40% since 2010 - and more for some - an already underfunded service is under serious threat. Around 1.2 million elderly and vulnerable people are not receiving any care at all or have unmet care needs, while councils have been forced to raise eligibility criteria to ration services to those 'lucky' enough to qualify.

The funding crisis and almost wholesale outsourcing of social care have led to unprecedented pressure on the pay and conditions of work of our members who are care workers – the vast majority of whom are women. Non-payment of the statutory National Living Wage and National Minimum Wage is endemic, zero hours contracts abound, few are paid sick pay and pensions are a very rare species! Training is largely inadequate and often takes place in workers' own time.

In this context, UNISON launched the Ethical Care Charter to highlight the crucial link between the quality of care and the ways that care workers are treated. We called on councils and other providers to sign up to our Charter by paying the Living Wage and sick pay and by providing proper training in work time. In doing so, we anticipated that high turnover of staff would be reduced, workers would feel more valued, enjoy greater job satisfaction and consequently deliver better standards of care.

Professor Moore's assessment of some of the 32 signatories to our Charter confirms that view, while showing that external pressures like caring responsibilities and the impact of higher earnings on in-work benefits do not always make the move from zero hours contracts attractive to care workers. This is a very valuable study, which we will use to develop our thinking and campaigning on social care. We hope that more councils and providers will recognise the value of investing in care workers and our Ethical Care Charter and adopt it. Above all, we hope that everyone who needs care will one day to receive the high quality services they deserve.

Heather Wakefield,

Head of Local Government, Police and Justice, UNISON

Introduction

UNISON's 2012 survey of homecare workers, *Time to Care*, found that working conditions are intrinsically bound up with the quality of care. UNISON's Ethical Care Charter (ECC) was launched as a response to the findings in 2012 and called for councils to sign up to becoming Ethical Care Councils by commissioning homecare services which establish:

> 'a minimum baseline for the safety, quality and dignity of care by ensuring employment conditions which a) do not routinely short change clients and b) ensure the recruitment and retention of a more stable workforce through more sustainable pay, conditions and training levels'.

Since its launch, 32 councils and care providers have adopted the Charter (Appendix1). This research comprises nine case studies of providers which adopted UNISON's ECC between November 2013 and October 2015 (Appendix2) - five local authorities, one voluntary organisation (Julian Support) and another council-owned arms-length company (CORMAC). The case studies are based upon interviews with local authority commissioners and managers (18), providers (9), homecare workers (11) and local UNISON reps (13). Eight are based in England. One is an authority in Scotland (Renfrewshire) where the public procurement environment is distinctive. The research explores the implications of the adoption of the Charter for homecare services - primarily for the working conditions of homecare workers, but consequently service users. It looks at change during the period over which the Charter has been in operation, identifies the key challenges and presents issues that have arisen in the implementation of the Charter and which will need further reflection.

Context

The environment in which adoption and implementation of UNISON's Ethical Care Charter is taking place is a hostile one and one which has only got worse in the period since the nine case study organisations introduced it. The ADASS Budget Survey for 2016 concluded:

> 'We are at the tipping point where social care is in jeopardy and this impacts on the millions of people needing care and support and the staff who care for them' (2016)

Nationally the ADASS survey[1] identified planned savings for 2016/17 of £941 million, 8% of the net Adult Social Care (ASC) budget and 29% of total council savings. Overall there has only been a slight increase in the ASC budget in the past financial year, but 70 councils reported a reduction. This is despite the introduction of the social precept allowing local authorities to increase council tax by 2% for social care, which is to be raised by 3% in the next two years. ADASS reports that the increase is offset by the establishment of the National Living Wage (NLW) in April 2016 with the total cost put at over £600 million.

The necessity for UNISON's ECC is the generalised outsourcing of local authority homecare services and it is interesting to note that the UKHCA has recently suggested that the crisis in social care and fragility of the market is such that councils might have to deliver services in-house, which it describes as a 'sobering thought' considering that on average in-house services are deemed to cost 2.5 times more than independent and voluntary sector provision[2].

[1] ADASS Budget Survey, 2016.
[2] UK Home Care Association, An Overview of the Domiciliary Care Market in the United Kingdom, 2016.

Key Findings

1. **The importance of political and financial commitment**

The ECC has been adopted in the context of severe cuts to council and ASC budgets and this has undoubtedly shaped implementation. However, the case studies demonstrate that this context is not determinate. Despite the harsh economic circumstances organisations are in a position to influence the pay and conditions of homecare workers and where they do, this makes a difference. In all case study organisations the introduction of the ECC is the result of clear political commitment from council members or, in the case of Julian Support, the Chief Executive, as a manager there commented:

> 'Julian Support really only has one asset - our staff, and we expect an awful lot of them. They are dealing with some of the most vulnerable people in our society and we expect them to model the best ethical behaviours when working with people who need their support. If there is a mismatch between how we behave as employers and how we expect our staff to behave there is no integrity in the organisation or the services we provide. People seek us out to work for us, we have a good reputation and I think it is more based on our culture and values as opposed to anything else. That's the draw.'

The case studies show that ASC staff have also welcomed and supported the ECC, for example in Reading:

> 'It definitely sets the benchmark for what good quality care should be, and for a long time care workers have obviously been neglected, especially given the work that they do and the contribution they make to society. They have long been overlooked, so I think from that point of view, we are all supportive of the Ethical Care Charter and we are committed to making sure that in Reading, that we can start delivering according to it. So yes, it's definitely a positive thing and sets the bar for how it should be'.

Where authorities have made most progress there was a concrete financial commitment and the ECC has been funded from central rather than ASC budgets. In Renfrewshire an £8.7million Scottish Government budget boost in 2016-17 was designed to protect ASC and ensure payment of the Living Wage (LW). The political and legal context in Scotland and promotion of 'fair work practices' through public procurement reform appears to have eased the introduction of the ECC there. In Camden, Islington and Southwark the ECC was funded corporately rather than through the existing ASC budget and council officers went to individual providers to negotiate uplifted rates and to get them to realistically calculate the cost of paying the London Living Wage (LLW) and travel time[3].

There are differences between case study authorities in the quality:cost ratios on which contracts are awarded. In Renfrewshire the quality:cost ratio is 80:20 whereas others reported tenders were evaluated on a 40:60 basis. Hourly charge rates for homecare in the case study organisations ranged from £12.75 in Lancashire to £18.40 in Reading, although in the latter the range was £15.90-£18.40. The

[3] In some instances the organisations did not take a staged approach to the implementation of the ECC or did not follow the consecutive stages proposed by UNISON. The ECC was introduced at varying stages in local authority procurement cycles; while some authorities aimed to adopt the ECC when recommissioning ASC, others had made interim arrangements with existing providers.

range was £16.64 - £17 in London and £12.72- £18.40 outside London[4]. Participants suggested that the cost of funding the ECC was nearer £20 per hour in London and this is in line with UKHCA calculations[5]. Julian Support would not tender for contracts which it felt would compromise the service, in one case £14 per hour, and were looking at a tender with a price cap of £17 per hour as more appropriate for its specialist services. Where there were in-house services, costs were reported as much higher, again in line with UKHCA data.

Where homecare services have been protected from the market the implementation of the ECC is undoubtedly less challenging. There is variation between the case studies in terms of the proportion of homecare that has been retained in-house. Of the seven case study authorities, four had outsourced all homecare, with Islington, Reading and Renfrewshire retaining re-ablement services in-house. Renfrewshire was distinct in that the authority delivered around half of its provision in-house. In the case of CORMAC, re-ablement and safety-net services had been transferred under TUPE legislation from Cornwall Council.

While initiated by UNISON's Local Government section, the ECC's success has been a function of strong employer relationships with UNISON branches and for some UNISON branch officers, the adoption of the ECC has gone hand in hand with pressure to bring homecare back in-house. Whilst awareness of the ECC was necessarily high amongst providers, there was consensus that homecare workers themselves had more limited knowledge and were unsurprisingly more likely to attribute changes to the adoption of a LW. In the context of cuts, UNISON reps in local authorities reported that time and energy was spent fire-fighting attacks on the jobs and conditions of directly employed members and dealing with constant reorganisation. This left limited resources for organising contracted-out workers.

The Branch Secretary of Cornwall local government branch that included CORMAC was pushing to get the ECC applied to external providers, but at the same time fighting to ensure that the council did not abandon its commitment to the Foundation LW in favour of the statutory – and lower - NLW for Council workers. Despite these constraints, a number of branches had - or were planning- recruitment campaigns amongst homecare workers: In Renfrewshire the branch was taking up the issue of registration costs for Scottish care workers. One homecare worker who was a union member and had been transferred from the local authority to CORMAC, had not heard of the Charter, although UNISON had publicised it locally, but once she had read it commented:

> 'I think it's a brilliant thing. When I read it, I thought, yes, that's so true. Our people that work in the private sector I think they get totally a bad deal, I mean, I count myself very lucky to actually work for the Council you know'.

2. Commissioning on the basis of client need

UNISON's ECC starts from the principle that commissioning should be around client need and not minutes or tasks, with workers having freedom to provide appropriate care and time to talk to clients. The UKHCA notes that, with very few exceptions, councils pay providers by reference to 'contact time'

[4] These are rates provided by respondents and documentation, they may be distorted by the fact that some reported averages and others the range of charges where the higher end might be more specialist provision.

[5] Overall the United Kingdom Homecare Association's (UKHCA) minimum cost for care for 2015-16 assuming no enhancements for weekend and evening working and including paid time for travel, training and supervision, statutory sick pay, along with the costs of a Workplace Pension, holiday entitlement and mileage were: £16.70 per hour from April 2016 taking into account the NLW; £19.03 taking into account the LW and £21.40 taking into account the London Living Wage

only, leaving the provider to ensure that they meet the full costs of the service. Only one of the case study authorities paid providers on actual contact time, others paid scheduled time and there was a general rejection of minute-by-minute payment for care facilitated by electronic monitoring, which was seen as incompatible with commissioning based upon client need. In the case studies there was a move away from 15 minute visits and three authorities are introducing flexibility in the windows of time in which care is delivered, giving service users more choice.

Southwark's High Level Service Specification states that time allocated by homecare workers will match the needs of clients, with a guarantee of no minute-by-minute commissioning and visits scheduled so that workers are not forced to leave to get to another client. Camden and Islington both expressed the intention of moving to a more flexible system of care, including time banking. Reading has introduced a time pilot so calls can be delivered within wider bands of an hour or an hour and a half and still be considered on time so long as visits take place within that band. Whilst some visits have to be time specific the pilot introduces flexibility for providers and service users. In the year since the introduction of the ECC 100% of randomly selected care plans were shown to be built around client need while spot visits confirmed that care workers were spending sufficient time with service users[6].

In three local authorities, providers were explicitly required to have clear procedures for following up concerns about clients and whistleblowing. In Southwark, the service specification demands that workers are effective as 'alerters' within the Pan London Safeguarding Policy and need approved training for this role. Julian Support Staff has a Whistleblowing Policy under which staff can raise concerns at any level of the organisation and are supported to do so.The need to highlight concerns about the wellbeing of clients is also made explicit through induction, learning and development, supervision and appraisal.

3. Payment for travel time

In line with the ECC, all the case study organisations required the payment of travel time. A provider survey in Reading confirmed that all but one paid travel time and expenses and funded uniforms, training and DBS checks. The one exception was addressing this. The calculation of travel time varies, with some authorities adding payment for an average number of minutes for travel to hourly pay, but others assuming or specifying inclusion in hourly pay rates – while this may be technically compliant with the NLW there is a qualitative difference in the benefit to care workers. In Julian Support and CORMAC and in those authorities with in-house services, there are fixed hours shifts and travel is part of paid working time, reflecting the residual local government model. Similarly, in those providers there are no unpaid gaps between visits, when the care worker may be effectively available to the employer in the way that they are when working on zero hours contracts (ZHCs). The Area Manager for a major national provider outlined how the introduction of travel time had been managed:

> 'We build it into the hourly rates, which means that for every hour that they work we add a certain monetary value which is the equivalent of X amount of minutes, I think it's seven minutes. Now, obviously that hourly rate stays the same whether they're doing a half-hour visit or a one hour visit, so it's actually quite advantageous to them because more visits are half-hour than they are one hour, so they're still getting that value within the hourly rate between all the visits no matter what time they stay'.

A worker employed by Julian Support confirmed the difference paid travel time makes:

[6] http://www.apse.org.uk/apse/index.cfm/members-area/briefings/2017/17-01-insights-into-social-care-practice/

> 'I've done those jobs before, where you're not paid it and you're not given the time, and you're not given the mileage and this is not it. So I get my wage and travel time included and then the mileage as well. So in terms of pay, in terms of conditions, it really makes a difference working here. One time, for a previous employer, it was an agency, I was on a push bike and they had me doing four split shifts; breakfast run, lunch run, dinner run, tea run. I worked it out one week: 56 miles in one week and that was over the winter and I was on a push bike and I didn't get paid for it'.

4. Moving away from Zero Hours Contracts (ZHCs)

While the case study authorities committed themselves to moving away from ZHCs, this has proved to be problematic. Southwark and Islington insist that providers offer 'Guaranteed Hours Contracts' (GHCs), with the former monitoring this and the latter setting a target for providers of guaranteed regular hours that exceed 16 hours for 70% of homecare workers. Overall in five of the seven local authority case studies there had been attempts to offer GHCs. However, both providers and council officers reported that, although some care workers appreciated the security, others are reluctant to move to GHCs. This was attributed to GHCS being less flexible because care workers cannot turn down shifts, but also because offers of GHCs are generally predicated upon the wider availability of workers, including early mornings, evenings and weekends. Those with caring responsibilities could not or did not want to work these shifts, but under GHCs they cannot then turn them down. A provider in Southwark described the issues with GHCs:

> 'It took a lot of explanation for the care workers to understand that they weren't being paid a salary, so it wasn't that you worked this to this and you get this over the year and that's how it works, guaranteed hours are about saying we will guarantee you a minimum of X amount of hours within your availability. So in other words if the care worker had a 60 hour availability that didn't mean we were guaranteeing them 60 hours, we might guarantee them 30 hours within that availability. So your availability had to be more than the hours you could work because it had to include travel time, downtime etc., and they were confused between guaranteed hours and salaried payments. So it took quite a while, and at the end of it what we found is what I expected, is that our uptake was less than 20 per cent.'

In this context GHCs are not fixed hour's contracts. For providers, the difficulties of abandoning ZHCs are the significant fluctuations in demand and the absence of guarantees from councils as to volumes of work. A requirement to increase those on GHCs would have to be reflected in the charge rate 'because we will have to pay for the times that they're not working' - that is, for what is generally referred to as 'downtime' between peak demand times. Camden council stated that it would not insist on the abandonment of ZHCs and others accepted that there could not be a blanket ban. In Camden a commissioning officer reported that there had not been much take-up of GHCs, however she did suggest that the establishment of GHCs might attract a different type of worker into care:

> 'There's different reasons why people go into care work and are on ZHCs and a GHC wouldn't give them that flexibility, so I think you have to balance it up. So the aim was that all existing and new workers would be offered it, but it would be their choice whether they took it up or not and the providers would have to accommodate whatever choice they made. I think that once it becomes more of a norm that people are on GHCs it might attract a different kind of person. So I think the people that are attracted at the moment they know that they're actually entering into an area of work that's generally a ZHC, but actually if the message gets out that

this could be different then it might attract a different group of workers. So I think there's an adjustment in terms of how workers see the contracts and how they understand how those contracts work'.

5. Paid training and supervision

Case study authorities monitored the training and supervision of homecare workers and three explicitly required providers to ensure training takes place in paid working time. The extent of training and frequency of supervision varied and was more intensive where there was in-house provision, in the former Council provider and the voluntary organisation. Southwark anticipated that the ECC might require an additional three days of training per worker on top of the Care Certificate and was developing a common workforce development approach for homecare workers, providing its own inductions. Lancashire Council required providers to demonstrate supervision every three months with annual appraisals, while Wirral specified six-weekly supervision. In Julian Support it is every four to six weeks and in CORMAC every eight weeks.

In line with UNISON's ECC, Southwark requires that workers are 'given time to meet co-workers to share best practice'. In Julian Support, time and a dedicated space are allocated to allow workers to share experiences and support. In one Camden provider there were quarterly forums for care workers which were unpaid, but the office was a focal point for workers providing a base between visits as a manager described:

> 'The Chief Executive wanted a care worker area so we could come here, relax in between visits, use the facilities and everything. So hence the sofas, the computers, so they can use that and because we are open until ten at night, care workers will have a break in between the visits, they can come here and wait here instead of having to sit outside somewhere. We have quite a lot of people using the computer facilities here, they might be doing some training, or they might be just browsing, looking at their own emails, making themselves a cup of coffee or anything, it's just warming up, especially when it gets colder. It's actually very good because we can just grab them sometimes and say, "Hello, how's it going with such and such client". So we have an open door policy basically. I always thought that whilst the pay for our care workers was quite low, we tried to compensate in other areas where we could. So that's why having things like this and doing little things like, the other day we had for Halloween pumpkin soup and muffins - just trying to engage with our workforce. So it's compensating in that way a little bit because with pay we can't really do much more'.

6. The Living Wage

The LW or LLW is undoubtedly the element of the ECC that has had the most impact on homecare workers, introducing a higher benchmark for pay and changing the wider care labour market by putting pressures on neighbouring local authorities to uplift rates. The LW was centrally funded by three local authorities and in the case of Renfrewshire, partly by the Scottish Government. While the introduction of the LW is part of the third stage of the ECC, a number of case study organisations had already adopted the LW or LLW or they had implemented it ahead of other elements. In some, adoption had initially been for directly employed staff and then extended to outsourced workers including homecare workers, However, two authorities, Lancashire and Wirral, had not yet extended it to outsourced workers - largely because of cost - and in CORMAC, although transferred staff protected by TUPE were paid above the LW, new recruits were not. In contrast, in Islington the extension of the LLW for externally employed care workers included requiring its three providers, Allied, Sevacare and London

Care, to pay at least the LLW through the contracts, but also increasing personal budget allowances in order that service users could pay the LLW to the homecare staff or personal assistants they employ directly. In London it was reported by providers that the LLW had become a benchmark for pay and that care workers now expected to be paid it and providers were becoming reluctant to tender for contracts in boroughs where it had not been adopted. Similarly outside London, a commissioning officer from Reading saw the introduction of the LW as establishing a benchmark, but also making monitoring easier:

> 'It can only be a good thing to pay your care staff fairly and it sets the benchmark, it's the same for everyone, everyone knows what to expect. From our point of view also it's easier to monitor when everyone is set at the same level and with the same standards, so it has helped with that, and I think it's made it easier for the providers, so they know where we are coming from, so that they can't, not that they have, dispute it, but it's a standard and it's there in black and white. I reiterate what the others have said, the ECC is a good thing to have, we know people are being paid for their travel time and they are getting sick pay and all those things. It's also easier to enforce - that might not be the right word - but the quality that we expect when we know people are being paid fairly and treated fairly, we are not expecting good quality for nothing'.

The introduction of the LLW was perceived as making a real difference to homecare workers in terms of pay, but one Camden provider reported that it had also encouraged care workers to take on more work:

> 'They felt that their work was being more appreciated. Of course, you know, some agencies they used to pay the minimum wage that was £6-something. Some of these care workers, they have to work 12 hours just to make maybe six hours of pay. Which is of course not very good. And so they felt more appreciated in that. And initially when we first started London Living Wage, what we noticed is not so much that we had benefits in recruitment, but what we noticed is that our existing care workers were more willing to take on extra shifts. Whereas before you sometimes quite often they wouldn't take on any additional work'.

One issue raised by the introduction of the LW is that of pay differentials. A number of providers reported that they had increased pay for operational staff, coordinators and supervisors, but absorbed the cost. In contrast, Camden and Reading had raised rates for these staff alongside the introduction of the LW so that there was no erosion of differentials.

7. Continuity of Care

UNISON's ECC states that clients will be allocated the same homecare worker(s) wherever possible. While this might reflect appropriate scheduling, the ability to fulfil this requirement is based upon the recruitment and retention of homecare workers. In Southwark, monitoring of the ECC between July 2015 and June 2016 showed overall reductions in staff turnover over three quarters from 5% to 2% and 11% to 4%); in both the main providers, with recruitment levels in line with staff turnover. There was also an overall increase in qualified staff in one provider and service user satisfaction was over the 90% target in both. Staff groups reported feeling more valued and their work recognised and the commissioning officer attributed the improvement in the service to the reduction in turnover.

In Islington, one provider, London Care, pointed to improvements in staff wellbeing as a result of the requirement to pay the LLW, with staff turnover reducing since its introduction in 2014 from an average of 10% to less than 3%. Islington's executive member for finance and performance, Andy Hull, responded that 'the results – better retention, performance, and morale – are striking'[7]. In Reading the Council stated that it was confident that changes precipitated by the ECC 'have improved the quality of care, enhanced working conditions for some of the lowest paid, most disadvantaged residents of the borough and strengthened their relationship with providers'[8].

Elsewhere the ECC was seen as creating benchmarks for employment and removing elements of competition between providers that might lead to a downward spiral in terms of terms and conditions and the consequent movement of workers between providers, reflected by officers at Wirral Borough Council:

> 'I think in the past there were lots of complaints about the quality of care and from a provider perspective, care staff were shifting from one provider to another quite a lot. It was very difficult to keep tabs on things so we felt the ECC was timely - at a time when we felt we could re-commission the market'.

8. Occupational Sick Pay

Across the case studies it was reported that providers generally paid statutory sick pay and a provider survey conducted in Reading confirmed that all providers did so. Julian Support staff received occupational sick pay of 26 weeks full pay and 26 weeks half pay after six years' service. The organisation also has disability leave to accommodate the employment of people who had experienced mental health conditions. Occupational sick pay tended to be a key difference between in-house and external providers. In CORMAC, new recruits had less entitlement to sick pay than those transferred under TUPE.

A number of respondents suggested that occupational sick pay is the most challenging element of the ECC for providers and currently remained an aspiration. This was put down to cost, but also to the demands it might make of organisations in terms of record-keeping and monitoring, while at least one provider suggested there may be abuse of such provision by care workers. At the same time, homecare workers pointed out the dangers of going into vulnerable service-users' homes when not well, in a situation where they could not be afford to take time off sick. As a care worker from Southwark reflected:

> 'The sick pay's a bigger disappointment in a different way because you're going to frail people and you're out in all weathers and you're in and out people's homes. I mean everyone's going to have a cold at some point in the year anyway and if I was going to a relative of yours and I was sneezing and coughing you wouldn't really like me to see to them would you? But then you can't afford to be off because you're not being paid, so it's a bit of a catch-22 isn't it?'

9. Monitoring

The local authority case studies reflect a proactive approach to contract management although cuts in staff may affect the level of monitoring authorities can provide. Three case study organisations, Southwark, Renfrewshire and Reading, specifically measure elements of compliance with the ECC.

[7] http://www.islingtongazette.co.uk/news/pay_the_london_living_wage_islington_council_urges_1_4294184
[8] http://www.apse.org.uk/apse/index.cfm/members-area/briefings/2017/17-01-insights-into-social-care-practice/

Lancashire and Southwark have performance monitoring frameworks with KPIs which cover the workforce. Where the LW had been introduced, authorities generally asked for proof of payment through wage slips and this usually extended to travel time. In most authorities, monitoring involved planned and unplanned site visits and four authorities promoted engagement with the workforce, either directly or through surveys. Southwark requires providers to undertake staff surveys and Islington encourages this. In Reading, a council committee report notes that 'no measurement or guidelines are available by UNISON to benchmark progress against the ECC' and the Commissioning Manager expressed a desire for UNISON guidance on monitoring the implementation of the ECC.

Conclusions

Whilst the current financial climate for local government severely constrains the terms and conditions of the homecare workforce and thus the quality of homecare, the case studies suggest it is not entirely determinate and that clear political commitment to UNISON's Ethical Care Charter makes a difference. This chimes with increasing acceptance that the downward pressure on homecare commissioning is no longer sustainable.

Where the ECC has been effectively implemented, political affirmation has been concretely reinforced by financial commitments from central or -in the case of Renfrewshire - national budgets. Where this has not been possible, implementation is more fragile. There are some issues with the calculation of travel time, which is more transparent where it is added to the LW and not absorbed within it. The abandonment of ZHCs has proved problematic: GHCs have not been introduced as fixed hours, but require further, unscheduled availability that homecare workers cannot always provide. Homecare worker's apparent 'preference' for ZHCs is driven by wider pressures, the absence of affordable childcare, the role of in-work benefits and housing costs, which mean that coming off benefits may not make financial sense. The drive to remove so-called 'downtime' from costs that outsourcing enshrines means that the contractual arrangements represented by both ZHCs and GHCs may be intractable.

It is clear that the UNISON ECC's requirement to introduce the LW and paid travel time has led to a qualitative shift in the care labour market – in certain authorities the LW is now a benchmark for homecare work and there is an expectation that travel time will be paid. Where authorities have monitored the impact of the ECC they have reported improvements in recruitment and retention and thus the quality of care, as well as improving the working lives of homecare workers and starting to recognise the value of their contribution to society.

Appendix 1: Councils who have adopted UNISON's Ethical Care Charter

East Midlands	Nottingham City
	Nottinghamshire
Greater London	Barking & Dagenham
	Camden
	Croydon
	Greenwich
	Hammersmith & Fulham
	Islington
	Southwark
	Tower Hamlets
Northern	Redcar & Cleveland
North West	Cheshire West and Chester
	Cumbria
	Lancashire
	Sefton
	Wirral
Scotland	Aberdeen
	Fife
	Inverclyde
	North Ayrshire
	North Lanarkshire
	Renfrewshire
	West Dunbartonshire
South East	Brighton & Hove
	Milton Keynes
	Reading
Wales	Swansea
Yorkshire & Humberside	Bradford
	Leeds

Other care providers

Julian Support

Optalis

Cormac

Appendix 2: The Case Studies

The selection of nine case studies as a basis for the research was agreed in discussion with UNISON. Of the 15 organisations that have adopted the ECC one was excluded because it was known to be the object of existing research, another declined to take part, while others had only just adopted the Charter and it was deemed too early to explore its impact. The case studies and the dates when the ECC was adopted are:

- Southwark (November?, 2013)
- Islington (November 2013)
- Wirral (November?,2013)
- Reading (March 2014)
- Renfrewshire (March 2014)
- Lancashire (October 2014)
- Camden (November 2014)
- Cormac, Cornwall (October 2015)
- Julian Support, Norfolk (October 2015)

The research took place between September and December 2016 and the case studies are based upon 51 interviews with local authority commissioning officers and/or service managers or with senior managers of organisations that had adopted the ECC along with providers, UNISON branch officers and/or reps responsible for homecare workers and homecare workers. Table 1 summarises these across the nine case studies. The interviews were contextualised by documentary evidence: ASC and budget strategies; information put out on adoption of the Charter, available tender and contract documentation.

Table 1 The Participants

	Local Authority managers/officers	Providers	Homecare workers	UNISON reps	Total
Total	18	9	11	13	51