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Adult Social Care Local Authority Commissioning Behaviours

Laura Jefferson, Julia Cream, Yvonne Birks, Karen Bloor, Richard Murray

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Key messages:

- By themselves, the fees paid by Local Authorities (LAs) tell you very little about the role, influence or objectives of a commissioner local context is key to understanding whether the rates reflect strategic intent. Wider factors beyond the control of the commissioner that appear to translate to higher or lower fees were: lack of supply (higher fees); affluence of an area (higher fees); deprivation or poor local economy (lower fees); longstanding contracts in place (higher fees). Commissioners also offer providers benefits through in-kind support, which can represent a substantial investment not reflected in fee rates.
- Financial context dominates commissioning decisions, with LAs challenged to do more with less
 over recent years, as the needs of the population increase and funding has decreased. This has
 led to greater emphasis on promoting independence, through effective reablement out of
 hospital and increased focus on domiciliary care. However, many commissioners also highlight
 the requirement to reassess users' needs in a bid to 'ration' the quantity of care provided.
- While most LAs had used costing models to generate an acceptable price for care based on providers' costs, there was variation in how these were adopted as those LAs facing challenges in supply were often forced to negotiate higher prices with providers on a case by case basis.
- Increased funding via the Improved Better Care Fund and Social Care Precept has been
 welcomed, but creates pressure between providers and commissioners as there have been
 misunderstandings as to how this can be used. Commissioners feel unable to raise rates as the
 funding is not secured long term, and are instead offering other incentives to providers which
 may be financial or take other forms such as free training for care staff.
- In some instances, LAs had set up 'arms-length' trading companies to operate services in house and these have tended to be developed in LAs that were paying below average fees. The reasons for this link are unclear: there are several possible drivers, including LA reactions to lower spending power, differing supply or quality of external provision locally, or differing approaches to commissioning. Further exploration may be needed as this appears to be a relatively new shift in approach to provision of services.
- Commissioners do not accept that there is a direct link between cost and quality, and they question whether higher rates paid to providers will be invested in quality-improving outcomes, such as staffing. While commissioners aspire to incorporate some form of quality assessment in social care contracts, in practice only a minority currently offer incentives for providers meeting certain standards (such as timeliness and continuity of staff).
- LAs are aware of the need to improve recruitment into and retention within the social care
 workforce, particularly in light of their Care Act responsibilities to manage the market, but are
 uncertain whether increasing fees would translate into higher wages or higher profits for
 providers.

1. Background

There is a wide variation in the type, amount, quality and cost of adult social care commissioned by LAs across England. For example, there is more than a six-fold variation between LAs in their rates of people supported in care homes, and an eight-fold variation in their provision of home care (Humphries et al, 2016). The cost per week of residential care for an adult aged 65 or over varies from less than £445 per week in the lowest 10% of LAs to more than £791 in the highest 10% of LAs in 2015– 16 (Phillips and Simpson, 2017).

Some of this variation can be explained by demography and geography, but for many areas, the degree of variation may reflect differences in policy and commissioning approach. In this report, we seek to understand better what lies behind the variation in fees paid to provide care for people aged over 65 in need of equivalent levels of support, and in particular, the role commissioning plays in determining the fee rate paid for local authority purchased care.

Commissioning practice in adult social care has undergone dramatic changes in the last five years. Reductions in LA budgets have affected *how* and *what* local authorities commission for their older populations; LAs have had a 40% real terms reduction in their core government grant since 2010 (Local Government Association (LGA), 2016). Although the scale of financial savings may have overshadowed commissioning decisions and LA strategy in the last few years, it has not been the only driver of change.

New legislation in the form of the Care Act 2014 gives commissioners greater responsibilities (Department of Health, 2016). LAs now have a duty to ensure that there is a functioning market for *all* those needing care and support in their area, not just those for whom they purchase care directly. Commissioners are expected to pursue an outcomes-based approach that promotes health and wellbeing. They are required to provide preventative services, and commission with the aim of integrating services within a whole-systems approach. Local authorities are also now responsible for 'Market Shaping' and facilitating a diverse, vibrant and sustainable market (Institute of Public Care (IPC), 2016). This research provides some insights into how LAs are approaching these new duties.

The Care Act (2014) is designed to encourage LAs to foster a sustainable care market and the guidance sets out explicit duties on how they agree a price for care:

'Statutory guidance to the Care Act 2014 is unequivocal: when considering prices paid, councils should "assure themselves and have evidence that ... fee levels for care and support services are appropriate to provide the delivery of the agreed care packages with agreed quality of care" and should understand that reasonable fee levels allow for a reasonable rate of return by independent providers that is sufficient to allow the overall pool of efficient providers to remain sustainable in the long term.'

(Chartered Institute of Public Finance and Accountancy (CIPFA), 2017).

Financial and legal requirements clearly drive commissioning decisions but it is unlikely that they explain all of the price variation we see across the county. There are other factors, including less tangible ones such as culture and leadership within a LA, which may also play an important role in determining the final price paid for care. We are interested in both what constrains - and what supports - commissioners in using their purchasing powers to shape the market.

2. Methods

Local authorities were approached to take part in qualitative interviews through a sampling strategy which aimed to generate variation in the following characteristics:

- Home care fees (including LAs in each quartile of the national distribution, oversampling below two recommended thresholds: the UKHCA (2015) recommended level of £16.16 per hour in 2015/16 and the level quoted by a large national provider as the minimum rate they would contract with local authorities - £15.91 per hour (LGiU, 2017)
- Residential care fees (above and below the LaingBuisson recommended threshold adjusted for housing costs)
- Spending power (a measure of the revenue funding available for local authority services, including Council Tax and locally retained business rates) (including LAs in each quartile of the national distribution)

Interviewees were chosen to include those with experience of commissioning in adult social care and with general strategic overview. These included Directors, Managers, Heads of Strategic Commissioning and some Directors (and Assistant Directors) of Adult Social Care.

Interviews were conducted via telephone or face-to-face and lasted approximately one hour. Interviews were semi-structured in nature using pre-defined topic guides to ensure that key topics were covered during the course of the interview. All interviews were digitally recorded and transcribed verbatim for analysis.

One researcher (LJ) conducted all interviews with LAs and associated data analysis. Consultation and discussion with all co-authors took place throughout to aid interpretation and the development of a thematic framework. Data were managed using NVivo 10 qualitative analysis software (QSR International Pty Ltd. Version 10, 2012) and MS Excel. The principles of Framework Analysis (Ritchie and Spencer, 1994) were employed; which followed the steps of familiarisation with the data through the reading and re-reading of transcripts and interview notes, sorting of the data into emerging themes and exploring relationships between themes. Findings were contextualised using quotations throughout.

The research project had ethical approval from the Department of Health Sciences Research Governance Committee, University of York.

Four national stakeholders were also interviewed by another researcher (JC) to gain their opinions about commissioning behaviours. These findings were analysed and discussed with all co-authors and included in this report to provide further context to adult social care commissioning behaviours.

3. Findings

3.1 Participant characteristics

In total, 23 participants from 20 organisations (local authorities and national stakeholders) were interviewed. The distribution of fees for participating LAs can be seen in Figures 1 and 2. As shown in Figure 2, although we attempted to sample LAs with a range of fee rates, slightly more LAs took part with residential care rates at the higher end of the national distribution.

For the purposes of analysing and describing the results, LAs were labelled as having either high, low or mixed fee rates, when compared to the national distribution (i.e. a 'high' fee LA had rates that were above the national average, although not necessarily above the UKHCA recommended threshold for domiciliary care). For the most part, LAs with higher residential care fees had higher domiciliary care fees and vice versa, although there were four LAs with a mixture of high residential and low domiciliary or low residential and high domiciliary fee rates (labelled 'LAs with mixed fees'). This reflects the national picture, where the rates for residential care and domiciliary care are correlated.

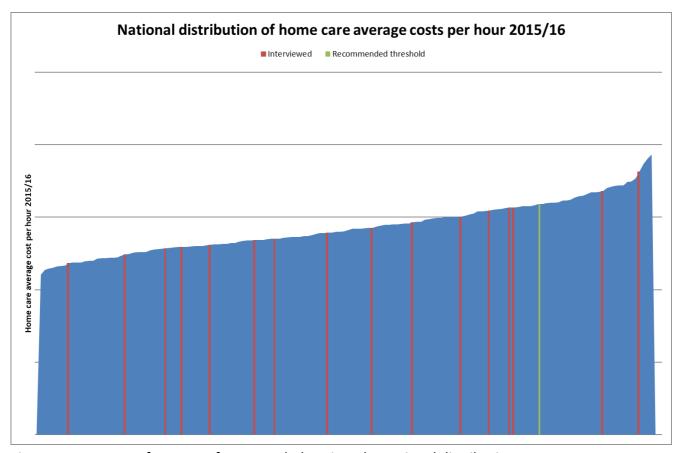


Figure 1: Home care fee rates of LAs sampled against the national distribution

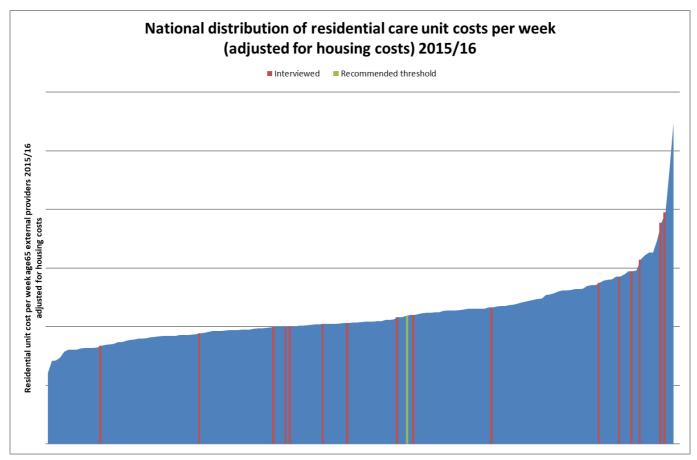


Figure 2: Residential care fee rates of LAs sampled against the national distribution

3.2 Commissioning practices and procurement

There was variation in commissioners' use of either a standardised fee set across all providers or negotiations with each provider. This decision largely seemed to relate to the level of supply in the locality (described further below). Some LAs had attempted to promote competition and diversity in the market through the use of e-marketplaces or e-brokerage to secure packages of care with providers competing on cost (and sometimes quality). Two LAs described their decision to move away from this system as they felt these had failed to provide sufficient supply to meet demand (particularly in rural areas) or had led to elevated prices, for example:

"There's been some challenges on demand so if there's no capacity out there you don't get any bids and then you're not able to place via the system so you have to step outside and there's lots of calling up care homes and asking for vacancies. There were some price fluctuations so prices going up when capacity was low... also it would take some time to process somebody through the system"

LA with lower fees (1014)

Although in the minority, some commissioners were open about how their roles had changed, largely as a result of financial constraints which meant they were not able to commission care as they would like, or in line with Care Act responsibilities:

"To be blunt, I think commissioning got pushed to one side in the bid to secure the savings."

LA with lower fees (1007)

3.2.1 Costing approaches

Almost all LAs interviewed had used some formal costing approach (e.g. open book exercises) to ascertain what would be a 'fair' market rate. One national stakeholder commented that:

"Very few commissioners will be doing what providers think they're doing – i.e. sticking a finger in the air and doing nothing."

National Stakeholder (001)

Some, though, despite undertaking these costing exercises, were still dominated by the market situation – i.e. they could not force providers to accept a 'fair' price where, for example, there was a lack of supply or competition from self-payers. These are explained in further detail in the next section.

In undertaking costing exercises, several LAs had used costing guides to help determine rates and some had invested in developing their own costing model with the support of external companies. This could be expensive, for example one LA had paid an agency £30,000 to create an analytical costing model for them using information from providers. Even then, one national stakeholder interviewed suggested that some LAs have been unable to implement the recommended 'fair rate' due to budget constraints:

"Relationships are dominated by affordability issues. One example, where Care England took the council to court when the council had done an open book exercise and then had to make a deal for less than the calculated fee – therein lies the challenge [for building relationships based on openness/trust]."

National Stakeholder (002)

Price seemed to dominate contract negotiations during the tendering process, although some commissioners also described their attempts to improve quality in local provision through tendering. Some, for example, used quality standards as part of their payment structure (described further under 'payments and quality'). Interviewees often stressed the need to achieve value for money through the tendering process, for example, one commissioner described a 'use of resources' form which providers had to complete and which enabled the LA to assess how spending was being used to improve care quality, rather than provider's profits:

"So the reason for looking at use of resources rather than price is, I could get homecare for £11.50 or £11.20, but the profit element could be more in the £11.20 and have less spent on staffing, than there is the £11.50. So what is better value to me? So price isn't necessarily what you just go off.

So to me, we look at use of... resources"

LA with lower fees (1001)

In a similar vein, other LAs had used this information about use of resources to vary pricing, particularly in residential care, depending on variation in providers' costs, such as the provider's mortgage situation:

"The reason for the [price] bands is it to some extent links with the provider's property arrangements. For example we've got SMEs, small family businesses... they'll own the property so invariably you don't see those additional property costs and therefore they tend to be able to submit prices that will be towards the lower band... the high band would be where obviously some providers are leasing their property, or they may have a mortgage so they're servicing either a leasehold or a mortgage that's then obviously included in their fee submission."

LA with mixed fees (1006)

Most LAs applied annual increases to their rates; often based on recommended increments from the Office for National Statistics, or on the Retail Price Index, and in order to reflect rises in the National Living Wage (NLW). Although fewer in number, some LAs described using an arbitrary rise, say 1%, or having frozen rates in previous years. These decisions were reflected in lower rates compared to the national average, but the LAs we spoke to were mostly now reacting to the needs of the market and NLW increases by raising rates.

3.2.2 Views on UKHCA pricing model

When asked about the UKHCA costing model and how their local rates compared with the UKHCA recommended threshold, all but two LAs thought these rates were unrealistic, did not reflect their local circumstances or were fuelled by business interests:

"I would very much love to able to pay what the HCA recommends. There's an ideal world and there's a practical world and I think the HCA probably nudges towards the impractical."

LA with lower fees (1012)

"We think there's some double counting... our accountants don't agree with the UKHCA formula and we also think it's got a bit of a bias of more, kind of, southern authorities, rather than, kind of, northern metropolitan [areas]... we would base it on [local] factors really."

LA with lower fees (1013)

"I think they're just a campaigning organisation... it's under a thin veneer of outcomes for individuals, but for me the focus is about profit... I don't feel like they are a genuinely campaigning organisation focussed on people. I think they're focussed on business."

LA with lower fees (1015)

Conversely, one of the national stakeholders felt that the UKHCA model was a useful tool:

"There has been a shift – I actually felt that the UKHCA rate was useful. I've looked at it closely – think it is an accurate reflection of cost."

National stakeholder (001)

Of the two LAs that did consider the UKHCA costing model when setting fees, both were among the higher paying LAs that we sampled and one had also adopted the UNISON Ethical Care Charter (the only LA doing so in our sample):

"We're one of about 25 councils that have adopted the UNISON Ethical Care Charter as well. Obviously we'll have financial implications about how we implement that because of the standards within it. So, for example, the Ethical Care Charter states that providers should pay the Living Wage, Foundation living wage rather than the National Minimum Wage, and I think that's...there's a couple of pounds' difference isn't there."

3.2.3 Use of a Market Position Statement

Market Position Statements were considered to be of limited use to the LAs we interviewed. Although some LAs acknowledged that they had used this as a tool to communicate local market needs to providers (including aspects of supply and capacity, as well as quality and integration agendas), the majority described these as an inefficient use of resources. Commissioners felt their time could be better spent actively cultivating relationships with providers and communicating market needs and changes more quickly than could be achieved through such a publication. As a result, many of these for the LAs interviewed were out of date, with three even dated prior to the Care Act.

"I think it's a load of rubbish... there's a lot of fashions in adult social care and public service generally and Market Position Statements were seen to be something that made people feel like they were being busy and efficient but I don't think any of our main providers would pay much attention to it."

LA with lower fees (1015)

3.2.4 Prevalence in use of Direct Payments

Some LAs were encouraging greater use of direct payments, not only because this was seen as offering a more personalised service but also due to savings that could be made through this approach. In one LA (1008), as many as 60% of adult social care users were using direct payments as this had been widely embraced by the local community (although this number could include other adult social care users such as those with learning disabilities). Commissioners commented on the lower administrative burden associated with their use as users chose their own providers (resulting in the LA managing fewer packages of care) and many of these providers may not have be subject to the same quality assessment if they were not part of a framework agreement with the LA (lowering costs for the LA but also potentially creating greater risk in terms of quality of providers in the marketplace). Meanwhile, direct payments were also offered at lower rates per hour than were paid to private providers, thus further reducing financial burden.

3.2.5 Local political agendas

Although not commonly discussed by interviewees, three LAs discussed how political decisions had influenced funding and approaches to payment for adult social care in either theirs or neighbouring boroughs. For example, one LA (1011) described their political motivation to raise rates in line with the London Living Wage, but although they had been an early adopter of this and this had led to greater labour supply at the time, this had declined gradually as other neighbouring LAs began to offer the same. Other LAs described their local Labour-led political agendas as having an accelerating the uptake of the London Living Wage, as well as decisions around raising the Social Care Precept and extending coverage of publicly funded social care to all local residents:

"Our council is Labour-led, and has been for some years, and it was a huge aspiration for members to move to London Living Wage. So, they were less concerned about the market, the impact on the market, and more concerned about what's that doing to individuals as well."

LA with mixed fees (1002)

3.3 Factors affecting ability to shape the market

3.3.1 Supply

Ability to shape the market locally seems variable, with local factors such as a lack of supply dominating decisions on fee rates – i.e. in some cases LAs are price-takers, not price-makers. Local market dynamics and the number of competing providers influenced decisions around setting fees. In areas where there was a steady supply of providers, commissioners often offered one set price to the whole of the market, as there was a buoyant market in place:

"People are in the market. So when people say we can't afford to provide it, you're in the market though. And actually our neighbours pay 50 quid a week less and you're in the market there as well, so you can afford to provide it. It's market management, you're either in the market or you're not in the market. If you can't afford it, then exit the market. Because some people can afford it."

LA with lower fees (1001)

In some areas, particularly those LAs located in London Boroughs, but also through ADASS regional networks, LAs had joined forces to create a 'collective contract' which provided greater power in negotiations with providers over fee rates.

In one area of very high supply of domiciliary care, the LA used the fee rate as a mechanism to manage the market by discouraging large numbers of smaller providers. This is perceived to be a fine balance, with commissioners voicing concerns about fragmented care and the need for economies of scale through higher volume packages of care, which should enable providers to invest in quality:

"[Fewer providers] offers more stability to the market, in that a smaller [number of] providers working with us will be able to respond more promptly in a better quality response rather than having call cramming... They should be able to have an anticipated volume of work in a defined geographical area and then be able to recruit and train the staff to respond accordingly to meet all the needs including people coming out of hospital."

LA with higher fees (1003)

"What you find is that, when you've got a much smaller share of the market, you don't get the economies of scale because your overheads, proportionally, are a lot larger with a smaller cut of the business. So, what we found is that, there are a lot of smaller providers that aren't getting the business, and what that's done is, it's created some issues within the market in terms of quality."

LA with lower fees (1008)

Meanwhile, in areas of lower supply, LAs were reacting to what providers asked for and described being "effectively held to ransom" (LA with lower fees, 1007), as they had to alter prices according to what providers dictated and did not feel able to negotiate due to lack of supply in the market:

"We use all the obvious sources about information about what's a fair and reasonable rate and how you would set a reasonable rate. But the market sets its own... if they don't want to accept our rate they don't. And if we're desperate for a bed then we will end up paying whatever the rate is on that day."

LA with higher fees (1003)

"We have come under huge amounts of pressure from providers this year to increase rates. We don't have the luxury, necessarily, of playing hard ball, no we're not going to negotiate with you at all, and risk them handing back hundreds of packages to us which we just simply would not have the capacity to replace."

LA with higher fees (1005)

Meanwhile, one LA commented that a lack of supply had created concerns around quality as there were too few existing providers, all of which had experienced issues with quality:

"We were only able to secure three providers and all of them have had quality problems over the last three years... So, the issue for us there is there are quite a small number of providers. So, there's not very much flexibility, limited choice for people living here but also when there are quality issues that's really problematic for us because we've got, you know, a significant proportion of our supplies which is really quite vulnerable providers."

LA with mixed fees (1011)

However, it seems that concerns over future lack of supply were also driving decisions around fee rates, with particular concerns about the closure of smaller residential homes and lack of investment in building new homes as companies struggle to finance this in the current climate of fee rates:

"In our area we've not had much inward investment, well, we've not had any real inward investment in new care provision. And I am a little concerned that in the 10, 15 year view that people could cash up these lovely, big, old, Victorian houses which are now worth more as property than they are as profit from care homes. And as these one-man-band providers get to a certain age and choose to retire they're cashing up the properties... So we need to be getting some investment in new bricks and mortar and the return on that, the difficulty at the moment is talking to the banking sector, they are looking for a minimum of 40 per cent return that these care homes have got to get. And we aren't at that level, they wouldn't be getting that on our price bases."

LA with lower fees (1012)

National stakeholders echoed concerns about long term stability:

"Given the feel of closures and the number of contracts handed back, councils by and large are trying to sustain the market, hold it up, stop it falling over and focusing on a different kind of sustainability – which is about getting good enough quality."

National stakeholder (002)

3.3.2 Locality

Affluence and level of deprivation

In areas of greater affluence, LAs believe supply was affected for two reasons. Firstly, in residential care, supply was lower because of high property prices driving out providers. This led to LAs placing service users outside of area if the rates offered by providers in neighbouring boroughs were more affordable. This, however, had a knock-on effect of increasing rates for neighbouring boroughs and creating pressure at times of high demand, such as during the winter months. Secondly, the affluence of an area also affected supply of staff in domiciliary care:

"There are some more affluent parts of the borough where you can't get carers to work, as many as we would like anyway, and therefore, we have to... do spot purchases because there isn't enough of a workforce to support some of the more affluent areas where people need home care."

LA with lower fees (1013)

Meanwhile, in areas of greater deprivation, several LAs argued that their rates were low as a reflection on the local labour market, which did not require higher rates of pay to attract sufficient workforce into the social care sector. Many had benchmarked their rates against other local authorities within their region and were confident that they could offer a competitive rate, for both providers and the workforce. This also reinforced their view that the rate recommended by the UKHCA (2016) was too high. Many also commented on there being a North/South divide, with benchmarking against the national distribution irrelevant as it does not reflect local market dynamics:

"A national distribution's of no consequence to anybody. Regional, we do a lot of work regional.

We have a regional commissioning group and we send round robins all the time, so we all know what we all charge."

LA with lower fees (1001)

"I think [our fees are below average] because we're not in the south of England. No, we're in the north. So, I mean, the more real issue for us, you know, we're more interested in people who might go and work in home care in [a neighbouring borough]... so it's the regional comparison that we would look at... things like the cost of housing, the cost of living... average income, I expect, in the south is much higher than it would be in the north."

LA with lower fees (1015)

Role of self-funders

Related to the level of affluence of an area, supply available for LA-funded care may also be reduced in areas of greater affluence as residential care providers do not need to look to them to fund care as self-funders were paying substantially higher rates. In these locations with greater proportions of self-funders there was an associated lack of capacity for LA users, which then drove up prices:

"We're commissioning for low cost affordable rates that the local authority can stretch to, but we're effectively bidding against private funders who are usually willing to pay quite often up to twice what is our usual fee that we would prefer to pay... we actually do business with a very small

proportion of [residential providers], because many of them can simply sell their beds...their capacity to the self-funder market."

LA with higher rates (1003)

"If the [residential home has] got a healthy waiting list then us trying to negotiate with them doesn't put us in a particularly strong position. If they know that if they wait a week or two they'll have a self-funder who will come along and pay their top fee, they're not going to be so interested in negotiating with us."

LA with higher rates (1005)

Conversely, in other areas with either greater capacity overall or a lower proportion of self-funders, commissioners acknowledged the important role self-funders played in cross-subsidising LA rates and potential for improved quality due to greater competition in the market. In some instances, providers and self-funders had raised complaints about this cross-subsidisation.

"The self-funder market helps drive some of the quality here... a lot of the care homes know if they want to attract, like, self-funders, they have to be at the top, they have to be really good quality."

LA with lower fees (1013)

Several LAs voiced concerns about the impact on LAs when self-funders run out of personal funds. This had led to difficult discussions with providers about evicting service users if LAs were not able to pay the higher costs of care and was true even for LAs already paying one of the higher rates for residential care:

"There are a number of care homes that just won't negotiate with us, meet us halfway or anything in terms of fees and will evict people."

LA with higher fees (1010)

LAs had tried to raise awareness of this issue amongst their local elderly population but there was a lack of awareness amongst the general population about these issues. Additionally, LAs were trying to predict when the self-funder market may need support from LA funding, but had found this difficult due to lack of information about the scale of the market locally:

"One of the biggest challenges is knowing who the self-funder market is, how much money it's got and when is it going to run out and when are we going to be picking up the costs?"

LA with higher fees (1003)

Rurality

Rurality led to higher rates for two reasons: firstly, many LAs offered higher rates of pay to domiciliary care providers operating in rural areas because of the greater travel costs associated with these packages of care. Secondly, there was often a lack of supply of both providers and workers in rural regions, which led to higher rates of pay to retain staff and compete both within and outside the sector for carers.

"You can see a £6 difference between one part of the county to another part of the county and that's to do with the geographical make-up... the more urbanised it is, bigger population you have, actually the cheaper home care is. Then when you get down to the more rural parts of the county where there may be obviously fewer packages and more travel time involved, those costs of care go up."

LA with higher rates (1005)

Several LAs had 'zoned' their coverage by splitting their regions geographically in recent domiciliary care tenders so that providers' costs associated with travel payments could be reduced as much as possible. This was also true in a London borough, which although not rural in nature, found travel to be costly:

"Commissioning [by geographical location] was partly to ease the workforce issues for the providers. So, the travel to work or the distance between calls is minimised and they've certainly benefited from that, having quite a small area where the carers can get round the calls and have limited travel to work and travel between calls."

LA with higher rates (1004)

3.3.3 Building relationships with the market

Several LAs commented on the importance of establishing and maintaining good links with local providers. Building strong relationships with providers may be particularly difficult to achieve where there is excess supply locally and it seems there is a balance to be struck in terms of achieving adequate supply in the market to ensure effective competition and excess supply which causes LAs to struggle to manage relationships and quality assurance.

Fostering good relationships with providers may also have been challenging for LAs over recent years as spending cuts had led many to cut back-office staff. Recently, some LAs had employed dedicated team members in roles solely responsible for maintaining these relationships, for example:

"Recently a member of staff was identified to actually improve that working relationship and have much more sort of phone and face to face contact with providers, and that seems to have speeded up the [uptake of packages of care]... our responses from our providers tends to be more prompt and are picking up quite a lot of the work on the first attempt, so that's worked quite well"

LA with higher fees (1010)

These relationships had been integral to the development of a costing approach in most instances, for example with providers giving information for open-book costing exercises. However, some commissioners had experienced resistance from providers who were not willing to offer information about their costs of care and this resistance tended to come from the large national chains.

"We've found engagement incredibly difficult... we haven't really engaged with the market and as a consequence of that, although we have an indicative rate, there are very few homes locally that accept our rates at all. They have determined their own rates, which, you know, we try to manage but actually, you know, they've really become quite fixed with the rates that they're expecting us to pay and they're much higher... They're significantly higher than any benchmark local areas compared to local authority rates."

Engagement with providers was also seen as important to offer support as part of the LAs' statutory duty to monitor financial sustainability in the market, so commissioners could deal first-hand with any providers' concerns around fee rates. In instances where LAs stressed the importance of good relationships, they had found providers were more accepting of fee rates, and less likely to complain.

One LA that we interviewed had been part of a Judicial Review of their pricing. This LA had won two judicial review cases and saw this as evidence that their (below average rates) were acceptable:

"We've got our own formula [for setting fees], and as I said, it was tested by judicial review and we received a very favourable judgment, both in terms of how thorough it was and how comprehensive it was."

LA with lower fees

No LAs we interviewed engaged with users when developing their costing approach and many did not see the value in this.

3.3.4 Longstanding block contracts

Three LAs that we interviewed (1002, 1009, 1010) were tied into longstanding contracts for the provision of residential care (two block contracts and one Private Finance Initiative (PFI) contract held with a large social landlord). These contracts were longstanding (between 15 and 30 years in length) and as a result of original negotiations taking place prior to wider funding restrictions, coupled with annual increases, the rates paid to these providers were now far higher than the rest of the market. These contracts also caused disproportionately elevated rates in these locations as other local providers, aware of the rates paid in the longstanding contracts, had been able to negotiate similarly high rates. One LA also cited a further cost of these types of contracts; they felt their commissioning team were insufficiently skilled to effectively manage these specialist contracts, which were more complicated in nature than their usual provider contracts, and so had planned to invest in additional externally-provided staff training on PFI contracts. There were, however, benefits perceived in these contracts, for example greater perceived control over quality and fewer capacity issues.

"It's a very long contract because we actually had new buildings out of that, obviously at the time, it wouldn't happen these days, would it, but at that time obviously it was thought to be a good thing. But anyway, the quality of that provision is very good for us, but I'm sure that that big block contract does have knock-ons in terms of the market as a whole."

LA with higher fees (1010)

"The bulk of our residential provision is through a PFI contract with [provider name], and that is at a much higher weekly rate than we would pay on the market, and I think that might somehow skew the figures... I think it's 12 years old now, and it's a 30 year contract, so the rates were set 12 years ago, and that's something that we have to, sort of, work with. There was a rate set, but the weekly rate would increase by the rate of RPI and that's part of the contract, and that's what we're involved in... So, that's been quite a challenge. I would also say, it's tricky, in terms of commissioning, it's a real area where you would need good expertise. And, like I say, we don't really have that in the local authority, and so we're considering putting one of our commissioning managers on training. We're, kind of, just weighing up the value of having that level of knowledge, against what it's going to cost us, both in terms of her time, and the cost of training. So, it's a complex model, it's not one that I would personally repeat.

LA with higher fees (1002)

3.4 Managing budgets through other means

3.4.1 Integration

Integration of care was seen as a way of making future cost savings, but was often perceived as being very difficult to achieve due to LAs and NHS Trusts holding different budgets and motivation. While integration was commonly discussed in Market Position Statement documents produced by LAs, in reality, it was being employed with varying success.

Three LAs were already working with integrated health and social care teams with a single point of entry into the system for patients and users and social care and nursing teams working in close collaboration. While the full effect of this integration was yet to be seen, commissioners commented on the greater collaboration and a more streamlined approach to delivering care using this integrated approach:

"I think having an integrated team... is much more cost effective because you'll be providing more coordinated, responsive service to get somebody back on their feet again as quickly as possible"

LA with lower fees (1014)

National stakeholders welcomed moves to better integrate care, but felt that joint commissioning was not the only route to joint working. They also highlighted examples of where competition between the NHS and social care caused problems:

"The other significant factor that increases fees and complicates the market is that the NHS is moving in. I know of NHS trusts picking up the council market supply and paying higher prices or by directly employing home care staff on agenda for change rates – this stops the social care market from functioning well. It's not very well coordinated – and is evidence of stressed behaviour on the part of acute trusts, coupled with stressed staff in councils."

National Stakeholder (002)

Meanwhile, LAs had found it difficult to negotiate with Clinical Commissioning Groups (CCGs) over the use of the additional funding provided via the Improved Better Care Fund (iBCF):

"The difficulty is, we both hold our own budgets, and anything that looks like part of my budget going to theirs or theirs coming to mine makes it a difficult conversation... I think the only way to do it is make one body dominant over the other... essentially you force integration... having two essentially large government directorates, they will cooperate but they will never assimilate because they have different drivers, and the only way to take that driver away is literally to take it away."

LA with lower fees (1012)

3.4.2 In-house provision

Following the move to place provision of social care within the private sector in the 1990s, the majority of LAs provided only services such as day care and reablement in-house. However, some described a move back to providing care (particularly residential care) in-house. In some instances, LAs had, or were planning to, set up external provision they described as 'arms-length trading companies' to run these services (1002, 1008, 1012, 1013, 1014). Motivations for this were twofold. Firstly, they were seen as a

way of generating income which could be reinvested to enable quality improvements in these services (as the LA was unable to make a profit on strictly LA-run services). Secondly, this was an attempt to increase stagnated supply in the market, for example one LA described how external providers had been discouraged from entering the market due to the property crash of 2008, while another had experienced difficulties placing care when a re-tender to large national operators had fallen through unexpectedly. In some instances other neighbouring LAs were now procuring services from these companies as they were able to offer lower rates than their competitors.

"Obviously local authorities can't trade so we can't make any profit off a care home. So if it costs us £900,000 less essentially we just have to make the price cheaper, because what we did originally was just kept the prices that [the large national provider] had because we didn't know any better and we found that made a surplus so we had to reduce our prices so that we weren't making a profit, which we can't legally trade... What we're looking at now is whether we set up an armslength trading company so that we could restore essentially and have that money to reinvest in care."

"So, the council has set up an arm's length, so a local authority trading company... there were a couple of reasons for it. One, in terms of the residential care provision, the homes that we were running were coming to... the end of their natural lives... our initial approach to that was to look to the market to say, okay, we're interested in working with a provider who either wants to build a building and provide the service, or we will build the building and you can provide the service. So, that process lasted for a huge amount of time. I think given the financial crisis back in 2008 and, you know, a series of other issues that there were with the market, the market just wasn't interested in actually investing in that kind of service and set-up... so the council took the decision that, actually it would build the home itself... and then we would look for a provider to run it for us. Now, that's a relatively recent thing that we've done. We went out to the market, the building actually was completed back in January 2017 and before then we'd gone to the market four times, looking for a provider to run it for us. On each of those occasions, none of the providers that we engaged were able to come up with an offer that made financial sense to the council."

LA with lower fees (1008)

The move to in-house provision may not always be successful. One LA (1001) had explored the potential for bringing services in-house, but their own review of CQC ratings for internally and externally provided services had shown that there were no quality improvements to be made through such a move, and an external company tasked with exploring the financial viability of this had shown this would not be feasible.

The creation of such trading companies was more common amongst LAs with lower fees, however most had only recently embarked upon this (post 2015/16 when the fee rates used for this project were taken). Therefore, whether these decisions have arisen as a result of these LAs having historically lower spending power, their wider approach to commissioning or a potential lack of supply in the market is unclear.

3.4.3 Use of additional funding

Some interviewees highlighted that although additional money provided to LAs via the Improved Better Care Fund (iBCF) and Social Care Precept was welcome, it was difficult to translate this 'emergency funding' into higher fees. For example, the additional funds provided through the iBCF were difficult to invest into higher fees as LAs did not have confidence that the increased funding would continue, meaning their fee rates had to remain realistic within current LA budgets. Providers were often confused about this and had unrealistic expectations:

"[Providers] don't understand how [the iBCF] works, they don't understand the process. It does say within the [Local Government Association] stuff around the iBCF, you need to manage the market and support providers. Give us the money recurrently then if you want us to do that."

LA with lower fees (1001)

"On the afternoon of the budget – commissioners were bombarded from calls on the one hand from the NHS to fund more consultants and on the other hand from providers to give them 10% increase in fees. There was chaos around this."

National stakeholder (002)

Rather than raising fee rates as a result of this funding, investment had been offered in other ways to increase quality. Differential ways of doing this may lead to some LAs rates appearing low, when in fact money is being invested in other ways.

"I will invite [providers] to bid for the money to invest in things that will mitigate cost going forward. If I can put in training, if I can put in technology, wander mats, the drivers in how I'm determining price is how I can determine not to pay any more on a weekly bed rate but how I can invest lumps of money around it. So a couple of providers last year who wanted more money for the weekly bed rate that I couldn't afford, we agreed that I would pay them an amount of money over three years to invest in the environment, the care environment, and they would hold their fee rates."

"For home care, we support those seven providers quite heavily in terms of safeguarding advice, training, you know, customer complaints handling, areas that... you know, recruitment and retention with Skills for Care. We work with them quite closely and with our in-borough kind of recruitment job fairs... we've got quite a lot of, as you can imagine, out of borough people travelling into work, particularly for the home are workforce. We're looking at supporting them again with, where we can, with some of the leisure passes and the travel concessions that council staff benefit from. We're looking at that as a possibility at the moment, to ease some of those pressures for providers. Yes, the workforce pressures, certainly there's a high turnover, generally, of the home are workforce. One of the initiatives... we're working with Health Education England on a hybrid trainee nurse associate programme."

LA with higher fees (1004)

3.5 Impact

3.5.1 Payments and quality

Although most LAs acknowledged the importance of moving towards an outcomes-based commissioning approach, in reality many described how the social care system is still based heavily on time and task, which prevents the introduction of meaningful quality assessment. Problems were seen to stem from failures in the system (e.g. social workers still reviewing users on a time and task basis, making it difficult to implement these outcome measures until they started to plan care based upon them) and because providers did not have adequate infrastructure (with office staff and training) to implement this sort of payment system:

"We had the intention of doing outcomes based commissioning and [it] was foiled completely by the fact that our social work teams were not doing outcomes based assessments... bluntly fell at the first hurdle because the assessments weren't done... And what we still have an issue with is actually even if you did an assessment how do we capture that series of outcomes that you want the provider to deliver and how do you transmit that to them. So technically what's your information recording system so that you can have a baseline of where you started and where you end up to see if the outcome was achieved."

LA with higher fees (1003)

"To be blunt, I think commissioning got pushed to one side in the bid to secure the savings. So, we're now in a position whereby we needed to stabilise the market, develop the market, shape it and then we need to bring in some initiatives, for example, Payments by Results, but we're too... immature, I think, at the moment to bring that on board."

LA with lower fees (1007)

In some instances, commissioners had developed a system which allowed monitoring of some basic quality indicators (e.g. timeliness, continuity of staff, staff trained and holding a 'Care Certificate') and this had been built into their payments to providers, who received higher fees if they met these criteria for each call:

"We've also introduced a quality premium payment as well for providers where they hit certain quality measures and we've got that evidence, we will then pay them 50 pence per hour extra on their rate... we engaged with service users and asked them what they wanted... the basic things they wanted were... continuity of staff... timeliness of visits...and they have to prove that staff have undertaken a care qualification... if they hit all three things, then they get 50p extra an hour."

LA with lower fees (1013)

One national stakeholder questioned whether initiatives that rewarded quality resulted in poor providers getting poorer:

"Some LAs have paid quality premiums over a long time, but the underlying funding of that is problematic. When quality starts to fail – you need a shift in resources. A key priority is to keep providers from failing. This means putting staff and training in to keep them going (safeguarding

concerns), sorting things out from care workers not being paid, to putting fuel in their cars. This is not reflected in rates - but is key to quality."

National Stakeholder (002)

A minority of interviewees (1004, 1006, 1007, 1016) thought there may be a direct relationship between quality and fee rates. Many interviewees that did not acknowledge a relationship here rationalised this by commenting on the variation in levels of providers' quality ratings locally (as rated by CQC), despite similar or equal LA rates. There was often a less explicit link made between quality and fees as interviewees commented on the importance of recruiting and retaining the workforce, but didn't seem to necessarily associate lower fees with lower hourly rates. Some LAs suggested they had little confidence that a rise in fee would be associated with a rise in wages. In one instance a LA had built this into their retender process to ensure that the increase was passed on.

National stakeholders appear to be more willing to acknowledge that "there's a level below which you don't get quality" (National Stakeholder 001). This view was linked clearly to insufficient staffing levels. They also argued that providers had a responsibility for only pricing care at a rate that could guarantee quality:

"[Providers] have got a responsibility for not putting in tender proposals that aren't sustainable.

Some providers are operating across multiple authorities – and they pick and choose which tenders to keep in."

National Stakeholder (002)

"The focus used to be on high fees, and a drive for low unit costs. Now the problem is really that providers are bidding too low. Providers say that commissioners are paying for care that's too low – but we'd argue that the way to correct the market is for providers to not put in tenders that can't be delivered – they'll do anything to say they can meet the spec - that's the only way to change."

National Stakeholder (001)

3.5.2 Controlling quantity of care and 'demand management'

Often termed 'demand management' by interviewees, there is an increasing drive to divert demand away from external provision of adult social care by increasing users' independence, with the aim of reducing future levels of care:

"I suppose what we do is actively reduce the speed at which people go towards the highest cost forms of care and support. So the fees are the fees... [we need to] try and turn the tap off in effect to slow the rate at which they reach that fee level."

LA with higher fees (1003)

There was emphasis on early intervention, use of assistive technologies, use of scrutiny panels and effective reablement services. In one example a LA incentivised providers with an additional payment for effective reablement within six weeks:

"If providers are able to achieve the outcomes for the individuals by actually getting people mobilised and reabled within up to six weeks and actually, you know, out of services if you like,

they're back home, all at home, not reliant on services then what we are doing is actually offering a 10% bonus."

LA with mixed fees (1006)

Additionally, extra care was often seen as a way of reducing demand for residential home usage. This was, however, being hampered by uncertainty in the market around changes in housing benefits which were expected at the time of interview; this was leading extra care or supported living providers to delay investment while they awaited further information:

"Rather than people going into residential care, they are going into extra care or supported living.

The government hiatus... in terms of what they are doing with housing benefit has created an awful lot of uncertainty in the market and has really, sort of, hampered us in terms of that development, because a lot of our partners are not willing to build if they are not sure what the income will be."

LA with mixed fees (1016)

In one instance where there were historically low levels of extra care facilities, the LA had used commercial planning agreements to force developers to invest in extra care housing schemes under the planning requirement to offer some social benefit to the local area.

A novel approach adopted by one LA (1008) was the use of social workers in training to run a "new access service" which acted as the first point of contact for any potential users to access information about LA services, with the aim of ultimately limiting demand. Although this had been effective at diverting 85% of contacts to other services, it had recently been replaced by a less costly generic support service that the commissioner anticipated would be less effective (as it no longer used workers with experience of the social care field, replacing them with generic scripted responses provided by untrained call centre workers).

Meanwhile, another LA had reviewed high value care packages to explore whether the care being delivered was still as per needs assessment, or based on 'wants'. Some LAs were open about the need to 'ration' care and their role in this process:

"Demand outstrips the budget available for social care, full stop... What we are, therefore, doing is rationing the care we provide. Now legally I have to meet an assessed need but determining what is meeting an assessed need, the difference between good enough and brilliant is the land we play on really. And it is very difficult, we challenge all the social work packages, do you really need 13 hours a week, could you make it 12? And that would have an impact."

LA with lower fees (1012)

3.5.3 Sustaining the market – recruiting and retaining staff

Many commissioners commented on their statutory responsibility to sustain the market as a result of the duties outlined in the Care Act (2014) and highlighted that a key concern in this was the ability to recruit and retain a quality workforce in social care, particularly in light of rises in the National Living Wage:

"Certainly we recognise there's a minimum where we shouldn't go below, you know. If we're asking providers to pay the London Living Wage or the National Living Wage and obviously they're...I mean they need to make a margin, you know, but there's a level where we wouldn't consider going below."

LA with higher fees (1004)

Attracting and maintaining the workforce appeared to be a greater issue in domiciliary care, with commissioners commenting on the transient nature of these workers and their willingness to move to different providers, or even out of the LA area (in larger urban settings):

"We're paying what we need to pay, because our biggest pressure in domiciliary care is our workforce, and actually we've always been a slightly higher payer but we know that when we pay any less, that we have real challenges around providers being sustainable... unless we give providers a sustainable, sort of, income, they don't invest in their staff. They'll have staff that will move for a difference of 20p per hour, then the continuity of care is then completely lost for service users"

LA with mixed fees (1016)

"There's a lot of benchmarking in home care and that's simply because the workforce starts to move. If people know that you can get more money in [a neighbouring LA area], well, we'll go and work [there], so you end up with that workforce shift that's problematic as well. So we're quite conscious that we've got to make sure that we're paying fees that are in line with elsewhere, so we're not then... causing lots of staff to go and say, well, I'll go and work for somebody else."

LA with mixed fees (1006)

An indirect link was often made by commissioners when asked about the relationship between fee rates and quality, as although most did not agree there was a direct relationship between the two, many thought that fees could be used as an incentive to promote greater recruitment and retention of staff. Nevertheless, several LAs were sceptical about a rise in fees being translated into higher wages and commented on wider issues within the profession that could not be solved through increased fees alone:

"Research we've been doing... has highlighted actually how little of the extra investment that goes into providers actually translates into either more people on the ground or more pay in people's pockets... I don't think we have much confidence that if we paid higher rates it would do anything other than increase profit margins.

LA with mixed fees (1011)

"I think there are more fundamentals to be changed than just the cost per hour in terms of the significance of the profession, the investment in the profession as a brand is something that people could see as these are great careers that are fulfilling... it's a bit cynical but... essentially to put 10p an hour on somebody's pay packet will cost me 30p an hour to the provider."

LA with lower fees (1012)

In line with this, commissioners offered support to providers through other means, for example through providing free training for social care staff. However, some commented on differential uptake amongst providers as some would not release members of staff for training (due to a lack of supply of staff and cost associated with paying staff time without it being associated with delivering a package of care). One LA (1013) had offered a financial incentive to providers enrolling staff onto such training courses as a means of overcoming this barrier and improving quality. National stakeholders also highlighted the support offered in-kind:

"There's other stuff that is offered or provided such as free training. I know in the past we have offered assistance on the purchasing of goods such as mattresses...There's a need to work with providers to get the fee right – to support staff, ensure training etc. – you can offer lots, and not just via fees. It's resource-intensive when the council has to step in to support a failing provider."

National Stakeholder (001)

Three LAs described actively working with organisations such as Skills for Care, the Nursing and Midwifery Council and local further education institutions to find ways of promoting social care as a profession and developing training programmes (1003, 1004, 1007).

3.5.4 Commissioning capacity

"The juggling of price, quantity and quality – and sustainability – is becoming more and more difficult."

National Stakeholder (002)

Commissioning teams have had to absorb their own share of savings and many have been restructured. National stakeholders were asked to reflect on the capacity and skills within commissioning teams. There is little if any data on which to draw firm conclusions, but the national stakeholders acknowledged that some LAs, particularly the smaller ones, may be finding commissioning more challenging:

"There has been some dilution of expertise with commissioning functions being centralised and a loss of expertise. Results from the sixth stocktake would support the view that efficiency savings have made it harder to shape the market in terms of commissioning resources."

National Stakeholder (001)

National stakeholders also had a sense that directors were taking on bigger portfolios, including other functions such as housing and public health. Commissioning capacity had also been reduced, and frequently merged into procurement. This was seen to be diluting the commissioning expertise found in adult social care. National stakeholders also highlighted the work being done with Skills for Care to develop a qualification in commissioning.

4. Discussion

This report focuses on commissioners' views about how they set their rates for older people's care. We have not sought to validate their views, or attempted to confirm them with either providers or users in their area. In this section, we use the interviews and draw on a broader literature to highlight key issues around the data and the disputes that arise over its use. We also explore commissioners' ability to use fees as a tool to shape the market.

Our research suggests that price alone may reveal little about commissioning intentions or expertise, and more about market factors such as rurality and local supply. Commissioners may pay higher fee rates because they need to incentivise quality, stabilise a fragile market, or because they need to secure places in a market dominated by self-funders. Higher fees are not necessarily a reflection that they are poor at negotiating on price nor that the LA sees this price as 'fair' or 'normal' (indeed quite the contrary). Moreover, LAs may offer other incentives to providers through free staff training or financial contributions to improve specific aspects of service delivery; substantial investments which are not captured through analysis of fee rates alone.

4.1 The data

Debates around the funding of adult social care are characterised by conflicting views and often contradictory evidence. It can be difficult to obtain accurate data and a competitive tendering process can further hinder transparency. Indeed, the most widely quoted data on home care fees was obtained through a Freedom of Information request (UKHCA, 2016). Our dataset for sampling was obtained from the Department of Health, derived from NHS Digital published information, supplemented where necessary by UKHCA figures. Some of the LAs we interviewed questioned the accuracy of the fee 2015/16 rates we were using. For example, one LA was aware of the quoted rates being too high (reported as £800 compared to their actual rate of £425) and had already raised this issue with LA accountants internally. Also significant is the increase in fees in 2016/17. Most LAs in our sample had raised rates recently as a result of the introduction of the National Living Wage, as well as greater pension costs for providers. This reflects national data, which shows that nearly all LAs in England (82%) increased the fees paid to providers, with fees in home care in particular rising quickly - 5% increases in a third of LAs (ADASS, 2016). Moreover, those regions that have historically experienced the lowest average fee rates have seen increases of above 5%. Even those areas with the highest fee rates (London and the South) still experienced fee rate increases of 3-5% from most LAs (Christie & Co, 2016).

4.2 What is a fair rate for care?

The question 'how much does it cost to provide quality care?' lies at the heart of negotiations on fee rates. The care home industry has put forward cost calculators that they believe identify the minimum price for care (see UKHCA (2015) for home care and Laing Buisson (2017) for residential/nursing care). Most of the LAs interviewed, however, were sceptical about these

industry-accepted models, and report that they inflate costs beyond a price which the LA can afford. Elsewhere, literature supports this disparity, for example, Dudley LA's Market Position Statement (2016) suggests Laing Buisson have identified a fair cost of care which is around £200 per week higher than the LA's current rate. Indeed, one LA we interviewed had faced two judicial reviews of their fee rates and argued that their success in these reviews supported their choice of fee rate, in the context of their local market.

Most of the LAs interviewed were using a formal costing approach, although the UKHCA (2016) have previously reported that only 24 LAs could provide a calculation of the costs of home care, so it may be that these costing approaches are predominantly being used for residential care. Without a consensus on which model to use, costing approaches seem to offer little resolution over how to identify and calculate true costs. Furthermore, most LAs felt these models did not reflect their local economy or market for social care, with many commenting on a North/South divide. Open book exercises may also be problematic for commissioners, who struggle to convince providers to provide financial information, resulting in reduced participation. In a recent CMA report (2017), Bupa provided some insight into why response rates are low:

"In practice, when setting fee rates, local authorities often appear to disregard information from providers about the component and total costs of delivering care and instead work from their own set of assumptions about the cost of care... [councils] create their own assumptions around ROI, profit, overhead, ratios etc. rather than seek detailed information from providers in order to get to the desired number within their affordability threshold."

Interestingly, while individual LAs may question the UKHCA model, the ADASS Budget Survey (2017) continues to reference it as a benchmark, despite noting that LAs are generally unable to meet this desired rate.

4.3 Are commissioners using fees to shape the market?

Reductions in LA budgets mean that financial constraints dominate every commissioning decision. This has prompted many LAs to revise radically their role in the delivery of care as well as what is purchased. In this section, we explore the factors that enable commissioners to feel confident about paying lower fees, followed by factors that influence commissioners' decision to pay higher fees.

4.3.1 When do commissioners feel most confident about paying low fee rates?

Commissioners feel most confident about setting low rates in areas where the market is buoyant and there is an adequate supply to meet demand. In these areas, commissioners report that they are in a strong position to exert their purchasing powers and secure low rates without jeopardising supply or quality. As described in the previous section, their position is further strengthened by their use of costing models, and some have felt vindicated in their decisions by winning judicial reviews.

Urban LAs, particularly those in areas of high deprivation, also appear to find it easier to negotiate lower fee rates. Commissioners report that providers can attract sufficient numbers of care staff at low pay in

these areas (albeit with potentially high turnover rates). Conversely, LAs serving rural areas experience lower supply of providers and face greater difficulties in securing a care workforce. These factors have been reported elsewhere in the literature, with County LAs feeling particularly under pressure. They argue that they are under-resourced compared to inner city areas, but face higher transport and staffing costs due to their fragmented care markets, and are net importers of people with care needs (e.g. County Councils Network, 2016 and County All Party Parliamentary Group et al, 2015).

Levels of deprivation also affect the proportion of self-funders in the market. There is significant variation in the proportion of self-funders across the country and the relationship between self-funders and LA rates is not straightforward. While our findings suggest that areas with higher proportions of self-funders may find that the market prioritises them due to their paying more than local authority clients, (thus restricting LA supply), many also believe they are propping up a market that is underfunded by LAs (Competition and Markets Authority, 2017). There seems to be a fine balance to be struck, with the level of supply in the local market potentially altering the impact self-funders may have on LA rates. To the surprise of many, the recent interim report from the Competition and Market Authority (CMA) (2017) counters much of the evidence and widely held view that self-funders subsidise the costs of LA-funded residential care. Although it concluded that homes with higher proportions of self-funded residents had higher profit margins, the CMA (2017) found no evidence that LA rates failed to cover residential homes' direct operating costs and added that many survive with few or no self-funder market. It did, however, raise concerns that low fee rates may prove insufficient to generate long-term sustainability of the LA market (CMA, 2017).

4.3.2 When do commissioners pay higher than average fee rates?

Arguably the biggest influence on fee rates in recent years has been the introduction of the National Living Wage and other regulatory requirements such as pensions and the 'Whittlestone' Ruling around sleep-in payments (ADASS Budget, 2017). Local authorities increased their fees rates significantly in 2016/17 in an acknowledgement that providers did not have the resources to absorb these costs within existing fee rates. This recent increase in fee rates has been welcomed but has done little to alter the geography of who pays high/low rates.

Market factors, commissioning skill and LA agendas can all contribute to care being purchased at higher than average rates.

Higher rates paid to secure and stabilise a fragile market

Commissioners are most likely to report inability to negotiate over fees when supply is limited, meaning that commissioners often accept the rate set by providers in order to secure a service for older people. The interviews also reveal an important but complex relationship between fee rates, quality and supply. When both supply and quality is low, the market is particularly fragile. National stakeholders highlighted the considerable impact market failure can have and the disproportionate resource that often goes into stabilising a market and preventing market failure. This can lead to higher rates being paid to avoid further destabilisation and improve staffing and quality. Commissioners perceive that purchasing care at a higher rate is a rational response in order to secure and stabilise a market, or may simply be left with

no alternative as they need to fulfil their statutory duties to procure care in a limited market. High property prices and higher staffing costs were also frequently cited as explanations for higher rates.

The balance of private/state funding in the market is clearly perceived to be an important influence on fees; as discussed above, providers are choosing to prioritise the more lucrative self-funder market and may even withdraw from the LA-funded market altogether, which drives up prices in areas of lower supply. A number of LAs are so concerned about the restricted supply for LA clients that they have intervened, or are considering intervening, in the market to provide services themselves in order to increase capacity and affordability. Our literature review supports this finding, with written evidence to the Communities and Local Government Committee's report on Social Care from Cambridgeshire County Council (2016) and Nottingham Council (2016) highlighting these LAs' interest in such an approach.

Higher rates paid to drive change

We also heard from commissioners that used fee negotiations to actively shape the market and recommission services. Several LAs reported how new frameworks with a smaller number of 'preferred providers', and often covering smaller geographical 'zones', have led to reductions in staff travel costs and improved relationships with providers. Further examples can be found in Bristol and Hull submissions to the Committee for Local Government's enquiry on social care (Bristol City Council, 2016, Hull City Council, 2016). These LAs pay higher than average rates but believe that their re-negotiated contracts deliver better partnerships with providers, improved conditions for staff, closer connections with the community and better outcomes and choice for users (Bristol City Council, 2016, Hull City Council, 2016). Conversely, we also found that commissioners may use price to limit over-supply in the market, as one commissioner commented that they had actively restricted prices for domiciliary care contracts in order to drive out lower quality providers and offer greater economies of scale for the remaining (mostly larger) providers.

Higher rates may also be used to drive improvements in quality of care. Some LAs had found ways to build collaborations in which commissioners and providers share an agenda for improving outcomes, for example through additional payments for providers meeting certain quality criteria. This is in line with recent guidance issued by ADASS (2017b), which encourages commissioners to take a more proactive role in ensuring quality, but also a need to scrutinise costs that appear too low and unsustainable. These collaborations, however, appear to be far from routine, and require a high level of skills in relationship building and a commitment to co-producing solutions for older people. When asked about the impact of fees on quality, few commissioners we interviewed acknowledged a direct relationship between higher fee rates and quality. This defensive position in the debate over cost and quality is common - a King's Fund study on home care reported similar views of local authority staff (Humphries et al, 2016) and ADASS (2017b) itself reminds commissioners that low rates can still deliver quality and cites examples of charities and family businesses that can operate at marginal rates.

Higher rates paid because commissioning expertise is limited

Commissioning teams have not been exempt from having to find efficiency savings. As a result, LAs have responded by consolidating staff and centralising commissioning functions. While we did not ask LAs

directly to reflect on their own commissioning abilities and capacity, some commissioners felt their roles had altered drastically as a result of repeated cost-saving measures. This was a minority view though, with little discussion from the commissioners' perspective to indicate whether this is having an effect on morale, turnover or ability to shape the market. Meanwhile, national stakeholders acknowledged that restructuring and loss of expertise made it difficult for some, particularly smaller LAs, to carry out their commissioning roles. The wider literature supports this, with providers also citing a loss of commissioning expertise (CMA, 2017). Of course, it is also possible that limited commissioning expertise leads LAs to set fees too low, leading to market instability and poor quality of care.

5. Conclusion

From the perspective of the fee rates calculated by the UKHCA and Laing & Buisson, many LAs appear to be paying rates that are too low. This, however, is not a perception shared by many of the LAs interviewed during this research. On the contrary, whether arising from their own costing models, benchmarking exercises and of course tenders themselves that successfully generated sufficient supply (or were tested in Judicial Reviews), many 'low' paying areas see their rates as appropriate for their local market. Equally, at least some 'high' paying areas point to long-standing contracts or shortages in local supply as the drivers of their higher rates rather than being a pro-active move by LAs.

LA interviewees could provide an explanation of their local approach (which was beyond the scope of this work to test) and some are experimenting with a range of new measures including re-entering direct provision. Many also recognised the need for better or closer relationships with providers, even if this was not necessarily easy to achieve either because of shrinking commissioning capacity with LAs or because of difficulties in managing relationships with providers in difficult market conditions.

LAs were aware of the different drivers in the market between residential care, with its link to property prices and need for longer-term investment in this property, and domiciliary care, with its reliance on relatively low paid staff but few other costs other than transport. Some had split their domiciliary care catchment areas to better reflect local labour market dynamics.

There are clear difficulties for LAs in overseeing the entirety of the social care markets in their areas. Many have little data on self-funders, and the relationship between fee rates and staff pay is not straightforward. LAs are unsure whether higher fees would necessarily translate into higher pay, and they do not accept a direct link between fees and quality. To make these links clearer, progress on outcomes-based contracts and/or contracts including quality markers may be necessary, even if these can present administrative challenges for both commissioners and providers. It is possible that moving to some degree of direct provision by LAs (or their arms-length companies) may also provide better information about the market and outcomes, even if this also fundamentally re-writes the commissioner-provider relationship. The impact of such direct provision goes beyond the scope of this research, but as an apparently growing trend, may merit further investigation.

References

Association of Directors of Adult Social Services (ADASS) (2016). *ADASS budget survey 2016.,* London: ADASS.

Association of Directors of Adult Social Services (ADASS) (2017a) Budget survey 2017., London: ADASS.

Association of Directors of Adult Social Services (ADASS) (2017b) *Ten top tips for sustaining home care (draft),* London: ADASS.

Bristol City Council (2016) Written evidence submitted by Bristol City Council to the Communities and Local Government's Committee's report on Social care. Available online at http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/communities-and-local-government-committee/adult-social-care/written/35875.html (last accessed 13/07/17)

Brunelcare (2016) Written evidence submitted to the Communities and Local Government Committee's report on Social Care. Available online at:

http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/communities-and-local-government-committee/adult-social-care/written/35798.html (last accessed 13/07/17)

BUPA (2017) Response to the statement of scope. CMA Market Study on Care Homes. Available online at https://www.gov.uk/cma-cases/care-homes-market-study (last accessed on 10/07/07)

Cambridgeshire County Council et al (2016) Written evidence submitted to the Communities and Local Government Committee's report on Social Care. Available online at http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/communities-and-local-government-committee/adult-social-care/written/36225.html (last accessed 10/07/17)

Christie & Co, (2016). *Adult social care 2016: funding, staffing and the bottom line.,* [London]: Christie & Co

Competition and Markets Authority (CMA) (2017) *Care homes market study: Update paper.* London: CMA. Available online at https://www.gov.uk/cma-cases/care-homes-market-study (last accessed 10/07/07)

Chartered Institute of Public Finance and Accountancy, Department of Health, ADASS, LGA and The Care Provider Alliance (2017) *Working with care providers to understand costs – a guide for adult social care commissioners*. London: CIPFA. Available online at: http://www.cipfa.org/policy-and-guidance/reports/working-with-care-providers-to-understand-costs (last accessed 18/07/17)

Communities and Local Government Committee (2017). *Social care: ninth report of session 2016-17.* London: House of Commons.

Community Care (2014) *Crisis for care providers: why latest legal ruling makes it necessary to reform commissioning practices.* Available online at http://www.communitycare.co.uk/2014/01/08/crisis-care-providers-latest-legal-ruling-makes-necessary-reform-commissioning-practices/ (last accessed 10/07/07)

Community Care (2017) *Council to face legal challenge over 'Care Act breach' claims*. Available online at: http://www.communitycare.co.uk/2017/04/11/council-face-legal-challenge-care-act-breach-claims/ (last accessed 06/07/17).

County All Party Parliamentary Group, Smith, H., County Councils Network and Local Government Information Unit (LGiU), (2015). *The state of care in counties: the integration imperative.*, London: [CCN].

County Councils Network, (2016). Delivering adult social care in challenging times., London: CCN.

Department of Health (2016) *Care Act factsheets.* Available online at https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-act-factsheets (last accessed 10/07/17).

Dudley Council (2016) *Market Position Statement*. Available online at: http://www.dudley.gov.uk/community/directorates/people-directorate/integrated-commissioning-hub/adult-social-care-market-position-statement/ (last accessed 06/07/17)

Hull City Council (2016) Written evidence submitted by Hull County Council the Communities and Local Government's Committee's report on Social care. Available online at http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/communities-and-local-government-committee/adult-social-care/written/35711.html (last accessed 13/07/17)

Humphries, R., Thorlby, R., Holder, H., Hall, P., Charles, A. and Nuffield Trust, (2016). *Social care for older people : home truths.*, London: The King's Fund.

Institute of Public, IPC (2016). What is Market Shaping? Market Shaping Review. Available online at http://ipc.brookes.ac.uk/docs/market-shaping/What%20is%20Market%20Shaping.pdf (last accessed 10/06/17).

LaingBuisson (2017) *Press release: Care home funding shortfall leaves self-funders filling £1.3 billion gap.* London: LaingBuisson Available online at https://www.laingbuisson.com/wp-content/uploads/2017/01/LaingBuisson_Care_Cost_Benchmarks_8ed_PR.pdf (last accessed 13/07/17)

Local Government Association, LGA (2016) *Adult social care funding: 2016 state of the nation report.*London: Local Government Association

Local Government Information Unit (LGiU) (2017) Paying for it: the human cost of cut-price care. Available online at: http://www.lgiu.org.uk/wp-content/uploads/2017/03/Paying-for-it.pdf (last accessed 25/07/17)

Northamptonshire County Council (2016) Written evidence submitted to the Communities and Local Government Committee's report on Social Care. Available online at http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/communities-and-local-government-committee/adult-social-care/written/36367.html (last accessed 13/07/17)

Office of National Statistics, ONS (2015) *National Population Projections: 2014-based Statistical Bulletin,* Office for National Statistics, London (2015)

Phillips D, Simpson P (2017) *National standards, local risks: the geography of local authority funded social care, 2009–10 to 2015–16.* London. Available online at: https://www.ifs.org.uk/publications/9122 (last accessed 11.07.17)

Ritchie J, Spencer L (1994) *Qualitative data analysis for applied policy research*. In: Bryman A, Burgess R, editors. In: Analyzing qualitative data. London: Routledge

UKHCA (2015) A Minimum Price for Homecare: UKHCA Briefing Version 3.1. Available online at https://www.ukhca.co.uk/downloads.aspx?ID=434 (last accessed 13/07/17)

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