National Care Forum Submission to the Consultation on Transforming Public Procurement Green Paper – March 2021

Who are we?

The National Care Forum (NCF) is the membership organisation for not-for-profit organisations in the care and support sector. NCF supports its 130 members to improve social care provision and enhance the quality of life, choice, control and wellbeing of people who use care services. We are the voice of the not-for-profit care and support sector.

1. Summary of NCF's Response to the Green Paper on Transforming Public Procurement

1.1 Our response largely focuses on Chapters 3 and 5 of the green paper and has been informed by consulting our membership.

1.2 The ambitions within the green paper to remove bureaucracy, rationalise procurement rules and encourage innovation are very welcome but the measures contained within do nothing to grapple with the fundamental problems facing local government (and CCG) procurement and commissioning rules with regards to social care services. We suggest that more thought needs to be given to procurement rules involving the procurement and commissioning of services which care for people. As it stands, the green paper seems to be written for the procurement of products rather than services that cater for the wellbeing of people with all their multifaceted needs and desires. We must not conflate the two. Social care requires partnership based on a common purpose and shared values, rather than market transactions.[1]

1.3 The way in which 'social value' is defined in the green paper is skewed. The green paper conceptualises it as a top-down imposition defined by the contracting authority and informed by a forthcoming National Procurement Policy Strategy. This is problematic when talking about people related public services, such as social care, as it produces a model of care which is overly paternalistic rather than giving those receiving care and support the ability to choose the care they value. It results in the procurement and commissioning of services which do not actually meet the needs and wants of the people they are supposed to serve – nor does it equip social providers to provide effective care.

1.4 The NHS White Paper suggests that the Integrated Care Partnerships will co-produce the procurement and commissioning of health services with the local authority and health providers. Equal voice must be given to social care providers and those who need care and support in conjunction with Local Authorities and NHS contracting authorities. This needs to be written into the governance arrangements of any such a procurement arrangement. The proposals in the green paper do not currently encourage this style of co-production and partnership.

[1] https://www.transformingsociety.co.uk/2021/03/04/why-transforming-procurement-wont-transform-procurement-with-social-value/

1.5 Dynamic Purchasing Systems fly in the face of the principles which underpin the Care Act 2014. In practice, no matter the weightings given to 'social value' or 'quality', they are specifically designed to get services as cheaply as possible and ignore any sense of the individual being able to exercise choice and control over their care. Our strongly held view is that they have no place in the procurement of care services for people.

2. The Current Precarious Position of the Social Care Sector

2.1 Social care is facing an enormous funding crisis, which has not been helped by current procurement and commissioning practices. These have been exacerbated by the COVID-19 crisis. Prior to the COVID-19 crisis there was an estimated shortfall of £8bn per year in terms of funding for the sector. However, following the first wave of the pandemic, the Health and Social Care Committee called for an immediate increase in annual funding by £7bn per year to deal with the impact of COVID-19 and demographic changes **as a starting point.** It was recognised that significantly more was needed to improve access to social care and the quality of care. Despite this adult social care was conspicuously absent from the 2021 Budget.

2.2 The funding situation has been exacerbated over the last 10 years, where we have seen sustained cuts to local authority budgets with spending on local public services falling by 17%. This has had an impact on the procurement and commissioning of adult social care services, as cost savings have often been prioritised over choice and quality of care. As a direct result of the current, prolonged funding crisis we are seeing a big disconnect between the vison of personalised care envisaged in the Care Act 2014 and the reality of the personal experience of care of the millions who use it.

2.3 The increasing pressure on local authority (LA) budgets has resulted in a reduction in spending per person on adult social care services by around 12% in real terms between 2010/11 and 2018/19 (taking into account an ageing population). This is resulting in a postcode lottery in terms of access to care and choice of care as LAs grapple with their funding pressures. The ADASS budget survey highlights these pressures and how they have been exacerbated by COVID-19. In particular, they noted the fragile nature of their local social care markets and a concerning rise in the numbers of people with unmet or unknown social care needs by LAs. Moreover, only 4% of respondents to that survey felt that their LA budget would meet their statutory duties this year. The majority of NCF's members are also reporting that they are not getting sufficient financial support from their LAs.

2.4 These funding pressures inevitably puts the focus on the those with the most acute need for care, reducing the ability to enable preventative care and an earlier offer of help and support to those for it may well prolong independence and delay the increasing acuity of need.

2.5 The current funding and commissioning of social care presents real challenges to the individuals who need to use care and support services and their families. The focus of LA and CCG commissioning practice has, for many years, been to drive down the price of care, using things like Dynamic Purchasing Systems for bidding to provide packages of care, which restricts choice and puts huge pressure on the quality of care available. This commodification

of social care has done little to support a truly person-centred approach based on the needs, wants and circumstances of those who need it most.

2.6 The current funding system also puts huge burden on those who need care and support and are able to pay for their own care and support under the current means testing arrangements. It is perceived to be fundamentally unfair and creates a huge uncertainty and anxiety about the future costs people may incur and creates a complex system around costs of care at precisely the time when care is needed urgently, often as a result of a crisis. Unlike in the NHS, whether people receive help from the state depends not just on their level of need but also on their wealth. For those who need care and have assets worth more than £23,250, they will have to pay for it, and this includes the value of their house if they have one and if they need to choose a care home to meet their needs. So, while some older people will live the rest of their lives without needing social care, a significant minority – those with intense care needs extending over many years – may face hundreds of thousands of pounds in costs.

2.7 This is exacerbated by the unofficial 'cross subsidy' effect faced by many people who have to cover the costs of their own care as the state's commissioning approach is driving down the fees that the state pays for those who cannot afford to pay for their own care, which is resulting in an increase in costs for those who can. Analysis from the Kings Fund highlights that '*this cross subsidy can be significant: on average, a self-funder's place costs around 40 per cent more than one paid for by the local authority*.'

3. Response to questions in Chapter 3

3.1 In this section we respond directly to Qs 6, 8, 9, 10 and 11 of the green paper. A common thread running through our responses will be the need for much more thought to be given to the procurement of people related public services, such as adult social care, in the proposals outlined. The measures proposed may well work for the procurement of goods but will most definitely not work, in our view, for services designed to care for people.

Do you agree with the proposed changes to the procurement procedures?

3.2 While no-one can oppose the rationalisation and simplification of complex procurement procedures, we cannot support the proposed changes as they currently stand because they have not been written with people related public services, such as social care, in mind. The measures contained within do nothing to grapple with the fundamental problems facing local government (and CCG) procurement and commissioning rules with regards to social care services. More thought needs to be given to procurement rules involving the procurement and commissioning of services which care for people.

Are there areas where our proposed reforms could go further to foster more effective innovation in procurement? & Are there specific issues you have faced when interacting with contracting authorities that have not been raised here and which inhibit the potential for innovative solutions or ideas?

3.3 Yes to both. The green paper as it currently stands does not give a voice to the adult social care providers and those who receive care and support services in the procurement of services. The importance of social value needs to be at the centre of any procurement approach and that does not seem to the case in these proposals. The green paper has a skewed view of social value. It conceptualises social value as a top-down imposition by the contracting authority and informed by a forthcoming National Procurement Policy Strategy. This is problematic when talking about people related public services, such as social care, as it produces a model of care which is overly paternalistic rather than giving those receiving care and support the ability to choose the care they value. Consequently, there is the risk that LAs will agree to arrangements, or services, which are undeliverable, ineffective, or inappropriate, based on the funding constraints of the LA, or NHS, rather than being tailored to the needs of those receiving care and support.

3.4 The funding pressures illustrated in section 2 exacerbate this problem. All too often, LAs begin to procure services based on affordability alone rather than first seeking to understand what the needs and preferences are of those in their area. This often also ignores those who self-fund their own care. This is not the way we would like to see future procurement work, so we urge changes to the proposals that ensure people related public services like social care are procured differently. Current funding pressures and procurement arrangements inevitably put the focus on those with the most acute need for care, reducing the ability to enable preventative care and an earlier offer of help and support to those for it may well prolong independence and delay the increasing acuity of need. They also underestimate the scale of need in a specific locality. We need a model of procurement and commissioning which places those who receive care and support front and centre, alongside the local authorities and the adult social care providers.

3.5 Top-down procurement and commissioning practices which are heavily influenced by economic value (and funding pressures) are not conducive to encouraging innovation in social care as publicly-funded care packages will often be designed to do the bare minimum, constraining the social care provider from providing innovative care. There is also the challenge of anxiety from the public sector that helping to support providers in innovation risks a breach, in some way of state aid rules. The green paper talks about innovation in procurement from the point of view of encouraging scientific innovation and R&D. However, we think that the 'innovation-friendly culture' described in paragraph 88 is exactly what is needed by those procuring social care services. Rather than mandating specific solutions, we need to encourage creative practices, with a focus on outcomes rather than being purely output and cost focused. Local authorities need support to make this culture change. We also need some clarity on the implications of state aid rules as part of this.

3.6 The NHS White Paper suggests that the Integrated Care Partnerships will co-produce the procurement and commissioning of health services with the local authority and health

providers. We suggest that the model presented in this white paper for health services may be one to build upon for social care. Social care providers and those who need care and support should be enabled to work in conjunction with LAs and NHS contracting authorities to design the services that they want to offer/ want to use. This needs to be written into the governance arrangements of any such procurement arrangement and give a meaningful voice to providers, those who receive care and their families. The proposals in the green paper do not encourage this style of co-production and partnership. Any partnership needs to include both self-funded and publicly-funded recipients of care, and the providers who provide it, otherwise there will be an underestimation of need, and services will inevitably be procured that do not deliver what is required.

3.7 Such an arrangement will require greater transparency on the part of the contracting party – in this case, the Local Authority. It is important that LAs publish the logic behind their procurement exercises for social care, as well as their rates and the logic behind setting them at a specific level for each type of care. As part of this there should be a commitment to pay rates that enable providers to pay the Living Wage (our preference would be the Real Living Wage). LAs are relying on the cross-subsidy mentioned above from self-funders to cover the low rates they are passing onto providers for publicly-funded care packages. No matter the source of funding, the price paid for care should be the same to ensure its quality. We need a fair price for care.

3.8 Any changes to procurement rules will need to be followed by resource to facilitate training costs for contracting authority procurement teams and social care providers to ensure not just the letter, but also the spirit of the changes are embedded.

3.9 Some comments from our members:

- 'I would like to see more emphasis on the individual having choice, and something specific put in place to stop local authorities who run their own services steering everyone towards those services and not considering local independent providers.'

- 'Resident choice, don't treat them like cattle in the market place. Be realistic of individual care needs and therefore individualised costings'

- 'There should also be a genuine and legally enshrined right to choose for service users/ families. Determination of commissioning based on quality and outcomes not cost and output.'

- 'When a person is looking for placement the LA should contact the person's preferred provider as opposed to the provider making a bid. They should also take into account individual care needs and agree a fair cost of care.'

- 'We have one out of county placement from XXXX. They have opaque routes to request uplifts, no automatic process, it is difficult to contact their payment team, their remittance advice notes are impenetrable, they expect us to collect client

contribution and deduct any increase we get to single band FNC from their fee. Frankly they are a great example of how not to do it.'

- 'XXXXX have been trying to move residents out of care homes if they think they can purchase the care cheaper elsewhere, despite the resident and family being very happy with the care received. We are also automatically excluded from referrals if we do not consider their basic rate despite the needs of the service user.'

- 'Generally, some commissioners responding to out of area placements, request the care home/provider to enter into a new overarching care home contract prior to the placement taking place. This not only duplicates work previously undertaken but could also delay the resident's move. We have numerous commissioners, LA commissioners in particular, that don't bother to return the fully signed copies of the contracts for our records/files.'

- 'Poor communication / response is often a problem with LAs. Also, their tender processes are often late/delayed and then have short deadlines'

- 'Fundamentally the approach appears to be cost centred. Unless you provide a saving to the authority then generally nothing happens. Also, an ingrained fear in local authorities that helping support providers in innovation due to perceived state aid barriers.'

How can government more effectively utilise and share data (where appropriate) to foster more effective innovation in procurement? & What further measures relating to pre-procurement processes should the Government consider to enable public procurement to be used as a tool to drive innovation in the UK?

3.10 The section on 'Innovation in procurement' does not seem to have been written with people related public services, such as social care in mind. It is focused on science and innovation in R&D type environments. In our response to the previous question, we called for more innovative procurement and commissioning practices by LAs when procuring social care services. In order for this to work, there not only needs to be partnership and co-procurement and co-commissioning arrangements in place between LAs, social care providers and the recipients of care and support, but there also needs to be more effective collection and analysis of data and insight on potential and future innovation.

3.11 The first wave of the pandemic highlighted just how little data central government and local government held about adult social care – and in particular those who self-fund their care. In response DHSC adopted the Capacity Tracker and various local authorities created their own equivalents, all seeking to collect data from, care homes at first, and now the wider adult social care sector, in order to inform the response to COVID-19. The NHS White Paper seeks to builds on this by consolidating and centralising data collection from adult social care providers for DHSC and other parts of the health and social care system. The proposals in the

white paper certainly identify the problems in term of consistent and accessible data for social care, but a better solution is needed. It isn't enough for DHSC to simply centralise data collection.

3.12 We need more robust data collection and analysis which involves both social care providers and those accessing care. Improved data collection requires resource and a focus on the right data at the right time with a rounded analysis. Social care has been locked out of that during the pandemic with the Capacity Tracker data which is supplied by the sector being unavailable to us. This is an opportunity to build a shared view of what data matters and for us all to use it to improve what we do and create more informed procurement and commissioning practices. We need an approach which engages the whole sector in a specific locality – self-funders and publicly funded care. This will result in better outcomes for individuals and reduce costs in the long-run due to a more preventative approach which ensures that there are enough providers in a particularly locality meeting the needs of *everyone* – not just publicly-funded care - in that area. In our view, the green paper as it stands will not facilitate or encourage this.

4. Responses to questions in Chapter 5

4.1 In this section we respond directly to Q 25 of the green paper.

Do you agree with the proposed new DPS+?

4.2 Absolutely not. The proposed DPS+ model does nothing to change the fact that these systems are inappropriate for the procurement of social care services for vulnerable people. At the root of the problem, as illustrated by the language and descriptions used in chapter 5, is the fact that DPSs are designed for goods and intangible products, not the provision of care services which focus on the wellbeing of individuals. The green paper is in danger of entrenching some of the worst procurement and commissioning practices by local authorities by encouraging the use of DPS+ system for procuring social care services.

4.3 DPSs are now used widely by LAs and CCGs to procure adult social care services but represent some of the worst practice. No matter the weightings given to 'social value' or 'quality', they are designed to get care services as cheaply as possible and ignore any sense of the individual being able to exercise choice and control over their care. They encourage a race to the bottom in terms of cost and quality of care. In our view, they should **never** be used in the procurement of care services. This commodification of social care has done little to support a truly person-centred approach based on the needs, wants and circumstances of those who need it most.

4.4 To illustrate our point, we have included the comments from some of our members:

- 'We have seen the impact of a DPS running in xxxx for some years. Social workers are tasked with getting placements at the lowest rate they can, and frequently tout potential residents around different homes, saying to each "Home X up the road will do it for less". They divide providers, encourage unrealistic rates as providers chase

occupancy and inevitably lead to bad care. Nobody gets the choice they should, and people without strong and present family involvement are particularly vulnerable to being parked in the cheapest setting.'

- 'XXXX use a DPS for placing residents as we have received the odd notification for residents looking for placements. For people it is undignified and far from person centred and where is resident choice in all of this!? The cost of care is always too low to meet the needs of the service user.'

- 'The general feeling amongst home colleagues is that they are customer eBay and / or a dive to the bottom – with systems weighted so heavily on price there is no option but to go for the lowest possible price. Also, in the past when completing tenders to register our homes for a DPS we have been required to complete the tender process and all the required documents separately for each and every home in the LA area which is both laborious and unnecessary.'

- 'Unless implemented properly, with appropriate governance, oversight and transparency these can result in a race to the bottom. The criteria need to be carefully thought through, and each decision to award a contract needs to be evidenced. The weighting of each element, (price, quality etc) needs to be fair, otherwise the system is near useless. The system can also exclude suppliers who are able to offer elements / or a proportion of their services at certain criteria but not to provide every single service.'

- 'It would be a more transparent system if the LA published the range of fee that they are willing to pay on each bid, and save wasted time where this would be unacceptable to providers.'

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