Paying for it
The human cost of cut-price care
Author: Ingrid Koehler, LGiU
I would like to thank LGiU for producing this important report. It comes at a time when there is growing public awareness about many of the problems in home care, but little understanding of how it impacts more than just care users and their families. Of course they feel the pain most acutely, but when the system no longer serves anyone well, it is past time to make a serious reflection on why and how we can fix it. Although much of this comes down to money, it is not simply about money, but about wider approaches to commissioning and a lack of transparency in accounting for costs and outcomes.

At Mears, we are fortunate to have 8,000 care staff, who all come to work wanting to make a real difference to people’s lives. We want them to work in an environment where they are enabled to give a great service and be fairly rewarded for this, just like anyone else. Unfortunately, there are too many parts of the country where it is simply not possible to do either of the above based upon the charge rate that the council is prepared to pay.

I welcome the recommendations in this report: as a home care provider we will play our part in improving the service we deliver, helping to join up services and making a career as a home care worker more aspirational than it is today.

We very much hope that we don’t have to give up any more care contracts but our first priority will be to only work in areas where we have a chance of delivering the kind of service experience, that we all want and need.

Alan Long
Executive Director, Mears

Social care has been slowly rising up the political and news agenda. There’s a growing realisation that it represents the keystone of local government: the failure of which could bring the whole edifice toppling down. For too long social care was the silent crisis in our system, so additional attention and especially any additional funding is, of course, to be welcomed, but a narrow focus on social care funding has two dangers.

First it becomes a technical discussion and as we talk about in billions and percentages, an abstract one. There’s a risk that we forget what we are really concerned with here: the human cost of inadequate care. Secondly, we can be seduced into thinking that this is a crisis to which we can find a purely financial solution when in reality we need to think hard about what constitutes good care and how as a society we want to provide it for ourselves and for our loved ones.

This report engages with both these aspects of the care crisis. It demonstrates compellingly that the care market is broken but it also illustrates unflinchingly the human cost of that market failure.

That cost provides a clear rationale for funding care properly and we make recommendations as to what both local authorities and central government need to do to achieve that level of funding. At the same time the report seeks to change the basis on which we fund care, moving from a time and task approach that is demonstrably inadequate to a focus on outcomes and results. Our aspiration is that this is of real and practical use to those who commission care.

Jonathan Carr-West
Chief Executive, LGiU
Home care is a special kind of market. At its best, it’s about creating relationships based on trust, kindness and the aspiration to help people live independent lives with dignity and comfort.

It is also almost the classic definition of a monopsony – a market where there is one buyer and many sellers. While there are a few independent buyers, by and large, the public sector is the only buyer of services within distributed geographic areas. Any time there is a significant imbalance between the number, or the power, of buyers and sellers there is potential for a distorted or even a broken market.

We are in this place now. The care market is broken. It is being held together by hope and good will, but that can only hold for so long.

Care is being purchased across England at prices that are simply not economically sustainable. Care providers, both businesses and charities, have the choice to either limp along propping up care, effectively subsidising the state and/or shorting workers and clients or they can go out of business. We have reached the point, where in many places in this country, the choice is as stark as that.

There are many reasons that this has happened. One reason is that the culture of purchasing care has focused on the chief care input – time, instead of looking at the chief care outcome: more comfortable, more independent, less isolated lives of people who need care but cannot afford to purchase it on their own.

However, the main reason the market is broken is that there simply is not enough money in the system. There is not enough money for all the people who need care to get it. There is not enough money for those who do receive care to be certain they will continue to receive care at an acceptable quality. There is not enough money for care businesses to keep going.

Local authorities that commission care are having their budgets slashed so mercilessly that they being are faced with a stark choice. Ration care further or pay for care at a rate so low that care businesses will limp along until they can go no further.

This is not simply a bureaucratic matter. We can no longer tinker around with small changes to commissioning or small uplifts in budgets or the price of care. We need radical reform in the way that we pay for and purchase care. We could allow the crumbling market to fail which would force change and it would force change fairly soon. The care market is on the point of collapse, and recent stop-gap funding will not address either the financial shortfall or the systemic market problems.

But this is not simply a matter of poorly managed markets. This affects people’s lives. It affects everyone in the care system. It is literally a matter of life and death. Much like the care system, people will continue to suffer until they pay the price with their well-being, their financial security, their health or perhaps pay the ultimate price.

In Paying for It, we look at the human side of a care market on the brink of failure with stories from across the care system. And we look at why care is priced so low and how people in the system end up paying for cut-price care.
Section 1: Background to the issue

The failure of the home care market has been foretold. This section covers the background to the looming crisis.

Receiving care at home should be the ideal way to help people stay connected with their communities, in an environment that is comforting and familiar and a means to maintain independence for as long as possible.

For many people, it does work this way. Increasingly, though good quality home care is in peril. Too many people are unable to access the care they need. A system which ought to provide a great deal of flexibility in terms of care as people need it and want it remains inflexible and focused on prescribed tasks at particular times rather than on people’s changing needs or personal aspirations.

The current home care system serves no one well. Hospitals are short of beds because the frail cannot be discharged without support that just is not there. Care workers are undervalued and underpaid – sometimes so much so that they are paid beneath the legal minimum. People who need care do not always get the care they need when they need it. Too often people are expected to receive care in slots of time that are too short – either because commissioned visits are short in duration or because visits are cut short through a practice called call cramming.

People now must have a higher threshold of needs to qualify for state funded care and home care is now used to address those complex, often clinical, needs but care workers are not being trained or paid at a level commensurate to those needs. Families, if they can, pick up the slack at a potentially high personal cost to people’s careers and the economy at large.

We know all this already. The LGiU has written about this before and so have a number of others. Little has changed since our last major care report Key to Care: Report of the Burstow Commission on the Home Care workforce that outlined a catalogue of systemic failures. We called for more money and more focus on outcomes rather than time and task in care. We asked for more training and regard for care workers, but little has changed in the two years since that report was published. In fact, the situation has grown worse.

We have an ageing population, which means there will be more and more people needing care. The number of people over 100 years old in the UK has grown by 65 per cent in the last decade and there were over a half million people aged 90 or over in 2015. In 2011 there were 9.2 million people aged over 65 in the UK and only half of them rated their health as good or better. Already there are over a million older people with unmet care needs (basic help for things like washing and dressing) which is up by 48 per cent since 2010. In a shocking number of cases, older people received no help at all. More often they received some help but not nearly enough or the right kind.

There is less money to fund care. All local authorities have tried to protect their social care budgets, and many have been able to protect it to some extent. Adult social care in many places has remained a relatively well-protected budget in comparison to other local government areas of spend. Across all councils with social care responsibilities, nominal spending remained relatively stable (including overspend) across all types of adult social care with an average reduction in local authority spending between 2010/11 and 2014/15 of 7.3 per cent.

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3 Age UK update, November 2016.

LGiU | Paying for it
of only around three per cent on outturns from 2011 to 2015. However that is in the face of rising costs and rising demand, meaning the overall ratio of spend to need has declined and the averages can hide the growing gap between funding and need in high-need areas.

According to the Care Quality Commission’s 2015/2016 State of Care report: “The number of older people receiving local authority funded social care fell 26 per cent from more than 1.1 million in 2009 to around 850,000 in 2013/14 (the last year for which comparable data is available), and 81 per cent of local authorities have reduced their real-term spending on social care for older people over the last five years.” But councils are now at a point where there is nowhere else to cut and adult social care budgets are also facing swingeing cuts and the Local Government Association (LGA) calculates that 28.5 per cent of budget cuts in 2016/17 have come from adult social care.

In 2016 a two per cent precept on council tax to support adult social care was meant to plug the gap but it is not enough. To add to the burden, the councils with the highest number of people who qualify for state supported social care because of financial need are also often the places with the lowest house prices, meaning that two per cent on already low council tax base is a drop in the ocean. The LGiU’s annual ‘State of Local Government Finance’ survey in February 2016 found that while almost all councils were planning to use the two per cent precept to fund social care, three quarters said this will not be sufficient to close the funding gap. The February 2017 findings of the same survey show that almost 96 per cent of councils think the precept will not be enough. For councils with social care responsibility (county councils, metropolitan boroughs, unitaries and London boroughs) the number one pressure on their budgets is adult social care.

Even where councils are trying to cut budgets in a managed way, because care is a demand led service and vulnerable to the impact of other service reductions – such as reductions in preventative services and diversion of NHS Better Care funding – a number of councils have overspent. In recent Association of the Directors of Adult Social Services (ADASS) research they projected a half billion pound overspend in adult social care. Councils are having to sell assets and seek other one-time funding in order to plug the gap in social care funding.

In addition to rising demand, costs are going up, too. The legal minimum wage has already risen from £6.70 an hour to £7.20 in April 2016 and is due to rise further to £7.50 by April 2017. It is expected to rise to over £9 by 2020. It is absolutely right that care workers should be paid more – in fact they should be paid at least a living wage. (In contrast to the National Living Wage which is not the living wage, but rather a new, higher legal minimum.) There is also a new apprenticeship levy which adds 0.5 per cent to hourly wages for larger employers. Caring is always about someone’s time, and much of this time costs money.

Fewer people are willing to care for a living. The home care workforce already had costly and unsustainable turnover – around triple that of other industries.

But there is yet another threat to adult social care that is increasing in severity. Care providers are increasingly less willing to provide care under current commissioning arrangements because they simply cannot afford to do so. The LGA estimates that the sector could need as much as £1.3 billion immediately simply to stabilise the adult social care provider market.

Care providers are handing back contracts. Councils warn of more to come. Other providers are simply choosing not to bid.

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8 Adult Social Care: Evidence of Deepening Crisis.
What is the difference between the National Living Wage and the Living Wage?

The Living Wage has long been a term used by campaigning organisations to describe the basic hourly wage needed for employees and their families to live on. It is calculated by the Resolution Foundation annually and takes into account things like rents and retail prices. The National Living Wage is the statutory minimum wage and is calculated by taking an average of market wages. It is set to rise to 60 per cent of the mean wage by 2020.

The similar naming has caused some confusion. The National Living Wage is a legal minimum requirement. It is not an aspirational wage intended to give workers a reasonable standard of living, but to set a minimum legal threshold for wages. In some cases the National Living Wage is below local market wages that are necessary to attract good quality staff. From April 2017, the National Living Wage will be £7.50 per hour, whereas the Living Wage is calculated to be £9.75 in London and £8.45 across the rest of the UK.

But there is a human cost, too.

We already know that there is an associated mortality to failing care homes. We know that people have died when care providers go out of business and residents have to be removed in less than ideal circumstances. There may well be negative impact on the health of older people when their care is interrupted. But there is wider unmeasured cost of personal anguish across the whole spectrum of care – business owners, care managers, care workers, commissioners and most importantly on people who need care and the families that love them.

This report looks at that emotional cost as well as some of the systemic problems in home care that make provider failure more likely and leave the most vulnerable in an even more precarious position.

on uneconomic contracts, and some big providers are exiting the market altogether leaving care in the hands of a few large providers and a shrinking number of local and regional providers. Where they can, providers are focusing on private care clients rather than those funded by local authorities. But as councils still purchase around 70 per cent\(^{10}\) of home care, this leaves a huge part of the market teetering on the brink.

This has a cost, too. Under the Care Act 2014, councils not only have a responsibility to nurture the care market they also have a responsibility to individuals when their care provider fails. Although this responsibility legally falls only within fairly tight financial criteria, councils also have safeguarding duties and a moral responsibility to help people in need. Working with failing providers, finding new providers and curating markets can have a huge financial cost to local authorities.

This section covers the basics of how home care works and how people usually get it.

Care at home or ‘domiciliary care’ provides help for people to live at home. Home care can be a mix of services that help people live more independently. Care might include activities like help getting out of bed and dressing in the morning or the reverse at night. There might be help providing meals or reminding people to take medication. For some home care might include accompanying someone who cannot go out alone on local errands or outings. Home care often includes intimate personal care, such as help bathing or using the toilet.

Generally speaking, home care is not meant to include health care, but there may be some care that can also be provided in a clinical care setting. Increasingly, though, home care can include some ‘clinical’ assistance, such as changing dressings or stoma care, which require skill, time and patience. This is partly because as the need for care rises the cut-off criteria for accessing care becomes much higher meaning there are more people who have complex and clinical needs. As there is a continued push for further health and social care integration, this will become more common.

Care is usually delivered in accordance with a care plan that is drawn up by an assessment team according to specific criteria. A care plan should take account of the support that individuals feel would help them live independently and with specific outcomes focused around an individual’s aspirations. In practice, care plans focus on contact hours and specific tasks that need to be undertaken – such as help with dressing or bathing with allotted times to complete those tasks. This is called time and task commissioning.

Section 2: How does home care work now?

Getting help at home

Over a half million people in England receive some paid-for care at home. A small proportion of people pay for their own care (about 12 per cent)\textsuperscript{11} but this is probably an underestimate, as some people will be paying for cleaners, housekeepers and other domestic assistance that provide some of the support that home care can offer. Some people purchase care through the direct payments they receive from local authorities to help them live independently, but most home care is purchased through local authorities. LangBuisson, who provide health and social care market intelligence, value the total home care and supported living market at £6.5 billion with only £300 million supplied by council in-house teams. Councils fund 69 per cent of this directly, with the remaining 31 per cent funded either through direct payments or self-funding\textsuperscript{12}.

If someone has social care needs and wants support from the local authority, they or their carer would contact their local authority for a social care assessment. Many councils undertake screening to help divert people away from an assessment if they are unlikely to qualify for assistance based on need or financial criteria. Assessment must be undertaken for all people who appear to need care and support, regardless of their finances or whether the local authority thinks their needs will be eligible. Local authorities are also required to give people advice and information about what support is available in the community. The assessment will determine whether or not the person’s needs meet the eligibility threshold and whether they have ‘eligible needs’ for care and support.

\textsuperscript{11} Adult Social Care in England, an Overview. National Audit Office, March 2014

\textsuperscript{12} Homecare, supported living and allied services. LangBuisson. June 2016.
For those entitled to financial support from the local authority, part of the plan will be a personal budget which sets out the costs of meeting their needs. Most people will be able, if they wish, to receive the personal budget as a direct payment, which they spend on their care and support, perhaps through employing personal assistants. If an individual is not eligible for financial support from the local authority they will be given an ‘independent personal budget’ which will show what the authority would pay for the care and support if it were meeting their needs. Local authorities have a responsibility to review care and support plans to ensure they continue to meet people’s needs and outcomes. Under the Care Act, they are expected to carry out a review no later than every 12 months, with a ‘light-touch’ review recommended six to eight weeks after the care and support plan is implemented.
Section 3: How is home care paid for?

This section covers how home care is commissioned and paid for and why that is driving the current crisis.

The vast majority of home care is paid for by local authorities. Very little of that is provided directly by council staff. Many councils still retain their reablement services in-house, but the vast majority of home care services are commissioned to care providers who are independent (private sector) businesses or from the voluntary sector. Care providers are given a care plan to fulfil and this is almost always a series of tasks with specific times to complete those tasks. In Outcomes Matter, the LGiU found that 90 per cent of councils commission services this way. In almost all cases, home care providers do their own assessment of clients as well to identify risks and needs, but this assessment usually does not alter the available budget in ‘contact hours’ – the amount of time that a care worker spends with a client. This means that almost all the care that people receive in their own homes is regimented and prescribed. Rigid ‘time and task’ commissioning does not allow care to flex around the needs of individuals.

By focusing on particular tasks, like getting washed or dressed, and the amount of time it should take to deliver those tasks, ‘value for money’ can be almost entirely driven by the price per contact hour – the amount of time a care worker spends with a person needing care.

In the ‘time and task’ commissioning, it is not always clear how councils determine the price they will pay for a contact hour. Councils are under extreme financial pressure and many are worried about how they will pay for the care that they are legally required to provide. It can be hard to avoid the temptation of simply dividing the available amount of money by the number of hours of care they estimate will be needed rather than focusing on how much it actually costs to deliver high quality care in people’s homes.

Commissioning differently

There is an aspiration to commission differently, for care to be commissioned based on outcomes.

The Social Care Institute for Excellence (SCIE) describes outcomes based commissioning in Outcomes-Focused Services for Older People.13

Outcomes refer to the impacts or end results of services on a person’s life. As such, outcome-focused services aim to achieve the aspirations, goals and priorities as defined by service users.

It enables commissioners to create the circumstances where provider organisations find innovative solutions to deliver improved outcomes for services users at a lower cost. This will enable the delivery of new models of care.

There is a strong desire to change the way that care is commissioned. Most councils, too, are trying to focus on outcomes and set personal goals in partnership with the people who need care. Some councils are trying new ways of commissioning, such as flexible banks of care hours or other methods to re-focus care commissioning on outcomes. Kingston Council, for example, is working in partnership with LGiU and others to develop an app to support outcomes measurement. However, we found that only around one in ten councils are making real strides toward achieving outcomes based commissioning.14

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13 SCIE Knowledge Review 13: Outcomes Focused Services for Older People, Social Care Institute of Excellence, January 2017
14 Achieving Outcomes Based Commissioning, LGiU, March 2016
Why not more outcomes based commissioning?

In our research, we have found some of the key barriers to outcomes based commissioning to be:

- lack of trust between providers and commissioners
- lack of trust in home care workers
- a cultural focus on rigid time and task planning of support.

Although lack of trust is a problem, blind trust is not advisable or desirable.

Commissioners and social workers need assurance that trust is warranted. This assurance can't happen if the only information that's available (if it is available) is the amount of time a care worker has spent in the home. Existing technical solutions such as care workers using the phone in a client's home to phone in to an automated system or using electronic tags installed in clients' homes reinforce the current method of commissioning based on time.

It can be very difficult to measure the outcomes themselves. While many people get help in setting personal goals such as getting washed and dressed on one's own or social goals like getting out to the pub or church, progress towards these goals are rarely measured in a timely and consistent manner. Even systematic monitoring of changing health conditions and social care needs or even people's experience of how good their care is done infrequently at best.

Councils have always aspired to reassess the care plan on an annual basis, with a check on the appropriateness of support about six to eight weeks after a care plan in implemented. Historically though, sometimes that assessment has slipped meaning that it might be longer than a year before care plans are reviewed. Under the Care Act 2014, care plans must be reviewed annually, which puts pressure on councils who have a rising assessment caseload and diminishing resources.

Of course, in reality, twelve months is too long for many people's needs to be reassessed. In a world of increasingly complex social care needs and chronic health conditions, needs change and fluctuate from day to day and week to week. In research LGiU conducted in early 2016, we found that fewer than a third of councils are routinely monitoring changes to individuals social care needs and health conditions.\textsuperscript{15}
Section 4: What does it cost to deliver home care?

The section breaks down all the costs to providers of delivering home care and illustrates what goes into making up the rate for a contact hour of care. These costs have been squeezed in recent years as a result of shrinking budgets and commissioning practice. In this section we will demonstrate how this is creating an increasingly fragile home care market.

There can never be a single figure to cover all of home care across the England, because delivering home care very much depends on a range of factors. Is it a framework contract? Are there guaranteed hours? Has the care been spot purchased? This will affect the cost of the provider's overheads and recruitment. How many clients are there and how close together are they? This will affect the amount of travel time and travel costs. What is the local labour market like? If there is a shortage of care workers in the area or it is generally a high wage area, then providers may need to raise wages to retain existing staff or attract new staff.

However there are some consistent costs in home care that mean that we can set a ‘minimum’ price for home care – a floor under which the price of a contact hour commissioned by a local authority should never dip.

The biggest driver of cost for home care is the caring professional’s hourly wage. As of October 2016 the minimum legal amount that a care worker over the age of 25 can be paid is £7.20 hour. This isn’t simply the amount of time that a care worker spends with a client, but they must also be paid for their travel time between appointments and other reasonable time needed to do their job. Councils usually commission and pay for care based on contact time – the amount of time a care worker spends with a client – so that must be figured into the cost of a contact hour. (A few councils now commission on contact hour plus travel time.) For every hour of paid service there are a number of associated costs – statutory sickness pay, legally entitled holiday pay and the employer’s contribution to National Insurance and the Apprenticeship Levy for larger care businesses. A minimum legal wage (including an estimate of travel time) plus the bare minimum, legal on-cost is £10.72 per hour. That does not include elements of employee costs that should be rightly met by the employer – for mileage, uniforms, necessary use of mobile phones, training and required DBS checks. This moral minimum directly spent on employing a care worker is £11.54 per contact hour. Even this minimum doesn’t include the time a care worker spends in separate supervision and management meetings and certainly doesn’t allow time for information sharing between care workers about how best to look after their clients.

These are not the only costs. Personal care is a regulated activity and the regulatory body, the Care Quality Commission, requires that every care business must have a registered care manager, so their salaries must be paid as well. Care workers must be supervised, too and so they need managers whose salaries must be paid. Most care providers also make their own review of the care plan to conduct a risk assessment and a practicable plan for care workers’ day-to-day activities and it takes at least a senior care worker to do this work. All of this must be figured into the price of the contact hour.

On top of all of these essential costs, there are other basic, essential costs of ‘doing

16 The Apprenticeship Levy is a direct levy of 0.5 per cent of hourly wages and applies to large employers with a total payroll bill of over £3 million. This money is reclaimable through qualifying apprenticeship training.

17 The DBS is a the Disclosure and Barring Service, formerly known as the Criminal Records Bureau check or CRB and includes checks on both criminal records and if people have been barred from working with, for example, children or vulnerable adults.
business: the cost of the office, the cost of computers and software to support scheduling, or the chairs that people sit on. Many councils also now require ‘call monitoring’ to check that visits are taking place when they are supposed to and lasting as long as they should. That is often paid for by the provider, but is sometimes paid for by the council, depending on the way that care is commissioned.

The United Kingdom Homecare Association used Freedom of Information requests to find out how councils calculated what price they should pay per contracted contact hour and few councils, only 13 per cent, were able to tell them. Without a clear way of estimating the costs that includes a fair and reasonable return to care businesses and the ability to pay people a legal wage or better yet a competitive wage, the tendency has been to set prices at a rate which is legally, practicably and morally far too low. If both providers and councils are open in the way they calculate the cost of care and use open book accounting when contracts are in place, it is far more likely that a fair and reasonable price for good quality care will be paid.

Mears is one of the largest independent care providers in England and provided sponsorship for this report. We included this interview with a senior executive at Mears to highlight the real problems that care providers have in supplying care at the current rates offered. Mears have withdrawn from several high profile contracts in recent years on the grounds that they are unable to supply quality care at the hourly rate they are offered. We believe that these cases reflect a market in crisis.

Alan Long is an Executive Director at Mears Group and has responsibility for developing services within the group, including care.

The home care part of our business is losing money. We’re losing about £3 million pounds a year. We are working hard to return to profitability this year, but that’s only because we’ve had to hand back unaffordable contracts and we’re not bidding for any contracts that pay less than our absolute minimum rate.

Our minimum price to provide home care to council-funded clients is £15.91 per hour that we spend with clients. We can’t afford to take any less than that and we don’t see how anyone else can either. Well, we know they can’t do it, because it would be impossible to do that without breaking the law or using bad practices like call cramming. I’ve seen some councils saying that they will only consider bids which are between £12.50 and £12.90 per contact hour. It simply can’t be done for that, not legally, not morally.

The £15.91 rate is based on the minimum amount that we pay home care workers, which is £7.92 an hour and above the current National Living Wage. We can’t recruit good care workers at the minimum and with all that they have to do, the responsibility they have to vulnerable people and working alone, we think they should be paid more. Of course, in many areas we’re paying more than £7.92 an hour.

Out of the £15.91, we have to pay for travel time, for National Insurance, sick pay, holiday pay, the Apprenticeship Levy. We’re also paying for uniforms, mobile phones and mileage. But there are other costs, too: recruitment, the office staff for scheduling and supervision. This is a
regulated business, we have to have a registered care manager who has serious responsibility in overseeing care workers who look after really vulnerable people. Our senior care staff are supervising 25 people on average, and really that’s too much. We pay for training, too. It’s so important now, particularly as the people we look after now have such complex needs.

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At £15.91 we wouldn’t be making a huge loss, if everything goes right. But in a complex service like this, things won’t always go right. Plus in many areas we can’t recruit at £7.92. The cost of the care model shown here excludes any charge for central support such as finance and IT.

So why do we continue, while making a loss? We do it, because I truly believe that we will find a solution to the current problems. Unfortunately I am unclear as to how many disasters there are going to have to be before we collectively move forward. Some of the other big companies have exited the market altogether. Smaller companies are folding. I think we’re about to see
another Southern Cross, but for home care. And I’m quite honest about it, while we are losing money now, our expectation is that by working with more forward thinking clients now, we will be well placed as a business for the long term and we may indeed be last man standing.

While I want to grow our business, I also know that there will be a lot of avoidable chaos and suffering if there is a big crash in the home care market. When companies hand back contracts, never mind when a company fails, there is a lot of confusion among staff. Staff start to leave and it’s impossible to recruit more. That means missed calls start to happen and there is particular pressure during the evenings and weekends. Even though we try to have a good transition and work with the council and a new provider, coverage slips. We see it from the other side, too when we take over contracts. By the time we can take over the service, it’s often a mess – missed visits, no continuity, staff and clients feeling very unstable.

Let’s not forget that people are already suffering and dying too soon because of this crisis. But it hasn’t hit the public consciousness in a big way. It doesn’t grip on public awareness the same way as if a child had died. When an older person dies, it’s harder to know that they died because of poor care. Many people are sick already, they are old, so who’s to say if they died because they are old and not very well or they died too soon because they didn’t get the care they needed? Of course, the families know. And people are living less dignified and comfortable lives than they should be in the mean time.

We could avoid this crisis if we – and other companies – could just be able to be paid a fair rate. And we have to make a return, all of us do, even the voluntary sector. That’s where investment comes from, growth of services, change and improvement and the development of new services. Yes, for us there would be a return to our shareholders. Right now, we’re not making any profit – although we still must figure it in to our bids, because if we can’t return to profitability eventually we simply won’t be able to carry on.
What goes in to the price of a contact hour?

Profit 5%
Overheads 16%
Direct staff costs 79%
3 minutes
10 minutes
47 minutes

What happens if care is priced below cost?

The United Kingdom Homecare Association (UKHCA) calculates that the minimum cost of providing home care per contact hour is £16.70\(^\text{19}\) per hour and that includes a reasonable return on doing business, otherwise known as profit. However, the UKHCA found the average price of care across Great Britain and Northern Ireland was only £14.58 per contact hour and only 10 per cent of councils were paying at or above their recommended minimum price of care.

Profit for independent care providers or a surplus for a voluntary sector provider is an important “cost” of doing business. Without this difference between what they take in and what they spend, there is no money to invest in improving the service, to grow it or provide a cushion against hard times or something bad happening.

Moreover, profit or surplus in a market is an indication that an organisation is doing something right – providing something that people value. In a failed market, organisations may be doing the right thing, but if there is no reasonable return on investment then the reward mechanism is faulty. A company or a charity that is losing money will rightfully seek to employ its effort elsewhere. And that is what is happening in the care market.

\(^{19}\) The Homecare Deficit: A report on the funding of older people’s homecare across the United Kingdom. United Kingdom Homecare Association, October 2016.
Companies who are paid less than the cost of care have a few choices, but none of them are good:

- they can short clients, by call cramming or sending poorly-paid, poorly-motivated and poorly trained staff to home care visits

- they can short care workers by failing to pay for travel time, scrimping on essential support like reimbursement of expenses or training or shorting them on minutes spent in the home by rounding down times, meaning sometimes care workers are actually taking home less than the legal minimum, the National Living Wage, or

- they can, where possible, take a loss, essentially cross-subsidising from other business activity or self-funding clients.

None of these choices are sustainable. If providers are paying wages that are too low, they will be unable to recruit staff or even worse pay their staff below the legal minimum. At some point, any provider who is running at a loss will ultimately have to make the choice to leave the care market or cease trading because they have run out of money. Sometimes this choice comes when there is literally no more money to pay care worker wages.
Section 5: The scale and impact of provider failure

This section looks at the scale of provider failure and the impact on quality of care.

In 2014-15, 48 per cent of councils reported at least one provider failure in home care across a 12-month period. Seventy-four per cent expected a failure in the next year. But in recently published data from ADASS, that number now seems wildly optimistic. A survey of Directors of Adult Social Care, “found that 62 per cent of councils have had residentila and nursing home closures, and 57 per cent have had care providers hand back contracts in the last six months. The closure of services and handing back of contracts has affected an estimated 10,820 people using council-funded care.

While this data was collected separately, comparing them there are strong indications that the pace of provider failure is accelerating, perhaps more than doubling for home care contracts in the space of around a year and a half. Some large care companies have left the state-funded home care market altogether including Care UK and Saga. The Chief Executive of Care UK has said that they left the business because he could no longer sleep at night worrying about the quality of care that they could provide at the price they

The growing failure rate

12 months 48%
6 months 57%

Failure rate 2014-2015

Faster failure in 2016

In 2014-15, 48 per cent of councils reported at least one provider failure in home care across a 12-month period.

In 2016, 57 per cent of councils had home care providers hand back contracts over a 6-month period.
were receiving. Mears, who are sponsoring this report, and Mitie have both posted operating losses for their care businesses. Non-profit providers are getting out of the care business, too. Housing and Care which operates in 150 council areas announced that it would be leaving the home care market in the Autumn of 2015.

Smaller business, too are folding. Some of them after submitting ‘suicide bids’ – essentially bidding within the uneconomical commissioning guidelines in the hopes that they could renegotiate rates after taking on or continuing the contract. Small independent care companies sometimes do this if they have a market entirely within one or two local authority areas and have few self-funding clients. If they refuse to bid, they go out of business. If they win the bid, the contact hour rate is so low that without an enhancement, they’ll also go out of business. Because it costs councils money and causes genuine distress to clients, loved ones and council officers – councils will sometimes renegotiate fees. It is a dangerous gamble to make for care providers, but one which some feel they must make.

**Signs of failure**

Every provider failure is different, each one has its own reasons, but most of them currently are driven by the low price of care. On some occasions, home care providers cease trading without notice. When this happens, it can often be because smaller providers have reached an insolvable cash-flow crisis. Occasionally it can be because an immigration enforcement action has taken place, but this is also underpinned by the low price/ low wage culture in home care.

Despite the occurrence of surprise closures, there are usually signs that a provider is on its way to no longer being able to sustain the business of care.

Any one of these signs on their own are not sufficient to indicate that a provider is nearing failure or withdrawal from the market, but several of these together and from a range of different providers can begin building a picture of a local care market that is crumbling under the pressure of low prices.
<table>
<thead>
<tr>
<th>Signs of failure</th>
<th>Causes</th>
<th>Link to low prices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missed visits</td>
<td>Low recruitment and retention levels, meaning that providers are unable to maintain a sufficient ‘float’ of staff who can cover a colleague’s absence, particularly at weekends.</td>
<td>Inability to recruit or retain staff at a given wage, meaning prices are not reflecting the market wage of a given area.</td>
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<tr>
<td>Poor continuity of care</td>
<td>Ability to recruit staff at a given wage, but inability to retain staff likely due to insufficient benefits, such as mobile phones, mileage etc.</td>
<td>Price per contact hour sufficient to cover the legal minimum costs, but insufficient to cover the moral minimum plus reasonable overheads and returns.</td>
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<tr>
<td>Poor quality of care</td>
<td>Staff may not be properly trained or experienced, senior and skilled care workers may not be used where required.</td>
<td>Price is insufficient to cover training or skill enhancements needed for more complex cases.</td>
</tr>
<tr>
<td>Poorly timed visits</td>
<td>Early bedtimes, late rising, odd meal times. Often caused by staff shortages meaning insufficient staff to cover peak times of waking, bedtimes and meals.</td>
<td>Low prices mean that a market wage cannot be paid to staff or the price does not reflect the additional costs of training, uniforms, etc for taking on additional staff, so care workers end up slotting visits in at inappropriate times.</td>
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<tr>
<td>Shortened visits</td>
<td>Short visits are often caused by the practice of call cramming.</td>
<td>When prices are too low to cover adequate travel time payments to care workers and associated on-costs, time is taken from the visits on either end.</td>
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<tr>
<td>Signs of failure</td>
<td>Causes</td>
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<td>High numbers of staff with poor English language skills.</td>
<td>New immigrants are generally prepared to accept lower wages for difficult jobs. Staff with poor English language skills will often have a harder time understanding clients and vice versa.</td>
<td>Wages too low to attract staff with adequate English language skills.</td>
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<td>Rising hospital admissions</td>
<td>Inadequate care at home can lead to poorer health outcomes and increased hospital admissions</td>
<td>If the price of care is too low to sustain good quality or consistent care in people's homes then health can deteriorate resulting in hospital admissions or re-admissions.</td>
</tr>
<tr>
<td>Complaints</td>
<td>There will be a rise in the number complaints about the quality of care and missed or rushed visits.</td>
<td>Poor quality care can be caused by a number of things and can be isolated management issues, but a significant spike in complaints can be a sign that a provider is suffering a cash-flow or wage/retention problem.</td>
</tr>
<tr>
<td>Price re-negotiation</td>
<td>Providers may ask for a higher contact hour price if current prices are unsustainable.</td>
<td>Commissioners may need to review accounts and costing models to ensure that adequate prices for care are being paid.</td>
</tr>
<tr>
<td>Notice of intent to withdraw from contract</td>
<td>At a push providers, may threaten or intend to withdraw from contracts.</td>
<td>If prices are too low to sustain business activity, providers may be forced to withdraw from local or national markets.</td>
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It should not be assumed that care is good until it stops. Often the quality of care deteriorates before the ultimate failure of a care business. Higher turnover of staff as providers struggle to retain good quality staff decreases the vital continuity of care. Good quality staff may be replaced by less well-trained and less-experienced staff. Bedtime care visits may be scheduled at odd times as providers struggle to roster workers and schedule appropriate visit times. Even where a strategic and planned withdrawal takes place, it can be hard to replace staff as they leave for more secure employment, which ends in a similar result.

During the time that care businesses or particular contracts are failing, people are often quietly suffering in their own homes. Sometimes they are suffering not so quietly. The Local Government and Social Care Ombudsman has reported a 25 per cent increase in the number of complaints about in 2015/2016 and a higher number of these complaints are being upheld\(^2\). In a snap survey conducted by ADASS in October 2016, they found that 79 per cent of councils had concerns about the quality of one or more home care providers\(^2\). The BBC's File on Four programme made Freedom of Information requests to local authorities in England, Scotland and Wales and to health and social care trusts in Northern Ireland. Only half of organisations returned data, but it amounted to over 23,000 safeguarding alerts. These included over 12,000 allegations of neglect and over 5,000 allegations of physical and emotional abuse\(^2\).

It cannot be overstated that the same pressures which are driving home care companies out of the market are the same pressures that are encouraging poor care for people who need it. The impact on people who need help at home is absolutely inexcusable. They often have poorer quality care and can feel a lack of control over the care that they receive. Their trusted and known care workers may suddenly disappear and their routines are disrupted. The uncertainty over their future care arrangements may be devastating. There is some evidence\(^2\) that an emergency closure of a care home can lead to increased deaths.

While there is little research on the impact of home care failure on mortality and morbidity, one can assume that effects are somewhat mitigated if individuals can stay in their own home, particularly if they have other support such as family and friends and if some continuity in care workers can be maintained by transferring care workers to new providers. However, that is not always possible. Gloria Foster died after her home care agency was closed following an immigration raid and local authority procedures to deal with home care closures failed. While the circumstances that led to her death were identifiable, too often it is difficult to untangle the effects poor care and disruption of care has on people who are very old and have complex health and care needs. And while a death may not result from care disruption, it can have significant impact on the quality of life for those who need care.

Families suffer too, as they struggle to communicate with care providers and the council trying to find out why the quality of care is deteriorating or visits have been missed. They feel increasing anxiety as they try to support loved ones appropriately.

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\(^2\) Budget 2017 Representation by the Association of Directors of Adult Social Services

\(^2\) File on 4: Neglect – The Story of UK Homecare, broadcast 28 February 2017

Karen's story

My ex-husband, James, had an acquired brain injury in 2011. We found out he had a brain tumour and then he had a brain hemorrhage and stroke during the operation to remove it. As a result he has some problems with mobility. He can't walk far or use his left arm. But the really disabling part of his injury has been the changes in his personality. He doesn't really have any empathy any more. He has very poor short-term memory, no executive function and he's quite vulnerable in social situations. He will talk to complete strangers, he's very disinhibited. He's not aggressive, but verbally he expresses very strong opinions. It can get him in trouble, because in some ways if you just meet him he doesn't talk like someone might imagine someone who'd had a brain injury might. So people don't see someone who has an impairment, they just see a man who is expressing strong opinions, often repetitively.

Because of these issues, he can't live at [the family] home anymore. He lives in a house about ten minutes away. He has four hours of support in the morning and an hour at tea time. In a lot of ways we're very fortunate to have so many hours, and he's had some very good carers. But it's not been an easy process at all to get the care package in place. I have professional contact with social care at another council through my work, so I'm not unfamiliar with the system and I had people I could ask questions of, but I don't think it helped me navigate the system very much. It was really hard. They [social services] have been very disorganised and don't monitor his support on an ongoing basis. We don't really complain about that, because I'm always afraid they'll review his care and take away some of his support. But he really needs it. The problem is when he talks to a social worker, sometimes he'll say he doesn't need support, and if they don't spend much time with him, if they don't know him — it's always a different social worker - if he's in one of his more 'cogent' modes, and he's still very articulate, they'll believe him. This happened once and his care package got slashed. I had to go to our MP, the Ombudsman, fortunately we had plenty of medical evidence — he'd been in a rehab facility, but it wasn't easy. He used to be a professional, he can still sound that way at times. But he really needs a lot of support.

James has medication he needs that he can't administer himself. He'll forget to eat or drink. He can't go out on his own, so if he doesn't have care support, he won't go out in the day. He's not left in bed, he can get up, but he needs help for pretty much everything else in his life. I have to work, so I can't always pick up the slack when a carer doesn't show up. Sometimes I have to take time off work to look after him, and it's really hard.

There are two companies who look after him. He's had some good carers. But if one can't show up, the main one in the morning, then there's nothing. The care company can't find a replacement and he gets no support until the evening. They really struggle with emergency cover, I think they have some problems with recruiting enough people.

Sometimes I don't find out about a carer not showing up until it's too late. I was down in London with our kids at half term and he didn't get a visit for two days. I was frantic trying to make sure he was looked after. But we stick with this company because they get good people who tend to stick around. But his latest carer who he really seems to get on with is leaving, I don't know if they'll be able to find a suitable replacement. I don't think they can attract people at the current rates. I don't know how sustainable their business is. I'm really worried about it.
James’ story

I was as fit as a butcher’s dog, until I got a brain tumour. I had a stroke on the operating table. I had time in rehab centre after that, which definitely helped. It helped me live here on my own. I had to get a divorce. My kids live with my ex-wife now. She is a wonderful mother. They are in the right hands. I am very content where I am now. I live in a village. People take the time to stop and talk, it’s lovely.

Mostly it’s ok now. I got on really well with the lady who was looking after me, but Tuesday was her last day. I don’t know who is going to come to replace her. I used to work in HR [human resources]. I used to have a very long fuse, now I have a short fuse. I get irritated by idiots. The majority of people that I’ve had working with me have been ok, but I’ve had one or two stonkers. They were under 30, wet behind the ears, and… well – the problem is that I find myself getting a bit irritated by idiots.

The problem is the quality of the people the care companies recruit – seems to be a problem getting the people of the right quality at the moment. If they’re over 30, they have some nous about them – it’s a bit frustrating really. Someone who’s seen a bit of life I can cope with – anyone else I find hard work.

I don’t know – I’ve offered my services and I use to work in HR, and as an end user, I think I can contribute something to the process. I think the people who get care should have more say over who they send us.

But I think there can be an issue with how much they’re paying people. It’s obviously minimum wage. When you pay that you get minimum initiative, etc etc. There are some good people, but also some misfits – people who irritated the hell out of me. I was given short shrift. They did send an idiot the other day who clearly didn’t have any common sense. He was supposed to come another time, but his car was broken down. I suspect he might not be working for them anymore.

I think just bearing in mind a lot of the people who work in the care environment aren’t always top drawer, and there needs to be… it’s useful to involve the end user in their recruitment and selection. I think the correct term for a lot of these people is minimum wage f***wits. But also some really good people, I really enjoy their company.

I can’t remember meeting a social worker, well there was one guy, but he was one of the most irritating people I’ve ever met, luckily he’s not with the council anymore. I get the impression that social workers seem to be very stretched, to be honest I can’t remember when I saw the last one, and frankly it probably wouldn’t make any difference. I’m very content where I am, I get support from the two companies. I can cope ok with that, y’know.

Care workers, too struggle as their already often insecure employment becomes less secure. Good care workers suffer significant emotional distress as they feel pressured to deliver care in a manner that is less dignified than people deserve and which is inadequate to their needs.

While care workers usually have some employment protection, transferring between employers can be unsettling even when it works well.

Care workers, like many low-paid hourly workers, may also be unaware of their rights. For example, a recent survey conducted by the Department of Business, Energy and Industrial Strategy found that 69 per cent of workers who earned under £15,000 per annum did not know that they should be
Harriet is a care worker in an outer London borough. The contract between her employer, a local branch of a national care company, and the local authority was terminated over the summer of 2016.

**Harriet’s story**

**An inspection and rumours of closure**

I worked for a large company in outer London, they had business with the local authority, they had a local branch, but it was a national company, too. Rumours started circulating in late Spring/early Summer that the business would be shutting down in our borough. We knew there had been an inspection, but we didn’t really know what was in it. We didn’t really get much information from the company. Someone had heard from a care manager from another company that our branch would be shutting down.

We got called into a mandatory meeting organized by the care coordinator. She told us the company was not shutting down, that it was just a rumour. But she said they might not bid again for care packages in the area, because the council was tendering too low and the prices were not covering the costs of care and office staff.

The rumours kept circulating. And then a colleague got called into a meeting with social services and she was really distressed, she thought there was something wrong, that she’d done something wrong with the client. But when she gets there they asked her if she was happy working with the client and would she be alright with being transferred to a new company to keep working with that client. They didn’t give her any indication beforehand of what the meeting was and she was really worried, thinking she was in trouble.

Then we have a second mandatory meeting in the middle of the summer. We were told that if we didn’t go to the meeting that we wouldn’t receive any more shifts. We thought it might be about telling us the local branch was closing. But when we get there we find out it’s someone from the head office and she tells us that it isn’t a meeting, but training. The woman from the head office tells us as a result of the inspection we need to brush up on our skills on record keeping. When we asked questions about the local branch shutting down, the woman said she was only offering training and that the local branch would have to answer those questions.

At this point I checked up on the inspection and I realised that it was unsatisfactory, partly because of the poor record keeping we had just been trained on.

**Shutting down and transferring over**

Then some of my clients began receiving letters about transferring their care to a new company and it was really upsetting them. Some of them were in tears, it panicked them. The letters were using words like “due to administration” and all these legal terms. They’d ask if this meant they’d have a new carer, they didn’t want to lose the carer they already knew. Usually when the clients’ families would contact social services directly, they’d be reassured.

Gradually, we realised that the branch was shutting down and we were told that we would be transferred to new companies. I don’t know what the process was. It seemed to me like the care paid for travel time between appointments. This means care workers can be vulnerable to losing out on pay or holiday entitlements or changes in terms and conditions as they transfer between a failing provider and a new one.

Low Paid Workers Confused Over Deductions from Wages, Populus Omnibus Survey, February 2017.
packages were loose on the shelf and anyone who wanted them could bid on them. Like “We have these packages available, who wants them?” I found out I was going to a new company while I was off work and on leave.

I asked my old company and the new company if there was any information they could send me about how the change would impact on us. I was told everything would remain the same. I went to a consultation meeting and they told us to nominate one of our colleagues to lead on the consultation and the handover – someone who would be a point person between agencies. Nobody really felt they could represent someone else, so we didn’t have a point person. So really nobody consulted with anyone and we just transitioned over.

A lot of the other carers didn’t want to go over to this particular new company because it’s so far away and in a different part of London, it takes over an hour to get there and they were worried about the travel time of getting to meetings and training and getting supplies. But I didn’t want to lose my job because I needed the money.

The new company said that they would make a weekly run of supplies up to our area, but that hasn’t really happened. They also said they would open up a branch in our area, but that hasn’t happened yet either, maybe it will. They won’t pay us our time or travel costs to go to the office to get supplies or get training.

Reflections on the transition

I feel like the old company lied to us. Deceived us. I understand why they did, because I guess they knew that everyone would just leave if they were completely honest with us about what was going on. But it still wasn’t good. We didn’t really have anyone to represent us or explain to us.

I’m not really happy with the new company. I feel like I have been cheated on my annual leave, that it didn’t all transfer over. They’re also not as organised, they won’t tell me who I’m working with when I go on a two-handed care call where you have to lift someone. They say it’s not my business, but it minimises emergency phone calls if you know that kind of thing in advance.

Because they hired people local to where the company is and not where the clients live, there can be a lot of transport delays. But the new company doesn’t want me to start working until the other person gets there for two-handers, so they don’t have to pay me. I could be getting on with making them a meal, etc, but they don’t want me to. They want me to just wait in the person’s house. But sometimes you can’t wait. People get regular, and they know when you are coming – so they will really need to go to the toilet when you arrive. You can’t just leave them there. Sometimes you arrive and people are so desperate they are crying. It’s ok for me to lift them, I’m kind of a big girl, but some of the other carers are so tiny, I don’t know what they do in those situations. But we’re not really supposed to lift on our own.

I do get paid more per hour now, but I don’t get any expenses or travel time. So I walk everywhere. Sometimes I’m out and on my feet for six hours, but I only get paid for three. I can’t really afford to pay for buses, because I’d be spending almost half my wages to get somewhere – £1.50 there and £1.50 back. Because I don’t get any of my travel time covered now or expenses, I feel like I’m losing out.

But there are some beautiful things, too. I have really helped people. I saved someone from a mini-stroke by calling an ambulance when I recognised the signs. I have arrived and found people on the floor covered in blood and I was able to help them. But even with those things, I have decided to stop being a carer in the New Year. I can’t put up with it anymore.
Care providers do not go into business to deliver bad care. It is often incredibly stressful for them as they try to ensure that clients are looked after and staff have new jobs to go to. Often small providers go into the care business because they wanted to make a difference having experienced a loved one needing care or having worked in care themselves. They continue to try to care for those around them, while suffering a business failure and facing financial ruin. The voluntary sector goes into care because they feel it supports their strategic aims, but they find themselves propping up home care to the detriment of other services they provide. Care managers at large or small providers are often frantic trying to find staff to cover shifts to make sure people are looked after.

Emma is a senior manager at a local community housing association who has responsibility for the care and support aspect of their business.

Emma’s story

We’re a housing association with a care and support department. Up until this year we had a care contract with the local council. It wasn’t a huge contract, about 400-500 hours a year, proving care to our tenants who had financial support from the council. We terminated the contract this year, because we were making fairly significant losses that we just couldn’t justify any more. We were getting just under £13 per contact hour.

It was a real shame, because we want to do dom care [domiciliary care]. We feel that dom care should be a core part of our offer. We have nearly 10,000 tenants and we know that if they need care they would rather purchase services from a provider they already have a relationship with. We had invested hundreds of thousands of pounds in developing this service and a lot of pride and effort.

We still provide some home care to people on direct payments and self-funders and top-ups and we still have contracts with the council to provide some residential care and learning disability support, but our home care contract with the council simply wasn’t sustainable any more. You know, those services are under pressure, too – but they are more outcomes focused in those areas, so there is more flexibility about delivery. We want to be in the home care business, but we can’t do it on the current rates and they way it’s currently commissioned.

There were several reasons that our losses mounted. One was the care certificate, we didn’t feel we could have staff working alone until they’d completed a lot of training – previously we’d trained people over a 12 week period. With the care certificate we had people shadowing other care workers a lot, so the staff bill increased by about a third. We also had an increase in salaries due to the National Living Wage. We were also struggling to recruit staff who were car drivers. We provided people with bus passes, but our travel costs really increased, because travel time went up massively. A 10 minute journey in a car, is maybe 25 minutes by public transport. We couldn’t recruit car drivers, we used to require that, but stopped. We were able to recruit more people, but then it was costing us a lot.

To be honest, the council was really great throughout this process. They wanted to keep us in the market. They worked with us to understand our costs, they offered a cash injection, they offered an uplift of 70p an hour. But that wasn’t enough. They had real trouble finding anyone to take over the contract. One of the big providers had pulled out of the market altogether and another had their contract suspended. The council ended up taking the contract in house and they are directly providing home care themselves now.

That was a good result for our care workers, they actually got an increase in their terms and conditions, although we already provided a lot of perks, but who knows how much that is
costing the council. Certainly a lot more than it would have cost to pay us what would have allowed us to at least break even in home care, which would have been around £16.75 an hour, a bit more in the more rural areas. We worked very well to transfer all the staff – it went out without a hitch. And as far as we know there was no impact on the individuals receiving services – as far as we know.

In all honesty transferring to a local authority helped – had we been transferring to a provider that wasn’t as ethnically sound it would have been harder. Had we been transferring a provider without that reputation – it would have been extremely difficult for us – we’d have had a lot more pain. We were wholly reassured being transferred to the council – they were dealing with a provider who had similar values to us – public sector ethos – different badge but similar organisation.

The registered care managers had to transfer with the service, too. One of the managers we transferred had been with us for 10 years. We tried to retain her, but she wanted to go with the customers, so she transferred out. It shows the dedication of the staff to the people they work with.

We are publically funded, not-for-profit, our money comes from rents that are paid by low income people. As a principle, we will invest in contracts, for a while we will take a loss to invest, but we cannot indefinitely do that. We simply can’t subsidise a statutory service with the rents of low-income people.

The home care market is on its knees. There is a lot of need. And providers are just not being able to fulfill the contracts, mainly because of recruitment. We can’t attract workers on the kind of salaries we’re paying. Then there’s the negative press – you never hear anything good, about people’s relationship – about how therapeutic and beneficial that care and those relationships are. You just hear about failure to comply, abuse, failure to meet needs, provider failure. It’s bad news everywhere you look. It feels like a toxic industry.

Councils have a legal duty to support people whose care provider has gone out of business in certain conditions defined by the Care Act 2014. However, councils have a general duty of care to anyone who needs help and a moral duty to help them transition to a new provider in an emergency. If emergency care is provided by the council, self-funding clients may be recharged for the cost of the care, however when a provider fails there are other costs which are not likely to be reclaimed.

A great deal of officer time will be required to find support for vulnerable people who have lost care at home and re-commissioning is very expensive and time consuming. Occasionally, councils have found themselves making cash injections and supplying labour to failing care companies to ensure people have the care they need to stay well and even alive.

And it is a risky business. Some small providers may have poor records and if they look after self-funders, the council may not have previously been aware of who they are and what kind of help they need. Our research26 with heads of adult social care and commissioners has indicated that councils feel less well prepared for home care failure and privately a number have expressed that they fear the impact of a home care provider failure more than the closure of a residential home.
Section 6: A bleak future

What happens if we carry on the way we have been?

Home care has been on the brink, but that edge is crumbling away. The system has long relied on the willingness of care workers to support people for little pay and little esteem out of the kindness of their hearts. It is now relying on small providers to take the risk that they’ll be able to stretch resources to pay their staff and provide the help that people who need care need. It is relying on some providers to cross-subsidise the cost of state-funded care with the fees of self-funders. It is relying on large care providers like this report’s sponsor Mears to cross-subsidise the cost of care with revenue from other parts of their business.

If something does not change soon, then more and more care providers will cease trading or shut down the care portion of their business. And if they are not forced to shut down because of cash flow issues, it may be because they simply cannot find enough people to do this work for the pay that is on offer. There is no room to raise wages on the prices that are currently offered. Already care companies are struggling to recruit enough workers. Mears, for example, say they have around 2000 vacancies unfilled and Sharon Allen told The Guardian in early 2016 that there are around 60,000 care vacancies on any given day. So long as care is poorly paid, held in low esteem and where there are few opportunities for career progression or basic recognition of skills, this workforce shortfall will continue.

What this means in practice is that even people who are entitled to local authority funded care will not get it. Already people are entitled to care are placed on waiting lists, because there is simply no one to care for them. Not only does this cause distress for individuals and their families, but it is causing knock-on problems for universal public services like the NHS. Too many older people who could be discharged are staying in hospital because the lack of appropriate support at home or a place in residential or nursing care. In April 2016, over 32,000 people had a delayed discharge from hospital because they were awaiting a care package at home, which is 125 per cent increase from April 2012. Each day costs the NHS money, but it has a cost for older people, too. Each additional day in hospital results in lower muscle tone, lower overall health and a reduced likelihood of regaining independence. Less well documented are those who are sent home without adequate care in place, resulting in acute distress for individuals and their families and unnecessary readmissions.

When people do get care, it will increasingly be given on a short shrift and cannot be focused on helping them to live better lives. Inadequate care means that people will struggle to maintain or improve their health and independence.

Carrying on as we are means that care becomes less dignified and more chaotic until the system falls over altogether and local authorities are no longer able to commission ethical providers or any providers at all. People will suffer and die. Hospitals will not be able to perform routine operations and will struggle with emergency admissions. The public outcry will reach the point where Government will have to step in and fix the system. We are part of the way there. We can avoid the cost and chaos of a care system failure if we invest now, otherwise we will all pay the cost.

29 CQC interactive data tracker on transfers of care published in conjunction with the State of Care report 2015/2016
Section 7: The way forward

In this section, we recommend what needs to change in home care in both the short- and long-term.

At the core of the current crisis in care is funding. Councils are hard pressed to stretch their budgets to all who need care. This follows years of pressure to ‘commission better’ by squeezing price creating a lowest cost culture. This is reinforced by a failure to understand the true costs of running a care business and who bears the brunt when those costs are not met.

However, this is not just a crisis of money. This is a systemic crisis. It has been caused by a system which over specifies times and actions at the cost of goals and outcomes. Too often, the system has been about procurement, rather than partnership. The culture is changing and more councils are seeking to change the way that they are commissioning care. But it takes investment of time, money and thought to change how we work and when council budgets are so strained, it is harder to make the changes that so many wish to make.

But an easy change to make, is to be much more aware of the cost of providing care, insisting on open book accounting when commissioning care to ensure that providers can make a fair return but also that care workers are fairly compensated for their labour in people’s homes and on their way there.

Providers, too, who are barely able to make a profit or a surplus are unable to make the investments they need to change to a more outcomes focused, partnership style of commissioning. Until care providers receive at least the UKHCA minimum payment of £16.70 per hour they will not have the resources to provide a real career of esteem, including training, specialisation, career advancement and job security.

Recommendations

For councils:

Councils should look carefully at the impact of reductions to their hourly rate. Councils must recognise that when they make the choice to reduce their hourly rate below around £15.90 an hour, it is an active choice to reduce one of the aspects of care outlined in our care calculator in Section 4. There are costs to delivering care. Reducing the hourly rate below a certain level puts councils and providers in moral jeopardy.

Councils should require (and make full use of) open-book accounting arrangements with their providers. Councils should expect their providers to offer a clear account of how the hourly rate is disbursed. Commissioners who have a clear understanding of how this rate is broken down are able to engage more effectively with their providers and develop more trusting relationships.

Councils should consider how they incentivise outcome-based commissioning. The ‘time and task’ approach to commissioning tends to build fragmented relationships with providers and does not incentivise quality, promote independence or provide dignity. Providers are driven purely by the need to be in someone’s home for a given period of time; the degree to which they deliver better outcomes for the service user is unmeasured and unrewarded. Councils should seek to measure outcome delivery as well as time in an effort to focus commissioning on outcomes rather than inputs.

However, we recognise that councils are extremely financially hard-pressed. Their responsibilities in delivering adult social care have increased in recent years, while...
their budgets have shrunk. However well-intentioned councils are in providing quality commissioning, these services will continue to be rationed leaving some individuals underserved, some not served at all and the care market in tatters.

**For central government:**

Central government must urgently review the mechanism for funding adult social care and plug the immediate financial gap.

We welcome the additional funding for adult social care announced in the Spring 2017 budget. But with the King’s Fund estimating a £2 billion gap in social care funding this year, the stop gap funding of £1 billion for 2017/2018 only goes halfway toward meeting the holes in local social care budgets in the first year and less than that in the two subsequent years of this emergency support. It is too little, and it may be too late.

There is an ever-increasing gap between demand and resourcing of adult social care. Incremental increases to the council tax rate will not and cannot plug this gap, and will only serve to increase regional disparities in funding, leaving places with a low council tax base and high demand for social care out of pocket.

This is a national crisis which requires a national solution, but with the freedom and flexibility to apply local solutions to local needs. The Chancellor’s budget announcement focused on the very real crisis of delayed discharge from hospital. But emergency funding for social care should not be focused on NHS crises, but on the real human benefits of helping people to live at home as well as the financial savings of helping to stay out of hospital or residential care unless absolutely necessary.

Central government must review longer terms solutions to social care that are not solely focused on funding.

We welcome the Chancellor’s announcement of a review of social care funding and a green paper to be published later in 2017. We agree that there are immediate funding needs for adult social care, but there is a need, too, to provide a clearer and more affordable way for people to pay for their own care.

Although this report has focused on the problems of low prices that relate directly to the funding crisis, this is not simply a question of money. The LGiU with Mears and others has highlighted a number of areas which need to be urgently fixed in order to have the best care for people who need it and a thriving care market for both those who are publically funded and those who pay from their own pocket. Good money spent through a system that focuses on time and tasks instead of outcomes, or to patch over the cracks of breaking market will not solve the social care funding crisis. So central government must:

**Address the financial instability in personal and public funding of social care**

- Provide real policy clarity about long-term funding solutions: Government must either take real steps to implement the recommendations of the 2011 Commission on Funding of Care and Support (the Dilnot Commission) or be honest about its demise and work to find a new, stable and feasible framework for social care funding.
- Develop a sustainable public funding framework for adult social care which does not put areas with lowest property values and greatest needs at a significant disadvantage.
- Within a stable policy framework, work with the financial services industry to stimulate and sustain a market for affordable financial products to help people fund their own care.
- Ensure that working aged carers are able to continue with their careers and contribute to the wider economy.
- Help councils provide support for people to engage in long-term financial planning for their potential care needs and provide good quality advice at the point of need for people who have immediate care needs, as we outlined
in Independent Ageing, the LGiU’s 2013 report on support for self-funders.

Address the problems within care commissioning and the wider care market:

- Provide support to councils to achieve outcomes based commissioning, this is likely to be best achieved through support, culture change and knowledge sharing and not through regulatory enforcement as we have outlined in Outcomes Matter.

- Urgently examine the care workforce issues as we suggested in Key to Care: the Report of the Burstow Commission on the Future of the Home Care Workforce. Care workers need a career of esteem, a sensible training and regulatory regime and a clear career pathway that involves specialisation and recognition of experience and skill. Basic entitlements to pay and conditions must not be overlooked either. Care workers must be able to bring home a living wage.

- Find ways to support better use of technology in providing home care and home care commissioning so that the advantages of modern information technology can be brought to the sector as a whole as we recommended in Achieving Outcomes Based Commissioning.

When reviewing the social care market and funding, Government must heed the wider lessons of workforce, commissioning and the wider financial markets and work with people who need care, their families, local government, care providers, the voluntary sector and financial services industry. If Government fails to take the opportunity to conduct a fundamental review and provide real solutions, the most vulnerable in our society will continue to pay the price.
LGiu is an award winning think-tank and local authority membership organisation. Our mission is to strengthen local democracy to put citizens in control of their own lives, communities and local services. We work with local councils and other public services providers, along with a wider network of public, private and third sector organisations.

Mears is the UK’s leading social housing repairs and maintenance provider and a major presence in the domiciliary care market – bringing the highest standards of care to people and their homes. Partnering with clients, 20,000 Mears Group employees work in communities across the country – from inner city estates to remote rural villages. www.mearsgroup.co.uk