Written evidence submitted by the Care Association Alliance [ASC 058]

The Care Association Alliance

The CAA is a group of local care associations across England, formed in 2010 to encourage the sharing of best practice and closer working relationships with local authorities.
Our 41 member associations represent more than 7000 individual providers of social care, including residential and nursing homes, domiciliary care, supported living and LD homes, meaning we have a broad view across the whole sector.
We believe in the importance of collaborative working with local and national commissioners and that our members, often SMEs, are an important but often overlooked part of social care delivery.
Further information can be found at https://careassociationalliance.org.uk/

Executive Summary

As an alliance of care associations across England we at the CAA believe that well-funded local care associations provide invaluable and cost effective vehicles for better partnership working across the sector. There are many examples of innovative solutions that have been developed through mature, trusting relationships between government health and social care authorities and care associations. We believe that these allow commissioners, public health bodies and providers to focus on their common goal - providing quality services to the people of England.

We have extracted our key messages below with further detail and references in subsequent sections.

How has Covid-19 changed the landscape for long-term funding reform of the adult social care sector?

- Costs have risen dramatically due to unprecedented levels of staff sickness and isolation.
- Income has fallen dramatically in the care home sector where occupancy levels are the lowest seen in 25 years.
- Significant proportions of the funding made available by government has either not reached the front line, been delivered late or been so targeted that it does not meet sector needs
- All of these factors have combined to dramatically shorten the time that the sector can survive in its current form. Kicking the problem into the long grass is no longer an option.

How should additional funds for the adult social care sector be raised?

- If taxpayers are to be asked for more money then this must be spent wisely. The National Audit Office found that the Department of Health and Social care “has no way of measuring commissioning effectiveness… or the cost effectiveness of money spent”.
- There is a lot of wastage in the sector as it is currently, and how to reduce this should form part of the discussion on future funding.

- Oversight of Commissioners is important to challenge the current practice of “passing the buck” to providers by knowingly paying rates below the cost of safe care.

How can the adult social care market be stabilised?

- The current mentality is “Price is King”. This needs to change urgently as current commissioning practices reward those who are willing to cut the most corners.
- A meaningful Workforce Strategy is vital as without good people good care is impossible.
- Funding decisions need to focus on more than short term budgets. Too often care that promotes independence is sacrificed for a lower unit rate/fee, even though this would cost less in the long run.
- The current system is too siloed to be effective. Often more expensive options are prioritised because part of the cost comes from a different budget. A truly integrated system that removed these false barriers would allow each taxpayer pound spent to fund more care.

How can the adult social care market be incentivised to compete on quality and/or innovation?

- Data is key. Prior to Covid 19 the only way to measure the health of the social care system was to count the crises in hospitals. We need to ensure that the data collection systems championed during the recent crisis continue and are further improved after the pandemic.
- Commissioners need to stop looking for short term savings at the cost of longer term independence for the people using services. More money up front in the right place could pay dividends for the individual and the state.
- Providers need to be enabled to engage in an integrated wider market so that care is a menu of options that a person can dip in and out of as appropriate, rather than each provider trying to keep hold of service users for as long as possible.
- Different commissioning practices could properly incentivise care providers. Currently a provider that invests in their staff, has minimum staffing levels to meet dependency and engages with relatives and individuals to improve their care is paid the same as a provider that cuts corners, has a poor quality rating and finds innovative ways to pay less than the minimum wage. The only difference is that the second provider probably makes a higher profit.

The CAA believes that the social care market includes some of the most innovative and successful entrepreneurs in our society. Most business owners own a small number of sites and genuinely care about the local health economy in which they operate. Through local care associations it is possible to bring these innovators together and share learning and expertise across the sector, yielding huge dividends in cost and quality. In the current system the diversity of providers, or the providers themselves, are too often seen as the problem. In fact these organisations hold the solutions to the current crisis, all that is needed is real co-production, and real engagement.

How has Covid-19 changed the landscape for long-term funding reform of the adult social care sector?

The dramatic impact of Covid-19 on the social care sector is likely to endure for many years. There were already serious long term issues, set out in multiple reports over the last two decades, including a funding shortfall estimated anywhere between £1.4bn and £12.2 billion per annum[1] and a workforce shortage of 150,000 or 10% of posts, at the same time that projections suggest 30% growth will be needed to meet predicted demand[2].

Financially the pandemic has been devastating for care homes in particular, with occupancy levels falling from around 90% to 75%[3] and recovery to pre covid levels a distant prospect. One report[4] estimated a 13% drop in occupancy by June 2020 equivalent to £2.6 billion lost annual income. The Government has provided £4.6 billion in additional funding to Local Authorities with social care included within the areas to be funded from this money, however according to the National Audit Office only around £300 million of this has made its way to providers within the sector.

Across the whole of adult social care costs have also increased in a number of areas as a direct result of Covid-19, most dramatically workforce costs. Care providers have statutory duties and cannot operate with significantly reduced numbers of staff, and with absence levels due to confirmed or suspected Covid-19 infection commonly up to 50% during outbreaks, had no alternative but to bring in agency staff at significantly higher cost. Knight Frank estimated in mid 2020 that this had increased staff costs by around 10%[5].

PPE costs have been another major cost. Age UK[6] estimated prices to have increased by 30% for gloves, 166% for aprons and 1000% for face masks, and with dramatic increases in the quantities required providers faced huge rises in costs prior to the introduction of supplies through the new PPE portal. The Department of Health responded by allocating £1.146 billion of IPC funding to be passported to care providers through strict allocation criteria to ensure it reached the frontline, but equally strict restrictions on how it could be spent prevented it being used to cover PPE costs, or indeed any costs incurred before 13th May 2020. A CAA member commented that “Using the ICF grant I can buy a bike for my care staff to protect them from covid but I can’t buy them a mask”. With government indemnity against Covid-19 claims only offered to the NHS, social care providers have also faced steep increases in insurance premiums.

These pressures led to significant drops in provider performance and profits. Knight Frank in mid 2020 found that 5% of care homes within their study were loss making, with a further 11% achieving an

[1] House of Commons Library. 2020. “Adult Social Care Funding (England).” (December).
[2] Skills for Care. 2020. “The State of the Adult Social Care Sector and Workforce in England.”
[3] NHS Capacity Tracker
[4] Laing, William. 2020. “Impact of coronavirus mortality on care home resident numbers (Updated 10 July).” (07).
[5] 2020 UK Care Homes Trading Performance Review
[6] Age UK. 2020. “Time To Bring Care Workers In From The Cold.”

EBITDA (gross profit) between 0 and 10%, meaning 3500 homes across the country were making at best minimal profits. In addition, many providers are in breach of covenants in place on pre-Covid finance arrangements, which commonly include occupancy levels and profitability based on historic performance. If lender goodwill is withdrawn, rapid multiple business failure could result. Even if banks impose modest increases in interest rates as a result of perceived increase in risk, large numbers of providers may cease to be viable.

The pandemic has undoubtedly placed additional strain on an already stretched workforce. Age UK sum up the hidden costs of the pandemic on staff:

"Many care workers are very tired, burned out and a significant number have suffered bereavement …. These last few months have been traumatic and the next period may be far from easy too, but it is still being assumed that our taken-for-granted care staff will keep turning up to work, no matter what"

Public acts of recognition such as 'clap for carers' have not translated into anything tangible and many front line staff feel forgotten and under-valued. Particularly at leadership level, large numbers are in danger of burnout without significant support, and there is a risk that even if providers remain, there will not be the managers to run them. Even those with long experience in this troubled sector have found the last year exceptionally challenging, and the coming months could see an exodus of large numbers of skilled and experienced carers, nurses, managers and owners, with catastrophic consequences for clients.

How should additional funds for the adult social care sector be raised?

Although we do not believe it is for the sector to advocate for any one of the many proposed funding schemes, we believe the scale of the issue means cross-party solutions must be sought, and that it is essential that the public are properly engaged in an apolitical process to develop a sustainable solution.

We believe not only that most people would support greater investment in social care, particularly in the light of the pandemic, but that in the long term it would be more cost effective than continuing to burden the NHS due to lack of provision. The Scottish experience supports this view.

The way in which care is commissioned contributes to the issue of cost, and increases the urgency of finding a better way of funding. The current system of cross subsidy by self-funders[7] is manifestly unfair, and although many people are unaware of it until they need care, causes considerable resentment. It has also led to a two-tier system in which those with significant funds can access care denied to those dependent on state funding. A 2017 report[8] found that homes with more staff on better wages, made possible by privately funded income, deliver better care outcomes. The same year, the CMA found[9] that self-funders in care homes paid a 41% premium over local authorities and private home care cost on

[7] Age UK. 2019. "Social care reform and funding."
[8] Knight Frank. 2017. "Is there a link between care home trading performance and CQC rating?"
[9] Competition and Markets Authority. 2016. "Care homes market study."

average £3 per hour more for those paying for themselves. It's remit did not extend to considering how commissioning practices contribute to these differentials, though a NAO report earlier this year[10] noted that "the Department assessed that the majority of local authorities paid below the sustainable rate for care home placements for adults aged 65 and over and below the sustainable rate for home care. The Department does not challenge local authorities who pay low rates"

We believe that robust oversight is necessary to ensure that taxpayer money is spent effectively. The National Audit Office found that "19 pence of every pound spent on care by local governments is spent on commissioning and other non direct care related expenses", which equates to almost £3 billion pounds of all government spending on social care. In 2016 the CAA was able to highlight this inefficiency and also signpost areas of the country that were the most efficient (Care Association Alliance 2016)[11]. Shortly after this piece of work was published, a change was made to the way in which that data was collected so that it is no longer possible for the public to analyse where money is spent by local authorities and identify inefficiency.

We welcome the Government's White Paper[12] and in particular the suggestion that openness and transparency should be a cornerstone of any reforms enacted. We would advocate for the suggested regulator oversight of commissioning to be introduced by CQC but also for the Local Government Ombudsman to be given the power to investigate complaints, whether care is being government or privately funded, so that there is openness and transparency for all and a mechanism to root out poor practice.

How can the adult social care market be stabilised?

We do not believe there is currently a commonly agreed definition of what a stable market would be. Our view is that in a stable and well-functioning market, an individual needing care could choose between a number of different providers in their local area that offer quality services at a reasonable cost, and feel confident that this service will continue to be available to them for as long as they need it. Such a market would allow each individual to be at the centre of a journey through the system and enable easy transition between services as their needs change.

Current commissioning practices inhibit such a market in a number of ways. Funding is currently siloed, with housing, health, local government and private individuals in a complicated system that often offers the service user only one option to 'choose' from and makes moving between different types of service more difficult.

There is an urgent need to address the drive that "Price is King". Most commissioning is motivated by cost, with quality and outcomes very much secondary considerations. Cost driven commissioning has

[10] National Audit Office. 2021. "The Adult Social Care Market in England."
[11] Care Association Alliance. 2016. "State of Commissioning Survey."
[12] Department of Health and Social Care. 2021. "Working together to improve health and social care for all."

led to the 15 minute care visit, and, in the absence of clearly set out statutory staffing levels, residential settings are driven to minimise staff numbers.

Across the sector pay rates are also put under pressure, particularly when annual fee increases are below statutory wage increases, or when no increase is awarded at all. Paying at or close to the minimum wage makes retaining staff difficult, and coupled to the lack of funds available for training, pushes up turnover. In a 'human interaction' sector, this has an inevitable impact on quality.

When below-cost fee rates lead to poor quality care, it is the providers that take the blame. Many are small businesses, often family owned and run, with 75% of care home providers running just one home and 90% of care at home providers operate from one location[13]. This means there is a significant power imbalance in commissioning relationships.

Providers of all types of care around the country report commissioning practices which have a destabilizing effect on individual services and the market, such as the imposition of new tiered pricing systems with little notice, and late notification of fee increases (often as late as June for increases due in April). Genuine consultation is so rare that many providers no longer attempt to engage with local exercises, or to provide data for costing exercises which have historically had no impact on rates.

As well as destabilizing care businesses, these practices have direct impact on the vulnerable individuals they support. It is often quicker for staff to carry out a task for a person than to support that person to do it for themselves, but 'by the hour' commissioning leads to the faster method being adopted, meaning the individual loses both dignity and independence. Too often, this hastens their decline, as unused skills are soon lost, and can often increase their lifetime care needs as a consequence.

In our view there is a lack of national and local recognition of the innovation displayed by many smaller care providers. It is possible to provide lowest cost residential placements in large purpose-built homogeneous facilities offering basic care, but managers of residential and nursing homes continue to strive to do much better. Often, the owners and managers live and work in their local community, and care deeply about looking after their residents, their friends and families, and the staff who work for them. We believe the public share their belief that the minimum is not sufficient.

We also believe that more partnership is necessary to increase understanding and cooperation between commissioners and providers. The high dividends and novel corporate structures of a small number of large providers have enhanced the perception that care providers are solely in it for the money, and many providers see commissioners as unnecessarily bureaucratic and lacking in understanding of the realities of work on the ground. The pandemic has shown us the importance of working together, especially in such a fragmented market, and how mutual respect can grow even in the most challenging of times. The entrepreneurial spirit of the people who own and run small businesses could make a genuine difference, if trust can be established to allow them to work with commissioners to develop collaborative local solutions everyone can buy into, in contrast to 'top down' innovations imposed on

[13] National Audit Office. 2021. "The Adult Social Care Market in England." NAO.

the sector from above. When these work in one location, other areas can learn from and adapt them; the Trusted Assessor model is a good example of such an initiative, developed in partnership in Lincolnshire, and working well where schemes have been designed with providers fully engaged and involved.

Finally we believe that the social care workforce is vital to a stable market. Social care is provided by people for people, and our clients deserve to be looked after by sufficient staff with the right skills and aptitudes for a role that can be extremely challenging. Too often the number of vacancies in social care roles within a locality is quoted alongside the number of unemployed people in that locality, suggesting "anyone can do it". With the introduction of values based care recruitment[14] and other similar initiatives it is finally being recognised that providing social care requires a skill set not everybody possesses. It is critical that a new Workforce Strategy be developed and properly resourced as the market cannot properly function until this issue is addressed.

How can the adult social care market be incentivised to compete on quality and/or innovation?

We believe that better information is a key step toward improving social care outcomes. In their recent report the national audit office described the department of health and social care as being "unable to gauge how money was spent by local authorities and what the outcomes or return on investment was for any investment made"[15] Prior to Covid there was no central data collection of fee levels, occupancy rates, workforce numbers or other key metrics to judge how healthy the social care market was, and in most localities there was not data collection at all. Without such data, commissioners and care providers have been unable to make informed decisions, or to judge the effectiveness of different choices. To a large extent, the effectiveness of social care has been measured by counting crises in hospitals.

To make a long term success of the data collection initiatives begun during Covid will require two things; Firstly providers must be involved in the design of the collection mechanism, and secondly they must be properly incentivized to complete returns.

Too often the process is highly onerous, and providers are unable either to influence the questions asked or the mechanism used. Providers are also often unable to access any of the information collected so have no incentive to complete returns, a problem made worse when the same data is separately requested by local authorities or the CQC, with no allowance for the cost of the necessary administration. A case in point is the NMDS dataset, which collects workforce data, and is highly complex and time consuming to fill in, with the publicly available data years out of date[16], and not used by many local authorities, who require providers to collate the same information for them.

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[14] Skills for Care. n.d. "Benefits of using a values-based approach."

[15] National Audit Office. 2021. "The Adult Social Care Market in England."

[16] currently the NMDS dashboard states that the average carer wage paid in the North East is £8.54, which is below the national minimum wage announced in April 2020 (Skills for Care, n.d.), this average can only be correct if over 80% of providers in the North East are currently in breach of national minimum wage laws.

We believe that integration and genuine cooperation between different parts of the health and social care systems will be key to improving outcomes for the people who use services. Individuals should not face a strict 'one way' journey to ever increasing levels of intervention, but should be able to 'dip in' for support to meet temporarily increased needs, for example after a hospital stay or fall, and be supported to return to their previous level of independence. To make this possible, providers need to be incentivised to support short term clients, rather than offered rock bottom rates which encourage them to institutionalise clients and 'hang onto' them in the longer term. This will require acknowledgement of the cost of assessing individuals and setting up care arrangements, and that short term placements cannot be funded at the same price as long term placements.

When price is the only criteria used in commissioning decisions, quality and innovation inevitably suffer and services are driven to the brink of acceptable quality and long term sustainability. 'Per bed' or 'Per hour' rates do not allow for services designed around the needs of the individual. Commissioning must instead reflect quality. Currently there are almost no areas in the country where CQC rating affects the rates paid to providers and social care providers are almost the only providers of services to the NHS that are barred from receiving CQUIN payments. Investing in infrastructure improvements, equipment and staff is costly, and currently no recognition of such investments is made in fees paid.

It will be important to find better ways of agreeing what high standards are and measuring whether these are being met. In many locations CCG and Local Authority quality teams have their own systems of rating providers, but hardly any have been developed in partnership with providers, and both the scheme and outcomes are often hidden from them. When the sector has a statutory regulator in the Care Quality Commission, the purpose of these schemes is unclear. Providers do not always welcome the CQC or agree with everything it says, but a properly funded and empowered national regulator responsible for inspecting commissioners and providers is the best way to improve care quality.

Providers also need support so that different types of service, such as day-care, dom care, extra care and residential settings, working together, can enable individuals to move between them more easily. Community healthcare services (including mental health, physio and OT) must be up to the task in our communities, including in care homes. Residential provision would benefit from funding and support to upskill staff to gain these skills, for example to promote mobility using physiotherapy, an initiative which would also offer development opportunities for our workforce.

It is critical that more funding is made available to properly invest in the workforce, and this funding must reach the ground where it is needed. The success of initiatives should be measured 'on the ground', for example by capturing data on the number of people coming into the workforce and retained in the sector, not just the number of hits on a new recruitment website.

Finally we believe that those working in social care need to be properly paid for the demanding work that they do. Offering a better quality service to those who need it will only be possible if we can attract and keep staff from carers to managers. As well as more pay, this needs a concerted and sustained effort to improve the poor image of the care sector to ensure it does not remain the poor relation of the NHS; it should be unthinkable that another budget report could fail to include a single reference to

social care. With an average staff turnover rate of 40%, too often all care providers are able to do is to keep teaching the basics. Any provider or user of care services can tell you that consistent, well trained and supported staff are critical to the provision of good care.

Contributing Care Associations

Individual Care Associations which contributed to this submission:

- Bedfordshire Care Group
- Berkshire Care Association
- Bradford Care Association
- Care and Support West
- Cornwall Partners in Care
- Derbyshire Care Association
- Devon Care Homes Collaborative
- Dorset Care Association
- East Sussex, Brighton & Hove RCA
- East Midlands Combined Association of Registered Establishments)
- Essex Care Association
- Gloucestershire Care Providers Association
- Hampshire Care Association
- Havering Care Association
- Herefordshire Care Homes
- Independent Care Group
- Isle of Wight Care Partnership
- Kent Integrated Care Alliance
- Kirklees Care Association
- Lincolnshire Care Association
- London Care and Support
- NorArch (Northamptonshire Association of Registered Care Homes)
- Oxfordshire Association of Care Providers
- Sheffield Care Association
- Somerset Registered Care Providers Association
- Suffolk Association of Independent Care Providers (SAICP)#
- Surrey Care Association
- West Midlands Care Association
- West Sussex Partners in Care
- Wessex Care Ltd
- Wiltshire Care Association

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