PSSRU

Personal Social Services Research Unit

University of Kent

Drivers and barriers to social care supply: Evidence from two local authorities

Executive summary

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Overview

- This report looked to assess the drivers and barriers to supply of social care in two local authorities, Bristol City Council and Kent County Council. The former is a unitary authority and the latter is a two-tiered county council. Both local authorities have areas of high wealth and deprivation.
- The initial draft of this report was written in late 2018 and the final version remains as if the adult social care and wider landscapes remain unaltered from that time. Ultimately, many changes have taken place, not least developments from the Covid-19 pandemic. The impact of the pandemic on these findings will be discussed elsewhere.
- The broad approach of the two local authorities, as elsewhere, is to reduce the reliance on care homes by encouraging the development of extra care housing and supporting people to live in their own homes.
- There is a wide range of social care services available in Bristol. As of February 2018, BCC spends almost £1.4m a week supporting nearly 3,200 older people with adult social care (£1.2m per week on over 2,300 working age adults), the vast majority of this (over £1m) being spent on supporting around a third of the total older people who are living in residential and nursing care.
- Kent has a large supply of adult social care, but availability of types of care can vary by location. Additionally, KCC provides enablement services in-house. In 2012-13, KCC supported over 34,000 adults, with two-thirds of these being over 65.
- Ten face-to-face semi-structured interviews with sixteen stakeholders in Kent and Bristol took place from October to December 2018. These included the Director of Older People and Physical Disability from KCC and the Head of Adult Care Commissioning from BCC. At provider level stakeholders from care home, domiciliary care and extra care housing providers were interviewed, and these included a range of local, regional and national providers.
- The interviews covered five key themes: demand, supply, staffing, relationship between providers and other stakeholders, and Extra Care Housing.

Demand

- There was a general view that those being supported by social care provider have much higher needs levels than compared to the past. LAs are seeing an increase in the needs levels of vulnerable adults, which has long-term implications for costs. However, providers also stated that with increasing needs levels, staffing needs to increase to support this, and that the pressures on staff were much greater.
- Self-funders pay more in Bristol and Kent – for Bristol can be almost double the LA rate in care homes and around £4 an hour higher in domiciliary care. A care home provider we spoke to in Bristol had only recently felt compelled to charge self-funders more following the introduction of a ceiling price by the council.
- In Kent it was strongly felt that the price that the council were willing to pay was very much determined by the level of supply in the area. There was also difficulties for providers who have rooms of different sizes and quality which meant that an indicative price given to prospective clients might not reflect the actual cost for certain rooms.
- Providers need to maintain occupancy or service-user levels in home care which means they are taking LA-funded residents or service users. In practice, some were genuinely concerned about their viability if they continued to be reliant on LA-funded residents.
- A preference for private payers was sometimes linked to the increased admin burden and time delays in receiving payment associated with dealing with LAs across providers.
- Even though BCC had main contractors for home care in Bristol, other home care providers felt there is still a place for them in the market, but that to survive they would need to increase their focus on self-funders if possible.
- In both Bristol and Kent the price paid was felt to have implications for quality delivered.
- In homecare, it was felt by smaller providers that accepting low prices and losses can be sustained short-term by larger, national, providers but that this would have implications for quality. For homecare, quality will be driven by the staff employed, so growth can also lead to problems with quality.
- Similarly in care homes, there was reference to higher care home fees being paid for a time by BCC which was then put to be used to improve standards and increase staffing levels, and in Kent it was acknowledged that low fees meant that standards had to be cut back somewhat, i.e. both general upkeep and the potential for investing in big renovation projects is reduced.
- Providers in general are using (any) higher fees to drive up quality and not profits.
- The CQC quality rating was seen as important. It was seen to be generating a need for continuous improvement in some providers, and it also was seen by some to be promoting positivity for the domiciliary and care home sectors overall. There were some worries over getting a lower rating over individual cases of personal error, where one mistake does not reflect the overall service.
- The rating does not necessarily impact on demand for care homes to a large extent, where it was generally felt that the key thing is the visit. There was some feeling in Kent that many were not aware of the CQC.
- It was felt that the impact of the rating may also depend on levels of competition. For example, a provider in Kent referred to another care home in a rural location that seemed happy to have a Requires Improvement rating as they could still charge a self-funding level of price and had no vacancies.

Supply

- There can be problems with the availability of supply, and particularly so for Kent, which is much larger. For Kent, there can be problems in certain areas with supply of provision for LA-supported service users, particularly care homes. For example, in West Kent there is a high level of affluence and so care homes can concentrate on demand from self-funders.
- In Bristol, difficulties can arise in provision where affluent wards contain the supply of provision then neighbouring poorer wards cannot afford the provision (e.g. for extra care housing). There was also a suggestion of an undersupply of residential care in South Bristol from a care home provider, with other areas in Bristol having stronger levels of competition.
- Market size can be very small. The home care providers we spoke to had specific market areas in Bristol, but many will work Bristol-wide. Care homes had relatively small markets where demand came from, based on

previous location of resident or the location of their family. There could often be a border issue, e.g. someone living on the outskirts of Bristol in South Gloucestershire would not necessarily want to move in to a care home in Bristol, and vice versa.
- Expansion is not straightforward. One home care provider would look to do it if the volume of demand was there, but it would also depend on the area. Certain parts of Bristol, e.g. with one major road, were gridlocked at key times when care services are required. Growth can also lead to problems with quality in home care, as employing more staff then it cannot be guaranteed that it is the right staff.
- The supply-side of the market is greatly affected by staffing.

Staffing

- There is a core of staff that will stay with a provider over a number of years. However, for domiciliary care in particular, there is a lot of job hopping.
- The national living wage has driven up wages at the lowest level but has compressed the wage distribution across levels of seniority. One care home provider now paid the same wage for carers irrespective of qualifications, but qualifications were still seen as to stand staff in good stead for future progression.
- Pay for staff for most providers was tied to the rates paid by local authorities. KCC had helped with recruitment to some extent by putting extra money in which had gone specifically to domiciliary care staff.
- Training and progression was seen as important by some providers, and can encourage retention. The costs that providers faced in supporting staff in training and qualifications was seen increasingly as a difficulty.
- There can be issues for Kent with staffing in certain areas of the county. This can be for certain forms of care, e.g. affluent areas harder to recruit for domiciliary care, less affluent areas harder to recruit staff with appropriate skills (e.g. nursing), and areas neighbouring London and Medway find more difficulty recruiting with greater competition.
- Increased health and social care funding (e.g. Better Care Fund) did help to reduce these problems as KCC were able to put money directly towards increasing pay for domiciliary care workers (paying for travel, time to travel).
- In Bristol, staffing is a concern, but seen as more problematic in neighbouring LAs. There was also a suggestion that providers can take advantage of the large student population in Bristol.
- There are large seasonality and timing issues for staffing. Providers find it difficult to recruit around Christmas, and also summer holidays as lots of single mums are involved in the market. For this reason, finding staff for times outside of school hours can be difficult as well. Additionally, Fridays and Mondays can be difficult to staff if providers require staff to work one day on the weekend. Night staff are also difficult to recruit.
- These issues naturally put more pressure on the core staff that can be relied upon to be available to work the difficult hours, and can lead to burnout and losing staff, particularly as providers could not pay more to reflect this effort.
- Additional money to ease winter pressure was welcomed in Kent but felt that there was a lack of planning around this. Just putting money in to the system at very short notice, and subsequently withdrawing it at the end of winter, will not help to solve the problems and it was assumed that the level of staffing could just rise and fall at the appropriate times.
- Staffing may be more difficult for certain care homes based on location. For example, more rural homes may restrict potential recruits to those with own transport.
- Brexit will have implications for at least some providers.

Relationship between providers and other stakeholders

- Providers understood and accepted the general approach of their respective LAs to focus on care at home and in the community, but it was seen more as a means to cost-cutting than enabling local residents.
- Communication was seen as improving in Kent and deteriorating in Bristol. Bristol had seen a lot of change in the pricing of care and former partnership arrangements had been abandoned leaving providers feeling like they had little voice. In Kent, a new tender for community services was co-produced by way of feedback and there was

increased consultation. However, there was also a concern in Kent that the LA lacked the resource to achieve their strategic vision.
- There was a general concern in Bristol that private sector companies are misunderstood and that there is a preference for LAs to work with voluntary sector providers. The private sector in social care is generally looking improve services with any increase in fees.
- The quality rating system of the CQC was seen in a positive light, although with some concerns around how a provider's rating could easily fall based on a single case of personal error (see Demand above).
- Providers mentioned the (sometimes large) rise in fees to be paid to CQC. In some instances the cost had tripled for domiciliary care providers given it is based on number of service users receiving personal care.
- Consistency of inspectors was seen as useful, and potentially cost-saving for CQC where one inspector could inspect a providers' group of homes in an area where policies are consistent across homes.

Extra care housing

- The detailed information on extra care housing was drawn from providers in Bristol.
- Demand for extra care housing was strong, although the one provider had experienced an increase in voids, which was attributed to administrative factors rather than a fall in demand.
- A change in eligibility criteria for people nominated by the BCC had resulted in an increase in the level of needs among residents, but not necessarily an increase in the number of care hours required.
- Changes to the commissioning arrangements had led to a greater focus on a time and task approach, similar to that employed in domiciliary care. This had created more rigidity, and made it more difficult to finance the provision of 24-hour care, a central feature of extra care housing.
- Staffing arrangements were generally less difficult than for domiciliary care, partly because staff were based at a single location. However, low wage levels and alternative forms of employment affected staff recruitment and retention.
- Both providers operated a range of types of support for training and career development, and since they managed services in a range of locations, it was possible for staff to transfer to different roles within the organisation.
- Some CQC inspectors and health service staff demonstrated a lack of understanding of the role and contribution of extra care housing, and there was a need to engage with other agencies to promote the role of the sector.

Conclusions

- Both Kent and Bristol face similar drivers and barriers in the supply of adult social care, but the issues facing the former tend to be on a larger scale given their respective sizes.
- Needs levels are increasing in social care, which has implications for supply, workforce and funding. Quality is driven by price, as are staff wages, and markets tend to be relatively local.
- Cooperation between stakeholders is important and the future success of adult social care markets will depend on good communication and co-production between all involved.
- This was a small-scale study with no scope to gather views from those who use social care services nor other national organisations (e.g. CQC). This report is therefore likely to offer a fairly one-sided, provider-focussed, narrative on what drives and inhibits adult social care supply, although their views do correspond with previous research.

Full report available at: https://www.pssru.ac.uk/publications/pub-5848/

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