



Communities and Local Government Committee

Oral evidence: Adult Social Care, HC 47 Wednesday 26 October 2016

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Watch the session

Members present: Mr Clive Betts (Chair); Julian Knight; Kevin Hollinrake; David Mackintosh; Mary Robinson

Questions 102-158

Examination of witnesses

David Behan, Chief Executive, Care Quality Commission; Professor Keith Moultrie, Director, Institute for Public Care; Paul Simic, Chief Executive, Lancashire Care Association; and Janice Dane, Assistant Director, Early Help and Prevention, Norfolk County Council

Q102 **Chair:** Good morning and welcome to this evidence session of the Committee's inquiry into the financial sustainability of social care and the quality of care provided. Thank you very much for joining us this morning. We will put on record any interests we may have relevant to this inquiry. I am a vice-president of the Local Government Association.

David Mackintosh: I am a Northampton county councillor.

Mary Robinson: My husband is a non-exec director of a not-for-profit CIC in this sector.

Kevin Hollinrake: I employ a local councillor.

Chair: We have got that on the record. For our records as well, could you say who you are and the organisation you represent? Thank you.

Paul Simic: I am Paul Simic, and I am the chief executive of the Lancashire Care Association. I also chair the Greater Manchester Care Home Network.

Janice Dane: I am Janice Dane. I am assistant director in Norfolk County Council adult social services.

David Behan: I am David Behan. I am the chief executive of the Care Quality Commission.

Professor Moultrie: I am Keith Moultrie. I am the director of the Institute for Public Care. We are part of Oxford Brookes University.

Q103 **Chair:** Mr Behan and Mr Moultrie, to begin with, looking at the national picture, how comfortable do you feel about the state of the care market? How stable is it? Does it look like something that is going to survive and thrive for the next five years, or something that is fragmenting, with providers dropping away given the pressures they are under?

David Behan: Last week we published this report, "The state of health and adult social care in England". This was presented to the House last Wednesday and is probably our most authoritative assessment of the state of health and care. There are specific chapters in there around adult social care. As to its key messages, the overall context of that report is that there has been an increase in the numbers of older people in this country. The figure I have tended to use is that between 2005 and 2015, we had a 31% increase in people aged 85 or over. That is a significant driver of the demand for health and care.

However, we know from ADASS and the Local Government Association that the number of people being assisted by local authorities is decreasing, down from 1.1 million in 2009 to about 850,000 in 2014, which is the last year for which we have figures. We also know from Age UK that the amount of unmet need is assessed to have gone up from 800,000 in 2010 to about 1 million. We have increasing demographic demand, decreasing numbers of people being assisted and increasing numbers of people being helped at home. I am sure that your advisers will tell you there is not a science around the assessment of unmet need, which is why I quote the evidence source for that.

The good news is that, of those care homes and domiciliary care agencies we rated using our new methodology—that is not all of them—we rated over 71% as "good" and 1% as "outstanding". That is good news: that is a lot of people getting care that meets the basic standards that this House has set through regulations and that we apply.

Q104 **Chair:** You might say that 30% are not getting it provided very well.

David Behan: Let us come to that point. The unmet need and those not getting the care is absolutely the key point. What are some of the reasons for this? First, we are seeing a decline in the number of care beds being provided. There is an increase in the number of domiciliary care providers. That decline in the number of beds is taking place, as I have already said, at a time when we would expect demand to be increasing. I can say more about that, but the key issue is that we have

seen an increase in nursing care beds from 2010 to 2015 of broadly 9%. From 2015, it stalled. Beyond what we published last week in the state of care report, there has been a decrease in the number of nursing home beds to September. That is a significant issue about the supply.

To your point, Chair, about the care that is not satisfactory, of those that we rated inadequate, over 76% improved. That improvement might have been to "requires improvement" rather than "good", but nevertheless there is evidence of improvement. Only 43% of the services we rated as "requires improvement" improved; i.e. they are stuck at "requires improvement". More worryingly, 8% deteriorated from "requires improvement" to "inadequate".

We flagged a third issue, which comes partly from our market oversight work, but also from LGA and ADASS. We have a number of providers handing contracts back to local authorities on the basis that they cannot deliver to the price and quality that they are being asked within the contract. Later today you have Colin Angel. They published a report yesterday, and we used some of their figures in our report. You are also seeing others later today about contract prices paid. One of the things I said in some of the media interviews I did last week, Chair, is that I have now been in this sector for 38 years, and I have never seen those five things coming together in the way that they are. This is why we ask whether we are "approaching a tipping point" in the report that we published last week. To answer your question in summary form, the sector is fragile.

Professor Moultrie: I will draw on our work over the last 10 years or so across the UK, including England, Wales and Scotland. I would not disagree with anything that David has said. I agree with him completely about the real concerns there are about price and the capacity of the market to respond, but market stability is more than just rates. Some of the qualities that we would look for in a stable market include demand and supply roughly being equal over time, good information on which people can base decisions about purchasing or securing services, and entry and exit to the market. If it is a market, there is going to be entry and exit, which needs to be handled smoothly and predictably, without trauma for people. Providers also need to have good access to information.

We would suggest that, overall, there are some huge challenges facing this market in all those areas. We would also suggest that there are two particular factors that need to be taken into account, in addition to looking simply at the money. One is about the management of demand, and I can come on to that and explore it in a little more detail. Demand for care placements is not a fixed figure; it is not inevitable, and it is affected hugely by the health and social care services that are available more widely in the community. I am sure we will come back to that.

Secondly, it is influenced by the market-shaping activities of local authorities and the extent to which they can help work with providers to

minimise risk and ensure as great a possible degree of predictability in the market. Both those areas are very important. We are concerned very definitely that the stability of the market is under real threat, but the long-term solution is not only about money.

Q105 **Chair:** From a local perspective, Lancashire and Norfolk will have different viewpoints. What is your experience?

Paul Simic: I will pick up first on the “tipping point” phrase. I have been around in my present role for 14 years in Lancashire. When I came, the world was going to end, but it did not; it moved on. But I think there is a tipping point now. It feels that, if you look at the way the market is set out and funded, and the issues around quality, oversight and, particularly for me, workforce—as I mentioned in the report, workforce, workforce, workforce is the big issue—we are at a tipping point. Things are not the same as they were.

That does not mean we cannot adapt, or that the market and its partners or stakeholders cannot adapt. I was at an NHS event a few months ago where a firm talked about how resilient and adaptable the market was in Lancashire. If the stakeholders in the provider sector, as well as the local authority, the NHS and the regulator overseeing the market, can develop a dialogue that is supportive and constructive, that tipping point can be managed.

You would expect somebody looking at the world from my position to say that there is structural underfunding, which has to be dealt with one way or another. If it is not dealt with, the market will become unstable and more fragile than it is now. Some of the trends that we are seeing in Lancashire are greater pressure on the nursing end of the market, a loss of nursing beds and re-registrations from nursing to residential care. We are also seeing a fundamental review of how domiciliary care works across Lancashire. There is a lot of weather around and change happening. That itself makes it difficult to manage, because change-management becomes a problem in itself.

Janice Dane: What I am going to say resonates already with a lot of what has been said. We have particular demographic pressures in Norfolk with our proportion of older people. We try to manage that demand and help meet people’s needs in other ways. We have almost 1,000 providers that we contract with, so the market-shaping and how we work with those providers is very important to us.

Providers are telling us that they need more funding for the national living wage, and a lot of them are now keen on carrying out private work with people who are funding their own care, because it is more lucrative for them. It becomes very difficult in terms of making sure that we have the right supply in the right places. We have experienced a loss of nursing beds for older people this year of about 5%. Currently, we have a homecare provider handing back the contract because they cannot make enough profit.

Q106 **Chair:** That has happened, has it?

Janice Dane: Yes, that happens periodically, and we have it at the moment. They have issues getting staff. That is also why we lost the nursing beds, for example, because they cannot get the suitably trained nurses. This provider was struggling to get the right staff and make a profit on the contract.

Q107 **Chair:** Do you experience providers of homecare not always delivering that care, because somebody goes off sick and they do not have cover?

Janice Dane: Yes, we experience that as well. We are lucky that we have a reablement and a Swiis 24/7 service in Norfolk. They end up not always doing reablement, which is obviously better for the person, but having to pick up contingency homecare at short notice on a particular day, over Christmas or whenever, where providers are unable to do it. We use them to back that up.

Q108 **Kevin Hollinrake:** David, you mentioned a perfect storm scenario hitting this whole sector. Are there areas of the sector that are at particular risk, whether homecare, services for older people or residential care? Which ones, if any, would you say are suffering the most pressure?

David Behan: I agree with what my colleagues have said. Janice and Paul's point about recruiting staff is a key one. The decline in the number of nursing beds since March 2015 and the slight increase in the number of beds in residential care homes in that same period is a reflection of the difficulty in securing the appropriate number of staff, particularly nursing staff.

First, I would go for nursing homes as being a key issue. The reason I would go for that is the increase in demographic trends and numbers of very old people. The ONS published material last week saying that the average life expectancy for a 65-year-old man has increased by 19 years, but they can only expect half of those to be spent in good health. That means the health and care system is dealing with older people with complex, often comorbid conditions. The people in nursing homes are very old and both physically and intellectually frail, and therefore the levels of skill and numbers of people required to make sure that they are clean, hydrated and fed is a key issue.

If you look at what we reflect in our reports, very often in care and nursing homes for the very elderly, it will be about the adequacy of staff and their care. That said, we rated 91% of the care homes we have inspected so far as "good" or better in relation to their caring attitudes. There is an issue about the workforce.

There is a lot of churn and turbulence in domiciliary care contracts. This is Keith's point, with which I absolutely agree, on the interdependency of the adult social care, health care and voluntary sectors at local level. The

availability of community nurses is key to maintaining people in their homes, being supported by domiciliary care. If there is a reduction in the supply of community nurses, which there has been over this period, as we flagged in the state of care report last week, services will be put under pressure for the more complex needs that we have.

Q109 **Kevin Hollinrake:** What reduction in community nurses have you seen?

David Behan: It is about 28%.

Q110 **Kevin Hollinrake:** Is that basically NHS cuts?

David Behan: Yes.

Q111 **Kevin Hollinrake:** Coming back to that statistic, someone who is 65 has a life expectancy of another 19 years.

David Behan: Yes. A 65-year-old woman today has a 20-year increase in life expectancy. ONS was saying only last week that healthy life expectancy is only half of that.

Q112 **Kevin Hollinrake:** Yes, something to look forward to.

David Behan: We all have that to look forward to, which is why this is an important social policy issue.

Q113 **Kevin Hollinrake:** Absolutely. Professor Moultrie, can I turn to you? Market-shaping is a big thing, and Paul Simic referred to it earlier. What does best practice look like?

Professor Moultrie: This is based on work that we have been doing with the Department of Health over the last four or five years, including work on market position statements, which every local authority now has to produce, with all 140 organisations. There has been a huge shift in the expectations of local authorities in this area, characterised by a move towards two particular sets of skills and practices.

One is about much better business intelligence—so, understanding the companies. It is about financial analysis of the companies, including their leverage, debt, income and how risky they are. It is also about commercial awareness, the service availability and the risks that exist there. The second is market intelligence, which is about understanding the needs and demands that are going to exist in the population.

To add a little depth to something that has been mentioned already, I do not see this as a single market; these are lots of different markets in different places, and they are characterised by very different wealth and geography. These market characteristics are hugely significant elements, and have to be managed either locally or regionally. It is about market intelligence, need and demand, business development and support, and the kind of offers that can be made to providers.

Best practice in this area for us is about moving away from simplistic procurement and contracting, which may be short-term and have short-term benefits, to longer-term partnerships and relationships with providers that can build in security and minimise risk of breakdown within

the market. That is quite a challenge in an environment where, perhaps in the past, local authorities have been really strongly encouraged to get the absolute best financial deal in the short term. That is challenged by this approach.

Q114 **Kevin Hollinrake:** Are you saying that it is a false economy? Is that what you are implying?

Professor Moultrie: Not inevitably, but very likely in many situations. We think there have been false economies, and we have certainly been told about them, just as we have been told about false economies in the healthcare sector regarding prevention and early intervention. For instance, last year I was talking to a group of GPs. I asked them what would help in reducing the amount of referrals into hospital. They said that, if they had a sitting service, a third of the referrals of people to hospital could be reduced.

Q115 **Kevin Hollinrake:** Who said that?

Professor Moultrie: GPs. Not having those simple services in place in the community, available at the right time, has an impact on hospitals. We know that, when people go into hospital, they are more likely to come out into residential care, and we know that the cost in the long term is going to be huge. There is a pattern.

Q116 **Kevin Hollinrake:** Can I hear from the rest of the panel about your experiences of market-shaping at the coalface?

Paul Simic: First of all, there is a question about the capacity and ability of local authorities to take a lead on market-shaping. That is not meant to be a criticism, other than that it is a big challenge, and I do not know who can properly shape markets. As Keith said, we are not talking about a market to be managed; we are talking about lots of different markets. To pick up on David's point about relationships, we spent many years working on a social care partnership in the Lancashire area that involves the county council and provider representatives. We have now extended that to be a health and social care partnership. It is a senior management-level steering group that can have sensible conversations and dialogue around something very challenging and complex.

We are operating across fault lines, between the NHS and social care, public and private, and big and small organisations. If we put in place infrastructure that spans some of those fault lines, market intelligence is better and, given that, market failure can be reduced. To do that, you need to have in place the right leaders and the right processes that allow you to cross some of those boundaries.

In Lancashire at the moment we are seeing a lot of change around the domiciliary care market, which is under fundamental review. We do not know how that is going to go or what impact it will have on the people using services in Lancashire, because it is a fundamental review.

In terms of market-shaping, we did work a while ago using the LaingBuisson fair price model to help give the market some dynamic. We used the model to develop the sector into four bands. When we started in 2004 or 2005, band 4 nursing homes were getting 104% of a fair price and band 1 homes 79%. Over a period of five or six years, we were able to work with the council to equalise that and bring some stability across the market. Band 1 homes were actually at more risk than band 4 homes in that circumstance, because they were further from their fair price.

The fair price model has moved on and been relabelled, but the principles behind it are still there. Where you have a long-established set of trusting relationships working across the organisational boundaries, using a rigorous methodology rather than just making an argument, markets will be more secure than if left to their own devices.

Q117 Kevin Hollinrake: In the interests of time, are there any additional comments you would like to put on record?

Janice Dane: There is a very important role for us in shaping the market. We invest a lot of time and effort into it. We have a comprehensive market position statement, which we have tried to make understandable. We have annual care conferences and local provider forums. We obviously have to comply with procurement legislation, which can sometimes hamper how you work with people, but we then try to make sure that we get the weightings right between financial, quality and other aspects of the tender. We do not go for the lowest price, and we will question whether really low prices cover everything like travel. We see that as a very important role for us, not just for the service users for whom we are procuring, but also for other people funding their own care in Norfolk.

David Behan: There is regional variation, which our report flagged. Within regions, there is also variation between people using services, and understanding that is important. We can send you graphs and figures, Chair, if that would help the Committee. Because Norfolk and Lancashire were represented here, I pulled our figures on where they are. Interestingly, for both, of the services we rated, we assessed about 69% as being "good" and 1% "outstanding". They are at opposite sides of the country, but we have rated them much the same, albeit with different base numbers.

We also flagged in our report that black and older people tend to be less satisfied than younger people with adult social care. Interestingly, on your regional point, Londoners tend to be less satisfied than people in the south-west with adult social care. This returns to Keith's point earlier. There are a complex number of influences here.

The Government wanted to see market-shaping, and there is a very interesting reflection on whether you can shape a market, but this is about matching the demand that you see coming through in your population with the numbers of places you are planning for. That should

then inform your commissioning strategy. Distilling it to its absolute essentials, that match between need as assessed and the supply of need is essentially what this is about.

Again, to Keith's point, it is not just a local authority issue in residential and nursing care, because the nursing and continuing care element present in many nursing and care homes is funded by CCGs at a local level. That is why local government, working with the local CCGs and, as Paul says, providers, is an essential way of ensuring there is a mature conversation about matching supply and demand, not just for today but for tomorrow, and anticipating what those services are.

Q118 Chair: I have a quick follow-on on this theme. How do you shape a market when your primary responsibility is to cut your budget?

Janice Dane: The phrase is "demand management". We have a promoting independence strategy. We are keen on trying to meet people's needs in other ways as much as possible: giving information and advice at the right time, reablement, assistive technology—anything that helps reduce people's need for funding services while giving them the outcome of staying in their own home, which most people say they want. We need to shape the market to respond to that as well.

Q119 Chair: Presumably it gets harder each year.

Janice Dane: Yes. It is like turning the line around. Everyone is set up, say, for a residential home for learning difficulties, and our policy at the moment is to try really hard not to put working age people in residential care, because we are an outlier. The impact on the market, in terms of whether it can change to the sort of services people want, is difficult.

Q120 Julian Knight: Mr Behan, first, I have some specific questions for you. In your inquiries, have you noticed an increase in providers merging, failing or exiting the market?

David Behan: In terms of numbers, we are seeing a reduction in nursing home beds from 2015 to date. As I mentioned earlier, that is on the back of a 9% increase over the period from 2010 to 2015. We are seeing a reduction in the number of residential care beds.

Q121 Julian Knight: Is that providers exiting the market?

David Behan: Some are. This is the point Paul was making. Some nursing homes, because they cannot recruit nurses, convert into care homes. There is some of that, but some providers are also exiting the market.

Q122 Julian Knight: Are there any other reasons, apart from what Paul has said, for this happening?

David Behan: Providers will be exiting the market because we have rated them inadequate and they have not improved. That is right; it is our job. This House, particularly, would expect us to do that. There is some of that in there. There are also a number of people who own care businesses and have reached that stage in life—60, 61 or 62—of asking

themselves if they want to carry on trying to make the balance. They will sell their business and come out. There are then a number of people who are literally unable to make the numbers work and are coming out.

We have the number of smaller care homes coming down as well, but we are seeing an increase in larger care homes. Larger care homes are only about 6% of the total population, so this is still a very small market dominated by single-owner providers or providers with one or two homes, rather than the big corporate groups that have 14,000 beds.

Q123 Julian Knight: For that reason, it is quite difficult to define the reasons why we are seeing this reduction in beds. What I get from what you have just said is that there seem to be many different reasons, particularly when you focus on the age on those who own these institutions. Professor, you are nodding your head. What do you think?

Professor Moultrie: I am. We have found another factor here. The age profile of people who own the one-person care homes is as David is describing. The issue, then, is who would take over or invest in those homes. The offer that is available is very limited, because many of those care homes are not turning out any real profit or an income sufficient for somebody to come in. Certainly, if they have a mortgage, which those older care home owners will have paid off now, they will find it very difficult.

Q124 Julian Knight: I presume they could make more money by selling the property itself.

Professor Moultrie: The owners very often can, yes. The other factor is that we have had reports from providers recently that banks are not interesting in supporting purchases of less than 35 beds. That is not necessarily everywhere, but that is where the money comes from to invest in this field.

David Behan: I would echo that. Our market oversight is showing that the market position is hardening. That is the point Keith has just been making. We have also flagged in last week's report that providers that are reliant for more than 50% of their income on the local authority are seeing their profitability reduced dramatically. This is where the margins are being squeezed. The issue is not just about profit. This is about capital reinvestment in decoration and upgrades in facilities.

Q125 Julian Knight: They can keep going for a few years, but then they struggle to do so.

David Behan: It begins to crumble when capital investment begins to halt. It becomes difficult to provide the services people, such as the 90-year-old who needs a nursing bed, require. The physical layout, in terms of managing where a hoist is required, or where two people are required to lift and turn people, is difficult in old, adapted buildings. That has contributed to the move towards bigger, purpose-built homes. It is

not just the economies of scale; it is an environment that assists in the way that care can be provided. On self-funded and local authority-funded providers, not many providers have achieved 100% funding from private payers, but it raises the question of whether we are approaching a two-tier market.

Q126 Julian Knight: Yes, I was just about to touch on that, and we have skirted around it. Are you finding that providers are handing back their local authority contracts in order to focus on the self-funding sector?

David Behan: I do not know, Chair, whether your Committee will speak to providers. If you do, you will see that some providers have business plans that are designed to attract private payers. There is a difference in what a local authority contract might pay for a place and what a private citizen might pay in relation to that. This is the issue about how the economies and the business plans of residential and domiciliary care providers work.

Q127 Julian Knight: Is that an expansion beyond the base they have from the local authority, or are you seeing, as Ms Dane mentioned in one case in her area, providers saying they can no longer provide a contract while, for want of a better phrase, going for high-net-worth, self-funding patients?

David Behan: We are seeing some evidence, from what providers are saying, that that is their strategy. When we look at our market oversight data—and this is only the largest providers, so it will be slightly skewed; I do not say it carries across all adult social care providers—we are seeing that income generated by publicly funded beds is hardening and reducing, and that is causing people to go to private payers.

To Kevin's question about regional variations, in a previous incarnation I was director of social services in Cleveland. My guess is that something like 80% of people in care homes in Cleveland are publicly funded, with around 20% privately-funded. In somewhere like West Sussex, my guess is that it will be the absolute opposite; 80% will be publicly funded. That is about a means-tested system in which people's wealth is assessed, and that wealth contributes. If you compare the value of a house in Redhill with one in Hartlepool, you will get some sense of what the equity people are taking into the assessment for care homes. You see those factors play through.

In our view, it is becoming harder to make some of the older homes pay, particularly where there is a dependency on local authority funding. Arguably, the oversupply that has been in the system historically is evaporating. As demand becomes greater than supply, then we can expect greater pressure on markets. This is not a true market like computers, pens or televisions; it is a very different market, but it will behave in some ways like markets do.

Q128 Julian Knight: Can I turn to Mr Simic and Ms Dane? Ms Dane, you

mentioned that you have experience of providers effectively ceasing trading and handing back their contracts. What type of provider was that? Which providers do you think are less or more affected by this trend?

Janice Dane: For us, it is across the market. In the last 16 months, we have had a reduction in nursing beds in seven different homes. Two homes have closed, and five have changed their beds to residential care. We had to relocate 114 people and lost 160 beds; that was 5% of that particular part of the market. The contract we are currently working on is with a provider that is struggling and wants to hand it back, and we are getting a new provider in. That is a homecare contract, and that happens periodically in homecare.

Q129 **Julian Knight:** It must be an enormous challenge at that point. Do you have a definite time period—three months or whatever—in which to sort it out?

Janice Dane: We are working with them. Often there are also quality issues, so we work with them in trying to improve the quality, and if they cannot sometimes a mutual agreement is reached. We try to work with them and line up new providers to minimise the impact on citizens. It is something we are monitoring, watching and looking out for all the time.

Q130 **Julian Knight:** You are on the lookout for it. Mr Simic, do you have any thoughts on this trend, and which providers are less or more affected?

Paul Simic: Going back to an earlier point, when you have a complex and diverse market, there is not one thing to say about it; there are a number of things going on. It is certainly the case in domiciliary care, where margins are so low, that many providers cannot take on a contract. We know of contracts being handed back because of the rates that are being paid. Where somebody is exiting the market because they are offering poor care and cannot change it around, that is the direction they should take. There should be some support in the system for making sure people can improve their quality of care, but, if they cannot, exit has to be inevitable.

From a provider's point of view, if you are only funded by the local authority, you are unviable in the medium to longer term. In the short term, you do whatever you can do to cut corners and manage. That is not a criticism of local authorities; they only have the budget that they have. From the point of view of actual costs to a provider, we have years' worth of evidence of what it costs to deliver care and local authorities cannot meet those costs. That is creating some of the skew in the market. Anyone running a care business has to get both the care and the business parts of it right; there is a requirement on both sides. If you are getting the business part right, you cannot be solely dependent on local authority funding, because it just will not add up.

Q131 **David Mackintosh:** Specifically looking at the local situation in Lancashire and Norfolk, I am interested in what the commissioner/provider relationship looks like.

Janice Dane: We try to work with providers. We are very keen to work in partnership. The funding issue raises its head periodically. We have had a legal challenge about our fee levels in relation to older people over the last couple of years. We have had to work with providers in reviewing and increasing our fee levels. That is the tension: even though we have increased fee levels, we are still getting calls from providers on the impact of things like the national living wage, not just on the lower-end staff, but on the differentials between levels and how they can cope with that while carrying on delivering quality. These are things we have already been discussing.

Paul Simic: As an association, we have majored on this over the last decade or more. When I started in the post, we were on the steps of the High Court in a judicial review between the association and the council. Both sides decided it was sensible to try to take a different course of action, and by agreement set up a formal social care partnership with terms of reference. We worked on a number of things around developing stability in the market through use of the fair price model, developing workforce planning, looking at safeguarding and monitoring impacts on the sector.

Over a period of more than 10 years, we initially had a social care partnership, which we have now adapted into being a health and social care partnership with the clinical commissioning group, NHS England and other colleagues. This may feel soft and woolly, but it is absolutely central. There have to be the right relationships to get the right sort of dialogue between key players and stakeholders in the sector.

We must somehow find a way of all getting around the table and talking sensibly about how the public sector can work with the private sector, and vice versa, to deliver the care we should be delivering. Developing those kinds of relationships and the structures that facilitate them is absolutely crucial. I have worked with 15 local authorities in different ways, on and off, over the years, and most of the time the relationships are pretty poor and do not involve a dialogue at all beyond head-butting—if that is dialogue.

Q132 **David Mackintosh:** Professor Moultrie, I want to ask you what best practice looks like. Ms Dane, I am then going to ask you whether that is the reality as you see it from the local authority's perspective.

Professor Moultrie: As I said, there are different solutions and different approaches in different places. I would echo what Paul said about the importance of good dialogue and relationships. There are three examples of really significant good practice specifically by local authorities, and these are perhaps areas that CCGs should be thinking about more. One

is about working out how they can offer planning consent or land opportunities to potential providers. That does not mean money; it means actually helping them think through what opportunities there might be.

Second, the local authority's responsibility in this area can be about building and supporting the development of workforce. The turnover from one company to another that you were talking about earlier is very often about change of ownership. However, the people who are doing the job are very often the same. You have a real challenge, and good practice in this area is about local authorities supporting recruitment and retention of the workforce. I would mention some really interesting work going on in the south-west of England at the moment; the Proud to Care initiative looks to be very exciting in that area.

Third, it is about framework opportunities and arrangements that minimise the transaction costs, so that we are spending less time on transactions and more on looking at the outcomes and impact for people. Those are examples of good practice in this area.

Q133 David Mackintosh: Thank you. Is that the reality?

Janice Dane: There is always room for improvement. We spend a lot of time working with the independent sector on workforce training; we provide training free of charge. Although there is turnover within the sector, there are also a significant number of people leaving the sector to work in other industries. They can earn more in supermarkets. It is a stress, constantly trying to recruit new people and make the care market an attractive career or job. We try to work with providers regionally and with other councils on that.

In terms of contracts, outcomes are hard. It is far easier to buy chunks of time and tasks than it is to work with outcomes. That is an area in which we are trying to improve, but it becomes very difficult to know when those outcomes have been achieved, who decides that and how to trigger the payment. Planning consent is something on which we work with the district councils. We can try to influence it, but it is not necessarily within our jurisdiction. Where people are applying for new housing, we will have conversations about how that could be set up for the future to support the community, as well as people's needs going forward. There is always more that you can do in those areas.

Q134 David Mackintosh: I know that, specifically in the area I represent, this can be an issue. Do you think that there is a divide between trying to get support in urban versus rural areas?

Janice Dane: We are predominantly a rural county, which gives us some particular issues with homecare, travel costs and travel time. If you are in an urban area, obviously you do not have to travel so far. We have pockets in the county where providers cannot get stuck, and the number of service users is quite sparse, making it unattractive.

Q135 David Mackintosh: Again, from a local authority's perspective, do

you have particular difficulties securing placements or services for people with high complex or specialist needs?

Janice Dane: We do, yes. I have mentioned nursing care, and dementia is an issue. For working-age people, there is provision, but it is about getting it at a cost-effective price. You can usually get it, but you have to pay an extortionate amount for it, in my terms. It might also not be in Norfolk. We try to keep people close to their families and homes, but we sometimes end up having to place people elsewhere. We struggle with homecare. We are normally able to find residential care placements, but not where we want or at the price we have set.

Q136 **Julian Knight:** On balance, do you think it is more difficult for rural than urban councils?

Janice Dane: As I said, we are predominantly rural. When we look across Norfolk, homecare is easier in the city of Norwich than it is nearer the fens.

Q137 **Julian Knight:** What about the actual provision of care homes themselves? I would imagine that the overheads to set it up, such as property prices, may be lower in the countryside; but staffing may be more difficult to find.

Janice Dane: Yes, and the market. In the conurbations, there are more people around who might need care in the future. Certainly, some of the newer provisions are very large—perhaps 80 places.

Q138 **Julian Knight:** Professor, you are nodding your head again.

Professor Moultrie: Yes. Zoning is a very popular approach in homecare at the moment, but if you are in a gigantic rural community a zone is a blooming big place and travel costs are huge. That is the reality of it.

David Behan: We do not feel we are quite at the stage that we can do the analysis conclusively, because our inspections of adult social care focused initially on those that were most at risk of delivering poor care. Our sample is skewed at the minute. But, for every rural area, there will be a “good” or even “outstanding” residential care home or domiciliary care agency next to one we have rated “requires improvement”. We need to understand this more.

There are particular issues in rural communities, as Janice has said. Paul will know this from Lancashire, where I was born and brought up. Here in London, it is travel time and not distance. To go three miles in London might take you as long as it takes to go 30 miles elsewhere. We need to understand this. To your point about property prices, London has a very low level of residential care, but a very high level of domiciliary care. That is understandable, given property prices historically. In former holiday towns in Devon and along the Fylde coast in Paul’s area of Lancashire, conversions of guest homes into residential care homes took place. Some of these are now exiting the market, to your question.

You need to understand what is going on in a geographical area based on that history, as well as travel times and rurality, et cetera. It is a rich picture we need to get underneath. In some places, such as Dorset, Devon and the Fylde coast, there has historically been overprovision of residential care—expressed as a rate per 1,000 people who live there—as distinct from domiciliary care.

To the question on market-shaping, the local authority responsibility to the Care Act is to strike a balance between the numbers of people who live in a council area and the services that should be supplied. That is different from what has historically and traditionally existed in a particular place.

Q139 **Mary Robinson:** At the heart of this, of course, are the people who are in need of the provision. From the quality point of view, could I ask you, David and Keith, what good quality looks like?

Professor Moultrie: Many things. I would make a particular observation, and Janice referred to this earlier on. There is a great trend towards looking at outcomes as a starting point for making judgments about quality of care—entirely appropriately, because we know that some care interventions can have a perverse effect on individuals. By providing more care, you are not necessarily supporting and helping them develop their independence and wellbeing. There is nothing inevitable about high levels of input that will result in improvements. That is why outcomes are so important for me; they start people off in thinking about the kind of impact that you want to have on somebody.

They are not a panacea. Quality has to consider a number of different areas. Importantly, it has to look at people's satisfaction and the happiness that people have in services; it has to have some minimum standards about the kind of services, how frequent, reliable and regular services are, and the skills of the people involved; it has to set standards around the quality of the work people are actually doing. It has to have a combination of those and a focus on outcomes.

As Janice was saying, you have to be really careful here, because you can end up creating a gigantic industry monitoring activities that are relatively straightforward in themselves, burdening them with too much regulation and control. Going back to what I said earlier, unless you are working on the basis of a long-term relationship, the danger is that you end up concentrating purely on the technical side of quality assurance. You have to look at all those elements.

Q140 **Mary Robinson:** Are the factors you have mentioned evenly balanced, or is there one that is more highly prized or valued, in your opinion?

Professor Moultrie: In domiciliary care, we are moving away from the idea that you concentrate on the inputs, such as the hours and minutes spent. We are quite rightly trying to move towards a much stronger focus on outcomes. We are in the middle of a change, and it requires a degree

of trust and confidence between providers and commissioners, which was not necessarily characterised by previous arrangements. The idea that you can appropriately specify what is required in a 15-minute visit is nonsense, in my opinion. You have to get to a much cleverer and more trustful way of working with providers, and we are seeing some really good examples of practice in those areas.

Q141 **Mary Robinson:** What would the CQC say?

David Behan: I will take this in three parts. There are five influences on quality: what commissioners do and how they do it; what providers do and how they do it, whether it is a large corporate or a small, single-owned home; what professionals do, because homes with nurses and social workers have a personal professional responsibility to deliver quality; what regulators such as the CQC and other professional bodies do; and finally, the voice of people using services. In my view, if you want sustainable quality in care, all five of those influences need to operate together. If you have an overreliance on regulation, for instance, you will not get sustainable quality. That is an issue that needs to be debated by the Committee, if I may say so.

In answer to your question, Mary, about what good looks like, we ask five questions in all our inspections: are services safe; are services effective; are services caring; are services responsive to the needs of individuals; and are they well led, whether it is a big institution or a very small home? This plays to Keith's point about experience. We ask people, "Do you feel safe here? Do you feel looked after here?"

On the last inspection I was on, I was deputed to speak to relatives visiting on that Friday. I sat down and asked them, "How do you think your mum likes it here? How do you like your mum being here? Do you feel safe?" All our inspections have that dimension of experience to them. We set out in a handbook what we call our key lines of inquiry, in order that we can answer those five questions. They are published and publicly available on the internet. We define what "outstanding", "good", "inadequate" and "requires improvement" care look like. We have set that out, it is available to anybody, and I hope it is written in nontechnical language.

You can meet all the standards and still be required to improve, because there are areas you still need to work on. "Requires improvement" is not below the line. It speaks for itself; you need to do more. Those key lines of inquiry are based on the regulations that were approved by both Houses of Parliament. They were developed following pretty extensive consultation between CQC and providers. The regulations were also developed following consultation between DH and providers.

Chair: We are getting close to the end of our session now.

David Behan: Very briefly, if I may, in our report last week, we pulled out five characteristics of "good" and "outstanding" services: first, strong leadership; secondly, a good oversight of care, in that the person running

the place knows what is going on; thirdly, having effective systems and processes in place, with people getting the right medicines at the right time in the right way; fourthly, a positive culture, where when things go wrong people learn and put them right rather than closing ranks; fifthly, services collaborating, because care homes and GPs that do not collaborate with one another will not be successful.

Q142 Mary Robinson: We have seen and talked about the ratings of care homes. What is your assessment of the quality of care across services?

David Behan: Again, it plays to this point about variation. We flag this in our report. We rated 90% of adult social care as being “good” for caring, but we were concerned about the quality of safety and leadership in a number of those care homes. You could be a good home and we would still have concerns about safety. An example of this would be about adequate medication practices and medicines management. People getting the right medication at the right time in the right way is a key issue; if they do not get that, there can be consequences.

Q143 Mary Robinson: Is this quality of care reflective of the local experience?

Paul Simic: I will echo some of David’s points. When the first home in the north-west was rated “outstanding” across the grades, we talked to the home about who and what they were. Fortunately, they were a Lancashire Care Association member; I was pleased about that. David highlighted the issues. The home had the strong and right leadership. They had retained good, well valued, well trained staff; there was not a lot of churn and turnover. They buddied up with other organisations, such as Hospice for training. Good care businesses network, mix with others and have open doors and a transparent approach. It was small, and there is an issue about managing care and the complexity of inspection. None of the residents were local authority-funded.

On the broader issue of quality, it takes a village to raise a child; I cannot get rid of that in my mind. Quality is delivered by a system. Providers are part of that system, as are the regulator, safeguarding, commissioners and obviously customers. It is the system that delivers care. Good quality care is when all parts of the system have the proper and proportionate light shone on them.

Janice Dane: I agree with exactly what everyone has said. I only wanted to add the quality of the conversations people in the council have with those who approach them for care and support. For us, it starts very much with a conversation about what help we can provide to people, how they can access information and advice and what prevention we can offer, starting right at the beginning, when someone approached us with a need or for some help. We are very keen to have strength-based conversations with people, as opposed to a deficit model, and help them

meet their needs in the best possible way. As I said, a lot of people want to stay at home.

Q144 **Chair:** I have to bring this to a close, to move on to the other panel. Thank you very much for coming to give evidence to us. It is really helpful for the Committee in this inquiry. Thank you very much indeed.

Examination of witnesses

Professor Martin Green, Chief Executive, Care England; Colin Angel, Policy and Campaigns Director, UKHCA; Andrew Dykes, Chairman, Exalon Autonomy Group; and Tim Hammond, Chief Executive, Four Seasons Health Care

Q145 **Chair:** Thank you very much for joining us. Could you begin by saying who you are and the organisation you represent?

Professor Green: I am Martin Green. I am the chief executive of Care England, and we are a representative body for care providers.

Colin Angel: Good morning. I am Colin Angel. I am the policy director for the United Kingdom Homecare Association, representing homecare providers largely in the independent and voluntary sector.

Tim Hammond: I am Tim Hammond. I have been the chief executive of Four Seasons Health Care for the last two and a half years. I should also say that, for seven and a half years, I have been a board trustee of Age UK.

Andrew Dykes: I am Andrew Dykes. I am the chairman of Exalon Autonomy Group, which is a small provider of specialist services for learning disability, primarily residential, but we also have a domiciliary care unit dealing with complex cases at home.

Q146 **Chair:** Thank you for coming. Looking at the wider picture to begin with, demographics are clearly having an effect on demand. Is that currently the key issue of change in the sector, or are there other issues of demand and supply affecting how you operate?

Professor Green: In his evidence, David Behan clearly showed that there is a real challenge in the sector. There is a challenge in terms of the dependency levels of people particularly in residential care. I was interested in what David Behan said about nursing care. If we have a sector, a large proportion of which is dealing with people with very high dependency, and it starts to see attrition and a demographic shift towards more people needing longer-term care, we will see some significant elements of challenge. There are also some challenges around geographical areas; some areas are losing services, or indeed not having new services developed, partly because of the challenges with funding.

Colin Angel: There are three issues, and the changing demographic is certainly up there at the top. We have particularly noticed that domiciliary care workers are becoming more like the district nurses from my nurse training in the 1980s, and are undertaking a range of health-related tasks that were never previously expected of that part of the social care workforce. We have people who are increasingly frail using homecare services and remaining safe and well at home. We have considerable challenges regarding the workforce, particularly in areas of the country where the supply of care workers is relatively inelastic. You could throw a fair amount of money at some parts of the country and actually not increase your worker recruitment dramatically.

Then, of course, there is the future impact of Brexit, depending on what happens with people being able to enter the UK. That will be an issue largely for London, the south-east and south-west, which is where the majority of non-British EEA nationals work.

Finally, there is finance. You have already heard in evidence this morning, and in previous sessions, about providers indicating the need to exit the market because contracts are becoming unsustainable.

Tim Hammond: I have the pleasure of saying I agree with everything I have heard so far today, in this session and the session before. I will not repeat that, but will add one or two extra points. We have not yet talked about dementia this morning. The large growth in people with dementia is another factor I would throw in on the demand demographic side. The figure I have from the Alzheimer's Society indicated that it is expected to increase by 40% within the next 10 to 15 years.

On the supply side, David Behan at CQC has already identified that we have gone from a growth in beds, particularly nursing beds, over many years to a slight decline. A few months ago, there was a think-tank report by ResPublica, commissioned by the industry, that projected the loss of over 30,000 beds or around 7% of capacity over the next four or five years based on current government approaches. That is the other thing I would put on the table.

To add a little local colour, I was in one of the Four Seasons homes in Enfield on Monday this week, and discovered to my pleasure that our home had had 12 inquiries the previous week. I thought that was a rather high number, and it turned out that there are actually five homes in the borough of Enfield currently in the process of closing, none of which are Four Seasons homes. You have local pockets of quite significant demand-supply stress, and perhaps other areas where there is a lot less stress.

Andrew Dykes: In the learning disability field, which I know most about, the demographic change is not perhaps the most important. There is an increase in demand in learning disability services, but the biggest cause of that is improvement in perinatal and postnatal care that came in quite a number of years ago, which improved life expectancy. More people survive at birth than would otherwise have done.

Life expectancy is improving for people with complex needs as well. In an echo of what Mr Hammond said about dementia care, the market is not yet addressing in any meaningful way the problem of elderly learning disability care, which will come to it fairly soon. It is completely unaddressed at the moment.

We support both residential and supported living services. The biggest issue for the residential provider is the emphasis that has been put on supported living in the last few years for budgetary reasons. People with complex needs are being pushed, in my view inappropriately, into supported living, which is very expensive, although it is cheaper for the decision-making purchasing authority. It leads to worse outcomes, is not properly inspected, is more dangerous and is not so good.

Q147 **David Mackintosh:** What are your current cost pressures?

Andrew Dykes: Wages is the biggest one. They represent in excess of 60% of costs. This is something that is not recognised by purchasers of residential care. I do not know if we are getting ahead of the question, but I assume cost is coming next. I have a graph that I would like to put in evidence before you showing how fees have simply not responded to changes in the national living wage over the past few years. With your permission, Chairman, may I provide that?

Q148 **Chair:** You can provide it to the clerk and we can circulate it. It is difficult for us in the middle of the hearing, but we will certainly reflect on that in due course.

Andrew Dykes: It shows that fees, despite pressures on wages, have not moved in the last five years.

Professor Green: There are issues such as regulatory costs, which are increasing. The burden of regulatory costs is shifting from the Government to the provider. There are also issues around training and development costs. There is the introduction of the care certificate, which is a good thing, and the apprenticeship levy is coming at us shortly. There have been a range of costs, some associated with general cost inflation, but also some imposed on the sector by Government. We have in effect been hit by the general inflation and wage costs, but also regulation and the levy on apprenticeships.

Colin Angel: In the homecare sector, wages are definitely a significant cost. This is not just the wages for the time people spend delivering care, but also time spent travelling between visits. We are very clear that that is working time and therefore must be paid at least at the national minimum wage. We have authorities that are taking quite a negative view of the use of zero-hours contracts and asking for providers to employ people on guaranteed hours. That is a really big ask if services are paid for based on the amount of contact time somebody has.

I mentioned inelasticity of supply. Recruitment costs are an issue. Providers have told me that they have spent thousands of pounds on recruitment and come up with three or four workers from one single

outlay. Authorities do not tend to pay for workers' travel time. Travel time is used as part of the calculation of how much a visit costs, and there has been a lot of focus on very short homecare visits over the last couple of years. If you pay for a homecare visit according to the length of time and gradually decrease the amount of time that a service user receives, nobody moves closer together to reduce the travel time. That travel becomes a larger proportion of the total cost.

We have a number of largely cash-strapped councils introducing systems of per-minute billing, so electronic call monitoring, either buying care and saying, if the worker was in the house for seven minutes, that is what you are paid for, or using a banding system. I had an example from a contract being let at the moment. You might work 25 minutes, but because it was not 30 minutes, the authority would round the time down to 15 minutes of pay.

Tim Hammond: I will add three things that have not been raised. The national living wage was a 7 or 8% rise, to take the raw statutory numbers. It may be helpful for the Committee to know that in a Four Seasons context we were looking at a circa 5% increase in our labour costs, because around half our people were on the old national minimum wage.

The second point is that there is a range. In the less well-off parts of the country, it will be in the higher end of the range; and, in the better-off parts of the country, it will be in the lower part, simply because there are fewer people there on the old national minimum wage. You get different things in different parts of the country.

The third point to make, which I believe we are coming on to in due course, is about the nurse shortage. I will just report that this creates a cost pressure, as you would expect. Just looking at our numbers, over the last two or three years we have seen nurse pay go up by around 4% per annum. It has not risen evenly, as there are certain towns and cities where it is very difficult to hire nurses and be competitive. We have had to put our rates up to account for that.

Q149 **David Mackintosh:** What proportion of your actual costs is covered by local authority fees, and how do you fund the difference?

Tim Hammond: LaingBuisson has a model, originally developed with the Rowntree Foundation, which I believe it updates each year. To take one example, imagine somebody requiring both nursing and dementia care. The latest number I have been able to obtain from LaingBuisson is £768 per week, which takes account of everything. Four Seasons is a very inclusive provider, roughly 75% funded by local authorities, 10% NHS and 15% self-funders. We are in the core of your inquiry. Our average rate from local authorities is around £685 for nursing dementia care, which is obviously more expensive than some other forms of care. The lowest we currently get paid is £557. You can see the challenges.

It raises all sorts of problems, trying to work out how you can make a particular home or organisation viable. We spend a lot of time trying to find ways to do it. Effectively, a lot of our energy goes into trying to drive up care quality to get as near to full occupancy as possible. We have put in place a unique customer feedback system and we have had 125,000 pieces of resident, relative and health professional feedback in the last year. That means we can learn a hell of a lot about what our residents want, and then be responsive. A lot of it just constantly trying to do better. Nonetheless, we will no doubt come back to the issue of where the market might be going.

Professor Green: It is also really important to recognise that in some areas the fee levels are quite staggeringly low. For example, in places like Sheffield, £377 per week for residential care translates into £2.24 per hour. Consider the level of dependency of people in care services, 80% of whom have some form of dementia. If you get access to a publicly funded care placement, it is usually because you have several comorbidities. These are often the end-of-life placements, because it is usually when somebody has had a critical incident such as a fall that they move into residential care.

The levels of funding in some of these areas are ridiculously low, if you look at the dependency levels of the older people they are looking after. Coventry's figure is £2.32 an hour. I am sure many of you have been into care homes in your own constituencies and seen the levels of dependency of some clients. They are the same people who would have been in hospitals 15 years ago, surrounded by doctors, nurses, physios, OTs and a range of other medical professionals. Care homes are now being required to look after those people at these very low levels of resourcing.

Colin Angel: In the homecare sector, yesterday we published a report called *The Homecare Deficit*. We looked at what local authorities were paying for homecare services against UKHCA's minimum price of £16.70 per hour, and that is most definitely a minimum price. In England, regrettably, we found that the weighted average price was £14.66, about £2 under our price. We have made the assumptions in calculating £16.70 publicly available; they have already been sent to the Committee.

Some providers are working absolute miracles to accommodate that cost, but there will inevitably need to be cuts in the number of supervisory and managerial staff who co-ordinate and run services. It will affect providers' ability to offer training time. Indeed, there are many independent sector providers who are not actually taking money out of their businesses. They are locked into a care business that is not providing a return for them.

Andrew Dykes: There is one particular aspect that makes the learning disability market different. Residential placements in learning disability tend to be very much longer-term. While you may accept a placement at a reasonable fee on day one, that fee does not then increase and you end

up with problems. That mostly affects, of course, the longer-term placements, which are by definition the successful placements, where the placement has not broken down and the individual service user has not had to move on somewhere else. In effect, the best homes are being penalised by that.

Q150 David Mackintosh: You have touched on some of this already, but how does the financial situation affect the levels or quality of the services provided?

Andrew Dykes: Within our service, we try very hard to keep the quality of care up. Obviously, you have to cut your clothing according to your cloth. Mainly, we have extended bank terms and reduced management overheads as far as possible. We have to keep up the number of staff on the shop floor; they are now no longer paid the premium over the living wage they used to receive, so we have trouble with recruitment.

I am very lucky that I have a very loyal staff and low turnover. However, the supermarket down the road is paying 20% less than we are, and my people are dealing with very complex behaviours, physical challenges and dangers to themselves. We have people in hospital from time to time, although fortunately very rarely. It really is quite tough to ask them to cope with that sort of risk.

Tim Hammond: From a Four Seasons perspective, we never want to provide care that is of a quality below a good standard. We are on a journey; we are continually improving in every home. We have come a long way and we have further to go. The key point is that if we cannot provide good care quality then we have to consider whether we should be providing a service at all.

I would look at it more like that: it is almost a cliff edge. We will provide good quality care if we can for that price. By the way, on the other factors you heard this morning, concerning availability of nurses, I can think of one or two cases where we are struggling to hire nurses and seriously wondering whether we should be doing nursing care. We happen to have a charity provider in the sector that a couple of years ago came out of nursing care altogether. You have those kinds of issues going on as well. If we cannot be providing good-quality care, we should not be providing care at all.

Professor Green: Linking to that point, there is an issue about whether or not services will be developed in some areas, because the funding position is so low you will not get people coming forward with new, creative and innovative services. There is a challenge not only for the services that are currently in existence, but also for whether we have services in the future that are fit for purpose in the 21st century.

Q151 Mary Robinson: I just want to look at the relationships between you as providers and commissioners. How good are local authorities at commissioning care services, in your view?

Professor Green: It is very difficult and the situation is not good. I have to say I a lot of sympathy for local authorities. You heard the evidence of Ray James and Sarah Pickup from the LGA and ADASS. The challenges that they have are increasing demographics and less money. There have been elements of new money put into the system, but not all of those have reached the front line.

You heard this morning from Paul Simic that we then have situations where the relationships often start to deteriorate. For example, there was recently a cost of care exercise done in Essex that acknowledged a significant amount of underfunding. The response of the council was to say, "We cannot afford to pay you what the independent cost of care exercise has said is appropriate, so we will not be able to give you that money." There is a misnomer in talking about negotiations with local authorities. The vast majority of local authorities have a set budget and the negotiation is about going down from a figure, not identifying what the true costs of care are. Those sorts of issues often lead to poor-quality relationships.

There has also been the challenge that some local authorities have tried to use the commissioning mechanism as a mechanism of control. In local authorities that tell you there is no money for frontline services, they are then developing quality assurance schemes and duplicating the work of the Care Quality Commission. Again, this is not helpful, because having to respond to a statutory regulator, and a raft of other requirements from the commissioner, is an added burden on the provider.

We have to understand the context, but also understand that difficult relationships will lead to difficulties around things like reconfiguring services, developing new services and moving services on. In some areas, there needs to be that transition of services moving from one model to another, but because the relationships are long-term, that is not happening very effectively.

Finally, another challenge we face is the constant churn of personnel in local authorities. Establishing long-term relationships between providers and local authority commissioners is sometimes difficult. Adult services directors in local authorities have pretty much the shelf life of a football manager; we are seeing this constant churn, and that does not lead to stable relationships.

Tim Hammond: I have a couple of commissioning points. The first thing to say is that it would be great if we had an agreed method, across the whole country, to say, "That is the true cost of care", on a completely open and transparent basis. I mentioned the LaingBuisson figures earlier. You will find some commissioners who accept those and some who dispute them completely. If we could just have one agreed method as to how to work out the true cost of care, it would be hugely helpful. There is a debate as to who should oversee that, if anyone.

The second point is that we have seen a complete divergence of commissioning practice this year at Four Seasons, in the sense of who has

responded to the challenges of the national living wage increase last April and the social care precept.

The social care precept, as you are no doubt aware, was raised by almost all English councils. I cannot give you an exact number, but roughly half of the 80 councils we deal with, which is quite a good sample, have responded positively, and I compliment them, and said, "We recognise your cost pressures. We do not want capacity disappearing from the market. We will give you a fee rise that compensates you for the national living wage rise." In the middle quarter of councils, six months later, debate is still ongoing. There is another quarter or third that do not recognise the pressures at all. There is a complete divergence of commissioning practice in quite a critical regard vis-à-vis the future of the sector.

Colin Angel: I would add to that. Relationships have become very fraught and financially orientated, which is understandable but not ideal. There is a polarisation in behaviours of local authorities, between those that have big frameworks that any provider of the right quality can apply to join, and those that are reducing the number to the smallest number of providers they think safe in order to reduce their transaction costs.

As to the reasons the discussions are so poor, Martin mentioned the cost of care exercise in Essex. We could only find 13% of councils in a sample that could tell us what they thought to be the cost of an hour's homecare. There is a real reluctance from many authorities to do that exercise openly with providers, because they are too afraid of the answer.

Q152 **Mary Robinson:** Before I move on to Mr Dykes—and you may answer this as well—is there a feeling that the market dominance of local authorities is used to put pressure on providers?

Professor Green: Yes, definitely. The monopsony commissioning power in local areas means that they are absolutely dominant in how they define the market.

Andrew Dykes: I broadly agree with everything the panel has said, particularly Martin Green's last comment. As a small provider, we do not have the market muscle to fight back. With us, it is a case of take-it-or-leave-it. There are exceptions, so do not think this is a blanket complaint. By and large, if we ask for a fee increase, we are treated badly, letters are not replied to and meetings are delayed for months. We are given the run-around in a way that would frankly not be possible in the private sector, because a private sector company behaving like that would be out of business.

Q153 **Mary Robinson:** If a private sector company behaved like that, the CQC would also be examining it. Should there be an oversight role for local authorities?

Professor Green: I have advocated an oversight role for a long time, because it is about the only bit of the system that is not accountable to anybody for its performance. I was interested in the evidence session

where market position statements were discussed. A lot of money was invested by the Department to support local authorities to develop market position statements. They often have wonderful statements on their website, but who is monitoring their performance? Who is looking at whether or not those market position statements are futureproofing the market? Are they looking at what the market needs now, but also 10 or 15 years ahead? You have to do that because of demographic pressures. Every stage at which there is a requirement to do something, the rest of the system is locked down, quite rightly, by someone with oversight. The local authorities are not in that space. There is a real problem about not having that element of the system properly monitored for outcomes and performances.

Andrew Dykes: There is very much a case for some sort of oversight. Of course, local authorities have democratically elected councillors, but my attempts to involve them in areas where councils are acting ultra vires or simply not looking at facts in a reasonable way have almost invariably failed. I am afraid that most councillors do not want to know, because it is a political hot potato and they think that it inevitably leads to more money being spent.

Colin Angel: Like Martin, UKHCA has consistently argued in favour of a regulatory body having some degree of oversight of local authorities, particularly how authorities in England meet their Care Act responsibilities for market-shaping. If you try to get an answer to who polices the Care Act, of course, nobody polices the Care Act; the assumption is that, if something is severe enough, it will end up going through a judicial review. That assumes that somebody is going to spend the money on a judicial review in the first place. The rest of it seems based on goodwill and honest behaviour rather than any oversight.

Q154 **Chair:** I have a yes-or-no question. Have any of you been before a scrutiny committee of a council looking at the issue of care provision in their area?

Colin Angel: Our organisation has; I have not personally.

Q155 **Chair:** Do they give any value?

Colin Angel: It was an extremely useful exercise for us, but I am afraid that the take-home message was that the elected members of the council, in this particular instance, did not appear to have been well informed by the officers about the state of its local care market.

Q156 **Chair:** We have two final issues to discuss. We have a limited amount of time, so please focus, and if you agree with what someone else has said just say so. First of all, what are main challenges in recruiting and training staff? It seems that this is one of the big issues to come up over and over again. Is it just about pay, and if you could increase your pay by £3 or £4 per hour would it all be solved?

Tim Hammond: No. It is partly about pay in certain localities, but it is, I would argue, mostly not about pay. Health Education England, in its submission to the Migration Advisory Committee last year, apparently said that there were 30,500 too few nurses across the country's entire health and social care system; many of those would be in hospital jobs. That is the issue we have, and I do not see that it is any better today than it was when that submission was made. Clearly, there are various challenges going forward, particularly in terms of east European and south European nurses. If and when they decide to go home, will new nurses want to replace them? The nurse shortage is a very real issue in this area.

Professor Green: There is a lot of talk about integration, but there is not very much thought about integration of the workforce. For example, the Department of Health plans its nursing workforce on the needs of the NHS, when in fact there are lots of nurses working in the independent sector. There needs to be a root and branch reform about integration and it needs to start with the entire system, not just bits of it.

People think about integration only in terms of service delivery, but there is a lot of planning and development stuff that needs to happen across health and social care in order to be fit for the integrated working we will need in the future. The demographics are increasing and the amount of available workforce is declining. We are in a space where we will have to be much smarter about how we use the workforce. We need to train them to move across systems exactly as people move across systems.

Colin Angel: In the homecare sector, there are three main issues. The first is terms and conditions of employment. We have a particularly mobile workforce that will move employer for relatively incremental increases in pay. There is a key issue about working patterns, particularly how the length of homecare visits relate to satisfaction and provision of good quality care. Interestingly, there is a demand for flexible working arrangements, despite some of the quite negative rhetoric over the last couple of years about the use of zero-hours contracts.

Andrew Dykes: Wages comes into it, but is not the only factor, as other people have said. The low-status public image of the care industry definitely has an effect on recruitment. People will sometimes turn to it as the last possible resort rather than something they should possibly look forward to as an opportunity. We tend to find, when we employ people, that they either stay for a very short time, because it is not for them, or they stay pretty much forever, because they like it and find it rewarding. That may be helped by the fact that we are primarily working in areas where there is a small pool of labour and of alternative jobs, but I do not particularly think so. That is it really, as we are short of time.

Q157 **Chair:** My final question was about integration, as has helpfully been addressed in the wider context. There is a very real issue of discharge from hospitals. Is the join-up between health and social services getting any better?

Tim Hammond: Let me be positive: very, very slowly. I can point to particular examples in particular parts of the country where we have become better joined up as a system. I will give you a stat: last winter, when usually the pressures are greatest, we had around 400 winter bed contracts, as I will call them, if that makes any sense to you; they are often called step-up and step-down. If an older person has a problem at home, often the only solution for them is to go to hospital, but, actually, they could go into a care home, have skilled care for a few days or weeks before being discharged to their home. Step-down is more common. This relates to your discharge point. It is about getting people out of hospital much more quickly, freeing up the system. It is of course much better for the patient, who might just need a few days or weeks.

We had around 400 of those contracts last winter versus roughly 200 the winter before. That is why I say "very, very slowly". If you look at the scale of the issue and the opportunity, there are circa 50,000 empty beds in the care home sector in total. I think the NHS only has about 100,000 beds in total. The opportunity for the care home sector to really play a role in helping the NHS is very real, and has been publicly recognised by many others in the last few months.

Professor Green: We need some clarity from the centre, in my view. Tim is right that it is good in some areas, but we need a centralised view about how we deliver something that is more appropriate for people, particularly older people going into or coming out of hospital. It should not be left to the vagaries of areas or to a postcode lottery. We need clear leadership about how money will flow across the system and transform things from where they are, basically a hospital model of health, to where they need to be, a 21st century model where people are characterised by having to live well with long-term conditions. The hospital system was set up to cure those people quickly, and that is no longer the scenario. Particularly for a great deal of older people, there are better options than being in hospital.

Colin Angel: Like Tim, I would say that progress is very slow, but encouraging. There is much greater willingness to learn from what works. There have been some quite good materials produced by NHS England on better use of care at home, for example. The thing that would help most is more organisation. Tim has talked about empty beds; in our case, it is about care workers who are available. Where do you go to say, "I have some capacity; how would you like to use it?", without getting a response to the effect of, "Sorry, we do not contract with you"?

Q158 **Chair:** Thank you all very much for coming to give evidence to us today. That has been very helpful to the Committee.