Care England response to Communities and Local Government Committee 2016 inquiry into local authority funded adult social care

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1. Introduction

Care England is the leading representative body for independent care providers in England. Our members provide a range of care and support services for adults, including residential and nursing care, homecare, housing and community support. Our members also deliver specialist services such as rehabilitation, respite, palliative care and mental health services.

We consider that it would be valuable for the Committee to hear Care England's oral evidence, as a leading voice in the social care sector with unique access to providers.

1.1 The Impact of the Comprehensive Spending Review (CSR) 2015

Social care is the largest area of spending at a local level: it has been hit hard by central government-enforced austerity. Meanwhile, demand for social care is rising: it is predicted to increase by 44% by 2030.[1] More people are living longer with more complex, long-term conditions that require a higher level of expertise.[2]

The Nuffield Trust estimate that by 2020 there will be a funding gap in adult social care of between £2 and £2.7bn, despite the new social care precept and the increased Better Care Fund (BCF) announced in the CSR.

As a result of rising demand and falling funding, think tank ResPublica has recently forecast that the sector will lose 37,000 social care beds before 2020/21.

The Health Select Committee conducted an inquiry into the impact of the Spending Review on health and social care. Committee chair, Dr Sarah Wollaston MP, concluded that:

'Historical cuts to social care funding have now exhausted the opportunities for significant further efficiencies in this area. Increasing numbers of people with genuine social care needs are no longer receiving the care they need because of a lack of funding. This not only causes considerable distress to these individuals and their families but results in additional costs to the NHS. We are concerned about the effect of additional funding streams for social care not arriving until later in the Parliament.'[3]

Our members tell us that they are expecting more services to become commercially unviable or to close.

[1] Based on information from the Office of National Statistics, the Centre for Workforce Intelligence has modelled growth in demand for adult social care over the next 15 years, to 2030. Their modelling shows in a rise in demand of 13% by 2018, 18% by 2020, 30% by 2025 and 44% by 2030.

[2] Epidemiology of multi-morbidity and implications for health care, research and medical education: a cross-sectional study, Barnett K, Mercer SW, Norbury M, Watt G, Wyke S and Guthrie B (2012), The Lancet online

[3] The Health Select Committee's report on the impact of the Spending Review on health and social care 2016 report www.parliament.uk/healthcom

2. The 2016 Association of Directors of Adult Social Services (ADASS) budget survey

The 2016 Association of Directors of Adult Social Services (ADASS) budget survey recorded that there was a national net social care overspend of £168m, the first recorded, and for the first time a majority of the 152 councils overspent their adult social care budget.

Despite numbers of older people increasing by 3% each year, there has been no increase in the numbers of older people actually receiving care. ADASS found that a quarter of 2016/17savings will come from cutting services or reducing personal budgets for people who need care.

80% of Directors said that providers in their area are already facing financial difficulties. ADASS calculates that the sector would need £1bn per year, just to allow the sector to 'stand still'.

3. The Better Care Fund

As the National Audit Office recently discovered:

'Only 40% of local authority areas had achieved their planned reduction in delayed transfers of care… the Better Care Fund has struggled with is a lack of alignment of incentives between the different local organisations.'[4]

Members told us they did not know how the BCF budget had been spent locally, or what difference it had made to the lives of people needing care. Care providers have not seen this money reach the front line.

Over 50% of Directors of Adult Social Services (DASSs) feel that the BCF was inadequate to protect social care in 2015/16.[5]

Although government has insisted that the BCF and the precept will amount to £3.5bn for the sector, the figure is closer to £3.3bn.[6] Furthermore, from 2017 the BCF will redistribute funds across local authority areas to compensate for the inadequacies of the social care precept, taking away from its original purpose to better integrate health and social care.

4. The Social Care Precept

This year the social care precept raises less than two-thirds of the costs of the National Living Wage.[7]

4.1 Care England Social Care fee uplift Data Collection

We have undertaken a data collection exercise to demonstrate the national picture of low fees for care, and how the social care precept[8] is failing to prevent market crisis. Providers are being asked to care for as little as £2.25 per hour in 2016/17.[9]

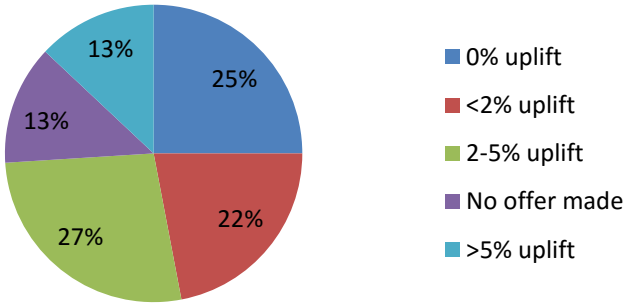
4.2 Care for older people

- Local Authorities offering 0% uplift = 34/152 councils with adult social care responsibilities. (CASSRs) (22%)
- Local authorities offering below 2% uplift (very low) = 38/152 CASSRs. (25%)
- Local authorities offering between 2-5% uplift (low) = 41/152 CASSRs. (27%)

[4] Discharging older people from acute hospitals, NAO report July 2016
[5] ADASS Budget Survey 2016
[6] Analysis by ADASS and Care England
[7] *ibid.*
[8] Which will be worth £380 million this year, according to the ADASS Budget Survey 2016
[9] Evidence drawn from our national fee data collection exercise. We are happy to share this data with the Committee if they should wish to see it.

- This means that 113 out of 152 councils are paying unacceptably low uplifts this financial year, despite the existence of the social care precept. (74%)
- 20 councils are still yet to give their fee offers from April 2016, or we do not have this data. (13%) Late offers are harmful to business, and therefore residents and families.
- This leaves just 19 councils offering above 5% uplift: this may still be below what is needed because of very low fee levels and increases in past years.[10] (13%)

Local Authority fee uplifts in older people's care: Care England Data Collection



4.3 Social care fee uplifts in Committee members' constituency areas

Sheffield City Council

Sheffield Council is offering providers an uplift of 4.3%-4.8%. Sheffield is a prime example of a long-term underfunded social care system. This uplift is contextualised by a provider: *'The 4.8% nursing increase is welcome; however this is to be taken in the context of increasing very low base fees.'* The price paid for care in Sheffield is one of the lowest in the country: for residential care, Sheffield pays £397 per week. This works out as £2.36 per resident, per hour. For residents with dementia, this rises to £2.52 per hour in Sheffield. Dementia is a complex and challenging health condition, often requiring constant observation and support with the most basic of tasks, and great amounts of staff time.

For the most complex of needs, nursing dementia care, Sheffield pays £2.60 per hour. Despite the complexity of health and care needs for these residents, the rate paid is far from the true cost of care.

London Borough of Southwark

Despite the strong advice that they use the Social Care Precept to shore-up their local systems, many councils are not offering fee uplifts to providers. Southwark have offered some providers 0% uplift. The precept money should be deployed where demonstrable cost pressures are known, such as covering the NLW in independent care services.[11]

[10] For information on the lowest payers in all categories of care, Care England can provide the committee with detailed analysis.

[11] Providers, with Care England's support, wrote to the local authorities with whom they work to illustrate the increased costs of the National Living Wage (NLW), the National Minimum Wage (NMW) increase of October 2015, plus the standard Cost of Living increase in contracts from the Local Authorities, and increases in CQC fees. We advised members to ask for a minimum 5% uplift, but this did not take into account regional variation and areas of long-term underfunding of the sector. For example, in some areas the aggregate impact of all of these additional costs, combined with the need to plug the growing funding gap, motivated providers to ask for uplifts as high as 8%.

North Yorkshire County Council

North Yorkshire has offered uplifts of between 4.19% and 10%. While it is positive that the council has used the precept as intended, this uplift comes against the backdrop of historic underfunding. North Yorkshire is now paying £499.73 per week for residential care, which is £2.97 per resident, per hour. Nursing care for adults with dementia is being costed at £3.59 per hour by North Yorkshire: this is an incredibly difficult climate for providers to survive in.

Leicester City Council

In Leicester, the council offered providers between 3% and 6.7%. For many, this is the bare minimum required to continue, and does not reflect the cost of care, or allow for improvement. Leicester offers care homes £575.00 per resident, per week for the highest-acuity nursing dementia care, for those with profound physical and psychological needs. This is £3.42 per hour, which does not reflect the true cost of care, nor is it sustainable.

Solihull Metropolitan Borough Council

Solihull Council offered care home providers 4.5% uplift in fees. When writing to local authorities, Care England advised all members to require a minimum of 5%, and negotiate upwards: even 5% uplift would not pay for the National Minimum Wage increase, the new NLW, increases in CQC fees and the cost of living. A 4.5% uplift offer will not secure the local market.

For Learning Disability services, in nearby Birmingham the City Council has decided only to uplift fees related to payment of the NLW: if the provider already pays above this amount, they get 0% uplift. This disadvantages those services already paying well. For specialised care for adults with learning disabilities, Birmingham pays just £436.50 per resident, per week or just £2.59 per hour. For the challenging provision of learning disability nursing care, the local authority is paying just £496.58, per week, or £2.95 per hour. Due to the scarcity of learning disability nurses, this low rate is unacceptable and damaging to the life outcomes of the individual.

Northamptonshire County Council

Northamptonshire Council has been offering uplifts of between 1.73% and 3.8%. These are far below what providers need: a minimum starting point of 5%.

In Northamptonshire, residential care is being paid for at just £406.72 per week, or £2.42 per resident, per hour. For residential dementia care, that rate rises to £480.17 per week, or £2.85 per hour. For nursing care, the rate offered is £563.03, or £3.35 per hour, rising marginally to £594.28 for nursing dementia care, meaning that £3.53 is paid per hour for very complex care. For Learning Disability Care, Northampton have offered just 2.36% uplift.

Oldham Metropolitan Borough Council

In Oldham, the council have offered 4% uplift to providers. Providers will now be paid £395.00 per week for residential care, or £2.35 per resident, per hour; £440.00 for residential dementia care, or £2.61, per hour; £507.00 per week for nursing care or £3.01 per hour for this challenging care; and for the most acute nursing and dementia care, £552.00, or £3.28, per hour. Oldham providers appear to be receiving moderate fee uplifts: in reality these are very low hourly rates for complex care.

4.4 Costs of care case study: Essex County Council

In order to assess the true costs of care provision in Essex, the council underwent a cost of care exercise, which found that providers would need £647 per week for a residential placement, and £665 per week plus FNC for a nursing placement to meet the costs of care.

After this process, Essex wrote to all providers saying that despite their findings, they would not be able to pay this amount. Instead, where providers were being paid below the rates above, they would receive an extra

£13.58 for residential and £13.79 for nursing residents per week and nothing if they were being paid at or above that amount. This is a stark example of a council admitting it cannot afford to pay the costs of care, therefore relying on the provider to absorb losses on their behalf.

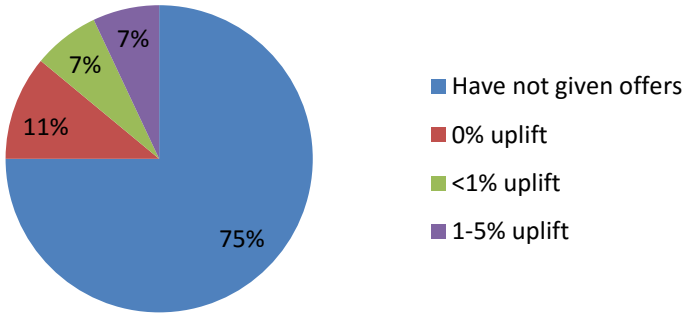
Furthermore, providers told us that the offer for 2016/17 of £13.58 and £13.79, the first increase since 2009, means that they are being paid an average of £440 for residential and £500 plus FNC for nursing frail elderly and dementia resident, per week for care. This is an extremely low rate by national standards, and is drastically lower than the cost of care.[12]

Care homes in Essex told us they were each losing, every year, more than 20% and having to subsidise Essex County Council funded residents. This situation is plainly not sustainable, nor is it an isolated example.

4.5 Learning Disability Care

- Only 39 Councils have given offers: 113 councils have still not notified providers of their 2016/17fees, effectively asking providers to 'buy blind'.
- 17 out of 39 offer 0% uplift.
- Of 22 others, 11 offer 1% uplift or lower: a negligible amount.
- The other 11 offer very low rates, between 1 and 5%.

Local Authority fee uplifts in learning disability care: Care England Data Collection



Analysis of 2016 fees data shows significant discrepancy between fee uplifts for older people's and learning disability care. Fair payment for learning disability care is suffering to provide small uplifts to older people's care providers. This is an unacceptable inequality.[13]

Average Fee Increase 2016 - Specialist vs Elderly Care

	Specialist Care	Elderly Care
Max	8.0%	8.5%
Average	1.9%	4.5%
Min	0.5%	1.9%

[14]

[12] Laing and Buisson's Fair Price for Care report 2015/16 found that the minimum necessary to provide care per week was £616 to £655 (residential) and £801 (nursing)

[13] For a breakdown of local authorities who have disadvantaged learning disabilities care in this way, please contact Care England for a full breakdown.

[14] Christie and Co analysis of CIPFA data 2016

It is important to remember that specialist providers have almost no self-funders, so cannot rely on cross-subsidy.

5. Commissioning Practice in Learning Disabilities care

Care England recently held a roundtable discussion with Learning Disability (LD) providers. They told us about poor commissioning practices:

- In council contracts, there are no KPIs. LD care providers find it very difficult to have 'an outcomes-based discussion' with commissioners, especially for high-needs individuals.
- Councils continually place adults into providers' care without a proper needs assessment.
- The 'Transforming Care' programme is not taking shape: discharge transfers are very slow. Providers have not been approached for ATU transfers as they expected.
- Commissioners are not engaging with providers; some providers have doubts about the skill-set of commissioners.

6. The Care Act 2014

Under the Care Act, local authorities have market shaping responsibilities. Low fees, like the ones illustrated, are not part of responsible market shaping. Providers tell us that the Care Act is not being realised in this regard. As part of their duties, local areas were encouraged to produce Market Position Statements.

Largely, these do not account for the impact of cuts to social care, nor do they explain where savings will be made. While they demand a lot from providers, they rarely outline gaps in the market, the impact of staff shortages, a long view of changing demography, or propose concrete solutions. Few offer any analysis of local workforce needs.[15]

Providers have told us that personalised commissioning[16] is not working because providers have to invest in a model without assurance that the local authority will send people based on their appropriate needs. Providers cannot invest on this basis, and this shows a failure of local authority market shaping.

7. Nursing Care

7.1 Nursing Shortage

Our 2014/15 research showed that the nursing shortage was having a profound impact on social care nursing.

The respondents comprised of 26 organisations providing a 58,527 nursing beds, owning approximately 2,000 homes employing 8,900 nurses. We estimate this survey to represent 15% of the sector.[17]

- 100% of respondents struggled to recruit nurses.
- Respondents could wait up to 2 years to fill vacancies.

[15] We have analysed the Market Position Statements of Committee members, to draw out some general themes and trends that they highlight in terms of local markets and local authority adult social care. If the Committee is interested, we can share our analysis. The Institute of Public Care has also observed a lack of workforce supply analysis across MPSs.

[16] Personalisation of services was another requirement of the Care Act 2015.

[17] Based on the figures provided in our previous year's submission quoting that the social care sector: 'has around 17,000 care homes providing care for approximately 400,000 people, including 50,000 nurses'. It complicated to establish an exact figure, but 8,900 is 17.8% of 50,000; 58,527 is 14.6% of 400,000 and 2,000 is 11.8% of 17,000, so we have approximated this to be 14.7% of the entire market.

7.2 Provider case studies

We collected several case studies illustrating the impact of the nursing shortage on the sustainability of social care in 2015/16.[18] One provider explained that it was *'extremely difficult to recruit'*. Across 72 homes they currently have more than 40 vacancies for Registered Nurses. Their pay rates are set competitively; they actively advertise, use agencies, attend job fairs, do leaflet drops and have even raised pay rates, to no avail.

As a result, this provider has several nursing homes that they cannot operate as such. These are large homes of around 80 beds, and make up a significant portion of their local markets.

7.3 Continuing Healthcare (CHC)

If the resident of a care home has a primary need for nursing care, the NHS covers the full cost of care and accommodation. This is known as 'Continuing Healthcare' (CHC). The right to CHC is not means-tested.

The National Tariff, laying out the rules on CHC, states:

'Where prices are determined locally, it is the responsibility of commissioners to negotiate and agree prices having regard to relevant factors … In addition, commissioners should ensure that local prices are in the best interests of patients.'

The National Tariff also demands that commissioners and providers work in the best interests of patients, and engage constructively with each other when trying to agree local payment approaches.

Sector Concerns:

- CCGs are setting standard CHC rates without knowledge or enquiry into what it costs providers to deliver the services. Standard CHC rates fall significantly below the actual costs of care. Serious underfunding of CHC rates is not in patients' best interests and is therefore a breach of the governing rules.

- The serious underfunding of CHC is making it increasingly difficult for providers to obtain and retain qualified nurses in a market where there is already a profound nursing shortage.

- CCGs are not adequately (if at all) engaging with providers over CHC fee rates.

Due to the above factors, providers are either reducing their nursing bed provision or withdrawing from the nursing care market entirely.

7.4 The impact: re-purposing homes and de-registering nursing beds

Many providers are forced to change the purpose of nursing homes due to inadequate funding, and the extent of the nursing shortage. A national charitable care provider told us:

'We have opened three new homes in the last two years which we had originally planned to provide nursing beds. As a result of our inability to source nurses we changed the category of care to residential or residential dementia. This represents approximately 120 places that would have been provided as nursing beds but are now residential. These are all in Wiltshire.'

The impact of this move will mean a greater strain on hospitals and community nursing care.

[18] We have shared one such case study, but should the commission be interested, we have several more in-depth organisational case studies available.

Another national, charitable provider explained that they had been forced to de-register nursing beds across five separate homes due to the nursing shortage, and had closed one home in part for this reason. A representative said:

'That doesn't mean to say it won't happen again: care providers don't know what impact Brexit will have.'[19]

8. Conclusion

The short-sighted underfunding of social care is having an impact on care quality: 82% of DASSs report that more providers face quality challenges as a result of the savings being made.[20] At current funding levels, the social care market is unsustainable.

Care England believes that these actions that must be taken to ensure sustainability of adult social care:

1. Increase the social care budget by a ring-fenced £1 billion each year, in line with ADASS calculations.
2. Address councils' use and distribution of the precept, challenging and intervening in any council that has offered 0% uplift or have ignored the cost of care in their commissioning practice.
3. Review the efficacy, reach, and achievements to date of the BCF, bearing in mind that it will soon be re-purposed for redistributing funding due to the failings of the precept.
4. Take action to ensure local authorities engage in meaningful market shaping and ensure a sustainable care market.
5. Ensure the Department of Health use the enforcement powers available to them to correct commissioning and funding malpractice, and take seriously their responsibility for market sustainability.
6. Ensure that Ministers and leaders support the independent care sector and recognise the vital work it does in supporting and caring for people in need and maintaining an efficient system.

For more information, please contact Saskia Goldman, Policy Officer sgoldman@careengland.org.uk

[19] Care England has been seeking innovative ways to mitigate the nursing shortage: we have developed a national 'Teaching Care Home' pilot with five test sites across the country, which seeks to develop care home nursing. We have also done extensive work to develop the Care Practitioner role, a hybrid role between a care worker and a nurse, which is intended to relieve the pressure of the nursing shortage and offer career progression for care staff.

[20] ADASS Budget Survey 2016