Lancashire Care Association (LCA)
Submission to Expert Panel on Adult Care and Support
23rd January 2017

Introduction and Background

LCA is a not-for-profit body representing independent sector providers in and across Lancashire and adjoining areas. It was formed in 1992 and was incorporated in 2001. Our key partnership forum is the Health and Social Care Partnership (HSCP), est. in 2004 as the ‘Social Care Partnership’ and re-designated with a health and social care focus and new partners in 2014. LCA jointly chairs the HSCP Steering Group with Lancashire County Council. It is a strategic forum for dialogue between the independent sector (LCA with colleague provider associations, LLDC and LDCPF), Lancashire County Council (senior officers and Councillors), colleagues from Mids and Lancs Commissioning Support Unit, the Lancashire CCGs, and NHS England.

LCA, itself, has a Board made up of providers from across the spectrum of private and 3rd sector care (care homes and domiciliary care). It is recognised nationally and locally as a reflective and effective stakeholder partner and innovative provider voice. LCA’s Board of Directors is listed here.

We have worked with LaingBuisson for over 10 years on a costings methodology that is transparent and can have the confidence of providers and commissioners.

We represent the independent sector on the Regulated Care Sector Board (part of the Lancashire and South Cumbria Change Programme) which is exploring issues of independent sector resilience and engagement.

A recent analysis of the Lancashire care homes market is set out in Lancashire *Older People's Residential Care Market: Market Analysis* - April 2015 (V1.2), Crabtree, I. and Sleightholme, J., LCC.

This follows on from an earlier care homes and home care market review by the Institute of Public Care from Oxford Brookes University - *Older people's care market review*, August 2012.

LCA has made earlier representations to the Cooperation and Competition Panel on care markets in relation to CHC thresholds (see 2011 *Conduct Cases archive: North Lancashire Conduct Complaint*).

Lancashire County Council and LCA have worked jointly with LaingBuisson on a *Fair Price for Care Homes in Lancashire* (Mickelborough, 2004, updated 2006) and *Actual Cost of Residential Care in Lancashire* (Mickelborough, 2014). There has been further work in Lancashire with LaingBuisson in 2016 on domiciliary care costs with learning disability colleagues (LLDC).

LCA recently submitted information and evidence to the Communities and Local Government Committee investigation into the funding of adult care which can be read, and the panel evidence seen, on the CLG website [here](#).

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We focus our response for this submission on the key elements of our association and partnership work on Priority Area 5 and Priority Area 6.
PRIORITY AREA FIVE: AN EFFECTIVE, INNOVATIVE AND RESILIENT CARE AND SUPPORT MARKET UNDERPINNED BY A VALUED SOCIAL CARE WORKFORCE

a. Evidence outlining specific challenges to the care and support market and workforce in the North;

- the workforce, north or south, shares common issues in relation to training and education, reward and career structure, and standing and perceived worth.

- there are well-recorded relative health and poverty indices in the ‘north-south’ divide: see Lancashire Health and Wellbeing Outcomes 2015 here.

- comparative wage rates by region are well-documented

- NHS and public sector competition with the independent sector for workers/ staff is of great significance for independent sector recruitment and retention because of generally better pay and terms and conditions in the public sector; there is private sector non-care job competition for the same potential workforce that impacts particularly on care assistant staff.

- longstanding uneconomic fees where monopsony commissioners hold down rates form the backdrop for any discussion of workforce because it shapes the independent sector employer offer. This is an oft-repeated concern expressed by the sector and it is repeated again here.

- the workforce is substantial and its importance to the NW economy significant yet it is subject to much criticism through the media and, unlike the NHS, no counterbalancing ‘positive regard’; morale and status are major issues for recruitment (younger students and mature adults making choices about careers) and retention.

- Workforce data: (Source: Skills for Care)

- An estimated 2,200 organisations with 5,100 establishments/care providing locations were involved in providing or organising adult social care.
- The number of adult social care jobs in the North West was estimated at 210,000. This has increased by an estimated 3% (5,000 jobs) since 2012/13
- As at 2015/16 the adult social care sector was estimated to contribute £40.4 billion per annum to the English economy, and £5.4 billion in the North West region.
- The estimated turnover rate was 27.5%; this means around 47,000 leavers each year.
- The estimated starter rate was 29.9%, so almost a third of all workers were new to their roles in the previous 12 months.
• The adult social care sector has an experienced ‘core’ of workers. Workers had, on average, nine years of experience in the sector and five years in their current role.
• Turnover rates have increased steadily, by 6.3%, between 2012/13 and 2015/16.
• The vacancy rate was estimated at 5.1%; an estimated 9,000 adult social care vacancies at any one time.
• A fifth (20%) of the workforce were on zero-hours contracts in 2015/16; this has remained relatively stable, increasing by 3% since 2012/13.
• The average worker was 43 years old and a fifth of workers were over 55 years old.
• The majority (91%) of the adult social care workforce were British, 3% had an EU nationality and 5% a non-EU nationality.
• The average annual pay of a registered manager was £26,900, occupational therapist annual pay was £28,400, registered nurse annual pay was £23,600 and social worker annual pay was £31,600.
• The senior care worker average hourly rate was £7.94 and the care worker average hourly rate was £7.22.
• 83% of senior care workers and 51% of care workers were qualified at level 2 or above.

b. Initiatives which can improve the functioning of the care and support market, including improving public levels of trust in the independent sector;

- secondary education, improving the narrative on social care. The Health and Social Care Partnership Steering Group in Lancashire is beginning discussion with partners around how to raise the status and profile of the workforce and make it an attractive choice for school leavers and older adults.
- The Regulated Care Sector Board reporting to the Lancashire and South Cumbria Change Programme Board has an intersectoral workstream on workforce. Hopefully, this can help with joint planning and learning re workforce development. LCA argues for ‘one workforce, one plan’.
- The media template is set. It doesn’t cover positive stories, certainly not with the prominence negative stories are covered, because of structural issues in the way the media construct social knowledge around care. There is no simple solution to this but there needs to be an awareness of its impact to demotivate care workers and deflect potential workers. It is manifestly different when considering the independent sector as compared, particularly, with the NHS where the narrative is towards public appreciation and where poor care, when it comes to light, is sympathetically set against the case made for quality being the consequence of more resources. This is not an argument the independent sector, particularly the private sector, can make.
c. **Initiatives which can improve the experience of the care and support workforce and bolster recruitment and retention of the care and support workforce**

- We need to support and develop the Registered Manager role. LCA facilitates the Lancashire area Registered Care Managers Network (RCMN) and notes support for other initiatives around the North-West and elsewhere from Skills for Care/ NSA.

- Recognition. LCA, with the Lancashire Workforce Development Partnership, began an annual awards’ event focusing on recognising care workers. This was a popular initiative but was affected by financial constraints. LCA are considering how we might take this on ourselves or with partners.

- A strategic overview of workforce structure, direction and reward through local partnership structures is necessary. Our key forum presently is the HSCP in the LCC area but there are emerging structures and process through Health and Wellbeing Boards and the Lancashire and Cumbria Change Programme which may have an impact on workforce planning for health and social care. Local Enterprise Partnerships have an important role to play.

- Provider fees based on ‘actual costs’ using a transparent methodology to enable providers to compete with NHS and local authorities’ rates and terms and conditions. We know from PSSRU data ([Annual Unit Costs of Care, 2016](#)) that local authority provided residential care, for example, is funded at substantially higher levels than private care homes. Local authorities, it would seem from the evidence, have a different perspective on the costs of care when in provider mode as compared to when in commissioner mode.

- There needs to be a career structure for care workers. What we call ‘social care’ needs the same culture of positive regard and standing in the public discourse as the NHS. It needs a vocational culture. Most providers LCA works with want to be able to operate in the context of a labour market in care which offers quality, competence and professionalism. This requires a quite a journey from where we are. But this journey is one not in the gift of employers. Commissioners of care are part of the answer.

- The sector needs heroes and heroines. We need to develop leadership in the sector and for there to be figures with a profile and standing that can act to attract new entrants when considering their career paths. This calls for a new debate on care.
PRIORITY AREA SIX: FINANCIAL SUSTAINABILITY

a. Evidence of efficiencies within the care and support system which could release funding for investment in additional services;

- the Lancashire Registered Care Manager Network has identified the priority of working at the interface of care homes and hospital wards and much could be done to improve ‘flows’ and improve patient experience

- telemedicine can help save system cost. There need to be drivers in the system that help this resource move from margins to mainstream. LCA engaged with telemedicine pilots which were successful clinically but required further development work to broaden the service availability (www.teleswallowing.com).

- support teams (eg falls, nutrition, skin care/ tissue viability) are extremely important to a ‘whole system’ approach; maintaining resources for such teams is crucial. Our recent experience is that such support can be patchy and episodic.

- equipment: we have worked with health colleagues on an agreed equipment policy (“Let common sense prevail”; Carmen, V., 2008) but practice moved away from the shared risk/ shared resource goals set. This is increasingly important given the levels of need being met in the care home sector and by home care workers and the specialist equipment required.

- SOLLA and planning for care: it is back in 2010 that the issue of planning for later life care was given initial prominence through the Jeff Jerome letter to Directors of SSDs. Proper and timely support can save local authorities money and give many service users/ customers more control. LCA is presently working with private sector partners to explore how more headway can be made by working with local authority colleagues at ‘secondary prevention’ stage as well upstream to ‘primary prevention’ an earlier advice and financial planning. The aim is that fewer people would need to claim for support from local authorities and/ or would need to claim later.

- LCA are working with private sector partners around small business accountancy support to providers and which will help individual providers with their financial management and forward planning and could also potentially generate systems data for planning so as to help reduce market fragility.

- extend personal budgets to residential care: it is not consistent or honest for rhetoric to emphasize choice in relation to care as a central principle and then not allow
consideration of a core option. Increasingly health and social care personal budgets will allow more ‘customer’-shaped markets.

- there are no standards for commissioning care. Commissioners should be subject to manifest standards and proper scrutiny in the way providers are. The care market is shaped by an interplay of forces not just by the actions of providers. There is too little awareness of commissioner competence and no audit of commissioning set against service outcomes.

- VAT: there have been discussions periodically over many years about the role of VAT, notably, why the care sector is exempt rather than zero-rated. Whether there is any motivation anywhere to revisit this and what the options might be that could help with sector sustainability is beyond the scope of this paper. The point merely is to note that there has at times been a live debate on the issue.

- LCA argued some years ago for Council Tax to be used to give local citizens influence over the available budget for care and we welcome that local authorities have this option. There needs to be some multiplier factored in to equalise the money raised between areas. The money should be ringfenced.

- Monitoring and evaluating resources allocated to monitoring and overseeing care and the impact on the market. LCA has longstanding concerns, as any provider voice would, that there is duplication of monitoring across different public and quasi-public bodies. It can consume resources that might better go to front-line care. It has a questionable impact on improving quality – the system goal. It can operate to demotivate a sector under extreme pressure unless it can operate with principles of ‘appreciative enquiry’ and ‘balanced scorecard’.

b. Factors unique to the population in the North which should be considered in the context of charging for care and support services;

- They key issue in the ‘North-South’ divide is, aside from issues around health outcomes comparisons, relative wage-rates and house values and disposable wealth, is the fact that the sector in the North is more reliant on commissioned care. Local authority commissioners (and NHS commissioners re CHC) consistently pay rates which are uneconomic for providers. The counterargument is that they are constrained by budgets. Without weighing into the debate, LCA’s longstanding view has been that we need standards for commissioning, and use of independent costings
methodologies, so we can attain a better level of dialogue on the adequacy of care funding.

c. **Evidence of the impact of charging on people who use services and care provision;**

- research conducted in Lancashire as part of the Fair Price work 2005-2010 showed that there was an inverse relationship between use of ‘top-ups’ and fees. The more fees began, for a period, to approach a Fair Price the less providers were asking for care contributions (aka ‘top-ups’). ‘Top-ups’ can’t just be used as a stick to beat providers with in the context of structural underfunding. There is also a high level public policy debate about the balance of responsibility between the state and citizen for health and care needs and the issue of care contributions is part of that debate. Given that public sector commissioners underfund and providers have a duty placed on them by CQC to operate their business so as to be financially viable, they are placed in an intolerable position. It tends to be portrayed as money-grubbing providers when in our experience in Lancashire it is more to do with squaring circles.

d. **Measures which could be adopted to address the perceived unfairness of charging for residential care.**

- adequate fees based on transparent costs (see LaingBuisson “Care Cost Benchmarks – A toolkit for care homes” 7th ed, 2016).

- whether purchasing care or commissioning it, the process of setting out costs should be transparent. In the LCC area, through the then Social Care Partnership, we drew up protocols around 3rd party contributions – aka ‘top-ups’ – so that potential residents, assessment staff and care home staff understood what the rules were. Those rules explicitly recognised that where there was structural underfunding that it was legitimate for providers to seek to charge contributions so long as agreed by the parties (provider, resident, local authority) and done properly and sensitively.

- better forward personal planning (see elsewhere herein re SOLLA). We have been working with private sector partners, and discussing with local authority colleagues, how we can work together to make sure those who are in care can manage their resources in the best possible way so as to delay or prevent the need to call on local authority financial support and to work with a more preventive agenda on education around forward financial planning for future care needs.

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Other key points that LCA have made in numerous national and local consultations over the years.
Coherence in planning

The main issue LCA would raise in relation to our longstanding work in the Lancashire area with providers, with health and social services colleagues is coherence and the notion of some sort of effective centre that operates as a learning organisation and maintains an informed view of the changing nature of the health and social care market. The HSCP in the LCC area is that forum.

Challenging ideology

We have a mixed economy of care and we have to operate a level playing field across that economy. The independent sector, particularly the private sector, is a partner in delivering good and excellent affordable care and has to be recognised as such and be inside the tent when it comes to strategic planning and leadership.

Positive messages

We need to find ways of delivering quality and articulating a positive message to show that system leaders are working to improve the whole system, showing leadership across organisational and sectoral fault lines not ‘avoidership’ which is what can happen when responsibility, which should be shared, is shifted back and forth across those divides.

Understanding costs

It is fundamentally flawed to start any analysis of the sustainability of care from the point of view of budgets. It has to start with a full and transparent understanding of public sector, third sector and private sector costs. We have models for costing and LCA has worked with LaingBuisson over many years to ensure rigorous costings information can inform commissioning and planning.

Structural underfunding

The reality we operate in is one of a mixed economy of care, with public, private, third and informal sector provision. We need a narrative that recognises the challenges faced and the strengths of each sector and addresses the weaknesses. We shouldn’t have a never-ending, never-resolved, discourse where care is batted back and forth between ideological standpoints. Hopefully, the Expert Panel can help find some resolution and consensus.

The absence of the workforce we need

The challenge to achieve and develop the workforce is a massive one. We have a crisis in the health and social care workforce now in relation to Registered Managers, nursing and care staff. We need to escalate our collective response and focus on the principle LCA espouses: “one workforce, one plan” for health and social care integration, support the Registered Care Manager networks and see
our call for manifest commissioning standards - which would include the requirement to address ‘actual cost’ drivers not only available budget limitations - addressed.

Comment

There have been numerous inquiries and consultations over the years which have identified the structural issues around costing care, paying for care, workforce issues, increasing levels of need and demand, the implication of ‘fourth-age’ care for care model design and for policy-makers and the impact of regulation on system outcomes. It is a time for action to make a real difference and perhaps the Expert Panel might be a vehicle for making some progress. Policy-makers can learn from those who lead in quality in the sector. Learning from the best to help the rest.

If there were one priority to highlight amongst all the priorities faced by the sector day in day out, it would be: Workforce. Workforce. Workforce.

Cross-party approaches

LCA have argued in the past for the case that we should de-politicise the debate and shift to a more evidence-based approach. It is what we have tried over some years to do in the local circumstance through forums and processes which are more evidence-based and collegiate rather than competitive and tribal in approach. To politicise it is to leave health and social care to the cross winds of party politics. It is unlikely, and whatever the rhetoric from any side, that we that we will see either a publicly owned health and social care sector free at the point of delivery funded solely from taxation or its polar opposite, a ‘free’ market in care. So, those of us working in the sector are always working in the context of a mixed economy of care and a managed, heavily regulated, substantially commissioned, ‘quasi-market’ where public, third and private sectors have to work together for the benefit of patients, service users and customers and to deliver the best care and support we can given the resources available.

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