Homecare Association

Homecare Association's response to the consultation on ending one-sided flexibility

We developed our response to this consultation with the input of members involved in our Employment Rights Special Interest Group, the contribution of case studies and data, member surveys and member webinars, and would like to thank all those involved. We respond on a UK-wide basis, drawing on data from across the United Kingdom. The proposed reforms extend to England, Wales and Scotland only, because employment law is devolved in Northern Ireland; we cite Northern Ireland and Health and Social Care Trust figures for context, not to suggest the legislation applies there.

Executive summary

The Homecare Association wants to see a valued care workforce with fair pay and working conditions. The main issues facing the homecare workforce are income insecurity and inadequate total earnings for hours worked. A hyper-fragmented market, zero-hours commissioning, and the purchase of homecare at below-cost fee rates for contact time only (often by the minute) prevent shift-based working and underlie these issues. Guaranteed hours legislation on its own will not address these problems.

Zero-hours working is common in homecare. This is because local authorities and the NHS buy 80% of homecare services, mostly on a zero-hour or even minute-by-minute basis. Many contract with large numbers of providers on framework agreements that guarantee no volume of work at all. If a council pays a provider in arrears for minutes of contact time only, at rates below the cost of safe, sustainable delivery, and does not guarantee work, the provider has little choice but to pay careworkers for contact time only at low wage rates. Providers cannot guarantee hours that nobody guarantees to them - there is insufficient income to do otherwise. So, working conditions follow commissioning and contracting practices. Skills for Care estimates that 42% of careworkers in domiciliary care services work on zero-hours contracts[1], against 21% across adult social care as a whole and 3% of the economically active population. It is notable that councils pay care homes per resident, not per minute of contact time, which means care home providers have greater security of

[1] Skills for Care (2025). The state of the adult social care sector and workforce in England

income and can therefore offer careworkers payment for shifts. A move to payment per capita in homecare would enable an improvement in employment conditions for careworkers and in outcomes for people drawing on services.

The evidence is stark. Our 2025/26 research showed that only 0.5% of councils and Health and Social Care (HSC) Trusts in the UK pay our Minimum Price for Homecare[2]. The weighted average council fee sat at £24.39 per hour and the NHS rate at £23.96, both far below the Minimum Price for England of £32.14 for 2025-26 (the Minimum Price for 2026/27 is £34.42 per hour, accounting for the increase in the National Living Wage (NLW) to £12.71 per hour)[3]. Almost 29% of councils and HSC Trusts paid average rates below the direct cost of employing a careworker at the minimum wage, nearly four times the 2023 figure. Across the UK in 2025/26, homecare faced a funding gap of £3.25 billion to pay wages equivalent to NHS Band 3 Healthcare Assistants with 2+ years' experience. 2026/27 has not seen much improvement to this – the Association of Directors of Adult Social Services (ADASS) report that the average homecare fee rate is £25.05 per hour[4], against our 2026/27 Minimum Price of £34.42. 61% of councils purchase no more than 500 hours per provider each week, a third or fewer of the roughly 1,500 hours needed for efficient rotas and financial viability at average rates, while only 1% use block contracts that guarantee provider income.

Our members already do what they can within those constraints. Our 2025 workforce survey found that 66% of providers offer guaranteed hours contracts and 78% offer zero-hours contracts[5], most often side by side, because careworkers themselves want the choice. The number of contracted hours is not, by itself, what careworkers most need. Predictability of income, reliable payment for travel time, continuity with the people they support, and a rota they can plan around matter as much as the figure in the contract. A guaranteed hours offer that a provider cannot reliably fulfil or can only fulfil by offering hours spread at irregular intervals across the week delivers none of these. This regularity is hard for most providers to offer because they receive insufficient, insecure hours from local authorities and the NHS. Despite receiving no payment from most commissioners when they cancel visits, three-quarters of providers always pay their careworkers when the person being supported or commissioner cancels a visit at short notice. The sector is not resisting security. It is absorbing the cost of it already, at a loss.

These measures require homecare employers to bear further costs and obligations, but public commissioning and procurement systems are not structured or funded to support them. The working conditions of the homecare workforce are part of a complex system. Forcing change on employers through legislation, without creating the conditions to enable its implementation by ensuring security of demand and adequate funding, risks significant unintended consequences.

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[2] The Homecare Deficit 2025
[3] Homecare Association (2025) Minimum Price for Homecare 2026-27
[4] ADASS Spring Survey 2026 - ADASS
[5] Voices of Homecare: Workforce

If enforcement is rigorous, this legislation may cause business closures, but it could also result in less visible impacts, like:

- Non-payment of travel time or other minimum wage non-compliance to cover costs
- Increased redundancies when demand drops
- Shortening of care visits to recoup costs
- Increased use of bogus self-employment models

Avoiding these consequences means reforming how councils and the NHS commission and pay for care and increasing their funding before the legislation comes in.

Our answers therefore rest on three consistent principles. First, we support improved security for careworkers (though we question if this is the best route to that). Second, the design must reflect the operational realities of personalised care in people's homes, where work responds to unpredictable human need leading to rota changes for reasons no employer controls. Third, these reforms will only work if Government funds them and reforms commissioning to match. It is not possible to legislate zero-hours working out of homecare without also addressing zero-hours commissioning.

We make detailed recommendations throughout this response and set out further analysis in our accompanying supplement. In summary, we ask Government to:

- **Redo the impact assessment** - quantify the costs of the legislation to the NHS and local authorities and take account of the impact on people who fund their own care.
- **Close the funding gap** - invest at least £3.25 billion across the UK, so that the sector can comply with existing employment legislation.
- **Reform commissioning** - move from fragmented, by-the-minute purchasing to locality and lead-provider models and block contracts that guarantee providers a volume of work, so that providers can in turn guarantee careworkers' hours.
- **Introduce a National Contract for Care** - a statutory minimum price for homecare, drawing on our Minimum Price methodology, so that public bodies cannot buy care below the cost of lawful employment.
- **Make commissioners pay for the changes they cause** - require councils and the NHS to pay cancellation and movement charges, fund the rota changes that hospital admissions and discharges generate, and stop short-notice contract cancellations.
- **Sequence commencement** - bring the duty on commissioners into force ahead of, or alongside, the new worker rights.
- **Adapt the mechanisms to the work** - define how the provisions apply to runs of visits rather than shifts, recognise the block working patterns of live-in care, set reference periods, regularity tests and thresholds that reflect how providers actually deliver homecare, and apply exceptions, including where care work depends primarily on one individual.

- **Regulate introductory agencies and review employment status** - so that these reforms do not simply drive work into the unregulated part of the market, where careworkers have no protection at all and care regulation does not apply.

These are the conditions that would let the reforms succeed rather than backfire, and we develop each of them in the answers that follow.

About you

Respondent type

Question 1: Please indicate whether you are responding as:

- An individual
- An academic, or on behalf of an academic or research organisation
- An employer
- A legal representative
- A business representative organisation (please specify) Homecare Association
- A trade union or staff association (please specify)
- A charity or interest group
- Other – please specify

Question 5: If responding as business representative or trade union, how many members does your organisation have?

2,100

Question 6: Where are you located? Please tick boxes for your main locations.

- North-East
- North-West
- Yorkshire and The Humber
- East Midlands
- West Midlands
- East of England
- London
- South-East
- South-West
- Wales
- Scotland
- Northern Ireland
- Other (please specify)

Question 7: What sector are you based in?

- Accommodation and food service activities
- Activities of households as employers; undifferentiated goods and services producing activities of households for own use
- Administrative and support service activities
- Arts, entertainment and recreation
- Agriculture, forestry and fishing
- Construction
- Education
- Electricity, gas, steam and air conditioning supply
- Financial and insurance activities
- Health
- Information and communication
- Manufacturing
- Mining and quarrying
- Production
- Professional, scientific and technical activities
- Public administration and defence; compulsory social security
- Real estate activities
- Repair of motor vehicles and motorcycles
- Social Care
- Services Sector
- Transportation and storage
- Water supply; sewerage, waste management and remediation activities
- Wholesale and retail trade
- Other service activities
- Other (please specify)

Part 1: The right to guaranteed hours

The hours threshold

Q1.a For directly engaged workers, which of the following options should the hours threshold be?

- 8 hours per week
- 12 hours per week
- 16 hours per week
- 20 hours per week
- 24 hours per week
- 28 hours per week
- 32 hours per week
- 36 hours per week
- 40 hours per week
- 44 hours per week
- 48 hours per week
- Other (please specify)

Q1.b Please explain your answer.

We recommend a threshold of 8 hours per week, and we ask Government to apply the same figure consistently across all four threshold questions in this consultation. A single threshold keeps an already complex regime intelligible for the small providers who make up much of our sector and who have no HR or payroll department to interpret it. A low threshold gives the Government an opportunity to test the impact of the legislation.

We think a properly valued homecare workforce would have higher levels of shift-based working, and we would like to discuss this with the Government as it would require completely different purchasing approaches. We believe guaranteed hours is the wrong answer, and it appears to be unfunded.

Zero-hours employment in homecare follows directly from zero-hours commissioning and purchase of homecare by public bodies. Skills for Care estimates that 42% of careworkers in domiciliary care services are on zero-hours contracts, compared with 21% across adult social care and 3% of the economically active population. That concentration tracks the commissioning model rather than any employer preference: councils and the NHS purchase by the minute or the hour, and framework agreements guarantee providers no volume of work. This contrasts with the approach of public bodies to care homes, where they pay providers per resident rather than per minute of contact time, enabling more secure employment of careworkers.

Our members already offer guaranteed hours wherever their work allows. Our 2025 workforce survey found that 66% of providers offer guaranteed hours contracts and 78%

offer zero-hours contracts[6], most often side by side, because careworkers want the choice. Some seek the security of a guaranteed minimum; others value flexibility around study, caring responsibilities, or a second job. It is important to note that the form of guaranteed hours contracts influences their attractiveness to careworkers. Some employers require careworkers to be available for 12 hours every day (84 hours per week) to guarantee, say, 21 hours of paid contact time per week. Others offer careworkers the same number of hours in compact runs on three consistent days per week. The latter arrangement is far better for a careworker but is hard for most providers to offer because they receive insufficient, insecure hours from local authorities and the NHS. We discuss this further later.

A threshold of 8 hours concentrates the right where insecurity bites hardest, and we support that. The consultation's own evidence bears it out: 68% of workers on contracts of 1 to 8 hours work beyond their contracted hours, against 19% of those on 16 to 24 hours.

We would resist a higher figure while the funding gap remains, because homecare work fluctuates dramatically for reasons providers do not control. A person dies, goes into hospital, moves to residential care, or changes provider. In end-of-life and fast-track services, a provider can lose 400 to 500 hours of work in a single week and take eight weeks to replace it. Providers meet volatility by adjusting hours, because commissioning does not fund them to hold paid, unfilled capacity.

Raising the threshold **without funding** would therefore produce consequences that harm the workers it aims to protect. Providers carrying guarantees they cannot fulfil could face redundancy situations and increase churn, which in turn damages continuity of care and workforce capacity. They could offer fewer hours to workers below the threshold (who they think want guaranteed hours) in order to limit future liability. Relationships between employers and careworkers could come under strain. Prices would rise for people who fund their own care – leading to them running out of funding faster and therefore seeking support from Councils quicker, and this could cause work to migrate to unregulated, self-employed and introductory agency models where these protections may not apply (note that in July 2026 the ONS reported a 51,000 increase in self-employment in the human health and social work activities sector[7]).

The Government has not undertaken a proper impact assessment of the cost to social care commissioners or self-funders. The impact assessment focuses on workers and employers, and not on local authorities or individuals buying services (or the cost-of-living impact on consumers in the general economy from the result of this legislation being implemented in other sectors). We urge the Government to correct this before implementing the legislation.

We would also observe that a number of contracted hours is not, by itself, what careworkers most need. Predictability of income, reliable payment for travel time, continuity with the people they support, and a rota they can plan around matter as much as the figure in the

[6] Voices of Homecare: Workforce
[7] Vacancies and jobs in the UK - Office for National Statistics

contract. A guaranteed hours offer that a provider cannot reliably fulfil or can only fulfil by offering hours spread at irregular intervals across the week delivers none of these.

One of the reasons why careworkers turn down a guaranteed hours contract at the moment is that in order to guarantee more hours, employers require the employee to have availability over longer periods of the week including a commitment to work a certain number of anti-social hours in order to keep the service operational. This is because the employer does not have reliable enough demand for work to guarantee regular work at a specific time (a point we discuss further later in this submission). Some workers are not able or prepared to commit to working weekends, evenings or to accepting the work offered to them regardless of timing, so prefer zero-hours work where they have more ability to negotiate what hours to work and when and to change and update their availability. Simply legislating for work to be available at regular times will not work without reforming the whole care system to manage workflow. Neither could you assume that because someone has worked 3-5 on Wednesdays for the last three weeks that they will be able to for the next three weeks because demand is constantly changing.

While the sector cannot escape the need to work anti-social hours; the issue of rotas being organised into runs or shifts could improve if commissioning practices change. Now, commissioners in some regions are fragmenting the market between many small providers, none of whom have enough volume or margins to support more regular working patterns. Block purchasing, locality-based working, or capitated funding models could help to provide providers with more control over their rotas, that could lead to more regular working patterns.

The honest position is that a careworker's interest lies not simply in a higher guaranteed hours threshold, but in the Government genuinely funding their work, guaranteeing hours and purchasing care in a way that supports well-organised runs or shifts where the employer pays the worker for all hours worked. An unfunded higher threshold risks precisely the outcomes that damage workers: fewer additional hours for those that can't commit to more work, more redundancies, a shifting of cost that could mean more non-compliance with travel time payments and a drift towards parts of the market that carry no employment protection at all.

Q1.c Which option(s) could have an impact on the number of contracted hours in job offers?

Any threshold will encourage employers to pitch contracts at or just above it where they are able to, in order to place roles out of scope and reduce admin and unplanned long-term pay liabilities.

Providers can only offer guaranteed hours when they have guaranteed demand. Where councils buy by the minute with no guaranteed volume, providers cannot raise guaranteed hours whatever figure Government sets.

Genuinely fluctuating work compounds this: where a provider's volume rises and falls with the health of the people it supports, at the moment, it will pitch contracted hours at the level it can sustain in a quiet period, not the level it can fill in a busy one at the moment. Using an

average instead in future means employers will have to pay workers when there is no work for them to do more frequently, and this is an unfunded cost – the higher the threshold; the higher the cost. The Government has not provided additional funding for social care to cover this cost, and the impact assessments undertaken to date do not quantify this.

Q1.d Which option(s) could have an impact on the availability of additional hours for workers?

Any threshold risks reducing the availability of additional hours because providers will hesitate to offer extra work if each hour feeds a higher guaranteed hours offer at the next reference period. We ask that genuine overtime hours sit outside the calculation (see Q18 and Q27).

A higher threshold would also change who receives additional hours. Providers would direct work first to staff already above the threshold, because those hours carry no further liability, and only then to workers below it. A worker on low guaranteed hours who experiences a spike in work would generate an ongoing cost for the provider, so the rational response is to route the work elsewhere.

Reduced willingness to offer additional hours could also cut the sector's capacity to respond. Homecare absorbs surges in demand largely by asking existing staff to take on extra work. That flexibility could reduce if every extra hour risks becoming a permanent obligation. It would not necessarily be in providers' interests to take this risk unless the hourly rate local authorities and the NHS pay providers for work included a margin that covered this cost. At present, 29% of councils and HSC Trusts[8] pay fee rates to providers at a rate that is below the direct employment costs of the careworker at the statutory minimum wage. So, for many care businesses, these margins do not exist.

Q1.e Which option(s) could have an impact on the availability of additional hours for particular groups sharing a protected characteristic?

Around 78% of workers in domiciliary care services identified as female, and 22% identified as male[9]. 27% of the social care workforce as a whole were 55 and above in 2024/25.[10] So, the homecare workforce is predominantly female and includes many older workers. Workers from minority ethnic backgrounds are overrepresented, with non-British nationals comprising about 30% of the homecare workforce. There are high levels of part-time working. Many part-time staff take additional hours to boost their earnings around other commitments, and many choose flexible arrangements for reasons connected to a protected characteristic — disability, age, religious observance, or care of a child or an adult relative.

Reduced availability of additional hours would cut the earnings of workers who rely on picking up extra work around other commitments. Employers may offer workers who cannot commit to the threshold fewer hours, because a provider will see them as carrying the risk

[8] The Homecare Deficit 2025
[9] Skills for Care (2025) Summary of domiciliary care services 2025
[10] Skills for Care (2025) The state of the adult social care sector and workforce in England, 2025

of a guarantee it cannot fill. This might mean people feel under pressure to accept guaranteed hours at a higher level than they want to work in some cases.

In the current labour market, it is possible that the risk may not fully materialise because providers are short of staff and will take whoever they can. But if recruitment eases, or if providers reduce headcount to manage guarantee liability, those workers would face the greatest exposure to redundancy. Government should assess these effects fully and fund the reforms so that these risks do not arise.

Q2.a Agency workers should not be entitled to guaranteed hours offers when (choose one):

- they already have a contract guaranteeing hours above the threshold (for example, by their agency) regardless of which hirer these hours are to be worked for
- they already have a contract guaranteeing hours above the threshold, specifically in respect of work to be done for one hirer (for example, by their agency)

Q2.b Please explain your answer.

The exclusion should apply wherever an agency worker already holds guaranteed hours above the threshold, whichever hirer the worker works those hours for. Such a worker already has the baseline income security this right is designed to provide, and a narrower test would impose duties on hirers in respect of workers who are already secure, adding cost and administration the sector cannot absorb.

Employment businesses usually place agency workers in homecare for short periods to cover sickness, a vacancy during recruitment, or a temporary surge. Providers use this relatively infrequently, as it is generally lower cost to flex hours within the existing workforce if possible – as at 19 August 2026, Capacity Tracker shows 1.5% of homecare hours being delivered by agency staff. Requiring a hirer to guarantee hours to an agency worker on a longer-term basis would make agency cover markedly less attractive, and would remove one of the few mechanisms providers have for meeting urgent needs without changing their own staff's hours.

Q3.a For agency workers, which of the following options should the hours threshold be?

- 8 hours per week
- 12 hours per week
- 16 hours per week
- 20 hours per week
- 24 hours per week
- 28 hours per week
- 32 hours per week
- 36 hours per week
- 40 hours per week
- 44 hours per week

- 48 hours per week
- Other (please specify)

Q3.b Please explain your answer.

For consistency with the directly engaged threshold and to target genuine insecurity, the agency threshold should sit at 8 hours. Simplicity of interpreting and understanding the legislation is important for workers and employers. Different thresholds risk confusion.

Length of the initial reference period

Q4.a How long should the initial reference period be for directly engaged workers?

- 12 weeks (Government-preferred option)
- 26 weeks
- 52 weeks
- Other

Q4.b Please explain your answer.

We recommend 26 weeks. A 12-week snapshot does not reflect how homecare demand behaves, and 52 weeks would delay the right too long to serve the workers it is meant to protect.

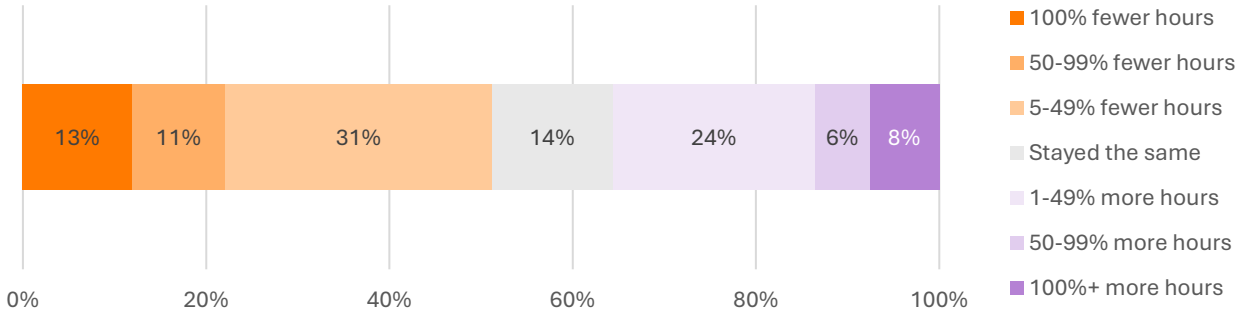
A careworker's hours depend on the specific people they support. When someone changes provider, moves into a care home, goes into hospital or dies, hours fall sharply and then recover as new packages arrive. Twelve weeks is short enough that a temporary spike or trough could set the guarantee and lock a provider into hours the underlying work does not sustain. Seasonal variation compounds this: a 12-week window falling across winter reads a peak as though it were the norm. Providers often manage busy periods by staff working additional hours rather than using short-term or agency staff because of recruitment difficulties and agency costs. But this can mean that average hours over 12 weeks is not representative of a viable long-term work pattern. A new starter's hours also settle over time as they build a round and get to know the people they support, so an early snapshot misrepresents their steady pattern.

52 weeks would bring fewer people into scope (which some employers may prefer), but it would also delay the security this legislation exists to deliver, and in a sector with high turnover, many careworkers would leave before ever reaching an offer. A year-long initial period builds in a long stretch of uncertainty for both parties, extends the administrative burden over a longer timeframe, and leaves expectations unclear. Twenty-six weeks captures a full half-year, while still giving workers a meaningful route to an offer.

The scale of variation in homecare hours is substantial. We worked with the Access Group (Figure 1) to examine aggregated data for a sample of 107,989 employees, comparing two consecutive 12-week periods — the first and second quarters of 2025 — and measuring how much each employee's working hours changed between them.

Figure 1: Variation in hours between two consecutive 12-week periods – bar chart

Figure 2: Variation in hours between two consecutive 12 week periods - by percentage



Only 14% of employees worked the same hours across both 12-week periods (Figure 2). More employees saw their hours fall than rise, which may reflect rising employment costs with the introduction of employers' National Insurance Contribution increases and the move from winter into spring. The central point stands: hours in homecare move for the overwhelming majority of the workforce, and a reference period must be long enough to reveal a genuine pattern rather than a moment in time, or else the contracts will be unsustainable and increase redundancy rates. Increased redundancy could critically affect the workforce retention of the sector as a whole.

Q5.a How long should the initial reference period be for agency workers?

- 12 weeks (Government-preferred option)
- 26 weeks
- 52 weeks
- Other

Q5.b Please explain your answer.

The same demand volatility applies to hours worked for a hirer through an agency, and consistency with the directly engaged period keeps administration manageable. We recommend 26 weeks for the same reasons we give at Q4.b.

Subsequent reference periods

Q6.a How long should subsequent reference periods be for directly engaged workers?

- 12 weeks (Government-preferred option)
- 26 weeks
- 52 weeks
- Other

Q6.b Please explain your answer.

Reviewing hours every 12 weeks would be problematic if that saw seasonal variations – like a busy winter period - as well as being admin-heavy. It could lead to hours being increased in the winter for some staff that the provider can then not sustain. Ensuring the legislation does not create guarantees of hours in peak periods is not a minor benefit for the employer; it is critical for business viability.

We recommend 52 weeks for subsequent reference periods. The considerations differ from those applying to the initial period. A worker who has already completed an initial reference period has either accepted a guaranteed hours offer or declined one, so the urgency of a first offer no longer applies, and we believe that the Government should give consideration to limiting a heavy and continuing administrative burden.

That burden is substantial. Every worker sits on their own cycle, beginning on their own start date, so a provider with forty careworkers operates forty staggered calculations rather than one. Providers have no spare administrative capacity and cannot justify or afford employing additional finance staff to track them.

Where a worker has already refused a guaranteed hour offer and wants to stay on zero-hours, frequent repetition serves little purpose. It obliges the provider to recalculate and re-offer, and obliges the worker to decline again something they have already considered and turned down, which risks becoming an irritation rather than a protection. A longer subsequent period respects that decision while preserving the worker's ability to take up an offer when their circumstances change.

Q7.a Should each reference period begin as soon as the previous one finishes?

- Yes
- No
- Other

Q7.b Please explain your answer.

We have selected ‘Other’ because our preference is neither straightforward continuation nor an arbitrary gap, but alignment.

Continuous, back-to-back reference periods create a permanent monitoring obligation, multiplied by every worker sitting on a separate individual cycle. We ask that regulations permit employers to align subsequent reference periods to a common cycle across the workforce — quarterly, six-monthly or annual — so that they can review groups of workers together rather than each on their own date. Tracking every employee individually would be unmanageable for providers without dedicated payroll or HR functions.

A worker’s initial reference period should continue to run from their start date, so that nobody waits longer for a first offer than they otherwise would. Alignment should apply to subsequent periods, where the ongoing monitoring burden lies. Aligning to existing pay, holiday or appraisal cycles also reduces the risk of calculation errors and gives careworkers a single, predictable date for reviews.

Some very small providers may benefit from gaps between periods. However, even relatively small homecare providers usually have a payroll system, and most payroll and rostering systems will have to adapt to track hours continuously in any event, and once systems automate that tracking, switching it on and off delivers limited benefit. The greater prize is a longer period, which avoids spikes and levels out seasonal averages. If there were a six-month gap between offers but the system discounted three-months then the risk of seasonal peaks being read as the norm would persist.

The Government could consider making the gap between periods optional so that very small employers that did not have seasonally fluctuating work could choose to opt into this.

Q8.a How long should subsequent reference periods be for agency workers?

- 12 weeks (Government-preferred option)
- 26 weeks
- 52 weeks
- Other

Q8.b Please explain your answer.

As at Q6, longer subsequent periods for agency workers reduce administration and better reflect sustained hours rather than short-term spikes.

Q9.a Should each reference period begin as soon as the previous one finishes (agency workers)?

- Yes
- No
- Other

Q9.b Please explain your answer.

As at Q7, hirers should be able to align subsequent reference periods for agency workers to a common cycle, with initial periods running from the start of the placement so that this doesn't delay the worker's first offer. The case is stronger still where a hirer engages agency workers alongside directly engaged staff, since operating two separate sets of staggered cycles would compound the burden without benefit to anyone.

Regularity requirements

Q10.a Which regularity option is preferred for directly engaged workers?

- Option A: A weekly distribution requirement.
- Option B: A weekly distribution requirement AND a total hours requirement.
- Other

Q10.b Please explain your answer.

We consider this absolutely critical to the legislation's being workable. There has to be an hour's margin that is enough to account for genuine overtime where colleagues are covering work for each other, where there is a vacancy in the team, or where someone needs an urgent temporary increases in hours to meet their care needs.

The alternative to a high-hours element to the regularity requirement would be to specify specific kinds of hours that employers could exclude from the reference period calculation – such as cover for a colleague's illness; extra hours to cover a vacancy etc. Actually implementing a system that categorises hours in this way would pose a very high administrative burden as the administrator would need not only to record the hours and calculate the average but also categorise the hours worked in a way that would not be subject to dispute and remove sick cover, etc. before calculating the average for the reference period.

If the Government includes neither of the above, then workers could easily end up in a situation where the hours the legislation requires that their employer offers them are unsustainable, and if they accept the offer, they may trigger redundancy scenarios.

Requiring both a spread of weeks and a volume of hours identifies genuinely regular patterns and screens out hours arising from short bursts of cover.

This should ensure that the law does not treat staff that are genuinely casual bank staff, who do not work regularly and only provide occasional cover, in the same way as regular employees. If the employer needed to find them work regularly to keep them on the books rather than offer them work when there is an urgent need, then this might remove the benefit of having a bank at all. However, it is fairly likely that many genuine bank workers would refuse guaranteed hours work if their employer offered it to them (e.g. students and people who are semi-retired might want to undertake this kind of work during exam period and so on, so a regular contract may not suit them).

Q11.a What should the minimum number of weeks be for the weekly distribution requirement (directly engaged)? The below options are framed around the government's preference for a 12-week initial reference period. The options would scale proportionally for a longer initial reference period.

- 6 calendar weeks across a 12-week initial reference period.
- 8 calendar weeks across a 12-week initial reference period.
- 10 calendar weeks across a 12-week initial reference period.
- 12 calendar weeks across a 12-week initial reference period.
- Other

Q11.b Please explain your answer.

We have selected 'Other' because a single figure cannot fit both visiting homecare and live-in care.

For visiting homecare we support 10 calendar weeks in a 12-week period, scaled proportionately — 22 weeks across the 26-week reference period we recommend at Q4. A higher threshold ensures the pattern is genuinely regular rather than incidental, and protects a provider's ability to offer occasional additional hours to bank staff on a casual basis without every short spell converting into a permanent obligation. Ten weeks in twelve also allows for two weeks of annual leave, which seems a reasonable accommodation of normal working life.

Providers must be able to continue using bank staff — genuinely casual workers who pick up occasional shifts to cover the regular workforce, much as supply teachers do in schools. Setting the requirement at 6 of 12 weeks could draw these workers into scope even though their work is genuinely irregular. Most would presumably decline a guaranteed hours offer, but the obligation to calculate and make repeated offers would create administration for employer and worker alike to no purpose. A 10-week threshold excludes genuinely casual working without any need to define bank staff as a category (see Q26).

Live-in care requires a different measure. Live-in careworkers commonly work in blocks — a week or a fortnight on placement, followed by an extended period off — so a test counting calendar weeks touched will misclassify a full-time, genuinely regular careworker as irregular. For workers doing blocks of unmeasured-time work we suggest a lower threshold of 6 weeks in 12. Live-in care needs to be treated as a distinct case throughout these regulations for the regime to work; the alternative would be to exclude it specifically.

Q12.a What should the total hours requirement be under Option B (directly engaged)?

(The below options are framed around the government's preference for a 12-week initial reference period. The options would scale proportionally for a longer initial reference period.)

- Fewer than 48 hours (in excess of contracted hours) across a 12-week initial reference period.
- 48 hours (in excess of contracted hours) across a 12-week initial reference period.

- 72 hours (in excess of contracted hours) across a 12-week initial reference period.
- 96 hours (in excess of contracted hours) across a 12-week initial reference period.
- Other

Q12.b Please explain your answer.

We have selected 72 hours, but this answer depends directly on how Government handles genuine peaks in demand, and we ask that the two be considered together. We consider 72 as a minimum and would also welcome 96.

Seventy-two hours across a 12-week period — roughly six hours a week, or an hour a day — sets a substantive floor that distinguishes sustained additional working from short-term cover. It also leaves room for genuinely chosen overtime. A careworker who wants to take on extra work for a period, perhaps to save for something specific or to help through a busy spell, can do so without the employer risking having to offer them more hours than they can sustain.

Homecare experiences real, short-lived surges — a person becoming acutely unwell and needing a step-up in support, or cover for a colleague's illness — which do not represent a lasting change in the work. If those hours count towards the calculation, the total hours floor becomes the only mechanism preventing them from converting into permanent guarantees, and the Government must set it high enough to do that job.

We would prefer the total hours floor to carry this weight rather than a bespoke exception. Excluding particular hours requires a provider to identify and record which hours arose from which exceptional cause, and to defend that judgement afterwards. That is a significant administrative burden for services with minimal back-office capacity. A well-set total hours requirement achieves a similar result automatically, with no additional record-keeping. We would rather the legislation averaged these out than removed them by employer audit.

Q13.a The government proposes that the regularity requirements should scale in the event of longer subsequent reference periods. Do you agree? For example, if the weekly distribution requirement were set at 6 weeks for a 12-week initial reference period, and if subsequent reference periods were 26 weeks long, it would be set at 13 weeks for subsequent reference periods.

- Yes, the regularity requirements should scale in the event of longer subsequent reference periods
- No, the regularity requirements should not scale in the event of longer subsequent reference periods

Q13.b Please explain your answer.

If reference periods lengthen, as we recommend, the distribution and total hours tests should scale proportionately, so that the standard of regularity stays consistent and continues to capture genuine, sustained patterns rather than isolated spikes.

Any adjusted threshold for live-in care should scale in the same way. If Government adopts a lower weekly distribution requirement for live-in care block working, as we propose at Q11, that lower figure should scale alongside the standard one rather than being left fixed.

Q14.a Based on the two options set out above for agency workers, select below which option is preferred:

- Option A: A weekly distribution requirement.
- Option B: A weekly distribution requirement AND a total hours requirement.
- Other

Q14.b Please explain your answer.

For consistency and to prevent gaming across engagement types, agency regularity should follow the directly engaged design, for the reasons at Q10.

Q15.a What should the minimum number of weeks be in which an agency worker is required to work during the reference period for a certain hirer to qualify (the weekly distribution requirement)?

(The below options are framed around a 12-week initial reference period. The options would scale proportionally for a longer initial reference period.)

- 6 calendar weeks across a 12-week initial reference period.
- 8 calendar weeks across a 12-week initial reference period.
- 10 calendar weeks across a 12-week initial reference period.
- 12 calendar weeks across a 12-week initial reference period.
- Other

Q15.b Please explain your answer.

Our reasoning follows Q11. For agency workers in visiting homecare, we support 10 calendar weeks in a 12-week period, scaled proportionately for longer reference periods, so that the legislation captures genuine regularity and incidental cover is not captured.

For agency workers in live-in care, the same difficulty arises as for directly engaged live-in staff: block working patterns mean a calendar-week test misreads regular work as irregular. A threshold of 6 weeks in 12 would be more appropriate for that work.

Q16.a What should the total hours requirement be under Option B (agency)?

(The below options are framed around a 12-week initial reference period. The options would scale proportionally for a longer initial reference period.)

- Fewer than 48 hours (in excess of contracted hours) across a 12-week initial reference period.
- 48 hours (in excess of contracted hours) across a 12-week initial reference period.
- 72 hours (in excess of contracted hours) across a 12-week initial reference period.
- 96 hours (in excess of contracted hours) across a 12-week initial reference period.

- Other

Q16.b Please explain your answer.

As at Q12, a substantive total hours floor separates sustained working from short-term cover for agency workers.

As with directly engaged workers, we would suggest employers need 72 hours plus to provide a workable route for genuine increases in hours arising from temporary peaks.

Q17.a S The government proposes that the regularity requirements should scale in the event of longer subsequent reference periods. Do you agree in relation to agency workers? For example, if the weekly distribution were set at 6 weeks for a 12-week initial reference period, and if subsequent reference periods were 26 weeks long, it would be set at 13 weeks for a subsequent reference period.

- Yes, the regularity requirements should scale in the event of longer subsequent reference periods
- No, the regularity requirements should not scale in the event of longer subsequent reference periods

Q17.b Please explain your answer.

For consistency with Q13, scaling keeps the regularity standard constant across longer agency reference periods.

Seasonal work and the definition of 'temporary need'

Q18.a Do you think there are examples of temporary need which are not related to a specific task or event – and would need to be addressed through regulations?

- Yes, there are examples of temporary need that are not related to a specific task or event - and would need to be addressed through regulations.
- No, there are not examples of temporary need that are not related to a specific task or event that would need to be addressed through regulations. Q18.b Please list examples of temporary need and explain each.

Q18.b: Please list examples of temporary need which are not related to a specific task or event - and would need to be addressed through regulations. Please explain each example.

We start from a point of agreement: most temporary work in homecare already fits, and should fit, the definition of a specific task or event. Hiring staff specifically for a named worker's maternity or long-term absence, and time-boxed reablement commissioned as a discrete service, both have a definable boundary, and we are content for regulations to treat them that way. We do not seek to widen the temporary-need category in general.

There is, however, a distinct group of genuinely temporary homecare work that the "task or event" test does not capture, because what ends the work is an external, uncertain future contingency rather than a task the worker completes or an event the employer can identify at the outset. Regulations should name these expressly:

- **Bridging and "discharge-to-assess" packages.** When a person leaves hospital, providers often deliver intensive short-term support while social workers arrange a long-term package, a care-home place, or a home adaptation. Everyone understands the work is temporary, but no single task ends it, and there is no scheduled event — it ends only when a separate arrangement falls into place, on a date outside the provider's control. This is a temporary need without a pre-identifiable boundary. Often providers manage to take on this work either by flexing the hours of their existing staff or, occasionally, by managing a block-purchased service. However, there may be some rare cases where providers take on workers for a short-term package.
- **Fast-track and end-of-life packages.** This support is, by its nature, short and of unpredictable duration. The "event" that ends it is a person's death, which the provider cannot schedule or define in advance, and which it would be inappropriate to treat as a qualifying event. The work is plainly temporary, yet it does not fit the task-or-event frame.
- **Crisis "step-in" cover following provider failure.** When another provider exits a contract or collapses, a provider may pick up a person's care at short notice to keep them safe until social workers can find a stable long-term arrangement. The work is temporary, but its end depends on that future arrangement materialising, not on completing a defined task.

Recognising these situations matters for the people who draw on care as much as for providers. Without a workable definition, providers cannot safely take on this legitimately short-term work, because the guaranteed-hours duty would threaten to make it permanent. That would make providers reluctant to deliver exactly the responsive, discharge-supporting, and preventative care the Government's shift to "care closer to home" depends on.

We recognise the concern that employers could misuse temporary-need provisions to keep workers on rolling short-term contracts. In much of the homecare sector, that risk is structurally weak. The binding constraint is a severe shortage of workers, not a surplus: the homecare vacancy rate according to June 2026 data from Skills for Care is now 9.4%[11], over four times the wider economy, and the international recruitment route has closed. In that market, a responsible provider with genuine, continuing work has every incentive to offer secure, guaranteed hours as quickly as possible, because the alternative is losing a valued careworker to a competitor or to retail and logistics. Continuity of care — keeping the same worker with the same person — drives the same behaviour.

Where misuse does occur, it clusters in the unregulated, self-employed, and introductory-agency parts of the market. One concerning case of this emerging is the NHS and local authorities contracting with platform introductory agencies such as 'ilarna' and Curam Care using 'self-employed' staff to deliver short-term hospital discharge support and long-term personal care, outside of the care regulatory system.

If the Government genuinely wants to address the working conditions of careworkers delivering end-of-life and intermediate care, then there needs to be discussions about

[11] Skills for Care (June 2026). Monthly statistics portal.

block-contracting services so that providers have guaranteed demand and income to support careworkers with gaps between work. Providers are resorting to zero-hours to manage demand fluctuation to try to deliver on fee rates that would be unviable otherwise. There are examples of this kind of work being block-purchased in some parts of the country.

Guaranteed hours offer calculation

Q19.a Which calculation method do you think should be used for determining the guaranteed hours offer for directly engaged workers?

- Mean average
- Median average

Q19.b Please explain your answer.

A median better represents the hours a careworker regularly works because it reduces the influence of outlier weeks — an unusually high week covering absence, or a low week when a client went into hospital. The mean pulls offers upward on atypical spikes, guaranteeing hours the underlying work cannot sustain and discouraging providers from offering additional hours.

Q20.a Do you think employers should have flexibility to determine the period over which the hours will be allocated (weekly, monthly, or other)?

- Yes, they should have the flexibility to determine the time period
- No, they should not have the flexibility to determine the time period

Q20.b Please explain your answer.

Homecare is not one market but many, and the right period over which to allocate guaranteed hours depends on how regular a provider's work genuinely is. That regularity varies enormously between sub-sectors, and a single mandated period cannot fit them all.

Consider two providers at opposite ends of the spectrum. A provider built around supported living for younger adults with a learning disability typically delivers long-term, stable packages: the person's needs have a settled pattern, the support is often continuous, and the rota barely changes from one week to the next. For this provider, a weekly allocation period works well. It can comfortably guarantee a set number of hours each week because that is genuinely what the work looks like, and a short period gives the careworker the greatest possible predictability at no cost to the business.

Now consider a provider specialising in end-of-life or fast-track care. Here the work is intensely variable and unpredictable: a package may be heavy for a fortnight and then end suddenly, or ramp up rapidly as someone's condition changes. Demand arrives and disappears without notice. If this provider were required to guarantee hours weekly, it would struggle severely unless it could negotiate a high enough hourly rate to cover slack (which is rarely heard of in today’s market) or negotiate a block-purchased contract. Allowing this kind of provider to guarantee hours over a month or a quarter does improve

the picture somewhat: it can flex hours across the weeks within the period — heavier when a package is active, lighter when it is not — while still guaranteeing the worker a meaningful total.

For providers with volatile work, a longer allocation period does not weaken the guarantee — it is what makes a worthwhile guarantee possible at all. Because a provider can only promise what it can reliably deliver in its worst week, weekly guarantees would generate unviable average figures that don't match actual work (unless commissioning changes). A longer period lets the guarantee rise towards the average, so the employer can guarantee the careworker more total hours and more income security, in exchange for some variation in when those hours fall.

Longer guarantee periods also support work patterns where workers work one weekend on and one weekend off, which can be a frequent feature of care services even when the total overall hours are relatively stable. These may often be based on 2 or 4 week patterns rather than weeks or months.

The law should therefore give employers the choice of allocation period, because only the provider knows the volatility profile of its own work and how it rosters weekends, and can match the period to it. A mandated one-size-fits-all period would harm workers whichever way the legislation set it. A short mandated period would suppress guarantees in fluctuating services where flexibility would have allowed more; a long mandated period would needlessly reduce week-to-week predictability in stable services where a weekly guarantee was perfectly deliverable. Flexibility lets each provider offer its workers the most security its particular pattern of work can sustainably support.

Government could reasonably require the chosen period to be set transparently at the point the employer makes the offer, so the careworker understands the basis of their guarantee.

Flexibility over the allocation period enables personalised care, where the timing and pattern of visits shift week to week around people's needs, and it reduces administrative complexity without changing the total number of hours guaranteed.

If the government wants to improve rota stability for care staff rather than just guaranteeing income, then there needs to be wider conversations about how to structure the whole care system to support shift-based working. Under current by-the-minute commissioning models, it is extremely difficult to offer shift-based working.

Q20.c (if yes) Which of the following time periods should employers be able to choose? (select as many as you see fit)

- A week
- A month
- Other – for live in care specifically - 3 months, 6 months

Q20.d Please explain your answer.

As we explain at Q20.b, the period over which a provider can reasonably guarantee hours varies considerably with the profile of work the business undertakes and how they roster weekends. Some providers could comfortably guarantee over a week. Providers with more volatile work would need to guarantee over a pay period, which for most visiting homecare providers means a month. Providers that have one weekend on, one off working patterns may be able to guarantee work over a fortnight but not a week.

Live-in care is a different case again. Live-in services can guarantee hours, but do so far more easily over a longer period of three to six months, because variation is much greater when a worker moves on and off placement. A careworker may take an extended break, or there may be a gap when one of their regular clients ends their care package while the provider finds new work for them. Over a longer period, the guarantee levels out. Over a short period, it would be extremely difficult, and in some cases impossible, because the careworkers are not working every week — it follows an unmeasured on and off pattern and sometimes workers choose to work several weeks in a row intensively and then have several weeks off to travel, for example. So, over 3-6 months employers could typically guarantee hours in some form, but over 1 month they may not be able to.

Q21.a If the government were to mandate a time period over which employers would need to allocate hours in guaranteed hours offers, what do you think this should be?

- A week
- A month
- Other

Q21.b Please explain your answer.

We have selected 'Other' because any mandated period must accommodate both visiting and live-in care.

If Government mandates a single period, a month or four weeks would work for most visiting homecare providers. It gives room to organise rotas around fluctuating needs while preserving certainty of total hours for the worker. It could also be over a pay period, which might not align exactly with a month (e.g. if this is on four-week cycles).

A month would not work for live-in care, where fluctuation in hours is far greater because of the unmeasured on and off working pattern. For live-in care, we suggest three to six months.

Q22.a Do you think employers should have the flexibility to use an adjustment margin?

- Yes, the margin should be a fixed figure
- Yes, the margin should be a percentage of the hours generated by the calculation
- No, employers should not have the flexibility to use an adjustment margin
- Other

Q22.b Please explain your answer.

An adjustment margin protects providers against liability for minor calculation errors and allows offers to align with the way the provider actually organises work. Given genuine unpredictability and very tight margins, a workable percentage-based margin is essential.

We should be clear about what a margin can and cannot do in homecare. For most providers it would not be possible to align an offer to a shift pattern of, say, eight hours, because providers build rotas around runs of visits rather than shifts (or in some cases scattered visits across a week), and actual working time varies substantially with travel time, traffic and the unpredictable needs of the people being supported — someone who is unexpectedly unwell or distressed, for example.

Other provisions do more of this work. The median calculation at Q19 and the regularity requirements at Q11 and Q12 mitigate most of the risks associated with variable hours. A margin remains useful as a secondary protection where calculations rest on highly variable working time, but it is not a substitute for those mechanisms.

Q23.a Which calculation method do you think should be used for determining the guaranteed hours offer for agency workers?

- Mean average
- Median average

Q23.b Please explain your answer.

As at Q19, a median gives a more representative figure for agency workers by limiting the effect of outlier weeks.

Q24.a Do you think hirers should have flexibility to determine the time period over which the hours will be allocated for agency workers? (weekly, monthly, other)

- Yes, they should have the flexibility to determine the time period
- No, they should not have the flexibility to determine the time period

Q24.b Please explain your answer.

As at Q20, flexibility over the allocation period reflects fluctuating care patterns and eases administration.

Q24.c (If yes) Which of the following time periods should hirers be able to choose? (select as many as you see fit)

- A week
- A month
- Other – for live in care 3 or 6 months

Q24.d Please explain your answer.

Hirers should be able to match the period to how they roster agency placements, often monthly or longer.

Q24.e If the government were to mandate a time period over which hirers would need to allocate hours in guaranteed hours offers for agency workers, what do you think this should be?

- A week
- A month
- Other – for live in care 3 or 6 months

Q24.f Please explain your answer.

As at Q21, a monthly or longer window balances scheduling flexibility with the worker's certainty of total hours.

Q25.a Do you think hirers should have the flexibility to use an adjustment margin to tailor the offer to their needs?

- Yes, the margin should be a fixed figure
- Yes, the margin should be a percentage of the hours generated by the calculation
- No, hirers should not have the flexibility to use an adjustment margin
- Other

Q25.b Please explain your answer.

As at Q22, a meaningful percentage-based margin makes the duty administrable and guards against minor-error liability.

Exemptions and exclusions

Q26.a Should there be any types of workers that are excluded from the right to guaranteed hours?

- Yes, there should be certain types of workers excluded
- No, there should not be certain types of workers excluded

Q26.b If yes, please list the types of workers.

1. **Where the work of the careworker is heavily dependent on the care of one individual.** For many workers in specialist, complex and live-in homecare, the majority of their working time is spent with one person. Providers match careworkers to individuals because of specific skills, continuity and availability — for example, complex health needs, learning disabilities, dementia or end-of-life support — and because their availability fits around that person's routine.

If that person's needs reduce following a council reassessment, the worker's hours reduce too. On a guaranteed-hours contract, this could require the provider to renegotiate the contract unless it can offer suitable hours with other people — which depends on the work available, the worker's skills and the worker's availability. Alternative work is not always possible – for example, in live-in care there may be no other people being supported by the provider in the geographical area to adjust a carers hours by a few hours a week.

A related issue arises when the person dies, moves into residential care, is admitted to hospital, or chooses another provider. The work may end immediately, and a small or specialist provider may have no replacement package that matches the worker's skills, location, and availability. Reallocation can therefore take time.

At present, because complex and specialist care is typically purchased by the minute at low rates, providers manage this volatility through zero-hours contracts. That means a worker's hours can move through intense periods of work followed by short gaps, with income fluctuating accordingly.

This arrangement is not ideal. It places income risk on the worker, and we would not consider it acceptable for community nurses or other professionals to be treated in this way. However, in the current commissioning model, and with the current funding constraints, it can prevent an immediate redundancy situation when the package that sustained the worker's hours ends or reduces unexpectedly. If Government wishes to change this, commissioners need either to pay significantly higher hourly rates, continue paying for several weeks after a package ends unexpectedly or a person dies, and give proper notice of planned changes; or, preferably, purchase care through block contracts that guarantee income during quieter periods.

Those commissioning changes would need to be funded and implemented well before the legislation takes effect. We have not seen any concrete plans for the Government to make changes of this scale. Even if the Government changed public commissioning, providers delivering care for one person funded privately or through direct payments would still face the same redeployment problem.

Without a funded route for redeployment, this situation could create significant redundancy risk:

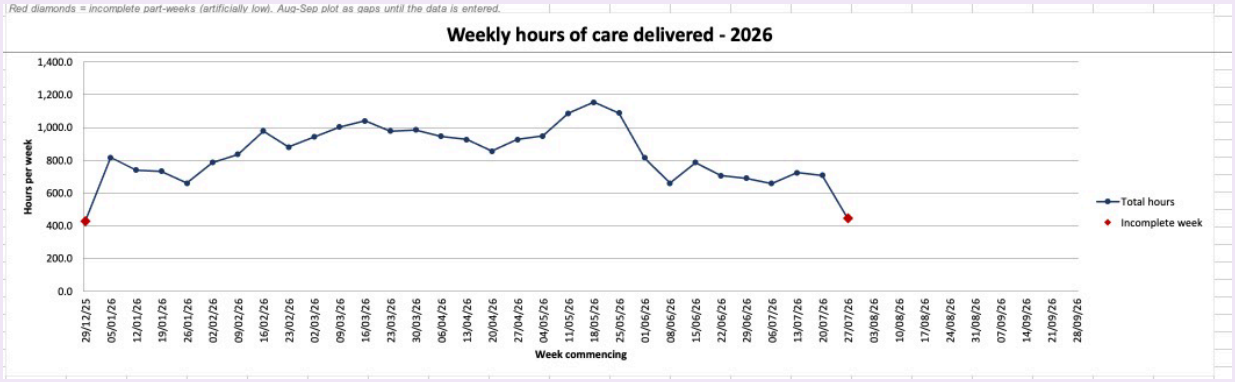
- The sudden loss of a package providing 45 to 90 hours of care a week could remove enough work for one or two careworker roles.
- Repeated redundancy processes could push experienced specialist careworkers into more stable employment, including the NHS or residential services, reducing homecare capacity.
- If one or two workers lose work because one person's package ends, the provider may need to consider whether they should redistribute work currently undertaken by other workers, creating wider redundancy and redeployment issues across the locality.
- Providers could quickly become involved in complex HR processes, including risks around redundancy selection, or actions to avoid fire and rehire charges.
- Maintaining employment without funded work to allocate would be unaffordable for many providers.
- Where there is no practical redeployment option, providers could face serious business viability risks.

This is why the sector needs a narrow exclusion. With a homecare vacancy rate of 9.4% as of June 2026 and the international recruitment route closed, providers already have every incentive to retain experienced specialist careworkers and place them on the next suitable

package. Keeping the employment relationship alive serves both parties better than severance, but providers need to have zero-hour flexibility (or more funding) to do that.

Case study – End of Life Care Provider in North of England, employs 46 staff

Figure 3: Hours of care delivered in end of life care provider



"We provide end of life care for NHS patients so that they can have their wish of dying in their own home fulfilled. Fast track end of life clients usually require 4 calls per day each with 2 careworkers which is 56 hours of care per week. If, as is often the case, a careworker is commissioned for 4 nights a week to be perform a waking watch at the bedside of the client, the total weekly package can be 96 hours. By the very nature of this type of care we do not know when we are going to be allocated a new end of life client by the NHS, how long that client will last and when they will pass. We often have the situation when several of these clients (each with a large number of hours of care per week) pass away within a few days of each other.

"This can be observed in January [see Figure 3] with a drop of nearly 200 hours per week and again in May/June with a drop of nearly 600 hours of care per week. A halving of our business. If guaranteed hours were set as the average number of hours over 12 weeks prior to the 18/5/26, the result would be 960 hours. Within 1 month the actual number of hours of care per week is 660, a drop in 300 hours per week. That is equivalent to a wage cost of £5400 per week (including pension accrual, employer National Insurance and holiday pay accrual). That is a cost of £23,400 per month. We would go bust within a month. The NHS commissions us on a zero-hour basis and we are experiencing a quiet summer from the NHS (as they cut back their budgets) and you can see that loss of 300 hours has not recovered by the end of July. We have no foresight of when or even if we will secure more packages of care from the NHS to rebuild those 300 hours. We are not given any guarantee of a base level of hours of care from the NHS and have to adapt as and when an opportunity comes our way. The same effect can be with the loss of any single large package of care e.g. a 24/7 live in care package will have the same impact.

"It takes weeks, even months, to win new clients to replace the loss in those hours. We would not survive long enough as a business to win back those 300 hours if we had to guarantee wages at the level of 960 hours per week in this example. This would take a highly trained and capable team off the board and reduce the care capacity available to the NHS locally when they need it. This would create more bed blocking in the hospitals at the cost of £1000s per day and the prospect of patients dying in hospital corridors instead of in the comfort of their own home. That is not a dignified end."

2. Sponsored workers with legal limits on how long they can work

Some care employers employ international students and people working supplementary employment in addition to work for a primary sponsor. The immigration rules impose legal limits on how much time these staff can work to 10 or 20 hours per week (depending on their visa situation). There is a particular risk for international students that the rules permit them to work more hours outside of term time. This means that their reference period averages, if taken over the summer, could exceed the figure that the law allows them to work in term time. The Government must not put employers in a position where they are required to contract staff for hours they are not legally allowed to work.

3. Live-in care: if no adjustments to the guarantee period

If the Government rejects our suggestion of allowing live-in care providers the possibility of guaranteeing hours over 3-6 months then, due to the incompatibility with the block working, unmeasured time approach, we recommend that the Government exclude live-in care workers from this legislation.

If the Government rejects our suggestion of excluding workers whose work depends on one individual, we recommend excluding live-in care workers. This will exclude more people, as some live-in careworkers work with multiple people.

If the Government makes no exceptions for live-in care, then there is a risk that more of the sector will move to the unregulated, self-employed introductory model and/or grey economy, which would circumvent employment rights entirely. This is not because employers want to abuse staff, but because the work is not shift-based and the Government has not designed the legislation for the operational practicalities of workers who are on an intensive on/off unmeasured work pattern.

Q26.c If no, please explain your answer.

Not applicable.

Q27.a Should there be any specific circumstances in which you think employers should be exempt from the right to guaranteed hours?

- Yes, there are certain specific circumstances in which employers should be exempt

- No, there are no circumstances in which employers should be exempt Should there be specific circumstances in which employers are exempt from the right?

Q27.b If yes, please list the circumstances.

We set out below two situations that genuinely require provision, and then explain why we would prefer most ordinary variability in homecare to be handled through the reference period and calculation rather than through exemptions at all.

1. Emergencies and major disruption: suspension for the duration of the event

This involves exogenous shocks that temporarily and dramatically change how much care a population needs and how providers deliver it. These are genuinely exceptional, externally caused, and capable of objective evidence. They include:

- pandemics, epidemics, and major public health emergencies;
- declared NHS or local system critical incidents;
- severe weather, flooding and fire;
- utility and power failures;
- cyber-attacks and major IT or telecoms failures; and
- suspension or revocation of a sponsor licence, which can remove a substantial part of a provider's workforce at very short notice.

In these circumstances, we propose that the Government suspend the duty to make a guaranteed-hours offer and the accrual of hours towards it for **the duration of the emergency**, resuming once it ends. Suspension is preferable to discounting individual hours: it is simpler, it avoids arguments about which particular hours were attributable to the event, and it does not require providers to construct records while they are managing a crisis.

For this to work, providers need to know when a suspension starts and ends. **We ask Government to issue clear guidance defining when an emergency situation begins and ends**, drawing where possible on existing declarations — a declared critical incident, a civil emergency, or a public health emergency — so that the trigger is external and verifiable rather than a matter of provider judgement. Without that clarity, providers will face uncertainty and inconsistent enforcement precisely when the crisis situation needs their attention.

2. Maternity, vacancies, or other long-term leave cover

The consultation has discussed short-term contracts for maternity leave, and employers will use these in many cases. However, in some cases one or several workers may adjust their hours upwards to provide cover for the hours of an absent staff member on a temporary basis (i.e. for long-term sick or maternity leave, or a vacancy in the team). Where employers make this adjustment by altering the hours of long-standing staff members rather than recruiting on a short-term contract, the legislation should allow the employer to exclude the additional hours of cover from the guaranteed hours offer as they are not sustainable.

3. School term-time related work

The legislation must adjust for the fact that some children's social care varies in hours depending on whether it is term-time or school holidays. Employers must be able to use a reference period that is term-time for term-time work and holiday-time for holiday-time work and guarantee hours only during term-time or holiday time.

3. Day-to-day variability: our preference is the reference period, calculation, and regularity requirements to be flexible, not exemptions

Much of the variability in homecare is not exceptional – it happens every single day. Hospital discharges, seasonal and winter fluctuations, packages starting and ending, and cover for colleague sickness, car breakdowns, and people being unwell and needing extra support are ordinary features of the work.

If the Government included these as exceptions, we are concerned that employers would then need to capture data on whether any of the hours related to the specified reasons and then exclude these hours from the guaranteed hour calculation. This would be administratively complex.

Instead, we propose that these features should be handled through:

- **A longer reference period** (see Q4 and Q6). A 26- or 52-week period captures summer troughs alongside winter peaks and produces a guarantee reflecting a true annual pattern. Seasonality does not need exempting; it needs a window long enough to measure a more sustainable average.
- **A median calculation** (see Q19), which limits the influence of outlier weeks caused by short bursts of cover or a package ending.
- **An adjustment margin** (see Q22), which absorbs ordinary week-to-week variations.
- **A meaningful total-hours and distribution requirement** (see Q11 and Q12), which ensures occasional cover does not by itself trigger a guarantee.

However, if Government proceeds with a short initial reference period of 12 weeks, a mean calculation, a negligible adjustment margin, or a low regularity threshold, then the calculation will not absorb ordinary variability, and providers risk guaranteeing hours that short-term cover created. **In that event, an exemption for routine cover would become necessary**, notwithstanding the record-keeping burden it would impose.

If the Government needs to introduce such an exemption, it should provide for the exclusion of hours related to:

- Colleague unplanned absence
- Travel disruption
- Extra hours to prevent hospital admission or support hospital discharge
- Responding to unpredictable health and care needs and medical emergencies
- Change in hours related to disciplinary procedures
- Change in hours related to careworker safety measures
- Training

Q27.c If no, please explain your answer.

Not applicable.

Q28.a Should there be any types of agency workers that are excluded from the right to guaranteed hours?

- Yes, there should be certain types of agency workers excluded
- No, there should not be certain types of agency workers excluded Q28.b If yes, please list the types of agency workers.

Q28.b: If yes, please list any types of agency workers that you think should be excluded from the right to guaranteed hours.

As per Q26

Q28.c If no, please explain your answer.

Not applicable

Q29.a Should there be any specific circumstances in which you think the duty to make a guaranteed hours offer to qualifying agency workers should not apply?

- Yes, there are certain circumstances in which the duty should not apply
- No, there are no circumstances in which the duty should not apply

Q29.b If yes, please list any specific circumstances in which you think the duty to make a guaranteed hours offer to qualifying agency workers should not apply

Apply the equivalent exemptions to Q27.

Q29.c If no, please explain your answer.

Not applicable — see Q29.b.

Q30.a Do you think there should be any cases where the duty to make a guaranteed hours offer should be placed on the agency or another intermediary instead of on the hirer?

- Yes, there should be cases where the duty to make a guaranteed hours offer should be placed on the agency or another intermediary
- No, there are no cases where the duty to make a guaranteed hours offer should be placed on the agency or another intermediary Should the duty ever fall on the agency or intermediary instead of the hirer?

Q30.b If yes, for which types of agency worker do you think the duty to make a guaranteed hours offer should be placed on the agency or another intermediary instead of on the hirer?

Where an agency or intermediary determines and controls a worker's hours across multiple hirers — for example, agency workers placed short-term across several hirers — it is better placed than any single hirer to calculate and honour an offer, so the duty should rest there.

Q30.c If no, please explain your answer.

Not applicable — see Q30.b.

Q31 Are there any other ways in which the right to guaranteed hours would need to apply differently to these types of agency worker? *For example, should the regularity requirements relate to the work done by the worker for any hirer while employed by the agency in scenarios where the duty to make a guaranteed hours offer would fall on the agency or another intermediary instead of on the hirer?*

The design should prevent duplicated obligations across agencies and hirers, avoid incentives to route work through unregulated introductory or self-employed models to escape the duty, and ensure that whichever party has greater control over the volume of work carries the corresponding obligation and cost.

Broader impacts (Part 1)

Q32.a Do you think that our proposals in Part 1 of this consultation, on the right to guaranteed hours, will have a particular impact on groups sharing a protected characteristic under the Equality Act 2010?

- Yes
- No

Q32.b Please explain your answer.

Around 78% of workers in domiciliary care services identified as female, and 22% identified as male[12]. 27% of the social care workforce as a whole were 55 and above in 2024/25.[13] So, the homecare workforce is disproportionately female and includes many older workers, part-time workers, disabled workers, and workers from minority ethnic backgrounds – non-British nationals comprise around 30% of the homecare workforce. The people who draw on homecare are overwhelmingly older or disabled. Both groups stand to be affected, and we ask Government to assess the impact carefully.

Flexibility in working hours is currently what allows homecare to be delivered at low cost and in a way that responds to need. Providers meet fluctuating demand by adjusting hours rather than by holding paid, unfilled capacity, because commissioning does not fund the latter and because people paying for their own care cannot easily afford it. If these provisions reduce that flexibility or increase its cost without new funding, providers will find it harder to respond to surges — particularly in end-of-life care and hospital discharge, where demand arrives without notice. Without block-purchased services that give providers a pool of paid time to work within, the capacity to absorb those surges disappears. Older and disabled people would feel this first, through delayed discharges, slower responses to deterioration and reduced continuity of care, but the impact on hospitals could be felt by the whole population.

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[12]Skills for Care (2025) Summary of domiciliary care services 2025

[13]Skills for Care (2025) The state of the adult social care sector and workforce in England, 2025

The effect on the workforce is equally significant. If the availability of zero-hours and low-hours work falls, providers will prioritise hours for workers who already hold guarantees, because those hours carry no additional liability. Careworkers who choose zero-hours or low-hours arrangements could then receive less work, or less regular work. Many make that choice for reasons connected to a protected characteristic: parents and others with caring responsibilities, disabled workers managing their own health, older workers reducing towards retirement, and students. A measure designed to improve security could, therefore, reduce the earnings and hours of precisely those workers who need flexibility most.

There is a further risk of substitution. Where regulated provision becomes more expensive and less flexible, some people will turn to unregulated introductory agencies or self-employed workers, where none of these protections apply. That shift would disadvantage both the predominantly female workforce and the older and disabled people who rely on it.

None of these effects are inevitable. They follow from imposing new obligations on a sector with no funded capacity to absorb them. Government should assess these impacts fully and fund the reforms so that the risks do not materialise.

Q33 Is there anything else you want to tell us in relation to Part 1?

The guaranteed hours' duty would work better under a shift-based model that current commissioning does not support.

Guaranteed hours require guaranteed work

The public sector purchases around 80% of homecare in the UK, and that single fact determines what providers can offer their staff. Only 0.5% of councils and Health and Social Care Trusts pay our Minimum Price for Homecare. Sixty-one percent purchase no more than 500 hours per provider each week – meaning that providers might have variability about how much work they have and where. Only 1% use block contracts that guarantee provider income. Providers cannot guarantee hours that nobody guarantees to them.

It may help to explain how homecare rotas actually work, because the model differs fundamentally from the shift-based sectors these provisions appear to assume. Providers do not roster careworkers onto shifts. They work runs of visits — typically eight to twelve calls in a day — each timed around an individual's needs, medication schedule and preferences, with travel time between them. A provider assembles a run from the packages of care a provider holds in a locality at that time. When a package changes, the run changes. Because visits are purchased by the minute or the hour for contact time only, and because the people supported are often frail or approaching the end of life, the volume of work moves constantly and without notice.

If fewer hours come in based in one locality, then there can be an increase in the number of gaps in rotas, and the provider's ability to group visits into runs becomes compromised – this affects working patterns as well as income. Providers pay shorter waits to maintain the integrity of a run, but in the worst-case scenario, visits become scattered across a week, and the careworkers' hours no longer fit into runs.

Availability

The ability to guarantee hours also depends on worker availability.

For example, the worker says they are available on Mondays, Tuesdays, Thursdays, and Saturdays within a geographic area, and within those four days and that geographic zone, the employer then allocates them 16 hours of work. As demand from different care packages comes and goes, the time that the careworker works on those days may not be exactly the same time, but in some cases the quantity of hours offered is reasonably consistent within those specifications.

In order to maintain the offer of those hours, it is vital that the availability remains the same. If the worker wants to work 16 hours but then removes Saturday from their availability window and adds Friday, the employer may not be able to offer 16 hours of work because there is more difficulty covering shifts and weekends, and therefore more work available on Saturdays. We would therefore request that the legislation allows employers to do as they currently do and base guaranteed hours contracts on the worker's availability (geographically and in terms of times and days). If the worker wants to change their availability, the contract would need to be renegotiated and may have fewer guaranteed hours.

If the legislation requires that the workers work at the same time each week, or if it allows workers to change their availability to do work without employers being able to change the quantity of hours in their contracts, it will be unworkable within current commissioning structures.

Implications

Guaranteeing hours is possible, but it costs, and providers need fee rates and work volumes that sustain it.

Case study – Visiting homecare provider in the midlands, 95 staff, offering guaranteed hours

One of our members offers guaranteed hours to 100% of their staff across four bandings:

- 15 hours
- 20 hours
- 30 hours and
- 37.5 hours

The Chief Executive explained the choice:

> *"From the start this was a choice about how I wanted to treat my team. It didn't seem right that each week or month our team would not know at least the minimum they would be paid. Zero hours contracts put all of the risk on the*

worker, it felt correct to me that as an employer we had to take at least some of that risk on."

That provider's experience shows both what is achievable and what it costs. In its early years the business paid for 5 to 10 unallocated hours per member of staff per month. With considerable effort it is now closer to 2 hours per worker per month, but there is no month in which it is not topping someone up, and this still eats into the bottom line.

Note that 2 hours per worker per month sounds low, but at our Minimum Price for Homecare would still amount to over £6,500 for the business as a whole (over £78k p.a.); 10 hours per worker per month would be over £30k for the business – almost £400k p.a.

The Chief Executive explained that this approach has constrained the business in three ways:

- It cannot be flexible about the availability it requires from staff, because guaranteeing hours at a decent level requires reciprocal availability guarantees, and many applicants cannot or will not offer that — although workers who have been let down by providers offering too few hours value the approach, which helps retention.
- It has to be more selective about the packages it accepts, generally looking for clients needing at least three calls a day so that there is sufficient work through the day.
- And balancing all of this carries an administrative cost: the provider estimates it needs at least one additional full-time equivalent in the back office purely to manage hours.

N.B. this is an illustrative example – we do not have representative data on how much unallocated hours would cost the sector as a whole and we recommend the Government update its impact assessment to review this.

This is what good practice looks like, and it is affordable **only where fee rates support it**. It gets harder for smaller and more specialised services. Not only are they less able to absorb the cost, they are also less able to find replacement hours when they lose someone they are supporting.

Councils need clarity and funding now, ahead of 2027, to make changes in advance rather than afterwards.

Part 2: Reasonable notice, and payment for shifts cancelled, moved or curtailed at short notice

Eligibility

Q34.a: What do you think the hours threshold for the rights to reasonable notice and short notice payment should be for directly engaged workers?

- 8 hours per week
- 12 hours per week
- 16 hours per week
- 20 hours per week
- 24 hours per week
- 28 hours per week
- 32 hours per week
- 36 hours per week
- 40 hours per week
- 44 hours per week
- 48 hours per week
- Other (please specify)

Q34.b Please explain your answer.

We recommend a threshold of 8 to 10 hours per week, applied consistently across these measures.

A single threshold keeps the regime understandable for small providers already managing reference periods, regularity tests, guaranteed-hours calculations and short-notice payment rules.

It also targets protection where insecurity is greatest. Workers on very low guaranteed hours have the least predictable income and are least able to absorb a cancelled visit. The consultation evidence shows that 68% of workers on 1 to 8 hour contracts work beyond their contracted hours, compared with 19% of those on 16 to 24 hours.

The two-tier concern

We recognise the objection that a low threshold creates two tiers: one careworker may receive a payment for a cancelled visit while another doing the same work does not. In principle, short-notice protection should apply across the workforce.

We propose a low threshold for two reasons.

The first is that – because of how the public sector buys care - providers organise homecare work in runs of visits and not shifts, and so movements and curtailments of visits within runs happen frequently. It is not currently clear how these movements would fit within this legislation. If the Government puts the sector in a position where moving work within

runs requires paying movement charges to workers, then this could require substantial changes in the way the sector operates with unknown implications for cost and care stability. We would urge the Government not to implement this kind of change without proper planning about how to maintain care delivery. For this reason, we have opted for a low threshold for this provision – unless the Government resolves this issue, it could create significant problems for the sector.

The second is that even if you look at cancellation fees for work cancelled by the person being supported, providers cannot currently fund the alternative. Only 43% of local authorities and 29% of NHS bodies pay providers when they or the person being supported cancel care at short notice, compared with 87% of private clients. Three-quarters of providers already pay their careworkers anyway[14]. Typical cancellation periods in the sector are 24 hours. These proposals are likely to increase costs by broadening the requirement even wider – to cancellations longer in advance, potentially, and to curtailment and movements not covered by existing cancellation policies. There is no guarantee that funding will match – it appears the Government has not considered the cost to social care in its impact assessment. If cancellation payments are to be paid in more circumstances, then the NHS and local authorities need to start paying more.

The cause is commissioning and purchase of homecare by public bodies

Short-notice changes in homecare usually reflect fluctuating human needs, not poor scheduling. People are admitted to hospital, discharged early, deteriorate, fall, die, or need more or less support than planned.

Where care is block-purchased or organised through locality contracts, providers have shifts and a pool of work to absorb that variation. Where care is purchased by the minute in small volumes, there is often no other work to offer when a visit falls away and no income to cover the worker's costs.

That is why the two-tier concern is real but misdirected. The solution is not an unfunded obligation on providers, but commissioning reform: block or locality-based purchasing, funded cancellation payments and rates that cover lawful employment.

Our position

We want better security for all careworkers, but providers cannot guarantee hours they are not themselves guaranteed or pay for cancellations commissioners do not pay them for. An 8 to 10 hour threshold is the level most deliverable within current funding. Government should not raise it without first reforming commissioning, requiring commissioners to pay cancellation fees, and closing the funding gap.

[14] Voices of Homecare: Workforce

Q35.a Agency workers should not be entitled to the right to reasonable notice and the right to short notice payments when:

- they already have a contract guaranteeing hours above the threshold (for example, by their agency) regardless of which hirer those hours are to be worked for
- they already have a contract guaranteeing hours above the threshold specifically in respect of work to be done for one hirer (for example, by their agency).

Q35.b Please explain your answer.

The exclusion should apply wherever an agency worker already holds guaranteed hours above the threshold, whoever the hirer, because such a worker already has the baseline income security the right is designed to provide; a narrower test would expose providers to guaranteed-hours duties for agency workers who already have security elsewhere, adding cost and administration the sector cannot absorb.

Q36.a: What do you think the hours threshold for the right to reasonable notice and the right to short notice payments should be for agency workers?

- 8 hours per week
- 12 hours per week
- 16 hours per week
- 20 hours per week
- 24 hours per week
- 28 hours per week
- 32 hours per week
- 36 hours per week
- 40 hours per week
- 44 hours per week
- 48 hours per week
- Other (please specify)

Q36.b Please explain your answer.

We recommend 8 hours per week, the same figure we propose at Q1, Q3 and Q34. Consistency across all four thresholds keeps the measures administrable for providers with no dedicated HR function and targets the workers whose income is genuinely least predictable. Different thresholds for different rights, or for directly engaged and agency workers, would create confusion for workers and employers alike without any corresponding benefit.

Part 2.A: Reasonable notice of shifts

Q37.a How much notice should be presumed reasonable for directly engaged workers?

- 1 week
- 2 weeks

- 3 weeks
- 4 weeks
- Other

Q37.b Please explain your answer.

We support a one-week presumed notice period because homecare must respond to unpredictable human needs. As one member told our Employment Rights Special Interest Group, “our sector is built around responding to unpredictable human need”. Another compared fixing rotas far in advance to asking an emergency department to schedule its patients.

One week reflects current practices and current systems. Most providers issue rotas a week ahead, and some rostering systems do not send rotas to careworkers’ phones further in advance. That reflects the reality that care packages, staffing, and people’s needs often change within the week.

A longer presumed period would not give careworkers more certainty. It would give them an earlier rota that is then revised repeatedly. Members tell us that a two-week rota is often pointless because so much changes before the work takes place, and repeated revisions unsettle staff more than a realistic rota issued closer to the time.

The reason is structural. Homecare providers rarely organise work in shifts. Workers deliver care as runs of visits, purchased by the minute and shaped around each person’s needs. A single hospital admission, death, fall, discharge delay, or staff sickness can reshape several careworkers’ runs at once.

For example, a Tuesday run might include a morning personal care visit, a double-handed hoist call, a time-critical medication visit, several lunchtime calls and evening calls. If one person is admitted to hospital, another falls, or a careworker calls in sick, the provider must rebuild the rota quickly to keep the right skills matched to the right people. That is not poor planning; it is the service working as it should.

In a shift-based system, providers could absorb some changes within paid operational capacity. Current commissioning does not fund that capacity. Local authorities and the NHS usually buy care at low rates, by the minute or hour, so providers cannot hold paid downtime in rotas. Preventing short-notice movement would therefore require either funded downtime or a less responsive service for the people being supported.

The consequences of setting the presumption too long should be clear. Providers would not be in automatic breach, because the presumption is rebuttable. But they would routinely have to justify short-notice changes caused by events outside their control, and could face claims or payments for ordinary features of homecare. That is why the exceptions at Q39 matter as much as the presumption itself. A one-week presumption works only if the legislation recognises why rotas change in homecare.

Q38 In what circumstances do you think longer notice should be required? Please explain your answer

Longer notice is reasonable for planned, foreseeable, provider-initiated changes — a scheduled service redesign, a planned package reduction following a review, or a rota change made for the provider's own business convenience. Where the provider controls the change and can foresee it, more notice is fair.

Live-in care can also support longer notice in a particular sense. Providers can usually tell a live-in careworker further in advance which weeks they can expect to be on placement and which they are off.

In visiting care, it is often possible to agree a longer-term pattern — which weekends a careworker will work, or which days they are available — well in advance, without committing to the exact hours or the specific people they will support. Government should recognise that notice of a working pattern differs from notice of a finalised rota, and that providers can often give the former earlier.

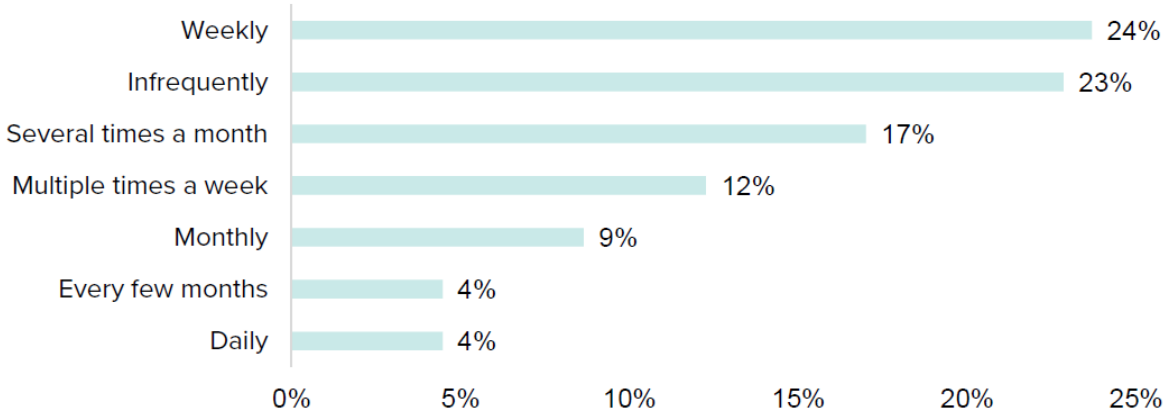
Q39 In what circumstances do you think shorter notice should be required? Please explain your answer

The legislation must permit shorter notice where the change flows from events outside the provider's control: a client's hospital admission, discharge or death; a commissioner moving or ending a package at short notice; a safeguarding concern; colleague sickness; or emergencies affecting the person's safety. Providers act to keep vulnerable people safe and cannot give longer notice, so regulations must treat this as reasonable rather than penalise it.

Our 2025 workforce survey[15] (Figure 4) shows how often careworkers' hours change and why. Nearly a quarter of providers (24%) change careworkers' hours weekly, 17% several times a month and 12% multiple times a week. Only 4% do so as infrequently as every few months.

[15] Voices of Homecare: Workforce

Figure 4: How frequently do you typically change a careworkers working hours at the moment?

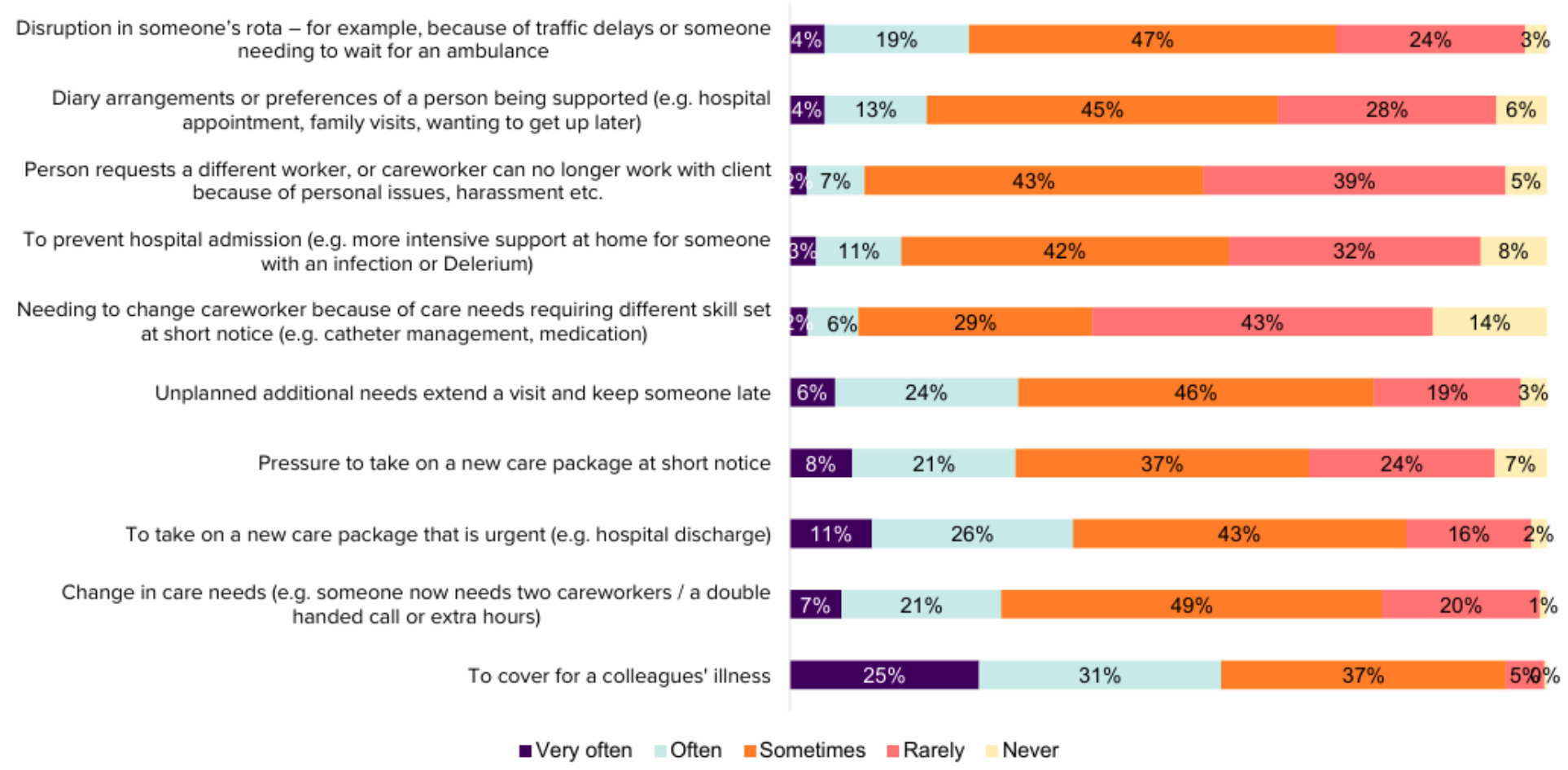


The reasons are overwhelmingly clinical and logistical rather than commercial (see Figure 5). Hospital admissions were the most frequent cause of cancelled shifts, reported as happening often or very often by 48% of providers. 56% of providers reported covering for a colleague's illness often or very often, causing changes. Changes in a person's care needs, urgent hospital discharges, unplanned additional needs that extend a visit, and disruption caused by traffic or waiting with an ambulance all featured prominently. These are not scheduling failures. They are operational realities.

Public commissioners are themselves a significant source of short-notice change, and should not be able to transfer the consequences to providers. 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 concerned and contrary to the Care Act 2014.

Hospital discharge deserves particular attention. Homecare providers currently offer a great deal of flexibility to support discharges, which rarely happen at the time the hospital initially plans. Careworkers may wait at someone's home for them to arrive back from hospital, only to find the discharge delayed on the NHS side. The local authority and NHS often do not compensate providers for that waiting time, and commissioners and hospitals appear not to consider the cost of the movement of care staff working hours in their planning. As well as pointing to the need for significant work on discharge procedures, this raises a serious risk: if providers face even heavier penalties for moving staff hours in response to shifting hospital timetables, hospital discharge will become harder to achieve, not easier.

Figure 5 Thinking about changing careworkers' hours at short notice - how frequently do the following reasons apply?



Regulations should recognise the full range of circumstances in which rota changes in less than a week can happen in ways that are outside the control of a provider. Our members identify the following:

- **Sickness and unplanned absence of colleagues** — short-notice illness, emergencies or family crises leading to rapid reallocation.
- **Travel and weather disruptions** — circumstances requiring short-notice changes of travel routes, traffic jams, or other incidents affecting call scheduling.
- **Medical emergencies or accidents** - that require extended or unplanned careworker visits.
- **Urgent new care packages starting** — new people needing support, hospital discharges, or urgent social worker referrals needing immediate cover.
- **Care packages ending or reducing** — a person moves to residential care, dies, or has their hours reduced after a review with immediate effect.
- **Regulatory, commissioner or funder changes** — local authority or NHS adjustments to funded hours, visit frequency or tasks or changes required by care regulators or safeguarding teams. Some of these can be managed by a longer-term adjustment but some need to change immediately for safety reasons.
- **Urgent changes in care needs** – changes in care needs that require an immediate response such as timed medication changes, the need for double-handed calls for lifting and handling, increase/decrease or change in the time needed to meet the needs that need to take effect immediately. Note that sometimes this will mean that a person requires a particular skill mix that only some careworkers match, which could mean a wider readjustment of several careworkers' rotas to meet the changing needs of one person.
- **Performance or safeguarding concerns** — moving a worker off a package because of complaints, compatibility issues or risk.
- **Careworker safety decisions** — changes to manage the safety of careworkers at work - two careworkers instead of one on a call, additional checks, or changed timings following an incident.
- **Rostering system constraints or errors** — software rules, automatic optimisation, or data entry mistakes needing correction.

There are also changes that employers accommodate now to improve service flexibility for the people being supported and workers:

- **Changes in visit times requested by the person or their family** — later mornings, earlier evenings or different days, which ripple across the rota.
- **Availability patterns change** — staff asking to change days because of school runs, second jobs or study commitments.

Case study – short notice and movement of calls – ambulance waits

The following two case studies are real examples of a care provider calling on additional staff and changing shifts in order to respond to the need to wait for ambulances. These are not extreme cases but common occurrences in homecare

delivery. In both cases, the incident affected **multiple careworkers across the rota and not just the staff immediately involved**. Under the new legislation there is a risk that the provider would be penalised for calling staff in late and/or moving staff to provide cover where a colleague is detained by unplanned circumstances. As can be seen in the first of these examples, the provider is not necessarily paid for the additional time the careworker spends with the person, so may already be out of pocket.

Example 1

A man in his 70s, living alone, is documented as being at end of life, with multiple long-term conditions. He receives a locally funded care package of two carers, four times a day, and has no next of kin available to support him.

Over a nine-month period from the end of 2025 to mid-2026, at least nine separate incidents required 999 or 111 involvement and were formally reported to the funding local authority as retrospective changes to the care package — roughly one a month. Each of these also meant the carer's remaining calls that day had to be picked up by colleagues at short notice, putting pressure across the wider rota, not just on the staff directly involved. Three incidents illustrate the pattern in detail.

In January 2026, while carers were using a sliding sheet to support him with personal care, the client slipped and fell from the bed onto the floor; he does not have a hospital bed, so carers had no safe way to reposition him without help arriving. Emergency services were called and initially quoted a wait of three to four hours. As he has no next of kin and could not be left alone, one carer stayed with him throughout. By mid-afternoon he was in significant and worsening pain from lying on the floor, and 999 was contacted again for an update; the ambulance did not arrive until late afternoon, when he was taken to hospital for further evaluation.

In July 2026, the lunchtime carer found the client — who is bedbound and does not normally attempt to get up — trying to get out of bed unaided, refusing all support, refusing food and fluids, and appearing confused. Carers judged this a marked, sudden change from his baseline that could indicate acute deterioration, and called 999. That carer stayed from lunchtime to late afternoon (3 hours 38 minutes). Following this, the teatime carer arrived for a full handover and continued the wait until late evening (a further 4 hours 41 minutes).

The care provider paid its care workers for the additional hours worked during the two longer incidents; the local authority has not reimbursed the provider for either of these costs.

Example 2

A (different) man in his 70s, living alone in sheltered housing, has a diagnosis of dementia with moderate cognitive impairment and an increased risk of falls; he receives a locally funded home care package.

Overnight in July 2026, the client slipped from his chair onto the floor and was in pain. Care staff could not assist him up under moving-and-handling policy, so 111 was contacted for a clinical decision; his brother was contacted but was too far away to attend.

The first care worker was scheduled to work until 22:00. She stayed on with the client for reassurance and support while awaiting guidance, not finishing until 23:20 — 1 hour 20 minutes of unplanned overtime beyond her rostered shift.

The second care worker was separately scheduled to work 18:00 to 22:00. As the wait continued, she picked up the overnight shift with no advance notice, remaining with the client until the ambulance finally arrived at 5:25am — a further 7 hours 25 minutes of unplanned night cover on top of her scheduled hours. She was paid an incentive rate for the overtime worked. Between the two workers, close to nine hours of unplanned overtime was worked overnight.

Furthermore, both the care workers work had to be covered for the following day which resulted in another care worker being asked to change their hours at short notice and for additional overtime pay.

The client was subsequently confirmed to have fractured his hip.

By contrast, once notified, in this case the local authority's out-of-hours safeguarding team responded immediately and commissioned the funded care package without delay (so the provider received some payment), it was specifically the ambulance response that took hours to materialise, not the wider social care system around it.

Q40.a How much notice should be presumed reasonable for agency workers?

- Less than 5 days
- 1 week
- 2 weeks
- 3 weeks
- 4 weeks
- Other

Q40.b Please explain your answer.

Agency workers in homecare are typically engaged precisely because an employer needs cover urgently, most often to fill a gap created by a careworker's sudden illness or a sudden escalation in an individual's needs. If a hirer cannot ask an agency worker to take on a placement at short notice without incurring a penalty, the principal purpose of using agency staff disappears, and the person needing care is the one who goes without.

We have therefore selected fewer than five days. Beyond that specific point, the considerations set out at Q37 apply equally to agency workers.

Q41 In what circumstances do you think longer notice should be required for agency workers? Please explain your answer

As at Q38, longer notice is reasonable where the work is not new and the hirer is covering a planned gap or absence — a booked period of annual leave or a scheduled change. In those circumstances, the hirer knows the requirement in advance and can give both the agency and the worker proper notice.

Planned live-in care placements fall into the same category. Where a provider arranges a placement in advance, it is reasonable to specify which weeks they expect the agency careworker to be on placement. This would not apply to urgent short-term cover.

Q42 In what circumstances do you think shorter notice should be required for agency workers? Please explain your answer

As at Q39. Wherever an agency worker is being called in to cover urgent needs.

Exemptions from the duty to provide reasonable notice

Q43.a Should there be any types of hirers that should not be liable for failing to provide reasonable notice?

- Yes, certain types of hirers should not be liable for failing to provide reasonable notice
- No, all types of hirers should be liable for failing to provide reasonable notice

Q43.b If yes, please specify any types of hirers that you think should not be liable for failing to provide reasonable notice.

Not applicable.

Q43.c If no, please explain your answer.

We do not think any category of hirer should be exempt from liability for failing to provide reasonable notice. Our reasoning turns on how the care regulations shape the homecare market, and on who actually holds the employment relationship in each arrangement.

The employment business model is uncommon in homecare

Registration with the Care Quality Commission depends on the regulated activity of personal care, and what brings an organisation into registration is directing and controlling how workers deliver that care — assessing need, planning support, supervising workers, monitoring quality and handling complaints.

We typically see three arrangements:

- An organisation that retains oversight of care delivery must register as a provider, at which point it delivers its own service rather than supplying labour. People sometimes call these organisations ‘care agencies’. This is legally incorrect. They are direct employers.
- An organisation that relinquishes the oversight of care delivery is no longer supplying an ongoing service; it is making an introduction and becomes an

introductory agency with no ongoing relationship. The individual with the care needs becomes the employer with no ongoing oversight from the agency; or the arrangement deems the worker self-employed (which is questionable).

- Care providers sometimes hire agency workers (as per the first bullet). Individuals do not usually do this.

If Government intends to protect individual employers, that is a different question

We recognise that concern about liability for disabled and older people is genuine, but we think the proposed exemption is misconceived. The situation people have in mind is an individual who employs a personal assistant directly, often following an introduction. That is not an agency arrangement. Any protection for individual employers would have to be constructed in the direct employment context.

The difficulty individual employers face is real. A person admitted to hospital cannot give notice of a cancelled shift, and few individual employers have the infrastructure to manage these obligations.

The wider risk

These provisions attach to employment businesses supplying agency workers. They do not attach to introductory agencies, which supply an introduction rather than an ongoing supply of labour, and where arrangements treat the worker as self-employed, the framework does not apply at all. The same absence of ongoing oversight that keeps an introductory agency outside CQC registration also keeps it outside these employment provisions.

We therefore ask Government to regulate introductory agencies and review the employment status of workers engaged through them.

Part 2.B: Payment for shifts cancelled, moved or curtailed at short notice

Q44.a What timeframe do you think short notice should be for directly engaged workers?

- 1 day
- 2 days
- 3 days
- 5 days
- 7 days
- Other

Q44.b Please explain your answer.

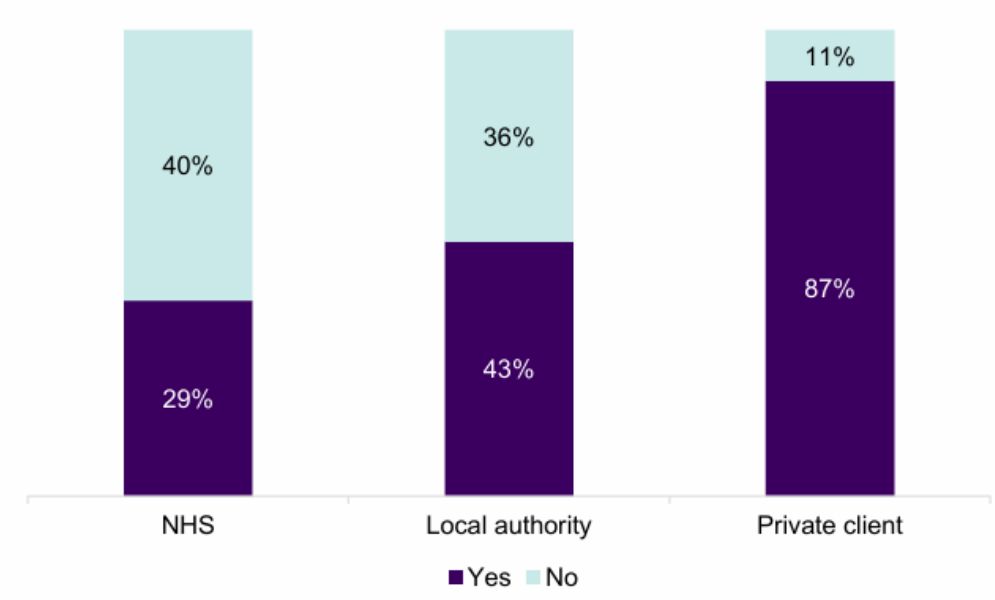
We have selected one day. Changes in homecare typically arise within a day or two of the visit — a hospital admission the night before, a death, or a same-day cancellation by the person or their family. From the worker's perspective, we can see that this could be slightly longer. However, our reasoning is as follows:

- One day reflects current contractual practice, and the public sector is already not paying cancellation fees when it should. If this is going to increase, commissioners need to pay cancellation fees that correspond to the legal position, and Treasury must fund this.
- This has relevance to a much wider situation than pure cancellations, where commissioners are currently not always paying providers, including payments following a death, payments for moving planned visits, and so on. These need to be paid to enable providers to pay staff in these situations.
- The movement and curtailment clauses pose a significant risk to the whole way of organising work into runs of visits unless the Government adapts the legislation for this.
- Providers are trying to balance responsiveness to individuals against fairness to careworkers.

Current practice – the public sector is bad at paying cancellation fees

One day reflects current contractual practices. Where care contracts contain cancellation clauses, they generally operate on 24 hours' notice, and members told us this is the standard they apply. Those clauses tend to exist with people who fund their own care. Many public sector commissioners do not pay cancellation fees at all: our 2025 workforce survey found that people funding their own care pay cancellation fees 87% of the time, but only 43% when a local authority cancels and 29% when the NHS does[16] (see Figure 6).

Figure 6: As a business, are you paid where the person cancels care calls at short notice?



[16] Voices of Homecare: Workforce

Non-payment in other situations that are relevant

Providers effectively cancel work in other contexts which are not strictly 'cancellations' from the users' perspective but are cancellations of work from the employee's perspective. However, similar to the above case, we often find that public sector commissioners do not always pay unless the carer delivers the care work, even if the employer has had to retain staff to manage the situation. However, these costs need to be met somehow, and current fee rates are not even sustaining minimum wage compliance in almost a third of the country[17].

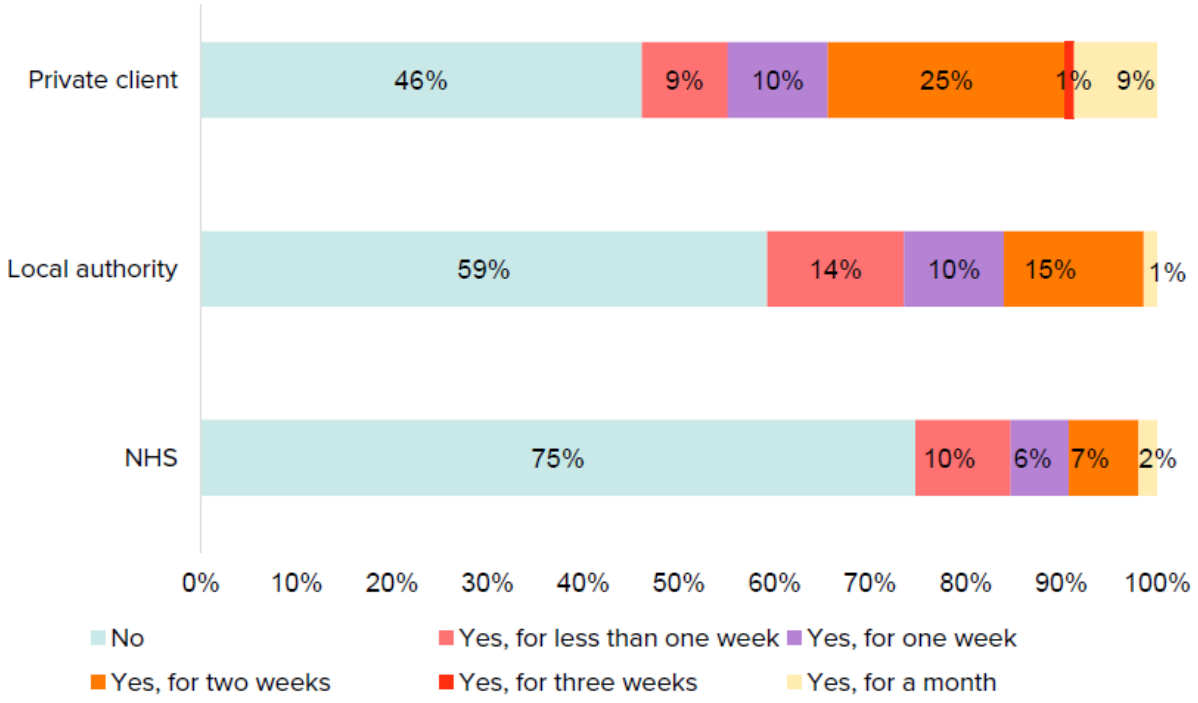
Whether commissioners or self-funders pay the care provider in the following contexts is also relevant to work cancellations:

- When a hospital admits someone who usually receives care at home
- When someone dies
- When hospitals reschedule discharge times, and a careworker is waiting at home
- Notice periods for when a package is going to end (planned rather than urgent)
- How commissioners manage payments around electronic call monitoring
- When they move visits

To illustrate this, we know that the NHS are least likely to pay care providers to retain careworkers work allocation when someone is admitted to hospital – 75% of NHS commissioners will pay no homecare fees when someone is admitted to hospital, whereas more than half of people who pay for their own care do pay. This has a direct implication for cancellations of work. If there is no payment and the provider is not sure how long the person will be in hospital for, then they may effectively receive repeated or rolling short-notice cancellations based on uncertain discharge dates or irregular updates from family members repeatedly call off work at short notice. It is much easier to pay careworkers for cancelled work when the funder of care pays the provider to keep the arrangement in place; otherwise the careworker has a temporary unfunded gap in their rota. The NHS and local authorities need to be able to budget to cover these expenses.

[17] The Homecare Deficit 2025

Figure 7: As a business, are you paid to hold someone's care arrangements open when someone is in hospital?



Movement and curtailment – potentially a significant risk to homecare and need for clarification

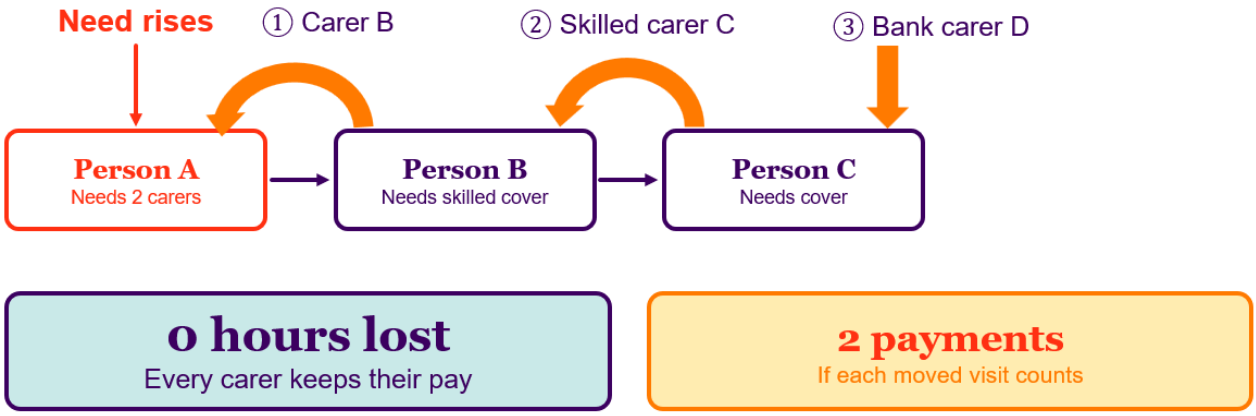
Cancellation clauses in contracts offer a route for providers to recover the cost of work lost at short notice. They do not address the wider problem. Rotas also change at short notice because of traffic, road accidents, a person becoming unexpectedly unwell, or a careworker waiting with an ambulance. It is far less clear how a provider could fund payments compensating for changes of that kind, unless the sector moved to a genuinely shift-based model. That would require a substantial change in how the public sector purchases care, away from time-and-task purchasing.

Homecare providers do not generally plan work in shifts. They organise work into runs of visits and often pay workers by the visit because of cost constraints. Providers can move, swap, shorten, lengthen, or cancel individual visits at short notice when someone's needs change. This legislation could mean every move, swap, shortening, or lengthening of a visit potentially incurs a cancellation fee.

Care providers are constantly rearranging rotas to balance different people's changing needs. Sometimes this doesn't result in any major change to the total hours that a careworker works in a day (though it's likely that the timings of the calls won't align precisely), but will cause multiple movements within the runs. For example (see Figure 8), someone's needs increasing so that they need two carers may mean that a careworker might need to be swapped who was supporting another person. However, that person may

need a careworker with a particular skill, meaning that a further swap is then necessary to meet everyone's needs. There is a risk that homecare providers could end up paying multiple fees for moving visits and that this cost could be unsustainable and unfunded. For a real example of this, see the case studies on ambulance waits above under Q39.

Figure 8 – Rearranging rotas to meet someone's needs



Electronic call monitoring makes this harder. Where councils pay only for the minutes a careworker is in someone's home, an unexpectedly shortened visit can mean no payment to the provider, sometimes through no fault of the provider or the careworker. That in turn affects the provider's ability to pay the worker, and the shortened visit may itself count as curtailment under these provisions – meaning the provider not only receives less money but could be required to pay a cancellation fee for curtailment to the worker.

We recognise that call clipping or call cramming is a real risk in the sector. However, if electronic call monitoring is used to reduce costs rather than to monitor service quality, the by-the-minute payment becomes extremely difficult to manage financially and affects working conditions significantly.

Paying the careworker by the minute could cause the careworker considerable anxiety and cause them to clock-watch. If the person is slow to answer the door, then the provider and careworker can lose payment, for example. If the person being supported wants the careworker to leave a few minutes early so they can go to sleep one night and wants the careworker to stay a minute or two to have a brief conversation the next night both will cause issues if precise timing is required. Care work is relational, and electronic monitoring by local authorities can already penalise care providers (and workers) for this.

It is absolutely vital that:

- The Government issues guidance alongside this legislation that enables providers to move careworkers to different visits within a run without this requiring cancellation payments
- There is clarity on who pays for moving, shortening, or lengthening visits – commissioners asking for short-notice adjustments may need to expect to pay more
- That commissioners review the use of electronic call monitoring to pay workers by-the-minute in light of these legislative changes.

Responsiveness, compassion, and fairness

Providers are reluctant to extend cancellation clauses further. The people affected are older and disabled, often on modest incomes, and charging them for care they did not receive sits uncomfortably with providers. Some members told us they do not charge cancellation fees at the end of a person's life, for example, because it feels inappropriate.

Q45.a What timeframe do you think very short notice should be for directly engaged workers?

- less than 1 day (please specify)
- 1 day
- 2 days
- 3 days
- 5 days
- There should not be a 'very short' notice period
- Other

Q45.b Please explain your answer.

A separate, very short notice tier adds complexity to an already complicated set of measures. In homecare, the shortest-notice changes are precisely those outside the provider's control, so a higher tier simply transfers more unfunded risk. A single, simple short-notice period is preferable unless there is a full commitment to fund these and to adjust commissioning practices.

Q46.a What timeframe do you think short notice should be for agency workers?

- Less than 1 day (please specify)
- 1 day
- 2 days
- 3 days
- 5 days
- 7 days
- Other

Q46.b Please explain your answer.

For consistency with Q44 and to keep the design administrable across engagement types.

Q47.a What timeframe do you think very short notice should be for agency workers?

- Less than 1 day (please specify)
- 1 day
- 2 days
- 3 days
- 5 days

- There should not be a ‘very short’ notice period
- Other.

Q47.b Please explain your answer.

As at Q45, a separate very short notice tier for agency workers adds complexity without fair funding for the changes that occur at the shortest notice.

Q48.a The short notice payment should be:

- A percentage of what the worker would have earned from working the shift or the relevant hours
- A percentage of what the worker would have earned from working the shift or the relevant hours at the relevant National Living/Minimum Wage rate

Other Q48.b Please explain your answer.

We have selected a percentage of what the worker would have earned from working the shift or the relevant hours.

The fact that National Living Wage rises affect half of careworkers and around 90% of care providers[18] suggests employers are paying many homecare workers at or near the National Living Wage, so in most cases the two bases would produce similar figures. The difference matters, however, for providers who pay transparently. Some pay a single headline rate intended to cover travel time between visits, while others itemise contact time, travel time, and waiting time separately. If the legislation calculates the payment on the National Living Wage rate alone, providers might compensate only the hours of the call at that rate. That would financially disadvantage employers who already pay openly for all working time, and would disadvantage careworkers working contact time only policies.

Basing the payment on actual earnings avoids that distortion and takes the worker’s real loss as the measure.

Q49.a If the short notice payment were a percentage of what the worker would have earned from working the shift or the relevant hours, what percentage should this be?

- 10%
- 30%
- 50%
- 65%
- 80%
- Other

[18] https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/workforceintelligence/resources/Reports/Topics/Pay-in-the-adult-social-care-sector-in-England-as-at-December-2025.pdf

Q49.b Please explain your answer.

We support 50%. A partial rate recognises the worker's lost opportunity and any non-refundable costs they have incurred, while still encouraging staff to take up alternative work offered on the same day. That incentive matters to some homecare businesses where securing cover can be difficult.

Whatever rate Government sets, public sector commissioners must pay it in full to providers, so that the employer can pay the worker. Without that, the obligation simply relocates an unfunded cost onto businesses already operating below the cost of care.

Our support for this measure would be stronger if the Government limited it to straightforward cancellation of a visit. Providers are seriously concerned about the scope of the payment, which also covers moving and curtailing work. Our workforce survey data suggests that three quarters of providers already pay careworkers when a person cancels their visit outright at short notice. They do not generally pay when a visit moves or curtails. We ask Government to define this scope clearly (see Q44.b and Q61).

Q50.a If the short notice payment were a percentage of what the worker or agency worker would have earned from working the shift or the relevant hours at the relevant National Living/Minimum Wage rate, what percentage should this be?

- 10%
- 30%
- 50%
- 65%
- 80%
- Other

Q50.b Please explain your answer.

If Government adopts the National Living Wage basis rather than actual earnings, we would again support 50%.

Many careworkers' wages are already at or close to the National Living Wage, so the two bases produce broadly similar outcomes for most of the workforce.

Our concern about higher rates is practical. Providers report that a payment at or close to 100% would remove the incentive for careworkers to take up alternative work offered on the day, which would create capacity problems.

Q51.a If the very short notice payment were a percentage of what the worker would have earned from working the shift or the relevant hours, what percentage should this be?

- 30%
- 50%
- 65%
- 80%
- Other

Q51.b Please explain your answer.

We do not support a distinct, very short-notice tier. If the Government introduces one against our advice, any differential should be modest, because the shortest-notice changes in homecare are those outside the provider's control. Like other cancellation payments, this will require funding.

Q52.a If the very short notice payment were a percentage of what the worker or agency worker would have earned from working the shift or the relevant hours at the relevant National Living/Minimum Wage rate, what should this percentage be?

- 30%
- 50%
- 65%
- 80%
- Other

Q52.b Please explain your answer.

As at Q51, we do not support a separate very short notice tier. If Government introduces one against our advice, the differential should remain modest. Many careworkers' pay is at or close to the minimum wage in any event, so the two bases produce similar figures, and a steeply escalating rate would simply transfer more unfunded risk to providers for changes they do not control unless commissioners pay.

Exceptions from the right to short notice payments

Q53.a Do you think there should be any exceptions to the requirement to make a short notice payment or very short notice payment?

- Yes
- No

Q53.b If yes, what should these exceptions be?

We therefore propose a small number of tightly drawn exceptions, and we begin by explaining one we deliberately do not seek.

Exception 1: genuine force majeure

No payment should arise where an event outside anyone's control prevents care being delivered as planned: severe weather, flooding, fire, power or utility failure, cyber-attack or major IT and telecoms failure, or a declared civil or public health emergency. These are exceptional, externally caused and objectively verifiable, and no party can reasonably plan around them.

Exception 2: worker-initiated changes

Consistent with the Act, no payment should arise where the worker initiates the change, is unable to work the visit, or where two workers voluntarily agree to swap.

Where a provider offers a worker alternative work in the same time slot, supporting a different person, and the worker declines it, there should be no payment due.

The same principle should apply to curtailment where the worker controls the decision. Where a careworker on electronic call monitoring chooses to leave a call early, the council may not pay the provider for the time not delivered, and may pass that reduction on. Where a visit ends early for reasons outside the worker's control, the provider should challenge the council and pay the worker in full, and we would expect that. But where the lost time results from the worker's own choice, the provider should not face a curtailment payment.

Exception 3: a minor movement threshold

The Department has framed the consultation around shift-based work, but providers currently deliver homecare in visits: a careworker typically completes a run of eight to twelve calls in a day. Calls move within that run constantly, for reasons that are ordinary and usually beneficial to the person receiving care:

- a person is late back from a GP, hospital or dental appointment, so their call moves by half an hour;
- a district nurse, therapist or social worker attends, and the care call moves around them;

In these cases, the careworker often experiences no detriment at all. They work the same hours, earn the same money, and travel the same route in a different order. The costs the payment is designed to compensate — wasted travel, lost childcare, forgone alternative work — do not arise. The purpose of a right is to compensate detriment, and where there is none, there is nothing to compensate.

We therefore propose a de minimis threshold. No payment should arise where a visit moves by only one hour from its original time.

Without such a threshold, providers will become reluctant to accommodate the small changes on which person-centred care depends. Rearranging a call so someone can attend their grandson's birthday is good practice, not employer convenience. If every accommodation triggers a payment, providers will refuse them, and the service will become less responsive to older and disabled people.

Exception 4: movement consequent on a worker agreeing to additional work

Where a careworker agrees to take on an additional call at short notice and the provider rearranges their rota to accommodate it, no payment should arise in respect of the resulting movement. Penalising a provider for a change the worker sought would be perverse and would make providers reluctant to offer additional hours, reducing the earnings opportunities careworkers value.

Exception 5: a minor curtailment threshold

We ask Government to consider a minor curtailment threshold alongside the movement threshold, for the same reasons.

Working time in homecare fluctuates slightly. A careworker's day varies with traffic, with how long each visit actually takes, and with waiting time between calls. If a run finishes ten

minutes early because traffic was light, or because one person needed slightly less support than expected, it would be unreasonable to treat that as a curtailed shift attracting a payment. We suggest that curtailment should not arise where the reduction is small — a threshold of fifteen minutes, or 10% of the day's hours — and the worker's hours are otherwise unaffected.

Electronic call monitoring makes this question urgent. Where councils pay by the minute, small variations in visit length are routine, and the system records automatically. Without a de minimis threshold, providers could face curtailment payments generated by nothing more than the ordinary variability of the working day, and by a payment mechanism that the council, rather than the provider, controls.

Exception 6: movement of visits within a run of visits if the pay change is negligible

To address the issue we outlined in Q44, we would strongly recommend that there be clarification and/or an exemption that movement of visits within a run of visits should not qualify for short-notice payments if the overall change to the careworker's pay is negligible.

Q53.c If no, please explain your answer.

Not applicable — we consider exceptions are essential (see Q53.b).

Q54.a Do you think there should be any exceptions to the requirement to make a short notice payment specifically for agency workers?

- Yes
- No

Q54.b If yes, what should these exceptions be?

Not applicable

Q54.c If no, please explain your answer.

The same exceptions as Q53 should apply, since the causes of short-notice change do not differ by engagement type.

Q55.a Do you think there are any types of hirers who should not be added to tribunal proceedings and potentially held liable for breaches regarding an exception notice?

- Yes, certain types of hirers should not be added to tribunal proceedings and potentially held liable for breaches regarding an exception notice
- No, it should be possible to add all types of hirers to tribunal proceedings and potentially held liable for breaches regarding an exception notice

Q55.b If yes, which types of hirers?

Not applicable

Q55.c If no, please explain your answer.

Our reasoning follows Q43. We do not think the legislation should exclude any category of hirer from tribunal proceedings in principle.

We recognise the practical concern that a disabled or older person arranging their own support has none of the infrastructure an employer would draw on, but it is a misconception to view them as hirers in an employment business from a legal standpoint.

Q56.a Do you think there are any types of hirers from whom it should not be possible to recover short notice payments under the Act?

- Yes, there are certain types of hirers from whom it should not be possible to recover short notice payments under the Act
- No, there are no types of hirers from whom it should not be possible to recover short notice payments under the Act

Q56.b If yes, from which types of hirers?

Not applicable — see Q56.c.

Q56.c If no, please explain your answer.

Individuals who receive care from directly employed staff will need to pay cancellation fees where their contract provides for it.

We believe that the construal of people with care needs as hirers from employment businesses is a misconception.

Enforcement of short notice payments

Q57.a Should the Fair Work Agency enforce the right to short notice payments?

- Yes
- No

Q57.b Please explain your answer.

We support effective enforcement of workers' rights. Enforcement aimed solely at providers would, however, penalise the symptom while ignoring the cause.

The Fair Work Agency should, like the Care Quality Commission's State of Care reporting, surface systemic issues — in particular the low public sector fee rates and by-the-minute commissioning that make lawful compliance impossible, and the refusal of most commissioners to pay cancellation fees. An enforcement regime that examines only the employer will never see this.

It should be unlawful for public bodies to purchase care at rates that do not enable providers to comply with employment law. 29% of Councils and Health and Social Care

Trusts currently pay providers fee rates that are lower than direct employment costs at the statutory minimum wage[19].

Q58 Should the FWA impose a penalty where it finds that an employer has failed to make a short notice payment?

- Yes
- No

Q59.a What should the penalty amount be?

- 50% of arrears owed to the worker (government preferred option)
- 100% of arrears owed to the worker
- 200% of arrears owed to the worker
- A different amount

Q59.b Please explain your answer.

It is important that there is consistent enforcement; otherwise, there is an additional risk that other providers who are ignoring the legislation entirely will undercut compliant employers.

Given the fragility of provider finances and non-existent margins, we have selected the lower option.

Q60.a What should the minimum and maximum penalty amount be?

- Minimum £100 per case, maximum £5,000 per worker (government preferred option)
- Minimum £100 per case, maximum £20,000 per worker
- Different amounts

Q60.b Please explain your answer.

The lower range is proportionate to a new right.

In the homecare sector, fee rates frequently fall below the cost of lawful employment[20]. We call on the Government to address this issue before increasing penalties.

Broader impacts (Part 2)

Q61 Is there anything else you want us to take into account in relation to Part 2 of this consultation, on reasonable notice of shifts and payment for shifts cancelled, moved or curtailed at short notice?

The two most important points are:

- The need for clarity on moving visits within runs and
- The need for changes to funding and commissioning to cover costs.

[19] The Homecare Deficit 2025
[20] The Homecare Deficit 2025

We ask Government to issue an urgent clarification on how the legislation will treat the movement of visits and undertake a fully costed impact assessment plus a clear plan of how commissioning and funding will adapt ahead of the legislation being implemented, covering:

- cancellation and movement charges;
- charges:
    - when a hospital admits someone who usually receives care at home
    - when someone dies
    - when hospitals reschedule discharge times and a careworker is waiting at home for them
- commissioning policies around:
    - sufficient notice being given to care providers when a package is going to end (in a planned way rather than urgently)
    - using electronic call monitoring for quality assurance and not as a cost-reduction measure
- raising direct payment and fee rates to cover the costs these measures create for spot-purchased, low-volume and specialist services that don't fit regular contracting practices.

Without that clarity, providers cannot model the cost of these measures, cannot configure their rostering and payroll systems, and cannot give careworkers accurate information about their entitlements. We would welcome the opportunity to work with officials on definitions that fit a visit-based service.

We would also like to highlight that the Government's own options analysis[21] says that for these policies *"The major non-monetised impact is a reduction of flexibility and increased risk of not meeting consumer demand... We know that employers use variable hours contracts where their demand is difficult to effectively predict. If the viability of these business models is affected by these changes, there could be a loss in output or an increase in operating costs."* The Government must seriously consider what this means in a social care context. Not meeting consumer demand when it comes to social care affects people's safety, not just their leisure choices.

Q62.a Do you think that the proposals in Part 2 of this consultation, on reasonable notice of shifts and short notice payments, will have a particular impact on groups sharing a protected characteristic under the Equality Act 2010?

- Yes
- No

[21] Right to reasonable notice of shifts: options assessment

Q62.b Please explain your answer.

In homecare, providers very rarely cancel shifts because they have over-provisioned staff — the sector faces severe shortages, with a homecare vacancy rate of 9.4% in June 2026[22]. Rota changes are almost always driven by others: a client goes into hospital or dies, a commissioner moves a package at short notice, or an emergency arises.

Around 78% of workers in domiciliary care services identified as female, and 22% identified as male[23]. 27% of the social care workforce as a whole were 55 and above in 2024/25.[24] So, the workforce affected is disproportionately female, and includes many older workers, part-time workers and workers from minority ethnic backgrounds who are over-represented – non-British nationals comprise around 30% of the homecare workforce. The people receiving care are overwhelmingly older or disabled. Both groups would feel the consequences of an unfunded scheme.

It is difficult to determine the impact of this legislation without further clarification around how the Government will view the movement and curtailment of visits.

If the payments make it difficult for care providers to move visits, then this could significantly impact how responsive care providers are to individual's needs.

It could also mean that care providers will start to choose to contract or organise work in ways that fall outside the scope of this legislation. This could be an advantage to some workers if it means that the sector moves towards more shift-based working with the support of commissioners; or it could create significant market instability and an increase in 'self-employed' careworkers – circumventing employment legislation altogether. This would then be bad for workers.

If the Government tries to implement the legislation without proper thought, funding or clarification, there is the risk of widespread non-compliance with both this legislation and other employment legislation (such as the minimum wage), as the Government has not funded providers to a level that they can comply[25]. Consider the situation with salary non-compliance that has arisen around sponsored workers – revocations are high and non-compliance is still common.

Part 3: Amending the Conduct of Employment Agencies and Employment Businesses Regulations 2003

Q63.a Should the government amend the Conduct of Employment Agencies and Employment Businesses Regulations 2003, to require relevant entities to share information they need to comply with their duties under the zero hours measures?

- Yes, the government should amend the Conduct Regulations

[22] Recruitment and retention
[23]Skills for Care (2025) Summary of domiciliary care services 2025
[24]Skills for Care (2025) The state of the adult social care sector and workforce in England, 2025
[25] The Homecare Deficit 2025

- No, the government should not amend the Conduct Regulations

Q63.b Please explain your answer.

Where duties depend on the hours a worker has actually worked across agencies and hirers, the parties can only comply if they share accurate information. Requiring that exchange is sensible and reduces the risk of inadvertent breach. The obligation should be proportionate and should not create disproportionate administration for smaller providers.

Q64 Is there anything else you want us to take into account in relation to Part 3 of this consultation, on amending the Conduct of Employment Agencies and Employment Businesses Regulations 2003 in respect of the zero hours measures?

Government should ensure these amendments do not create incentives to route homecare through unregulated introductory or bogus self-employment models that sit outside both the Conduct Regulations and these worker protections. The overarching risk across the whole consultation is the same: without funding and commissioning reform, well-intentioned rules will push work toward the least-regulated, least-protected corners of the market.

What must change for these reforms to work

We restate our central message. The Homecare Association supports better security, pay, and conditions for careworkers. Our members already offer guaranteed hours wherever their work allows, and three-quarters already pay careworkers for cancelled visits. The obstacle is not employer willingness. Ultimately, work organisation change requires system change, and that means that the government needs to fund and purchase care differently. Trying to force through employment changes without system changes could lead to widespread non-compliance and unintended consequences.

Providers cannot organise homecare into shifts easily under current commissioning models. They can only deliver via runs of visits, purchased by the minute, for people whose needs change without warning. To make these reforms deliverable, Government must:

- **Redo the impact assessment for this legislation** – quantifying costs to the NHS and local authorities from implementing the legislation and taking into account the impact on people who fund their own care.
- **Close the funding gap** — invest at least £3.25 billion across the UK[26], to enable the sector to comply with existing employment legislation.
- **Reform commissioning** — move from fragmented, by-the-minute purchasing to locality and lead-provider models and block contracts that guarantee providers a volume of work, so that providers can in turn guarantee careworkers' hours.
- **Introduce a National Contract for Care** — a statutory minimum price for homecare, drawing on our Minimum Price methodology, so that public bodies cannot buy care below the cost of lawful employment.

[26] The Homecare Deficit 2025

- **Make commissioners pay for the changes they cause** — require councils and the NHS to pay cancellation and movement charges, fund the rota changes that hospital admissions and discharges generate, and stop short-notice contract cancellations.
- **Sequence commencement** — bring the duty on commissioners into force in advance of or alongside the worker rights.
- **Adapt the mechanisms to the work** — recognise live-in care's block working patterns, define how these provisions apply to visits rather than shifts, and set reference periods, regularity tests and thresholds that reflect how providers actually deliver homecare. Apply exceptions, including where care work is dependent primarily on one individual's needs.
- **Regulate introductory agencies and review employment status** — so that these reforms do not simply drive work into the unregulated part of the market, where careworkers have no protection at all and care regulation does not apply.

With proper funding and commissioning reform, these measures can improve careworkers' lives, support the shift of care closer to home, and keep high-quality care sustainable. Without proper funding and commissioning, they will achieve the opposite: fewer hours for the workers who need them most, less responsive care for older and disabled people, and the growth of a market that no one regulates.

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