UKHCA Commissioning Survey 2012

Care is not a commodity

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Introduction

Home-based care is a lifeline for over 640,000 people in the United Kingdom,[1] who rightly expect dignified, quality services that keep them safe in their home environment and able to remain in their local community. It is not a commodity to be purchased like paperclips - yet the findings in this report suggest that this is the direction of travel during a period of constrained public spending.

The vast majority of homecare services continue to be purchased by councils in England, Wales and Scotland, and by the Health and Social Care Trusts in Northern Ireland. The commissioning of these services is becoming increasingly commoditised and poses considerable risks: the viability of homecare providers is fundamental to the sustainability of local provision and meeting the needs of ageing, frail and disabled citizens in their communities, now and in the future.

This report contains the first results from the analysis of our comprehensive survey of the way that homecare services are commissioned by local councils and trusts. The results are not encouraging and must be addressed urgently. The forecasts for economic recovery are gloomy and our findings must act as a call to action for central, devolved and local government to safeguard the interests of citizens and to maintain the capacity of the homecare sector and the skills and experience of our workforce.

Our findings present a worrying picture:

- Short homecare visits being commissioned by councils to undertake intimate personal care, with risks to the dignity and safety of people who use services;
- Continued downward-pressure on the prices paid for care, where lowest price has overtaken quality of service in commissioning decisions;
- Contracting arrangements which have resulted in visit times and the hourly rates paid for care as the decisive factors in the viability of the sector.

Our findings illustrate how cost-cutting, unilateral control of fee rates by councils and changes to contract terms have brought these risks about, and the impact this is having on what should be positive and constructive relationships between purchasers and providers.

Despite some encouraging growth in the numbers of people accessing direct payments, there is little evidence of the use of Individual Service Funds, and our member organisations question whether a move to managed personal budgets, where they are available, is effecting any genuine change in the way that services are commissioned and arranged.

[1] The number of people using state-funded homecare is calculated differently across the four UK administrations. Our estimate includes: 543,000 people in England in the financial year 2010-11; 24,638 people in Wales at 31st March 2011; 51,700 people in Scotland in 2010-11 and 23,522 in Northern Ireland in a survey week in 2011.

In highlighting our findings, we wish to raise the key issues impacting on homecare services to allow them to be addressed quickly. It is not in the interests of either providers or councils for the courts to be used to seek resolution of commissioning decisions, but the issues raised suggest the need for councils to consider the potential risks of requests for judicial review by local providers. We hope that actions taken on the recommendations which follow will help reduce the possibility of this happening.

The key findings of our report are summarised on page 7. While this current study looks at the commissioning practices of councils, it is supplemented by our research from August 2011, which identified the impact of shortened visit times and a reduction in the number of visits for people receiving homecare.[2] Case studies from this report are provided in Appendix 12, to illustrate the real human impact of commissioning on the lives of people who rely on homecare services.

Our findings come at a time when little progress has been made in any of the UK administrations in resolving the real and urgent need to address the long-term funding of care. We cannot but stress the need to resolve this issue for the future, and also address the immediate picture of homecare commissioning presented in this report, to turn homecare from being a commodity to a valued service, which is individually planned, purchased and delivered.

[2] United Kingdom Homecare Association Commissioning Survey 2011, available from www.ukhca.co.uk/pdfs/UKHCACommissioningSurvey2011.pdf.

Recommendations

For local authorities with social service responsibilities and the Health and Social Care Trusts in Northern Ireland

1. The elected members of councils in England, Wales and Scotland, and the directors of the Health and Social Care Board and the Trusts in Northern Ireland, should prioritise safe, dignified and high-quality homecare, in the competing pressures on their limited financial resources.

2. Authorities should audit the profile of their visit lengths, paying particular attention to whether the homecare visits are being commissioned inappropriately for the types of personal care being undertaken ***and*** seek the views of people who receive these services (and their providers) on the dignity and safety of services within the time available.

3. Authorities should review the findings in this report, to supplement their understanding of the implications of commissioning practice on the sustainability of their local provider market, bearing in mind the increase in demand which will inevitably follow with the growth of older people and those living with life-long conditions.

4. Authorities should review their contracting arrangements with local providers, in an open dialogue to find creative solutions that will foster and sustain the viability of their local sector and identify potential savings that ease the financial pressures for both purchaser and providers.

5. Authorities should work collaboratively with people who use homecare services and providers to develop new models of genuinely person-centred care, which shift the focus of commissioning away from rigidly prescribed care tasks that must be delivered in limited periods of time.

6. Authorities should work with providers to identify good commissioning practice and share this with other authorities through their networks and professional associations.

For central and devolved government in the UK administrations

7. Governments should address the immediate shortfalls in the funding of social care, while taking urgent steps to address proposals for the long-term funding of social care.

8. Government in each UK administration must take active steps to reassure itself that the commissioning practices of local authorities and Health and Social Care Trusts is robustly scrutinised by an independent body, particularly in relation to the impact of commissioning on the quality and sustainability of the homecare sector and the terms and conditions of the homecare workforce. These actions are, in our view, their duty to their citizens.

UKHCA will seek to support any such genuine incentives for the benefit of people who use homecare services, and those who seek to provide it into the future.

Key findings

1. Survey size and coverage

This is a large-scale survey of the impact of local authority commissioning of homecare services. 739 complete responses were received from homecare providers supplying to 189 (90%) of the 211 local authorities in England, Wales and Scotland and the Health and Social Care Trusts in Northern Ireland.

2. Extensive use of 15 and 30 minute homecare visits

We are alarmed by very short visit times that councils are commissioning for increasingly elderly and disabled people and those receiving support. 73% of homecare visits in England appear to be 30 minutes or shorter and a staggering 87% in Northern Ireland (42% in Wales and Scotland).

There is evidence of the use of visits which are 15 minutes or fewer in all administrations, and as high as 28% in Northern Ireland. We believe that this accounts significantly for reports of homecare services appearing to be rushed, or lacking sufficient dignity.

The degree of physical frailty and disability of the overwhelming majority of people in receipt of state-funded social care should raise serious questions at a national and local level about the adequacy of services currently being commissioned by councils and Trusts in the United Kingdom.

3. Safety and dignity of service users at risk during shortest visits

34% of providers reported concerns that their councils required them to undertake personal care in such short visit times that the dignity of service users was at risk, including 6% who were concerned that safety could also be compromised. The concern expressed by providers in Northern Ireland over risks to dignity is particularly striking (87%).

We feel compelled to question whether inappropriate commissioning of short visits by councils and Trusts amounts to institutional abuse.

4. Councils commissioning for lowest price, not high quality

Almost three-quarters (74%) of providers said that, over the last twelve months, the councils they traded with had become more interested in securing a low price over the quality of service delivered.

5. What councils pay for homecare

The weighted average charge paid by councils in the UK for one hour of week-day, daytime homecare in the UK is estimated at £12.87. However, rates as low

as £9.55 and £10.04 were reported by providers in Wales, the West Midlands, the North West and Northern Ireland.

The price councils pay for homecare services is fundamental to the capacity of the sector to meet the needs of an ageing population, particularly with homecare being commissioned in such short episodes: Employers must be able to deliver services using staff who are motivated, properly trained and correctly managed in order to undertake the increasingly complex work required of them. In addition, it is essential that independent sector providers and their backers receive a sufficient return on capital to remain and continue to invest in the sector, and that voluntary sector providers make a sufficient surplus to remain viable and invest in new services.

6. Councils fixing the maximum price they pay for homecare

Over half (53%) of providers reported that the council they traded with had stated a maximum price they would pay for homecare services, sometimes at worryingly low levels. We believe that this shows councils are using their dominant purchasing power in the local area to reduce prices to inappropriately low levels. UKHCA questions whether councils employing these practices have genuinely assessed their providers' actual costs of delivering service – a pertinent factor in recent judicial reviews brought against councils by providers from the residential sector.

7. Councils' unilateral control over fee increases

We believe that the homecare sector is highly-exposed to future inflationary increases and public spending cuts during this and succeeding years. We found that almost 90% of providers are either required to maintain (or reduce) their prices over the life of their contracts or that the council maintains a unilateral right to grant or refuse price increases.

Just 7% of providers reported automatic arrangements in contracts to increase prices in line with an inflationary index, an almost universal expectation until the last few years.

8. Real-terms fee reductions during the financial year 2011-12

Our findings suggest that 9 in every 10 providers received a real-terms decrease in the fees paid by their council for their existing business during the financial year 2011-12, effectively creating a saving for councils at the expense of people receiving homecare. Over three-quarters (77%) of providers received no price increase. And 15% reported actual price decreases.

9. Homecare increasingly bought "by the minute"

Historically, providers were paid for the planned or commissioned length of a homecare visit, which largely remains the case in Wales and Northern Ireland.

However, there is increasing use of payment for the actual visit time (often to the nearest minute) as recorded on a paper-based timesheet, or through a system known as "electronic monitoring". 40% of providers in England and 27% in Scotland reported this to be the case.

We expect these calculation methods to become more wide-spread in all four UK administrations and without careful implementation (including payments that cover travel time) this system poses risks to providers' ability to comply with the National Minimum Wage regulations and providers' financial viability.

We heard reports of councils using electronic monitoring data to calculate actual visit durations, but then rounded this figure up or down within specified time-bands. A number of providers believed these systems invariably act to the council's financial advantage. We also heard reports of councils employing time-consuming authorisation procedures before agreeing to pay for care that lasted longer than the commissioned time.

10. Lack of payments for short visits, weekends and public holidays

Employers face significant problems incentivising workers to undertake short visits, because of the travel time involved. Employers generally have to meet these incentives from the council's hourly rate, as 72% of providers across the UK reported their council offering no enhanced payments to cover visits shorter than one hour (and a similar lack of incentives for anti-social hours working). Unless the hourly charge rate is sufficient to support the vast number of shorter visits now being commissioned there are serious threats to the recruitment and retention of staff; compliance with National Minimum Wage and the financial viability of the sector.

11. Lack of payment for travel time and travel costs

The overwhelming majority of councils expect providers to cover careworkers' travel time and travel costs out of the hourly rate paid for the time spent in the service users' home, emphasising again the importance of a sustainable charge rate to comply with National Minimum Wage.

12. Delayed payment and disputed invoices

While the majority of providers reported that their councils paid their invoices on time (and sometimes early), 25% of providers reported payment of "most" of their invoices after the contractual due date, with particularly poor payment rates reported in Northern Ireland.

Late payment carries cash-flow implications for providers, creating difficulties paying staff (who expect regular payment), and can incur avoidable charges of credit control, bank lending, or invoice factoring. In addition, it exposes councils to litigation under the Late Payment of Commercial Debts (Interest) Act 1998, as amended.

24% of providers reported their councils "regularly" disputed invoices, a situation which increases the costs for both providers and councils. It is reasonable to suggest potential for savings for both sides if providers present accurate invoices which are then subject to efficient verification procedures by councils.

13. Lack of guaranteed purchase by councils

The majority of councils' contracting arrangements offer no guarantee of volume purchase and are likely to inhibit long-term planning and investment in services by homecare providers. Only 24% of providers in the UK held contracts with any guarantee of purchase.

Having obtained discounted prices for guaranteed volume block contracts in the past, councils appear to expect similar (or lower) prices for contracts through spot or framework agreements, or with the additional administrative costs of individualised packages of care obtained using a personal budget or direct payment.

14. Lack of transparency over councils' allocation of packages of care

Over a third (34%) of providers thought that they way that their councils allocated packages of care to local providers was unclear. A significant proportion of providers (42%) believed the processes to be opaque and unfair.

15. Tender processes abandoned by councils

38% of providers in the UK reported that their councils had either abandoned (or significantly delayed) tendering exercises, a situation which results in unnecessary expense for both councils and providers. Responses from providers suggest that these may reflect councils' concerns about actual or potential legal challenge, insufficient resources, changes in personnel at the council or a lack of certainty about future purchasing requirements.

16. Deteriorating relationships with councils and departments

Homecare providers generally report a positive relationship with their councils. However, this has been damaged over the last year, with 41% of providers reporting a relationship that had "deteriorated" or "significantly deteriorated", compared to just 22% where the relationship had improved.

Understandably, with the evidence provided in this survey, the emphasis on cost-cutting was most frequently cited as the reason for providers' frustration. However, a lack of collaborative working with providers and difficulties in contacting the right person in the council to resolve problems were frequently reported, a matter which could be quickly addressed without undue effort on the part of councils.

Survey analysis and commentary

1. Survey size and coverage

This is a large-scale survey of the impact of local authority commissioning of homecare services. 739 complete responses[3] were received from homecare providers supplying to 189 (90%) of the 211 local authorities in England,[4] Wales and Scotland and the Health and Social Care Trusts in Northern Ireland.[5]

1.1. Survey design

Each independent and voluntary sector provider participating in the survey was asked to complete a detailed, confidential, on-line survey form asking for information about their supply of homecare services to a single local authority (or Health and Social Care Trust in Northern Ireland) with which they currently trade.[6] Responses were gathered over a four week period spanning March and April 2012 and we estimate that the survey took providers around 20 minutes to complete.

The survey was designed to be completed by someone who knew details of the individual contracting relationship between the council and their organisation. As many homecare agencies supply to more than one council, it was possible for a single business to provide information for more than one council. However, in our analysis, we did not detect multiple submissions by individual providers about the same council.

1.2. How we report our data

The data collected was recorded against each individual council and is analysed at the levels of UK administration, government region and individual local authorities.

As the survey asked for commercially sensitive information, UKHCA promised that anonymity would be maintained, and that results would not be published in a way

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[3] Incomplete responses were excluded from the results reported in this survey. Unless otherwise noted, all questions were compulsory, although the majority included an option to specify that information was unknown, or that the provider would prefer not to answer. For clarity of reporting, our calculations exclude responses where providers were unable or unwilling to answer a specific question.

[4] Including the West London Alliance (a purchasing group representing 6 local authority purchasers in West London).

[5] For convenience, we refer to "councils" from this point, which should be assumed to include Health and Social Care Trusts in Northern Ireland, unless the contrary is explicit or implied.

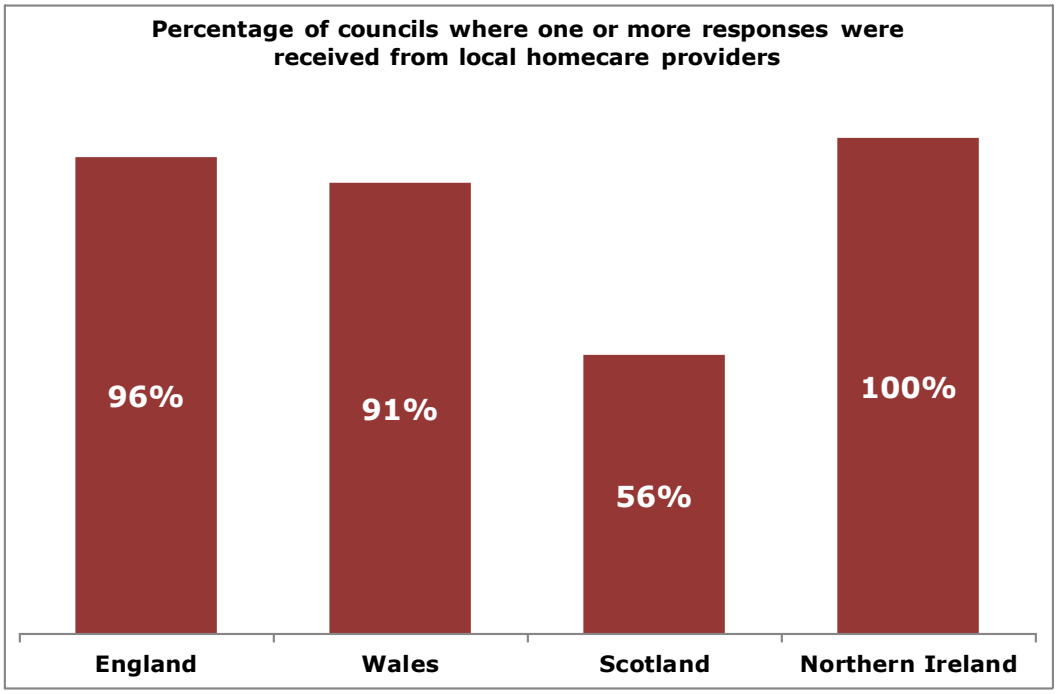
[6] Questions at the beginning of the survey sought to verify that providers were independent and voluntary sector organisations currently supplying homecare services to the council they were describing; to exclude responses from council in-house services; or individuals without a trading history.

that a council might be able to identify an individual organisation supplying UKHCA with data. We therefore confine the analysis in this report to the picture at UK administration and government region.

Percentages are rounded to the nearest whole number, meaning that some of the graphs in this report may total 99 or 101%.

1.3. Response rate by UK administration

90% of UK councils were represented by responses from one or more providers, as follows:

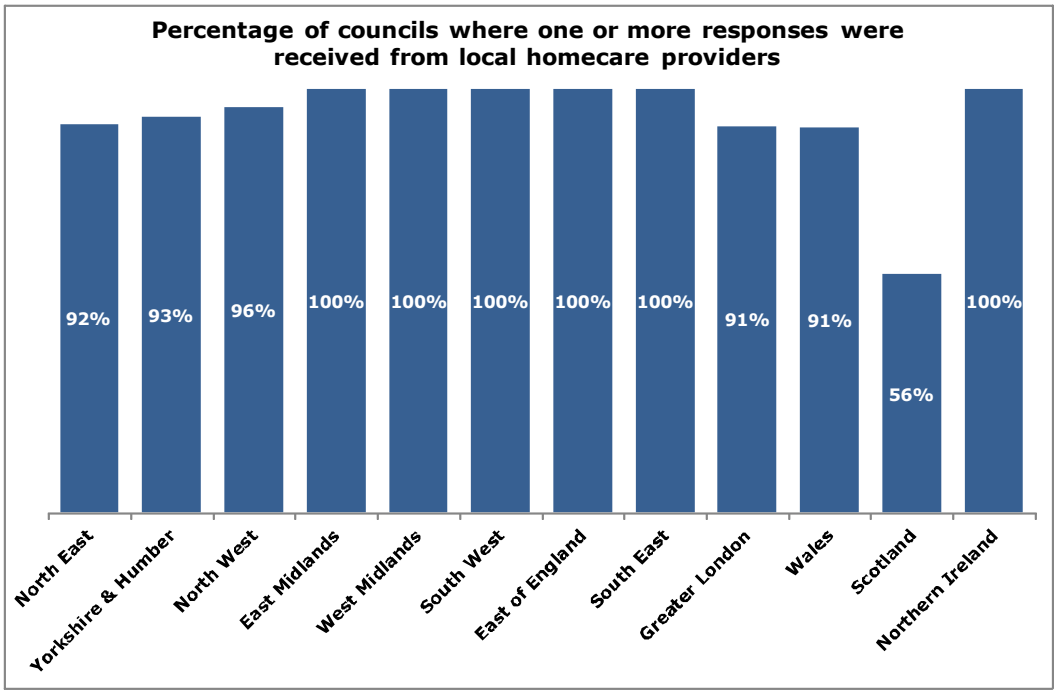


The number of councils and response rates are shown below, and illustrated in Appendix 1.

Country	Total councils	Councils with 1+ responses	% councils covered	Total responses received
England	152	146	96%	655
Wales	22	20	91%	43
Scotland	32	18	56%	26
Northern Ireland	5	5	100%	15
Total:	**211**	**189**	**90%**	**739**

1.4. Response rate by government region

Between 91-100% of all councils in each government region were represented in the survey, with the exception of Scotland (56% of councils represented).[7]



189 out of 211 councils received at least one response from a provider, averaging 3.9 responses per council, ranging from 1 to 32 responses per council.

48 councils received responses from 5 or more providers, the highest response rates being:

Council	Responses
Hampshire	32
Lancashire	26
Kent	25
W Sussex	22
Essex	17
Dorset	14
Birmingham	12
Norfolk	12

Council	Responses
Staffordshire	12
Suffolk	12
Surrey	12
Cambridgeshire	11
East Sussex	10
Oxfordshire	10
Wiltshire	10

Councils in the devolved administrations with the highest numbers of responses were Cardiff (7 responses); City of Edinburgh (5 responses); and the South Eastern Health and Social Care Trust in Northern Ireland (6 responses).

[7] We suspect that this is a combination of the relatively low number of providers in the more rural counties in Scotland and the fact that public spending cuts may not – at least for the time being - have affected providers in Scotland as severely as other regions within the United Kingdom.

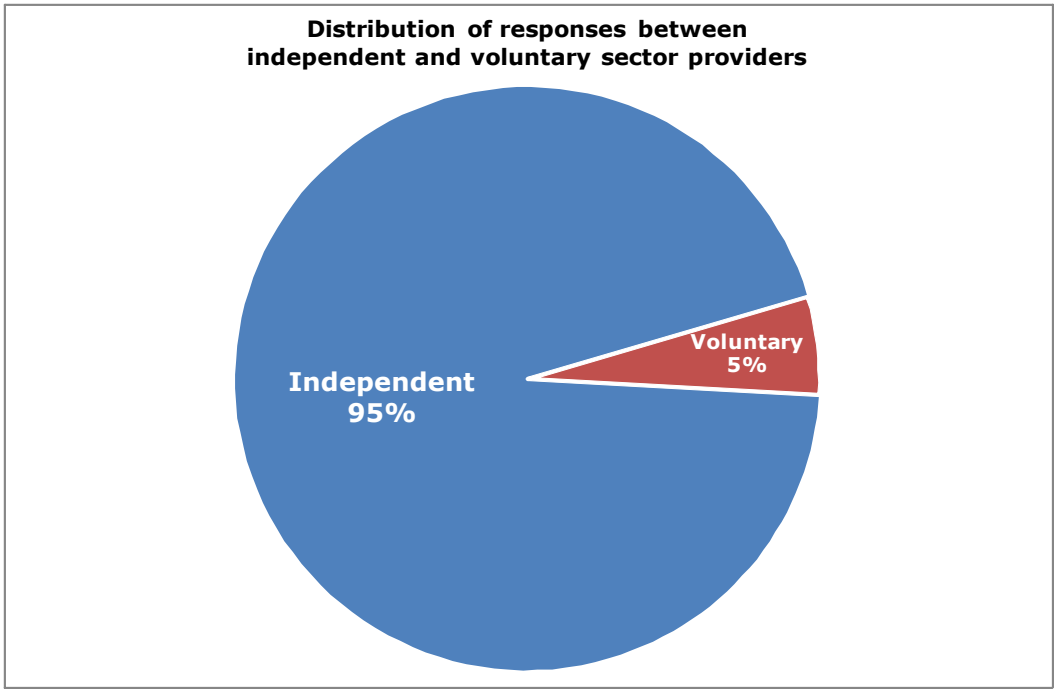
We suspect that high response rates are most likely to represent councils where there are a significant number of local providers, or where local providers have active networks. They may also indicate councils where there are strong feelings about the council's commissioning practice.

1.5. Providers responding to the survey

95% of responses came from independent (for-profit) providers, and 5% from voluntary (not-for-profit) providers, who together provide the majority of homecare services commissioned by the state.[8] Over 90% of responses were submitted by senior post holders in provider organisations who had been trading with the council for at least 12 months, and often longer.

1.6. Distribution of responses between the independent and voluntary sectors

The distribution of responses between the independent and voluntary sectors is illustrated below:



[8] The independent and voluntary sectors supply the following proportion of all hours of homecare commissioned by the state: England (87%), Wales (68%), Scotland (around 47%) and Northern Ireland (58%).

1.7. Job role of person completing the survey

Responses were completed by senior post holders within the organisation:

Owner, partner, chief executive, director, or similar	50%
Registered Manager, or other senior manager	47%
Another employee or consultant	3%

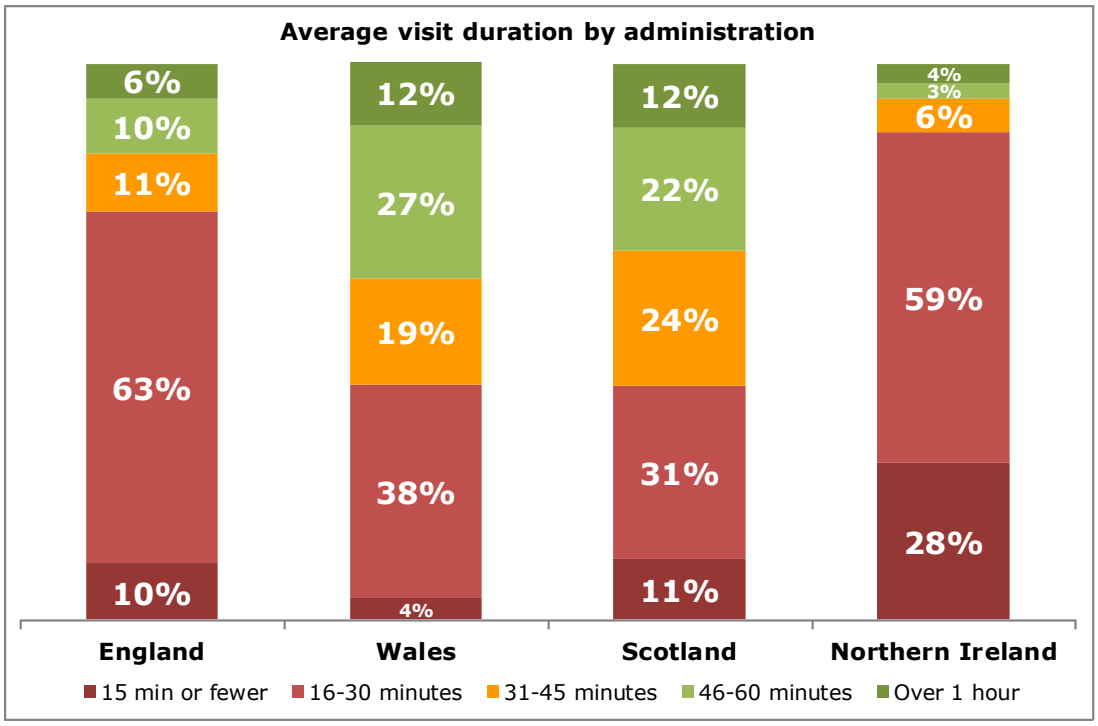
98% of responses came from organisations that currently trade with the council they were describing in the survey. Of these, 92% of responses were from organisations that had traded with the specified council for at least one year, and 78% had been doing so for 3 years or longer.

2. Extensive use of 15 and 30 minute homecare visits

We are alarmed by very short visit times that councils are commissioning for increasingly elderly and disabled people and those receiving support. 73% of homecare visits in England appear to be 30 minutes or shorter and a staggering 87% in Northern Ireland (42% in Wales and Scotland).[9]

There is evidence of the use of visits which are 15 minutes or fewer in all administrations, and as high as 28% in Northern Ireland. We believe that this accounts significantly for reports of homecare services appearing to be rushed, or lacking sufficient dignity.

[9] Recognising the difficulty of gathering this information as part of an on-line survey, this question was made optional. Data used for these calculations were provided by 297 providers. Regrettably, the original data sample for Scotland and Northern Ireland was relatively small, and in the case of Northern Ireland was disproportionately weighted towards the commissioning practice of a single Health and Social Care Trust. An additional data gathering exercise was therefore undertaken with the assistance of a number of providers in these administrations working with different local authorities and Trusts to ensure that a more representative picture could be presented in this report.



Homecare is currently almost entirely purchased in units of time. To be effective each visit must have sufficient time allocated for the care provider to meet the service users' needs safely and with dignity.

Remembering that over time local authority eligibility criteria in England and Wales generally ration state-funded care to people with the most severe needs, providers are now assisting people who are significantly more frail or disabled than in the past, evidenced by a 24% increase in people requiring "intensive" homecare over the 5 years to 2010.[10]

All other things remaining equal, visit times would be expected to accommodate people who require significantly longer to undertak daily activities because of the amount of support they require.

The use of visits as short as 15 minutes has received considerable public attention in the last two years. However, the significant use of visits of between 16-30 minutes is also a considerable concern. This is shared by our member organisations and reported in section 3 below.

Readers may wish to consider the amount of time they spend undertaking their own personal care in the morning, such as getting out of bed, using the bathroom, washing and dressing and eating breakfast and imagine whether 15-30 minutes provides sufficient time to prepare for their day, even without requiring physical assistance to do so.

[10] Figures relate to England. "Intensive" homecare is defined as 10 or more hours of homecare over 6 or more visits per week. Analysis from data published in Community Care Statistics for Home care services for adults by the Information Centre for Health and Social Care.

The degree of physical frailty and disability of the overwhelming majority of people in receipt of state-funded social care should raise serious questions at a national and local level about the adequacy of services currently being commissioned by councils and Trusts in the United Kingdom.

2.1. Implications for the quality of life for people who use homecare services

This research project only examines the duration of visits actually arranged for people receiving homecare services. In research that UKHCA undertook in August 2011 we found that not only were up to 82% of councils in the survey sample reducing how much care they would pay for, but they were also reducing the number of homecare visits people receive on individual days or over the week.[11]

Case-studies which illustrate the implications for service users as a result of shortened and reduced numbers of visits from our August 2011 research are provided in Appendix 10.

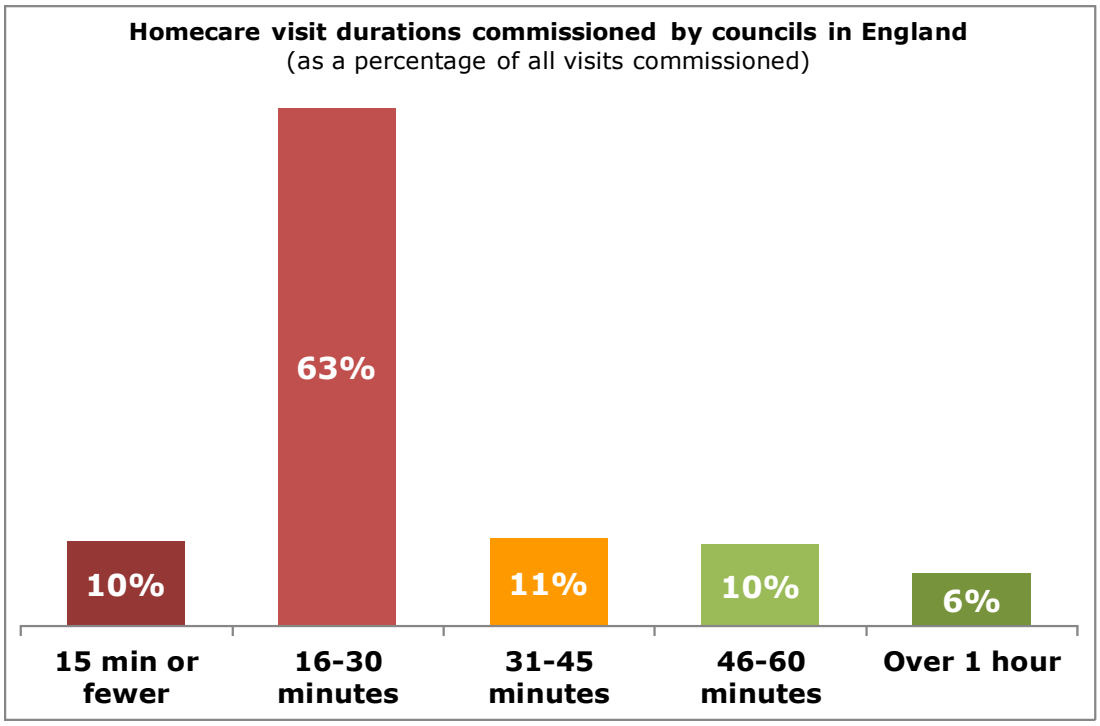
2.2. Implications for providers, careworkers and the capacity of the homecare sector

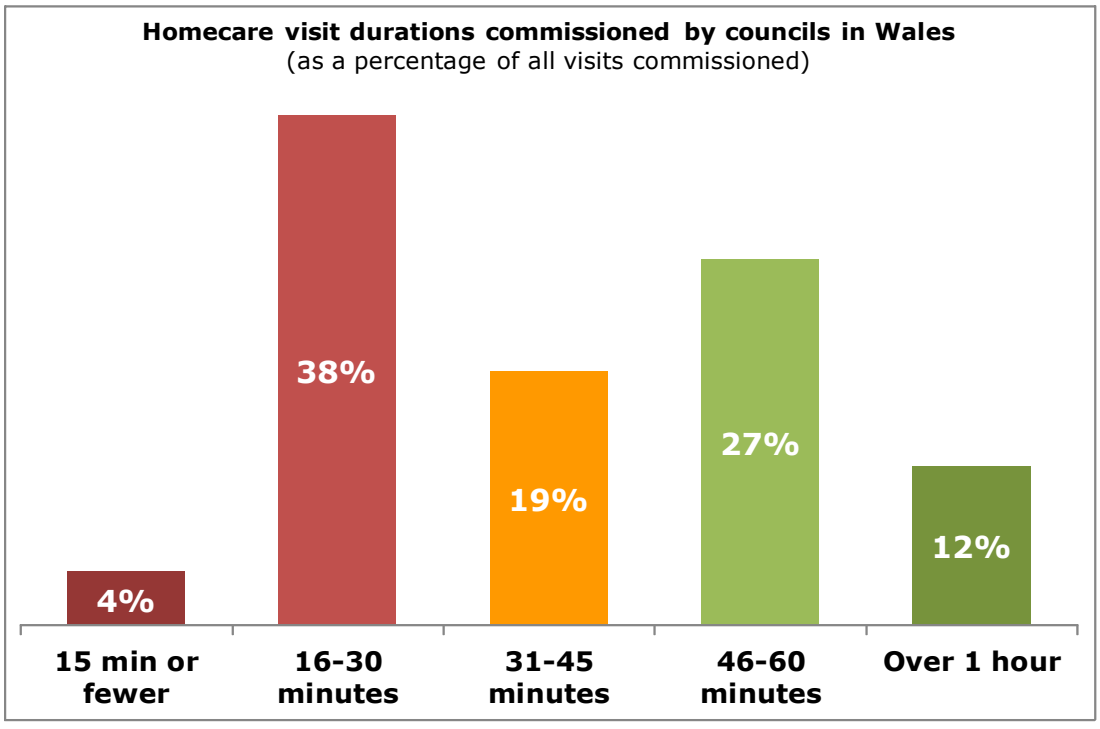
Other findings in this report identify that the pattern of visit duration and the price paid for homecare are the critical factors which affect providers' viability and ultimately, their ability to recruit, retain and reward their workforce. This raises serious implications for the capacity of the homecare sector to deliver sustainable services in the future.

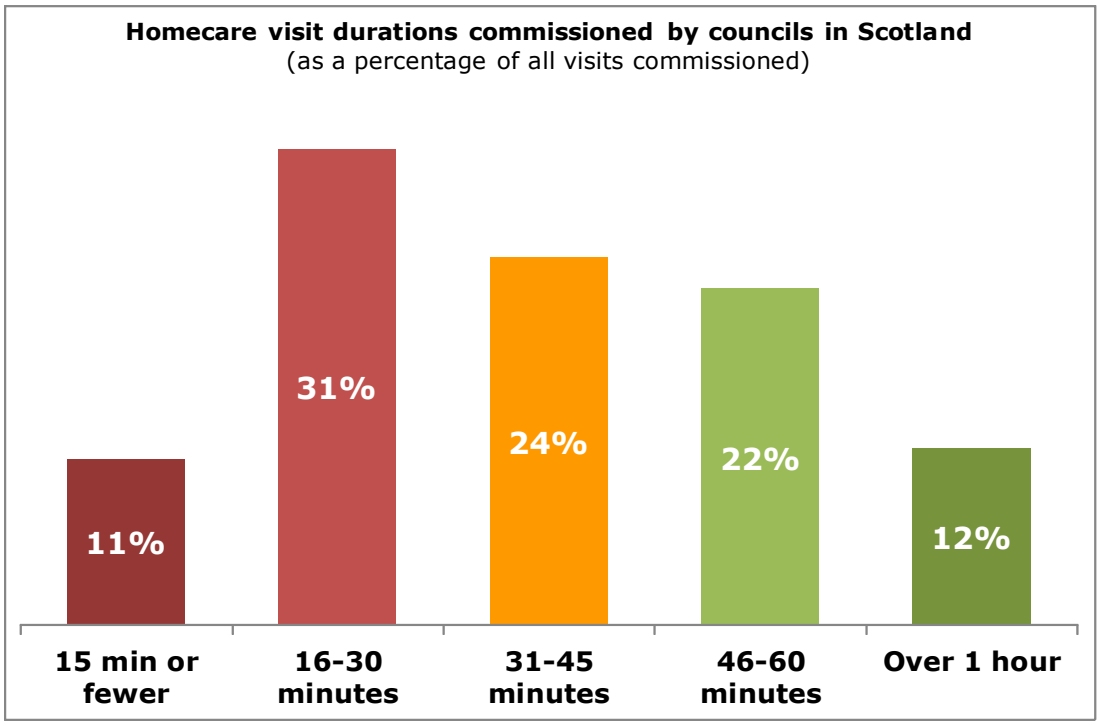
2.3. The use of short visits in different UK administrations

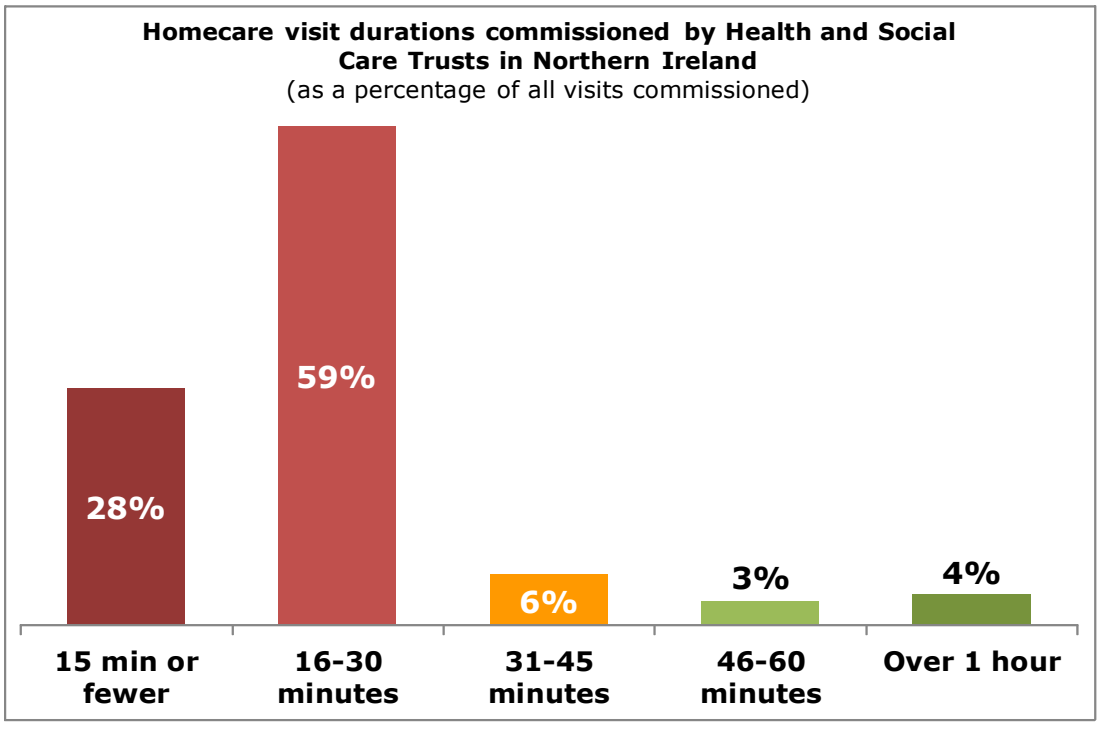
We note that Northern Ireland, followed by England, have the shortest visit lengths reported. While this may provide a limited degree of comfort for service users in Scotland and Wales, we note that the impact of public spending constraints may be felt at different speeds across the UK. Our concern for the sector in Wales and Scotland is the potential for further deterioration in visit times in what could become a disastrous race to the bottom in cost-cutting practices.

[11] United Kingdom Homecare Association Commissioning Survey 2011, available from www.ukhca.co.uk/pdfs/UKHCACommissioningSurvey2011.pdf.

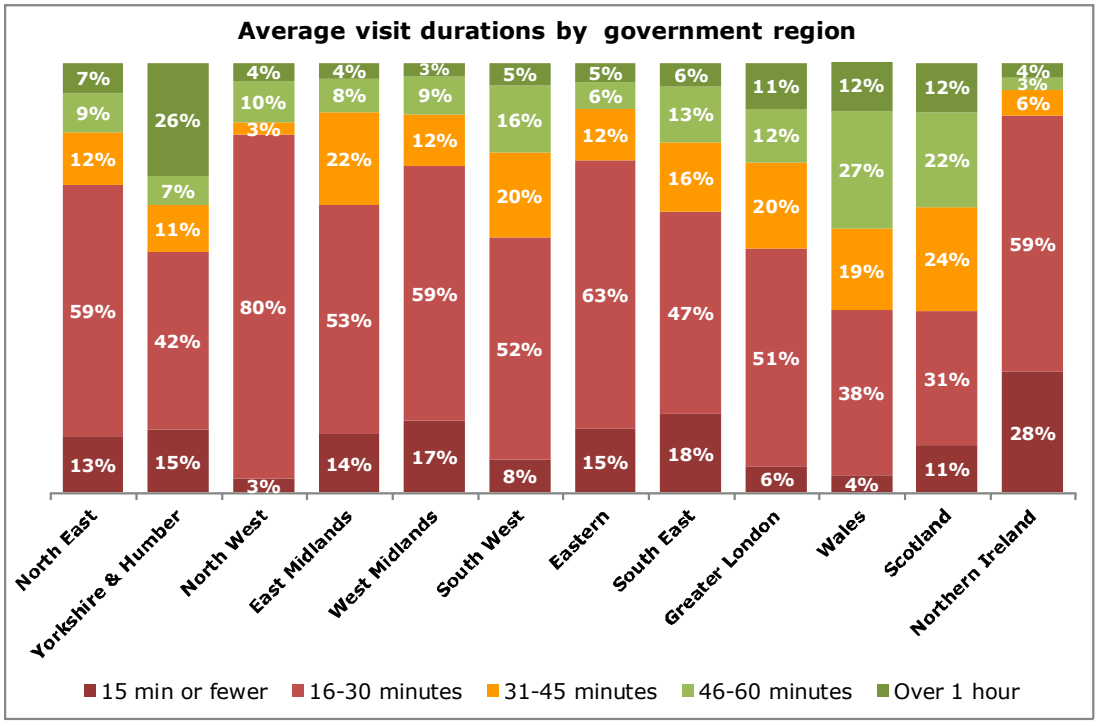








The distribution of visit lengths by Government region is summarised below:



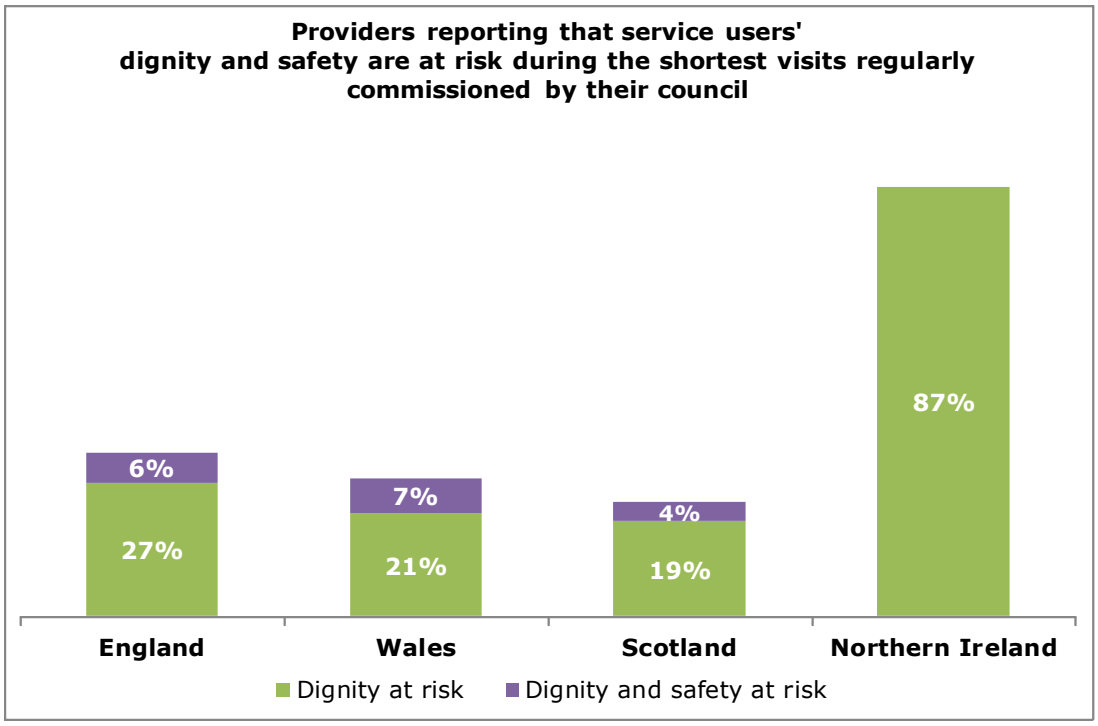
We naturally expect there to be some degree of variation between councils over the distribution of visit duration, influenced by the relative degree of independence, health and disability of individuals in local communities. However, the variation in our findings between regions begs the question of whether the duration of visits is as much a reflection of attempts to reduce costs by some authorities, than a reflection of need, particularly in those areas where there is a disproportionate use of very short visits of 15 minutes or fewer.

3. Safety and dignity of service users at risk during shortest visits

34% of providers reported concerns that their councils required them to undertake personal care in such short visit times that the dignity of service users was at risk, including 6% who were concerned that safety could also be compromised. The concern expressed by providers in Northern Ireland over risks to dignity is particularly striking (87%).

We feel compelled to question whether inappropriate commissioning of short visits by councils and Trusts amounts to institutional abuse.

We asked providers to describe the care that they were required to undertake in the shortest visits their council commissioned them to provide. Concerns are shown below (with a breakdown of results by government region shown in Appendix 2).



32% of providers said that short visits were used for prompting or safety checks only, while 34% said they were asked to do some form of personal care, which could be accompanied safely and with dignity in the time available.

However, 28% of providers described councils who required them to undertake care where the service users' dignity might be at risk, and a further 6% described being asked to undertake personal care in such a short period of time that safety could be at risk. Most worryingly was the number of providers in Northern Ireland (87%) reporting personal care that could be undignified during the shortest visits requested by their Health and Social Care Trust.

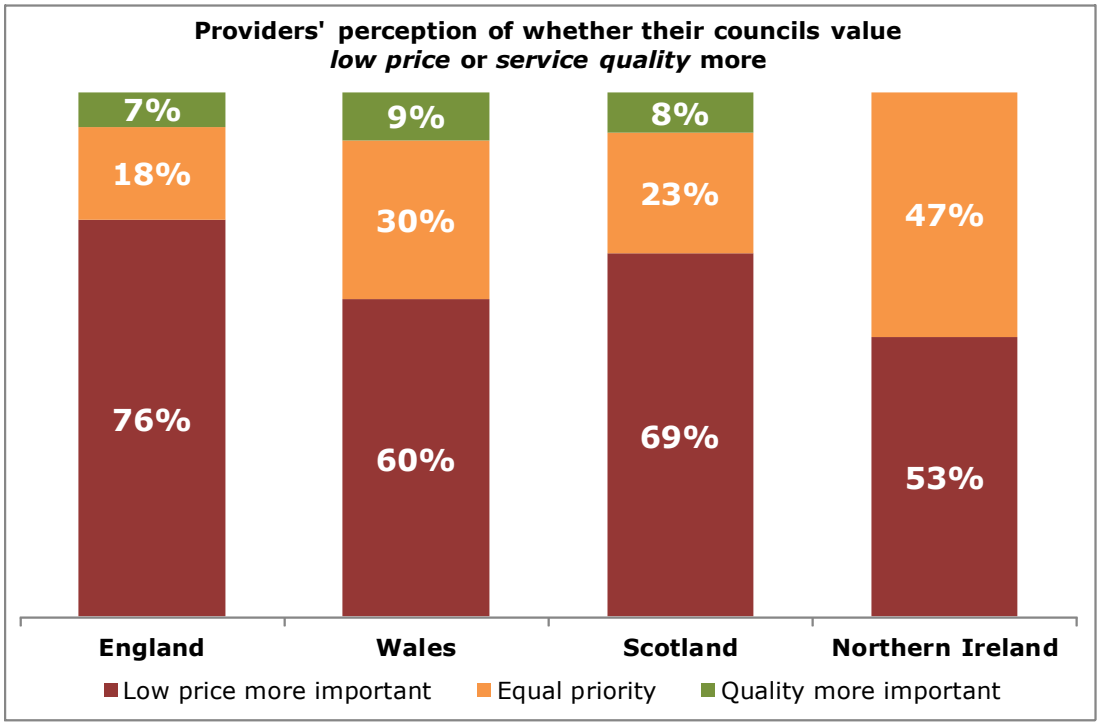
Providers' responses to the type of care undertaken in their shortest visits is summarised in the following table:

Administration	Check or prompt only (non-personal care)	Personal care that can be undertaken safely and with dignity	Personal care where dignity at risk	Personal care where safety at risk
England	33%	34%	27%	6%
Wales	28%	44%	21%	7%
Scotland	46%	31%	19%	4%
Northern Ireland	0%	13%	87%	0%
United Kingdom	**32%**	**34%**	**28%**	**6%**

4. Councils commissioning for lowest price, not high quality

Almost three-quarters (74%) of providers said that, over the last twelve months, the councils they traded with had become more interested in securing a low price over the quality of service delivered.

The findings of this question in the survey are no doubt coloured by recent constraints on public spending. We doubt that any council deliberately commissions unsatisfactory services for its local community, nor do we believe that in every case councils are stating this *overtly* in their communications with providers. However, the data gives a telling description of how messages about cost-saving and competition for council business are being implied and perceived.

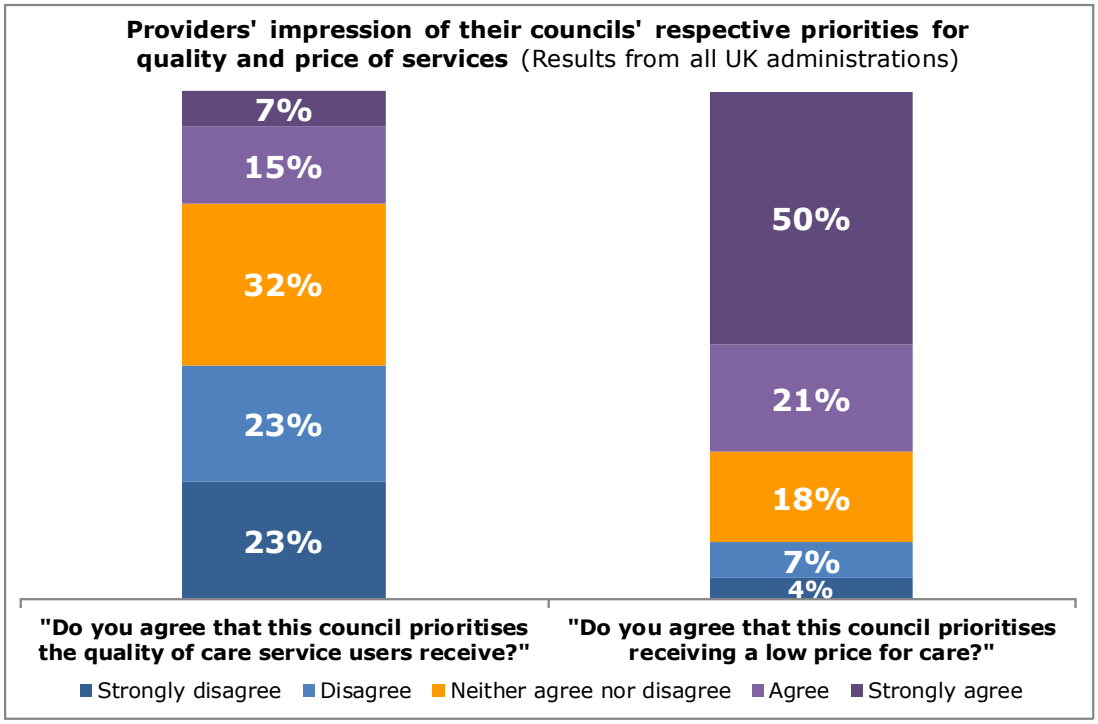


Across England, 66%-84% of providers believed their council favoured low price over quality service. It is also noticeable that no provider in Northern Ireland stated that they believed that their Health and Social Care Trust was more interested in quality than low price. For a regional breakdown of these figures, please see Appendix 3.

If it is not corrected, this perception is troubling. While councils will rightly talk about the importance of quality in service delivery, there appears to be a lack of credibility that this is backed-up by a commitment to funding quality services adequately.

It goes without saying that it is highly undesirable for people who use services, and providers who deliver them, to feel that they must focus on cost reduction at the expense of quality to maintain business with local authorities.

We also asked providers about their perception of their council's priorities for obtaining high quality and low price as two separate questions. The results are shown in the following graph:



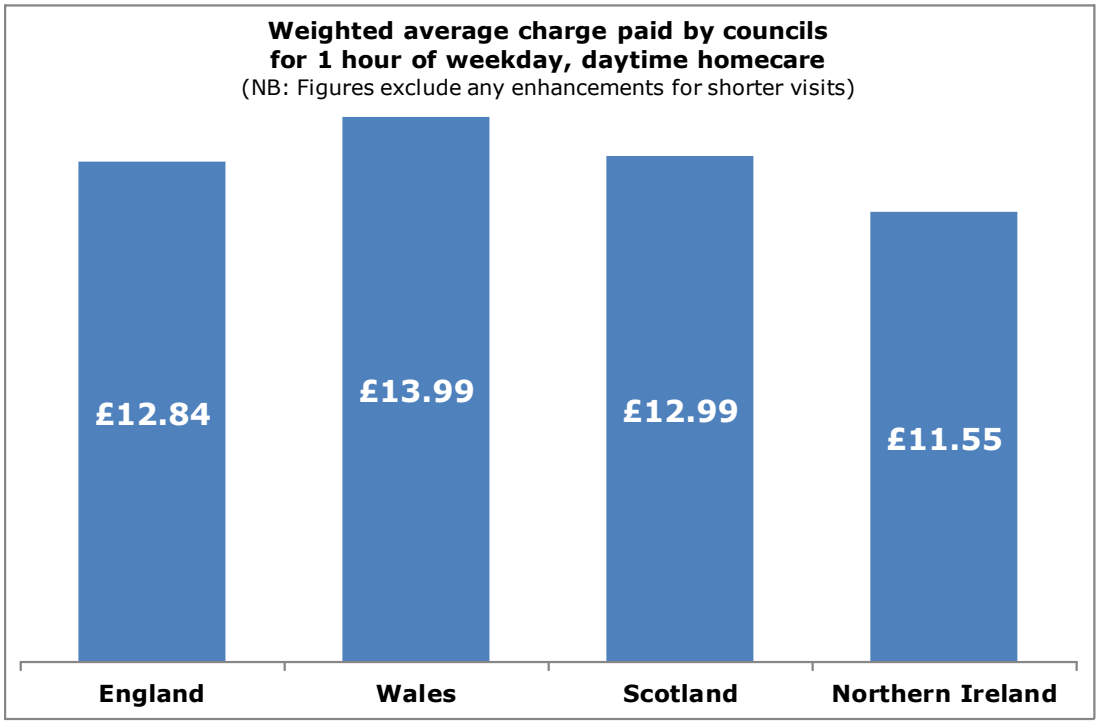
While not tested in this survey, a recent engagement event with over 50 homecare providers[12] suggests that a sizable number are already attempting to reduce the volume of business they undertake with councils in favour of private purchase. Providers' ability to follow this course of action successfully will obviously depend on the relative affluence of the local population, but it raises questions about the availability of services to people receiving state-funded support in the future.

[12] Event held on 17th May 2012, attended by homecare providers from small, medium and large providers from different parts of England.

5. What councils pay for homecare

The weighted average charge paid by councils in the UK for one hour of week-day, daytime homecare in the UK is estimated at £12.87. However, rates as low as £9.55 and £10.04 were reported by providers in Wales, the West Midlands, the North West and Northern Ireland.

The price councils pay for homecare services is fundamental to the capacity of the sector to meet the needs of an ageing population, particularly with homecare being commissioned in such short episodes: Employers must be able to deliver services using staff who are motivated, properly trained and correctly managed in order to undertake the increasingly complex work required of them. In addition, it is essential that independent sector providers and their backers receive a sufficient return on capital to remain and continue to invest in the sector, and that voluntary sector providers make a sufficient surplus to remain viable and invest in new services.



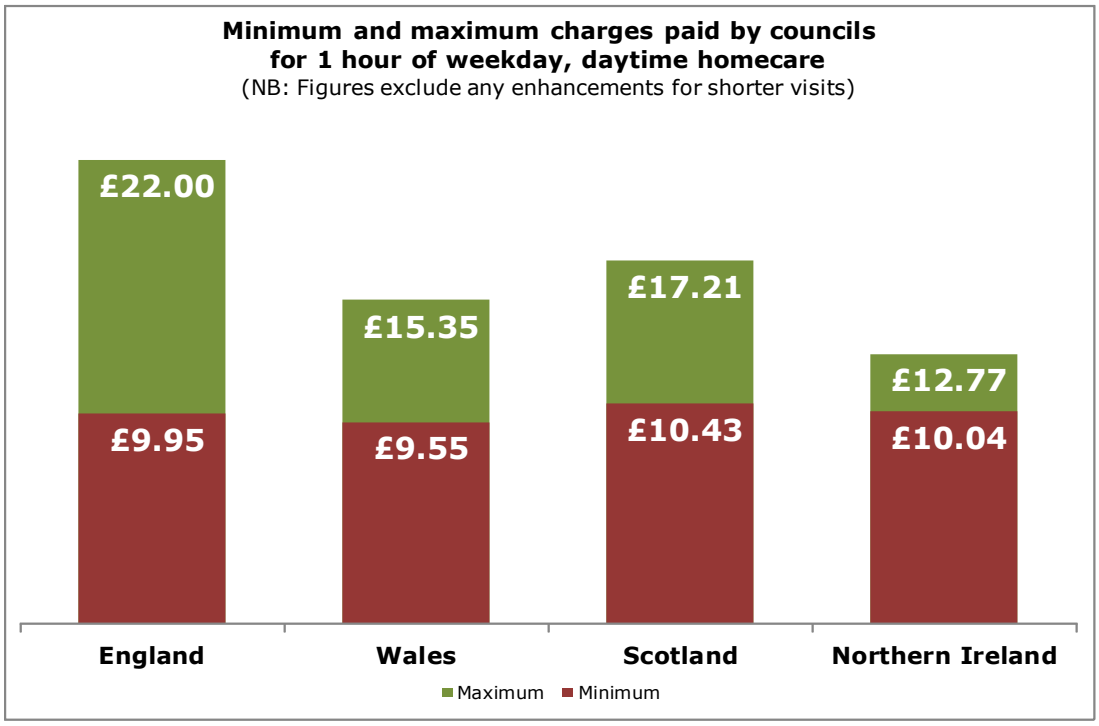
Administration	Minimum reported	Maximum reported	Weighted average
England	£9.95	£22.00	£12.84
Wales	£9.55	£15.35	£13.99
Scotland	£10.43	£17.21	£12.99
Northern Ireland	£10.04	£12.77	£11.55
United Kingdom	**£9.55**	**£22.00**	**£12.87**

Data used for the weighted average calculation was supplied by 348 providers, who supplied both the charge rate agreed (or set) by the council and an

indication of the number of hours they undertake in an average week.[13] The rates quoted will cover those from block and/or spot contracts and framework agreements.[14] They do not represent a gross hourly average rate for all homecare purchased by councils.[15]

In section 10 of this report we identify the widespread practice of councils of applying the price for an hour of homecare on a pro-rata basis, despite shorter visits incurring proportionately greater transport costs and travel time. This hourly figure is therefore a reasonable indicator of rates paid, but will slightly underestimate the average price of homecare for visits of all durations and during weekends, public holidays and unsocial periods where councils still enhance payments for shorter visits or excessive travel in rural areas.

We were also able to analyse the minimum and maximum prices for 1 hour of weekday, daytime homecare, as follows:

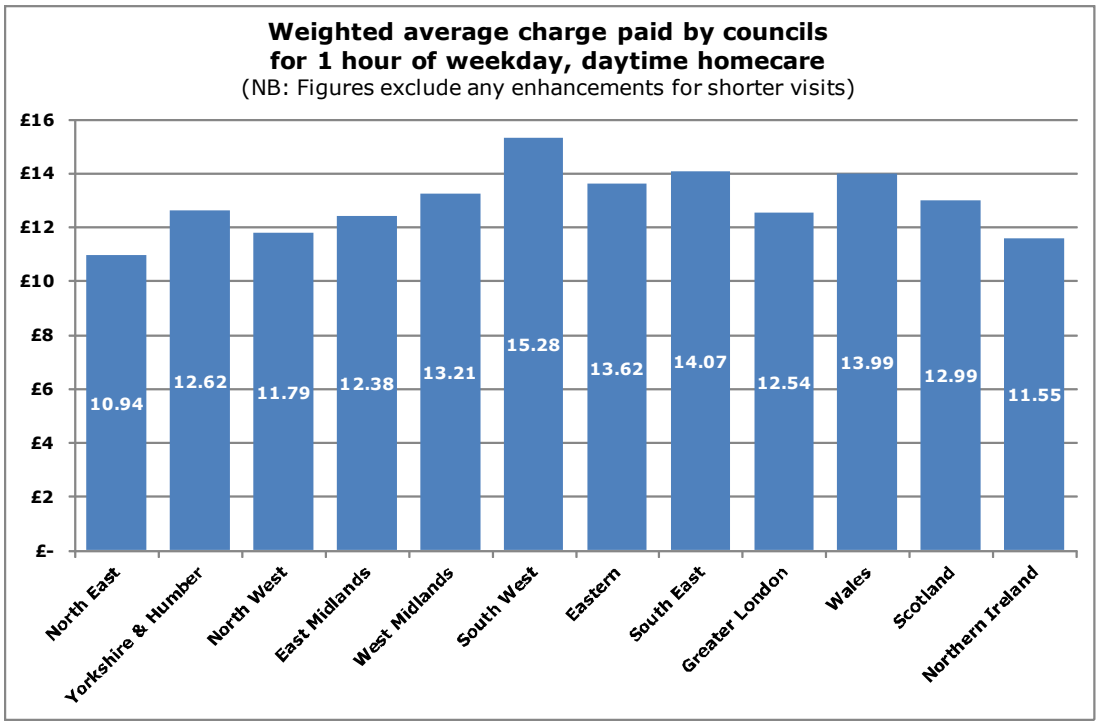


Minimum and maximum rates quoted showed considerable variation between individual regions and councils across England.

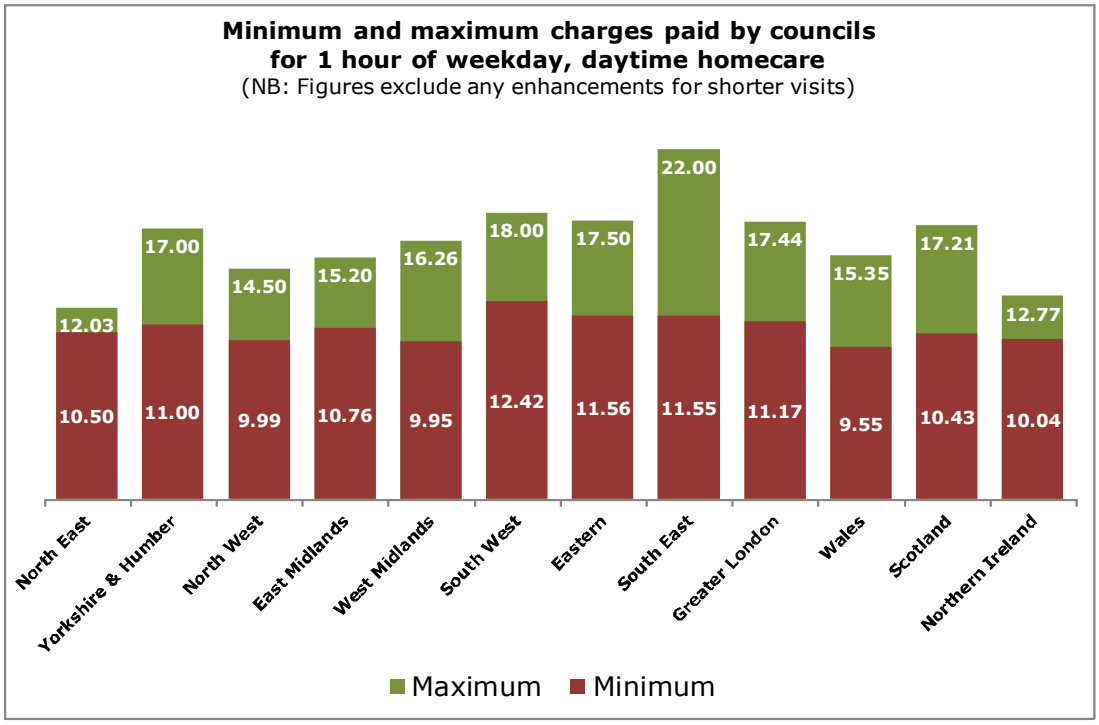
[13] A further 56 responses contained an hourly rate, but no indication of volume, allowing this data to be included in the minimum and maximum figures, but not the weighted average.

[14] The figures also include services provided to people with a personal budget receiving council-arranged services. The data excludes providers only supplying users who receive a direct payment and effectively purchase care as though they were self-funders.

[15] The complexity of gathering this data was thought to be too onerous for providers to submit in an on-line survey format. In addition, total cost and hours of care purchased by councils is collected by the Information Centre for Health and Social Care.



A breakdown of this data at regional level shows providers in the North East and North West of England experiencing the lowest rates, and providers in the South West, South East and Eastern regions and in Wales with the highest rates.



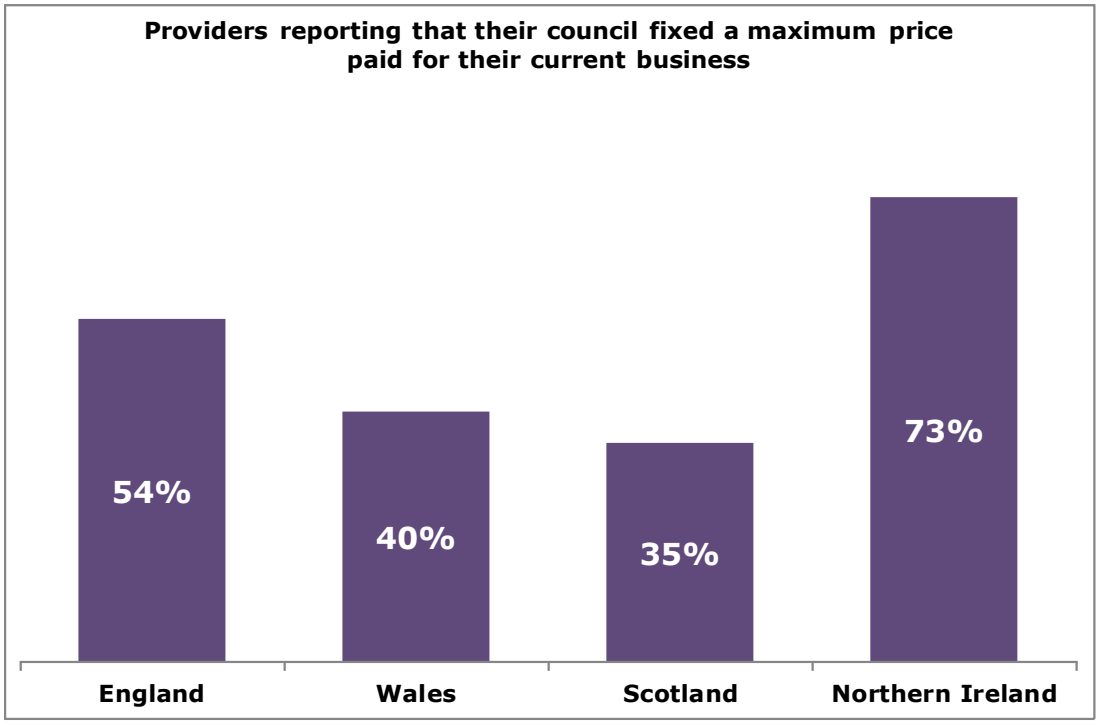
The major component of the cost of an hour of homecare is careworkers' wages, so some variation in charge rate should be expected. However, these rates must support not just wages, but the operating costs of the business, including management time, travel time and travel costs of careworkers and costs associated with recruitment, training and supervision of the workforce and

registration. Some of the more recent additional cost pressures facing providers are summarised in Appendix 11. Homecare providers will also need to incentivise their workforce to undertake visits shorter than one hour within this standard fee, as shown in section 9 below.

The impact of councils' commissioning practices on the terms and conditions of the homecare workforce will be the subject of further analysis, building on the findings of this survey.

6. Councils fixing the maximum price they pay for homecare

Over half (53%) of providers reported that the council they traded with had stated a maximum price they would pay for homecare services, sometimes at worryingly low levels. We believe that this shows councils are using their dominant purchasing power in the local area to reduce prices to inappropriately low levels. UKHCA questions whether councils employing these practices have genuinely assessed their providers' actual costs of delivering service[16] – a pertinent factor in recent judicial reviews brought against councils by providers from the residential sector.



Councils will no doubt argue that stating a maximum price for care allows prospective suppliers to quickly assess whether they can afford to do business with the council. It may also indicate the rates that the council believes it can

[16] Additional costs include tax, National Insurance contributions, pensions, holiday pay, insurance and overheads.

secure services from the local provider market, either currently, or in the run-up to letting new tenders.

We are concerned, however, to see a number of councils setting maximum prices at very low rates (under £12/hour reported in our data) and very few providers who stated that there had been any engagement between the councils and themselves on whether the maximum price reflected the costs of delivering the services specified.

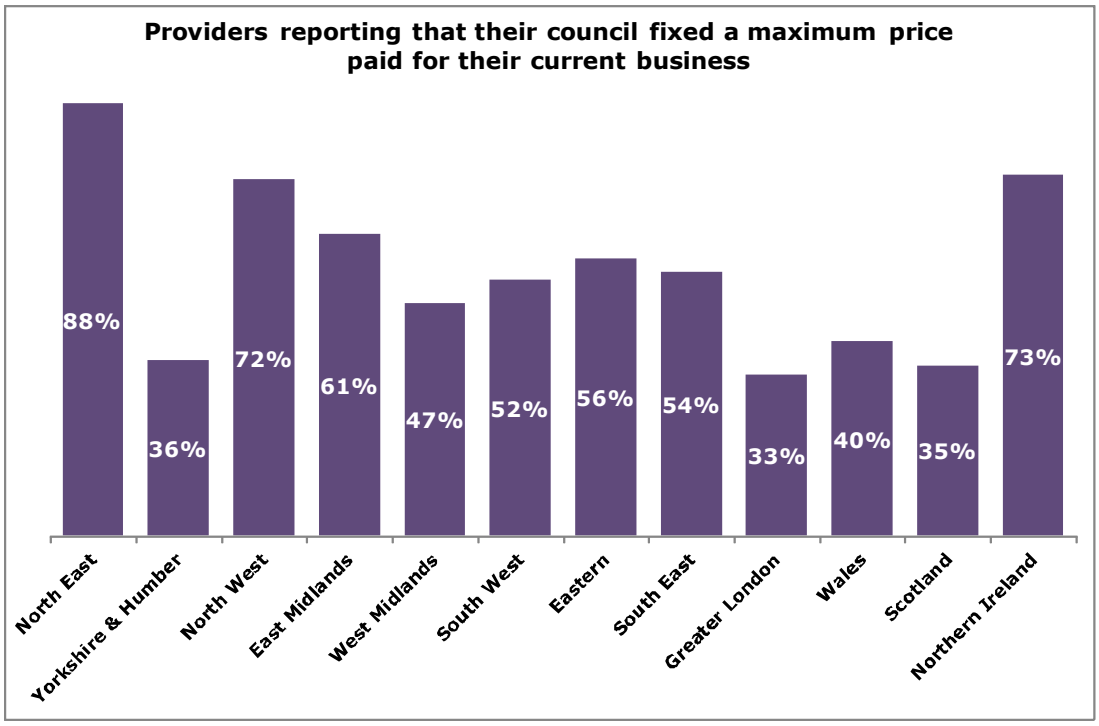
The practice of setting maximum prices will have a significant impact on rates submitted by providers, particularly where councils specify that acceptance of a tender, or the volume of service purchased is largely dependent on price. UKHCA has seen examples of invitations to tender which include marking schedules indicating that the price offered by the provider carries up to 80% or more of the total available score in the council's marking schedule (leaving just 20% or less of the marking schedule relating to quality).[17] Our knowledge of the sector suggests that until recently, councils generally weighted quality to price in an 80:20 ratio.

In practice, we believe that faced with a stated maximum price, local providers feel compelled to attempt to submit a lower price to maintain volume purchase. This may be an understandable short-term strategy for councils, but we must highlight the potential risk that - unless prices keep abreast of increasing costs during the length of a contract term (which is no longer necessarily the case) - providers may find their business becomes unsustainable. The consequences of such a situation include deterioration in quality, or exit from the market of state-funded care, which in some parts of the UK could pose serious risks to the capacity of the local sector and pose major disruptions for people who use homecare services.

It is obviously a providers' responsibility to assess the profitability of business before agreeing to supply at a given price. However, councils remain the overwhelmingly dominant purchaser of homecare in a local area and for many providers, supply to the council is the only viable way to secure volume business and competing below the council's maximum price may become the only effective survival strategy, at least in the short term.

We note considerable variation between government regions (33-88% of responses) in the proportion of providers reporting their local council set a maximum price for business, as shown in the following graph:

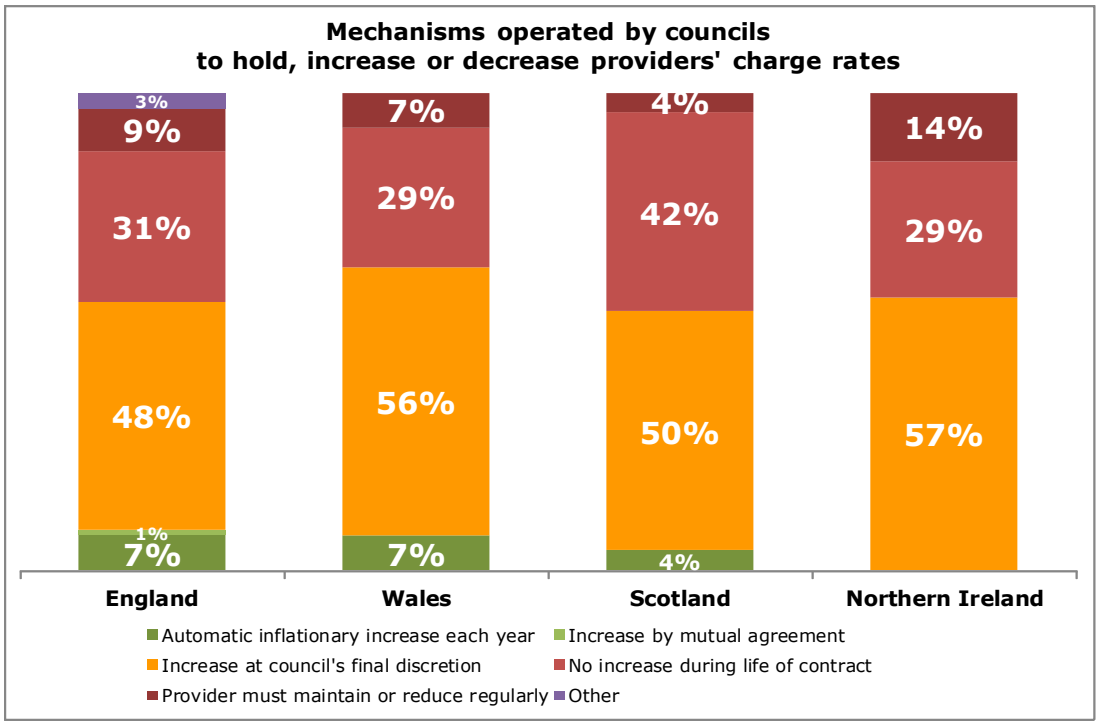
[17] In one example, the marking schedule was decided entirely on price, on the basis that quality had been assessed through a pre-qualifying questionnaire stage and only providers judged to be able to meet the contract specification were invited to tender.



7. Councils' unilateral control over fee increases

We believe that the homecare sector is highly-exposed to future inflationary increases and public spending cuts during this and succeeding years. We found that almost 90% of providers are either required to maintain (or reduce) their prices over the life of their contracts or that the council maintains a unilateral right to grant or refuse price increases.

Just 7% of providers reported automatic arrangements in contracts to increase prices in line with an inflationary index, an almost universal expectation until the last few years.



Until recently, providers have expected to tender a price at the start of a contractual relationship and rely on the contract to include a price increase mechanism, usually linked to an inflationary index, such as RPI, RPIX or CPI.[18] Just 7% of providers reported having contracts where this mechanism now operates.

Almost half (48%) of providers held contracts which granted the council unilateral right to determine whether a price increase would be granted in successive years of the provider's contract. Given the downward pressure on prices, this may be extremely challenging for providers, as our figures for the price changes awarded in the financial year 2011-12 suggest (see section 8 below).

Almost one third of providers (32%) reported having to maintain the original contract price throughout the life of the contract without variation. In practice this means that providers must have obtained a sufficient rate to cover inflation and any additional costs during the second and third (and possibly the fourth and fifth) years of their contract. Even where providers have an opportunity to tender a realistic price, it requires them to anticipate inflation rates for future years and to estimate the likely costs of changes in regulation and the wage-expectations in the local labour market.

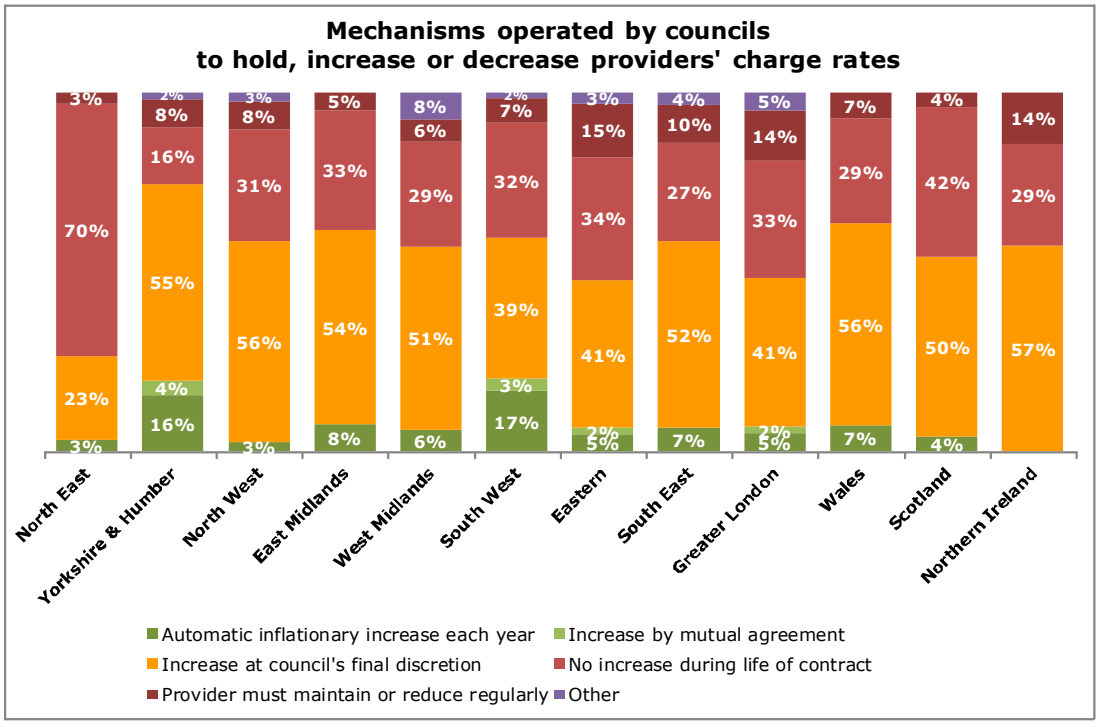
We also note that 9% of providers reported contracts where there was an expectation that the charge rate to the council would be reduced (or at least maintained) during the life of the agreement. While these arrangements could indicate councils attempting to find constructive ways to cushion providers from

[18] Contracts have generally used RPI (Retail price index), RPIX (Retail price index less mortgage interest payments), CPI (Consumer Price Index) or a similar formula.

the impact of aggressive spending cuts, we suggest that this is largely the impact of recent framework agreements, which attempt to offer increased volume of business by creating on-going price competition between providers wishing to gain a position at the top of "preferred provider" lists.

UKHCA's recommendation to providers preparing tenders or applying for framework agreements is that (unless the contract specifically grants an inflationary increase) they should calculate prices which anticipate inflation and foreseeable costs and to think very carefully before submitting bids which may become financially unviable during the contract term. Councils have an indisputable responsibility to consider the impact of their proposed price increase mechanisms on their local provider markets and avoid creating a system which could threaten their chosen providers' sustainability and reduce the availability of quality services for local citizens. This is particularly important where the council also intends to impose a maximum rate on tendered prices.

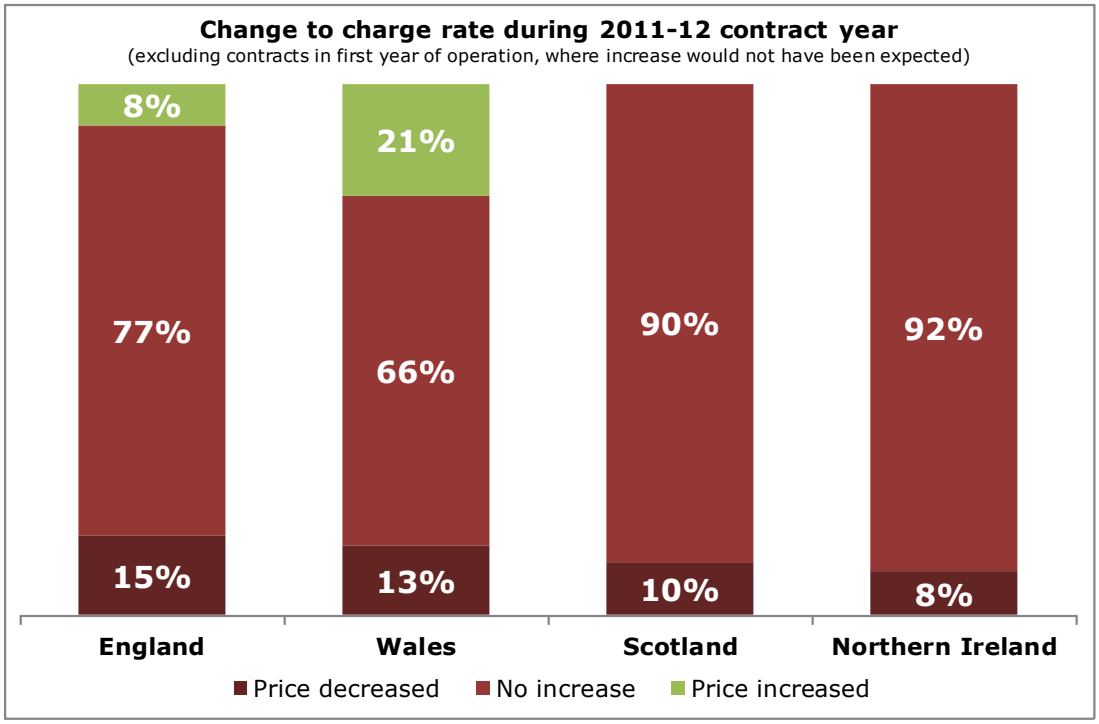
We find a generally consistent picture across Government regions, but with variation in the proportions of providers enjoying automatic inflationary increases, as shown in the following graph:



8. Real-terms fee reductions during the financial year 2011-12

Our findings suggest that 9 in every 10 providers received a real-terms decrease in the fees paid by their council for their existing business during the financial year 2011-12, effectively creating a saving for councils at the expense of people receiving homecare. Over three-quarters (77%) of providers received no price increase. And 15% reported actual price decreases.

We asked providers with contracts which had been in operation for over 12 months to state whether the council had increased, decreased or maintained the contract price, summarised in the graph, below.



We note, particularly, the absence of price increases in Scotland and Wales. While this could be a reflection of the relatively small sample size for these administrations in our data, it suggests that last year may have been particularly hard for local providers.

More detailed graphs, including the charge rate changes by government region are included in Appendix 4.

The timing of our survey (March-April 2012) also made it difficult to assess the picture for the coming financial year. However, we note from the data we were able to obtain that a significant number of providers were not aware of their council's intentions about prices for 2012-13 within weeks of the start of a new financial year.

Our survey did not attempt to quantify rate increases over previous financial years, but free-text comments from providers contained reports of councils which had not increased the price they paid for the two, three or four years, or had done so at a lower rate than specified in the contract, as shown in the following responses to the survey:

> "We have not had an increase for three years and have just been asked to reduce our prices as the council can't afford to pay us our rates." (Provider in the East Midlands)

> "This year we received an uplift of 1%, the first increase in three years. The Head of social services told all the providers in a meeting that 'we should be grateful'!" (Provider in south east England)

> "The rates were last set in April 2009. No increase has been applied and we have been told we are unlikely to get one until 2013." (Provider in Scotland)

> "The council decides to decrease rates, asks the company for its feedback, but decreases the rates anyway." (Provider in north west England)

Where contracts contain inflationary uplifts, we heard reports of councils striking them from the contract, or failing to honour increases previously agreed:

> "The contract states there is an inflationary uplift, however the Council has now deleted the clause from the contract." (Provider in south west England)

> "The council refused to pay the contracted increase and have been in material breach for nearly 12 months." (Provider in south east England)

> "The contract states a formulated increase, however over the past 3 years we have been given *significantly less* than the contracted formula." (Provider in south west England)

> "Despite the council stating in writing (but not in the contract) that we would receive a 0.5% uplift in April 2011, the council decreased the hourly rate paid by approximately 7%." (Provider in north west England)

We also see examples of contracts with built-in price *decreases,* or councils expecting aggressive price reductions from providers to maintain their existing business:

> "The council reserves the right to *reduce* our price *each year* by up to 2% for the next four years". (Provider in north west England)

> "The council informed us of their reduced rates in an email from an administrator giving all providers 24 hours to accept them or they wouldn't receive any more work from them." (Provider in Greater London)

> "We have just been asked for a 10% decrease or they will not give us any more work." (Provider in south east England)

> "We have had to decrease our hourly rate and make it fully inclusive of weekends and bank holidays to try and maintain business from the council and have not had an inflationary uplift for 4 years." (Provider in the south east England)

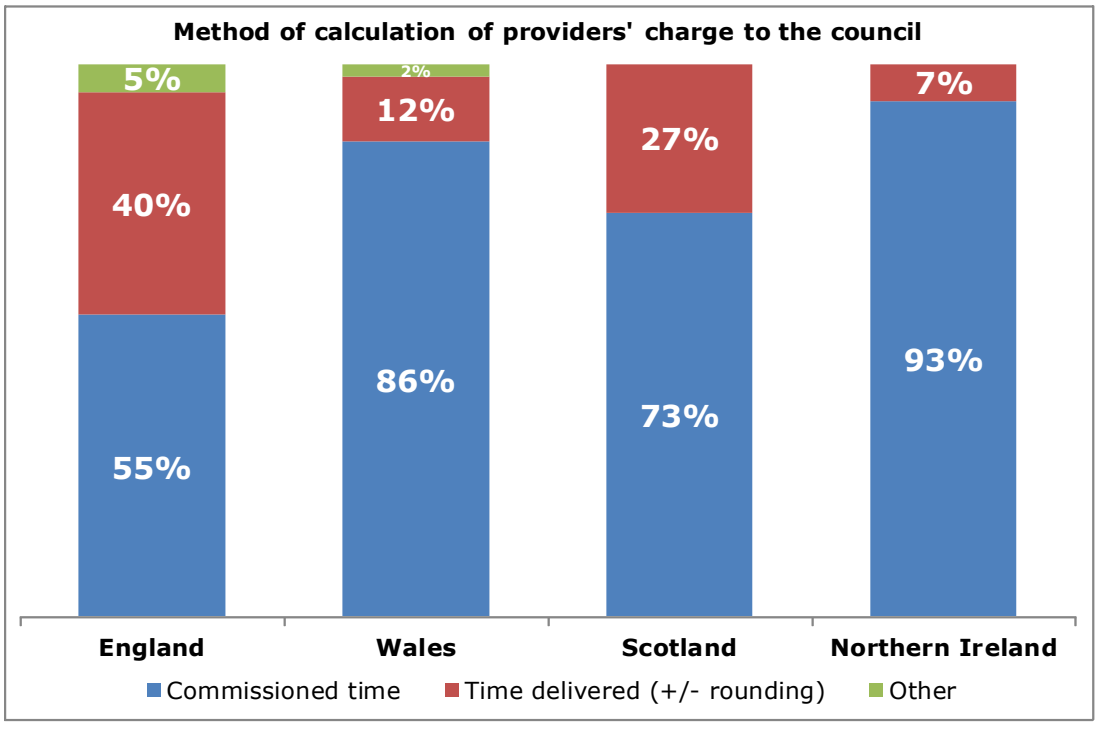
9. Homecare increasingly bought "by the minute"

9.1. Payment for time commissioned or time delivered

Historically, providers were paid for the planned or commissioned length of a homecare visit, which largely remains the case in Wales and Northern Ireland. However, there is increasing use of payment for the actual visit time (often to the nearest minute) as recorded on a paper-based timesheet, or through a system known as "electronic monitoring".[19] 40% of providers in England and 27% in Scotland reported this to be the case.

We expect these calculation methods to become more wide-spread in all four UK administrations and without careful implementation (including payments that cover travel time) this system poses risks to providers' ability to comply with the National Minimum Wage regulations and providers' financial viability.

Providers were asked what unit of calculation was used to calculate the fees councils paid for their services.



It is entirely reasonable for councils to pay for time actually delivered, although this carries additional administrative burdens for both councils and providers

[19] "Electronic monitoring" (also known as "call monitoring", "call logging" or "electronic call monitoring") is a system which captures the times of the careworker's arrival and departure from the service user's home using the terrestrial or mobile telephone network. The system is analogous to the "clocking-in" procedures used in workplaces in the past.

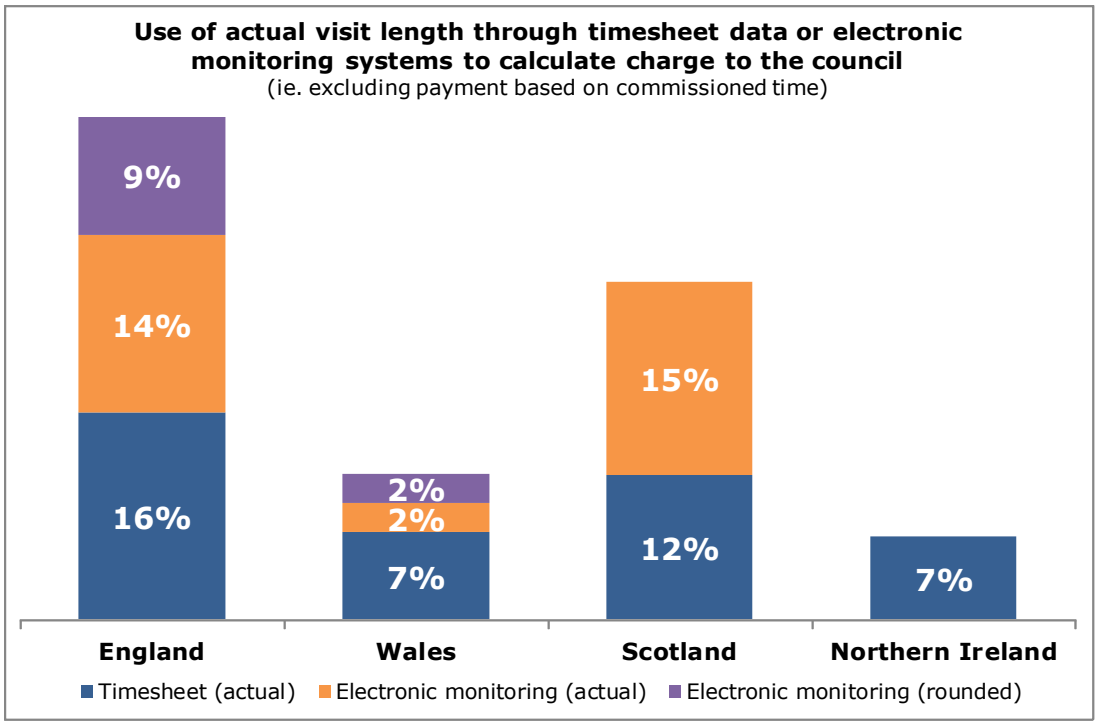
through data-entry of timesheet records, or additional costs if using "electronic monitoring" software.[20]

We have already seen that providers are paid almost exclusively by reference to the visit time. We are concerned that the introduction of any system of "per-minute billing" by councils is not always accompanied by the opportunity for providers to adjust their contract price. Where this is the case, there could be considerable implications for providers' financial viability.

The variation of these methods of calculation around the UK is shown in Appendix 5.

9.2. Payment for actual time delivered through timesheet data and electronic monitoring

We heard reports of councils using electronic monitoring data to calculate actual visit durations, but then rounded this figure up or down within specified time-bands. A number of providers believed these systems invariably act to the council's financial advantage. We also heard reports of councils employing time-consuming authorisation procedures before agreeing to pay for care that lasted longer than the commissioned time.



[20] Costs associated with "electronic monitoring" systems include initial set-up costs (which may be borne either by the council, or the provider, or both) and an on-going fee for data collection and transfer (generally borne by the provider).

The introduction of electronic monitoring systems make payment for actual time delivered more straightforward to complete, and providers should expect their purchasers to expand its use over the next few years. We found a number of providers who, while not using electronic monitoring at the time, were expecting it to be introduced imminently.

However, for some providers in England (9% of all providers) and Wales (2% of all providers), the council operated a system of rounding the times up or down. The survey did not specifically ask providers whether they regarded the rules to determine rounding were fair, however, in free-text comments in the survey (and consistent with enquiries through UKHCA's telephone helpline) we saw reports of rounding that appears to operate to the council's financial advantage,[21] or where time-consuming variation reports or other investigations were necessary before the council would agree to pay above the commissioned time.

As previously stated, payment for actual time is entirely reasonable. However, because of the need to meet National Minimum Wage, the importance of having a sufficient fee rate to cover both visit time and travel time becomes increasingly significant. Downward pressures on fees, the shortening of visit times, and paying for actual time places increasing risks of reduced financial viability and difficulty meeting (or at least keeping ahead of) National Minimum Wage.

The pattern of payment of actual visit times by timesheets or electronic monitoring is provided in Appendix 5.

9.3. **Payment for achieving "outcomes" for service users**

Interestingly, we found only 7 examples (less than 1%) where councils were paying providers to achieve an "outcome" (eg. ensuring that someone is well-fed, can bathe and dress as they wish, or able to participate in community activities), rather than paying by reference to time commissioned or delivered (a practice known as "time and task" commissioning).

For all the interest that "outcome-based commissioning" has created, there is very little evidence of its use, at least in the way that providers are paid for their services. This is no doubt a recognition that payment for homecare is still very closely allied to the time commissioned or spent with the service user.[22]

We encourage councils to emulate those forward looking authorities who are now commissioning for outcomes, rather than specific time-limited care tasks, and to consider using "individual service funds". These not only benefit the person using

[21] For example, the council pays for the actual time of the visit if less time is spent in the service users' home than was commissioned. However, the council only pays for commissioned time if the visit takes longer than agreed.

[22] It is not entirely possible to deduce the actual use of outcome-based commissioning based on providers' response to this question alone, as some outcome-based commissioning could be dealt-with by paying the provider for the actual time spent in the user's home, rather than the time commissioned.

services, but allows them to negotiate a more flexible pattern of care with their provider and avoids bureaucracy.

10. Lack of payments for short visits, weekends and public holidays

Employers face significant problems incentivising workers to undertake short visits, because of the travel time involved. Employers generally have to meet these incentives from the council's hourly rate, as 72% of providers across the UK reported their council offering no enhanced payments to cover visits shorter than one hour (and a similar lack of incentives for anti-social hours working). Unless the hourly charge rate is sufficient to support the vast number of shorter visits now being commissioned there are serious threats to the recruitment and retention of staff; compliance with National Minimum Wage and the financial viability of the sector.

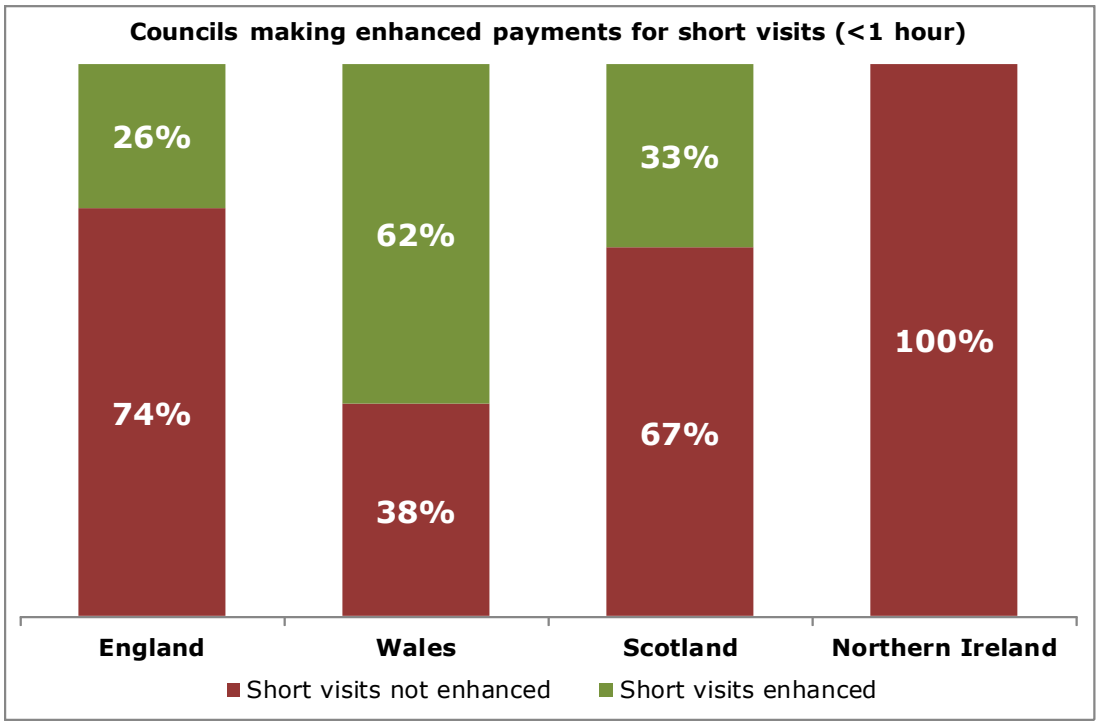
10.1. **Enhancements for short visits**

Providers were asked whether their council(s) applied an hourly charge rate on a *pro-rata* basis,[23] or paid enhanced rates for shorter visits.[24]

Nationally, only 28% of providers are paid a higher rate for undertaking visits of less than one hour. No providers in Northern Ireland reported receiving enhanced payments for anti-social hours working, as follows:

[23] This is that a 30 minute visit is paid at half of the hourly rate, and a 15 minute visit paid at 25% of the hourly rate, etc.

[24] That is that a 30 minute visit is paid at a higher rate than half of the hourly rate, etc.



This issue is particularly important for two reasons:

- The significant proportion of visits which are commissioned at 30 minutes or fewer, means that recruitment and retention of workers can be impeded if the employer is unable to incentivise their workers;
- The impact of payment for careworkers' travel in order to comply with National Minimum Wage legislation and to incentivise workers to undertake short visits.

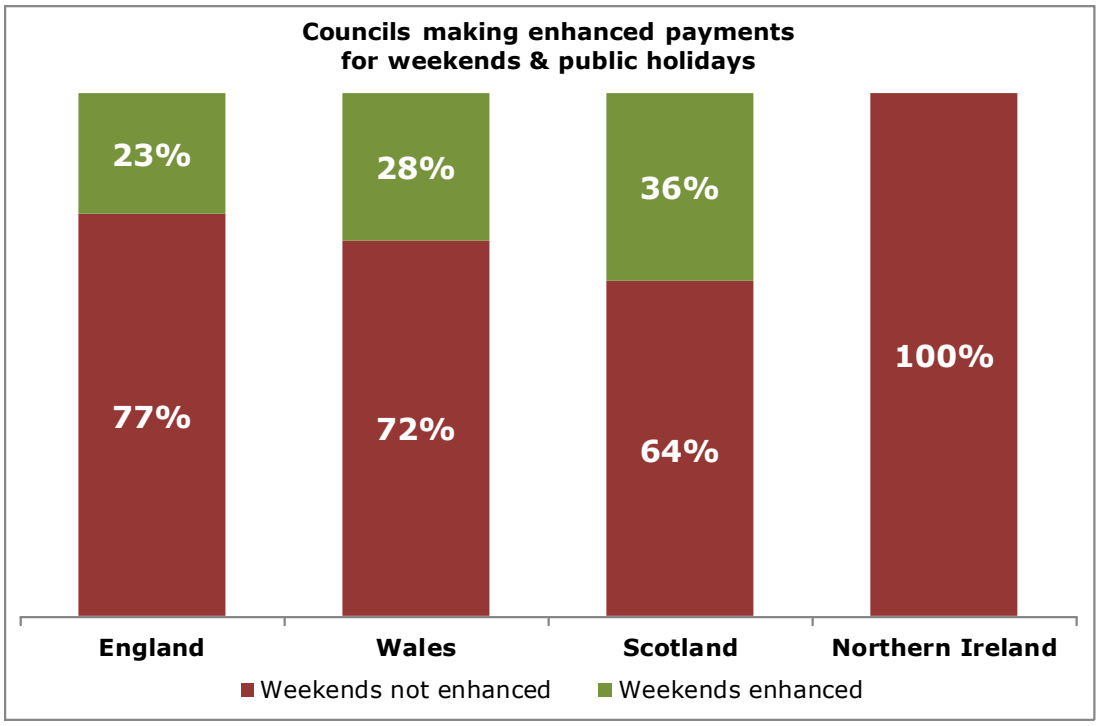
The practice of paying visits on a pro-rata basis is not in itself unreasonable, so long at the hourly rate is sufficient for short visits and the associated travel time to be adequately funded. This becomes less probable as prices are depressed and/or shorter visits increase. We believe that both have been happening for several years.

We are not aware of any previous data that would demonstrate whether this practice has changed over time, but we believe that application of the hourly rate on a pro-rata basis has increased significantly over the last few years.

A more detailed breakdown of these enhancements is given in Appendix 6.

10.2. Enhanced payments for weekends and public holidays

There is a broadly similar pattern of councils making enhanced payments for work commissioning at weekends and public holidays, with the exception of Wales, where providers are much less likely to receive an enhanced payment than they would for short visits.



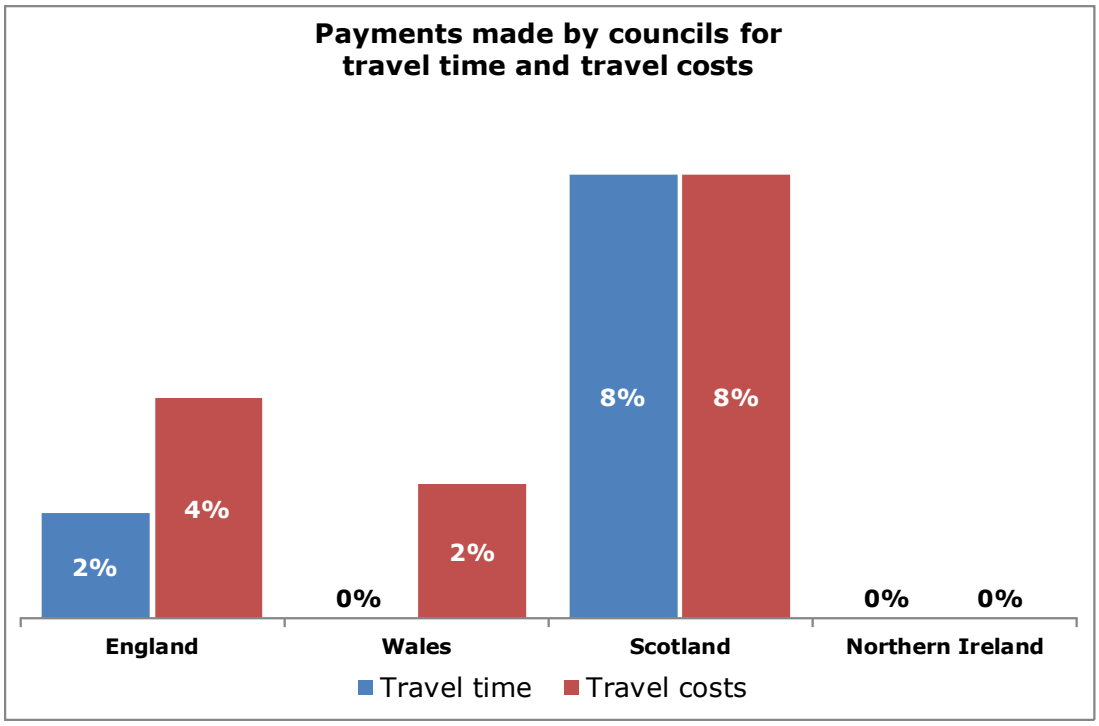
A more detailed breakdown of these enhancements is given in Appendix 7.

11. Lack of payment for travel time and travel costs

The overwhelming majority of councils expect providers to cover careworkers' travel time and travel costs out of the hourly rate paid for the time spent in the service users' home, emphasising again the importance of a sustainable charge rate to comply with National Minimum Wage.

We found fewer than 2% of providers in England were paid anything at all towards careworkers' travel time (8% in Scotland, but none in Wales and Northern Ireland).[25] A small minority of providers receive some form of contribution towards the careworkers' travel costs, although no providers in Northern Ireland reported such payments.

[25] We found four councils in the North West who appear to be paying some providers for travel time.



The question in the survey that asked providers whether councils might pay for anything other than the length of the visit provoked several ironic comments in the responses received. Another provider made the following comment on the impact of non-payment for travel time on recruitment and retention:

> "The council does not make any contributions to any travel costs and this is the most common reason for workers leaving domiciliary care."

Providers, like all other UK employers, must comply with the National Minimum Wage (NMW) Regulations and meet careworkers' expectations for remuneration, regardless of how councils stipulate how the final charge rate is calculated.

The rules for calculating NMW are difficult to interpret because of the episodic nature of homecare. A simple summary would be that workers' pay, when divided by the time spent in the service user's home and *applicable* travel time[26] should be equal to, or above, the prevailing rate of NMW. In addition, any out-of-pocket expenses incurred by the careworker (eg. petrol and vehicle depreciation) incurred while working and not reimbursed, must be deducted.

Some providers reported payments for travel only where this was part of the package of care (eg. taking the service user to the shops). Others reported occasional payments to incentivise workers to cover visits in extremely rural areas.

[26] Not all travel time counts towards National Minimum Wage. For example, the first journey to the user's home, and the last journey, during a span of duty are excluded.

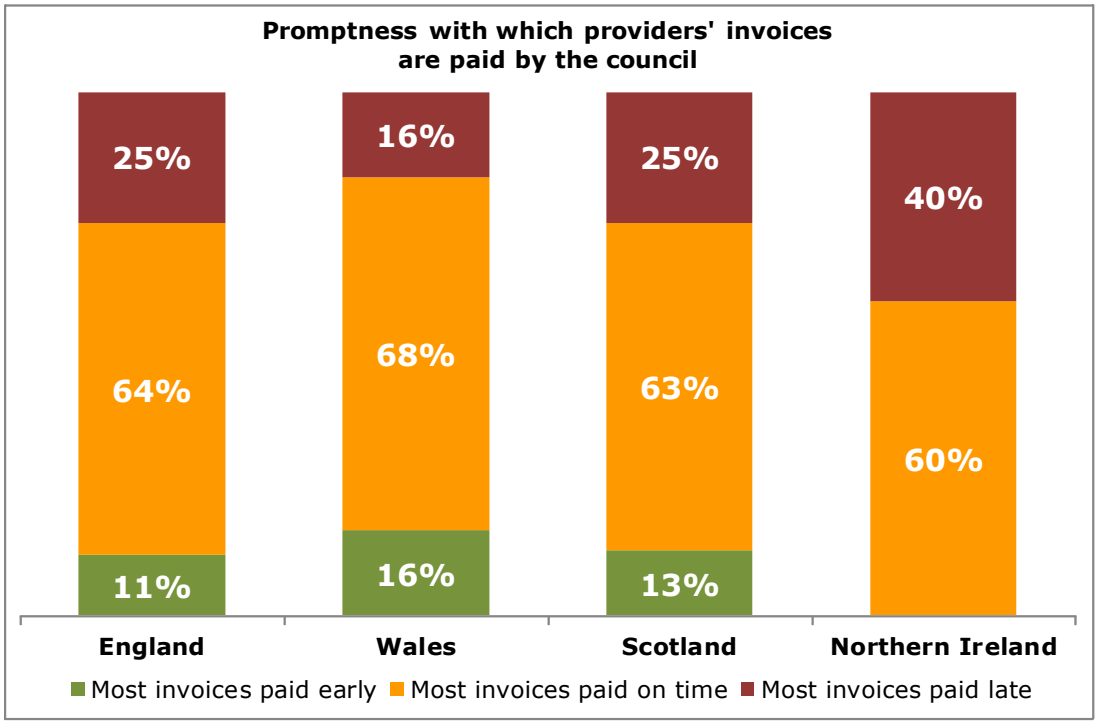
The impact of price competition, short visit duration and councils implementing charging regimes on a 'pro-rata' basis, places considerable strain on providers' ability to reward their workforce adequately, while remaining financially viable.

12. Delayed payment and disputed invoices

12.1. Payment within agreed times

While the majority of providers reported that their councils paid their invoices on time (and sometimes early), 25% of providers reported payment of "most" of their invoices after the contractual due date, with particularly poor payment rates reported in Northern Ireland.

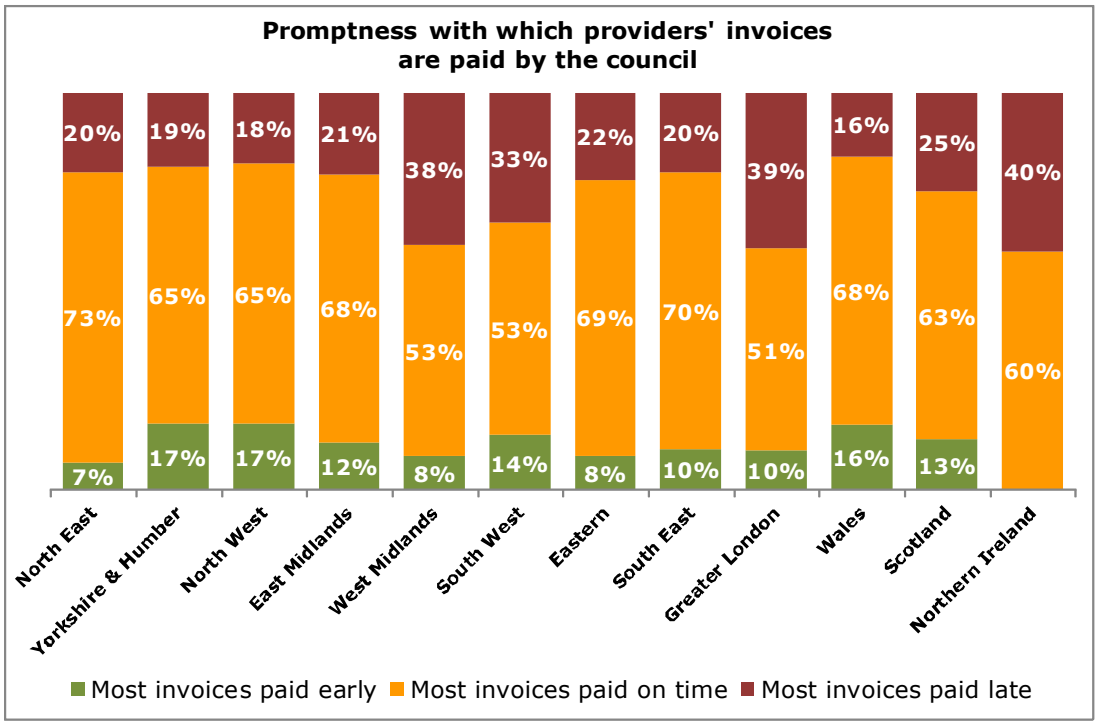
Late payment carries cash-flow implications for providers, creating difficulties paying staff (who expect regular payment), and can incur avoidable charges of credit control, bank lending, or invoice factoring. In addition, it exposes councils to litigation under the Late Payment of Commercial Debts (Interest) Act 1998, as amended.



The additional costs associated with late payment impact directly on providers' financial viability and their ability to reward their workforce. Prompt payment mechanisms within councils would help off-set the downward pressure on charge rates.

In addition to the significant late payment reported in Scotland (40% of responses), across the regions, councils making late payments were particularly

notable in Greater London (39% providers), the West Midlands (38%) and the South West (33%).



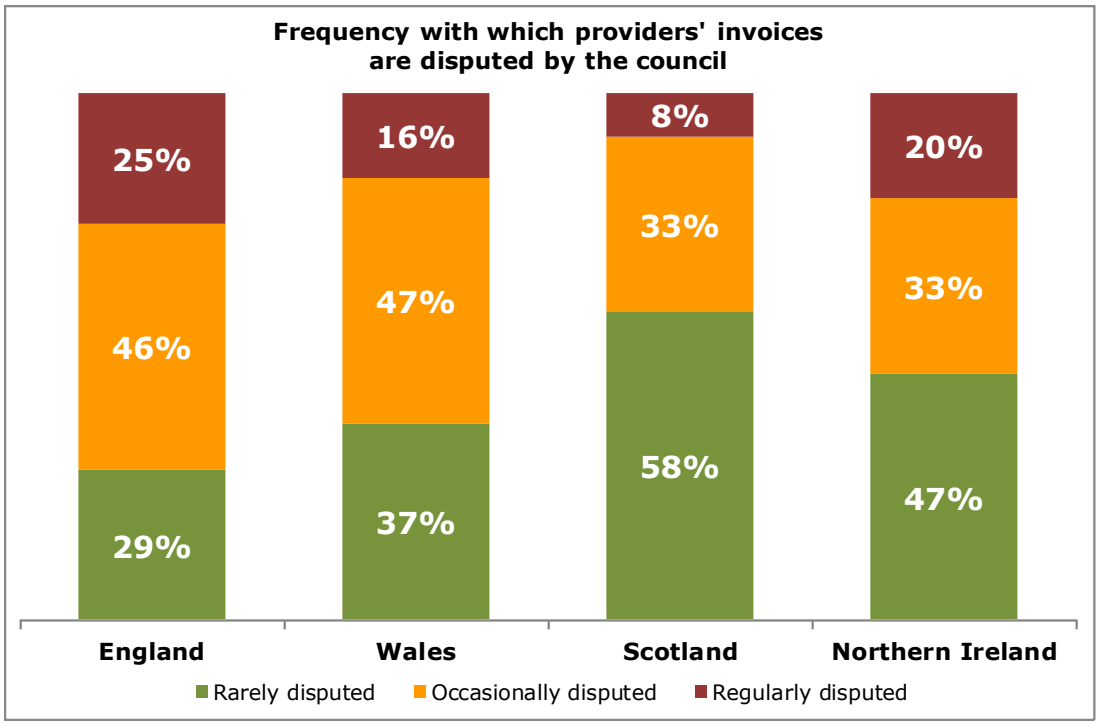
Although we found evidence of councils in all regions making payment before the invoice fell due, this did not appear to outweigh the size of late payments experienced by other providers.

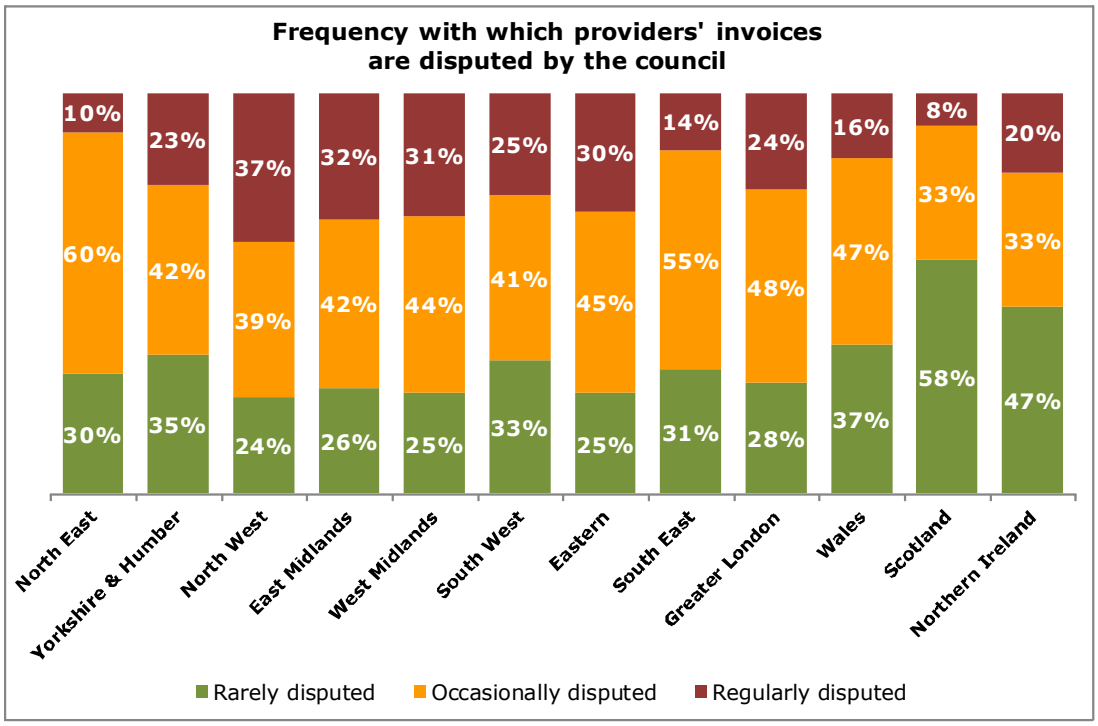
We commend the number of local authorities who have signed-up to the Prompt Payment Code, administered on behalf of the Department for Business Innovation and Skills by the Institute of Credit Management.[27] Providers supplying to participating councils may wish to discuss whether their experiences reflect the spirit of the Code, or ask why their council is not yet a signatory.

12.2. Disputes over invoices

24% of providers reported their councils "regularly" disputed invoices, a situation which increases the costs for both providers and councils. It is reasonable to suggest potential for savings for both sides if providers present accurate invoices which are then subject to efficient verification procedures by councils.

[27] See www.promptpaymentcode.org.uk, where signatories from central and local government can be found from the "code signatories" tab.





It was not possible to analyse the reasons behind disputed invoices from the survey data. No doubt the situation could be improved by both parties working together, and local authorities maintaining open communication channels between internal departments, leading to efficient verification processes and procedures.

Although not tested in the survey, we are led to believe that there is a common-place practice amongst councils of withholding payment of whole invoices where

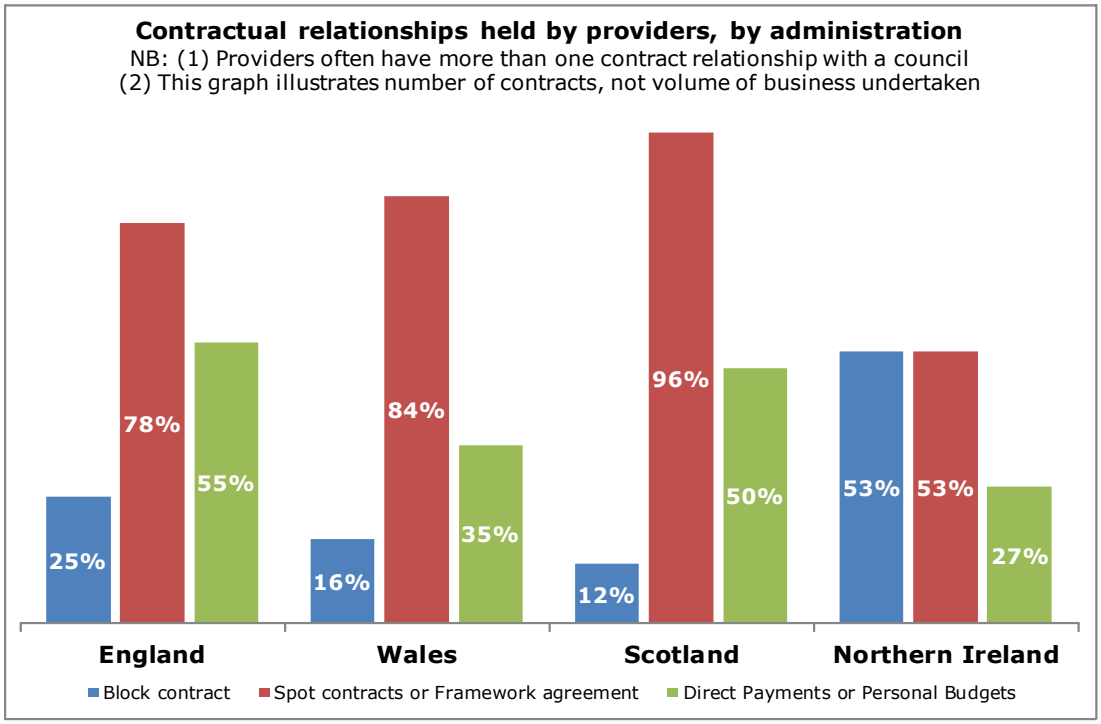
only a small proportion of the total is disputed. Where this is the case, there is a legitimate question of whether this represents efficient use of resources.

13. Lack of guaranteed purchase by councils

The majority of councils' contracting arrangements offer no guarantee of volume purchase and are likely to inhibit long-term planning and investment in services by homecare providers. Only 24% of providers in the UK held contracts with any guarantee of purchase.

The use of framework agreements and 'spot purchase' account for the majority of purchasing arrangements, followed by direct payments and council-managed personal budgets.

Providers indicated the different contractual relationships they held with their councils.[28] The following graph illustrates the frequency in each UK administration (see Appendix 8 for a more detailed view).



Block contracts have never been as prevalent in Wales and Scotland as in England and Northern Ireland. Block contracts became a significant mechanism for councils to obtain high-volume business at a competitive price, and to a large extent have allowed the homecare sector to build-up capacity, based on predictability of income over a three to five year period. However, there is now

[28] These figures related to a particular contract type, not the size of purchase (in hours or financial terms).

limited (and diminishing) use of 'block' contracting arrangements (between 12-25% of providers in England, Wales and Scotland hold this type of contract).

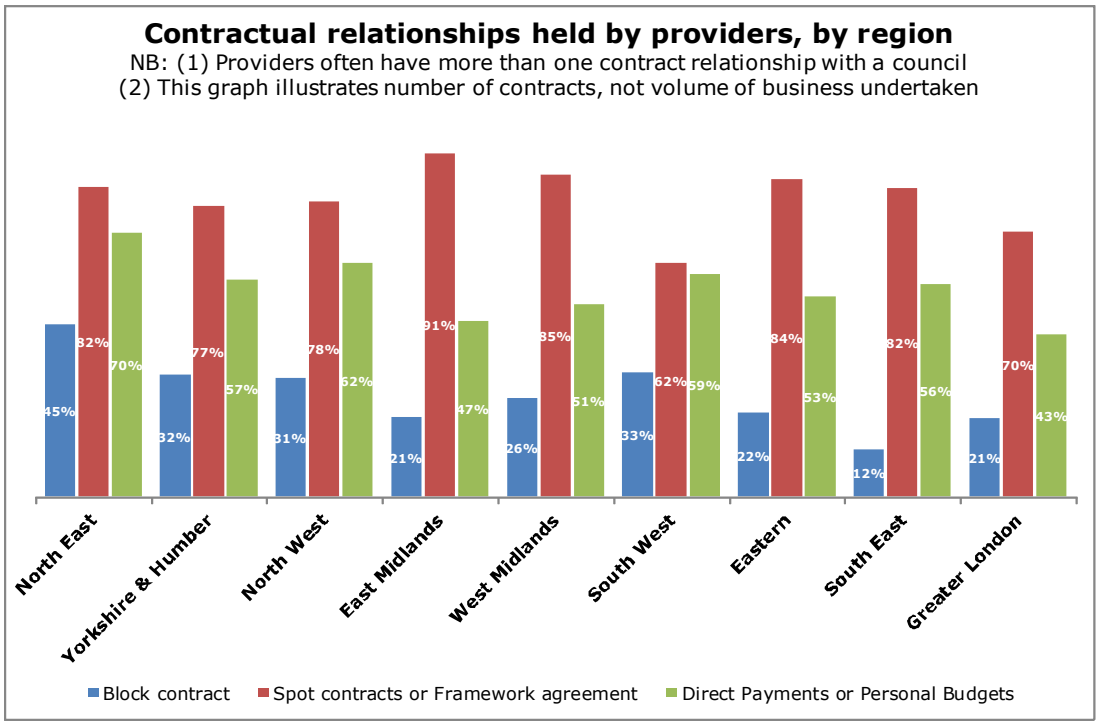
Over time it is probably true to say that the volume discount offered by providers in return for the guarantee of block purchase has become the "starting price" for future contract negotiations, but without the security of business, and without recognising the additional overheads associated with managing small volumes of highly individualised packages of care. This is not itself an argument against greater use of personalisation, but should act as a caution against an aggressive price-squeeze, the effects of which are shown in the analysis of hourly charge rates illustrated in section 5 of this report.

Having obtained discounted prices for guaranteed volume block contracts in the past, councils appear to expect similar (or lower) prices for contracts through spot or framework agreements, or with the additional administrative costs of individualised packages of care obtained using a personal budget or direct payment.

Framework agreements offer considerable flexibility for councils (particularly as many involve considerable price competition) and direct payments and managed personal budgets have been heralded as improving choice for service users. However, these purchasing arrangements also carry the unintended consequence of fragmenting provision.

The general direction towards "personalisation" of services (also referred to as "self-directed support") is likely to reduce the availability of traditional block contracting arrangements even further, replacing them with personal budgets, often in the form of a direct payment. This is particularly significant for providers in Northern Ireland, who appear to have significantly higher use of these contracts than elsewhere in the UK.

However, the approach across administrations towards personalisation is inconsistent between the UK administrations. Relatively few providers in Wales (35%) and Northern Ireland (25%) appear to support service users in receipt of Direct Payments from the authorities they trade with, compared to 50-55% in England and Scotland.

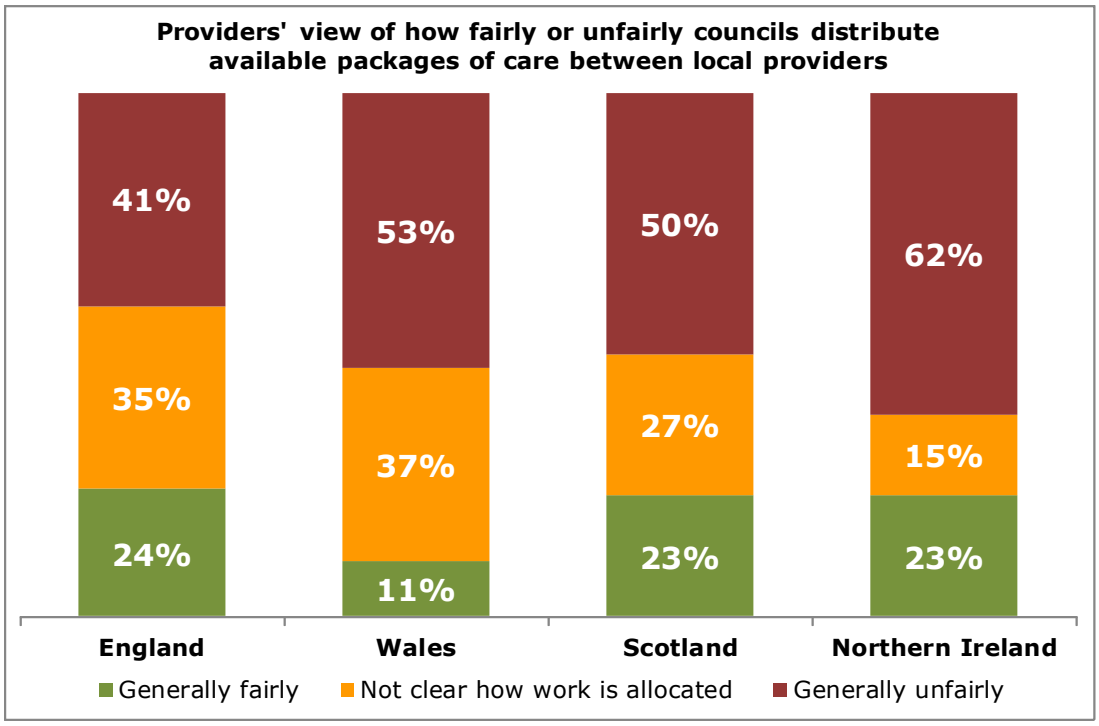


In the English regions there is considerable variation in the prevalence of block contracting, with councils in the North and South West generally having more providers with block contracts (31-45%) compared to London, the Eastern and South Eastern Regions (12-22%).

14. Lack of transparency over councils' allocation of packages of care

Over a third (34%) of providers thought that they way that their councils allocated packages of care to local providers was unclear. A significant proportion of providers (42%) believed the processes to be opaque and unfair.

Providers were asked to report their impression of whether their councils allocated available packages of care fairly among local providers.



Answers to this question will inevitably be subjective, and may depend on many factors, including whether providers have been successful in gaining volume business from the council, and how much emphasis the council places on providers supplying services of an acceptable quality at a price they are willing to pay.

However, at the very least, the findings suggest a lack of transparency over the allocation process, particularly as 34% of providers stated that they did not understand the rationale for how their council(s) distributed packages of care.

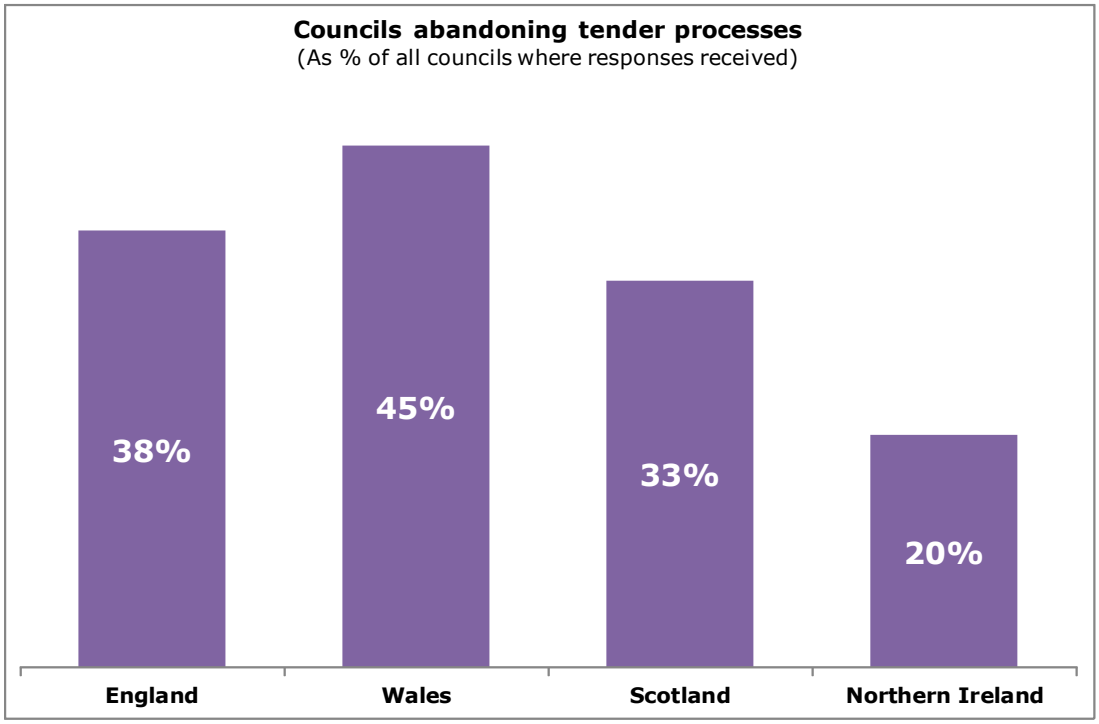
Some degree of variation in providers' impressions at a regional level is shown in Appendix 9.

15. Tender processes abandoned by councils

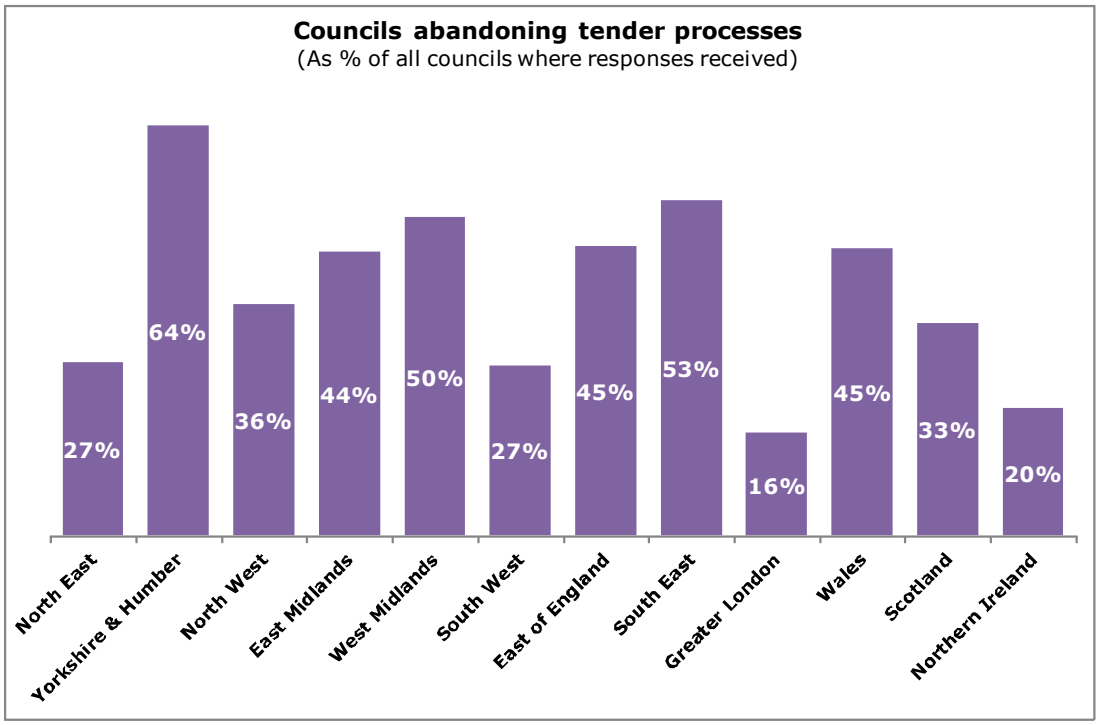
38% of providers in the UK reported that their councils had either abandoned (or significantly delayed) tendering exercises, a situation which results in unnecessary expense for both councils and providers. Responses from providers suggest that these may reflect councils' concerns about actual or potential legal challenge, insufficient resources, changes in personnel at the council or a lack of certainty about future purchasing requirements.

Tender exercises are inevitably complex procedures. Abandoned tender processes cause considerable expense for the authority and providers, particularly where the process is abandoned once pre-qualifying questionnaires or tender bids have been prepared. There is also the potential for damage to the relationship between providers and purchasers.

38% of councils in the UK were reported as abandoning a tender processes by one or more providers across the UK. Rates were particularly high in Wales (45%) and England (38%).



At a regional level in England, this was particularly marked in Yorkshire and the Humber (64%), the South East (53%) and the West Midlands (50%).



From the 152 reports of cancelled or delayed tenders which specified why the tender was abandoned, the following themes emerge:

Apparent reason for cancellation	Responses
Actual or potential legal challenge	16
Insufficient resources or planning; change in personnel at council	12
Purchasing requirements changed	9

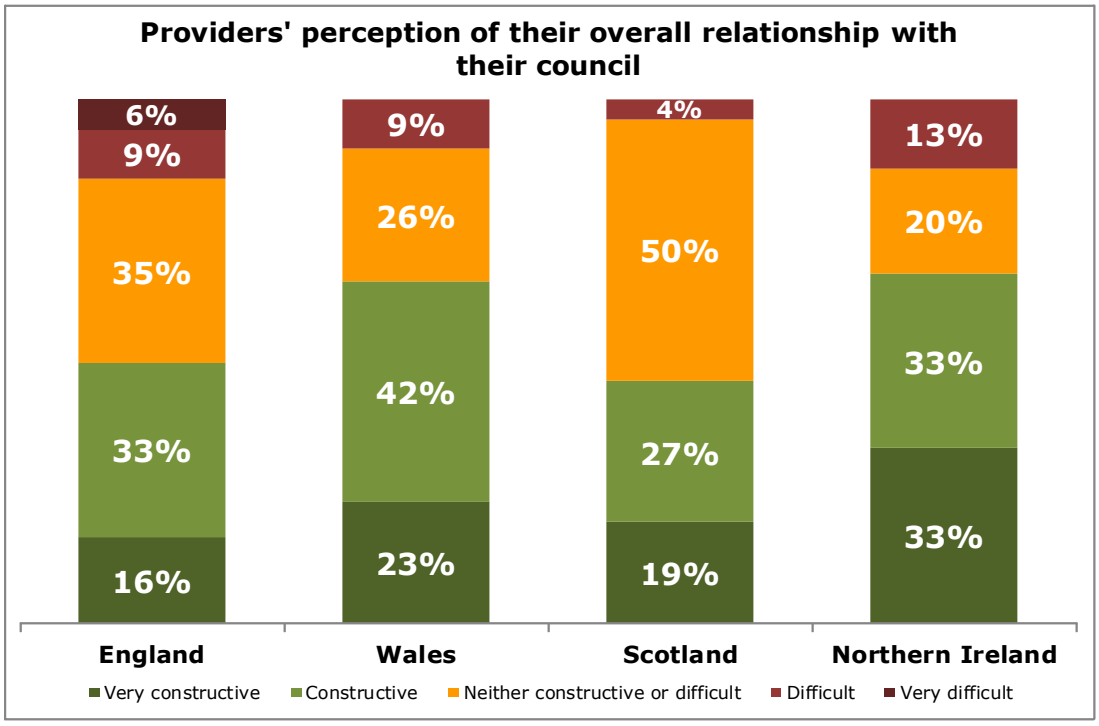
16. Deteriorating relationships with councils and departments

Homecare providers generally report a positive relationship with their councils. However, this has been damaged over the last year, with 41% of providers reporting a relationship that had "deteriorated" or "significantly deteriorated", compared to just 22% where the relationship had improved.

Understandably, with the evidence provided in this survey, the emphasis on cost-cutting was most frequently cited as the reason for providers' frustration. However, a lack of collaborative working with providers and difficulties in contacting the right person in the council to resolve problems were frequently reported, a matter which could be quickly addressed without undue effort on the part of councils.

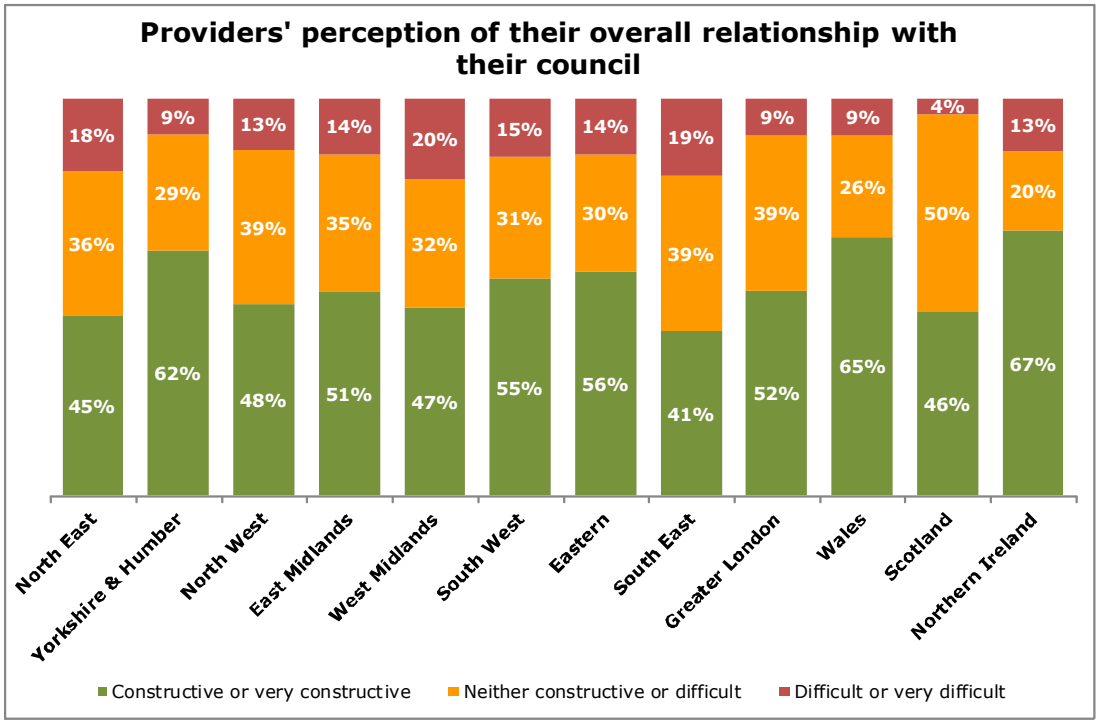
16.1. Providers' overall relationship with their councils

It is, at one level, reassuring that providers' perceptions of their relationships with their purchasing authorities are generally positive, or at least neutral.



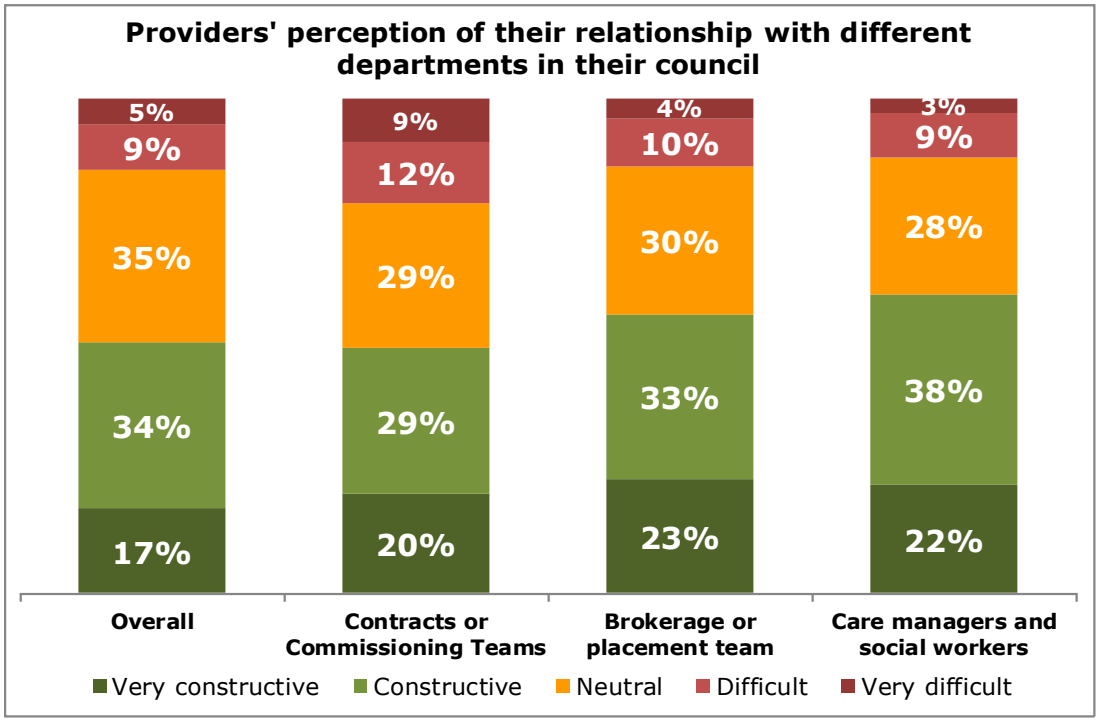
It is noticeable that providers in Scotland reported fewer positive relationships with their councils, and providers in England were more likely to report more

strained relationships. However, providers in England reported "very difficult" relationships with their councils (6%), while no providers in the other administrations picked this description.



At a regional level, providers in the South East reported the lowest number of "good" or "very good" relationships (41%) and the second-highest number of "difficult" or "very difficult" relationships (19%). Providers in the West Midlands produced the highest number of negative relationships (20%).

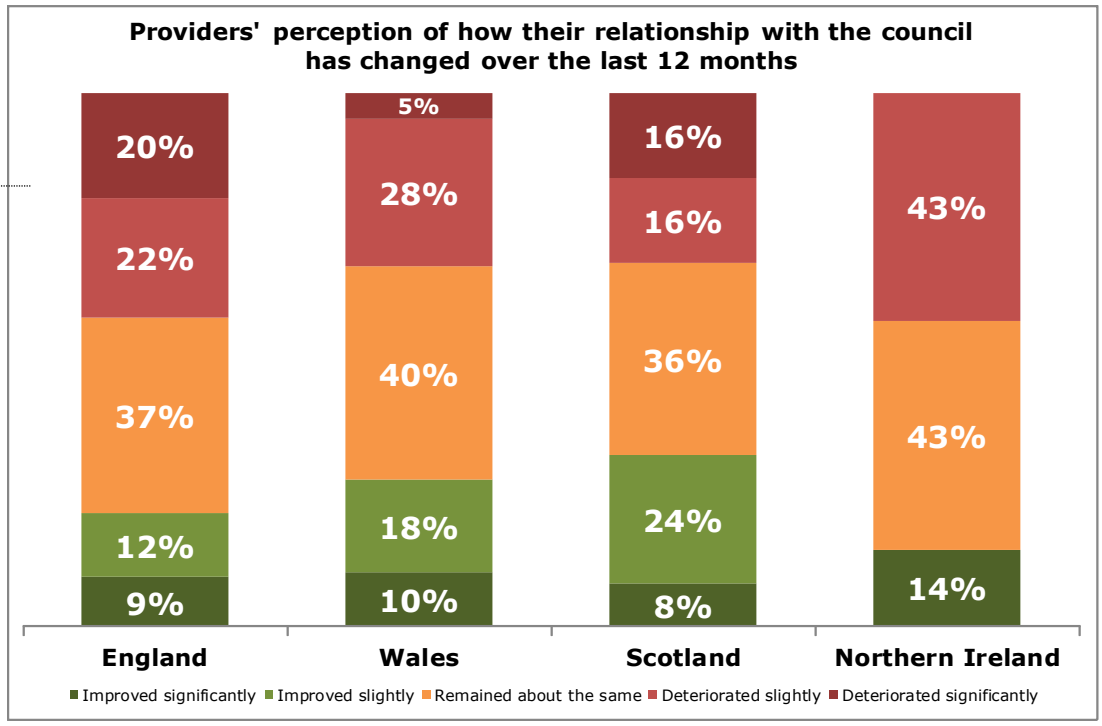
16.2. Providers' relationships with different council departments



Looking at the main departments within the purchasing authorities that providers deal with, relationships with the contracts or commissioning teams show the highest frequency of "difficult" or "very difficult" relationships (21%). We suggest that this is likely to be because of the decisions that these departments undertake, particularly during tendering exercises and granting "approved provider" status, have significant impact on providers' overall business.

16.3. How providers' relationships have changed over the last 12 months

There is a clear indication of relationships deteriorating over the last 12 months. Of providers who had traded with their council for over a year and who expressed a view, 41% reported a relationship which had "deteriorated" or "significantly deteriorated", compared with just 22% who said the relationship had "improved", or "significantly improved". Providers in England and Scotland were more likely to have reported a significant deterioration than elsewhere. A breakdown of this information by government region is provided in Appendix 10.



The 242 providers out of the 283 who said that the relationship with the council had deteriorated over the last 12 months offered a range of reasons, broadly categorised as follows:

Reason for *deterioration* in relationship	Number of occurrences
Council's emphasis on cost saving	103
Council's lack of consultation, engagement or collaborative working	74
Inability to maintain or develop business, or obtain a sustainable price for services	72
Ability to contact the correct (or suitably experienced) person in the council to resolve problems and issues	67
Implications of councils' commissioning on safety, wellbeing or choices of service users	21
Reduction in visit times	20
Quality not being rewarded or recognised	19
Delays, inefficiencies or errors in council processes	16
Implementation of call monitoring or per-minute billing	14
Increased bureaucracy	12
Service users' access to direct payments or personal budgets restricted by the council (whether deliberately or not)	12

The 95 providers (out of the 149 who said that their relationship with the council had improved over the previous 12 months) provided a range of reasons, broadly categorised as follows:

Reason for *improvement* in relationship	Number of occurrences
Council's willingness to consult, engage or work collaboratively with providers	65
Ability to contact the correct (or suitably experienced) person in the council to resolve problems and issues	27
Ability to maintain or develop business, or obtain a sustainable price for services	26
Quality being rewarded and recognised	11

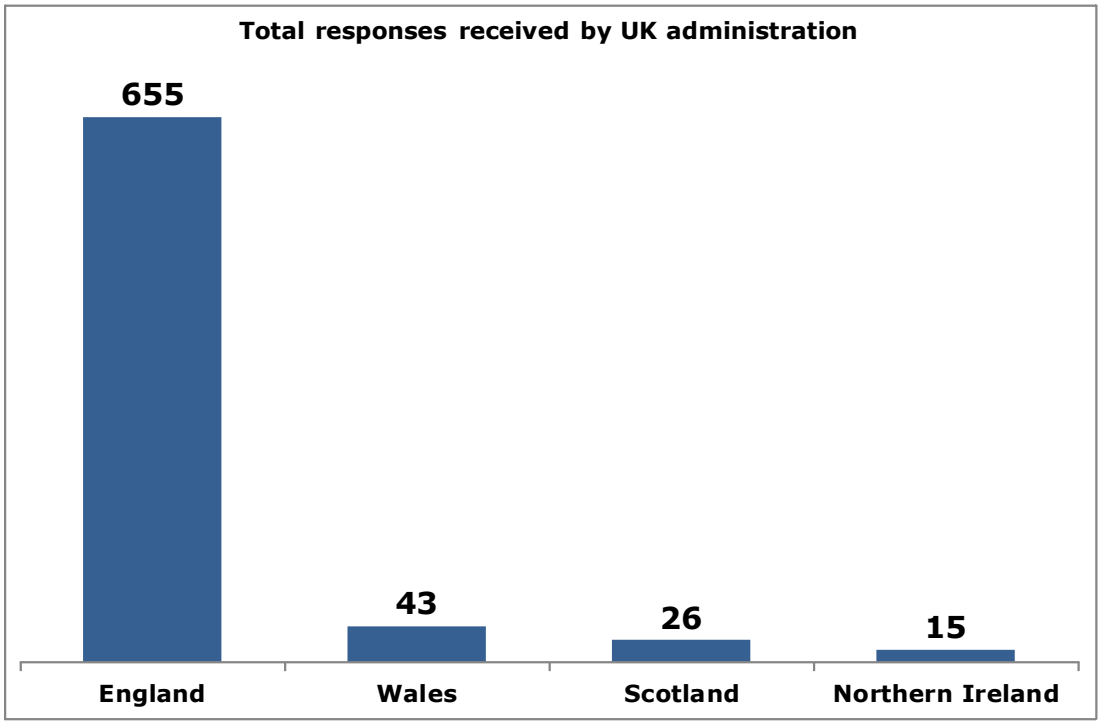
Our thanks for assistance with this report

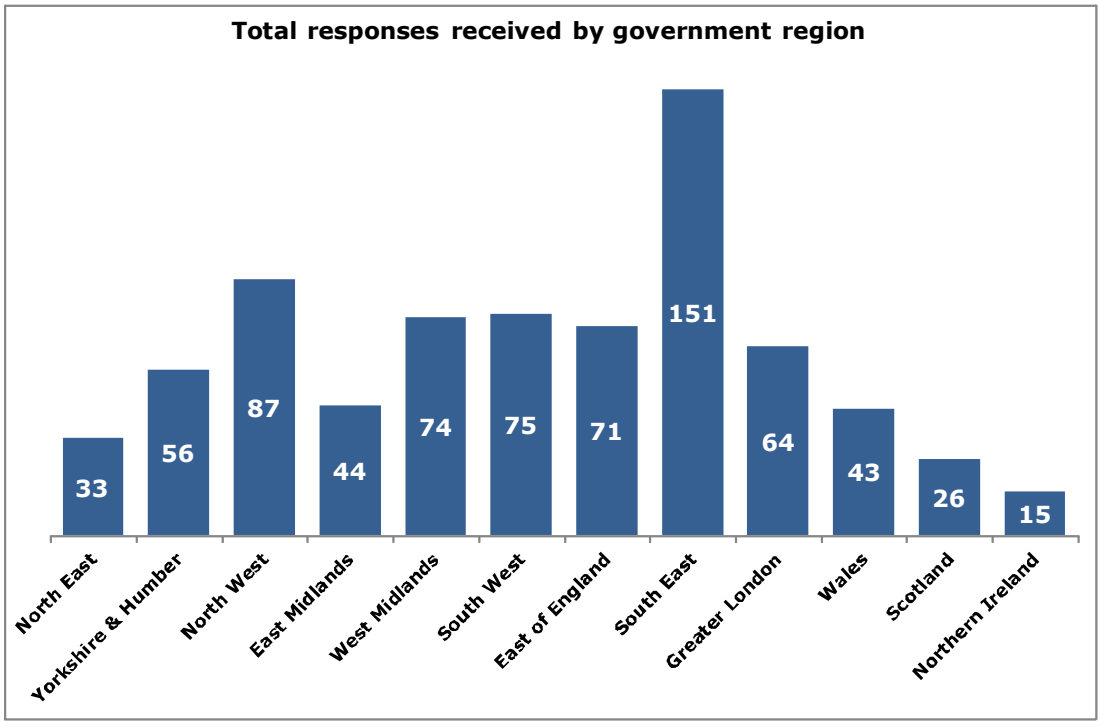
We would like to thank UKHCA provider organisations supporting and advising on this project and our colleagues in other professional associations who promoted our survey among their members.

However, our particular gratitude must be expressed to the many hundreds of homecare providers who took time out of their extremely busy schedules to provide the complex data that made this report possible.

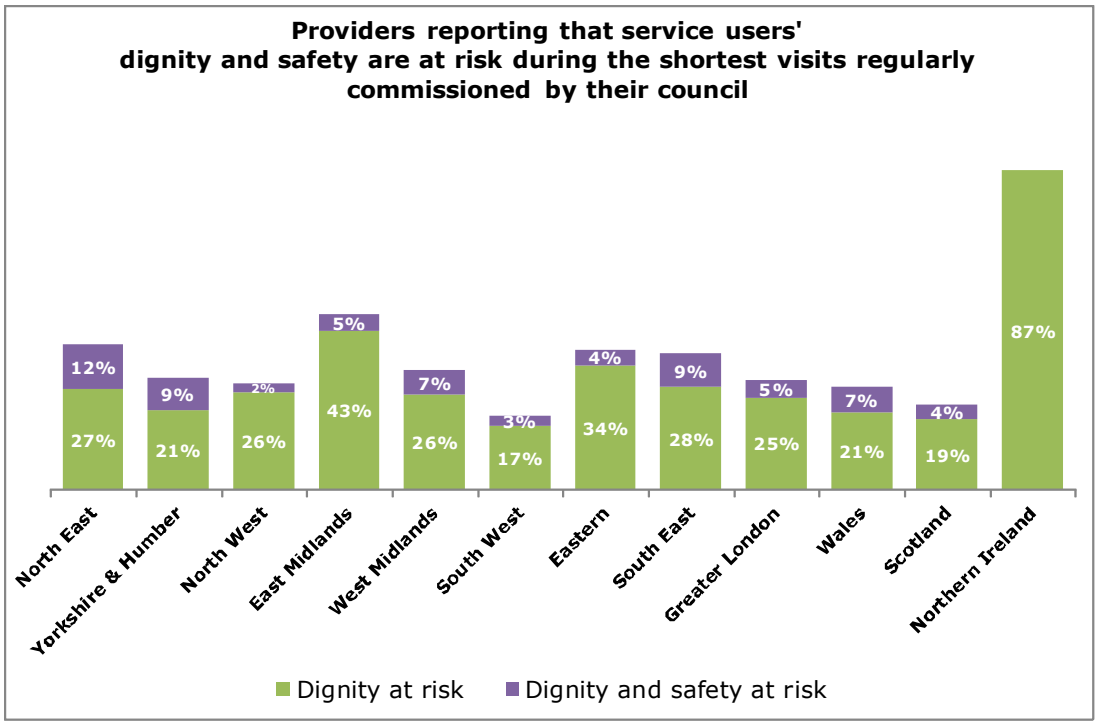
Appendices

Appendix 1. Number of responses received by UK administration and government region

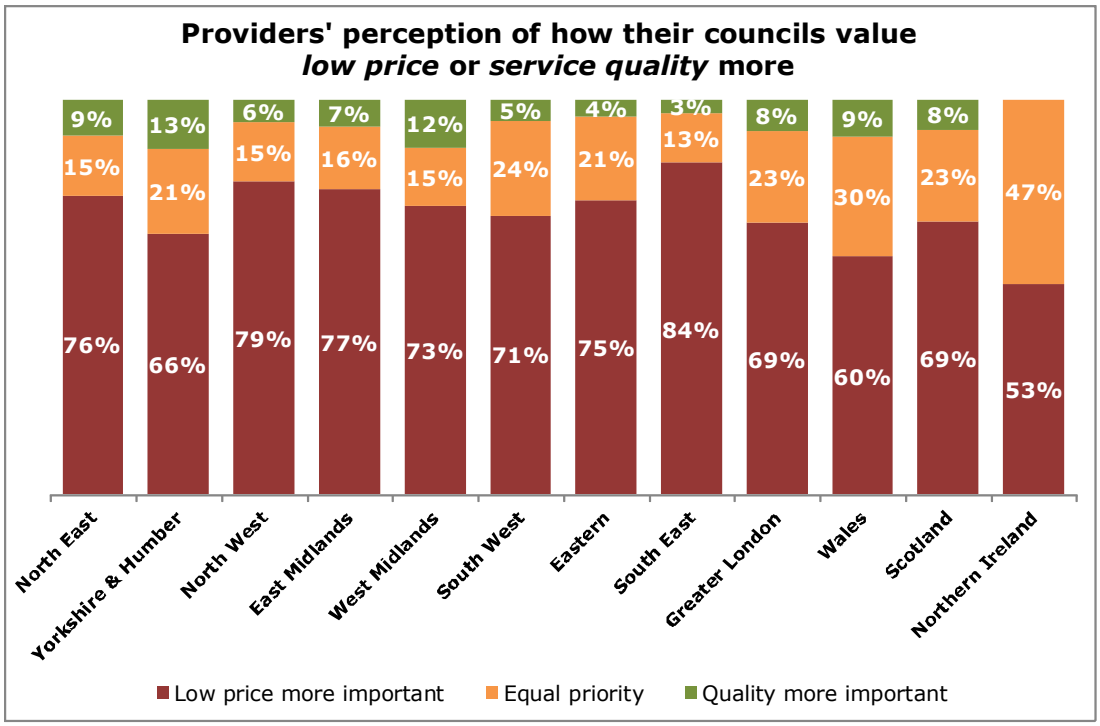




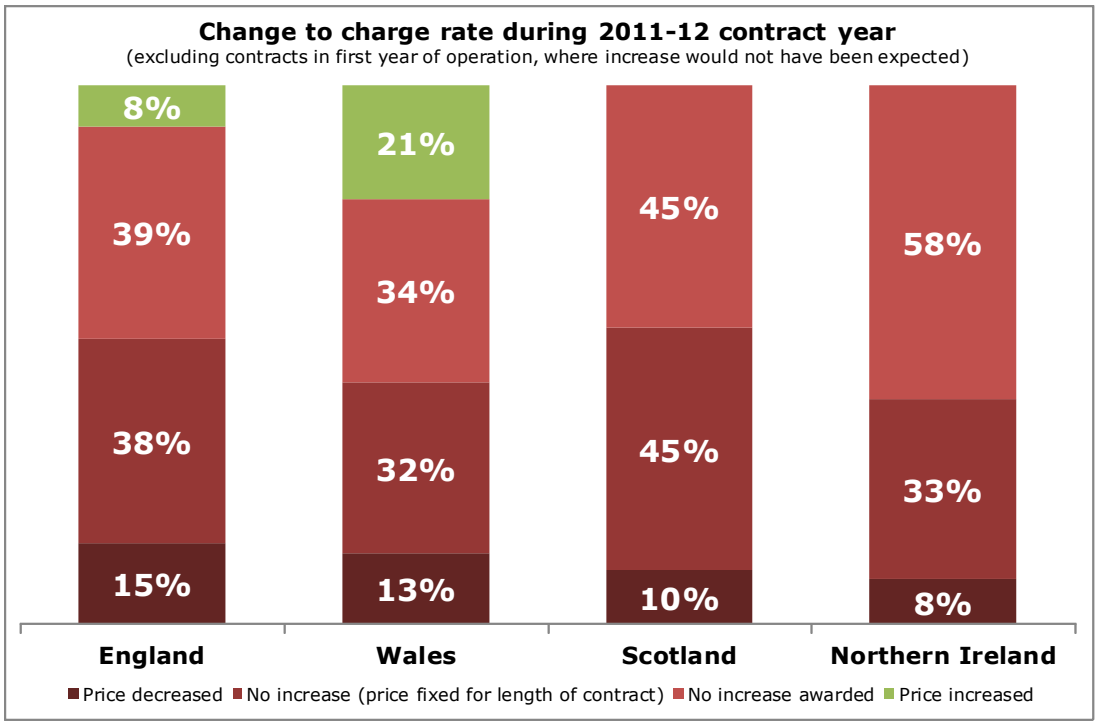
Appendix 2. Dignity and safety of shortest visits commissioned by councils

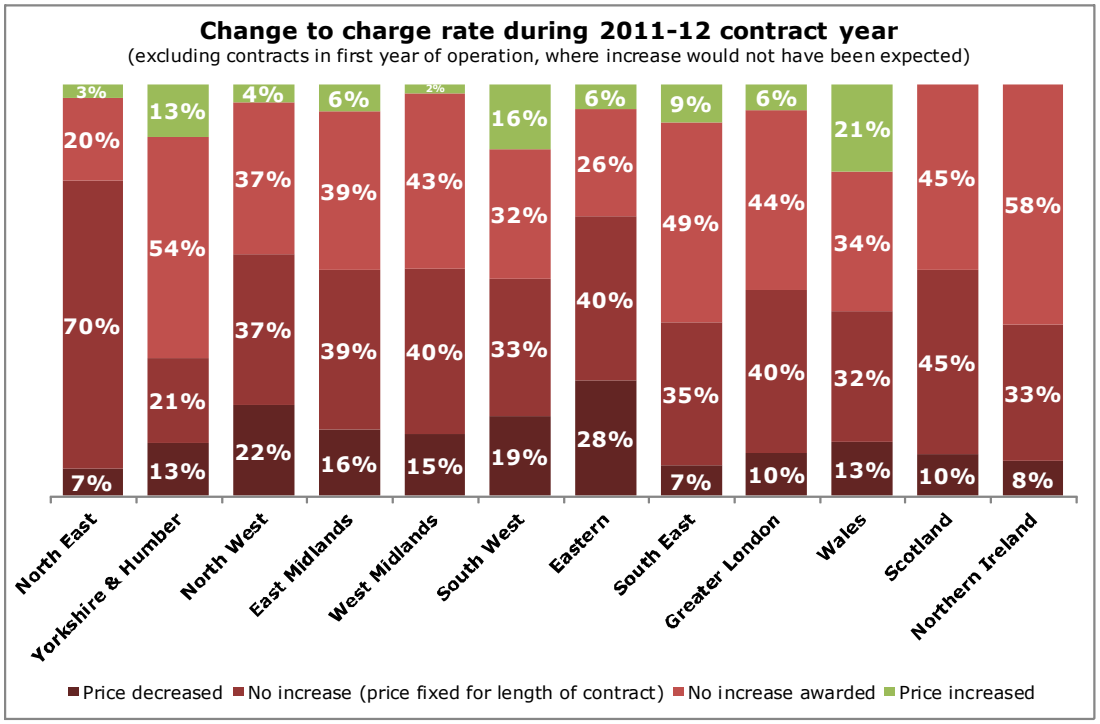


Appendix 3. Comparison of price vs quality

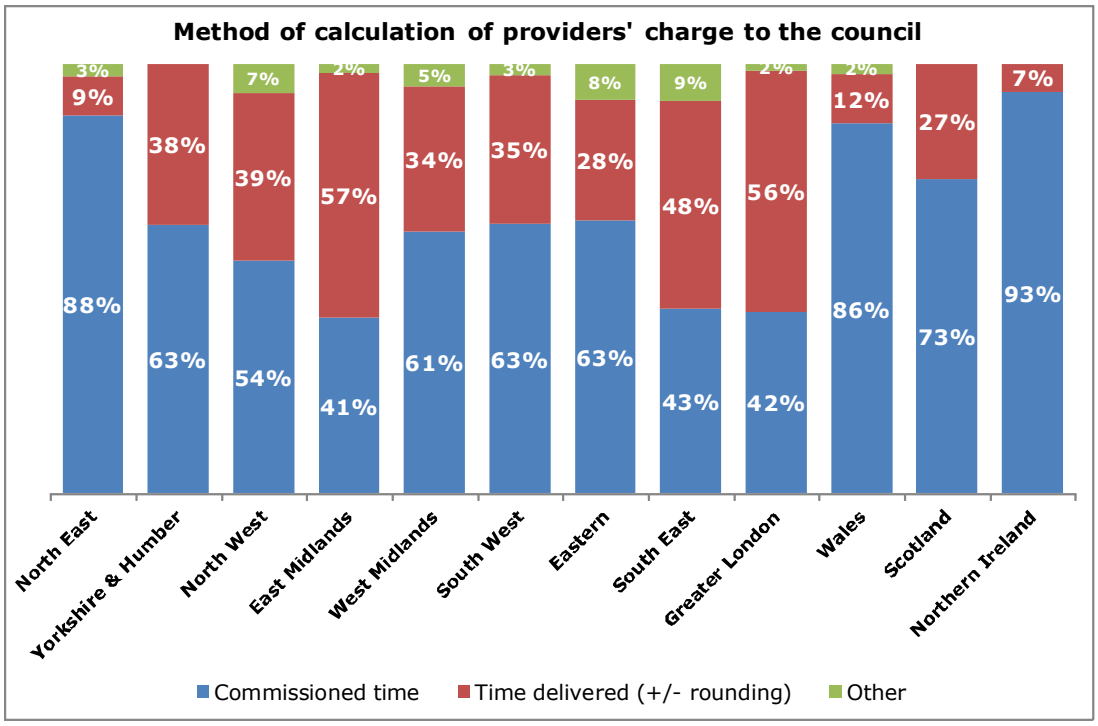


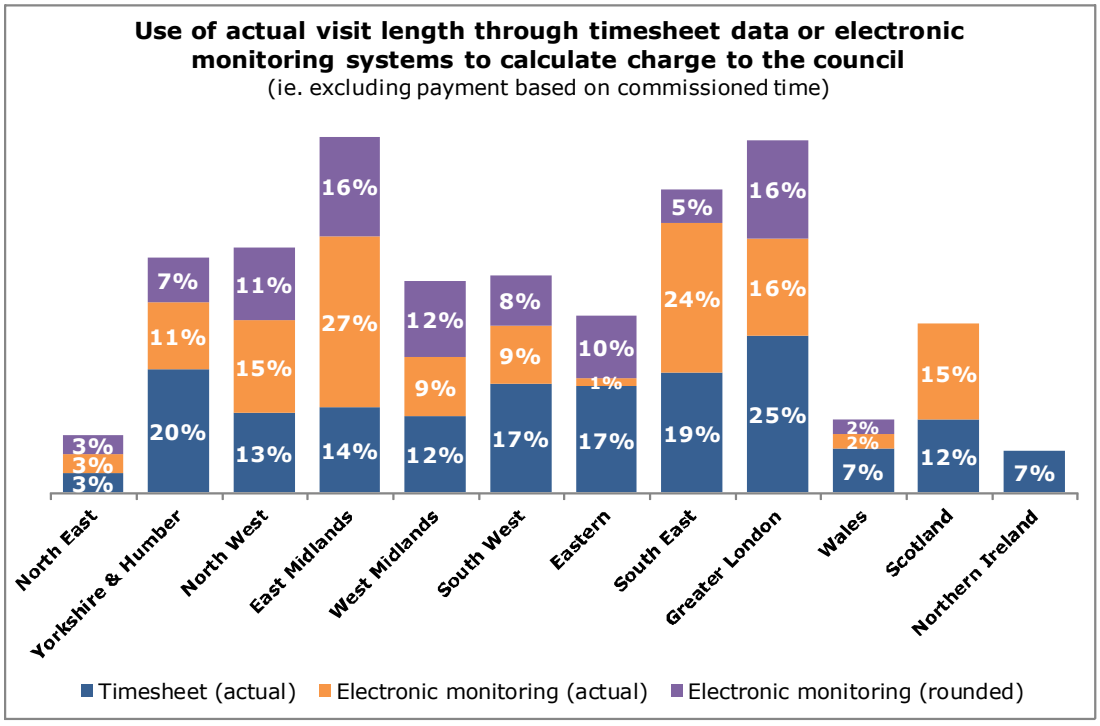
Appendix 4. Changes to providers' charge rates during 2011-12



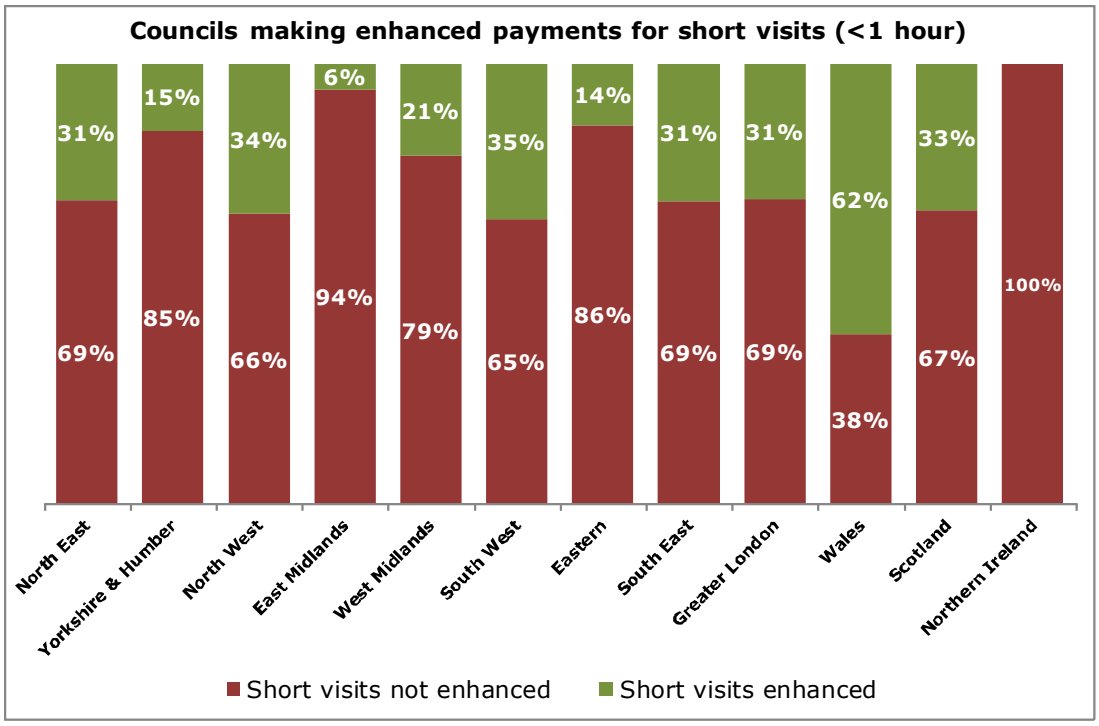


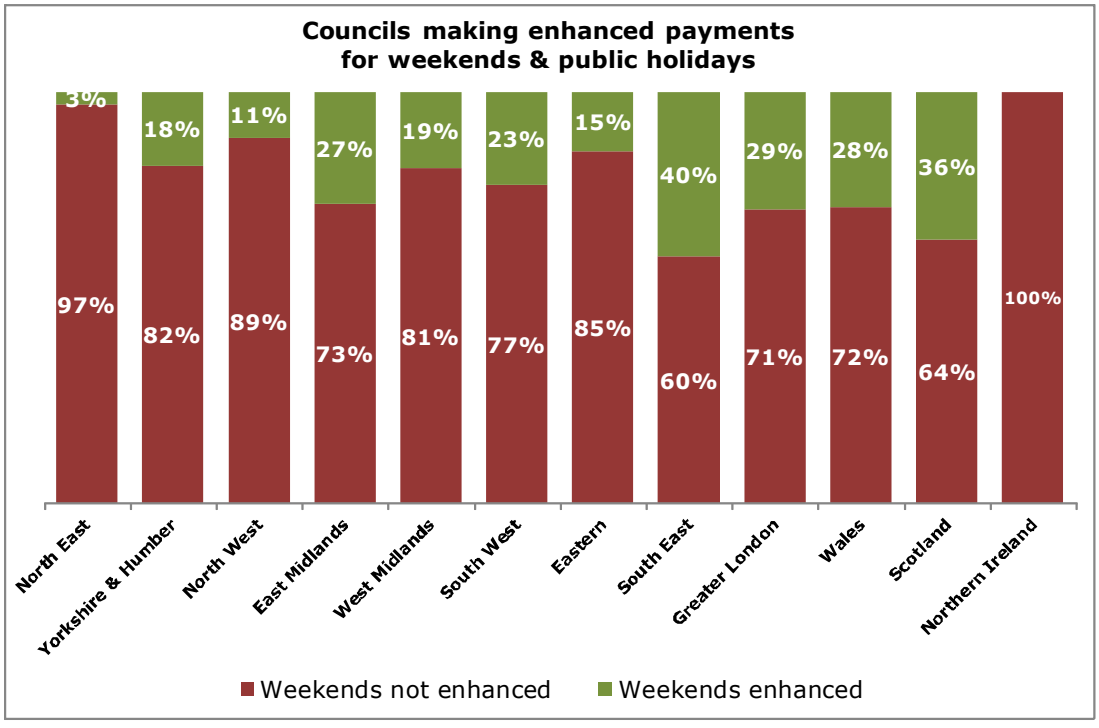
Appendix 5. How providers calculate the charge to the council



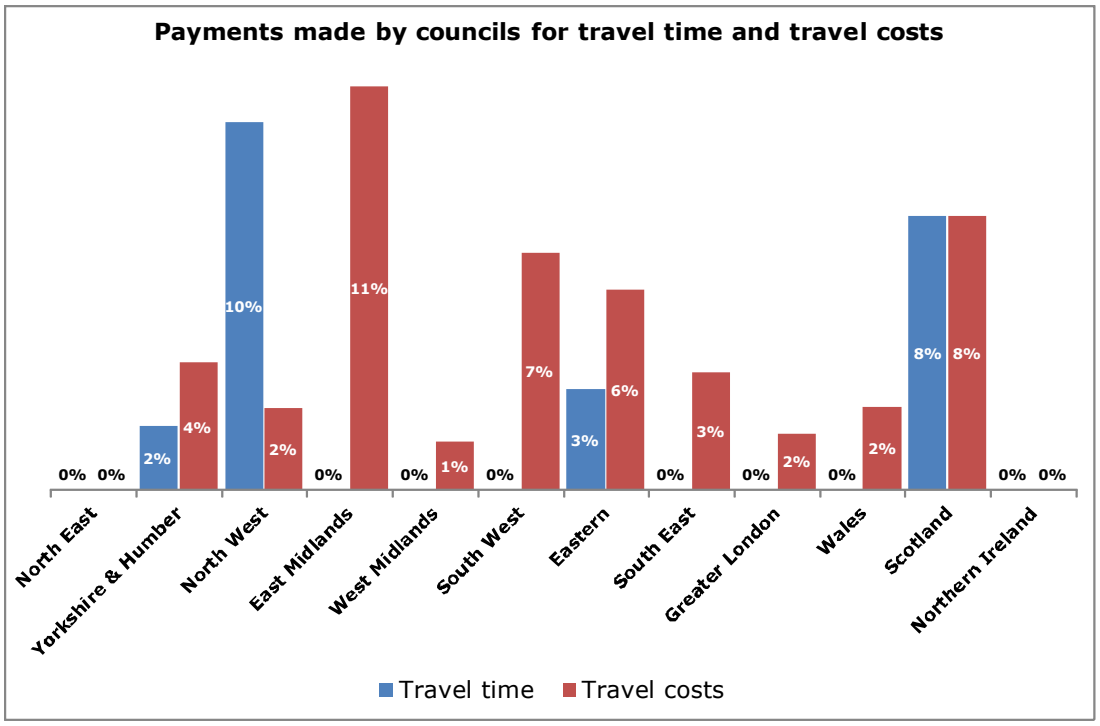


Appendix 6. Enhancements made for short visits, weekends and public holidays

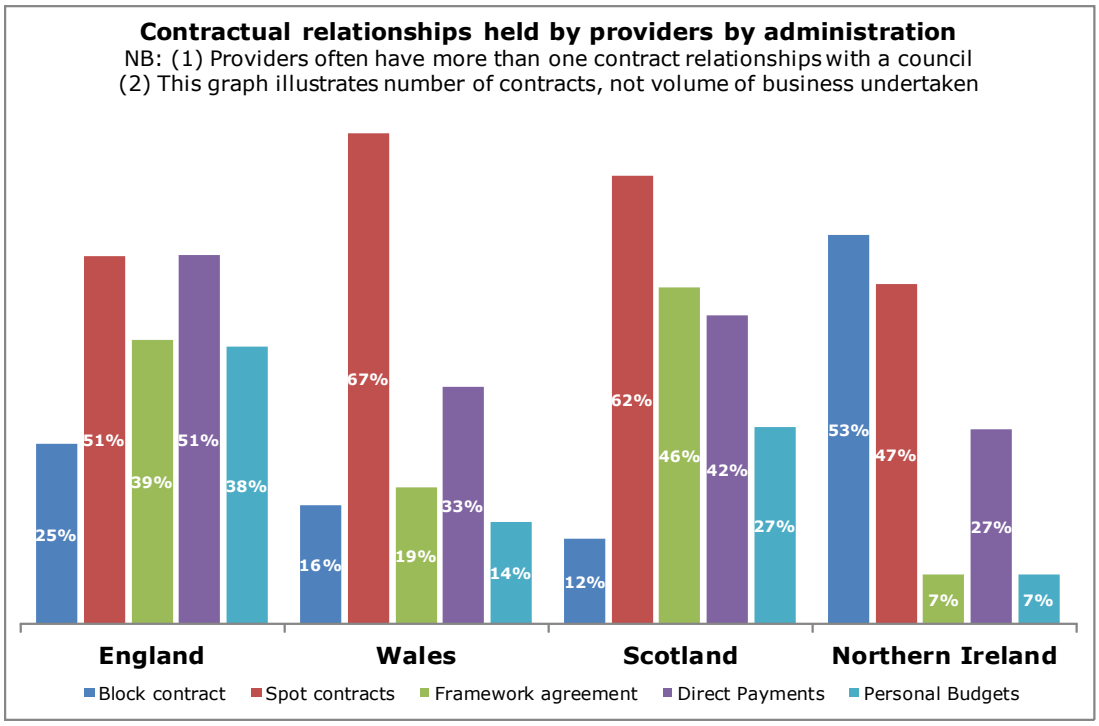




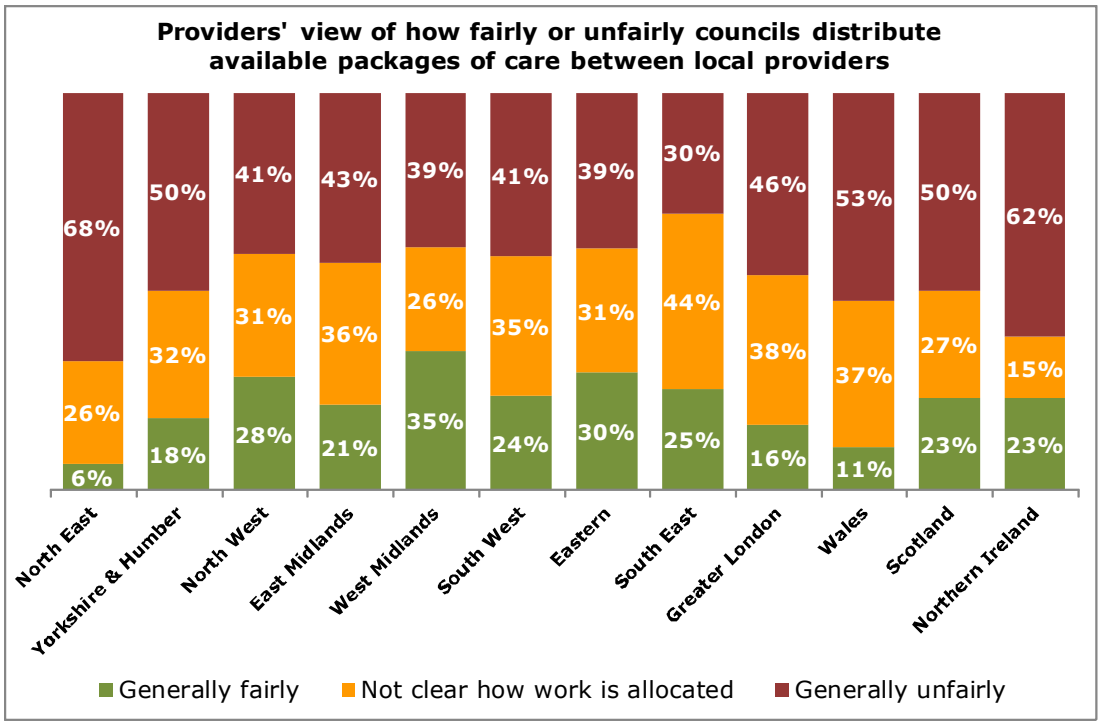
Appendix 7. Councils' payment for travel times and travel costs



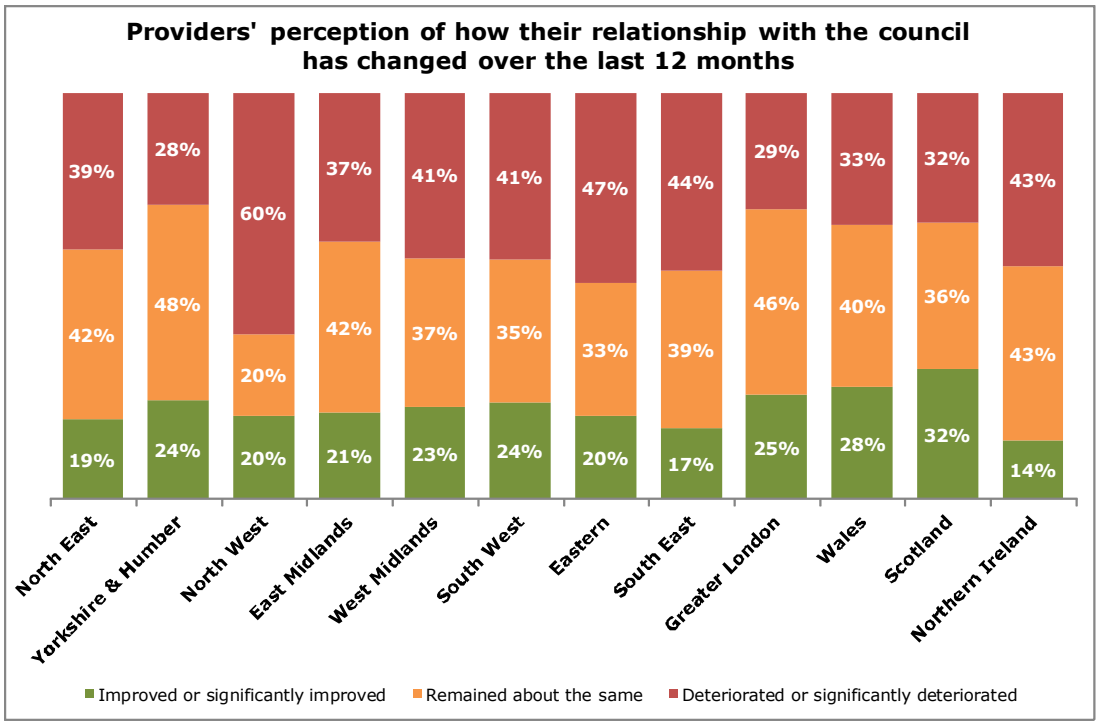
Appendix 8. Contracting relationships with councils



Appendix 9. Councils' allocation of packages of care



Appendix 10. Providers' relationship with their councils



Appendix 11. Recently occurring cost pressures on providers

The following non-exhaustive list draws together some of the *general* inflationary costs which homecare providers are likely to have faced recently:

- The challenges of recruiting and retaining careworkers - even in the current job market.
- Meeting workers' pay rates ahead of National Minimum Wage – The main adult rate increased from £5.80/hour in October 2009 to £5.93 and then to £6.08 in the following two years, rising again in October 2012 to £6.19.
- Fuel price increases incurred through business travel since April 2009. According to the AA Fuel Price Report average unleaded petrol prices have increased from 95.0ppl to 138.5ppl and diesel from 102.7ppl to 145.5ppl to March 2012;
- Two increases in statutory holiday pay, currently at 5.6 weeks for full-time workers.
- 1% increase in employers' and employees' National Insurance contributions.
- An increase in VAT to 20% on January 2011 – while councils will not be paying VAT on regulated homecare services, providers will be paying VAT on applicable goods and services, which they may not be able to claim back.
- The future introduction of compulsory employer contributions to employee pension schemes.
- Two additional public holidays in the last two years – with staff expecting enhanced pay rates.

Appendix 12. Case studies: the impact of reducing visit time and number of visits for people who use services

The following descriptions are a selection of the 50 case studies submitted in response to an earlier survey undertaken in August 2011, which looked at what UKHCA believes is a concerted pattern among some local authority commissioners to reduce the number and length of homecare visits provided to service users.[29]

9. A provider's request for an additional 15 minutes of care each evening to check on the wellbeing of a lady in her 80s was denied by a council in the South West of England funding her care. She had developed an infection, but wanted to stay at home rather than go into hospital. We estimate that these visits would have increased the cost of this lady's care by £26 per week, in addition to the £103 the council already paid. The cost to the NHS would have been significantly higher.

10. A gentleman in his 90s had his care reduced by 92% after his council in the Yorkshire and Humber region cut his original 28 visits per week (each lasting 45 minutes) down to just 7 visits per week (each lasting only 15 minutes). The council saved around £230 per week, and now spends just £20 a week on 1.8 hours of care, which is described as 'seriously insufficient' by the provider.

11. A lady in her 80s in the North West of England lost much of the assistance she needed to remain at home, including shopping; paying her bills and help with her laundry. The 7.5 hours of care she received each week was cut by 67%, leaving careworkers little time to fit these activities around help with her personal hygiene needs in the three visits she receives each week.

12. A daily half-hour visit to help a lady prepare a meal and attend to her personal hygiene in the South East of England was discontinued without discussion with the agency about her needs. The provider believes that the council responsible is undertaking a policy of cancelling packages of care that only require a single visit per day.

13. A gentleman in his 40s in the South East of England receives a specialist homecare service for people with mental health needs. He no longer receives sufficient one-to-one care to monitor and support his psychological state, leaving his provider describing his care as 'seriously insufficient'. The 23 hours of care he received each week has been reduced by 83% by reducing 14 visits a week down to just four.

[29] United Kingdom Homecare Association Commissioning Survey 2011, available from www.ukhca.co.uk/pdfs/UKHCACommissioningSurvey2011.pdf.

14. A council in the South West of England reduced the amount of care for an older lady by declining to pay for a second careworker to help use a mechanical hoist to use the toilet safely. This measure saved the council £61 a week, but increased the risk of injury to the service user and the careworker.

15. A lady in her 80s in East Anglia has Parkinson's disease. The 14 hours of care she received was halved in May 2011, by halving each of her half-hour homecare visits, despite her needs not having reduced. Parkinson's is associated with variable exacerbation where people may require more assistance than usual. The provider said "on bad days we have to rush. All four calls per day have been reduced to 15 minute visits, which includes delivery of personal care".

16. A lady in her 90s no longer receives the seven evening-time visits to help with personal care and check-up on her safety. Since the council in the South West of England reduced her care by 41% in January 2011, she has been scalded attempting to make a cup of tea; has spent a night lying on the floor undetected after a fall; and a skin condition has deteriorated as she is unable to apply the lotion she needs. She now regularly telephones her daughter in the evenings in a state of distress. This has saved the council £62 a week.

17. A younger disabled adult in her 30s received the equivalent of over 76 hours of intensive care a week at her home in West Scotland. Her care was reduced by 26%, after the introduction of a direct payment, which now only covers two of the four visits where careworkers were needed in pairs. On the other visits one careworker has to cope alone. The provider believes the care is now 'seriously insufficient'.

18. A lady in her 70s has had 5 minutes shaved from each of her 20-minute visits, despite care being necessary to help with physical activities, including getting in and out of bed and using the bathroom. The provider said that 20-minute visits were 'somewhat insufficient', but rates the shorter 15-minute calls as 'seriously insufficient'.

19. The condition of a frail gentleman in his 90's in Northern Ireland began to deteriorate. His needs were being met with four half-hour visits a day from two careworkers, working together. This cost the local Health and Social Care Trust £305 per week. The Trust declined to provide any additional time to help the gentleman use the toilet, wash and dress, leaving the provider describing the care they were paid to deliver as 'seriously insufficient'.

20. A provider in the East Midlands felt compelled to accept a 20% fee reduction to enable a younger disabled gentleman to remain with the agency that he's used for the last 17 years. The social worker commissioning the care wished to introduce care at a rate below the £12.73 per hour charged. The provider has foregone £423 a week to help

this gentleman remain with the service he knows and trusts. However, each time councils push down the price they pay for care, less money is available to support workers' training, wages and the agency's other running costs.