Market Oversight in Adult Social Care

Consultation

DH INFORMATION READER BOX

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Contact Details	Market Oversight Consultation Team (Area 313B) SCP Policy and Legislation Department of Health Richmond House, 79 Whitehall, London SW1A 2NS 02076339944 http://caringforourfuture.dh.gov.uk/
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Market Oversight in Adult Social Care

Consultation

Prepared by the Department of Health (DH)

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The consultation

1. Section 1 explains the background to this issue, the measures that are in place today to manage provider exit and why the Government believes there is a case for change in this area.

2. Section 2 explains the Government's proposals for improving oversight of the market.

3. The consultation Impact Assessment (IA) and equalities analysis contains further analysis on the rationale for our approach and the options we considered in developing this policy proposal. The full document is available on the Department's website.[1] Details about the options considered are discussed later in this document in 'Annex B.'

4. This consultation relates to social care in England, as social care is a devolved issue. To reduce the burdens on businesses working across the UK and to support the coordination of activity in the event of future provider failure, the Government will also engage with the Devolved Administrations in designing new measures, whilst recognising the different circumstances across the UK.

Responding to the consultation

5. As part of this consultation, our intention is to hear a range of views on:
   - what further measures are needed to strengthen and clarify the responsibilities of local authorities; and,
   - whether a targeted model of central oversight would be appropriate, if so, what the elements of this model should be.

6. In addition to receiving written responses, we intend to meet with care users, regulatory bodies, care and support providers, commissioners, investors, professional services firms, and sector groups, before formulating Government policy in this area.

7. The closing date for responses is **Friday 1st March 2013** and all responses should be submitted via the pro forma at 'Annex C' and returned to: **marketoversightconsultation@dh.gsi.gov.uk**. We would appreciate if all responses over four pages in length included a summary of the key points.

Summary of the consultation

8. A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Department's consultations website at http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.html

[1] http://www.dh.gov.uk/health/category/publications/consultations/

The consultation process

9. The consultation principles can be found on the Cabinet Office's website at: http://www.cabinetoffice.gov.uk/resource-library/consultation-principles-guidance

10. These principles inform Government departments of the considerations that should be taken into account during consultation. These include consideration of the subjects of consultation, the timing of consultation, making information useful and accessible, and transparency and feedback.

Comments on the consultation process itself

11. If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact

    Consultations Coordinator
    Department of Health
    3E48, Quarry House
    Leeds
    LS2 7UE

    E-mail: consultations.co-ordinator@dh.gsi.gov.uk

    Please do not send consultation responses to this address.

Confidentiality of information

12. We manage the information you provide in response to this consultation in accordance with the Department of Health's **Information Charter.**

13. Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

14. If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

15. The Department will process your personal data in accordance with the DPA and, in most circumstances, this will mean that your personal data will not be disclosed to third parties.

Purpose of consultation

We are consulting on policy proposals to strengthen oversight of the social care market. Our proposals are summarised on pages 8-12.

This consultation has two elements;

- first, what further measures are needed to strengthen and clarify the responsibility of local authorities in relation to care users in the event of the failure of a care provider (see pages 25-28)

- second, whether a targeted model of central oversight would be appropriate and if so, what the elements of this model would be (pages 29-45)

Scope to influence:

The consultation document sets out several questions and we will analyse and consider in full your responses to these to help inform the policy. We ask that your responses are set out in the pro forma at 'Annex C' in this consultation document. This helps us to analyse responses to each question in turn. However, we will consider points relating to questions that are made in other sections and responses in all formats, provided they are submitted by the closing date of **Friday 1st March 2013.**

We believe the proposals set out in this document are the most effective solution, based on our assumptions and analysis. However, if a reasoned explanation is provided through the consultation, we are willing to reconsider;
- any of the four alternative models set out in the Impact Assessment[2]
- the assumptions in this consultation document, for example that a central oversight regime would not be required for local operators, as local authorities are well-placed to manage continuity of care services in cases of local exit.

[2] The Impact assessment and equalities analysis is available on the Department's website at http://www.dh.gov.uk/health/category/publications/consultations/

Executive summary

16. In the Care and Support White Paper *Caring for our Future: Transforming Care and Support,*[3] the Government was clear it is not acceptable for people to be left without the care and support they need if a provider fails and goes out of business. Under current legislation no-one would be left without the care and support they need should a provider fail. The Government is now considering to what extent further measures are necessary to manage provider distress and failure to support a smooth transition for people who depend on care services.

The case for change

17. The Government believes that there is a need for greater reassurance to people receiving services which are likely to close or transfer to new ownership. The primary motivation for any change is to minimise the risk of a negative effect on the health and wellbeing of care users in the event of a provider failing financially and ceasing to provide services.

18. Recent events have highlighted the need for the Government to review whether or not current mechanisms to oversee the social care market are sufficient, and whether additional measures are necessary to protect service continuity for care users;
    - the difficulties faced by Southern Cross Healthcare in 2011 demonstrated that there are specific challenges associated with monitoring and managing transition and continuity of service if a provider that is operating across England with highly complex financial structures fails
    - the National Audit Office (NAO)[4] recommended that the Department of Health should determine where current oversight was insufficient and where more central oversight is necessary. The NAO stated that the case of Southern Cross demonstrated that the Government needs further arrangements at a national and local level to protect users from provider failure
    - the Government committed to developing continuity regimes for key services in the *Open Public Services* White Paper.[5]

The future direction of travel

19. Care and support services can be critical to the health, well-being, safety and dignity of individuals and carers. It is not acceptable for people with care and support needs not to receive the services that they need because a business fails or chooses to close. Should a provider exit the market, it is critical for the process to be well-managed to avoid undue stress and anxiety on individuals, their families and carers. This is particularly the case if a service has to stop completely (rather than be transferred to a new operator).

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[3] *Caring for our Future: Transforming Care and Support*, HM Government, July 2012 available at http://caringforourfuture.dh.gov.uk
[4] *Oversight of User Choice and Provider Competition*, National Audit Office, September 2011
[5] HM Government, *Open Public Services* White Paper 2011 http://files.openpublicservices.cabinetoffice.gov.uk/OpenPublicServices-WhitePaper.pdf

20. The Government is clear that all providers and the organisations that invest in care services have a responsibility to the people who rely upon them for their care and support. At all stages of the process, the providers and their partners have the primary responsibility for delivering good quality care. The well-being of people in their care must be their first concern. Even in the case of failure, the providers and their investors or partners should take action at all levels of their business from the board to the frontline staff to;
    - reduce stress and anxiety for care users, their families and carers
    - to reassure care users that their care needs will continue to be met
    - keep all affected people informed about the process
    - to share all relevant information with local authorities and future providers so that people's care and support needs can be seamlessly met by a new provider; and
    - to act in every way possible to put the people receiving services at the forefront of all business considerations and to take responsibility for ensuring their needs are met.

21. The Government believes that its role is to put in place effective systems to oversee service continuity for individuals and carers, and make provisions so that the different bodies operating within this system are clear about their roles and responsibilities and effectively co-ordinate with each other. The Government set out principles which will underpin our approach in *Caring for Our Future*[6]*:*

Strengthening and clarifying the responsibilities of local authorities (pages 25-28)

Proposal to clarify and strengthen local authorities' legislative duties in relation to provider failure

22. Under existing legislation local authorities must arrange for people to be provided with the care and attention they need in residential accommodation if that care and attention is not otherwise available to them. The duty applies in the case of provider failure.[7]

23. In the Care and Support Bill[8] we intend to provide a new legislative provision to apply specifically in the case of provider failure. It will impose a duty on local authorities to meet the needs for temporary care and support of any person whether self - funded and whether in receipt of residential or non - residential care if they have urgent unmet needs as a result of provider failure. Such a provision will extend and strengthen existing powers and duties[9] to provide care and support and provide clarity for people who are receiving care at the time their care provider fails.

Rationale for proposing greater market oversight of national providers only

24. The Government considers the majority of the market should continue to be overseen by local authorities, as part of their core responsibilities for ensuring local people receive care and support services. We expect local authorities have plans in place to;
    - support a process of transition that is well-managed

[6] http://caringforourfuture.dh.gov.uk/
[7] Section 21, National Assistance Act 1948 http://www.legislation.gov.uk/ukpga/Geo6/11-12/29
[8] The draft Care and Support Bill is available at http://careandsupportbill.dh.gov.uk
[9] Section 21, National Assistance Act 1948, section 47(5) National Health Service and Community Care Act 1990

- involve all care users and their families and carers to understand how they will be affected and the timescales for any change
- take into account the views of care users, their families and carers, and
- reduce stress and anxiety for care users, their families and carers.

25. Small care home providers with fewer than three care homes make up 43% of the care home market, in terms of places.[10] The vast majority of home care services are small; Laing & Buisson estimate they make up 60% of the home care market.[11] Often these services are based within local communities and operate across quite small geographical areas. Therefore we believe it is right for local authorities to manage continuity of service with this level of localised entry and exit.

26. Local authorities have been managing provider entry and exit for over twenty years, without it being necessary for central government to become involved. Evidence shows that during the year to April 2011, 114 homes were de-registered (representing a 20 year low in closures) and 133 new care homes were registered.[12] New registrations and de-registrations are approved by the Care Quality Commission (CQC). We believe the current powers are working effectively. Furthermore we believe that activity is coordinated where necessary with other parties such as the NHS (which commissions 8% of residential care places), other local authorities and insolvency practitioners. Best practice guidance on care home closure[13] has also been published by the Social Care Institute for Excellence (SCIE) to support local authorities.

Further considerations, consumer protection and equalities considerations

27. The Government also supports increased choice and control for individuals with care and support needs. In instances of provider failure, as in periods of business as usual, individuals should be aware of their rights and entitlements, understand where to go if they are dissatisfied and be included and informed about all decisions that concern them.

28. The Government is aware that transition to a new care provider can pose specific challenges and concerns to individuals with protected characteristics[14] as defined by the Equality Act. We welcome evidence about specific impacts which should be taken into account in developing policy on market oversight in social care.

Proposal for targeted market oversight (pages 29-45)

29. **The Government believes that there may be a case for additional oversight of those care and support providers that are above a risk threshold because they pose the greatest risk to continuity of care (due to one of the factors listed below).** The purpose of this would be to ensure, as far as is possible, that should one of these providers exit the market, it is handled in a way which prioritises the health and well-being of individuals. Additional oversight may be needed, due to;
    - the size and scale of the organisation;

[10] Laing & Buisson, Care of Elderly People UK Market Survey 2011/12
[11] Laing & Buisson, Care of Elderly People UK Market Survey 2011/12
[12] Laing & Buisson, Care of Elderly People UK Market Survey 2011/12
[13] SCIE Online Guide (Sept. 2011) http://www.scie.org.uk/publications/homeclosures/index.asp
[14] The Equality Act 2010 states 'protected characteristics' are age, disability, gender reassignment, marriages and civil partnerships, pregnancy, maternity, race, religion or belief, sex, sexual orientation and carers (by association)

- regional or sub-regional geographical concentrations (market-share), or
- highly specialist services with a wide catchment area of dependency.

30. Our favoured proposal is to have stronger requirements on such providers to disclose relevant information to a regulator, and for them to have robust plans in place in case they fall into distress. Our view is that this would require an effective regulator to oversee and enforce this process, whilst also ensuring that in the event of exit, there is co-ordination and information sharing between all parties, supporting the work of local authorities.

Early warning system

31. The proposal is that providers that meet a certain risk threshold should be required to provide financial and other information. The model would be light-touch and the metrics should be similar to the information required by investors, lenders and boards.

32. The regulator would collect and analyse such information and perform a further risk-assessment, including considering the sustainability of a providers business model. The regulator would require reassurance that this model supported the delivery of quality care services. A sub-set of the providers who posed the greatest level of risk would then be required to develop scenario-based contingency plans.

Well managed provider recovery or transition

33. The first part of contingency planning would be prepared by the provider based on a series of scenarios describing different possible situations that might lead to failure (e.g failure to refinance, an economic shock, a significant drop in occupancy, breaching agreed banking covenants etc.) and setting out a number of actions they would take to attempt to 'recover'. The plan would include provisions to maintain the quality of care during this period.

34. The second part of contingency planning would address the situation when recovery was not possible and failure was inevitable. It would be based on mechanisms to manage a smooth transition to either new ownership or closure whilst ensuring continuity of quality care during this transition period. This model is based on the 'living wills model' being piloted in the banking sector.[15]

35. The Government is not currently proposing to establish a special administration regime. However, we recognise the pros and cons of such a regime and therefore we set out the rationale for our current position in this document.

36. We believe that there is often a link between operational performance (the quality of care services) and financial performance of a provider. For example, where quality falls, providers experience lower demand for their services and lower occupancy rates that reduce the profitability of the business. Therefore, although this consultation is

[15] Further information on Recovery and Resolution plans can be found on the FSA website. The following webpage explains the concept, and provides a link to the FSA's recent consultation on the issue: http://www.fsa.gov.uk/library/communication/pr/2011/070.shtml

specifically focusing on financial oversight, the Government believes that all financially viable providers must have quality services at the heart of their business.

Costs

37. This consultation sets out what a targeted model of central oversight might look like and seeks to gather evidence about what it might cost, so we can then take an informed view on whether it is the right option to pursue in the current financial climate when resources are constrained. Any additional regulation will have some cost to both taxpayers (Government) and providers. We welcome any evidence of direct or indirect costs which could arise as a result of these proposals.

Section 1

The social care market

38. Social care has been operating as a market in England for over twenty years. The 1980s saw the start of the growth in private provision, with the Community Care Reforms of the 1990s providing a major stimulus for growth.[16] Throughout this time, local authorities have continued to be responsible for ensuring that the care needs of their local populations are met.

Demand

39. Social care is purchased by a range of consumers of care services:
    - Of all residential care places, 51% are commissioned by local authorities, 41% by individual consumers and 8% by the NHS.
    - Of all home care contact hours, 60% are purchased by local authorities, 21% by individual consumers, 10% by direct payment holders,[17] 7% by the NHS.[18]

40. It is expected that the number of purchasers of home care choosing their services and purchasing them via a direct payment will increase over time, in line with Government policy. It is intended that this financial mechanism should encourage a vibrant market place in which a range of different services and different ways of meeting the needs and goals of the person, are available. Individual consumers will also have greater access to information about local services, which should also support the development of services tailored to the needs of individuals.

41. The proportion of individuals funding their own residential care services is increasing, whilst the proportion of local authority funded residential care places is declining over time. NHS funded places are also increasing. However there are large geographical variations with 53% of residents in the South West of England paying for their care, compared to only 21% in the North of England.[19]

42. The services available in the market will develop based on demand for services and over time, this may mean some services exit the market whilst at the same time new services become available.

Supply

43. There are a range of different financial and business models operating within the sector, with providers of all different sizes and purposes. For example:

[16] HM Government *Caring for People* 1989 Command Paper, National Health Service and Community Care Act 1990
[17] Direct payment holders are local authority funded care service purchasers that directly receive a cash payment in lieu of a council organised service and make independent choices about the services they wish to purchase from the care market to meet their care and support needs
[18] Laing & Buisson, Care of Elderly People UK Market Survey 2011/12
[19] Laing & Buisson, Care of Elderly People UK Market Survey 2011/12

- the largest providers of both residential care and home care are corporate providers backed by a larger investment group, such as Saga (backed by Acromas) and Four Seasons (backed by Terra Firma);
- the not-for profit sector provides a significant proportion of care, through a variety of different models of provision – including social enterprises, charitable provision, micro-enterprises, and mutuals. The Government is keen to encourage this diversity[20]
- the vast majority of providers are small businesses; 43% of care home places are provided by operators with fewer than three homes whilst 60% of the 7,145 registered domiciliary care agencies are single agency businesses[21]
- the majority of care provision is not from formal services but by unpaid carers, mainly spouses/partners, adult children and other close family. Around 5 million people in England provide such unpaid care, and
- the vast majority of paid care provision is from the private and voluntary sectors. The proportion of services supplied by councils has fallen greatly over the last 15 to 20 years and they now provide less than 10% of residential care places for older people and around only 16% of home care.

44. There are also a range of models of care and retirement housing, such as extra-care housing. Specialised housing is a growing sector, however accurate data on size is hampered by multiple definitions and differing methodologies. The Elderly Accommodation Counsel (EAC) data[22] suggests there are 821 extra care housing schemes in England although the Care Quality Commission reports there are 564 extra care locations.[23]

Market trends (concentration and exit)

45. In residential care the ten largest providers account for 20% of the UK care home market, by places. The top twenty providers account for 28% of the market, by places. On this basis, Four Seasons and Bupa both have almost a 5% market share, with both having over 20,000 beds. Barchester and HC-One both have around a 3% market share and around 12,000 beds. Care UK has a 1% share, with around 5,000 beds.[24]

46. In home care, there is a multiplicity of small providers, and fewer, larger providers with SAGA the biggest, following its purchase of Allied and Nestor Healthcare. There were 5,400 registered homecare businesses in England at mid-2011 (including 675 in the public sector). The estimated total market size in 2010-11 is £5.7bn (annual turnover) and the top 10 operators account for 16.5% of the market (by annual turnover). The CQC approves around 500 new domiciliary care agencies in England each year.[25]

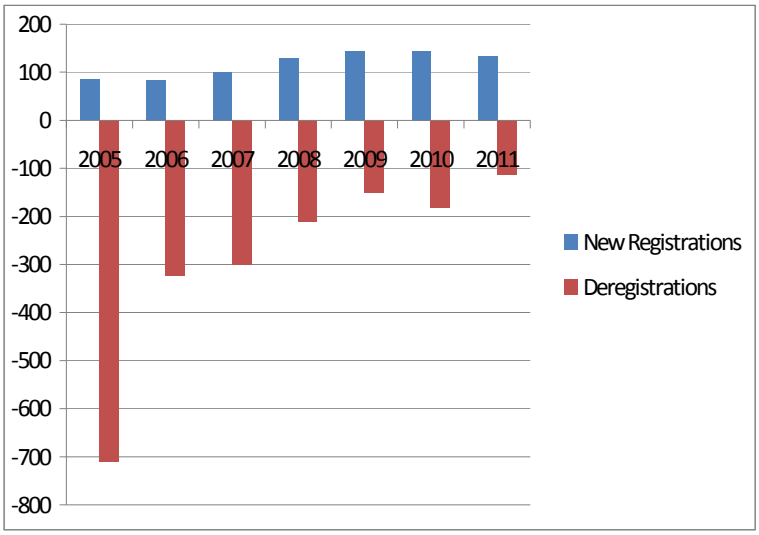
47. However national statistics can overlook important regional and local market concentrations, particularly in specialist areas of care. For example the recent NAO report

[20] The Government has set out its aspirations to encourage a range of different models, including mutual models, in the Open Public Services White Paper, July 2011. See: http://files.openpublicservices.cabinetoffice.gov.uk/OpenPublicServices-WhitePaper.pdf
[21] Laing & Buisson, Care of Elderly People UK Market Survey 2011/12
[22] Statistics on Housing with Care (EAC June 2010)
[23] CQC State of Care Report 2010-2011
[24] Laing & Buisson, Care of Elderly People UK Market Survey 2011/12
[25] Laing & Buisson, Domiciliary Care UK Market Report 2011/12, and from Laing's Community Care Market News, May 2012

highlighted that Southern Cross as a large national care home provider had 9% of the market nationally, but a much greater share in certain regional areas.[26] In parts of the North East, Southern Cross accounted for some 30% of care home places. Data from CQC show that eight English local authorities have a single care home provider which provides over 25% of residential care places in their area. In more specialist areas of care, such as nursing care, concentrations can be higher.

48. There has been market entry and exit at the local level for 20 years, without it being necessary for central government to become involved. Evidence shows that the year to April 2011 114 homes closed (representing a 20 year low in closures) with 182 homes closing the year before. 133 new care homes were registered in the year to April 2011, with 145 new registrations the year before.[27] In fact over the past two decades, many providers have entered and exited the market (Figure 1 illustrates changing patterns of capacity over time). Local authorities have had responsibility for managing these changes in the market.

Figure 1: Registrations and deregistration 2005-2011 UK independent sector homes for older and physically disabled people[28]



	2005	2006	2007	2008	2009	2010	2011
New Registration	85	84	100	130	145	145	133
Deregistrations	-711	-323	-301	-212	-151	-182	-114

[26] *Oversight of User Choice and Competition,* NAO, September 2011
[27] Laing & Buisson, Care of Elderly People UK Market Survey 2011/12
[28] Laing & Buisson, Care of Elderly People UK Market Survey 2011/12

The case for change

Impact on welfare

49. The Government believes that the primary motivation for any change is to put plans in place so that if a provider fails, people continue to get the care and support they need. In considering any change the Government was mindful of the following;

- **care and support is an essential need:** Many individuals, families and carers rely on providers of care and support services to preserve their health, well-being and dignity. This is especially the case for those with very high levels of complex needs, those nearing the end of life, or for those with dementia and their carers
- **care homes have particular emotional attachments:** In residential care, not only do people need to continue to receive vital care and support services, but they also rely on the provider for their accommodation and daily needs. The care home becomes the individual's home and they naturally build trusting relationships with the staff and other residents
- **care users do not know what provider failure means for them**: In some cases this would be a minor change but they would retain many of the same staff and if they are in a residential home they may be able to stay in the same home under new ownership. If the service is to close they may find they receive their care from different staff, or even that they must move to a new care setting. In all cases their care needs would continue to be met. However there is no clear process to reassure individuals and often uncertainty can cause unnecessary stress
- **care quality could decline in cases of poor financial health:** Quality and financial viability closely relate, with problems in one area leading to problems in the other. For example, if a provider is finding it difficult to repay its lenders, then cuts may be made in areas of service delivery that affect quality (such as refurbishment of the fabric of buildings, food, staffing or training). Financial pressures may mean cuts in capital expenditure are necessary, again affecting the quality of the service and user experience. Equally, if a provider does not place sufficient emphasis on quality, then it may see demand for its services fall, which may tip it into financial difficulties. Whatever the cause, the care and support services delivered must continue to meet essential quality standards, and those using services should be reassured that the provider has the financial resources to deliver quality care, and
- **gaps in care services are not acceptable:** The social care market has been developing in sophistication over the past 20 years. Some have argued that the oversight and accountability frameworks have not kept pace with these changes. Social care contrasts with other public services delivered by the independent sector (such as utilities and the railways[29]) where there are more formal oversight and continuity arrangements in place to protect users of services.

Market trends

50. The market trends below suggest that a more formal system of market oversight may now be needed. For example:

[29] There are a number of different independent regulatory bodies overseeing different essential services, such as: the Financial Service Authority for financial services; OfGem for overseeing gas and electricity markets; and the Office of Rail Regulation which is the safety and economic regulator for Britain's railways

51. **The emergence of large providers, operating across multiple boundaries;**
    - when a provider operates across a number of local authorities it is unclear who has complete oversight of that provider's operations – both in terms of the risks to continuity of service and co-ordination should something go wrong
    - managing the transfer or closure becomes increasingly difficult when there are many thousands of residents and a high number of stakeholders and authorities involved
    - evidence suggests that the sector is likely to see larger operators over time across residential, domiciliary and extra care services[30]
    - high market concentrations at a regional level (e.g. some highly specialist provision) are challenging for individual local authorities to oversee,
    - however, the social care market remains highly diverse. This plurality should be a powerful safeguard against service discontinuity, as there should be a range of alternative providers who can step in, especially when there is demand for services
    - as mentioned above, many providers have left the market over the past twenty years, and local authorities and regulatory bodies have managed these exits effectively.

52. **Interdependencies with wider financial markets leaving possible exposure to economic shocks;**
    - there are increasingly complex operating and financial business models emerging in the care and support sector. Investors in social care companies can have a wide-ranging portfolio of diverse, international business interests
    - many providers are also carrying substantial debt, structured in complex arrangements and the subject of covenant restrictions
    - the care market has close, and complex, interactions with other markets, such as the property and financial markets.

Southern Cross

53. In 2011, Southern Cross – then the largest independent provider of residential care services – fell into financial difficulties and ultimately failed. At its peak, Southern Cross owned or operated over 700 care homes across the whole of the UK. The scale of its operations coupled with the complexity of its business and financial structure, meant that managing its closure was challenging and required close working between different parts of government, professional advisors, investors, landlords and providers.

54. The reasons for the failure of Southern Cross are complex and accumulated over time. Southern Cross developed a business model which worked well during times of increasing property values and buoyant occupancy levels in care homes but was at greater risk during periods of economic downturn. The company entered into contracts with its landlords which proved to be financially unsustainable and it became caught in a downward spiral as occupancy fell. Evidence suggests that the provider was also struggling to maintain the quality of its services, which reduced occupancy rates and staff retention. These factors together led to its problems, and ultimate collapse.

55. In resolving the Southern Cross situation, the Government welcomed the commitment from all parties to ensuring that the transfer of Southern Cross homes to new operators was smooth, effective and minimised the disruption to residents. In the end, almost all

[30] Laing & Buisson, Care of Elderly People UK Market Survey 2011/12

homes were transferred to new operators (Four Seasons and HC-One acquired the majority of homes) and residents did not have to move. Only one home closed in England and two homes in Scotland –which were unviable in the long term. Only a small number of Southern Cross staff lost their job.

56. Although the situation with Southern Cross was successfully managed the case has highlighted the risks associated with the collapse of a large provider, with a very complex business model, operating across the whole of the UK. We know that during this period of uncertainty, residents, families and carers, felt a great deal of stress and anxiety as there was no clear system in place to reassure them and to oversee a smooth transition process.

57. Southern Cross was resolved by the providers, landlords and their advisors negotiating the transfer of Southern Cross's operations to other operators. The Government encouraged the business and its stakeholders to reach the settlement, acting in the interests of commissioners and users, however formal powers to compel action by any party or to enforce delay did not exist. The Government and parties involved in this process reached a resolution because it was clearly unacceptable for people to be left without the care and support they need, however, as with any negotiation, there are no guarantees that this successful resolution would be replicated in future. Although of course, the legal power exists to prevent anyone from being left without the care and support they need, disorderly failure on this scale would pose many practical challenges and risks to ensuring continuity of care. The Government believes an established process would provide greater clarity and reassurance to people receiving care in future cases.

58. The collapse of Southern Cross brought to the Government's attention the following;
    - there was no early warning system to anticipate failure and put plans in place to oversee continuity of care for individual people receiving care
    - that no part of the overall system (central government, local government or the Care Quality Commission) has the remit or responsibility to formally monitor financial health or performance of a provider for the purposes of assessing its future viability in the market
    - in the aftermath of Southern Cross, it has become clear that many parties held partial information that could be helpful to a central oversight regime, should one be deemed necessary, but that if the current system prevailed, no one party would have the complete picture or the responsibility to predict and/or manage failure
    - the transfer of services to new providers was extremely complex and required coordination due to the business model and the size of the business, and
    - the Government had no mechanism designed to apply specifically in cases of provider failure to ensure the process was well-managed and smooth and that the quality of services was maintained during transition.

59. The National Audit Office (NAO)[31] recommended that the Department of Health should determine where current oversight was insufficient and where more central oversight is necessary. The NAO stated that the case of Southern Cross demonstrated Government needs further arrangements at a national and local level to protect users from provider

[31] *Oversight of User Choice and Provider Competition*, National Audit Office, September 2011

failure. Furthermore the Government has committed to developing continuity regimes for key services in the *Open Public Services* White Paper.[32]

60. In taking this work forward, we have been mindful of what we have learned from Southern Cross. The situation was serious because of the;
    - size of the provider (supporting many thousands of people)
    - complexity of the business' capital structures, and
    - scale of the operations of the provider meant some central co-ordination was required of all the different stakeholders involved.

Discussion paper on market oversight

61. As part of the engagement on future reform of care and support in England, the Department published a discussion paper analysing the issue of market oversight and inviting responses. The feedback we received from stakeholders has informed our proposal, details are provided in Annex A of this document.[33]

Principles underpinning reform

62. As part of this work, we have set out in *Caring for our Future*[34] a clear set of underpinning principles which have informed our proposals;
    - local authorities have had oversight of their local care markets for many years and have been managing provider failure effectively. They are also accountable for the delivery of care services. **As such, local authorities should continue to have the lead role in this area**
    - the goal is to ensure that no-one is left without the care and support services they need and that the disruption and distress of a move, or a change of provider, are kept to a minimum. To that end, **any new measures in this area should support service continuity for care users through better information, planning and coordination, but not support individual providers**. The Government will not support a failing private business at taxpayers' expense. The company, its directors and investors are responsible for the operation of the company and must face the consequences of their decisions
    - **any new measures should be targeted and proportional**, based on the level of risk to service continuity. Should any new regulations be introduced, these should meet the Government's principles for better regulation, and
    - finally, **any reform should take account of the Government's wider objective to encourage a vibrant, diverse market**. We want to drive continuous quality improvement in services for individuals, so it is important that poor quality services close, leaving higher quality, and more responsive services, to flourish. The Government wants to encourage new private investment in the social care market.

[32] HM Government, *Open Public Services* White Paper 2011 http://files.openpublicservices.cabinetoffice.gov.uk/OpenPublicServices-WhitePaper.pdf
[33] *Oversight of the Social Care Market*, Department of Health, October 2011
[34] *Caring for Our Future: Transforming Care and Support*, HM Government, July 2012 available at http://caringforourfuture.dh.gov.uk

63. Furthermore, the Government believes any person receiving care (whether publicly or privately funded) and their families should be reassured that they will continue to receive the care they need should their provider fail – whether it is small, big, charity or business.

The current system and oversight arrangements

64. **Local authorities;**
- local authorities have existing legal powers and duties to arrange for people to continue to receive the care they need if a provider fails,[35] and
- the Government recommends that all local authorities consider SCIE's best practice guidance in managing cases of provider exit today.[36]

65. **Care Quality Commission (CQC);**
- CQC provides assurance of essential levels of safety and quality in regulated social care services. All providers of regulated activities in England must be registered with CQC and meet the registration requirements for quality and safety, which are set out in regulations made under the Health and Social Care Act 2008
- the regulations include a requirement to ensure financial viability so far as is necessary to meet the essential standards of safety and quality but not for the purposes of assessing future viability in the market, and
- CQC is responsible for ensuring providers of regulated activities comply with the quality and safety requirements and if they find that a service provider is not meeting the required standards, it has a range of powers to take action to ensure compliance, including cancellation of registration, and for provider registration and deregistration.

66. **Monitor;**
- Monitor's overall objective is to protect and promote the interests of people who use health care services, by promoting health care services which are economic, efficient and effective and which maintain or improve the quality of services
- it has a specific role in relation to continuity of services which could cover social care providers who are also providing significant health services. Monitor is currently considering the responses to its recent consultation on its approach to regulating health services.[37] The Department of Health is working to avoid any duplication with future oversight in social care, and
- the Vision for Adult Social Care (2010) and the specific provisions in the Health and Social Care Act 2012 enable Monitor's functions to be extended to social care.[38]

67. Today, the Government is working with partners and providers to identify any financial risks so that should a problem arise, people understand their roles and responsibilities and what action needs to be taken to support individuals who may be affected.

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[35] Section 21, National Assistance Act 1948 http://www.legislation.gov.uk/ukpga/Geo6/11-12/29 and section 47(5) National Health Service and Community Care Act 1990 www.legislation.gov.uk/ukpga/**1990**/19/contents

[36] *Achieving closure: good practice in supporting older people during residential care closure by* ADASS, SCIE and the University of Birmingham

[37] Further details of Monitor's work, its new role and its consultations see: http://www.monitor-nhsft.gov.uk

[38] The Health and Social Care Act 2012 (s65), gives the Secretary of State powers to provide for Monitor's functions to be exercisable in relation to the provision of adult social care services see A Vision for Adult Social care, Department of Health, November 2010, available at http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121508

68. Should a major care provider fail before any new measures take effect, the Government would act so that all parties involved understood their responsibilities towards the individuals, and families, reliant on the provider's services. As for Southern Cross, we would act with a view to brokering a successful resolution through working with the provider, its advisors and any administrators. We would also work closely with local government and the CQC to support the transfer of services to new providers, so that should any resident have to move, that this was done in line with best practice. However, the Government does not intend to support a failing provider at taxpayers' expense. The provider, its directors or trustees and investors are responsible for the operation of the organisation and must face the consequences of their decisions.

69. The Government was pleased with the response and commitment of all parties to resolving the situation with Southern Cross. It has been building on this work so that should a situation like Southern Cross arise in the future, a similar positive result is achieved. In conjunction with ADASS, the Local Government Association and the CQC, the Government is taking steps to monitor the market and certain providers. These measures include;
    - **gathering and sharing market intelligence** at a local, regional and national level. In the White Paper we also announced additional support for local authorities to develop market position statements[39]
    - engaging with the largest residential care providers on potential risks to service continuity, including **encouraging increased transparency** of financial and business operations so those commissioning care and the public can make decisions that are better informed, and
    - **agreeing clear roles and responsibilities** between the Department of Health, local government and the CQC, should there be a significant provider failure. This means that everyone is clear what they need to do within their existing remit, should a situation arise, at the national, regional and local level. For example, in instances of provider failure, the CQC should ensure that all new operators meet the necessary registration requirements and are registered without delay.

70. These measures and organisations have been extremely effective in filling the gap that exists in current roles and responsibilities. However, our view is that in the long-term, there is a case for formalising such arrangements. This is because;
    - currently government – central or local – has no formal powers to require information from providers about their financial viability, nor to take action should they find that there is a problem. This means that there is a real risk that government may be aware of a potential problem, but has no formal role in market oversight to support recovery or continuity of service, and
    - there is no agreed point at which any intelligence on providers should be shared with local authorities or the NHS. This risks information being shared too early which could precipitate failure or too late, which could pose risks to continuity of care.

[39] A market position statement is a statement by the local authority to the local market, outlining how it operates and the likely demand for services. Our intention is that these statements should support local authorities in improving their understanding of the market, and be the basis of more productive relationships between providers and commissioners.

Section 2

Our current preferred model

71. This section of the consultation document outlines our preferred way forward based on current evidence and goes into more detail on each of the underpinning elements. The Government would be grateful for views on the costs and benefits of the proposals, to inform our analysis of whether it would be effective and affordable to proceed.

72. Regardless of the system that Government has in place, all providers and the organisations that invest in care services have a responsibility to the people who rely upon them for their care and support. At all stages of the process, the provider and their partners have the primary responsibility for providing good quality care. The well-being of people in their care must be their first concern. Even in the case of failure the provider and their investors or partners should take action at all levels of their business from the board to the frontline staff, to;
    - reduce stress and anxiety for care users, their families and carers
    - reassure care users that their care needs will continue to be met
    - keep all affected people informed about the process
    - share all relevant information with local authorities and future providers so that people's care and support needs can be seamlessly met by a new provider, and
    - act in every way possible to put the people receiving services at the forefront of all business considerations and to take responsibility for ensuring their needs are met.

73. **The Government believes that there is a case for:**
    - **strengthening and clarifying the role of local authorities; and,**
    - **additional oversight of those care and support providers that pose the greatest risk to continuity of care.**

Strengthening and clarifying the responsibilities of local authorities

Proposal to clarify and strengthen local authorities' legislative duties in relation to provider failure

74. Under existing legislation local authorities must arrange for people to be provided with the care and attention they need in residential accommodation if that care and attention is not otherwise available to them. The duty applies in the case of provider failure.[40]

75. In the Care and Support Bill[41] we intend to provide a new legislative provision to apply specifically in the case of provider failure. It will impose a duty on local authorities to meet the needs for temporary care and support of any person whether self - funded and whether in receipt of residential or non - residential care if they have urgent unmet needs as a result of provider failure. Such a provision will extend and strengthen existing powers

[40] Section 21, National Assistance Act 1948 http://www.legislation.gov.uk/ukpga/Geo6/11-12/29
[41] The draft Care and Support Bill is available at http://careandsupportbill.dh.gov.uk

and duties[42] to provide care and support and provide clarity for people who are receiving care at the time their care provider fails.

76. The Government considers the majority of the market should continue to be overseen by local authorities (LAs), as part of their core responsibilities for ensuring local people receive care and support services. We expect them to have plans in place that ensure, so far as is practically possible, that;
    - the process of transition is well-managed
    - all care users and their families and carers understand how they will be affected and the timescales for change
    - the views of the care users, their families and carers are taken into account to minimise disruption and act in line with their preferences wherever possible, and
    - efforts are made to reduce stress and anxiety for care users, their families and carers.

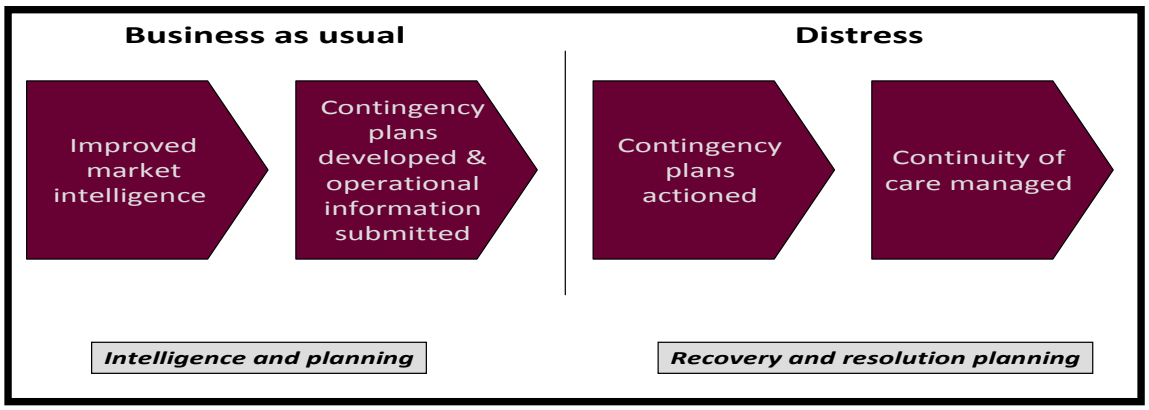
Proposal for targeted market oversight

77. The purpose of this would be so that should one of these high risk providers exit the market, it is handled in a way which prioritises the health and well-being of individuals. This is necessary, because there are providers which individual local authorities will not be able to monitor effectively, for instance those spread across multiple areas.

78. Whilst we believe the system needs to be different for providers that pose a higher risk to continuity of service, we do not believe there should be any difference in the guarantees and outcomes for individual users of care services, their families and carers.

79. Our favoured proposal is to have stronger requirements on such providers to disclose information, and for them to have robust plans in place in case they fall into distress. Our view is that this is likely to require an effective regulator to oversee and enforce this process, whilst also ensuring there is co-ordination and information sharing between all parties, supporting the work of commissioners. Our proposed approach is outlined below (figure 3).

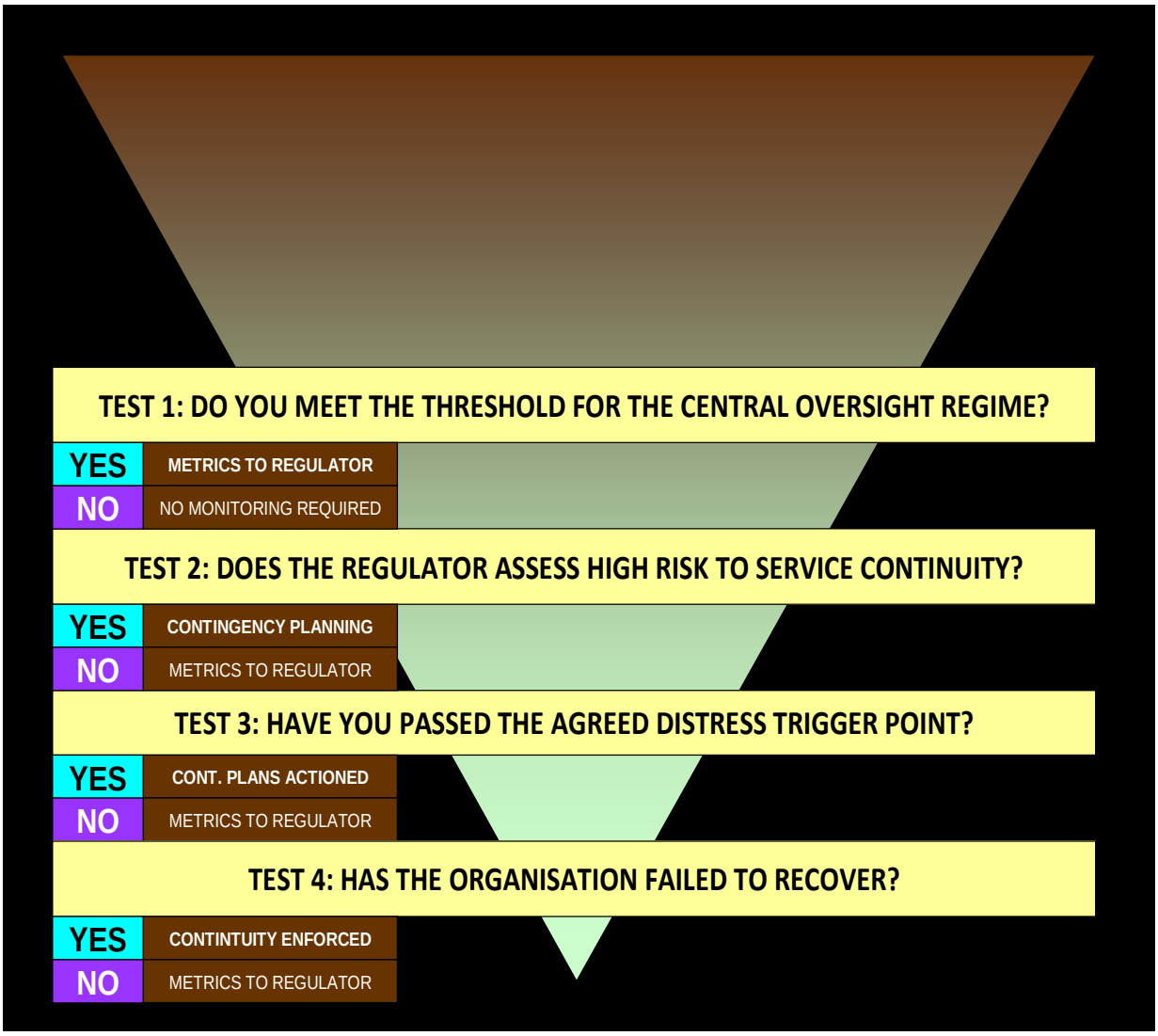
Figure 3: Overall approach



[42] Section 21, National Assistance Act 1948, section 47(5) National Health Service and Community Care Act 1990

80. The Government proposes this model is underpinned by a light-touch framework. The diagram below (figure 4) illustrates the four key tests which will determine the level of activity and burden that the system will place upon providers. In line with the principles set out in the *Caring for our Future* White Paper we believe this approach is proportionate, targeted and would support of a diverse market of high quality services to continue to flourish, with the important guarantees that vulnerable people should expect from these services.

Figure 4: Four test system



81. This document will next describe the four tests above in more detail, and what roles and responsibilities might be expected of organisations in the different circumstances.

Q8. What do you think of the overarching framework the Government has put forward for oversight of the social care market in the future?

TEST 1: DO YOU MEET THE THRESHOLD FOR THE CENTRAL OVERSIGHT REGIME?

NO NO MONITORING REQUIRED

82. As stated above we intend to provide a new legislative provision to apply specifically in the case of provider failure. It will impose a duty on local authorities to meet the needs for temporary care and support of any person whether self - funded and whether in receipt of residential or non - residential care if they have urgent unmet needs as a result of provider failure. Such a provision will extend and strengthen existing powers and duties[43] to provide care and support and provide clarity for people who are receiving care at the time their care provider fails.

83. In these circumstances, as now, **the local authority will be responsible for oversight of their local market and ensuring people continue to get the care and support they need if a provider fails.** It is expected local authorities will continue to do this in line with current best practice which includes;
    - ensuring a **diversity of local providers** so that care users can transfer to another provider or owner in the event of market exit[44]
    - developing **good relationships** with all providers and through regular business meetings to know of any company financial distress (it is not expected formal financial monitoring would be necessary at this level)
    - having **plans in place,** agreed with other relevant commissioning bodies such as the NHS and other authorities, to cope with the failure of a provider, with clear lines of responsibility, and
    - ensuring **local people are informed** about the change of provider and will involving users, their families and carers in all decisions affecting their care and to minimise disruption and act in line with their preferences wherever possible.

[43] Section 21, National Assistance Act 1948, section 47(5) National Health Service and Community Care Act 1990
[44] Local authorities have included a duty to promote a market offering a range of high quality services in the draft Care and Support Bill available at http://careandsupportbill.dh.gov.uk/home/ Local authorities are being supported to deliver this through the new Developing Care Markets for Quality and Choice programme http://caringforourfuture.dh.gov.uk/2012/09/18/dcmqc-launch/

The rationale for no further Government intervention in local markets

84. We do not believe that it would be proportionate, and it would be too great a burden on business, to assess the financial health of these smaller organisations at a national or local level – especially as we want to reduce barriers to market entry and actively encourage new, innovative providers of care such as micro-enterprises, mutuals and social enterprises.

85. Small care home providers with fewer than three care homes make up 43% of the UK care home market, in terms of places.[45] The vast majority of home care services are small - Laing & Buisson estimate they make up 60% of the UK home care market.[46] Often these services are based within local communities and operate across quite small geographical areas. We would expect small organisations to be below any threshold, subject to consultation.

86. Our assessment is that within local markets, there is generally adequate competition, as evidenced by the fact that there has been market entry and exit at the local level for 20 years. Evidence shows that in the year to April 2011, 114 homes were deregistered (representing a 20 year low) with 182 homes deregistered the year before. 133 new care homes were registered in the year to April 2011, with 145 new registrations the year before.[47]

87. Given the number of providers and level of competition in care services, we believe it is reasonable to argue that there is no significant market failure at the local level, *at the current time*, arising from the financial collapse of a single provider, as alternative provision has always been available for local care users. Given this, it is our view that local authorities continue to be best placed to manage continuity of care during the transition process in local care markets.

88. The draft Care and Support Bill also strengthens local authorities' duties in relation to developing a diverse and sustainable care market that supports choice and control for individuals. The precise clauses are set out in full in the draft Care and Support Bill[48], which the Government is consulting on and is subject to Pre-Legislative Scrutiny.

[45] Laing & Buisson, Care of Elderly People UK Market Survey 2011/12
[46] Laing & Buisson, Care of Elderly People UK Market Survey 2011/12
[47] Laing & Buisson, Care of Elderly People UK Market Survey 2011/12
[48] The draft Care and Support Bill is available at http://careandsupportbill.dh.gov.uk

The Government will offer support to all local authorities to perform these duties through **Developing Care Markets for Quality and Choice.**[49] This programme aims to strengthen the market shaping capability of LAs; supporting greater use of market intelligence, commissioning for outcomes and developing strategic relationships with providers. In particular it will help LAs to develop or strengthen their market position statements. These statements provide a powerful signal to the market by summarising important intelligence and explaining how the local authority intends to commission services in the future, and encourages development of high quality provision to suit the local population based on outcomes. It will build on the work of the National Market Development Forum a part of the TLAP Partnership[50] and encompass the principles set out in "Stronger Partnerships for Better Outcomes: a Protocol for Market Relations", published in July 2012.

89. Some reports have noted the lack of central statutory guidance on care home and service closures, noting this presumably leads to inconsistencies of approach between local authorities[51] although, conversely this also allows scope for the development of solutions that are tailored to local circumstances.

90. **As this is a legal duty on local government, the Government would expect all local authorities to have plans in place today, which follow best practice. We would encourage authorities to review, stress test, and seek to improve their strategies and processes; and to consider how they work with their neighbouring authorities, and partners such as the NHS, to ensure their plans are robust and effective. In particular, plans should have clear roles and responsibilities agreed with the NHS with regard to NHS funded care service users.**

Equality

91. The government is aware that a transition to a new care provider, can pose specific challenges and concerns to individuals with protected characteristics,[52] as defined by the Equality Act 2010. We have considered some of these impacts as set out in our Equalities Analysis document, which is published alongside this consultation.[53] We welcome evidence about specific impacts which should be taken into account in developing policy on market oversight in social care.

Consumer protection

92. The Government supports increased choice and control for individuals with care and support needs. In instances of provider failure, as in periods of business as usual, individuals should be aware of their rights and entitlements, should understand where to

[49] More information on Developing Care Markets for Quality & Choice is available at http://ipc.brookes.ac.uk/dcmqc.html
[50] Further information on this work see: www.thinklocalactpersonal.org.uk
[51] ADASS & University of Birmingham 'Achieving Closure' 2011 available at http://www.birmingham.ac.uk/Documents/news/BirminghamBrief/AchievingClosureReport.pdf and Le Mesurier, N**,** Littlechild, R., (2007) A Review of Published Literature on the Experience of Closure of Residential Care Homes in the UK, Birmingham, University of Birmingham
[52] The Equality Act 2010 states 'protected characteristics' are age, disability, gender reassignment, marriages and civil partnerships, pregnancy and maternity, race, religion or belief, sex, sexual orientation and carers (by association)
[53] http://www.dh.gov.uk/health/category/publications/consultations/

go if they are dissatisfied and should be included and informed about all decisions that concern them.

93. The Government has been exploring evidence on current contractual arrangements in social care. The Office of Fair Trading (OFT) published guidance on unfair terms in care home contracts in 2003, and published an independent evaluation of the impact of the OFT's 2005 market study in 2011.[54] The independent evaluation noted that: "*for the full benefits of information to materialise, consideration should be given not only to the provision of relevant information but also to raising consumer awareness of (such) information and its potential value. Among the care home residents and their representatives that we interviewed, there was relatively limited use of information*."

94. We would welcome trade bodies examining the guidance that they provide to members in relation to provider failure including contract terms and conditions, complaints procedures, and transparency and accountability, in cases where individuals are paying for the services themselves and where services are paid for by the local authority.

Q1. Are local authorities currently managing provider failure effectively and how could they plan and carry out their plans more effectively?

Q2. Do you agree with the proposal to clarify and strengthen the duties of local authorities in relation to failure?

Q3. Are current registration and de-registration powers adequate in cases of provider failure?

Q4. Is information sharing and coordination sufficient between local relevant parties such as local authorities, the NHS, CQC and with insolvency practitioners?

Q5. Do you think there are any equalities issues that would result from the proposals about oversight of the social care market which require consideration? If so, please provide evidence of the issue and the potential impact on people sharing the protected characteristics covered by the Equality Act 2010[55]

Q6. What further steps to support consumer rights are necessary in the care sector?

Q7. What more should providers do and plan to do in times of distress and financial failure?

[54] *Evaluating the impact of the 2005 OFT study into care homes for older people*, May 2011, available at http://www.oft.gov.uk/OFTwork/publications/publication-categories/reports/Evaluating/oft1322

[55] disability; race; age; sex; gender reassignment; religion & belief; pregnancy and maternity and sexual orientation and carers (by association)

TEST 1: DO YOU MEET THE THRESHOLD FOR THE CENTRAL OVERSIGHT REGIME?

YES **METRICS TO REGULATOR**

95. As stated above we intend to provide a new legislative provision to apply specifically in the case of provider failure. It will impose a duty on local authorities to meet the needs for temporary care and support of any person whether self - funded and whether in receipt of residential or non - residential care if they have urgent unmet needs as a result of provider failure. Such a provision will extend and strengthen existing powers and duties[56] to provide care and support and provide clarity for people who are receiving care at the time their care provider fails.

96. **However, where the size and scale or type of service provision makes it difficult for an individual local authority to ensure people continue to receive the care they need if that organisation fails, the Government proposes to establish a new system which will oversee the market and work with local authorities to help.**

97. **Those providers that meet a threshold set by the regulator would be required to provide financial information. The model would be light-touch and should be similar to the information required by investors and management boards for example.**

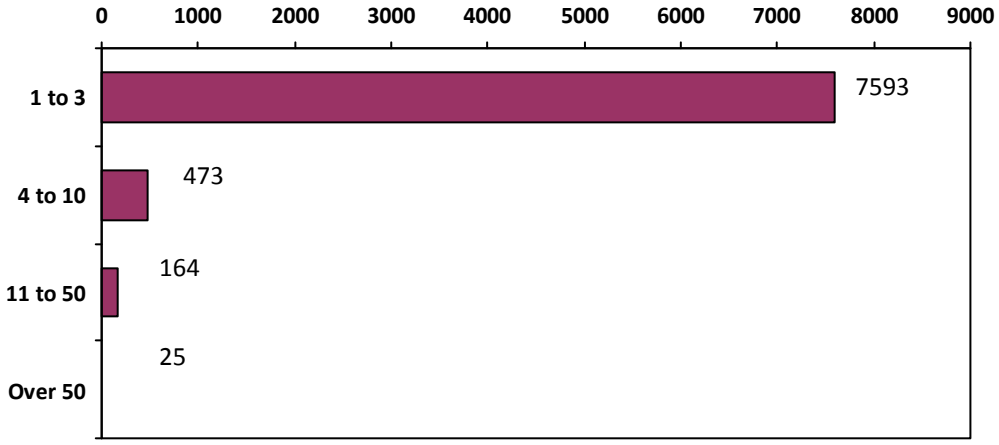
98. Our view is that the proposed system would be regulatory. The regulator would need to work with the Department of Health (DH) to develop a strategic, risk-based approach for targeting the oversight. Initially the regulator would need to establish a risk-based model to act as a threshold to decide which organisations should be brought into the central oversight regime. In most situations we expect organisations will be below such a threshold for the central oversight regime. This consultation aims to explore where the threshold should sit to bring providers into the central oversight regime only where they

[56] Section 21, National Assistance Act 1948, section 47(5) National Health Service and Community Care Act 1990

pose a significant risk to service continuity. Our initial assumption is that risk would be based on the following four factors:

- size and scale
- regional or sub-regional geographical concentrations, and
- highly specialist services with a wide catchment area of dependency.

Figure4: Analysis of the residential care market by size



99. For illustrative purposes the graph above shows the distribution of providers by number of care homes owned. The horizontal axis shows the number of providers while the vertical axis shows the number of homes operated e.g. there are 7593 providers which operate one, two or three homes. Clearly if we considered number of places or care service users as the indicator of size the chart above would be very different, as mentioned previously, operators with fewer than three care homes make up 43% of the UK care home market *by places*.

100. **There are a range of possible approaches to measure size, for example by turnover or number of people receiving services. This consultation seeks your view about the best approach and factors which the Government should consider to set the threshold level.**

101. The assessment of risk should be based on principles so that the approach to oversight will capture all types of provision that pose a substantial risk to continuity of care, now or in the future. The risk assessment itself would determine whether a provider should fall within the regime. However, the regime would need to take into account the different legal forms, types of service and sectors.

A light-touch, intelligent and confidential system

102. In taking this work forward, the Government recognises that the social care sector is currently facing significant financial pressures. We aim for this approach to be as light touch as possible, whilst making sure there is an effective system in place to reassure those who rely on care and support services.

103. Under the proposed approach, we would expect the regulator to develop a ‘dashboard’ of key metrics based on information from providers and other public and non-published information sources e.g. local authorities, CQC, investors. The precise make-up of these

would be for the regulator responsible to determine in liaison with the Department. They also may differ from provider to provider based on the nature of their business. We would expect information gathering to be light-touch and we would want the responsible regulator to seek to minimise any new reporting requirements on providers.

104. In any such system, we understand that collecting these metrics provides only an indication of risk, but that no system can provide a 100% guarantee that future failure can be predicted, for example, given international finance structures and the potential range of corporate activity undertaken by a single provider. The limitations on what information collection can achieve should be accepted.

105. Our view is that there should be a small number of targeted metrics which providers report on, reflecting existing management information, where possible. They should be similar to that required by investors or management boards for example. These will need to be kept under review to ensure that they continue to be effective indicators of risk within a changing context. Illustrative examples of possible metrics are: debt to earnings ratios, occupancy rates, capital investment in fabric and facilities, numbers of homes embargoed by local authorities, turnover of registered managers and compliance with CQC's essential standards of quality and safety.

106. We are mindful of the sensitivities surrounding the type of information the regulator may need to collect in order to obtain a fuller picture of the risk profile of an individual provider. This information would need to be provided to the regulator in confidence and the regulator would have to respect the commercial sensitivity of such information. However, although we do not intend to require this through these proposals, we would strongly encourage providers themselves to be more transparent in publishing data and explaining their performance and financial position to those commissioning services and the public.

107. The regulator would collect and analyse such information to perform a further risk-assessment. The regulator will use a dashboard of metrics and an understanding of providers' business models to determine which of the organisations falling within the central regime poses the highest risk to service continuity. As is common practice, risk levels will be determined both by the;
    - **impact** of a failure (extending the factors that determine which organisations meet the threshold in 'test 1'), and
    - **likelihood** of failure (this may involve a range of factors related to business models or capital structure).

108. This further assessment will identify the providers that pose the highest risk to service continuity. For example it may be that charities that meet the threshold for inclusion within the central oversight regime are viewed as posing a lower risk to service continuity and therefore are asked only to continue providing information to the regulator rather than to undertake the actions below. Although it would be for the regulator to decide, the Government would expect the number of organisations deemed to be at highest risk to service continuity to be reasonably small.

109. The providers deemed to pose the highest risk to service continuity would be required by the regulator to;
    - prepare **scenario based contingency plans** to the regulator for approval

- take action, or demonstrate what action would be taken, to **protect continuity of quality services** during any period of distress and transition, and
- submit **information to support continuity of service** in distress e.g. regarding the business structure and operating costs.

110. Our view is that having a centralised approach means that an expert national body with regulatory powers is required, that;
    - is adequately resourced with corporate finance and business recovery expertise
    - has a clear set of enforcement powers to enforce compliance with information gathering requirements, an ability to challenge providers on whether their model supports the delivery of quality care services and action in line with contingency plans
    - addresses the current information gaps in the system, and
    - replaces unnecessary monitoring of providers by 152 local authorities, which would be burdensome and inefficient and could lead to wider, structural problems being missed through a fragmented approach.

111. Other sectors, such as in health, banking and utilities all have regulatory bodies overseeing the market in order to protect individuals. Our view is that this is equally, if not more necessary in social care.

Who would take on the role as regulator?

112. If as a result of the consultation, the decision was taken to formally regulate the providers that posed the greatest risk to service continuity operating within the social care market then the Government would not want to create a new body. Instead it would look to either the Care Quality Commission (CQC) or Monitor to take on this function. We understand that this would be an additional and different type of role for both organisations and further skills and probably powers would be required.

113. Monitor and CQC have their own clear accountabilities and responsibilities, whichever organisation took forward the role it would be necessary to work very closely together. Furthermore information sharing between regulators and with local authorities would be vital to aid coordination and to manage burdens on providers.

114. In the Vision for Adult Social Care (2010) and the Health and Social Care Act 2012 the Government put in place specific provisions to enable Monitor's functions to be extended to social care[57] if required.

115. If Government decided Monitor should undertake this role it could support the integration of health and social care services by having a single regulator looking at the financial health of providers. There is also an argument for separating economic and quality regulation to avoid any conflict of interests. This would be on the understanding that the two regulators share key information to allow a holistic picture to emerge, which effectively triangulates quality and financial indicators.

[57] The Health and Social Care Act 2012 (s65), gives the Secretary of State powers to provide for Monitor's functions to be exercisable in relation to the provision of adult social care services see A Vision for Adult Social care, Department of Health, November 2010, available at http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121508

116. If it took this work forward, it would be necessary for Monitor to ensure that the approach is proportionate and appropriate for social care. The market has very different characteristics to health – with a far greater number of providers, operating within a well-established market environment, in often highly localised areas. There is also no central pricing regime in social care. If Monitor were to take on this role, we would expect it to develop approaches for social care which take into account these specific characteristics and are light-touch and proportionate.

117. The CQC currently has the statutory powers to require registered providers to take all reasonable steps to run their business so as to ensure the financial capacity to maintain compliance with standards and registered providers have specific responsibilities to notify CQC if the organisation fails.

118. The primary objective of the CQC is to protect and promote health, safety and well-being of users of health and adult social care providers. We know that disruption to services can have a detrimental effect on the health and well-being of service users. In line with this purpose, the CQC collects a great deal of data and information already, in order to monitor providers' compliance with the essential standards of quality and safety.

119. It is important that quality and financial intelligence is shared regardless of which organisation were to take this forward and there are established communications between the CQC, local authorities and social care providers, as part of their day-to-day monitoring of the quality of care.

Q9. What are your views on;

- A. gathering greater national and regional market intelligence?
- B. targeted monitoring of the providers that pose the greatest risk to continuity of care?
- C. how and where the threshold should be set to monitor providers that pose the greatest risk to service continuity?
- D. what information would be required to assess risk?

TEST 2: DOES THE REGULATOR ASSESS HIGH RISK TO SERVICE CONTINUITY?	
YES	CONTINGENCY PLANNING
NO	METRICS TO REGULATOR

120. Providers that are assessed by the regulator as posing a lower risk to service continuity will continue to provide routine information to the regulator for regular risk assessment and regular monitoring as set out previously.

121. Those providers that are assessed by the regulator as posing a higher risk to service continuity will be required to;
    - reassure the regulator that this model supported the delivery of quality care services;
    - prepare scenario based contingency plans to the regulator for approval
    - state the action they would take to protect continuity of quality services during distress and transition, if they were to exit the market, and
    - submit operational information to support continuity of service in distress e.g. regarding the business structure and operating costs.

122. The Government envisages that the information provided above, will form two plans, a 'recovery plan' and a 'resolution plan';

    - **recovery plan:** The first part of contingency planning would be prepared by the provider based on a series of scenarios and setting out a number of actions they would take to attempt to 'recover' in each scenario. The plan would include provisions to maintain quality of care during this period
    - **resolution plan:** The second part of contingency planning would be prepared by the regulator and would be based on mechanisms to allow a smooth transition to new ownership and continuity of quality care once the organisation is no longer able to continue its operations.

123. This approach is based on the '**living wills model'** being piloted in the banking sector[58] which we believe could be amended to form the basis of an appropriate model for the social care sector.

Recovery and Resolution Plans

Banking Sector: Recovery and Resolution Plans

Recovery Plans: The key aspect of the pre-failure regime is the preparation of Recovery Plans whereby regulated entities are required to prepare plans which detail what would be done if the business were to fall under extreme financial stress e.g. business or asset disposals, reductions in the risk profile of the business or a restructuring of liabilities. These options depend on the cause of the financial stress and hence the plan would be scenario based. The recovery plan is owned by management of the provider but should be approved and enforced by the regulator.

Resolution Plans: These plans aim to ensure that should there be a failure, there is an orderly resolution, carried out in a way that preserves or facilitates continuity. A Resolution Plan includes key information that a regulator/administrator would require for an effective resolution of the provider entity. The business information in the resolution plan is submitted by the bank, but the plan is developed and acted on by the Financial Services Authority (FSA) and the Bank of England.

124. Such an approach would need to be adapted to the social care market. Below, we outline more detail about how this approach could work for social care. However, decisions about how a pre and post-failure regime would work would be for the regulator to design in detail and implement, working with DH.

Recovery measures

125. As stated previously, those providers who were, firstly, within the threshold for inclusion within the central oversight regime and secondly, were assessed as posing the highest risk to continuity of service, would be required to support contingency planning. These plans would need to cover;
    - a range of different scenarios based on a comprehensive risk assessment, such as problems re-financing debt and accessing capital, or a major quality failing affecting the overall viability of the company. The scenarios would reflect the events that posed the greatest risk to the provider's business and so would be different for each provider,
    - specific measures or a 'trigger' against which a recovery success or failure could be determined. This may include agreed points at which local authorities should be informed, and
    - measures to protect quality during the period of 'recovery'.

[58] Further information on Recovery and Resolution plans can be found on the FSA website. The following webpage explains the concept, and provides a link to the FSA's recent consultation on the issue: http://www.fsa.gov.uk/library/communication/pr/2011/070.shtml

126. Our view is that for these plans to be effective a regulator would need to approve and enforce adherence to the plan. The involvement of a regulator is a route to develop plans that are robust, realistic, and deliverable. However, it would be for the providers – with its funders and advisors – to then take forward the implementation of the plan should it become necessary, but with the knowledge that if they did not do so, the regulator would be able to compel them to take action.

127. As part of this plan, the regulator may also want assurance that for any period of distress or failure, the provider has considered how it will effectively manage its key infrastructure that is required for service continuity such as property, utilities and most importantly, the workforce. The recovery plan should therefore also identify key impediments to successful recovery and business continuity and what mitigating actions can be taken in a recovery scenario.

128. This is a preventative measure with the specific aim of reducing the chances of disorderly failure where the impact on individuals could be more extreme and there could be unplanned/ rapid moves required. The intention is that if the recovery plan was successfully implemented, the provider would return to a stable operating position with no adverse impact on individuals reliant on their services.

Resolution measures

129. As outlined above the second part of contingency planning aims to protect the health and well-being of individuals, through ensuring;
    - a smooth, well-managed transition to new ownership or services, and
    - continuity of quality care.

130. The ‘resolution phase’ occurs when a company passes the point at which it could realistically recover and return to being a viable business. This is the situation which the recovery plan aims to avoid. At this point, insolvency practitioners may become involved, as would alternative providers who may be considering taking over services.

131. As such a resolution plan will be prepared by the regulator based on the compendium of key up-to-date information on business operations and structures from the provider’s management in a ‘business as usual’ environment. That compendium of information should contain the necessary information assembled in one place that would be required to plan and support a local authority to take action to manage continuity of service. For example, a clear map of the structure of the organisation, key infrastructure, operational costs, creditors, suppliers, supplier contracts, and potentially alternative operators or alternative homes for residents.

132. The resolution plan and the role of the regulator and local authority will also need to be sufficiently flexible to operate effectively in a range of scenarios, to respond to changes in the structure of the care market and in line with insolvency law and practices. Crucially the purpose of the regulator will be to support temporary and urgent continuity of quality services for care service users with the cooperation of all relevant parties.

Special administration regime

133. Some stakeholders have suggested that a special administration regime would be appropriate. A special administration regime would prevent 'normal' Insolvency Act procedures in which creditors' rights are paramount, from applying. A special administration regime would put in legislation a requirement that that the provider's services be maintained until this protection is no longer required i.e. at the point that the provider is rescued, or all or part of its business transferred to a solvent entity. This continuation of service would take priority over the rights of creditors.

134. Special administration regimes normally operate in sectors where;
    - there are a small number of providers (often that are under tight public sector control through licensing regimes), and
    - the physical infrastructure needs to continue to operate in order to meet people's needs, for example in the case of the rail, water, energy industries and of course, hospitals.

135. In social care there are a high number of independent sector providers. In residential care alone there are roughly 10,000 operators, 20,000 homes and 470,000 places. The Government's work with providers and investors through and following the events of Southern Cross have led us to form the opinion that it is very rare that care homes close, rather than be taken over, as in most cases if a provider fails the care service itself is viable but the debt levels and business models are not. Also given an ageing population, care services remain an attractive proposition for investors and providers. Therefore in most circumstances, alternative providers would look to take over some or all of the services. In the rare instances where some of the services were not viable (which we expect would be a minority homes out of a provider's overall portfolio) the Government takes the view that the protections should focus on the individual not the asset.

136. Care homes were purchased or built entirely by the private or voluntary sector and given the multiplicity of care homes it is not necessary to keep an individual care home running where there are alternative high quality providers nearby that could offer the care and support an individual needs. In line with local authorities' legal duty and with the support and clarity provided by this new system, the local authority would have plans in place, would engage with residents and would need to move the individuals to a new provider.

137. The Government notes that the closure of any care service, particularly a care home poses significant health risks to frail individuals and must be done sensitively to protect an individual's health and well-being. In either instance the people concerned would receive services from a new, financially sustainable provider who would be better placed to invest in the facilities and service the individual received. The Government recognises the advantages of having a clear legislative requirement to prioritise continuity of care. Furthermore special administration regimes ensure that any costs of continuity are met until alternative provision is secured. These costs could be met either by provider(s) or the Government.

138. However, the Government currently does not propose a special administration regime because we believe the likelihood it would be used is low due to competition levels, system incentives, the ability to move individuals as a last resort and the potential

negative impacts on the whole social care system if such a regime is introduced. These impacts are set out below;

- such a regime could require money to be set aside by providers, which would take money out of the system for providing quality care services
- any additional cost to providers would be likely to raise the cost of care for individuals and local authorities
- the change to creditors' rights could limit investment in the sector and cause existing investment arrangements to be changed which could precipitate failure
- the case of Southern Cross was resolved by all parties acting responsibly to find a solution and preserving continuity of care. This is in the best interests of all parties, which could be altered by a special administration regime. The system for resolving the commercial aspects of failure should sit with the market, and
- whilst the Government should have measures in place to protect people's care Government should not be intervening in commercial procedures unless there is a need to continue use of the asset.

139. The Government has set out the assumptions and current position above in order to be fully transparent. We welcome views on whether our assumptions are correct.

Supplier of last resort

140. Although we do not currently propose to establish a special administration regime, we are aware that in some circumstances it may be appropriate to consider a supplier of last resort if this could operate outside of such a regime. For example, as part of the resolution planning the regulator could establish an open 'concordat' amongst larger providers, where these providers agree to step in and manage care services during the transition phase, in the event that one of their competitors left the market. This would be a temporary measure and it would need to be done on a cost neutral basis, whereby creditors were satisfied and staff wages could be maintained. The justification for this is that the largest providers are likely to have the greatest capacity to provide support in the transition phase. Using the information submitted by providers for the resolution plan, the regulator could match the care services to other providers' activity so that services could easily be taken over temporarily by another supplier in a planned way. The temporary management of such care services would need to have no impact on the assessment of bids to take over services, nor impact upon the rights of creditors

TEST 3: HAVE YOU PASSED THE AGREED DISTRESS TRIGGER POINT?	
YES	**CONT. PLANS ACTIONED**
NO	METRICS TO REGULATOR

141. Very few providers are expected to enter the next phase of activity. However in the few cases where a provider passes beyond the pre-agreed 'trigger' point (set out in the recovery plan) and passes into financial distress the actions in the scenario based contingency plans would be taken forward. For the majority of providers who reach the threshold for the central oversight regime, will never reach this stage. However, they will continue to provide routine information to the regulator for regular risk assessment and regular monitoring and to update the information in the recovery and resolution plans as necessary.

142. At this stage providers would be required by the regulator to;
    - keep the regulator informed of all activity
    - take the agreed action outlined in the scenario based contingency plans. Where a scenario had not been envisaged or new information comes to light, alternative action should be agreed with the regulator, and
    - demonstrate that the quality of service level is maintained through this period.

143. At this stage the regulator would;
    - keep in touch with the provider and relevant parties throughout negotiations
    - enforce adherence to the plan of actions needed to support recovery
    - ensure Government is appraised of the situation, and
    - at an agreed point, it is our view that the regulator should have the powers to inform commissioners that there was a real risk to service provision, and local contingency plans were likely to be called upon.

TEST 4: HAS THE ORGANISATION FAILED TO RECOVER?	
YES	**CONTINTUITY ENFORCED**
NO	METRICS TO REGULATOR

144. If the provider has recovered and the actions taken in the contingency plan have been successful, the provider will continue to provide routine information to the regulator for regular risk assessment and regular monitoring. Providers will also update their scenario based contingency plans as necessary.

145. In a very few cases, despite the increased preparedness, a provider will fail to recover. In that event, the provider's management will begin to consider the processes that need to take place to resolve the organisation. This may be through a pre-insolvency or insolvency procedure, which could impact the timescales for a managed exit, which can vary considerably.

146. If an organisation went into formal insolvency, then existing Insolvency Law governing Great Britain would apply.[59] We are not recommending that a special administration regime is developed for social care; the rationale for this is outlined in the Impact Assessment[60]. This means that the insolvency practitioner may assume responsibility for the direction of the organisation. The insolvency practitioners would be bound by their code of ethics but be primarily responsible for creditor's interests. The insolvency practitioners would manage expressions of interest from alternative providers and investors over the assets and operations of the out-going organisation.

147. At this stage the provider would be required to notify the regulator of their plans to resolve the organisation and regularly update the regulator on progress.

[59] More information on GB Insolvency Law can be obtained from the Insolvency Service. See: http://www.bis.gov.uk/insolvency
[60] The Impact Assessment is available at http://www.dh.gov.uk/health/category/publications/consultations/

148. At this stage we propose that the regulator would keep in close contact with negotiations and have coordination and information sharing powers. The regulator would oversee continuity of care, in particular it would;
    - engage with insolvency practitioners, providers, and investors to monitor the transition process
    - use the information provided on business operations to support services to continue at appropriate quality level, which may include considering of a supplier of last resort
    - the regulator would communicate & coordinate across local authorities and the NHS
    - if a care services did not attract a new owner and would need to close, the regulator would notify the relevant local authorities
    - the regulator would horizon scan for any issues that would change the pace of resolution and would communicate nationally on progress to provide reassurance and up to date information on next steps
    - work alongside the insolvency practitioners to oversee an orderly winding down of the business, making certain that a media handling strategy is in place that ensures all those affected have sufficient information to give them reassurance about continuity of care
    - we intend that the regulator would also make provisions so that organisations offering information, advice and employment services are informed if there are likely to be staff job losses to support such individual social care workers, and
    - liaise with Government as necessary.

149. All providers and the organisations that invest in care services have a responsibility to the people who rely upon them for their care and support. At all stages of the process, the provider and their partners have the primary responsibility for providing good quality care. The well-being of people in their care must be their first concern. Even in the case of failure the provider and their investors or partners should take action at all levels of their business from the board to the frontline staff to;
    - reduce stress and anxiety for care users, their families and carers;
    - to reassure care users that their care needs will continue to be met;
    - keep all affected people informed about the process;
    - to share all relevant information with local authorities and future providers so that people's care and support needs can be seamlessly met by a new provider; and,
    - to act in every way possible to put the people receiving services at the forefront of all business considerations and to take responsibility for ensuring their needs are met

150. We would be interested in evidence and reasoned views from stakeholders about whether this model would offer sufficient assurance with respect to the continuity of high quality services and reassure care users, their carers and families.

Q10. What are your views on the proposals, for those providers which are above the threshold in particular relating to;
- A. recovery plans?
- B. enforcement powers?
- C. regulatory functions?

Q11. Do you agree with the Government's current assumption that a special administration regime would not be appropriate?

Q12. Do you consider that a supplier of last resort model could offer additional protections without changing the insolvency regime?

Costs and impacts

151. Any additional regulation will have some cost to both taxpayers (Government) and providers and the Government will need to consider whether and how these costs can be met, taking into account questions of affordability and wider government spending commitments. The Government understands that;
    - this is a new function, any body given responsibility for performing this function would need to be funded to do so. This could be met through cost savings in other areas or may need additional funding from Government or providers
    - if it was decided to go down a regulatory route, those major providers covered by the new regulations, would need to meet costs associated with the new requirements (the scale of which would depend on the scope of the regulations). We aim to minimise these costs and we also recognise that increased provider costs may be passed on to commissioners and individuals, and
    - any significant new regulations, which impact the operations of the company, could affect their overall investment prospects.

152. We have sought to minimise costs to businesses as far as possible. Our view is that the main tools proposed in this consultation, namely, monitoring of key financial metrics for an effective early warning system and robust contingency and continuity planning should be part of good business management and planning processes. In that respect, it is our assessment that in a business as usual scenario, the proposed new requirements should broadly align with current investor and board objectives.

153. We understand that any new regulations would need to be fully costed and factored into the Government's "one in one out" rules on regulation.[61] We welcome any evidence of direct or indirect costs which could arise as a result of these proposals.

154. Our approach has also been designed in a way which has minimal impact on small and micro-enterprises, and should not put significant new requirements on not-for-profit providers. In analysing the options, the Government has also been mindful of the need to develop an approach which is cost effective and delivers value for money.[62]

Q13. Could you provide any evidence of estimated direct or indirect costs to providers which could arise as a result of these proposals?

[61] For more information see: http://www.bis.gov.uk/policies/bre/one-in-one-out

[62] This is in line with the Government's statement in the *Open Public Services* White Paper (2011) which states that "Continuity regimes should ensure continuity of service in a way that is consistent with the Government's plans for fiscal consolidation".

What will this system mean for you?

155. **As a result of these proposals, what will this system mean for you…**

…if you are a person receiving care services, a family member or carer

Every person receiving care and support will continue to get the care they need if a provider exits the market, regardless of whether they are state funded or privately funded because;

- Government will clarify and strengthen the legal duty on Local authorities to meet the care and support needs of local people should a provider fail
- where the size and scale or type of service provision makes it difficult for an individual local authority to ensure people continue to receive the care they need, the government will introduce a new system to help.

….if you are a provider of social care services

All providers and the organisations that invest in care services have a responsibility to the people who rely upon them for their care and support. At all stages of the process, the provider and their partners have the primary responsibility for providing good quality care. The well-being of people in their care must be their first concern. Even in the case of failure the provider and their investors or partners should take action at all levels of their business from the board to the frontline staff to;

- reduce stress and anxiety for care users, their families and carers
- to reassure care users that their care needs will continue to be met
- keep all affected people informed about the process
- to share all relevant information with local authorities and future providers so that people's care and support needs can be seamlessly met by a new provider, and
- to act in every way possible to put the people receiving services at the forefront of all business considerations and to take responsibility for ensuring their needs are met.

Under the proposed system, in most circumstances providers will continue to operate as usual and will not fall within the regulatory regime as continuity of quality services can be adequately overseen by their local authority. However local providers have a responsibility towards those they provide care services to and we expect providers to notify their local authority of any potential exit to support continuity of service for those people in their care.

But there will be changes if a provider meets the risk threshold it would be required to submit regular information to the Regulator to enable the regulator to perform a risk assessment of its business.

If a provider is assessed by the regulator to pose a threat to service continuity they will be required to;

- provide reassurance their business model supports the delivery of quality care services
- prepare scenario based contingency plans to the regulator for approval
- demonstrate what action would be taken, to protect continuity of quality services during any period of distress and transition, and

- submit information to support continuity of service in distress e.g. regarding the business structure and operating costs.

If a provider meets the agreed 'trigger' for entering a period of distress;

- keep the regulator informed of all activity
- take the agreed action outlined in the scenario based contingency plans. Where a scenario is not envisaged or new information comes to light, alternative action may be agreed with the regulator, and
- demonstrate that the quality of service level is maintained through this period.

If a provider fails to recover they would be required to;

- keep the regulator up to date on progress in order to manage an orderly exit, and
- take all necessary steps to maintain the quality of their services in the event of exit and that their actions support a smooth transition.

…if you are a local authority

As now, the local authority will be responsible for ensuring that if a care provider fails, people continue to receive the care and support they need, regardless of who funds their care. It is expected local authorities will continue to do this in line with current best practice which includes;

- ensuring a diversity of local providers so that care service users can transfer to another provider or owner in the event of market exit[63]
- developing good relationships with all providers serving their local population and through regular business meetings will know of any company financial distress (it is not expected formal financial monitoring would be necessary at this level)
- having plans in place agreed with other relevant commissioning bodies such as the NHS and other authorities to cope with the failure of a provider and to be clear about roles and responsibilities where the care people receive is commissioned by the NHS
- ensuring local people are informed about the change of provider and involve users, their families and carers in all decisions affecting their care
- the care users and their families and carers views are taken into account to minimise disruption and act in line with their preferences wherever possible, and
- that efforts are made to reduce stress and anxiety for care users, their families and carers.

In some cases Government believes a regulator is needed to support local authorities in their role to oversee continuity of service. In such instances the local authority, would first be informed that there is a risk to an existing provider in their area and we would expect local authorities to;

- have in place contingency plans and ensure that there was an effective way forward for care users should specific services have to close
- implement their plans in line with the regulator's coordination efforts

[63] Local authorities have included a duty to promote a market offering a range of high quality services in the draft Care and Support Bill available at http://careandsupportbill.dh.gov.uk/home/ Local authorities are being supported to deliver this through the new Developing Care Markets for Quality and Choice programme http://caringforourfuture.dh.gov.uk/2012/09/18/dcmqc-launch/

- engage with care users to communicate, explain and involve care users, their families and carers in changes or if necessary, to find alternative provision in their area
- manage the transfer of residents if necessary, ensuring compliance with good practice and the law and that safeguarding procedures are in place during this process, and
- work with their national support bodies, such as the Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA) to support the work at the national and regional level.

….if you are the regulator overseeing the system

Prior to distress and failure, it would be for a regulator to;

- monitor financial and other information for organisations that are above the risk threshold
- perform a risk assessment based on certain metrics to determine which organisations pose a high risk to service continuity
- challenge providers to ensure their business model supports the delivery of quality care services
- require this sub-set of organisations to develop scenario-based contingency plans 'recovery plans', which they test for robustness
- collect information on business operations, and
- have responsibility for the development of the 'resolution plans' comprising business information, to support communication and continuity in the event of failure.

If a provider entered a period of distress a regulator would;

- keep in close contact with the provider and relevant parties during negotiations
- enforce adherence to the recovery plan, and
- at an agreed point, it is our view that the regulator should also have the powers to inform commissioners, if they felt that there was a real risk to service provision, and local contingency plans were likely to be called upon.

If a provider failed to recover a regulator would;

- engage with insolvency practitioners, providers, and investors to monitor the transition process
- use the information provided on business operations so that services continue and at appropriate quality level, which may include considering of a supplier of last resort
- the regulator would communicate and coordinate across local authorities. If a care service did not attract a new owner and would need to close, the regulator would notify the relevant local authorities
- the regulator would horizon scan for any issues that would change the pace of resolution and would communicate nationally on progress to provide reassurance and up to date information on next steps
- work alongside the insolvency practitioners to oversee the orderly winding down of the business, making certain that a media handling strategy is in place so that those affected have sufficient information to give them reassurance about continuity of care
- we intend that the regulator would also make provisions so that organisations offering information, advice and employment services are informed if there are likely to be staff job losses to support such individual social care workers, and
- liaise with Government as necessary.

Conclusion and next steps

156. In this consultation document, the Government has set out what it believes to be the appropriate framework for market oversight in the future. We would welcome views on this framework, and the different elements which underpin it;
    - first, what further measures are needed to strengthen and clarify the responsibilities of local authorities in relation to care users in the event of the failure of a care provider (see pages 27-30).
    - second, whether a targeted model of central oversight would be appropriate and if so, what the elements of this model would be (pages 31-47)

157. The Government considers that this proposal is a proportionate response given the current structure of the social care market. However, others may believe that further additional powers could be necessary to ensure the approach is robust, or indeed that these additional regulatory powers are unnecessary. We would welcome views on the balance between; level of oversight, the degree of risk and the acceptable level of regulatory costs of further measures to both taxpayers and providers.

158. This consultation will finish on **Friday 1st March 2013**. During this time, we will continue to work with the sector on the proposals and the principles which should underpin any new framework. We will then publish a response to the consultation, setting out the Government's decision and next steps.

159. Should additional primary legislation be required to implement the measures, we would seek to include this in the forthcoming Care and Support Bill.

Summary of consultation questions

	Questions
1.	Q1. Are local authorities currently managing provider failure effectively and how could they plan and carry out their plans more effectively? Q2. Do you agree with the proposal to clarify and strengthen the duties of local authorities in relation to provider failure? Q3. Are current registration and de-registration powers adequate in cases of provider failure? Q4. Is information sharing and coordination sufficient between local relevant parties such as local authorities, the NHS, CQC and with insolvency practitioners? Q5. Do you think there are any equalities issues that would result from the proposals about oversight of the social care market which require consideration? If so, please provide evidence of the issue and the potential impact on people sharing the protected characteristics covered by the Equality Act 2010[64] Q6. What further steps to support consumer rights are necessary in the care sector? Q7. What more should providers do and plan to do, in times of distress and financial failure?
2	Q8. What do you think of the overarching framework the Government has put forward for oversight of the social care market in the future? Q9. What are your views on; • A. gathering greater national and regional market intelligence? • B. targeted monitoring of the providers that pose the greatest risk to continuity of care? • C. how and where the threshold should be set to monitor providers that pose the greatest risk to service continuity? • D. what information would be required to assess risk? Q10. What are your views on the proposals, for those providers which are above the threshold in particular relating to; • A. recovery plans? • B. enforcement powers? • C. regulatory functions? Q11. Do you agree with the Government's current assumption that a special administration regime would not be appropriate? Q12. Do you consider that a supplier of last resort model could offer additional protections without changing the insolvency regime? Q13. Could you provide any evidence of estimated direct or indirect costs to providers which could arise as a result of these proposals?
If there is anything else regarding market oversight that you would like to feedback to the Government, please include this in your response.	

[64] disability; race; age; sex; gender reassignment; religion & belief; pregnancy and maternity and sexual orientation and carers (by association)

Instructions for responding to the consultation

We would appreciate it if all responses would use **the response pro forma at 'Annex C'**. Also for responses over four pages in length please include a summary of the key points.

All responses should be returned to:

marketoversightconsultation@dh.gsi.gov.uk

Or if you would prefer to send your response by post:

Social Care Policy & Legislation Branch
Department of Health
Area 313B. Richmond House
79 Whitehall
London
SW1A 2NS

The closing date for responses is **Friday 1st March 2013**. Responses received after this date may not be read.

Annex A

Discussion paper on provider failure (Oct. 2011)

160. As part of the engagement exercise on future reform of care and support in England, the Department published a discussion paper analysing the issue of market oversight and inviting responses.[65]

161. We spoke to key stakeholders including the providers and their trade bodies, banks and professional services firms, local authorities, the devolved administrations, and academics. We received over 20 formal responses to the paper, and many organisations and individuals chose to comment on this issue as part of the wider engagement on social care reform, there were 565 responses to the engagement exercise[66]. Below we provide a summary of the key themes that emerged from the engagement.

Summary of Feedback from the 'Caring for our Future' Engagement Exercise

All responses voiced concern over the collapse of Southern Cross and the impact that provider failure could have on residents' health and wellbeing. There was widespread agreement that the protection of care users should be the principal concern in such situations – especially as residential care providers are providing both care and accommodation. Many commented on the need for all those reliant on services from an independent provider to be protected appropriately, whatever the size of the provider. Some commented that those with high-level needs who relied on domiciliary care should be given similar reassurance.

We also heard from many that any new measures in this area should take into account the need to continue to encourage private investment into social care and promote a greater diversity of services. Some felt that any measures which inadvertently weakened the investment proposition risked undermining the wider sustainability of the care and support system. A small number of respondents questioned the role of private equity in the market, believing that this had led to a focus on short-term gains and irresponsible lending decisions – incompatible with long-term stability and a focus on the needs of individuals. However, there was widespread acknowledgement that a market operated in social care, and that the Government's policy was for this market to continue.

Some providers and professional advisors argued that the successful resolution of the Southern Cross situation illustrated that the market could cope with such failures successfully. It was also noted that social care had a diverse market with many thousands of providers, which was a powerful way to ensure service continuity. However, others thought that greater regulation and government intervention was required to protect service users.

On further regulation, some believed that appropriate regulation could bring greater stability and improve the sector's reputation, but said it must be implemented in a proportionate and fair way. Others stated that the sector may be unable to sustain the increased costs and burdens often associated with regulation. A number requested greater clarity over CQC's remit in this area, most notably over the regulator's role in assessing whether a provider had the financial

[65] *Oversight of the Social Care Market*, Department of Health, October 2011
[66] A full independent analysis of the *Caring for Our Future* engagement by Ipsos Mori can be found at: www.caringforourfuture.gsi.gov.uk.

resources to meet its obligations. Many also commented on the likely correlation between quality and financial indicators.

From the wider engagement on markets, a common view emerged that local authorities needed to better understand their local market, identify risks to provision and commission in a more strategic and sustainable way. Some, however, raised the issue of whether it was realistic for local authorities always to manage the market effectively, given the size and complexity of some providers. Linked to this were comments about the role of local authorities in purchasing care and fee levels. The Devolved Administrations also raised the issue that that the larger providers operated across the UK and that there were benefits in a co-ordinated response.

162. These discussions and written responses have been central to the development of the proposals outlined in this consultation paper.

Annex B

The consultation Impact Assessment and equalities analysis

Impact Assessment

The proposal we outline in this document is for targeted oversight of the providers that pose the greatest risk to service continuity should they fail. This is based on our view that the objectives could be best achieved through additional regulatory oversight. In coming to this judgement, we have examined a range of other possible approaches (following the engagement on the discussion paper last year). These include;

option 1: maintaining the status quo and the approach developed during Southern Cross. We believe that there may be ways to address a disorderly closure of a large national/regional provider that are more effective. We are keen to explore proposals during the consultation process

option 2: a sector-led model including greater financial transparency or a shared risk pool such as the ATOL model in the travel industry. We are not confident that this scheme would offer adequate protection to care users. Such a scheme would probably only be effective if small and medium providers were able to contribute financially to a sector-led scheme. This would place unjustifiable burdens on small providers who do not pose the same level of risk to continuity of care in cases of failure

option 3: continuity clauses in local authority contracts. Our assessment is that this would not offer any protection to services for self-funders only. Self-funders comprise 41% of those in UK care homes (159,000 residents).[67] It is likely not to be effective in insolvency. If the system were ineffective, it would offer no benefits to care users

option 4: The system of targeted regulation outlined in this consultation document.

option 5: A special administration regime for social care under insolvency. The prevalence of competitive market forces suggests this level of intervention is disproportionate, it is also high cost. However, it would create a firm protocol for continuity.

All five options were considered in the Government's impact assessment, which is published alongside this consultation. [68] Options 2,3 & 5 were eliminated from further consideration, however we welcome views on these options or any other potential solution as part of this consultation.

[67] Laing & Buisson, Care of Elderly People UK Market Survey 2011/12
[68] The Impact Assessment is available at http://www.dh.gov.uk/health/category/publications/consultations/

Equalities analysis

The Equality Act 2010 created the general equality duty. In developing policy, we are required to have due regard to eliminating unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act; advancing equality of opportunity between people who share a protected characteristic and those who do not; and fostering good relations between people who share a protected characteristic and those who do not.

Protected characteristics are: disability, race, sex, age, gender reassignment (including transgender), sexual orientation, religion or belief, pregnancy and maternity and carers 'by association' with people sharing some of the characteristics e.g. disability and age. It also applies to marriage and civil partnership, (in respect of the requirement to have due regard to the need to eliminate discrimination)

We are taking the following steps to abide by this duty;

- consulting on our proposals

- publishing this Equality Analysis alongside the consultation document

- holding specific discussions with relevant stakeholder groups to identify and avoid any negative impact of this policy upon individuals who share a protected characteristic. We expect these groups to include the Race Equality Foundation, LGB&T Partnership, Faith Action and Age UK.

The full equalities analysis is published alongside this consultation document[69].

[69] The Equalities analysis is available at http://www.dh.gov.uk/health/category/publications/consultations/

Annex C

Pro forma for consultation responses

Response to consultation: market oversight in adult social care

Full name:
Job title:
Organisation:
Type of organisation:
Contact address:
Telephone number:
Email:

Instructions for Responding to the Consultation

We would appreciate it if all responses over four pages in length had a summary of the key response points.

Summary of key response points:

Summary of consultation questions

Section 1 Questions	**Response**
Q1. Are local authorities currently managing provider failure effectively and how could they plan and carry out their plans more effectively?	**YES/NO** **Please provide more details:**
Q2. Do you agree with the proposal to clarify and strengthen the duties of local authorities in relation to provider failure?	**YES/NO** **Please provide more details:**
Q3. Are current registration and de-registration powers adequate in cases of provider failure?	**YES/NO** **Please provide more details:**

Q4. Is information sharing and coordination sufficient between local relevant parties such as local authorities, the NHS, CQC and with insolvency practitioners?	**YES/NO** **Please provide more details:**
Q5. Do you think there are any equalities issues that would result from the proposals about oversight of the social care market which require consideration? If so, please provide evidence of the issue and the potential impact on people sharing the protected characteristics covered by the Equality Act 2010[70]	**YES/NO** **Please provide more details:**
Q6. What further steps to support consumer rights are necessary in the care sector?	**Please provide details:**
Q7. What more should providers do and plan to do, in times of distress and financial failure?	**Please provide details:**

[70] disability; race; age; sex; gender reassignment; religion & belief; pregnancy and maternity and sexual orientation and carers (by association)

Section 2 Questions	Response
Q8. What do you think of the overarching framework the Government has put forward for oversight of the social care market in the future?	**Please provide details:**
Q9.(A) What are your views on gathering greater national and regional market intelligence?	**Please provide details:**
Q9.(B) What are your views on targeted monitoring of the providers that pose the greatest risk to continuity of care?	**Please provide details:**
Q9.(C) What are your views on how and where the threshold should be set to monitor providers that pose the greatest risk to service continuity?	**Please provide details:**
Q9.(D) What are your views on what information would be required to assess risk?	**Please provide details:**
Q10. (A) What are your views on the proposals, for those providers, which are above the threshold in particular relating to recovery plans?	**Please provide details:**
Q10. (B) What are your views on the proposals, for those providers, which are above the threshold in particular relating to	**Please provide details:**

enforcement powers?	
Q10. (C) What are your views on the proposals, for those providers, which are above the threshold in particular relating to regulatory functions?	**Please provide details:**
Q11. Do you agree with the Government's current assumption that a special administration regime would not be appropriate?	**YES/NO** **Please provide details:**
Q12. Do you consider that a supplier of last resort model could offer additional protections without changing the insolvency regime?	**YES/NO** **Please provide details:**
Q13. Could you provide any evidence of estimated direct or indirect costs to providers which could arise as a result of these proposals?	**Please provide details:**

If there is anything else regarding market oversight that you would like to feedback to the Government, please include this in your response.

The closing date for responses is **Friday 1st March 2013**. Responses received after this date may not be read. Consultation responses should be returned to:

marketoversightconsultation@dh.gsi.gov.uk

Or if you would prefer to send your response by post:

Market Oversight Consultation Team
Social Care Policy & Legislation Branch
Department of Health
Area 313B. Richmond House
79 Whitehall
London
SW1A 2NS

What we will do next
We hope and expect that we will receive a lot of responses to this consultation, so we do not intend to write back to everyone who contacts us. However, we will read and consider all responses and, will publish our final response and explain how comments and views influenced the final decisions around market oversight.