

Title: Market Oversight in Adult Social Care IA No: 9532 Lead department or agency: Department of Health	Impact Assessment (IA)		
	Date: 26/03/13		
	Stage: Final		
	Source of intervention: Domestic		
Type of measure: Primary legislation			
Summary: Intervention and Options			RPC Opinion: GREEN

Cost of Preferred (or more likely) Option			
Total Net Present Value	Business Net Present Value	Net cost to business per year (EANCB on 2010 prices)	In scope of One-In, Measure qualifies as One-Out?
£95m	-£3.0m	£0.365m	Yes IN

What is the problem under consideration? Why is government intervention necessary?

The financial distress of Southern Cross (the then largest provider of residential care in the UK) and Castlebeck, and recommendations from the Public Accounts Committee, have highlighted the need for greater oversight of the social care market to protect the welfare of service users, and for additional measures to support service continuity in cases where a provider of care services fails or chooses to exit the market.

What are the policy objectives and the intended effects?

The policy objective is to ensure continuity of care for vulnerable care service users in the event of financial distress and market exit of a major provider of care services. This will provide reassurance and protection for those receiving care now and in the future, their carers and their families.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

We believe our proposal for targeted regulation is the most proportionate, effective and fair option available. The other options considered were 1) do nothing 2) sector-led regulation 3) contract clauses 4) special administration regime. These have been dismissed either because i) we feel it is inappropriate for the cost to fall to smaller providers when the risk lies with primarily larger players in the sector or ii) we do not believe the measures are sufficiently robust to offer the public the guarantees they need that their care services will continue in the event of failure.

Will the policy be reviewed? It will not be reviewed. If applicable, set review date: Month/Year					
Does implementation go beyond minimum EU requirements?				n/a	
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.		Micro No	< 20 No	Small No	Medium Yes
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)				Traded: n/a	Non-traded: n/a

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) that the benefits justify the costs.

Signed by the responsible Minister: Norman Lamb MP Date: 26 March 2013

Summary: Analysis & Evidence

Policy Option 1

Description:

FULL ECONOMIC ASSESSMENT

Price Base Year 2010	PV Base Year 2014	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: 95.0	High: 141.0	Best Estimate: 95.0

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	0.1	1.555	13.0

Description and scale of key monetised costs by 'main affected groups'

The main cost will be that of the regulator (£1.2m pa). The other affected group will be social care providers covered by the regulation (those most difficult to replace if they fail). The total cost to providers will be ca. £0.365m pa. This includes: the cost of providing information to the regulator; quarterly meetings with the regulator; where the risk develops a sub-set of providers will also produce sustainability plans; independent business reviews; and continuity of care

Other key non-monetised costs by 'main affected groups'

There are no non-monetised costs that we are aware of.

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional	11.7	108.1
High	Optional	16.7	154.0
Best Estimate		11.7	108.1

Description and scale of key monetised benefits by 'main affected groups'

The main beneficiaries of this proposal will be care users. We have estimated the annual benefit to their health and wellbeing from ensuring provider failures are managed in an orderly way at £11.7m pa.

Other key non-monetised benefits by 'main affected groups'

The benefits to carers, families and care workers have not been monetised. The process of regulation may lessen the likelihood of provider failure, due to financial mismanagement. This benefit has also not been monetised.

Key assumptions/sensitivities/risks

Discount rate (%) 3.5

We have assumed based on CQC data for residential care that the regime will cover 50-60 providers. We have also made assumptions, as set out below, about the level and cost of resource providers will require to comply with the regime, and the number of providers who will be required to comply with different stages of the regime. Finally, we have assumed that 6 firms covered by this regime will fail over a ten-year period. The costs have been discounted by 3.5%, the benefits by 1.5%

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: 0.365	Benefits: -	Net: 0.365	Yes	IN

Evidence Base (for summary sheets)

Summary

The total costs of our proposals will be **£15.7m** over a 10 year period. Our proposals will cost the regulator £12m and providers £3.7m over this period.

The total benefits will be between £11.7m and £16.7m per annum.

A: Policy context / Background

1. This Impact Assessment accompanies the market oversight clauses in the Care and Support Bill and provides detail of the Government's analysis.
2. In the Social Care White Paper, *Caring for our future; reforming care and support*¹ the Government committed to consult on the issue of market oversight. The Government believed there was a need to review whether current mechanisms to oversee the social care market are sufficient, and whether additional measures are necessary to support service continuity in cases where a provider of care services fails or chooses to exit the market.
3. The consultation on market oversight in adult social care was launched on December 1st 2012 and closed on March 1st 2013.
4. The consultation document set out the recommended direction of travel. The recommended approach was for a system of targeted regulation. We believed this option offered the best combination of greatest benefits to care users with the lowest cost burden on social care providers.
5. The consultation responses reinforced the Government's belief that targeted regulation was the best approach in this area.
6. 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.

The Social Care Market

7. 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. Throughout this time, local authorities have continued to be responsible for ensuring that the care needs of their local populations are met.

¹ <http://caringforourfuture.dh.gov.uk>

8. Today, the vast majority of 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. Furthermore, 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 businesses².
9. There are a range of different financial and business models operating within the sector, with providers of all different sizes and purposes. There is significant for-profit activity in this sector, and the corporate providers are often backed by a larger investment group, such as Saga (backed by Acromas) and Four Seasons (backed by Terra Firma). We also know that there are some providers who are highly leveraged and with highly complex capital structures. The not-for profit sector also provides a significant proportion of care, and there are a variety of different models of provision – including social enterprises, charitable provision, micro-enterprises, and mutuals – operating within the sector. The Government is keen to encourage this diversity³. Of course, 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.

Policy Framework

10. The Department of Health sets the strategic policy framework for adult social care, working with local government as partners, to provide overall direction and national objectives for adult social care. Delivery is the responsibility of local authorities, in line with their own locally determined priorities. Local authorities can also be a source of advice to support people purchasing their own care; around 40% of all those in residential care are now self-funders. The Government has recently published an accountability statement for social care, which outlines this approach in more detail⁴.

Market Oversight

11. Events over recent years, including Southern Cross falling into financial difficulties, 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 support service continuity for vulnerable people, in cases where a provider of care services fails or chooses to exit the market:

² Laing & Buisson, Care of Elderly People UK Market Survey 2011

³ 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>

⁴ *Department of Health Accounting Officer System Statement*, January 2012. This can be found at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132351.pdf

- Southern Cross demonstrated that there are specific challenges associated with monitoring and managing failure of very large providers, operating across many geographical boundaries and where there may be highly complex financial structures, which present risks to continuity of service (see below).
- The National Audit Office (NAO) in their report *Oversight of user choice and provider competition in care markets*⁵ highlighted that there are no formal arrangements for monitoring, and if necessary intervening in, markets that cross local authority boundaries. The NAO also said that the recent financial problems faced by Southern Cross illustrated the need for Government to develop a system to address serious provider failure.
- In 2011, the Government published its *Open Public Service White Paper*⁶. The White Paper included a commitment for departments to consider continuity regimes in cases where a provider exits the market. The Government is clear that should a provider exit, it is not acceptable simply to allow services to cease abruptly or for services to be of a poor quality, because local people will feel the impact of that failure. The White Paper stated that if providers of public services are unable to meet minimum standards “*it is essential that the state identifies these providers and intervenes quickly in order to ensure continuity of service*”.

12. The case of Southern Cross demonstrated specific challenges for the existing local authority based system. The situation was challenging, because;

- ♦ there was no early warning system to anticipate failure and put plans in place
- ♦ there was no formal mechanism to ensure exit was well-managed and quality maintained in transition
- ♦ residents & families felt a great deal of anxiety and there was no clear system in place to reassure them
- ♦ 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
- ♦ the size of the provider (supporting around 31,000 people)
- ♦ the complexity of the business’ capital structures
- ♦ the scale of the operations of the provider meant some central co-ordination was required
- ♦ there were no protocols agreed for all the different stakeholders involved, including individuals receiving care from Southern Cross
- ♦ the transfer of services to new providers was extremely complex

⁵ *Oversight of user choice and provider competition*, National Audit Office, September 2011. The main recommendations on developing and overseeing user choice and provider competition can be found on page 9 of the report.

⁶ *Open Public Service*, HM Government, July 2011. The section on developing continuity regimes can be found under ‘Intervening in the case of institutional failure’.

13. Despite the collaboration which successfully managed the Southern Cross exit arrangements, the circumstances demonstrated the need for:
- earlier awareness of financial risk,
 - mechanisms for intervention if required, and
 - clear processes to manage exit and achieve continuity of care during transition
 - to reassure people about the process and what it will mean for them, in order to reduce negative impacts on health and well-being caused by stress and anxiety.
14. The Government is therefore reviewing its approach to oversight of the social care market.

Engagement

15. The Government's consultation on market oversight in adult social care was launched on December 1st 2012 and closed on March 1st 2013. The consultation set out the Government's proposals for targeted oversight of adult social care providers.
16. The consultation received c.56 written responses. During the consultation, the Department held and attended events with 111 organisations, which included local authorities, providers, user groups, and banks. These events included four 'deep-dive' roundtables with relevant experts to consider and scrutinise the proposals in greater detail. The four expert sessions looked at:
- a. Clarifying the local authority duty to provide services and where the threshold for entry into the market oversight regime should be set
 - b. Challenge mechanisms for unsustainable models that compromise quality and legal powers
 - c. Determining the metrics for risk assessment and content of recovery plans
 - d. Examining the model in cases of failure; resolution phase mechanisms and supplier of last resort
17. The key themes to emerge from the consultation responses and events were:
- a. **Near-unanimous support for greater oversight-** While there were numerous detailed comments, very few respondents argued against the introduction of a stronger and more formal market oversight regime.
 - b. **Managing local impact –**

- ♦ Respondents highlighted the tensions between sharing information with local authorities early to support planning and creating a self-fulfilling prophecy.
 - ♦ There were also risks of duplication on oversight requirements through local authority contract management. It was suggested that local authorities would welcome specific guidance on proportionate oversight which might mitigate risks.
 - ♦ There was universal support to clarify that the local authority duty applies to all people in all forms of regulated care. Again local authorities would welcome some guidance and further support to execute this function.
- c. **Targeting ‘difficult to replace’ providers** - There was agreement with the principle of targeted oversight and that this should be targeted at services that are difficult to replace, such as big organisations, providers with a strong regional concentration and specialist services. Local market share was considered to be very important, along side the number of users and the number of local authorities relying upon a provider’s services. Some voluntary organisations argued to be made exempt from the regime as they considered themselves of lesser risk but this was not a view shared by all voluntary providers or the financial sector.
- d. **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 KPIs (key performance indicators) similar to those required by lenders. There should be regular dialogue with key providers. Respondents put emphasis on the need for skilled individuals to do the oversight work and the need for ‘skilling-up’ the regulator taking on the function. Some respondents did make the distinction between ‘light-touch’ monitoring and ‘light-touch’ powers, arguing that the regime should have stronger ‘teeth’ (see below).
- e. **Effective risk management and mitigation:** There is some debate about whether contingency plans can be prepared before a risk develops. There was clear support for the regulator to monitor risks to sustainability and to satisfy themselves that the provider had a strategy in place to mitigate risks. However, the benefit of taking some reasonable steps to prevent avoidable failure through better risk management was welcomed.
- f. **Stronger “teeth”:** Most organisations argued for the regime to have greater powers or “teeth” to enforce compliance amongst providers. The vast majority of organisations felt that a risk pool or special administration scheme would be disproportionate. There was however, a call for a ‘pause’, similar the Homes and Communities Agency (HCA) power, which can call a 28 day

moratorium to work with creditors and insolvency practitioners when companies fail. Respondents generally recognised that commercial mechanisms already exist to support an orderly failure and exit, with a transfer to alternative ownership, in the majority of cases. Many also thought that the CQC enforcement powers were strong (e.g. the power to deregister) and could be used as a threat. It was argued that the new regime should be built around the existing system.

- g. **Communications: Respondents envisaged a role for the regulator to effectively communicate with service users about the process of failure as in many cases this will have no material impact on the care services they receive.** The regulator and local authorities should reassure people that their services will continue. The language of the regime risked misinterpretation by the public and commissioners and should be amended to avoid causing unnecessary anxiety or market impacts.

- h. **Rejection of alternative proposals** – The impact assessment for the consultation set out a series of alternative interventions, including a special administration regime and a risk pooling system. There was near unanimous support for our initial view that we should not proceed with these options. These proposals have therefore been rejected.

On-going engagement

18. The Department of Health has regular engagement with key stakeholders and will continue to do so. The above consultation therefore, builds on earlier engagement with interested parties. In autumn 2011 the Department published a discussion paper analysing the issue of market oversight and inviting responses.⁷ We received 21 formal responses to this paper. Furthermore, as part of a wider engagement exercise on adult social care reform the Department sought views on market oversight. There were 565 responses to that engagement exercise⁸. Below we provide a summary of the key themes from earlier engagement.

Summary of Feedback to ‘Oversight of the Care Market’ and 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 providers are providing

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.

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

From the wider engagement on markets as part of '*Caring for Our Future*', 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.

B: Analytical narrative

19. The need to support continuity of service is a feature of many markets where there are limited alternative providers or where the loss of the service, even temporarily, can cause a significant reduction in consumers' welfare. For example, the utility sector in the UK (water, electricity, gas)

has a continuity of service requirement on the network provider wherever it is a natural monopoly. In addition, retail providers of the same service can be required to act as the provider of the last resort, if one retail company were to fail; for example, the gas and electricity regulator requires that one retail service provider acts quickly to address the needs of the consumers of the failing provider. Implicit in these continuity of service provisions, is the argument that the loss of the service, even temporarily, can cause significant reduction to consumer welfare because the services are considered as essential for carrying out normal activities.

20. Service provision in social care, by its very nature, addresses the needs of people with high levels of need. Social care supports people of all ages with certain physical, cognitive or age-related conditions. Those with a high level of needs and their families rely on the provider for ensuring their overall health, safety, dignity and well-being. Should the provider close or fail, these individuals and families may not be in a position to be able to find alternative service provision at short notice. However, it is essential that they continue to receive the services to meet their needs.
21. Any intervention needs to be targeted at those providers who would be most difficult to replace if they were to exit the market. Responses to the consultation confirmed the Government's view that local authorities are currently able to manage the vast majority of provider exits successfully, and that a central regulator is only necessary for those providers who have a larger regional or national presence, or those who provide very specialist services.

C: Rationale for intervention – what is the market failure?

22. In this section, we discuss the rationale for intervention. This falls into three main parts – a) the rationale for intervention to preserve service continuity overall, b) issues relating to continuity of care arising from local level provider exit and c) issues relating to continuity of care arising from larger regional and national, and specialist, providers.

A) The rationale for preserving service continuity

23. A market has been developing in social care for over twenty years; and as part of their role, local authorities have been managing provider entry and exit. Throughout this time, local authorities have been ensuring individuals' needs continue to be met.

24. Evidence suggests the disorderly closure of a social care provider can cause a great deal of anxiety to individuals, carers and their families.⁹ If poorly managed, there is a significant risk that there may be an adverse effect on the health, well-being and dignity of users.

25. The most recent evidence, from interviews with 70 residents in Birmingham before, during and after care home service closures suggests that when exit is managed well by a local authority, there should be no negative effect on individuals' health and wellbeing.¹⁰ Indeed, a move could be beneficial if it leads to higher quality care. However this study notes, that in the case of large-scale emergency closures, well-managed processes may not be possible, given the lack of time for a local authority to plan and also because the scale of impact may be across a number of local authority areas.

26. The collapse of Southern Cross raised the prospect of such a risk to individuals' health and well-being. Although in the end, this overall risk was limited only to the closure of two care homes in the UK, during the uncertain period when the company fell into financial distress, some residents, families and carers were caused a great deal of anxiety. The potential for similar risks and potentially of higher magnitude from other providers, remains a concern.

27. We are not aware of any evidence relating to the effect of closure of a domiciliary service on the health and well-being of individuals receiving services, and their families and carers. We believe it is reasonable to assume that the effect would be of a similar significance to the effect of a residential care provider failing.

⁹ Scourfield P, 2004, 'Questions raised for local authorities when old people are evicted from their care homes'; Woolham, J (2001). *Good practice in the involuntary relocation of people living in social care*

¹⁰ Evidence from the Health Services Management Centre at the University of Birmingham has found adopting good practice limits potential negative impacts on individuals' health and well-being and, for some people, may give slight improvement in outcomes. See: *Achieving closure: Good practice in supporting older people during residential care closures*, July 2011. This is a joint publication by Health Services Management Centre at the University of Birmingham and ADASS, in association with SCIE.

28. In both the consultation and the engagement exercise that the Department of Health ran in 2011, a number of responses highlighted that people could find themselves in a vulnerable situation, should their provider fail and therefore steps needed to be in place to preserve service continuity.¹¹
29. There is currently little available evidence on how well provider exit is managed across the country. Through both the consultation and the 'Caring for Our Future' stakeholder engagement, the Government heard that practice might not be consistent or uniform across the country. The evidence suggests that if a move to a new residential care home is managed well, the risks to health and well-being can be effectively mitigated; and indeed, in some cases if a move leads to improved quality, outcomes can improve. SCIE have published best practice guidance on how to manage the closure of a care home.¹²

B) Issues relating to continuity of care arising from local level provider exit

30. Continuity of care is important regardless of the type of service provision. While the smaller care home operators could span more than one local authority boundary, the vast majority are likely to be operating in very limited geographical areas. CQC data shows that there are only 39 providers of residential care in England with more than 1000 beds¹³
31. Our assessment is that within these local markets, there is generally adequate competition¹⁴ as evidenced by the fact that 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 were deregistered (representing a 20 year low in closures) with 182 homes were deregistered the year before. 133 new care homes were registered in the year to April 2011, with 145 new registrations the year before.¹⁵
32. Given the number of providers and the level of competition in care homes, we believe it is reasonable to argue that there is no significant market failure at the local level, at the current time. The impact of closure of a small provider can be satisfactorily handled at the local level and the well-being of its users adequately protected, without any need for new measures.

Continuity of care at the local level

33. The provider should be primarily responsible for transition arrangements and ensuring no one who accesses their services is left without care.

¹¹ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_130439.pdf

¹² <http://www.scie.org.uk/news/mediareleases/2011/080911.asp>

¹³ CQC raw data, 2012 (unpublished)

¹⁴ Forder J, Allan S (2012) *Care Markets in England: Lessons from Research* available at <http://www.pssru.ac.uk/publication-details.php?id=4127>

¹⁵ Laing & Buisson, Care of Elderly People UK Market Survey 2011

34. We believe it would be too great a burden on business and would not be proportionate, if we were 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.
35. In order for local authorities to continue to be able to manage local-level provider failure successfully, our view is that;
- commissioners will need to promote diversity and have regard to the importance of market sustainability, particularly through commissioning practices. For example, there could be significant risks, if a single provider develops a dominant position within any local market
 - commissioners and providers will need to have the information to facilitate an effective solution e.g. up to date data on alternative providers and services. If sufficient information is not available, it could become a barrier to ensuring effective service continuity. This points to the need for local market intelligence and relationships that are fit for purpose.
36. Notwithstanding the argument that plurality within the market should act as a powerful safeguard, we do know that if any provider exit is managed badly at a local level, there is a risk that there may be a negative impact on the health and well-being of those individuals affected. However, this process is within the control of the local authority and provider, who can ensure that effective systems are in place and that best practice in cases of any home closures is followed.
37. The *Care and Support Bill* is looking to strengthen and clarify local authority duties with regard to the market.¹⁶
38. Specialist services may not face the same level of competition as care services for frail older people. Were there to be financial failure of such a provider and disorderly closure, the analysis could be similar to that for a national or regional provider, even if the provider was local.
- C) Issues relating to continuity of care arising from larger regional and national, and specialist, provider exit*
39. We classify these providers as those with a significant national or sub-national coverage, of a level that would pose significant information and coordination challenges, should they fail. Such instances present risks to ensuring continuity of care.
40. Where 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

¹⁶ <http://careandsupportbill.dh.gov.uk/home/>

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 further consolidation over time, meaning provision could become more concentrated in the future and we may see a greater number of larger providers across residential, domiciliary and specialised care and housing services.

41. There may also be risks to continuity of care associated with those providers that have high market concentrations at a regional level or offer care that is highly specialist. The nature of the social care market suggests that local and regional concentrations are just as important as national patterns of provision. Indeed, the recent NAO report 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.¹⁷ In parts of the North East, Southern Cross accounted for some 30% of care home places. We know that this may be a particular issue for some specialist services. To note, the Office for Fair Trading consider a range of indicators when assessing market dominance (including market share, the ability to raise prices, barriers to entry) and these all need to be analysed to assess the extent of market power.
42. We are also seeing increasingly complex operating and financial business models emerging in the care and support sector, particularly in residential care, which can make it harder to assess financial viability and be difficult to untangle quickly in distressed circumstances. For example, investors in social care companies can have a wide-ranging portfolio of diverse business interests. We are aware that many providers are carrying substantial debt, which are often structured in complex arrangements and the subject of covenant restrictions. Some of these debts will need to be refinanced over the next few years and, given the current circumstances in the wider economy, this will be challenging. We also know that the care market has close and complex interactions with other markets, such as the property and financial markets; and we understand that there is appetite from providers to offer services spanning both health and care, and housing and care. Where there are a number of different branches or subsidiaries to a company, there is a risk that problems in a different part of the business could affect their social care provision.
43. Our analysis of the situation for larger players operating nationally or regionally is different to smaller providers. Here, we believe there is a case for a different approach, as the market (which includes commissioners and providers) may not be able to deliver an effective solution on its own. If an organisation providing care to many hundreds or thousands of vulnerable people were to run into financial distress and risk of sudden failure, making arrangements for continuity of care for such large numbers of users, would require a substantial degree of coordination between many councils and potentially many alternative providers. It would be challenging for this to be

¹⁷ *Oversight of user choice and competition*, NAO, September 2011, p30.

conducted effectively by individual councils. This is evidenced by the need for central government coordination and information sharing activities during the difficulties with Southern Cross. Moreover, news of the financial distress and risk of failure of such a large provider would cause anxiety and potential significant welfare loss to large numbers of users and their families, even if a solution was subsequently found.

Residential Care

44. In residential care, the ten largest providers account for around 20% of the UK care home market by places. The top twenty providers account for around 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.¹⁸

¹⁸ Laing & Buisson, Care of Elderly People UK Market Survey 2011/12

Provider	Number of places (January 2012)	Market share (as % of England)
Four Seasons	23,446	5.4
BUPA	21,720	5
Barchester	12,683	2.9
HC-One	11,430	2.6
Care UK	5,007	1.1
Methodist Homes	4,812	1.1
Anchor	4,203	1
Orchard Care Homes	3,879	0.9
Bondcare Group	3,781	0.9
European Care	3,719	0.8

Home Care

45. 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.¹⁹
46. The Government recognises that there are risks to the individual should a home care provider fail – and these need to be properly assessed and addressed by both providers and commissioners. However, the majority of home care providers are much smaller operations and local authorities are best placed to manage their local entry and exit (as explained above). In considering the risks to continuity of care for individuals if a larger home care service provider exited the market we made the following observations;
- in the home care sector, users are in their own homes.
 - the core cost component in providing continuity care would be the home care staff themselves. An alternative provider could

¹⁹ Laing & Buisson, Domiciliary Care UK Market Report 2011/12, and from Laing's Community Care Market News, May 2012

- employ such staff on the same terms or an individual could do so themselves, relatively quickly.
- there is neither physical infrastructure nor accompanying debt conditions.

Specialist Housing (Housing with Care)

47. 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) data²⁰ suggests there are 821 extra care housing schemes in England although the Care Quality Commission reports there are 564 extra care locations.²¹ In most cases the care provision would be classified as domiciliary care provision (see above). In some cases the organisations will be overseen by the Homes and Communities Agency. In future regulation will need to ensure it does not stifle important innovations in the sector and that risks of duplication are managed. It is therefore our intention to exempt providers currently regulated by the Homes and Communities Agency (HCA) but ensure cooperation and coordination where necessary to manage continuity of care.

Summary

48. The argument for intervention is that resolving a large scale failure requires a coordinated effort to bring about a solution, and that this needs to be achieved in a way which acts in the interest of all. A further issue is that potential alternative operators, keen on taking over the failing provider's business may be hampered by lack of information and coordination, leading to greater barriers to finding a market-led solution. In summary, there are two key types of potential market failure from the failure of larger providers – information failure and coordination failure, arising from both the lack of information and the misaligning of incentives between different purchasers or between providers and purchasers.

Proposal for intervention: Targeted regulation

²⁰ Statistics on Housing with Care (EAC June 2010)

²¹ CQC State of Care Report 2010-2011

49. The Government is proposing this intervention, which is based on the premise that local authorities continue to oversee the smaller players in the local care market and to put effective plans in place to ensure continuity of care, should any provider exit the market in their local area. This is based on our assessment, outlined earlier in this document, that there is no market failure amongst smaller providers to warrant central Government intervention.
50. The Southern Cross case illustrated among other things that the Government did not have sufficient early knowledge of the financial situation and hence intervention was more protracted. In order to avoid such a situation in the future, we believe some early knowledge of the financial situation of those providers whose potential financial failure is likely to cause the highest adverse effects, is needed. This knowledge would help in a resolution appropriate to the level of risk posed by the financial failure of these providers.
51. Based on the risk profile of these providers, our assessment is that further regulation is required to ensure that any potential financial collapse of these providers does not result in adverse effects to users. This could happen if the provider were to close in a disorderly manner. It is important, however, that any regulation is targeted and proportionate to the level of the risk.
52. We propose new targeted regulatory interventions;
- enhanced intelligence of a group of providers that are above a certain threshold, set according to their difficulty to replace
 - sustainability planning: when it spots threats to the ongoing sustainability of a provider, the regulator will need to assure itself that the provider is taking sufficient steps to mitigate the threat
 - measures to manage provider distress and failure, including the development of continuity of care packs containing information that the regulator requires to ensure there are no gaps in the care individuals receive from the provider, if and when the provider fails. This could include a 28 day moratorium power, to provide additional time to find an orderly resolution if needed.
53. The regulatory powers would be used to;
- require the submission of financial data from a targeted set of providers to a central body. This will provide an early warning system and aid in the planning of large-scale market exit.
 - have some power to coordinate information and possibly activity, in cases where a provider's business crosses more than one local authority area. As discussed earlier, there is a risk of an information or co-ordination failure in such instances. In the consultation, we argue that addressing these failures would require a national level response and some coordination powers.

- a power to commission an independent business review, at the provider's expense to examine opportunities to avoid failure and manage risks to sustainability
- potentially to provide a period of pause, where necessary, of 28 days to find a solution that guarantees a smooth transition to another organisation

54. We also propose to clarify the responsibilities of local authorities when providers fail. We propose that local authorities have a duty to meet the needs for temporary care and support of any person whether self-funded or local authority supported, and whether in receipt of residential or non-residential care, if they have urgent unmet needs as a result of provider failure. The consultation responses indicate that this accurately reflects the role local authorities are already performing when providers fail. We therefore do not believe this clarification will impose costs on local authorities.

Coverage of the regulation

55. We believe that the regulation does not need to extend to all providers, but needs to be targeted on those likely to present the greatest risk from disorderly closure. This means that burdens would not fall on small and medium providers.

56. It could be argued that this may seem unfair to the larger providers and that might impact upon their ability to compete effectively; however we are of the view that choosing those providers whose failure could cause the largest adverse effects on service users is a proportionate response to the risk they carry and which a competitive market should recognise.

57. We believe that the following types of providers will need to be monitored, regardless of their financial stability;

- providers that are large
- providers that have significant geographical concentrations
- providers of specialist services, where alternative care provision may be difficult to secure.

Responsible body

58. The Government is currently considering the appropriate regulatory body who can undertake this function. The body will be either CQC or Monitor.

D: Costs

Costs to perform the function of regulation

59. The role of the regulator would be to oversee providers that are 'difficult to replace' if they were to fail. This includes providers who are large, have particular regional concentrations and are specialist (so have a wider catchment of dependency on their services). We assume that this will be 50-60 organisations based on available CQC data.
60. This assumption is based on analysis of the residential care data, which show that there are 30 organisations operating in over ten local authorities and providing over 1,000 beds. We do not have sufficient data on domiciliary and specialist care to conduct similar analysis of these sectors. Given the more fragmented nature of the domiciliary and specialist care sectors, we estimate that there will be circa 15-20 domiciliary care organisations, and 5-10 specialist care providers, in the regime.
61. We have considered the costs of regulators who perform similar function including Monitor, the Civil Aviation Authority and the Homes and Communities Agency.
62. Based on the costs and functions of the above regulators we estimate that to oversee c. 60 organisations the regulator will need to employ approximately 15²² FTE staff, of which around 2/3 will be senior staff and 1/3 will be junior staff.
63. In the Health and Social Care Bill Impact Assessment²³ staff performing the function of provider regulation were expected to cost £84K, including on-costs, after applying pay rate assumptions. This would apply to c. 10 staff. We assume the remaining 5 staff would be expected to cost £40,000 including on-costs.

Category	Unit Cost (£s)	No. of Units	Total Cost (£000s)
Senior Staff	84,000	10	840
Junior Staff	40,000	5	200
Total wage costs, including on costs			1040

²² This staff mix is based on the CAA's staffing structure. We also assume 1 regulator per 4 providers..

²³ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalassets/dh_129917.pdf

64. In addition, we expect there to be some additional running costs relating to spend on consultancy services and corporate services including legal advice.
65. We estimate the consultancy costs will be £150,000 initially, and £50,000 a year thereafter. We assume that extra consultant time will be needed in the first year to help define and implement the new regime.
66. We have no information on the likely costs of corporate services. However, at Monitors inception, DH estimated that the new organisation would require an annual budget for legal services of £4 million. Assuming that the need for legal advice is proportionate to the size of the organisation, we assume that the new regulatory function will require legal advice and other corporate services of around £100,000 per year.
67. This suggests that the cost to the regulator of carrying out this regulation would be of the order of **£1.3 million** in year 1 and £1.2 million thereafter. The exact cost will depend on the exact regime adopted.

Costs of providing data for firms in the threshold

68. The consultation provided no data on the cost of providing financial data to the regulator. Many respondents said that they did not have enough information to estimate a cost, or that the cost would depend on the data requested. Some were concerned that charities would need to put in place new financial systems in order to produce the data required.
69. However, the CQC and KPMG were of the view that the data the regulator would require from all companies above the threshold is likely to be the same information that firms produce regularly for their own management purposes. BUPA's consultation response said that costs should be minimal providing information requirements remain 'light touch' and do not significantly add to that which is already provided and the threshold set at an appropriate level.

Estimating Costs

70. We do not have any information on the cost of extracting existing information from management reports and providing it to a third party. However, we assume that this would largely be an administrative role, with some oversight from a corporate manager.
71. We assume that providers will be required to assemble and send the financial information to the regulator once a quarter. We assume that it would take around 3 hours per organisation per quarter and that on costs are 30%.
72. The 2010 Annual Survey of Hours and Earnings (ASHE) provides the following median wage rates for

Administrative and secretarial	£9.75
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Corporate managers, including senior managers £19.40

73. If we apply these, and assume that 80% of the time will be administrative and 20% required for manager oversight, then the annual cost of providing data will be

No of data collections * no of hours work * (admin costs *80% + management costs * 20%)* on costs

$$= 4 * 3 * (80%*9.75 + 20% * 19.40)*1.3$$

=£180 a year per organisation

Costs of Meeting the Regulator

74. In addition, we assume that the each firm above the threshold will meet the regulator quarterly to discuss their metrics. We assume that each meeting will last half a day, and require in total 2 days of manager time including preparation.

75. The cost of meeting the regulator is then

Number of meetings * staff time to prepare and meet regulator * hourly wage * on costs

$$4 * 14 * £19.40 * 1.3 = £1,410$$

76. Our best estimate is that the annual cost to any social care provider in the threshold of providing metrics data to the regulator and meeting to discuss it will be **£1,590** per year per organisation.

Cost of Preparing Sustainability Plans, Independent Business Reviews and Continuity of Care Packs

77. The key cost drivers in terms of the above requirements are likely to be the following:

- The number of organisations that are required to prepare these
- Whether these organisations prepare these using internal resources or have to ask external advisors to prepare these on their behalf
- Frequency- whether these are prepared once at the start then updated regularly or prepared as a one-off.

Number of Organisations

78. We assume that 50-60 organisations will be required to submit the metrics. On that basis, in terms of the number of organisations that are required to prepare the documents, we have made the following assumptions:

		No	Profile over 10 years
A	No of orgs required to submit metrics	60	
B	Number of orgs (from A above) required to submit Sustainability	30 (50% of A)	Spread evenly over the 10 year appraisal period

	Plans		
C	No of orgs (from B above) required to commission Independent Business Reviews (IBR)	12 (40% of B)	Spread evenly over the 10 year appraisal period
D	Number of orgs (from C above) required to submit Continuity of Care Packs (for Continuity of Care Plans)	6 (50% of C%)	Spread evenly over the 10 year appraisal period

79. There are no existing benchmarks for the costs of preparing sustainability packs or continuity of care packs, as their scope and content will be determined by the regulator and will depend largely on the size, type, complexity of the organisation as well as the nature of the issue causing distress. Therefore, the costs below are based on assumptions. Discussions with some of the stakeholders suggest these cost estimates for the Sustainability Plans and Independent Business Review represent a low estimate.

Sustainability Plan

80. Providers facing challenges will be required to produce 'sustainability plans' when risks develop, to satisfy the regulator that they have a strategy in place to manage the challenge and a contingency plan.

81. We assume that when an organisation is required to produce a sustainability plan, that 50% will use a mix of internal resources (Admin, Senior Finance Managers and Senior Management Team members such as CFO/CEO) and 50% will use external advisors. Even when external advisors are used, this will require some input from provider senior managers and directors.

82. While the challenge persists or is being addressed, we assume that the sustainability plan will to be updated on a monthly basis over a 3 month period and that the updates will take 2.5% of the time taken to prepare the initial plan.

Cost of Sustainability Plan

1. Delivered using Internal Resources

	Days
Senior Finance Manager time	55
Chief Finance Officer/Senior Management time	20
Admin secretarial	10
Admin secretarial	£1,014
Senior Finance Manager Benchmark cost ²⁴	£21,993
Chief Finance Officer/Senior Management Benchmark cost ²⁵	£10,242
Total Cost for delivering a Sustainability plan using internal resources	£32,235

²⁴ Corporate Managers And Senior Officials hourly rate of £38.45 plus 30% on-costs used from 2010 ASHE, based on 8 hours/day

²⁵ Directors and chief executives of major organisations hourly rate of £49.24 plus 30% on-costs used from 2010 ASHE, based on 8 hours/day

2. Delivered using Advisors

External Resources

Number of advisor days	50
benchmark advisor daily rate	£999 ²⁶
Cost	£49,950

Internal resources to provide information etc

Admin secretarial	5
Senior Finance Manager days	20
CFO/Senior Management days	4
Cost	£10,553

Total Costs for delivery of Sustainability plan using external Advisors	£60,503
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Updating the Sustainability Plan

Plan prepared once when the challenge first emerges

Updated every month

Updating cost per month as proportion of initial cost

2.5%

Updating cost per episode as proportion of initial cost-using internal resources

2,418

Updating cost per episode as proportion of initial cost-using advisors

4,538

83. If we assume that 30 sustainability plans are produced during a 10 year period then the cost per year will be the

average cost of a sustainability report * 30/10,

where the average costs of a sustainability report is:

[(cost of internally produced report + cost of internal update) + (cost of externally produced report + cost of external update)] all divided by 2

84. So the annual cost is

$$30/10 * [(32,235+3*2418)+(60503+3*4538)]/2 = \mathbf{£149,500 \text{ per year}}$$

Independent Business Review

85. An Independent Business Review (IBR), would be conducted by external advisors. Some input would be required from senior managers and directors to provide information and hold management meetings. Also, the IBR, by its very nature, would be required as a one-off and once completed, is unlikely to require updating.

Cost of Independent Business Review

²⁶ Blended daily rate using DH benchmarks.

Must be delivered using Advisors

External Resources

Number of advisor days	75
benchmark advisor daily rate	£999
Cost	£74,925

Internal resources to provide information etc

Admin secretarial	5
Senior Finance Manager days	24
CFO/Senior Management days	6
Cost	£13,177

Total Costs for Independent Business Review	£88,102
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86. We assume that 12 Independent Business Reviews will be required in 10 years. Making the annual cost of IRB's in the new scheme

$$£88,102 * 12 / 10 = \mathbf{£105,70085 \text{ per year}}$$

Continuity of Care Pack

87. The Continuity of Care Pack would be required by the Regulator and produced by the provider. It would include details on the business model and ownership structure, the services offered, the number of clients in each area, and any other information the regulator deemed necessary. It would be required at a time of crisis and, we assume, will need to be updated every two weeks over a 12 week period when the company is in distress. As a conservative assumption, we have estimated that the cost of updating the continuity of care pack will be the same as the initial cost, in a rapidly evolving and changing failure scenario.

D. Cost of Continuity of Care Pack

Internal resources to provide information

Senior Finance Manager days	6
CFO/Senior Management days	2

Cost of continuity of care pack	£3,423
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Cost incurred every two weeks over a 3 month period,

Updating cost per 'episode' requiring a Continuity of Care Pack	£20,541
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Total cost of a continuity pack	23,964
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88. We assume that 6 continuity of care packs will be required in a 10 year period. Making the annual total cost $23,964 * 6 / 10 = \mathbf{14,378 \text{ per year}}$.

89. The Total Costs for each of the elements over the 10 year appraisal period are shown in the table below.

	Start End Year	01-Apr-15 31-Mar-16 1	01-Apr-16 31-Mar-17 2	01-Apr-17 31-Mar-18 3	01-Apr-18 31-Mar-19 4	01-Apr-19 31-Mar-20 5	01-Apr-20 31-Mar-21 6	01-Apr-21 31-Mar-22 7	01-Apr-22 31-Mar-23 8	01-Apr-23 31-Mar-24 9	01-Apr-24 31-Mar-25 10
Regulator Costs (£)											
	<i>Regulator ongoing costs</i>	1,290,000	1,190,000	1,190,000	1,190,000	1,190,000	1,190,000	1,190,000	1,190,000	1,190,000	1,190,000
Provider Cost of supplying metrics (£)											
	<i>Supplying and meet</i>	95,400	95,400	95,400	95,400	95,400	95,400	95,400	95,400	95,400	95,400
Provider One off Costs (£)											
	<i>Sustainability Plan</i>	139,107	139,107	139,107	139,107	139,107	139,107	139,107	139,107	139,107	139,107
	<i>Independent Business Review</i>	105,722	105,722	105,722	105,722	105,722	105,722	105,722	105,722	105,722	105,722
	<i>Continuity of Care Pack</i>	2,054	2,054	2,054	2,054	2,054	2,054	2,054	2,054	2,054	2,054
Provider Updating Costs (£)											
	<i>Sustainability Plan</i>	10,433	10,433	10,433	10,433	10,433	10,433	10,433	10,433	10,433	10,433
	<i>Independent Business Review</i>	-	-	-	-	-	-	-	-	-	-
	<i>Continuity of Care Pack</i>	12,324	12,324	12,324	12,324	12,324	12,324	12,324	12,324	12,324	12,324
Total Costs (£)		1,655,041	1,555,041	1,555,041	1,555,041	1,555,041	1,555,041	1,555,041	1,555,041	1,555,041	1,555,041

One In Two Out

90. The equivalent annual net cost to business has been estimated as the cost to firms of complying with the new regulatory regime. This is estimated as follows:

Action	Cost
Supplying metrics	£95,400
Sustainability Plans:	
One-off production cost	£139,107
Updates	£10,433
Independent Business Review	£105,722
Continuity of Care packs:	
One-off production cost	£2,054
Updates	£12,324
Total	£365,041 or £0.365 million

E: BENEFITS

91. The main benefit of this proposal will be to care users, their family and carers and the people who work for a social care provider that has failed while in this regulatory regime. In the event of the failure, a provider has no incentive to, and may be unable to, transfer the care of their clients in an orderly way. This proposal should ensure the smooth transition of the care users concerned to their new care arrangements. The benefits to users are monetised below. The benefit to carers, families and care workers has not been monetised.
92. Secondly, the process of regulation may lessen the likelihood of provider failure, due to financial mismanagement. This is because the regulator will assess financial metrics and, for those at risk, will have the power to request the production of sustainability plans and to commission independent business reviews. This benefit is not monetised
93. Finally, in the event of a regulated provider failing, there will be benefits to the local authorities who commissioned its' services. These benefits are twofold. Firstly, the regulator will support local authorities to manage the failure effectively. This will include collecting and distributing timely information to local authorities on the individuals receiving services from the failing provider
94. We know from Winterbourne View that the spot price of care can rise dramatically where local authorities have to purchase that care for a large number of individuals at short notice, and that people can be placed in very expensive temporary care while the situation is resolved. The orderly closure of social care providers should go some way to preventing this. These benefits have not been monetised.

Benefits to Care Users

95. Evidence suggests the disorderly closure of a social care provider can cause a great deal of anxiety to individuals, carers and their families.²⁷ If poorly managed, there is a significant risk that there may be an adverse effect on the health, well-being and dignity of users.
96. However, this does not have to be the case. Where a closure is well managed, clients can receive a benefit from their new and potentially more appropriate care. They need not experience anxiety during a well managed transition.
97. This is illustrated by a study in Birmingham in which 70 residents were interviewed, during and after service closures (including care home closures). This suggests that when a provider exit is managed well by a local authority, there should be no negative effect on individuals' health

²⁷ Scourfield P, 2004, 'Questions raised for local authorities when old people are evicted from their care homes'; Woolham, J (2001). *Good practice in the involuntary relocation of people living in social care*

and wellbeing.²⁸ Indeed, a move could be beneficial if it leads to higher quality care. However this study notes that in the case of large-scale emergency closures, well-managed processes may not be possible, given the lack of time for a local authority to plan and also because the scale of impact may be across a number of local authority areas.

Best estimate

98. As a best estimate, we approximate the well-being impact of preventing the disorderly closure of a residential care provider regulated by this regime.

99. We make the following assumptions to calculate the well being affect of market oversight:

- where providers close in a disorderly way, people receiving care services experience a substantial increase in their anxiety.
- where providers close in an orderly way, people receiving care services experience no increase in their anxiety, in line with evidence from the Birmingham study above.
- the positive impact on their quality of life can be represented by a move from “severe anxiety” to “no problems” on the EQ-5D scale. This translates to a quality of life improvement of 0.586.
- we expect this improvement to have an average duration of 3 months. This is an estimate of the time taken to resolve the disorderly closure of a care provider, provided by stakeholders during a roundtable and in written responses. It is a conservative estimate, and assumes that there is no ongoing effect on care users anxiety from a disorderly transition to new care arrangements.

100. Taken together, the above assumptions suggest that the well-being effect of an orderly resolution to a care provider failure is 0.1465 quality-adjusted life years (QALYs) per affected care services user. With a QALY valuation of £60,000, this would give an expected monetised benefit of **£8,790** (=0.1465 * £60,000) per care user.

101. As set out above, this calculation is an approximation in that there are limits to our knowledge of prevalence and the impact of the additional stress caused by having one’s residential care re-arranged in a disorderly way.

102. We do not know what proportion of residents would be fully aware of any financial pressures, and hence would experience anxiety. If providers actually reach the point of failure, we would expect the proportion to be high. Our analysis assumes that all residents in affected providers see

²⁸ Evidence from the Health Services Management Centre at the University of Birmingham has found adopting good practice limits potential negative impacts on individuals’ health and well-being and, for some people, may give slight improvement in outcomes. See: *Achieving closure: Good practice in supporting older people during residential care closures*, July 2011. This is a joint publication by Health Services Management Centre at the University of Birmingham and ADASS, in association with SCIE.

some effect, but this may be an overestimate. On the contrary, the experience of Southern Cross demonstrates that failure of a major provider can have anxiety impacts on residents of other organisations, and on carers and relatives in wider society. We have not monetised this wider societal estimate. It would offset any overestimate of benefits, but indicates directly that there is a degree of uncertainty in our calculations.

103. We do not have any comparable information for home care.

Sensitivity analysis – levels of stress and anxiety

104. As sensitivity analysis, we vary the extent to which an orderly closure of residential care will reduce the stress and anxiety of care users. As a lower bound, we assume that people experience moderate anxiety when a care provider closes in an orderly way and severe anxiety when a care provider closes in a disorderly way. This translates to a quality of life improvement of 0.434. If we assume that the disorderly closure takes 3 months to resolve, and that people feel mild anxiety for three months following an orderly transition to new care arrangements, then the lower bound quality of life improvement is then

$$(0.434 * 3/12 * 60,000) = \mathbf{£6510} \text{ per client affected.}$$

Estimating the number of people to benefit from the scheme.

105. In order to estimate the number of care users to benefit from the new regulatory regime, we need to estimate how many providers within this regulatory regime are at risk of failure in future years. We do not have this information.

106. We know that in the last two years, two providers who may have been covered within the regime have failed or experienced financial distress. These are Southern Cross²⁹, which had 31,000 care users and a 9% share of the residential care market in England, and Castlebeck, a very specialist provider who have less than 100 social care beds³⁰ in total. This confirms that provider failures do happen, and that the scale of the benefits from an orderly transition to new care arrangements will vary considerably from year to year.

107. To estimate the benefit from regulation, we make the following assumptions about the firms regulated and their failure rate:

- That the new regime will include 50 – 60 social care providers, including, the largest residential and domiciliary care providers and those with strong regional concentrations and providers of specialist services who are dominant in their market.
- That in any 10 year period, 6 firms will fail. Matching the assumptions made in the costs section above.

²⁹ *Oversight of user choice and competition*, NAO, September 2011, p30.

³⁰ 2012 CQC registration data

108. Even with the assumptions above, there is a level of uncertainty about how many people would benefit from this new regulatory regime in a 10 year period. In terms of care users, there are substantial differences in the number of people cared for by the top 30 residential care providers. The largest provider cares for around 20,000 people in England and the 30th largest provider for around 1,300. On average, CQC registration data shows that the top 30 residential care providers have 4000 social care beds on average, and that the bottom 2/3rds of these have an average of 3000 social care beds.

109. Given this uncertainty, we have estimated a range of benefits. To produce an estimate of the benefits of the scheme, we assume that 6 providers fail within a 10 year period. In our high scenario, we assume that this includes one of the top 10 providers, and that the remainder are all smaller providers. For our low scenario, we assume that all the failures are smaller residential care providers. We do not have any information on the number of people who receive domiciliary care services from the larger home care providers. We have not included them in our estimate of benefits.

110. Under both scenarios, the people receiving care from the regulated firm that failed benefit from an orderly transition to new care arrangements under the new scheme.

111. This is a conservative estimate of the number of people who would benefit from an orderly transition to new care arrangements. Staff, families and carers would also see a reduction in their anxiety from an orderly transition to new arrangements, compared with a disorderly one. However, we have not monetised this.

112. The estimated benefits are as follows:

113. High estimate assumptions:

- No of failures in 10 years 6
- No of people affected $1 * 4000 + 5 * 3000$
- Benefit from orderly transition £8790
- No of years that benefit is spread over 10

Annual Benefit = $(19,000 * 8790) / 10 =$ £16.7 million per year

114. Low estimate assumptions:

- No of distress situations in 10 years 6
- No of people affected $6 * 3000$
- Benefit from orderly transition £6510

- No. of years that benefit is spread over 10

Annual Benefit = $(6 \times 3000 \times 6510) / 10 = \text{£}11.7 \text{ million}$

Net present value calculations

115. This section summarises the costs and benefits identified in the preceding sections, relative to the do nothing scenario, in which large care providers, providers with a presence in many local authorities or providers with a dominant share of a specialist market are not subject to the proposed light touch regulation.
116. It presents the changes between the do-nothing scenario and the best estimate costs for the proposed policy. The main monetised costs and benefits include changes:
- the costs to firms of complying with the regulation;
 - the cost to the regulator of administering the regulatory regime;
 - the benefits to recipients.
117. There is a degree of uncertainty, in particular in estimates of the number of providers who fail and in the scale of anxiety arising amongst service users in those organisations. Whilst the headline figures demonstrate a substantial net benefit, with benefits outweighing costs, our judgment is that the evidence does not demonstrate a substantial gain from the policy. There is sufficient evidence to demonstrate that the policy is cost effective and appropriate, but the degree of uncertainty in the figures means it would be unwise to draw conclusions beyond that.
118. To account for this uncertainty in some components of the preceding analysis, we present a range of benefits.
119. Finally, it should be noted that table below presents our current best estimates and is subject to uncertainty with regard to the distribution of the identified costs. In particular, the regulator will select the threshold for this regime, specify the metrics to collect from providers and ensure compliance.

	Start Year	2015/16 1	2016/17 2	2017/18 3	2018/19 4	2019/20 5	2020/21 6	2021/22 7	2022/23 8	2023/24 9	2024/25 10	Total
Regulator Costs (£)		1,290,000 ³¹	1,190,000	1,190,000	1,190,000	1,190,000	1,190,000	1,190,000	1,190,000	1,190,000	1,190,000	12,000,000
Provider Cost (£)												
Ongoing												
Supplying metrics		95,400 ³²	95,400	95,400	95,400	95,400	95,400	95,400	95,400	95,400	95,400	954,000
One off costs												
Sustainability Plan³³		139,107	139,107	139,107	139,107	139,107	139,107	139,107	139,107	139,107	139,107	1,391,075
Independent Business Review³⁴		105,722	105,722	105,722	105,722	105,722	105,722	105,722	105,722	105,722	105,722	1,057,220
Continuity of Care Pack³⁵		2,054	2,054	2,054	2,054	2,054	2,054	2,054	2,054	2,054	2,054	20,541
Updating Costs (£)												
Sustainability Plan³³		10,433	10,433	10,433	10,433	10,433	10,433	10,433	10,433	10,433	10,433	104,331
Continuity of Care Pack		12,324	12,324	12,324	12,324	12,324	12,324	12,324	12,324	12,324	12,324	123,245
Total Costs (£)		1,655,041	1,555,041	1,555,041	1,555,041	1,555,041	1,555,041	1,555,041	1,555,041	1,555,041	1,555,041	15,650,411
Total Benefits-High (£)	16,701,000	16,701,000	16,701,000	16,701,000	16,701,000	16,701,000	16,701,000	16,701,000	16,701,000	16,701,000	16,701,000	167,010,000
Total Benefits-Low (£)	11,718,000	11,718,000	11,718,000	11,718,000	11,718,000	11,718,000	11,718,000	11,718,000	11,718,000	11,718,000	11,718,000	117,180,000

³¹ This estimate includes staff costs, on costs and consultancy and legal costs. Full details in para 59 to 67

³² This estimate includes the cost of staff time to provide data and meet the regulator, including on costs. Full details in para 70-76

³³ We assume that producing and updating sustainability packs will cost £149,500 per year on average. We assume half will be produced in house and half by consultants. See para 78 to 84.

³⁴ This reflects our assumption on the costs of carrying out an Independent Business Review, including the input needed from the provider to service the review. Further details para 85 and 86.

³⁵ This estimate includes the staff costs of producing and updating continuity of care plans when a business fails. Further details para 87 and 88.

Real NPVs discounted at 3.5% (costs) and 1.5% (benefits) as at 1 April 2015		
		£'M
Costs		£13.0
Benefits-High		£154.0
Benefits-Low		£108.1

Base year for prices 2010

Equality Analysis

Consultation on Oversight of the Social Care Market

Policy objective

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).

The Government believes that its role is to ensure that there are effective systems in place to ensure service continuity for individuals and carers, and that the different bodies operating within this system are clear about their roles and responsibilities and effectively co-ordinate with each other.

The Government is therefore proposing to improve the system of oversight of the social care market. Under this system, providers posing significant risk to service continuity of service will be required to disclose information to a regulator, and have robust plans in place in case they fall into distress. The regulator will oversee and enforce this process, and ensure that in the event of exit, there is co-ordination and information sharing between all parties, supporting the work of commissioners. As a result, 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.

Public Sector Equalities Duty

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)

Who will be affected?

These proposals will affect:

- individuals using adult social care services in England
- the families and carers of these individuals

The groups most affected are those who are most likely to use the relevant services;

- elderly: the median age of entry into a residential care home is 82
- women: as they live longer
- adults suffering from a mental or physical disability

- unmarried people: men were three times as likely, and women eight times as likely, to be in a care home if they were unmarried (2001 census)¹
- disabled people

We have identified the following groups as at particular risk of negative effects arising from provider failure, beyond the effects that all service users could face;

- people who live in a care home specifically because it caters for their specific religious or cultural needs and for whom a different and suitable home may not be available, or may present a less tolerant environment
- carers reliant on support services, who may lose some or all of this support and/or may have to travel further to visit and support their relative
- LGBT people who may find themselves having to move to a less tolerant environment following provider failure
- people self-identifying, or identified by others, as belonging to a racial minority who may face intolerance and discrimination.

Impact of our proposals on protected groups

We believe our proposals will benefit groups sharing protected characteristics for two reasons:

1) It is expected that the proposals will provide users of social care services and their families and carers, including people who share a protected characteristic, with greater peace of mind, and improve their experience of the social care system.

2) The proposals are intended to ensure that provider failure is managed in an orderly fashion sensitive to the needs of service users. The establishment of contingency plans in case of provider failure will create an opportunity for the local authority and provider to consider at an early stage the effects of failure on service users, and consider how they might mitigate these effects. These deliberations could, where appropriate, include potential problems relating to groups sharing protected characteristics.

This would be an improvement on the current system, where the lack of central oversight and an entrenched system of contingency planning for providers posing significant risk to service continuity means that there is no such opportunity to consider these issues before the provider fails.

The responses to the consultation supported this view.

Ensuring protected groups are considered in the policymaking process

We have taken the following steps to abide by the Public Sector Equalities Duty;

- consulting on our proposals, including on a specific question relating to the impact of our proposals on protected groups
- publishing an 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.

Evidence of potential impact on people sharing protected characteristics

¹ Laing & Buisson, p. 150.

Summary

LGBT people are likely to face intolerant and discriminatory environments, which can lead to feelings of isolation and anxiety. When providers fail, they are therefore at risk of having the services they receive relocated to a less compassionate setting.

People who are religious and/or self-identify or are identified by others as belonging to a certain race and/or are from certain cultural backgrounds can also experience intolerance and discrimination. They may also have specific dietary, worship-related or other cultural requirements that not all providers can offer.

Carers rely on social care services for vital support. Provider failure can lead to them losing this support, or receiving inferior support.

LGBT

Several researchers have argued that LGBT people are likely to face intolerance and discrimination in residential care homes because of the relatively recent culture shift in attitudes to these groups. People over the age of seventy who grew up in a world where homosexuality was illegal and severely stigmatised are more likely than younger people to continue to hold such attitudes.

There is a danger that LGBT people will feel greater isolation and anxiety if they find themselves in an intolerant environment (Langley, 2001; Tully, 2000). Research has shown that experiences of marginalisation and oppression lead to mistrust of health and social services networks, and invisibility obstructs the development of sensitive and appropriate health, social service and long-term care alternatives (Brotman et al, 2003).

Evidence has also demonstrated that LGBT people are likely to have different preferences with regard to the services they receive in comparison to the heterosexual population. For instance, a study by Hubbard and Rossington (1995) showed 91% of lesbians and 75% of gay men would prefer separate accommodation.

A 2009 literature review found that most research in this area has focused on lesbians and gay men, and there is inadequate evidence relating to the specific needs of bisexual and transgender people. (Addis et al, 2009). However, it appears reasonable to assume that people undergoing, or who have undergone, gender reassignment are likely also to face intolerance and discrimination, with similar effects on health and wellbeing.

Race, Religion and Ethnicity

Researchers have noted the need for service provision to be sensitive to religious or cultural differences (Manthorpe et al, 2009). People from certain religious or cultural backgrounds may have specific needs, or face specific problems, as a result of their background. They may;

- face discrimination, intolerance or lack of understanding
- have specific dietary requirements
- feel isolated if they are not in a sufficiently religious environment
- feel unable to practice their religion

It is accepted by many researchers that people who self-identify, or are identified by others, as belonging to a racial minority can face discrimination and intolerance (for example, Blakemore, 1999). There is no reason to believe that the knock-on effects and health and wellbeing that research has demonstrated LGBT people experience would not also be present for racial minorities. As with sexuality and gender, researchers have noted the need for service provision to be sensitive to ethnic background (Manthorpe et al, 2009).

Carers

The 2001 census identified roughly 6 million carers in the UK. Research has shown that caring has a negative effect on 83% of carers' physical health and 87% of carers' mental health (Carers UK, 2012). Support services are important to mitigating these impacts, and more widely to helping carers be as effective as they can be in their caring role. People sharing this protected characteristic will therefore be differentially impacted by provider failure, and mechanisms for managing it, as a result of their caring responsibilities.

For instance, if the relevant service is a residential care home it may become considerably harder for the carer to visit regularly. This could affect the carer's health and wellbeing, and the ability of the carer to be involved in the person's care in the way they wish to be.

Similarly, if the service is domiciliary, the carer may lose important support if alternative service provision is not found, or is inadequate in quality, location, or any other way. This could damage the carer's health and wellbeing by reducing the support available.

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