Department of Health

Oversight in Adult Social Care

The consultation response

May 2013

Published to gov.uk, in PDF format only.
www.gov.uk/dh

Contents

MAY 2013

Enquires about this document should be addressed to:

marketoversightconsultation@dh.gsi.gov.uk

Introduction

1. This paper sets out the Government's response to the consultation on Market Oversight in Adult Social Care[1] which closed on 1st March 2013.

2. The consultation invited views on two changes to the current system:
    - First, what further measures are needed to strengthen and clarify the responsibility of Local Authorities (LAs) in relation to care users in the event of the failure of a care provider;
    - Second, whether a targeted model of central oversight would be appropriate and, if so, what the elements of this model would be.

3. The aim of any change would be to protect people receiving care services by taking steps to ensure continuity of care in the event of the financial failure of a provider.

4. Although this consultation has focussed on provider failure, the Government recognises that managing provider failure is one element our wider aim to support people to have choice and control over their care and support services[2]. To enable people to make an informed choice between services, the Government is:
    - legislating to place clear duties on LAs to provide information and advice to people about all services in their local area, including access to independent financial advice;
    - making more information available at a national level. NHS Choices is being updated to provide new information on care and support, including a single facility to search and compare information on all registered providers, to help people think about how best to meet their care needs;
    - legislating to place a duty on LAs to promote a diverse, high quality and sustainable market for care and support services that meets the needs of local people; and working in partnership with LAs to provide a support programme to help with this - Developing Care Markets for Quality & Choice (DCMQC).

Tackling failure in health and care

5. Failures across the health and care system in recent years have demonstrated the need to take a closer look at organisations delivering health and care services and to allow the necessary interventions if things go wrong.

6. The Government has recently responded to two serious cases of quality failures in healthcare providers: to the report by Sir Robert Francis into failures at **Stafford Hospital**[3] and to the criminal abuse at **Winterbourne View Hospital**[4]. The Government is very clear

---

[1] Available at http://caringforourfuture.dh.gov.uk/2012/12/03/provider-failure/

[2] More information in the Caring for our Future White Paper available at http://caringforourfuture.dh.gov.uk/

[3] Available at https://www.gov.uk/government/news/government-publishes-initial-response-to-the-mid-staffordshire-nhs-public-inquiry-report

[4] Available at https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response

that these failures were wholly unacceptable and has set out a number of key actions that it is taking forward to tackle failures in health and care to protect people. In particular, the Government is taking the following measures:

- new Ofsted-style ratings for hospitals and care homes overseen by an independent Chief Inspector of Hospitals and Chief Inspector of Social Care
- a statutory duty of candour for organisations which provide care and are registered with the Care Quality Commission
- a strengthened failure regime for hospitals[5]
- proposals to strengthen accountability of boards of directors and senior managers for the safety and quality of care which their organisations provide by spring 2013.

7. The failure of the social care provider **Southern Cross Healthcare**[6] did not result in the dangerous quality failings that were seen at Winterbourne View and Stafford Hospital. The case of Southern Cross did however demonstrate the risk a business failure can pose to the quality of care that people receive and to the continuity of those care services. Although in the case of Southern Cross the risks to continuity of care were managed effectively, this outcome was not a forgone conclusion and was the result of considerable effort by a number of organisations and individuals, without formal processes and powers to call upon. The case of Southern Cross is discussed in more detail below.

8. In each case of failure – Stafford Hospital, Winterbourne View and Southern Cross – the failure has taken a different form and had different causes and impacts. They have however, all led to significant concern and distress among the people receiving services, their families and carers.

9. **The Government sets out in this document the action it intends to take to protect people from the negative impacts of business failure in adult social care.**

The current system of oversight and the case to strengthen current arrangements

The current system

10. Under the current system, there is oversight of quality in social care and individual care providers have to comply with a certain level of financial scrutiny if they provide services for people via the Local Authority (LA), through contract management requirements.

11. Although there are no formal measures currently in place for financial oversight of social care providers, in order to operate a provider is required to take reasonable steps to ensure the financial viability of the service they are offering. In addition, there is a duty on every LA to help people to arrange alternative care in the rare instance where a provider failure results in a service closure. This means that all service users are protected in the case of failure.

---

[5] Available at http://www.skillsforhealth.org.uk/about-us/news/code-of-conduct-and-national-minimum-training-standards-for-healthcare-support-workers/

[6] Southern Cross fell into financial difficulties in 2011. They were the largest residential care provider in the UK, caring for c.31,000 people.

Why current arrangements need to be strengthened

12. First, in many other sectors of the economy there are formal mechanisms for oversight of a provider's financial "health" at the national level. These sectors include travel (aviation and tour operators), energy, rail and, of course, health. This oversight is necessary because it is unacceptable for individuals to be left without the services they need or have paid for, or because the removal of these services could have a negative impact on the well-being of that individual. The Government regards it as a point of principle that adult social care should have the same standing.

13. Second, the financial performance of a provider, whether exceptionally good or exceptionally poor, can be a leading indicator of serious quality failings. This could be because a provider is struggling to invest in the services it provides or is distracted by the challenging financial circumstances it faces. Alternatively, a provider could be out-performing other care providers by cutting corners in order to increase profits, putting vulnerable people at unacceptable risk. Identifying these financial issues at an early stage can play a role alongside regular inspection and customer feedback to help pick up quality failures.

14. Third, there is no current system to capture early warnings that a provider is facing difficulties and to take action to stop the situation deteriorating. Early warning systems can help to:
    - Identify key risks to the business and give it the best chance to turn itself around and continue to deliver quality care services
    - Ensure that the provider's business and service information is up to date, so that another provider could take over the services quickly and smoothly with little or no negative impact on the people relying on those services.
    - Ensure that the LA knows of any people in its area where services are not going to be taken over by another provider and will therefore have to close. This allows LAs to work with the people affected to inform them of their choices and to support them to find new services.

15. Fourth, over the last twenty years, the care market has evolved. It is no longer true that providers are small and mainly operate locally. Where providers are small, it is clear that LAs have a responsibility to talk to local providers and to work with them if they decide a service must close to ensure that people are given the necessary support to arrange alternative care. Today, there are also a number of medium and large providers of care, operating across large parts of the UK, on a significant scale. The impact of such a provider failing affects many parts of the country and it is not reasonable to expect individual LAs to manage the situation. National coordination and oversight is needed. Keeping abreast of the commercial negotiations that occur if a major company has to be wound up cannot be done effectively at the local level. This indicates a strong need for a regulator to take on the role of overseeing those care providers whose services, for whatever reason, would be hard to replace if failure occurred.

Table 1.0

No. of people supported (residential care places offered)	**%. Residential care providers** (without nursing)
1-99	93
100-1999	7
2000-4999	0.2
5000-20000	0.1

Table 1.0 shows the proportion of providers of residential care services (without nursing) in England that offer services to specific numbers of people

(Source: CQC raw data, October 2012)

Table 1.1

No. of registered home care agencies (roughly equivalent to local areas covered)	**% Home care providers**
1- 9	98
10-19	1
20-49	0.3
50-200	0.1

Table 1.1 shows the proportion of providers of home care or 'domiciliary care' services in England
that offer services by number of registered agencies, which roughly equates to local areas covered

(Source: CQC raw data, October 2012)

16. The conclusion that arrangements must be strengthened was underlined by the failure of Southern Cross in 2011 which demonstrated specific weaknesses in the system:
    - There was no organisation charged with looking out for early warning that a provider may be in difficulty. Many social care providers and financial experts have since told the Government that problems could have been spotted earlier and possibly even overcome, or greater time secured to manage an orderly exit of the company
    - No part of the overall system - central government, local government or the Care Quality Commission (CQC) - has the remit or responsibility to formally monitor financial health or performance at a provider level
    - There is some evidence that Southern Cross's financial position contributed to quality failings. The CQC will pick up quality failings in individual care homes but because the scale of the financial problems facing the company was unknown there was no reason to increase quality scrutiny in other Southern Cross homes
    - There was no formal mechanism to ensure the company's exit from the market was well-managed or to ensure that everyone receiving services from Southern Cross was aware and informed about the process. This left residents and families uncertain, with little information and facing a great deal of anxiety.
    - The complexity of the business's structure and the details of its operating model and financial arrangements were largely unknown outside the company itself and proved to be a significant hurdle in resolving the situation. Had a regulator been charged with the function of understanding the company's structure and financial arrangements in advance, a quicker and smoother resolution might have been possible.

17. The Government recognises that the case of Southern Cross represents the only major failure of a care provider in the last twenty years, and that failures happen on a smaller scale frequently across the country and the impacts of these are managed successfully at the local level. The Government therefore is mindful to ensure that its response is appropriate for the

social care market and gets the balance right between protecting people and imposing burdens on providers.

The Government's response to the possibility of provider failure

18. Following the failure of Southern Cross, the Government began to engage with a range of organisations to fully consider the most appropriate response.

19. In October 2011, the Department published a discussion paper analysing the issue of market oversight and inviting responses.[7] Workshops were held with stakeholders, including providers, their trade bodies, banks, LAs, the devolved administrations, and academics. Over twenty formal responses to the discussion paper were received. In addition, many organisations and individuals chose to comment on this issue as part of the wider engagement on social care reform that happened at the time. There were 615 responses to the engagement exercise[8].

20. The views of stakeholders enabled the Government to develop and publish a clear set of underpinning principles for any future regime on market oversight in the *Caring for our Future*[9] White Paper in July 2012. These principles informed the proposals which were the subject of the recent consultation exercise:
    - Local authorities have had oversight of their local care markets for many years and have been managing small provider failure effectively. They are also accountable for the delivery of care services. As such, LAs should continue to have the lead role in this area
    - In the circumstances of a provider failing, the goal must be 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, is 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 the continuation of 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 proportionate, based on the level of risk to service continuity. Any new regulations introduced 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. The aim is 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.

---

[7] *Oversight of the Social Care Market*, Department of Health, October 2011

[8] A full independent analysis of the *Caring for Our Future* engagement by Ipsos Mori can be found at: www.caringforourfuture.gsi.gov.uk.

[9] *Caring for Our Future: Transforming Care and Support*, HM Government, July 2012 available at http://caringforourfuture.dh.gov.uk

21. On 1st December 2012, the Government launched a consultation on a number of proposals to improve market oversight in adult social care. The consultation set out the Government's proposals for targeted oversight of adult social care providers, based on the considerations of earlier engagement and in line with the principles above[10].

The consultation feedback

22. The consultation received 61 written responses. During the consultation period, the Department of Health (DH) held and attended events with 111 organisations which included LAs, providers, user and carer representative groups, banks and commercial advisors. The events included four 'deep-dive' roundtables with relevant experts to consider and scrutinise the proposals in greater detail.

23. The questions asked in the consultation are at Annex A, more detailed analysis of the responses to each question is at Annex B, and Annex C lists the organisations and individuals which responded to the consultation or attended a meeting or roundtable event as part of this consultation process.

24. The consultation responses were generally supportive of the broad shape of the model and the principles set out in the *Caring for Our Future* White Paper. However, there were a small minority of respondents that argued against the introduction of additional oversight. They argued that the case of Southern Cross demonstrated commercial systems were adequate. The Government rejects this argument for the reasons set out in the previous section (see paragraphs 12 to 17).

25. The vast majority of responses gave their support for the proposed regime, subject to further detailed considerations. The key themes that emerged from the responses were:

- **A clear role for local authorities in local oversight and failure:** There was almost universal support to clarify that the LA duty applies to all people in all forms of regulated care. Out of 61 respondents, 46 responded to this question. Of those, 27 answered explicitly "yes" they agree with the proposals to clarify the duty and only 2 "no". (A number of respondents gave a generally positive view but did not indicate a firm yes or no answer). Respondents also highlighted the importance of clear information sharing arrangements between the regulator, LAs and relevant partners. There are risks of duplication with LA contract management.
- **A system that targets providers that are 'difficult to replace' nationally or sub-nationally (operating above LA oversight):** Respondents including LAs, providers, user groups and the financial sector were supportive of the principle of targeted oversight and that this should be targeted at providers that are "difficult to replace", such as big organisations, providers with a strong regional concentration or specialist services.
- **A light-touch and intelligent system:** Respondents generally felt that the process of oversight should not be burdensome and should focus on a set of key performance indicators similar to those routinely required by lenders. The regulator should have regular dialogue with key providers, led by appropriately skilled individuals.

[10] The consultation document is available at http://caringforourfuture.dh.gov.uk/2012/12/03/provider-failure/

- **A responsible system that avoids unnecessary failure but does not prevent exit:** Respondents agreed that providers which reach the point where failure is inevitable must exit the market. There should be no propping up of a failing business. However, it was considered responsible for the regulator to take some steps to help prevent avoidable failure through better risk management i.e. the regulator should monitor risks to sustainability and satisfy itself that the provider had a strategy in place to mitigate risks.
- **A system underpinned by stronger powers that protects people:** Several organisations argued for the regime to have greater powers to enforce compliance. Respondents acknowledged that commercial mechanisms already exist to support an orderly failure and exit, with a transfer to alternative ownership in most cases. The vast majority of respondents felt that a risk pool or special administration scheme would be disproportionate. Of 61 respondents, 41 responded to question 11 on special administration. Of those, 23 answered explicitly yes they agree that it would be disproportionate and only 3 answered no. (Several did not indicate a firm yes or no answer but generally agreed this would be disproportionate). Some respondents called for the regulator to be able to instigate a ‘pause’ in the proceedings to work with creditors and insolvency practitioners when companies fail. Many also thought that the CQC enforcement powers were sufficiently strong and argued that the new regime should be built around the existing system.
- **A people-focussed system that involves and informs:** Respondents envisaged a role for the regulator, working with LAs, to communicate with service users, their families and carers, about the process of failure. Many respondents felt that coordination between LAs, the NHS and insolvency practitioners could be improved, which may support understanding. It was felt that many people did not know what failure meant for them and feared the worst whereas, in reality, it often will have no material impact on the care services they receive.

The Government's decisions on a system of oversight of the adult social care market

26. First, the Government believes that all people receiving care, regardless of whether it is paid for by their LA, the NHS or out of their own or their families' pocket, should have the peace of mind that their LA will support them in cases of provider failure. **The Government will therefore create a new legislative provision to apply specifically in the case of provider failure.**

27. Second, the Government believes that financial factors can put at risk the quality and continuity of people's care. **The Government intends therefore to bring in a system of financial oversight** which requires providers to disclose financial information, creates an early warning system, and allows necessary interventions to protect people's care.

28. The following paragraphs describe the main points made in the consultation responses on the key components of the regime and set out how the Government has decided to proceed.

All local people can access protections from their local authority

What the consultation responses told us

29. There was widespread support for the proposal that the duties of LAs in respect of provider failure should be clarified and strengthened. Particular points were made about the need to clarify the scope of care services, the arrangements where a person is receiving services in one LA but they are arranged by a different LA and the situation of people funded by the NHS. Questions were also raised about the requirements for needs assessments in cases of failure, how self-funders might access alternative services and how these services should be paid for.

30. There was consensus that LAs have historically managed failure effectively but some respondents expressed uncertainty whether LAs could cope with wide scale failure. Other respondents felt that LAs needed more information and guidance in order to monitor the market effectively and lacked the expertise to assess the financial "health" of providers. Respondents also referred to the wider role LAs have to stimulate a diverse and sustainable market for care and support that meets the needs of local people.

What the Government has decided

31. The Government will introduce a new legislative provision to apply specifically in the case of provider failure. It will impose a clear duty on LAs to meet the needs for temporary care and support of any person, whether state or 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[11] to provide care and support and provide clarity for people who are receiving care at the time their care provider fails. The Government intends to clarify in law that:
    - the LA where the person receiving services is actually living, is the responsible authority for the urgent period;
    - where services such as nursing care services are commissioned by the NHS and LAs jointly or individually, the commissioning body will be responsible for the people they pay for, but must also cooperate and coordinate with each other in line with closer working relationships between these organisations to support integration;
    - there will not be a requirement to carry out a needs assessment at the point of failure as we do not believe there should be a delay in meeting needs, however the responsible body should engage with service users, their family and carers as far as possible when making alternative arrangements;
    - self-funders will be able to request support from the LA, either in the form of information and advice about other services, or for arrangements to be made on their behalf. Where arrangements are made on an individual's behalf, the LA would be able to pay for this initially on behalf of the person for expediency, but this amount would need to be paid back to the authority in due course.
    - The LA duty will become active when they know about the failure, this will either be because i) the regulator has informed them; ii) contract management; iii) through their ongoing relationships with all providers and stakeholders in their area; iv) a

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

person who is a ‘self-funder’ or other appropriate person contacts them to request help.

32. The Government has introduced a support programme for LAs to fulfil their new legal duty - to promote a diverse, high quality and sustainable market for care and support services that meets the needs of local people. ‘Developing Care Markets for Quality & Choice (DCMQC)’[12] supports authorities to produce market position statements capturing an assessment of what local people want and need, the current range of local services and how they intend to support the development of local services in the future. Recognising that LAs will need to work with a range of partners, the Government has brought together a Reference Group for the programme which comprises banks, providers, LAs and user groups to share information with each other and to consider the key challenges in developing services that are fit for the future.[13] Building on the lessons from the DCMQC programme, feedback to this consultation and to the consultation and parliamentary scrutiny of these proposals, the Government will explore what further support can be made available to LAs in the form of guidance and sector-led peer improvement groups.

A system of central oversight that targets ‘difficult to replace’ providers:

What the consultation responses told us

33. The Government considers that the LA oversight system is under particular stress where a provider is large, or where a provider has a particular regional concentration or where its services are highly specialised. The consultation responses confirmed that to be the case. There was strong support for the principle of a central regime targeting certain providers that sits above the LAs’ arrangements with local providers. Some respondents suggested that the regime should be targeted on providers that were ‘difficult to replace’ and that it should be for the regulator to decide how to interpret that term. The consultation responses did not specify how and where the threshold for entry into the regime should be set but did suggest that certain factors were particularly important, for example, market share in local areas and the number of LA areas that depend upon the service provider to meet the needs of their local population.

34. Some responses from some charitable sector umbrella bodies argued strongly that voluntary sector providers should be exempt from the regime. It was put to the Government that as a result of their charitable purpose, these providers’ financial models are more stable, and furthermore that such organisations are often relatively small, offering services to only a few thousand people. This view was not supported by all voluntary organisations nor by the financial sector. A number of respondents from the financial sector argued that many charitable providers face financial risks and have complex finances. Although the risks can be different to corporate providers, the risks to continuity of care are the same. There were several responses that raised concerns about potential duplication for those voluntary sector organisations which provide social housing in addition to social care services and are currently regulated by the Homes and Communities Agency.

---

[12] http://caringforourfuture.dh.gov.uk/2012/09/18/dcmqc-launch/

[13] Reference Group members are listed on the Institute for Public Care (IPC) website http://ipc.brookes.ac.uk/dcmqc.html

35. There was support from the majority of respondents to continue with or improve financial information and scrutiny. Several respondents suggested greater clarity was needed on what information is most relevant. A common response was that the gathering of financial information from providers must be proportionate and avoid duplication with information provided for other purposes. There was general consensus that the regulator would need to triangulate financial, quality and other management information. Some respondents expressed the view that the regulator should engage in regular dialogue with the providers, in part to ensure any financial information was correctly interpreted, and in part because it was felt this function should be based on an established relationship between the regulator and providers falling within the regime. This dialogue would also help the regulator to understand each provider's business and the risks that it faced.

What the Government has decided

36. The Government will introduce a central oversight regime of "difficult to replace" providers. The Government accepts that the concept of "difficult to replace" is a helpful way to identify the providers that should fall within the regime, noting that the examples given at the start of paragraph 33 provide a good starting point to develop a definition of "difficult to replace". Further work will be necessary to determine where the threshold for entry into the regime should be set. However, the Government believes there is a strong case to base a future assessment on factors such as local market share, the number of people receiving services and the number of LA areas that depend on the provider's services to meet the needs of their local population. The Government has done some initial modelling based on available data in residential care using the factors above and some general assumptions for domiciliary and specialist services. On this basis, the Government expects the regime to cover around fifty to sixty organisations in total at any given time. These numbers should be regarded with caution, as final decisions will be taken in discussion with the regulator.

37. The Government's view is that voluntary organisations that fall within the 'difficult to replace' threshold should not be exempt as any failure in the voluntary sector would raise the same challenges to ensure there is continuity of care for people. However, where providers are already regulated by the Homes and Communities Agency, the Government intends to exempt them from the oversight regime whilst ensuring the regulators work together where necessary in cases of failure.

38. The Government's consultation proposals were based on this function being undertaken by either the Care Quality Commission (CQC) or Monitor. Although the consultation did not invite views on that decision, a few respondents chose to comment. The responses echoed the Government's view about the benefits of this function sitting with either regulator. On balance, the Government believes there are greater benefits for service users to having a single regulator which oversees care and support services and can build a picture of overall performance combining quality and financial data**.** Consequently the Government will legislate to enable the CQC to undertake this function.

39. The Government accepts the points made about improving financial information and scrutiny in adult social care. This must be a key feature of any future oversight system and must complement the efforts made by LAs in understanding the market in their local area. Respondents listed the financial information that could inform the regulator's assessment of a provider's financial sustainability. The Government is grateful for the candour of banks and commercial advisors in sharing details of their own assessment processes to inform this consultation. The Government will make available to the regulator the consultation

responses that include suggestions for relevant financial information and how they should be used to help the regulator decide on the information it wishes to collect to underpin the regime.

The central oversight regime should focus on continuity of quality services not continuity of providers

What the consultation responses told us

40. The consultation proposals were aimed at ensuring continuity of service rather than continuity of provider. The consultation responses confirmed that this is the right approach.

41. The Government set out in the consultation the proposal that the regulator should be able to challenge the provider where its financial arrangements were giving rise to quality failings either because profit was being put before quality or because financial difficulties were preventing investment in services. The Government held a dedicated roundtable on this topic where attendees called for appropriate interventions and sanctions in such cases.

42. The majority of respondents agreed it was important for better planning and preparedness to mitigate key business risks and avoid unnecessary failure, but not to prevent failures. Furthermore, most respondents agreed that there were clear benefits to having plans in place with up to date information to support continuity of care for people, in those rare cases of major provider failure.

43. The Government had proposed that each provider should develop plans against each of the likely risks the company might face. These plans would then be on hand should those circumstances arise. The consultation responses supported that approach. However, a number of respondents felt this approach would lead to nugatory work because it was unlikely that the risk would materialise exactly as envisaged in the contingency plan and, at the point the risk did materialise, the circumstances and therefore the action required would probably be different. Some respondents felt the proposals should go further by encouraging the regulator to take steps to avoid the failure happening while not going so far as to ensure the continued trading of the current provider.

44. The Government's proposals envisaged that information about the provider should be held by the regulator for use if failure became inevitable. The information would include things like the structure of the company and its subsidiaries, its financial arrangements, its suppliers, and the location of each of its facilities and the number of people receiving services. This information would be used by the regulator, in conjunction with LAs, to oversee the arrangements to manage the failure. There were many comments from LAs suggesting they would need early access to this information. There were also comments that such information is commercially sensitive and must be handled carefully.

45. Some respondents were concerned that once LAs knew failure was likely they would immediately stop commissioning from that provider, or redirect existing service users to alternative providers, thereby expediting the failure process at the expense of an orderly and smooth transition. Even in situations of business failure, threats to continuity of care often

do not arise, because ownership passes from the failing provider to other providers. However, if this were not the case, respondents confirmed the information held by the regulator would be of vital importance.

46. The Government had proposed that the regulator's role at this point would be limited to acting as the central liaison point between the commercial negotiations and the LAs which would manage any change to services in their local area. This role would essentially comprise communication and coordination functions. Whilst it was recognised that this would place on a formal footing the role the Government and other relevant public bodies played in the case of Southern Cross, respondents advocated that the regulator should be more active if a commercial solution was unlikely or disorderly.

What the Government has decided

47. The Government has decided that difficult to replace providers will be required to submit key metrics, undertake regular dialogue with the regulator, and generally satisfy the regulator that they have a strategy in place to manage key business risks. In most cases this will take the form of the sharing of key management information and risk registers.

48. The Government agrees with the view of respondents that financial arrangements should never be at the expense of quality in care. The Government has therefore decided that financial and quality data will be routinely triangulated to attempt to spot risks to quality of care that arise from financial arrangements. If the financial oversight raises concerns about quality, this will trigger a review within the Care Quality Commission. The Government envisages that this will be closely scrutinised by the new Chief Inspector of Social Care who will personally have a role to champion and inspect the quality of care and take appropriate action where failings are found.

49. In some cases the financial risk will develop. We have agreed with consultation respondents that the production of sustainability plans should take place at this point to ensure relevance and usefulness. Any provider where the risk has developed and therefore the regulator deems it necessary to do so will be required to produce a 'sustainability' plan to satisfy the regulator that it can manage this risk. This will need careful handling and close cooperation between the regulator and the provider to ensure the plan is not produced too late. It will be for the regulator to decide when production of the plan should be triggered.

50. The Government accepts the comments about the regulator being more active in trying to avoid and manage failure. Therefore, the Government has decided to give the regulator the power to require an independent review of the provider's sustainability on occasions where the risk has developed and the regulator deems it prudent to do so. As is standard in other regulatory regimes, the cost of this review will be met by the provider. It is envisaged the recommendations of that review will support the provider to recover and will act as the basis for the regulator to discuss further action that the provider should take. However, the Government will not make complying with the outcome of the review binding on the provider - that should remain the decision of the management and shareholders. In this way, Government is not preventing failure at all costs but is attempting to avoid it where possible, in order to support continuity of care.

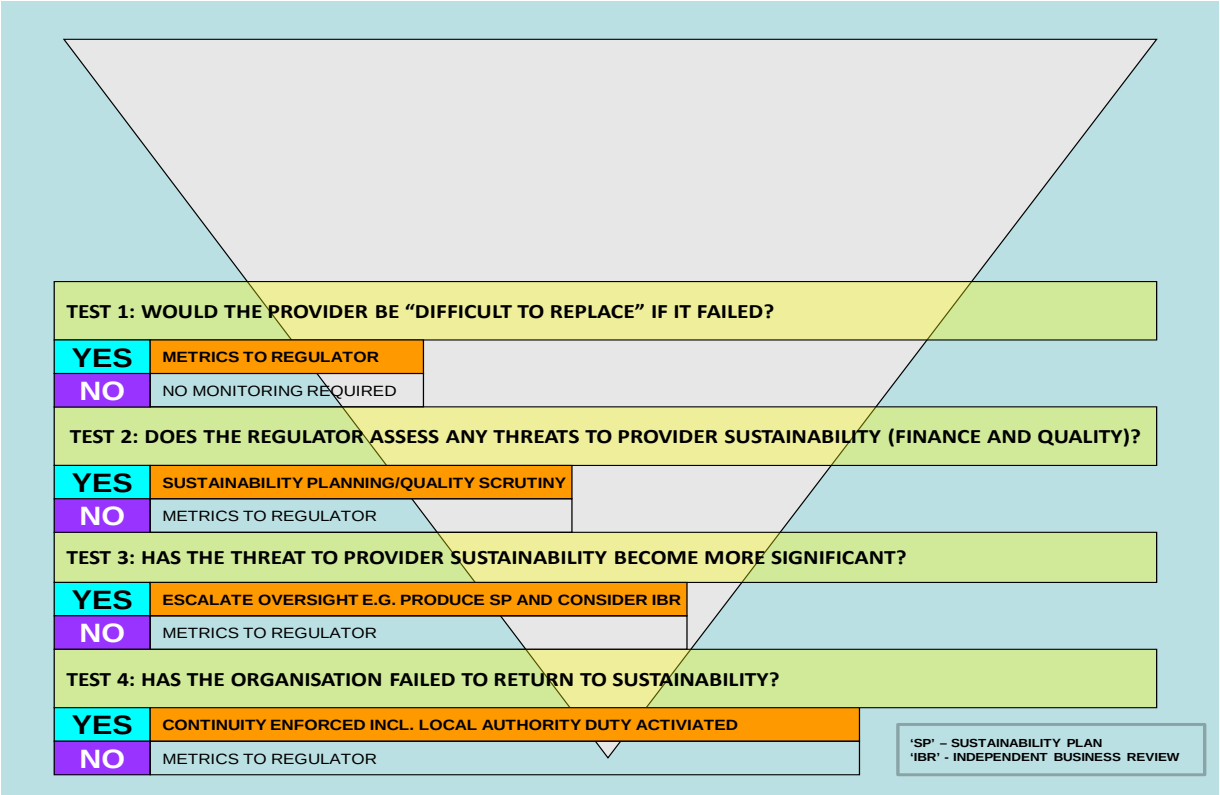
51. The consultation has confirmed the need for key information on business structures, ownership model and service users to be readily available. Some information will be required on the operations of all organisations in the regime. The Government will therefore

require providers to submit and refresh all necessary information in cases where the risk has developed. This information will be used by the regulator to develop a continuity of care plan. Further work will be needed to determine the information that would be included in this plan. The Government also envisages an important role for the CQC as part of the new Chief Inspector of Social Care's functions in this phase, to ensure the quality of care remains acceptable.

52. The Government acknowledges the tension surrounding when this information should be shared beyond the regulator. It is the Government's view that it is not possible to define uniquely the point at which information should be shared, as this will vary from case to case. The Government will therefore look to the regulator to take these decisions in the light of the circumstances presented.

53. In response to the comments about the regulator playing a more active role in this phase, the Government will consider whether to give the regulator the power, in certain circumstances, to actively intervene in the commercial processes to support continuity of care. The Government is investigating a similar power to one held by the Homes and Communities Agency which can call a 28 day moratorium on creditors' rights to sell land, which would be extended to prevent services ceasing abruptly during a period of time. The aim of this policy would be to allow the usual commercial activity that might result in a new provider taking over the services of a failed provider, but to not allow activity which seeks to sell assets or terminate services within the 28 day period. This creates a period of certainty for those using the services, more time in which a consensual solution might be found and time in which LAs can mitigate any local impacts of closure. Whilst there are clear benefits from such a power, this would impinge on commercial negotiations, creditors and insolvency law and there may be unintended negative consequences. The Government is carefully considering this option and in doing so, will engage with relevant experts and public bodies to inform the final view.

54. The revised model is shown in the diagram below.



Next steps

55. This document has described how the Government will respond to the consultation and put in place a system for financial oversight of 'difficult to replace' adult social care providers.

56. While the decisions described here set the framework for the new regime, much detail remains to be resolved. Some of this can be done by Government, some must wait for the regulator to take on this function, and there may be some details that Government or the regulator will wish to consult on further.

57. We are committed to legislating at the earliest possible opportunity to enshrine these provisions in law, subject to the will of Parliament

Annex A

List of questions asked in the consultation

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 201064

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?

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?

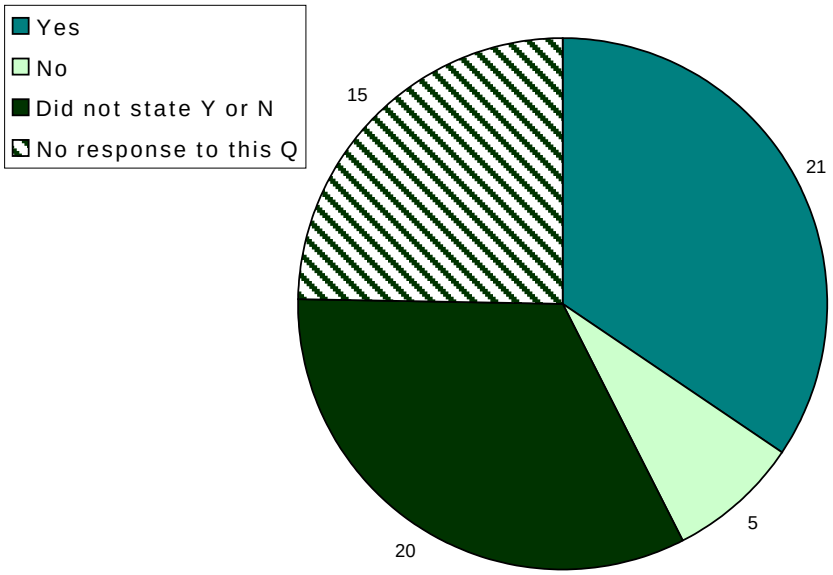
Q13. Could you provide any evidence of estimated direct or indirect costs to providers which could arise as a result of these proposals?

Annex B

Response summary to specific questions

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

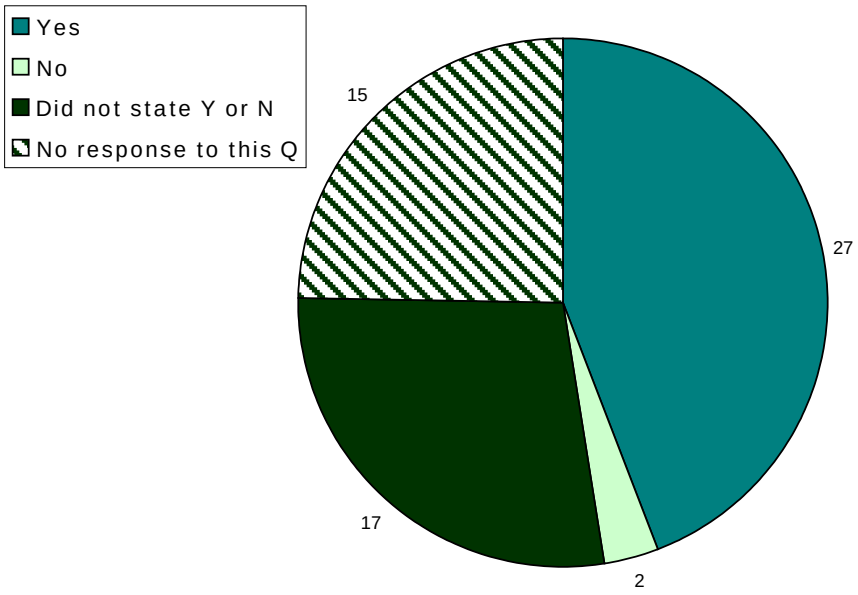
Out of 61 respondents, 46 responded to this question. Of those, 21 answered explicitly yes and 5 no. A number of respondents gave a generally positive view but did not indicate a firm yes or no answer.



In the main respondents agreed that LAs were managing failure effectively, though they did not submit evidence to support this. There was however, some concern that wide scale failure may not be managed well, as the current system lacks mechanisms for early warning. Many responses therefore welcomed the introduction of an oversight regime. Respondents felt that up to date information on services and service users is required to manage failure better in future. In addition, clarification on powers that LAs have was welcomed (see question 2) although LAs may lack the capacity to manage provider failure. Improvement and coordination between organisations and the Department of Health was important. The need for clearer and better strategic relationships was encouraged.

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

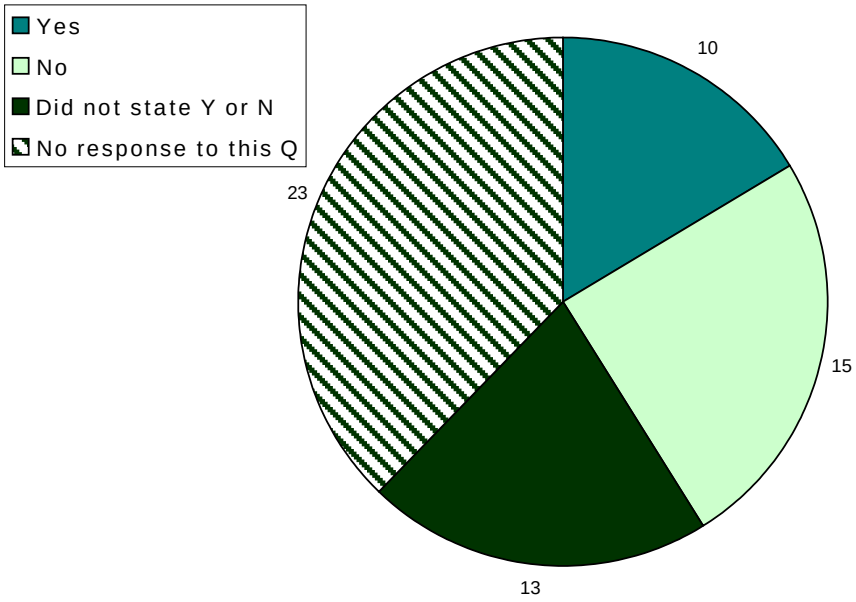
Out of 61 respondents, 46 responded to this question. Of those, 27 answered explicitly yes and 2 no. A number of respondents gave a generally positive view but did not indicate a firm yes or no answer



There was widespread support that clarification and strengthening of the duties for LAs was required. LAs confirmed that current practices mirror those set out in the proposed new duty. A minority off LAs however, felt they would need more funding following clarification. LAs asked for specific clarity around the scope of care services, the responsibilities in cases where people received services ‘out-of-area’ or services funded by the NHS, requirements for needs assessments and how self-funders access support and where costs fall, so that LAs fully understand their role and remit. It was also clear from responses that LAs want more powers to compel information from providers, both for early warning and to coordinate resolution; information-sharing with the regulator was seen as important.

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

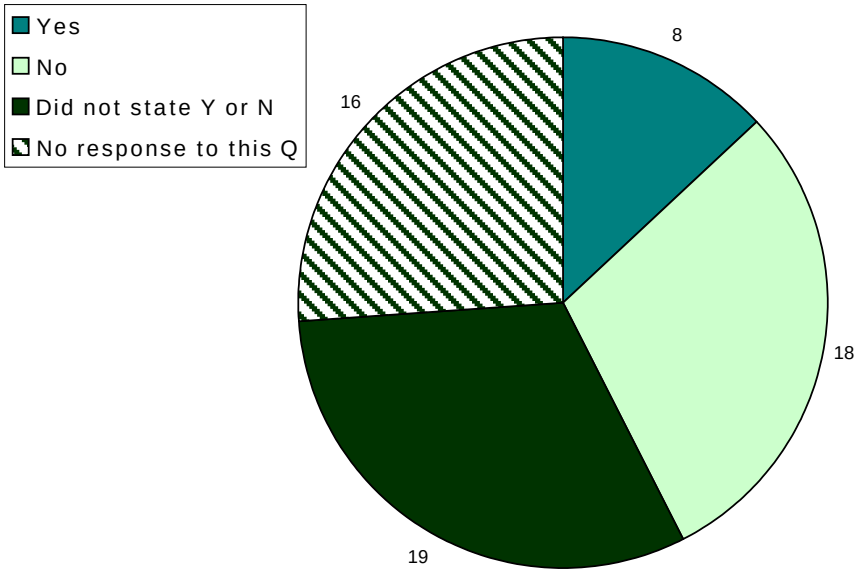
Out of 61 respondents, 38 responded to this question. Of those, 10 answered explicitly yes and 15 no. A number of respondents considered that there was scope to improve implementation in cases of failure – although detailed explanation of improvements were not given. Many did not indicate a firm yes or no answer



A large number of respondents, mainly LAs answered ‘no’ to this question. However, there was no consensus among them regarding why and what needs to be done. A few responses suggested that the powers, which exist at present, are adequate but there is a problem with implementation of them. It was felt by many that the current registration and de-registration process takes too long and an interim period for re-registration might be helpful in the cases of failure. Many responders agreed that providers and CQC should be obligated to inform LAs of a deregistration and the reasons for that decision.
Some LAs called for stronger requirements around financial viability to be included within the registration process and one response called for a provision requiring providers to retain records of the clients they serve.

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

Out of 61 respondents, 45 responded to this question. Of those, 8 answered explicitly yes and 18 no. Many did not indicate a firm yes or no answer

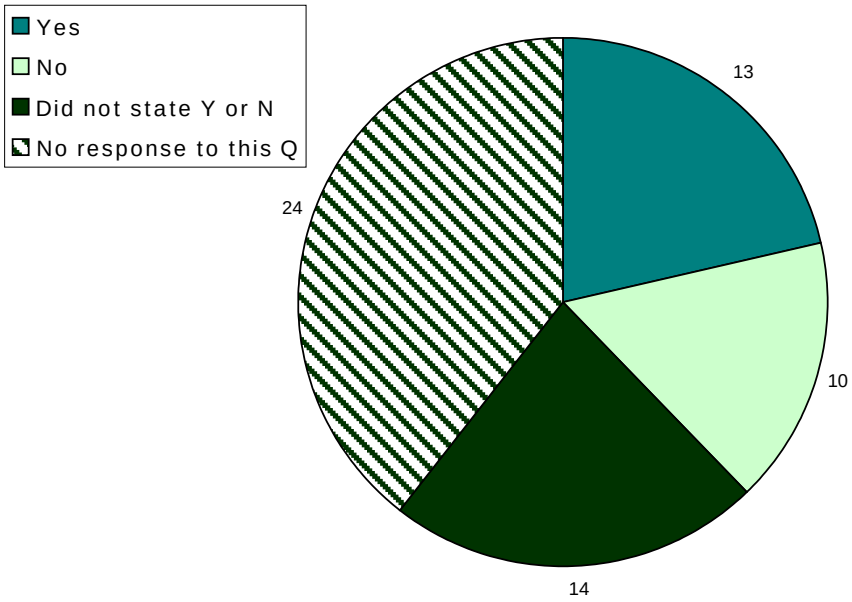


Providers were generally quite negative in response to this question, with other stakeholder groups giving a range of views. Several respondents felt that information and coordination was inconsistent across the country.

LAs felt there was a particular gap regarding working and information-sharing with IPs, lawyers and banks. Some wanted to receive information about problems earlier to manage issues better. Specific coordination challenges were raised regarding: out of area placements and coordination with health bodies.

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?

Out of 61 respondents, 37 responded to this question. Of those, 13 answered explicitly yes and 10 no. Several did not indicate a firm yes or no answer.



There was concern expressed that people with specific cultural/religious needs may have particular requirements upon provider failure and further consideration should be given to how these aspects would be met and the extent to which LAs may have a duty to consider such requirements. Some respondents felt that there might be an improvement in the overall management of failure, which may benefit vulnerable individuals in the longer term. There was also concern expressed that; users should have choice about replacement providers and any replacement providers should be required to offer at least the same standard of service to ensure there was no negative impact; provider failure could place undue burdens on carers and families and therefore provider locality should be considered.

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

Out of 61 respondents, 47 responded to this question.

Responses to the question were varied, amongst the main views expressed there were lots of views about quality ratings and information being available to the public – not all relevant to this consultation. Only one small user-group, argued that care homes should not be allowed to close.

Some respondents suggested better care contracts from care providers, which are accessible, and include clauses on notice periods for service termination and notice periods for fee increases. The general view was that choice and involvement should remain, even in provider failure and that information available to individuals in cases of provider failure is proportionate

and focussed. A response from several LAs felt that this should align with Government policy to increase personal budgets and better information for local people. Other respondents felt there is also a need for greater transparency during provider failure about the stages of the process and what it means for individuals. A commercial advisor raised concerns that some closures may happen too quickly in administration. A provider representative body were concerned that costs from this regime may be passed on to consumers.

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

Out of 61 respondents, 41 responded to this question.

The majority of respondents agreed it was important for providers to have better comprehensive plans, detailing; financial risk, quality and sustainability, emergency, recovery and continuity planning to ensure continuity of care.
It was suggested that clear timeframes and action plans should be developed as part of the plans.

There is broad agreement that early warning signs of failure need to be highlighted to DH, LA's and regulators where an open review of contingency and continuity planning can take place. An improvement in the openness and transparency between organisations was encouraged to lead to better partnership working. This openness can then provide a platform for all parties to work collectively to spot issues early, be able to demonstrate and evidence issues and utilise business continuity plans to work collectively in handling and managing any risks and/or likely failure.

A few responders' favoured financial contingency reserves to be set aside to aid transition or continuity of care in times of failure (see question 11 on special administration).

Q8: What do you think of the overarching framework the government has put forward for social care?

Out of 61 respondents, there were 57 responses to this question

Respondents were largely supportive of the model across all sectors e.g.LAs, providers, user groups and the financial sector. All sectors called for central oversight to be staffed by those with expertise and corporate skills. Many LAs felt there is an opportunity to develop their capacity to understand local and regional markets and support continuity of care. They would welcome some guidance and peer-learning to do so.

Providers were also largely supportive of the proposals. However, they highlighted; the need to avoid duplication between regulator and LAF oversight and that fee levels should be included in the assessments of provider sustainability. A provider representative organisation and a provider argued the regime focussed too heavily on prevention rather than continuity of care and questioned the need for this system given the successful management of continuity of care for people in that case. The majority of individual provider respondents did not share this view.

Finally, a number of respondents raised the potential for misunderstanding and unintended consequences because of the language around 'risk' 'recovery' and 'resolution'. One provider suggested referring to 'sustainability plans' rather than 'recovery plans' and 'difficult to replace' rather than 'poses a risk to continuity of care'. A user group argued for clearer messaging around failure as it does not usually affect services and people are currently made anxious

unnecessarily. A bank also felt that providers should have public relations plans in place so that people receiving services, their staff and the public are kept informed about the changes throughout the process.

Q9(a): What are your views on gathering greater national and regional market intelligence?

Out of 61 respondents, there were 43 responses to this question. Most were supportive of the Government's proposals.

There was broad support from respondents to continue with or improve the current collection of market intelligence. Several responses suggested clarity was required on what information is required at local and national level and that gathering of this intelligence must be proportionate, not onerous or burdensome to all parties involved. Most importantly intelligence gathering should be streamlined and duplication avoided. One single response suggested intelligence should be provided or collected frequently enough to keep pace with market change

Q9(b): What are your views on targeted monitoring of the providers that pose the greatest risk to continuity of care.

Out of 61 respondents, there were 41 responses to this question. Most were supportive of the Government's proposals.

Several respondents commented on the issue of risk definition, in summary any definition should; be based on the principle of "difficult to replace" not just size, follow the wellbeing principle outlined in the draft Care and Support Bill and reflect local risk and not national risk. A suggestion was made that LAs should be asked to identify providers to fall within the central oversight regime, if necessary. Some responders felt that LAs should have the same legal powers as the regulator but recognised they didn't have the competence to monitor complex financial viability. Some voluntary sector respondents argued that the voluntary sector was less risky and should be exempt from oversight – this was not supported by the financial sector. It was felt that providers who are already regulated by the Homes and Communities Agency (HCA), for example, should be passported through any new system of regulation to lessen the burden on them and the regulator.

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?

Out of 61 respondents, there were 42 responses to this question. Most were supportive of the Government's proposals.

There was strong support from LAs, residential care providers and CQC for the threshold to be based on the principles of size, concentration, and specialism. Most LAs and providers agreed that the metrics should be based on market share and number of people receiving services. Some LAs suggested 7.5% or 5% market share in a LA as a threshold for significant impact, based on an average 7% vacancy rate. Another public sector body suggested >500 beds in residential care. A provider representative body noted that they expected a future consultation on this question may be required by the regulator.

Q9(d): What are your views on what information would be required to assess risk?

Out of 61 respondents, there were 43 responses to this question. Most were supportive of the Government's proposals.

Overall there was a general consensus that the regulator will need to triangulate financial, quality, and management information, together with governance arrangements and engage in regular dialogue with providers to develop adequate risk assessment. Respondents agreed that risk metrics would need to be considered over time, and that a 'one-size-fits-all' approach may not work. It was noted that most organisations that have a relationship with a bank would collect management information. The regulator may need to take a different approach for medium sized organisations. Overall, it was agreed that consideration needs to be given to what level of risk is assessed. Different sectors may require different metrics. For example in domiciliary care, cash flow will be particularly important as providers in this sector operate on very tight margins. There could be a very different set of risks from those of other provider types.

Q10(a): What are your views on the proposals for those providers which are above the threshold, in particular in relation to recovery plans.

Out of 61 respondents, there were 38 responses to this question. Most were supportive of the Government's proposals.

The vast majority were strongly or moderately supportive of the Government's proposals. A small number of respondents felt all providers should have recovery plans and that such planning should be part of "business as usual". A proportion of respondents questioned the worth of preparing recovery plans in advance and argued that this would be nugatory work given that plans could never cover the precise nature of the risks that caused problems. They argued that it was better to wait until problems appeared. A few respondents wanted the regulator to have stronger powers if it felt the 'recovery plan' was inadequate. A few respondents were also concerned that the proposals were too burdensome for providers.

Q10(b): What are your views on the proposals for those providers which are above the threshold, in particular in relation to enforcement powers?

Out of 61 respondents, there were 36 responses to this question. Most were supportive of the Government's proposals.

Broadly it was agreed, most strongly by the financial sector, LAs, some providers and user groups that a threat of enforcement was needed at the end of the enforcement process e.g. to give added 'teeth' or 'bite'. Very few solutions about what this could look like were offered. There were some comparisons with tougher existing regimes e.g. the Homes and Communities Agency (HCA) powers to call a 28 day moratorium on the sale of land. Some respondents felt CQC powers were sufficient e.g. the threat of deregistration. In addition respondents highlighted the need for effective coordination powers, powers to enforce recovery plans and powers to look at governance and appoint board members

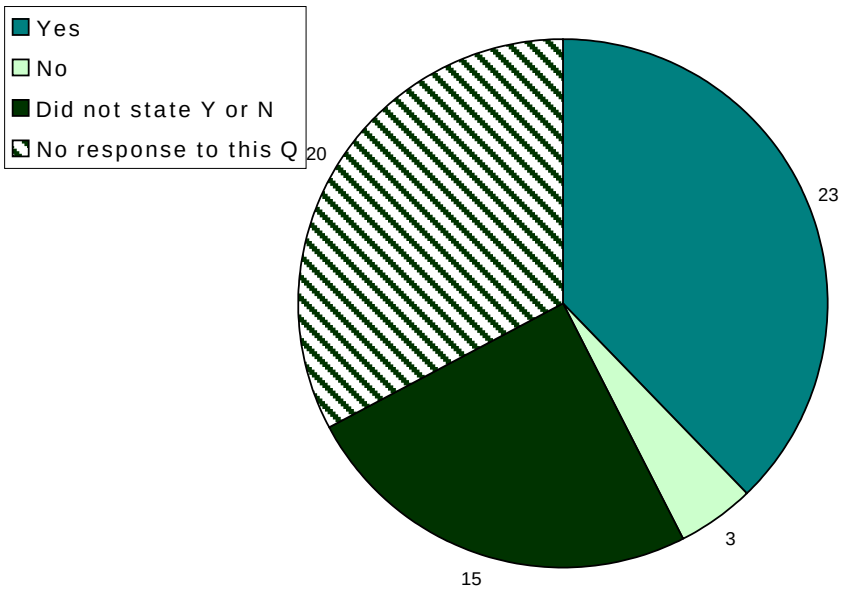
Q10(c): What are your views on the proposals for those providers which are above the threshold, in particular in relation to regulatory functions?

Out of 61 respondents, there were 28 responses to this question. Most were supportive of the Government's proposals.

Overall it was agreed that there is a need for good working relationships between the Regulator and LAs, the NHS, CQC and Monitor. A strong focus on good communication and engagement and the expertise of the regulator was important. Strong enforcement is required in rare cases of failure. Some respondents commented on whom the regulator might be, CQC or Monitor, arguments were reasonably balanced, with a strong focus on key expertise.

Q11: Do you agree with the Government's current assumption that a Special Administration Regime (SAR) would not be appropriate?

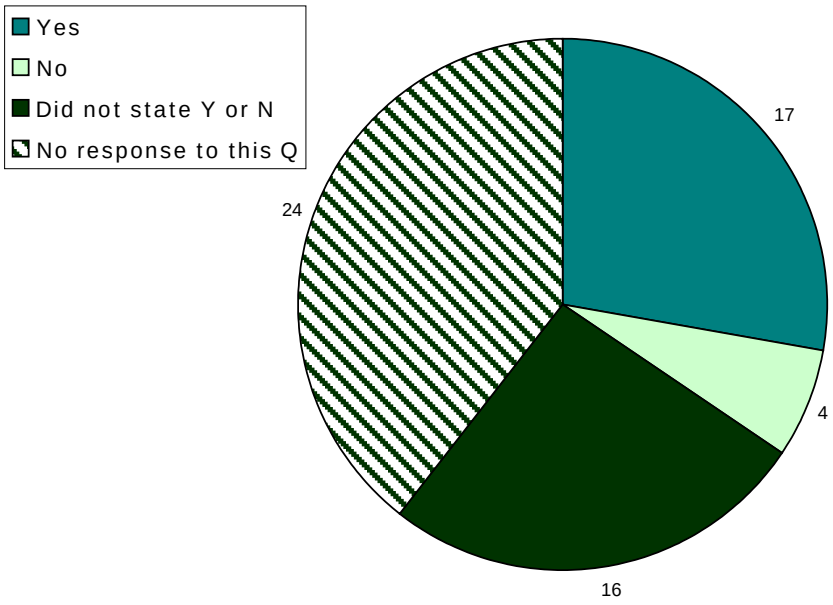
Out of 61 respondents, 41 responded to this question. Of those, 23 answered explicitly yes and 3 no. Several did not indicate a firm yes or no answer but agreed that a SAR was disproportionate.



There was broad agreement from most respondents that a Special Administration Regime (SAR) would be a disproportionate response to the issue of continuity of care and would not be appropriate for the sector. If providers across the sector share the necessary information with the regulator and put contingency plans in place then a special administration regime is probably not needed. It was felt that in the vast majority of cases a commercial solution will prevail, without the need for active intervention from the government/regulator. This ultimately ensures continuity of care for individual care users, although a level of uncertainty during the period of transition from one provider to another will always exist. Government or regulator has a role by providing a framework for facilitating such transition to take place smoothly. A handful

of respondents felt continuity of care should always be prioritised over the rights of creditors– they were particularly supportive of a defined transition period where continuity of care was assured.

Q12: Do you consider that a supplier of last resort model could offer additional protections without changing the insolvency regime?
Out of 61 respondents, 37 responded to this question. Of those, 17 answered explicitly yes and 4 no. Several did not indicate a firm yes or no answer but were generally supportive of the Government's proposals.



Most respondents agreed that a supplier of last resort (SOLR) model could offer additional protections without changing the insolvency regime. As an alternative, some respondents, mostly LAs, suggested a voluntary concordat among larger providers in each market rather than regulator imposed SOLR. Most of the respondents stated that an SOLR would only be temporary solution to ensure continuity of care in the short term.

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

Out of 61 respondents, 36 responded to this question.

There were no responses which provided any evidence on costs.
Overall, respondents thought that large providers will face small additional costs from light touch regulation. A few respondents raised concerns that smaller and voluntary providers may face disproportionate costs, which could affect their competitiveness.

Most organisations thought that firms would collect the data already. It was recognised that staff with specialist skills and high wage costs will be required to carry out this regulation.

Annex C

Written responses to the consultation were received from the following:

ADASS West Midlands	Leonard Cheshire Disability
Age UK	Linkage Community Trust
Anchor	London Borough of Hounslow
Barchester Healthcare	London Councils
Bracknell Forest Council	MCCH Society
Buckinghamshire County Council	Mears
BUPA	Mencap
Bury Council	Monitor
Care and Support Alliance	National Care Forum
Care Homes Group	National Federation of Occupational Pensioners
Care UK	National Housing Federation
Carers UK	National LGB&T Partnership
Cheshire East Council	Newcastle City Council
Cheshire West & Chester Borough Council	Nigel Knowles
CQC	Nottinghamshire County Council
David Roy	Office of Fair Trading
Derbyshire County Council	Oxfordshire County Council
Dimensions	Patients Association
East Sussex County Council	RBS
English Community Care Association	Real Life Options
Grant Thornton	Royal College of Nursing
Hampshire County Council	Sandwell Metropolitan Borough Council
Healthwatch England	SOLACE, LGA & ADASS
Help the Hospices	Stockton Borough Council
Ideal Care Homes	Suffolk County Council
Independent Age	The Lesbian and Gay Foundation
Institute of Public Care	The Relatives & Residents Association (R&RA)
Jade Claridge	Trowers & Hamlins LLP's
Kent County Council	UNISON
KPMG	Voluntary Organisations Disability Group
	Wolverhampton City Council

Meetings or roundtable events were attended by the following organisations, as part of this consultation process:

Aaronite	HC-One	Sayer Vincent
Access HR	HFT	SeeAbility
Action for Prisoners Families	Hogan Lovells	Sense
Action on Hearing Loss	Home Instead	Sevacare
Advance	Homes and Communities Agency	Shropshire Council
Age UK	Impact Change Solutions	SOL
Agincare	Institute for Public Care	SOLACE
Anchor	Kemble Care	Solihull Council
Anthony Collins Solicitors	KPMG	St Monica's Trust
Audley Care	Leonard Cheshire	Stoke City Council
Bank of Ireland	Lester Aldridge	Surecare
Barchester Healthcare	Lloyds TSB	Surrey
Barclays	Local Government Association	Telford & Wrekin Council
Birmingham City Council	MacIntyre	Turnaround Management Association
Blue Ribbon	Martha Trust	UKHCA
Brandon Trust	Mears	United Response
BUPA	Medacs	VODG
Care UK	Mens Health Forum	Walsall Council
Caremark	MHPF	Walsingham
Carers Trust	MITIE	WHEC
Carers UK	Monitor	Wolverhampton Council
Carewatch Care Services	NAS	Women's Resource Centre
Caring Homes Group	National Heart Forum	Young Epilepsy
Castleoak	National Housing Federation	
Clarendon	National LGBT Partnership	
Coventry City Council	National Voices	
CQC	NAVCA	
DCLG	NCHA	
Deloitte	NCPC	
Department for Communities and Local Government	Newcross	
Dimensions	NHP	
Disability Rights UK	Norwood	
Do Care	Outlook Care	
Dudley Council	Patron Capital	
ECCA	Prestige Nursing	
Eleanor Nursing	Quercus	
Enfield	RBS	
Ernst & Young	REF	
Four Seasons	Regional Voices	
Grant Thornton	Registered Nursing Home Association	
Guide Dogs	Ridouts	
Guinness Care and Support	Right at Home	