

## Submission to the Competition and Markets Authority "Care Homes Market Study" Update Report

### Robin Hall, Bursar, Home of Comfort for Invalids, June 2017

*The author is also a local representative for the Hampshire Care Association and although this submission is made on behalf of the Home of Comfort, it also reflects to some extent the wider concerns of providers of residential and nursing social care in the Portsmouth area.*

The Home of Comfort is a Nursing Home run by a Charitable Trust. We have operated as a non-profit making respite and care home for the elderly in Southsea, Portsmouth since 1896. Today we offer fully Nursing care and are registered for up to 29 beds with the Care Quality Commission, all in single rooms.

Approximately 25% of our residents pay their own fees, 25% are funded by the NHS Continuing Healthcare scheme and 50% are funded by Local Authority Adult Social Care.

Our current fee rates are as follows:

- Our self-funding fees are £96.42 per day, or £674.94 per week.
- Our local authority, Portsmouth City Council, currently pays £75.69 per day, or £529.83 per week; This is approximately 20% short of our self-funding rate. (PCC pay a higher rate of £584.22 per week for clients with a dementia diagnosis, but although we have a small number of residents for whom we receive this rate, the Home is not primarily a dementia care home.)

For our self-funding and ASC funded residents, we receive Single Band FNC funding in addition to the above rates of fees.

In April 2016, we increased our self funding fees by 2.6%, the first increase since 2013. At the same time, we were awarded an increase by PCC and PCCG of 1.1%. The Trustees felt that although regrettable, a further widening of the gap between self- and local authority-funded rates could no longer be avoided if the Home is to remain viable.

This April, we increased our self funding fees by a further 1.5% (to the rate above). We have been awarded a 4% in Social Care fees, and are still waiting to hear whether we will receive any increase to CHC fees.

Most of our ASC funded residents are funded by PCC. We have two residents from other local authority areas. Both of their funding authorities are paying us PCC rates, and matched the increases we received last year and this year.

We submit the following detailed information for the consideration of the committee.

### General

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

In the main, we agree with your analysis and consider your report to be thorough and clearly laid out.

However, we note the highlighted sentence below and would like to ask you to consider further evidence on this point:

*6.16 The price difference has been referred to as a cross-subsidy, with the assumption that self-funders are contributing to the costs of serving state-funded residents. It is widely believed that the prices paid by local authorities impact on those paid by self-funders. Indeed, we have been told of homes that set fees for self-funders once they know local authority fees in order to achieve a revenue target. **We have seen no evidence of local authorities paying fees that fail to cover the home's direct operating costs in providing care, and many homes survive with very few or no self-funders. Nor are prices for self-funders lower in homes without local authority funded residents. However, there is scope for local authorities to pay rates that cover operating costs***

*and allow homes to remain open, but below the rates that would cover the costs of long-term investment in new capacity.*

We have submitted evidence to the Commons Select Committee review of Adult Social Care in August setting out our costs and showing how these are in excess of the funding rates provided by our local authority. This is most clearly illustrated by the fact that the Home is not making large surpluses in spite of the substantial difference between the rate we charge to self-funding residents and the rate we are paid by local authorities (approximately 20%).

In 2015, the last year for which accounts are available, we made a loss of £23.250.

It should be noted that unlike any of the commercial homes that operate in our area, we do not have any mortgage or other finance costs to pay, and we have received an income from our investment portfolio over recent years. We do not believe that we pay our staff significantly more than other local homes. We suggest our financial results illustrate how difficult it must be for commercial providers to cover finance costs and make a profit in the current local market.

We have been engaged with the local authority and provided them with full details of our operating costs, including evidence of staffing levels and wage levels. Their own calculations, carried out at the end of last year so before the increase in the National Living Wage, show the cost of providing care to residents whose needs don't trigger for CHC funding to be £626.57 per resident week (exclusive of the FNC payment) which is 18% below their 2017 funding rate.

During discussions we have been told that PCC do not believe there is an issue with their funding rates because providers in the local area are not exiting the market, i.e. going bust or closing down. We believe they are ignoring the issue of cross subsidy which exists in every nursing home in the area which is still accepting local authority funded residents. The long term result of this will be a reduction in the number of places available for those who are local authority funded, and a resulting lack of choice.

We also believe they are not considering the impact on the quality of care given. More than half of the nursing beds in Portsmouth are in homes which have been found to require improvement or inadequate. The local authority continues to place new residents in those homes.

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

We ask that the CMA investigate further the actual cost of care, and whether local authorities are paying a realistic rate. We fear that in many places the rates on offer are not sufficient to cover the cost of providing safe services.

We would be happy to supply any information which the CMA would find useful to look into this. We also suggest the latest Lang Buisson report provides evidence of the shortfall in adult social care funding rates.

We would also like to ask the CMA to consider the impact of occupancy on costs and rates. Presently there is a lack of capacity in our local area which has led to a bed shortage. This puts pressure on everyone in the system including:

- Providers who are pressured to turn rooms around and process admissions very quickly
- Commissioners who are spending time chasing rooms around, and
- Those looking for care who are often having to join a waiting list, unable to go to the Home they would prefer because there is not a space, and find themselves pressured to make decisions quickly.

High occupancy is the only thing keeping some local providers afloat at present. If this changes due to a new home in the area, one unforeseen result may be the rapid closure of others due to a drop in occupancy. We do not believe local commissioners understand the very significant effect of changes to a Home's occupancy rate on its financial position.

We would also like to ask the CMA to consider the pressure placed on families to make decisions more quickly than is reasonable when their relative is in hospital and there is pressure on hospital beds. (We will expand on this request below later.)

## 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?*

There are a large number of different websites available, including NHS choices and carehome.co.uk. At least one local authority we deal with also has their own online directory. Both providers and those looking for care find this confusing, and providers often do not bother to try to keep them all up to date as there are so many. It would be helpful for those seeking care if there was a single place where details of vacancies and rates could be kept up to date.

We need to be realistic about vacancy information. In areas such as Portsmouth, there are not enough nursing beds and providers often maintain a waiting list. It is very difficult to keep commissioners up to date because the situation changes often. (People both in the Home and waiting to come here often die, may change their minds, or have a change in needs.)

Commissioners are rightly working to help service users return to their own home where-ever possible, but often fail to keep providers informed. This can mean that we are not aware of plans that are being made which will lead to a room becoming vacant.

It is difficult for a provider to know whether any of the enquiries they have received will turn into admissions. We currently have two empty rooms at the Home of Comfort. One new admission is planned for tomorrow, and everything is in place, so this is likely to go ahead – though not certain, as the individual may pass away or decline in health. We have a list of people interested in the Home, some of whom have said they wish to be notified if we have a vacancy as we are their preferred provider, though it may be that those people have gone elsewhere. Some of those people may also have died. So although we have an empty room we do not know whether we should be advertising it until we have checked with everyone on our list.

We note that it is common practice for some providers to always state that they have a vacancy when asked for the purposes of vacancy directories to make sure that they do not miss out on potentially desirable admissions. We also believe some providers will be 'in discussions' with more than one potential resident for a single vacancy, as the number of 'defaults' (i.e. clients who are expected to be admitted and then are not) is significant, and providers rely on keeping occupancy high.

Conversely, providers report being asked to come to a hospital to carry out a pre admission assessment only to find multiple providers have been asked to do so is very common. Another local provider very recently reached agreement with the CCG on a CHC funding rate after carrying out an assessment only to find the client was placed elsewhere without anybody informing the provider. That provider had carried out a considerable amount of preparation work prior to the expected admission, and had turned away other potential residents for the room. This damages trust between commissioners and providers, and encourages the kind of undesirable practices described above.

*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?*

Local and central government must find a way to bring social care up the news agenda and encourage people to think more about what they want for themselves and their relatives. The consequences of longer life expectancy and improved survival rates must be the subject of a calm and well informed public debate around social care and how this should be funded.

GPs may be able to play a role in this as they are in contact with many older people who are at risk of such a sudden crisis. It would be helpful if GPs raised these issues at regular healthchecks with older people. If ways can be found to encourage the insurance industry to offer more products in this area, this could also stimulate discussion and press coverage.

In our experience, as described in your report, most people coming through our door have absolutely no idea what residential nursing care is likely to cost until the day when their Mum or Dad has a need for it. For so many reasons, we must find ways to increase that level of awareness.

*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, eg giving greater personalised assistance through 'care navigators' and other advocacy services?*

In our experience, the current support system for those who are looking for care is often inadequate. There have been huge cuts to the social work team locally and resulting in insufficient capacity. For a new referral to be allocated a social worker often takes more than a week. We are aware of a case in which a gentleman remained in hospital while medically fit for discharge for eleven days before a social worker was even allocated to arrange the care needed before he could be discharged.

Most of our residents come to us from hospital, often after a stroke, other illness, fall or infection which has caused a deterioration in their condition to the point where they are no longer safe to return home.

There is a team of discharge social workers at our local hospital. There is also a separate discharge brokerage team, who we understand are financially rewarded for arranging quick placements.

Families looking for a placement for a loved one usually come through our door knowing very little about the system for funding of care, and having had no support to help them know what criteria they might use in making their choice.

Partly this is due to the bed shortage in our area; often families will effectively have no choice, being forced to go where there is a vacancy, if the potential resident is not self funding or not likely to be self funding for very long.

We would also say this reflects pressure on the staff responsible for offering support, who seem to use to be very stretched, and poorly trained. To offer two examples:

One specific and major error: We are aware of one case where a family sold a property after being told a gentleman would need to pay for his own care, when in fact they were entitled to have the value of this property disregarded because a close relative who had looked after him was living there, and was made homeless by the sale. It took more than three months for the local authority to admit this was an error, by which time the family had exchanged contracts on the sale.

One general issue: Hampshire CC and Portsmouth CC produce a number of information leaflets about choosing and paying for residential care. There are generally very good, comprehensive, informative and clear. It is very rare for any family members to have seen these before they come to view our Home and in fact we keep a stock of them to hand out. We cannot understand why they are not being provided to people at the point at which they are told that their relative needs nursing care, and feel this should be a simple thing to fix. (We have reported this at the numerous forums we have been asked to attend about how to improve the hospital discharge process, but nothing appears to be changing).

It also appears to use that many staff are focussed on getting patient out of the hospital bed, rather than ensuring that person's care needs are met. Few if any of the discharge staff appear to show any empathy for those family members who are burdened, often without warning, with the need to find care. Your report acknowledges the pressure that people in this situation are under. Our experience is that those who are supposed to be helping them rarely acknowledge this.

There is considerable pressure on providers to offer speedy admissions; we received a letter in December from the CEO of our local hospital asking us to prepare to assess potential residents in the morning and admit that afternoon to help clear 'blocked beds'. This kind of timescale allows no opportunity for individuals or families to consider their options.

Often these individuals have been in hospital for many weeks, or even months. We do not understand why families are not warned in advance that there might be a need for residential care and asked to prepare accordingly.

In our area, we believe there are people in place who should be responsible for managing discharges and liaising with clients and their families, but due to manpower shortages, poor training and lack of empathy or appropriate focus, they often fail to do so in an organised and empathic manner.

### **Complaints and redress**

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

As your report identifies, this is a cultural problem. Every care home must work hard to develop a positive attitude to comments, suggestions and even criticism from residents and visitors. We use regular residents and relatives meetings, anonymous surveys and comment cards and try hard to encourage everybody who works here to be focussed on what we can do better. This attitude has to come from the very top and be 'lived' on a daily basis by managers, including around their own performance.

We would emphasise that while we believe this works for much of the time in our home, it does not increase the number of formal complaints; instead we believe it means we hear about problems earlier and can discuss and address them before they reach the formal complaint stage.

We do believe it is vital to ensure every resident and their representatives are made aware before they come that we have a formal procedure, and that there are places they can go to if they are not happy with our response. We have a copy of our complaints procedure on the wall in the entrance of our Home, and include one with every information pack we give out to potential future residents.

Fundamentally, we believe it would help if Care workers were better paid and valued by society and if the profession had more status. However the cost of doing this would be significant.

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

Yes, so long as this process allowed for variations in the structure of different homes. For example, we have a board of Trustees, where Homes in a chain may have a regional manager or overall quality manager.

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

We do not feel that 'local government ombudsman' is an obvious place to go with complaints to ordinary members of the public. Often they feel that the CQC would be the place they would go.

It is up to every Home to make sure residents know that the ombudsman exists and what it could do for them.

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

The CQC is the public face of improving quality and should support members of the public who wish to make complaints.

### **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?*

We would like you to consider specifically what support and protection is in place for clients who do not have relatives who are able to assist them. There is a common assumption that everyone coming into care has children or other relatives who will be able to help them chose a Home and do things like read through the Home's contract to check it is fair and appropriate. In our experience this is often not the case; not only are

there many older people without children (a group whose numbers are increasing), but more often than you might think any children may be geographically distant (we have several relatives whose children are all overseas), estranged from their parents or unable to take on these onerous responsibilities. As the population ages, it is not uncommon for the next generation to have died before our residents, or to have suffered health problems themselves.

Social services, stretched from years of budget cuts, are usually involved in the end, but we have never known them ask to review out terms and conditions for private residents. We believe there are many more people whose placement is arranged by a friend because there is no social service involvement. In our experience most of these friends are good people and trying to do their best, but they are even less likely than family members to ask rigorous questions about payment arrangements and simply do not appreciate how vulnerable both they and the individual are in this situation. No doubt there are also cases where elderly people are taken advantage of by someone who is arranging care. Providers find ourselves in very difficult circumstances at times, and such situations are not helped by the long delays in obtaining support from safeguarding teams. (The last safeguarding referral we made about a resident with no family who we believed was suffering financial abuse took more than 2 weeks to be attended to by PCC ASC.)

*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; We believe the managers of many homes lack awareness of this area of law. We are also of the view that just as (as described in your report) most members of the public do not recognise the care of an elderly person in a residential setting as a consumer – supplier relationship, many smaller providers do not readily think of their relationship with residents in this way, and so it would not occur to them to consider the provisions of UK consumer protection laws.

Clear guidance would help to raise awareness and to educate providers about their responsibilities and residents/families about their rights.

Should new guidance be produced, it would be important that they be circulated as widely as possible.

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

We suggest caution in relation to any initiative which might generate more administration and paperwork that could simply become something else for providers to keep up to date for it's own sake, rather than drive a change in ethos. Providers almost always have a statement of their ethos and values and policies on complaints and duty of candour and we believe these would be the appropriate place to include statements on consumer rights.

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

The CQC should check how complaints are handled by any provider, and carry out checks to make sure that terms of residency are clearly set out before each admission. We believe they should speak with residents (where appropriate) and relatives to ensure not just that they were provided with full information, but that this was clear and they had ample opportunity to review it and raise any questions and concerns.

We believe this should be part of the CQCs consideration of whether a service is 'Caring'; simply providing good care 'on the floor' of a Home is not enough without proper genuinely caring support before people come to the Home.

*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, eg in relation to ensuring clear, timely and comprehensive information for people when choosing care homes and to safeguard residents' deposits in full?*

In an ideal world, some sort of 'cooling off' period would help to ensure nobody is pressured into signing a contract to secure a place which may not in fact be suitable for them or their relative. However we cannot see

how this could be implemented in practice, given both the shortage of places in reasonably priced Homes, and the pressures on people to move quickly once a need has been identified.

We feel considerable reluctance to advocate the introduction of a deposit security scheme as the last thing anybody in the sector wants is more regulation and administration, but if there are Homes which are not fairly and promptly returning deposits something must be done.

Providers need to be able to ask for some kind of upfront payment to ensure that there is a mechanism for funds to be paid (we have encountered plenty of situations where a resident has funds, but is not able to access them), but if the bad practice described in your report is anything other than a few isolated cases something will have to be done to address it.

Any deposit scheme must be easy and low cost for providers to use, as any costs are likely to be passed onto residents and families; otherwise it must only be compulsory for providers who take a deposit, rather than an advance payment of the first months fees.

It would be greatly helpful if \*\*\*\*\*

### **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, eg in relation to offering choice to people and facilitating top-up payments?*

Sharing of good practice is so poor as to be non-existent. Every Local Authority has their own processes and these differ in substantive ways; for example, the dates of payments, the length of payment periods, the date of review of fees and client contributions, how these are notified to the Home and whether client contributions are collected by the Authority or by the Home directly.

In addition, when we are asked to take a client from a new Authority, it is extraordinarily difficult to find out how their system works as most staff simply do not realise that not everybody does it their way. It is problematic to find the right person to help with this query, especially now several authorities have outsourced payment solutions to third parties who not only cannot help, but are unable to provide a contact point that can.

A clear and common system would be very helpful, not just for providers but also for residents and families. Another common issue is poor communication from Local Authorities in relation to existing placements, for example when a client is depleting her or his own funds and is being assessed for Social Care funding. Families commonly assume that the Home will be informed by the social worker involved, but this rarely happens. We, and administration staff from other Homes, often find ourselves sitting with families trying to work out what is happening in regard to their relative's placement from the communications received by them and by us.

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

This price differentiation is unavoidable while the shortfall in public funding rates for social care continues. Providers are finding their costs increasingly rapidly and fee rates are not keeping pace with this. (We have healthcare funded residents who have been at the Home since 2010. In that time our staff costs have risen dramatically partly due to increases in the legal minimum wage; we have received so far only one fee increase of 1.1%.)

In the Portsmouth area, we have been told that the city council will not place with providers who charged a top up fee unless this top up is to cover a specific additional cost which the resident has chosen to incur, for example an en suite bathroom.

In these circumstances Homes like ours have no alternative but to charge self funders higher fees.

Our actual cost of operating the Home is approximately £725 per resident week (based on occupancy of between 90 and 95%). This means that we need an income of £570 per resident per week, plus the single band FNC payment, to cover our costs. Our local authority rate is only £530, which is why our self funders are being charged £675.

We are happy to provide the authority with all of the information we have already send to our local commissioners during our negotiations with them for 2017/18 fee rates, including our management accounts, if you require evidence of these costs.

For now we will include only one attachment, a spreadsheet devised and completed in October 2016 by the finance team at PCC based on the data we sent to them. These figures, which do not take into account the increase in wage costs in April this year, determined our actual cost of providing care to be £626 per week plus the FNC contribution.

We suggest other data sources your study should consider are the Lang Buisson reports, and the NatWest annual care home survey.

We also ask you to consider the lack of any commitment by public commissioners to increase agreed rates in line with increasing costs. We appreciate that commissioners do not have an endless pot of money, their current practice is failing to reflect year-on-year increases in the cost of providing care. This disincentives providers from offering care to CHC funded residents. It also incentivises those who will accept healthcare funded residents to inflate their initial rates to cover potential cost increases in the future, a situation which is detrimental to commissioners and best use of public funds.

### **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?*

Providers face considerable risk of increase to future costs. A typical home is spending between 50 and 70% of turnover on staff costs (for us at the Home of Comfort, with no finance or mortgage costs, approximately 85% of our spend is paying wages). Other costs are increasing – for example, providers face significant increases in the cost of consumables such as gloves and aprons as the value of the pound is falling – but it is staff costs that are the primary issue.

Every increase in the National Living Wage pushes up these costs across the board; it is not possible for a provider simply to increase their lowest rates of pay, because if Care staff and Senior Carers are not receiving a pay differential for the work and responsibility involved in their role, they will not want to take on that work and responsibility. For nursing homes, the situation is exacerbated by the current and worsening crisis in nurse recruitment. Providers have also faced staffing cost increases due to changes in statutory payments and the introduction of auto-enrolment pensions.

Given the long lead time getting a new home fully operational, and the failure of public funding rates to keep pace with rising costs any provider considering opening a new home cannot rely on their calculations of profitability carried out today to be realistic.

Some providers also report problems with accessing finance. Banks take a highly cautious approach to a business which is spending so much on staffing, and some existing (and profitable) homes have reported issues with their banks simply to obtain credit for refurbishment or to refinance existing loans.

*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?*



Commissioning bodies can only influence a market which they understand, and it is our belief that those in senior (decision making) positions in many authorities do not understand the care market. In a number of parts of the country, there is no dialogue at all between commissioners and providers or provider representatives. Where this is happening, providers often feel that commissioners are simply paying lip service to the requirements of the Care Act and that no meaningful dialogue is taking place.

Our local commissioners do carry out quality surveys and audits, but local providers complain these duplicate the information required by the CQC. It would be helpful if commissioners could make use of information that providers are already supplying to CQC rather than asking for it in slightly different formats.

In Portsmouth, commissioners are continuing to place clients in Homes which have received Requires Improvement or Inadequate ratings from the CQC. It is hard to see how this practice incentivises other providers to maintain or improve quality standards.

If a commissioning body is having a positive influence on market developments, they will have a good knowledge of local providers and be able to identify and respond to expected future gaps in the market. A shortage of suitable placements indicates a failure of 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?*

Coordination between local authorities, even neighbouring ones (such as Hampshire and Portsmouth) is, in our experience, very poor at present. There must be scope to improve local provision by working together to develop practices and processes, and by coordinating their efforts to speak to providers.

There is also scope to share effort and best practice between Health and Social care. Alas, even in Portsmouth (where commissioning is supposed to be integrated) we have differing approaches and practice, staff acting in a territorial fashion, protection of individual budgets at the expense of total cost to public funds and a failure of coordination. This can be as simple as inviting each other to meetings and forums; providers in our area have been invited to so many separate meetings on the same topic areas (improving hospital discharge and workforce development are two particularly popular ones) by different people who are rarely even aware of each other – let alone talking to each other – that most providers no longer make time to attend these sessions.

At the end of last year we wrote to the organisers of a local hospital discharge improvement forum asking for improved coordination and the response we received suggested our letter hadn't even been read.

When providers see such obvious waste of commissioning resources, we are hardly motivated to provide support for the series of cost reduction initiatives being rolled out, or indeed to accept arguments that funds are simply not available for fee increases.

*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?*

There must be an opportunity to improve matters as the current situation is so poor. Encouraging local authorities to communicate and work together would be helpful; if they would develop consistent practice that would be even better.

### **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?*

We believe so. Leaving the market to set rates is dangerous, partly as self-funders will be increasingly asked to cross subsidise inadequate publically funded payments, partly because quality will inevitably suffer before provider failure and also because the market is so slow to react to change. New beds do not come online quickly.

We should also be aware that a failing provider means vulnerable individuals are receiving poor care. While this statement sounds obvious, saying that the market will in time correct itself implies we are content for vulnerable people to suffer in the meantime. Inevitably, additional pressures will also be placed on healthcare services. A Home that closes means considerable upheaval for those who live there, and we should accept more intervention for markets such as this that have so much impact on people's lives.

*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?*

We believe every local authority should be obliged to publish their own calculation of care costs and base their fees on this. Currently, social care fees are set on the basis of 'what we can afford' with no regard to what care is actually costing to provide.

This would also make it much easier for self funding residents to consider whether the fees they are asked to pay are realistic and reasonable.

*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?*

There are huge problems with recruitment and retention of qualified nurses. (This is apparent in community healthcare and hospitals as well as nursing homes).

We would like to see a reinstatement of the training bursary for student nurses, an immediate pledge that general nurses will remain on the qualified shortage skills list (for Tier 2 visas) to encourage more to come to the UK and central government efforts to encourage more people to train as nurses. We hope to see a clear, easy and financially supported training route for care staff to train as nurses without needing to give up work and study for a degree, perhaps through the nurse associate route.

We would also like to see all student nurses carry out a placement in a nursing home as part of their training to encourage them to consider this as a future workplace.

We believe Care workers are underpaid and undervalued. All parts of government must support an effort to focus on good care and the difference they make the lives of vulnerable people. Funding for Level 2 and Level 3 qualifications should be preserved to enable people to qualify in this important area.