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Cornwall Development Company

Care Sector Business and Skills Analysis

Final Report

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OXFORD BROOKES UNIVERSITY

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Cornwall Development Company

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1 Introduction

Cornwall Development Company (CDC) commissioned the Institute of Public Care (IPC) at Oxford Brookes University to undertake an analysis of businesses and skills within the care sector in Cornwall and Isles of Scilly (CIoS). The purpose of this analysis is to:

- Understand the current and anticipated future economic value and impact of the Care Sector in Cornwall and Isles of Scilly.
- Examine the market opportunities afforded by an ageing population over the next 20 years.
- Review the economic benefits of and market opportunities for supporting people with lifelong conditions into and towards employment and maximising independence.
- Report on the skills and support requirements of the Care Sector, both current and future.

The analysis included:

- A desk based review of policy, guidance, practice, data and market information – both locally and nationally.
- An online survey of providers within Cornwall and Isles of Scilly.
- A series of telephone interviews with providers.
- Telephone interviews with sector stakeholders including commissioners and FE colleges. A full list of participants can be found in Appendix 3 and the details of the survey in Appendix 4.

The following report outlines the findings from this research, which took place between September 2014 and January 2015.

2 The Care Market

2.1 Defining the care sector

The care market, for those not familiar with this sector, can be stratified in a number of different ways. For example by:

- Who provides care (private, public or voluntary as well as care provided by carers).
- The intensity of the care received (ranging from occasional support through to '24 hour' nursing care in a specialist setting).
- Location (care home, extra care housing, home care, day care).
- Staffing (from unpaid, untrained, volunteers through to social work and nursing staff).
- Who pays (the individual recipient, relatives, the local authority or any combination of these)?
- Whether the service is regulated or not.

For these reasons, trying to establish a typology of services which contributes to the whole social care economy is challenging. Therefore, the definition of 'care activities' used in this work is limited to 'paid for' care for adults, including residential care (with and without nursing), domiciliary care, and supported living.

Care activities are broadly linked to the Standard Industrial Classification (SIC) Codes' Division 87 (Residential Care Activities) and 88 (Social Work without accommodation for the elderly and disabled)[1]. However, clearly there are other activities and forms of provision which would normally be considered as care which come outside this definition as indicated in the table in Appendix 1.

2.2 Development of the care market

Over the last few decades social care provision has gradually moved from being delivered by the state into the voluntary and, in particular, the private sector. In the past, local authorities and the NHS were predominantly providers and often the only quality controllers of their provision.

By 2012/13 the vast majority of adult social care in England was being delivered by the private and voluntary sector (with around 92% of care home places and about 89% of domiciliary care hours purchased by local authorities being provided by the independent sector[2]).

[1] http://www.ons.gov.uk/ons/guide-method/classifications/current-standard-classifications/standard-industrial-classification/index.html
[2] Laing Buisson, Care of Elderly People Market Survey 2012/13 (percentage relates to 2011/12)

This shift has not been without its problems. On 11th June 2011 the shares of England's biggest residential care provider for older people, Southern Cross Healthcare PLC, were suspended from trading on the London Stock Exchange. Shortly afterwards Southern Cross, which operated 752 homes and looked after 31,000 older people, collapsed.

Although the market, working with central and local government ensured no older people were left without care, this sudden, and to some, unexpected collapse, led to market reforms being included in the Care Act 2014.

In considering the care sector it is important to recognise that this is not a 'free standing' market. For example, it is influenced by health and housing provision, by the availability of labour, by the price of land and by the extent of legislation and regulation. It is a sector which is far from traditional definitions of a 'free market':

- The local authority as purchaser is also on occasions a provider of the same commodity although without the same constraints, ie, competing with others in the market on price.
- There are many sellers and only one, or few, purchasers – most often the local authority. Although there are a number of self-funders they are not always effective as consumers, ie, making hurried purchases in distressed circumstances.
- The recipient of the service may have very limited choice of the services available to them.
- Providers may have little choice of who they deal with given that the majority of the market is made up of small businesses with little capability to trade far outside their own local authority area.
- Given the power of the local authority as a purchaser they have the capacity to enforce terms and conditions on providers which may make it harder for those providers to survive.
- An external party, ie, the regulator has the power to terminate care businesses, either directly through the regulation of poor practice and noncompliance or through increasing the 'cost' of regulation which can mean some small providers leave the sector or are deterred from entering it.

In 2014 IPC carried out research on behalf of the Care Quality Commission (CQC), which investigated the stability of the adult social care market in England[3]. As part of this project IPC interviewed a wide range of providers and other key stakeholders as well as analysing the financial performance of some of the larger adult care providers in England. We came to the following conclusions:

[3] http://www.cqc.org.uk/sites/default/files/201402-market-stability-report.pdf

- Very few of the providers and financial advisors we interviewed ruled out the possibility of another Southern Cross style crisis. The gravest risk arises in relation to providers who run care homes but do not own at least some of the properties (leasehold at 50% was felt to be an acceptable level of risk).
- There is always the potential for a 'Winterbourne View' type failure to occur, ie, public exposure of poor quality care. As more than one provider stated, this is a low wage, often untrained, sector where there are a huge number of staff and often thin managerial lines of command. If you employ thousands of people in relatively closed settings there is always the possibility of something going wrong.
- Any further reduction in fees or maintaining the current standstill in fees is more likely to exacerbate such problems as all non-essential activities get withdrawn, ie, fewer competent managers, less training. Equally, a combination of an increase in the National Minimum Wage and a rise in interest rates could lead to an increased likelihood of financial crisis in the sector.
- In older people's residential care a significant indicator of viability is average length of stay. The more this lowers, the more vulnerable providers become as the total amount of time when there are empty places will increase.
- Any increases in regulatory requirements hit smaller providers disproportionately hard because they do not have the infrastructure or spare resources to implement them.

Traditionally, care has either been purchased by local authorities on behalf of people who have identified social care needs; or by individuals who are not eligible for state funding. The emphasis is now shifting to one of greater choice and control, through personalisation, personal budgets and direct payments, and a role for the local authority in facilitating a care market for everyone who needs care – not just those which it funds directly. People's expectations are changing, seeking solutions that support them to remain within their own homes for as long as possible through community based interventions and care which encourages and allows them to be active citizens within their own communities regardless of the level of their need or complexity of their condition.

These developments have often been slow and piecemeal, pursued by some local authorities but not by others. To speed up and unify a personalised approach to care, the government has introduced the Care Act 2014, which will have a significant impact on the sector and in the next section we will explore the key features of change and the impact these might have on providers.

2.3 Conclusion

- The delivery of care is predominantly a private sector activity.
- It is a market with permeable boundaries between health and housing both of which can considerably influence who enters which element of the care market.
- As Southern Cross demonstrated, the market has its vulnerabilities. These are only likely to increase as and when state funding for social care diminishes further.
- Provider failure can occur not just through financial risk, but through revelations about the poor quality of care. Reputational risk in this market, particularly given its distributed delivery and low staff qualifications, is significant.

3 Demographic Change

3.1 What does our population look like now?

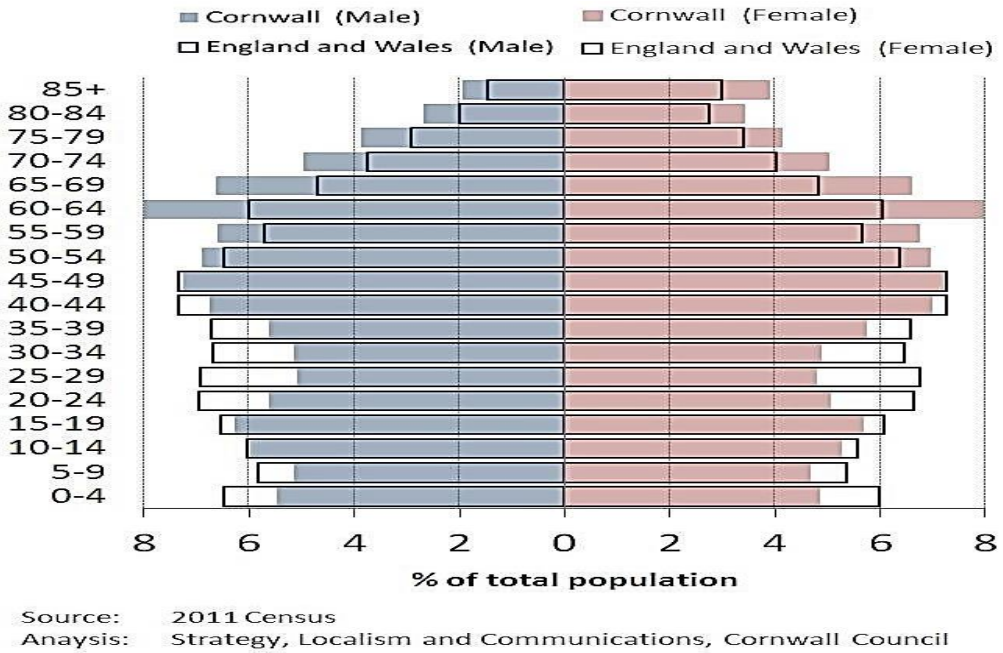
The population of Cornwall and the Isles of Scilly in 2014 was estimated to be 548,800 people. Table 1 below shows how that population is broken down by broad age group. Of the above figure some 2,200 people live on the Isles of Scilly.

Table 1: CloS population estimates 2014[4]

Age group	Cornwall		Isles of Scilly	
	Population	Percentage	Population	Percentage
Under 18	104,600	19.1%	500	22.7%
18 – 64	312,900	57.3%	1,100	50.0%
65 and over	129,100	23.6%	600	27.3%
Total	**546,600**	**100%**	**2,200**	**100%**

Figure 1 below shows the age structure of Cornwall's population (solid bars), compared to England and Wales (outlined bars). The percentage of the population in each age and sex group is shown.

Figure 1: Population pyramid for Cornwall by age and sex, 2011[5]



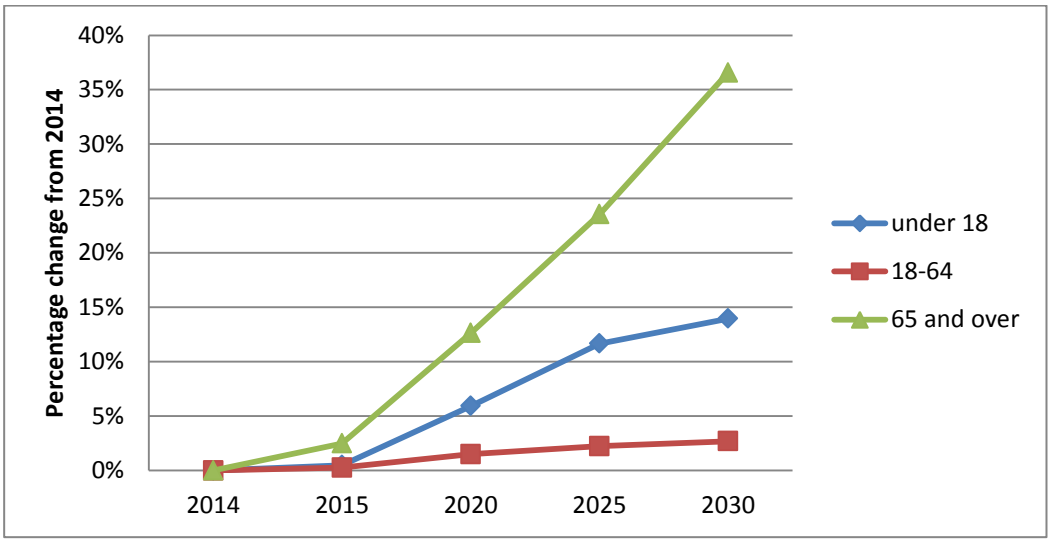
[4] www.poppi.org.uk version 8.0 and www.pansi.org.uk version 7.0.
[5] Cornwall Council http://www.cornwall.gov.uk/council-and-democracy/data-and-research/data-by-topic/population/

The figure shows that more women are living to the oldest age groups than men, and that the age/sex structure for Cornwall is different to that of England and Wales. At the top end of the pyramid, above the age of fifty, there are more older people in Cornwall than the national average. There are lower proportions of working age people, particularly those aged 20-44 years, and lower proportions of children and young people under 18.

3.2 What will our population look like in the future?

Figure 2 below shows population projections for Cornwall from 2014 up until the year 2030. The projections show that, if current trends continue, the total population will grow up to 18% by 2030 (see Appendix 8). However, the greatest rate of growth is in older people within the County, with an increase of 37% for those aged 65 and over. The biggest increase by far is for the age group 80 and over: projections suggest a dramatic 81% increase by 2030.

Figure 2: Population projections for Cornwall, all people, 2014 - 2030[6].



In contrast, the population of the Isles of Scilly is expected[7] to decline over the next 15 years, in particular amongst the 45-54 and 65-69 age groups[8]. Therefore as Table 1 and Figure 2 both illustrate there is a considerable growth in the population aged 65 and over. This is likely to have the biggest impact about ten years from now, as the population aged 65 to 75 moves into oldest old age.

[6] www.poppi.org.uk version 8.0 and www.pansi.org.uk version 7.0.
[7] www.poppi.org.uk version 8.0 and www.pansi.org.uk version 7.0.
[8] Caution should be exercised with these figures. Population projections are made to the nearest 100 people. In the Isles of Scilly this is forecast as a drop from 400 people to 200 people for those aged 44-54, and from 200 to 100 for those aged 65-69.

3.3 What factors affect demand for care?

Demographic change is not directly in proportion to demand for health and care services or public expenditure, eg, in recent years the number of older people in Cornwall receiving state funded care as a proportion of the population has fallen, but not as swiftly as South West comparator[9] authorities or the Isles of Scilly[10]. The relationship between demographics and care take up is a complex one. Pure demand can be influenced by personal behaviour, eg, smoking, drinking and eating habits and by the quality of health care and housing available to people. Actual demand, ie who arrives at the 'front door of adult social care' will be influenced by wealth, eligibility thresholds, public perceptions of state funded care and legislation.

Much of the demand for care services comes from older people and within the population aged 65 and over it is the population aged 80 and over that gives rise to the greatest demand for health and care services, particularly those living alone and with dementia. Specific points to note are (see Appendix 8 for more details):

- The number of older people living alone is forecast to increase considerably by 2030, particularly among the over 75 age group, from 28,900 in 2015 to 46,400 in 2030.
- The number of people forecast to live in care homes is expected to increase over the next 25 years, with the most growth in the 85 and over category accordingly.
- As the number of oldest old people increases, so too do the numbers of those unable to care for themselves, and the number of oldest old people providing unpaid care. As a report by the International Longevity Centre notes[11] "*Whilst life expectancy may have shown a strong tendency to increase over time, healthy life expectancy and disability-free life expectancy may not show the same rates of improvement".*
- The number of people with dementia is projected to continue to grow, from around 9,000 now to nearly 15,000 by 2030.
- The number of owner-occupiers is higher among the younger age bands, which may influence self-funder numbers in the next decade.
- As noted in Section 6, Cornwall already has an above average proportion of people in receipt of Carers Benefits.
- The number of people with learning disabilities, including those with more severe learning disabilities and thus more likely to be in receipt of services, is not forecast to increase much. The most notable growth

[9] The South West Comparator authorities used were Devon, Dorset, Gloucestershire and Somerset.
[10] NASCIS RAP P1
[11] Linking state pension age to longevity, David Sinclair, Kirsten Moore and Ben Franklin, International Longevity Centre,2014

among the number of people with learning disabilities will be in the older population as better healthcare and support enable more people in this group to live to older ages.

- The number of adults with a moderate or severe physical disability is not likely increase much over the next 15 years.
- Long term predictions of populations with a mental illness are notoriously difficult given its wide prevalence in terms of conditions such as depression and also as recognition and treatments of conditions can radically change.

A further unpredictability in the CIoS population is the number of second homes. The South West in general has an estimated 57,000 second homes, the highest in the United Kingdom. Figures[12] suggested that there were almost 14,000 dwellings in Cornwall that were categorised as second homes in 2012.

Second homes are an issue in a number of ways. The high cost of houses is partly due to the number of second homes in Cornwall although the impact of this varies from area to area. They make predicting the number of people who may retire to an area difficult, and they are often in the case of Cornwall waterfront properties that are not necessarily accessible to older people.

3.4 Conclusion

Cornwall, like most South West authorities, has a high proportion of older people within its population, a number that is forecast to grow considerably over the next ten to fifteen years. The greatest demand for health and care provision is likely to come from the oldest old population, ie aged 80 and over. This is further exacerbated by potential migration into Cornwall from people who retire to the County and from second home owners choosing their Cornish property to live in as they age. Where one partner in a relationship dies then people who have migrated to Cornwall may be left without familiar community support that they might have enjoyed from friends and family prior to their move. Some of that isolation may come simply from the fact that Cornwall is also remote from the main centres of population.

However, migratory populations should not just be seen as a problem. It also needs to be recognised that the second home owning population that migrates to permanent residence in the County is likely to be more affluent and affluent pensioners in early old age spend more in the local economy on entertainment and social activities as Table 2 below shows.

[12] Cornwall Council (2012) Second and Holiday Homes Housing Evidence Base Briefing Note 11"

Table 2: Differences in spending by comparative wealth[13]

Actual and proportion of spend by pensioner couples if dependent or not on state pension (65+)	Spend per week if dependent on state pension £s	% of total spend	Spend per week if not dependent on state pension £s	% of total spend
Food & Non-alcoholic drink	47.50	18	53.60	14
Housing, fuel &power	36.70	14	41.60	11
Transport	25.70	10	43.40	11
Recreation and culture	41.90	16	80.80	21
Restaurants & hotels	14.10	5	27.00	7

See http://www.ifs.org.uk/elsa/report06/ch9.pdf

Affluent older people are also more likely to fund their own care provision if needed in older old age. In addition, in line with the rest of the country, the highest number of volunteers is normally to be found amongst the younger old age population.

Therefore, notwithstanding the caveats mentioned at the start of this section about no direct correlation between the growth in the older persons population and the demand for care there is every reason to suppose that pressure on health care, on social care and on housing suitable for older people will grow, and grow considerably, over the next ten to fifteen years in Cornwall. Current attention tends to focus on meeting demand and doing so through service reconfiguration eg, integration of services. In the future it may be equally as important to look at how service provision reduces demand.

[13] Taken from the ELSA studies on old age 2012.

4 Legislative and Regulatory Changes

4.1 Care Act 2014

Nationally, the care sector is about to undergo significant change as a consequence of the implementation of the Care Act 2014. Key provisions in the Act that are relevant to the business and skills analysis of the adult care market in CIoS include:

- A new duty to promote the wellbeing of individuals, and a duty to promote integration between health and social care services.
- A new framework of responsibilities in relation to the provision of social care and in the provision of support for carers. This includes:
    - New requirements to assess and meet the needs of carers.
    - A single national test of eligibility for local authority involvement in arranging and funding care.
    - A requirement for local authorities to offer deferred payment to people who wish to delay paying for their residential care.
    - All people to have personal budgets for their eligible care and the offer of a direct payment.
    - A cap on costs that people will be charged for their eligible, assessed needs.
    - Provisions which will increase transparency about costs of care.
- Local authorities are now required to ensure that all adults in their area with a need for information and advice about care and support are able to access it.
- A requirement to arrange for the provision of preventative services, ie, services which will reduce, prevent or delay the development of need for care and support.
- New requirements for local authorities to manage provider failure, although informally most authorities have done this for some time. The Act requires local authorities to ensure that the needs of people continue to be met if their care provider becomes unable to carry on providing care because of business failure.
- A requirement that local authorities ensure there is a sufficiency of supply of care and support in their area and that the local care market is sustainable.

Implementation of the Act will occur in two stages. The majority of implementation will run from April 2015 with the sections regarding finance from 2016. It is probably not until 2017-18 that the full impact of the new legislation on the providers will begin to become clear. Therefore, the material below is an assessment of how the Act might impact on care

providers in CIoS, given that most of the Act's provisions mainly concern duties on the local authority.

Eligibility – The Act divides eligibility up into two activities. First, assessing whether a person is eligible for care and support using the new national eligibility framework. If a person has eligible needs, there is then a second assessment of finances which defines what the local authority will pay and what the individual will pay towards their care and support. For providers this may create short term delays as local authorities manage what may be considerable demand for assessments, particularly from those who are self-funded and already in care homes or in receipt of home care. Secondly, the new arrangements may mean local authorities arrange (but not necessarily pay for) more people's care and so may play a greater part in selecting care provision.

Self-funders – Many older people in care homes are self-funders or at least make some contribution to their care costs. It has long been suspected that care homes subsidise state funded residents by increasing the price that self-funded residents, or those with a third party top-up, pay. With greater visibility of pricing it is possible that the differential between the state funded price and the self-funded price will become eroded. In the longer term this may mean some providers exit the market. In addition, more care users are likely to be coming to providers with direct payments for their care. This may mean the market both engaging in more advertising to attract users, but also finding ways of managing increased invoicing arrangements where a wider number of people are acting as de facto self-funders.

Market oversight – The Care Act makes significant changes to the market oversight regime. For large providers, of which a number are present in Cornwall, they will be required to regularly report their financial state of health to CQC. Local authorities will also have a duty, for any provider that fails and has a service in their area, to maintain continuity of care for the individuals receiving that service, regardless of whether they are state funded or not.

Market shaping or facilitation – In addition to the safety net role of market oversight, the Care Act also sees the local authority taking a wider steering role towards the care market in their area. This includes effectively mapping future potential supply and demand, estimating the numbers of self-funders within their area, ensuring choice of quality care for users, that there is a sufficiency of supply and maintaining good contact with providers. *"Local authorities should have effective communications and relationships with providers in their area that should minimise risks of unexpected closures and failures"*[14] .

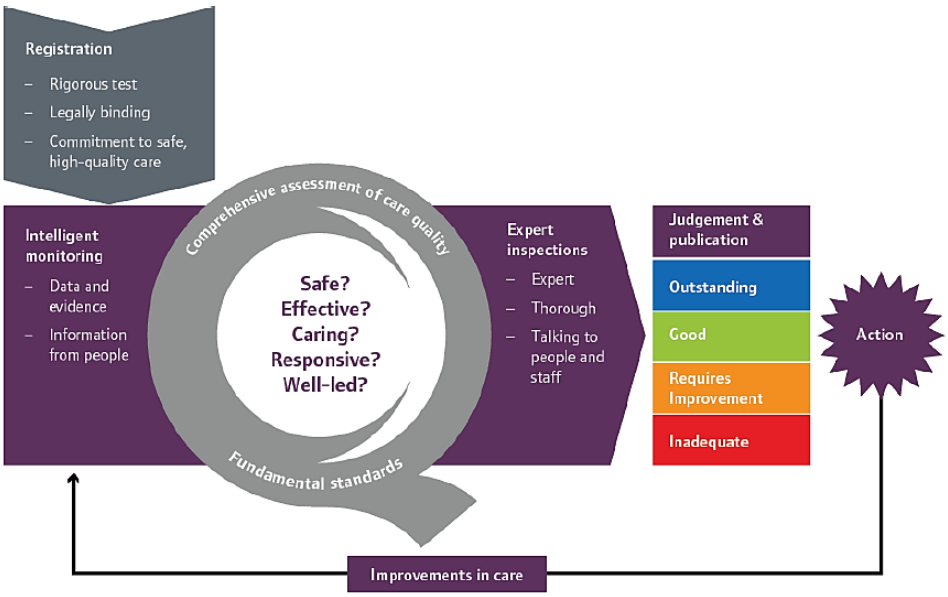
[14] Section 4.36 Care and Support Statutory Guidance, Care Act 2014, Department of Health, 2014

Fairer contracting – Many providers have complained that local authorities enforce harsh contractual terms or unfair costs. In recent years this has led to a spate of judicial reviews. Local authorities now have a duty to take into account the impact of their pricing policies and terms and conditions. Section 4.31 of the statutory guidance states: *"When commissioning services, local authorities should assure themselves and have evidence that contract terms, conditions and fee levels for care and support services are appropriate to provide the delivery of the agreed care packages with agreed quality of care. This should support and promote the wellbeing of people who receive care and support, and allow for the service provider ability to meet statutory obligations to pay at least the national minimum wage and provide effective training and development of staff... Local authorities should have regard to guidance on minimum fee levels necessary to provide this assurance, taking account of the local economic environment"*.[15] It is interesting that this is the first time staffing arrangements of providers have been linked to the price the local authority will pay, although we have yet to see what impact this may have.

4.2 Changes to the regulatory regime

Providers of care services will also have new standards to meet. In the recent past CQC has judged providers to be either compliant or non-compliant. The regulator is now returning to a system of grading providers. As Figure 3 below shows there will be five tests for providers to be measured against, ie, whether the service is: Safe, Effective, Caring, Responsive and Well-Led and four grades against which CQC will report: Outstanding, Good, Requires Improvement and Inadequate.

Figure 3: New CQC care standards process



[15] Section 4.31 Care and Support Statutory Guidance, Care Act 2014, Department of Health, 2014

Changes to the inspection regime have been suggested for some period of time, not least of all by providers who argue the old star rating system allowed them to demonstrate the quality of their service as compared to others; good or outstanding ratings can form the basis of positive marketing material that helps providers stand out from other services. CQC are also suggesting there will be tougher criteria for new registrations of care providers.

"… for new services wishing to be registered and existing services that wish to vary their registration…. [CQC]…will undertake assessments to ensure existing and potential services have the capability, capacity, resources and leadership skills to meet the relevant statutory requirements, and are therefore likely to provide people with safe, effective, caring, responsive and high-quality care"[16].

This is likely to mean additional costs and pressures on providers of the new regime, such as the one off cost of completing a Provider Information Return (PIR). Services requiring improvement or given inadequate ratings will see inspection costs increase as they will be inspected more regularly. Services without a registered manager for long periods of time without good reason are likely to see increases in costs resulting from fines or other sanctions. Whereas better performing services may find reduced levels of scrutiny from commissioners.

Appendix 5 indicates the level of performance expected of services rated good or outstanding. The difficulty for providers in meeting the new standards is balancing the quality required with a falling price from local authorities combined with ongoing difficulties in recruitment. Many care homes recruit staff from Eastern Europe[17] and elsewhere to maintain a labour force at a price that is affordable.

4.3 The integration agenda

Greater integration between health and social care has been a central tenet of policy and practice for a number of years. Since 2012 it has gained greater momentum with the Health and Social Care Act 2012 and the Care Act 2014 placing reciprocal duties on the NHS and local authorities to actively promote and develop integrated services where there is perceived benefit to the outcomes for the service user.

[16] CQC (2014) Changes to the way we regulate and inspect adult social care: Final regulatory impact assessment

[17] In 2010 Skills for Care last reported that 25% of the 34,600 care workers supplied to care operations for employment during the last year were from overseas and that overseas workers accounted for 31% of the estimated 74,000 temporary workers placed in care operations in the last year. A third were of Eastern European origin with Poland alone accounting for an estimated 16% of all overseas care workers. http://www.easterneuropeans.co.uk/recruitment/carers.php

In the last year much of the integration agenda has focussed on improving community services and a £3.8 billion Better Care Fund (BCF) was announced by the Government in June 2013[18]. The fund is a 'mixture of new and existing funding some of which is transferred from the health service to a new budget controlled by the local authority and designed to reduce emergency admission to hospital and protect social care' through integrating local provision. It gives greater control to local authorities and potentially paves the way for more radical changes[19]. Cornwall has an allocation of £12.8 million from the BCF for 2014/15 and £42.47 million in 2015/16.

Cornwall is already one of fourteen Department of Health 'Pioneer' sites, as part of the BCF initiative, with the aim of improving health and wellbeing; improving people's experience of care and support; and reducing the cost of care and support through greater integration. 15 health and social care organisations from the NHS, the Local Authority and the community and voluntary services across Cornwall are involved.

The concept was first trialled in Newquay in 2012, when 100 people were supported by this new way of integrating care. The Newquay Pathfinder claims to have reduced hospital admissions, improved people's health and wellbeing and saved money. The approach is now being used in West Penwith.

Cornwall has also developed enhanced alarm and monitoring systems through the "My Alfi" system provided by BT Cornwall. Based in the county, it provides telecare, telehealth, telecoaching and teleconsultation, aspiring "*to become the first truly joined up, fully managed assisted living service provider born out of the NHS and Social Care*"[20]. Alfi (Assisted living for independence, formerly Cornwall Lifeline) is a partnership between BT, Cornwall Council, Peninsula Community Health and Cornwall partnership NHS Foundation Trust. However, few of the providers questioned as part of this project knew of the system.

4.4 Conclusions

The care sector faces a number of considerable challenges over the coming years: a reduction in state funding for care; new legislation to be introduced; new regulations governing care providers; and a rising population of older people. Alongside this is uncertainty over how integration between health services and care provision may work.

[18] See http://www.local.gov.uk/documents/10180/6391705/Better+Care+Fund+-+Revised+Planning+Guidance.pdf/d58c0de0-c283-46f8-adfb-2628e6273b37

[19] For example the proposed changes to health and care in Greater Manchester will create a Greater Manchester Health and Wellbeing board which will bring together, 10 local authorities, 12 clinical commissioning groups and 14 NHS partners. See http://www.bbc.co.uk/news/uk-england-manchester-31615218

[20] https://www.myalfi.com/professional-services

The challenge for care providers is ‘how do they position their business for the future’? In terms of residential care, what is the optimum size of the business and what is the best balance between state funded residents and those that self-fund? Providers need to be able to evidence what outcomes their services deliver and how they can help to prevent demand in line with the Care Act 2014.

Therefore, the next two sections of this report look at care provision within the county and at the labour force available.

5 Business Analysis

5.1 Overview of provision

There are currently 357 CQC registered social care providers[21] operating in CIoS. There are 253 registered care homes in CIoS, nine of which also provide domiciliary care, and one of which is located on the Isles of Scilly. The breakdown of the type of care homes is shown in Table 1 below.

Table 3: Type of care homes

Type of care home	Number of homes
Registered care homes with nursing	58
Registered care homes without nursing	190
Registered care homes with dual registration	5
Total	**253**

There are 110 registered domiciliary care providers[22]; 7 of which appear to be registered to do so in the context of extra care housing[23]. 15 of the domiciliary care organisations are registered to provide services to both adults and children. One organisation provides services only to young people with a learning disability[24]. 1 service (Addaction, which has 6 branches in Cornwall) only works in connection with people who suffer from substance abuse. For example, supporting adults and young people to recover from drug and alcohol addiction both in a "residential rehab" setting, or while remaining in their communities.

In terms of size, whilst several provider organisations are classed as micro-enterprises, 89 of the 357 providers listed are treated by CQC as being part of a group that is large enough to be considered a 'brand' where there is a franchise or group structure of homes. These undergo an additional inspection of the franchise or group to ensure there is no systemic failing across the group. Of the brands in Cornwall, 66 are care homes whilst 23

[21] Data as at 2nd January 2015

[22] The CQC system of registering providers for certain activities and also for certain "service types" can lead to discrepancies, for example most but not all domiciliary care providers are registered to provide "personal care" and are also registered under "service type Domiciliary care service" but some organisations are registered only under "personal care" and some only under "service type Domiciliary care service". Eg in Cornwall Brandon Trust at Olympus House is registered to provide "personal care" and supported living but not "Domiciliary Care". Bowden Derra Domiciliary Support Services is registered as "service type Domiciliary care service" but not under "personal care". For this report we have counted organisations that are either registered as providing "personal care" or under "service type Domiciliary care" as providing domiciliary care.

[23] carehome.co.uk, Housing and Care 21. One home of which is due to open in June 2015.

[24] Oakwood Court College

provide other registered care services. Examples include Cornwall Care, Barchester Healthcare, SCOPE, Leonard Cheshire Homes, Anchor Trust, Bluebird Care, Brandon Trust, Livability and Methodist Homes.

5.1.1 Residential and nursing care

In respect of older people, Cornwall has consistently paid below the national average for residential and nursing placements, most recently £439 per week for residential care in 2013/2014 compared to £654 in Devon, and an average of £538 nationally[25]. Payment for nursing care costs £498pw in 2013/14 (£22 less than five years before). The Isles of Scilly has very high costs for residential care at £955pw. There does not appear to be any evidence to suggest that fees are lower in Cornwall because costs are lower. Cornwall also spends a lower proportion of its social care budget on older people (48% as compared to a regional average of 54% and a national figure of 51%). It has been the Council's policy[26] to "reduce the relative number of Care Home placements and increase the number of people that can have their care needs met in their chosen accommodation".

For other service user groups, the trend of low costs for residential care costs also applies. Some individual points of note are given below, with further detail in Appendix 7:

- **People with a learning disability.** Contrary to other authorities, the number of adults with a learning disability in residential care in Cornwall has risen in the last five years, although a marginal decline is now taking place. The numbers of adults with a learning disability in nursing care in Cornwall is similar to comparators with 5-10 individuals accommodated.
- **People with mental health needs**. The number of adults with mental health needs in residential care is broadly in line with comparators. Similar to other service user groups, unit costs are lower than comparators at £417pppw. Comparators' unit costs ranged from £513pppw in Devon to £652pppw[27] in Dorset. There are no adults[28] with mental health needs in nursing care in Cornwall.
- **People with a physical disability.** There has been a pronounced fall in unit costs for residential care in the last few years, from a high unit cost of £1,134pw in 2011/12 to a very low one of £559pw in 2013/14. The closest comparator authority is Devon, paying over £200 more per week at £768pw. Numbers of people with a physical disability in

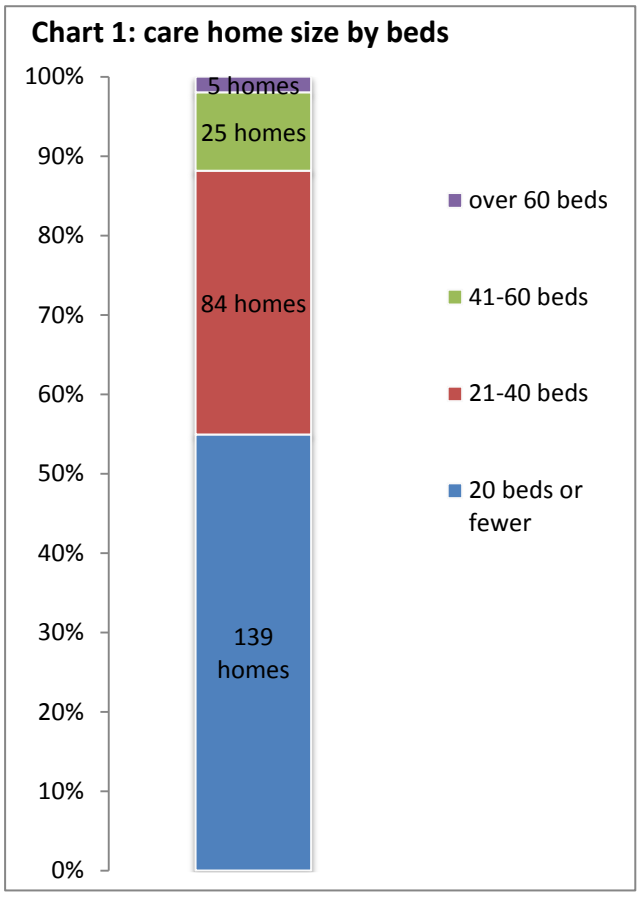
[25] NASCIS PSSEX Unit Costs 2013/14. See Appendix 7
[26] Cornwall County Council, Care Home Commissioning Strategy 2012-2015
[27] The unit cost of residential care for adults with mental health needs in Gloucestershire is £1990, a clear outlier amongst the comparator group and therefore not referenced as part of the comparator range here.
[28] NASCIS does not record numbers under 5 individuals, and therefore there could be a few adults with mental health needs in nursing care who are not recorded in NASCIS reports.

nursing care are on the high end of the comparator group in Cornwall. Unit costs here are very low at £475pw in 2013/14, the lowest they have been for at least 5 years.

Whilst on the surface, it might appear that commissioners in Cornwall are getting a 'good deal', low fees can mean:

- Lower wages for staff, fewer or less skilled staff employed.
- New providers and investors more reluctant to enter the care market.
- More self-funding residents being expected to 'top up' any shortfall in the business model.

Residential care in Cornwall is predominantly delivered by a range of small providers. There are a total of 5,624 beds across Cornwall in 253 care homes registered with CQC. 195 of these identify themselves as care homes, and 63 as nursing homes[29]. The significant majority of these are registered to cater for more than one service user group[30].



There is one residential care home for older people in the Isles of Scilly with up 14 registered beds available. This care home does not provide nursing care. If someone on the Isles of Scilly requires nursing care they have to move to Cornwall to receive it, or receive nursing care at St Mary's Hospital.

As shown in Chart 1, of the care homes within the County, over half have 20 beds or fewer, and nearly 90% have 40 beds or less[31]. The figures are of course for all groups of service users. Many of the small homes will be for people with a learning disability or autism with living

[29] 5 care homes are listed as residential and nursing care
[30] For example, only 50 homes catering for older people are only registered to cater to older people, the majority are registered to cater to other service user groups, predominately dementia, learning disability, mental health and physical disability
[31] Data from CQC website

in staffed accommodation (for example Spectrum and Mencap as described below).

Nursing homes have significantly more beds per home than residential care at 40.6 beds per home on average compared to 16.4 beds[32]. Over half of care home beds are in nursing care, despite less than a quarter of the homes being for nursing care.

Of the care homes in Cornwall approximately 74% are private sector, 1% are local authority care homes[33] and the remaining 25% are not-for-profit[34].

Table 4 shows that the majority of care home beds are in homes where the provider owns a single home. 26 providers own the 114 homes that are owned by providers with more than one home. Providers with more than one home make up 45% of care homes and beds, but only 15% of the total number of providers with homes.

Table 4: Numbers of care beds, homes and providers

Type of care home	Number of beds	Number of homes
Providers with a single home	3,081	140
Providers with more than one home	2,557	114

Source: CQC

Table 5 and Table 5Table 6 below show the largest providers in CIoS. The size of care homes is influenced significantly by the service user group to whom they are intended. For example, Cornwall Care is the provider with the largest number of beds, with 671 beds in 17 homes. Spectrum (Devon and Cornwall Autistic Community Trust) have more homes (21 homes), but a fraction of the beds (112 beds) as they provide specialist homes. Similarly, both Green Light PBS Limited and the Royal Mencap Society both have 6 or more homes making them two of the largest providers in CIoS under this criteria, but have a low number of beds per home.

The tables show the diversity of the care home market in CIoS, but also the need to be cautious in how care homes are counted and categorised when seeking to establish a 'picture' of the market given the number of small specialist homes which distort the picture. The tables also show that half of the largest providers have homes both with nursing and without in their portfolio.

[32] Averages exclude the 5 homes that are registered to provide both care with nursing and without nursing. The difference may in part be explained by registered homes for people with a learning disability being much smaller.
[33] CQC data indicates that there are 3 local authority care homes in Cornwall and one in the Isles of Scilly.
[34] Carehome.co.uk

Table 5: Largest providers by number of beds

Provider Name	Portfolio (with nursing, without nursing, mix)	No of Homes	No of Beds
Cornwall Care Limited	Mix	17	671
Morleigh Limited	Mix	6	239
Barchester Healthcare Homes Limited	Nursing	2	207
Swallowcourt Limited	Nursing	3	194
Cornwallis Care Services Limited	Mix	4	133

Source: CQC

Table 6: Largest providers by number of homes

Provider Name	Portfolio (with nursing, without nursing, mix)	No of Beds	No of Homes
Spectrum (Devon and Cornwall Autistic Community Trust)	Mix	112	21
Cornwall Care Limited	Mix	671	17
Green Light PBS Limited	Without nursing	28	7
Morleigh Limited	Mix	239	6
Royal Mencap Society	Without nursing	44	6

Source: CQC

Residential and nursing care is not necessarily supporting people previously resident in Cornwall. The interviews conducted for this review showed that some people came from across the South of England to Cornwall, some for specialist care, eg, Barchester Healthcare's Kernow House Care Centre which provides care for people with Huntington's disease (as well as for other care users). However, older people also often move to receive care near their families, so a number of Cornish residents are also likely to leave Cornwall on this basis.

Nationally, the proportion of the 65 and over population in residential care has been decreasing over recent years, although mainly through a reduction in the number of state funded residents as compared to self-funders. Five years ago, Cornwall had one of the lowest proportions of state funded older people in residential care. Since then, comparator numbers in residential care have dropped, whilst Cornwall has maintained theirs. It consequently now has a relatively higher proportion of older people in residential care. In comparison, numbers in nursing care have fallen as per the national trend.

Throughout our interviews and survey responses care home providers highlighted a number of frustrations, challenges and risks within the care home market. These included:

- Lower than comparator authority fees paid by the local authority for both residential and nursing care[35], despite people often entering care with higher levels of need than ten years ago (see Appendix 6).
- Small profit margins resulting in an inability to reinvest in the business and improve care.
- A shift towards more community based services meaning that the dependency on residential care is weakening in some areas, or that people are presenting at the care home with higher levels of need, resulting in a higher turnover of residents.
- A shortage of good quality dementia care.
- A shortage of care for people with complex learning disabilities and challenging behaviour (either in a residential care setting or in community based services).
- That good quality provision is not always available for local communities and people are often reluctant to move further away due to the poor transport links and close-knit community ties.
- Concerns over the number of residential care home and nursing care home owners who are likely to retire or sell up in the next five years.

It could also be suggested that here is a lack of clarity about who benefits from residential care and hence who is best served by a placement there. The former County strategy talks of outcomes[36] but does not discuss what are the outcomes sought by a residential care placement.

5.1.2 Domiciliary care, supported living and community-based services

The domiciliary and supported living market has similarities to the residential and nursing care market in Cornwall. They both are often delivered by a range of small providers, with care commissioned on a spot-purchase basis. Community based services have a particular focus on supporting people to remain as independent as possible.

There are 110 domiciliary care providers in Cornwall and Isles of Scilly. Of these, 22 Domiciliary Care providers belong to 17 different ‘brands’, implying that the majority of domiciliary care provision is carried out by providers that are not part of a larger group.

[35] NASCIS PSSEX unit costs for people aged 65 and over in Cornwall for residential care were up to £200 lower than its comparator authorities in our analysis; whilst nursing care unit costs were up to £70 lower.
[36] Cornwall County Council, Care Home Commissioning Strategy 2012-2015 p21.

Table 7 shows the 'brands' delivering domiciliary care, and where those brands also deliver other care in Cornwall[37]. As client numbers constantly fluctuate these are not recorded by CQC. It is notable that a number of brands with a domiciliary care arm in Cornwall also have a care home in Cornwall.

Table 7: Large organisations that provide domiciliary care in Cornwall

Brand	Number of branches in Cornwall	Any additional Cornwall care provision provided by the brand
Acromas Healthcare	1	Primary Care Health Centre x 1 Primary Dental Care x 1
Addaction	1	Residential substance misuse treatment / rehabilitation x 2
Bluebird Care	2	None
Brandon Trust	1	None
Cornwall Care Limited	1	Care Homes x 17
Embrace	1	Care Home x 1
Guinness Care and Support Limited	1	None
HF Trust Limited	2	Care Home x 5
Home Instead	1	None
Lifeways Community Care Limited	1	None
Livability	1	None
Nurse Plus & Carer Plus (UK) Limited	1	None
Retirement Villages	1	Care Home x 1
Royal Mencap Society	2	Care Home x 6
SCOPE	2	Care Home x 1
Spectrum (Devon and Cornwall Autistic Community Trust)	1	Care Home x 21
United Response	2	None

Source: CQC

Domiciliary care provision in the Isles of Scilly is delivered through the residential home, Park House, which is registered to provide this.

Historically, Cornwall has had a low proportion of older people receiving community based services. Similar to residential care, as patterns of care have changed over the last years, Cornwall has changed less than most,

[37] There are no 'brands' delivering domiciliary care in Isles of Scilly.

now having high proportions of their older population in receipt of state funded community based services when compared to their comparators. Per head of population however, CIoS spend around 50% more on domiciliary care than their comparators. In contrast, they spend less than 5% of the money per head of population than their comparators do on equipment and adaptions at £48,000 per 100,000 population of older people. This is somewhat in contrast to their neighbours, Devon, who spend £3.6milliion per 100,000 older people. Unit costs of day care, home care and direct payments are broadly on the high end of average when compared against the comparator group. However, as CIPFA often state, these figures are somewhat suspect and depend on what amounts are included in unit costs and what is not.

Community based service provision appears to be rising across most client groups. More detail is provided in Appendix 7[38], but for example:

- 2013/2014 saw an increase of 270 additional adults with a learning disability receiving community based services, bringing the total to 1,775.
- Cornwall has extremely high numbers of adults with mental health needs receiving community based services at 7,200 – double that of Devon, and over 5 times as many as Somerset. In 2013/14 there was approximately one adult with mental health needs in residential care in Cornwall for every 100 receiving community services.
- The data indicates that adults with mental health needs last received direct payments in 2010/11[39], but that no direct payments have been used for this service user group since. Cornwall and the Isles of Scilly are joined by only two other local authorities in not using direct payments for people with mental health needs in 2013/14.
- Costs of community based services in Cornwall for people with a physical disability are in line with comparators.

Cornwall Council has identified a number of issues with the domiciliary care market, including a lack of capacity in some areas; rapid turnover of staff and providers struggling to respond to the changing agenda in relation to personalisation, early intervention and reablement.

Recent tendering exercises reduced the number of approved providers on the local authority framework contract from 66 agencies to 29[40], with the aim of improving the quality of services and enabling providers to look at more flexible approaches to care delivery. The move has generated concerns

[38] All data from NASCIS
[39] In 2010/11 there were 21 people with mental health needs in receipt of direct payment. In 2009/10 there were 337 people. For more information see Appendix 7
[40] With 41 providers on a sub contract list

amongst providers and Healthwatch Cornwall, who are working with Cornwall Council to look at the concerns in more detail[41].

The domiciliary care agencies we spoke to were concerned about: the nature of their contracts; low rates paid by the local authority; and the issues they had with limited time with each client. Providers that failed to get on the framework have doubts that they will remain in business.

One interesting development to note was the fact that agencies were also experiencing people coming to them with higher levels of need than in the past. In these cases providers often see themselves as now having to offer quasi-healthcare tasks, such as changing dressings and administering medication: which may have previously been undertaken by district nurses. However, these required greater skills and more training than providers had previously given, all of which add to the costs of the business (see also Section 6)

There are 12 supported living properties registered in Cornwall. All are registered to cater to older people and/or people with a learning disability, and other service user groups. The local authority has told us that "*demand for supported living far outstrips levels of supply from the current market*".

Shared Lives South West[42] operates in Cornwall with over 100 approved Shared Lives carers in Cornwall, supporting over 100 long term service users and 50 regular short break service users. There is a specialist short break service for people with dementia. They are currently expanding their services in all areas of Cornwall and are developing new Shared Lives services for people with mental health needs and parents with a learning disability.

5.2 Gross Value Added and the CIoS economy

Gross Value Added (GVA) is a long term indicator of the value of the economy in an area. It is the value of the products and services minus the cost of producing them. There are several ways of estimating the GVA of the Care Sector in Cornwall and the Isles of Scilly which we discuss below.

The ONS estimates that figures for the GVA of the CIoS economy as a whole was approximately £8,000 million in 2012[43]. The figure for Public administration, education, health was £1,911 million[44].

[41] Healthwatch Cornwall are producing a report that will focuses on the reported issues with the Framework and the effect it having with the carers and cared for. An interim report is expect in late February 2015, with a final report due in April 2015. In addition a review of the framework is planned as well as a Select Committee looking at how it is working.
[42] Shared Lives South West is registered in Devon, although operates a Cornwall office in Redruth. Consequently it does not show up in CQC searches for Cornwall.
[43] http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-339598

The most recent Skills for Care data[45] concludes that the care sector in England has a direct contribution GVA of £20billion and employs 1.5million people in total, of which CIoS employs 17,300. If we assume the GVA of the sector in CIoS is the same per employee as for England as a whole, then it is reasonable to assume the GVA for the sector in CIoS is £230million.

If indirect and induced effects are taken into account such as the sector's spend on goods and services, and wages spent, this adds another £258 million to the CIoS economy, bringing the total GVA to CIoS of the care sector to £489 million. It is worth noting that this may be an overestimate due to the low wage economy in Cornwall, lowering the GVA of the sector.

Indeed, figures from the Office for National Statistics[46] estimate that the GVA for the care sector in CIoS in 2012 was £161million[47], with residential care activities valued at £118 million and social work activities without accommodation at £43 million.

5.3 The financial structure of the sector

5.3.1 Profit margins

The financial performance of the sector is crucial to its continuing existence. Regardless of their governance, financial performance will be important to every provider, whether it is profit for shareholders, to ensure reserves, to reinvest and/or grow the businesses.

Providers were reluctant to share their annual turnover, despite assurances of confidentiality, although most stated that they expected turnover in the next financial year to be broadly the same as for the last financial year. Figures for turnover varied widely as would be expected from such a wide range of providers. However, when asked about profit as opposed to turnover, many of the providers whom we interviewed said that they were making almost no profit at the moment. This level of return is often despite the fact that some the providers in question are debt-free and are, therefore, not paying interest on loans or mortgages.

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44 http://www.neighbourhood.statistics.gov.uk/HTMLDocs/NUTS3GVAbyindustry/NUTS3MotionChart.html

45 Skills for Care (2013). The economic value of the adult social care sector in England. Last accessed 30th January 2015 at http://www.skillsforcare.org.uk/NMDS-SC-innovation-evidence-and-impact/evidence-impact/Research-reports/The-economic-value-of-the-adult-social-care-sector-in-England.aspx

46 ONS (2015) ABS 2011-2012 aGVA data for Cornwall and Isles of Scilly. Last accessed 12 February 2015 at http://www.ons.gov.uk/ons/about-ons/business-transparency/freedom-of-information/what-can-i-request/published-ad-hoc-data/business-and-energy/january-2015/index.html

47 Based around the SIC codes 87 and 88 – see Appendix 1.

This is particularly significant in the case of residential care providers because their businesses rely on having the right sort of buildings and often have large overheads. The cost of rent or interest on borrowings is usually a substantial part of residential care providers' budgets (in England as a whole)[48]. If residential care providers who do not have borrowings or rent to pay are still not generating much profit from their homes it is a sign that fee levels are set at a level that is too low (see section 5.1.1). This may prevent new providers from committing to the level of capital investment required to enter the market and may cause the market to stagnate.

Providers need to make a profit (or in the case of not for profit organisations a "surplus") in order to be able to re-invest in the business, provide staff training, and support their business planning activity. Providers who are operating at a loss will eventually go out of business. If not operating at a profit they will find it much more difficult to access finance and so a vicious cycle of under-investment can occur[49] leading to poor quality services and increased risk of provider failure.

Providers in Cornwall told us that low fee rates affect the ability to attract capital investment and develop or improve homes. Homes in Cornwall they felt were below the standard in other parts of England.

5.3.2 Analysing accounts

As part of understanding the structure and size of the market, as well as its weaknesses and risks, we have looked at the accounts of some of the bigger providers of care in Cornwall. This includes a mix of providers who provide care in Cornwall and those which are large national care providers but only have a small presence in Cornwall. It also includes others who provide care extensively in Cornwall but do not provide much (or any) care elsewhere in the country.

The analysis has been very light touch and has been based around the ideas that financial stability in the case of not for profit providers depends on them generating a sufficient surplus each year to be able to re-invest in the organisation and that financial stability in the case of private, for profit, providers depends on them generating sufficient profits to be able to re-invest in the business.

We obtained comprehensive reports from Dunn & Bradstreet[50] for four well known private 'brands' which provide care in CIoS. These reports did not

[48] http://www.cqc.org.uk/sites/default/files/201402-market-stability-report.pdf
[49] Of course sometimes profits are siphoned out of a company as well as, or instead of, re-investment. This is not possible in the case of not for profit organisations.
[50] Dunn & Bradstreet provides commercial data about businesses and their credit history. It describes itself as "the world's leading source of commercial data, analytics and insight on businesses"

show any serious concerns. Three were given "green" risk indicators, ie, low risk. One was given "amber", ie, a moderate risk of failure.

5.3.3 Investment

Nationally, although some of the enthusiasm for investing in the care sector seems to have diminished since Southern Cross, there are still private equity investors and Real Estate Investment Companies (REITs) who have been, and look to be, prepared to enter the market. The rationale for this is a simple one: there is an ageing population, there is an increasingly affluent pensioner community, a proportion of the income received is state backed (and hence less likely to be subject to bad debts). Hence demand for care is likely to rise with a higher proportion of the market being occupied by self-funders. Therefore, this is a good market to invest in, particularly as an element of funding is state backed and hence less likely to default.

However, whilst this may attract some investors this is a simplistic view of what is a complex market.

- Margins in residential care and particularly domiciliary care are small. Therefore, to be commercially viable means either being at the premium end of the self-funder market or being able to deliver bulk across small geographical areas.
- The days of block contracts for services have considerably reduced, meaning that care providers have less dependable revenue against which to borrow. For domiciliary care there is an uncharted market of informal care (people who are paid to 'help') outside the regulated market. This depresses prices in the regulated market and also makes it harder to develop a self-funder business.
- With bank lending being restricted it may not be possible for people to enter the market as a care home provider if they have to borrow money to buy or build[51] a care home and in some instances homes that come on the market are too small to be viable anyway which is why they are being sold.
- Some private equity companies have found it hard to get a return on their original investment. HC One which took on many of the Southern Cross care homes found it hard to find a buyer and there are a number of indictors of potential instability ahead.

In addition to private equity funding and REITS, whilst providers say bank funding has been harder to obtain, some banks are still lending to social care businesses. For example, Lloyds Banking Group specifically refers on its website to its willingness to lend to social care providers. It states that

[51] Increasingly new care homes are new build. The cost of conversion of existing buildings, the lack of suitable buildings for conversion and improved standards for care homes, eg, ensuite, wheelchair accessible, etc, make buying an existing property increasingly unfeasible.

"*care providers will be better placed to provide the highest standards of care for the increasing number of elderly people they are receiving that suffer with dementia. Implementing long-term investment takes bravery and commitment from management teams, but Lloyds Banking Group is available to support businesses throughout their journey*"[52].

Not for profit providers may be able to benefit from sources of funding such as Big Issue Invest[53] and Impact Investment which both invest in social enterprises[54]. In addition, social impact bonds are slowly being used[55]. The Regional Growth Fund is another potential source of investment for the sector. Social housing providers often have assets and resources they can use to develop supported and extra care housing. However, all of these sources of funding are only "potential" until the particular project for which funding is required has been put forward. We were told by some care home providers that they have recently decided to raise money for expansion by selling land they owned rather than by borrowing because it was easier to arrange.

5.4 An assessment of the quality of care delivered

CQC suggest that there is a link between providers who do not have a registered manager and the delivery of lower quality care[56]. Many of the providers interviewed corroborated this, saying that "*good care is generated by good management*" and "*wherever you have a good service you find that the person at the top is good*".

Of the providers based in Cornwall, CQC data[57] asserts that 35 care homes did not have a registered manager at the time of reporting, 24 residential care homes and 11 nursing care homes. 17 domiciliary care providers did not have a registered manager listed on the CQC data. Proportionately therefore, nursing care homes are most likely not to have a registered manager in Cornwall. It is also worth noting that the CQC also found that "*people in residential (non-nursing) care homes tend to receive better care than those in nursing homes*"[58], although clearly wide variation exists. They also observed that smaller residential care homes tended to perform better than larger ones

[52] http://www.lloydsbankinggroup-cr.com/story/adapting-changing-demographic
[53] http://bigissueinvest.com/
[54] http://www.nesta.org.uk/get-funding/impact-investments
[55] For example MENCAP developed a SIB to help fund new accommodation provision through its housing arm. See https://www.mencap.org.uk/news/article/10-million-charity-housing-bond-launched-golden-lane-housing-and-mencap
[56] CQC (2014) State of Care 2013/14. Performance against quality standards was 10-15% higher for care homes with a registered manager than for those without. Care homes without a registered manager were more than twice as likely to be non-compliant than other care homes.
[57] 2 January 2015
[58] CQC (2014) State of Care 2013/14

We conducted an analysis of CQC inspections in 2014 for Cornwall. The format of inspections has changed in recent years so the recording of standards is not uniform. However, there were 1,003 outcomes inspected across 173 care homes under the old method of inspections in 2014. Of these 870 (87.24%) of the outcomes inspected were considered compliant, 128 (12.76%) non-compliant. Non-compliance was most commonly identified in the following areas:

- 13% of homes inspected were non-compliant in assessing and monitoring the quality of service provision
- 13% of homes inspected were non-compliant in their records
- 8% of homes inspected were non-compliant in the care and welfare of the people who used their services

The key issues which emerged from this brief analysis of CQC reports seem to relate mainly to the quality of management and a lack of leadership.

CQC identified particular concerns in their State of Care Report 2013/14 around workforce recruitment (particularly the shortage of nurses in care homes), performance on safety and safeguarding and ensuring that staff were suitably skilled. These are broadly in line with findings from Cornwall – with the care and welfare of people who use services clearly a safety and safeguarding issue. Challenges around the adult social care workforce in CIoS are explored further in Section 6, and echo national concerns from CQC.

It is too early to draw any conclusions about the new regime of inspections and what they tell us about care in Cornwall. So far, four inspections of properties have been recorded by CQC for Cornwall. Of these inspections, three were rated good overall, and one required improvement.

Relatively few domiciliary care agencies were found to be non-compliant. The reasons behind the non-compliance that did occur included poor record management, and a lack of skilled and caring staff.

Our interviews with commissioners echoed the inspection findings, indicating concerns around staffing, skills levels and about the quality of care provided in Cornwall, in particular about nursing care due to the difficulties associated with recruiting suitably trained staff (See Section 6.2 for further detail). Workforce is looked at in more detail in Section 6.

5.5 Conclusions

Making sense of the data about homes and registration is not always easy as, for example care providers can register for more than one category of user group even though they may never take anybody from that category.

However, in general care provision can be characterised in the following way:

- There are a few large providers of care homes and domiciliary care, but the majority of care is delivered by small providers who either only have one or two homes or, in the case of domiciliary care, where their business covers a very local area.
- Most of the sector is reliant on state funded care recipients, even those organisations that have a high proportion of self-funders still tend to say the business is not viable without state funded residents or care recipients.
- Many of the challenges facing the care sector in Cornwall reflect the wider national picture, including uncertainty arising from the legislative and regulatory changes. Further reductions in the price paid for care by the local authority would undoubtedly lead to some businesses exiting the sector.

The challenges are often compounded by delivering services in largely remote and disparate communities. Throughout our interviews, stakeholders discussed the issues they face delivering support across a largely rural County with poor transport links. This means care and support services are fragmented and it can be difficult to establish and grow businesses.

Strong local communities bring with them advantages in terms of offering opportunities for local community based solutions, but these are frequently delivered by small or micro-businesses who struggle to generate enough revenue to stay in business or improve services and find tendering processes hard to meet. It also means that more specialised care or services requiring significant upfront investment are often difficult to deliver due to economies of scale.

Providers spoke frequently about the challenges of operating in a highly regulated market, where the prices are set externally and where significant changes in procurement practice by the local authority can impact on their ability to deliver high quality care. Indeed, Cornwall appears to have a relatively low proportion of older people as self-funders[59] in comparison to national estimates and so by comparison to other areas there is a heavier reliance on state funded clients, leaving providers vulnerable to changes in public funding, commissioning practice and changes to eligibility criteria. The significantly lower fees paid by Cornwall may also lead to under-investment in the sector.

[59] Estimates range from 23% to 45% self-funders in residential and nursing care homes in Cornwall. Nationally, an estimated 45% of residents are self-funders. For calculations see Appendix 8.

Investment in recent years has been hard to come by through more traditional routes and hence the presence of private equity and real estate investors. Whilst without such investment the sector could be even poorer it does pose problems. Where ownership of the property is separated off from the ownership of the care business, as was the case with Southern Cross, then it becomes harder for the care business to raise finance because it is not property backed. Private equity may also be looking to adopt a quick 'buy and build' approach without investing in the long term development of the sector.

Finally, both national and local government says it wants innovation in the care sector, however it needs to look at how that is to be achieved. A viable care company may say "Why should I take risks?", especially if there is no shortage of business; a less viable company may be prepared to take risks but may seek to do so in ways that would be unacceptable.

6 Current Supply and Demand for Labour, Skills and Support

The Care Sector employs a diverse range of people, ranging from health and social care professionals such as nurses, social workers, and occupational therapists through to care staff and personal assistants. Understanding the structure of the workforce in the Sector is difficult, not least because defining what constitutes a care role can be confusing, but also because there are a wide variety of contractual arrangements from full-time positions within public sector organisations through to zero-hours based contracts and self-employment in the private sector. This is also further compounded by the blurred margins between health and social care, where different rates may be paid for very similar tasks and where health conditions such as dementia do not necessarily attract health care funding to provider care and support.

6.1 The National workforce

- The numbers of organisations[60] involved in providing or organising adult social care in England in 2013 increased by 1% from 2012.
- The total number of direct payment recipients continued to increase (by 11% between 2012 and 2013). The total number of direct payment recipients directly employing their own staff was estimated to have increased since 2012 (by 5%), with nearly one third of direct payment recipients directly employing their own staff
- In 2013 there were 1.31 adult social care jobs for every one whole time equivalent job.
- The number of adult social care jobs was estimated to have increased by around 2% between 2012 and 2013 and by 15% since 2009.
- Since 2009 the workforce continued to shift away from local authority jobs (-20%) and towards independent sector jobs (+20%), the personalisation of adult social care was also apparent with a large increase in the number of jobs for direct payment recipients since 2009 (estimated at +50%).
- The majority of the increase in adult social care jobs since 2009 came from an increase in jobs for domiciliary care services (up by 160,000 or +35%).[61]
- Nationally the role of migrant workers in the care sector has become increasingly important. It is estimated that one in four care workers are now non UK born.[62]

[60] The total number of PAYE- or VAT-registered whole organisations (i.e. enterprises).
[61] Skills for Care (2014) The size and structure of the adult social care workforce in England 2014.
[62] In 2009 Compass, The centre for migration studies, reported that, “The employment of migrant workers in care occupations has increased significantly in recent years. Almost one in five care workers and one in three nurses employed by organisations providing older adult care in the UK are foreign-born, with higher proportions in the South of the country,

6.2 The care sector workforce in the South West

Skills for Care, the national strategic workforce agency for care in England, published a regional analysis for the South-West in January 2015[63]. Although a regional analysis, the Skills for Care report provides a useful snapshot of the care sector and many of its findings were corroborated in our interviews for Cornwall, particularly low wages for care workers and difficulties in recruiting staff (especially nursing staff).

Regionally, the report estimates the sector employs around 135,000 whole-time equivalent staff (WTE) across residential, domiciliary, day and community care services. Of these the greatest proportion are within the independent sector, and the numbers of people employed through direct payments are increasing (3%, with the majority being employed for domiciliary care support). The vast majority of employment is to deliver direct care (74%), although estimates suggest that 11% are employed in managerial or supervisory roles. Only 7% across the region are employed in professional roles[64].

The residential care market is currently the largest social care employer across the South-West (56%), followed by the adult domiciliary care sector (33%). The remainder of employees are based in community care, day care or other care settings. The data suggests that the majority (89%) are employed on a permanent basis, but that 42% of these work on a part-time basis, and further 10% are neither full-time nor part-time[65].

Skills for Care state[66] that there is heavy reliance on zero-hours contracts in the South-West, with a propensity for these within domiciliary care services. National Minimum Data Set for Social Care (NMDS-SC) information is created or updated within the past 12 months and puts the median hourly pay[67] in the South West for Care Workers at £7.13 and Senior Care Workers at £7.79.

Recruiting and retaining care workers in the South-West may be an issue and is something that was backed up by our interviews in Cornwall. The regional analysis by Skills for Care suggests that 37% of care workers had started in the sector within the last three years, whereas over half of the senior managers/supervisors had been working in the sector since before 2002. The vast majority of staff are female (over 70% for senior

and among those recruited in the past two years. It is believed the number has risen since then. See http://www.compas.ox.ac.uk/research/labourmarkets/migrantcareworkers/uk/

[63] Skills for Care (2015) sector Adult social care and the workforce in the south west

[64] Total number of whole-time-equivalent (37 hours or more contracted) adult social care jobs by sector across the South West by service type and job role group *(Skills for Care 2013)*

[65] Skills for Care (2015) Adult social care sector and the workforce in the south west

[66] Skills for Care (2015) Adult social care sector and the workforce in the south west

[67] National Minimum Data Set for Social Care. NMDS-SC information is created or updated within the past 12 months

manager/supervisors and community support and outreach work; higher for other roles in care) [68].

The highest turnover rates are amongst care workers and nursing staff (over 30% in each case), with an estimated 2,000 vacancies for care staff across the South West.

Skills for Care[69] estimate the total number of adult social care jobs in CIoS as totalling 17,300, with 1,300 jobs in the local authority, 15,000 in the Independent Sector and 900 from direct payment recipients.

6.3 Employment, wages and the workforce in Cornwall

Cornwall is a low wage economy, but like Devon it has relatively high house prices. The Office for National Statistics (ONS)[70] shows that the annual, median gross pay for men and women in fulltime employment and resident in Cornwall was £22,246. For England as a whole the figures are £27,375.

Cornwall has a lower unemployment rate than the South West and Great Britain at 5.2%, compared to 5.3 regionally and 6.5 nationally[71]. Underlying this is a notable disparity by gender, which is far more pronounced than in regional or national figures. Whilst the overall unemployment rate is 5.2%, this breaks down to 6.1% unemployment for men and 3.6% for women. The proportion of adults aged 16-64 claiming Job Seekers Allowance (1.4%) is higher than the regional figure (1.2%), but lower than the Great Britain figure of 1.9%. Underlying these figures are seasonal fluctuations[72].

Cornwall has a high proportion of adults aged 16-64 in receipt of carers benefits (1.6% compared to 1.2% regionally and 1.4% nationally) and disabled benefits (1.4% compared to 1.2% regionally and nationally). It also has a significantly higher proportion of people claiming Employment and Support Allowance (ESA) and incapacity benefits (7.1% compared to 5.6% regionally and 6.2% nationally).

For all workers, median pay is lower in Cornwall than regionally or nationally at £10.41 per hour[73], compared to £12.13 per hour regionally and £13.14 nationally[74].

[68] Cornwall Council (2013) Cornwall's economy at a glance: January 2013. Of 25,798 individuals employed in "Caring, leisure and other service occupations", 21,396 are female.
[69] Skills for Care (2014) The size and structure of the adult social care sector and workforce in England 2014: Appendix 4
[70] http://www.ons.gov.uk/ons/rel/ashe/annual-survey-of-hours-and-earnings/index.html
[71] NOMIS for October 2013 to September 2014, using a model based approach. Last accessed 12th February 2015 at http://www.nomisweb.co.uk/reports/lmp/la/1946157349/report.aspx
[72] Cornwall Council (2013) Cornwall's economy at a glance: January 2013
[73] Excluding overtime
[74] NOMIS Earnings by Workplace (2014).Last accessed 12th February 2015 at http://www.nomisweb.co.uk/reports/lmp/la/1946157349/report.aspx

Overall, this paints a picture of a workforce that is proportionately less healthy than the national data, with potentially[75] a higher corresponding proportion of carers. Employment is higher for women than men, potentially creating greater competition for jobs that attract female applicants.

Figures for the care sector in Cornwall are similar to the figures for England overall, with the median hourly pay for a Care Worker in Cornwall at £6.91 and at £7.55 for a Senior Care Worker. It should be noted that care workers are currently paid under the recommended UK living wage of £7.85. The median pay in the residential home in the Isles of Scilly was £8.23ph[76].

Several providers and other stakeholders interviewed for this project, were concerned about their ability to recruit into posts, stating that fewer people applied for each vacancy than 5 to 10 years ago. Where staff are "*working to benefits*" level some providers struggle to get people prepared to work unsociable hours, or do over-time.

Recruiting and retaining good quality staff was a constant challenge when care work is not seen as a good career option. Several people we spoke to thought this was partly due to how care is perceived (often as a "*last resort*"); whilst others suggested that schools and colleges should be encouraged to teach students that there are opportunities for career progression in the care sector. Some interviewees also thought this was more indicative of a vicious cycle in CIoS; where poor public transport infrastructure (see Section 5), combined with a low population density and low wages mean that some carers remain in low paid jobs and do not get promoted, because, to improve their career prospects, they would need to relocate or increase their travel costs.

Despite these challenges providers said that they were keen to retain staff and therefore paid them as much as possible, feeling that "*they deserve more*". Some providers told us that they pay their care workers the Living Wage (£7.85ph). Every provider asked said that if the fees that the provider received were to increase the provider would ensure that most of the increase was paid directly to staff.

Providers who pay over the minimum wage (£6.50ph) tend to retain their staff for longer. However, as the minimum wage rises, if fees and therefore provider incomes do not also rise it will be increasingly difficult for providers to maintain pay levels for their staff. The last minimum wage increase, for example, was a raise of 3%. In addition, any rise in national minimum wage rates puts pressure on the system, not just through increasing basic pay but

[75] Not all carers will be in receipt of carer benefits.
[76] National Minimum Data Set for Social Care based on 5 returns for the Isles of Scilly. NMDS-SC information is created or updated within the past 12 months

through managing differentials: if a care workers' pay is increased the people who supervise them will expect corresponding rises.

Staff turnover in Cornwall is marginally higher than the regional average for adult social care at 28.7% compared to a regional average of 27.5%[77]. Within the different sectors, turnover is highest amongst domiciliary care staff at 34.1%[78]. Also of note is the differential between turnover for Care Workers (which would include those working in care homes and in domiciliary care) at 36.9% and for Senior Care Workers at 12.5%. Some providers we spoke to said that they did not have a problem retaining staff, of these it was generally felt to be due to fair working environments and arrangements, good supervision and training and development opportunities.

Registered nurses have the highest turnover of any job role at 39.7%, above the regional rate, also high, of 37.2%. This ties into comments covered in Section 6.2 about the lack of nursing staff in general in the care sector and in Cornwall in particular.

Turnover figures for the Isles of Scilly are not recorded on the National Minimum Data Set for Social Care.

6.4 Training and development within the care sector in Cornwall

Within the South West, Skills for Care estimates[79] show that 55% of all adult social care workers have a social care qualification which is slightly lower than the English average of 57%. The majority of workers in professional job roles have a Level 4 or above qualification, whilst direct care staff have a Level 2 qualification. Of work based, minimum training standards fire safety, safeguarding and moving and handling are amongst the most common.

Further education (FE) includes any study after secondary education that is not part of higher education. Courses can range from basic English and maths to Higher National Diplomas (HNDs). FE also includes technical level qualifications and applied general qualifications, which have replaced diplomas and vocational qualifications[80].

Formal FE training and development opportunities in Cornwall vary considerably. There are recognised national qualifications as well as a range of provider specific and work-based training opportunities.

[77] National Minimum Data Set for Social Care based on returns for 6,123 staff in Cornwall.
[78] Although this is lower than the regional figure of 35.2%.
[79] Skills for Care (2014) Size and Structure of the Social Care Sector and Workforce 2014
[80] Definition and range from https://www.gov.uk/further-education-courses/overview. Last accessed 2nd March 2015.

Of the 3 main further education colleges in the County, two offer health and social care qualifications. These are Truro and Penwith College and Cornwall College (see Appendix 9 for a detailed breakdown). In addition, Cornwall College offers degree level training in health, community and social sciences.

Courses range in length from a few weeks through to 2-3 years, depending on the level of qualification. They are aimed at those intending to work in health or care, providing a range of competencies and techniques, personal skills and attributes for participants, and include apprenticeships. Some courses do not require formal entry qualifications.

Data around student numbers within further education is not routinely collected and published, making analysis difficult in this area. A proxy indicator can be used based upon Individual Learner Records (ILRs). Each student in FE has an Individual Learner Record within which at least one 'learning aim' is recorded from a choice of 38 different aims[81]. These 'learning aims' relate to the further education course being studied. We looked at students recording a 'learning aim' of 'adult social care', and used these as a proxy indicator for numbers of students.

Each 'learning aim' cannot be equated to one student studying towards one qualification in one year as one student could undertake a number of different courses in a year, recording an adult social care 'learning aim' for each course attended. Accordingly, this data provides a starting point for looking at the spread and variety of further education provision across FE colleges and independent training providers in Cornwall.

However, the majority of training for social care qualifications in Cornwall are not delivered by colleges but by independent training providers, some locally based, some based outside the South West. Given this mixed market of provision it is not possible to access data on how many students achieve certain qualifications in a given year). This raises questions about how this market can be shaped to deliver the training and provision needed by employers and service users. Further detail about providers and types of provision is given in Appendix 9.

The Skills Funding Agency divide up further education into three main elements depending on where/how the training is delivered, namely:

- Education and Training: Conventional, classroom based teaching and training.
- Apprenticeships: Apprentices are employed by their host organisation, with a Skills Funding Agency approved provider providing appropriate training.

[81] 38 different learning aims were available to choose from in 2012/13

- Workplace. Covering qualifications assessed in an individuals' own workplace. They are allocated an Assessor who visits them to carry out observations of their work and help them to identify relevant evidence of their competence in work.

These are explored below, together with Higher Education provision in the County.

6.4.1 Education and Training

The classification of 'Education and Training' covers a wide range of classroom based teaching and training, from a half day course on catheterisation, or a day course on dementia and end of life care, to courses that are delivered through apprenticeships such as Health and Social Care (Adults) for England (QCF) Diploma Level 2 and may take 12 to 15 months to complete.

Short course provision is dominated by two main providers, Acacia Training & Development, a private limited company based in Plymouth, and Cornwall College, between them delivering 340 of the 460 adult social care learning aims in 2012/13. Details of provision offered by both providers is given in Appendix 9.

6.4.2 Apprenticeships

Apprentices are employed by their host organisation, with a Skills Funding Agency (SFA) approved provider providing appropriate training. The curriculum is designed by Skills for Care[82]. There are three different types of apprenticeships funded by the SFA:

- Intermediate apprenticeships receive Level 2 training. Intermediate apprentices can be in range of roles including care assistant, supported living support worker, key workers in residential, domiciliary or day services, home care support worker re-enablement worker[83].
- Advanced apprenticeships receive Level 3 training. Examples of roles that apprentices can be trained in include care supervisor, senior support worker, social work assistant, or personal assistant.
- Higher apprenticeships receive Level 4 training and above.

There are many more providers delivering health and social care apprenticeships in Cornwall than for other types of FE provision. Table 8 shows the numbers of apprentices by the largest health and social care apprenticeship providers in Cornwall and at what level. It should be noted

[82] Recognised apprenticeships follow a set curriculum and are known as SASE (Specification of Apprenticeship Standards for England) apprenticeships.
[83] Further examples are given here https://www.gov.uk/health-and-social-care-apprenticeships

that this table records the participation, rather than 'success' of apprentices. A fuller version of this table is in Appendix 9.

Table 8: Health and Social Care Apprenticeship Participation by Sector Subject Area and the 10 largest apprenticeship training providers 2013/14

	Health and Social Care		Care Management & Leadership
	Intermediate	Advanced	Higher
Acacia Training And Development Ltd	65	28	3
Cornwall College	179	84	
D M T Business Services Ltd	59	85	
Focus Training (SW) Limited	28	19	
GP Strategies Training Limited	200	227	15
Learndirect Limited	13	12	
Marr Corporation Limited	334	156	22
Newcastle College Group (NCG)	72	78	
Skills To Group Limited	27	19	
Truro And Penwith College	39	26	
26 other providers	100	97	7
Total	**1,116**	**831**	**47**

Source: Cornwall Council/Local Enterprise Partnership

The Skills Funding Agency works with providers to agree numbers in an area, thereby determining the supply of funding for apprenticeships. It is our understanding that the SFA has recently begun to engage with employers. As the funding agency for further education, there would appear to be an obvious gap in communication with the local authority who are responsible for the facilitation of the care market. The care market is reliant on a supply of skilled staff to meet demand and changes in role demand in the future. If the SFA does not use this information, typically held in a market position statement, then the task of supplying a workforce fit for the future becomes all the much harder.

As a number of care providers are part of larger organisations, these often contract with apprenticeship 'providers' at a national level, thereby not necessarily using local Cornwall based providers to deliver the training.

Because the SFA contract directly with a training provider, the apprenticeship market is primarily driven by the training providers and

students rather than based on the needs of employers or a strategic view of needs from the local authority. Accordingly a comprehensive view of what is offered is difficult to obtain.

Not included in Table 8 above, but of interest, is Barchester Healthcare who are also a registered training provider with the SFA. In 2013/204 they had nine participating intermediate apprentices and two advanced apprentices, demonstrating that some larger providers have made a business decision to deliver 'in house' apprenticeships. Similarly, Acacia is the training arm of growing regional care provider, Somerset Care.

Apprenticeships can be held from age 16 onwards. Section 5 refers to poor public transport links in Cornwall. This poses specific problems to those who have not yet reached the age where they can get a driving licence, or cannot afford to learn, let alone maintain a vehicle. Wheels to Work is a scheme that loans mopeds for up to 24 weeks to people with a firm offer of work who have no public or private transport to suit their needs[84]. It is not clear to what extent this service is known, and hence apprentices are referred to it by providers or employers.

A typical apprenticeship allows apprentices to work four days per week and attend college or an in-house training equivalent, one day per week. The employer generally pays for the salary of the apprentice (with some help available from Skills for Care's Workforce Development Fund). The Skills Funding Agency funds the provider for the training provision, although for an apprentice aged 19-23, the employer may be asked to make a financial contribution. Apprenticeships typically last one to two years with a minimum hourly salary of £2.73ph for apprentices aged 16-18 or aged 19 or over and in their first year of an apprenticeship. All other apprentices are entitled to the National Minimum Wage for their age.

We have been told that it is hard to recruit students to care work with older people, with childcare and people with learning disabilities being more 'attractive' client groups for potential care workers. 'Care at Home' has been marketed as a route into nursing, with the attraction of a career path seeking to outweigh the bias against the client group.

6.4.3 Workplace

Workplace based learning covers qualifications assessed in an individuals' own workplace. Learners are allocated an Assessor who visits them to carry out observations of their work and help them to identify relevant evidence of their competence.

Examples of qualifications that can be achieved through this route are Health and Social Care (Adults) for England (QCF) Diploma Levels 2 and 3,

[84] http://wheelstoworkcornwall.co.uk last accessed 12th February 2015

and a Management (QCF) Diploma Levels 3 to 5. Typically these are qualifications that might also be obtained by apprentices as part of their training.

Appendix 9 shows workplace learning participation[85] for 2013/14 by provider. In 2013/14 138 students undertook health and social care workplace learning with the majority of provision coming from Cornwall College and DMT Business Services Ltd, a Cornwall based training provider.

6.4.4 Higher Education

As set out in Appendix 9 and above, Cornwall College and Truro & Penwith College offer a range of further education. Cornwall College also offers social care higher education qualifications as a partner of Plymouth University, with a similar arrangement starting imminently for Truro & Penwith College.

6.5 Current skills and qualifications

Our analysis of data from Skills for Care suggests that the level of qualifications of people working in adult social care in CIoS is better than for the South West as a whole (see Table 9 and Appendix 6). However, it should be noted that the table for Cornwall is based on returns for 3,628 jobs whereas Cornwall is believed to support about 17,300 jobs in total. This considerable gap is due to the fact that firms submit data voluntarily to Skills for Care.

Table 9: Current level of skills – across all job roles in Adult Social Care in Cornwall (total number of jobs: 3,628)

	Cornwall		South West
Group	Number of Staff	Proportion	Proportion
Any other qualification(s)	52	1.4 %	1.8%
Other relevant social care qualification(s)	526	14.5 %	8.7%
Entry Level or Level 1	14	0.4 %	0.3%
Level 2	927	25.6 %	21.9%
Level 3	617	17.0 %	15.8%
Level 4 or above	586	16.2 %	16.1%
No Qualifications Held	906	25.0 %	35.4%

Source: Skills for Care

[85] Numbers participating in the course will be higher than numbers who successfully obtain a qualification. Figures are not available for this later number.

The figures for the South West and England as a whole, show that 65% and 68% of care workers have a care qualification of some kind. The figure for Cornwall shows that 75% have a care qualification of some kind.

The figures for the Isles of Scilly, show that less than 60% of care workers have a qualification (see Appendix 6). However, given that the numbers are small (32 people) making any long term conclusions is not sensible as this could go up or down fairly rapidly.

Despite the choice and variety of formal qualifications across Cornwall nearly everyone we spoke to said that formal qualifications were not necessarily an indication that a person would make a good care worker.

Employers stated that they valued a good work ethic and "*the right sort of attitude*" in their staff more highly than formal qualifications. Several said that they recruit based on "*values*". The job is very "*hands on*" and requires a wide range of skills including empathy, the ability to solve problems, task based working, time keeping, and patience. Most providers said they were prepared to train staff when they arrive, including, in some cases, providing them with help to learn basic literacy and numeracy skills; whilst others felt that some care staff came into the career with poor experiences of formal education and learnt more effectively from work based learning.

Skills for Care in the wake of the Francis Inquiry will be introducing this spring a new basic level Care Certificate primarily designed for health care and social care assistants. It will replace the Common Induction Standards and the National Minimum Training Standards and is primarily focussed on new staff. Currently, CQC regulated care providers must ensure that new staff are trained to comply with the Common Induction Standards within their first 12 weeks of their employment.

6.6 Size of the future workforce

Skills for Care states[86] that the sector employed 1.5 million people in 2013, and by 2025, it is estimated that another 300,000 to 800,000 workers will be needed to meet England's growing social care demands. The same relative increase[87] would mean that the current estimated workforce of 17,300[88] in CIoS in 2013 would need to grow by between 3,400 and 9,400 workers to

[86] Skills for Care (2014) Size and Structure of the Social Care Sector and Workforce 2014.
[87] Workforce numbers required to deliver care will vary by type of care delivered, service user need, and other variable local and national policy and budgetary factors.
[88] Skills for Care (2014) Size and Structure of the Social Care Sector and Workforce 2014: Appendix 4. Last accessed 26th January 2015 at http://www.skillsforcare.org.uk/NMDS-SC-intelligence-research-and-innovation/NMDS-SC/Workforce-intelligence-publications/The-size-and-structure-of-the-adult-social-care-sector-and-workforce-in-England.aspx

up 26,700[89]. The CIoS Local Enterprise Partnership highlights the need to increase and upskill the workforce:

"Health and care…is a strong employment sector but it is struggling to recruit and develop new talent from entry to management level. With an ageing population who expect a high standard of care, increased skills at all levels are required."[90]

National trends over recent years[91] show a large increase in the number of domiciliary care jobs, including new jobs in independent sector CQC regulated non-residential services, and new jobs for direct payment recipients. Jobs in residential services have declined.

6.6.1 Future GVA value to the CIoS economy

Using the estimated size of the future workforce in the previous section it is possible to make an estimate of GVA to the CIoS economy by 2025. This is presented below in Table 10, taking into account the different definitions of GVA and the potential range of size of future workforce.

Table 10: Estimated future GVA of adult social care sector in 2025 (using Skills for Care figures)

	Estimated size of workforce	Estimated direct contribution GVA	Estimated indirect and induced effects GVA	Total GVA
CIoS 2013	17,300	£230 million	£258 million	£489 million
CIoS 2025 (Lower estimate)	20,700	£276 million	£309 million	£585 million
CIoS 2025 (Upper estimate)	26,700	£356 million	£399 million	£755 million

Source: Skills for Care

These estimates see the GVA of the sector rise to potentially £585 - £755 million by 2025. Clearly, increases (or decreases) in wages and fees in the future will have a notable effect on this.

Applying the same projected increases in workforce as above, but using an ONS GVA figures as a baseline, an alternative estimate of GVA in 2025 is

[89] Figures relate to actual jobs. National figures for whole time equivalent (WTE) adult social care jobs are 76% of this number.
[90] Cornwall and Isles of Scilly Local Enterprise Partnership at https://nationalcareersservice.direct.gov.uk/advice/planning/LMIMaps/Pages/South%20West/Cornwall-and-Isles.aspx. Last accessed 27 January 2015
[91] Skills for Care (2014) Size and Structure of the Social Care Sector and Workforce 2014

shown below. Clearly in all estimates the relative balance between residential care activities and social work without accommodation activities are assume to stay the same. Our report suggests that this is unlikely to be the case.

Table 11: Estimated future GVA of adult social care sector in 2025 (using ONS figures)

	Estimated size of workforce	Residential care activities GVA	Social work without accommodation activities GVA	Total GVA[92]
CIoS 2012[93]	17,300	£118 million	£43 million	£161 million
CIoS 2025 (Lower estimate)	20,700	£141 million	£51 million	£193 million
CIoS 2025 (Upper estimate)	26,700	£182 million	£66 million	£248 million

Source: ONS / Skills for Care

6.7 Conclusions

There are a number of key factors concerning the care workforce that need to be drawn out from this section.

- This is a sector where the majority of staff are female, part time and part of an essentially transitory workforce with high turnover.
- Any low wage, unskilled labour force is more susceptible to changes in economic conditions, ie, when an economy is depressed they are the first group to lose employment, when it rises they are the first group to be increased. Therefore, the care sector over the last five years has been able to recruit staff either from the UK or Europe because other economic sectors have been less active. With further cuts in local authority expenditure and wider employment opportunities elsewhere, as the recession comes to an end, this could lead to an increasing workforce crisis for the care sector.
- 52% of care workers and 62% of senior care workers in the South West are aged 40 and over[94]. This is precisely the population that is under represented in Cornwall as Section 3, on Demographic change, of this report showed. Therefore, employers are always dipping into a smaller part of the local labour force or looking to recruit from within the

[92] Figures are rounded to the nearest million and therefore may not sum across rows.
[93] Assumes no change in the workforce between 2012 and 2013 for ease of comparison
[94] See page 20 of Skills for Care Workforce in the South West, 2015, http://www.skillsforcare.org.uk/Document-library/NMDS-SC,-workforce-intelligence-and-innovation/NMDS-SC/Regional-reports-2015/SFC-SWREGION-WEB.pdf

European community or wider labour markets. Restrictions on the ability of employers to recruit labour from outside the UK could have a significant impact on the care sector.

- When IPC conducted its study for CQC some domiciliary care providers indicated that who controlled the local workforce in effect controlled the care market, ie, the local authority could issue contracts and preferred provider agreements but if you did not have the workers available to deliver these, then the work would go to those providers who did have such resources available.
- Training and development seems to be somewhat confusing with few central drivers in the County defining what is needed. There are a plethora of organisations involved in delivering training and development at a variety of levels and qualifications.

Therefore, based on national trends, and the future market potential in Cornwall, we would expect to see:

- If extrapolated against the population trends then it would be expected that there is an increase in the size of the workforce (by at least 3,000 people over the next ten years). If the amount of state funding diminishes then an increasing number of these jobs may well be found in the private sector or in the informal labour market.
- Given the desire in the Care Act to increase the personalisation of adult social care services and, as above, given a further diminution in state funding, then there are likely to be more people self-employed either as personal assistants or working within the unregulated, hidden economy as 'domestic staff' but who take on care roles. Accordingly, the proportion of staff with appropriate qualifications is unlikely to increase.
- Again based on the desires of the Care Act the expectation is that more employment would be based within the community and on health and care prevention rather than in residential settings.
- At the same time as the above trends, given the desire to bring health, care and housing roles together, we would expect to see a rise in more senior care staff who take on a wider diversity of tasks. To achieve this would depend on restrictive practices in the health sector, which defines certain tasks as belonging to certain job roles, being relaxed.
- That wider diversity of tasks could also occur through the development of extra care housing and a more rehabilitative approach to community based services.

7 The Future

7.1 Challenges and characteristics of the care sector in Cornwall

- **Demographics.** Across England and true for Cornwall is the increase in its oldest old population (as identified in Section 3). People are living longer into old age but are not necessarily enjoying a greater number of disability free years. Although an increasing number of people, given pensioner wealth, are likely to be funding their own care it is still essential that all services focus on demand reduction. GP provision that tends not to recognise and diagnose incontinence or dementia, falls programmes that fail to pick up on frequent fallers, rehabilitation programmes that do not offer full recovery to stroke survivors are all likely to increase hospital admissions and peoples dependency on care services from known and preventable conditions. Commissioning residential services by bed days or domiciliary care by the hour does not incentivise providers to reduce demand.

- **Tensions in the market**. Providers interviewed as part of this project said that the low levels of fees paid by Cornwall meant that some providers operated at a loss. Some providers are looking to increase their proportion of self-funders who they can charge higher prices to, than those paid for by the LA. Whilst it is often argued by commissioners 'that they would say that', in an environment where fee increases have been less than inflation, where labour costs have increased and where we know there are market vulnerabilities, this would indicate a sector under pressure. Particularly, for domiciliary care providers issues around paying for travel time are also always an issue. It was not part of this project remit to examine whether there was evidence to suggest that the quality of care in Cornwall or the fabric of care homes was worse than other parts of the UK.

- **Care Act uncertainty.** As outlined in Section 4 there are a number of factors that may influence the care market in the future arising from the Care Act. This includes more people with some element of local authority funding, uncertainty over the long term impact of price differentials between state funded and self-funded users of residential care.

- **Direct payments**. Increasing numbers of people are choosing or being persuaded to take direct payments from the local authority. The intention was that direct payments not only gave people more control but also meant they would seek our more innovative approaches as to how their care needs could be met. Whilst this has happened in some areas of care, in others the payment has simply been used to purchase the same care service at a rate determined between the LA and the

provider. Further reductions in the amount an individual might receive as a direct payment is likely to mean more pre-determined purchases will take place. Direct payments also only work well if there is a labour force to recruit into personal assistant roles.

- **Use of technology** Use of technology has two potential ways in which it can impact on the care sector in the future. First, is through improving electronic data capture. Particularly in the provider arm of the care sector it is likely there will be a growth in web and app based technology for recording service user information and retrieving data, particularly across health and social care. Secondly, although there have been a wide variety of experiments in using technology few of these have been implemented extensively, other than community alarm schemes. We would expect to see an expansion of detection and warning equipment particularly for people with dementia over the coming years.

- **High costs of housing and land prevent buildings based development**. Housing and land costs militate against residential care and supported housing providers, as do bank limitations on lending. Particularly in Cornwall where there are a large number of costal building restrictions it inflates land prices and also leads to planning restrictions. Some local authorities are also concerned about developments increasing the flow of older people into communities and hence use planning controls to limit development, although the economic case that older people disadvantage communities is not proven[95].

- **Reduction in residential and nursing care**. In the interviews conducted for this project a number of the providers spoken to were planning to sell their homes in the next five years. Some currently envisage they will sell the premises (in some cases for re-development) instead of selling the business as a going concern. There can be a variety of reasons for this from regulations through to the home, if small, not being viable, but with limited potential for expansion. Any sudden loss of care home places could cause problems for both local authorities and self-funders.

- **Rural locations not attractive to workforce**. Providers working in rural locations find it hard to recruit staff, including those at management grades who are discouraged by housing costs. Poor transport links make it difficult for staff to move around without a car.

[95] See http://www.mccarthyandstone.co.uk/documents/research%20and%20policy/eia%20report%20-%20mcs%20final%20july%202014.pdf

7.2 Challenges and characteristics of the care sector in the Isles of Scilly

Obviously some of the challenges facing Cornwall also face the Isles of Scilly. However, the Isles have their own particular challenges, mainly a result of being a small island community:

- **Investing in prevention and early intervention**. Every local authority wants to do this, but on the Isles of Scilly, when crises are particularly expensive and traumatic, the business case is likely to be especially convincing. Preventative measures such as exercise classes for people at risk of dementia are recognised by IoS as a priority.

- **Achieving personalisation and choice and control**. At present the local authority is the sole provider of social care on the Isles of Scilly. Commissioners would welcome local people to setting up private domiciliary care businesses and other businesses to help residents have greater choice in how to spend their personal budgets. Concerns by potential providers over PAYE and administration can act as disincentive.

- **Delivering high level care 'off island'**. At present limited care is delivered on St Mary's (residential care and a GP led hospital). For acute care people have to go to Truro in Cornwall. Aside from being expensive, it takes people away from their community and support mechanisms when they are at their most vulnerable.

- **Integrating health and social care provision**. There is a desire to set up joint health and social care provision so that nurses from the hospital are involved in care in a new build residential home with residential care and nursing care being offered. The care workers could be trained as health care assistants. A new home could potentially provide for respite care; high level care; end of life care; dementia and rehabilitation.

- **Improved accommodation options for older people**. Commissioners identified in their draft Market Position Statement that there are limited options for appropriate accommodation for older people: 52% of older people in the Scillies do not wish to end their days in residential care[96]. Estimates of future supply and demand have identified that there is a shortfall in current supply that will rise over time. Investment in services that improve the liveability of people's homes, for example adaptations and assistive technology, are also options for the future.

[96] Council of the Isles of Scilly (2014) Market Position Statement (draft)

- **Skill gaps.** In the Isles there are gaps in advocacy; mental health professionals; and best interests assessors that will need to be filled in the future.

7.3 Commissioners' views of the future

Providers and commissioners[97] interviewed as part of this project considered that there will be increased demand for:

- Specialist services, eg, dementia services, autism services, nursing care, mental health service user accommodation[98].
- Alternatives to residential care eg for people with a learning disability: supported living, shared lives, core & cluster schemes and other models eg for older people: extra care housing and other models
- 'Help to live at home' services eg domiciliary care, services purchased through Direct Payments, day care, Acute nursing home services
- Carers services, eg, respite beds, carers support
- Integrated services, eg, Pioneer projects, extra care housing
- Greater use of telecare and telehealth technologies, where suitable, across all provision

Commissioners[99] would also like to see a growth in the development of extra care housing across the County. In general, Cornwall's joint Strategic Market Needs Assessment (SHMNA) completed with neighbouring authorities[100] indicated that there will be a sustained need for new housing to meet the needs of a growing. In total the SHMNA suggests that there will be a requirement for an additional 45,900 to 69,900 dwellings by 2031 to meet the demands generated by new household formation and the labour force demands of a growing local economy.

Commissioners felt there would be a decreasing demand for state funded residential care for both older people and people with a learning disability.

[97] Information from interview and supported by the draft Long Term Accommodation Strategy 2015-2018
[98] MH service users who are currently "staying in hospital for long periods as there is a shortage of appropriate accommodation" Cornwall Council (2015) Long Term Accommodation Strategy 2015-2018 (DRAFT)
[99] Cornwall Council (2015) Long Term Accommodation Strategy 2015-2018 (DRAFT)
[100] GVA/Edge Analytics (2013) Strategic Housing Market Needs Assessment Main Report: Plymouth City Council, South Hams District Council, West Devon Borough Council, Cornwall Council and Dartmoor National Park

9 Conclusions and recommendations

- **Market facilitation:** The Care Act identifies market shaping or market facilitation as one of the key roles that Local Authorities need to take on in the Care Sector. We see it as significant that Cornwall has yet to produce a Market Position Statement identifying how it will deliver this across the sector. Linked into this is the need to improve information for the public, again as required under the Care Act. This could be used as a vehicle to bring the County and providers closer together.

- **Innovation:** The Pioneer programme in Cornwall looks to be a significant development. However, there is a need for innovation across the care sector and in particular at developing a range of services needed to prevent hospital admission and people moving on towards intensive forms of care. At the moment there are few incentives on providers to deliver this (indeed as commented earlier in domiciliary care the incentives are perverse). If innovative risk are to be taken then the burden of this needs to be proportionately shared between commissioning bodies and the provider sector. Without this, innovation is less likely to occur. It is also likely that such innovation will need to be 'home grown', given that although there are a number of national providers of care present in the County it is hard to attract new providers, given Cornwall's geographical isolation and the potentially stretched lines of managerial command, unless you are already a provider in the South West.

- **Investment:** Alongside innovation comes investment. There are already examples of social enterprise in the South West but few examples in the care sector in Cornwall. In addition, it is worth exploring the potential of social impact bonds as a way of attracting investment. MENCAP report that their housing based scheme was oversubscribed very quickly. This may be because people view such initiatives as a cross between charitable giving and an investment and hence may prove popular if targeted at the right investor audience. If developed as venture capital it also attracts tax benefits to the giver.

  In terms of attracting investors in care both in terms of modernising care homes and in extra care housing, then the County needs to recognise that low fee levels in comparison to other authorities is bound to be a disincentive to providers to develop in the County. Some of this will also be influenced by the numbers and wealth of potential self-funders. The danger for the County is if the amount they pay for a care placement, either via a direct payment or via a contract, falls too low then the local authority will increasingly get squeezed out of the market.

- **Increase in roles to support Direct Payment recipients and self-funders as 'employers'**: Direct Payment take up can be limited due to recipients being unwilling to act as 'employers'. There is a growing

market in individuals and organisation dedicated to supporting service users to meet these obligations. Budget constraints on local authorities, coupled with changes in the Care Act make it likely that the relative self-funder population to local authority funded population receiving care will increase, potentially fuelling further demand for employment support.

- **Incentivising and encouraging volunteerism:** Traditionally, rural communities with older populations have always attracted a high degree of volunteerism, although some of this has diminished. First of all through people's perception that the state should provide and then through changed employment patterns, meaning people often have less time available. Again it would be beneficial if voluntary organisations, private providers and the local authority could work together to look at how it can act to stimulate volunteering. A number of authorities have explored how incentives can be used, such as through leisure centre or transport concessions and through schemes such as time banking etc.

  Volunteerism may also be a good starting point for recruiting a wider and more diverse workforce, based around values. The National Skills Academy for Social Care, Skills for Care and the charity MacIntyre have developed a values-based recruitment toolkit for employers[101]. This builds on research by MacIntyre to find the personality profile of the perfect care worker. It found that ideally the individual should be "*an introvert who likes to work in a structured environment and takes a low-profile approach in the workplace, yet is a confident decision-maker with a genuine concern for others*" Many CIoS providers, as mentioned in Section 6.5 said that they tried to recruit staff who shared their values. They considered that having the "right" values was more important for new staff than qualifications or experience. Skills for Care[102] also has an online toolkit for recruitment called 'Finders Keepers' as well as resources to help care providers recruit and retain disabled people and older workers.

- **Changing job roles:** There is a strong argument for supporting the creation of new roles working across professional boundaries and supporting integrated delivery[103]. For example, there is currently a demand for more nursing staff, particularly in nursing care homes, and as people enter at a higher stage of acuity this demand could increase. CQC is recommending[104] more nurses in care homes. However, it is

[101] National Skills Academy et al (2014) Recruiting for values in adult social care. Last accessed 28th January 2015 at https://www.nsasocialcare.co.uk/values-based-recruitment-toolkit
[102] Skills for Care (2014) Finders Keepers. Last accessed 28th January 2015 at http://www.skillsforcare.org.uk/Finding-and-keeping-workers/Practical-toolkits/Practical-toolkits.aspx
[103] Institute of Public Care / Skills for Care (2012) Evidence Review: Integrated Health and Social Care
[104] CQC (2014) State of Care 2013/14. Accessed at

still hard to attract nurses to work in the care sector even where there is greater availability of such staff.

In general, as more people remain in the community with a higher level of need so the tasks of both home care staff and as a knock on effect, care home staff, become more complex. For example, ten years ago care homes would have dealt with many frail older people but who were still mentally alert. Now they will deal both with people who have a higher degree of frailty and a far higher proportion with dementia. Skills and salaries have not kept pace with this change. Our interviews found care staff increasingly taking on nursing tasks. Domiciliary care managers stated that they increasingly perform health related skills. This needs to be recognised and planned for across the sector.

This is particularly important in a rural authority where the costs of delivering professional care in the form of nursing, occupational therapy and physiotherapy are higher given the amount of time taken in travelling. Given that the Pioneer programme is expected to have a significant impact on the delivery of care in the community if it expands across Cornwall and the Isles of Scilly as a whole, the need for transferability of skills will only increase. Therefore the need is to train and develop staff that can perform para-health skills under appropriate supervision. This is not only care staff but could also involve personal trainers delivering falls programmes, and heating engineers warning where people are living in un-heated homes in winter. Such developments also of course help to stabilise the workforce and lessen turnover as it begins to offer greater career progression.

- **Identifying a workforce development strategy:** As identified in the section on staffing there is a plethora of training organisations working across the County at a range of different skill levels and qualifications. If not already in place there needs to be a County wide training and workforce development strategy, developed with and across the range of providers that takes the potential patterns of future demand and the skills required and develops an integrated approach to training procurement and delivery[105].

http://www.cqc.org.uk/content/state-care-201314. "*Encouraging more nurses to work in the care home sector should be a higher priority. In 2013/14, one in five nursing homes did not have enough staff on duty to ensure residents received good, safe care*."

[105] Skills for Care produced a national strategy in 2011 "Capable, Confident, Skilled: A workforce development strategy for people working, supporting and caring in adult social care", May 2011 see http://www.skillsforcare.org.uk/NMDS-SC-intelligence-research-and-innovation/Workforce-development-strategy/Workforce-development-strategy.aspx
An example of a local strategy can be found for Cambridgeshire, see http://www.cambridgeshire.gov.uk/downloads/file/1551/adult_social_care_workforce_development_strategy

Such a strategy also needs to explore how there can be a strengthening of, and an increase in, management skills. Recent CQC inspections highlight quality of management as a concern above any other issue. Combined with the CQC noted shortfall in registered managers in homes, and anecdotal evidence about the region not being attractive to managers, in part due to house prices, there would appear to be a broad development and capacity issue around suitable care managers in Cornwall. This could include care management development programmes[106], mentoring[107] and coaching, but also publicity around care as a career. Support with accessing affordable housing in rural areas could be considered, or allowances for moving to the area.

- **Technology:** In the preceding section issues concerning information technology were identified in two ways; one in terms of use of technological equipment to help sustain people in their own homes and secondly in terms of improving recording skills amongst care staff. Given the growth in the use of smart technology it seems unlikely that in the future care services will remain dependent on paper based recording. The LEP states that "all levels of staff will have to review and update their skills and abilities as the new ways of working in telehealth/care come in. Therefore, there is need for innovation skills but also the practical application of technologies from health/social care assistant roles."[108] This is not just an issue for training, although it does need to be addressed there but also about having relevant care software and apps that people can use. Some of this in the case of delivering medication or health checking needs to be by visual imagery rather than text. Given the rurality of the County the same is true in terms of linking remote sites and individuals to hospital and health centres, some of which the BT project is beginning to address.

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[106] Such as the Advanced Diploma in Leading Care Services aimed at care managers. For further information see http://ipc.brookes.ac.uk/courses/dev_programmes.htm
[107] For example, the National Skills Academy is starting to run a registered managers mentoring programme for social care providers, both those working in domiciliary care and residential care.
[108] Cornwall and Isles of Scilly Local Enterprise Partnership at https://nationalcareersservice.direct.gov.uk/advice/planning/LMIMaps/Pages/South%20West/Cornwall-and-Isles.aspx. Last accessed 27 January 2015