# Providing a viable Domiciliary Care sector in 2021

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CARE CITY

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# Background

Care City is an innovation centre for healthy ageing and regeneration. Its mission is to create a happier, healthier older-age for East Londoners. To achieve this, Care City works as the innovation partner to East London's health and care system. It delivers research, innovation and growth of local benefit and national significance. Care City is a community interest company.

This report has been written in an accessible way for many audiences. We hope these reports stimulate discussion, but we don't think there is one solution to the vast interconnected problems within our sector and are not promising we have the solution, but we aim to have captured the concerns from all sides in a fair, but realistic way.

# Introduction

Care City was asked by a London based local authority to investigate ways to improve pay in the local adult homecare sector. This included exploring how we ensure more care workers in the borough earn a London Living Wage.

To better understand the issues that providers are facing we:

- interviewed the providers in August and September 2020
- analysed routine, anonymised data collected by commissioners
- surveyed providers about issues relate to workforce, pay, recruitment, retention and development
- held a workshop with providers in March 2021

Providers were candid about the issues they face and the opportunities they see. As a result, a clear narrative emerged about the task of improving pay in care. However, we are conscious that this is only one narrative from one group of stakeholders. Commissioners and service users, for example, will also have their own perspectives, which it is equally important to hear.

In our workshop, providers were conscious of the need to balance different interests and perspectives, and keen to collaborate with commissioners and service users.

Providers admitted to some concerns that the issue of the London Living Wage might become a focus for criticism of providers, already - like local authorities - under significant pressure. However, providers are eager to collaborate with commissions to improve the system for everyone.

In the main body of this report, we play back the data we received from providers, as a contribution to the long-term project of achieving a London Living Wage for all care staff.

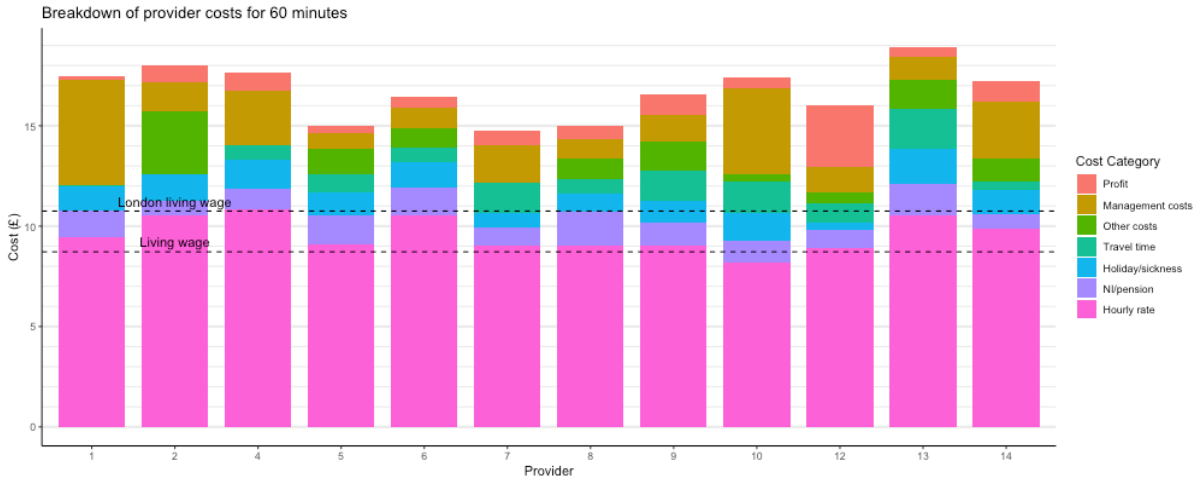
# Issues faced by Commissioners

This section looks at the quantitative data shared with Care City through the provider survey and routine data collected by commissioners and what it tells us about the challenges facing commissioners in seeking to pay the London Living Wage to homecare staff.

Anonymised data collected as part of the responses to an invitation to tender for provision of homecare that were submitted in the summer of 2019. It shows which providers are currently paying the living wage (both national and London) and what the cost would be to the local authority if:

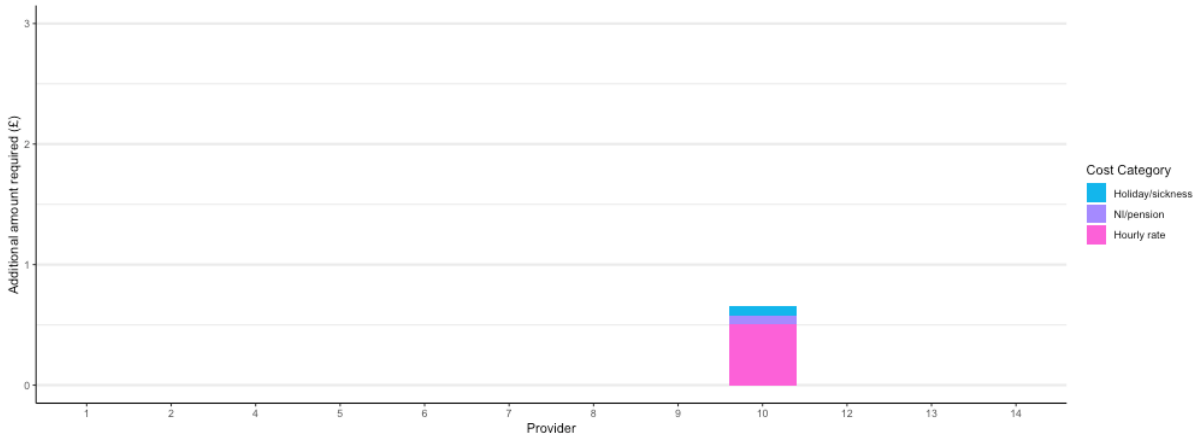
- The local authority increased the hourly rate paid to any provider who does not currently pay the national living wage by the difference between their current hourly rate and the national living wage (£8.72)
- The local authority increased the hourly rate paid to any provider who does not currently pay the London living wage by the difference between their current hourly rate and the London living wage (£10.75)

The chart shows a breakdown of costs as reported in the ITT for a 60 minute visit. There is only one provider (10) not paying the national living wage as an hourly rate (see pink bars). Only one provider (4) is paying the London living wage.




If the local authority insisted that providers pay the national living wage, here are the additional costs the local authority would incur per hour, by provider. We have assumed that NI, pension, holiday and sickness costs would increase in proportion to the increment in hourly wage. We do not know the number of hourly contracts given to each provider so cannot calculate the overall cost.

**Additional rate per hour the local authority would need to pay to meet living wage:**

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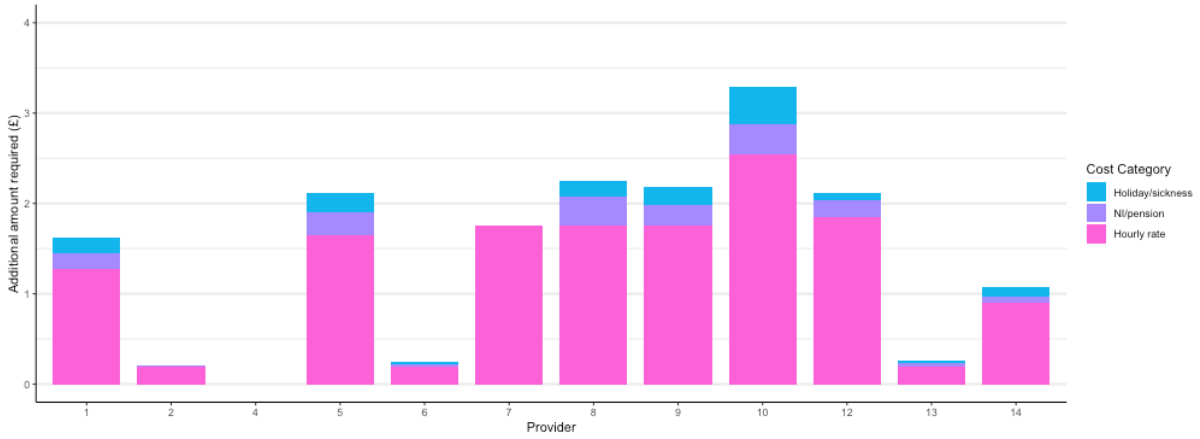
**Additional rate per hour the local authority would need to pay to meet London Living Wage:**




According to the homecare tender data only 1 provider was paying LLW, since then interviews have noted that more providers are paying their care workers the LLW. Some feel that increased COVID related costs mean LLW seem unlikely. Management costs, office space and profit being the largest three costs above wages. A median average increase of £1.75 is required for all providers to pay the LLW (plus an additional £0.38 to cover NI/pension/holiday).

UKHCA has published its annual Minimum Price for Homecare a research paper currently stating that “£25.70 per hour from April 2021 allows full compliance with the London Living Wage and the delivery of sustainable quality homecare services to local authorities and the NHS.” None of the providers are charging care at this rate and if there was a rate increase of £2.13 (£1.75+£0.38) for all providers then still none would be near to the UKHCA’s London minimum price. They would not even be close to the £21.43 put down as the UKHCA’s minimum price for providers nationally outside London.

# Issues faced by Providers

This section draws together the feedback from interviews with homecare providers.

## The constant need for recruitment

When interviewed providers felt that the constant need for recruitment was one of the biggest challenges they faced. The costs to recruit, train and induct each new care worker was estimated to be about £1k. With up to 40% of management time being spent on recruitment.

The large numbers of providers mean that staff often move from provider to provider. Skills for Care records show that for the local authority in question 81% of those who left a care provider remained in the sector. Providers told us that staff would often move either, when the opportunity arose to increase salary with a competitor; or when staff faced disciplinary action following incidents, then they tended to resign knowing they could quickly get a job elsewhere.

The Care Certificate, although created to be a “competency passport” to remove the amount of induction required to train care staff, is not accredited. Concern how to demonstrate proof of competency to the Care Quality Commission (CQC) most providers ask care workers to complete the Care Certificate anew when they start.

## Struggling to create career progression opportunities

On average 85% of care workers are on zero hours contracts, nationally this figure is 50%.

Positively, this means care workers can flexibly work more hours to raise their overall pay. Although, in comparison, supervisors often have set hours without the opportunity to get additional pay. This means in practice promotion would often result in lower wages. So to increase their take home pay, most care workers would rather move on to other providers than try to progress in their existing organisation. Negatively, many staff work for long hours, but only get paid for the time spent on calls. Travel time is paid as a rate per visit, usually below £2. One example provided was that a care worker would do a 14 hour day and only get paid for 8 hours of visits.

Providers said staff will often want to progress to work at ‘extra care’ or care homes to reduce their travel. It is more regular, structured work and does not involve poor weather conditions or risk of street crime.

Providers wanted to see creative ways of commissioning that moved away from task based packages and pay per call rates to reduce the reliance on zero hour contracts. But also help them find channels and ways to offer their staff the opportunity to progress in the health sector.

## Risks are too high for some to manage

Providers told us how staff, concerned over the level of accountability, can move into roles around the same rates of pay in other sectors such as retail because of the lower risks involved. From an individual's perspective, negligence in care duties could result in death and imprisonment for failure to follow instructions – a risk they could face at each care visit. Whereas in retail these risks are much more unlikely to happen and even then with much less frequency.

There is also a sizable group with each organisation's recruitment process who reportedly will go through the expensive induction stages, then resign when they realise the realities of the difficult and at times unpleasant parts of the role.

Providers had some suggestions about how to help staff feel confident in managing the risks. Providers who provide staff with Level 2 and 3 Health and Social Care, reported they had a much more satisfied and confident workforce. Other providers had mentoring schemes to build confidence and competence.

Another area of concern was the disconnect between care workers and health professionals. Care workers are taught they are the eyes, ears and hands of social services and health professionals. If there is an area of concern they need to contact the GP or pharmacist to address the area of concern. In reality care workers don't feel empowered to call GPs, (or have the time to wait on hold) they ask their managers for support, who often speak to GPs. However, with the COVID pandemic moving many GP surgeries to become only accessible via online forms (e-consult), providers have said it has become almost impossible to get a response from GPs. Meaning issues are handled more and more when they become crisis acute problems handled by emergency services.

With Local Authorities and the CQC reviewing and critiquing the care plans, providers said they wanted the local authority to increase sharing information with providers. Some packages commissioned by social workers had little information beyond 'provide personal care' and so it was hard to negotiate with the customers at times what was and wasn't considered personal care. Providers wanted a steer as to the level of risk the local authority was happy with. Care plans with complete step by step instructions for a 15min visit could easily be longer than 50 pages, which would realistically be unlikely to be read on each visit as per CQC expectations.

Providers also felt that training costs in specialisms were often prohibitively high. Providers also wanted to have the reintroduction of training provided by the Local Authority, especially with regards to areas that may lead to career development for the care worker.

## Transient Workforce

Providers report a 31% turnover rate. That's more than double the national average. In the 2017 Associated Retirement Community Operators annual conference one provider stated that it had calculated that, based on their high rate of turnover they were projected to have employed everyone within the country by 2023.

Many providers told us that care workers would often move to another provider than face the consequences of an investigation following an incident. Since the likelihood of incidents are high, such as medication recording errors, a large number of staff move from provider to provider without learning from their mistakes.

# The short-term impact of COVID

As well as the themes set out above, we uncovered some specific reflections directly flowing from the experience of how the pandemic has played out in the care sector. It seemed critical to take these points into account as context for the other themes, but also as context for future interventions.  COVID resulted in a stress-test of health and care providers beyond many expectations and it is critical to understand where the strains of the situation have been felt most acutely.

## Embedding and building on positive changes

Providers were keen to point out that they were able to remain resilient during this pandemic. They reported that staff felt an increased recognition from the general public for their work, but wanted to see that translate into better conditions. One example given was asking the local authority to provide the same reduced travel and parking costs that nurses receive.

They also appreciated how the Local Authority was supporting customers (those in receipt of care packages) well-being by sending out communications about how to cope in the crisis, they felt the knock on benefits of this and asked the Local Authority to provide more well-being communications.

## Practical impacts to tackle

However, care providers also felt there was a lot of learning that could be taken from the handling of the COVID response.

Many noted a reduction of care packages, which was impacting staff retention, with many newly recruited staff moving on because of the lack of work. One provider noted how they were two years into their contract, and had only had one care package.

The increased costs with PPE have made protecting staff difficult to manage, some even having to buy from Amazon at large mark ups. Some providers felt they had sufficient support with PPE, while others felt they had less support. It was felt that some providers, even in the same tiers, had a prefered relationship than others and the COVID crisis was increasing the divide.

## Covid aftermath questions

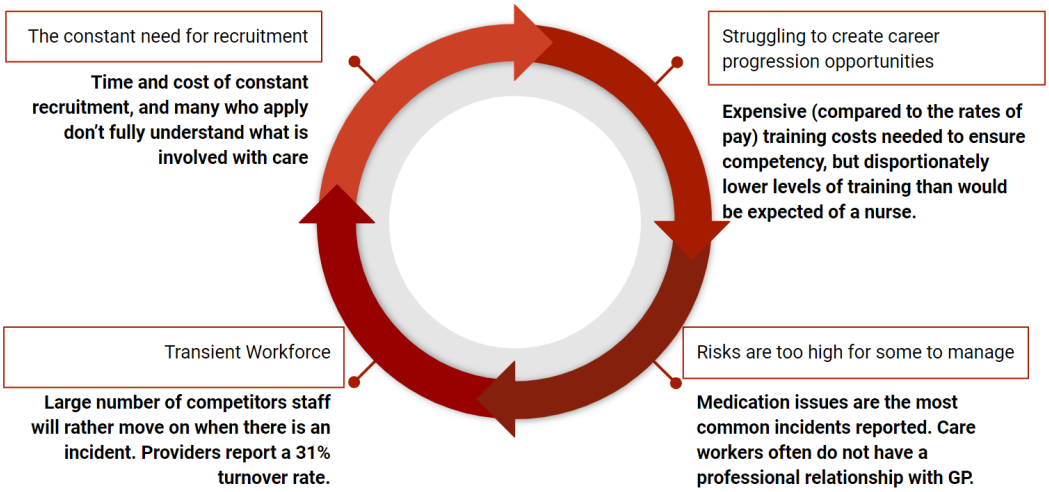
They also noted an increase in expensive ‘Crisis’ packages, where people are not assessed until they are in the community, with the package often cancelled after a few weeks. This can be an expensive process for the provider as when they take on a new customer they have to undertake the care planning and risk assessment stage at this point. Providers were concerned that Crisis packages were becoming the norm. Traditionally this sort of package would be handled by a reablement service provider, but has shifted into the purview of the care provider.

Following on from this, a long-standing issue, which has been exacerbated from the pandemic, was the frequent disagreements between social workers and mental health teams as to who would be paying for the package. It was felt that work could be done to get both teams to work more efficiently together.

Providers also noted that Long-COVID was increasing demand for care in other locations and were interested in seeing how this would have a long-term impact for the sector.

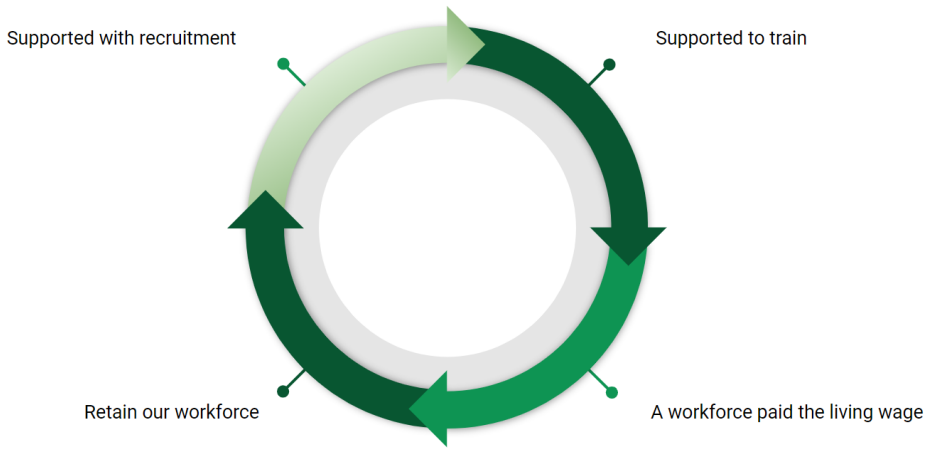
# How do we break the cycle?

Most of the issues care providers face are compounding the other issues and providers feel like they are trapped in a vicious cycle.




The high cost of recruitment and induction means that organisations managers' time is taken away from oversight of the care delivery. It also means there aren't enough resources to provide impactful training that builds competency, most care workers have to shadow other care workers to build confidence. Interpersonal dynamics of remote working with peers has a huge impact on job satisfaction, but also on establishing working standards. The lack of training results, pressures on time and skills of carers results in errors, with medication errors being the largest area of safeguarding reports being made. With the large number of providers and no central register, care workers will often prefer to move to another provider than face the consequences of a safeguarding, or will move into retail or hospitality. Which leads back to the need to recruit.

However also the interlinked nature of this cycle means that gains and progress in just one area can reduce the stresses in other areas. So you can turn the vicious circle into a virtuous one.



If we could get care providers to feel supported with recruitment and reduce that resource burden, then they can focus on upskilling the staff, which reduces risks, and increases competencies. When a staff is confident, paid a living wage, and feel they have an opportunity to progress in their career then they are less likely to move on to other providers or out of the sector.

# Interventions to break the cycle

Providers had a number of initial thoughts about how to break the cycle and they included:

- Changing commissioning to outcomes based per person rates, with minimum levels of care being included in risk assessment. This could help providers find a way to reduce the use of zero hour contracts to below national level of 50%.
- Hold provider forums which providers felt empowered to raise concerns.
- Reinitiate the provision of training in specialist areas.
- Increase rates.

Providers realised that these were not quick fixes, but required large conceptual changes to the way care was delivered and provided. It was also realised that support in one area would reduce the pressure, but it would build up again in other areas and maybe a whole system approach to care commissioning and provision would be needed.

In order to start the conversation with providers as to what it would take to change the circle into a virtuous one we held a workshop with providers. We considered a number of interventions related to the issues facing care providers to gauge their reaction and begin discussing what would be feasible and relevant to local providers. The scope of the interventions were a systems approach, with some suggestions relying on third parties or other stakeholders to enact them.

## *Look at supporting a provider alliance for North East London*

Through Covid-19, many providers are collaborating informally, to support one another and share learning. There is an opportunity to build on this, to improve recruitment and retention, enhance services and strengthen collaboration with health.

Providers noted that in other boroughs there is a sense of more transparency and greater dialogue. They felt this was lacking in comparison to the local authority and felt that a provider alliance could help bridge that gap and help speak for providers. However, there was a concern about competition, so it was suggested any provider alliance be a voice for the whole North East London patch, rather than just one area.

Forums do exist, however, there may be a need for a sector-led group to support sector development, such as the newly formed Carer Providers Voice group.

## *Engage with new digital care record providers beyond CM2000*

Administration of home care is moving from paper based to digital and smartphone first. This is reducing back office costs and increasingly supporting quality. Many are using these systems for billing and increasingly for scheduling appointments.

Providers told us the local authority exclusively uses CM2000, which has limited functionality. Providers are increasingly interested in the potential of new systems.

## *Look at new approaches to sharing home care packages with the market*

Providers noted that the way they work in other local authorities was popular. In one local authority they get new packages to come online for every provider to consider 4 times a day, providers are given time to consider if they want the package. Information provided outlines the type of client, including basic needs, the postcode and times of care commissioned. This helps the providers to schedule packages based on geography and cut down on travel time. Providers felt the local authority approach, of direct calling providers and decisions needing to be decided then and there, doesn't allow for this type of consideration resulting in a more chaotic approach.

## *Look at expanding access to training through collaborative provision*

Some local authorities have commissioned academies that provide care workers access to training, a research hub, and information about career progression. They offer basic qualifications and additional qualifications to help staff progress their careers. They also offer management and leadership training.

## *Use innovation to enhance quality and career progression*

The group talked about Care City's work, using training and digital technology to enhance care work and create progression opportunities.

Providers noted how there can be friction between care workers and nurses about handling issues during a nurse's absence. Nurses may wish for care workers to help them do things, such as change a dressing, but the care workers are not trained to do so, and the insurance won't allow them to do what is considered nursing care.

Providers like the concept of new tools and new roles, such as enabling Nursing Associate roles within social care. Many staff view this as an attractive career opportunity, and many have shown interest in the project. It was also felt that this would help reduce hospitalisation. Many providers would like to have a nurse on their staff, but often can not afford the cost. These benefits were hoped would help them to have greater discussions with commissioners because of the increased value of their service.

## *Review providers' suggestions in relation to outcomes-based commissioning*

Providers expressed a preference for outcomes based commissioning, where they could focus on rates for individuals rather than time. Currently, many care packages remain unchanged throughout the length of the package and there is little business incentive for providers to end support for their customers. If care providers were working towards outcomes then they would be reporting on progress made and unnecessary packages could be discontinued or moved on to personal assistants. If providers who were the most effective at improving outcomes became preferred providers and then this would act as an incentive,

as compared to the standard practice where there is no incentive to support the customer towards ending their care needs.

**The scope of this research mainly focused on paid care providers, the work did not focus on personal assistants and the role they could play and impact they could have, but we feel this is worthy of greater investigation.**

## *Additional ideas*

There were also some recommendations that came up from the discussions which may be down to policy decisions for commissioners:

- *Provide those receiving care, communications to support their wellbeing. Information could be sourced and developed with care providers as part of the provider forum.*
- *Facilitate increased partnership between social workers and mental health teams through management processes.*
- *Extend the free/discounted parking permit scheme for Nurses to include Care Workers.*

# Recommendations

***Based on the research reported here and wider work, Care City made a set of recommendations for the local authority in relation to improving pay in the homecare sector. These recommendations draw on the research featured here and a broader set of Care City projects focused on enhancing social care. Although tailored to the local authority in question, broader recommendations have been made for wider consideration.***

Care City believes that in the short-to-medium-term pay can only be improved through a comprehensive approach to strengthening the local social care sector. All stakeholders need to consider how they might be able to invest in the :

- Services users
- Staff
- Sector

## *Investing in Service Users - Prevention*

There is a huge pressure on social care budgets. However, lots of low-level demand for paid care entrenches a model of care as high-volume, low-skill, low pay work.

- We are still in the early stages of realising the potential of **digital care technology** to help people to remain independent in their own home and to delay or reduce demand for homecare. This situation is mirrored in healthcare, where growing numbers of clinical leaders would like to be able to deploy technology into people's homes, but lack the infrastructure through which to do it.

  **Progress work to unlock the full potential of care technology, using quality data to understand its impact. Work with leading homecare providers to understand the relationship between care technology and the week-to-week need for paid care. Collaborate across East London, to evolve shared approaches, enabling system-level partnership work with health colleagues around the deployment and use of technology in the home.**

- Local authorities need to collect and review **data** when making decisions**.** Even so, we are still learning about the relationship between frailty and its progression and demand for social care. For the NHS, identifying frailty and pre-frailty and intervening to allay its progression is a growing priority (for example, through the Older People & Frailty Transformation Board).

  **Engage closely with this work and understand its potential impact on demand for social care.**

## *Investing in Service Users - Quality*

Once service users are receiving homecare, there is a great deal that homecare can do to allay demand for care homes and for healthcare.

- Care City has developed an **enhanced model for homecare**, focused on spotting early signs of deteriorating health. It can be a challenge to spot decline in health, and carers don't feel empowered to speak to health providers. Expert Care involves training domiciliary care staff to effectively use simple diagnostic tools, helping them pass on accurate information (NEWS2 score) to primary health clinicians. Expert Carers use Whzan to record vital signs, reporting to a cloud triage system. Whzan also enables care workers to measure temperature, blood pressure and pulse and other Bluetooth enabled devices can be added.

  **Build on Care City work to secure CCG investment into Expert Care to make this model business as a model for healthcare.**

- Reablement and rehabilitation is an opportunity to uncover shared interests between the healthcare and care systems. For example, Care City is prototyping an Enablement Champion role, a Level 4 apprenticeship for senior care staff, helping them to learn the skills to support fidelity to healthcare plans, including for people recovering from Covid-19. This is an opportunity to retain the best care staff, support modest wage growth and ally demand for nursing home care.

  **Work with Care City to continue to look at the future of reablement, and its potential to support the health of service users, enhance care quality and build new career opportunities for care staff.**

- As we heard from homecare providers, there is tension between care home staff and district nurses about tasks such as wound care, which are time-consuming for district nurses and well below 'the top of their licence', but which care staff are not supported or insured to perform. In partnership with the local authority and many others, Care City is prototyping a model for supporting Apprentice Nursing Associates and Nursing Associates within care settings with no nurses.

  **Work with Care City to explore the potential for the Nursing Associate role in care, both to transform career opportunities for care staff and enhance access to healthcare for care home residents.**

## *Investing in Staff*

- Care is a tough job, physically and mentally. Enforced retirements amongs care staff in their fifties is high, even though these are the experienced staff that providers want to retain. A 2017 study of suicide found that the rate amongst care staff was twice the national average. We know that Covid-19 has been very tough for care staff, too, as it has been for health staff.
  In healthcare, as part of Covid-19 recovery, work across East London is looking at improving occupational health support and ensuring all staff have good access to this support, including through digital tools.

  **Local authorities should work together at an East London level to ensure that this work seeks to enhance occupational health support for care staff as well as health staff, exploiting economies of scale.**

- Providers talked about parking rules and costs as a significant issue for staff and providers, with margins of time and money so tight. There was some discussion about the range of in-kind benefits locally for care staff that might significantly improve their experience of work.

  **Look at in-kind benefits for care staff - including parking - and see what more the local authority can do to enhance their experience of work, beyond their salaries. Compare these in-kind benefits to those available to health staff.**

- Alongside pay, part of the challenge in social care recruitment is about prospects. There is a notional career path to become a manager and perhaps even an owner of an agency, but this path is only motivating to a few, and is taken by even fewer. As care changes, a new career path based on growing expertise is becoming visible, through Level 4 apprenticeships to roles like Nursing Associate and Rehab Assistant.

  **The local authority should tell this story of career opportunities in care. They should seek to embed this career trajectory in the work of the emergent BHR Health and Care Academy, connecting directly with social care staff to build aspirations and help them to be realised.**

## *Investing in the Sector*

- The local authority is already exploring what more it can do to provide business support to the homecare sector and to explore the potential of a range of different business models.

  **The local authority should continue to support the development of homecare businesses, and to work with external partners to look at options for strengthening and improving these businesses. Where possible, the local authority should seek to do this work in a way that connects to the wider work - described above - to strengthen the services homecare agencies provide to service users.**

- The points made by agencies in the course of this research about opportunities to come together with other providers and ensure their voices are heard by leaders and commissioners are important. Similar feelings have been expressed across BHR, and have prompted the creation of Care Provider Voice, a collaboration of providers across BHR, brought together for this purpose. This is important in its own right, and potentially vitally important in enabling systematic approaches to raising quality and pay, and to collaboration with health.

  **The local authority should engage with the growth of Care Provider Voice, and - if it proves successful - consider how its own governance might include appropriate dialogue with this group, including about pay and conditions.**

- In the longer-term, raising quality and support for the health of service users relies on a wider digital infrastructure. For example, Care City is collaborating with Birdie and

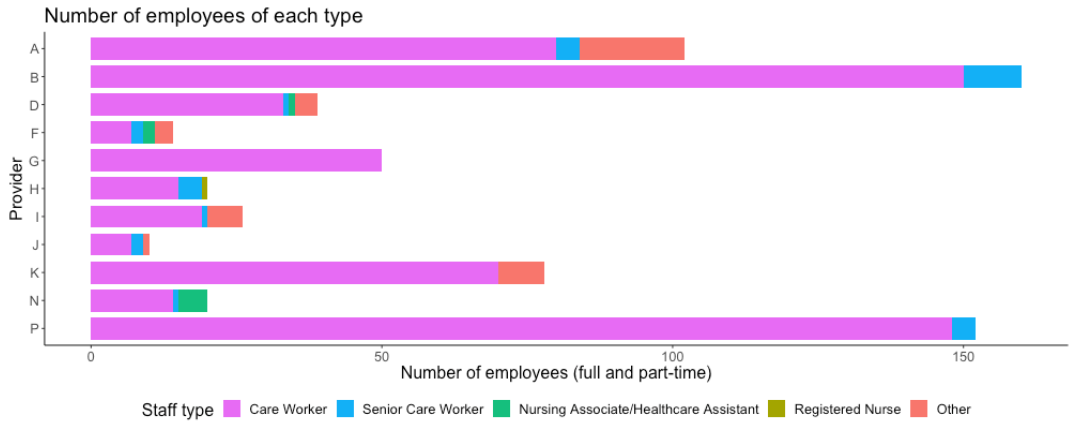
Satalia (a world-class UCL spin-out specialising in AI optimisation) to create a leading scheduling application for all healthcare at home, capable of helping care staff and district nurses collaborate better.

**The local authority should look at how common platforms around scheduling, reporting and data-sharing could help to enhance quality in care and collaboration with healthcare. They should reflect on how this learning could be embedded in future commissioning rounds.**

Improving pay in the homecare sector is a complex task. Neither commissioners nor providers can simply decide to increase pay. The challenge is to grow a stronger homecare sector over time, by investing in services users, staff and the sector. Care City argues that establishing homecare as a platform for better preventive health is one way to do this. In the process, social care can simultaneously improve the lives of homecare staff and recipients *and* play a pivotal role in integrating health and care.

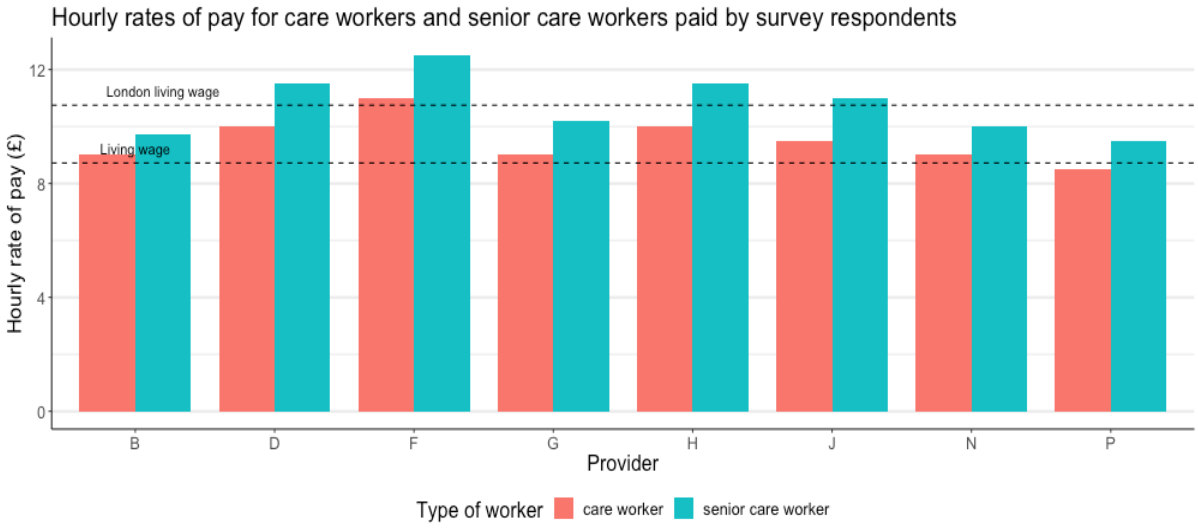
# Appendix A: Additional Research findings

There were some other points of interest highlighted by the tender for provision of homecare documents that were submitted in the summer of 2019.

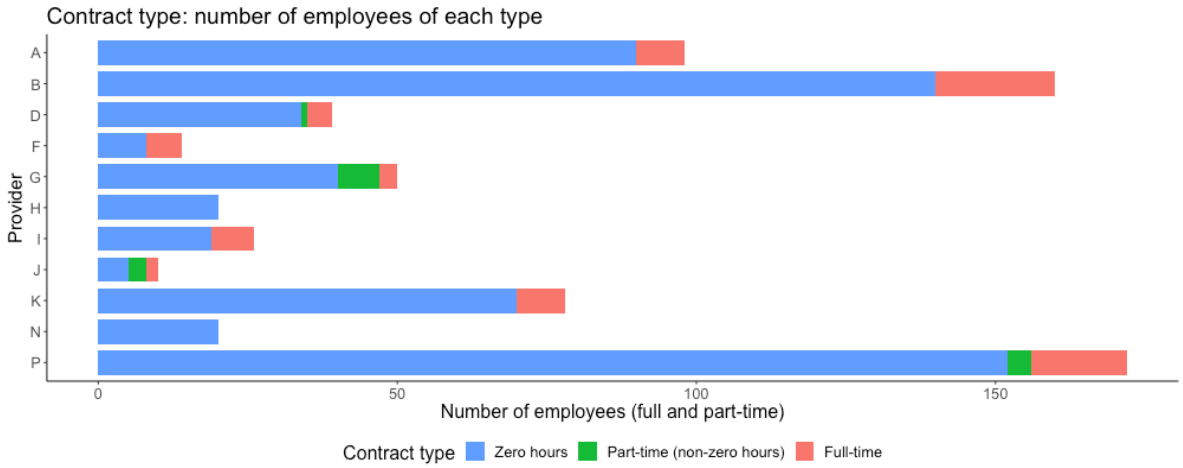



This chart shows the mix of employees in each organisation. F and N are notable for being small organisations with nursing staff.

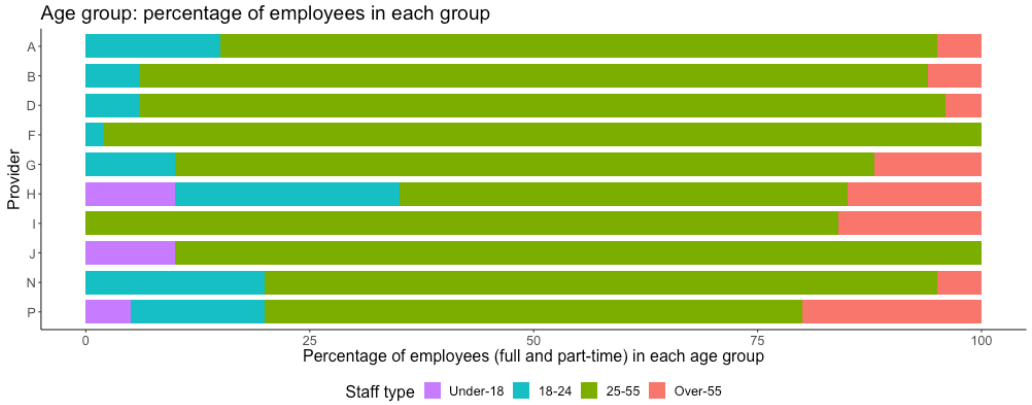
This chart shows the hourly rates of pay for care workers and senior care workers, as reported by the survey. P pays below living wage for care workers. D and F pay above the London living wage:



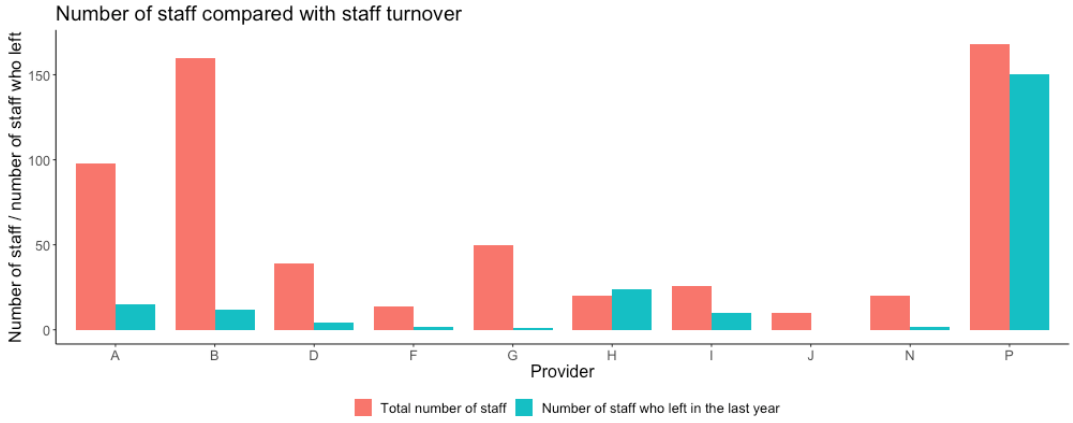
The vast majority of workers are on zero hours contracts. The Adult Social Care Workforce Data Set shows that 83% of the workforce are on zero hour contracts. This is lower than the average in the survey results, which report 87% of staff on zero hour contracts. In comparison the national average is 50%:



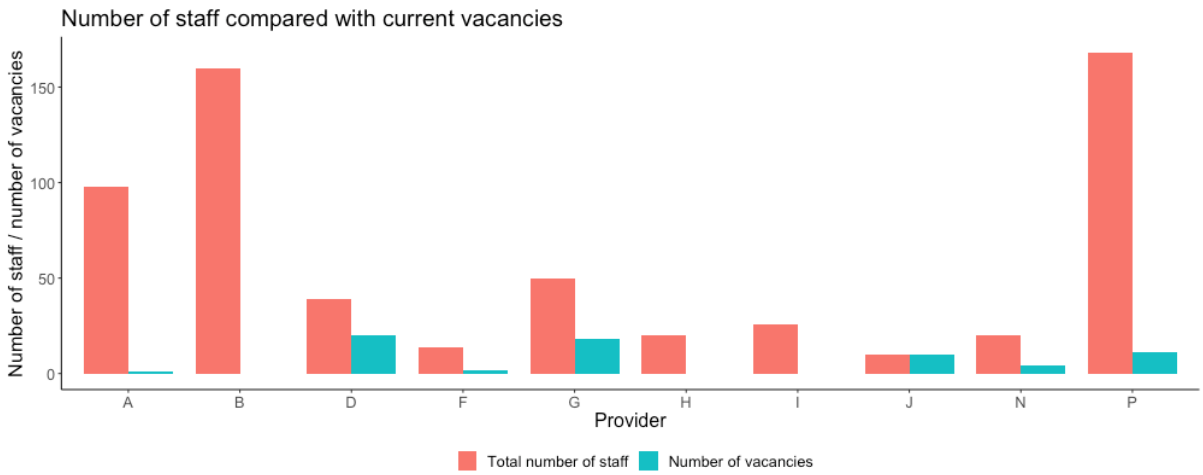

The Adult Social Care Workforce Data Set shows a very similar breakdown to those surveyed. They also note that the average age is 43. with 81% being in the 25-54 age bracket.



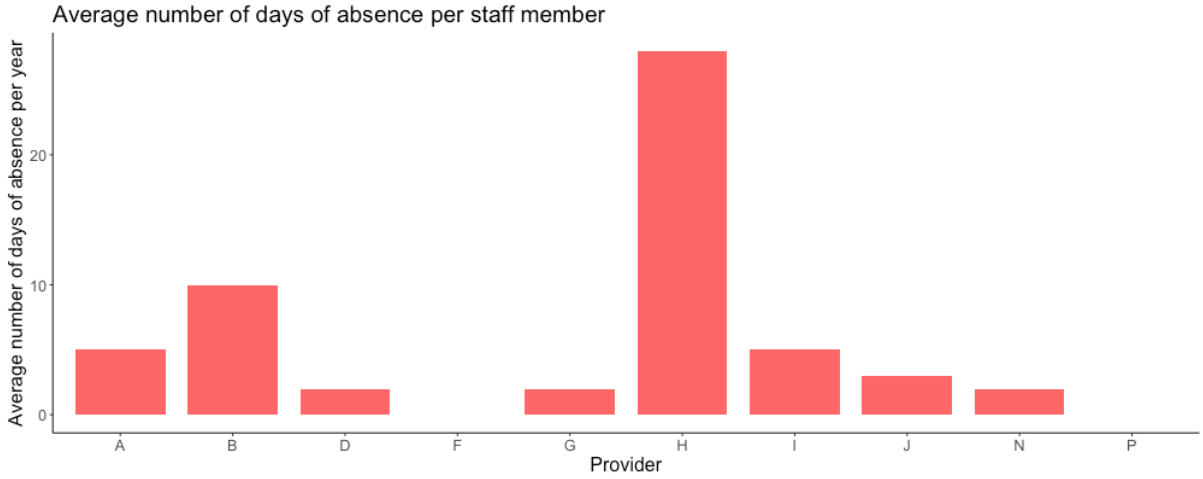

The Adult Social Care Workforce Data Set shows a 28.9% turnover rate in 2018/19 which is close to the survey response of 31%. 81% of those who left remained in the sector.




The Adult Social Care Workforce Data Set shows a 4.7% vacancy rate in 2018/19, whereas the survey response was 10%.




The Adult Social Care Workforce Data Set shows the average number of sick days is 1.6. This is similar to the median number of absences in the survey - 2 days. The average in the survey is much higher due to two organisations with large numbers (28 and 10 days).



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