



**Response to the Demos and Paul Burstow consultation on the
future of residential care**

31 May 2014



About Independent Age

Founded 150 years ago, Independent Age is a growing charity helping older people across the UK and Ireland through the 'A, B, C' of advice, befriending and campaigning. We offer a national telephone and email advice service focusing on social care, welfare benefits and befriending services, which is supported by a wide range of printed guides and factsheets. This is integrated with on-the-ground, local support, provided by a network of over 1,500 volunteers offering one-to-one and group befriending.

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Independent Age is also a member of the Care and Support Alliance: a consortium of over 65 organisations that represent and support older and disabled people campaigning to keep adult care funding and reform on the political agenda.

1. Executive Summary:

The delivery of high-quality residential care is crucial for over 420,000 older and disabled people across the UK. This group represents around 0.7% of the population but their quality of life and the services they receive is a matter for public scrutiny like never before. The Commission on Residential Care (CORC) presents us with a timely opportunity to examine what is going right – and what is also going wrong – in residential care.

We need to engage in a proper debate about the problems that risk destabilising the sector; whether it's a failure to provide high enough standards of care, or a failure in the care market and its ability to serve many of its customers. We welcome the work the commission is doing to deliver a vision for the future but we also think it is legitimate for the commission to address the problems that trouble residential care today. We have focused our response on three main problems:

1. **the sector's image problem** and the public's lack of confidence in residential care,
2. **the failings in the residential care market** and problems connected with a lack of funding, and
3. **the difficulties recruiting and retaining sufficient numbers of staff** with adequate enough training to deliver the care older and disabled people expect.

We understand the logic of looking to the future and building a positive vision for residential care, but Independent Age believes CORC needs to highlight the scale and severity of these problems as part of its wider work to stimulate a debate about the role of residential care in a new care landscape. Until we address these problems head on, we fear we'll continue to see a sector characterised by high levels of public mistrust and questions about its future sustainability.

Main recommendations

1. We need to restore public confidence in the care home sector. The Demos survey (November 2013) highlights that fewer than one in four would be willing to consider moving into a care home. Recent stories of abuse, highlighted in programmes such as Panorama (30 April 2014) threaten to further undermine public confidence in the sector. To address the concerns about the sector head on, the Care Quality Commission (CQC) should consider conducting a workforce survey to investigate the validity of recent claims that abuse and neglect affect the quality of care many older residents receive. The CQC's survey would help to establish whether public fears about residential care are justified or not.

2. Furthermore, we would like to see more care homes sign up to the independent *Your Care Rating* survey as a means of building confidence in a sector that has recently come under attack.

3. Central government needs to fund councils so they can meet the real costs of residential care. We believe the residential care sector is under funded by at least £595 million, a shortfall that needs to be plugged at the 2015 Spending Review.

4. The Commission needs to identify practical ways in which councils can fund the real costs of care, using a 'fair price for care' model. One of the Commission's aims should be to map out what councils could do to move towards setting a fair price for care over the medium-to long-term.

5. All care workers should be required to register with the Health and Care Professions Council (HCPC) and have a Licence to Practice. We need to further professionalise the workforce.

6. Local authorities should sign up to a new charter that requires them to protect residents and their families from paying unfair top-up fees just to meet the basic costs of care.

Many of the problems we have highlighted in this response have one root cause: a chronic lack of funding. We believe under funding is the underlying cause of many of the inequities in residential care. These include: inappropriate top-up payments that family members of elderly care home residents are asked to pay but can't afford, and unreasonably low wages for hard-working and dedicated care home staff.

2. What the Commission needs to prioritise

Independent Age advises older people and their families on their options for care and support. We receive daily calls about residential care and how people can pay for it. We know that a care home isn't always the best solution and older people will want to consider the full range of options, including care in their own home, before they look at the practicalities of moving into a care home.

However, when someone makes a decision to go into a home our advice service and range of guides and public information are there to help older people and their relatives through every step of the process.

From a policy perspective, we have a number of concerns relating to residential care.

Whilst the Care Act 2014 promises to address *some* of the major problems that have emerged in recent years; so for example a new regime to oversee the finances of care homes and a stronger set of safeguarding arrangements, a great deal still needs to be done. This is particularly true when we consider public levels of confidence in residential care: the Demos survey (November 2013) showed that fewer than one in four adults would be willing to consider moving into a home if they become frail in old age.

The call for evidence focuses on a small number of set questions looking at the outcomes people value and whether, and how, residential care can deliver these.

As the background information on the Demos website attests, the sector is at a "crossroads...it can no longer continue with business as usual".

Given this, we have briefly answered three of the five consultation questions, but we have also highlighted a number of fundamental issues we believe the commission should take into account to properly assess the future health of the residential care sector. Delivering a positive vision for the future is clearly important, but so too is rooting out poor practice today.

There are immediate steps we believe CORC needs to call on authorities – like central government and the Care Quality Commission – to implement.

With a 51% rise in the number of over-65s and a 101% increase in the number of over-85 between 2010 and 2030, residential care must continue to be commissioned as one of the main forms of care provision for older and disabled people. If local authorities are going to manage the increased demand that will inevitably result from a rapidly ageing population, residential care has to remain a viable choice for many decades to come.

i. But the sector has a big image problem: public levels of confidence are low

- The residential care sector has a big image problem, which needs tackling if the sector is going to remain a relevant choice in an age of personalisation and increased use of direct payments. Whilst we welcome a number of the steps the Care Quality Commission is taking to clarify the fundamental standards care providers have to meet, there are worrying signs large numbers of people already view care homes as a choice of last resort. Recent stories of abuse threaten to undermine public confidence in the sector.
- To address concerns about the sector head on, Independent Age believes the Care Quality Commission should consider conducting a one-off workforce survey that seeks to establish whether public fears about abuse and neglect are justified or not. The survey would need to be anonymised to ensure a lack of prejudice for staff to express full and frank views about the standards they see in care. This should include direct questions about whether members of staff have themselves witnessed care that they would regard as neglectful or abusive, similar to the questions about bullying that are now routine in many organisations. The sector is at a crossroads and whatever positive initiatives are now underway to pioneer excellent care, we need to engage in a grown-up debate about what appears to be going wrong in too many of our care homes. To build public trust in care homes we first need to demonstrate their trustworthiness.
- Furthermore, to restore the confidence of prospective customers and to give larger numbers of care home residents a voice, we believe all care homes should take part in the independent Your Care Rating Survey which gives older residents living within care homes the opportunity to provide views and feedback on aspects of life and services in the home.

ii. Residential care is underfunded and there are failings in the care market

- There are many other problems that need to be addressed before residential care can meet an ageing population's needs. There is a danger the commission will produce a vision for residential care that sounds attractive enough, but ignores fundamental failings in the residential care market. We have to remedy these basic failings before residents and their relatives can truly be said to experience choice, voice and control in relation to their care.
- Residential care needs investing in. Independent Age believes the residential care sector could be under-funded by anywhere between £595 million and £820 million. We often use the £700 million figure, which if anything, we believe might be an underestimate.

- The promise of high quality care is too often compromised by local authority commissioning practices, which result in below-inflation or small increases in the costs they pay to homes to fund care places.
- And the root cause of these local authority practices is chronic underfunding of adult social care. More and more residents find themselves needing to part-fund or privately pay for all their own care. The capped costs reforms being introduced in 2016 are unlikely in our view to change this a great deal since only around 8 to 15% of adults in residential care will benefit from the cap. Central government needs to fund adult social care so councils can pay care homes the 'real cost of care'. The Treasury can make progress towards this long-term goal with its 2015 Spending Review.
- We need to see a fairer deal for residents and relatives; whether they are supported by their local authority and indeed when they pay for their own care. Multiple issues have been identified with the way care is priced and the relationship between price and quality in residential care. The monopsony power of local authorities, which means they can block purchase a number of care home beds, has become a big problem, not least for self-funders who continue to pay excessive fees to cross subsidise local authority-supported residents. We believe the commission should consider the ways in which care can be priced more fairly for residents, to reflect the real costs of care.
- We back the charter the Kingsmill Review called on local authorities to sign up to, but crucially, it should include a commitment that local authorities protect residents and their relatives from paying unfair top-ups to meet the basic costs of residential care.

iii. ***There are serious questions to answer about the future workforce***

- The government needs to ensure the workforce is ready to meet the changing expectations and needs of future residents, many of whom will be living with dementia and will have a complex mix of health and social care needs. Unfortunately there is a long way to go. Over 300,000 care workers are on 'zero hours' contracts and nearly a third of care workers receive no regular ongoing training. A fifth of Health and Social Care Apprentices are said to receive no training at all. We worry not enough young professionals are attracted to join the care workforce, which raises serious questions about future rates of recruitment unless we rely on migrant workers. The commission could also usefully consider the future sustainability of the care workforce should additional controls restrict migrant workers from entering the UK labour market.
- Independent Age backs many of the recommendations made by Baroness Kingsmill in her recent report, *Taking Care*, and we strongly endorse the

recommendation that all care workers should be registered and required to hold a Licence to Practice. New measures to professionalise the workforce will help care workers and residents alike.

In terms of embedding good practice, there are many international examples worth considering, including the Eden Alternative in the United States of America, but there are examples closer to home too: the best practice themes identified by My Home Life and the work of the Partnership on Dignity in Care have all pointed the way to better standards in care, so we should be drawing on their work.

If a home has strong leadership, feels connected to the community it is located in and provides the space for meaningful relationships between staff, residents and relatives, it is likely to be a place older people want to live. We finish our consultation response by briefly reflecting on the key characteristics of a fairer and sustainable care market.

3. Residential care now and in the future

Questions (1), (2) and (3)

How do you define residential care? Do you see extra care, retirement villages and other "housing with care" options as different by definition? What makes them different?

What outcomes do people value when it comes to care and support (eg choice, control, independence)?

Can existing residential care (as you define it) deliver these outcomes? If so, in what ways? If not, what would need to change for it to do this?

- 3.1** Residential care, broadly speaking, can be distinguished from other types of care, in that it includes personal (and sometimes nursing or dementia) care, help with medications; regular meals, plus a structured programme of social activities. This help is concentrated in a single home that caters for multiple residents, with a round-the-clock supply of care workers. There are generally higher ratios of staff to residents than can be found in other types of care settings, such as extra care or sheltered housing schemes.
- 3.2** Sheltered housing schemes, or supported housing have some shared facilities such as a lounge and laundry, a non-resident warden and sometimes also a built-in emergency alarm, grab rails in the bathroom and non-slip floors. Residents have privacy and independence but also reassurance and company.
- 3.3** Extra care schemes have all the facilities of sheltered housing with on-site care staff during the day and sometimes also at night.
- 3.4** Retirement villages have various types of housing – perhaps including a care home – on one site.
- 3.5** There are a number of benefits of residential care, one of which is that it can orientate you if you are confused in place and time. If your memory is failing, you can benefit from the structured routine of institutional care. For example, a person with failing memory smells food cooking or sees residents filing into the dining room and remembers that it's lunchtime. In addition, residential care can provide purpose for life and stimulation, where residents were otherwise at risk of becoming isolated, depressed or bored in their own home. In a residential care home, you can benefit from the stimulation and variety of meeting several different people, having experts experienced looking after older and disabled people concentrated in one location and specialised equipment that might not be available (at least, not cheaply or quickly) in one's own home.

Independent Age produces public information, including our free Wise Guide, Choosing a Care Home: Support and Advice to get the best from your Move to help older people and their families navigate a very complex system.

3.6 We advise that it may be time to think about full-time care when an adult needs a great deal of care by day, but crucially, also during the night. We also advise that full-time care in a residential care setting might be suitable when your need for support or supervision can no longer be met in your own home.

3.7 Whilst definitions can be useful up to a point and help families in need of simple information and advice about their options, we feel a large body of evidence already exists¹ on the outcomes older people value when it comes to care and support and the extent to which residential care delivers these outcomes. We believe question 3 in the call for evidence rather misses the point: residential care always has, and we believe, always will represent a suitable choice for some older and disabled people with care needs. The key point to be examined is not whether residential care is a suitable choice, but whether indeed it represents a **viable** choice going forward, in the context of personalisation, downward funding pressures on local authorities and damning claims about abuse and neglect in care homes.

3.8 We believe residential care still represents an important choice of care provision so commissioners should continue to shape care markets with residential care offered as one of the main choices available to adults with care and support needs. Joint strategic needs assessments and joint Health and Wellbeing Strategies should consider current and likely levels of demand for residential care and set commissioning priorities based on these assessed levels of needs.

3.9 Interestingly, the recent story of residential care is that it increasingly appears to be focused on adults with very high care needs who might not otherwise have their needs met in a community setting. There are a number of factors at play here, but one explanation is that stricter rationing of state-funded care and tighter interpretations of eligibility criteria have led a number of local authorities to restrict who can receive means-tested help in a care home. Although the trend overall sees local authorities moving towards domiciliary care or supporting adults to remain independent in community settings, in Laing & Buisson's view, pressures from the ageing population will make it harder for commissioners to contain placement levels in residential care². The needs

¹ See for example 'Outcomes-focused services for older people', Glendinning C, Social Care Institute for Excellence (2006).

² Laing and Buisson, Care of Elderly People UK Market 2013/14

profile of the care home population has changed with increasing numbers of residents experiencing substantial or critical levels of social care need. The 2011/12 Laing & Buisson report on the UK older people's care market showed levels of dependency had become substantially greater over a six-year timeframe. Quoting evidence from a Bupa survey, the proportion of residents with dementia had risen from 36% to 44% between 2003 and 2009³.

3.10 Anecdotal feedback from people we support at Independent Age has led us to believe that for many people, residential care has become inextricably associated with a loss of independence and autonomy. Our [2030 vision consultation](#) – asking members of the public how the UK can become a better country to grow older in – has revealed worrying levels of unease, and even fear, regarding a move into a care home. We have provided a number of illustrative quotes from our extensive consultation about planning for ageing directly below:

- *"I am terrified by the thought of going into residential care and not being treated like a human being."*
- *"I am concerned that should I lose my independence I may be subjected to negligent treatment because of an implicit acceptance of poor standards of care ... often given to the elderly."*
- *"Being vulnerable and dependent in a society which has a care system that in so many areas, ie care/nursing homes appears to be letting old people down in the level of care that they need. Old age is a frightening prospect and longevity a worry and a fear."*
- *"My main concerns about growing older are that I and/or my husband might get a horrible condition like Dementia and end up in a grim care home which we will have to spend all our savings on and not be looked after very well. Why? It happened to my parents. My father had Dementia and my mother had to spend most of their hard earned savings to pay for him to spend the last three years of his life in a not particularly nice care home."*
- *"I fear being unable to speak for myself and have others make decisions based on tick boxes and not on any real knowledge of me, the person, the human being; I fear the indignity of losing choice and control. I find many of the stories in the media terrifying and have already said I would rather opt out than endure such treatment as reported. I fear not having the ability to even make such a choice and all being taken out of my hands; I fear what I have seen happen to others..."*

3.11 This association of residential care with a loss of independence, combined with horror stories about poor quality care, and the abuse of some of society's most vulnerable people, means it is unsurprising residential has an

³ Laing & Buisson, Care of Elderly People UK Market Survey 2012/13 p.15 - A series of censuses of Bupa care home residents carried out between 2003 and 2009, covering about 16,000 residents on each occasion, has found an increase in the prevalence of nearly all the common medical conditions of old age, indicating that care home populations have become markedly more dependent over the period

[image problem](#). Demos' own polling in 2013 noted that attributes associated with care homes are overwhelmingly negative, and poor public perceptions around abuse means that only a quarter of people would consider moving into a care home if they became frailer in later life⁴. Given this image problem, we have chosen to focus the rest of this submission on the big failings we hope the commission and other stakeholders can acknowledge need addressing before we can prioritise other pieces of work. Developing a positive vision of residential care can only really take place once we have solved the problems many perceive as widespread in the UK's 21,000 care homes.

⁴ Demos, [Boring, isolated and lonely: Britain's damaging perceptions of our care homes](#), October 2013

4. The sector's image problem: abuse and neglect

4.1 The spring 2014 Panorama programme exposing abuse in older people's care homes in Essex and Croydon, like a number of documentaries shown in recent years, raised serious questions about the scale of abuse and neglect in the UK's care homes. A 2011 episode of Panorama highlighted shocking abuse targeted at adults with learning disabilities and autism, a programme that in no small part led the government to bring forward strengthened safeguarding arrangements in the recent Care Act. The documentary and the serious case review that then followed the investigation also played a part in the Care Quality Commission (CQC) reviewing its approach to inspections. Other programmes, for example a further expose of abuse at Ash Court presented by Fiona Phillips in 2012, have served to illustrate the worrying levels of sub-standard care, and in a very small minority of cases, even criminal, neglect and abuse witnessed in some of our care homes today.

4.2 It is important to note that significant action was taken in response to each of these cases. Criminal prosecutions have taken place. The government and the CQC have introduced a number of measures designed to prevent and tackle abuse and neglect.

4.3 In its final response to the scandal at Winterbourne View, the Department of Health, together with NHS England, Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA) set out a number of far-reaching changes they would take to address the commissioning and regulatory failures that had taken place at the home run by Castlebeck Ltd. Some of the most significant reforms have been included as provisions within the Care Act 2014, including greater powers for the CQC to oversee and inspect care homes and a new duty of candour on registered care providers to be open with people when things go wrong.

4.4 Independent Age does not in any sense trivialise the progress that has been made or the serious work now being taken by public bodies to prevent (or at least improve arrangements dealing with cases of) abuse and neglect. Crucially, the steps being taken seek to deal with some of the root causes of mistreatment. New measures helpfully focus on the training and support provided to care workers and assistants, a priority identified by the Cavendish Review back in July 2013. The plan to introduce a new training certificate with care workers having to prove they have reached a certain level of competence within 12 months of getting a job, plus the work that Skills for Care is leading on around minimising the use of physical restraint in settings where people with social care needs display

behaviour that challenges or resist essential care: we welcome these initiatives.

4.5 Unfortunately, a lot of damage has already been done. We agree with the assessment of ministers, leaders in local government and many others in the sector when we say it is deeply troubling that just a small minority of cases threaten to undermine public confidence in residential care. Like others, we believe the majority of residential care providers provide good, if not excellent care. Notwithstanding this, too many members of the public now appear to hold the view that abuse and neglect are more common than many professionals working in the sector believe to be the case. The Demos poll (November 2013), which surveyed 2,000 adults, “suggests an overwhelmingly negative perception of social care”. Only 24% of adults surveyed said they would consider moving into a care home were they to become frail in later life, compared with 43% who would not. Concerns about the risk of being badly treated by staff were cited as the main reason. Among those who would rule out moving into a residential or nursing care home, 54% said they feared being neglected or abused. There is a worrying disconnect between what many in the sector affirm – that there are generally high levels of care and the “vast majority” of care homes are good or excellent – and what the customers of care increasingly seem to think.

4.6 It is for this reason we call on the commission to widen its scope and in addition to collecting evidence about what works in residential care, CORC should shine a spotlight on what is wrong in the sector and what therefore urgently needs investigating and correcting. CQC inspections will increasingly look at how providers are led and whether fundamental standards relating to safety and dignity are being met. We believe this new approach to regulation and inspection is broadly the right approach, although we recently cautioned the CQC not to use CCTV as the default means of monitoring the quality of care.

4.7 All things considered, we think there is a strong case for calling on the CQC to conduct a one-off survey, to be carried out on an anonymous basis, looking at staff views about the quality of care they have witnessed. The survey would need to be carefully designed with the input of relevant professional bodies including Care England, the National Care Forum and Skills for Care. But, the purpose of the survey would be to establish the prevalence and frequency of the problems highlighted in media reports, not least the recent Panorama programme, Behind Closed Doors: Elderly Care. Results will either underline the generally high levels of care that can be found across the country, and that abuse and neglect are rare. This is what we would expect to see reported and we hope such findings would go some way to restoring public faith in a much maligned profession.

- 4.8** Alternatively, the results would signal the extent to which staff witness abuse, neglect and sub-standard care and reveal it as a problem that needs further work to eradicate. We think the sector's image problem is best tackled by firstly acknowledging it and accepting that it won't change simply by saying it's not true. We need a viable and sustainable residential care sector for many decades to come but now is the time to tackle head on the staggering levels of public doubt that care homes are safe places for older and disabled people to live in.
- 4.9** There are other levers we could use which in their own way could restore faith in the residential care sector. These would be straightforward to introduce and uncontroversial. These would include encouraging all CQC registered providers to sign up to the Your Care Rating survey and perhaps even making a provider's outstanding rating under the new scheme of fundamental standards contingent on a home taking part in the Your Care Rating survey. The Your Care Rating survey is the largest and "most authoritative" survey of care home residents in the UK, with providers as diverse as Anchor Homes, Barchester Healthcare, Jewish Care, HC-One, Methodist Homes and The Abbeyfield Society all taking part. A large number of smaller care homes also take part.
- 4.10** A growing number of online 'Trip Advisor' type-guides have been developed to help care users share their experiences and assist families with meaningfully comparing homes. However on current evidence it seems unlikely that these sites will generate sufficient user reviews to provide a useful service. The CQC of course provided overall quality ratings which served as a snapshot of performance (and the overall quality of life) in a home. We look forward to seeing how the new ratings scheme judging whether providers are 'outstanding', 'good', 'inadequate' or 'require improvement' will operate once it comes into full effect from October 2014.
- 4.11** However, the Your Care Rating survey is conducted by a leading market research organisation and methodologically it is the most robust and comprehensive means of giving care home residents a voice. It is based on four easy-to-understand measures, ranging from quality of life in the home to residents' ability to have their say about how they live their lives and the way the home is run. It has long been observed that the residential care market is confusing and complicated to navigate. Information and advice is hard to obtain and make sense of. Families are often placed in the unenviable position of needing to choose a home for an older relative at a time of distress. However, where we can demonstrate that the majority of care homes are well-run and safe to live in, we generate a double dividend. Care homes can play a role in supplying reliable information about their performance from the perspective of

existing residents (giving older people a voice), but they can also go some way to restoring public confidence by opening themselves to scrutiny.

4.12 One other obvious way in which the sector can rebuild public trust is to follow the lead set by the likes of Anchor and Barchester Healthcare who have opened themselves up to their communities. As many providers acknowledge, the care home sector has for too long been marred by “the negative press associated with a small number of badly run homes”⁵, and what is perhaps most impressive in their case, is that together with a number of other providers, they have developed a National Care Home Day to show local communities what care homes are really about. National Care Home Day is taking place on 20 June 2014, and what is so welcome about an initiative like this, is that it is breaking down the boundaries between care homes and the communities they are located in. This is another great way to debunk some of the myths about residential care and show people what really goes on in care homes.

5. Funding and failings in the care market

5.1 Put simply, the residential care market fails many of its customers. As the *Strategic Society Centre*, a respected think tank, argues: “analysts have long identified problems with the way in which the price of residential care in England is determined, whether this is paid for by local authorities, self-funders (and their families), or a combination of these sources”. Key issues that have come to the fore now the government is reforming long-term care funding include:

- a. local authority monopsony power (councils are by far the largest purchaser of care services) which can distort the price of care and have negative impacts on care home finances,
- b. there is an imperfect relationship between price and quality in large parts of the residential care sector, with self funders in particular affected by excess premiums and price discrimination, which they have little clout or collective purchasing power to influence,
- c. the price of care is not well understood by the public, which means many adults experience shock when they learn social care is means tested and not free at the point of use; we hope the Care Act will mitigate some of these pressures on families by requiring local authorities to provide residents with improved information and advice about how the care system operates and indeed by providing for deferred payments that residents can use to keep their main asset (their home) in their lifetime,
- d. there is public ignorance about what local authorities pay for care – so even when adults understand how the care market operates, there nonetheless remains widespread ignorance about how local authority rates for care often differ from the real market costs of care. This leaves many families shocked when the care homes they or their loved one prefer charge rates of care well in excess of the rate the local authority will cover through a personal budget. This can result in families of the poorest older people paying a top-up to meet the costs of care.

5.2 Many of the problems in the care market are well documented (for example in reports like *Right Care, Right Price* jointly produced by the *Strategic Society Centre* and *Anchor* in September 2013). Laing & Buisson, the respected care market analysts, have shown there has been a 5.2% real terms cut that care homes have had to absorb in council-funded places since 2010-11. Local authorities found themselves in a challenging position after the 2010 Spending Review and many responded by

imposing below-inflation upratings in fee levels. Average council fees are said to remain between £31 and £130 per week below the minimum of 'floor' level that the Laing & Buisson 'Fair Price' Model calculates is "necessary to offer investors and operators a reasonable return".

5.3 Whilst the draft guidance on personal budgets the Department of Health is consulting on this summer aims to clarify that local authority personal budgets have to be **sufficient** to meet the assessed eligible needs of residents, local authorities face many years of difficult budget rounds. The Institute of Fiscal Studies have predicted local authorities, like other public bodies, could face austerity measures through to 2018/19 at the earliest. The key bit of the Department of Health guidance we fear will militate against realistic rates of care being paid to care home providers is the section that ultimately emphasises the costs that need to be set out in a personal budget will need to be the costs to the local authority of purchasing care. The personal budget will not have to include the costs to the individual of purchasing care on the open market through a direct payment.

5.4 The significance of this is that – for the next five years at least – local authorities will face significant funding pressures. The serious risk is that they will be unable to pay care homes the real, market costs of care. As Independent Age has made clear through its End the Secret Subsidy campaign (www.independentage.org/campaigning/secret-subsidy/) this results in twin subsidies: the top-up fee many ordinary families are asked to pay to supplement the costs of care paid for by their elderly relative's council, a top-up many families cannot afford to pay. And then there is the subsidy self-funders have to pay through an excess premium, in effect cross-subsidising local authority-supported residents for the same quality of residential care.

5.5 We raise these concerns because it would appear odd not to acknowledge them. Yet the call for evidence says very little about these issues. We hope CORC can address these fundamental failings in its final report. As we argued in our joint November 2013 report with the Strategic Society Centre, Short changed: The Care Bill, top-ups and the emerging crisis in residential care funding, the Care Act, far from solving these problems, threatens to intensify the crisis for care providers. Clause 30 of the Care Act will enable people to make their own top-ups in the future, which is a measure Independent Age supports. However, Clause 18 of the Care Act enables local authorities to arrange care for an adult who pays for their own care. From 2016, we predict many self-funders will want to exercise their right to request the council arranges a care home place for them at the local authority 'usual cost' / 'standard rate', a cost below the rate care homes would normally come to rely on from people who pay for their own care.

5.6 Based on Laing & Buisson estimates regarding the gap between local authority rates for care and the minimum floor fair price for care, Independent Age believes the residential care sector is underfunded by anywhere between £595 million and £820 million, taking into account the losses it has to incur in terms of below-inflation increases and unrealistic rates of care councils pay that gives little or no regard to the real, market costs of care. It is important to stress these are estimates. As far as we are aware, there haven't been any recent attempts to quantify the overall levels of underfunding in terms of the gap between the rates local authorities pay for means-tested residents' residential care and the so-called minimum floor 'fair price' for care.

5.7 If one assumes, that on average, the 143,000 care home residents whose fees are paid by local authorities (in full) are funded £80 per week below the minimum 'fair price' for care (this is the mid-point figure between £31 and 30), spread across a year this comes to represent an annual shortfall of at least £595 million for the care home sector. When you combine this figure with the estimated correction in funding that would need to take place to eradicate unnecessary and inappropriate top-ups – and we have to be clear, we don't know the number of top-ups that are paid as a result of a genuine choice - it is at least arguable that the care market as a whole is underfunded by £820 million. The total number of top-ups recorded in 2013/14 was 54,000, which again, taking the £80 per week figure as our guide, might suggest the 'top-up problem' is as high as £225 million.

5.8 We recognise the need to identify good practice in the residential care sector, and there are plenty of pioneering examples CORC would do well to highlight in its final report. However, until the big problems in funding are dealt with, and we properly articulate the significance of sustainable funding in bringing about system-wide improvements, we worry the sector risks putting itself in a position where funding is somehow under-played as the main driver of reform. Instead, we would like to see CORC take a leadership role and outline the bold steps any future government needs to take, starting with the 2015 Spending Review, to tackle one of the root causes for many of the problems in the residential care market: years of underfunding.

5.9 There are different possible means by which a future government might seek to address these problems. Some of these ideas are set out in 'Right Care, Right Price' (September 2013), so for example creating a fairer and level playing field for self-funders and local authority supported residents by tasking third part care brokers with securing care for both council-funded residents and people who pay for their own care.

5.10 One other suggestion Independent Age has heard about and which still needs to be developed also concerns improved protection for self-funders and their families. The recent report from the Institute and Faculty of Actuaries on pensions and how these could be utilised to help some people meet the future costs of long-term care is an excellent contribution to the debate on funding future care needs. However, it doesn't address the problem of care home inflation, where year-on-year, the increase self-funders pay in residential care costs tends to outstrip any increases paid by local authorities for local authority supported residents. This causes the problem of price discrimination and cross-subsidies that are used as a means by which care homes can make good the shortfall in local authority funding.

5.11 One recent idea put to us, that we would be happy to work with the commission on, and look at in more detail, is that in future, customers could be supported to buy an annuity which would guarantee lifetime care in a home approved or certified by the annuity provider. The provider would be responsible for paying the fees, not the annuitant. This would mean that :

- a. the annuity provider could negotiate competitive rates for its annuitants, under a bulk purchase arrangement similar to that already existing with the councils.
- b. the annuity provider could potentially hedge cost increases by owning, or part owning, the homes. Thus the cost of any increase in fees would be exactly matched by the increase in income.

It would take some thought and there would have to be some certification against a standard, and the certification would have to be independent. However, BUPA run a similar scheme with healthcare, and the model should be easily transferable.

5.12 There are pros and cons to all these ideas, but nonetheless it is clearly within the commission's power and remit to suggest which ideas might be worth pursuing and what we need above and beyond the capped costs reforms to secure a fair and sustainable care homes market.

- **Recommendation: The commission should identify practical ways in which councils can fund the real costs of care, using a 'Fair Price for Care' model. One of the commission's aims should be to map out what councils could do to move towards setting a fair price for care over the medium-to long-term.**

5.13 Demos has already made an excellent contribution to this debate with its February 2014 report, *Unlocking the Potential*, which recommended 'nudging' people into making provisions for long-term care.

But whatever solutions are identified, and we hope in the long-term, adopted, the big elephant in the room will always be the funding question. Whilst the £500 million + being raised each year to extend the means test and fund the costs of the new cap on care costs will deliver peace of mind to a number of people with care needs, we think the next government needs to use its 2015 Spending Review to reappraise the long-term demands on, and subsequent costs, in terms of publicly-funded residential care. The Office for Budget Responsibility and Government Actuary Department could help with this task. We think there is at least a £595 million funding gap that needs plugging to ensure care homes exposed to below-inflation increases in council funding get the fair price to meet the 'real costs' of care from 2016/17.

- **Recommendation: Central government needs to fund councils so they can meet the real costs of residential care. We believe the residential care sector is underfunded by at least £595 million, a shortfall that needs to be plugged at the 2015 Spending Review.**

5.14 The extension in the means test and the capped costs reforms will clearly be of benefit to many future users of the publicly-funded care system, including from 2016/17, an additional 35,000 older people who pay for their own care today. But we don't believe these reforms can improve, at least not directly, the quality of care on offer from care homes. Without a £595 million injection in increased funding many care homes will have to struggle. Laing & Buisson in its 2013/14 market report suggests many homes might find themselves exposed to high levels of publicly paid residents – the funding for whom - just doesn't reflect real market rates for care.

5.15 In fact, one threat to the residential care sector we would strongly encourage the commission to analyse and highlight as a risk that needs mitigating, is the 'fee wars' scenario Laing & Buisson refer to in their 2013/14 market report. The implications of the 'own resource' or 'self funder' top-up provisions in section 30 of the Care Act "have attracted surprisingly little comment to date", argues William Laing, but put simply, in 2016, there will be 35,000 newly 'enfranchised' care home residents with the extension of the upper capital threshold to £118,000. Typically, these residents will have been paying fees which are higher than the council's 'usual costs' / 'standard rate' because of the endemic cross-subsidisation of publicly paid fees by privately paid fees. The question William Laing therefore raises – and Independent Age, together with the Strategic Society Centre also identified as a problem in our 2013 report, Short Changed – is whether councils are likely to seek a reduction on the fees that these residents have hitherto paid as private payers. And indeed whether most care homes, reliant as they are on cross subsidies, will resist such fee reductions.

5.16 There might be other problems to attend to, not least the concern held by some care providers - that private payers in care homes with assets in excess of £118,000 will become aware that their private fees are typically in excess of the 'usual costs' that are being accrued for them towards the care cap. The question at stake here, is whether some of these residents and their families will seek to use their right under Section 18 of the Care Act to ask the council to arrange care for them – at the 'usual cost' rate rather than the going private rate. This could lead councils to seek reductions on fee rates and this is the 'fee wars' scenario Laing & Buisson therefore predict might destabilise the sector from 2016. The worst case scenario is that there is a possibility "that unpredictable market dynamics could lead...to major dangers for care home operators forced to reduce fees for large numbers of residents who were formerly private payers".

5.17 There is a power imbalance that means people with scarcely any bargaining power are helpless in terms of knowing what fees are fair or not and how they can actively influence what the council pays for their care, and indeed if they are a private payer, how they might hope to influence the increase in fees a care home might introduce in any one year. We need to improve older people and relatives' rights so they no longer face unfair top-ups for care that should be paid for by the council.

5.18 Third party top-ups are significantly more frequent than they were a decade ago, with 27-28% of council-funded residents in receipt of top-ups in each of the five years from 2009 to 2013 according to Laing & Buisson surveys. However, these are just estimates. We know from our Freedom of Information exercise, detailed in our July 2013 Secret Subsidy report, that around 72% of councils in England don't know how many top-up contracts have been arranged in their area and therefore can't be fulfilling their legal obligations to check whether the third parties paying 'top-ups' are 'willing and able' to do so. It is at least arguable that a large number of the 27-28% of council funded residents in receipt of top-ups are paying top-ups, not through choice, but because they feel they have no choice not to. We think it's wrong that families of some of England's poorest older people should have to pay a secret subsidy for essential residential care. We think it's wrong that local authorities do not carry out their legal duties to protect them. And we think it's wrong that residential care is underfunded to the extent that top-ups are needed. Regrettably, no one knows for sure how many top-up fee arrangements exist or how many of these top-up fees are unnecessary and are being paid just to meet the costs of basic care.

- **Recommendation: Local authorities should sign up to a new Charter that requires them to protect residents and their families from paying unfair top-up fees just to meet the basic costs of care.**

5.19 The recent Local Government Ombudsman report highlighted an increase by one quarter in the overall number of complaints about residential care. In fact, between 2012 and 2013 complaints about residential care represented the biggest increase in complaints across the whole of social care. 17% of complaints received were about fees or charges. Dr Jane Martin, the Ombudsman, said that she receives complaints that providers have sought to “charge top-up fees in circumstances where the person’s care needs should be fully covered by public funding”. To prevent this rise in complaints about residential care from becoming a long-term trend we need to tackle the root causes of many of these complaints, which in our view is chronic underfunding. Interestingly, on page 11 of the LGO report, Dr Martin writes: “the data from last year’s complaints shows that the issue of funding and fees is one that is having a practical impact on people now and where, in more than 50% of cases we are upholding the complaint”.

5.20 In summary, there are significant failings in the residential care market and big problems concerning the overall level of public funding. Whilst the Care Act could “open the floodgates” to a new “top up market” in care homes and thereby increase the level of private money flowing from top-ups into the lower end of the residential care market (Laing and Buisson, April 2014), what is more probable at this stage is a “polarisation” in the care homes sector. Those care groups with client bases which are already primarily made up of council-funded residents could see grave new threats as councils fee rates continue to lag far behind Fair Price levels.

6. The workforce

6.1 There are a number of strong recommendations in the Kingsmill Review on working conditions that we would like to see the Commission endorse. Rather than rehearse all the arguments here, our general observation is that many of the inequities that have led to failings in the care market also affect the care workforce. We believe the main cause of these problems, in terms of low pay and zero-hours contracts, is chronic underfunding of adult social care.

6.2 In fact, we believe that low pay and zero hours contracts in adult social care are symptomatic of a care system that is in crisis. We firmly believe any future attempts to tackle exploitation in the care sector cannot be divorced from a wider, more fundamental look at how we pay for care and whether as a society we are prioritising public expenditure on long-term care. The two issues are inextricably linked.

Migrant workers

6.3 In the policy document Baroness Kingsmill's team used to call for evidence, the review team stated that:

"Between 2001 and 2009 the proportion of foreign-born care workers more than doubled – from about 7% in 2001 to 18% in 2009. This situation is bad for the migrants who are being exploited; bad for local workers who are being undercut and bad for our elderly people, who suffer from a lower quality of service."

6.4 In our response to the call for evidence, we cautioned Baroness Kingsmill and her team not to make any recommendations that would inadvertently have the effect of destabilising an already stretched social care workforce.

6.5 Shereen Hussein in her 2011 piece *The Contributions of Migrants to the English Care Sector* (for the *Social Care Workforce Periodical*) is clear that although proportionately greater numbers of non-EEA nationals work in the private sector or rely to some extent on agency work (and there is some research to suggest pay and conditions are on the whole less generous) there is apparently little evidence that migrant workers are on the whole less qualified or less able to perform caring roles.

6.6 In fact, Hussein tells us that the data from the National Minimum dataset indicates that migrants from the four main nationality groups are more likely to have completed a period of induction than those from the UK. For example, 80 to 83% of migrants from different nationality groups are reported to have completed induction, compared to only 72% of UK

workers. The proportion of workers with level 3 NVQ is considerably higher among non-EEA nationals than other groups, including UK workers.

- 6.7** We have not seen evidence that conclusively demonstrates there is a link between an increase in the proportion of foreign-born care workers, increased levels of exploitation and ultimately a lower quality of service.
- 6.8** We were therefore pleased to see the final *Taking care* report stopped short of making any recommendations targeted at migrant workers alone. Wherever steps need to be taken to root out exploitation, this should happen irrespective of care workers' nationality.
- 6.9** Historically most migrants working in the care sector have come from the Philippines and India. Other main nationalities include Zimbabwe, Nigeria and South Africa, and in recent years the sector has seen an increasing number of workers from Poland and the other Eastern European countries that joined the EU in 2004.
- 6.10** As part of its blueprint for the residential care sector, the commission will need to factor in how immigration policy will have a role to play in creating a sustainable workforce that can manage increased demand for care provision. What would be wrong in our view would be to divorce the short-to-medium term requirements of the care workforce (in terms of recruiting enough skilled staff) from a really hard-headed look at immigration policy and how controls on migrant workers either serve to ease or otherwise exacerbate problems in overall levels of recruitment and retention.

Professionalising and regulating the workforce

- 6.11** The government needs to ensure the workforce is ready to meet the changing expectations and needs of future residents, many of whom will be living with dementia and will have a complex mix of health and social care needs. Unfortunately there is a long way to go. Over 300,000 care workers are on 'zero hours' contracts and nearly a third of care workers receive no regular ongoing training. A fifth of Health and Social Care Apprentices are said to receive no training at all. We worry not enough young professionals are attracted to join the care workforce, which raises serious questions about future rates of recruitment unless, of course we continue to rely on the same rates of migrant workers coming through as today.
- 6.12** New measures being introduced helpfully focus on the training and support provided to care workers and assistants, a priority identified by the Cavendish Review back in July 2013. As we highlighted earlier in our response, the plan to introduce a new training certificate with care workers having to prove they have reached a certain level of competence

within 12 months of getting a job, plus the work that Skills for Care is leading on look like welcome and important initiatives. However, we need to go further so we call on the commission to implement a number of the recommendations contained in *Taking Care*.

6.13 We should stress we believe there are many hard working and dedicated professionals in the care workforce, often displaying exceptional levels of compassion in the most challenging of circumstances. However, it neither helps these hard working professionals nor prospective customers of residential care to continue seeing media stories pointing out the poor skills base and low level of qualifications evident across large parts of the care workforce. The sector can take proactive action now to enhance its reputation.

Recommendation: All care workers should be required to register with the Health and Care Professions Council (HCPC) and have a Licence to Practice.

7. Delivering a positive vision

7.1 The commission is rightly looking to develop a positive vision for residential care. We trust many organisations have shared their views and we look forward to seeing the final report later this summer. *My Home Life*, plus many other initiatives, including some of the ideas contained in the International Longevity Centre's 2012 report, *Care Home Sweet Home*, all point the way to a better future for residential care. We would like to see inclusive, open care homes connected to their communities. We foresee volunteers playing a positive role in keeping care home residents' active and facilitating older and disabled people to lead rich, purposeful lives.

7.2 Through our response, we hope we have explained why in our view the commission first needs to highlight the fundamental failings in the care market and why indeed addressing current levels of mistrust in residential care must be the priority over the next few months. On their own the terms 'care' and 'home', separated out, evoke warm emotional responses. Taken together, the term, 'care home' has become associated with something rather less comforting, even evoking anxiety and fear. The November 2013 Demos survey is testament to that with only 1 in 4 saying they would consider a move into a care home if they were to become frail in later life. We want to avoid being too pessimistic. However, we also need to be realistic about the situation the sector is in today and confront the problems that unfortunately we think have become endemic across much of residential care.

8. Conclusion

We believe the key characteristics of an improved residential care sector include:

- inclusive, open care homes strongly connected to their communities,
- relationship and person-centred care, with a focus on empowering older and disabled people and enabling people to live as independently as possible,
- a voice for older people, their relatives and also staff, so care homes are built around the involvement and participation of everyone who lives or works in residential care,
- transparency about what life in a care home feels like, with multiple opportunities for residents to share feedback on how the home is run, and for prospective customers to obtain information so they can make a positive choice about which care home they would like to live in,
- a skilled, motivated and respected workforce with improved levels of recruitment and retention,
- a fairly funded system, with transparency about the fees people have to pay,
- improved rights and means of redress for people who want simple information about care and what it costs,
- and a long-term strategy for meeting the real costs of care in the context of an ageing population.

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