

# National Care Forum

The following is a summary of the main points that National Care Forum (NCF) members made in response to the CMA's update paper at a meeting on 6 July 2017.

## **Complaints processes**

- A model complaint process would be good. This would be better than providers individually working up their own models (in terms of both cost and consistency).
- There was broad agreement the onus was on the care home provider to fix the issues that were brought to its attention, whether through informal feedback or through complaints processes. Smaller care homes may be unable to operate the same kind of systems as may be practical for larger homes.
- Limited use of complaints systems was an issue across the health sector and not limited to the care home sector. The word 'complaint' was felt to be loaded with negative connotations. Use of words with more positive or neutral connotations such as 'enquiries' or 'feedback' might encourage greater engagement with the current complaints systems.
- When the NHS Patient Advice and Liaison service expanded, it took on more inquiries, but the overall consequence was that complaints fell.
- Also, agreement that issues were more cultural than systemic, ie people's reluctance to raise issues.

## **Information/guidance**

- Better sign-posting to information sources would be good too.
- Clearer standards about what information should be provided to people would be helpful. The ARCO code was mentioned as a good model of clarity.
- Voluntary codes of practice could also be of practical help in addressing transparency issues too.

## **Pricing information**

Transparency around pricing was regarded as being a difficult area and NCF members had various comments on this issue, as follows:

- Care is a bespoke purchase, and cannot be costed on a 'hotel' basis.
- Individuals assessed care needs will vary greatly and will change over time.

- Providing a price range may mean people discount too early a home that they should be considering (because it will provide them with the care that best fits their needs).
- Greater price transparency would expose the difference being charged under state-funded rates (which were below cost) and the self-funder rate (which was the 'true cost' of care).
- A 'service users' guide' for residents would be helpful. This would have a minimum required content, would set out all the services provided and charged for (and the things that were not included and/or provided).

### ***Consumer protection***

- NCF members asked what was 'very long' in the context of charges levied after death for the former resident's room. NCF noted that 28 days' notice was a common period for allowing for the removal of goods in many sectors.
- Some LA contracts cease payment on the day the resident dies or just one day after. This is unfair on the provider and the family of the person who has died. It was noted that there was a period required after death where both families and providers needed time, and any agreement on this needed to be reflected in both state (NHS and LA) and self-funded contracts.

### ***Local Authorities (LAs)***

- LA contracts can be extremely complex and complicated documents and their terms can be very unfair to care home providers. One NCF member noted that contracts could be more than 108 pages long compared to 8 for a self-funder contract. Provider contracts are not this long. Complexity of LA contracts can increase back-office costs, particularly for providers with a specialism, who attract residents from a range of authorities.
- LA rates do not generally provide sufficient returns that might enable providers to invest in improving infrastructure or expanding capacity. Laing-Buisson research supports this finding (as do the CMA's findings as set out in its update paper).
- Dynamic Purchasing Systems (DPS) encourage a 'race to the bottom' on price. An example was offered on an LA which no longer commissions based on quality, just price. Further, under DPS, there is insufficient information for providers to be able to accurately gauge what the care needs of the individual are when they tender for the contract. There is a risk that a two-tier system will develop where state-funded provides lower quality services and only those that can finance their own care will get better quality care.

- DPS was generally regarded as being 'completely inappropriate for the purchasing of care' because the assessed needs of the person requiring care are compromised and the lowest price always wins which means the quality aspect of care is neglected (ie only price matters).
- LAs sometimes reduce fee levels by 40% when a resident has to have a stay in a hospital. Where there are repeated admissions over a period of time, this can have a big impact on the provider's costs. The only 'saving' for the provider when a resident is in hospital is essential food costs for the individual and light costs for the room ie negligible (staff costs remain the same, the room cannot be re-let, etc). The 40% fee reduction does not equate with the provider's costs. This creates perverse incentives – a care provider would not want to accept or retain a resident with chronic conditions requiring occasional hospital admission under these terms.
- LA's often reduce fee rates to providers without carrying out any reassessment of the needs of individuals. Providers then have to absorb the shortfall in cost. This form of commissioning practice requires much more significant scrutiny. It was noted that this was increasingly happening in CHC funded services too, and the same issues apply.
- There is a great deal of uncertainty around what income streams are and will be for state-funded residents, as well as a great deal of variability in what is being paid by different LAs. This means that it is difficult to plan for the future and makes entry into the state-funded segment of the market unattractive. This means that primarily homes that cater for self-funders are being built.
- LAs are not fulfilling their market shaping duties as required under the Care Act 2014. Because they do not pay the 'true cost' of care and do not make allowance for any excess to be earned that might be re-invested in the business (either to expand or improve quality) therefore the market is not able to respond to increased demand or changing needs – for example increased demand for dementia services or complex care.
- Further, the homes that are being built are being built in the more affluent areas of the country, such as the south-east, where there are sufficient self-funders. This means that capacity is not being built where it is needed, but where people can afford to pay the 'true costs' of care ie capacity will be built 'where providers are paid the most'. Some areas of the UK are already underserved because of this.
- Use of personal budgets have increased. However, for this to properly work there must be greater transparency around fees.

## ***Remedies – to be applied to both LA and NHS contractual arrangements***

- An independent body that could look at costs would be helpful, provided it had teeth and could ensure that the ‘true costs’ of care were then reflected in LA rates. Laing-Buisson’s work or similar modelling may provide a framework that could be used to establish the costs in a locality.
- LA contracts and NHS contracts should be made available to and accessible to everyone so that self-funders could then have a reference point for what the local authority should be paying for care services.
- People funded by either health or LA should have sight of the contract that determines their own care, particularly where the authority is purchasing care on a managed personal budget basis.
- LA commissioning is costly and wasteful. A standardised national contract, as in Scotland, could reduce costs for LAs and providers and a national funding formula applied universally across LA areas, although this would need to have due regard to significant localised differentials, in particular, the cost of staff.
- Need to look beyond delivering adult social care services through LAs. National solution may work better?
- Keeping people in their own homes when this was realistic or fitted in with their wishes was a sensible strategy; to make this work requires wider thinking eg on housing design, provision of sheltered housing and care villages etc.
- LAs should reinforce their social care funding and commissioning role, and not allow decisions to be dominated by their procurement function.
- CMA’s findings should feed into and take account of the CQC ‘deep dive’ work which will follow 20 individual care journeys through the system. This work is beginning now in 12 authorities, and NCF encouraged CMA to get engaged in this process.
- The ability to borrow money more cheaply or VAT exemptions would help care homes raise funds to invest in new capacity and/or quality improvements.
- Sharing examples of what ‘best practice contracts’ should look like would be helpful to the sector.

## ***General comments***

- It is a needs driven purchase. As such, the market is not analogous to other wholesale/retail markets.

- CMA should look at LA and NHS contracts as well as provider contracts.
- The market is very fragmented. There are a significant number of operators will respond positively, but there remain providers who are unlikely to change their practices. The CMA needs to come up with remedies that have some 'teeth'.
- In order to invest in new capacity/ new build under current market conditions, a provider would need to work on the basis of a 70-100% mix of self-funders to state-funded residents. To shift this balance and invest in the services needed for the future, there is a need for an immediate review of how local authorities and NHS contracts are costed to reflect the 'true costs' of care.