



CMA, Market Study of Care Homes, Statement of Scope:

Barchester Healthcare Response

Introduction

Barchester Healthcare is a major independent provider of social and health services in the UK, with over 200 homes providing high quality nursing care, residential care, close care (assisted living linked to residential schemes) and supported living. We predominantly offer services to older people with high support needs and older people living with dementia but we also provide neuro-rehabilitation services, assisting younger adults with traumatic brain injuries and others in need of specialist care.

We also manage seven independent hospitals for people with mental health issues, often linked to facilitating transitions for people with long-term care needs moving back into the community.

We support approximately 11,000 residents and patients in our homes and hospitals, employing around 15,000 people, with about 2,400 Registered Nurses in the 85% of our homes that are registered to provide nursing care.

We are responding to consultation questions in our capacity as an independent provider. Please note that we are responding on the basis of our Barchester Healthcare's practice rather than care homes in general unless otherwise indicated throughout this response.

CMA themes and key questions

Theme 1: Consumer protection issues in the care home sector

1. *What are the main consumer protection issues in the care home sector? How widespread are these issues and what harm do they cause to residents and their families?*

1.1 The Citizens Advice paper of February 2016 'Hidden charges in care homes'¹ lists these areas as the principle consumer issues where there are opportunities for change with which it believes the Competition and Markets Authority (CMA) should engage:

- a) Stronger guidance on suitable notice periods for care home fee increases: Barchester Healthcare protects consumer interests in this area by giving residents and families a minimum of four weeks written warning about fee rises, which are discussed with families if they wish. Our standard contracts clearly indicate that charges are subject to review, usually on an annual basis.
- b) Clear guidance about good practice when care home residents are away for extended periods of time: Barchester Healthcare protects consumer interests through clearly stated terms and conditions: we charge full fees for the first six weeks of a stay in hospital and will then discuss reductions in fees with residents and families. This is made clear in contractual terms signed prior to residents moving into our homes.
- c) Clear breakdowns of home costs, including the prices of essential services that are not included in the weekly rate: Barchester Healthcare protects consumer interests by a commitment to transparent charges. Barchester Healthcare do not believe a breakdown of costs for care homes should be made available (see our response Q 2.3 d) but we are careful to make clear all extra costs in our terms and conditions, and 'Welcome' pack. As a matter of policy, possible extra charges are discussed with residents and families as part of the pre-admission process. There may be rare exceptions to this process of discussion (see 2.3 d) but they are rare and we strive to eliminate them where possible.
- d) The Care Quality Commission (CQC) to promote consumer protection, stepping up scrutinising care homes financial arrangements with residents: while this is primarily a question for CQC, Barchester Healthcare notes that CQC (and other UK regulators) are already stretched in terms of responsibilities. That said, regulators often check terms and conditions and 'Welcome' packs on inspection visits - and presumably

¹ <https://www.citizensadvice.org.uk/about-us/policy/policy-research-topics/health-and-care-policy-research/public-services-policy-research/hidden-charges-in-care-homes/>

scrutinise financial arrangements further if they find these unsatisfactory or if residents and families raise the issue with them.

- e) Complaining about poor experiences in a care home should be easier: Barchester Healthcare has a clear and transparent complaints policy, which it keeps under ongoing review. We also discuss complaints processes at length and facilitate complaints where we can (see our response to Q 4). UK regulators regularly check complaints procedures during inspections.

1.2 Some residents and families find the process of finding a home and arranging admission a struggle. Beyond logistical issues, this is partly because many purchasers are surprised to find that social care is not free at the point of delivery like NHS care. It is also partly because finding a home is often a distress purchase made under considerable and unwelcome pressures, as the CMA's consultation 'Statement of Purpose' suggests. Lastly, the funding sources are sometimes complex. The intricacies of third party contributions or of health-funded contributions are not always easy for people to grasp.

1.3 We ensure that staff in our homes invest considerable time in explaining to potential funders what is in our contract and elements of it that they need to be mindful about, which we regard as a mutually beneficial act. We discuss fees, the possibility of funds running out and the possible consequences in terms of having to move on and establish that finances are realistic where we can. We also encourage self-funders to take independent financial advice to ensure that they have the money to pay for their care, and set up regular "Care Fee Planning" seminars in many homes.

1.4 The principal harm done to residents and families in the care sector arise from unsustainable commissioning practice that has resulted in a two-tier service in terms of quality, a diminution of choice and a genuine threat to the market overall.

1.5 Year-on-year cuts in government funding to local authorities² have been accompanied by year-on-year fee payments to care homes that have not met cost inflation³. Local authority payments do not cover the real costs of care. Self-funding residents do not cross-subsidise publicly funded residents; publicly funded residents are subsidised by providers, many of whom consequently do not generate sufficient cash to sustain their businesses, properly maintain existing properties and invest in new properties. This results in a contraction of supply to the market.

1.6 Health funding is also insufficient (e.g. funded nursing care and continuing health care funding), and approaches to allowing for 'life style' factors (a payment reflecting the high quality of Barchester Healthcare's services, accommodation and food) are inconsistent, varying from commissioning group to commissioning group. These shortfalls in payments are placed in the context of the sector paying the new national living wage for all staff over

² <http://www.bbc.co.uk/news/uk-england-35633213>

³ <http://www.carehomeprofessional.com/liverpool-council-named-and-shamed-for-paying-just-299-per-week-for-care-home-placements/>

25, with increased running and insurance costs, and of increased demands from UK regulators.

1.7 Choice is diminished for residents by the imposition by some local authorities of 'preferred choices', listing homes that will accept residents at low fees. In such homes quality of life standards will be basic. Information about a right to choice on the basis of third party contributions is not always made available.

1.8 We have closed three homes because they were financially unviable and may have to close more in the future. Homes predominantly or solely reliant on certain local authority placements simply cannot cover the costs of care to the standard we provide. There are similar problems with health funded placements Small providers are going out of business or cutting corners and larger providers are at genuine and unprecedented threat⁴.

2. *To what extent are care homes complying with consumer law, in particular in relation to the fairness of their contracts and their behaviour towards residents and their families?*

2.1 On the basis of independent legal advice we believe our contract and terms comply with consumer law

2.2 We do not believe complying with consumer law is a problem for large providers, though financial pressures are a real factor.

2.3 As our response to Q1, we believe we have transparent charges. In addition, at present:

- a) We return all funded nursing care and continuing healthcare monies from health commissioners to purchasers. We manage this by quoting the gross fee prior to admission but making it clear to self-funders that if the funded nursing care contribution is received we will reduce the net fee accordingly⁵.
- b) As part of our pre-admission process we give out contracts and terms and conditions and insist on contracts being signed before admission. However, we know that this does not always happen, sometimes as a result of a need for response to an emergency, sometimes as a result of families feeling pressured by hospitals and sometimes as a result of administrative failures on our part. For local authority and CCG funded clients we are reliant on the funding organisation providing their contract before admission. Currently about 3.7% of our residents are admitted before a contract is signed but we are working hard to reduce this figure.

⁴ <http://www.independent.co.uk/news/uk/politics/social-care-crisis-government-cuts-austerity-elderly-ageing-population-nhs-a7441836.html>

⁵ Disputes between families, care homes, local authorities and health commissioners about eligibility for health care funding sometimes result in health commissioners deciding that health funding should be stopped. Sometimes this is backdated to a point where an assessment takes place and sometimes we are not informed of the decision. This can mean we ask families to repay a backlog of fees.

- c) Payments for local authority placements are largely fixed by the individual local authorities and we often have no choice but to be a 'price-taker' if we agree to accept the placement. Contracts are between local authorities and the individual and family concerned. Unless a third party contribution is involved we have no direct involvement and our terms and conditions are not signed: we have a framework agreement in place with local authorities, which is signed with them by the resident or family
- d) We would be reluctant to publish fees for self-payers on our websites, however, because the reality is that people pay differing amounts. Putting aside the issue of levels of dependency and care needs, one reason for this is difference between size and quality of room facilities. A more important key driver is local micro-market dynamics at the time of purchase, with each home having to balance local competitor capacity, service offering, reputation and pricing with our own. Within any particular home of ours there will be a range of fees received according to whether the resident is a) publicly funded and we have accepted the price offered b) publicly funded where we have negotiated a third party contribution from the resident or their family to close the gap between the public fee and the true cost of care or c) a self-funder where the fee has been negotiated on an individual basis according to the prevailing market dynamic at the time of placement.
- e) We make it very clear in our terms and conditions and 'Welcome' pack where there may be extra charges (e.g. hairdressing, private chiropody services). Occasionally homes may arrange *ad hoc* events that some people will want to attend and others will not that may involve payments: a visit to the theatre, for example.
- f) Third party contributions are problematic in terms of explaining what is being purchased because the reality is that they very often do not bridge the gap between local authority payments and the real cost of care. It is worth noting that in our experience local authorities leave the issue to be negotiated between relatives, residents and providers. Similarly, the overwhelming majority of local authorities ask us to collect third party contributions on their behalf. Local authorities are, of course, well aware of funding shortfalls and of the pressures on providers, particularly small providers.
- g) There are problems for residents who work through their savings as self-funders and can no longer pay our fees. We are careful about checking finances prior to admission where we can: we discuss the issue with residents and relatives prior to admission and on an ongoing basis⁶, offer advice ourselves and recommend independent advice but this does not ensure that running through savings does not occur. In fact, we often bear a funding gap for people who have been with us for a significant length of time (roughly 2 years or more), although we would not say this openly - but we do sometimes ask people to find alternative accommodation. This is rare but it can be difficult for all parties.
- h) We have to raise fees for residents whose dependency levels increase significantly (e.g. developing dementia or a need requiring one-to-one care, etc.) but we always hold a review involving family or other advocates, as appropriate, before raising fees. The possible need for such increases is included in our terms and conditions – we would expect homes to cover the possibility in discussions of terms and conditions prior to or on admission.

⁶ Not just on admission but on an ongoing basis.

2.4 The market is under genuine strain as the result of financial pressures on local authorities, CCGs and health commissioners passed on as unsustainable payments. Many commissioners are very worried about the market and are open about this with providers. Small providers are going out of business - and we would expect at least one large provider to fail financially in the near future. The only precedent for this is the history of Southern Cross. While the collapse of Southern Cross was distressing for many residents and their families it was, in fact, managed well by all parties involved. In particular, a number of providers were prepared to buy and manage Southern Cross homes, while others absorbed displaced residents or people who chose to move as a result of uncertainty. In the present financial climate taking over the management of services funded predominantly or entirely through low paying local authorities may be significantly less attractive.

3. *Are the current protections offered by consumer law and other measures (such as sector regulations) sufficient to address these issues?*

3.1 Measuring Barchester Healthcare against the February 2016 report published by Citizen Advice, 'Hidden charges in care homes, exploring consumer protections within the care home market':

- a) **Key charges:** our terms and conditions make key charges clear (see our response to Q2); we ensure that residents have access to GPs and to NHS chiropodists, although private chiropody care is also available. Our fees include contents insurance for residents' property and Wi-Fi where it is currently available.
- b) **Notice period for fee increases:** we give a minimum of four weeks' notice for fee increases, and provide an explanation for the reasons for them.
- c) **Complaints procedure:** we have a simple complaints procedure, outlined in our 'Welcome' pack and frequently discussed at residents and relatives meetings. It involves complaint through the General Manager, the Regional Director or our Complaints Manager but also lists other avenues for complaints such as the local authority, social services, the local health commissioners, the UK regulators (the Care Quality Commission (CQC), the Care Inspectorate (CI), the Care and Social Services Inspectorate Wales (CSSIW) and others) and the relevant Ombudsmen. We also have links with local and national advocacy organisations for residents who may be not be able to complain for themselves. We have a monitored duty of candour policy in place and are committed to openness and honesty as an organisation. We continuously review our management of complaints.
- d) We ensure our terms and conditions are in conformity with the Consumer Rights Act 2015, the Consumer Contracts Regulations 2013 and Consumer Protection Regulations 2008.

3.2 The care home sector is heavily regulated in many respects: CQC, CI, CSSIW and other UK regulators have responsibility for ensuring providers are clear about charges and have satisfactory complaints procedures in place, for example⁷.

4. *Are there barriers to residents and their families raising complaints when something goes wrong, and how effective are the current complaint and redress systems for care home residents?*

4.1 Barchester Healthcare is conscious that some older people and their families worry about the possible consequences of making complaints.

4.2 We go to considerable lengths to make residents and families aware of their right to complain and to educate them in the methods available. We have a clear complaints policy regularly reviewed, with commitment to clear time lines on investigation and reporting, verbally and in writing. It suggests alternative methods of complaint (while recommending complaining through the immediate shift manager or the General Manager it offers the option of taking complaints to senior management, for example). It also informs residents and relatives what to do if they are dissatisfied with our response.

4.3 Our 'Welcome' pack is clear about the right to complain, setting out rights, pathways and alternatives. These are regularly discussed at resident and relative meetings, where we also report back on investigations and resolution of complaints where appropriate.

4.4 The introduction of a Barchester Healthcare policy, associated training and audit on the Duty of Candour has helped improve General Managers' understanding of how to respond to complaints. The policy commits us to openness, honesty and to offering support to residents and relatives if they wish to make complaints.

4.5 Complaints, investigation and progress towards resolution or escalation are monitored by our Complaints Manager and our Chief Operating Officer.

4.6 The UK regulators (CQC, CI, CSSIW and others) regularly check on the quality of complaints management, and we make local changes accordingly.

4.7 Our complaints policy is currently under review: we are concerned to simplify it, to streamline processes where possible and to tighten audit.

Theme 2: Older people's decision making on care homes

5. *What information and advice is available for older people and their representatives when deciding about entering or moving between care homes? Is it easy to access and*

⁷ We adapt and improve local complaints management in response to regulator's reports and review central policies if necessary.

***understand this information? How can existing information and advice be improved?
What further information would be useful?***

5.1 Local authority information is generally minimal and Care Managers (Social Workers) refusing to offer direct advice is often perceived as unhelpful but:

- a) Knowing what you need as a potential resident is paramount (e.g. nursing care or dementia care) and should always be explained by Care Managers and providers.
- b) An ongoing campaign to make it clear people may have to pay a contribution (either as a client contribution or as a third party contribution) for social care is needed: it is still not widely understood.
- c) There are helpful organisations like the Elderly Accommodation Council⁸, which has a free website, a free telephone helpline and will tailor advice packages for a fee.
- d) There are web portals brokering care homes, most recently joined by Laing and Buisson.
- e) 'carehome.co.uk' and similar sites offer 'trip advisor'-style customer opinion on homes. 'www.yourcarerating.org' offers aggregated survey results on customer satisfaction.
- f) Regulatory reports are available on every home's website, and for all their faults are a very useful guide to homes. As a provider we often make action plans agreed with regulators available in a jargon-free version on our home's websites, too.
- g) Age UK, the Alzheimer's Society, Independent Age and other organisations offer advice through help lines, backed with a range of leaflets, website information, etc.
- h) Local knowledge about homes is plentiful, with GP or nurse recommendations supplemented by community word of mouth as care homes become increasingly open.
- i) There are independent brokers who will help people find care homes for a fee either from the person concerned or from the provider.
- j) All reputable providers have information on websites, booklets, etc. and will discuss options with potential residents and their families. We provide a great deal of on-line and written information to help people decide what is right for them⁹. We encourage people considering residential care to visit our homes – and to visit possible alternative homes, too.

⁸ <http://www.eac.org.uk/>

⁹ Leaflets and internet advice include: 'Assisted living', 'Choosing a care home', 'Choosing a dementia care home', 'Paying for care – a finance guide', 'Respite care' and 'Selecting your ideal care home'.

- k) All our General Managers would signpost independent advice - and would signpost people to alternative solutions if they felt residential care was inappropriate.

5.2 As CMA's 'Statement of Scope' recognises, a problem is that moving into a care home is very often a distress purchase. Information about fees would help but is not straightforward to provide, varying from room to room, home to home and purchaser to purchaser.

5.3 Critically, it depends on individual support needs and individual preference for location, accommodation style and affordability – please see our response to Q 2.3 (d).

5.4 Moving between homes is inherently difficult: more or less by definition care home residents are frail and will have trouble visiting alternative homes. However, we expect our homes to facilitate the process to the extent that they can.

6. *What other factors may impede older people in choosing a care home initially or subsequently in moving between care homes (if appropriate)?*

6.1 An initial choice to move into a care home can be impeded by local authority policies designed to prevent admission to care homes or to limit choice.

6.2 Some residents and families are not sure what they want or need (e.g. specialised nursing or dementia care).

6.3 There is some evidence to suggest that gay, lesbian and transgender people are reluctant to come into a care home environment that they worry may be intolerant.

6.4 Some cultures and families still regard admission to a care home as a source of shame to the family concerned. They may also worry about issues of religious observance and cultural tolerance.

6.5 Many people will be put off by bad publicity in the media about care homes. It is an unfortunate but widely acknowledged truth that articles and news items on really good care practice are virtually non-existent in the national media.

6.6 Factors impeding moves between care homes include distress, time and other pressures, travel difficulties, physical illness or mental ill health, cost factors and the unwelcome prospect of getting used to a new environment, a new group of friends and new staff.

6.7 Factors common to both initial moves and moves between homes include:

- a) Some residents and families are not sure what they want or need (e.g. specialised nursing or dementia care)
- b) The time and energy required can be very demanding

- c) The immediate costs of visiting homes can be off-putting, as can difficulties with transport, including physical frailty.
- d) Lack of specialised care homes – for example, homes able to cope with Lewy Body dementia or sensory loss, or homes that cannot cope with a particular language.
- e) A reluctance to offer care from some homes in the case of people who are perceived as being ‘difficult’ or who cause problems through behaviour unacceptable to other residents.
- f) Long term costs and the poor quality of low cost care.

Theme 3: Regulation of care homes

7. What impact do regulations have on competition in this sector, particularly on price and quality?

- 7.1 Existing consumer protection measures are clear, often helpful and generally understood by purchasers once they have some experience of the sector.
- 7.2 CQC (and to differing extents all other UK regulators) are struggling with current responsibilities and significantly reduced funding, unable to meet targets such as time between inspections or return of reports following inspections. In this context CQC’s declared broader strategic aims look overambitious: for example, the newly added areas of themed inspection of local services and financial advice to Trusts¹⁰.
- 7.3 Regulation has driven up quality overall – and deserves respect for it - but inspection report judgements are inconsistent, unhelpful and unfair in some areas.
- 7.4 Regulation has certainly added to the pressures that have driven some homes to withdraw from the market as the result both of compliance costs and of provider payments for their services increasing sharply without a linkage to an increase in local authority payments.
- 7.5 Better financial oversight is needed: CQC has a defined responsibility for this role in England but there is no indication that this will prevent any of the 50 largest providers failing, some of whom are clearly struggling. Small providers are failing on a regular basis¹¹.
- 7.6 Oversight of commissioning is badly needed. At present it is unaccountable, plainly unfair and largely fails to move towards integrated health and social care or a basis in outcomes, both of which are clearly necessary to cost-effective commissioning and to providing the highest quality care and support.

¹⁰ <http://www.cqc.org.uk/content/state-of-care>

¹¹ See footnote 3

7.7 In essence, regulation drives up costs but improves quality. Regulation is in danger of buckling under financial strains, however, and current pressures on them contribute to pressures on providers.

8. *How do local authorities' commissioning and procurement practices affect competition in this sector?*

8.1 Please see our response to Q6 and Q7, above.

8.2 In practice there are currently a wide range of types of home, fees and occupancy levels across the UK, though this range is in danger as the result of unsustainable payments in areas where the local authority dominates the market.

8.3 Homes develop unique selling points as the result of staff approach, resident, relative and other stakeholder's involvement – they are not selling widgets. This means there is real choice, though it is not always easy for consumers to identify. In this context it is worth noting that local authorities often state that they are not interested in lifestyle issues. They choose not to recognise that it is necessarily more expensive to purchase services in a new, purpose-built care home with larger bedrooms, larger communal areas, kitchen and laundry facilities, as opposed to homes that may have been converted from Bed and Breakfast accommodation in the 1980s.

8.4 We find it difficult to understand the CMA's 'Statement of Scope' documentation's implicit suggestion that there may be uncompetitive practice in the market, which does not match our experience.

9. *To what extent is local authorities' 'market-shaping' role affecting competition in the care homes sector?*

9.1 Where we are aware of market-shaping taking place at all it is often crude in the extreme (e.g. rejecting new applications on the grounds of possible costs).

9.2 Exemplars of this lack of commissioning expertise include:

- a) A lack of an outcome-focus
- b) An inability to move towards services integrating healthy and social care or relieving 'bed blocking': in fairness, there is some good practice in this area but it is not widespread
- c) When we closed a home recently because it was no longer financially viable many residents had subsequently to be placed in homes where fees were considerably higher than those the local authority was prepared to pay us

9.3 It is worth noting that local authority managed homes run at far higher cost per client than they are prepared to pay in fees to the independent sector.

9.4 There are islands of good practice in commissioning and market-shaping but they are localised and often dependent on personal relationships

Theme 4: Competition between care homes

10. How well does competition work between care homes?

10.1 As described in our response to Q 8, the market is currently diverse; there is a lot of consumer choice.

10.2 It is also a highly fragmented market: the top four largest providers (which include Barchester Healthcare) only account for 15% of beds and the top ten only account for 27%¹².

10.3 However, it is clear that some small providers are struggling with market conditions, particularly in areas where self-funding is low.

10.4 Occupancy stands at slightly above 90% for the market as a whole¹³.

10.5 Sector commentators believe at least one large adult social care provider is likely to be forced into collapse in the near future – the effects of such an event on competition are unpredictable – see our response to Q 2.

10.6 There is a minor distortion of the market as a result of care homes managed by people or organisations who already own the building used and who therefore do not face loan costs in this area.

10.7 Shortage of trained nurses makes providing nursing home care very difficult. It is difficult to fill permanent posts; agency nurses are generally available (though not always) but costs are high and quality of commitment and care is unreliable. There is every indication that this shortage will worsen significantly in the future as the result of an ageing workforce, the withdrawal of bursaries for training in England and the possible effects of Brexit. This will mean providers such as us considering withdrawing from nursing home care, at least in some localities.

10.8 Commissioning currently does little to shape the market beyond the approach that is currently developing a two-tier care system. It seldom actively encourages competition, discourages it or promotes co-operative projects.

11. What are the key pressures for care home providers that are affecting their long-term sustainability?

11.1 Key pressures include:

¹² Laing and Buisson 2016 survey

¹³ Care England figures

- a) Unsustainable payments from monopsony local authorities and health commissioners.
- b) Unfunded wage rises.
- c) Unfunded quality demands.
- d) Competition for nurses in an undersupplied market.
- e) Local authorities are now often unwilling or unable to meet the needs of people in the community who would benefit from care home admission. This is counterproductive: people being 'looked after' in the community by a domiciliary care agency are often admitted and re-admitted into hospitals. As a result, when such individuals enter residential care they are in a very frail state: earlier admission would genuinely offer a much better quality of life and reduce strains on the NHS.
- f) Many commissioners' apparent reluctance to move 'bed blockers' into care homes, which would be much better for residents, hospitals and care homes. This reluctance is in part a matter of inflexible bureaucratic requirements that only a few commissioners are prepared to bypass.
- g) A lack of a clear and intelligible plan for long-term care funding to replace the Dilnot proposals.
- h) It is too early to predict the overall impact of Brexit on care homes but we are worried as an employer by possible consequences for non-UK EU workers – particularly nurses. It is possible, of course, that compensating opportunities may emerge for recruiting non-EU overseas nurses from historically important countries such as the Philippines.
- i) There is under-provision of specialist care in some areas.

12. What, if any, barriers exist to care home providers entering the market and/or expanding their activities? Is there a lack of capacity in some geographical areas?

12.1 Barriers include:

- a) Unsustainable payments/high costs of care/low profits/increasing quality imperatives from regulators.
- b) The availability of finance from lenders to fund new developments.
- c) The availability of land designated by local planners as suitable for care homes.
- d) The cost of land, which rules out many possibilities
- e) An undersupply of nurses.
- f) A market place in which care workers are frequently paid less than people working in supermarkets.
- g) A lack of clarity over local commissioning and long term planning.
- h) It is very difficult to make contact with commissioners (let alone hold discussions). This is compounded by the very rigid gate keeping of Commissioning Support Units. It is extremely unhelpful in terms of expanding activities

12.2 There is a lack of capacity in some areas and a lack of specialist care. Current commissioning payment rates and practices are unhelpful.

Conclusion and further comments

Barchester Healthcare believes that on the whole the UK care home market is diverse and inherently competitive from the point of view of the purchaser.

We believe the materials we and other providers make available to potential purchasers and their families aid decision making and that the practices we have in place constitute good practice, albeit always in need of review.

Though UK regulation may not be perfect it provides useful protection to consumers.

The principal factor determining the care home market is unsustainable local authority, CCG and health commissioning payments. Any CMA market study will have to recognise this if it is to be meaningful.

Barchester Healthcare welcomes the opportunity to respond to the Competitions and Markets Authority's consultation on the scope of their market study of care homes.

We should be pleased to respond to the Competitions and Markets Authority if any issues raised above require clarification or amplification.