



**A Voice for Older  
People in Care**

## **The Relatives & Residents Association**

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### **Response to CMA Care Home Market study**

#### **Written evidence from The Relatives & Residents Association**

##### **About the R&RA**

I. The Relatives & Residents Association (R&RA) speaks up and speaks out on behalf of older people in care homes. It is the only national charity for older people providing a daily helpline, which concentrates entirely on residential care for this age group.

II. R&RA was founded to campaign for a better quality of life for older people living in care homes. By using the unique perspectives of relatives and residents, we work in harness with others to help improve service and standards. We also try to influence policy and practice by reflecting the experience of our members and callers who use our daily Helpline and thus can make evidence based comments on the case we make, the research and training we carry out and the policies we advocate.

III. We provide support and information through our Helpline and enable older people and their relatives make better informed decisions about looking for a home, explain their rights under guidance and regulations, and the benefits and standards they should expect.

IV. We also act as a listening ear to help support families and individuals at what is often a time of crisis and trauma for them, when it becomes apparent that a partner, parent or friend can no longer live at home. We also help them when there are difficulties, complaints and concerns about the standard of care and often act as brokers between the relative/concerned individual and the care home.

V. Our comments are based on our Helpline service and our activities, including training, research and feedback about the reality of daily life in care homes for older people. Inevitably, our Helpline service is largely sought by relatives experiencing problems within care homes. However, we acknowledge there are many homes where very good care is provided and that there many frontline members of staff who are doing their utmost to provide the best quality of life they can for older people living in residential and nursing homes.

##### **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.**

They are sound on the whole but it is important to differentiate the different players. As the report makes clear, the care sector is made up of a wide range of providers, from owners of very few homes (i.e. less than five), who make up the vast majority, to large corporations. Some of these are made up of multi-nationals, with numerous subsidiaries and, often, complex funding/debt arrangements. It is difficult to discern the true state of the sector from many of the current generalisations and descriptions of larger providers. They are regularly described in the context of buyouts, bond issues, refinancing and inter-company loans, which does not help comprehension or analysis about current or prospective profitability and the future prospects. [✂]. There is general agreement that local authorities have suffered greatly from major budget cuts which have affected their purchasing power and the

**Chair** Judy Downey

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fact that they are financing fewer care home residents, despite the known demographic pressures, which has led to general despondency about the state of the 'market'.

However, some sector experts are stressing the high levels of return to be expected from investment in the residential care home sector. The recent report on care home trading performance from Knight Frank ([Care Home Trading Performance Index, February 2017](#)) makes fascinating reading. The report, completed for the fifth consecutive year, offers a benchmark for performance as measured by the key indicators of occupancy rates, average weekly fees, staff costs and profitability. This detailed report shows that the care home sector shows a third consecutive year of higher average fee levels and higher occupancy. This means that, despite rising staff costs, care providers have still been able to realise a rise in average profitability to 27.5% (up from 27.1% in the previous year). See, too, the following two extracts:

[http://www.carehomeprofessional.com/care-home-market-rude-healthsayssavills/?utm\\_source=Email+Campaign&utm\\_medium=email&utm\\_campaign=42388-212534-Care+Home+Professional+DNA+-+2017-06-16](http://www.carehomeprofessional.com/care-home-market-rude-healthsayssavills/?utm_source=Email+Campaign&utm_medium=email&utm_campaign=42388-212534-Care+Home+Professional+DNA+-+2017-06-16) and

[http://www.carehomeprofessional.com/health-plus-care-healthcare-sexy-says-knight-frank/?utm\\_source=Email+Campaign&utm\\_medium=email&utm\\_campaign=42388-214472-Care+Home+Professional+DNA+-+2017-06-29](http://www.carehomeprofessional.com/health-plus-care-healthcare-sexy-says-knight-frank/?utm_source=Email+Campaign&utm_medium=email&utm_campaign=42388-214472-Care+Home+Professional+DNA+-+2017-06-29).

According to the Knight Frank report, average weekly fee rates are now £694 i.e. an increase of 2.7% on the previous year and the fifth consecutive year of growth. Fee levels are higher for nursing care, again with significant regional variation from £566 to £897. In addition, the reliance on self-funding clients (which almost certainly accounts for the rise in fee rates) varies from 19.5% in the North East to 51.2% in the South East.

As a percentage of income, staff costs now account on average for 58.2% of turnover although it's 61.1% in the North of England. It is also higher for not-for-profit providers as a result of the combination of higher pay rates, better terms and increased staffing levels. This analysis is for the period to the end of March 2016 and therefore does not include the impact of the new National Living Wage. This review estimates that profitability has slightly increased to 27.5%. Interestingly, personal care homes are achieving higher profits than nursing: 32.3% compared to 26.4%.

Although the data are complex, there is also evidence that profit in some of the largest care homes peaks at 35.9%. Knight Frank concludes therefore that the underlying trends suggest the care home sector is reasonably well insulated from many of the economic challenges faced by the U.K. Whilst the National Living Wage and the use of agency staff may well put pressure on staff costs, occupancy and fees look set to continue rising. For various reasons, we can expect that smaller care homes will be most at risk.

These findings appear to fit well with the themes highlighted in the roundtable and survey report of Barclays, Knight Frank and Pinsent Masons facilitated by Caring Times, which indicates rising occupancy levels, improving relationships with local authorities and generally positive confidence for the future. Focusing solely on care homes certainly appears to show a confidence for profitability.

It is, therefore, a mistake to see the care home market as an undifferentiated one. In relation to England, there are many markets within the country, and sometimes within local authorities, which present quite different realities. There are areas with a range of choices and others where this is severely limited. There are also important regional and local variations, apart from the varying policies and budgets of the commissioners. The market has become quite skewed with the virtual disappearance of local authority provision and the dominance of the private sector, with a very small not-for-profit sector.

It is also erroneous to link cost with quality. There are far too many homes charging much higher than average fees, and which nonetheless, continue to breach many of the basic standards required by the Regulations and give great cause for concern.

Nor are we convinced that simply increasing Local Authority (LA) funding will improve the quality of care or investment in the sector without far better protections for residents to ensure that the regulations and their needs are met. When the NHS contribution to the nursing element goes up, fees tend to go up to exactly the same amount, without any noticeable improvement in staffing or care.

References to third party top-ups (TPTU) within the report are not always accurate. They are erroneously described as though they provide a positive way to increase choice. There is, however, evidence to suggest that they are out of reach for most families, and have been misused by LAs, reducing their own financial burden. (See Independent Age's report and the Local Government and Social Care Ombudsman (LGO) report 'Counting the Cost').

The CMA report says some providers have expressed concern that local authorities are not permitting residents to pay top-ups (section 3.25), and thus limit choice. This misinterprets the Care Act. The local authority is required by law under the Care Act 2014 (but was in fact already the case), to ensure that any person taking on a TPTU can afford to do so. The essence of this is that it is a third party. Further, unless all parties agree otherwise, this should always be paid to the LA and not to the care home. This is a practice that we would encourage as it is the LA who is responsible for contracting the care and ultimately responsible in ensuring that a resident's fees are paid.

However, we still hear of LA's providing poor information about care home funding, requesting TPTUs from relatives to prevent the resident from moving into a care home far from family and friends as well as attempting to distance themselves from arrangements for additional fees sought by care homes from residents' representatives in direct breach of the Care Act. This practice can lead to real financial hardship to relatives, who may be on a limited income and retired themselves.

TPTUs can easily reach a £1000 per month and TPTU costs usually increase disproportionality to that of the LA contribution. Confusion around care home funding has led to families agreeing to TPTU because:

- they have been worried about the care in the single choice of care home offered by the LA;
- misunderstood and thought that they could pay the TPTU from the resident's income;
- hadn't realised that a TPTU was going to be charged because they thought the fees would be met by the LA, given the home had been 'chosen' from a list supplied by the LA and did not then wish to move their relative. (This topic is discussed further below)

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

The report makes useful points about the lack of equity for the consumer (or their representative) and the subsequent failure of the care sector to be subject to normal consumer pressures, due to the nature of a "distressed purchase" of this kind. It also describes the lack of information and nervousness about the dangers and considerations involved in moving elsewhere, even where there are major anxieties and concerns about the care in the current home. However, there is little discussion about remedies to help overcome this lack of "purchasing power".

### **Choosing care homes**

#### **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?**

Providing clear information about contract terms and fees with details about what services are included and what additional fees may be incurred would be useful. This might well save exhausted and stressed relatives many unexpected bills for 'extras'. However, we are cautious about the value of ratings and the number of different awards produced within the sector, which are difficult to evaluate by prospective residents, their relatives and other purchasers.

We would like to see more relevant information produced by the homes themselves and by the regulator in their inspection reports. Important information, like staffing ratios; turnover; training undertaken and its status i.e. whether e-training or actual hands-on and accredited training. For example, whether or not all staff, including kitchen staff, cleaners, maintenance staff, hairdressers, etc., are trained in dementia communication?

Does the home organise visits from health professionals, like an NHS dentist, optician, chiropodist and audiologist? Is medication regularly reviewed by a pharmacist? Do physiotherapists visit? These are the kinds of questions people wish to know about and the answers should be freely available. Much of this information is already recorded within the Provider Information Returns required by the CQC, but is not publicly available.

#### **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?**

Those people who thought they were planning ahead and took out the then available insurance products a few years ago, found that many of these financial products contained small print that made them irrelevant when they were needed. The few, more honourable, products could not sustain the unpredictable costs which ensued. Most people expect to get to retirement age but few can afford to plan for their retirement, judging by the statistics on savings. Most people do not think that they will necessarily need residential care. The vast majority of those now entering residential care have some form of dementia, often associated with a number of other degenerative health conditions (or co-morbidities).

At present, a relatively small proportion of the age group goes into residential care. In addition, it is a destination feared by most people according to recent surveys and the vast majority wish to end their lives at home. It is, therefore, an uncomfortable topic which people find hard to face and this is unlikely to change. Most people become residents after a crisis affecting their care e.g. death or serious illness of a partner or other close relative who is the main carer, or after a deterioration in their own conditions, often after an acute hospital episode, involving pressure to “find a bed” elsewhere, often at short notice.

We suggest it is more important to improve standards and quality of care. There needs to be more publicity about what good care looks like and also more about what is unacceptable and should not be allowed to continue. Educating people on what they can expect and what quality care can achieve may help to strengthen the “consumer” position. This also implies having greater transparency about how care is delivered in residential care homes. Most people don't place relatives in poor care homes on purpose and only find out about the poor care after they have moved in and the shiny façade of awards and glossy brochures falls away. We, at R&RA, produced the *Keys to Care* resource, not just for care workers but also to help relatives know what they should expect from decent care.

#### **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?**

We support the idea of advocacy. However, it should be truly independent. We have heard of ‘care brokers’ finding homes that have no relevance to the person needing care. This includes an example where an elderly gentleman was moved into a failing care home too far away for his wife to visit and double the LA rate, despite having only a few thousand pounds over the capital limit.

We are not sure what is meant by ‘care navigators’. This used to be the role of social workers. However, it is rare now, due to budget constraints, that trained and experienced staff take on this role. It is now more usual that fairly junior administrators are given this responsibility and are often ill-equipped for the complexity and sensitivity of this task. Whoever takes it on would need to be bound by appropriate confidentiality, keep detailed and accurate records and have training in both assessment and funding requirements under the Care Act, and have real accountability to the people and the families they are helping.

## **Complaints and redress**

### **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?**

We regularly take CQC to task, due to its unfortunate and illogical stance on complaints. This has been an intrinsic part of the regulatory role since the 80s and until 2007, when the second national regulator, CSCI, had a major budget cut. It is true that the system used was too bureaucratic. The answer was not, however, to abolish the role completely. It is still part of the role of the regulator in Scotland. Setting up new systems will have little effect unless those who have concerns and complaints feel less vulnerable and feel reassured that there will not be repercussions. Most of our callers with serious complaints will not give us permission to inform CQC and are wary of raising the complaints with the home itself.

The now superseded regulations<sup>1</sup> in England required homes to give details of their complaints process to all residents and their representatives. The regulations currently state that there must be such procedures but omit the need to promote them as actively as before. Having a third party involved, such as an advocate, might be a possible way to reduce negative and defensive responses to complaints.

However, we believe that this is not the main barrier. Ultimately it is both the disparity of power between consumer and provider that is the fundamental problem, as the CMA report emphasises, as well as the failure of some inadequate care providers to take responsibility for their actions. In England, unlike Scotland, the bodies charged with reviewing complaints do not have the power to take action against the provider should they find in the complainants favour. This is another reason why the regulator, which has strong enforcement powers, should be fully involved.

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

Unless there was a body put in place to oversee this complaints system, such as the CQC, that had the power to ensure redress to a complainant, it would not make any fundamental difference but would be seen to be a token gesture if nothing else changed. To have a process for the four nations would mean that Scottish consumers would lose the redress under the regulations they now enjoy since their regulator continues to investigate complaints.

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

The ombudsman has produced some excellent reports. However, it lacks enforcement powers. It cannot insist that the care home changes its practices by a particular date or reduces its intake, or force any action upon a care home. In addition, time constraints mean this is not an avenue that will correct poor care, as many residents needs may well have changed radically or some may have died, by the time a case is investigated. Most relatives are deterred by the time scale the LGO needs, and also because they generally know little about sources of redress, even when they have the energy to pursue their concerns. At best for care issues, it may provide an apology, which is worth little after such a long period, nor does it generally provide an avenue for change and better care via the regulator, as the CQC does not take into account evidence more than six months old.

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

R&RA has long argued that it is and always was, until the relatively recent past, an intrinsic part of the regulator's role to investigate complaints, as stated above. CQC accept that it is their responsibility to respond to breaches in the Regulations. However, the problem is that, not surprisingly, the average person does not usually know that what they see as a complaint or serious concern is actually a breach of the regulations. They don't even know that they exist. Most complaints relate to poor care or neglectful care. Many of these are caused by the lack of training and supervision given to staff, and sometimes by the high turnover of the staff and/or the failure of the registered manager to be good enough themselves or to ensure adequate standards of competence. Something like one in five care homes has no registered manager in post.

CQC's website states that it does not investigate individual complaints, meaning that their role is focused on the way the home operates. This is confused and confusing to most people and goes against most good practice in

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<sup>1</sup> The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

regulation. If a person is not being fed, has lost weight or does not get out of bed until the afternoon, because there aren't enough staff, raising this kind of complaint gives the regulator exactly what it needs to know about the way in which the home is or is not complying with the Regulations. To tell those who raise concerns/complaints to go back to the provider, or as happens sometimes, passing the complaint to the LA Safeguarding Team, is a totally unsatisfactory response.

It also means that the regulator is abdicating its responsibility to take appropriate enforcement action. Despite its best intentions, the regulator comes across to those expecting its protection as unresponsive and remote. Neither the LA nor the LGO can take such action. It also has the effect of allowing poor care and, sometimes, dangerous care to continue for far too long. For example, a care home in the North West received a 'good' rating and had passed all inspections. Yet, we are informed that it agreed with the LA to restrict entry into the home between the last two inspections due to major safeguarding issues. In addition, we understand the LA worked with the home for months to prevent further major risks to the residents' well-being. During the same period, we are aware that a relative raised their own concerns about a resident's care and were asked by the home to remove that resident on the grounds that they could no longer meet their needs and their concerns were said to be "unfounded" by the home. CQC were aware of these problems but it was left to the LA to resolve these problems before CQC carried out another inspection.

## **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?**

It is not just only self-funders who need consumer protection or who have problems with contracts, this also affects LA supported residents, their families and their attorneys (POA). It is often the case that they (or their representatives) may never get to see the terms agreed for their care. They, too, need to know what these are. There should be far more transparency about contract terms with this group, too, if unfair additional expenses are to be avoided. This is very important when so many residents will be frail and lack capacity. Sometimes the home manager has been given or acquires control of their personal finances. These situations make it even more difficult to understand 'extras' charged for. Even those residents who have capacity, as well as those with relatives who are closely involved with their care, find it impossible to challenge them. Local authorities, too, could protect their citizens better by ensuring that contracts make it quite clear that these kinds of practices should not occur.

We are also very concerned about providers putting pressure on those who have POAs to guarantee fees. They are often not in a position to agree to such unknown costs and it can be tantamount to asking a person to sign a blank check. We strongly believe this practice should be made unlawful, if existing consumer law does not already prevent it.

This is well illustrated by a recent example from the R&RA Helpline. We were recently contacted by a resident's daughter, who had a severely restricted income and no savings. She was her mother's attorney. She had signed just such a contract. It had given her responsibility for paying top-up fees for two years after her mother's funds had run down. She had signed it under pressure from the care home manager, who had produced the agreement during a visit to her mother and had required her to sign it there and then. Given that her mother was already in the home and she did not want to move her, she felt she had no choice but to agree. It was only when she got home and read the contract that she understood the implications.

Under the Care Act, it is unlikely that she would have been granted a TPTU agreement, since her finances were insufficient to be able to demonstrate that she could maintain such payments. The pressured insistence by the care home manager placed her in an impossible position.

TPTU seem to be seen by the CMA report as a means of achieving choice. However, as already explained, they can quickly become financially crippling. There has also been much publicity in the past about some LA's using TPTU as a norm for placements. TPTU should not be seen as a means to keep older vulnerable people close to spouses, families and friends. Both the Care Act (*6.106 of the Care and Support Act Guidance states that an eligible outcome that needs to be considered is the ability of a resident to maintain family or other personal relationships*) and the Human Rights Act is also clear about the right to family life. The CMA report unfortunately seems to give the impression that this practice can be condoned. Given the particular vulnerabilities of residents, and many of their

representatives, in addition to their relative lack of knowledge and power, it is unreasonable to ask for these 'guarantees'. As shown above, these can too often become exploitative because most family members will not wish to antagonise the home.

It is not just TPTUs that are sought directly by care homes, either with or without the consent or knowledge of LA's. We have had two cases in different areas where the residents' contribution has been required to be paid directly to the home, and not to the local authority, despite the resident having no contract with them, not to mention the fact that it is contrary to the provisions of the Care Act.

### **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?**

Yes, but it would need to be quite clear about its status and also include the relevant provisions in the Care Act as well as what would be considered good practice. This would also need to be widely promulgated by the CQC and become part of the regulatory process. In ordinary consumer law, it might be acceptable to accept contributions directly from residents and their representatives. However, it needs to be understood that this is a contravention of the Care Act, which prevents this practice, to protect both the resident and their representatives. It is our experience that many providers often have little knowledge of the Care Act, particularly at home manager level. The report raises the issue of the common fear of complaining due to fears of retaliation with eviction or other restrictions. However, it makes no suggestions about combatting this prevalent attitude.

It might be helpful to consider these responses as breaches of contract. For example, where home managers produce the seemingly spurious argument that they can no longer 'meet the person's needs' and ask for them to be moved in response to queries, questions or complaints, despite the fact that both their registration category and statement of purpose make it reasonable to expect that they would be able to cope with precisely such needs. There should, in such cases, be a requirement for a full explanation of why this is the case and also that this detailed response is copied to the CQC, as well as to the resident and their representative. This stated inability to meet the needs of a particular individual might also suggest, unless the person has exceptional needs, that the home is not capable of complying with regulations in terms of the needs of that client group.

This might then act as a much needed deterrent to arbitrary eviction, or restrictions in visiting, where in fact the person has no unusual needs, but the relative or resident is seen as a nuisance or worse. Perhaps, in addition, unless there is good evidence to the contrary, the regulator should treat this kind of arbitrary action as an indicator of lack of fitness by the management, which should trigger an inspection.

### **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?**

There is no evidence for this kind of approach. Indeed, a quick search of CQC's website will show many care homes which consistently breach the regulations, yet never seem to perform below some notional threshold for long enough to be subject to enforcement action. These are some of the most worrying homes. R&RA considers that given the weak bargaining power affecting most residents and representatives, and the lack of normal market forces to challenge care sector providers, self-regulation would have no impact and may lead to abuses of power as demand continues to rise.

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

We believe that the regulators, as in Scotland, should return to being responsible for investigating complaints. While England continues to use 'light touch' regulation and providers are not held sufficiently accountable for their management of complaints system, with no rights of tenure and little choice, 'consumers' will not feel confident to raise concerns or challenge providers. Given the frailty of residents who are often totally dependent on the service for their daily well-being and quality of life, those investigating a concern/complaint about a provider must have the power to act and act swiftly. It would also be helpful if CQC reports were less stolid and formulaic and more user-friendly. We have recently undertaken an exercise comparing both the style and content of the current regulator's approach with that of their predecessor (the CSCl). The latter had far more relevant and useful information and was easier to understand. They also used to include the name of the author of the report, which seemed more helpful and approachable, as well as conforming to reasonable standards of open government.

More frequent inspections would also be helpful, bearing in mind the increased frailty of residents and the known fragility of care homes. This would mean that there would be shorter gaps between inspections and reports might then be more reliable and up-to-date.

**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?**

If consumer laws are not currently tight enough to prevent use of guarantors, deposits or hidden charges, or separating residents' monies as required in other sectors (housing), legislation needs to be tightened and practice changed as suggested above.

In some places, LAs are in a powerful position to ensure homes they contract with are providing a good standard of care to their residents. However, on the basis of research we have previously carried out it seems clear that most authorities don't even know how many of their residents have no kith or kin or anyone in regular touch with them. This figure is normally around 10% of the care home population. For this group of residents there is no one to speak up or speak out on their behalf.

**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?**

Emphasis about choice is surely a proxy for quality. The disappointing level of care and staffing in too many homes (see CQC's own figures on the unacceptably low percentage of 'outstanding homes' for older people (around 1%), compared with the percentage rated as outstanding in schools (c20%) or early years providers (15%). Also, please see above our concerns over use of TPTU's to help 'choice'.

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

Clearly, there are and always have been major differences in purchasing power, depending on the status of the purchaser. For example, as exemplified by the wholesale and retail price differential throughout most markets. However, even where the LA is purchasing individual places, there needs to be a balance between their fiduciary responsibility to their population and the needs of vulnerable groups. The dilemmas posed in the context of austerity do not have obvious or straightforward solutions.

Councils could, however, be more responsive to the needs of their care home residents by ensuring that assessments are made by properly trained professionals and take full account of these assessed needs in placement decisions. They should be emphasising the quality of care they are contracted for and ensure that the contract does not allow for 'extras' to be charged for basic services and necessary appointments. These can include going to medical or out-patient appointments, entertainments, shopping or other outings or excursions, which should be an intrinsic part of normal care home life. (See earlier comments on the LA and contracts.)

**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?**

This question seems to regard the average care home resident as comparable with hospital patients. Most good and competent care home providers are providing far more than just 'beds'. They will present a positive and stimulating total living environment, with interesting and engaging activities, even for those with complex needs. Most members of staff in such homes are trained, skilled and empathetic in their interactions. The meals are sociable and nourishing, with a good range of choices and sensitively offered help and support, with appropriate additional services. They happen in a context where different kinds of activities and other kinds of social engagement flourish. To refer to 'beds' in this way adds to the negative perception of life in a care home. However, it is undoubtedly true



that most local authorities seem unable to respond to future or current needs imaginatively in the current financial climate, where budget cuts continue to bite.

The current expenditure context means that the quality of older people's services seems to have regressed in many ways. Crude assumptions made about the needs of older people, based on simplistic lists of physical tasks, which makes the work of care staff arduous and demanding with little room for relationships and stimulus, as described above. Unlike care designed for younger people with disabilities, it is unusual for activities and outings, for example, to be included into a care package for an older person.

**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?**

We have seen some excellent examples of good LA commissioned care, designed to ensure high quality homes in their area. For instance, some years ago the London Borough of Islington commissioned three care homes to the highest standards of care. However, those days seem long gone.

**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?**

Many years of austerity and outsourcing of residential care services have made it difficult for commissioners to concentrate on improved quality, when the need to move 'bed-blockers' and cut services seem paramount.

**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?**

Developments are already happening with CCG's and others where there is a shortage of care home capacity to meet local needs. However, there must be caution in creating new institutional structures and those which may complicate the market further for consumers.

**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?**

Who is best placed to do this? LaingBuisson calculations on the cost of care generally give little or no value to training, which should be intrinsic to good care. There seem few drivers in the current market to promote quality of care, as distinct from the quality of the environment, i.e. en-suites and 'hotel' type decoration in too many expensive homes. We would wish to see any innovation on these grounds focusing on the quality of life for residents, with trained and skilled staff, low turnover and decent pay. The current discourse is focussed on the cost of care and not enough about its quality. There is some interesting innovation in the not-for-profit sector but it is hard to see how this can be widely promulgated in the current marketplace without improved local and health budgets.

**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?**

What would this achieve? There is not one market as we have stressed elsewhere. We know that there is no relationship between cost and quality. However, where it is clear that local authority or any commissioned care is not good enough, there is too little action to ensure rapid changes in standards. On the other hand, many relatives and residents would welcome more transparency from care home providers about fees i.e. what they cover and what is excluded,.

**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?**

Those care homes that pay the real living wage, like Anchor, have seen significant reductions in staff turnover. Generally speaking those care homes with good leadership, who invest in their staff and train them well, have better staff ratios and provide good meaningful training retain their staff and rely less on agency workers. Even with an

improvement in the minimum wage, unless there is proper mandatory training, which is appropriately accredited and which ensures career progression and decent pay, the crucial complex work care home workers undertake will remain unrecognised and unrewarded.

ENDS

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