

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

**Case of the UK**

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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.

# Introduction

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]](#footnote-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]](#footnote-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’:

* 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]](#footnote-3) so this particular tool to establish flexibility has not been much used much.
* 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]](#footnote-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]](#footnote-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. In addition, Health and Safety legislation in the UK was already well established in 1998.[[6]](#footnote-6)

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.[[7]](#footnote-7) 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.[[8]](#footnote-8)

## **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, 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.[[9]](#footnote-9) 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, proving £132 billion of care per annum[[10]](#footnote-10). In contrast, there are 1.87 million social work/care and support employees working for 63,000 employers.[[11]](#footnote-11) 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.[[12]](#footnote-12) 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[[13]](#footnote-13)) by 2020, starting 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.[[14]](#footnote-14) 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.[[15]](#footnote-15)

## **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/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.

## **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.

## **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.[[16]](#footnote-16) 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.

# **WTR: 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.[[17]](#footnote-17) This ambivalence is reflected in the National Minimum Wage Regulations 2015, which state:

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 law case 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.[[18]](#footnote-18) 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[[19]](#footnote-19), 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.

## **Travel time and the WTR:**

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.[[20]](#footnote-20)

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’.[[21]](#footnote-21) 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.

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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). [↑](#footnote-ref-1)
2. E.g. Neil Kinnock, Vice President of the European Commission and leader of the opposition in the UK 1983- 1992. [↑](#footnote-ref-2)
3. Blackburn J.et al. 2016. Pessis 3: Promoting employers’ social services organisations in social dialogue: Country Study. United Kingdom. [↑](#footnote-ref-3)
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6. E.g. Health and Safety at Work Act 1974. Workplace (Health and Safety and Welfare) Regulations 1992. [↑](#footnote-ref-6)
7. Care: Sector Skills Assessment. Briefing Paper UK Commission for Employment and Skills (UKCES) 2013. [↑](#footnote-ref-7)
8. ‘Care: Sector Skills Assessment briefing paper’ ibid. [↑](#footnote-ref-8)
9. Supporting Personal Assistants working in adult social care DH 2011. [↑](#footnote-ref-9)
10. Carers UK 2014. [↑](#footnote-ref-10)
11. Skills for Care and Development 2015. [↑](#footnote-ref-11)
12. Care: Sector Skills Assessment. 2013. Op cit. [↑](#footnote-ref-12)
13. Conversions correct at Feb 2017. [↑](#footnote-ref-13)
14. 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. [↑](#footnote-ref-14)
15. 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. [↑](#footnote-ref-15)
16. ‘Care: Sector Skills Assessment briefing paper’ Op cit [↑](#footnote-ref-16)
17. Select Committee on the European Union. 9th Report. 2009. [↑](#footnote-ref-17)
18. The Scale of Minimum Wage Underpayment in Social Care Laura Gardiner 2015 (Resolution Foundation Briefing) [↑](#footnote-ref-18)
19. Turnover can be well over 20% in some areas. [↑](#footnote-ref-19)
20. Minimum Pay Regulations. 2015. [↑](#footnote-ref-20)
21. Appeal number UKEAT/0128/13/BA [↑](#footnote-ref-21)