Future options: **Residential Care Homes for Older People in Birmingham**

June 2000

Report for the Residents Action Group for the Elderly (R.A.G.E.) commissioned by UNISON Birmingham Branch

Written by

The Centre for Public Services is an independent, non-profit organisation. It is committed to the provision of good quality public services by democratically accountable public bodies implementing best practice management, employment and equal opportunities policies. The Centre was established in 1973 and operates from a base in Sheffield. It has unrivalled experience of working with local authorities, other public bodies including the Improvement and Development Agency and the Equal Opportunities Commission, trade unions and community organisations and specialises in research, strategy, planning and training.

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Summary and recommendations

Best Value Pilot

- The council has conducted a Best Value pilot review of residential care and produced a set of targets, which include plans to reduce in-house unit costs. However, this excluded the five homes initially scheduled for closure - Guestholme, Florence Hammond, Palmers Croft, Minworth Grange, Lyttleton House. The proposed trust option is not part of a review being conducted currently. The pilot review process was heavily criticised by users, their families and the trade unions. A comprehensive Best Value review which includes assessment of options should be conducted with the full involvement of service users and families, staff and trade unions prior to any decisions being made for a preferred option.

- User rights under the Best Value guidance and Local Government Act 1999 will be broken if proposals for the homes, including the trust option, are made without full consultation with residents and their families. It was recognised by the Scrutiny Committee Report that the Social Services Department did not consult residents and families satisfactorily on the proposed home closures. In addition, users and staff may have cause to use the provisions of the Human Rights Act 1998 if consultation is not conducted fully and views of users and staff not taken into account in making a decision.

- Consideration of the trust option should be stopped until a comprehensive and accurate analysis of Birmingham's full range of care provision for the elderly and its costs has been carried out. This needs to look at accurate comparisons in terms of types of care and identify inputs to the service, not only 'price'. This will also have to take into account staffing requirements, skills levels and user needs. The Government has clearly stated that users should be centrally involved in local authority services and that Best Value is concerned with valuing staff, not mirroring the lower standards in the independent sector.

Trust option

- The closure option for five homes initially considered by the council, has been rejected in favour of the trust option involving all homes. The Scrutiny Committee recommends that the majority of all 31 residential homes are transferred to a trust. This report identifies many of the issues experienced in transfers to independent trusts - a form of externalisation. A full understanding of these issues is essential before any consideration of the trust option is taken any further.

- The independent sector acts commercially, adopting business values and practices. Trusts are responsible to trustees and not service users. Trusts and other not-for-profit organisations are economically vulnerable and their activities including the treatment of staff very much mirror private providers.

- One of the purposes of a trust would be to raise capital funds for improvements to homes and reduce costs. In the longer term these arguments are economically unsustainable and do not represent value for money. The option of retaining the majority of homes and achieving an improved and more cost effective and flexible service under council control, and within the Best Value framework, has been overlooked.

- The council is arguing that raising standards is crucial. Currently 60% of the city council's homes are quality assured, whilst only 13% of homes in the independent sector are. The

emphasis on registration requirements and physical changes to the homes is important but will not be solved by trust status. Whatever the future requirements for improved standards are, they will apply equally to the local authority and independent sector.

- The transfer of homes to a trust would result in less coordination of services to the elderly. It would also weaken the council's bargaining strength for placements in the independent sector in the future. In the longer term independent operators could raise fee levels and leave the council in a very weak position when purchasing residential care places.

- Transfer of homes to the independent sector would remove choice for future residents and undermines the decision taken by existing residents and families who have already chosen council homes.

- The quality of care for residents is directly linked to quality of employment and training for staff. If attempts are made to cheapen the service, the council's care practices and residents' rights are bound to suffer. This research shows that in the majority of cases of transfers to a trust, staff have faced major reductions in pay and conditions of services. In addition, the independent sector lags way behind local authorities in terms of training and development programmes for staff.

- Transfer of all or part of the service would remove democratic control and accountability from the council. It would also result in the loss of integrated services and separate residential care from other services to the elderly. It would reinforce the move towards a fragmented, individualised service.

Vulnerability of the independent sector

- The market analysis undertaken for this report clearly illustrates the economic instability of the independent sector within which a residential care trust would have to operate. A major surge of home closures is expected to result from the new National Standards.

- The care sector is in disarray following two decades of growth among private companies. Occupancy levels in some areas have been falling and many independent operators are critical of the Government and local authorities over the level of fees. Many are facing severe financial problems. In addition, independent providers have expressed concern that profit margins will be squeezed further.

- The private sector is putting pressure on the Government and local authorities to meet the costs of the proposed new National Standards, additional training and staffing costs.

Financial options

- Where would the money for investment come from if the homes were transferred? Non-profit operators are not going to invest unless they have a return on their investment which could in turn mean higher fees and less money spent on staff, training and development.

- Capital provided by the independent sector will not be "free money" and repayments will be reflected in the weekly operational costs of care.

- Transfer to a trust would result in weakening the council's bargaining strength for

placements in the independent sector in the future.

- The council should explore funding options and alternative sources of finance for an integrated community care service which includes in-house provision of residential care, home care, respite care and other specialist provision. This is in the context of Government plans for long term care and pressure to increase public spending, particularly on health and care services. Councils will be freer to borrow for capital investment once European accounting conventions are adopted and planned changes to the regulations governing capital spending.

There are three main strands to financing capital works:
1. Increased funding from the council's capital programme .
2. Access to capital including loans from the Public Works Loans Board and alternative funding though the European Investment Bank which has large assets and is looking to invest in health and social services following a broadening of its remit after the European Union Amsterdam Summit in 1997.
3. Future Government spending programmes and initiatives in health and community care.

The future funding of residential care is also expected to change which could reduce pressure on council budgets and in-house provision:
* The Government intends to create a level playing field through the redistribution of the Residential Care Allowance.
* The cost of purchasing residential places in the independent sector will increase as new Care Standards are imposed on all providers and the impact of the National Minimum Wage and European Working Time Directive take effect.

The costs of the independent sector will increase at a much faster rate than those of the local authority, thus closing the current gap between the local authority and independent sectors.

New standards and regulations

- Raising standards will be crucial for all residential care homes. Whatever the future requirements are, they will apply equally to the local authority and independent sector, and will require a phased programme of investment.
- The council needs to adopt a longer term perspective which fits more clearly with the approach adopted by the Government for a high quality and responsive service which meets the specific needs of the elderly in Birmingham.

The importance of the in-house service

- The care of elderly people in Birmingham is a crucial public service. This report argues that the option that support and care should continue to be provided by the local authority should be fully explored. The trust option presented for the future of residential care put the commitment, investment and high standards built up by the council at risk and obscure the Best Value process.

- The justification for the trust option has little to do with the quality of care. Its prime focus is to reduce costs, achieve savings and raise capital. Any savings made will come from reducing the wages and conditions of staff who currently deliver the service for the

council.

Integrated and joined-up services

- The Government is placing increasing importance on the coordination and integration of services for the elderly. 'Joined-up government' means widening the range of services provided to meet the different needs of the elderly, improving the management of services, and ensuring that frontline services are linked. Transfer of the homes will jeopardise this approach and result in fragmented services.

Quality of care at risk

- The justification for the investigation of the trust option has little to do with the quality of care. The Department of Health's emphasis on the quality of staff, recruitment issues and improvements in training and management will have to be incorporated by the council in their predictions for the future.

- There is no evidence to suggest that the independent sector can provide a better service than the local authority. A higher proportion of local authority homes have 2 and 3 star ratings, whilst most of the independent sector homes only achieve 1 star. In addition, staff turnover in council homes is only 4% per annum, by contrast with the private sector rate of 13%. The 1997 joint annual report of the Department of Health's Social Services Inspectorate and the Audit Commission stated that local authority homes provide quality services and value for money.

- The trust option would involve major disruption to the continuity of care; residents will be the first to recognise reductions in care, dissatisfied staff, and reduced activities in the homes because of high staff turnover and casualisation.

Equal opportunities implications

- Over 90% of residential care staff are female, making the investigation of options an important gender issue. Women will bear the main brunt of any changes to staffing levels, pay and conditions of service. This must seriously question the council's commitment to implementing its own equal opportunities policies. CCT was found to be discriminatory in terms of the treatment of some groups of women workers, with several councils involved in long legal cases and high compensation payments. There is evidence that care staff who are transfered to the independent sector suffer similar changes. Before embarking on any suggestions for transfer of staff, the council should examine new guidelines for testing the impact of Government policy making in terms of equal treatment (Women's Unit, 1999) and the Centre for Public Services Code for Quality Employment (1998) and await the specific guidance on Fair Employment expected as part of the Government's guidance on Best Value.

Recommendations

We recommend that:
1. Birmingham maintains ownership of its residential homes and continues to directly employ staff engaged in these homes. Any reorganisation and redirection of resources should be in the context of user needs, in-house provision and joint work with health organisations, rather than transfers to the independent sector.

2. Services to the elderly, including all residential care homes and other integrated services for the elderly such as home care, day care and respite care, be subject to a comprehensive Best Value service review which includes a detailed examination of all options.

3. The council works with users, user organisations, the trade unions and staff to develop the in-house service. As part of this a review of the operation and management of the service should be conducted with the full involvement of the trade unions, users and the wider community in accordance with the Best Value requirements .

4. Alternative funding options and the impact of phased improvement work on the capital programme require further detailed investigation before any decisions are made.

5. The City Council makes representations to the Government to:
* Respond to the recommendations of Royal Commission on Long term Care for the Elderly.
* Remove the anomalies between the local authority and independent sector created by the Residential Care Allowance.
* Publish the final National Care Standards.
* Release increased funding to meet the needs of elderly people and improved care provision, including increased levels of skilled staffing, training, improved standards, capital investment.

6. City Council staff are fully informed of the implications of the Human Rights Act 1998 for the public and private sector and that training is conducted in Risk Assessment Procedures.

Introduction

This report is primarily concerned with the recent proposal from Birmingham City Council's Social Services and Health Scrutiny Committee for the city's residential homes to be transferred to an independent trust. The report assesses this option in the light of:
* The national experience of transfers to trusts.
* The national and local market for residential care services.
* Evaluation of alternative options and criteria.
* The Best Value process (though it does not make a full assessment of the Best Value review and Action Plan).
* Impact on elderly residents, their families and staff.
* The Human Rights Act 1998 and user rights.

The report presents evidence to show that trust status will not provide a satisfactory option for the future of elderly care services in the city.

Commissioned research

The Centre for Public Services was commissioned by Birmingham UNISON to prepare a report on the council's proposals for residential care homes. In commissioning the report, UNISON is supporting the Residents Action Group for the Elderly (R.A.G.E.). This report is based on analysis and assessment of council reports, national data, market analysis and files held by the Centre on trusts as well as a range of literature on the sector.

The Centre has extensive experience of the impact of residential care transfers nationally and is advising a number of local authorities and national organisations on the application of Best Value.

List of key reports used in the research:

Birmingham City Council, 'New Homes for Old: Residential to Extra Care' July 1996.
Birmingham City Council, 'New Homes for Old: Options' 9th September 1998.
Birmingham City Council, 'Further Implementation of the City Council's New Homes for Old Strategy', 17th February, 1999.
Birmingham City Council, 'Review of New Homes for Old,' Report of the Social Services and Health Scrutiny Committee, 16th May 2000.
Birmingham City Council, 'Best Value Performance Plan 2000-2001" 2000.
Centre for Policy on Ageing, "A Better Home Life" 1996.
Centre for Public Services, " Best Value Implementation Handbook""1999.
Department of Health, "A New Approach to Social Services Performance" , 1999.
Department of Health, "Fit for the Future? National Required Standards for Residential Homes and Nursing Homes for Older People", 1999.
Department of Social Security, Attitudes and Aspirations of Older People", 1999.
Institute for Employment Studies, "Supporting Skills for Care Workers", 1998.
King's Fund, "When we are very old" 1999.
Knightsbridge C.S. "Report for the Social Services and Health Scrutiny Committee" 12 April 2000.
Laing & Buisson, " Care of Elderly Market Survey", 1999.
Laing, William,"A fair price for care? " Joseph Rowntree Foundation, 1998
Office of Fair Trading, "Older People as Consumers in Care Homes" 1998.
Residents Action Group for the Elderly, New Homes for Old: Best Value for whom?, April 2000.
Royal Commission on Long Term Care "With respect to old age" 1999.

Part 1

The market for residential care

Demand for the service

Demand for all services to the elderly will increase substantially over the next decade and beyond. The UK population aged 85 and over is projected to rise from 1.1 million in 1999 to at least 3 million in the year 2056 (Laing & Buisson, 1999). The demand for paid care may also be greatly increased by changing family structures and greater participation by women in the labour market.

There is already evidence of increased demand from elderly people with high levels of dependency, including dementia and other health problems requiring intensive support and care.

Local authority support

Public sector funds form the largest proportion of income to the residential care sector. This is likely to increase in proportion as the costs of introducing new care standards and staffing costs rise. The number of supported residents in all types of residential homes has continued to rise during the 1990s, from 149,000 in 1994 to 244,600 in 1998. Around 21% are in local authority run homes, 48% in independent residential homes, 29% in independent nursing homes and 2% in unstaffed local authority accommodation. People aged 65 and over accounted for 81% of all local authority supported residents (Community Care Statistics, 1998).

Independent care homes sector

There are over half a million places (554,100) in residential care homes for long stay care of elderly and physically disabled people across the private, public and voluntary sectors in the UK. The total value of the market is estimated to be £8.5 billion, of which the private sector accounts for £5.4 billion and the voluntary sector £950 million with the public sector accounting for £2.1 billion (Laing & Buisson, 1999).

The following table shows that the majority of privately owned care homes are small, providing 10-30 beds. In the not-for-profit sector, most care homes fall into the 20-40 bed categories.

Table 1.1: **Distribution of sizes of for-profit and not-for profit residential homes for the elderly, 1998**

	For-profit		Not-for-profit	
Beds	**Number**	**%**	**Number**	**%**
75+	8	0	13	1
50-74	96	1	89	5
40-49	300	4	262	18
30-39	747	9	375	23
20-29	2,276	28	419	25
10-19	3,631	45	312	19
Less than 10	939	12	178	11

Source: Laing & Buisson, 1999.

Table 1.2 shows the leading private providers in the sector. By the end of 1998 there were only 9 UK publicly traded nursing and residential care home providers, a much reduced number from the early 1990's. This was reduced to five in 1999 when Westminster Health Care was taken over by Canterbury Healthcare and then to four when Cresta Care was taken over by Carat Secre. The four remaining publicly quoted companies are Care UK, Associated Nursing Services, Tamaris and Regency Homes.

Table 1.2: **Top 10 for-profit providers of long term care for the elderly, 1998**

Company	Homes	Beds	Market Share
Bupa Care Services	217	15,967	4.2%
Ashbourne PLC	142	8,180	2.1%
Westminster Health Care	94	5,968	1.6%
Tamaris PLC	99	4,928	1.3%
Highfield Group	68	3,511	0.9%
Crestacare PLC	56	3,361	0.9%
Craegmoor Healthcare Co	65	3,253	0.8%
Associated Nursing Services PLC	47	3,076	0.8%
Southern Cross Healthcare	37	2,063	0.5%
Ultima Holdings	39	1,988	0.5%

Source: Laing & Buisson, 1999.

Ownership and control within the care homes sector

The majority of the home care market is run by independent small businesses, many of which are run by owner managers. However, the average size of nursing homes in particular continues to rise leading to higher barriers to entry for owner/managers (Laing & Buisson, 1999).

During the mid 90's major providers have increased their share of the care home market. In spite of this, the care homes market remains fragmented, with lower levels of concentration of ownership than many sectors of the economy. Market reports indicate strong pressures for further consolidation, particularly among the larger groups, to increase profits by merging and reducing head office overheads. The result will be a further limiting of choice for elderly people in need of residential care.

Key companies

During 1998/9 there were several changes involving takeovers and mergers among the leading care home operators. For example, BUPA acquired Goldsborough Healthcare and Care First. Further consolidation is expected to achieve economies of scale and reduce overhead costs. Mergers may also occur among smaller homes and financial failure is expected to drive the process forward by creating acquisition opportunities for remaining operators (Laing & Buisson, 1999).

In July 1999, Grampian Care Group, one of the largest residential care home groups, went into

receivership. The company, which ran 24 nursing homes in Scotland and one in England, blamed cash flow problems. 1,000 residents and 2,000 staff were affected by problems which arose following reduced occupancy levels in the homes. In Sheffield three large, purpose built residential homes owned by NPH, have gone into receivership.

The trend to separate ownership from the operation of care homes has accelerated over the last five years. The value of homes operating under sale and leaseback arrangements had grown to £1billion. Many of the largest companies have also withdrawn from new development, reflecting poor market conditions, and the number of new registrations by for-profit companies has dropped. 1998 was the first year in which new registrations did not exceed de-registrations (Laing & Buisson, 1999).

BUPA is now the largest operator of local authority residential care with contracts either in place, or being finalised, in Bedfordshire, Bromley, Berkshire, Staffordshire and Powys.

Key characteristics of the private sector

The following points illustrate a sector currently facing economic instability:

* The shift to private sector residential care meant huge growth for the sector during the 1980s. This has slowed down in the 1990s. Private residential home capacity remained fairly static in the mid-1990s and actually decreased in the last year.

* As a result there have been a number of closures as a result of overcapacity, takeovers, reducing profits and financial failures. Takeovers have resulted in market concentration, particularly following BUPA's acquisition of Goldsborough Healthcare and Care First.

* There has been a substantial drop in the number of new care home registrations.

* Recent indicators show that whilst the volume of demand continues to grow, competition between care home operators has increased leading to economic uncertainty. The number of closures of residential care homes has accelerated during the last two years and is expected to increase.

* Specialisation and diversification of care home providers to the provision of other services.

* Reduced occupancy rates (average 85%), well below the levels of the early 1990's.

* Lowest profit margins ever recorded in 1999/2000.

Funding constraints

The level of funding from local authorities for residential care places is crucial. Well over 50% of independent sector care home residents have their fees paid by local authorities.

The shift away from local authority care during the 1990s is explained by a number of factors. In addition to the obligation on local authorities to spend 85% of their Special Transitional Grant on private or voluntary sector care services, there was also a financial incentive for local authorities to contract with "independent" providers rather than provide additional residential services in-house. Residents of independent care homes are entitled to a Residential Care Allowance if they pass the means test. Residents placed in local authority care homes are not entitled to this allowance.

In recent years, care home operators have complained about low levels of fees paid by local authorities.

Voluntary sector and not-for-profit providers

This part of the sector must be divided into:
* Local authority trusts.
* Other voluntary sector providers.

Trusts

Residential care in the voluntary/not-for-profit sector also grew in the mid-1990s with the transfer of some local authority homes to trusts (Appendix 1). The main driving force for the trusts was making residents eligible for the Residential Allowance and access to private sector funding. By December 1998 there were 17 trusts operating a total of 11,600 beds. The market report by Laing & Buisson states : ***"There is unlikely to be another wave of transfers to trusts. The original transfers left expensive staffing terms and conditions and inefficient working practices in place. Most trusts failed to deal with these issues in their first years of operation and as a result a number of them have since experienced financial difficulties".***

Trusts set up by local authorities involve the transfer of the service to an established organisation or a new trust. Trusts are usually charitable or 'not-for-profit' organisations which are run on commercial lines and often by managers committed to a private sector ethos.

Table 1.3 lists the existing local authority trusts, most of which were established in the early to mid 1990's and have failed to expand since. There is no evidence of local authority residential care trusts being formed over the last two to three years.

Table 1.3: **Trusts established as a result of the transfer of local authority residential care homes**

Name	Homes	Beds	% Profit before tax
Quantum Care	28	1,394	
CLS Care Services	38	1,294	2.1%
Somerset Care	26	1,056	
Coverage Care (Gloucestershire) Ltd.	23	904	
Dorset Trust	18	771	6.4%
Fremantle Trust	19	722	0.1%
Orders of St John Trust	17	695	3.6%
HICA Specialised Care Homes Ltd	15	674	
Cornwall County Care Ltd	18	674	
Manchester Care Ltd	16	628	-11.7%
Sheffcare Ltd	13	520	1.3%
Borough Care Services	14	559	0.8%
Tameside Care Group	12	536	8.6%

Sources: Care of Elderly People Market Survey, Laing & Buisson, 1999 and The Fitzhugh Directory, 1999

Charitable or non-profit organisations

There are 136 other not-for-profit providers, the largest of which are Anchor Homes, Leonard Cheshire Foundation, the Congregation of the Poor Sisters of Nazareth and the Abbeyfield Society - holding 9.5% of the nursing and residential homes sector. Some of the providers in this category have housing provision as their core business and this is likely to increase where specialist services are developed.

In-house initiatives

Several local authorities are recognising the need to change the service and develop new in-house initiatives.

Authority	Initiative	Year
Hampshire CC	£1.5m improvement programme for its residential homes jointly with Health	1999
Leeds MBC	Extra care sheltered housing - housing and social services departments	1999
Nottinghamshire CC	Building 5 purpose built homes to replace 12 homes	1998

Source: Compiled from Community Care Market News, 1999-2000

Nottinghamshire developed a strategy to replace 12 residential homes which are below modern standards with five purpose built homes (Community Care Market News Aug/Sept 1998). It involves:
* Additional investment to provide care, new buildings and to increase staffing levels involving investment of up to £4.5m in 5 years.
* Involvement of residents, users and carers in planning the service.
* Development of new residential services in partnership with the health service.
* New partnerships with district councils - providing intensive social services support to sheltered housing residents.
* Investment in developing support groups working to improve the quality of life for older people.

Comparisons between the private, voluntary and local authority sector

The independent sector continues to seek to reduce staffing costs in order to remain profitable.

Analysis of the sector as a whole shows that average employee costs vary between types of companies and between the private and voluntary sector (Table 1.4).

Table 1.4: **Summary of average employee costs, 1995**

Type of provider	Average cost per employee	Operating revenue per employee
Publicly quoted company	6,500	12,200
Private company	6,200	11,400
Non-UK owned	4,700	8,200
Charity	8,800	12,600
Total	**6,800**	**12,000**

Source: Compiled from Fitzhugh Directory, 1996.

The transfer of residential care staff out of local authorities has affected large numbers of low paid women workers. Reduced pay and conditions, and lower staffing levels are expected by residential home operators and by trust managers.

The key differences between local authority terms and conditions and the private/not-for-profit sectors are not only the pay differentials but also the overall package of terms and conditions covering allowances, holidays and sick pay.

Poor terms and conditions for staff, including new recruits, can have a negative impact on the quality and level of care for residents. Where it results in higher levels of staff turnover managers face greater difficulty obtaining suitable qualified and trained staff because of lower rates of pay.

The report by the Accounts Commission for Scotland (1999) slowed that the higher running

costs in council run homes largely relate to staff costs and in some cases a larger number of management tiers.

Table 1.5 provides evidence of the average cost per employee in not-for-profit home operators in the 1996-98 period. Although average cost reductions can be achieved from a number of sources, for example, economies of scale, the extent of the reduction on the local authority rate indicates that this could only have been achieved by cuts in pay, condition and/or hours. In addition, employee costs in the transferred homes were well below the average for the not-for-profit sector as a whole which includes many charities and housing associations, providing nursing and other specialist care.

Table 1.5: **Average cost per employee in transferred home operators** (£:000)

Organisation	1996	1997	1998	No employees 1998
Borough Care Services	8.2	8.9	7.4	592
CLS Care Services	7.5	6.7	7.4	2074
Community Integrated Care	11.0	11.2	11.7	1820
Cornwall Care Limited	15.9	13.9	-	-
Dorset Trust	14.0	14.7	14.9	434
Manchester Care Ltd	10.2	11.0	11.7	697
Sheffcare	9.2	9.7	10.1	478
Tameside Care Group	7.4	7.3	8.0	722
Warwickshire Care Services	9.3	9.0	10.2	531
Average not for profit sector	**15.1**	**13.9**	**16.6**	**Total 22,135**

Source: The Fitzhugh Directory 1999.

Role of the local authority

The independent sector relies for much of its market from local authorities. There is a clear recognition within the industry that local authorities will have to be prepared to pay higher fees in the future for:

* Staff training schemes.
* Quality assurance programmes.
* Single rooms.
* En-suite facilities.
* To meet the requirements of the minimum wage and annual increases.
* To meet the requirements of the Working Time Directive.
* Human Rights Risk Assessment Procedures.

New care standards

The Government is proposing new Standards of Care (Modernising Social Services, 1999). The system of regulation will create Commissions for Care Standards - independent regional authorities responsible for regulation of care services. These will regulate all existing residential care homes for the elderly and develop codes of practice for domiciliary services. There will also be guidance on complaints procedures, promotion of community involvement and enforceable standards of conduct and practice for the whole workforce. This will cover staff recruitment, training, management and supervision, and prevention of abuse procedures. All providers, whether public or private will have to meet the standards with major implications for

staff training and qualifications.

The Centre for Policy on Aging was commissioned by the Government to produce national Baseline Standards for residential care homes covering all aspects of care provision. This document provides national standards which can be adapted locally. In addition, the Government has commissioned an audit of care homes which will inform the changes proposed in the White Paper. New requirements on staffing and the physical environment of care homes will have a great impact on the independent sector.
It is expected that the national standards will trigger a shake-out of non-compliant homes (Laing & Buisson, 1999).

A Bank of Ireland report states that only 57% of residential care homes meet the standard for single rooms. The report suggests that the financial implications of the introduction of National Standards will be:
* Loss of revenue of up to £308m
* An increase in wages of up to £61m
* Unknown figure for capital expenditure
* Acceleration of home closures.

Inter-agency working

The Government expects local authorities to work with NHS services to work together to agree local joint investment plans for community care services and to provide specialist services such as rehabilitation. This is also being encouraged by the Audit Commission.

Conclusion

The independent sector is heavily reliant on local authority funding of residents. Local authority trusts are almost totally dependent on public funding.

The sector is in crisis and is blaming the Government and local authorities for inadequate funding.

Sooner or later the Government will have to face up to the fact that the funding of residential care is inadequate. The independent sector will become increasingly unprofitable unless the Government recognises that fee levels will have to increase to meet:
* User needs
* Improved staffing levels.
* Better training and qualifications.
* New national standards.
* Increasing dependency levels.
* Continuous improvement under Best Value.
* Human Rights Risk Assessment Procedures.

This will have the result of reducing the difference in the cost of residential care places between the public and private sector.

Part 2

Assessment of proposals and options

The future for Birmingham's residential homes

The Social Services and Health Scrutiny Committee report (16th May, 2000) recognised that:
* The twin objectives of the New Homes for Old strategy - increasing the availability of extra care sheltered housing and raising the quality of in-house residential care remain.
* The demographic changes in the city are likely to continue the need for residential care, including meeting the needs of an increasing number of elderly with dementia and the needs of minority ethnic groups.
* Quality of care should be the essential benchmark.
* Proposals to close five homes should be abandoned.
* The city needs a range of care services for the elderly including care homes to allow for choice and flexibility.
* Lack of local authority investment in their homes over a ten year period.
* In the future homes will have to meet higher registration standards, whether public or private.
* Cost comparisons between the public and private sector are complex and any comparison must be based on comparing like with like in terms of quality and level.
* All local authorities await the outcome of the Government's response to the Royal Commission on Long-term care.
* All local authorities await Government decisions on the financing of improvements in residential care.

The process of how these areas are achieved has been criticised from a number of quarters.

The points made by RAGE and UNISON on a wide range of issues were also valid and should be taken into account. These included:
* Inadequate consultation with residents, their families and the local community on proposed service changes.
* The potential for a legal challenge under the Human Rights Act 1998 of any proposed closure or transfer of local authority homes.

Birmingham's case for a trust

At the end of the paper prepared by the Chair of the Scrutiny Committee, the proposal to transfer the majority of council run homes to an Independent Management Trust is made without any reference back to many of the above points.

The report also recommends that a small number of units are retained under direct council control for specialist services or as beacons of excellence.

The following arguments for a trust are made, based on the report by Knightsbridge Consultant's are:
"*1. The residents and carers are directly involved in the management and running of the homes, including the style of life and the services delivered.*

2. It facilitates local democracy and empowerment and could embrace the notion of neighbourhood management committees.

3. It increases individual choice and encourages participation in policy and practice for the users and their advocates.

4. It provides opportunities for the local community to be included in the decision-making

process. Management could include local councillors, trade union representatives and independent advocates.

5. Quality of care is best decided upon by the residents themselves."

All the five advantages are in no way exclusive to trusts, and there is no evidence which shows that trusts do operate under this ethos.

The advantages are unique to well run homes, many of which remain local authority controlled. They are also key to the consultative requirements of Best Value which is being primarily targeted at in-house services.

By contrast the independent sector is not experienced in democratic decision making. Trusts operating in the residential care sector are usually run by an executive of senior managers, overseen by appointed trustees. We have no examples of user involvement or involvement of staff and trade unions in the decision making structures of residential homes run by trusts.

The paper to the Scrutiny Committee (16th May 2000) also states that: *"a Trust would be liberated to raise funds for the refurbishment of the accommodation".* This is a major unsubstantiated claim which is addressed in Part 4 of this report. The money will have to come from somewhere, and is most likely to come from the public purse. The independent sector already faces financial insecurity and trusts are not exempt from the economic pressures which are expected to increase over the next decade.

In fact, the Scrutiny Committee report concludes by emphasising the need for the local authority to continue to support a trust: *"..it would still be necessary that the Council would support the Trust raising funds for refurbishment, and could offer some contractual support over the early years of the Trust's existence by guaranteeing commissioning of a number of places".* This is likely to be for a limited time; trusts are usually expected to become separate financial entities after a few years.

National framework

The Royal Commission on Long Term Care made clear proposals which are still being considered by the Government. The future funding and direction of Government policy on residential care for the elderly remains unclear. The trust option is premature; the council should await the national framework before embarking on an option which is potentially of great risk.

Registration standards

Currently there is no legal requirement for local authority homes to meet registration requirements. The Government intends to alter this so that all residential care homes owned by local authorities and the independent sector will be required to register, and will be subject to inspection and enforcement procedures (Modernising Social Services, February 1999). The standards are intended to provide a baseline for performance and regulation. The Government emphasis on recruitment of staff and development of training programmes will have more serious cost implications for the independent sector than for local authorities where qualifications and training have always been important.

The Council has highlighted two areas which may involve considerable expenditure in the future - suitability of some buildings and investment to meet increasing dependency and specialist requirements of residents.

However, these are issues facing all councils. It remains unclear exactly what registration standards are likely to alter in the future. An essential prerequisite for any review of the service is to identify exactly what the problems are with meeting registration standards in the future.

In-house service maintained

The following examples highlight the strength of the potential to retain services in-house. The following councils recently considered transferring residential homes to the independent sector but decided to retain the service in-house.

Scottish Borders: Scottish Borders Council agreed in November 1998 to retain its six residential care homes in-house, following proposals to outsource the service.

St. Helens: The residential care homes stayed in-house following a major community campaign. The Council carried through a tendering process, inviting seven organisations to tender and receiving two bids from CLS Care Services (the transferred Cheshire County Council homes trust) and English Churches Housing Group/Heritage Care. Their bids were rejected because they *"have not demonstrated satisfactory performance in all areas of the specification with regard to the quality of the services they currently provide."*

Lancashire: The council decided to retain its 48 residential care homes following a trade union campaign highlighting the detrimental impact of transfer. This has now created an opportunity to integrate home care and residential care, using the homes as a base for a more responsive service. The service is being coordinated through a new business unit located within the council.

Rejection of Trust model

Cambridgeshire County Council ruled out the possibility of setting up a trust to run its homes because of the significant capital borrowing requirements and large start up costs.

Part 3

Evidence from transfers to trusts

Residential care trusts

Residential care trusts are part of the independent sector which, as Part 1 of this report showed, operate in a highly unstable economic market. They are usually not-for-profit organisations.

1. The majority of transfers of local authority residential care homes have been to trusts / not-for-profit organisations. Many of these these have faced major financial problems and have sought to reduce staffing costs.

2. Not-for-profit organisations operate at a distance from a local authority and are in effect another form of externalisation / privatisation.

3. Trusts are run by a board of appointed and elected members over which there is little local authority control and little potential for user or staff involvement.

4. Partnerships with trusts involve complex financial and legal arrangements through contracts which can weaken the position of the local authority in terms of ensuring service quality, monitoring and evaluation of the contract.

5. Transfer to a not-for-profit organisation has the same consequences for the staff and service, as for any outsourcing. Not for profit organisations are forced to act commercially by adopting business values, reducing costs and generating income. These factors, rather than quality of care, have dominated the activities of the transfers of care homes to trusts and not-for-profit organisations so far.

Tameside MBC was the first council to externalise its residential care services almost a decade ago. It no longer directly provides any residential care for the elderly in the borough. The council transferred its 12 homes to Tameside Enterprises in 1992 and subsequently to Tameside Community Care Group. Following serious mismanagement and financial problems, staff wages were first cut in 1993. Further cuts in sick pay and maternity leave were made in 1996. Staff contracts were terminated in May 1998 and new terms offered with cuts in pay, reduced holiday and an end to paid sick leave. Following industrial action, 200 staff were dismissed in May 1998. The majority of staff employed by the Care Group are now paid the minimum wage rate, well over £1.50 an hour less than if they worked for the local authority.

Democratic accountability

Any transfer would limit the ability of the council to carry out its policies and programmes in terms of a comprehensive community care service. Democratic control and accountability would be limited.

Trusts have to operate as stand alone organisations which means they are also financially vulnerable although in different ways than local authorities.
Transfer to a trust will mean:

- the running of the homes will be externalised to a quasi-public organisation

- direct democratic control of the service will cease

- service quality will be put at risk through the contract process

- staff, who are the most important element in quality of care, will transfer from the Council and will be employed by the organisation. The protection of their terms and conditions of service is not guaranteed.

- business values, reductions in costs and income generation become priorities over the quality of care.

All independent providers require financial equity over the longer term. Bank loans often come with strings attached. For example, a covenant was attached to a bank loan to Tameside Care Group imposing a requirement that the wage bill should not exceed 67% of income. Trusts may be able to access capital for improvement work more readily than the local authority but whatever amount is borrowed has to be paid back - which means higher fees or cutbacks in staff and and the quality of care. There is no such thing as a free bed!

Contracting

The lessons of CCT show that the level of influence is limited under contract. The service will be more fragmented and it will be much more difficult to retain an integrated community care service.

Transfer of part of the service is unlikely to be the last and if all the homes were eventually transferred there would be serious implications for other aspects of the service to elderly people. The authority would lose its ability to compare in-house costs against the independent sector. The council's bargaining strength with the independent sector would be eroded as external operators gained more ground in terms of running the service.

Management of trusts

In the case of Tameside, the longest running residential care trust, the council mismanaged this structure through political appointments, poor management, weak financial controls and lack of transparency.

There has been a constant need for the council to intervene in the activities of the Tameside Care Group. The council agreed to support the company in the early 1990s in circumstances where it may not have survived if it had been an independent private firm. The political and financial issues raised by the District Auditor in 1993 have never been fully resolved.

Failures of the trust model

National research on trust status conducted by the Centre for Public Services shows that it does not shelter the organisation from the pressures of being an independent body separate from the local authority. The original aims of establishing a Trust are often not maintained and the charitable ethos of Trust status is not usually applied in the longer term.

In spite of trusts having charitable status, commercial factors and market forces are the key driving forces in the independent sector, and financial issues have dominated the performance of trusts and arms-length companies. The savings made under the transfer option nationally have largely come from wages and conditions and a reduction in staffing. In addition, there has been increased use of temporary and casual staff, less training and fewer resources for health

and safety measures.

Trusts established by local authorities are also facing financial restructuring. For example, Sheffcare, the trust which took over 13 of Sheffield's residential care homes is in the process of demerging from the Sheffield City Trust and operating independently. It also wishes to change its status as a charity so that it can operate outside the city.

Tameside Care Group has changed its status from a trust in which the council owned a share to one which severs ties with the council. An employee benefit trust has been set up and staff who have worked for the trust for more than a year will be given shares in the company.

Financial priorities

The long term future of any trust and its subsidiary companies remains uncertain. As a stand alone organisation trusts are highly vulnerable to economic pressures to increase efficiency and cut costs. For example, Tameside Care Group was unable to absorb even minor reductions in funding and accumulated large debts. The question of whether economic pressures are accommodated entirely internally by a trust has to be addressed.

In Tameside major problems arose when the council moved from its position of supporting the Care Group through financial difficulties to one where it sought to squeeze further savings out of residential care by reducing fees. In turn the company substantially reduced terms and conditions of employment without any serious consideration of alternative options. This came on top of a five year pay freeze and and an improvement in the company's pre-tax profits.

Responsibility for residential care services

Under any transfer of local authority services to trusts there remain major issues of responsibility for the future of the service.

There is a need to incorporate clarity and transparency in terms of council relations with trusts and and any subsidiary companies in assessment of options.

Impact on social services and other council departments

Service coordination and integration will be much more difficult if residential care service are either reduced or transferred to an independent operator.

The transfer of several hundred staff will have a knock-on effect on other council departments, particularly those supplying support services. National research by the Centre for Public Services on transfers shows that loss of work will mean a reduction in workload for payroll, finance, accountancy services, legal and other services, with a knock on effect on jobs.

Employment

The majority of transfers of local authority homes have been to not-for-profit organisations, most of whom have suffered from major financial difficulties, resulting in major changes in staffing.

Sheffcare: Sheffcare, a non-profit making trust, running 15 of Sheffield City Council's former residential care homes, announced in May 2000 that wage cuts and new terms and conditions would be imposed on 200 staff who were transferred from the council. This represents a quarter of the workforce and affects all levels of staff including managers. The decision was blamed on economic pressures in the care sector, reduced fee levels and new regulations. Grant aid provided by the city council to renovate homes is also expected to diminish over the

next few years. The basic rate for care workers in the company is £4.19 an hour.

Coverage Care: Coverage Care, a non-profit making company which took over 23 of Gloucestershire County Council's homes, reduced costs by introducing a three year pay freeze for staff. This follows the end of a six year rent amnesty in Gloucestershire. To meet the rent costs, managers proposed a package of measures including loss of sick pay and night premium and a reduction in holiday.

CLS: The staff in Cheshire's homes transferred to CLS were forced to accept wage cuts, following financial problems. In addition, new staff were paid at substantially lower rates.

Cornwall Care: A dispute arose in 1996 when Cornwall County Council transferred 18 residential care homes, involving 700 council workers, to Cornwall Care. Six months after the transfer, the company terminated contracts of employment and rewrote them with reduced terms and conditions of employment. This included cuts in overtime rates and holiday pay with some staff losing up to £50 per week. An employment appeal tribunal ruled that staff had been unfairly dismissed and were entitled to their original terms and conditions of employment. Two years later, in July 1998, the company and unions agreed compensation payments for the staff.

Dorset Trust: 18 homes were transfered to a not-for-profit trust in 1991. Transferred staff were not given a pay rise for five years.

Manchester Care: Manchester City Council transferred 18 of its homes to Manchester Care. A financial crisis in 1998 led to cuts in terms and conditions of employment and two homes closed. New contracts for staff were introduced resulting in an overall reduction in wages, following a two year wages freeze.

Tameside Care Group: The council transferred its 12 homes to Tameside Enterprises in 1992 and subsequently to Tameside Community Care Group. Following serious mismanagement and financial problems, staff wages were first cut in 1993. Further cuts in sick pay and maternity leave were made in 1996. Staff contracts were terminated in May 1998 and new terms offered with cuts in pay, reduced holiday and an end to paid sick leave. Following industrial action, 200 staff were dismissed in May 1998.

Borough Care Group: 14 of Wigan's residential care homes were transferred to Borough Care Services, a council owned arms length company, and then to CLS who reduced terms and conditions of employment, and abolished enhanced payments leaving staff £30-£40 a week worse off. As a result there have been 300 industrial tribunal claims against the company.

In 1992 eight of Stockport's homes were also transferred to Borough Care. The company imposed pay cuts and reduced sick pay from 26 to 13 weeks. In addition, there are no enhanced rates of pay for new starters.

Issues for assessing under the trust option

The following issues must be raised in terms of the trust option

- Form of externalisation / privatisation
- Loss of democratic accountability
- Temporary or permanent
- Corporate consequences for local authority
- Council's strategic "provider" role weakened
- Service fragmentation
- Sustainability over the longer term
- Erosion of public service ethos

Ownership and accountability

* Complexity of ownership models
* Trust board with limited local authority representation
* Role of trustees
* Trust meetings - openness to public scrutiny
* Loss of accountability for employees, community and users
* Contract model
* Role of subsidiary companies
* Community and social welfare objectives
* Implementation of Best Value.

Part 4

Economic costs of transfer

Any transfer proposal will have to include comparison between the local authority, not-for-profit trusts and the private sector. Cost analysis will have to take into account the following:

* The independent sector faces increased costs to maintain the minimum wage, improve training levels and other staffing requirements; there is substantial evidence from national surveys which show the widespread pattern of low wages in the residential care sector.

* Both local authority and independent homes will have to meet the cost of higher standards; the report of the Chair of the Social Services and Health Scrutiny Panel recognises this in para 5.8 which states that the council would have to support a trust in raising funds for refurbishment. In other words the local authority would still have financial obligations to fund improvements, at least in the early years of a trust.

* A trust would, like the local authority, have to meet requirements to provide adequate staffing and cover. The danger is that under trust status financial problems dominate and homes are operated with minimum staffing levels.

Fees

Fees in the independent sector are expected to increase over the next few years because of:
* National Standards
* Increasing investment in buildings.
* Increased staff costs.
* Added training costs.

According to the report by Knightsbridge C.S. the average cost in a local authority home in Birmingham was £380 per week and in the independent sector £240 per week. However as the report states it is unclear whether the figures can be compared as costs are not being compared on the grounds of user needs or quality of service. In fact, 60% of the councils homes have already achieved quality assurance ratings, as opposed to only 13% of the independent sector homes.

In March 1999 average weekly fees were £259.00 for private residential care in the UK (the average for a single room was £262.00). The care home industry considers the fees to be too low and largely blames local authorities for the lack of increase.

However, there is a need to look at differences in types of provision and quality of care. Some local authorities pay higher fees for beds in the independent sector which are in single rooms, have en suite facilities and higher quality facilities.

There is a great deal of pressure from the independent sector to increase fees paid by local authorities and this is bound to develop with the implementation of the National Required Standards, expected in 2001. Already, local authorities pay more for beds in many of the trusts than in other parts of the independent sector. For example, Sheffcare receives an additional £30.00 a week per bed from the city council than other providers; yet the trust also wishes to reduce wages and conditions of employment of transferred staff.

The cost of care

Birmingham MBC is clearly aiming to reduce the costs of residential care through its proposals for the service.

Crude comparisons have been made about unit cost differences. Any such comparisons should take into account a Best Value approach which not only looks at cost but effectiveness in terms of service quality and meeting specific local social needs. This work should involve service users and staff working across the community care service.

The reasons for higher unit costs are important in the discussion about the future of the homes in the city. The largest element of the cost differential are staff costs which are higher in the local authority and the Residential Care Allowance (currently £59.40) which is available to all operators except council managed homes. Once the Government removes this anomaly the cost difference will be much reduced.

We cannot disaggregate the unit costs any further without a detailed breakdown. Staff cost differentials are often cited as a key difference between public and private provision. Research by the Centre for Public Services for the Fawcett Society and a survey by UNISON confirmed that there are substantial differences with most independent operators paying well over £1- £2 an hour less to employees than the local authority. In addition the research found poor working conditions in most cases, with less holiday, no company sick pay scheme and no pension scheme.

The independent sector will find it increasingly difficult to compete with local authorities once the national minimum wage and working time directive are introduced. A report by William Laing,*"A fair price for care?"* showed that if care assistants wage rates are £3.50 an hour, the fee required to give operators a reasonable return for good quality nursing home stock is £355.00 per week and if wages went up to £4.00 an hour fees would have to rise to £368.00 per week. The return includes £2.75 profit per bed per day, representing a 6% return. These costs would be substantially more than Birmingham is paying for residential care in the independent sector.

Assessment of cost needs to take into account differences in quality of care and any savings projections must be fully analysed over the longer term.

Who will pay for improvements in standards?

New requirements on local authorities and all other providers to improve physical standards of homes along with staffing and training will be introduced over the next few years.

Where would the money come for investment come from if the homes were transferred? Independent or non-profit operators are not going to invest unless they have a return on their investment which could in turn mean higher fees and less money spent on staff. The independent care homes sector is stating that the Government should meet the cost of the new national standards.

The emphasis in terms of physical standards does not reflect the full picture. Whilst buildings and facilities are important, the type of service provided is more important. Experienced, committed and well trained staff in council residential homes are more likely to provide a consistent and high quality of care.

The lower cost of the independent sector is predominantly related to staff costs, an area which the Government recognises needs to increase to achieve improved staffing levels.

Costs and savings of transfer

Any savings from the transfer of homes to the independent sector are unlikely to have a significant impact on the council's overall financial situation. Financial savings are not guaranteed in any sense. The costs of externalisation also need to be taken into account. Monitoring and evaluation costs will be high under the trust option, particularly as service improvements are expected under Best Value.

Future funding of residential care

The Government intends to create a level playing field through the redistribution of the Residential Care Allowance.

The funding of residential care places is currently unfair and benefits the private and voluntary sector. In the future the Government will either remove the benefit from the independent sector or allocate the allowance to the local authority sector. Either way, the cost differences between the two sector will be reduced.

A report from the House of Commons Select Committee on Health (May, 1999) fully endorsed the findings of the Royal Commission on Long Term Care, describes the current arrangements as "mean, inequitable and the quality of care is often inadequate", and has called on the Government to act urgently.

Alternative funding

Options for funding need to be thoroughly investigated. One source of funding could be through the European Investment Bank which has large assets and is looking to invest in health and social services following a broadening of its remit after the European Union Amsterdam Summit in 1997.

The council needs to conduct a comprehensive cost analysis in the context of Best Value and investigate alternative sources of finance. There are other options for funding service improvements.

Part 5

Best Value analysis: user and staffing implications

The report by R.A.G.E. showed that service users and their families have not been given direct access to involvement in the development of future service options for residential care within Birmingham's Social Services Directorate. User organisations have complained that consultation was totally inadequate under the Best Value pilot review process.

The report by Knightsbridge C.S. also stated that the consultation process over the future of five homes was inadequate. In the consultation process, which included meetings and open surgeries *"the perspective gained by carers was that the meetings were not consultative, but little more than information giving".*

User rights will also be of particular interest to the Audit Commission and Best Value Inspectorate in their audit of the conduct of Best Value reviews.

User consultation with residents and their families is under-developed in the independent sector.

Best Value review of the residential care homes

A Best Value Review should be comprehensive and focus on quality, equalities, effectiveness, as well the cost of the service, and service improvements in care services for the elderly. Reviews must challenge, compare, consult and demonstrate competitiveness.

The evidence analysed as part of this report shows that the Best Value pilot project:

- failed to adequately consult with residents, their families and the public
- failed to fully examine the quality of care currently provided by the in-house service
- failed to properly address equal opportunities issues
- failed to adequately compare Birmingham's service with others on a like for like basis
- failed to examine why the council provides the service and to fully examine all options for all the homes.

The Council seems willing to put the quality of care it has built up and resourced over the years in jeopardy by transferring the homes to a trust. It has become fixated with lowering unit costs and options for closure or transfer.

Examine services for the elderly as a whole, not piecemeal

We understand that a fundamental service review is currently underway. A comprehensive review would be in the best interests of the elderly, the Council and care staff. It would examine the needs of the elderly for residential care in all homes, day care, respite for carers, rehabilitation, and how other services such as education, social services, leisure and libraries can target services for the elderly. Best practice from the public sector should also be assessed.

Consulting local residents

There has been inadequate debate and consultation with the local community on the future of the city's residential homes. This is in spite of the fact that community care reforms and the requirements of Best Value are designed to open up opportunities for responsive and

participative decision making. The homes represent a key front-line service of major importance and their future deserves thorough local debate and discussion.

Consultation needs to take place with local user groups, community organisations, carer's groups, pensioner's groups, and black and ethnic minority organisations.

Consulting service users

Initial consultations on options for the service were held in five care homes. There has been no further round of consultation with residents and families. A clear consultation process, which is properly time-tabled and resourced by the council, needs to be conducted. From this, reports should be drawn up on the findings to be used in discussions and decision making about future options for the service.

Consulting staff and trade unions

Staff are the key asset in residential services, yet their views have not been sought. There has been limited consultation and involvement of the trade unions, representing staff in all the care homes. The quality of residential care services depends on them. The transfer option puts their jobs and conditions of service immediately at risk. **Staff and trade union representatives have ideas and suggestions to make about the service which should be incorporated into a proper Best Value review.**

Public accountability: What is needed

- A Council plan to meet the Government Best Value requirements to consult the community
- A proper timetable for consultation and public debate
- Mechanisms for involving service users, their families, the local community, staff and trade unions in deciding on the future of the service.

Who are the users?

Nationally it well known that users of residential care are usually women, aged over 75, have no partner or relative who can look after them in their own home, and are very frail with a number of disabilities.

There are increased dependency levels and reports of higher age of admission over the last decade. This is well documented in Birmingham.

Improving quality

The report by the Accounts Commission for Scotland (1999) identified the following methods for improving quality:
* Respecting residents' right to privacy, independence and dignity.
* Maintaining strong community links.
* Ensuring that residents' individual and social care needs are catered for.
* Enabling residents to exercise choice and control in how the home is organised.

Many of these aspects are already evident in the homes owned and run by Birmingham City Council. The majority are already quality assured and achieve high star ratings. The report by Knightsbridge C.S. identified key advantages in the five homes scheduled for closure:
Quality of Care: residents and relatives spoke highly of the staff and were very satisfied with the quality of care they received.

Communal space: Council homes have high amounts of communal space - one of the standards which will be required in the National Requirements.
Gardens: All five homes have large and enclosed gardens, particularly important to the quality of life of elderly residents.

Major changes in staffing and the inevitable lowering of staff morale brought about by transfers have affected the quality of care for the elderly. Several care homes in Tameside for example, have faced problems in achieving satisfactory standards of provision following cuts in pay and conditions of staff.

Choice

A national study of the attitudes and aspirations of older people (Department of Social Security, 1999) found that elderly people in residential care homes saw independence as being able to exercise choice over their day to day living arrangements. They also identified how a sense of independence could be achieved by allowing them some degree of control over how their own lives and how they spent their time.

The Council believes that elderly people should be able to exercise freedom of choice in terms of how and where they live. Significant numbers of applicants currently express a preference for the Council's own residential provision and domiciliary services. The elderly and their families in Birmingham currently have the choice of public or independent sector care. The transfer of homes out of local authority control would remove or limit choice for future residents and override the choice current residents and their families have made for a local authority home.

The emphasis on the quality of staff, recruitment issues and future improvements in training and management have been disregarded by the council in their predictions for the future.

New skills needs

A range of policy developments in the care of elderly people will impact on the skills needed in the sector (Institute of Employment Rights, 1998). User needs in terms of dignity, rights, empowerment, choice, fulfilment and privacy are all now recognised within the sector. Added to this are:
* National care standards.
* Accountability, quality and efficiency required under Best Value.
* Development of standards and competencies.

All these will have a major impact on the skills required by people working with elderly people. In addition to personal skills such as sensitivity, patience, honesty skills which can be developed through training include medical, social and domestic care.

This was also recognised in a report by the King's Fund (1999) which found that in order for the quality of life for older people to be enhanced, there is a need for greater valuing of older people. *"Higher status for those working with older people will help improve the provision of treatment, care and support. In turn, greater valuing and higher status needs to be translated into increased resources, more services and staff, and enhanced professional training".*

The proposed national care standards include the stipulation that a minimum of 50% of staff in residential care homes must be qualified to NVQ level 2 or above by the year 2005.

Recruiting staff into social care is becoming more and more difficult. Equally, staff retention is a major issue for many residential homes. This has led to the increased use of agency staff, leading to lack of continuity and threatening service quality.

Continuity of care

Continuity of care is very important for the elderly. It is also important for staff teams who are paid at higher rates than the independent sector. Transferred home operators regularly employ new staff on much lower pay rates.

Continuity would be much harder if the homes were transfered to a trust which is likely to use different agencies, often leading to the use of untrained staff. Continuity would decline but so would quality. High staff turnover would lead to a vicious cycle of higher recruitment costs, increased staff resources involved in patching up gaps in cover and recruitment and increased monitoring costs,

Many residents in Birmingham's care homes are categorised as "highly dependent" and need emotional support from highly skilled and experienced staff.

Implications for care staff

Caring is still perceived as a low-status health care role and rates of pay in the independent sector reflect this. Poor conditions of employment such as sick pay and pensions also apply to care workers and the domestic staff, such as cleaners and kitchen staff, working alongside them. The jobs of care assistants and domestics in care homes are amongst the most undervalued occupations in the UK.

These staff merit higher wages and improved terms and conditions of employment in the majority of cases. The growth in low paid and undervalued employment in the independent care sector is also contributing to a situation within the economy where women are more than twice as likely to be low paid as men.

Staff cost differentials are cited as a key difference between public and independent provision. Recent research by the Centre for Public Services for the Fawcett Society and a survey by UNISON confirmed that there are substantial differences with most independent operators paying well over a £1 an hour less to employees than the local authority. In addition the research found poor working conditions in most cases, with less holiday, no company sick pay scheme and no pension scheme.

National Minimum Wage

The impact of the Minimum Wage, introduced in April 1999, will continue to affect the independent sector with annual increases.

Working Time Regulations

All employees in care homes are now entitled to a minimum four weeks paid annual leave; this represents additional costs in the independent sector where the previous industry standard was two weeks.

Employment practices in the independent sector

The independent care sector pays low wages and employs staff on poor conditions of service. These operators often employ staff with minimal experience and qualifications and have a low commitment to training. In addition, there is widespread use of casual and temporary part-time labour.

According to Laing & Buisson (1999) wage costs in private sector homes amount to 56% of revenue. They also state: *"As occupancy expectations have fallen back in recent years, operators have reined back on core staff on their books and have made greater use of temporary staff and part-time staff on flexible contracts with the effect that considerable savings have been made in payroll costs such as national insurance and allowances for annual leave, public holidays and staff training.".*

Industrial relations

Many of the transfer cases have involved acrimonious disputes between staff, trade unions and the company or not-for-profit organisation.

TUPE protection limited

The evidence from residential care transfers, is that independent employers have generally exploited TUPE regulations to achieve savings. Whilst existing pay and conditions of service would transfer to a new employer on day one, there is great uncertainty about the length of time TUPE would apply. Most independent operators believe that they are legally entitled to harmonise terms and conditions of employment within months of a contract starting.

Once a transfer takes place, the new employer, not the council has complete responsibility for jobs, pay and conditions. New employers usually seek to cut costs by reducing pay and conditions of service soon after transfer.

Abolish vacant/temporary posts: A new employer is likely to abolish most vacant or temporary posts.

All new staff on reduced terms and conditions: Independent sector operators will seek to create a two tier pay structure from day one. New staff or existing staff transferred from other parts of the organisation are not covered by TUPE.

Reduce and /or eliminate payments for weekend and unsocial hours: These payments are likely to be the main target of a new employer.

Reduction in working hours: Care assistants and other staff working over 20 hours per week or less could have their hours reduced and/or pay cuts in order to avoid the employer paying National Insurance contributions. The 1999 Lower Earnings Threshold for National Insurance was £83.00 per week. For staff paid £4.60 an hour this is 18 hours per week before the earnings threshold is reached. This practice reduces the employers wages bill as a result of the reduced hours and/or lower pay rates but also reduces the employer's National Insurance contribution.

This practice has major implications for care staff. Although staff earning below the Lower Earnings Threshold do not have to pay the employees National Insurance contribution, they are excluded from contributory state benefits such as statutory sick pay, maternity pay, unemployment benefit and state pensions.

Sick Pay: Sick pay entitlements are likely to be reduced as part of changes to terms and conditions of employment.

Pensions: The TUPE regulations require a 'broadly comparable' pension to be provided by the new employer. Employers often require staff to be employed for a minimum period before they can join and often exclude part-time staff by imposing a minimum number of hours requirement.

Women most affected: Any closure or transfer will disproportionately affect women, who in most care homes form at least 90% of employees. The gender impact of any changes to staffing levels and conditions of service must be challenged under the council's own equal opportunities policies.

Local labour market impact

Transfer to a trust will result in the loss of council setting a standard in the local labour market. The transfer will have a knock-on effect of driving down terms and conditions in this sector for

all care workers in the Birmingham area. Hence the transfer is likely to be supported by independent sector homes.

This means that transferred staff will be an increasingly small and isolated group in the labour market which will only intensify the eagerness of employers to reduce the size of this group. It will also provide a pressure on annual pay awards because percentage increases for this group will always be more expensive than for a comparable group of new staff on lower rates.

It is also likely to increase casualisation further undermining job security for women.

Effect on the local economy: Reduced earnings will have a knock-on effect in the local economy. We have carried out a number of social and economic audits which have assessed the impact on cuts and reduced earnings on spending in the independent sector. This has shown that for every four jobs lost in the local authority one additional job is lost in the retail and service sector.

Whose saving?: Whilst the Council may be able to show a 'saving' in its budget, this will not be the case in the public sector as a whole. Central government expenditure will be affected by:

* increased expenditure as more families are able to claim allowances because cuts in earnings and/or hours worked make them eligible for low pay income support.

* increased expenditure because there are likely to be more claimants for housing and council tax benefits.

* a loss of income as a result of lower earnings leading to lower PAYE and National Insurance payments and less VAT and indirect taxation because lower earnings results in lower consumer expenditure.

A full analysis of the costs and benefits will show that it is false for the council to claim a saving when other parts of the public sector incur increased expenditure and/or a loss of income.

Equal Opportunities

Equal opportunities policies linked to good employment practices promoted in local government are not generally applied in the independent sector. Poor quality employment conditions usually results in a higher turnover of staff affecting the quality of care.

Key issues

- **No further decisions on future options until a thorough and accountable consultation process is completed and views are taken into account as part of a Best Value review of the service.**

- **The local community, residents of the care homes, staff and trade unions should be involved in determining the future of this key front line service.**

Part 6

User rights

The following key areas must be considered along with the consultation process discussed in Part 5.

Economic constraints

The residential care market is not geared to meeting user needs. Local authorities are far in advance of the independent sector in terms of consultation and involvement processes.

A recent study by Counsel and Care (2000), which provides advice to older people concludes that the current market for care to the elderly has resulted in the interests of residents - particularly in terms of choices, needs and preferences - coming a very poor second to economic necessity and market management.

The report states: *"A volatile care home market means residents of homes might be considered assets of a business. Treating care homes as a financial investment means residents may be seen as a drain on resources".*

Concept of a 'home for life'

Wandsworth council recently won in its dispute with Four Seasons Healthcare over the proposed closure of a former council-run home, transferred to the company in 1996 (Community Care Market News, April 2000). The claim was that the residents in the home at the time of transfer were guaranteed a "home for life" by Cresta Care, which was subsequently taken over by Four Seasons. A new agreement, incorporated into a court order now ensures that the fourteen original residents will not have to be moved and that the other 23 residents who moved to the home since 1996 are secured a 'home for life'. This means that any of the 23 residents who move to one of the other two homes in the borough run by Four Seasons will not have to move again, effectively securing the future of the two homes run by the company.

The case raises issues about the security of tenure for the elderly in residential care homes.

Implications of the Human Rights Act 1998

The key areas concern an indvidual's right to liberty, their right to a fair hearing and their right to respect for their privacy and family life.

The Human Rights Act 1998 is already in operation in terms of its potential impact and comes into full force in October 2000 local authorities, the health service, statutory bodies, trusts and in some cases charities will have direct responsibility for ensuring human rights are upheld, protected and enforced. The legislation will impinge on all providers of residential care.

The key areas where the legislation could impact on residents living in local authority care homes are:

Closure and transfer of residential homes

* Property rights (Article 1).
* Right to life (Article 2) - the implications for the care of elderly people subject to change of home from one sector to another could be raised under this article.
* No torture, inhuman or degrading treatment (Article 3) - the issue of continuity of care could be questioned under this article, especially where there are major staff changes and casualisation.
* Security and comfort of residents (Article 8) - the **right to respect for private and family life**. Article 8 may be applied in the case of a proposed closure of a residential home where the

decision is not in accordance with the wishes of elderly residents (Local Government Information Unit, not dated).

In the context of Article 8 it may be argued that to take away a person's home, and to disrupt someone who is frail or vulnerable, is a breach of the Convention. This would be particularly applicable if that person is not properly consulted and listened to, and if the alternative facility on offer is not as convenient for the individual's needs.

Only in exceptional circumstances will the courts allow a health or social service authority to break a verbal promise to a patient or patients that they will not be moved again and that their residential care home would be a permanent home.

Article 8 may also enable a challenge for working hours which prevent an employee from having a family life, such as changes in hours of work, extension of working hours or Sunday working.

Prohibition of non-discrimination

It is unlawful to discriminate in the provision of a service to anyone on any ground (Article 14). The Article states that we should be able to enjoy rights without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status. It therefore strengthens arguments against discrimination.

Implications for the City Council

The authority will for the first time have to respect and protect citizens' human rights. All decisions will have to be considered in terms of:
* the right to life
* freedom form inhuman or degrading treatment
* respect for privacy and a family life
* the right to a fair hearing
* the right to freedom of expression.

The precise impact of these rights will depend on the legal challenges brought by victims. One area expected to be challenged is whether a council can claim that lack of resources is a defence for not providing adequate care facilities.

Claimants may also be able to show that their relatives' right to life was breached, without having to prove negligence.

Areas related to care for the elderly which need to be considered under the human rights legislation include:
* Client information - how it is held, access to it , the client's right to know and disclosure.
* All inter-agency working arrangements.
* Personal responsibilities of staff.
* Resource issues, particularly the lack of resources.
* Best Value and Quality Framework.

All current and future legislation must comply with the act.

Part 7

Evaluation of options for the in-house service

Options appraisal

Under Best Value an assessment of options is expected for all services. The Scrutiny Committee proposal to transfer services to a trust is not considered in this context and we are not aware that the pilot review considered this option.

The real baseline for comparing options should be the continued management of the existing homes along with an action plan to resolve known problems.

Options available

The report by Knightsbridge C.S. briefly presented the following options, but not in the context of Best Value:
* Refurbishment; which could be carried out with residents remaining in occupation.
* Transfer to alternative ownership. This has been totally opposed by residents and their families.
* Private Finance Initiative. Rejected by the council.
* Houses in Multiple Occupation. Deregistration rejected.
* Independent management trust. Recommended with no supporting evidence.

The in-house option does not appear to have been satisfactorily considered in any detail.

Criteria to assess options

Given the report of the Scrutiny Committee, we propose that the council adopts the following criteria to assess options, following a comprehensive review involving residents, families, community organisations, staff and trade unions:

* Flexible, responsive and comprehensive services for the elderly in Birmingham.
* Choice of provision for the elderly.
* High standards and continuity of care.
* Highly skilled, committed and experienced staff.
* Adequate staffing levels and training programmes.
* High value attached to the contribution of women care workers with good employment conditions.
* Equalities mainstreamed throughout the service.

Comprehensive review of all services for the elderly

Residential, Nursing and Domiciliary Care services were part of the Birmingham's Best Value pilot. The council's Performance Plan 2000-2001 states that targets were set and efficiency savings achieved. The plan states that a comprehensive range of consultation techniques were used to listen to the views of users and partners in the provision of services. However, this is refuted by the Residents Action Group for the Elderly (2000).

The Service Improvement target set out in the Performance Plan*"We will adopt a new strategy to ensure our resources are used widely and that our Elderly Persons Homes meet modern standards and the requirements of the new legislation"* It is unclear how the strategy is to be developed. The initial Action Plan was geared to the reduction of unit costs. Cuts to staff terms

and conditions were rejected by UNISON after full consultation with members. The council is attempting to implement other parts of the Action Plan already.

Birmingham City Council should not take any decisions about the future of residential care until they have carried out a comprehensive review of all services for the elderly including all the residential care homes, day care, home care, and other related services. This should be carried out as a Best Value review involving residents and families of service users, staff and trade unions.

The review should take a broad view of the quality of service and take into account user and staff involvement, democratic accountability and plans for continuous service improvement. Whilst it is recognised that capital investment in residential care is necessary, the current emphasis on the physical standards of the homes is misdirected. A review also needs to consider and recognise the quality of care provided by staff - an area which will is being given much greater emphasis under Best Value.

We would also recommend that a strategic review commences in the autumn, with a clear timetable for involving residents, families, staff and trade unions in the review process with regular report back sessions.

Joint work with health organisations

There are increasing opportunities for joint funding and collaborative work with health organisations. We recommend that this is explored in terms of care services to the elderly as suggested by the Government. This may include, for example, integrated teams of health and social care staff. Funding options could also be explored through the programme of innovatory approaches adopted in the Health Action Zones.

The importance of local authority quality care

It is essential when examining residential care services to constantly return to the key advantages of in-house provision. These elements have remained important in the vast majority of local authorities where residential care continues to be run directly by the council. These elements will also be highlighted through the requirements of Best Value:

- Choice of provision for elderly; how will the needs of residents be met in the future?
- Quality of care requirements are labour intensive - how will the service be organised to recognise the importance of highly skilled and experienced staff?
- Good quality care is the prime motive of local authority provision rather than profit and market share.
- Integrated community care services.
- Public provision provides a benchmark for private and voluntary sectors.
- Good quality employment conditions in a sector noted for exploitation.
- Training, skill and care base within the service.

The council should recognise the key features of sustaining high quality services and an assessment be made of the wider social and economic consequences of alternative options for

the future of residential care in the city. The value of elderly care in Birmingham's residential homes has been well documented by R.A.G.E.(page 21 2000).

Assessment of the trust model

This report shows that the application of the seven part definition of Best Value (Centre for Public Services, 1998) in a framework to assess the extent to which the current arrangements highlight substantial problems.

Applying the Best Value regime to the Trust model

Definition of Best Value	Application to Trust model
1. Quality of Service	Identified through regular monitoring and inspection. No evidence of added value
2. Achievement of sector/industry best practice	No substantial difference. Economic instability.
3. Quality of employment and training	Not maintained to local authority level.
4. Implementation of corporate policies	Difficult to implement key policies
5. Democratic accountability not	Loss of accountability for employees and users. Community involvement limited. Trust meetings always public or open to scrutiny.
6. Cost effectiveness	Savings not achieved. Cost reductions have major impact on staff.
7. Social and economic equity and	Changes to employment policies and conditions of service have had wider social economic effect.

Appendix 1

Major providers of care homes in the UK, 1989-1996

Private	Year	Providers	Homes owned	Beds	Homes managed	Beds
UK publicly quoted	1989	20	138	6722	14	405
	1996	11	448	30,330	40	1866
Non-UK publicly quoted	1989	1	19	951	0	0
	1996	2	126	7,363	1	38
UK private company	1989	62	310	11,053	5	164
	1996	168	978	40,368	32	1065
Individual/partnership	1989	23	101	3,300	13	576
	1996	113	478	16,467	19	644
Provident association	1989	2	11	376	0	0
	1996	1	31	1,243	0	0
Not-for-profit	1992	38	741	231,139	9	232
	1996	142	1,465	46,240	24	536

Source: Laing & Buisson “Long Term Care Directory of Major Providers”.

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