



Care Homes Market Study
Competition and Markets Authority
7th floor Victoria House
37 Southampton Row
London
WC1B 4AD

5th July 2017

Dear Sirs,

Response of the Care Providers Alliance to the Care Homes Market Study

The Care Provider Alliance (CPA) welcomes the opportunity to respond to the recently published report from the Competition and Markets Authority regarding care homes.

We note it is asking for comments to twenty three key questions as the next stage in its investigation. In response we have provided an overall response from across our respective members and look forward to providing more detailed evidence in discussion with CMA personnel over the coming months.

We find there is little to disagree with within the findings of the report. We feel that CMA has listened, not just to care providers, but also to the sector in which they operate and the circumstances and situations that they face with commissioners from both local authorities and CCG's

Our response:

We support the findings of the report and support the need for transparency. CPA had already committed to providing some examples and material regarding what good practice looks like.

1. We agree with the initial analysis of the CMA in its report. We would welcome further dialogue to determine which issues care providers can address, and which issues other parts of the system need to address.
2. We welcome the fact that taking enforcement action where excessive practice is not in the consumer interest. However, we would request that in future the prevalence of that excessive behaviour should be included in public reports.
3. One of the areas where care homes could be more transparent is to publish what were previously called Service User Guides under previous regulatory regimes. We would be pleased to supply samples of this to the

CMA to see whether you agree. Providers should be encouraged to publish fees for privately funded residents although this will have the effect of allowing consumers to see the significant discounts that are being demanded for state funded residents.

4. We are of the view that until a social care funding system is in place that is seen as being for the long term, then individuals will not have the necessary information on which to plan for their needs. Certainty is needed in order to create a stable market. In the short term, we can encourage financial services providers to publicise immediate needs annuities more widely, possibly asking care home providers to ensure potential residents are aware of such products at the time of admission. However, most care homes do not wish to become too heavily involved in the promotion of financial products.
5. This topic needs to be covered within the Information Advice and Guidance provided by different local authorities under their Care Act duties. Local authorities should already be providing this sort of facility such that individuals at retirement, or shortly after, can start thinking about the choices available to them, e.g. care at home, and when that might be suitable for them, live in carers and when this service might be utilised, as well as residential care. Part of this information should be how these services can be funded, with what role is played by the State through the benefits system, as well as funding provided for social care through the local authority.
6. There are several issues in this area. One is a systems issue where complaints have been overtaken by the safeguarding system. Providers are required to report any incident where there was harm or potential harm to the local authority as a safeguarding incident. Providers are not allowed to investigate the incident (since the police may be involved and they may be required to investigate). Virtually any incident can be deemed to be potential harm and hence virtually nothing is treated as a complaint. A second issue is the sheer complexity of the different agencies which can be involved in considering a complaint within care. Thirdly, a positive attitude of care homes to actioning suggestions can have a significant impact on the number of incidents which are dealt with as complaints.
7. These model complaints procedures already exist but are not used for the reasons given in 6 above.
8. Better signposting to the ombudsman may assist but has to be seen in the context of a very complex set of complaint mechanisms involving, potentially, the NHS complaints systems, local authority complaints systems as well as the provider and the ombudsman. However, we do not consider that this alone would solve the issue.
9. As stated above, to draw a complaints process map which includes local authorities as well as providers, and potentially the NHS services is already extremely complicated. To add regulators has, in the past, confused the process even more and in many cases simply placed the regulator in the "disgruntled staff" loop rather than the genuine resident complaint. What is

needed is a simpler map of who can be complained to in what circumstances, such that there is an easy route that leads eventually to the ombudsman.

It should be noted that, since the introduction of a national regulator in 2002, the various regulators have insisted that the investigation of complaints is not their responsibility.

10. We would seek to address the issues of termination, mentioned in your report, with a suggestion to encourage providers to add three termination clauses to a provider contract. These clauses would describe termination when somebody dies, termination when somebody wants to leave the care home, and finally termination when the needs of the individual are such that the service can no longer meet their care needs. The practical as well as legal termination could then be described.
11. We consider it would be useful to have available a guide on consumer law. Care providers are required to meet many different legal requirements and have little staff management resource to ensure that they meet all the different regulations. Hence a guide with sufficient detail to help providers meet their legal duties in the area of consumer law would be helpful.
12. We believe that self-regulation could play a greater role in driving up good practice and we, as the Care Providers Alliance, are offering to work with the CMA to develop consumer-facing codes of practice as part of the market study.
13. Sector regulators have a track record of not attempting to be expert in every area and, therefore, develop memorandums of understanding with other expert organisations, e.g. HSE, to report concerns and allow the experts to undertake the detailed investigation. In this case we are of the view that a similar MoU with the CMA would be a sensible way forward since CQC do not currently inspect financial or contractual matters.
14. The Care Act clearly places a statutory requirement on local authorities to provide information advice and guidance on all social care and, as such, any additional consumer protections should not be required.
15. Providers regard the continued procurement of care home places at the lowest possible cost as being to the long term detriment of consumers since every provider is required to simply cut costs to the absolute minimum. This practice is best exemplified by online auctions where care providers are asked to continually reduce the price to be paid to secure the business, there can be nothing which lacks dignity more than for a patient to be auctioned online as if they were no more than a 'widget'. We view this practice as one which should be banned for social care. Commissioning on assessed need of the individual, at a fair price for that care, must be the preferred option.
16. The factors which need to be considered include geographic variations in income, private pension entitlement, property prices, the volume of private

payers as well as the policy of each local authority to the treatment of private fee payers and the policy of each local authority to the use of top-ups. We have reports from our members of some local authorities attempting to place everyone on a local authority contract at local authority banded rates, and of others banning the use of top-ups altogether. These policies result in a lack of choice for consumers since providers will, in general, restrict investment in these areas.

17. The two major barriers to providers in responding to future needs are State funded consumers do not generate enough revenue to generate a reasonable return and hence we get continued investment in services aimed at self-funding consumers, whilst the State is forced to pick up the capacity leftover. The second major barrier is the lack of suitable staff. Low levels of unemployment, coupled with an increasingly difficult job, paid at the National Living Wage means that sector is perceived as “only working in care”, in other words of low esteem. Whilst child care and emergency care are seen as the areas of greatest appeal. Immigration of staff with suitable values to work in the sector is vital for future, unless the attractiveness of the sector is seriously addressed to generate sufficient staff already living in the country.

What is fundamentally missing, however, is any commitment on the part of the Government to properly address the impact of demography. The 'baby boomers' will start to reach 85 years old in 2031. 85 is regularly used as a measure of the need for residential care and, currently circa 17% of people over 85 are in residential care. The Office of National Statistics estimates that there will be 3.2m people over 85 in 2031, 17% which is 527,000. There are currently around 420,000 beds, which, if not addressed, will result in a shortfall of in excess of 100,000 beds. There needs to be a significant increase in confidence in the market to encourage providers to invest to the future.

18. Unfortunately there is little evidence that local authorities can “shape” markets. Market Position Statements are frequently statements of purchasing intent for statutory services and ignore the privately funded individual. Further there is little appetite for discussion on the subject since many local authority staff believe that they should control, or even own, the services rather than shape the market. Marketing skills are almost unknown within local authority staff.
19. We would welcome more examples of good practice in this area since the levels of trust and respect between the statutory authorities and care providers continue to be at a low level.
20. In our view there is scope to establish an independent body with a duty to provide support and guidance to commissioning bodies. This could then debate and determine a view about what capacity is optimal at a national level taking into account not simply demographics but also the likely advances in medical treatments.
21. An independent body to review a framework for reasonable care fees rates could work. We have operated the current system since 1993 and

over the period we have seen a consistent increase in the fee rates paid by the private fee-payers. In 1993 this premium was zero, gradually increasing to a level of the Personal Expenses Allowance (around the £20 per week) and has now mushroomed to be £300 to £400 per week in many areas, and much higher still in some other areas. Such a body would also be able to negate to some degree the monopsony powers of the state purchasers, particularly in areas of low numbers of private payers.

22. There would indeed be merit in local authorities being required to be more transparent in relation to fee rates. Discussions with providers tend to revolve around the local authority budget and what is available in the budget. Whilst this is indeed a matter for a Local Authority it is frequently used to justify the price increase paid. The need from a provider viewpoint, is to demonstrate that they pay a fee that covers the costs of a fair provider working in that geography after an independent assessment of the needs of the individual.

23. Providers report that whilst there is much talk around recruitment and retention there is little action by the statutory sector. The effect is that, since the sector is geographically and organisationally diverse, there is little coordinated action. Immigration for care assistants is now restricted to the European Union whilst nurses can be recruited from outside the European Union after proving a lack of UK nurses through the Resident Labour Market Test. Until the image of the sector is addressed with significant resources then little change is likely to happen. This is compounded by a lack of coordinated local planning and the lack of detailed local workforce surveys. Political objectives of charging UK employers for migrating staff in an attempt to motivate them to train more UK staff will always fail when the numbers of potential staff is minimal and the responsibility for the costs of basic training remain divided between different agencies.

The Care Provider Alliance looks forward to working at a practical level with the Competition and Markets Authority to maximise the effectiveness of this market study over the coming six months such that the maximum information and transparency is achieved for existing and potential residents of Care Homes

Yours sincerely,

Bridget Warr CBE, Chair

Care Provider Alliance