

# Value and strategy for homecare

Professor N Bosanquet, Consultant Director, Reform and  
Emeritus Professor of Health Policy at Imperial College London

Andrew Haldenby, Director, Reform

November 2015

## **Report and acknowledgements**

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This report was produced by Professor Nick Bosanquet and Andrew Haldenby, writing in a personal capacity. It was commissioned by the United Kingdom Homecare Association (UKHCA).

The authors are grateful for those homecare commissioners, providers and investors that participated in research interviews. They are grateful to Professor Sir Julian Le Grand of the Department of Social Policy at the London School of Economics for his comments and advice. They are also grateful to A Denney for his research assistance.

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# Value and strategy for homecare

Professor N Bosanquet, Consultant Director, *Reform* and Emeritus Professor of Health Policy at Imperial College London

Andrew Haldenby, Director, *Reform*

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November 2015

## Letter to Bridget Warr

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c/o Imperial College London  
London  
SW7 2AZ  
n.bosanquet@imperial.ac.uk  
andrew.haldenby@reform.co.uk

Mrs Bridget Warr  
Chief Executive  
United Kingdom Homecare Association  
Sutton Business Centre  
Restmor Way  
Wallington  
SM6 7AH

20 October 2015

Dear Bridget

You commissioned us to provide an independent view on the funding of homecare and its relevance to the Government's agenda on NHS reform.

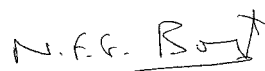
You asked us to focus on three key questions:

1. what is a sustainable cost per hour of homecare from April 2016, following the introduction of a National Living Wage;
2. is there a disparity between local authority funding and the sustainable rate, and if so, why; and
3. what contribution can homecare make to the prompt discharge of NHS patients from hospital to come.

We have the pleasure to provide this to you. We trust this report demonstrates that homecare is now at a tipping point. With a sustainable rate, it can provide a vital service for achieving integrated care. Without a stable economic base, there will be a disincentive to invest and an inability to supply the necessary quality of service. Homecare should be seen as a key resource for developing a sustainable NHS.

Our report draws primarily on data from England. However, we note that it carries important messages for governments, regulators and commissioners in all four UK administrations.

Yours sincerely,



Professor N Bosanquet



Andrew Haldenby

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## Key points

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- This is a crucial time for homecare. It can start on a downward slide towards being a low cost, commoditised service (purchased in fractions of an hour) and facing huge problems with quality of care. Alternatively it can begin a development phase in which it can be a key resource for reducing pressure on acute care and improving quality of life for older people and those with severe disabilities living at home.
- We set out the case for a sustainable hourly rate of around £16.00 an hour now rising to £23.00 an hour over the next four years. This is required to develop the “key resource” option rather than the “low cost, commoditised service” default option.
- The NHS now faces major challenge in providing better care for elderly people who are currently admitted to hospitals. In the Five Year Forward View, NHS England has set out the priority of integrated care outside hospital. Homecare could be a key lever for making this happen.
- NICE has now researched standards for homecare which are realistic and positive. They represent a real advance in defining a quality service. To make this development however requires realistic and sustainable funding.
- With a sustainable rate, homecare can also invest in IT and remote monitoring. There is great potential for using technology as well as personal contact to improve service to users. This is also vital for improving collaboration with health and social services.
- There is already some experience with a more developed approach aimed at improving outcomes. Outcome based commissioning has great promise but such increased capability needs an economic base.
- Homecare is now at a tipping point. With a sustainable rate, it can provide a vital service for achieving integrated care. If homecare does not have a stable economic base, there will be a disincentive to invest and it will not be able to supply the quality of service needed for this wider role in integrated care. As we show, there are some very worrying developments beginning to take place with the withdrawal of providers from the service. Homecare should be seen as a key resource for developing a sustainable NHS. Consistent strategic action is needed to make this happen.

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# Introduction

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## Introduction

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1. Homecare is now a key resource - a service for nearly 900,000 people per year across the UK which has been built up by private and public collaboration. This could be a greater resource in the future: a key asset for the redesign of health services as set out in the NHS England Five Year Forward View (NHS England 2014). Homecare could also deliver on the personal, outcomes based approach set out in the 2014 Care Act for England. This will depend on developing a longer term collaborative partnership between commissioners, providers and people who use services to deliver the best outcomes and improvements in value.

### The baseline position

2. Homecare has strengths in its organisation and infrastructure which have made it possible to provide care in all local areas.
3. It is also delivering on quality. The recent CQC review of all services wrote of “many examples of excellent care”. On the previous CQC performance standards - respect and dignity, safeguarding and safety, care and welfare, monitoring quality and suitability of staffing - domiciliary care agencies showed strong performance and some improvement between 2011-12 and 2013-14. There was 97 per cent compliance with the standard on respect and dignity and over 88 per cent on the other standards. User satisfaction was high (Care Quality Commission 2014).
4. UKHCA was able to produce more recent figures for this research, for the period October 2014 - September 2015, based on figures provided by the CQC under its new quality ratings. These provide ratings for 1,281 homecare providers. Of these:
  - > 0.6 per cent provided “outstanding” care.
  - > 68.0 per cent provided “good” care.
  - > 28.4 per cent provided care that “requires improvement”.
  - > 3.0 per cent provided “inadequate” care.



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# What is a sustainable rate for regulated homecare?

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## Summary

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5. The costs of homecare firms comprise two main elements: labour costs (both wages and on-costs, such as National Insurance and pensions contributions) and the costs of running the business.
6. Labour costs are rising and will continue to do so. The National Living Wage will increase wage levels directly. Homecare firms will be under pressure to pay more than the National Living Wage due to growing competition for labour. To provide a quality service, they will invest more in training since the client population is becoming more dependent and in need of more intensive support.
7. On latest data, the median homecare firm is relatively small and locally based. It provides around 500 hours of care per week and employs around 17 care workers in any given week. Such a firm does incur costs for running the business, comprising a small number of managerial staff and a small office space.
8. UKHCA estimates of a sustainable rate for homecare are reasonable, given these factors. They imply a low management overhead for a typical small firm (one manager, one administrator and some office space). Homecare providers typically operate with a very flat hierarchy between careworkers and the most senior manager.
9. UKHCA estimates might be improved by taking account of the additional costs of sick pay, training programmes and the effects of labour market competition. It is our view that a sustainable rate for homecare should rise to £23.00 by 2020, compared to £16.70 from April 2016.

## UKHCA estimates

10. UKHCA has produced estimates of a “minimum price for homecare”, most recently in July 2015. These are set out below, including the impact of the new National Living Wage from 2016.

**Table: “Breakdown of prices at National Minimum Wage and National Living Wage”**  
Source: UKHCA (2015b), p.25.

<b>At National Minimum Wage (and National Living Wage from April 2016)</b>		<b>Oct 2015 to Mar 2016 (£)</b>	<b>From Apr 2016 (£)</b>
Hourly rate for contact time		£6.70	£7.13
Enhancement for unsocial hours etc	0 per cent of basic hourly rate	£0.00	£0.00
Travel time	11.4 minutes per hour of contact time	£1.27	£1.35
National Insurance Contributions	9.5 per cent of gross pay	£0.76	£0.81
Holiday pay	12.07 per cent of gross pay	£0.96	£1.02
Training and supervisory time	1.73 per cent of gross pay	£0.14	£0.15
Pension contributions	1 per cent of gross pay	£0.08	£0.08
Distance travelled	4.0 miles to 1 hour of contact time, £0.35 per mile	£1.40	£1.40
Running the business		£4.37	£4.26
Profit or surplus	3 per cent of total price	£0.48	£0.50
<b>Total</b>		<b>£16.16</b>	<b>£16.70</b>

## Commentary on UKHCA estimates

### Hourly rate for contact time

11. The figures accurately reflect levels of the National Minimum Wage and National Living Wage.
12. As the economy recovers, homecare providers face greater competition for workers. They may well have to pay more than the various Government benchmarks in order to secure labour.
13. The ONS Annual survey of hours and earnings (2014) and LaingBuisson (2013) allow a comparison between the gross pay of care workers and homecare workers, sales and retail assistants and retail cashiers. These show that the care sector staff had nearly lost its pay premium compared to the retail sector.

#### Table: narrowing difference between care workers and retail workers

Source: Table 14.5a, Hourly pay - Gross (£) - For female full-time employee jobs: United Kingdom, ONS (2014); LaingBuisson (2013), p.258.

	2012	2012	2014	2014
	Median	Mean	Median	Mean
Care / sales	110%	106%	105%	102%
Care / cashiers	110%	113%	107%	110%

#### Table: narrowing difference between care workers and retail workers

Source: Table 14.5a, Hourly pay - Gross (£) - For female full-time employee jobs: United Kingdom, ONS (2014); LaingBuisson (2013), p.258.

	2014	2014
	Median	Mean
Care workers and home carers	£7.78	£8.31
Sales and retail assistants	£7.38	£8.14
Retail cashiers	£7.21	£7.56

### On-costs

14. UKHCA estimates accurately reflect the costs of National Insurance contributions and pension contributions under auto-enrolment.

### **(Lack of) enhancement for unsocial hours etc**

15. UKHCA estimates include no uplift for work during unsocial hours. This is realistic. A LaingBuisson survey in 2012 found that:
- 81 per cent of councils that reported a night rate paid the same hourly rate for days and nights
  - 93 per cent of councils that reported a weekend rate paid the same hourly rate for weekdays and weekends
  - 85 per cent of councils that reported a bank holiday rate paid the same hourly rate for weekdays and bank holidays.
16. Nevertheless that is unlikely to be a sustainable position given competition for staff. UKHCA is right to emphasise that, “Under no circumstances should our ‘minimum price’ for homecare, particularly at a flat rate of National Minimum Wage without enhancements, be treated as a national acceptance price capable of achieving a stable workforce, or a sustainable organization.” (UKHCA, 2015b). A business will be more sustainable if it has the flexibility to incentivise workers to provide care during peak times of demand, typically early mornings and late evenings and out of hours, where few alternative services are available.

### **Travel time**

17. UKHCA is accurately based on a survey quoted by LaingBuisson 2013: “An analysis of visit lengths undertaken by the private company CM2000 during one week in September 2010 using data from its electronic time-sheeting service indicated that 19 per cent of a homecarer’s time was spent travelling in 2010 compared with 17 per cent in 2009 and 22 per cent in 2007.”
18. It is important to note that the Low Pay Commission is highly concerned that failure to reflect the costs of travel time means that some workers are not receiving the full minimum wage.

*Low Pay Commission (2015): “In our 2014 Report, we concluded that care workers remained at a high, and possibly increasing risk, of non-compliance with the NMW. Evidence provided by HMRC had suggested that the reasons for non-compliance included non-payment for working hours (such as for travel time and time spent training) and deductions which took pay below the NMW (such as for uniforms and accommodation). We had previously estimated that up to 10.6 per cent of care workers may not be being paid the NMW. Government promises to develop tougher measures to deter non-compliance and support compliance had been slow to materialise.”*

*5.92 Failure to pay care workers for travel time again featured heavily in stakeholder evidence as a central cause of under-payment of the NMW in this sector. In its evidence the Government (BIS 2014h) said it was aware that non-payment of travel time was a particular issue for domiciliary care workers and that it had updated the official NMW guidance to make it clear when travelling time and rest breaks must be paid. Despite this, we heard from stakeholders that payment for travel time remained sporadic and additional enforcement and guidance was needed.*

### “Running the business” and profit or surplus

19. LaingBuisson 2013 reports that, in its 2009 survey, the median responding independent sector outlet provided 510 hours per week of hourly-paid homecare.
20. UKHCA figures suggests a management cost (“running the business”) of around 25 per cent of total hourly cost of around £16.00 per hour.
21. On that basis, the management cost of the median outlet would be 510 hours per week @ £4.00 per hour = £2,040 per week or £106,080 per year.
22. That would pay for one manager, one member of administrative staff and low cost office accommodation. The median salary for care home and homecare managers in March 2013 was £30,000 in England. (LaingBuisson 2013, based on National Minimum Data Set - Social Care). National Insurance and other costs must be added to that.
23. The turnover of the median outlet would be £424,000 per year at an hourly rate of around £16.00. On UKHCA’s estimate of 3 per cent, the profit for such an outlet would be around £12,500 per year.
25. The median outlet can therefore be described in the following terms, taking a £16.00 hourly rate:
  - Hours of care provided per week: 510
  - Hours of care provided per year: 26,520
  
  - Annual turnover: £424,000
  - Management fee (“running the business”): £106,000
  - Profit: £12,500 per year
  
  - Staff: one manager, one administrator, 17 care workers in any given week
26. LaingBuisson 2013 provides illustrative examples of larger firms, for comparison:
  - Mears Care, for example, employed 5,734 care workers to deliver over 153,000 hours of homecare each week i.e. 26.7 hours per week per care worker.
  - Carewatch Care Services employed around 8,500 care and support staff to deliver 200,000 hours of homecare each week i.e. 23.5 hours per week per care worker.

## A sustainable rate in future

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27. The Government's target is for the National Living Wage to reach £9.00 by 2020. If the £16.70 sustainable rate was updated proportionally to take account of the £9.00 National Living Wage, the rate would rise to £21.60.
28. It is highly likely that pension costs and travel costs will rise further in the next five years. It will also be essential to spend more on training given the nature of the client population. We would stress that the shift in service to more intensive support of people with critical needs involves a big increase in responsibility and workload. As of now the majority of homecare service users are in the critical category i.e. they are totally dependent on carers for daily activity. They cannot get up in the morning, dress themselves, eat or get to bed at night. This critical group greatly increases the need for a dependable service and one which is vital and personal. The shift to higher dependence levels has been frequently mentioned but the implications for workload and responsibility are often ignored. This raises the need for training and also for staff stability to provide continuity of care.
29. The authors would think it prudent to add a further £1.40 for contingencies. Thus the sustainable rate for 2020 would be £23.00. This is the rate required for the development of homecare as a key resource. It is a vital investment in better service.

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# Disparity between local authority payments and the sustainable rate

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## Summary

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30. On average UK councils pay at below the sustainable rate outlined above. Local government spending in general has been heavily constrained since the financial crisis. The National Audit Office has reported that central government will have reduced its funding to local authorities by 37 per cent in real terms between 2010-11 and 2015-16 (National Audit Office 2015).
31. Homecare providers, and investors into homecare businesses, have naturally sought to maintain their services in a much more difficult financial environment. Investments have been made and firms will hope that the financial environment will improve. At a certain point, however, firms will conclude that their future prospects do not justify remaining in the market. It is likely that the homecare market is at that tipping point.
32. The Low Pay Commission is concerned that some councils are not funding homecare at the full rate, in particular workers' travel time.
33. We are concerned that many councils are paying well below the current sustainable rate. It is not realistic to think that such lower rates can be a foundation for service development. Their continued use threatens the future of the service.

## Local authority rates

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34. The most recent UKHCA survey, using Freedom of Information requests, found that the average hourly rate paid by local authorities in the UK was £13.66. The breakdown for the constituent nations was: England, £13.66; Scotland, £13.68; Wales, £14.28; and Northern Ireland, £11.35 (UKHCA 2015a).
35. LaingBuisson conducted a similar survey in 2012. The equivalent figures were: England, £13.54; Scotland, £14.31; Wales, £13.89. (LaingBuisson 2013).

## Deterioration in market position over the last three years

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36. LaingBuisson (2013) reported that “many firms” were able to make “good profits” at local authority rates. It nevertheless noted that cost pressure on providers had “recently” increased:

LaingBuisson 2013: “Independent sector providers have for long complained that local authorities are putting them under price pressure, either by offering increases in hourly rates that are lower than the rate of private and earnings inflation or by rolling-over contracted hours beyond the original contract period. This is no doubt true for many businesses, but there were many others that are able to make good profits at local authority rates. A few years ago there were signs that some local authorities were willing to pay more for homecare, but recently the cost pressure on providers has increased.”

37. The most recent survey for UKHCA (2015c) gives a very different picture, no doubt due to the pressure on local government spending in the intervening period. The survey reported:

- 50 per cent of providers who were aware of tender opportunities from their local councils had declined to bid for one or more contract on the basis of price.
- Over the last 12 months, 71 per cent of providers trading with councils had refused to take on new packages referred to them “regularly” or “occasionally” on the basis of the price offered.
- 93 per cent of providers trading with councils had faced a real-terms de-crease in the price paid for their services in the last 12 months.
- 74 per cent of providers trading with councils said that they would reduce the amount of publicly funded care they delivered, estimated to affect 50 per cent of all the service users they support.
- 11 per cent of all providers thought that they would “definitely” or “probably” have ceased trading within the next twelve months.

## Market exit

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38. In May 2015, it was reported that two of the leading five domiciliary care providers had decided to leave the market. Saga had placed Allied Healthcare up for sale, retaining ownership only of a private-pay homecare business. Care UK was continuing plans to sell its domiciliary care and learning disabilities services. (LaingBuisson 2015).

39. The UKHCA survey (2015c) found that 11 per cent of providers thought that they would “definitely” or “probably” have ceased trading within the next twelve months.

## **Commoditisation and withdrawal of service**

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40. One consequence of increased financial pressure on councils has been a shift to “time and task commissioning” i.e. short episodes of care, sometimes lasting 15 minutes, or even fewer, focused on particular tasks rather than the wider wellbeing of the client. In its recent guideline, the National Institute for Health and Care Excellence (2015) advised against 15 minute appointments where possible. They are widely seen as demoralising for staff and client. They also impose extra administration costs on both commissioner and provider.

## **Cross subsidy**

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41. Some may say that homecare firms should be able to sustain themselves by increasing their private pay market, and using that revenue to cross subsidise their local government business. Private payers are generally expected to pay higher rates than local authority commissioners.
42. The authors’ view is that this would not represent a dependable support for the regulated sector. In an interview for this research, UKHCA reported that providers tend to specialise in one market or the other. While the homecare itself may be similar, the organisation and payment of the service is very different comparing local authority and private.

## Non-compliance with National Minimum Wage

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43. As noted above, the Low Pay Commission is concerned that some workers are not receiving a true minimum wage since their wages do not reflect travel time and time for training.

*Low Pay Commission (2015): "In our 2014 Report, we concluded that care workers remained at a high, and possibly increasing risk, of non-compliance with the NMW. Evidence provided by HMRC had suggested that the reasons for non-compliance included non-payment for working hours (such as for travel time and time spent training) and deductions which took pay below the NMW (such as for uniforms and accommodation). We had previously estimated that up to 10.6 per cent of care workers may not be being paid the NMW. Government promises to develop tougher measures to deter non-compliance and support compliance had been slow to materialise."*

*5.92 Failure to pay care workers for travel time again featured heavily in stakeholder evidence as a central cause of underpayment of the NMW in this sector. In its evidence the Government (BIS 2014h) said it was aware that non-payment of travel time was a particular issue for domiciliary care workers and that it had updated the official NMW guidance to make it clear when travelling time and rest breaks must be paid. Despite this, we heard from stakeholders that payment for travel time remained sporadic and additional enforcement and guidance was needed.*

44. The Resolution Foundation (2014) stressed that "social care is one of the main obstacles facing any strategy to tackle low pay" (p.52). It is one of the five sectors, and the largest of the five, that "face particularly prohibitive costs if they were to eliminate low pay by paying their lower paid workers more". Our development plan would be the best opportunity for rising earnings by raising service value.

*Resolution Foundation (2014): "This exploratory analysis also reconfirms that social care is one of the main obstacles facing any strategy to tackle low pay. Our analysis suggests that five sectors of the UK economy face particularly prohibitive costs if they were to eliminate low pay today by paying their lowest paid workers more. These sectors are: Personal Services (e.g. hairdressing), Residential Care (e.g. nursing homes), Accommodation Activities (e.g. hotels), Food and Drink Activities (e.g. restaurants) and Social Work Activities (e.g. elderly care and childcare). These highly problematic sectors together contain 1.25 million low paid workers, a third of whom (420,000) are employed in the largely publicly-funded sectors of Residential Care and Social Work Activities."*

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# Prompt discharge of NHS patients from hospital to home

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## Summary

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45. Delayed discharges are a growing and immediate problem for the NHS. There were 138,076 delayed days in the year to May 2015, compared to around 115,000 in the three previous years.
46. Homecare is a key solution. Excluding patients waiting for an assessment, around 20 per cent of delayed days were due to a wait for a care package at home, in the latest month for which statistics are available (May 2015). The number of delayed days due to a wait for a care package in the home has risen sharply over the period June 2014 - May 2015.
47. Past studies in the NHS indicate that for between 42 and 55 per cent of bed days, an alternative setting - including home with medical services, home or a nursing home - would be more appropriate for patients.
48. A strong private and voluntary sector homecare market should provide savings to the taxpayer. The average cost of homecare based on daily visits and intensive support is £200-250 a week. The cost of nursing home care is now £800 a week. Hospital care ranges from £1,500-£2,000 a week.
49. Homecare from the private and voluntary sector is much cheaper than local authority-provided care. In the last LaingBuisson survey (2013), the mean in-house cost of local authority provision was more than double (240 per cent) the cost of an independent sector hour purchased by local authorities. That ratio had increased considerably since 2005-06 (157 per cent).
50. Homecare has contributed to a fall in long term care home places. In 1995 there were 508,000 places in residential care. By 2010 this number had fallen to 418,000 (a fall of 18 per cent).

## Delayed discharges

51. Delayed discharges are a growing and immediate problem for the NHS. There has been a significant jump in the number of delayed days in the last year.

**Table: Annual number of Delayed Days during the reporting period, Acute and Non-Acute, NHS organisations, England**

Source: DTOC Timeseries May 2015, Department of Health

June 2011 - May 2012	114,981
June 2012 - May 2013	115,542
June 2013 - May 2014	118,565
June 2014 - May 2015	138,076

52. The Department of Health timeseries suggests that the homecare contribution could be of immediate benefit:

- Excluding patients waiting for an assessment, 20.5 per cent of delayed days were due to a wait for a care package at home, in the latest month for which statistics are available (22,700 out of 110,674 days, May 2015).
- The number of delayed days due to a wait for a care package in the home has risen sharply over the period June 2014 - May 2015. The most recent figure, of 22,700 delayed days in May 2015, is by far the highest monthly level seen in the current timeseries which began in August 2010.

**Table: Monthly number of Delayed Days due to “awaiting care package in own home” during the reporting period, Acute and Non-Acute, NHS organisations, England**

Source: DTOC Timeseries May 2015, Department of Health

June 2014	13,851
July 2014	14,779
August 2014	17,139
September 2014	17,338
October 2014	17,941
November 2014	18,018
December 2014	19,592
January 2015	21,033
February 2015	19,693
March 2015	21,139
April 2015	22,342
May 2015	22,700

## Reducing admissions and length of stay

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53. Past studies in the NHS indicate that for between 42 and 55 per cent of bed days, an alternative setting - including the person's own home with medical services, or a care home or a nursing home - would be more appropriate for patients.
54. Hospitals are having continuing problems in rehabilitation of older patients. 80 per cent of emergency admissions who stay for more than two weeks are patients aged over 65. It is also widely reported that people with dementia experience avoidable deterioration in their condition. Such facts have been well known for years. For years too there has been a conviction by managers and clinicians that 20 per cent of patients in hospitals did not need to be in-patients. Yet there has been little progress in reducing length of stay. A University of Birmingham Report in 2004, which is still the most detailed review available, was not optimistic about how progress could be made. (Glasby 2004).
55. Homecare can offer a new opportunity to make progress. The initial target has been set out very clearly in a report by the King's Fund: "Reducing admissions of patients staying for more than 14 days by 5 per cent... would reduce total bed days by 800,000." (Poteliakhoff and Thompson 2011).
56. Support programmes from homecare could be available to many more people and facilitate discharge, providing there is sufficient lead-in time to enable recruitment and training for seasonal variations in demand. This opportunity was simply not there in earlier times when the problem first emerged. In North Yorkshire and other areas there has already been positive experience for programmes with discharge support and re-ablement.
57. This positive role for homecare is crucial for the quality of service that the NHS is going to be able to offer to patients. The number of acute beds is set for continuing gradual decline and there are serious problems in staffing those that will remain. Any increase in admissions pressure will create even greater stresses for quality of care in hospitals. Homecare offers a resource for making real progress here on a problem that is crucial for the future sustainability of the NHS.
58. NHS England is about to publish the potential contribution of homecare. It has established a "Better Use of Care at Home Work Stream" under its Independent Care Sector Steering Group. The work falls under the remit of the Urgent and Emergency Care Programme Board. (NHS England 2015).



## Potential cost savings to the taxpayer

59. A strong private homecare market should provide savings to the taxpayer for a number of reasons. First, homecare is cheaper to purchase than residential care or hospital admissions. Second, homecare provided by the independent and voluntary sector is much cheaper than local authority-provided care.
60. Without quality homecare, most service users would have to be looked after either in nursing homes or in hospitals. The average cost of homecare based on daily visits and intensive support is £200-250 a week. The cost of nursing home care now averages £800 a week. Hospital care ranges from £1,500-£2,000 a week. Without homecare there would be extreme pressure to increase use of these high cost services. Homecare is a strategic resource for the key priority of containing spending and pressure on the NHS.
61. In the last LaingBuisson survey (2013), the mean in-house cost of local authority provision was more than double (240 per cent) the cost of an independent sector hour purchased by local authorities. That ratio had increased considerably since 2005-06 (157 per cent). LaingBuisson commented: "These increases in the differences may be attributable to the reduction in the in-house workload not being matched by a corresponding reduction in in-house overheads."

## Contribution of homecare to fall in residential care places

62. In the past ten years there has been some fall in numbers of people moving into long term residential care. In 1995 there were 508,000 places in long term care. By 2010 this number had fallen to 418,000 (a fall of 18 per cent).

**Table: Fall in care home places, 1995-2010**

Source: Office for Health Economics (2011)

	1995	2000	2005	2010
Total	508,000	469,000	421,000	418,000

63. Even from 2001 to 2011 the number of people over 90 (of whom 50 per cent or more are likely to be in long term care) has risen from 340,000 to 430,000 (a rise of 26 per cent). The UK is unique among developed countries in this degree of reduction in long term residential care places against a background of an 89 per cent increase in the over-75s since 1974. Obviously factors such as improved housing conditions have contributed but the most important factor in our view has clearly been the increase in the availability of homecare.
64. The realistic option in day to day living depends on the support given by homecare workers. Without their help it was quite likely that continued living at home would not have been feasible. There would also have had to be more long term accommodation within the NHS since some would have qualified for NHS support. The number of NHS places in "geriatric" hospitals was reduced from 68,000 in 1990, and 43,000 in 1995, to 14,000 in 2010. The increase in homecare made possible a substantial shift in the balance of funding away from the taxpayer.

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# Developing homecare

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65. Homecare faces a number of key challenges:

- The labour market has improved with many more opportunities for job seekers. Homecare providers will face more challenge in recruiting and retaining staff.
- The living wage is expected to rise to £9.00 by 2020. It is in the interests of employers to pay their workforce as well as possible. With 70 per cent of homecare purchased by local authorities, however, such an increase is likely to cause obvious problems for providers if the additional costs are not recouped from customers.
- At present there is a serious equity problem: it is not clear whether all users with critical or substantial needs are actually receiving suitable support. In a publicly funded service it must surely be a priority to ensure that such groups in high need should be getting service (groups with inability to carry out daily living routines and significant health problems in the case of critical risk). The CQC is calling time on unacceptable variations in quality of care. This is not just about the performance of providers but about differences in access brought about by commissioning policies across an area.
- There are likely to be further reductions in the number of acute beds in the NHS and in nursing home places. The nursing shortage will continue for the next few years at least together with admissions pressure.
- There are new challenges in training, including the Care Certificate and the need for specialist training for meeting the needs of people with increasingly complex care needs.

66. Homecare should be seen as a vital, in fact indispensable, resource for the new agenda of more supportive care outside hospital and long term residential care. At present the incentives are to deliver the maximum number of hours for the minimum unit cost. This model may have worked over the last few years in which the labour market has allowed for recruitment of care-workers. It is unlikely to work as well with a low paid workforce with lower staff stability struggling to care for an increase in the number of very frail service users. The one size fits all model will not allow for the development of the service so that it can be a key resource for achieving the aims set out in the Five Year Forward View.

67. The key direction of change is towards outcome based commissioning. There is already promising progress being made here. Local authority commissioners should be able to agree with the client the services and outcomes they want to achieve. The key change is to commission for personal outcomes rather than in hours. Providers are paid a fixed annual sum to deliver outcomes for a local population. Wiltshire County Council has been a key leader here.

68. There needs to be a development path which allows choice of services and the emergence of many more programmes to fulfil specific roles purchased from the independent and voluntary sector, including reablement and support after early discharge. These new challenges must mean a new development agenda, and are already supported by the NICE guidance for homecare (NICE 2015).

69. Homecare has already made large savings in reducing the demand for long term care. Now there is an opportunity to reduce costs of hospital admissions where elderly patients are often poorly served by emergency admissions. Such increased capability nevertheless needs an economic base.

**70. In summary homecare could be a key resource in advancing the Spending Review aims of more digital use and devolution: a service which offers local flexibility and quick response in meeting key aims of personal service and reduced pressure on the NHS.**

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© United Kingdom Homecare Association 2015

Sutton Business Centre  
Restmor Way  
Wallington  
SM6 7AH

020 8661 8188  
policy@ukhca.co.uk  
Registered in England No. 3083104

Andrew Haldenby and  
Professor N Bosanquet

c/o 45 Great Peter Street  
London  
SW1P 3LT

andrew.haldenby@reform.co.uk  
n.bosanquet@imperial.ac.uk