Working Time Directive in Social Care and Support Services for Persons with Disabilities:

Case of the UK

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Contents

1. Introduction

This report is based on existing academic research and 'grey' sources, including articles in newspapers and professional journals. Although effort has been made to focus on the social services sector, it is often not possible in the literature to disaggregate workers who support people with disabilities and long-term conditions from those who provide support for older people.

Britain implemented the Working Time Directive (WTD) under an unwilling Conservative Government in 1998. It was transposed into UK law as the Working Time Regulations (WTR). Later that year (and until 2010) the new Labour Government embraced the WTD and EU employment legislation in general. Since that time, however, whilst Trade Unions (via the TUC) have been broadly in favour of the WTR, The Confederation of British Industry (CBI) and other business representatives have been less enthusiastic. Public opinion has swung between these two positions. The employment protections offered by the European Parliament were initially welcomed, for example as many workers saw their holiday entitlement improve at a stroke.[1] In 2004 the majority of Britons wanted to abolish the individual opt-out from the 48-hour working week, meaning the 48-hour week would apply to all workers. However, a shock referendum result in 2016 saw the British public vote to leave the EU, apparently eschewing its employment protections with no guarantee of what will replace them. 'Brexit' will undoubtedly take some considerable time to unfold, some observers say potentially as long as 10 years.[2]

The Working Time Directive in the UK

The aim of the WTD is to ensure workplace health and safety for workers. The WTR in the UK are implemented in the following way:

- The maximum working week should be no longer than 48 hours. Workers can work longer provided their working weeks average out as 48 hours over a 'reference period'. This is most usually 4 months, but can be extended to 6 or 12 months in certain circumstances and if Trade Unions agree.
- Workers should have a break every six hours (20 minutes) and 11 consecutive hours rest every 24 hour period. They should have a full day off each week; or two days off every two weeks.
- Everyone is entitled to 4 weeks of paid holiday. Since 2008 this has been extended to 5.6 weeks when 'bank holidays' were also included in the holiday entitlement.
- Night shifts must not be longer than 8 hours and night workers should be offered a risk assessment with regards to the effect on their health.
- Workers under 18 are subject to different rules.

Derogations in the UK

The WTD allows EU countries various 'opt-outs':

[1] When the directive came into force in the UK over 6 million workers got an extra week holiday, and some (mainly women) enjoyed paid leave for the first time. (Barysch, K. 2013).

[2] E.g. Neil Kinnock, Vice President of the European Commission and leader of the opposition in the UK 1983-1992.

- The 48-hour rule and rest requirements do not apply to 'persons with autonomous decision-making powers'. This term is not properly defined, and is often not used in the UK because of this lack of clarity. Where it is used, it tends to apply to senior managers and to self-employed people, though the latter is itself a group with uncertain parameters. Different rules can be adopted for some sectors because of their need for more flexibility: social care in the UK does not fall into this group at present.
- Trade unions and employers have leeway to agree their own rules in some cases (e.g. changes to rest periods and the consequent inclusion of 'compensatory rest') through collective agreements. In the UK, collective agreements cover less than one third of the workforce (usually in the public sector)[3] so this particular tool to establish flexibility has not been much used.
- Of particular importance is the fact that member-states can allow workers to opt out of the 48-hour rule individually. Workers need to agree the opt-out in writing and have the right to change their minds. Employers must not pressure workers to sign opt-out agreements. This derogation has been used by the UK since the WTD was implemented in 1998, (the UK was the first country to use the individual opt-out) but the requirements for rest and holidays remain unaffected.

The general impact of the Working Time Directive in the UK

The UK is amongst the member states that have implemented the WTD most assiduously. However, since 1998 the WTR have been amended many times so that it can be difficult for non-lawyers to establish what exactly they mean. There is both complexity and confusion. Nor is it easy to establish the overall impact of the WTR in the UK. In 2010 the European Commission asked Deloitte to study the impact of lower working hours on productivity in Europe.[4] The researchers found "no clear pattern" across industries or countries. For the UK, clear results were only obtained for textiles, banking and the power sector: in all three productivity went up as working hours fell. In 1998, there was already a move toward a general reduction in the incidence of long working hours, as industrialisation led to big gains in productivity. This move has continued since that time, with the trend being towards shorter working days.[5] This may in part be due to the effects of the WTR, but is also created by changes in working patterns. These have become more diverse: there is an increase in remote working and virtual teams: there are more part-time, flexible and temporary jobs with specialists contracted for short-term projects: people are working for longer as the distinction between work and retirement blurs, and there are more women in the workforce[6]. In addition, Health and Safety legislation in the UK was already well established in 1998.[7]

[3] Blackburn J.et al. 2016. Pessis 3: Promoting employers' social services organisations in social dialogue: Country Study. United Kingdom.

[4] Deloitte Study. 2010. DG for employment, social affairs and equal opportunities. An impact assessment on further action at European level re directive 2003/88/EC and the evolution of working time organisation.

[5] Devlin, Ciaran and Shirvani Alex. Dec 2014. Dept. for Business, Innovation and Skills (BIS).

[6] The impact of the working time regulations on the UK labour market. A review of evidence. EASPD: response to review of the WTD 2003/88/EC 2016.

[7] E.g. Health and Safety at Work Act 1974. Workplace (Health and Safety and Welfare) Regulations 1992.

The WTR in the UK had the intention of protecting ***all*** workers, and has undoubtedly brought many benefits. However, it has had some unintended and negative consequences for some sectors. Social Care is one of those sectors.

2. Social Care in the UK

Definition

The social services sector in the UK includes people working in early years, children and young people's services, and those working in social work and social care for children and adults. Early Years provides services for preschool children (up to 5 years of age) and includes nurseries, play groups, childminders and nannies. The latter 2 are self- employed. The Department of Health predicts the number of people over 65 needing support with long term conditions will increase 4-fold in England by 2050.[8] Younger adults and children with long term/life threatening conditions or disabilities are also living longer. This has increased the demand on social services across the UK, and the sector continues to grow steadily. Pressure for the recruitment and retention of staff remains high. Although there are a few very large employers, 92% of the 63,000 employ less than 50 people, meaning that the workforce is fragmented. The distribution is not even across the UK, with England accounting for by far the largest percentage of social service workers: 81% of the workforce is in England, 11% in Scotland, 6% in Wales and 2% in Northern Ireland.[9]

Interface with health services

It is relatively easy in the UK to differentiate between social services and health, both in terms of statistics and of employment, although sometimes the former measures 'Human Health and Social Work' activity without a disaggregation of the two. There is also some blurring of roles between health and social services, created by the increase in integrated services. For example, in Scotland new legislation (2014) requires the 32 Local Authorities and 14 Health Boards to work together to plan and deliver integrated Health and Social Care services across the country. In Northern Ireland work is underway to develop a new hybrid role, 'Advanced Care Practitioner', that will bridge the gap between a social services support worker and a qualified nurse. In England, new induction training has been developed for use with workers across both health and adult social care to signal commonalities in the roles. Nevertheless, health and social service workers across the UK continue to work to different professional codes, different job descriptions and different rates of pay. In general, health is better resourced and has higher status.

The National Health Service (NHS) does not fund social care provision. Registered nursing homes, on the other hand, provide a mixed Health and Social Services function and act as a boundary between fully state funded health care (via the NHS) and privately funded nursing care. Where a 'primary health need' is established, the state will pay all nursing home costs. If this primary need is not established and 'nursing care' is said to be required instead, the NHS may pay a Registered Nursing Care Contribution, with the remainder of the fee paid by the individual/family/ local authority. This adds a level of complexity and confusion to funding arrangements, causing many disputes between families, the NHS and Local Authorities.

Types of service provision for People with disabilities

The European Disability Strategy 2010-2020 seeks to empower people with disabilities to fully exercise their rights and participate in society and the economy on an equal basis to others. It builds on both the UN Convention of the Rights of People with Disabilities (UNCRPD), to which the EU is a signatory,

[8] Care: Sector Skills Assessment. Briefing Paper UK Commission for Employment and Skills (UKCES) 2013.
[9] 'Care: Sector Skills Assessment briefing paper' ibid.

and the wider Charter of Fundamental Rights of the European Union, which became law in 2009. This latter brings together in one document the fundamental rights protected in the EU. It focuses on Dignity, Freedoms, Solidarity, Citizen's Rights and Justice. In the UK this has meant a move from the medical to a social model of support and services have tended to reflect this as they are designed to maximise personal choice and control for those people living with disabilities.

Service provision in the social care sector in the UK is varied and includes domiciliary care services (supporting people in their own homes), supported living (including the support of people in custom made accommodation e.g. sheltered housing) and residential and day care services. Residential care is no longer provided in large institutions, but some would argue that although the largest of care/nursing homes offer economy of scale, they are still too large to support proper implementation of the UNCRPD through things such as person centred planning, active support and active risk taking. The introduction of direct payments/personalised budgets has meant that some people with disabilities have been able to employ their own staff (personal assistants), though this number is still relatively small. Figures have been difficult to find but the Department of Health has anticipated there will be nearly 1.2 million personal assistants in England (adult social care) by 2025.[10] They are most often not unionised and they work alone or in very small teams. There are also some 'intentional communities' in the UK where people with learning disabilities live together in small 'villages' and their staff live amongst them as a lifestyle choice. This type of service provision is controversial and certainly presents some challenges for the application of the WTR. The majority of those with care needs, however, are still cared for by family members. There are 6.5 million family carers in the UK, providing £132 billion of care per annum[11]. In contrast, there are 1.87 million social work/care and support employees working for 63,000 employers.[12] Reflecting a mixed economy, most services are now in the independent sector, a mixture of private and voluntary (not for profit) sector provision.

Funding systems

Despite the economic downturn starting in 2008 the Social Services sector has grown steadily in the UK. The shift from public to private employment/services in the sector since the 1990s means that the majority of services are now outsourced and purchased through a competitive and open market. Less than a third of services are provided by the public sector (27%), 49% are provided by the private (for profit) sector and 24% by the voluntary (not for profit) sector.[13] Public sector services are provided by Local Authorities (Health and Social Care Trusts in Northern Ireland). These same Local Authorities use central government funding to commission services from the private and voluntary sectors for those people who are unable to pay for all of their own care. Market forces are therefore heavily influenced by the superior purchasing power of local authority commissioners, who can drive down prices for their own block purchases. Funding for Social Services is means tested across the UK. Rules are complex and vary between countries, as each nation takes decisions about how the central government grant will be used. They may also vary between Local Authorities where decisions about certain aspects of payment can be taken locally.

National Minimum/Living Wage

The National Minimum Wage (NMW) was introduced in 1999. Its purpose was to attack poverty and exploitation and increase employment, economic investment and productivity. It was set at what the market was thought to be able to stand and was dependent on age. The Living Wage Foundation (LWF) set different rates for London and the UK (London being set higher) based on the poverty threshold, although these were not legal requirements. In response to LWF lobbying, the government pledged to introduce a National Living Wage (NLW) of £9 per hour (10.61 Euros[14]) by 2020, starting

[10] Supporting Personal Assistants working in adult social care DH 2011.
[11] Carers UK 2014.
[12] Skills for Care and Development 2015.
[13] Care: Sector Skills Assessment. 2013. Op cit.
[14] Conversions correct at Feb 2017.

incrementally at £7.20 per hour (10.21 Euros) in April 2016 for all. There is no difference between London and the rest of the UK, so in fact this does not reflect poverty thresholds for all, and pay levels are still dependent on age, with younger workers (under 25 years) being paid less.[15] The hourly rate will rise to £7.50 per hour in April 2017. There has been considerable concern amongst low pay employers that they will not be able to afford these increases due to recent year on year cuts to their budgets by central government. However, the first of the increases in 2016 was absorbed fairly successfully as care providers received an uplift from local authorities (for commissioned services) to help foot the bill.[16]

Work patterns

Shift work is common in the social services sector in the UK, and this includes night work, especially in residential services. Rest per 6 hours of work is usually for 20 minutes with 11 consecutive hours of rest per 24-hour period. It has been impossible to find any existing research about how far this is adhered to in the sector, but the author is not aware of breaches presenting a particular issue. Night work only presents difficulties where it is seen as 'on-call'. This situation is dealt with separately, below in section 3. 'Stand-by' work is not used frequently in the social care sector in the UK. Where it is, it is usually for workers such as wardens of sheltered housing who have their own accommodation on the complex and can therefore be seen as available to respond to any emergencies that occur. Workers in intentional communities can be in a similar position. For these workers, the application of the WTR is unclear.

The reference period for the averaging of the 48-hour working week is most usually 4 months in the sector. It would be useful to extend this in some circumstances e.g. in relation to some migrant workers who wish to work longer hours for an intense period and then move onto other commitments.

Care at home workers travel between clients, most usually visiting for 15-30 minute slots when they support people to wash/dress/eat/prepare for sleep. There is no time for anything more. Unions have been pressing service providers and commissioners of services to extend these slots but so far with little effect. Staff shortages and reductions in funding linked to increased demand have meant that improvements to services cannot be made. Other workers such as personal assistants or those living in 'intentional communities' work with fewer clients (sometimes only one) for much longer periods of time. They may 'live in' or work shifts outside of the WTR (see section 3 below).

Agency workers are used in social care only when it is absolutely necessary as they are expensive and as they do not know the client well (or at all) the quality of care offered can be somewhat mechanical and not respond well to individual needs. Nevertheless, in areas of the country where the problem of recruitment is particularly acute, agency workers are used frequently.

Stress management

Work in the social care sector is rarely monotonous. It can, however, be stressful: supporting clients who have behaviour that challenges or working with end of life care provide examples of work that can create emotional stress. Although service providers would like to provide extra help for workers who experience these kinds of stresses, for example through training, support groups or individual 'supervision', in reality this is expensive and is unlikely to happen with more than the very best providers. Commissioners of services have demonstrated a refusal to provide funding to support such activities.

[15] The NLW does not apply at all to 16-17 year olds. People in the age bands 18-20 and 21-25 receive lower rates than the over 25s. Apprentices receive the lowest rates of all.

[16] 82% English councils increased payments in 2016, 46% by more than 3% and 1 in 3 councils by more than 5%. This was raised by increasing local council taxes.

Contracts

The most usual contracts in social care are full/part time permanent. Fixed term contracts are little used. There has been an increase in the number of people working part time (voluntarily) in the sector. This is in part due to the fact that of the 1.7 million people who work in the UK social care workforce, over 81% are women: 1 in 10 of all women workers in the UK are in the Social Services sector.[17] Part time work is often seen by women to be helpful in terms of fitting work around family responsibilities. Anecdotally, some employers favour contracts for 20 hours per week or less due to the cost saving in the avoidance of National Insurance contributions (they are not paid for 20 hours or below).

Zero hour contracts are also used in the sector, most often by care at home services, where some of the worst conditions of service can be found. Whilst these contracts can offer welcome flexibility for some (and they are therefore somewhat controversial), for those who require a regular guaranteed income, they are damaging, especially when accompanied by clauses forbidding other employment. The Kings College Research Unit found that there were some 307,000 workers on zero hour contracts in 2013, and Unions (e.g. Unison) have been pressing for a reduction in this number.

The WTR are not clear in relation to how the 48-hour maximum applies to multiple contracts. Where health and safety issues are paramount (e.g. where heavy plant machinery is being used in construction) and employers are responsible for ensuring workers have not exceeded safe limits, this is often addressed on a shift by shift basis rather than by overall contract hours. This does not happen in social care. Where employers ask their staff about other work commitments, this is often only at the point of employment. This relies on worker honesty and is not easy to monitor throughout the life of the employment.

The effects of age and length of service on entitlements

Whilst all workers in the UK, regardless of age and length of time working for the organisation, receive the same basic rights in terms of holiday entitlement (and some organisations offer levels above this), it is common for extra days to be granted based on length of service or seniority. Similarly, using the NLW (National Living Wage) as the basic minimum, it is not uncommon for remuneration to improve with length of service and the associated expected increase in experience. The NLW itself varies, somewhat inexplicably, with age, being paid at a higher rate for the over 25s.

3. Working Time Regulations: specific issues facing Social Care

The WTR in the UK had the intention of protecting ***all*** workers, but has had some unintended and negative consequences for social care. The main issues for social care employers and their workforce (and by extension for the people with disabilities who they support) are the definitions and payment of 'on call' time and travel time.

'On-call' time

In 2000 and 2003, (SiMAP and Jaeger, respectively and Dellas in 2005) the ECJ established that on-call time should, in its entirety, be counted as working time for the purpose of calculating working hours, even when a worker is asleep and inactive. The UK felt that these decisions went beyond the underlying principles of the WTD, and was concerned (rightly) that they would also have implications for sectors beyond health.[18] This ambivalence is reflected in the National Minimum Wage Regulations 2015, which state:

[17] 'Care: Sector Skills Assessment briefing paper' Op cit

[18] Select Committee on the European Union. 9th Report. 2009.

> 27 (2) In paragraph (1)(b), hours when a worker is available only includes hours when the worker is awake for the purposes of working, even if a worker is required to sleep at or near a place of work and the employer provides suitable facilities for sleeping.

This interpretation contradicts the earlier SiMAP/Jaeger rulings and adds to the lack of clarity and confusion which continue to affect the implementation of the WTR in the social care sector.

'Live-in care'

An increasing number of disabled people in the UK currently use a model of care where a worker or workers live for periods of time in their private residence. This model is known as 'live-in' care. It includes employment by private individuals or families as well as employment commissioned by care provider organisations, often using direct payments as a source of funding. More than one worker may be employed as part of a small team, covering support needs 24/7 between them and living with their employer for regular periods of time. Because the worker is at a 'workplace' for long periods, often 24 hours a day, the ECJ interpretations of inactive 'on-call' time as working time potentially make all 'live-in' care unlawful (even though adequate rest is assured). Prohibiting the use of this 'live-in' care model has a serious impact on the ability of people with disabilities or long term conditions to engage in normal activities of daily living such as work, education and family life. It would prevent them from fully exercising their rights and participating in society and the economy on an equal basis to others and as such would contravene the UNCRPD and undermine the European Disability Strategy 2010-2020. Domestic servants and 'family workers' are exempt from the WTD, but there is no definition of these groups in the Directive and it is unclear if the terms could be used to cover 'live-in' social care staff.

No employment case law is known yet to have addressed inactive on-call time in the specific circumstances of 'live-in' care, but reference has been made, in personal injury compensation cases, to the possible unlawfulness of the 'live-in' model. This uncertainty has denied some individuals the opportunity to choose their preferred support model, with consequent adverse effect on their lifestyle. The same kind of impact appears to extend into a wide variety of other social care work, where the worker resides at the place in which they are 'on-call'. For example, in the UK case MacCartney v Oversley House Management (2006), it was held that wardens living in their own apartment, within a housing complex for elderly/ disabled people, were working 24/7 because they might have to respond to an emergency with one of the other residents of the complex.

In pursuit of greater social integration, choice and independence for people with disabilities, the UK Government strongly encourages 'self-directed' care arrangements. This approach maximises individual choice and autonomy and is in tune with the support of the rights of disabled persons, enabling them to establish a greater degree of normality in their lives. This normality is not available to people if their lives are bound by the strict, regular timetables of visiting or shift-based models of care. The intrusion of large numbers of workers working shifts over a 24-hour period inevitably disrupts relationships and household organisation and is expensive to maintain…often beyond the means of direct payments and other UK funding systems. For some, the removal of 'live-in' support would mean the very real threat of 're-institutionalisation'.

Interface of the National Minimum/Living wage regulations

The impact of the WTR on social care in the UK cannot be properly understood without some discussion of its interface with the National Minimum/Living (NM/L) wage regulations. It seems sensible that if hours count towards working time, they should also count as paid time, and vice versa. However, the progressive merging over time of the interpretation of the WTR and the NLW (as well as some confusing differences) has created problems and employers do not know which

regulations/guidance to follow. Sometimes hours must be counted as working time, but not necessarily paid, and vice-versa.

A report in 2015 estimated that 160,000 workers in the UK are paid less than the NMW (National Minimum Wage) and are losing out on £130 million per annum as a result.[19] Her Majesty's Revenues and Customs (HMRC) has begun to crack down on these breaches and where they are confirmed, to require up to 6 years of back pay (plus a potential fine). With the high turnover of staff in the care sector[20], this back payment will be difficult to achieve. Nonetheless, a judgement in an Employment *Appeal* Tribunal in 2014 (Whittlestone v BJP Home Support Ltd.) found that a worker 'on-call' who can sleep for a significant portion of the shift, should be paid for all hours, including when they are asleep. This overturned the original tribunal decision. Despite the fact that the National Minimum Wage Regulations (2015) contradict this (see above), the Department for Business Energy and Industrial Strategy (BEIS) has provided guidance that supports it:

'A worker who is found to be working, even though they are asleep, is entitled to the NM/L wage for the entire time they are at work'.

HMRC has decided to apply the BEIS guidance rather than the Minimum Wage Regulations. This decision has massive implications for the social care sector. Not only will 'inactive on-call' time be counted for working hours, it will have to be paid in full at the NM/L wage (with 6 years back pay). The Voluntary Organisations Disability Group (VODG) estimates that one member with an annual turnover of £10 million is anticipating a back pay liability of £1.8 million. This situation is untenable unless the government provides funding to help employers with these payments or the current interpretation of working time is changed. Providers will otherwise be forced to close down and the current crisis over lack of sufficient social care provision in the UK will deepen.

Interviews revealed that employers are extremely concerned about this situation and it is not going without challenge. For example, Anthony Collins, a Solicitor, is presenting numerous challenges to HMRC on behalf of employers and is considering judicial reviews for all areas concerned.[21] At least one judicial review is being currently undertaken directly by an employer. There seems to be a good legal basis for these challenges and many employers are awaiting the outcome before deciding on their strategy for managing sleep-in/on-call time. Some are choosing to do nothing yet in the hope that government will intervene, some are considering different ways to 'get around' the problem e.g. the use of contracts based on 'unmeasured work time', or the use of workers 'on standby' rather than 'on-call'. The latter means fewer workers can be used to respond to the needs of people with disabilities in the night, as one worker could cover several sites. Others still are considering an increased use of technology (surveillance equipment) to resolve the issue. Although these models reduce cost, they also reduce quality of service and may have health and safety implications. One large employer conducted internal research which suggested 'on call' workers were active for only 1% of their time on call. Given findings such as this, and the context of reductions in funding, it is easy to see why new options are being considered, even if they represent a poorer service.

[19] The Scale of Minimum Wage Underpayment in Social Care Laura Gardiner 2015 (Resolution Foundation Briefing)

[20] Turnover can be well over 20% in some areas.

[21] Anthony Collins Solicitors 31st March 2017 post. New grounds to challenge HMRC on sleep-in inspections.

Travel time and the Working Time Regulations

There is also considerable confusion in the UK about the treatment of travel time, both in relation to whether it should count towards working hours and if it should be paid. Domiciliary (home care) workers in the social care sector usually travel to support a number of clients throughout each day/evening, often spending very little time with each. Most employers do not count the hours their workers spend travelling from one client to another as working time and only pay for direct contact time between worker and client, defining only this as 'working time'. However, the Minimum Pay Regulations say that a worker should be paid for:

> 27 (3) (a) hours when the worker is travelling for the purpose of carrying out assignments to be carried out at different places between which the worker is obliged to travel, and which are not places occupied by the employer.[22]

An Employment Appeal Tribunal (Whittleston v BJP Home Support Ltd. 2014) had already found in favour of this position and overturned a Tribunal decision in relation to the payment of travel time, stating that travelling time is 'time work, except where incidental to the duties being carried out and the time work is not assignment work'.[23] Nevertheless, despite Union pressure, both payment of travelling time and its inclusion in working hour calculations is patchy in the UK. The interface between the WTR and the Minimum Pay Regulations and their application to the sector are far from clear and therefore make challenge difficult.

4. Conclusion

Conclusions drawn in this research must be considered within the UK context of continuing austerity measures and a shrinking financial envelope for employers in the social care sector. Many feel that social care is in crisis. The wide variation in service delivery means that regulations must provide sufficient flexibility to support a range of working patterns tailored to client need. The following has emerged from this research:

- There is wide support for the WTR in the social care sector in terms of protection of workers, work/life balance and health and safety. The Regulations are generally well known, but the detail is not always understood.
- In most areas, the WTR seem to work well, despite some areas of the WTR becoming overly complex and confusing in the transposition from the WTD into UK law. However, there are some very specific problems of application in the social care sector for which there are no sector specific derogations or exceptions. The WTD of 20 years ago was not constructed in a way that considered the needs of an emerging social care sector. It was more applicable to occupations where rest and work-time are less able to be flexible e.g. lorry drivers and machine operatives, and where more rigid regimes do not impinge upon the human rights of others. The social care workforce in the UK is fragmented and not supported by social dialogue structures beyond the immediate workplace (and sometimes not even there), making it difficult to negotiate flexibilities through collective agreements. The lack of a specific body for social dialogue in the sector at a European level exacerbates this situation. Derogations and exceptions for the social care sector have therefore not occurred.
- The main areas of concern for the social care sector in relation to the WTD/R are:
    - the treatment of inactive 'sleep-in/on-call' time 'as work time,

[22] Minimum Pay Regulations. 2015.
[23] Appeal number UKEAT/0128/13/BA

- the inflexibility of 'rest/compensatory rest' in relation to meeting the needs of people with disabilities, especially when it is applied to 'live-in' care and support.
- the treatment of stand-by time creates similar problems, but this type of work is less used in the sector. (NB 'Waking nights', where a worker is awake, available for work and paid in full for the whole shift, are not at issue.)

'Sleep-in/on-call' time is a different matter: here the worker is most likely to be asleep for the whole of the shift. This has historically not been counted as work time, and has most commonly been paid at a flat rate. Any hours where sleep is counted as working time and paid accordingly. The European Court of Justice (ECJ) set the stage in 2000, 2003 and 2005 by ruling that 'sleep-in/on-call' time should, in its entirety, be counted as working time for the purpose of calculating working hours, even when the worker is asleep and inactive.

UK ambivalence about these ECJ rulings is reflected in the National Minimum Wage Regulations 2015, which state that a worker is only 'available for work' when awake and so NMW calculations are to be based on these hours alone. Nevertheless, an employment appeal tribunal in the UK has found in favour of the ECJ ruling, and BEIS has issued guidance supporting this. Confusion reigns.

Recent judgments pointing to the necessity to pay the NLW for all hours counted as 'working time' means that the cost of providing care and support at night has escalated to a point where it is for many employers untenable. HMRC is currently enforcing payment of NLW for 'sleep-in/on-call' time, with fines and 6 years back pay also being demanded. Legal challenges are being mounted, but the situation remains very serious for the sector and for the people it supports. All types of service provision with a 'sleep-in/on-call' element are affected, including 'live in' care/support.

In addition, the WTR requirements for rest/compensatory effectively make the 'live-in' care support model unlawful. These requirements also have implications for 'sleep-in/on-call' work, in that workers would (technically) need to be woken up in order for them to take their 20 minutes rest breaks! This is clearly ludicrous.

- The effects of these interpretations and rulings are potentially severe for people with disabilities. As end recipients, they have not been consulted about how their care and support might be affected and what their preferences might be. There is clearly a balance to be struck between the welfare rights of workers and the human rights of people with disabilities. Both are enshrined in international law, the former by Health and Safety legislation and the WTD and the latter by legislation including the UNCRPD and the wider Charter of Fundamental Rights of the European Union. The European Disability Strategy 2010-2020 builds on these charters and seeks to empower people with disabilities to fully exercise their rights and participate in society and the economy on an equal basis to others. The focus is on dignity, choice, freedoms, and citizen's rights. In order to be equal partners in society, people with disabilities must be able to influence the shape of the care/support packages they receive and have access to flexible provision which does not prejudice the health and safety of workers. However, if current rulings and interpretations re the WTR/D stand, they will have the following effects:
  - Being unable to fund the necessary increases in wage bills, many smaller UK providers will be forced to close, reducing available services and deepening the crisis in social care.
  - Those workers formerly employed in these businesses will lose their jobs.
  - The model of 'live-in' care will no longer be tenable, due not only to wage bills but also to inflexible rest requirements. Those people who have enjoyed this model face a very real threat of re-institutionalisation.

- Those employers who are able to survive will be forced to 'find ways around' the legislation. This may lead to unofficial practices which will not be scrutinised or monitored.
- There will be a wider threat of re-institutionalisation as a cost saving exercise.
- The rights of people with disabilities will be eroded.

5. Recommendations

Recommendations can only be sector specific. The social care sector has very particular features which make it different from others, and one size will not fit all. The issues identified in this report require resolution at both European and National levels. Both routes would benefit from consultation with the social care sector, with the aim of working towards specific derogations/exemptions where these will not work across the board. The following would be useful considerations:

European level:

- Inactive 'sleep-in/on-call' time could be re-designated non work time in the social care sector. Inactive stand-by time could be treated in the same way.
- Requirements for rest/compensatory rest could be made more flexible to enable wider models of service provision.
- Live-in care/support workers could be exempted from the WTD (like domestic servants and 'family workers').
- Travel time between clients could be clearly designated work time.
- It could be made possible for the 48 hour opt out to be written into contracts where there is a demonstrated requirement for longer hours in order to meet client need.

In May 2017, the European Commission launched a social package proposing progress on the social dimension of the European Union (26/04/2017). The package includes initiatives relating to the Working Time Directive, providing an 'Interpretative Communication' on Directive 2003/88/EC. The purpose of this Communication is to help interpret aspects of the Directive in line with the growing body of case law. It is for guidance only, and does not provide a full review of the legislation. Nevertheless, the publication of this package is significant at a European level to all country reports on the WTD. There is therefore an addendum to this UK report, to be found below in Appendix 3, reflecting on the initiatives and their lack of reference to the social care sector, suggesting areas where there could be room for interpretation in its favour.

National level:

- More funding could be made available by central government. This is unlikely to happen unless a new party is elected in the forthcoming general election (June 2017). This money would need to be ring-fenced in some way for use in commissioning of care services by Local Authorities.
- A clearer interface between WTR and the National Minimum Pay Regulations. This could include a declaration that inactive 'sleep-in/on-call' time be paid at a designated flat rate (e.g. a percentage of the NLW) and only active time paid at full NLW.

- The wording of the WTR could be revisited to aim for greater clarity. It would of course be important to ensure that the regulations are fit for purpose in the UK context and not oversimplified.

Appendix 1: Coverage of the organisations interviewed

Type of organisation	Disability services offered	Number of employers/members	Geographical coverage
Sector expert	N/A	N/A	UK
Sector expert	N/A	N/A	UK
Sector Expert who is also pwd and uses PAs	N/A	N/A	UK
Union	N/A	Not known how many SC members.	UK
Union	N/A	Uncertain how many SC members	UK
Employer (co-operative)	Children's day care (fully integrated) and family outreach	100+ workers	Regional (England)
Employer	Adult/young people. Home care, residential care, supported living, employment services	3,500 workers	England and Wales
Employer	Adult/young people. Supported living, community support, respite, residential	10,000 workers	England, Scotland, Wales
Employer	Adults, young people. Home care, sheltered housing, supported living, residential care	900+ workers	England and Wales
Employer	Adults and children. Support at home, including specialist person centred 24-hour live-in care	560 workers	England
Employer (Agency)	Adults and children. Support at home, including specialist person centred 24-hour live-in care for physical disability and neurological conditions. Respite Care.	1,700 workers	England, Wales, Scotland
Umbrella org	Members cover full range of services for pwld	200+ organisations	UK
Umbrella org	Members cover full range of services for pwld	144 members including councils (statutory sector), independent sector providers, and individuals	Wales

Appendix 2: Interview schedules

Interview schedule for employers:

1. What type of service does your organisation offer?
   a. Client group(s)
   b. Service delivery e.g. dom. care, residential care, supported living, employment services
   c. National (UK), National (one or more nations), Regional (England)
2. Which sector does your organisation belong to?
   a. Statutory (public)
   b. Private
   c. Voluntary (not for profit)
   d. Other (describe)

3. Is your funding mainly from local government (commissioned), self- funders or other sources?

4. Do any of your workers work unsociable/unusual hours eg shift work, night work, on call? Do you know roughly what percentage?

5. Are 'on-call' hours/ 'sleep-ins' (at workplace) included in these hours? If so, how are they paid? E.g. flat rate, percentage of hourly rate, active 'on-call' only paid, all hours paid at usual hourly rate.

6. In your view, should the working time regulations in relation to the treatment of 'on call'/'sleep-ins' be changed in any way? If so, how?

7. Do any of your staff work 'stand-by', i.e. away from the workplace but available if needed?

8. How are they paid for this standby time?

9. In your view should the working time regulations in relation to the treatment of stand-by time be changed in any way? If so, how? E.g. should there be a maximum stand-by time in a given period?

10. Do you use the 'opt-out clause' in relation to the working-time regulations?

11. What is your view on the opt-out clause? E.g.is it useful, does it provide sufficient flexibility, should it be amended in any way?

12. Do you know roughly what percentage of workers work over 40 hours per week?

13. Do you know of differences in the way the WTR apply to Health Care Services? If so, would the application of these to the Social Care Sector be beneficial?

14. The 48 hours per week referred to in the WTR are averaged over a period of time. When averaging hours, does your organisation use the period of 1, 4, 6 or 12 months?

15. In your view, do these periods offer sufficient flexibility? Should they be amended in any way?

16. What is the most usual working pattern per job position? E.g. typical working week for support worker, senior support worker, manager, senior manager, nurse, social worker.

17. What is the current impact of the WTR on your organisation (positive and/or challenges).

18. Does your organisation employ night workers? If so, roughly what % of all staff do night work?

19. How many night shifts does each worker do per week/per month?

20. Roughly what % of your workers are in a multi-shift job, and what % in single shift?

21. What positions work multi shift? What positions work single shift?

22. How much annual leave does your organisation offer to workers? Does it vary according to things such as age, position, or time worked for the organisation?

23. What is the most usual type of contract used by your organisation?
    a. Full or part-time permanent
    b. Fixed term
    c. Zero hour
    d. Other (please describe)

24. The WTR are now 20 years old. Should any changes be made to them to reflect changing working patterns e.g. flexitime, performance based work, telework, live-in support for people with disabilities?

25. Is it common for your workers to have several contracts at the same time? If so, roughly what % of workers?

26. Should the WTR apply to all contracts taken together or to each separately? What are the benefits/drawbacks of each approach?

27. How should 'autonomous workers' e.g. senior managers be covered by the WTR

28. Do you use agencies? If so, are you satisfied with the service they offer?

29. Do you support your workers to manage stress? If so, how?

30. What additional benefits do your workers get? Does this this vary with things like age, position, time with organisation?

31. How does rest and 'compensatory rest' work in your organisation? Should the WTR on rest and compensatory rest be amended in any way?

32. Any other comments?

Interview schedule for sector experts, umbrella organisations and unions:

1. Is your knowledge/experience of the social care sector UK wide? If not, what is the geographical scope?

2. Is there a typical working week for the staff employed in the SC sector? E.g. Is shift work common? Are unsociable/unusual hours a general feature?

3. Is it typical in the sector for workers to work a 40-hour week or more?

4. Are 'on-call' work (i.e. at place of work) and sleep-ins common features?

5. What is the most usual way for 'on-call' and 'sleep-ins' to be paid? E.g. all hours paid at full hourly rate, hours paid at % of hourly rate, only 'active' on call time paid, flat rate paid.

6. In your view, should the WTR treatment of 'on-call/sleep-ins' be amended in any way?

7. Is 'stand-by time' i.e. available for work if required but not present at workplace, used in the sector. If so, how is this paid?

8. In your view, should the WTR treatment of 'stand-by' hours be amended in any way? E.g. should there be a maximum number of stand-by hours allowed in a given period?

9. Is the individual Opt-out much used in the sector? If so, what is the general view about it? E.g. is it sufficiently flexible, should it be amended in any way?

10. Do you know of differences in the way the WTR apply to Health Care Services? If so, would the application of these to the Social Care Sector be beneficial to the sector?

11. The 48 hours per week referred to in the WTR are averaged over a period of time. When averaging hours, does the sector most often use the period of 1, 4, 6 or 12 months?

12. In your view, do these periods offer sufficient flexibility? Should they be amended in any way?

13. What is the current impact of the WTR on you're the social care sector? (positive and/or challenges).

14. What is the most usual type of contract used in the social care sector?
    a. Full or part-time permanent
    b. Fixed term
    c. Zero hour
    d. Other (describe)

15. The WTR are now 20 years old. Should any changes be made to them to reflect changing working patterns e.g. flexitime, performance based work, telework, live-in support for people with disabilities?

16. Is it common for workers in the social care sector to have several contracts at the same time?

17. Should the WTR apply to all contracts taken together or to each separately? What are the benefits/drawbacks of each approach?

18. How should ‘autonomous workers’ e.g. senior managers be covered by the WTR?

19. Are agencies used in the social care sector? If so, is the service offered generally satisfactory?

20. How do employers in the social care sector support workers to manage stress? Does this vary with things like age, position, time with organisation?

21. Has the social care sector identified any issues with ‘compensatory rest’? Should the WTR on compensatory rest be amended in any way?

22. Are the WTR clear? Could clarity be improved?

23. Could the WTR better support Social Care? How? E.g. offer more protection for workers, offer more flexibility for both workers and employers, be funded differently?

24. Any other comments?

Appendix 3: Addendum to UK report on the Working Time Directive:

2 May 2017

Since the completion of this UK section of the report, the European Commission has launched a social package proposing progress on the social dimension of the European Union (26/04/2017).[24] The package includes initiatives relating to the Working Time Directive[25], providing an 'Interpretative Communication' on Directive 2003/88/EC. The purpose of this Communication is to help interpret aspects of the Directive in line with the growing body of case law. It is for guidance only, and does not provide a full review of the legislation.

There is no specific mention of the Social Care sector, nor any consideration of how the WTD creates difficulties for both employers and those receiving services. This is surprising given the size of the social care sector in terms of employment and may be related to its low status and the absence of any meaningful social dialogue structures in social care at European level. The needs and views of people with disabilities are nowhere considered.

Although the Communication concedes that there can be exceptions to the Directive made for 'public service activities' (even when provided by private organisations), this is only where work patterns are 'exceptional'. 'Usual' work conditions presume patterns other than those common in social care, where they must fit with the needs of the client. In places, the guidance actually appears to reduce the possibility of flexibilities that could work for the sector e.g. it seeks to strengthen the rigour of the requirements around rest/break periods and confirms a narrow interpretation of 'on-call' time as working time. Social care work is not amongst those occupations listed as needing different treatment under the Directive (e.g. oil-rig and mobile workers). Overall, interpretations of the Directive seem to become ever more complex and consequently are unlikely to offer assistance to other than legal minds.

There are, however, three areas where there could be room for interpretation in favour of the social care sector, although it must be borne in mind that most such interpretations are required to be based on collective agreements beyond the simple worker/employer agreement. In the UK, and perhaps in other member states too, this is problematic due to the fragmented nature of the social care workforce and the lack of internal social dialogue structures. The following areas may be of interest:

1. There is the possibility of a reduction in WTD requirements justified by the need to 'encourage another objective, distinct from the implementation of the agreement'. This could perhaps include be the pursuance of human rights for PWD as enshrined in other EU law e.g. the UNCRPD. (See page 21 of the Communication)

2. The list of 'autonomous workers' given in the Directive only provides examples, and is not exhaustive. It would therefore be feasible to add more categories to it, especially, for example, 'live-in workers'. The test that autonomous workers must be able to manage their own time with reference to no-one else could apply equally to 'family workers' and social care workers, though potentially questionable in *both* cases. (See page 60 of the Communication)

[24] <http://europa.eu/rapid/press-release_IP-17-1006_en.htm>

[25] Working Time Directive: Interpretative Communication on Directive 2003/88/EC of the European Parliament and of the Council of 4 November 2003 concerning certain aspects of the organisation of working time – C(2017) 2601

3. Derogations can be made for 'certain activities'. This includes 'the need for continuity of service (or production)'. Social care is not in the list of examples, but this list is not exhaustive and social care could therefore be added. (See page 60 of the Communication).

Given that the 'Interpretative Communication' is narrowly aimed at clarification of the *current* Directive it is perhaps not surprising that it does not address those issues which impact on the social care sector. Reference to the 'growing body of case law' cements its focus on legalistic aspects of interpretation that do nothing to support a flexible and responsive social care sector. Only a full review of the WTD, which includes consultation with people who have disabilities, demonstrates both an understanding and regard for their services and provides for national differences, will resolve the issues currently faced by the sector.

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