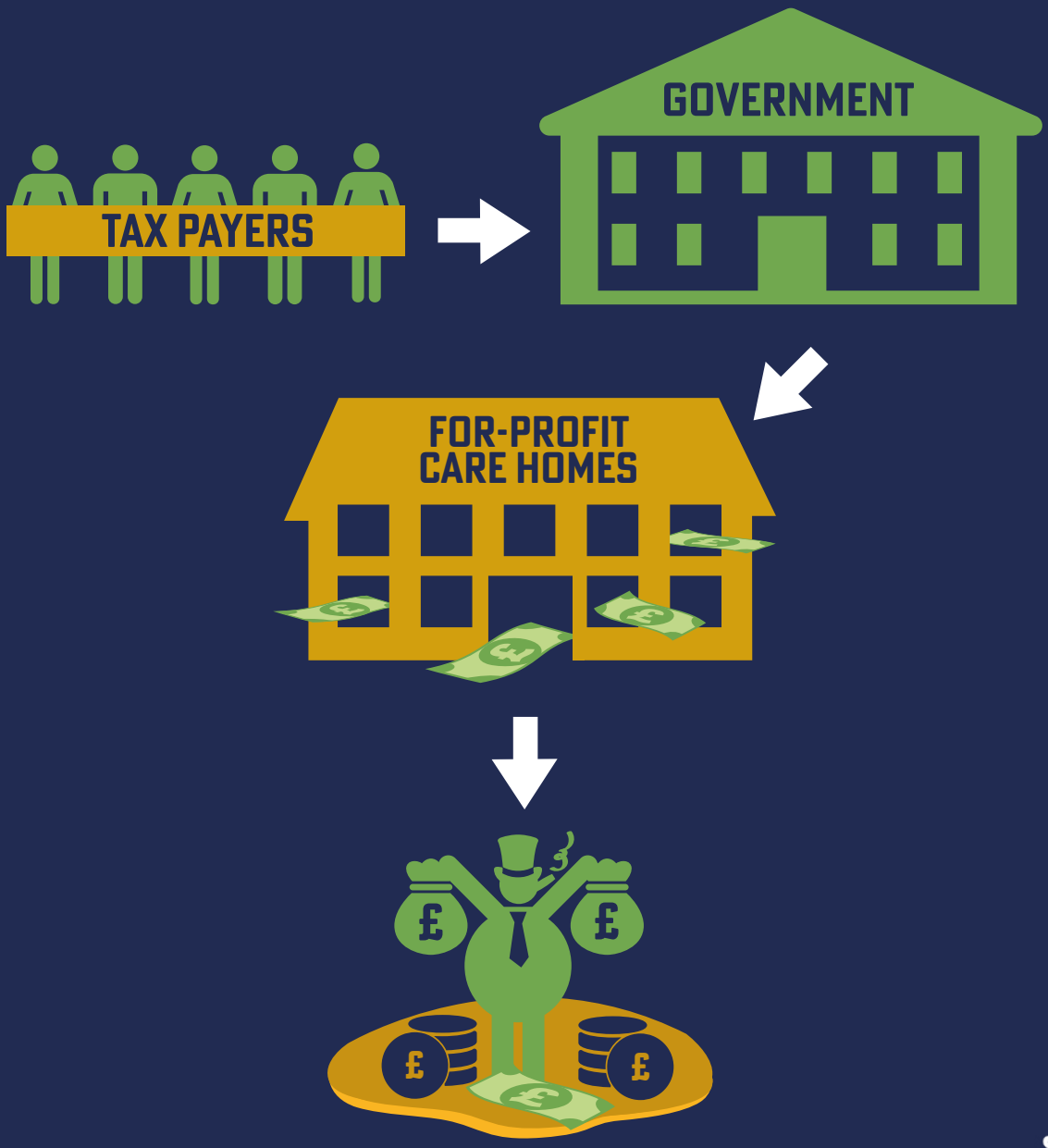
PROFITING FROM CARE:

WHY SCOTLAND CAN'T AFFORD PRIVATISED SOCIAL CARE

JUNE 2022



STUC 125 years

EXECUTIVE SUMMARY

In the wake of the pandemic, there is widespread consensus that we need to re-found and reimagine social care as an essential public service.

The 2021 Independent Review of Adult Social Care (the Feeley Review) declared that "if we want a different set of results, we need a different system." The Scottish Government duly promised to create a National Care Service (NCS) based on Scottish people's human rights to high quality care, fair work and a voice in decisions that affect them. However, perhaps surprisingly, the proposals do not involve any substantive changes to who actually provides care. Indeed, the then Health Secretary declared even before the Feeley Review reported that the NCS would give care "national attention" but would not be "run by the state".[1] This has been justified by two key claims: first, that ownership of care services does not affect the desired outcomes of quality care and fair work; and second, that bringing care services into public ownership would be too expensive.

These claims are surprising given the extensive international literature linking financialised and privatised care with poor outcomes and excess profit extraction. However, to date there have been no studies exploring these links specifically in relation to Scottish social care. For the first time, this report examines the evidence for Scotland to see if it supports the Scottish Government's policy approach. In short, we find that it does not. Large private providers are associated with lower wages, more complaints about care quality, and higher levels of rent extraction than public and third sector care providers.

They also hold a concerning level of market power, particularly in some areas, raising questions about whether this approach really provides the 'choice' for care users by which it is often justified.

First, we present new analysis of data from the Care Inspectorate, Scottish Social Services Council and Labour Force Survey on the shape of private care provision in Scotland and whether it differs systematically from other types of provision. Our key findings include:

- Big providers run older people's care homes that are **double the size of those not run for profit**. A quarter of homes in our sample of big providers have at least 80 registered places.

- There is **significant market concentration**: the ten largest for-profit care home providers account for around **a third or more of registered place**s in care homes for older people in Glasgow, Edinburgh, North Lanarkshire, Aberdeen and Angus. **In Midlothian, two big companies account for half of the registered places**. This is a real risk to provision given that two of the UK's largest for-profit care home operators have failed since 2010.

- Nearly **25% of care homes run by big providers had at least one complaint upheld** against them in 2019/20, compared to 16% in the rest of the private sector and 6% in homes not run for profit.

- In older people's care homes, **staffing resources are 20% worse** in the private sector compared to the not for profit sector.

- Over the last six years, the **public sector** has paid on average **£1.60 more per hour** to care workers.

1 Freeman, J. (2021, 19th January). 'Freeman: We won't nationalise social care'. https://healthandcare.scot/mobile_default.asp?page=story&story=2406

Next, we analyse the accounts of the 10 largest for-profit and 10 largest non-profit care home operators in Scotland, to see where the money spent by the government, care users and their families is going. Our key findings include:

- Between 2017 and 2020, the ten largest for-profit firms spent **£8.45** of every **£100** received in fees on profits, rent, payments to the directors, and interest payments on loans. For the ten largest not-for-profit care home operators, the figure is around **£3.43**.

- This corresponds to approximately **£4000 of 'leakage' per bed each year** on these non-care expenditures by for-profit providers. Excluding two heavily loss-making providers, the rest of the 'Big 10' for-profit providers 'leaked' over **£10,400 per bed** (or £20 of every £100 received in fees) with the **most profitable taking out £13,600 per bed** (or £28 of every £100 received in fees). While this spending is not all necessarily illegitimate, for-profit providers spend systematically more on these kinds of expenditures than non-profit providers.

- In some cases this 'leakage' represents profit extraction by other means. Financialised firms are often loss-making or barely profitable on paper, but are using an array of other tactics to extract disguised profits from the business (such as intra-group loans or rental payments). In one case in our sample, a large care-home group books a pre-tax profit margin of under 3 percent on paper, but actually makes related-party interest and rental payments that could constitute a real profit extraction of up to 22 percent of revenue.

- 'Leakage' is at the expense of workers: the largest for-profit providers spent **25 percent less** of their revenues on staff costs than the largest non-profit providers in 2017-20.

- It is also at the expense of taxpayers in Scotland. At least five of the ten largest for-profit care home operators received £57 million of extra Covid funds in 2020 and 2021. One of these companies made a loss, but the other four made over **three times as much profit as the Covid grants they received** (over £108 million in profits in 2020 and 2021).

- One company paid out three times the money it received as Covid grants to its owners as directors' fees, dividends, and rent to a related company. This includes dividends 25% larger than the money received from the Coronavirus Job Retention Scheme, and salary and pension payments to its owner-directors that were 80% more than the covid grants received.

Based on these alarming findings, we argue that the Scottish Government's current approach of being 'ownership neutral' in the design of the NCS is untenable. Instead, we recommend:

- A truly transformative National Care Service must be based on a **not-for-profit public service**, delivered through **local authorities** with an ongoing role for the **voluntary sector.**

- The Scottish **care home estate should be transferred out of private ownership gradually over time** - for instance, through a multi-year plan backed up by Barnett consequentials from the UK government's NI tax rise, SNIB loans, 'care bonds' or capital borrowing. For the most extractive providers, this could pay for itself within a matter of years.

- Ethical commissioning' should mean **an end to new procurement from for-profit providers** and competitive tendering. Instead, commissioners should seek to identify public and non-profit entities that can be trusted to treat workers and care users well, and support them with **stable long-term funding**.

- **Local authorities** should retain responsibility for care services in their area, and should be **supported to in-source services** where appropriate.

- A new programme should be set up to nurture an ecosystem of local **community-led and co-operative care provision**, including through business support and access to finance.

- **Trade unions must be recognised for sectoral collective bargaining**, backed up by **increased funding**. This, alongside a concerted effort to improve **union density** in the care sector, should be the key mechanism for driving up pay, terms and conditions.

- The Care Inspectorate should be required to proactively assess the risk of provider failure, and work with public bodies to establish **contingency plans for taking assets into public or community ownership** (both where providers fail altogether and where care quality is persistently unacceptable)

- **Freedom of Information** legislation should be extended to all care providers in receipt of public funding.

- The Care Inspectorate should also be required to provide **regular and robust analysis on providers' performance and finances**, made publicly available in an easy-to-read, comparable format (e.g. factsheets and benchmarking tables).

Ultimately, we conclude that Scotland's ambition to build a truly transformative National Care Service - one that respects the human rights of care workers and care users alike - simply cannot be achieved without a radical transformation of power and ownership in the sector.

INTRODUCTION

The covid-19 pandemic focussed public attention on social care like never before, highlighting its essential nature even as it brutally exposed the system's shortcomings.

People suffered the heartbreak of elderly relatives dying alone, as pressure to discharge covid patients from hospitals saw the virus rip through care homes. Carers were clapped from our doorsteps on a Thursday night, yet continued to be undervalued, often lacking adequate PPE and sick pay to keep themselves and their families safe.[2] As The Fair Work Convention has highlighted, a combination of low pay (an average £9.79 an hour), insecurity (one in five care workers are not on permanent contracts) and high stress levels (13% work more than 50 hours a week) is contributing to a crisis of recruitment and retention in care work.[3] Across the spectrum, the consensus has grown that it is time for a reckoning. We need to refound the care system as a properly-funded public service, available to all at the point of need, and built on dignity for care workers and care users alike.

The introduction of a new Scottish National Care Service (NCS) offers a 'once in a generation' opportunity to reset the care system in Scotland so that it works better for everyone. Sadly, the current proposals fall far short of this ideal. While significant time and resources are being devoted to changing who commissions care and how, the NCS proposals have almost nothing to say about the critical question of who actually provides care and how.

While energy and attention is focussed on restructuring the procurement machinery, almost no attention is being given to the structure of the marketplace of care providers which it is procuring from - or, indeed, whether such a marketplace is the most efficient way to provide care in the first place.

This curious decision arises partly from the recommendations of the Independent Review of Adult Social Care (IRASC) - the Feeley Review - which treated these questions as largely unimportant. The Review acknowledged that the ownership and business models of the care sector were important to stakeholders: consultees overwhelmingly felt that "social care services should not be run for profit as a matter of principle", and "the extent to which some privately-run care homes yield profits for their shareholders was raised with us repeatedly as an issue of concern". But it nonetheless concluded that "the evidence suggests that nationalisation would not in and of itself improve outcomes for people using care" - and, in any case, would be "unaffordable".[4] On this basis, it recommended no substantive changes to who owns and runs care services in Scotland. The Scottish Government's consultation on the NCS echoed this, saying that "there is no evidence that providing services through the public sector increases quality", and that "it would also be enormously expensive to take social care into public ownership, expenditure that could be better used working to improve care".[5]

2 Pelling, L. (2021) 'On the Corona frontline: The experiences of care workers in nine European countries.' Friedrich Ebert Stiftung, Kommunal & Arena Idé. https://www.fes.de/en/politik-fuer-europa/on-the-corona-frontline
3 Scottish Centre for Employment Research (2018). 'Fair, Innovative and Transformative Work in Social Care'. Fair Work Convention. https://www.fairworkconvention.scot/our-report-on-fair-work-in-social-care/
4 Independent Review of Adult Social Care
5 Scottish Government (2021). 'A National Care Service for Scotland: Consultation'. https://www.gov.scot/publications/national-care-service-scotland-consultation

There are three problems with this. First, the Feeley Review considered a very limited range of evidence, using just two pieces of data to conclude that ownership type did not affect care quality, and considering no evidence at all on the relationship between ownership and fair work. Second, immediate and total 'nationalisation' of all care is something of a straw man. The Review did not consider other proposals for the gradual democratisation of care - such as ending new for-profit procurement and transferring failing care homes into public or community ownership. Nor did it consider a model which excludes for-profit provision but retains a role for the voluntary sector - despite finding that the latter delivered significantly better care. Third, its conclusion that publicly owned care was unaffordable considered only one side of the balance sheet. Despite repeatedly insisting that spending on care should be seen as an "investment" - and expressing "concern" over the "leakage" of this spending out of the system via excess profits of financialised chains - it made no effort to quantify the potential savings from plugging these leaks, or the returns on investment from bringing profitable assets into public ownership.

A considerable UK and international literature already exists on these issues which the review could have drawn on. For instance, a 2016 report found that, of the £776 a week then considered the 'fair price' of a UK nursing care bed, some £277 - over a third - was accounted for by the cost of capital, with investors demanding returns of up to 12% a year.[6]

A further study in 2019 found that, of the care sector's £15bn annual income, £1.5bn (10%) leaked out via rent, dividends, interest payments, profits and directors' fees.[7] A 2020 report looking specifically at HC-One found that it reported an artificial £12.2m operating loss, while extracting £47.2m in dividends, rent and interest paid to related parties.[8]

Studies have also raised less tangible concerns about the business models of large chains and their impact on workers and care users. For instance, research in Canada has found that for-profit homes deliver inferior care,[9] and that Ontario's financialised care homes suffered more covid deaths than municipal and non-profit homes.[10] In 2020, the Scottish Government's own figures showed that 69% of private care homes had suffered a suspected covid case, compared to 57% of publicly-run homes and 38% of non-profit homes.[11] Such findings are often explained by the fact that large for-profit chains tend to favour bigger care homes in which the virus spread more easily.[12] Larger homes are also associated with worse quality care.[13]

6 Burns, D. et al. (2016) 'Where does the money go? Financialised chains and the crisis in residential care'. CRESC Working Paper. https://hummedia.manchester.ac.uk/institutes/cresc/research/WDTMG%20FINAL%20-01-3-2016.pdf
7 Kotecha, V. (2019) 'Plugging the leaks in the UK care home industry: Strategies for resolving the financial crisis in the residential and nursing home sector'. CHPI. https://chpi.org.uk/wp-content/uploads/2019/11/CHPI-PluggingTheLeaks-Nov19-FINAL.pdf
8 CICTAR for UNISON (2021) 'Death, Deception & Dividends: Disturbing Details of the UK's Largest Care Home Operator'. https://cictar.org/wp-content/uploads/2021/12/Death-Deception-Dividends-Dec-3.5.pdf
9 Stall, Nathan M et al. (2020). 'For-Profit Long-Term Care Homes and the Risk of COVID-19 Outbreaks and Resident Deaths.' https://www.cmaj.ca/content/192/33/E946
10 Brown, J. (2020) 'The financialisation of social services: Implications for planning cities that value care over profit.' MEs thesis, York University, Toronto
11 'MSPs say national care service is the answer', Wednesday 3rd June, healthandcare.scot https://healthandcare.scot/mobile_default.asp?page=story&story=1798
12 Burns et al, op cit. Future Care Capital, Data that Cares https://futurecarecapital.org.uk/research/data-that-cares/
13 CMA, 2017, 'Care homes market study: Final report.' https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf

Scotland's own Fair Work Convention noted in its report on social care that "workers in local authority services generally have relatively better terms and conditions."[14] At EU level, a recent report concluded that the privatisation of social care had "put Europe on a poor footing for a pandemic".[15] A qualitative study of care workers' experiences across nine countries found that "efforts to increase productivity by means of privatisation have often led to a deterioration both in the quality of care and the working conditions of the employees," and that during the pandemic, lack of sick pay, PPE and training had put workers and users at risk.[16]

And yet, despite this wealth of evidence that privatised care is not working, neither the Feeley Review nor the Scottish Government conducted any new research into the link between ownership and outcomes in Scottish social care. This report aims to fill that gap.

Using new data analysis, we show that the Feeley Review was simply wrong to suggest that ownership and business models do not affect outcomes for workers and care users. Through analysis of the accounts of Scotland's largest care providers in one sector, residential care, we also find that the finance costs, property rents and directors' remuneration of large for-profit providers are systematically greater than those of large non-profit providers, using up more of the revenues they receive as care home fees while spending less on staff and other direct care costs. **If large for-profit firms are delivering systematically worse outcomes for workers, care users and the taxpayer, the question must be asked: why should we continue allowing them to provide care services at all?** We conclude with policy recommendations for a fresh approach, arguing that the Scottish Government quite literally cannot afford to remain neutral on who owns and provides care.

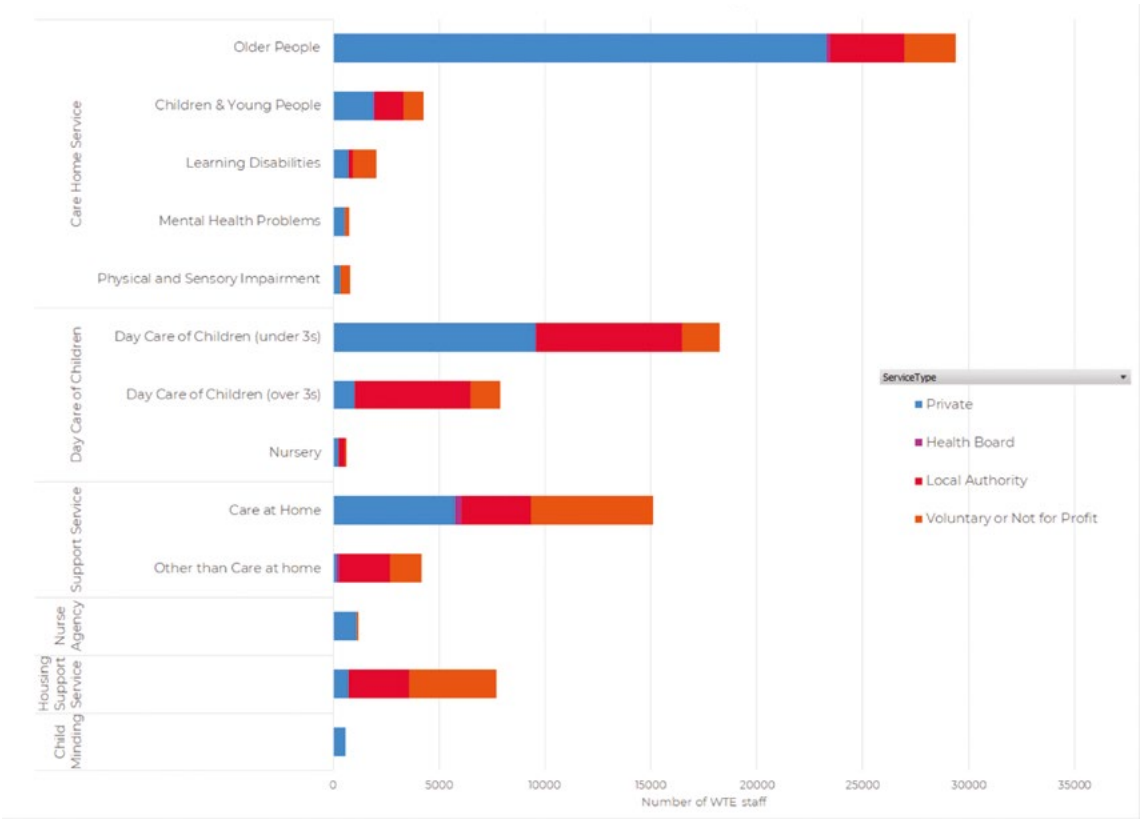
14 Fair Work Convention (2019) 'Fair Work in Scotland's Social Care Sector' https://www.fairworkconvention.scot/our-report-on-fair-work-in-social-care/
15 Corporate Europe Observatory (2021), 'When the Market becomes Deadly'. https://corporateeurope.org/sites/default/files/2021-01/healthcare-privatisation-final.pdf
16 Pelling, L. (2021) 'On the Corona frontline: The experiences of care workers in nine European countries.' Friedrich Ebert Stiftung, Kommunal & Arena Idé. https://www.fes.de/en/politik-fuer-europa/on-the-corona-frontline

WHERE DO PRIVATE SECTOR CARE STAFF WORK?

According to the Scottish Social Services Council (SSSC), as of the end of 2020 there were 209,690 people working in regulated Scottish social care, of whom around 80% work in care homes for adults, housing support or care at home or the day care of children[17].

Out of all workers, around 39% work in the private sector, 34% in the public sector and 27% in the voluntary sector[18]. This is based on Care Inspectorate annual returns and a census of local authority social work staff conducted in the same year. Using data collected annually by the Care Inspectorate from registered services[19] allows us to look in more detail at the breakdown of whole-time equivalent (WTE) staffing in different sub-sectors.

Fig 1 - Number of whole time equivalent staff in different areas of Scottish social care by employer type.



Source: Care Inspectorate Datastore, March 31st 2022

17 SSSC (2021) 'Scottish Social Service Sector: Report on 2020 Workforce Data', pg 12. https://data.sssc.uk.com/images/WDR/WDR2020.pdf
18 Ibid, pg 16
19 Care Inspectorate (2022). 'Datastore (as at 31 May 2022) CSV', available from https://www.careinspectorate.com/index.php/publications-statistics/93-public/datastore

As of the end of March 2022, the equivalent of 45,882 full-time care sector staff were working in the private sector. Over half of this staffing is in care homes for older people, around a fifth in the day care of children under three and just over a tenth is providing care in people's own homes[20].

Care homes have the highest proportion of WTE staffing in the private sector. In particular, **nearly 80% of staffing in care homes for older people is in the private sector**, nearly 70% in care homes for people with mental health issues and 45% in care homes for children and young people. Similarly, over half of WTE staffing in day care for children under 3 is in the private sector and **40% of WTE staffing in care provided in people's own homes is employed by private providers**.

The following analysis therefore focuses on care homes and care at home, given the higher proportions of staff working in the private sector. It's important to note that there are also large numbers and proportions of staff in the private sector working in daycare for children under three. Although registered services, these are different from statutory services provided to 'looked after' children and so fall out of scope of questions relating to the National Care Service. An interview with a STUC affiliated trade union organiser highlighted, however, that conditions and pay are often poor amongst private sector day care workers, who are often younger and more transient than workers providing social care.

The interviewee spoke of how these workers often feel even more marginalised and underappreciated and how there is a risk of policymakers and wider society seeing childcare as a lifestyle choice on the part of parents and not a vital public service requiring urgent attention. Therefore whilst this report does not consider childcare in general, it is important to acknowledge that this sector should form part of the conversation on private and public models of care provision in Scotland.

20 Some services have entries in the data under both housing support and care at home as they provide both. This estimate excludes housing support entries that are combined services to avoid double counting of staff. For some entries, however, WTE staff is put in either the housing support or care at home entry, for others it is split between them. This means that WTE figures for care at home or housing support could be underestimated.

PERSONAL ASSISTANTS

The Social Care (Self-directed Support) (Scotland) Act 2013 introduced the right for 'Self-Directed Support' or SDS, where people in need of care are able to choose how that care is paid for and managed.

Under 'Option 1', people in need of care or their families receive a payment and employ personal assistants directly to provide support in their own homes and other environments. In 2016, 7% of social care clients chose this option[21]. Unlike carers in regulated services, personal assistants do not need to be registered with SSSC and so there are no reliable figures for the number currently working in Scotland. Skills for Care, however, estimated that in 2016, there were 4,600 personal assistants in Scotland providing the equivalent amount of care as 2,100 full time staff[22].

Interviews with a trade union organiser working as a PA highlighted several potential employment issues that should be addressed in any NCS discussions. They highlighted that whilst the principle of allowing someone control over their care was an important step forward, a lack of resources made the implementation a failure. Budgets are allocated purely on tasks and time needed, with no additional funding for training, travel or supervision. This has led to PAs struggling to access even basic training in safeguarding and manual handling[23].

The interviewee said that this had created a 'two tier system', where clients and families with resources who were able to top up budgets and provide better wages, sick pay and holidays were more able to recruit and retain PAs. Whilst PA budgets increased to allow the payment of £10.50 wages in April 2022[24], the interviewee highlighted that this was done unilaterally by the Scottish government without negotiation with any unions, who could have highlighted how the continuing shortfall in budgets was only giving 'choice to people with resources'.

In addition, the complexity of becoming an employer can be challenging for people receiving care. This has led to broker organisations, many in the third sector, who facilitate recruitment and payroll processes. Trade unions flagged that private sector recruitment[25] and payroll companies[26] are now also providing these services to people receiving care on a for-profit basis. They expressed concerns around how this may muddy the employment relationship between those receiving care and PAs and pointed to the experience of construction workers and PAYE companies[27] as an example of how this could result in negative experience for both PAs and clients. Consideration of this important sector in any NCS should include how to protect and balance PAs' and clients' rights from exploitation by companies seeking to extract profit by managing this sensitive relationship.

21 Scottish Government (2018). 'Self-directed support, Scotland, 2016-17'.
https://www.gov.scot/publications/self-directed-support-scotland-2016-17/
22 ICF Consulting Limited (2018). 'The Economic Value of the Adult Social Care sector - Scotland', pg 9. Skills for Care and Development.
https://skillsforcareanddevelopment.org.uk/wp-content/uploads/2019/03/11-_-2018-The-Economic-Value-of-the-Adult-Social-Care-sector-Scotland.pdf?utm_source=pocket_mylist
23 Scottish Centre for Employment Research (2018). 'Personal Assistants working under SDS Option One: experiences of fair work'. Fair Work Convention.
https://www.fairworkconvention.scot/wp-content/uploads/2018/11/Personal-Assistants-working-under-SDS-Option-One-experiences-of-fair-work.pdf
24 Self-Directed Support Scotland (2022, 8th June). 'Personal Assistant Newsletter June 2022'
https://www.sdsscotland.org.uk/personal-assistant-newsletter-june-2022/
25 For example https://topcare.co.uk/testimonials/
26 For example https://family-payroll.co.uk/about-us/
27 TUC (2021). 'Umbrella companies: Why agencies and employers should be banned from using them'.
https://www.tuc.org.uk/research-analysis/reports/umbrella-companies-why-agencies-and-employers-should-be-banned-using-them

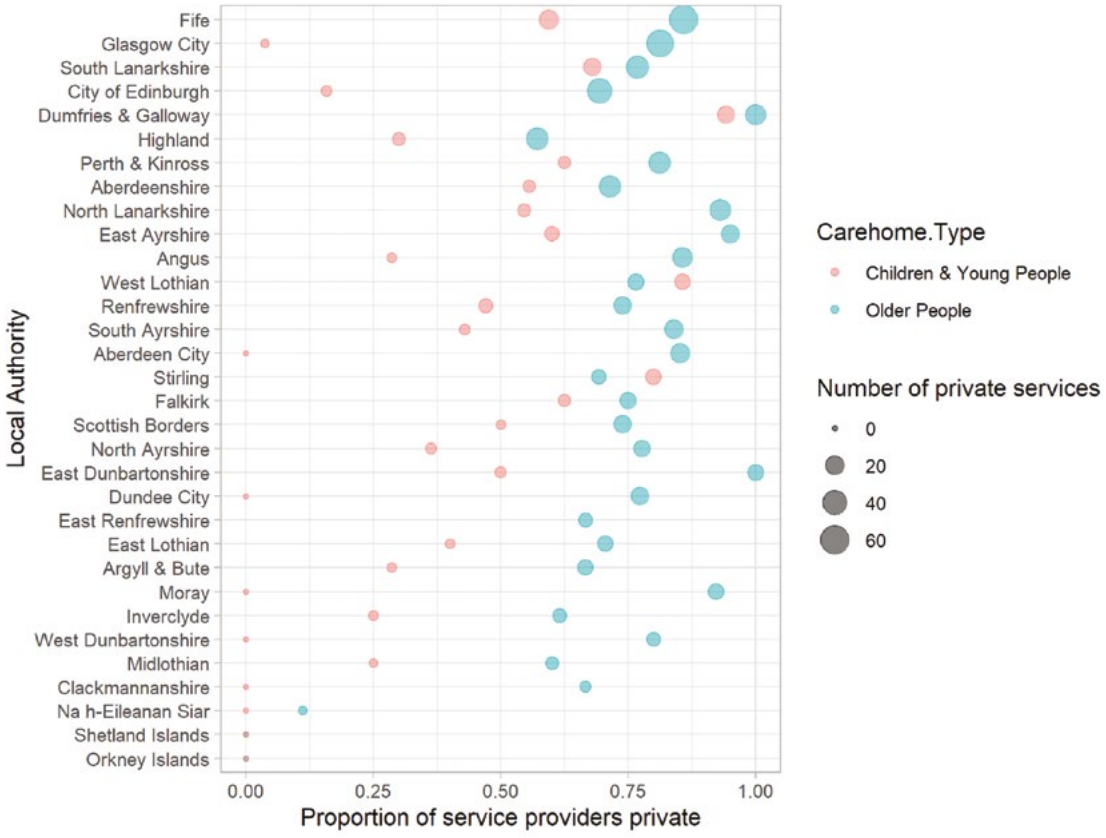
PRIVATE PROVISION OF SERVICES VARIES BY GEOGRAPHY

The use of the private sector varies substantially between client groups and different local authorities.

Aside from the three smallest island local authorities, **at least 50% of older care homes in all other areas are private** and in the majority of places the proportion is over 70%. **Several areas have over 85% private provision**, including Dumfries & Galloway (100%), East Dunbartonshire (100%), East Ayrshire (95%), North Lanarkshire (93%), Moray (92%), Fife (86%), Angus (86%), and Aberdeen City (85%). Fife has the largest number of private care homes for older people (71), followed by Glasgow (52)and Edinburgh (43).

With 334 care homes across Scotland, residential care for children and young people makes up the next biggest sub-sector. Although 45% of these are private, more than half of care homes in over half of the local authorities are provided by the local authority or the voluntary sector. Again, this varies by local authority. For example, in Dumfries and Galloway all but one of the 17 homes for children are private and all but two of the 14 homes in West Lothian are private. The local authorities with the largest numbers of care homes for children have very differing levels of privatisation. In Fife, 60% of the 37 care homes for children are private and in South Lanarkshire, nearly 70% of the 25 homes are private. This sits in contrast to the 27 care homes for children in Glasgow, only one of which is private.

Fig 2 - Number and proportion of care home services in Scotland run by private providers for older people and children and young people. Local authorities ordered by the number of private care homes.



Source: Care Inspectorate Datastore, March 31st 2022

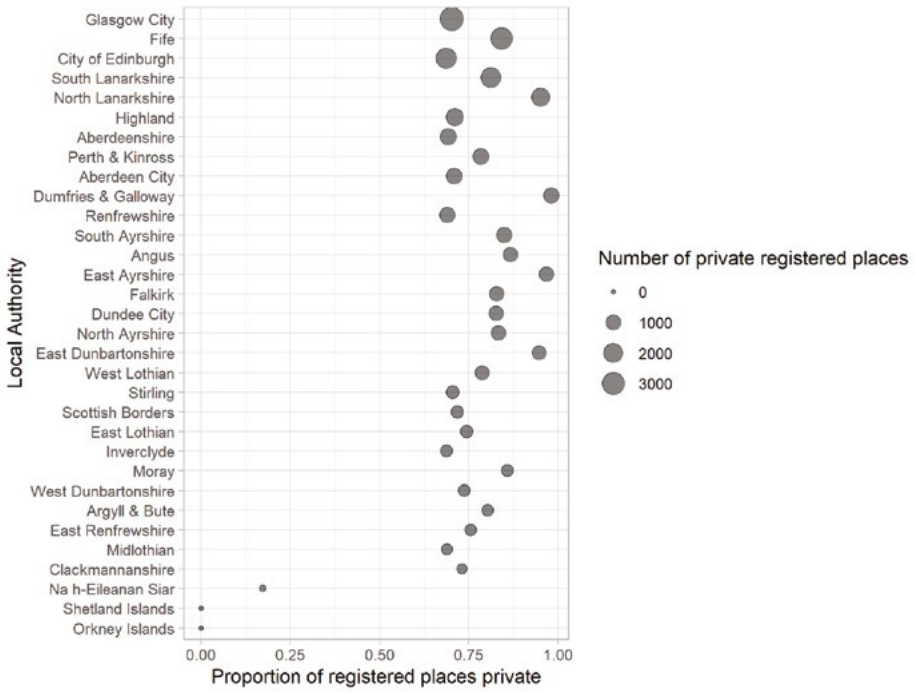
There are fewer care homes for people with learning disabilities and of the 147 in Scotland, over 60% are provided by the voluntary and not for profit sector. A third of all learning disabilities care homes can be found in Aberdeenshire, Aberdeen City, West Lothian and the City of Edinburgh, with over 80% voluntary provision in Aberdeenshire and Aberdeen City. East Ayrshire, Argyll & Bute, East Lothian, North Lanarkshire, however, all have between one to three care homes for people with learning disabilities provided solely by the private sector.

There are far fewer care homes for people with mental health problems or physical and sensory issues (52 and 33 respectively) and again the voluntary and not for profit sector is responsible for the majority of provision (63% and 76% of care homes respectively). The largest number of homes for people with mental health issues is in Glasgow, where all but two of 17 homes are provided by the voluntary sector.

The geographic distribution of private sector care home WTE staffing mainly follows the distribution of providers, with slightly higher proportions of WTE staffing in the private sector than proportions of registered services. In some local authorities, there are substantially higher proportions of staff in the private sector than the proportion of services. For example for older people's care homes in Argyll and Bute, 67% of registered services are private but 79% of WTE staff are in the private sector. This suggests that some private providers in these local authorities are larger than providers of other types and so employ higher proportions of staff. Conversely, in Glasgow City, although 81% of care homes for older people are private, 73% of WTE staffing is in the private sector, suggesting they employ proportionately fewer staff.

This is borne out by looking at the proportion of registered places in care homes in the private sector. For example, the proportion of registered places provided by the private sector in Argyll and Bute is 80%, whereas in Glasgow it is 70%.

Fig 3 - Number and proportion of registered care home places in Scotland provided by private companies. Local authorities ordered by number of private registered places.

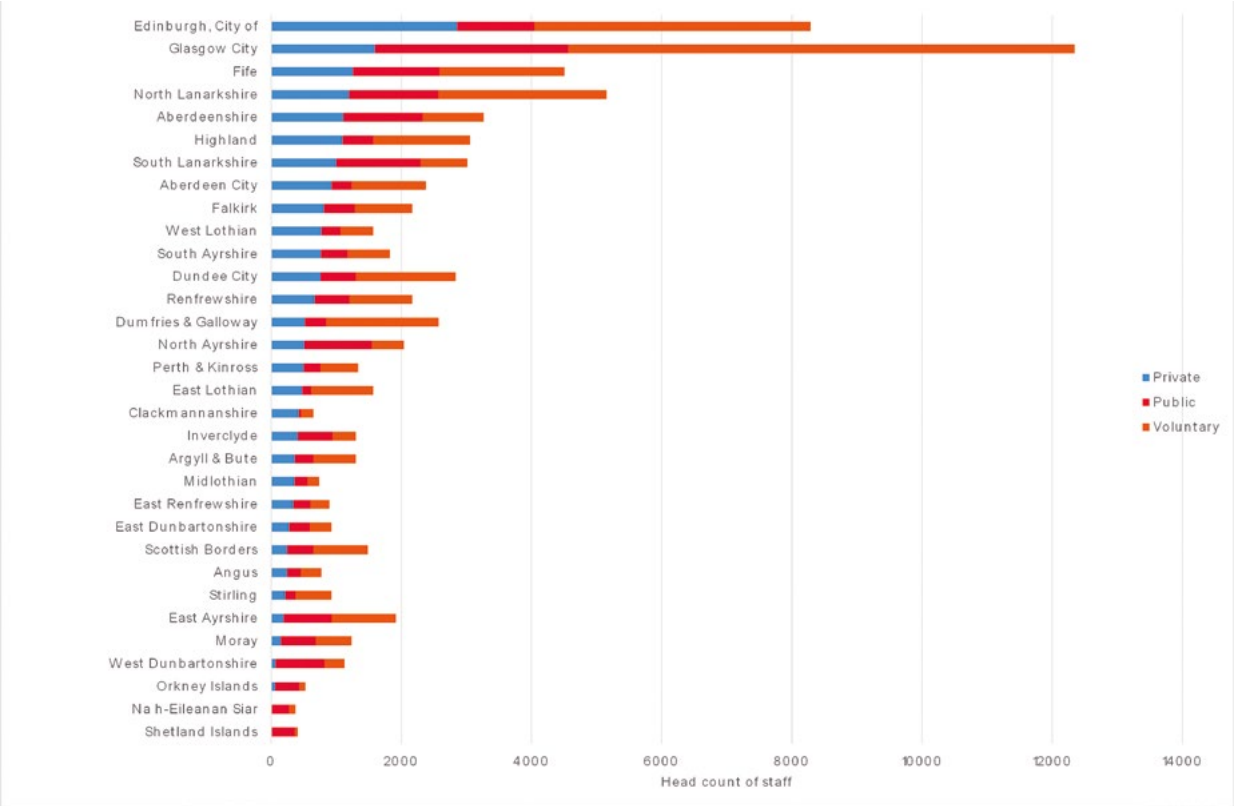


Source: Care Inspectorate Datastore, March 31st 2022

Due to potential inaccuracy in the Care Inspectorate staffing data, the distribution of staff providing care at home or housing support is looked at using SSSC data[28]. **In 2020, of the 74,790 people working in care at home or housing support, 27% worked for private providers, 26% for public providers and 47% worked in the voluntary sector**. As with other types of social care, this varies greatly by local authority. For example, around half or more of staff providing these services in Midlothian (49%), West Lothian (50%) and Clackmannanshire (65%) work for private providers.

The inclusion of housing support in these figures may skew them towards the voluntary sector, as housing support is likely to be offered by housing associations in order to help their residents maintain their tenancy. This means looking at the numbers of staff in each local authority might be more useful to get a sense of the scale of private care given at home in each local authority. In terms of the numbers of staff working for private providers, the largest numbers are found in Edinburgh (2860), Glasgow (1600), Fife (1260), North Lanarkshire (1200), Aberdeenshire (1110), Highland (1100) and South Lanarkshire (1000).

Fig 4 - Headcount of staff providing care at home and housing support in Scotland by employer type.



Source: SSSC, Workforce Data, December 2020

28 SSSC (2021). '2020 detailed workforce information'. Available from https://data.sssc.uk.com/local-level-data/277-2020-detailed-workforce-information

PRIVATE CARE HOME PROVIDERS OPERATE LARGER CARE HOMES AND PROVIDE UP TO 98 PERCENT OF CARE HOME PLACES IN SOME REGIONS

Private for-profit companies dominate residential care provision in Scotland.

Of the 42,489 registered care home places in March 2022, 77 percent were in privately-run care homes, 11 percent in voluntary-sector care homes, and 12 percent in care homes operated by local authorities or health boards. There is some market concentration: **ten large for-profit companies – five operating only in Scotland, and five UK-wide – provide 30 percent of all for-profit care home places** in Scotland, and 23 percent of all places overall.[29]

The private sector operate larger care homes: **the median privately-run care home for older people is 40 percent larger than the median local-authority or third-sector elderly care home** (Table 1). **The largest 10 private providers, however, run bigger care homes:** the median care home size is twice as big for these 'Big 10' for-profit providers than non-profit providers of all types. In a quarter of care homes run by these providers there are 80 registered places or more.

Table 1 - median number of registered places in Scottish care homes for older people by provider type.

Care homes for older people - provider type	Registered Places - median
Big 10' for profit providers	**60**
Rest of private sector	42
All private sector	**46**
Local Authority	32
Voluntary or Not for Profit	32
All not run for profit	**32**

Source: Care Inspectorate Datastore, March 31st 2022

The propensity for these 'Big 10' for-profit providers to operate much larger care homes means that in some local authorities, they control very substantial proportions of registered places for older people's residential care. In Glasgow, Edinburgh, North Lanarkshire, Aberdeen and Angus they account for around a third or more of provision. In **Midlothian**, a smaller local authority with fewer registered places, **two big companies account for half of the registered places** (Table 2). This market concentration presents real risks to the availability of residential care in these regions should one of these large firms fail: two of the UK's largest care home companies have gone into administration since 2010, including the firm that was previously Scotland's largest.

29 Calculations from Care Inspectorate provider data.

Table 2 - Proportion of registered places in care homes for older people run by 'Big 10' private providers in Scottish local authorities where they have the highest market share.

Local Authority	Total older people's care homes registered places	Provider Company	Number of registered places provided by company	Proportion of registered places provided by company
Glasgow	4123	HC one Four seasons Other 'Big 10' private providers **All 'Big 10' private providers**	845 285 178 **1308**	20% 7% 4% **32%**
Edinburgh	3042	Four seasons Care UK HC One Other 'Big 10'private providers **All 'Big 10' private providers**	845 285 178 **1308**	20% 7% 4% **32%**
North Lanarkshire	1719	HC One Four seasons Thistle **All 'Big 10' private providers**	845 285 178 **1308**	20% 7% 4% **32%**
Aberdeen	1316	Renaissance Care Barchester Other 'Big 10' private providers **All 'Big 10' private providers**	845 285 178 **1308**	20% 7% 4% **32%**
Angus	1067	HC One Barchester Four seasons **All 'Big 10' private providers**	845 285 178 **1308**	20% 7% 4% **32%**
Midlothian	523	Barchester HC One **All 'Big 10' private providers**	845 285 **1308**	20% 7% **32%**

Source: Care Inspectorate Datastore, March 31st 2022

LARGE FOR-PROFIT PROVIDERS SPEND LESS ON STAFF AND MORE ON NON-CARE COSTS

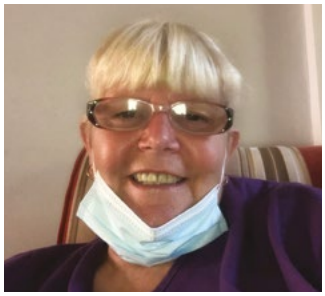
Does the type of provider affect how care home fees – both publicly funded and self-funded by residents – are spent?

Previous UK-wide studies have examined how money is 'leaking' from for-profit care homes not only as profits and dividends to for-profit care home owners, but also in less obvious ways: as rent on buildings not owned by the company operating the care home; as interest on loans for new property acquisitions or business expansion; and as management fees or direct remuneration to the directors of the care home providers.[30] Critics have linked such expenditure on items that do not directly contribute to care provision to the growing financialisation of the care sector. This term encompasses in general the growing role of financial markets and financial institutions in the economy. For the care industry, it signals the rise of business models in which care home owners draw profits and gains not simply (or even mainly) from the provision of care, but from buying and selling care businesses and their assets (especially property); and from using those assets to raise finance for further expansion or market speculation.[31] It also indicates the use of financial instruments by business owners themselves to extract profits from care home businesses: through high interest payments on loans from one company to another commonly -owned company (i.e. owned by the same shareholders), opaquely-priced management or licence fees paid out to a commonly-owned company; and other mechanisms which sometimes operate in tax-efficient ways.

Both of these characteristics – asset speculation and financial leverage on the one hand, financialised profit extraction on the other – are evident in the Scottish for-profit care sector. To understand what they mean for the use of care home fees, we looked at the financial accounts of the ten largest for-profit providers, measured by the number of registered places in the care homes they operate. Collectively these 'Big 10' provide around 30 percent of all private care home places, and 23 percent of all care home places in Scotland. These ten companies were selected (1) in order to cover a significant proportion of care home provision in Scotland, and (2) because the largest providers in the market are likely to be those whose business models involve expansion powered by debt, property sales and other mechanisms.

Building on work done by the Centre for Health and the Public Interest (CHPI), we examined four channels of possible 'leakage' of care home fees: either through profit extraction; or through payments to third-party investors.[32] These four channels are: rental payments, interest paid on loans (net of interest received from others, for instance on bank deposits), remuneration to directors, and pre-tax profits.[33] More revenues from care home fees spent on these costs means less money available for staff or non-staff costs of care provision itself.

Temilola Mackinnon, Social Care Worker, UNISON member



Kathy Paton, Social Care Worker, GMB member

30 Kotecha, V. (2019) 'Plugging the leaks in the UK care home industry: Strategies for resolving the financial crisis in the residential and nursing home sector'. CHPI. https://chpi.org.uk/wp-content/uploads/2019/11/CHPI-PluggingTheLeaks-Nov19-FINAL.pdf
31 Inter alia: Institute for Public Policy Research. (2019) 'Who cares? Financialisation in Social Care', https://www.ippr.org/research/publications/financialisation-in-social-care ; Corlet Walker, C., Druckman, A., and T Jackson (2021). 'Careless finance: Operational and economic fragility in adult social care'. Centre for the Understanding of Sustainable Prosperity. https://www.cusp.ac.uk/wp-content/uploads/Careless-finance-final.pdf
32 Kotecha, V. (2019) 'Plugging the leaks in the UK care home industry: Strategies for resolving the financial crisis in the residential and nursing home sector'. CHPI. https://chpi.org.uk/wp-content/uploads/2019/11/CHPI-PluggingTheLeaks-Nov19-FINAL.pdf
33 These channels are not an exhaustive list – they don't for instance cover management and licence fees - but they do constitute comparably-reported accounting items that can be compared across time and between different companies. Note also that income from government grants has not been included in revenue figures, though they may also 'leak'.

Importantly, we are not arguing that all of this 'leakage' is illegitimate expenditure. Not all loans and rental payments are to related parties making hidden profits on them. Directors, whether they own the business or not, need to be remunerated, and will be paid under any form of ownership. If care homes do not own their buildings, they will have to pay rents whether they are operating for profit or not. In many cases, however, rental costs result from the sale and leaseback of properties to third-party investors by for-profit care home operators in order to generate liquidity from rising property values. Rather than judging the legitimacy or necessity of these costs, we instead sought simply to see whether comparable non-profit providers had similar 'leakage' through these channels, or whether for-profit providers spent systematically more on these items. We therefore also examined the spending in these areas of the ten largest non-profit care home providers in Scotland. As Table 3 shows, these non-profit providers are not individually as large, but collectively they have a comparable share of the non-profit care home market as the 'Big 10' for-profits' share of the for-profit market.

Fiona Barclay, Social Care Worker, Unite the Union member

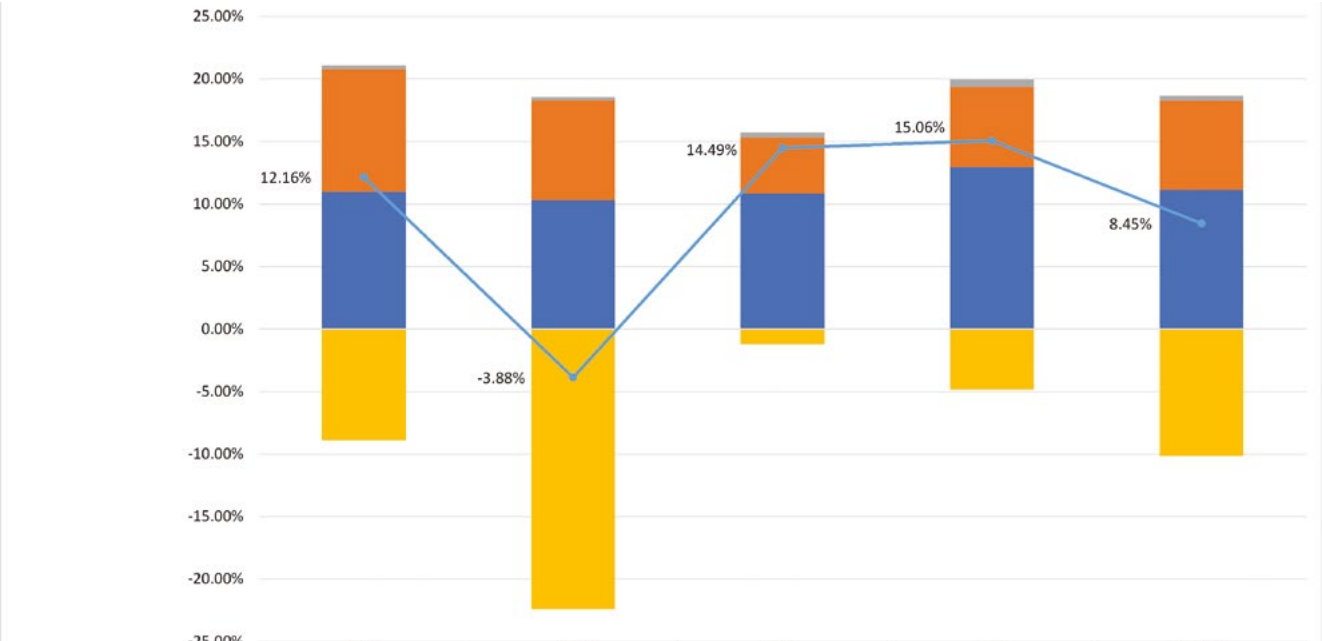
TABLE 3: 'BIG 10' FOR-PROFIT AND NON-PROFIT CARE HOME PROVIDERS

Provider sample	Number of care homes (2020)	Number of registered places (2020)	Percentage of registered places (2020)	Percentage of non-profit/for-profit registered places (2020)
10 largest for-profit providers	152	9801	22.9%	30.2%
10 largest non-profit providers	85	2132	5.0%	40.0%

Source: Care Inspectorate datastore, 31 March 2020
Note: Financial accounts are filed in arrears, and therefore the financial data for the providers in the samples is only available (for all providers) up to 2020. For this reason we describe the sample using 2020 Care Inspectorate data.

Comparison of these two groups of providers shows that between 2017 and 2020, **for every £100 that the 'Big 10' for-profit providers received in care home fees, they spent £8.45 on rents, net interest payments, remunerating their directors and profits** (Figure 5).[34] **For the largest 10 non-profit providers, the equivalent figure was £3.43** (Figure 6). We do not claim that all this spending is illegitimate or that it all constitutes profit extraction, though in some cases some of these flows do appear to constitute hidden profits. Nonetheless this differential is clear evidence, contrary to the Feeley Review's assertions, that there are systematic differences in the way that the largest providers – for-profit and not-for-profit – spend the money they receive from both self-funding residents and the public purse.

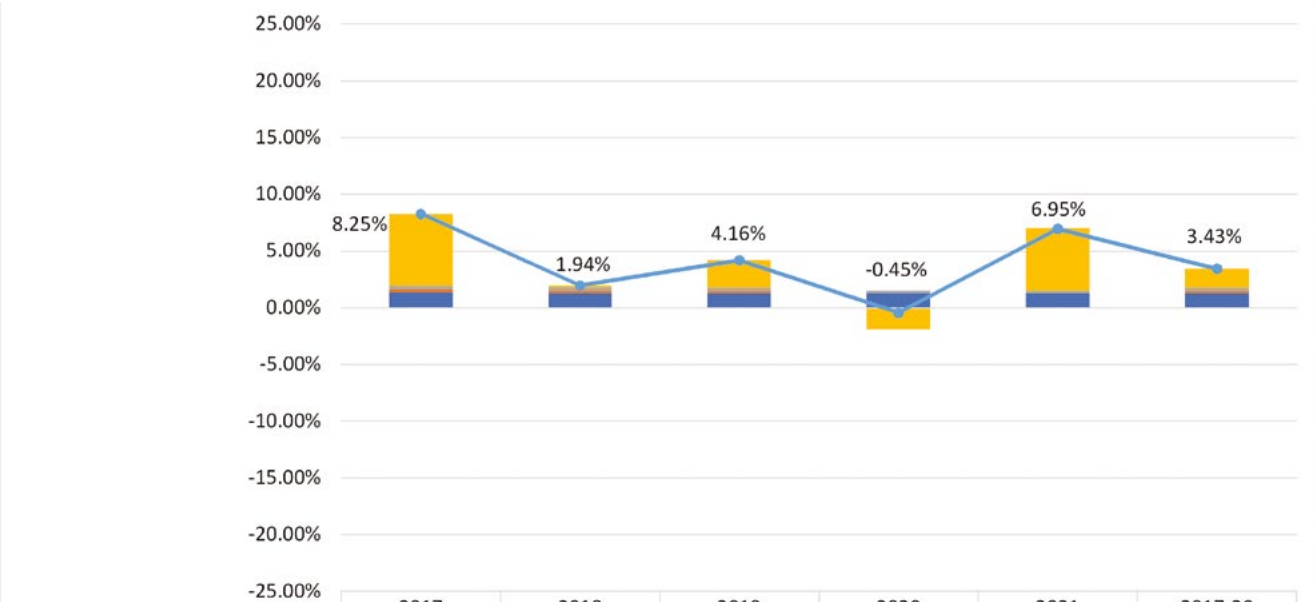
Figure 5: Percentage of revenues spent on 'leakage' channels by 'Big 10' for-profit providers, 2017-20



	2017	2018	2019	2020	2017-20
PROFIT BEFORE TAX	-8.92%	-22.42%	-1.22%	-4.88%	-10.18%
DIRECTORS REMUNERATION	0.32%	0.27%	0.43%	0.58%	0.39%
NET INTEREST EXPENSE	9.80%	7.97%	4.45%	6.42%	7.10%
RENT	10.96%	10.30%	10.84%	12.93%	11.14%
TOTAL	12.16%	-3.88%	14.49%	15.06%	8.45%

34 N.B. In the case of five of the ten 'Big 10' for-profit providers it was not possible from their financial reporting to disaggregate financial results and 'leakage' between their Scottish and English/Welsh care home operations. We have therefore assumed in this calculation that the proportion of revenue 'leaked' through these channels is not significantly different in their Scottish care home operations compared to their overall UK-wide operations.

Figure 6: Percentage of revenues spent on 'leakage' channels by biggest 10 not-for-profit providers, 2017-20



	2017	2018	2019	2020	2021	2017-20
SURPLUS	6.38%	0.20%	2.44%	-1.93%	5.52%	1.73%
DIRECTORS' REMUNERATION	0.28%	0.29%	0.31%	0.24%	0.22%	0.28%
NET INTEREST	0.26%	0.20%	0.17%	-0.02%	-0.03%	0.15%
RENT	1.33%	1.25%	1.25%	1.25%	1.24%	1.27%
TOTAL	8.25%	1.94%	4.16%	-0.45%	6.95%	3.43%

These figures mask considerable variation. In particular, the amount 'leaked' by the 'Big 10' for-profit providers is depressed by substantial pre-tax losses made by the largest two providers, including Four Seasons Healthcare, the largest care home provider in Scotland in 2020, which collapsed into administration in April 2019. The rest of the 'Big 10' for-profit providers have overall been profitable between 2017 and 2020, and **they booked collective profits of nearly 9 percent of their revenues in 2020, the first year of the pandemic**, up from a collective loss of 1.5 percent of revenues in 2019.

Indeed, comparing profits and dividends with the large additional payments from the public purse that many care home companies received to help with Covid-19 employment support and infection control set these 'leakages' in particularly stark relief.

Five of the ten largest for-profit providers specifically declared the receipt of Covid grants totalling £57 million in their annual accounts for 2020 or 2021 (though it is likely that others received grants too).[35] These grants were intended to ensure that struggling care homes had funds to try to stop infection spread, and ensure that they could continue to look after their vulnerable residents. We cannot determine from the accounts what proportion of these grants related specifically to Scottish care homes, but we can see that four of these five companies declared pre-tax profits in the same year as they received the grants.

35 These include payments under the Covid Job Retention Scheme, and payments from the Adult Social Care Infection Control Fund. They do not include Covid-related business loans.

FOR PROFIT CARE HOMES

NOT-FOR-PROFIT CARE HOMES

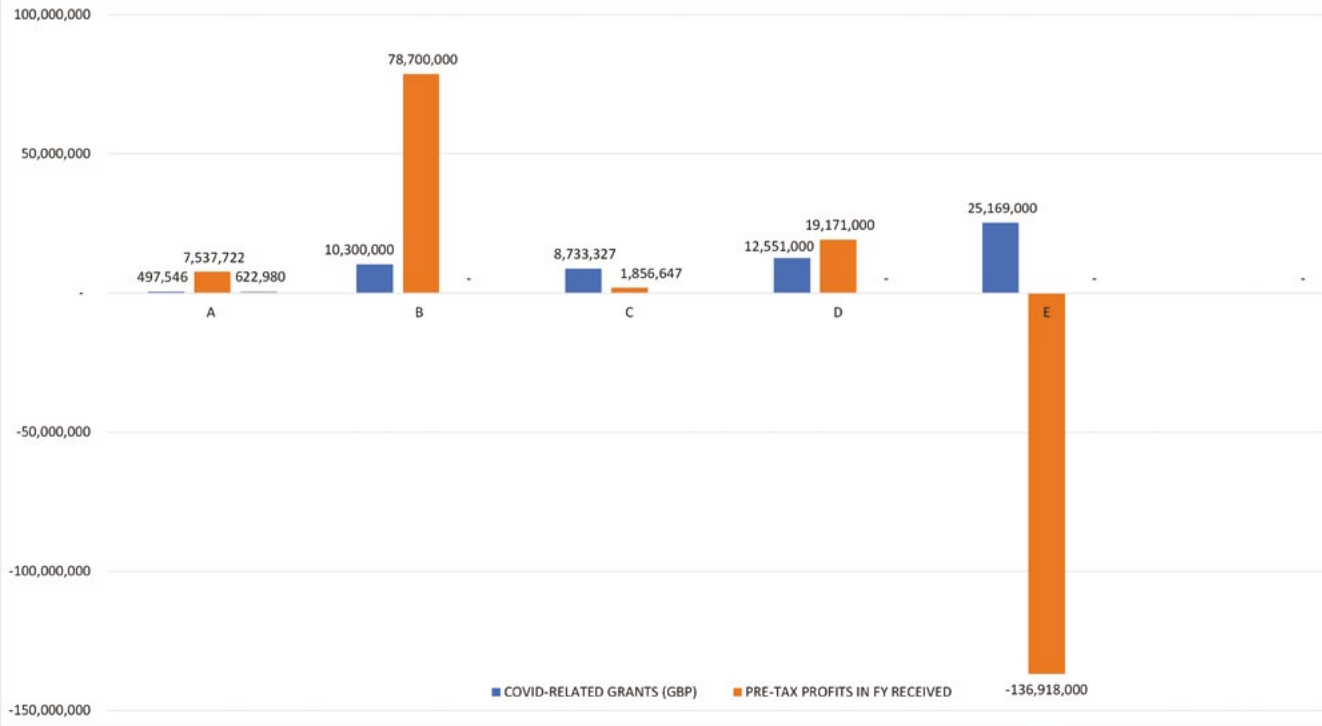
THE MOST PROFITABLE LARGE PRIVATE CARE HOME OPERATORS IN SCOTLAND TAKE OUT £28 OF EVERY £100 OF CARE HOME FEES IN RENT, LOAN INTEREST, DIRECTORS' REMUNERATION AND PROFITS.

LARGE NON-PROFIT PROVIDERS SPEND AT MOST £8 OF EVERY £100 OF CARE HOME FEES ON THESE COSTS.

Two of the five, indeed, declared profits larger than the Covid grants they received. And one, a family-owned business, paid out dividends to its owners 25 percent larger than the Covid grants it received in the same year, on pre-tax profits 15 times larger than its Covid grants (Figure 7).

Finally, there is a clear difference between the proportion of revenues spent on staff – whose ratios and skill levels are strongly correlated with care outcomes (see below) - between these two groups of providers (Figure 8). **The largest ten non-profit providers are dedicating 30 percent more of their revenues to staff costs than the largest ten for-profit providers**.[36] Financial accounts cannot show what this differential means in practice: whether it reflects higher wage levels, more skilled staff (perhaps working with higher-acuity or more specialist

Figure 7: Covid-related grants (blue), pre-tax profits (orange), and dividends (grey) declared in year that grants were received.

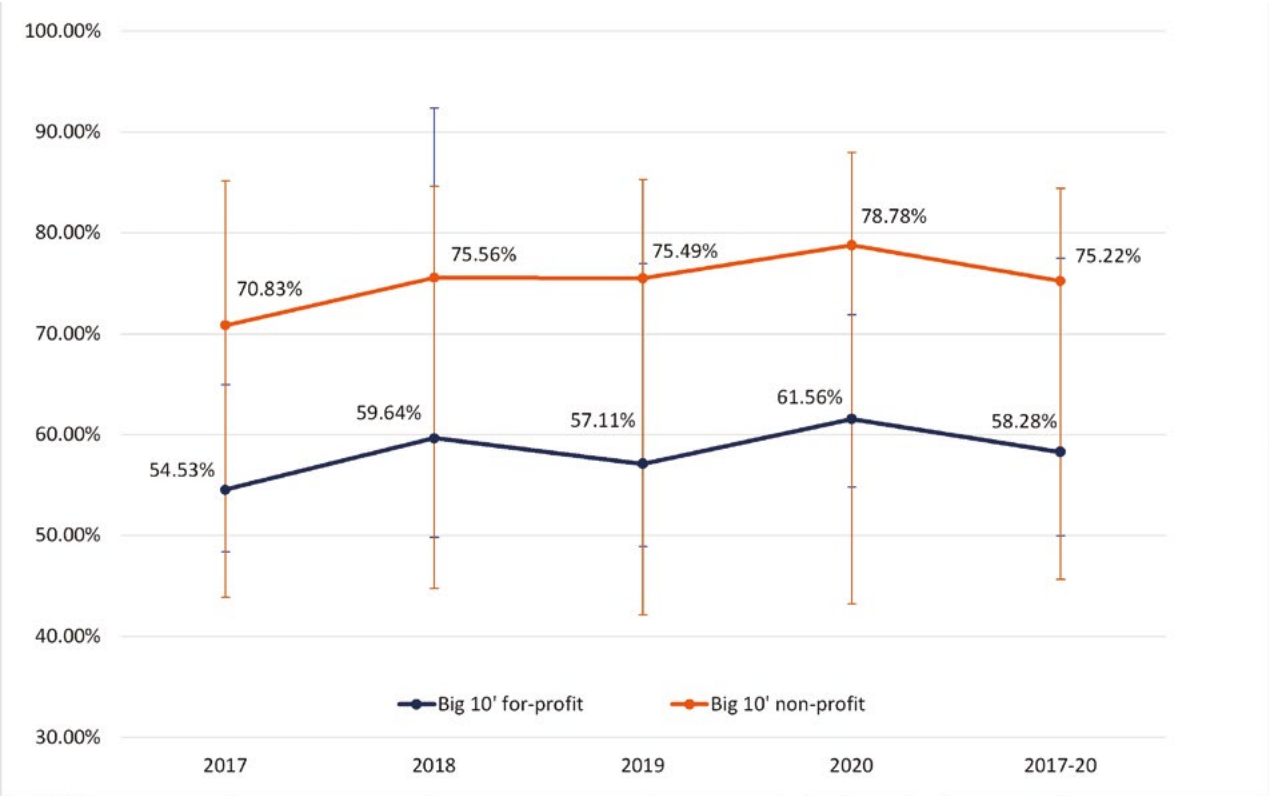


Source: Financial accounts for companies A-E, FY 2020 and FY 2021.

care needs of the kind that the non-profit and public sectors tend to cover), or better staff: resident ratios. Certainly the non-profit sector is not exempt from allegations of poor wages and conditions in frontline care.[37] And there is a significant spread here: some of the large for-profit providers devote more of their revenues to staff costs than some large non-profit providers, as shown in the figure below. Nonetheless, overall, **the for-profit and non-profit sectors are clearly making substantially different choices about how much of their income they devote to paying their employees**.

36 N.B. staff costs as they appear in corporate accounts we hvae analysed include both front-line and managerial staff, including directors' remuneration in some cases.
37 The Common Weal Care Reform Group, Dalzell, C., Hill, J., Kempe, N., MacLeod, M., McAlpine, R., Smith, M., Turbett, C., & Watson, N. (2022). Caring For All. p. 36.

Figure 8: Staff costs as a percentage of revenues, 'Big 10' for-profit and non-profit care home providers, 2017-20



Source: calculations from financial accounts of ten largest for-profit and non-profit care home providers, 2017-20

Of the four channels we examined, **rents are the largest source of 'leakage' from the revenues of large for-profit providers, using up over 11 percent of revenues between 2017 and 2020 (compared to 1.3 percent of the revenues of large non-profit providers**). In many cases these are rents paid to third-party property investors (though often as a result of sale and leaseback deals undertaken by the care home operators themselves). By contrast, charitable providers of non-profit care may often benefit from an existing, historical property portfolio from bequests and other sources. However, in some cases rents may also constitute profits, taken out by a route other than the 'bottom line'.

The care home operator in our for-profit sample with the largest rental 'leakage' spends nearly £22 of every £100 it receives in revenues on rents: some £890 a month for each of the 1340 care home beds it has in Scotland.[38] Three-quarters of this rent between 2017 and 2020 was paid out via complex corporate structure to a company, also belonging to the care home group's owners, in a Caribbean jurisdiction which enjoys a 0 percent corporate tax rate. While some of these rental payments may finance third-party loans for the purchase of the care-home properties, they do so in a highly tax-efficient manner, and we have no way of seeing how much profits are left in the Caribbean, tax-free.

38 Analysis of financial accounts, 2017-20.

CARE HOME REVENUE SPENT ON STAFFING

IMPACT OF FINANCIALISED BUSINESS MODELS

Financial leakage is an issue in principle, as it represents money that could be spent on improving mutually reinforcing conditions for workers and residents.

Whilst there is limited information available that can help fully illustrate the link between this and outcomes for workers, Care Inspectorate data can be used to examine differences in staffing resources. This data has also been used to look at one of the more straight-forward measures for issues at care homes - complaints made to the regulator that are upheld or partially upheld.

A lack of time and being spread too thin amongst service users was recently highlighted in a survey of care workers as contributing to high levels of stress, with nearly three quarters of care home workers reporting that they felt that they did not have enough time to deliver safe and dignified care.[39] As part of their annual returns, registered services report the number of registered places and details on staff employed by the service.[40] The Care Inspectorate uses this to publish whole time equivalent staffing figures based on this in their 'Datastore' monthly release[41]. In order to look at potential differences between different provider types, an estimate of staffing resource was constructed by dividing the number of registered places at a service by the number of whole time equivalent (WTE) staff. As WTE staffing data is unreliable for care at home, this has only been calculated for care homes.

Table 4 - Median ratio of registered places to WTE staff in Scottish care homes for older people.

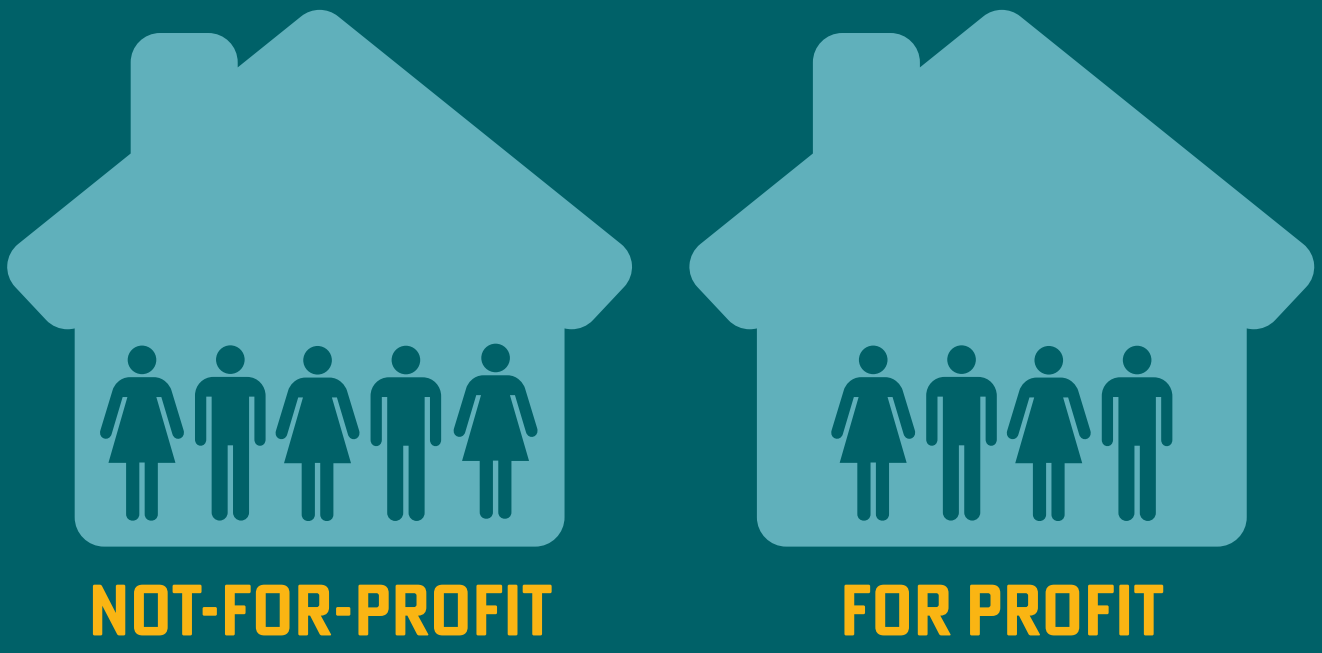
Care homes for older people - provider type	Registered places per WTE staff - median
All private providers	**1.24**
Voluntary or Not for Profit	1.09
Local Authority	0.99
All homes run without profit	**1.03**

Source: Care Inspectorate Datastore, March 31st 2022

It's important to note that this is not an indicator of staffing ratios, especially for a given shift. The number of WTE staff might be made up by a larger number of people working part-time whose availability and work patterns fluctuate and care homes may meet staffing needs by booking agency workers to make up numbers for any given shift.

The median ratio of registered places to WTE staff is higher in the private sector but this is driven by ratios in care homes for older people. For these homes, the median registered places to WTE staff ratio in the private sector is 1.24 compared to 1.03 for local authority and voluntary sector providers. This suggests that **staff resources in care homes for older people are 20% more stretched in the private sector** than in care homes run by organisations that don't make profit.

39 Donaghy, E. and Fisher, M. (2021). 'Show you care - Voices from the frontline of Scotland's broken social care system'. GMB. https://www.gmbscotland.org.uk/Show%20You%20Care%20-%20Full%20Report%20Compressed.pdf
40 Care Inspectorate (2021). 'Annual returns frequently asked questions 2021/22'. https://www.careinspectorate.com/images/documents/6418/Annual%20Returns%20FAQs%202021-22%20(1).pdf
41 Care Inspectorate (2022). 'Datastore (as at 31 May 2022) CSV', available from https://www.careinspectorate.com/index.php/publications-statistics/93-public/datastore



STAFFING RESOURCES IN OLDER PEOPLE'S CARE HOMES ARE 20% WORSE

In older people's care homes, staffing resources are slightly more stretched in the voluntary sector than in local authority homes. For the larger providers included in the financial sample, staffing resources are less stretched compared to the median for all private providers but still more stretched than local authority and voluntary sector homes. In addition, the range of registered places to WTE staff is broader for private sector homes, with more outlier homes with around three registered places for every WTE staff.

Table 5 - Median ratio of registered places to WTE staff in Scottish care homes for children and young people.

Care homes for children - provider type	Registered places per WTE staff - median
Private	0.33
Local Authority	0.48
Voluntary or Not for Profit	0.41

Source: Care Inspectorate Datastore, March 31st 2022

It is important to note that this pattern in staffing resources available is not the case for all types of care homes, especially those for children and young people. Overall, care homes for children and young people appear better resourced according to Care Inspectorate data, however private care homes for children have fewer registered places per WTE staff on average than care homes run by local authorities or the voluntary sector.

In care homes for older people, private care homes not only have poorer levels of staff resources but a higher proportion of homes have complaints upheld against them. As can be seen in table 6, the proportion has been consistently higher for homes in our 'financialised' sample. In 2018/19, only 3% of homes not run for profit (voluntary and local authority) had 1 complaint upheld against them. Of care homes run by the 'Big 10' largest for-profit care home companies, 14% had 1 complaint upheld and 2% had 2 complaints upheld. For the rest of the private sector, 8% of privately-run care homes had 1 complaint upheld against them.

Fig 9 - Percentage of homes with at least one upheld complaint in Scottish care homes for older people by provider type.

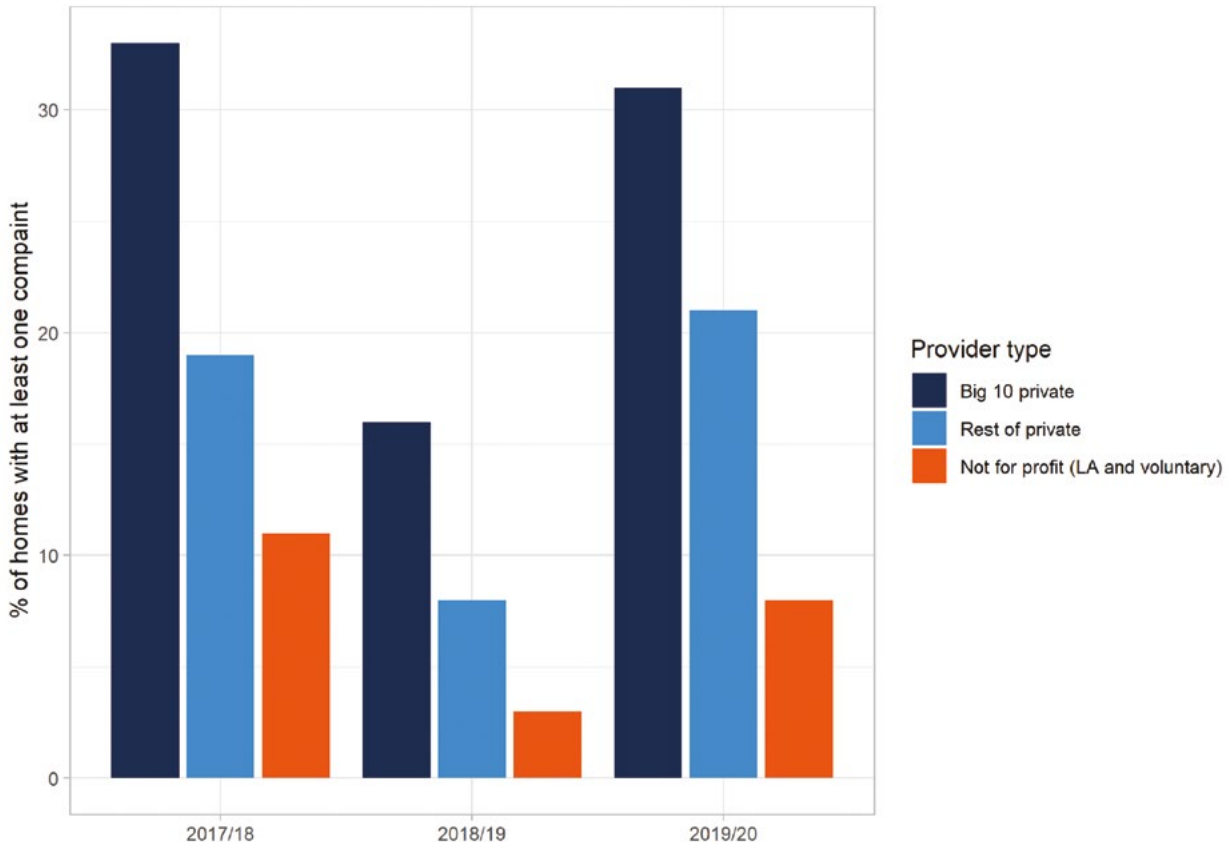


Fig 9 - Percentage of homes with at least one upheld complaint in Scottish care homes for older people by provider type.
Source: Care Inspectorate Datastore, March 31st 2022

Complaints increased overall during the pandemic years of 2019/20 but much more for homes run for profit. **6% of not for profit homes had 1 complaint upheld and 2% had 2 upheld. For 'Big 10' for-profit care homes, nearly a quarter (23%) had at least one complaint upheld, 5% had two, 2% had three and one home had four complaints upheld against it**. In other privately-run care homes, 16% had one complaint, 4% had two and 1% had three.

CARE HOMES WITH AT LEAST ONE COMPLAINT UPHELD 2019-20

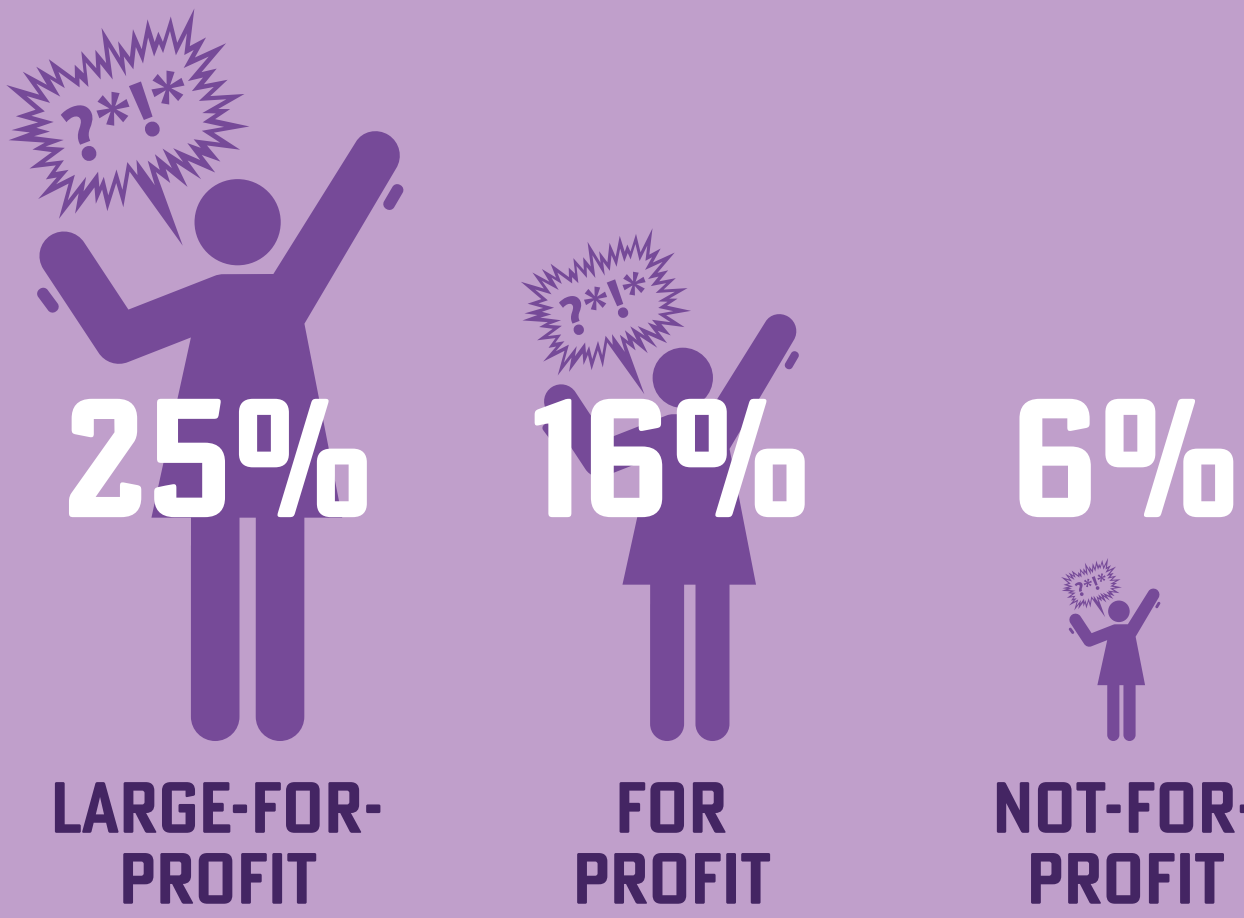


Table 6 - Percentage of homes with upheld complaints in Scottish care homes for older people by provider type.

Number of complaints fully or partially upheld	Financial sample			Rest of private sector			Not for profit (LA and voluntary)		
	2017-18	2018-19	2019-20	2017-18	2018-19	2019-20	2017-18	2018-19	2019-20
1	22%	14%	23%	12%	8%	16%	9%	3%	6%
2	11%	2%	5%	5%	0%	4%	0%	0%	2%
3	0%	0%	2%	1%	0%	1%	1%	0%	0%
4	0%	0%	1%	1%	0%	0%	0%	0%	0%
5	0%	0%	0%	0%	0%	0%	1%	0%	0%
6	0%	0%	0%	0%	0%	0%	0%	0%	0%

Source: Care Inspectorate Datastore, March 31st 2022

PUBLIC, PRIVATE AND NOT-FOR-PROFIT DIFFERENCES

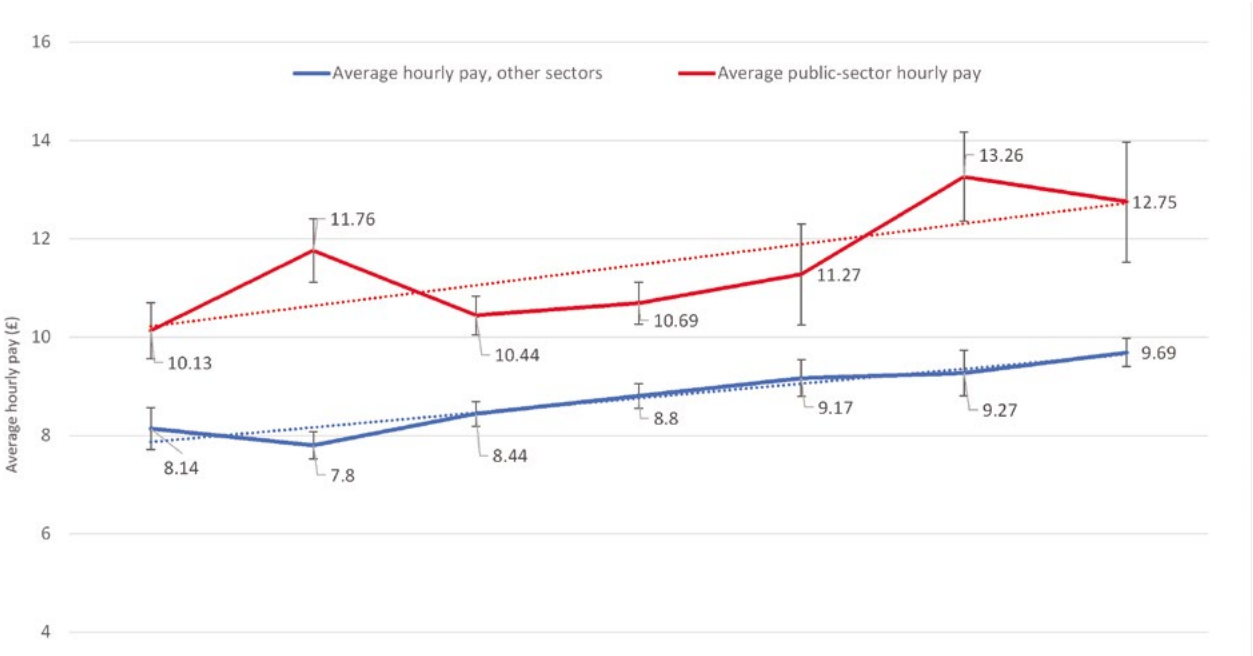
Multiple sources of information, including insight from interviews with trade unions and stakeholders, suggest pay and conditions are higher for public sector employers in adult social care.

Publicly available data is not available to look systematically at how wages and conditions compare between our financial analysis sample and other providers but there is information that indicates some difference between for-profit and not-for-profit providers.

To try and understand any differences in pay the Quarterly Labour Force Survey (QLFS) can be used, which gives data for residential and domiciliary carers combined, split by 'public' and 'private'[42]. In the QLFS, 'public' corresponds to local authority or central government run organisations and 'private' corresponds to all other organisations[43].

This analysis suggests that public sector hourly pay has been consistently higher than pay in other sectors for the last six years. Conservatively, **over the last six years, the public sector has paid on average £1.60 per hour more than other sectors**[44].

Fig 10 - Average hourly pay of residential and care at home Scottish carers, by public sector and all other providers.



Source - Quarterly Labour Force Survey

42 Office for National Statistics, Social Survey Division, Northern Ireland Statistics and Research Agency, Central Survey Unit. (2022). Quarterly Labour Force Survey, January-March 2015 to Oct-Dec 2021. Available form the UK Data Service https://ukdataservice.ac.uk/
43 ONS (2021). 'LFS User Guide. Volume 3 – Details of LFS variables 2021'. Available from: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/methodologies/labourforcesurveyuserguidance
44 See Appendix 1 for more details, including caveats around sample size.

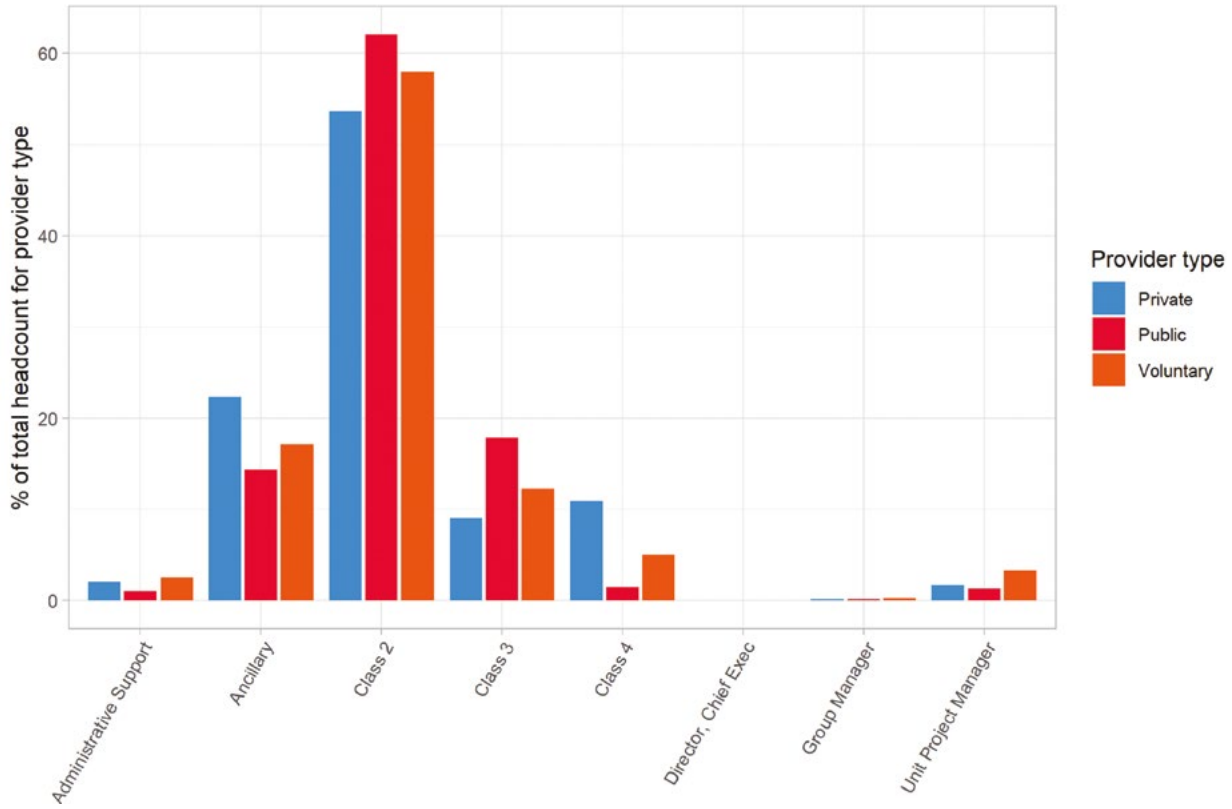
CARE HOME WAGES ARE £1.60 PER HOUR HIGHER IN THE PUBLIC SECTOR

This figure corresponds to a difference of **around £3,000 a year for a full-time member of staff working 37 hours a week**. It is in keeping with a Skills for Care 2016 estimate that Scottish public sector residential care workers are paid a full-time equivalent of £2,900 more than in other sectors[45].

Data collected by the SSSC can be used to further look at any potential differences in the mix of skills of staff in the different sectors. This is calculated by summing numbers of 'class' of workers for each local authority by provider type, as defined by the SSSC46. In care homes for adults, there is a higher proportion of workers in the private sector in a 'Class 4' role, which includes registered nurses and allied health professionals (11% compared to 1% in the public sector and 5% in the voluntary sector). This could be driven by a preference on the part of the private sector for nursing over residential homes and has declined from 14% in 2010.

A higher proportion of private sector workers are in ancillary roles such as kitchen porters and don't provide care directly (22% compared to 14% of public sector workers and 17% of voluntary sector workers). There is also a **considerably lower percentage of 'class 3' or senior carers in the private sector (9% compared to 18% in the public sector and 12% in the voluntary sector**), which could point to reduced opportunities for progression and recognition of experience of carers in the private sector.

Fig 11 - Proportion of workers in different SSSC 'classes' in Scottish care homes for adults.



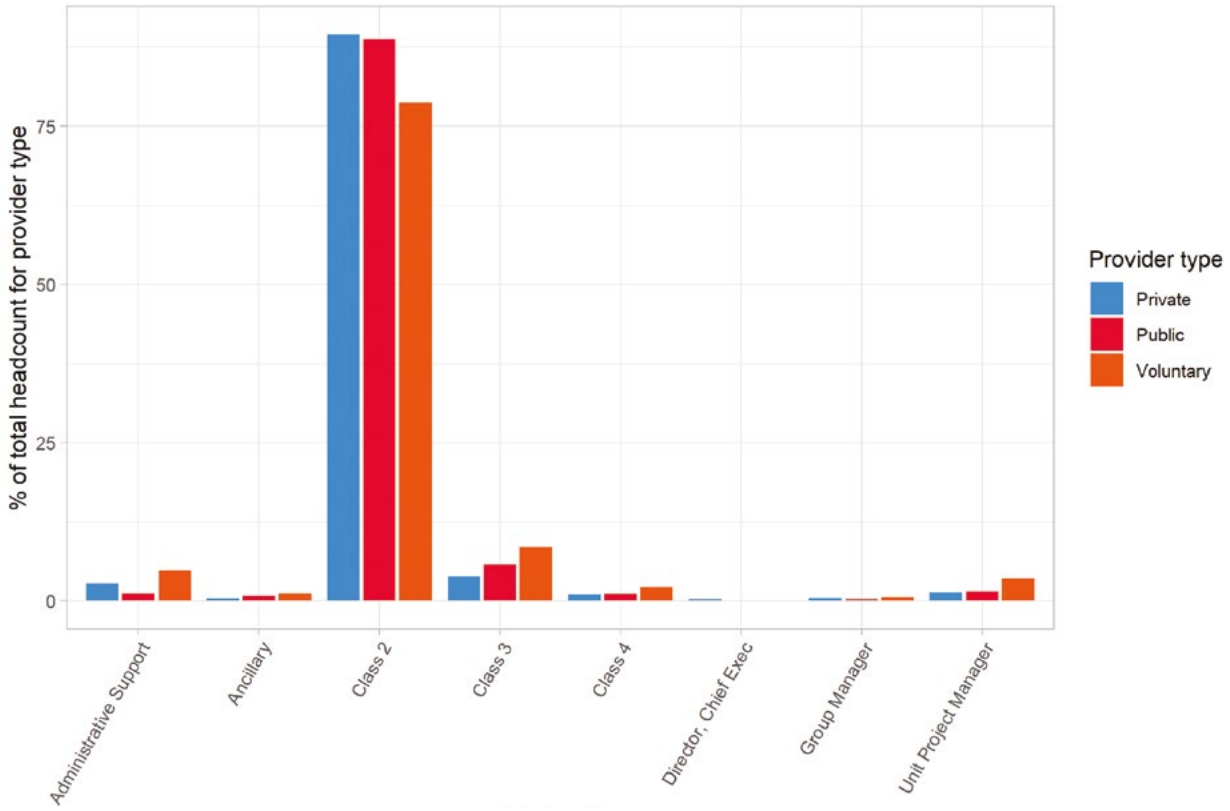
Source: SSSC Workforce Data, December 2020

45 ICF Consulting Limited (2018). 'The Economic Value of the Adult Social Care sector - Scotland', pg 13. Skills for Care and Development. https://skillsforcareanddevelopment.org.uk/wp-content/uploads/2019/03/11-_-2018-The-Economic-Value-of-the-Adult-Social-Care-sector-Scotland.pdf

46 In order to avoid biassing the proportions, entries where the number of staff with an unknown job function was more than 25% of the total staff headcount were excluded, as these entries tended to occur more frequently for private sector statistics. See Appendix 2 for full SSSC class definitions.

This is mirrored in the proportions of workers providing care at home and housing support, where the proportion of Class 3 workers in the private sector is 4% compared to 6% in the public sector and 9% in the voluntary sector. There is a lower proportion of senior support workers or carers across provider types but this is likely driven by the inclusion of housing support workers, who don't provide services such as personal care, in the data on home-based social care. Unlike in adult care homes, the voluntary sector has a small but slightly higher proportion of Class 4 workers than private and public, 2% compared to 1%.

Fig 12 - Proportion of workers in different SSSC 'classes' in home care and housing support.



Source: SSSC Workforce Data, December 2020.

POLICY IMPLICATIONS

In summary, our analysis casts serious doubt on the claims made by the Feeley Review and the Scottish Government that changing the ownership of care services in Scotland is undesirable and unaffordable. The problems we have identified fall into three groups:

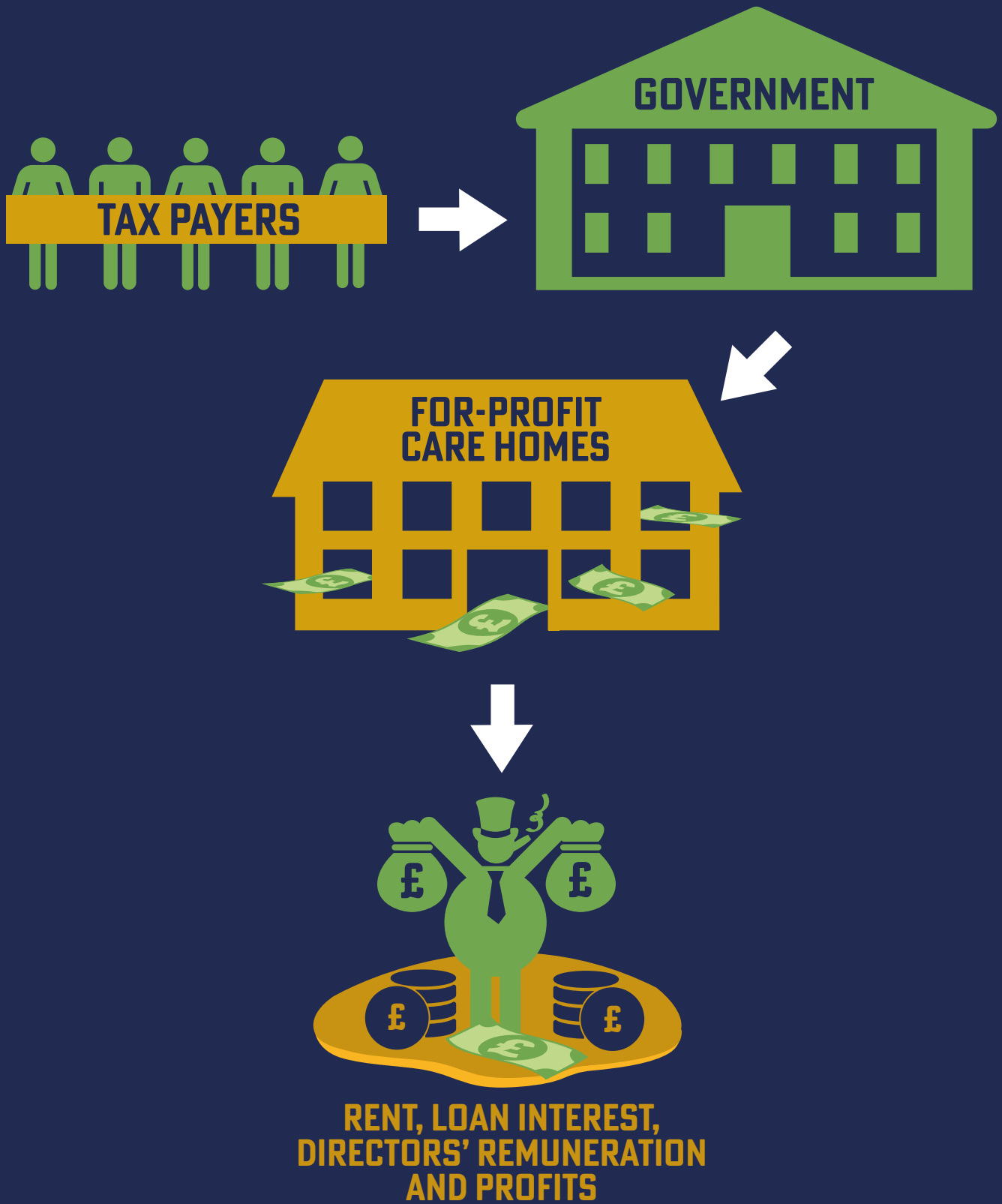
- **Where does the money go?** We identify strong evidence of "leakage" out of the system through various strategies to maximise (often hidden) profit extraction and minimise tax liabilities. For every £100 received by the ten largest for-profit providers, £8.45 goes on costs other than providing care (profits, rent, directors' emoluments and interest payments), and in some years up to £15. This is double the figure for the ten largest non-profit operators. Some of this comes at the expense of the Scottish taxpayer, and some at the expense of workers: for instance, our data confirms that wages are £1.60 an hour lower in private than public care services. It is also likely that self-funding care users are subsidising these excess profits, for example through higher accommodation fees.

- **Who cares?** But the problems with large for-profit firms' business models are not solely financial. There are also less tangible concerns about the conflict between the imperative to maximise returns to investors and the goals of good care and fair work. In other words, there is a mismatch between policymakers' stated aims and the incentives of the institutions entrusted with achieving them. To take just one particularly stark example, large financialised chains tend to favour larger care homes due to the economies of scale they offer. But there is robust evidence linking larger homes with poorer care. It is likely that this helps to explain why private homes suffered more covid deaths. We also find that significantly more complaints are upheld against for-profit care home providers, especially those that are highly financialised. Large for-profit homes also appear to have more stretched staffing resources and fewer senior carers than other types of provider.

- **Who has the power?** Our analysis also reveals that the largest for-profit providers hold a concerning amount of market power, especially in some geographic areas where their market share is particularly high. This gives them the ability to shape how care is offered and to dictate pay and conditions for workers (which, through competitive procurement processes, also acts to drive down standards in the market as a whole). By contrast, workers often have little control individually over their day-to-day work, and little collective voice in working conditions. There is also a clear inequality of arms' between large providers who deploy highly complex strategies of financial engineering and creative accounting, and the ability of regulators and commissioners to identify and stamp out these practices. Finally, the rhetoric of 'partnership working' increasingly gives these providers direct input into policymaking and commissioning, including representation on commissioning boards. We question the appropriateness of such power being held by institutions whose incentives are directly contrary to the goals of good care and fair work.

In light of this new evidence, we believe there is a strong case for reopening the question of how care should be provided under the NCS, and by whom. In the remainder of this report, we consider some alternative options.

PROFITING FROM CARE



THE NATIONAL CARE SERVICE: CURRENT PROPOSALS

As noted earlier, the NCS proposals in their current guise focus on reforming commissioning rather than care provision itself.

In our view, this is the wrong focus. The key change is to shift responsibility for care from local authorities to the Scottish Government. Changes are also being proposed to the commissioning process, with responsibility being transferred to new 'Community Health and Social Care Boards' (CHSCBs) modelled on existing Integration Joint Boards (IJBs). The main lever for driving up working conditions and care quality will be new national standards, including 'ethical commissioning' frameworks. The Scottish Government also pledged in its joint statement of intent with CoSLA to develop "a minimum standards framework for effective voice across the whole of the social care workforce", to support "an effective collective bargaining role in the sector".[47] However, it is as yet unclear whether this will meet the trade union movement's demands for full sectoral collective bargaining, and whether new minimum standards will be binding on providers. (One option canvassed by the consultation was a 'Fair Work Accreditation Scheme' and 'National Job Evaluation Framework' which providers could opt into.) It is also unclear exactly what additional funding will be provided to back up the reforms.

By largely sidestepping questions of ownership and funding, these proposals miss two critical pieces of the puzzle. Concerns have even been raised that they could move us further away from the goal of a democratic, people-centred care system.

For instance:

- COSLA have criticised the plans as an "attack on localism", emblematic of a "centralising approach".[48] Whilst giving responsibility to Scottish Ministers and setting up a new national body aims to improve Scotland's ability to set national standards, many are concerned that it will undermine local democracy and accountability - bypassing elected local authorities in favour of unelected CHSCBs.

- Some observers have suggested that this could actually accelerate the trend towards privatisation and outsourcing, as well as expanding its scope (for instance, by taking activities like children's social work outside of local authority control). Without a significant increase in budgets, CHSCBs will still be under pressure to cut costs, which may further hollow out local authority provision and/or drive down wages for their workforce - a trend we are already seeing.[49] In Edinburgh, the Integration Joint Board (EIJB) sought to close five local authority care homes without the knowledge or consent of the council or local community, and was only forced to pause the plan after a public backlash.[50] [51] Unison has said it holds evidence of major commissioners actively intervening to drive down working conditions through the procurement process in order to cut costs.[52]

47 Scottish Government (2021). 'Adult social care - independent review: joint statement of intent'. https://www.gov.scot/publications/adult-social-care---independent-review-joint-statement-of-intent/
48 Scottish Parliament Information Centre (2021, 5th October). 'More money or more reform? How are the UK and Scottish Governments thinking differently about health and care reform'. https://spice-spotlight.scot/2021/10/05/more-money-or-more-reform-how-are-the-uk-and-scottish-governments-thinking-differently-about-health-and-care-reform/
49 This potentially applies to both care workers and commissioning staff themselves. For instance, Motion 51 passed at STUC Congress 2022 expressed concern that the proposals would "tak[e] workers out of their current wage bargaining structures" within local authorities.
50 Swanson, I. (2021, 2nd October). 'Edinburgh care homes proposed for closure should be refurbished or replaced, says MSP'. Edinburgh Evening News. https://www.edinburghnews.scotsman.com/health/edinburgh-care-homes-proposed-for-closure-should-be-refurbished-or-replaced-says-msp-3403972
51 Swanson, I. (2021, 15th November). 'Edinburgh care home closures: Decision postponed until after next year's council elections'. Edinburgh Evening News.
https://www.edinburghnews.scotsman.com/health/edinburgh-care-home-closures-decision-postponeduntil-after-next-years-council-elections-3457299
52 Unison Scotland (2021, October). 'Care Futures No3 – What would 'Ethical Commissioning' look like?'.
https://unison-scotland.org/care-futures-no3-what-would-ethical-commissioning-look-like/

- Stakeholders have also expressed concerns that the proposals are largely uncosted, and that the top-down reorganisation of commissioning will intensify "upward cost drift" at the expense of frontline care.[53] It is striking that the IRASC and Scottish Government dismissed public ownership outright as an 'unaffordable' distraction from improving services, yet are content to proceed with extensive and disruptive structural changes to the bureaucracy surrounding commissioning, without any attempt to cost these proposals or evaluate the alternative options.

- There are dangers in emphasising 'partnership' approaches to commissioning whilst ignoring questions over whether large for-profit firms are appropriate entities to include in such partnerships. (There has even been some suggestion that provider representatives could become full voting members of CHSCBs.)[54] Whilst we agree that market competition is not the best way to organise care services, shifting towards "collaborative procurement" without altering the sector's ownership structure amounts to giving extractive private providers a 'seat at the table' and insulating them from the pressures of competition. At worst, this could accelerate the cartelisation of the sector and the corporate capture of policymaking and commissioning.

- Connected to this, stakeholders are concerned that the process for designing the NCS itself is not living up to the government's ambitions on co-production. Both Unison and the Health and Social Care Alliance have expressed concern about the involvement of KPMG and PriceWaterhouseCoopers - with Unison noting that their interests in privatised care are "not simply wide but also direct to the point that we would argue they constitute a conflict."[55] By contrast, worker representatives and civil society experts we spoke to in the course of our research felt largely in the dark about how the plans were progressing.

Building on the Feeley Review's recommendations, the Scottish Government does appear to be considering some (extremely limited) steps to address unduly risky or extractive business models in the sector - including transparency requirements in the ethical commissioning framework, and a new 'market oversight' role for the Care Inspectorate. Within what follows, we consider the likely effectiveness of these proposals and ways they could be improved.

53 COSLA, cited in Scottish Government's analysis of consultation responses
54 Scottish Government, 2021, 'A National Care Service for Scotland: Consultation'
55 Unison Scotland (2022, 17th February). Letter to First Minister Nicola Sturgeon MSP. https://unison-scotland.org/wp-content/uploads/Letter-to-First-Minister-PW-KPMG-social-care.pdf

A CARE SERVICE FOR PEOPLE NOT PROFIT

In our view, the evidence discussed in this report more than justifies the complete exclusion of for-profit providers from the care system.

We broadly support the Common Weal Care Reform Group's proposed alternative, which would entail:

1. A single cradle-to-grave service, with all care provided on a non-profit basis, free at the point of need.
2. Public sector as the default provider, but with a key role for the voluntary sector, particularly in specialist services and informal, preventative community provision.
3. 'Local Care Hubs' to be the first port of call for care services, co-locating with other community services such as housing/debt advice and credit unions.
4. Care workers to be given more discretion to use their judgement and build relationships with those they support, rather than a 'time and task' approach.
5. Individual care users to retain control over their own care where they want it.
6. Funded by the Scottish Government, but delivered by local authorities, through bottom-up participatory planning.
7. National collective bargaining, led by trade unions, as the key mechanism for setting sector-wide pay and conditions.
8. A national Board of Councillors, chaired by a Scottish Cabinet Minister, to be responsible for a limited range of functions including workforce planning, training, collective bargaining, and national commissioning of specialist services.
9. The Care Inspectorate and Scottish Social Services Council to be merged and refocussed on holding local authorities to account for the quality of services.
10. Worker's fitness to practice to become the responsibility of employers, not employees.

We believe these proposals are consistent with motions passed at STUC Congress 2022 which call for a "not-for-profit NCS", "properly funded and publicly owned … delivered free at the point of need and involving participation from trade unions and local government".[56] They are also supported by the evidence we have gathered.

It is worth noting that the language of 'nationalisation' used by the Feeley Review is misleading here, because what we are really talking about is local democratic control. The evidence overwhelmingly suggests that **care quality cannot be guaranteed from the top down, either by large chains or government-led standard setting**. As one team of academics highlights, "a care home is not like a fast food franchise because care involves complex human relations, judgement and discretion. Chain organisation appears to deliver few benefits in care because the chains have been unable to proceduralise excellence: all have branches which range from excellent to awful."[57] Good care can only be built from the bottom up, by empowering workers and care users to build strong and lasting relationships. Similarly, a step-change in the status of care workers will not be achieved solely by top-down standard-setting, but by changing the structure of the system to give those workers more power, voice and discretion.

56 STUC (2022). 'Scottish Trades Union Congress - 125th Annual STUC Congress, Final Agenda'. https://stuc.org.uk/files/Congress_22/STUC_Final%20Agenda_2022.pdf

57 Burns, D. et al. (2016). 'Where does the money come from? - Financialised chains and the crisis in residential care'. CRESC Public Interest Report. https://hummedia.manchester.ac.uk/institutes/cresc/research/WDTMG%20FINAL%20-01-3-2016.pdf

Evidence suggests that there are significant diseconomies of scale when it comes to quality care, both at the level of the care setting and the company itself. At UK level, smaller care homes tend to be higher rated by the Care Quality Commission. As we have seen, large private providers systematically favour larger care homes, with this trend likely explaining their comparatively high levels of covid deaths. At provider level, research has documented a similar dynamic in non-residential care. While large providers displayed a clear trade-off between price and quality, 'micro-businesses' (defined as those with five employees or fewer) were able to provide more personalised and highly valued care without a higher price tag.[58] All of this suggests that we should be aiming for a care sector that is **underpinned by public investment, but run by an ecosystem of small-scale providers – under both public and social ownership – that eliminates value extraction and prioritises the human needs of those involved**.

BRINGING CARE HOMES INTO PUBLIC OWNERSHIP

The Feeley Review declared that "nationalising the sector would require an unaffordable level of public outlay, particularly in terms of investment in capital".

This conclusion was evidenced solely by the £900,000 cost to the public purse of taking over Home Farm care home on Skye. Another frequently -cited figure is the £2bn estimated value of the Scottish care home estate, provided by Christie's to the Scottish Government at the height of the pandemic. (Even this act prompted a hysterical reaction from some providers, with one CEO suggesting it had broken their "trust" and asking, "How can Scottish Care and the independent and voluntary care home sector continue to work with the Scottish government after this?" This veiled threat of non-cooperation - during a public health emergency in which their residents were dying - arguably reveals a concerning level of entitlement and complacency.[59])

These figures are not meaningful as an estimate of the 'cost' of expanding public ownership for a number of reasons. First, the value of care home assets is based not just on the land and buildings but on the licence to operate care services within them. At present, this provides a highly reliable stream of fees to care home owners, particularly since the Care Inspectorate's sanctions against poorly performing homes are few and rarely used (partly because the ultimate sanction is closure, which is a bad option for residents and the wider system). In other words, valuations reflect the fact that there is minimal risk of providers' licence to operate being revoked, however poor the care. If steps were taken to **strengthen regulation - for instance, by providing that poorly performing homes would be taken into public ownership**, as Home Farm was - this would in itself be likely to reduce these homes' value as financial assets, thus reducing the cost to the state of acquiring them.

58 Needham, C., Allen, K., Hall, K., McKay, S., Glasby, J., Carr, S., Littlechild, R., Tanner, D. (2015). Micro-Enterprises: Small enough to care?, University of Birmingham. Retrieved from: https://www.birmingham.ac.uk/news/2015/micro-enterprise-small-enough-to-care

59 Healthandcare.scot (2021, 4th January). 'Valuation request sparks care home takeover fears'. https://healthandcare.scot/mobile_default.asp?page=story&story=2374

Indeed, Common Weal's calculations suggest that the Home Farm takeover cost just under £26,000 per bed. Taking this as a benchmark (as the Feeley Review does), they suggest that the 31,757 private sector care home beds for adults in Scotland could be bought for less than £1bn. Under the UK government's recent changes to National Insurance, Scotland is expected to receive between £1bn and £1.45bn extra per year in Barnett consequentials.[60] As Common Weal propose, **the care home estate could be brought into public ownership gradually over time** using a portion of this money - say £200m a year - leaving the remainder to spend on other priorities such as raising pay and expanding free entitlements (which most stakeholders believe were under-costed by the Feeley Review). Alternatively, **the Scottish National Investment Bank could be mandated to provide loans to local authorities or community groups** seeking to buy out care homes. Another option (suggested by commentator Nick Kempe) is **'care bonds' marketed at Scottish citizens** with savings to invest;[61] or simply treating this as infrastructure investment and using the Scottish Government's capital borrowing powers.

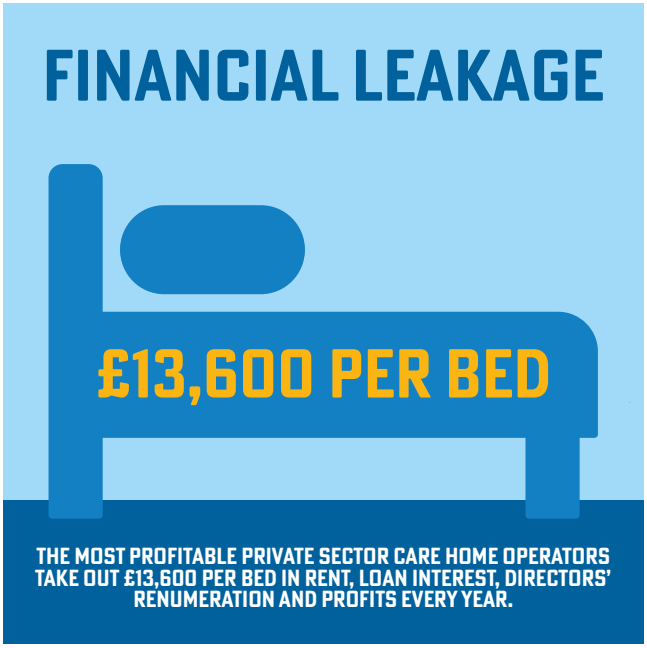
Of course, treating this expenditure as a pure 'cost' is in any case misleading. The Feeley Review rightly insists that social care spending should be seen as "a good investment in our economy and our citizens". It also acknowledges that a significant amount of that "investment" currently leaks out of the system altogether via extractive for-profit arrangements (in other words, it is not really 'investment' but simply money down the drain). Also to be considered are the indirect costs of managing relationships with private providers - including competitive tendering processes, regulatory oversight and contract management. These costs might be justified if they were shown to deliver superior care - but, as we have seen, if anything the opposite is true. By contrast, capital expenditure on acquiring care homes would be the opposite of 'money down the drain': it would be a genuine investment in acquiring a valuable asset.

Most obviously, by acquiring property assets, rental fees would no longer be flowing out from the public purse to private companies; instead they would be flowing in from self-funding care home residents to the public sector. Rent is the single biggest area of 'leakage' for Scotland's largest for-profit providers, accounting for 11.45% of revenues (compared to 1.27% for large non-profits). In real terms, this means the largest for-profit providers spend around **£5300 per bed per year** on rents: if smaller for-profit providers spend around 1/8th of this as a proportion of their revenues, as previous UK studies have found, this amounts to perhaps **£73 million a year** across all for-profit providers in Scotland.[62] Public ownership of care homes could all but eliminate this cost. Instead, government would only need to finance its own repayments on any borrowing necessary to acquire homes. These would be at much lower interest rates than the substantial loan repayments currently being made by private providers, which the public sector is already financing indirectly. The real question, then, is the payback time on the up-front capital investment involved in acquiring care homes. Neither the Review nor the Scottish Government have made any attempt to quantify this. Whilst the figures cited above are inevitably crude approximations, the fact that the NCS proposals have not been informed by even this basic level of cost-benefit analysis is striking.

60 Estimates vary; Common Weal put the figure at an estimated £1.45bn, while Audit Scotland have placed it at £1.1bn (see https://www.audit-scotland.gov.uk/publications/social-care-briefing).

61 Nick Kempe, 5 Feb 2021, 'The Feeley Review on Adult Social Care offers only more of the same', Source News. https://sourcenews.scot/nick-kempe-the-feeley-review-on-adult-social-care-offers-only-more-of-the-same/

62 See Appendix 2 for details of this calculation. Rent leakage is greater than total leakage due to large losses by the two largest for-profit providers. The ratio of 1:7.7 for the rental payments of small/medium vs. large for-profit providers is in Kotecha, V. (2019) 'Plugging the leaks in the UK care home industry: Strategies for resolving the financial crisis in the residential and nursing home sector'. CHPI. https://chpi.org.uk/wp-content/uploads/2019/11/CHPI-PluggingTheLeaks-Nov19-FINAL.pdf
It is unclear whether this ratio applies equally to the Scottish market, so the estimate of £80m rent expenditure per year should be regarded only as a rough reckoning.



More widely, any costing of taking private care homes into public ownership should recognise the opportunity cost of them remaining in private hands. Overall the amount spent by the ten largest private-sector care home operators on rent, loan interest, directors' remuneration and profits equates to **approximately £4000 per bed each year** between 2017 and 2020.[63] (This figure is lowered by the large losses suffered by the two largest providers, HC-One and Four Seasons Healthcare, the latter going into administration in 2019. Excluding these two providers, **the rest of the 'Big 10' for-profit providers 'leaked' over £10,400 per bed** through these channels, with **the most profitable taking out £13,600 per bed, seventy percent of which was paid out to the directors, owners, or companies related to them**). If, as other studies suggest,[64] such 'leakage' is even half as large across the rest of the (smaller) private care home providers in Scotland, this represents 'leakage' on these costs of **over £100 million a year**.

Not all of this 'leakage' is illegitimate, or would be eliminated by public ownership: the public sector might still have to borrow to acquire or upgrade properties, though likely at much lower rates, and would still pay senior managers. Nonetheless the type of provider and its business model clearly makes a difference: equivalent 'leakage' of revenues from the ten largest not-for-profit care home providers in Scotland through these four channels is less than half of the leakage through the ten largest for-profit homes.[65]

Of course, if we accept that large private providers are favouring suboptimally large homes, we might ultimately want to use public and community ownership to reformat care, rather than simply taking over existing homes. We focus here on the latter not because it is the most important piece of the puzzle, but because it is the basis for flawed claims that changing care ownership is unaffordable.

It is also important to be clear that we are not suggesting that tackling private sector 'leakage' is a substitute for proper funding of adult social care. The sector is right to highlight systemic under-funding as a driver of poor quality care and low wages. No solution to Scotland's care problems will work if it does not address this. But this funding challenge is precisely why Scotland cannot afford to waste the money it does spend on care. As our financial analysis shows, claims by large private providers that they cannot make ends meet, and that their own poor practices would be rectified by a further injection of public funds, are self-serving and disingenous. As a landmark report on UK care homes put it, "**giving the financialised chains more money is like pouring water into a leaky bucket**".[66]

63 See Appendix Two for details of this calculation.
64 A UK-wide study using companies' financial accounts from 2017 found 'leakage' through these channels was 7.07 percent of revenues for small to medium sized private care home providers, and 13.35 percent of revenues for large private care home providers. See Table 3 (p.30) in Kotecha, V.(2019) 'Plugging the leaks in the UK care home industry: Strategies for resolving the financial crisis in the residential and nursing home sector'. CHPI. https://chpi.org.uk/wp-content/uploads/2019/11/CHPI-PluggingTheLeaks-Nov19-FINAL.pdf
65 'Per bed' leakage is difficult to estimate for non-profit providers because these providers are typically providing a range of social services to various service user groups, for which revenues and costs are not usually accounted in comparable ways. The largest ten for-profit residential care providers, by contrast, are exclusively residential care providers. For this reason, comparison of leakage by % of overall revenues is a more justifiable comparison.
66 Burns, D. et al. (2016). 'Where does the money come from? - Financialised chains and the crisis in residential care'. CRESC Public Interest Report. https://hummedia.manchester.ac.uk/institutes/cresc/research/WDTMG%20FINAL%20-01-3-2016.pdf

'ETHICAL' COMMISSIONING

The Feeley Review recommends that "the National Care Service should take [leakage] concerns into account as part of its development of a new approach to ethical and collaborative commissioning.

National contracts, and other arrangements for commissioning and procurement of services must include requirements for financial transparency on the part of providers along with requirements for the level of return that should be re-invested in the service in order to promote quality of provision and good working conditions for staff."The Scottish Government's consultation on the NCS sought views on a financial transparency requirement, but did not mention re-investment.

In our view, this approach is simply unworkable and displays a lack of understanding of the financial engineering strategies used by large chains to extract profit. As our analysis shows, financialised firms are often loss-making or barely profitable on paper, but are using an array of other tactics to extract disguised profits from the business (such as intra-group loans or rental payments). In one case in our sample, a large care-home group books a pre-tax profit margin of under 3 percent on paper, but actually makes related-party interest and rental payments that could constitute a real profit extraction of up to 22 percent of revenue. "Requirements for the level of return that should be reinvested" would thus be trivially easy for providers to game. "Financial transparency" in itself will not be enough to prevent this, particularly in a situation where regulators and commissioners have no extra resources to scrutinise disclosures which are likely to be highly complex.

This could be somewhat mitigated if regulators specified **a set of simple reporting metrics**, perhaps corresponding to the metrics we have analysed in this report - for instance, percentage of revenues spent on staffing costs, directors' remuneration, interest payments, rental payments and UK tax paid, in addition to profits, which companies could be required to disclose in an easy-to-read factsheet. **This is the bare minimum** that could be done to address the issues we have highlighted: commissioners and civil society actors cannot be expected to dig through companies' accounts to work out this information. The Care Inspectorate could **benchmark providers against the sector** as a whole and raise 'red flags' with commissioners about signs of excess profit extraction or unduly risky business models. They could go further and set limits above which providers would be ineligible for procurement processes, or be given stronger powers to **disqualify specific providers** from being 'fit and proper persons' to provide care by reason of their business model. However, we are still concerned that providers would find ways to 'game' or capture any framework of this kind, leaving regulators struggling to hold their own. Ultimately, **we remain unconvinced that this is a better approach than simply excluding for-profit providers** from procurement altogether.

'Ethical commissioning' is also a key plank of the Scottish Government's plans to ensure that fair work criteria are met in the care sector. However, once again, providers will be strongly incentivised to squeeze workers in other ways. As Nick Kempe points out, setting specific requirements around criteria such as hourly pay rates leaves open the possibility that providers will seek to recoup these costs elsewhere - including through the range of tools we know they already use to pass on costs to workers, such as unpaid travel time, requiring them to pay for their own equipment and training, etc. He and others also suggest that the recent requirement to pay care workers the Scottish Real Living Wage may have contributed to de-skilling and pay compression further up the pay scale.[67] This may help to explain our finding that for-profit firms employ proportionately fewer senior carers. Finally, concerns were raised with us that providers facing uncertainty about the costs of the NCS reforms may simply look to crystallise their gains by selling off care homes in a booming property market - potentially causing shortages of provision in some areas.

67 Kempe, N. 2020. 'The predictable crisis: why covid-19 has hit Scotland's care homes so hard.' Common Weal. https://commonweal.scot/wp-content/uploads/2020/05/Predictable-Crisis.pdf

In our view, **mandatory sectoral collective bargaining is the right tool to ensure minimum standards for pay and conditions** - supported by a **concerted effort to increase union density in the care sector** and **a funding settlement which adequately covers these costs**. Unless new standards are backed up by a significant increase in funding, cost pressures will continue to push procurement towards the lowest common denominator. 'Ethical commissioning', by contrast, should **focus on the *kinds of organisations* that are best suited to providing good care** and a fair deal for care workers. As long as care provision remains in the hands of companies whose overriding interest is to maximise profit for investors, commissioners and regulators will be constantly playing 'whack-a-mole' against companies with vastly more resources than them. Conversely, policymakers should be seeking to understand the institutional factors that underpin good care and spread them as widely as possible. For instance, the Feeley Review admits that care quality is generally highest in the third sector, but fails to interrogate why. It would not be surprising to find that charities whose mission is to support care users are better at safeguarding user interests than private entities whose mission is to deliver investor returns.

'Ethical commissioning' should thus consider factors such as **business model, ownership structure, governance, scale, worker and user voice, trade union recognition/collective bargaining rights and institutional culture**. Shifting the focus of commissioning to these factors would facilitate the move away from competitive tendering and framework agreements - which have been consistently identified as contributing to poor working conditions in the sector, such as insecurity and overwork[68] - towards the 'partnership' approach which Scotland aspires to. Instead of tendering for a specific service on a short-term basis, commissioners could identify organisations which could be trusted to treat workers and care users well, and back them with the stable long-term funding they need to do so - using a blend of approaches such as 'public-social partnerships', community commissioning and direct core grants.[69] Of course, the quid pro quo must be a discerning approach to who is deemed a fit and proper institution to be a 'partner' in this way. It may also require commissioners and policymakers to work proactively to in-source services, or incubate new organisations, where these institutions do not exist.

Criteria could thus be both positive and negative - for example, seeking to **support and incubate local public, community-led or co-operative care solutions** (see box), whilst **excluding for-profit providers** whose business models are in conflict with the public interest. In our view this should encompass all for-profit providers; but, even if policymakers do not wish to go this far, **the case for excluding large financialised chains is overwhelming**. In the case of care homes, this would require a long-term plan for acquiring the necessary assets to provide beds in other ways, as discussed above. The barriers to reshaping community-based care provision are much lower, since this part of the system is less asset-intensive.

68 See for example https://www.ccpscotland.org/hot-topics/improve-commissioning/procurement
69 For a good overview of approaches to collaborative commissioning between the public and voluntary sector, see the Coalition of Care and Support Providers in Scotland (CCPS)' Commissioning and Procurement Resources page: https://www.ccps-big-ideas.org/commissioning-procurement-resources

Criteria must also be designed to avoid support being directed to large firms deploying the same extractive strategies as for-profit firms via a non-profit or co-operative wrapper. This, in our view, is the key danger of a mixed ecosystem of care provision, as opposed to a fully public service. Whilst these risks can be justified by the higher quality of care that genuinely user-led, community-based organisations can provide, and by the rights of care users to control their own care, policymakers and commissioners **must be mindful that the boundary between for-profit and non-profit services can be blurred in practice. They must therefore always look 'under the bonnet' at firms' business models and practices**, rather than simply assuming that firms with a particular organisational form or structure will automatically meet their requirements. The Care Inspectorate's 'market oversight' function (see below) could support this.

There are many examples of good practice to draw on from local authorities across the UK who are already using commissioning to shape the local care ecosystem. For instance, the London Borough of Newham has specified that home care providers must have a good knowledge of the community and must operate from an office in Newham. They are required to actively recruit care workers who reflect the Borough's diverse population, pay a living wage and adhere to UNISON's ethical care charter. Each provider is limited to one lot, which is inherently unattractive for large providers seeking economies of scale and high market share.[70] This has helped to ensure that care is provided by small local businesses which keep wealth circulating in the community.

Other local authorities have proactively sought to incubate new community-led providers. For instance, under the auspices of its wider community wealth building strategy, Wigan has deployed its business development team to support local care workers to set up community interest companies (CICs) - helping them to apply to the Community Investment Fund, and in some cases providing loans to assist with cash flow. While in this case the initiative was prompted by the closure of council-run daycare services, it is easy to see how the same principles could be adapted to prepare the local community to take over services from existing private providers.

The Feeley Review does recommend that "the development of … co-operatives, user-led and community-owned organisational models, and social enterprise models, should be encouraged to help improve quality, flexibility, resilience and responsiveness to people's needs". It also recommends that care "should feature prominently in economic policy … as a focus of investment supported through organisations like the Scottish National Investment Bank and economic development funding." No concrete proposals have yet been made to join these dots. We therefore recommend **a specific programme to grow the community-led and co-operative care sector, led by the NCS in partnership with local authorities, the SNIB and the voluntary sector**. This could include support with business development, skills and access to finance, alongside supportive commissioning practices.

 70 Lloyd Goodwin, T. 2020. 'Transforming ownership in the adult social care sector.' CLES.

CASE STUDIES: CO-OPERATIVE CARE

Equal Care Co-op is a platform co-operative based in Yorkshire whose stated mission is to put "power in the hands of those who matter most - the people who give and receive care and support."

It delivers home-care through self-governing teams, or 'circles', where the person receiving support selects the other team members – a mix of paid workers, family members and community volunteers. These teams are free to organise themselves as they choose without having to constantly refer decisions up a management chain. Decisions at both team and organisation level are based on consent, using a model known as 'sociocracy'. The aim is to build lasting, respectful relationships – so that people see the same person day in, day out. Free from the imperative to extract profits, they also offer a materially better deal for workers. Members set their own rates and take home an average £14-15 an hour - much higher than the sector average - with 80% of revenues going on staff costs. The technology behind its online platform is also co-operatively owned.

Highland Home Carers is one of the largest home care providers in the Highlands, with 500 staff and a turnover of £5m. Founded in 1994, it became owned by its employees in 2004, and is now the second largest employee-owned business in Scotland. It differs from Equal Care Co-op in that it does not have a multi-stakeholder model which includes care users alongside workers, nor does it have the same 'sociocratic' governance structure. However, employees do receive a profit-share bonus and workers are represented on the board.

A final option is, of course, for **local authorities to simply bring provision back in-house ('insourcing')**. In Halton, Merseyside, the local council has successfully brought four care homes back in-house.[71] Salford City Council has been a pioneer of in-sourcing care services, including most recently the 'Shared Lives' service, previously delivered by a private company called Aspire, whose staff were transferred into the council under TUPE arrangements. Part of the rationale has been the ability to co-locate staff with the council's adult social care team, giving them both more support and more ability to shape the services on offer. Such approaches show how, even within the existing system, local authorities can seek to shift from a fragmented and inefficient market towards an integrated public service. Of course, this is made more difficult by the **proposal for the NCS to bypass local authorities** and instead become a relationship between the Scottish Government, a national NCS body and CHSCBs. We therefore recommend that this change **should not go ahead**.

Salford City Council has also worked directly alongside Salford Unison to improve workers' bargaining power and involve carers in decision -making and commissioning. Among other things, this helped to achieve a £19m pay rise for care workers at Anchor Hanover, England's largest provider of specialist residential and elderly care.[72] In turn, the sense that workers are being listened to by the council has helped to buoy workplace organising and improve union penetration amongst Salford's private sector care workers. These strategies were partly driven by the failure of voluntary initiatives such as the Salford Employment Standards Charter to deliver significant improvements to pay and conditions. Scotland would do well to learn from this in developing its approach to 'ethical commissioning': **a 'Fair Work Accreditation Scheme' is likely to be similarly ineffective in the absence of changes to the structure and power dynamics of the sector**. Unions have a critical role to play in this.

71 ibid
72 Steven North & Paul Dennett, 8 Dec 2021, 'How Salford Won Big for Carers', Tribune

THE CARE INSPECTORATE'S 'MARKET OVERSIGHT' ROLE

The Feeley Review recommended that "the care home sector must become an actively managed market with a revised and reformed National Care Home Contract in place, and with the Care Inspectorate taking on a market oversight role."

The Scottish Government's consultation suggests that this role may include "strategic understanding of the care market, and the sustainability of providers" to enable contingency planning against "care service closures and other market failures". It cites the UK Care Quality Commission as a model to follow - astonishingly, the Care Inspectorate does not yet have similar powers to require providers to share financial information. In our view, care providers in receipt of public money should be subject to Freedom of Information, so that they can be held to account by ordinary citizens as well as regulators. Audit Scotland has also highlighted that "with the growing financial and workforce pressures facing private and voluntary providers, it is important that Integration Authorities have contingency plans in place and that the financial health of key strategic providers is monitored".[73]

As we have explained, large financialised providers do not simply 'face' financial risks: they actively create them through the use of debt to maximise profit extraction. **The Care Inspectorate should be required to proactively assess these risks, and work with public bodies to establish contingency plans against provider failure**. Scotland must not repeat the mistakes made following the collapse of Southern Cross, which simply replaced one large financialised chain with another, very similar large financialised chain - the newly-established HC-One. Among the homes affected was Home Farm on Skye, which NHS Highland was forced to take over during the pandemic after a covid outbreak and an unannounced inspection which found the quality of care was inadequate.[74] The relatives of Colin Harris, one of ten residents who died in the outbreak, are now joining other families of HC-One residents in suing the company over "allegations that systemic failings at their homes led to hundreds of COVID-19 deaths which would otherwise have been avoided".[75] If a large chain collapses in future, contingency plans must be in place to **transfer their assets to an organisation better equipped to provide good care - preferably under local public or community ownership**.

We would also question whether the Care Quality Commission offers a sufficient model to follow, given that the issues we have highlighted in this report remain rife across the UK care system. The NCS reforms should go further, requiring the **Care Inspectorate's market insight function to work proactively with local and national authorities to reshape the care sector**. For instance, it could identify areas where particular providers have undue market power and support commissioners to address this, including through in-sourcing and incubation of community-owned care as discussed above. It could also be required to provide policymakers and commissioners with regular and robust analysis of the various issues covered in this report, such as how different providers perform on various key outcome metrics. Market analysis should be undertaken by in-house public servants, not outsourced to consultants who may have conflicts of interest relating to private care provision. This could be a step on the road towards **a care service that is democratically planned in the public interest, rather than simply a 'managed market'**.

73 Audit Scotland (2022). 'Social care briefing'. https://www.audit-scotland.gov.uk/publications/social-care-briefing
74 NHS Highland (2020, 2nd November). 'Transfer of Home Farm care home to NHS Highland'. https://www.nhshighland.scot.nhs.uk/News/Pages/TransferofHomeFarmcarehometoNHSHighland.aspx
75 Leigh Day (2020, 10th September). 'Potential legal case against largest UK care home operator HC-One'. https://www.leighday.co.uk/latest-updates/news/2020-news/potential-legal-case-against-largest-uk-care-home-operator-hc-one/

SUMMARY OF RECOMMENDATIONS

In summary, we have uncovered strong evidence that Scotland's for-profit private care providers - particularly large financialised chains - perform systematically worse than other types of provider in terms of working conditions, care quality and value extracted from the taxpayer. This adds to a growing body of international evidence.

Based on these findings, we recommend that:

- A truly transformative National Care Service must be based on a **not-for-profit public service**, delivered through **local authorities** with an ongoing role for the **voluntary sector**.
- Social care should be viewed as critical infrastructure in Scotland and the sector supported as a key economic growth sector providing sustainable employment opportunities.
- The Scottish **care home estate should be transferred out of private ownership gradually over time** - for instance, through a multi-year plan backed up by Barnett consequentials from the UK government's NI tax rise, SNIB loans, 'care bonds' or capital borrowing. For the most extractive providers, this could pay for itself within a matter of years.
- 'Ethical commissioning' should mean **an end to new procurement from for-profit providers** and competitive tendering. Instead, commissioners should seek to identify public and non-profit entities that can be trusted to treat workers and care users well, and support them with **stable long-term funding**.
- **Local authorities** should retain responsibility for care services in their area, and should be **supported to in-source services** where appropriate
- A new programme should be set up to nurture an ecosystem of local **community-led and co-operative care provision**, including through business support and access to finance.
- **Trade unions must be recognised for sectoral collective bargaining**, backed up by **increased funding**. This, alongside a concerted effort to improve **union density** in the care sector, should be the key mechanism for driving up pay, terms and conditions.
- The Care Inspectorate should be required to proactively assess the risk of provider failure, and work with public bodies to establish **contingency plans for taking assets into public or community ownership** (both where providers fail altogether and where care quality is persistently unacceptable)
- **Freedom of Information** legislation should be extended to all care providers in receipt of public funding.
- The Care Inspectorate should also be required to provide **regular and robust analysis on providers' performance and finances**, made publicly available in an easy-to-read, comparable format (e.g. factsheets and benchmarking tables).

Ultimately, we would draw attention to the words of the Feeley Review itself: "All structural change involves effort, and money, which some people will argue would be better used in supporting people. We do not disagree. But structural change is necessary if the structures themselves are impeding good care and support for people, which we believe is currently the case." The Review was talking about the case for a top-down reorganisation of commissioning. But in our view, the evidence presented in this report demonstrates the truth of these words in relation to for-profit care. The business models of large financialised chains are clearly "impeding" the outcomes we want, both in terms of fair work and quality care. Addressing this problem is a worthwhile - indeed, essential - investment in Scotland's future.

APPENDIX 1.1
WAGE DIFFERENTIAL ANALYSIS

Comparing wages in the private sector to other providers is challenging because of a lack of publicly available data.

Whilst available datasets of the Annual Survey of Hours and Earnings provides estimates of average hourly wages for Scottish carers, this is not broken down by provider type[76]. To try and understand the difference in sectors, the Quarterly Labour Force Survey (QLFS) was used instead, combining the four quarterly datasets in each year to provide an estimate for each calendar year[77]. This gives data for residential and domiciliary carers combined, split by 'public' and 'private'. In the QLFS, 'public' corresponds to local authority or central government run organisations and 'private' corresponds to all other organisations[78]. This means it is only possible to understand how the public sector compares to other sectors using QLFS data and not the difference between for-profit and not for-profit.

Although the survey includes entries for 75,000 individuals, only around 5500 are Scottish. Selecting carers further narrows this down, resulting in relatively small sample sizes as shown in table A1.

Table A1 - Sample size by public vs private after adding waves 1 and 5 from each quarterly dataset in each calendar year and selecting Scottish carers.

Year	Private (for profit and not-for-profit)	Public (central government and local authority)
2021	71	17
2020	43	16
2019	64	28
2018	85	42
2017	74	35
2016	74	32
2016	90	44

This suggests caution should be used to interpret any averages calculated from this data. Averages and standard errors for the public and 'private' sectors were calculated, as shown in Fig 10. This suggests that public sector hourly pay has been consistently higher than pay in other sectors for the last six years. To produce a conservative estimate of how much higher, the difference can be taken between the lower bound of wages in the public sector and the upper bound of wages in the private sector, as shown in Table A2.

76 ONS(2021). Earnings and hours worked, region by occupation by four-digit SOC: ASHE Table 15. Available from https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/datasets/regionbyoccupation4digitsoc2010ashetable15

77 Due to the longitudinal nature of the Labour Force Survey, only individuals form wave 1 and wave 5 were selected from each quarterly dataset in order to prevent double counting of their entries. This is similar to how the Local Area Database is constructed, see https://www.ons.gov.uk/file?uri=/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/methodologies/labourforcesurveyuserguidance/volume6.pdf

78 ONS (2021). 'LFS User Guide. Volume 3 – Details of LFS variables 2021'. Available from https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/methodologies/labourforcesurveyuserguidance

Table A2 - Average hourly pay and standard errors for Scottish carers by public and other sectors.

Year	Average public-sector hourly pay	Public-sector hourly pay standard error	Average hourly pay, other sectors	Other sectors hourly pay standard error	Public sector pay lower bound	Other sector pay higher bound	Difference
2015	10.13	0.57	8.14	0.42	9.56	8.56	1.00
2016	11.76	0.64	7.8	0.27	11.12	8.07	3.05
2017	10.44	0.39	8.44	0.25	10.05	8.69	1.35
2018	10.69	0.43	8.8	0.25	10.26	9.05	1.21
2019	11.27	1.03	9.17	0.37	10.24	9.54	0.70
2020	13.26	0.90	9.27	0.46	12.36	9.73	2.62
2021	12.75	1.23	9.69	0.29	11.52	9.98	1.55
						Average	1.64

The difference is calculated by subtracting the upper bound for other sectors from the lower bound of public sector pay.

This difference ranges from £0.70 per hour to £3.05 per hour, with this variation likely driven by small sample sizes. To account for this, the average difference over the last six years is calculated. This suggests that over the last six years, the public sector has paid on average £1.60 per hour more than other sectors.
This figure corresponds to a difference of around £3,000 for a full-time member of staff working 37 hours a week. It is in keeping with Skills for Care 2016 estimate that Scottish public sector residential care workers are paid a full-time equivalent of £2,900 more than in other sectors[79].

79 ICF Consulting Limited (2018). 'The Economic Value of the Adult Social Care sector - Scotland', pg 13. Skills for Care and Development. https://skillsforcareanddevelopment.org.uk/wp-content/uploads/2019/03/11-_-2018-The-Economic-Value-of-the-Adult-Social-Care-sector-Scotland.pdf

APPENDIX 1.2
SSSC WORKER CLASS DEFINITIONS

C0	Administrative/ Support worker	Ancillary staff whose main remit is to provide administrative, clerical and business support or direction and who normally have little direct, and no unsupervised contact with service users. They may be involved in a strategic role such as finance or policy planning.	C0A - Secretarial/clerical C0B - Finance/Accounts C0C - Human Resources/Training C0X - Other Administrative/Support
C1	Ancillary worker	Ancillary staff whose main remit is not providing care but who normally have direct, often unsupervised contact with service users.	C1A - Catering C1B - Domestic Services C1C - Portering C1D - Gardening C1E - Building Maintenance C1X - Other Ancillary
C2	Class 2 worker	Staff who provide direct personal physical, emotional, social or health care and support to service users and are accountable for dealing with routine aspects of a care plan or service. These staff usually have no supervisory responsibility.	C2A - Routine Care/Support Work (other than Home Care, Care Home and AHP assistance) C2B - Home Care C2C - Routine Care/Support Work (Care Home) C2D - Allied Health Profession assistant C2E - EY&C Support Workers C2X - Other Level 2 Care work
C3	Class 3 worker	Staff who supervise the delivery of particular aspects of care and services in a particular setting which usually involves supervising other staff on a day-to-day basis (eg. Meals Supervisor, Chargehand, Day Care Instructor, Senior Care Assistant). Staff may also contribute to the assessment of care needs, the development/implementation of care plans and the monitoring/ evaluation of the delivery of care and services, as required.	C3A - Senior Care worker (other than Day care/Care home) C3B - Senior Care worker (Day care) C3C - Senior Care worker (Care home) C3D - EY&C Practitioners C3E - Care workers in school hostels and special schoolcare accommodation C3X - Other Level 3 Care work
C4	Class 4 worker	Staff responsible for the assessment of care needs, the development/ implementation of care plans, the delivery of care and services and the monitoring/evaluation of the delivery of care and services within a specific setting. Staff work with minimal supervision, are likely to but don't necessarily supervise other staff and may be designated to take charge of a discrete service delivery area in the absence of the person with continuing responsibility.	C4A - Social Worker C4B - Deputy Unit/Project Manager C4C - (Senior) Allied Health Professional C4D - Teachers C4E - Registered Nurses C4F - Care workers with supervisory responsibilities in school hostels and special schoolcare accommodation C4G - House staff in independent schoolcare accommodation C4X - Other Level 4 Care work

C5	Unit/Project manager	Staff with continuing responsibility for the management of care and service provision in a discrete service delivery area (eg a single service care home, a service delivery unit in a care home with multiple services, a specific project involving a number of professional staff, a social work team). Staff are responsible for monitoring and maintaining standards of care and the management/deployment of staff and other resources in that service delivery area.	C5A - Senior Social Worker C5B - Team Leader C5C - Project Manager C5D - Care Home manager (single service) C5E - Other Service Delivery Unit Manager C5F - Senior/principal teacher C5G - Senior/charge nurse C5H - EY&C Lead practitioner/Manager C5I - Managers in special/independent schoolcare accommodation and school hostels C5X - Other Unit/Project Manager
C6	Group manager	Staff with continuing overall responsibility for the management of care and service provision in two or more discrete service delivery areas (eg a group of care homes, a care home comprising a number of service delivery units, a number of projects, a number of social work teams). Staff are responsible for monitoring and maintaining standards of care, setting aims and objectives and the management/deployment of staff and other resources across those service delivery areas.	C6A - Service Delivery Unit Group Manager C6B - Project Group Manager C6C - Care Home Group manager (single home with multiple services, or group of homes) C6D - Depute/Head Teacher C6X - Other Group Manager
C7	Director/Chief Executive	Staff with the highest level of continuing overall responsibility for the management of care and service provision in the organisation. Staff at this level have a given place on the organisation's governing body (eg the management board) with a major say in overall strategic direction, organisational policy and the deployment of financial, human and physical resources.	C7A - (Deputy) Director of Social Work/ Chief Social Work Officer C7B - (Deputy) Director of Independent Social Care Organisation C7C - Care Home Owner (single or group) C7X - Other Director/Chief Executive

APPENDIX 2
'LEAKAGE' ANALYSIS METHODOLOGY

The concept of 'leakage' and its quantification is drawn from work done by the Centre for Health and the Public Interest (CHPI) in 2019. [1] For consistency and comparability, we have sought to match their methodology:

1) We recorded the staff costs, rents, net interest expense (gross interest expense minus gross interest income), directors' remuneration, and profit before tax, as declared in the profit/loss account and notes to the annual accounts filed by the relevant operating company or group at UK Companies House. These are the four channels of 'leakage' systematically analysed by CHPI.

2) We calculated each of these expenditures as a percentage of revenue/turnover in the relevant financial year.

We are happy to make the underlying dataset and calculations available on request.

As explained in the main text, we do not characterise all spending on rents, interest or directors' remuneration as illegitimate, but simply seek to compare their levels in for-profit providers with providers of other ownership types.

Likewise we do not label all these outflows as hidden profit extraction, though in some cases we have been able to determine such mechanisms. Overall, however, many of the accounts of the companies in our sample do not allow us to determine whether rents and interest are being paid to related parties or unrelated parties, particularly because many companies take advantage of the exemption to disclose related party transactions under International Accounting Standard (IAS) 24. Even where it is possible to identify payments of this type to related parties, these payments do not necessarily represent gross profit, since the related party may also have to pay on interest or rental payments to third-party creditors or property-owners.

Where the related parties are based in jurisdictions lacking a requirement to file publicly-available annual accounts, these on-payments are not always visible.

For the companies in the non-profit sample, we used trustees' remuneration as a comparable measure to directors' remuneration, and annual surplus/deficit before transfers as a comparable measure to pre-tax profit.

Rental costs do not include payments on finance leases: the interest portion of finance lease payments is instead included in interest expense.

Rental costs of property and other items (vehicles, equipment) are not disaggregated in the accounts, so for comparability we have included all operating lease costs. Where rental payments for different types of assets are disaggregated, the vast majority are property rents.

SAMPLE SELECTION

CHPI's 2019 study examined all identifiable UK care home companies' accounts for one year (2017 or the latest available year).

We did not have the resources to replicate a sector-wide study. Instead, therefore, we have examined a sample of care home companies across four years (2017-20). 2020 is the latest year for which accounts are available for all the companies in the sample, at the time of writing.

N.B. We expected that 2020 and 2021 would be highly exceptional and largely unprofitable years for the companies in the sample due to the Covid crisis. In fact, those companies that were previously profitable continued to be profitable in 2020 and (where visible) 2021, while those companies that filed significant losses were loss-making prior to the pandemic.

The sample of care home providers selected are the 10 largest for-profit providers and 10 largest non-profit providers of residential care in Scotland, as measured by the number of registered places provided by companies in the corporate group in 2020 (the latest year for which accounts are available for all the companies in the sample). We used Care Inspectorate data to identify providers and registered places. In 2020 the providers in the non-profit sample provided 40 percent of all registered places in Scotland provided by voluntary/non-profit residential care providers, and 5 percent of all registered places overall. In 2020 the providers in the for-profit sample provided 30 percent of all registered places provided by for-profit residential care providers, and 23 percent of all registered places overall.

In each case we used the accounts of the main care home-operating company or consolidated group within the larger corporate group. In some cases these are UK-wide operating companies, not Scotland-specific, so the leakage percentages we have calculated cover their entire UK-wide operations.

We make the assumption therefore that leakage levels are not substantially different in their Scottish vs. their English/Welsh care home operations.

There is one case where we used two sub-groups within the same consolidated group: due to Four Seasons Health Care going into administration, the Four Seasons Health Care group moved the corporate location of care home operations within their group from Elli Investments Ltd (2015-18) to Mericourt Ltd (2018-20). During 2018, some Scottish care homes were operated by Elli Investments Ltd and some by Mericourt Ltd, so for that year we have analysed leakage as a percentage of revenue for both companies. This means that overall there are 21 companies/groups in the sample across 2017-20.

We excluded one large provider from either sample (for-profit/non-profit) because of contested views about its nature and business model: BUPA Care Homes, part of the BUPA healthcare group. BUPA is a major player in the Scottish and UK care home markets, and in theory operates a non-profit model, headed by a private company limited by guarantee, without shareholders. However, although this means that profits are reinvested, BUPA operates via ordinary private limited subsidiary companies in the UK, is subject to tax, and shares many of the growth- and surplus-maximising objectives of private for-profit companies. In the absence of agreement about its classification, we have excluded it from the sample, but it remains an important element for any comprehensive analysis of the Scottish care sector.

The two samples (for-profit/non-profit) are obviously not representative, so any extrapolation from them must be treated with great caution. We have ventured qualified extrapolations in two cases:

(i) We estimate a highly approximate figure for the possible costs of rental payments across the entire for-profit residential care sector in Scotland.

To do this we have used the ratio of rental payments by large for-profit companies and small/medium for-profit companies, which CHPI determined for all UK care home providers. CHPI found that rental payments by small/medium for-profit companies were on average 1/8th of those of large for-profit companies, as a percentage of their revenues (i.e. care home fees). We cannot know the size of the revenues of the companies outside our sample, so we calculated leakage on a 'per bed' basis for our for-profit sample, and then hypothesised that the leakage per bed would be at least 1/8th of this amount for the remaining beds provided by other for-profit companies in Scotland. We therefore divided by eight our 'per bed rental leakage' figure from the large for-profit companies, and multiplied it by the number of beds provided by for-profit providers outside our sample. To this we added the actual rental leakage found in our sample.

This estimate contains numerous assumptions which we are unable to test without additional data, and should therefore be treated as an order-of-magnitude estimate only. It assumes that rental payment differentials between large and small/medium companies was not significantly different in 2017 (CHPI study) compared to 2017-20 (our analysis), and that it was not significantly different in England and Scotland. It also assumes that 'per bed' spending is a valid proxy for spending as a percentage of revenues.

(ii) We estimate an equally approx imate figure for the possible total 'leakage' through these four channels across the entire for-profit residential care sector in Scotland.

To do this we have again used the ratio of 'leakage' by large for-profit companies vs. small/medium companies, which CHPI determined for all care-home beds. CHPI found that 'leakage' through these four channels by small/medium for-profit companies were on average 1/2 of those of large for-profit companies, as a percentage of their revenues. Again, we cannot know the size of the revenues of the companies outside our sample, so we calculated leakage on a 'per bed' basis for our for-profit sample, and then hypothesised that the leakage per bed would be at least 1/2 this amount for the remaining beds provided by other for-profit companies in Scotland. We therefore divided by two our 'per bed total leakage' figure from the large for-profit companies, and multiplied it by the number of beds provided by for-profit providers outside our sample. To this we added the actual leakage found in our sample.

This estimate contains all the untested assumptions listed above.

LEAKAGE PER BED

To calculate 'leakage' per bed for each company/group, we have used an average figure for the number of beds of each company/group in the UK between 2017-20, as disclosed in the directors' report appended to each company/group's financial accounts.

Since occupancy levels are not known for all providers, we have simply used 'number of UK beds' disclosed in accounts. We have then calculated the average number of registered places provided in Scotland by each company/group 2017-20 according to Care Inspectorate data. We divide the total leakage for each company 2017-20 (as shown in financial accounts) by the average number of UK beds in that period to get an estimate of leakage per UK bed. We assume that leakage is not significantly different in England and Wales operations vs. Scotland operations. We therefore multiply the leakage per UK bed figure by the number of registered places in Scotland, to estimate (approximately) total leakage attributable to Scottish operations for each company/group.

We have not been able to calculate comparable 'per bed' figures for leakage from non-profit providers. This is because unlike the for-profit providers in our sample, almost all the non-profit providers undertake multiple activities and services, and do not systematically disaggregate income or spending for residential care specifically. For example, the Social Affairs Council of the Church of Scotland, the largest non-profit residential care provider in the sample, also provides services ranging from substance abuse counselling to homelessness support. While we can calculate 'leakage' figures for the totality of their operations as a percentage of total revenues, turning this percentage into 'per bed' monetary values would lead to artificially high values, since we would be assuming that all the 'leakage' across their entire operations was borne by the much smaller part of their operations dealing with residential care.

[1] Kotecha, V. (2019) 'Plugging the leaks in the UK care home industry: Strategies for resolving the financial crisis in the residential and nursing home sector'. CHPI. https://chpi.org.uk/wp-content/uploads/2019/11/CHPI-PluggingTheLeaks-Nov19-FINAL.pdf

PROFITING FROM CARE:

WHY SCOTLAND CAN'T AFFORD PRIVATISED SOCIAL CARE

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