Homecare Association

Supplementary submission: ending one-sided flexibility

Submitted by email on 24.08.2026

The Homecare Association supports secure, predictable, and fairly paid work for careworkers. We have campaigned for it for years. Our concern with these reforms is not their purpose but their design, their funding, and their fit with how homecare actually works. Changes to work organisation require system redesign. As in our main response, we respond on a UK-wide basis: the proposed reforms extend to England, Wales and Scotland only, because employment law is devolved in Northern Ireland, and we cite Northern Ireland and Health and Social Care Trust figures for context, not to suggest the legislation applies there.

In this supplement, we address four further points that require consideration outside of what we cover in the consultation response:

- Government **has not funded the reforms**. Its impact assessment does not recognise the cost they place on a sector that the public sector already underpays to the point that it cannot comply with existing employment legislation
- **The measures assume a shift-based workplace**, which homecare is not, and providers urgently need to know how the rules apply to a service delivered in runs of visits
- **The commissioning system that drives insecure hours must change**, or the reforms will fail.
- Guaranteed hours, on their own, do not solve the problems careworkers most need solved which are **payment for all their working time** and work regularity

1. The Government hasn't funded the reforms — and the impact assessment does not recognise the cost to homecare

Homecare is not a normal market. The public sector purchases around 80% of homecare in the UK, and it purchases much of it below the cost of delivering it safely and lawfully. Only 0.5% of councils and Health and Social Care Trusts pay our Minimum Price for Homecare. Almost 29% of councils now pay average rates below the direct cost of employing a careworker at the minimum wage — nearly four times the 2023 figure. Across the UK, homecare carries a funding gap of £3.25 billion to pay wages equivalent to NHS Band 3 Healthcare Assistants with 2+ years' experience[1].

Into this market, these reforms introduce new duties which will introduce costs. These will include:

- **Increased slack hours** when an employer has to pay a worker without having income-generating work for them to do. *We include the following for illustrative purposes, it is based on a series of assumptions which are uncertain – what is key is that the magnitude of the*

[1] The Homecare Deficit 2025

figure is substantial and merits further investigation. If there are 595,000 homecare workers and 35%[2] are on zero-hour contracts, then that's 208,250 workers[3]. If half of these moved onto guaranteed hours and incurred 2-10 unused hours per month each then, at our minimum price per hour the cost to the sector would be in the **£86m-£430m**[4] range with 80% of this falling on public sector provision. Of course, this doesn't include anyone already on guaranteed-hours contracts, so the figure is quite likely to be higher. Even if demand for work is quite high, this will not always match worker availability, so perfect efficiency is unusual where employers guarantee hours, even in well-run businesses.

- **Increased cancellation charges –** Again as an illustrative figure to show the kind of scale we are talking about: Birdie – one of the key UK homecare systems provider – undertook an analysis of visits and found that in the last 12 months 1.8% were cancelled for reasons other than planned unavailability (i.e. not including planned holiday or hospital-stay type absences). We only know who initiated the cancellation in a small share of cases, and never whether a commissioner was involved.. We think there are over 300 million visits per year undertaken in England– so that would be over 5.4 million cancellations. If around a third of the cancellations were cancellation of work by people on zero-hours contracts (who make up 35% of the workforce – obviously this could be higher if low guaranteed hours are included also) and the average visit length was half an hour, the cost figure would be about £32 million per annum for zero-hour cancellations if 100% fees paid (at our minimum price) or £16 million if 50% of fees paid. Our workforce survey suggests that at the moment only 43% of local authorities and 29% of NHS bodies pay providers for cancellations. There are a lot of assumptions here – but this will mean local authorities would need millions of pounds of additional funding per year just for cancellations, let alone curtailment and movement, and we urge the Government to investigate this seriously (working with local authorities and the sector) and to adequately fund this cost.
- An increased need for the public sector to pay for:
    - when a hospital admits someone who usually receives care at home and a package is being held
    - when someone dies (to enable the employer to keep the careworker on guaranteed hours while new work is found)
    - when hospitals reschedule discharge times, and a careworker is waiting at home for them
    - movement fees

[2] Note that elsewhere we have said 42% of domiciliary careworkers are on zero hours contracts. Both this and the 35% figure are true – the 35% figure includes all homecare staff including people whose job title is not careworker. The other main staff group in homecare on zero hours are nurses – 64% of homecare nurses are on zero hours. Nurses would equally be likely to have variable hours and have unused down-time if on guaranteed hour contracts. See Skills for Care's data visualisation.

[3] Summary of domiciliary care services 2025

[4] This is calculated by taking half of the 208,250 zero hours workers, multiplying by 2 hours for the lower figure and 10 for the higher; multiplying by 12 to reach the annual figure (as the 2 or 10 hours is per month) and then multiplying that by our minimum price for homecare in England for 2026/27 which stands at £34.42.

- **Direct Payments** need to be increased to cover additional charges.
- Individuals paying for their own care may run out of funding and seek public support sooner.

The Government's impact assessment and options analyses do not appear to recognise this. We believe that the cost estimates in the options analyses are gross underestimates because they only cover business administration costs and assume that improved workforce planning will improve rota efficiency within the new operating parameters. Evidence from existing providers who have transitioned to guaranteed-hour models suggests that there is often still some unused or slack time implicit in these models, even with good workforce planning, and this comes at a cost. The impact assessments also treat the new obligations as costs that employers will absorb, without accounting for a sector in which the dominant purchaser fixes the price below cost and guarantees the provider no volume of work.

The preferred measure of underlying profitability for asset-light businesses like homecare and supported living is EBITDA (Earnings Before Interest, Tax, Depreciation and Amortisation of goodwill). LaingBuisson maintains information spanning over two decades from the statutory accounts of independent health and social care providers which are sufficiently large to post profit and loss at Companies House.

Homecare average EBITDA margins have fallen from a peak of 10.8% in 2012 to a low of 5.2% in 2019, with some recovery to 7.6% in 2024, followed by a fall to 6.3% in 2025. These figures reflect a small number of large businesses. SME businesses deliver a significant proportion of homecare,and they do not benefit from volumes of commissioned hours or economies of scale, and therefore this figure does not represent the wider market. We believe, following unfunded Employers National Insurance Contributions increases in April 2025, that EBITDA has fallen by over 5% for half of respondents to a Care Provider Alliance survey in October 2025. Some providers currently operate on tight margins of 0–4%. This is because between 70–90% of their cost relates to employment, and low fee rates from state purchasers can leave providers operating on very thin or negative margins.

We therefore ask Government to do what its own impact assessment has not: cost these reforms against the reality of a publicly funded sector, and fund them. Specifically, provide **ring-fenced national funding to cover the guaranteed-hours, notice and cancellation obligations these regulations create**, and require public bodies to reflect those costs in the fees they pay.

2. Homecare: runs of visits, not shifts

The Government has designed these reforms for a shift-based workplace, and homecare is not one. A careworker does not clock on to a shift. They work a run of visits — typically eight to twelve calls in a day — each timed around an individual's needs, medication and preferences, with travel and waiting time between them. A provider assembles that run from the packages of care it holds in a locality at that moment, and the run changes whenever a person's needs change. Almost every operative concept in the consultation — the shift, its cancellation, its movement, its curtailment, the hours guaranteed — has to be translated before it means anything in a visit-based service. Providers cannot configure their rostering and payroll systems, model the cost, or tell careworkers what the new legislation means until the Government provides that translation. We ask for it as a priority.

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(a) Availability guarantees

The consultation measures a worker's historic hours and asks whether to convert them into a future guarantee. In homecare, historic hours are an incomplete measure because they are the product of the worker's availability, not employer demand alone. A careworker averages, say, twenty hours a week only because they have offered a wider pattern of availability — across mornings and evenings, alternate weekends and specific geographical areas — within which a scheduler can build a safe, continuous, person-centred rota. The availability pattern, not the raw hour count, is what makes those hours schedulable.

This matters because the relationship between availability and schedulable hours is not linear. A small change in a worker's pattern can remove a disproportionate number of workable hours: a later start time that loses an existing run, a narrower travel radius, a move to a different town, or a switch of shift type can each cut schedulable work far more than the headline change in availability suggests. A guarantee built on historic hours alone, without recognising the availability pattern that produced them, could oblige a provider to supply work it cannot safely or sensibly allocate once the worker changes that pattern.

We therefore need Government to confirm two things. First, that a guaranteed-hours offer reflects **both the hours regularly worked and the availability pattern within which the employer achieved the offer** — days, time bands, geographical coverage, shift type, and rota cycle. Second, that where a worker materially changes that pattern after accepting a guarantee, there is a **fair, prospective, mutually agreed review** of the arrangement. To be clear, this is not unpaid standby, and it is not a route for employers to claw back hours a worker is still available to work; it is a way to keep the guarantee tied to work that the employer can actually offer.

(b) What counts as movement and curtailment

The greatest ambiguity, and the greatest financial risk, lies in how the payment for cancelled, moved and curtailed shifts applies to a run of visits. Because a run is a chain of linked calls, one change ripples through it. When a person's needs rise and require a second careworker, a provider may move one worker from another person to cover it, move a third worker with the right skill to fill that gap, and bring in a bank worker at the end of the chain. One clinical event can move four or five workers — and yet, if the chain resolves, not one of them loses an hour of work. The provider has reordered the visits, not removed them.

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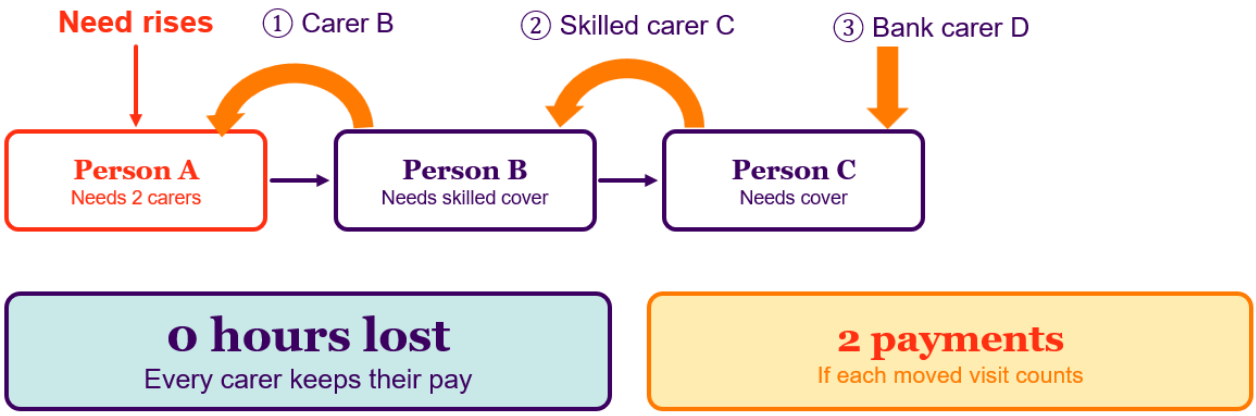
Figure 1 – Rearranging rotas to meet someone's needs



If the payment attaches to each moved visit, that single reshuffle could generate four or five payments if each visit reallocation is seen as a cancellation and then an offer of new work — and it does so most often precisely when the provider has protected every worker's hours. The regime would tax good practice: a provider would face a penalty for matching the right skilled worker to the right person. The fix is a matter of scope, and it is the most urgent clarification we seek. The legislation should assess the need for a payment based on whether **a worker's net financial position across the working day has shifted substantially, not on each individual visit-movement within their run**. Where a worker's hours for the day are unchanged or greater, no payment should arise however many times the employer shuffled their calls.

Electronic call monitoring makes this urgent in a second way. Where a council pays only for the minutes a careworker is in someone's home, an unexpectedly shortened visit can mean reduced payment to the provider, sometimes through no fault of the provider or the worker (for example, if the person was slow to answer the door) — and that same shortened visit may then count as curtailment the provider must pay for. We ask Government to confirm how these provisions apply to a single visit within a run, to substitution of one visit for another, and to by-the-minute purchasing, so that the cost falls on the party that controls it rather than on the provider caught in the middle. We would strongly recommend limiting electronic call monitoring to use for quality assurance and not using it for cost reduction. A district nurse would not have their pay cut if they left a house 6 minutes earlier than scheduled.

Minor movement and curtailment exemptions are also absolutely vital to take account of variability in travel time and visit length so that the legislation does not penalise care providers with charges whenever there is heavy traffic or a person asks a careworker for help with a task just before they leave the house.

3. Commissioning must change

The reason zero-hours working is so common in homecare is not employer preference. It is how public authorities buy care. Councils and the NHS purchase by the minute or the hour, through dynamic

purchasing systems and frameworks that guarantee providers no volume of work. By contrast, public bodies pay care homes per resident rather than by the minute, which gives care-home providers greater security of income and the ability to offer careworkers shifts; a move towards per-capita or block funding in homecare would enable the same improvement in employment conditions. Sixty-one per cent of councils buy no more than 500 hours per provider each week, a third or fewer of the roughly 1,500 hours that make it easier to schedule runs of calls and to find replacement work when a person being supported moves on, and only 1% use block contracts that guarantee provider income. A provider cannot guarantee its careworkers hours that no one guarantees to it. Fragmented, spot-purchased commissioning is the direct cause of the insecurity these reforms seek to cure. While this could continue, it should mean higher fee rates – providers need more money to pay careworkers for more downtime if there is no guaranteed work. As we have seen in section 1, this could amount to hundreds of millions of pounds.

Demand fluctuates because commissioners move, reduce and end packages, often at very short notice — we are aware of NHS commissioners giving five hours' notice or less that they are moving a person's care to a cheaper provider, frequently without consulting the person and contrary to the Care Act 2014. A reform that charges the provider for that volatility, while leaving the commissioner who causes it untouched, addresses the symptom while protecting the cause, and the careworker often ends up paying.

Government cannot legislate zero-hours working out of homecare without also legislating zero-hours commissioning out of it. Work organisation changes require system changes. We ask for four changes:

- a move from by-the-minute purchasing to **locality and lead-provider models and block contracts** that guarantee providers a volume of work;
- a **National Contract for Care** setting a statutory minimum price so public bodies cannot buy below the cost of lawful employment;
- a duty on commissioners to **confirm annual fee rates by the end of February and**
- **to pay for the cancellations and movements they cause**.

We need these commissioning changes ahead of or alongside the legal changes on zero-hours contracts.

Investment here is not a cost without return: the Health and Social Care Committee's 2025 inquiry into the cost of inaction found that every £1 invested in the sector generates an estimated £1.75 return to the wider economy.

4. Guaranteed hours does not solve the right problem

Our final point is the most important, and we make it in the interests of careworkers as much as providers. Government has reached for guaranteed hours as the principal remedy for insecurity. It is not the remedy careworkers most need. Two other changes would do far more for their pay and their security, and we urge Government to treat them as the priority.

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Pay for all hours worked

The largest issue with homecare pay is not the number of hours in a contract. It is that many careworkers are not paid for all the hours they actually work. The dominant 'contact-time-only' purchasing model pays a higher headline rate for the minutes a worker spends inside someone's home. This rate should be high enough to cover travel and waiting time between visits at National Minimum Wage, but it does not always do this. The Homecare Voices survey found that 72% of homecare workers' employers paid them contact time only[5].

A careworker gains far more from being paid for every hour they work than from a higher number of hours on a contract they may not be able to fill. A guaranteed-hours offer does nothing to fix unpaid travel time; **enforcing and funding payment for all working time would**. If Government wants these reforms to raise careworkers' real earnings, it should make payment for travel and waiting time a priority — and fund commissioning at a level that lets providers pay it — rather than relying on a guaranteed-hours mechanism that leaves the deeper problem untouched. The situation is symptomatic of the fact that 29% of councils and HSC Trusts are paying fee rates that are lower than the amount employers need to cover direct employment costs at the National Living Wage[6] and enforcement is lax.

Genuine shift-based working

Careworkers value predictable, guaranteed, schedulable work. A guaranteed-hours figure written into a contract does not, by itself, create it. What creates it is shift-based working — and shift-based working in homecare depends on block-based commissioning or service agreements based on capitated spend. A provider that holds a guaranteed volume of work in a locality can build genuine shifts, guarantee hours it can actually fill, and offer the continuity that both workers and the people they support want. A provider holding a thin, spot-purchased volume cannot, even if the employee's contract is technically a guaranteed hours contract. Guaranteed hours could still deliver a rota with significant gaps in it – this is not security in practice.

What we ask

We support the aims of these reforms, and we want them to succeed. To make them work for careworkers, for the people who draw on care, and for the responsible providers who employ most of the workforce, we ask Government to:

- **Cost and fund the reforms honestly** — revise the impact assessment to reflect a publicly funded sector, and provide ring-fenced national funding to cover the new guaranteed-hours, notice and cancellation obligations within public-sector contracts.
- **Translate the rules for a visit-based service** — confirm, before 2027, that guaranteed-hours offers reflect the working pattern that made the hours schedulable, with a fair prospective review where that pattern changes; and that short-notice payments are assessed on a worker's net position over the day, not on each moved visit within a run.

[5] Behind closed doors | a report by Homecare Voices
[6] The Homecare Deficit 2025

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- **Reform commissioning** — move to locality, lead-provider and block contracts; introduce a National Contract for Care; require commissioners to confirm fee rates by the end of February and to pay for the cancellations and movements they cause; and commence commissioner duties alongside the worker rights.
- **Fix the right problem first** — reconsider as to whether the Government can prioritise payment for all working time, including travel and waiting time, and the move to shift-based working through adequate funding and block commissioning, as the changes that would most improve careworkers' pay and security.

We would welcome the opportunity to work with officials on the detail.