Learning Disability and Autism Social Care providers

# Financial impact assessment

October 2022

CordisBright

## Executive summary

The organisations taking part in this research are independent social care providers who:

- Have a combined operating turnover of £1.8 billion.
- Together, support over 29,000 people with a learning disability and autism.
- Together, employ over 43,000 staff.
- Collectively represent 68% of learning disability and autism providers that are part of the CQC Market Oversight programme.

Organisations participating in this research include Affinity Trust, Alternative Futures, Choice Support, Creative Support, Dimensions, Mencap, Turning Point and United Response

**The key findings from this research are:**

The levels of financial settlement reached with local government and the NHS to fund social care are below the rate of cost inflation being experienced by providers. In 2022/23 average pay uplifts are running at 8%, local authority fee uplifts at 6% and NHS uplifts at 5%. A 10% uplift for the UK Living Wage was announced from September 2022.

Data collected from not-for-profit providers by Cordis Bright as part of its annual Viewfinder survey shows that financial settlements have been lower than increases in costs for many providers for at least 5 years, although there was a slight improvement in 2020/21 as a result of Covid grants.

Providers are trapped between two financial pressures: on the one hand they want to pay their skilled workforce as much as they can, and they also recognise the need to try and stay above National Living Wage (NLW), and if possible, to pay UK Living Wage or higher. At the same time, they are limited in the resources they have to pay these additional uplifts given their financial dependence upon local government and the NHS. Ultimately, they are competing in a reduced pool of labour not just with other sectors of the economy and the NHS, but with staffing agencies themselves who then sell staff time back to the provider at a higher rate.

Over the past three years there has been a substantial increase in staff turnover and vacancy rates. The average vacancy rate has increased from 12% to 18% and staff turnover rate from 23% to 28%.

The providers in this study saw a rise in agency costs from £56m in 2020/21 to £144m by 2022/23. This equates to an increase in agency covered hours of over 4.3 million.

Spend on agency staff has nearly trebled. Agency staff are c.80% more expensive than permanent employees. This results in over 7.8 million hours of care and support being delivered by agency staff, unfamiliar people, unfamiliar faces in beneficiary's own homes, assisting people with some of the most intimate aspects of their lives. This is not an exceptional experience but one which is repeated again and again.

If the current trends in the growth of the use of agency staff are maintained across all the participants in this research, then costs are likely to increase to between £175million to £220million

Providers are clear that unless they can increase wages for care staff, their ability to compete for labour will deteriorate rapidly and call into question the viability of more and more of the contracts they hold. The high level of spend on agency staff is unfunded and unsustainable.

There is increasing financial impact on social care providers for people with a learning disability and autism. Three quarters of the providers surveyed expect to lose money or at best break even this year. Every CEO interviewed reported operating some services at a loss.

In response to these impacts providers have started to hand back contracts and are critically reappraising investing in new services/development. All CEOs interviewed believed that contract hand back would increase and accelerate over the next 18 months as there is nothing currently proposed by central or local government that would prevent it.

**The consequences for people with a learning disability and autism are that they will ultimately be denied the choice and dignity of a decent, fulfilling, and stable quality of life.**

Providers will do all that they can to protect the people they support but they are not the government, and they are already going beyond their charitable or business remits by sustaining loss making services.

**Proposals for action:**

- Central Government should commit to the principle of pay parity for equivalent roles across the whole NHS and social care economy, promoting this as the minimum pay floor rate for social care staff, and fund local authorities accordingly.

- The pay rates for staff working in social care should be tied to the NHS Agenda For Change. This would mean most front-line care staff aligning with NHS Pay Band 3, which is currently £10.40 per hour. Additional funding for this could be specific and targeted, with employers providing audit trail proof that additional monies have gone into the wage packets of staff.

- A one-off winter pressures payment equivalent to the additional £500million already provided by central government to try and speed up discharges of older people from hospital to support providers in the management of inflationary pressures and the likely intensification of workforce issues over the winter months.

In the medium to longer term, the single biggest change which would derive the greatest efficiency and enable providers to deliver with more flexibility and a greater focus on personalised services would be commissioning on the basis of outcomes for individuals, as opposed to inflexible packages of hours, often commissioned many years ago with little or no ongoing oversight.

# 1 Introduction

Cordis Bright was commissioned by a group of providers (both private sector and not for profits) of services for adults with a learning disability and autistic people to undertake a financial impact assessment of the current economic environment. All participants in this research are part of the Care Quality Commission's Market Oversight Scheme established through legislation in 2015 following the collapse of Southern Cross in 2011.

As a consequence, the organisations taking part in this research are larger than the vast majority of independent social care providers, with a combined operating turnover of some £1.8 billion, supporting over 29,000 people with a learning disability and employing over 43,000 staff. Virtually all the income spent on services is from the public purse. A total of 19 organisations were approached and thirteen agreed to participate in the research through the submission of data and taking part in interviews. This included Affinity Trust, Alternative Futures, Choice Support, Creative Support, Dimensions, Mencap, Turning Point and United Response. The sample overall represents some 68% of learning disability providers that are part of the CQC Market Oversight programme. The findings are therefore authoritative by virtue of scale.

This research is taking place at a time of extreme economic upheaval with events moving quickly and unpredictably, where decisions on fiscal and monetary policy can produce unforeseen economic turbulence which can have negative consequences not just for organisations, but also the people that work for them and the people they support and care for.

By August of this year inflation had reached 9.9% and is predicted by the Bank of England and other respected forecasters to rise higher through the end of this year and into next before starting to fall. Interest rates have increased to 2.25% and are now at their highest level since 2008 with the expectation they will rise higher, possibly reaching 6% by next year. We also have a level of employment not seen in this country for nearly 50 years [1]:

The government under its new Prime Minister set out a 'fiscal event' on 23rd September. By October 17th large parts of this mini budget had been retracted leaving a much reduced energy costs subsidy scheme set to end 18 months earlier than originally planned, the

[1] The jobless rate was 3.6% in the three months to July 2022 – the lowest since 1974. See: https://tradingeconomics.com/united-kingdom/unemployment-rate

cancellation of the uplift in national insurance contributions for employees and employers and the abolition of the Health and Social Care levy.

The benefit to social care of these measures is limited. The Employers National Insurance uplift of 1.25% has only be in effect since April of this year and is now being cancelled some eight months after its introduction. The financial data analysed as part of this research shows clearly that the challenges facing social care providers supporting people with a learning disability and autism predate this temporary uplift in taxation. There is of course some direct financial benefit in the abolition of the Health and Social Care levy, probably a saving of just under 1% overall.

The Energy Bill Relief Scheme (EBRS) for businesses remains unchanged ending on 31st March 2023. The government have indicated that any further assistance will be reduced and more targeted. For providers included in this research the benefit of the scheme was always more limited as although some providers operate and own buildings with energy costs that would fall within this scheme many do not. Where buildings are owned and operated, they are not comparable for example to older persons residential care being substantially smaller and not requiring the same level of energy usage.

In the governments retraction of its mini budget, it also made clear that previous commitments to protect public spending no longer applied and they plan to bring forward a range of measures to reduce expenditure at the end of October. At the time of writing the scale and form of these measures is unknown, but clearly any reductions in funding to adult social care will simply exacerbate the challenges identified in this report.

Local Authorities and NHS commissioners, social care providers, their employees and the people they support will have to wait and see what impact these changes have on their lives.

This research covers three main areas:

- The financial impact on social care providers for people with a learning disability and autistic people, and the consequences for their workforce and the people they support, with particular reference to staff related costs.
- The levels of financial settlement reached with local government and the NHS to fund social care.
- The current or planned responses by providers to these impacts and the likely consequences for care market stability and the people that depend on its effective operation to maintain their quality of life.

Cordis Bright undertook data collection survey and conducted interviews with CEOs, as well as drawing on other data sources such as the Bank of England, ADASS Annual Budget Survey, and Office for Budget Responsibility reports.

# 2 Financial impact on providers

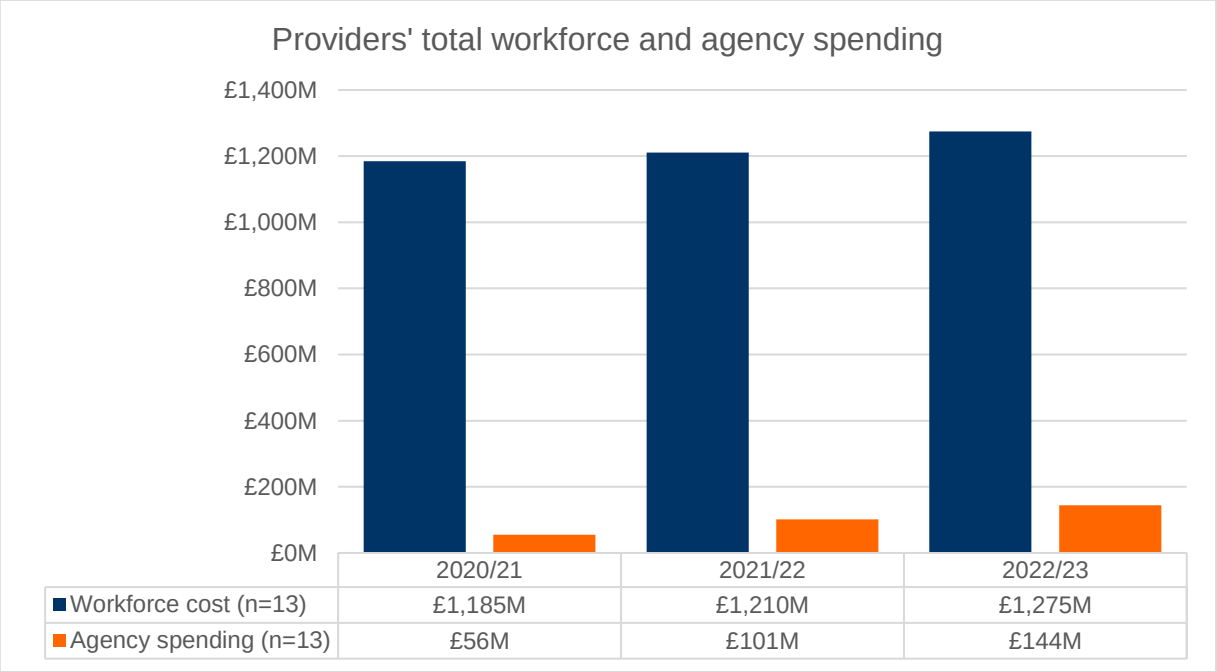
## 2.1 Workforce supply and costs

Participants in this research see two main challenges in relation to workforce: supply and the ability to pay competitively. These two factors are linked but they also act independently to impact on providers.

The cost of the permanent workforce equates to 75% of income for the providers in this research. The cost of agency staff, used to fill staff absences or vacant posts, is a bellwether for the overall staffing situation for providers. Agency staff are around 80% more expensive than permanent employees and are a last resort for covering shifts in care services. The relentless increase in the use of agency reflects the real and sustained deficit in a permanent workforce. **The spend on agency staff has nearly trebled in the last three years covered by this research.**

For the people being supported this means over 7.8 million hours of care and support being delivered by agency staff, and whilst providers do all they can to ensure consistency in agency workers, this inevitably results in unfamiliar people and unfamiliar faces in their own homes, assisting them with some of the most intimate aspects of their lives. This is not an exceptional experience but one which is repeated again and again. Consistency of support is known to be of critical importance, particularly for people with highly complex needs.

*Figure 1: Providers' total workforce and agency spending 2020/21 – 2022/23*




| | 2020/21 | 2021/22 | 2022/23 |
|---|---|---|---|
| Workforce cost (n=13) | £1,185M | £1,210M | £1,275M |
| Agency spending (n=13) | £56M | £101M | £144M |

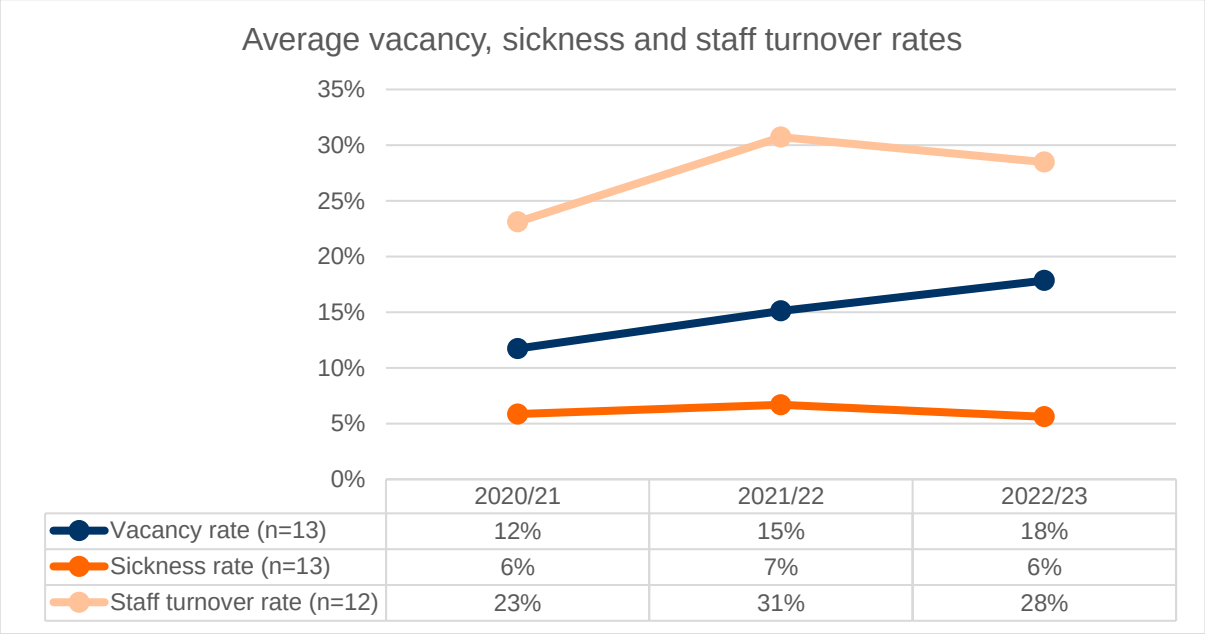
Most organisations budget for expenditure on the occasional use of agency staff but it is clear from the data collected for this research that a sustained shortage of permanent employees has driven an unprecedented demand for temporary labour. Where organisations

have incurred end of year deficits the main area of overspend has been agency staff. Ultimately social care is competing in a reduced pool of labour not just with other sectors of the economy, such as retail and hospitality and the NHS, but staffing agencies themselves that then sell staff time back to the provider at a higher rate.

### *Supply*

Staff turnover and vacancy rates are a growing problem for providers. The chart below shows that whilst staff sickness rates have reduced slightly over the period, there has been a substantial increase in staff turnover and vacancy rates. Higher rates of staff turnover often result in short term vacancies whilst posts are filled again, but the rising vacancy rates clearly indicates a fundamental problem in recruiting and retaining sufficient staff.

*Figure 2: Average vacancy, sickness and staff turnover rates 2020/21 – 2022/23*




| | 2020/21 | 2021/22 | 2022/23 |
|---|---|---|---|
| Vacancy rate (n=13) | 12% | 15% | 18% |
| Sickness rate (n=13) | 6% | 7% | 6% |
| Staff turnover rate (n=12) | 23% | 31% | 28% |

Labour supply in the UK workforce has faced two main challenges. Firstly, the pandemic impacted disproportionately on younger and older workers[2]; youth employment recovered quickly from the spring of 2021 but many older workers opted to retire early. The September UK Labour market statistics report[3] prepared for Parliament shows that 9 million people aged 16-64 were economically inactive, which is 565,000 more people than before the pandemic. Although vacancies have fallen slightly, they are still 470,000 above pre-pandemic levels.

The second event to impact on the workforce has been the post Brexit changes to migration which became effective in January 2021. This was the point at which free movement ceased and the UK introduced a points-based system for immigration. Key to this change was an

[2] https://commonslibrary.parliament.uk/research-briefings/cbp-9366/

[3] https://researchbriefings.files.parliament.uk/documents/CBP-9366/CBP-9366.pdf

initial general minimum salary threshold of £25,600. This was reviewed and the minimum salary threshold reduced to £20,480 p/a, or £10.47 p/h based in a 37.5 hour week. This remains 97p p/h above the current National Living Wage of £9.50 p/h. Only four participants in this research reported payrates above this amount and no provider reported paying as much as 2% above this figure. Four providers reported paying significantly lower rates which were much closer to NLW.

This salary threshold clearly affects all lower paid jobs across sectors such as retail and hospitality. Any reduction in the pool of lower paid labour will manifest as shortages across all sectors including social care. As set out in the earlier section of this report the cost of living in the UK is now significant, with high inflation and increasing costs which may impact on peoples willingness to move to the UK when the salaries paid are seen in this context.. There may be additional practical complications for providers considering this option such as the need to provide housing for overseas workers.

There is a cost to organisations for every recruitment exercise that they undertake regardless of success. CEOs reported that this process has become relentless and has required the redirecting of resources which could have been spent on other activities such as staff training and development. It also means many managers of services are working shifts to provide cover rather than being able to fully focus on their manager responsibilities, resulting in potentially adverse effects on the quality of services.

In practical terms there are more jobs than there are people who are likely to fill them. Inevitably this means that employers that are able to, will seek to increase wages to try and secure the workforce that they need. Although there are clearly examples of employers taking this approach, the reality is that not all providers are able to do this.

### *Competitive reward*

Low pay in social care is not a new phenomenon. Many employees working in this sector benefited from the introduction of the National Minimum Wage (NMW) and later the National Living Wage (NLW). Research for this report shows that large employers are generally able to pay on average at a slightly higher rate than NLW although their ability to do so is steadily declining.

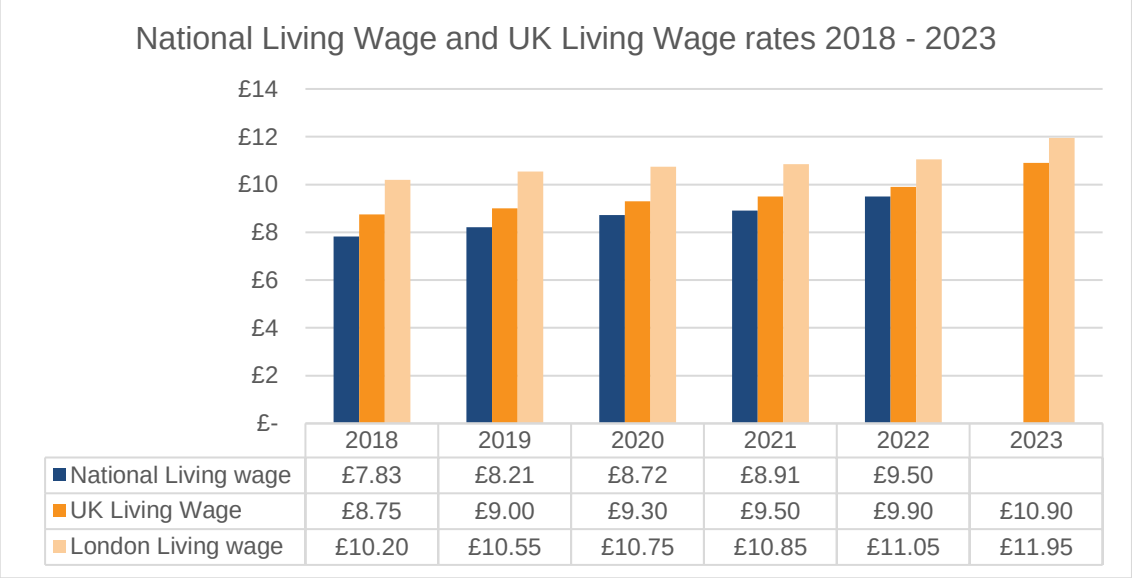
There are local authorities that stipulate that the UK Living Wage[4] should be paid to care and support staff working in services that are contracted by them, but there are also reports from CEOs interviewed for this research of some local authorities requiring this level of staff reward without being willing to fully fund it. UK Living Wage rates have on average been over 4% higher than the pay rates reported by participants in this research.

NLW and UK Living Wage uplifts are proving challenging for the health and social care sector. A mandatory uplift to the hourly rate of the lowest paid employees means that other salaries for more senior posts also need to increase to maintain appropriate differentials. Even where local authorities have increased funding to reflect NLW increases for front line posts there is rarely additional funding for other roles where costs will also need to rise.

[4] Calculated annually by the Resolution Foundation and overseen by the Living Pay Commission

We do not yet know what level the Low Pay Commission will determine for NLW for 2023. In recent years the gap between NLW rate and UK Living Wage has reduced. In 2018 it was 11.7% and this had fallen to a gap of 4.2% in 2022. To maintain the same difference of 4.2% would require NLW to increase to £10.46.

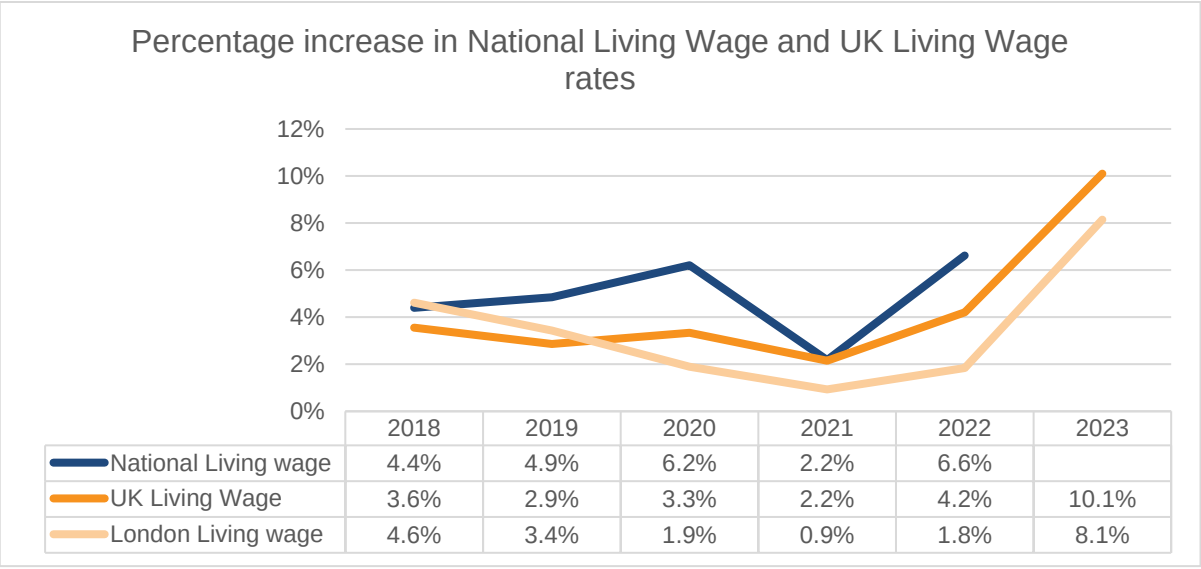
*Figure 3: National Living Wage and UK Living Wage rates 2018 – 2023*




| | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|---|
| National Living wage | £7.83 | £8.21 | £8.72 | £8.91 | £9.50 | |
| UK Living Wage | £8.75 | £9.00 | £9.30 | £9.50 | £9.90 | £10.90 |
| London Living wage | £10.20 | £10.55 | £10.75 | £10.85 | £11.05 | £11.95 |

The new rates of UK Living Wage and London Living Wage have been announced and both show a substantial percentage increase. Just over 10% for UK Living Wage and just over 8% for London Living Wage. Many predictions are that it will increase to around £10.33 per hour, which is just short of 9%. If this is the outcome, then it will be a reversal of the trend of convergence between the two rates.

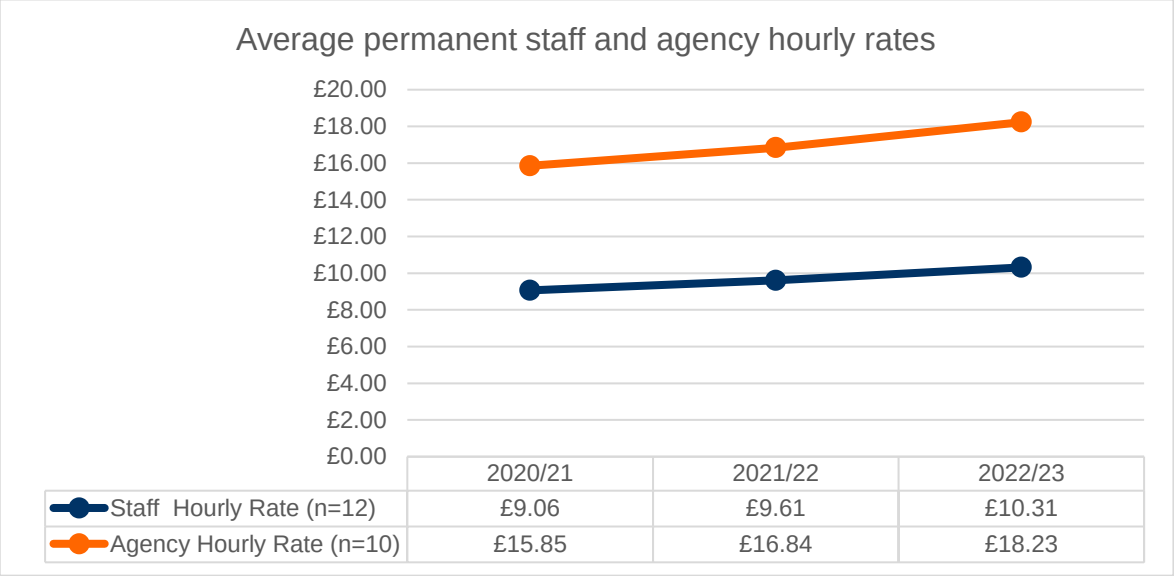
*Figure 4: Comparison of percentage increases in National Living Wage and UK Living Wage 2018 - 2023*




| | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|---|
| National Living wage | 4.4% | 4.9% | 6.2% | 2.2% | 6.6% | |
| UK Living Wage | 3.6% | 2.9% | 3.3% | 2.2% | 4.2% | 10.1% |
| London Living wage | 4.6% | 3.4% | 1.9% | 0.9% | 1.8% | 8.1% |

Social Care providers are trapped between two financial pressures: on the one hand they want to pay their skilled workforce as much as they can, and they also recognise the need to try and stay above NLW, and if possible pay UK Living Wage or higher. At the same time, they are limited in the resources they have to pay these additional uplifts given their financial dependence upon local government and the NHS.

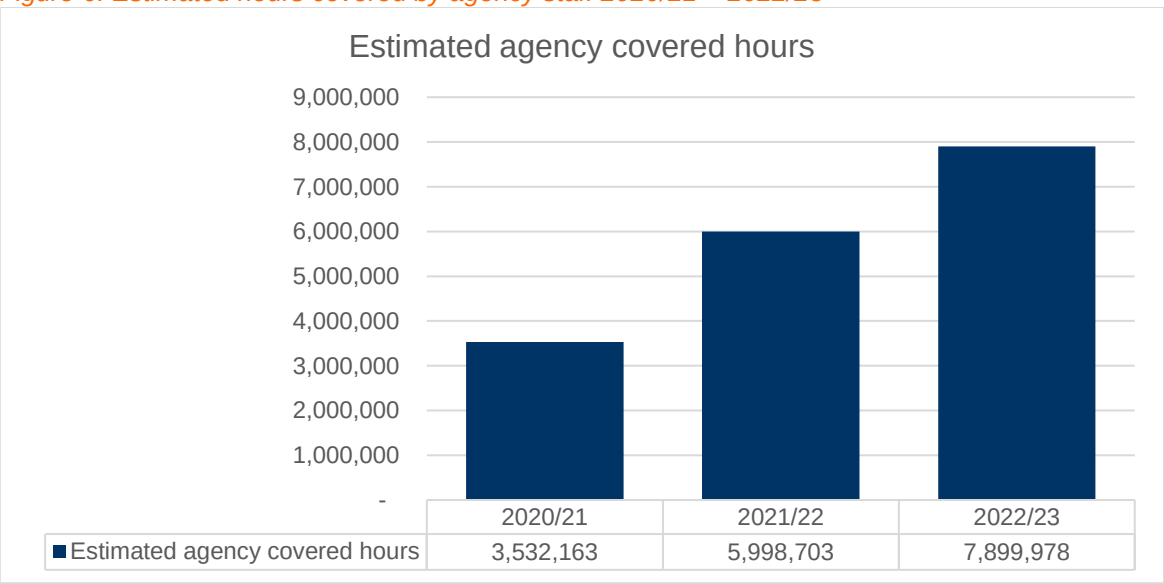
*Figure 5: Average hourly rate of permanent and agency staff*




| | 2020/21 | 2021/22 | 2022/23 |
|---|---|---|---|
| Staff Hourly Rate (n=12) | £9.06 | £9.61 | £10.31 |
| Agency Hourly Rate (n=10) | £15.85 | £16.84 | £18.23 |

Whilst providers have some very limited discretion about levels of pay for their own staff, they have little or no choice in terms of the costs of agency staff, where increased demand for from across the care sector are driving up costs. The providers in this study saw a rise in agency costs from £56m in 2020/21 to £144m by 2022/23. This equates to an increase in agency covered hours of over 4.3 million.

*Figure 6: Estimated hours covered by agency staff 2020/21 – 2022/23*




| | 2020/21 | 2021/22 | 2022/23 |
|---|---|---|---|
| Estimated agency covered hours | 3,532,163 | 5,998,703 | 7,899,978 |

Providers are concerned that this situation will further deteriorate in 2023/24 with an increasing need to hire agency staff as vacancies grow across the sector. If the current trends in the growth of the use of agency staff are maintained across all the participants in this research then costs are likely to increase to between £175million to £220million. The consequences for some providers will be larger year end losses and in the case of not-for-profit providers further weakening of their reserves position.

As already stated, low pay is not a new issue in social care but the consequences of low pay in the context of rising inflation and rising interest rates can of course be devastating for individuals. CEOs reported the use of food banks by some care staff, which is borne out by research showing 14%[5] of nursing staff using this type of provision. Qualified nurses earn more than care staff, suggesting the impact on the social care workforce will be even greater.

Below are two case studies supplied by participants in this research that report their experience of the challenges faced by their staff, and their views on what this means for the delivery of adult social care.

**Case study 1 – United Response**

Joe is the Team Manager a service. He says, *"I am currently 2 staff short within my service and several of my team have approached me saying that they are either actively looking for other jobs or potentially dropping to relief/part time as the cost of living and inflation is completely crippling them. I have this gut-wrenching feeling that by October/November I will be 3/4 staff short. Our agency usage is high also.*

*"For me as a team leader, I am feeling deflated and upset for them. Sickness then becomes high; people start to not show up (not always). I know times are hard, and I do fully understand that you as a company are always trying your best across the country to ensure it is done fairly, but I am worried it could result in a lot of homes in our area closing. Recruitment also is so difficult when staff can get other jobs which pay £10.50 minimum, with some up to £12.50/£13 an hour. At £9.80 I do not believe we stand a chance.*

*I am feeling the strain personally, my own rent has gone up from £650 to £900, my shopping for the month has gone from approx. £120 to £165/£170, council tax has gone from £135 to £165."*

**Case study 2 – Dimensions**

*James has a sister who is PEG -fed (via a tube through her abdominal wall and directly into her stomach). He visited her whilst she was in hospital and noted that none of the senior nurses there were confident in how to keep her PEG clean. James supports a person with a PEG every day and had to tell the nurses how to do it., They're paid double his wage. James is going to leave social care, not because he doesn't love his job, the*

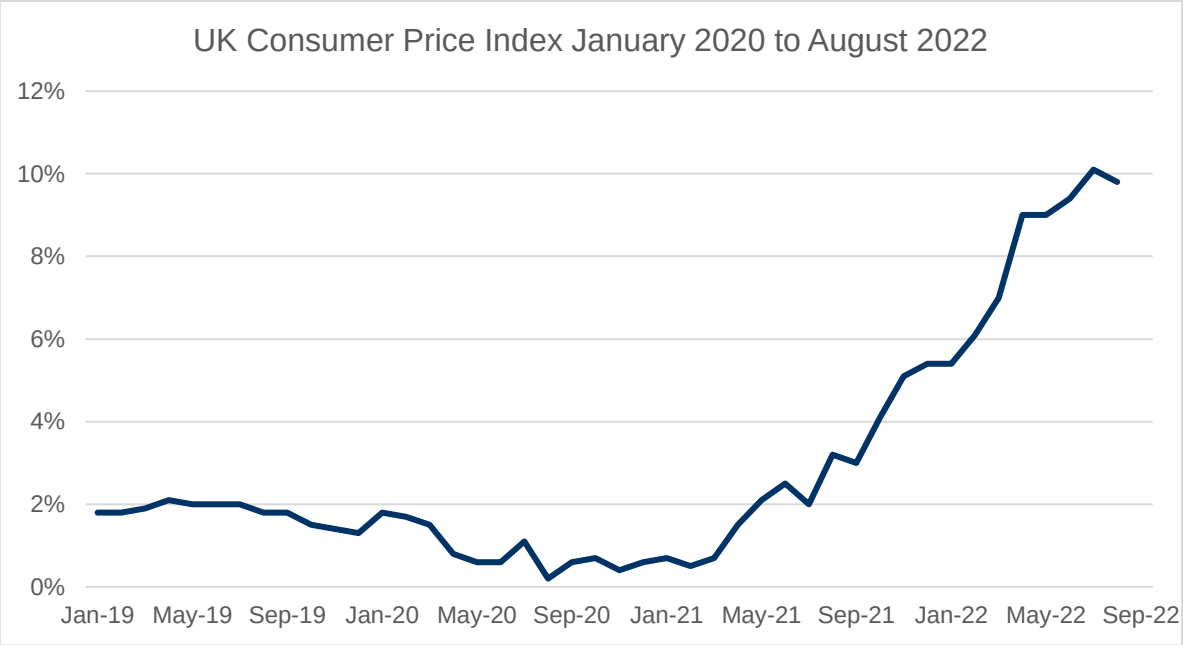
[5] June 2022 survey of 2,500 nurses and health workers, carried out by the Cavell Nurses' Trust, found 14% were using food banks to feed themselves and their family

*people he supports or his team, but because he has his own family to think about. James knows he can walk into a better paid job in the NHS tomorrow, and with the cost-of-living crisis to consider, his decision, in his own words, is a 'a no brainer.'*

## 2.2 Inflationary Increases

Inflation (as measured by the Consumer Price Index) has been rising steadily since March 2021, with particularly large increases since the start of 2022.

*Figure 7: UK Consumer Price Index January 2020 to August 2022*




Inflation has a direct impact on providers through the cost of goods and services that they require to deliver their services, but indirectly through staff costs. Rising inflation makes already low pay in the social care sector worse, and providers have very limited ability to respond by increasing their own prices, as is happening in the retail and hospitality sector.

As highlighted in the figures above on pay rates, providers in the survey are already paying above the National Living Wage and their scope to increase wages further is very limited.

## 2.3 Income, outturn and reserves

Direct wage costs and agency costs combined are the single largest expenditure for care providers, representing some 83% of their income. Rising wage costs have a direct impact on the financial stability of these organisations.

The Figure 8 below shows that six respondents were expecting to be in deficit by the end of the current financial year. In total combined losses will be around £15.8m. For not-for-profit providers this means drawing down on reserves, which in turn weakens the organisation's balance sheet and increases vulnerability to further financial pressures. When a not-for-profit

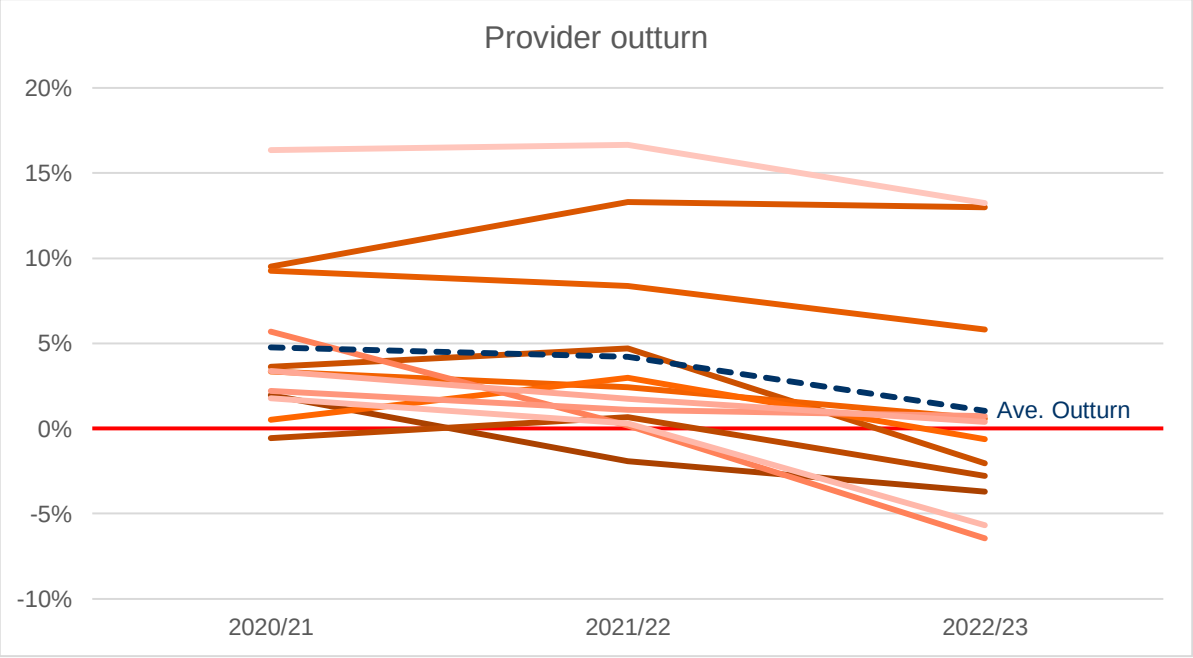
organisation makes a loss, it means that money that could have been spent on investment or service improvement is no longer available.

Even where organisations are not operating at an overall deficit every CEO interviewed reported operating some services at a loss.

The concern for all providers is that the financial situation which is impacting on them now will only deteriorate further. The government have put forward the Energy Bill Relief Scheme (EBRS) which will apply to energy costs between October 2022 and the end of the financial year in March 2023. This will offer some limited relief although clearly prices had already risen significantly before this scheme was introduced. The government have indicated that help is likely to continue from April 2023 but that this is to be more targeted and therefore more limited.

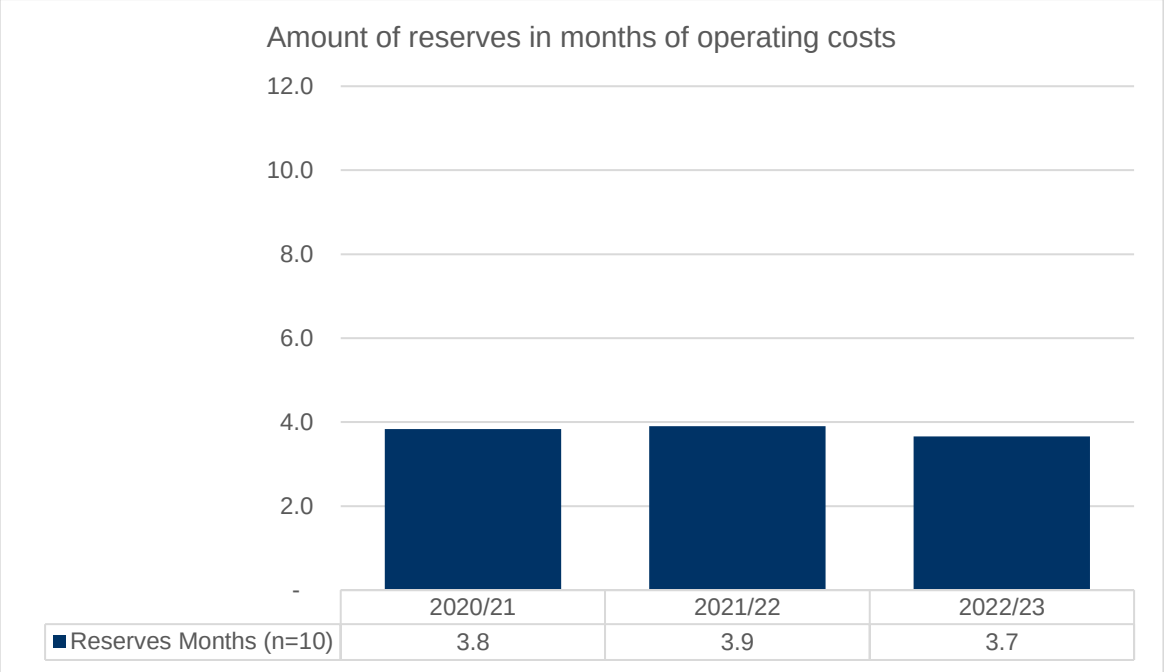
Providers are clear that unless they can increase wages for care staff their ability to compete for labour will continue to deteriorate and call into question the viability of more and more of the contracts they hold. The high level of spend on agency staff is unfunded and unsustainable.

*Figure 8: Individual provider outturn expressed a percentage margin 2020/21 – 2022/23*




Not-for-profit providers can use their reserves to cover deficits, but this can only be a short-term measure. It is clear from the figures supplied by providers that levels of reserves across the group are low, representing in 2022/23 under 4 months of operating costs. Low levels of reserves mean that the resilience of organisations is reduced. The recent bank holiday for the Queen's funeral cost one provider an unbudgeted £675,000 in additional staff costs, in the current climate such costs are significant for organisations to bear.

*Figure 9: Provider reserves expressed as months of operating costs 2020/21 – 2022/23*



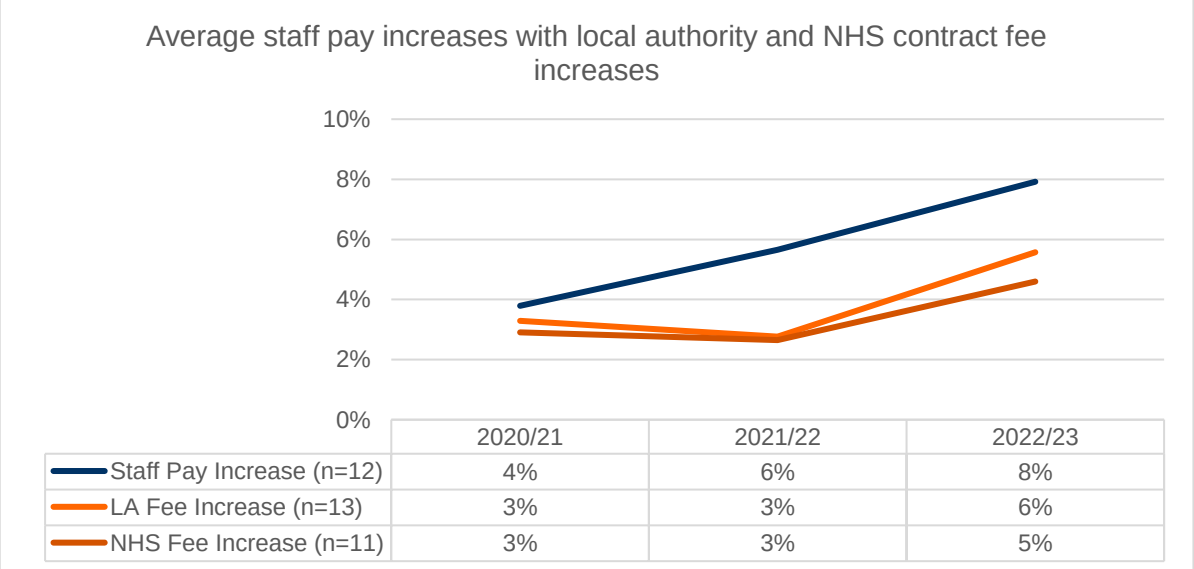
# 3 Financial Settlements with Local Authorities and the NHS

As we have noted, the vast majority of the funding for the services operated by these providers comes from contracts with local authorities and the NHS. Some funding may come directly from people purchasing their own care under Direct Payment arrangements, but this funding too comes from local authorities. As a result of this, the financial fortunes of these providers are closely tied with those of the local authorities and NHS commissioners that purchase their services.

Average contract fee increases from local authorities and the NHS have been lower than the increases in wage costs for the research period. Data collected from not-for-profit providers by Cordis Bright as part of its annual Viewfinder survey shows that financial settlements have been lower than increases in costs for many providers for at least 5 years, although there was a slight improvement in 2020/21 as a result of Covid grants.

The chart below shows the average level of local authority and NHS funded contract fee increases over the past three years. At the top of this range was a 7.5% increase, but at the bottom only 3.8%. Similarly, with NHS funded increases the top of the range was 7% but the bottom was 2.1%. This range reflects the different circumstances and approaches of different local authorities and NHS commissioners.

*Figure 10: Average staff pay increases compared with local authority and NHS contract fee increases 2020/21 – 2022/23*




| | 2020/21 | 2021/22 | 2022/23 |
|---|---|---|---|
| Staff Pay Increase (n=12) | 4% | 6% | 8% |
| LA Fee Increase (n=13) | 3% | 3% | 6% |
| NHS Fee Increase (n=11) | 3% | 3% | 5% |

Local authority and NHS commissioners are recognising the impact of rising staff and other costs on the sector, and the reported fee increases from local authorities are substantially higher than in previous years, but still fail to keep pace with cost increases experienced by providers. Local authorities are facing similar financial pressures and their ability to fund social care services beyond their own financial settlement from central government is very limited

Providers reported that they were often aware that local authorities in particular would pay more if they had the resources to do so. This is not a problem that local authorities or the NHS can solve on their own; the only place that this can be addressed is within central government.

# 4 Consequences for the sector

No service is improved by the high use of agency staff, or from the perspective of a person with a learning disability or autism, strangers coming regularly into their home. No service has ever been improved by the staff that work in it facing such acute financial distress that they need to rely on food banks to feed their families, and no service will be improved by the hand back of a contract which results in its closure and the loss of a person's home.

At its most basic the current approach to the commissioning of adult social care for people with a learning disability means that the consequences of inadequate funding are displaced from local government onto independent providers, (both not for profit and private). It is these providers that are expected to bear the losses and deal with the day-to-day realities of underfunding. From the employer they are transferred directly onto the employee who is grappling with endemic low pay. It would be hard not to conclude that this situation must also have a serious and negative consequence for the lives of people with a learning disability and autistic people.

Factors appear to have converged that makes the continuation of this approach increasingly untenable for the large providers interviewed for this research. Firstly, the inadequate funding is a long-sustained phenomenon, stretching back to the introduction of austerity. Secondly, the surge in inflation, the increase in borrowing costs and the shortage of labour are unavoidable for providers. Their scope for management strategies is becoming increasingly limited and means that actions which would not have been considered previously are now being planned and implemented.

### *Contract hand-back*

Section 4.31 of the Care and Support Statutory Guidance states the following:

> *When commissioning services, local authorities should assure themselves and have evidence that contract terms, conditions and fee levels for care and support services are appropriate to provide the delivery of the agreed care packages with agreed quality of care. This should support and promote the wellbeing of people who receive care and support, and allow for the service provider's ability to meet statutory obligations to pay at least the minimum wage and provide effective training and development of staff.*

One of the areas explored with CEOs was what happens when this standard is not met and the continuation of the service poses a financial or reputational risk to the provider. The ending of the contract is often described as 'contract hand back', although in some instances this is a misnomer as the actual result is service closure. Nearly all the comments made by the CEOs related to their experience of working with local government.

There were different ways that contracts might be ended by a provider dependent upon a range of factors such as legal status, position within the local market etc. and these are summarised later in this report. The drivers for exiting contracts were consistent across all providers regardless of other factors.

Organisations identified four main drivers for ending contracts:

- **Losing money on the day-to-day operation of the service** and the local authority unwilling or unable to increase payments to a level where no loss was incurred. The hand back for this reason would show an immediate positive financial benefit for the provider. A number of providers were clear that they expected their overall revenue to fall but their losses to decrease once these contracts were removed from their portfolio.

- **Inability to recruit and retain a permanent workforce** meaning that agency staff were needed and this additional unbudgeted cost making the contract unviable. It was also noted that the quality of services suffered when operated largely by non-permanent staff. This issue was in most cases a geographically specific challenge with insufficient supply of labour endemic across the local employment market as a whole.

- **Increased regulatory pressure from CQC** was also cited as a factor, often as a direct result of operating a service with a large number of agency workers who do not know the clients. There was a concern that because the Market Oversight Scheme largely focuses on past performance, the future risks to the sector which are still emerging may be only partially recognised.

- **Onerous and perverse contract conditions** which exported risk away from the local authority, and on occasions the housing provider, and rested this entirely on the care and support provider. In this case risks might relate to voids in residential services or failure to supply a domiciliary worker within a fixed time period. Although these types of contract terms were unfair and unrealistic pre-covid, post covid they present a major risk to providers, who can exert little or no control. If local authorities are not making placements there will be voids in services, if there is insufficient supply of labour in a local area it may not be possible to secure a domiciliary worker within the required time.

These four drivers were reported as common and often presented in combination. The way in which providers approached the exiting of contracts differed more greatly. In summary there are three main trends that we can identify.

- Firstly, there is an approach of simply waiting until the end of the contract and then either not participating in the re-tender or submitting a bid which accurately reflects the sometimes significantly higher operational costs of the service. This means that, win or lose, the provider is no longer exposed to loss making activity. This approach is not new, and it may not even have been detected by local authorities. Given the levels of inflation it is increasingly hard to envisage the re-tendering of a contract resulting in a cost reduction. Changes to providers even in this form are disruptive and generally result in some loss of existing workforce even where TUPE applies.

- Secondly, there is a piecemeal approach where an attempt to renegotiate a specific contract does not produce the outcome which means it can be retained. This could be described as operational rather than strategic as each contract negotiation is viewed as a specific and isolated event. In many ways this is a continuation of the status quo, although there was a sense among interviewees that the frequency and scale of this activity is increasing. For people with a learning disability, and autistic people using these services there is significant risk of negative service disruption.

- The third and more strategic approach is where a provider reviews all its contracts, determines those which are losing money and systematically seeks uplifts in funding or exits the contract. In the case of accommodation-based services, where a care and support provider does not own the property, the local authority can either choose to take the service in-house or seek to re-tender and bring in another independent provider. If the funding is inadequate, it may prove impossible to re-let the contract on the original terms, forcing the local authority to offer improved terms to attract a new provider. This means that the lives of individuals with a learning disability and front-line staff can be significantly disrupted, and the local authority or NHS organisation will have expended unnecessary time and energy and still need to pay more for the same service.

  It was also noted that in a number of cases providers may have had to increase staff salaries above the amount originally budgeted for in the contract. These higher salaries would be protected under TUPE which may make seeking a provider willing to deliver on the original contract price impossible.

  Where the care and support provider is also the owner of the building the consequences for people with a learning disability can be catastrophic, as 'contract hand-back' actually results in a service closing. A 'service closing' is experienced by the person with a learning disability or autism as being forced to leave their home, to be supported by new people they do not know and to have no power or control over this process. Finding a new home and support provider is the responsibility of local authorities and places extreme pressure on the system, particularly where there are concentrations of this activity.

All CEOs interviewed believed that contract hand back would increase and accelerate over the next 18 months as there is nothing currently proposed by central or local government that will prevent it.

*Contract negotiation and relationship with local government*

Providers believe that the majority of local authorities conduct contract negotiations in good faith taking a competent and rational approach, even if their financial circumstances mean that a successful agreement cannot always be reached. There are however a clear minority of councils which do not take this approach.

Providers interviewed for this research were mystified by the approach taken by a minority of local authorities to contract negotiation. All of the providers spoken with were happy to offer open book accounting to local authorities. In other words, they were willing and able to prove to local authorities the level of funding required, yet still some local authorities refused to acknowledge there was a problem. All providers reported experiences of some local authorities seeking to avoid engagement and 'play for time'. A recurring theme was a perceived lack of understanding around the costs and conditions associated with capital funding. It appeared that a number of local authority officers did not appreciate that providers needed to borrow money in order to develop services. There was also very limited understanding of the terms and conditions that lenders placed on organisations.

This pattern of market dysfunctionality is a common theme and so ingrained within the experiences of providers it has until now been largely accepted that some services will always operate at a loss because they are inadequately funded. The sea change which is

occurring is not a sudden shift but an evolved response to sustained underfunding and poor commissioning practice by a minority of local authorities over many years. The growing pressure of higher inflation and the shortages of workforce are forcing providers to take more rapid and comprehensive action to address this situation.

As was noted by a number of providers, the minority of authorities which underpay are actually being subsidised by other local authorities that are willing and able to pay the correct fees for the service they buy. This cross subsidy is seen in most cases as long standing within the social care economy, and is similar to the cross subsidy long seen in older peoples services where private funders cross subsidise those who are state funded

There is no reason, practical or moral, why organisations working on behalf of local government and the NHS should subsidise the costs of supporting vulnerable people. There is no reason why it should be acceptable to expect a provider to take on all financial risks when these relate to factors which are beyond their control. There is no reason why a local authority should expect providers to pay the UK Living Wage but not fund them to a level where this is possible. Yet all of these are current practices occurring regularly across social care.

National government has become increasingly aware of this issue and in particular how the mismatch between the funding of services and their costs is likely to affect their plans for the funding reform of social care for older people. There is currently work being undertaken to establish the Fair Cost of Care although it is only mandatory for 65+ residential services and 18+ domiciliary services. It is already likely that the funding allocated to address this issue will be inadequate and because this exercise excludes residential care for working age adults there is in fact no additional monies allocated for this group. It is far from clear if central government recognise that there is an equally acute funding problem for services for working age adults.

# 5 Proposal for action

The providers that participated in this research do not think that the challenges which are being faced will be solved quickly. They are large in scale, affecting the nation's economy as a whole while at the same time often being highly complex and locality based.

What is clear to providers is that there is nothing particularly positive on the horizon at this time, other than a possible reduction in the rate of inflation in the latter half of 2023, although given the world events which have driven the rise to date there can be no great certainty in this forecast.

There are three main areas where action mandated by central government and implemented by local authorities and the NHS could have real impact in the short to medium term:

- Central Government should commit to the principle of pay parity for equivalent roles across the whole NHS and social care economy, promoting this as the minimum pay floor for social care staff and funding local authorities accordingly. This approach would be in line with the efforts being made to establish the fair costs of care for residential care for older adults.

- Given the competitive environment for labour, social care needs to be able to compete on a level playing field within the whole health and social care economy. The pay rates for staff working in social care should be tied to the NHS Agenda For Change. This would mean most front-line care staff aligning with NHS Pay Band 3, which is currently £10.40 per hour. Additional funding for this could be specific and targeted, with employers providing audit trail proof that additional monies have gone into the wage packets of staff

- A one-off winter pressures payment equivalent to the additional £500million already provided by central government to try and speed up discharges of older people from hospital to support providers in the management of inflationary pressures and the likely intensification of workforce issues over the winter months.

Providers recognise that local authorities no longer have the capacity to truly commission individual personalised services at scale and, although Direct Payments do work for some people with a learning disability, they are usually dependent upon the presence of active family involvement.

In the medium to longer term, the single biggest change which would derive the greatest efficiency and enable providers to deliver with more flexibility and a greater focus on personalised services would be commissioning based on service outcomes for individuals, as opposed to inflexible packages of hours, often commissioned many years ago with little or no ongoing oversight.

Providers interviewed for this research had no difficultly in envisaging how an effective and professional partnership with local authorities could work to deliver positive outcomes for individuals with a learning disability and their families. They were also clear that not grasping this opportunity would represent a failure to deliver attainable improvements to the quality of people's lives.

# 6 Conclusion

The findings of this project are starting to show the culmination of sustained underfunding and shortage of labour which increases cost, reduces quality, creates greater market instability and is in turn exacerbated by low pay. Given what is forecast for the next two years, this picture only worsens over time.

Inaction effectively places these consequences squarely on the shoulders of people with a learning disability and/or autism, and their families. It will ultimately deny them choice and dignity of a decent, fulfilling and stable quality of life. Providers will do all that they can to protect the people they support but they are not the government, and they are already going beyond their charitable or business remits by sustaining loss making services.