



Erasmus+



# User Commissioners Report

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## Introduction and Overview

The aim of this report is to highlight the research findings of the Helpcare Project (UK) to date. These findings emerged from data collected from a variety of sources; interviews with carers, prospective users of services, service providers and a review of relevant and current literature. Issues relating to commissioning, regulation, qualifications, cost and the impact of immigrant workers are also included.

It is important to begin with an overview of some of the factors which are influencing the delivery of home care for the elderly; service provision and commissioning. There is no doubt that the need for health and social care services for older people is set to rise. The UK population's changing demographics predict an increase in the ageing population and its impact on social care will ultimately require a significantly higher number of employees in the adult social care sector in the future. By 2041, the number of people in England aged 85 is expected to increase by 2.5 times the 2010 figure to 3.2 million representing 5% of the total population (Skills for Care, 2015). There are near to seven million carers in the UK which equates to one in ten people. ([www.carersuk.org](http://www.carersuk.org), 2015).

Home care for older people is commissioned in a number of ways. Commissioners include; social services, health authorities, families and the older people themselves. Despite some of their differences, all of these 'commissioners' really have the same objectives or desired outcomes from a home care service; person centred, well led, value for money and user involvement for example. However, it is fair to say that budget cuts are putting commissioners under increasing strain to buy in affordable services. There are a number of reports which give guidelines and advice to those responsible for commissioning services. For example the Local Government Information Unit (LGIU) carried out a survey to determine the extent to which 'outcome based' commissioning is used. Furthermore, the Social Care Institute for Excellence (SCIE) also state that an emphasis on outcomes would be more beneficial than merely concentrating on hours used "approaches that are focused on what can be achieved rather than on the number of hours of care received or the type of care received" ([www.scie.org.uk](http://www.scie.org.uk), 2014)

Care is currently provided by informal and formal carers (unpaid and paid) Skills for Care (2015), estimates that the number of paid adult social care jobs could increase from the current 1.63 million, to between 2.1 million and 3.1 million by 2025 and over the next 30 years, the number of carers will probably increase by 3.4 million (around 60%). To cope with this predicted growth of adults requiring supported care, it will be necessary therefore to significantly increase the number of trained and qualified employees in the adult social care sector, or risk having inadequate care provision in the future.

Most people who need care rely on family members, friends and neighbours these are categorised as informal carers. [National surveys estimate](#) that there are approximately 6.4 million family carers in the UK, an increase of over 10% since 2001. This figure represents 12.6% of the adult population. It is predicted that this number of informal carers will soar to nine million by 2037 and that three in five adults in the UK will become a carer at some point in their lives. ([www.communitycare.co.uk](http://www.communitycare.co.uk), 2012). With the increasing number of people taking on informal care roles, clearly there will be a need to provide greater help, information and guidance to support this growing area.

## Qualifications and Training

In the future, informal carers may need to access some of the existing training offered to the formal workforce to provide effective care. Justine Cawley, director of the Elizabeth Care project supports this view in an article ([www.telegraph.co.uk](http://www.telegraph.co.uk), 2015); she states that “To deal with our ageing population – and one with increasingly complex conditions, we not only have to train the existing workforce.....that should include training unpaid carers”

In a report by Skills for Care (2011), the social care workforce (excluding managers and social workers) is relatively unskilled. In 2010 two-thirds (67 per cent) of people working as ‘care assistants and home carers’ claimed to be qualified to the basic NVQ Level 2 or above, and 7 percent had no qualifications at all.

The previously recommended Common Induction Standards (CIS) has now been replaced since the 1<sup>st</sup> of April 2015 by the Care Certificate. The Care Quality Commission (CQC) who are responsible for the inspection of care providers expects providers to induct, support and train their staff appropriately. Their expectation is that those who employ health care support workers and adult social care workers should be able to demonstrate that staff have, or are working towards, the skills set out in the Care Certificate, as the benchmark for staff induction (CQC, 2015).

However, this qualification is not mandatory which could still create inconsistency in the quality of service provision. Having said that Skills for Care maintain that employers still have to ensure the CQC at inspection they are compliant with the provision of training and induction and this could be met in part by the Care Certificate. A report on a pilot of the Care Certificate states that although there will be formal assessments required that the common view was that poor quality training will not necessarily be improved by its introduction. In its defence the report claims that the Care Certificate was not brought in to specifically address training and goes on to say:

***“So whilst some pilot leads would question whether enough priority is being given to eradicating poor quality training across the country, they also acknowledge that the Care Certificate is well placed to introduce greater consistency in how Support Workers are prepared for their roles.” (UNISON)***

So whilst it seems that there are training opportunities available these are not always taken. A UNISON study published in April 2015 states that the safety of elderly and disabled people who rely on homecare is being put at risk because staff are receiving inadequate training, for example;

***“Almost a quarter of staff (24 per cent) administering medication had received no training, despite some of them distributing drugs such as liquid morphine and insulin”***

These views were clearly echoed by some of the carers interviewed and were an obvious concern;

***“On that Saturday my last shift I got given medication it was a nebuliser I didn’t have a clue how to use it and I said so.... I had asked for help when I went down to see the senior carer and I said am I supposed to be trained in this and she said technically yes technically” (ULANC 6)***

***“So you know I can tell you I see it’s a big problem in Great Britain the care of the elderly. If you want to take care of any people you should have the good skills and knowledge. Not everybody***

***has proper training, not everybody has good skills of working with people who have special needs you know like elderly or disabled people” (ULANC 8)***

***“Additionally if the carers working like a qualified carer they should every year provide some training. But not online because you are getting some knowledge you know but it is only information, you can’t taught the skills in practice they should be practising things” (ULANC 8)***

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During an interview with a Social Care Support Officer it was noted that the shift from local council operated home care services to private agencies could be partly responsible for the lack of consistency in training, qualifications and experience. It was felt that previous systems had a far more rigorous training programme and that standards were more closely monitored. The officer interviewed had some responsibilities for ensuring both short term and long term packages of care for older people and said that a common complaint from older people was time allocated and having to retell their situation to a number of carers as there was little continuity of care. The officer was often responsible for discharging older people from hospital and found that frequently they were not medically fit. Although the officer recognised that there was a shortage of beds, it was felt to be false economy as many of these older people returned to hospital quite quickly.

## **Continuing Professional Development**

In addition to the lack of basic and essential training it seems that many carers felt that there were little or no opportunities for professional development;

***“The carers don’t see any way for professional development sometimes. I meet carers for 15 years who have good skills and knowledge who were never pushed up. Do you understand? Still a simple care assistant” (ULANC 8)***

ULANC 7 was noted to have said that she didn't see her career progressing but that was in part her choice although she said that unless she wanted to go into management there was little scope and many of the younger ones went into nursing.

The Cavendish Review (2013) also comments of a lack of progression opportunities within social care. Whilst it recognises that some carers are happy in their current role there should be scope for those who seek advancement. However, these opportunities should not take them away from their caring role:

***“In social care particularly, it will be important that talented carers do not have to move away from the frontline to get promotion” (The Cavendish Review, 2013)***

67% of the services users interviewed stated that they would prefer a professional carer and not a family member, the main reason given that they would not want to be a burden on their family.

## **Valuing the Carer**

Those interviewed also felt on the whole that carers were undervalued. The following information supports the view that carers are undervalued in terms of the uncertainty of their working hours; of

the people currently employed in social care, 307,000 workers in England are employed on zero hours contracts (Norman Lamb, Care Minister, 2014). Zero hours contracts occur when 'people agree to be available for work as and when required, but have no guaranteed hours or times of work' (ACAS, 2012). According to the [Office for National Statistics' Labour Force Survey](#) (2012), the social care sector is well above average compared to other sectors in using zero hours contracts for formal care.

Another example of how care work is undervalued is by the practice of not paying carers for their travel time. This often results in pay below the minimum wage when this time is taken into account. A subject which UNISON has commented on:

***"Unfortunately – despite some councils changing their ways, like the good people at Cumbria council who signed our ethical care charter last week – this mistreatment and underpayment of care workers is still widespread. And it shows just how little some local authorities value care staff doing such a vital job" (UNISON)***

The older people interviewed by the co-researchers also shared the view that carers were not always valued:

***"Not nearly enough..... Well they seem to have desperately poor pay and not enough time to do the job....they should be paid a decent wage to do a decent job" (ULANCa)***

LMCa and LMCc also commented that they felt that carers ***"were underpaid for the job they do"*** and ***"not valued enough"***.

## Preferred Models of Care

100% of the service users interviewed by the Helpcare researchers said that they would like to be cared for at home and all but one believed that it would be better if they were qualified to do the job. All stated the importance of having confidence that the carer knew what they are doing.

***"Home is a powerful symbol of autonomy and independence, whereas institutions are associated symbolically with the loss of autonomy"*** Ryan, A.A., McCann, S. and McKenna H. (2009)

***"I would like if it has to come down to it, if I have to have care I would like to stay in my own home and have carers come to me."*** (ULANC c)

***"At home if that's possible....well because it is familiar, I've got all my own things around me"*** (ULANC a)

***"At home....because I know where I am and it would be comfortable and nothing else really"*** (ULANC b)

## The Importance of Time

Time allocated for care visits was noted by some of the service users, both in terms of their own needs and the feeling that this also put pressure on the carer (another way that they were devalued) This was backed up by views from some of the carers interviewed;

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***“If everyone could just have an extra 15 minutes... You know you’d be sorted but they are so tight on how long you are allocated to each person you know they are only allowed so many hours in a week” (ULANC 7)***

***“So really you know to spend a bit of time with somebody that doesn’t see many people during the day must be nice just to have 5 mins chat” (ULANC c)***

***“well as long as it takes for them to do what they have to do and a little chat you know maybe another 10 minutes quarter of an hour” (ULANC c)***

A recent Unison report – entitled *Suffering Alone at Home* – which was based on an online survey of 1,100 homecare workers (and with data obtained from a Freedom of Information request (Fol) to the 152 local authorities in England that commission social care visits) discovered that the UNISON survey findings mirrored those of the Fol request to local councils, for example:

***“Three quarters (74 per cent) of homecare workers who responded felt they did not have enough time to provide dignified care for the elderly and disabled people they visited. Worryingly says UNISON, 61 per cent said visits of just a quarter of an hour meant they frequently had to rush the care of people who were over 90 years old”(UNISON, 2016)***

Discussions with local service providers reinforced this view and commented on this being more of an issue in rural areas:

***“Less time is allocated to spend with clients. For example 10 years ago an hour would be allowed so that a meal could be cooked for the person. Now the expectation is on a ready meal. 15 minute visits are allocated to give medication or check on a person – totally unreasonable and unrealistic in the rural area within which we operate”***

A number of carers and service providers who took part in the Helpcare research noted that there was a social aspect to the job and that they felt that they were unable to fulfil this need due to lack of time.

***“Homecare workers also said that more than a third (37 per cent) of the people they saw have hardly ever had visits from friends or relatives, which is why they felt it was important to be able to spend time in each person’s home” (UNISON, 2016)***

***“Most people being cared for at home want a warm relationship with their paid carers and place a lot of value on conversation. A friendly and sociable carer is regarded by service users to be a marker for whether they are a good paid carer or a poor one. Paid carers themselves complain that they often don’t have time to talk to their clients, and that this part of their role is not recognised as important. Many users feel that their paid carers are constrained by time during***

***their visits – they can either talk or do, but not both.” (Commissioning home care for older people, SCIE)***

## Issues of Cost and Pay

At least 70% of all homecare is purchased by the state, mostly by local councils, and by health and social care trusts in Northern Ireland. (UKHCA, 2015)

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The United Kingdom Homecare Association (UKHCA) 2015 have produced a report which claims to reveal the underlying cause of the unacceptably low pay and conditions experienced by home care workers and claims that central Government’s reluctance to address this and hold local commissioners to account makes them responsible. The following figures illustrate the average price paid for an hour of homecare in September 2014;

- United Kingdom: £13.66 / hour
- England: £13.77 / hour
- Wales: £14.28 / hour
- Scotland: £13.68 / hour
- Northern Ireland: £11.35 / hour

The report claims that most councils did not pay service providers enough money to ensure that they receive the UK Living Wage (£9.40 in London, for the rest of the UK see NMW) and that this was even less likely in London. This, the report claims makes it incredibly difficult for the independent and voluntary sector to attract and retain care workers of the standard required. The report states that it is vital that local authorities pay a rate which will allow the payment of the National Minimum Wage (£7.20, £6.70 for those aged 21-24) whilst allowing enough profit for the provider to remain viable.

However, paying a minimum wage to the carer is not necessarily enough as it has been seen when the cost of travel time and mileage is not taken into consideration. Furthermore, local councils or authorities who plan on the payment of the minimum wage need to factor in additional costs. For example:

Monthly Pay	Employers NI	LGPension Scheme	Total cost to employer
£1080	£55.75	£198.72	£1344

(This is based on a 37.5 hour week at £7.20 an hour)

So even on minimum wage, the hourly rate to the employer is £8.96. If you factor in a competitive hourly rate, then it can be seen how quickly this becomes unaffordable to the service provider.

Key messages outlined in the Budget Survey 2015 (ADASS, the association of directors of adult social services in England) point to a need for government to protect essential care and support services to the most vulnerable members of our community. They claim that there have been 5 years of reductions amounting to £4.6 billion and that this is set to continue:



***“This year, adult social care budgets will reduce by a further £0.5 billion in cash terms. Taking the growth in numbers of older and disabled people into account, this means that an additional £1.1 billion would be needed to provide the same level of service as last year” (ADASS, 2015)***

In a report written by the Local Government Association and ADASS (2014) they have looked closely at government spending and some of the reasons for increasing costs for social care budgets. They discuss their concerns for any possibility of savings being made and comment on the cost of reforms set out by the Care Act 2014. They also comment that:

***“The local government funding gap is growing at £2.1 billion a year. This is the equivalent of more than 125 million hours of home care provision. By the end of 2015/16 the local government funding gap will stand at £5.8 billion. This is the equivalent of 8 times the net expenditure on street cleaning in England” (ADASS, 2014)***

## **Specifically Rural**

This rural issue is seen here from the perspective of an Age UK North Craven I & A worker (Information and Advice) and highlights one of the problems as being the limited number of care providers in rural areas means that for many clients it is a ‘take it or leave it’ option.

***“...that because of location some people simply cannot receive home care or that home care providers choose not to provide the care because time constraints and access to properties mean it is not cost effective to them to provide a service.... No access to care in some areas; we have had contact with some clients where they cannot access home care services because of their rurality. Typically clients living on farms with poor access/unmade roads and tracks” (GB Age UK)***

Furthermore, the Age UK worker comments on other issues which affect the levels of care received by the elderly in rural areas;

***“...we repeatedly pick up complex care cases from clients who have referred themselves to us when they have exhausted all other lines of support including HAS (Health and Adult Services). In the last 12 months I personally have worked on 32 intensive support cases where clients have needed help with bereavement, debt, isolation, loneliness and housing issues. These have all been cases where HAS teams have not had the resources to assist clients. We find that HAS usually only respond and try to address similar issues when we make safeguarding referrals to them”(GB Age UK)***

Some of the research into the experiences of older people is conflicting; with articles saying that older people in rural areas are more isolated due to transport problems yet more supported by friends and family. Further surveys have concluded that older people in rural areas are more likely to say that they are happy than those living in the city. However, according to ACRE (Action with Communities in Rural England) and supported by figures from Defra, older people in rural communities may struggle more financially:

***“Older people are also the single largest group on low incomes in rural areas and they are further disadvantaged by the extra costs of accessing essential services and impacts of heating older, less fuel efficient homes. This means that the rising level of elderly people who find themselves***

***financially excluded and the availability of local services are inextricably linked”***  
(<http://www.acre.org.uk/rural-issues/older-people>)

## Specifically Urban

Research shows that older people in urban areas are more likely to live alone (McCann et al, 2014) unlike their rural counterparts who are more likely to live with their adult children and it is claimed that even after accounting for living arrangements, admission rates to care homes were higher in urban areas. This may suggest that informal care and support may be lacking in these areas which will in turn mean an increased need for formal care.

It could also be argued that older people living in cities are likely to face higher levels of isolation or the prospect of moving as city centres are not designed with their needs in mind. A design expert at Leeds University is quoted in an article in the Daily Telegraph (2014):

***“City centres are now spaces for employment or for the leisure of people who are employed....***

***This is more or less the pattern across the UK, it is the idea of economic flow where older people are excluded in the sense that it is expected that we work and then retire and fade out and are no longer part of the landscape”***

(<http://www.telegraph.co.uk/finance/property/retirement/10986304/Elderly-shut-out-of-British-cities.html>)

It is believed that simple failures such as not recognising the need for street benches and the location of bus stops for example can deter older people from getting out and about.

It is now widely recognised that social interaction is vital for health and well-being for all people. However, cities are making this difficult for older people and a whole range of factors are responsible for this according to an article in the Guardian (2015)

***“.. its cluttered streets, uneven pavements, poor lighting and signage. Details – like the bus driver who moves off before you have time to sit down, or doesn’t park close enough to the kerb – have a huge impact on their sense of confidence and safety”***

Furthermore the article suggests that the narrative about ageing should look at how the environment can be disabling for older people and not just focus on the biomedical approach:

***“Ageing becomes a “problem”, and a personal matter rather than a relational one, that takes place in the symbiosis of body and culture. What would it be like to reconfigure this, so we’re not seen as impaired by age – to understand that human needs change over a lifetime and the well-designed city should be sensitive to them?”*** ([www.theguardian.com](http://www.theguardian.com) March 2015)

## The Impact of Migrant Workers

It is believed that there are increasing numbers of migrant workers being employed as carers in the UK and in a recent study by the Independent Age and the International Longevity Centre (2015) it was reported that 1 in 5 of the adult social care workforce (18.4%) in England was born outside of the United Kingdom, which includes 150,000 working in residential care homes and 81,000 working

in adult domiciliary care and non-EU migrants account for the greatest proportion of migrants working in adult social care – approximately 1 in every 7 care workers (191,000 people). The study also notes that the care sector could face a shortfall of 1 million workers in the next twenty years which is in part due to restrictions on immigration and a failure to attract British workers. It suggests that there needs to be a review of salary thresholds and visa routes which have both impacted on migrant workers ability to gain and retain employment in this sector in the UK. Furthermore it needs to make greater investment in social care in terms of training, qualifications, development opportunities and pay, so that it is more attractive to UK workers.

Cangiano(et al) 2009 also comment on the numbers of foreign born workers in this sector but make no distinction between EU and non EU migrants. They state the increase as having doubled from the 1990's to the date of their research

***“The weight of migrants in the care workforce has more than doubled over the past decade: in 1998 only 8 per cent of care workers were foreign born”*** (Cangiano et al, 2009, p72)

It has been argued that this is creating a number of different issues for example; language, communication, cultural knowledge and sensitivity in the delivery of care. Some service providers have claimed that migrant workers have a stronger work ethic, but this could be due to them being tied to their employer as part of their temporary visa conditions. Although this research revealed that most older people were more concerned about the quality of their home care rather than the nationality of their carer, it was felt that there were greater concerns to be addressed:

***“The more informal the setting, the lower the worker’s earnings, the greater likelihood of migrant employment, and the greater concern there is for abusive working conditions and threats to the quality of care”*** (Spencer, S. et al (2010))

Despite the fact that most older people placed more importance on the quality of their rather than the nationality of their carer, it has been argued that communication in their own language is paramount. It is also possible that the carers themselves may be vulnerable to racism.

Dr Shereen Hussein (2014), scientific adviser to the Department of Health, told BBC Radio 5 live that poor language skills could lead to bad care and abuse.

***“Migrants from outside the European Union have a long history of working in the UK’s care sector, and have always had to prove their efficiency in the English language before securing jobs in the industry, but this is not the case with new arrivals from EU countries....It would be really beneficial to have a standard interview process to establish English language proficiency, communication skills and softer skills of all care workers aiming to work in the sector”*** (Radio 5 live)

The research carried out by ULANC was predominantly in the North of England and more specifically in the North West. It was noted that there was a lower percentage of migrant workers than in other areas of the country, although two of the carer’s interviewed were in fact migrant workers and there were comments made about the possible differences from their own countries particularly in terms of how they felt the UK cared for its older people. ULANC 8 discussed her views on the reality of person centred care:

***“So you know I can tell you I see it’s a big problem in Great Britain the care of the elderly. If you want to take care of any people you should have the good skills and knowledge. Not everybody has proper training, not everybody has good skills of working with people who have special needs”; “They need to be exactly in the centre not just on paper, writing that people are at the centre of the care because it is absolutely not true in practice”(ULANC 8)***

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It is quite different in the South of England, London for example; there is a very high concentration of migrant workers, with nearly 3 in 5 of its care workforce born abroad, and approximately 9 in 10 of its migrant care workers coming from outside of Europe. In addition the South East also has a relatively high proportion of migrant workers – with 1 in 4 care workers born abroad. (Franklin and Bucati, 2009)

## Conclusion

It is clear from the research so far that providing an effective and caring service for older people in the community is fraught with issues. The issue of cost is complex; it is not just about ensuring that service providers are allocated enough time per person but that time is spent effectively to achieve positive outcomes. Furthermore, pay levels appear to still be influenced by the increasing numbers of migrant workers in the UK. It remains an argument that migrant workers are paid less and are prepared to accept this, thus keeping wage levels down (although real evidence for this seems quite difficult to find). Arguably this can then impact on the quality of care; firstly, the more qualified and experienced workers will not work for low pay and move on to other jobs and secondly communication difficulties arise affecting how the older people are cared for.

It is also clear that services need to work together. Increasing numbers of older people with complex care needs will need help from a number of services to address health and long term conditions including social needs. This appears to be an area which needs improving with the research showing that budget restrictions can mean that older people are passed to other services as quickly as possible or not at all. The research also shows that the number of older people likely to want to receive help in their own home is not going to reduce, therefore local authorities and other commissioners will need to decide where their money is best spent. It appears that older people rarely opt for residential care as their first choice whether that is for respite or on a more permanent basis. It is felt by some that this is the beginning of the end and not something they want to face. User involvement needs to be meaningful for it to have any impact on service provision and older people deserve to be given the choice of how they would like to be cared for (recognising that there will always be some limitations) At present choice is limited by availability for older people living in rural areas and in other areas it is limited in some cases by the working practices adopted by the services themselves.

Qualifications are not standardised throughout services and the experience held by employees varies greatly. Although the introduction of the Care Certificate is a step in the right direction a more robust and measurable system of training and qualifications is needed. Placing more value on the carer’s ability and professional development can only be a good thing. People who are valued generally take more pride in their work and it is likely that staff turnover would decrease thus improving the continuity of care received by the older people.

Finally and possibly most importantly is the issue of time. Again this is not a straightforward issue, on the face of it; it seems that it could be solved by merely assuring that enough time was allocated to complete the required tasks. But it could be argued that this is not going to be enough. Many of the people interviewed for the purpose of this research; carers, service users and service providers maintain that there is a need for more than making a meal and personal care. Older people have social and emotional needs which are not being met. There is a need for companionship and friendship which many older people are missing out on. Today, families rarely all live in the same locality and physical mobility problems can prevent contact with friends. Home care does allow older people to retain a sense of self and identity and to a degree some independence but it will not keep them company.

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## **Other suggested sources of information**

[www.ageuk.org.uk/](http://www.ageuk.org.uk/)

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[www.communitycare.co.uk](http://www.communitycare.co.uk)

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