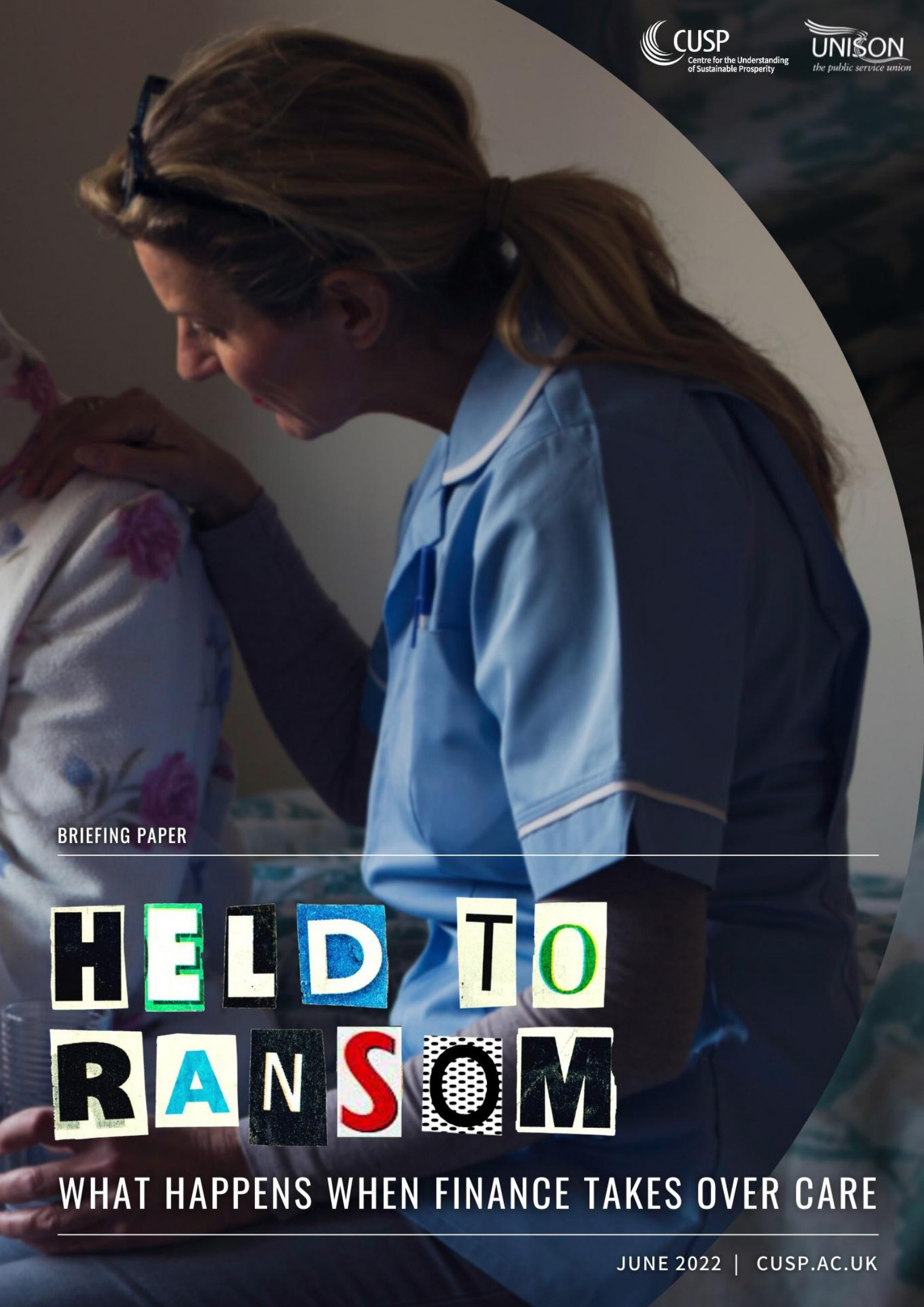

CUSP Centre for the Understanding of Sustainable Prosperity

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BRIEFING PAPER

HELD TO RANSOM

WHAT HAPPENS WHEN FINANCE TAKES OVER CARE

JUNE 2022 | CUSP.AC.UK

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Executive summary

There is mounting concern over the involvement of investment firms in the UK's adult social care sector. Many of the strategies that investment firms use to achieve returns for their investors expose whole chains of care homes to large costs and increase the risk of bankruptcy and closure. This 'financialisation' of care has been implicated in the high-profile collapse of several large care home chains. However, little research has been done looking at what impacts these strategies have on-the-ground for workers and service users in the care homes that are owned by these investment firms.

In our study[1], we interviewed people who were working in care homes during, or shortly after, they had been taken over by an investment firm. We identified five key themes relating to the behaviour of these owners from analysing the interview data. These were: exploiting care staff; cutting corners on service delivery; covering up mismanagement; failing to communicate; and prioritising profit over care. We explain them briefly in the following.

The first theme we developed through our analysis details the various ways that our participants' employers exploited them, from reducing staff benefits to chronically understaffing the care homes.

The second theme builds on these insights, and goes into the range and depth of under-resourcing in the sector, beyond staff shortages. From experiences of rationing medical and sanitary supplies and food, to neglecting care home maintenance and failing to deliver enriching activities for residents, participants painted a calamitous picture of a care sector that has been stripped back to the bare bones.

Our third theme reflects participants' views that their employer was often mismanaging their care home, and that, in some instances, they were trying to conceal the problems caused by that mismanagement from the industry regulator (e.g., by falsifying paperwork or putting more staff on shift during an inspection).

This perceived mismanagement was compounded by a failure of internal communications—leading to our fourth theme. Here, participants repeatedly expressed their frustration at the lack of open and effective channels for communication with their employer, leaving them feeling ignored and in the dark about their future and the future of the care home.

Finally, we heard from many of our interviewees that they felt their employer was primarily involved in the care sector to make money, and that they didn't care about the wellbeing of staff or residents. These accounts are summarised in our fifth theme, which ties together the experiences captured in the four other themes, revealing participants' perceptions about the motivations behind their employer's actions.

In addition to our interviews, we also studied the financial accounts of fifteen of the largest care home chains in the UK, uncovering a large and widening pay gap between directors and employees between 2015 and 2020—which had grown fastest in investment-firm-owned chains. The pay ratios between the highest paid director and average employee in large care chains were similar to the pay ratios often found in large for-profit companies in other sectors, but far higher than those found in public services like the UK's National Health Service (NHS).

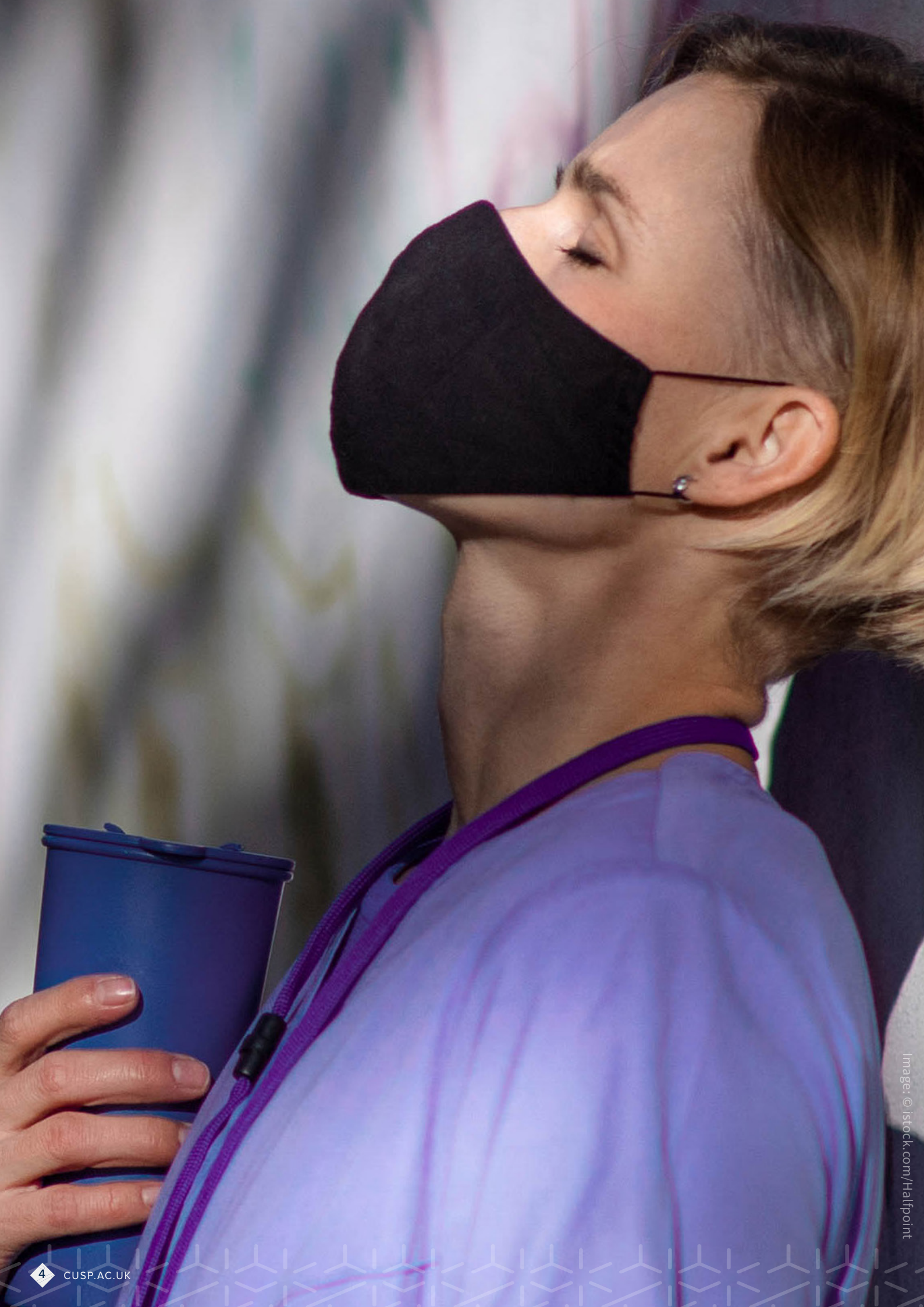
By 2020 the highest paid directors working in for-profit care groups owned by investment firms earned on average 38 times more than the average employee. In other profit-oriented care organisations, the pay of the highest paid director was 63 times the average employee pay. Even in not-for-profit groups the highest paid director was earning on average 29 times that of the average employee. This indicates that pay disparities are a problem across the board in care home chains, but they are particularly pronounced in for-profit company types.

Our thematic analysis and review of accounts portray a sector that is deeply unfair, not only in terms of who benefits from the financialisation of care, but also in terms of who pays the price.

Our findings lead to a number of core recommendations, including:

- **removing the profit motive from the care sector;**
- **reducing the size and complexity of care home groups;**
- **and strengthening care workers' rights and voice in the workplace.**

This briefing paper is a summary of an in-depth analysis published in CUSP Working paper No 35: *Held to ransom—What happens when investment firms take over UK care homes*. Available at www.cusp.ac.uk/care-for-ransom.



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Introduction

The pandemic, the government's proposed cap on social care fees, and recent coverage of large dividend payments to offshore shareholders are bringing a lot of attention to unaddressed issues around quality, fairness, and value for money in the UK's adult social care sector. In particular, there is mounting concern over the growing involvement of investment firms since the 1990's (e.g., private equity, real estate investment trusts, and hedge funds), and the impact their presence is having on workers and residents in care homes.

Many of the strategies that investment firms use to achieve returns for their investors (typically grouped under the heading of 'financialisation') expose whole chains of care homes to large costs and increased risk of bankruptcy and closure.[2] These techniques were implicated, for example, in the recent collapse of two large care providers: Southern Cross in 2011 and Four Seasons Health Care in 2019. So far, very few studies have looked directly at how investment firm ownership impacts working conditions and quality of care within care homes.[3] Yet, this is an issue of international concern as many other countries show a similar trend towards financialisation.[4]

Currently available data in the UK (such as care quality ratings from the Care Quality Commission) offer a very limited basis for such analyses. There is a pressing need to understand what on-the-ground changes result from investment firm ownership and from the financialisation of care more broadly. In this briefing, we therefore ask:

What happens to quality of care and working conditions when an investment firm takes over a care home?

Our findings raise concerns around the impact of investment firm ownership on care quality and working conditions and are intended to inform the current debate about financing structures and provider types in the UK's care sector. In this briefing paper we introduce the core themes developed from our participant interviews, and summarise our analysis of care company financial accounts. We present our key findings and offer a series of recommendations for the care sector, moving forwards.

Our approach

We undertook a series of semi-structured interviews with sixteen care workers and managers, most of whom were working in residential and nursing homes at the time that they were taken over by an investment firm. We included a small number of interviews with workers who experienced other types of ownership change to gain insight into how these processes might be similar/ different in other contexts. We covered elderly care, as well as care for adults with mental health needs and learning disabilities.

Readers should bear in mind that participants were self-selecting (i.e., they volunteered to take part) and were recruited from a database of union members. Both factors increase the likelihood that we are capturing more negative experiences than positive. Nonetheless they give us vital insight into what can happen when ownership goes wrong and why.

In addition, we reviewed key business metrics and performance indicators from the financial accounts of 15 of the largest adult social care groups in England over three years (2015, 2018, 2020), accounting for more than 90,000 care beds between them (approximately 20% of all care beds) by 2022.[5] Our sample consisted of six for-profit care groups with an investment firm owner/ significant partner, five for-profit groups who were not owned by investment firms, and four not-for-profit groups. This analysis allowed us to better understand the top-down goals and strategies employed by these large care groups.

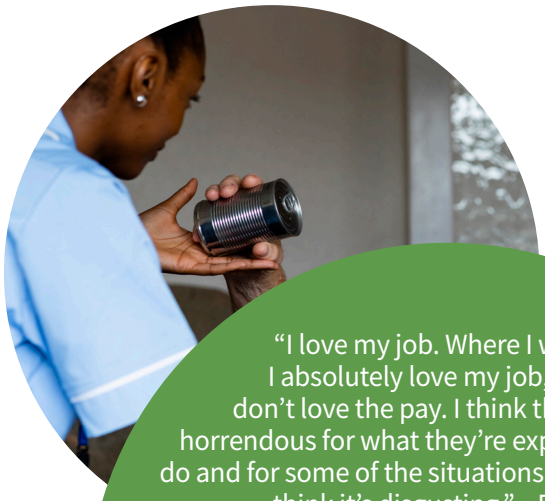
What care workers told us

Exploiting care staff

Across the interviews, study participants painted a picture of care worker exploitation. They show a systematic attempt by many employers to squeeze as much as possible out of each care worker, for as little money as possible.

Sometimes care workers said this explicitly themselves, but other times, they simply conveyed the different ways in which the company limited how much they were spending on staff or pressured staff to take on more work. These tactics ranged from reducing non-wage benefits for staff to expanding carers' job remits and chronically understaffing the care home.

Some participants spoke about how they felt that their commitment to the residents was being taken advantage of to further the understaffing. This theme was raised the most frequently by our interviewees, with all sixteen participants contributing to it.



"I love my job. Where I work, I absolutely love my job, but I don't love the pay. I think the pay is horrendous for what they're expecting me to do and for some of the situations we get put in. I think it's disgusting."—Emily

"That's what I think [the company] use so much of… the caring factor of the individual [care worker] who cares for those [residents], and it's almost like an unspoken ransom, you know, 'Well if you leave what's going to happen to [the residents]?'"
—Lisa

"They just tell the cleaner, 'right, you're caring for the day'… they seem to think it's acceptable and they do it on a regular basis."—Michael

Cutting corners on service delivery

Participants repeatedly spoke about issues with sub-par service delivery. This theme, in particular, reflects instances where they felt that tight budgets had resulted in corners being cut. As one participant put it "*they had choices to make, budgets to respect*".

Across our study participants, this was reported to have impacted staffing levels, medical and sanitary supplies, quality and quantity of food for residents, timely maintenance of equipment and the built environment, and access to enriching activities. All of which our respondents felt was detrimental to the quality of care and service delivery they were able to provide to residents.

In particular, they felt that these changes meant residents sometimes went without the appropriate care, timely medication or sufficient sanitary supplies, with some left feeling hungry or isolated. All sixteen participants brought this up as an urgent issue.

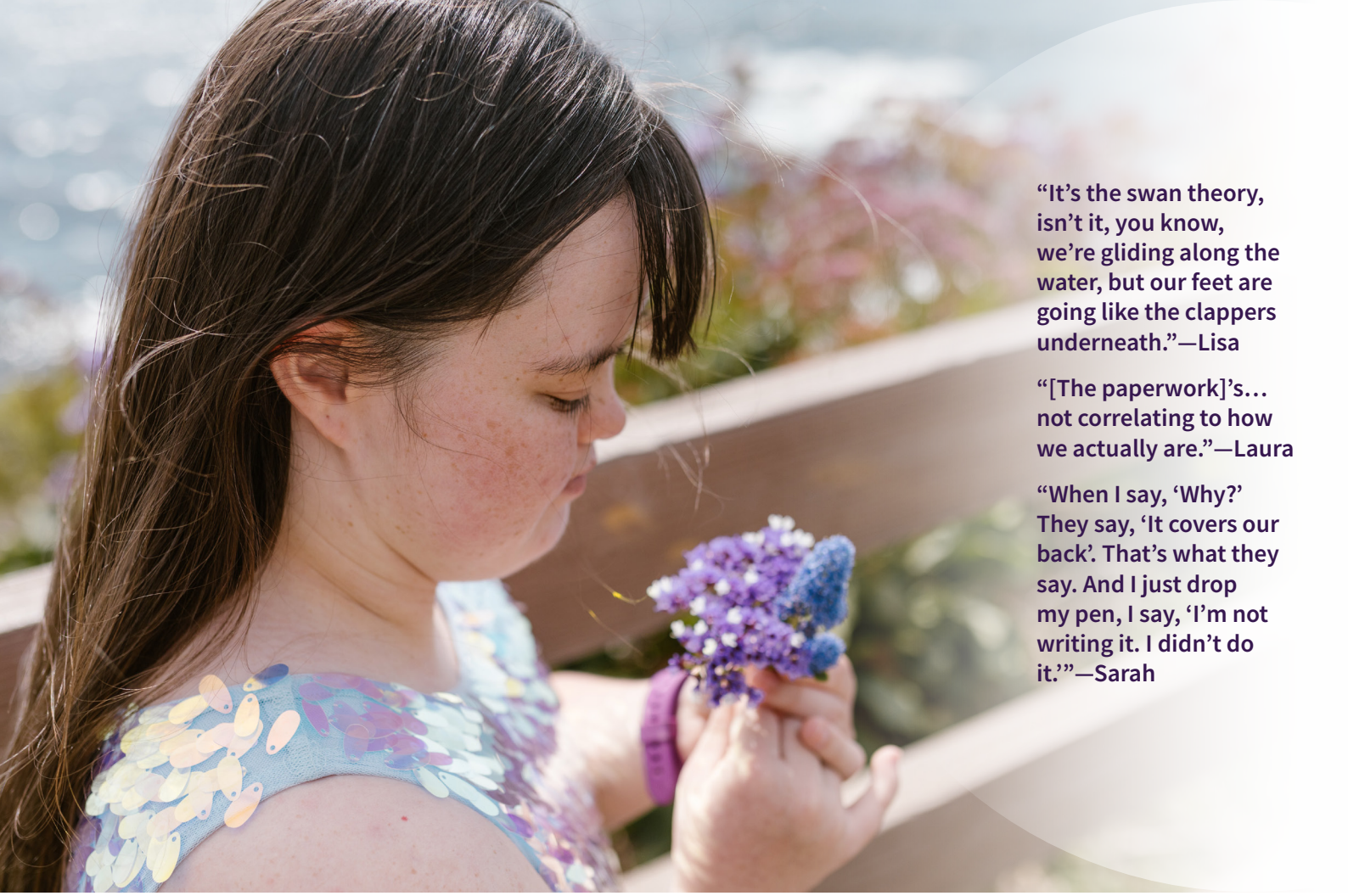
"When you're hungry you're agitated, so if you get hungry people at night they're not sleeping properly because they're hungry."—Jennifer

"We have to skip some stuff, because it's just two people. Two people cannot do four people's jobs."
—Sarah

"We had an agency member of staff who did nights about two months ago... thirteen medication errors... And if you've got somebody who say is on Warfarin... if you don't have the right gap between the medication, you can overdose them."—Michael

"Even [sanitary] pads, they would tell us 'We are on a budget. You have to use one pad a day'."—Sarah

"It's just basically containment and just wait for you to die and we'll get somebody else to fill your room."—Michael



"It's the swan theory, isn't it, you know, we're gliding along the water, but our feet are going like the clappers underneath."—Lisa

"[The paperwork]'s… not correlating to how we actually are."—Laura

"When I say, 'Why?' They say, 'It covers our back'. That's what they say. And I just drop my pen, I say, 'I'm not writing it. I didn't do it.'"—Sarah

Image: pexels.com / RODNAE Productions

Covering up mismanagement

This theme captures participants' feelings that their employer was mismanaging their care home, and that they were more interested in hitting targets, and in how the care home *appeared* to families and regulators than they were in the *actual* quality of the care being delivered.

Examples of employer-incompetence recalled by our participants included: hiring staff and managers who were inexperienced or unqualified; pressuring staff to take on residents who were not suitable for their particular care home (e.g., due to extra medical needs); and implementing inappropriate policies and procedures for their type of care home (e.g., an unnecessary activity-based checklist for adults in supported living who have full capacity).

Given the self-selecting nature of our study, it is unsurprising that many of the people who came forward to take part in our interviews felt that their employers were not offering the kind of care or working conditions they would like to see. Indeed, many of our participants felt that their employers were making bad decisions about how to run their care home.

Several participants reported that in order to cover up this mismanagement their employer had put additional staff on shift for Care Quality Commission inspections, specifically to give a better impression to inspectors, as well as removing outspoken staff from the rota on inspection days. Some expressed that the regular care paperwork they were asked to complete was more about covering the backs of staff and management in case anything went wrong than about delivering good care.

One respondent explicitly stated that the paperwork was not a true reflection of how things really were in their care home. In the extreme, we found that one carer was even asked to lie about the level of care they had been providing to residents. Several interviewees expressed that because of the already insufficient staffing, the focus on making everything *look* good to regulators was taking time away from vital care jobs.

"I think [the company] have no idea how to run a care home… I think anywhere that has that [company] motif, I don't think it's right good."
—Jennifer

"The staff morale dipped big time because we were perplexed as to why this company has taken us over and they have no, well very little, understanding of mental health."—Emily

Failing to communicate

This theme describes the disconnect between those living and working in the care homes and the upper management of the company. It is characterised by poor communication and a lack of transparency from participants' employers.

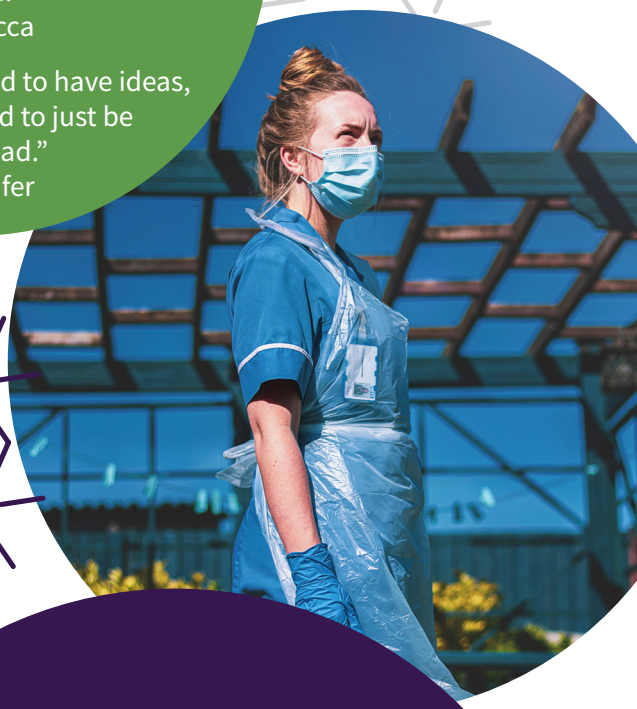
The theme includes participants' accounts of difficulties in communicating feedback to their employer and affecting change within their workplace, as well as their impressions that the company was disinterested in service delivery. Some reflected on how infrequently upper management would set foot in the care home, while others reported that their care home manager had become increasingly isolated and hidden away in their office.

The lack of effective channels through which staff could communicate their needs, and the lack of responsiveness from their employer when they did try to tell them about issues, left the care workers in our sample feeling ignored and disempowered. This, combined with a lack of transparency about finances and decision-making, created concern and uncertainty among participants about the future of their care home and their job. One of our interviewees even likened her employer to the suspicious company at the centre of a murder mystery TV series: '*people know things; things have happened that nobody talks about*'.

"We felt that we were completely left out, ignored."
—Amanda

"[The manager] was sitting in [the] admin building and like I said for three months some of us had no idea how she looked."
—Rebecca

"You're not supposed to have ideas, you're supposed to just be brain-dead."
—Jennifer



"We were saying we actually need things for the young adults, we need things for the people we support… We felt like we were never seeing any of the executive[s] coming into our settings… No one was ever coming to check what was needed fixing."
—Amanda

"I don't trust them, and I don't think they're being honest."
—Isabelle

"We're subtly having our hours reduced without actually being advised that, you know, because of restructuring... this is what is going to happen."
—Lisa

Image: unsplash.com / Luke Jones

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Prioritising profit over care

This thematic cluster reflects the fact that many of our participants felt their employer was much more interested in making money than in the wellbeing of their staff and residents. Some participants spoke indirectly about how their new employer was very corporate and/ or took little interest in the care home staff and residents.

Others were clear that their employer was involved in the care sector primarily with the goal of making money. Indeed, eleven of our study participants made comments like 'it's a business' or 'it's all about money' at some point during the course of the interview—even those working in charities.

The theme of profit prioritisation ties a lot of the issues from the other themes together, with participants regarding financial motivations as the explanation for various issues, including understaffing, and cutting corners on service delivery.

"It was all money, money, money."—Isabelle

"It is more about money than the people, definitely."—Emily

"It's all about business. It's all about their profits."—Sarah

"They're not in it for the charity, everyone's got to make money."—Will

Review of financial accounts

Director pay

Across our sample of care home groups, we found that from 2015 to 2020, average pay per director grew at almost double the rate of pay per employee (when averaged across all ownership types). This meant that by 2020 average pay per director across the 11 care groups with comparable data was 11 times higher than average pay per employee. We found that the increase was largely driven by investment-firm owned care companies where average director's pay had grown to 13 times average employee's pay, whilst it declined in not-for-profit groups over the same period to 7 times average employee pay (see Figure A).

The ratio between the *highest* paid director and the average employee also grew between 2015 and 2020 in all for-profit groups (both investment-firm-owned groups and others), reaching 63 times average employee pay in those for-profit firms *not* owned by investment firms.

However, the largest increase between 2015 and 2020 was again seen in investment-firm-owned groups. These two pay ratio analyses indicate a couple of things: one, pay disparities are a problem across the board in care home chains; and two, by 2020 pay disparities had become particularly pronounced in for-profit company types.

These ratios of highest paid director to average employee pay are broadly in line with ratios in other large for-profit companies (e.g., average CEO to median employee pay ratio for FTSE 350 companies was 53 to 1 in 2020)[6]. However, they stand in stark contrast to the pay ratios in the UK's National Health Service, where the pay of the chief executive is approximately seven times that of the average employee.[7] Additionally, the yearly pay of a director in a care chain that is owned by an investment firm is likely to be an underestimate in the long run because they typically receive a large chunk of their compensation upon the successful sale of the business.

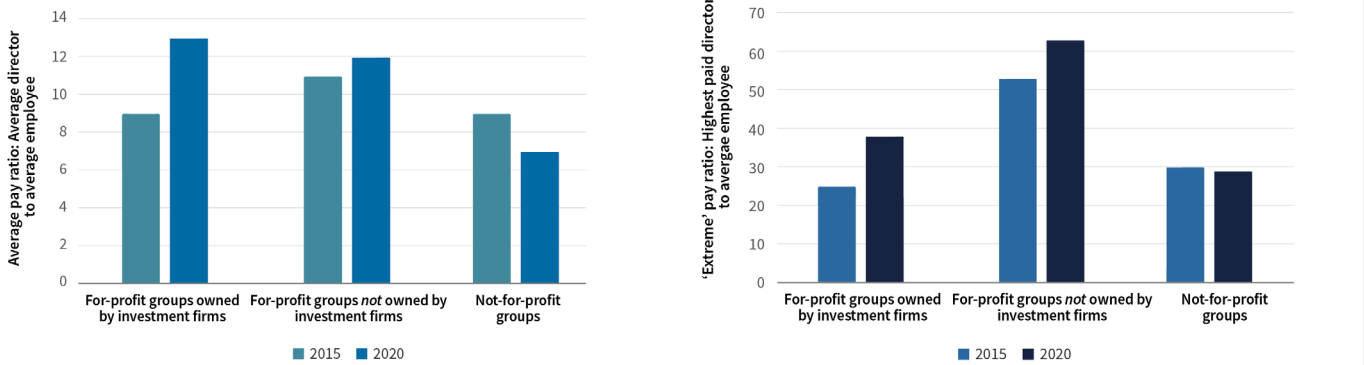


Figure A

The left-hand graph shows the ratio of average pay per director to pay per employee in 2015 and 2020 (sample of eleven care groups with comparable data). The right-hand graph shows average ratio of highest paid directors' pay to pay per employee in 2015 and 2020 (sample of eight groups).

Key Performance Indicators

Reviewing the accounts of fifteen companies we found that the majority of them had KPIs in the following categories: 'capacity and occupancy', 'income and resident type', 'sustainability and profitability', and 'cost control' (see Figure B). This reflects the fact that key profitability drivers in the care industry are occupancy, income, and limiting the impact of cost increases. Indicators monitoring staff wellbeing and training were less commonly included, despite staff being the main input for a care business. Those that did include staff-related indicators tended to focus on staff as a cost to be managed, rather than an asset to be nurtured.

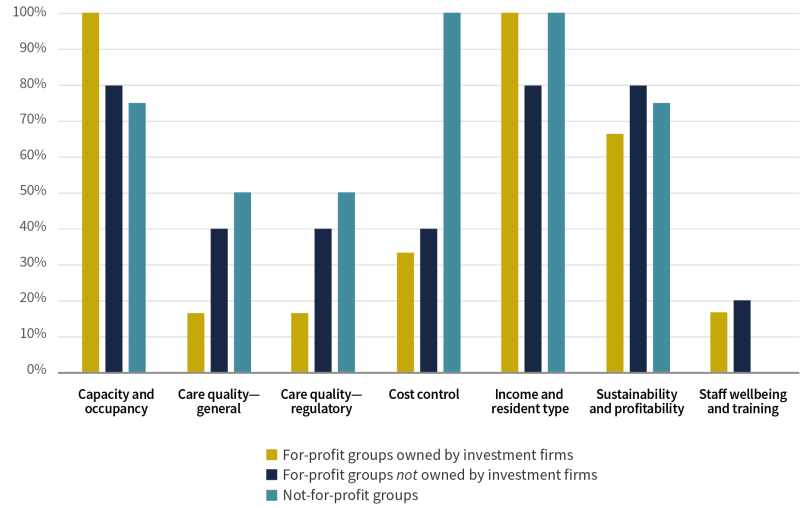
We found that not-for-profit groups were more likely to have KPIs relating to 'cost control'. There are several reasons this might be the case. First, there is a trend towards local authorities placing increasingly complex residents in residential homes, which tend to be less expensive than nursing homes. These settings are typically less-well equipped to manage the needs and associated costs of high acuity residents. Within our sample, the not-for-profit care groups were comprised of a greater proportion of residential homes without nursing care (67%), compared to the for-profit groups in our sample (45%).

This may explain in part why these not-for-profits are focusing more explicitly on cost-control KPIs, as a larger proportion of their business is likely to be impacted by the trend towards costly, complex residents. Further, the not-for-profits in our sample had, on average, 10 fewer beds per care home than the for-profit groups, limiting their opportunities for economies of scale at the level of the individual care home, and their ability to spread the costs of new equipment and training across multiple residents.

Although there was a more explicit focus on cost control KPIs within not-for-profit groups, we know that care groups owned by investment firms are cost-controlling in a context where they are also attempting to deliver something in the region of a 12% return on investment to their investors[8]. In a revenue restricted environment (like the one created by austere welfare policies), this is likely to lead to a downward pressure on wages, staff benefits, investments in care home improvement, and quality of care, as companies have a limited number of ways that they can respond to increasing cost pressures. This might go some way to explaining why a vast majority of eligible respondents who approached us to participate in the study and provide insights into their working environments were from investment-firm-owned care homes, despite these cost-control KPIs being more prevalent in not-for-profit groups.

Figure B

Proportion of care home groups with KPIs in each category by ownership type in 2020



Our findings

The findings in this briefing confirm much of what is commonly assumed and has already been found in the literature, including high directors' fees, low staffing levels, restrictions to budgets that affect food, maintenance, equipment as well as medical and sanitary supplies, and worse quality care as a result of these factors. Building on this, the main takeaway messages from this briefing are as follows:

Care workers are being exploited. Some employers appear to be exploiting care staff by creating a hostile work environment in which care workers are made to feel replaceable, exacerbating their already-precarious employment status. In some cases, employers are taking advantage of the commitment of care staff to their residents, relying on them to continue delivering care, even under difficult working conditions and with consistent under-resourcing of the care home.

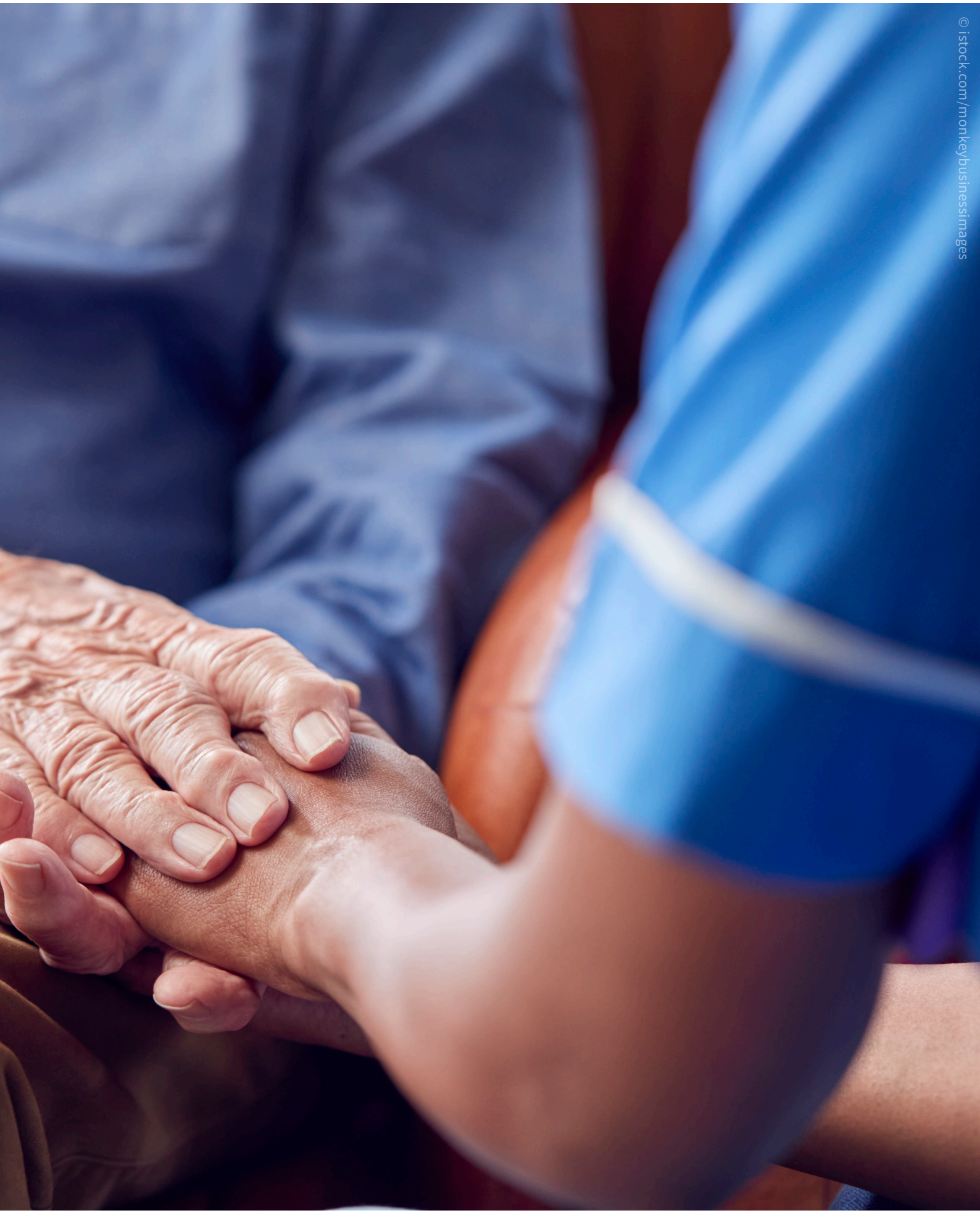
Cost cutting is driving poor outcomes. Although cost minimisation targets are present across different types of care home group (including those owned by investment firms as well as those which are not), our thematic analysis suggests they may be having a more negative impact in those homes where profit is a primary consideration. Most importantly, we find that cost minimisation strategies focused on reducing staff time and rationing medical and food supplies, no matter who is implementing them, is leading to poor outcomes for residents and care workers.

Care staff feel disempowered. Attempts by large companies to counter the problems of communication and control associated with their complex corporate structures are negatively impacting staff morale and quality of care. In particular, a lack of transparency, limited channels for staff to feedback to their employer, and onerous monitoring and paperwork processes are leaving staff feeling disempowered and frustrated.

Our recommendations

On the basis of the findings presented in this briefing paper, and detailed extensively in the accompanying *CUSP working paper No. 35*, our five key recommendations are as follows:

1) **Remove the profit motive from the care sector.** This would involve transitioning to either a national care service or a mix of not-for-profit provider types. If coupled with sufficient government funding that meets the true costs of care provision (something which is currently not in place), it would offer a number of benefits including greater financial accountability, value for public money, and likely greater attention to achieving quality care rather than generating a return for investors.
2) **Reduce the size of care groups.** This will relieve some of the communication and control problems created by large and complex corporate structures. It may also facilitate more responsive and person-centred care delivery.
3) **Strengthen care workers' rights.** This would support care workers to demand a fair wage and to prevent them from becoming a squeeze point in the sector. Reducing the exploitation of care home staff will also translate into better care.
4) **Give care workers a say.** Giving workers a say in how their workplace is run is key to creating a well-functioning care sector. This could be achieved through better communication and feedback mechanisms, union membership or cooperative models of ownership.
5) **Improve data availability.** There seems to be both an excessive burden of regulatory paperwork and yet a lack of useful care quality information available. Streamlining the quality and accessibility of data could help to improve our understanding of the drivers of care quality and the state of working conditions in the sector.



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Notes

1 This briefing paper is a summary of an in-depth analysis published in the CUSP Working Paper Series (No 35): Corlet Walker et al. 2022: "Held to ransom—What happens when investment firms take over UK care homes". Guildford: University of Surrey. Available at www.cusp.ac.uk/wp35.

2 A 2021 report from the Centre for the Understanding of Sustainable Prosperity looked at the prevalence of financial engineering among large care providers in the UK. See Corlet Walker, C., Druckman, A. and Jackson, T. (2021) 'Careless finance: Operational and economic fragility in adult social care'. Guildford: Centre for the Understanding of Sustainable Prosperity. Available at: www.cusp.ac.uk/careless-finance.

A Centre for Health and Public Interest report from 2019 also estimated the costs associated with financial engineering practices in large care chains. See 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'. London, UK: Centre for Health and the Public Interest, pp. 1-53.

3 Key works on this include Burns et al. (2016)'s analysis of the impacts of financial cutbacks in UK care homes the wake of the 2008 financial crisis, and Horton (2019)'s analysis of interviews with a range of actors involved in private equity care home ownership in the UK

Burns, D. J., Hyde, P. J. and Killett, A. M. (2016) 'How financial cutbacks affect the quality of jobs and care for the elderly', Industrial and Labor Relations Review, 69(4), pp. 991-1016. doi: 10.1177/0019793916640491.

Horton, A. (2019) 'Financialization and non-disposable women: Real estate, debt and labour in UK care homes', Environment and Planning A, 0(0), pp. 1-16. doi: 10.1177/0308518X19862580.

4 For example, some of the largest care providers in Sweden, Norway, Canada and the US are also owned by private equity firms. See Corlet Walker, C., Druckman, A. and Jackson, T. (2022) 'A critique of the marketisation of long-term residential and nursing home care', The Lancet Healthy Longevity, 3(4), pp. 1-9.

5 Authors' own calculations based on publicly available CQC data, as at 1st March 2022. Online at: https://www.cqc.org.uk/about-us/transparency/using-cqc-data

6 See Kay, R. and Hildyard, L. (2020) 'Pay ratios and the FTSE 350: an analysis of the first disclosures', (December). Available at: https://highpaycentre.org/pay-ratios-and-the-ftse-350-an-analysis-of-the-first-disclosures/.

7 Authors' own calculations based on data from the Cabinet Office and NHS Digital.

Cabinet Office (2021) Cabinet Office senior officials 'high earners' salaries, GOV.UK. Available at: https://www.gov.uk/government/publications/senior-officials-high-earners-salaries.

NHS Digital (2022) 'NHS Staff Earnings Estimates, December 2017, Provisional Statistics—NHS Digital', (December 2021). Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-staff-earnings-estimates/nhs-staff-earnings-estimates-december-2017-provisional-statistics.

8 See Laing, W. (2008) '*Calculating a fair market price for care: A toolkit for residential and nursing homes*'. Bristol, UK: The Policy Press, pp. 1-56.

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