



# BARCHESTER

*Celebrating life*

## **Competition and Markets Authority, Market Study of Care Homes, Update Consultation:**

### **Barchester Healthcare Response**

#### **Introduction**

Barchester Healthcare is a major independent provider of social and health services in the UK, with over 200 homes providing high quality nursing care, residential care, close care (assisted living linked to residential schemes) and supported living. We offer services to older people with high support needs and older people living with dementia predominantly but we also provide neuro-rehabilitation services, assisting younger adults with traumatic brain injuries and others in need of specialist care.

We also manage seven independent hospitals for people with mental health issues, often linked to facilitating transitions for people with long-term care needs moving back into the community. We have excluded consideration of our hospitals from this response.

We support approximately 11,000 residents and patients in our homes and hospitals, employing around 15,000 people, with about 2,400 Registered Nurses in the roughly 85% of our homes that are registered to provide nursing care.

Barchester Healthcare welcomes the opportunity to respond to the Competition and Markets Authority (CMA)'s update on its market study of care homes.

We are responding to consultation questions in our capacity as an independent provider.

Please note that we are responding on the basis of Barchester Healthcare's practice rather than care homes in general unless otherwise indicated throughout this response.

## Key questions

### General

1. *Do you agree with our analysis of the issues affecting the care homes market? Please provide evidence in support of your views.*

1.1 On the whole, Barchester Healthcare welcomes the CMA's report, which we regard as honest and direct, underpinned by a good grasp of market issues for care homes. We broadly agree with the analysis of issues affecting the market. In particular, we were pleased that the CMA both recognises the prevalence of good practice in the care sector<sup>1</sup> and identifies a problem with commissioning payments and potential investment in new homes<sup>2</sup>. We wish to make several points in this context, however:

- a) We do not agree with your analysis that local authority and health commissioners' payments cover the costs of care<sup>3</sup>. This position seems contradicted by the rate of homes exiting the market<sup>4</sup> and implicitly by the Care Act 2014's insistence on the need for sustainable fees. It is patently true that many conscientious and dedicated small providers struggle to sustain quality of life for residents, the standards of care to which they aspire and a reasonable profit if they are dealing exclusively (or almost exclusively) with local authority-commissioned clients. It is also widely accepted that a high proportion of local authority funded residents was a very significant factor in the collapse of Southern Cross.
- b) In our own case, Barchester Healthcare set lifestyle standards above the market norm. We take no pleasure in closing care homes, a process that is depressing or worse for everyone involved: however, we have been obliged to close three homes recently: we could not match our standards of care –

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<sup>1</sup> Competition and Markets Authority, Market Study of Care Homes, Update, 2.8

<sup>2</sup> *Ibid*, 7.13 and *passim*.

<sup>3</sup> *Ibid*, 6.16 and *passim*.

<sup>4</sup> <http://www.telegraph.co.uk/news/health/news/11543398/Wave-of-home-closures-leaves-elderly-stuck-in-care-warehouses.html>

and the requirement for a reasonable profit - to some local authority payments.

2. *Do you have any comments on our proposed next steps and remedial action, including any suggestions for other remedial action?*

2.1 We would welcome greater clarity around a tension in the update between a desire to make payments made by self-funders and commissioner-funded residents more evenly balanced against a recognition that companies cannot invest in their future without margins that self-funders give them: there is occasional explicit reference to some markets needing differentiated price structures to thrive but also references to the current payments gap being both unfair and lacking transparency.

2.2 We would welcome greater clarity from the CMA on how it believes payments that give a margin for investment can be delivered by financially squeezed local authorities.

2.3 We would welcome greater clarity on how the CMA believes top-ups can be facilitated and local authorities prevented from denying the right to top-ups, given that such practice restricts choice, as the update points out.

2.4 We also agree with the CMA that it is unacceptable for local authorities to offer only one home to potential residents because it is the only home that meets its agreed payment rates. We would welcome greater clarity on action to be taken to prevent such practice occurring<sup>5</sup>.

2.5 We would ask the CMA to note that we believe that one of the three options to reduce price differentiation the update considers, the option of encouraging local authorities to negotiate payments for self-funders, would constitute a further tightening of LAs monopsony position in relation to care homes; it would have a potentially catastrophic effect on the market<sup>6</sup>.

2.6 We agree with the CMA that greater investment in care homes is a necessity but it is not immediately clear from the update how this can be achieved or what 'appropriate incentives'<sup>7</sup> (besides fairer payments) might constitute. In terms of mature commissioning relationships and market shaping it is vital that the Competition and Markets Authority understand that it takes approximately three years to develop a

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<sup>5</sup> Competition and Markets Authority, Market Study of Care Homes, Update, 6.5.

<sup>6</sup> *Ibid*, 6.20.

<sup>7</sup> *Ibid*, 8.23.

care home and deliver new capacity into a local market. If there are either low commissioner funded fee rates or a lack of a long-term commissioning strategy in a geographical location then no care provider will take the risk of investing £8m to £10m in a project that will both face future uncertainty and deliver a poor return on capital.

2.7 Although we have reservations about the role of ‘care navigator’ and a body with oversight of fees and/or investment (see our responses to Qs 5 and 20 respectively) we would welcome further indications from the CMA on how it believes this role and organisation should be shaped. However, when new roles such as ‘care navigator’ or new ‘bodies’ with responsibility for oversight are proposed it is important to acknowledge that these will require funding from an already severely constrained public funding ‘pot’. The inevitable consequence of such proposals is a further, no doubt very significant, drain on either existing or future funding that could be better spent on front-line services.

2.8 We would welcome greater clarity on how the CMA believes poor market shaping by local authorities can be remedied – see our response to Q 20.

*3. What could be done to make information about care homes more useful and easily accessible so people can see which care homes have availability and compare factors such as fee rates, quality ratings and contractual terms or whatever other information they may find useful and can engage with?*

3.1 We stated in our original response to the CMA consultation that we would be reluctant to publish fees for self-payers on our websites, because the reality is that people pay differing amounts. Putting aside the issues of levels of dependency and care needs, one reason for this is difference between size and quality of room facilities. However, a more important key driver is local micro-market dynamics at the time of purchase, with each home having to balance local competitor capacity, service offering, reputation and pricing with our own. Within any particular home of ours there will be a range of fees received according to whether the resident is a) publicly funded and we have accepted the price offered b) publicly funded where we have negotiated a third party contribution from the resident or their family to close the gap between the public fee and the true cost of care or c) a self-funder where the fee has been negotiated on an individual basis according to the prevailing market dynamic at the time of placement.

3.2 We make information about home’s facilities available through our websites and make information about vacancies available to phone callers. We also have a range of

guidance for consumers: leaflets and internet advice include 'Assisted living', 'Choosing a care home', 'Choosing a dementia care home', 'Paying for care – a finance guide', 'Respite care' and 'Selecting your ideal care home'.

3.3 Our websites link to regulatory bodies' sites across the UK so that inspection reports are available. We also publicise 'Your Care Rating' and 'carehome.co.uk' scores, with comments from residents and relatives – negative as well as positive.

3.4 We ensure that staff in our homes invest considerable time in explaining to potential funders what is in our contract and elements of it that they need to be mindful about, which we regard as a mutually beneficial act. We discuss fees, the prospect of funds running out and the possible consequences in terms of having to move on. We establish that finances are realistic in terms of our fees and length of stay where we can. We also encourage self-funders to take independent financial advice to ensure that they have the money to pay for their care, and we set up regular "Care Fee Planning" seminars in our homes.

3.5 We believe that we make available the information that potential residents and their families require. More broadly, however, it is still the case that some people are unaware of the care home market and are sometimes surprised to find that they have pay charges for care. A campaign to make people more aware of the issues should accompany a revisited alternative to the Dilnot commission: a strategy for managing care costs, caps and long-term care placement is overdue.

3.6 We note also that a sustained theme of the Care Act 2014 is the duty of local authorities to provide advice to older people on care and support options, including offering advice to potential self-funders looking for residential care placement. It is patent that local authorities are failing in this duty.

*4. How could people be encouraged to consider, and plan ahead, for care needs away from an immediate crisis or circumstances arising that trigger a decision to move into a care home at short notice?*

4.1 This is a difficult question. It is certainly true that the lack of forethought about the possibility of admission to a care home frequently results in distress and rushed decisions. Within the care and advice sectors this has been a widely acknowledged fact for a long time, and a source of largely fruitless debate about mitigating the problem. It is arguably less the case in countries such as the Netherlands, where care homes are better integrated with local communities than they are in the UK, linked with schools and with volunteers, running cafés, restaurants and shops. Barchester Healthcare has adopted all these strategies; many of our homes also run advice sessions for local

communities on older age issues and host appropriate local clubs. While it is probably true to say that significantly fewer people give the issue of planning ahead for care needs no thought at all now as opposed to, say, 20 years ago, it remains an issue that many are reluctant to consider, apparently as the result of an entrenched reluctance to face the prospect of old age, frailty and dependency. Reviving the debate around the issue of long-term care needs, costs and caps last considered in depth by the Dilnot Commission would allow for an airing of issues that might encourage more people to think through the possibility of future care needs.

4.2 The Care Act 2014 placed a duty on local authorities to offer advice on care and support options for older people. If that were to be delivered upon the public as a whole would be much better informed on the need to consider options for care needs and to plan ahead.

*5. Do people need greater support in considering the care options available to them and in choosing a home, and if so what are the best ways to ensure this is delivered effectively, e.g. giving greater personalised assistance through ‘care navigators’ and other advocacy services?*

5.1 Brokers for care home services already exist: there are a wide variety of agencies offering advice, such as Independent Age, Age UK and the Elderly Accommodation Counsel. Additions to available advice would be welcome - but it is difficult to see where ‘care navigators’<sup>8</sup> would emerge from or how they could preserve neutrality whilst being sufficiently familiar with the care home market to make recommendations. Perhaps there are some choices for which we simply have to take personal responsibility.

5.2 We would reiterate the point that when new roles such as ‘care navigator’ are proposed they require funding from already severely constrained public funding. The inevitable consequence of such proposals is a further drain on either existing or future funding that could be better spent on front-line services.

5.3 It is worth noting that responsible care homes make available as much information about care options as they can and are more concerned with making sure individuals know about the best options available to them than simply with filling their own beds.

5.4 See 3.6 and 4.2, above.

## **Complaints and redress**

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<sup>8</sup> Competition and Markets Authority, Market Study of Care Homes, Update, 3.30 (a).

6. *How can people be helped so that they feel more comfortable in making a complaint about a care home, e.g. through advocacy or support services?*

6.1 Again, this is a difficult issue. It is clear that many older people and their relatives are uncomfortable complaining about care home services, as the CMA suggests, lacking the capacity to complain<sup>9</sup> or feeling that they may be discriminated against if they do so<sup>10</sup>.

6.2 We have tried hard to address this issue at Barchester Healthcare, inculcating a culture based on openness, learning and the duty of candour. It is nonetheless clear from remarks reported by regulators that a proportion of residents and their relatives remain uncomfortable with the prospect of complaining about services.

6.3 To some extent this may be a reflection of a particular time. We hope that a commitment to openness and the contribution of complaint to positive change will eventually find a resident and relative culture eager to embrace it.

6.4 We have experimented with buying in advocacy and support services in the context of complaint in various forms and have not always found it helpful for residents and relatives. There is often a disparity between how advocates see their role and how residents and relatives see it.

7. *Would it be helpful to introduce a model complaints process specifically designed for care homes in each of the four nations?*

7.1 Yes. A model process in this area would be helpful although there are clearly some dangers in a 'one size fits all' approach. There will be a need for a degree of flexibility.

8. *To what extent would better signposting and access to the ombudsman improve the complaints processes?*

8.1 We signpost the ombudsman in our homes' statements of purpose, tailored to each separate UK regulatory regime. However, In general we hope to resolve complaints without the need for residents or relatives to approach the ombudsman.

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<sup>9</sup> Competition and Markets Authority, Market Study of Care Homes, Update, 4.8.

<sup>10</sup> *Ibid*, 4.7 and *passim*.

9. *What role should regulators play in relation to complaints systems and complaints from individuals?*

9.1 We believe that all national regulatory bodies should offer their help to residents and relatives who want to make a complaint. It is a vital form of oversight, expected by residents and relatives.

**Consumer protection**

10. *Are there any other consumer protection concerns in relation to care homes that we have missed and which we should be looking at?*

10.1 We do not believe so.

11. *Would it be helpful to produce further guidance for care home providers on their obligations under consumer law and, if so, what should it cover?*

11.1 Further guidance would be useful in this context: what is required from providers is not always clear and may have evolved over time in a way that provider responses have not always matched.

12. *Could self-regulation play a greater role in this sector to drive good practice e.g. through the development of voluntary consumer-facing codes of practice?*

12.1 Yes. The process suggested in Q 11, above, might inform the development of such codes. There are a number of reputable provider representative groups covering a wide spectrum of provider interests that would be prepared to work on such codes of practice and would be effective in doing so. In most cases, as the CMA update suggests, the care home sector strives for openness with potential clients. That is not to say that we could not do better.

13. *What role might sector regulators play in helping to further 'embed' compliance with consumer law and best practice across the sector?*

13.1 The CMA clearly envisages a role for regulators in embedding compliance with consumer law. Indeed, it is difficult to think of a workable alternative. On the other hand there is a genuine issue of capacity. The Care Quality Commission (CQC), for example, has experienced major cuts in its funding and an increase in its responsibilities: there are signs in terms of time taken to produce reports and engagement with providers that it is under strain.



*14. Are there any areas where additional consumer protections may be necessary beyond those provided by consumer law, existing sector legislation and national care home standards, e.g. in relation to ensuring clear, timely and comprehensive information for people when choosing care homes and to safeguard residents' deposits in full?*

14.1 We do not believe that further legislation is necessary in this area. As an organisation we safeguard residents' deposits and trust that other providers do the same. We strive to communicate clear information about the services we provide because we believe it is in everyone's interest to do so. It is certainly true to say that many potential residents and their relatives consider their choice of a care home ill-prepared and under stressful circumstances. A culture shift is perhaps already underway in this regard, with such a high proportion of the population in potential need or already in a position where a relative or friend has considered available care home options. While a general, awareness-raising publicity campaign associated with a post-Dilnot strategy for care costs, caps and long-term care would be a positive move we do not believe that care homes can be asked to do much more that they currently do.

#### **State procurement**

*15. Are there any areas in relation to the procurement of places in care homes where more sharing of good practice amongst public bodies would be useful, e.g. in relation to offering choice to people and facilitating top-up payments?*

15.1 Yes, we believe so. As the CMA report suggests<sup>11</sup>, it is clear that providers believe some local authorities do not offer genuine choice to individuals looking for care homes and their relatives. This is clearly contrary to the spirit and letter of the Care Act 2014 and the prior Choice of Accommodations Directions<sup>12</sup>: it cannot be acceptable.

*16. What factors should we take into account in our further work exploring price differentiation between publicly funded care home residents and self-funders?*

16.1 This is a complex question, and one about which the CMA update seems to us to be ambivalent.

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<sup>11</sup> Competition and Markets Authority, Market Study of Care Homes, Update, 6.5 and *passim*.

<sup>12</sup> Guidance on National Assistance Act 1948 Choice of Accommodation) Directions, DH 1992.

16.2 From our own perspective it is clearly difficult to justify inequitable payments between self-funders and commissioner-funded placements: we are on record as objecting to this inequity in a number of consultations about care sector payments. On the other hand it is difficult to imagine financially squeezed local authorities and a government in a time of austerity finding the requisite cash to step up payments through local government to a point where they cover the margin for investment in care homes for the future. We welcome (and agree with) the CMA update pointing out that such investment is a necessity in the face of rising demand<sup>13</sup>.

16.3 In our view the Scottish government made a commendable attempt to bridge this gap, supported by providers: unfortunately it is clear that the attempt failed, resulting in rationed care, a postcode lottery in terms of what is offered to older people and renewed disputes between providers and commissioners on what should be acceptable levels of payment.

16.4 The reality is that in our care homes overall commissioner-funded residents' costs are not covered by commissioners' payments: we chose to accept them on the basis of keeping up occupancy levels. Bluntly, we could not run care at the standards we do in our homes without a substantial number of self-funders paying a higher rate for care. We are committed to those standards, which we believe are an important aspect of our offer, and appreciated by residents and relatives, including those paying premiums for it.

### **Investment in future capacity**

#### *17. What are the barriers to providers responding to future needs for care home beds and how are these best addressed?*

17.1 Barriers include:

- a) Unsustainable payments/high costs of care/low profits/increasing quality imperatives from regulators.
- b) The availability of finance from lenders to fund new developments.
- c) The availability of land designated by local planners as suitable for care homes.
- d) The cost of land
- e) An undersupply of nurses.
- f) A market place in which care workers are frequently paid less than people working in supermarkets.
- g) A lack of clarity over local commissioning and long-term planning.

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<sup>13</sup> *Ibid*, 8.8, 8.14 and *passim*.

17.2 It is very difficult to make contact with commissioners, let alone plan confidently for the future together. This is compounded by the very rigid gate keeping of Commissioning Support Units.

17.3 There is a lack of capacity in some areas and a lack of specialist care. Current commissioning payment rates and practices are unhelpful, as the CMA update notes.

*18. Can local authorities and other commissioning bodies effectively 'shape' how local care home markets develop and, if so, what are the indicators that this is working well?*

18.1 As stated in our previous consultation response, where we are aware of market-shaping taking place at all it is often crude in the extreme (e.g. rejecting new applications on the grounds of possible costs).

18.2 Exemplars of the lack of strategic thinking and the failure to live up to the demands of the Care Act 2014<sup>14</sup> underlying commissioning practice include:

- a) A lack of an outcome-focus
- b) An inability to move towards services integrating healthy and social care or relieving 'bed blocking': in fairness, there is some good practice in this area but it is not widespread
- c) When we closed a home recently because it was no longer financially viable many residents had subsequently to be placed in homes where fees were considerably higher than those the local authority was prepared to pay us

18.3 It is worth noting that local authority-managed homes run at far higher cost per client than they are prepared to pay in fees to the independent sector.

18.4 We would not want to deny that there are islands of good practice in commissioning and market-shaping - but they are localised and often dependent on personal relationships

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<sup>14</sup> <https://www.gov.uk/government/publications/adult-social-care-market-shaping/adult-social-care-market-shaping>

*19. What is the potential to promote long-term considerations through better sharing between local authorities and other commissioning bodies of good practice on care home 'market shaping' and planning and procurement?*

19.1 Please note our response to Q 18, above. We agree, of course, that sharing of good practice is a valuable exercise in principle.

19.2 Nottingham provides a rare example of effective commissioning for integrated health and social care planning and investment in care homes, the need for which is recognised by the NHS Five Year Forward Plan<sup>15</sup> and has been a major theme of recent informed commentary. Nottingham offer training to care home workers on medical issues and provide a specialist NHS support team for residential and nursing home providers. That means that 'step up' and 'step down' options prevent unnecessary or unnecessarily long hospital admissions for older people. Such admissions are notoriously deleterious. Local care homes offer re-ablement in an environment where choice, comfort, preservation of life skills and an avoidance of anti-psychotic medication as a treatment for dementia are articles of faith, overseen by regulation. As with palliative care, it is clear that properly supported care homes provide a more comfortable, less debilitating and cheaper alternative to hospitals. Given that this is well known and that guidance to commissioners has stressed the benefits of integrated health and social care for many years it is an extraordinary indictment of commissioning practice that so little has been achieved.

*20. What is the scope to establish an independent body or bodies with a duty to provide support and guidance to local authorities and other commissioning bodies in relation to long-run planning and facilitating development of care home capacity?*

20.1 We strongly believe that there is a case for oversight of commissioning bodies active in the care market, probably involving regulatory bodies, as the CMA update implies. While there is evidence of good commissioning there are too many instances of very poor commissioning and a dearth of strategic thinking. Current commissioning practice is far too often simply contracting for the lowest price and, as a consequence, the negation of consumer choice in that market.

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<sup>15</sup> Demand is also heavily impacted by... availability of social care." "The NHS Five Year Forward View crystallised a consensus about why and how the NHS should change.... also dependent on well-functioning social care..." <https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf>

20.2 We find it difficult to conceive of an effective ‘independent body (or bodies)’ able to influence commissioners without such oversight. There is also the issue of cost. We make the point for the final time that such an independent body or bodies will require funding in an environment where resources are scarce and best spent on front-line services.

### **Funding and staff challenges**

*21. Would there be merit in establishing an independent body (or bodies) to develop a framework to estimate reasonable fee rates, which will take account of the full cost of care, to advise local authorities and other commissioning bodies, and to adjudicate on disputes between local authorities and providers?*

21.1 With the caveat expressed in 20.2 above, yes. The current situation benefits no one, with local authorities setting payments that they refuse to break down and match against care home costs and care home providers forced to take recourse in legal action and judicial review<sup>16</sup>. The position is widely perceived as even worse for domiciliary work<sup>17</sup>. The increasing use by local authorities of ‘Dynamic Purchasing Systems’ or ‘reverse auctions’ where providers who choose to take part are forced to undercut one another distort the market and remove choice for consumers, effectively treating people as commodities.

21.2 Laing and Buisson (in collaboration with the Joseph Rowntree Foundation) have already produced a tool that is a widely accepted basis for determining the true costs of residential care<sup>18</sup>.

*22. Would there be merit in local authorities being required to be more transparent in relation to the fee rates they pay for care home places and how these fees are determined?*

22.1 Yes. Please see our response to Q 21, above.

*23. How should the challenges of recruitment and retention of care home staff be addressed, including by local authorities, in particular are there any regulatory barriers to the labour market?*

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<sup>16</sup> <http://www.walesonline.co.uk/news/wales-news/judicial-review-of-care-home-fees-1880078>

<sup>17</sup> [http://www.careshowcase.org.uk/sites/default/files/5%201230%20Duncan%20White\\_REV\\_0.pdf](http://www.careshowcase.org.uk/sites/default/files/5%201230%20Duncan%20White_REV_0.pdf)

<sup>18</sup> <https://www.jrf.org.uk/report/calculating-costs-efficient-care-homes-0>

23.1 Our principal recruitment difficulty as a care home provider is recruiting and retaining nurses, a difficulty likely to be exacerbated in the future by an ageing nurse population, falling student nurse recruitment, Brexit and the consequent reluctance of EU nationals to take up positions in the UK. We are pleased to note the CMA's suggestion that other UK regulators should adopt CQC's recognition of Enhanced Care Assistants<sup>19</sup>. We are currently providing training for our existing care workers with the aspirations and abilities for this career progression. We also note the Care and Social Services Inspectorate Wales' very recent proposal that nursing homes should not necessarily be overseen by nurses on a 24-hour basis<sup>20</sup>. While we have reservations about this suggestion it may be the only practical way of guaranteeing the future of nursing homes in the UK.

***Barchester Healthcare welcomes the opportunity to respond to the Competitions and Markets Authority's update on their market study of care homes.***

***We should be pleased to respond to the Competitions and Markets Authority if any issues raised above require clarification or amplification.***

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<sup>19</sup> Competition and Markets Authority, Market Study of Care Homes, Update, 8.6: Barchester Healthcare has its own training and role, known as 'Care Practitioner' on similar lines.

<sup>20</sup> Phase 2 implementation of the Regulation and Inspection of Social Care, Part 10.