

Care homes market study

Update paper

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1. Summary

- 1.1 This document provides an update on progress in our market study into care homes and invites views on our findings so far, our future focus and possible recommendations. We welcome written responses to the update paper by 5 July 2017. Section 10 sets out some specific questions for response and details of how to respond.
- 1.2 Our evidence collection and analysis process is still underway. There are significant differences in the sectors, policies, regulation and issues between and within the nations of the UK. But several key findings are emerging on how the market is working for residents and their families and the public purse:
- (a) For this market to work well, prospective care home residents and their families need to be able to make informed choices. The initial results from the Competition and Markets Authority's (CMA) consumer research suggest that many people find it challenging to make decisions about care under the stressful and time pressured circumstances which generally apply. Even when good information is available people rarely seek it or engage with it. Many people do not seek more information and in many cases they are confused by the social care system and funding arrangements, and do not know how to find and choose between homes.
 - (b) Where a resident is dissatisfied with their care home, it is generally not realistic to expect them to move to another one. Once settled, the upheaval of moving from a familiar environment can be extremely disturbing, and can adversely impact on the resident's health. It is therefore essential that effective mechanisms are in place for residents to express their views and, where necessary, have them acted upon. Our findings, however, indicate that complaints and redress systems often do not work well, as residents often find it very challenging to make complaints.
 - (c) While many care homes offer a good service, we have identified concerns that some might not be treating residents fairly and that certain business practices and contract terms might break consumer law. Many of these consumer protection concerns relate to how some care homes treat self-funded residents, including for example issues around the lack of indicative pricing information on websites, the charging of large upfront fees and deposits, care homes having a wide discretion to ask residents to leave, and requirements to pay fees for an extended period after a resident's death.

- (d) There is evidence of competition between care homes to provide care home placements to local authorities. However, some providers have told us of instances where they have found local authority and NHS (Health and Social Care (HSC) in Northern Ireland) procurement processes are complex, inflexible, and insufficiently person-centred. Some providers have also argued there is inadequate provision to encourage and reward quality.
- (e) Whilst the possibility for families and friends to make top-up payments¹ can give residents greater choice of accommodation, some providers have told us that top-ups are not always encouraged or facilitated. In addition it appears that in some areas, making a top-up payment may be the only way a prospective local authority-funded resident will have a choice of care homes to go to.
- (f) Demand for care home services is expected to increase very substantially in the coming years. The number of people aged 85 and over is projected to more than double by mid-2039, and the level of care needed for people moving into a home is increasing over time because, having spent longer in their own homes, people are more frail when they do move into a care home.
- (g) Building additional care home capacity takes time, and investment therefore needs to take place in good time for places to be available when they are needed. Our initial analysis of recent financial performance suggests that returns to the sector overall are sufficient to cover current operating costs. But they are insufficient overall to attract adequate investment in new care homes. There is likely to be a lot of variability; investment will be attractive in some local areas and particularly where there are expected to be substantial further numbers of self-funding customers.
- (h) In contrast, short-term funding pressures, in the forms of current fee rates, the number of placements local authorities make in care homes (rather than meeting needs through other means such as domiciliary care) and uncertainty over future funding, mean that there are at present weak signals and incentives for the sector to undertake future investment necessary to grow capacity primarily intended to serve state-funded residents. Our initial results suggest homes primarily serving local

¹ Where someone chooses a home which is more expensive than an alternative which also meets their needs, this additional charge or 'top-up' will not generally be covered by the local authority and should normally be paid by a third party. In other words, top-up fees arise when the prospective resident's preferred care home costs more than the amount specified in the resident's budget set by the local authority.

authority-funded residents have lower margins than those with higher proportions of self-funded residents. It seems likely that the incentives to attract investors to build new capacity will be lowest where it is aimed at primarily serving state-funded residents. Our analysis is ongoing.

- (i) We have, however, heard from some local authorities who have adopted long-term perspectives to shape the market, provide improved clarity both to investors and prospective residents, and encourage appropriate investment focused on the areas of greatest need (eg dementia and nursing care). Local authorities are well placed to understand the market, predict needs, assist operators and shape outcomes. They are also well placed to assist and guide prospective residents, and so they have the opportunity to greatly improve outcomes. We are keen to explore ways of increasing long-term planning in the sector as a whole.

1.3 We are considering possible recommendations in relation to these and other issues. Our intention is to develop a package of recommendations that will make a long-lasting improvement to tackle the issues we identify and to deliver better outcomes for residents and their families. For example, the kind of areas we are exploring are:

- (a) Making choices easier through better information and support. We are considering how greater support can be provided to prospective residents and their families and representatives to help them to make good choices and to access comprehensive and comparable information. We are also considering whether people's awareness and consideration of social care options could be raised earlier.
- (b) Improving complaint and redress systems. We will be looking at recommendations which make it easier for care home residents and their families or representatives to raise and escalate complaints, and to support providers to improve their complaints and redress systems.
- (c) Improving consumer protection. We have opened a consumer protection case to investigate concerns that some care homes may be breaking consumer law – this is focused on concerns about certain care homes charging families for extended periods after a resident has died, and homes charging large upfront fees. We are also considering how other issues we have found can best be addressed using our range of tools (for instance, as appropriate, through consumer enforcement action, guidance on consumer law, codes of practice and/or recommendations to government, regulators or the industry). More generally, we are looking at whether the protections afforded by existing consumer law (and relevant

sector regulations) are sufficient to ensure good outcomes for residents and their families.

- (d) Public sector procurement. We are considering opportunities for the sharing and monitoring of good practice, eg on procurement by local authorities of care home services and on how top-ups are explained to care home residents and their families and used by them.
- (e) Investing for the future. We wish to address how the sector will develop in the long term to address the changing levels and types of needs. We are considering how potential barriers to investment can be addressed and how the sector can be incentivised to respond to demand. In doing so, we will look at measures which could provide a framework that incentivises future investment. So, for example, we will consider fee rates and whether guidance on appropriate fees would be beneficial, and whether there may be a role for an independent body in planning and facilitating the development of appropriate capacity.

2. Introduction

Background

- 2.1 The CMA launched its market study on 2 December 2016 and will issue its final report by 1 December 2017. We continue to obtain information and to engage with stakeholders to progress our analysis. To assist our work, we would welcome submissions on the issues we address in this update paper.
- 2.2 As explained in the statement of scope,² this study is focused on the provision of residential care for older people aged 65 years or more in residential homes (care homes which only provide accommodation and personal care) and nursing homes (care homes which provide personal care and nursing). We are focusing on care homes in order to be able to explore the issues and evidence in depth. Adult social care also encompasses a range of alternative care activities, such as domiciliary care provided in the person's own home, day care, respite care, sheltered-housing, hospices and other services, and may be directed at younger adults. We only consider alternative adult social care services where they are part of the services offered by care homes or are a part of the user's experience that takes them to a care home, and to the extent that they provide a potential constraint for care home services.
- 2.3 The study covers the whole of the United Kingdom. Adult social care is a devolved policy matter, therefore different policy and regulatory frameworks exist in England, Northern Ireland, Scotland and Wales. Significant reform is underway in each nation, but not all of these changes have yet been fully implemented.³ The markets for care home services will differ regionally and locally depending on a variety of local factors including local demographics, supply structures and the actions of local authorities (HSC trusts in Northern Ireland).⁴
- 2.4 We now set out how the provision of adult social care works and outline some characteristics of the sector.

² [Statement of scope](#) paragraphs 6.1-6.9.

³ There have also been many reviews of the sector since the Office of Fair Trading (OFT) looked at care homes in a previous market study in 2005, and some of these are ongoing. For example in March 2017, the former government announced its intention to set out proposals in a green paper that would put the social care system in England on a more secure and sustainable long-term footing ([Spring 2017 budget](#), p3).

⁴ For the purposes of this document, reference to 'local authorities' in general should be taken to include the HSC trusts in Northern Ireland unless otherwise indicated.

Overview of the care homes sector

- 2.5 Care homes comprise a sector worth around £15.9 billion a year,⁵ with around 433,000 people⁶ occupying care home places in the UK. On average, across the UK, 41% of residents are entirely self-funded (ie pay the full cost of their care), 37% are funded by the public purse and others self-fund part of their care or receive other funding (eg from the NHS/HSC).⁷ However, there is a great deal of variation both between and within regions.⁸
- 2.6 Our analysis indicates that there is a total available capacity of around 454,000 beds in 11,293 care homes.⁹ Care home services are mostly supplied by independent care providers, made up of a mix of both for-profit (83% of the market) and not-for-profit businesses, but with some local authority provision.
- 2.7 There are around 5,500 care home providers in the UK. They vary in size, the vast majority are small with around 4,000 owning just one home to the largest six groups with over 100 homes each. On a national basis, the largest six providers have a combined share of 11% of all care homes and 17% of care home beds.
- 2.8 There are also independent quality regulators in each nation. These regulators register care providers against national criteria and inspect care providers regularly and are empowered to publish findings and take enforcement action where necessary with a fundamental aim of enforcing minimum standards of quality and safety. It is worth noting that while there is considerable public awareness of past examples of poor care, in the main the CMA's consumer research (see paragraph 2.18) found residents and relatives received good care. Overall we find the sector performs a vital public service that benefits many people.¹⁰

⁵ September 2014. Source: LaingBuisson, Care of Older People UK Market Report 27th edition.

⁶ September 2014. Source: LaingBuisson, Care of Older People UK Market Report 27th edition.

⁷ People with assets of more than £23,250 in England, Wales and Northern Ireland, and £26,500 in Scotland pay the full cost of their care. Below these thresholds, there is a sharing of costs down to a lower threshold (£14,250 in England) and below this the individual receives full state funding. A property occupied by a partner is disregarded in calculating someone's assets. However, even for local authority-funded residents, any personal income, such as state and private pensions, is offset against the cost of publicly funded care other than for a small personal allowance. The current thresholds mean that many self-funders will not be 'well-off', their income could be very low and anyone who owns property, however modest, is likely to be caught.

⁸ In this document we use the term 'self-funder' to refer to those who pay the costs of care themselves. There are differences in descriptive terms used in the nations depending on their particular social care arrangements and options. For example in Northern Ireland a 'self-funder' is one who pays the full cost of his/her care, but whose care is arranged and managed by their HSC trust, as opposed to a 'private funder' who arranges and pays for their own care under a private contract, with no involvement of an HSC trust.

⁹ This figure excludes around 8,000 care homes, as identified by LaingBuisson, which do not primarily cater for older people.

¹⁰ The Department of Health pointed to the sector led work, coordinated by CQC, to develop a framework for improving quality and an action plan to improve quality of adult social care. This initiative, known as 'Quality

Organisation of social care

- 2.9 Within each nation, local government is responsible for the delivery of adult social care. People with care needs may receive a contribution to the cost of their care, but this depends on a financial eligibility assessment. Local authorities must arrange an assessment which identifies the level of an individual's needs and make an eligibility determination on whether it will meet the person's needs. It will then carry out a financial assessment. Many people have to pay something towards their own care and some will have to pay for all of the costs (self-funders).
- 2.10 Local authorities are responsible for meeting people's eligible care needs where the person is below a means tested threshold. But even below this threshold there is still an element of self-pay down to a lower level of assets and, in any event, most personal income such as pensions will be offset against costs of care. This includes commissioning and buying care services or providing direct payments.
- 2.11 Additionally, across the UK, the NHS (or HSC in Northern Ireland) commissions nursing care services for people who require Continuing Health Care (CHC).¹¹ The exception is Scotland where CHC has been replaced by Hospital Based Complex Clinical Care. The number of people eligible for CHC is limited to people with substantial and ongoing healthcare needs, and this is not means tested. In England and Wales, the NHS will also contribute to the nursing care costs of people who live in a care home who require care from a registered nurse (Funded Nursing Care) but are not eligible for CHC.¹² In Northern Ireland, for those who are assessed as requiring care in a nursing home, payments for nursing care cover the cost of providing the nursing care element. In Scotland those whose needs are approved receive free personal and nursing care but may need to pay accommodation costs.
- 2.12 Local authorities are required to provide care for those they fund with the consequence that if a suitable care home place cannot be procured at the local authority's standard rate, if it has one, then it will need to increase the fee it is prepared to pay. However, where a prospective local authority-funded resident chooses a care home that is more expensive than an alternative that

Matters' is due to be launched on 12 July. We understand that it sets out for the first time a single definition of quality and commits organisations across the sector to take action to improve quality.

¹¹ CHC is arranged and funded solely by the NHS for individuals who are not in hospital and have been assessed as having a 'primary health need'. To be eligible for CHC the person must have substantial and ongoing care needs.

¹² The NHS pays a flat rate contribution directly to the care home towards the cost of this registered nursing care.

also meets their needs, this additional charge or ‘top-up’ will not generally be covered by the local authority and should normally be paid by a third party.

Purpose of our market study

2.13 Our market study of the care home sector aims to understand why the care home market may not be working well for residents and their families, and to develop proposals to make it work better.¹³ We are also undertaking a review of providers’ compliance with consumer protection law. As noted in paragraph 2.3, there are various initiatives under way in the different nations and we intend our study to be complementary to them.

2.14 Our statement of scope sets out four broad themes:¹⁴

- Choosing care homes, including the difficulties faced by prospective residents in understanding the adult social care system, choosing the right care options and finding an appropriate home, and also any problems that may restrict moving between care homes.
- Regulation of care homes, including how the public sector procures places and how local authorities and regulators affect outcomes in this sector, including through their commissioning practices and ‘market shaping’¹⁵ activities.
- Competition between care homes and consideration of the key pressures for care home providers.
- Consumer protection issues in the care home sector (including the working of complaint and redress systems).

2.15 We have been exploring these themes over the first six months of the market study. Our emerging findings on each of these areas are set out in the remainder of this document.

¹³ Market studies are examinations into the causes of why particular markets may not be working well, taking an overview of regulatory and other economic drivers in a market and patterns of consumer and business behaviour (*Market studies and investigations - guidance on the CMA’s approach: CMA3*, paragraph 1.5)

¹⁴ *Statement of scope*, paragraph 5.1.

¹⁵ Market shaping (as required in England) refers to a range of activities where a local authority ‘collaborates with relevant partners to encourage and facilitate the whole market in its area for care, support and related services’. The core activities of market shaping are to engage with stakeholders to develop understanding of supply and demand and articulate likely trends that reflect people’s evolving needs, to signal to the market the types of services needed now and in the future to meet them, encourage innovation, investment and continuous improvement (*Care Act statutory guidance paragraph 4.7*). This is intended to facilitate an efficient, effective, diverse and sustainable market for high-quality care and support in their area, for the benefit of their whole local population, regardless of how the services are funded.

- 2.16 We have received evidence from a wide range of stakeholders through submissions, meetings and stakeholder roundtables:
- (a) Many of the submissions we have received from care home providers, trade associations, consumer bodies, charities, regulators, local authority representative bodies, and members of the public have been published on our website,¹⁶ together with a summary of around 150 submissions from care home residents and their relatives.
 - (b) We have also received evidence forwarded to us following a Which? campaign¹⁷ and some via other charities and consumer groups.
 - (c) We have requested views and supporting evidence from a sample of care home providers and have reviewed their customer contracts, and similarly have requested information from a sample of local authorities.
 - (d) We have met with over 100 stakeholders including consumer groups, charities, trade associations, government bodies, regulators, local authorities and their representative bodies, academics and over 50 care home providers.
 - (e) We have held face-to-face roundtable discussions with public sector bodies and providers in England, Scotland, Wales and Northern Ireland.
- 2.17 In addition, we have conducted detailed interviews with some care home providers, relevant local authority/public bodies, and local consumer groups, in five areas across the UK (Sunderland; Tunbridge Wells; Edinburgh; Coleraine; and Newport (Wales)) to develop our understanding of how the care and nursing homes market works at a local level.
- 2.18 We have also commissioned the market research agency Ipsos MORI to conduct qualitative research, based around in-depth interviews with decision makers (family members and friends of residents in a care home, care home residents themselves and social care representatives) for up to 100 care home placements, in 25 care homes across the UK (referred to in this document as 'CMA consumer research'). Although this work is not yet complete, the findings to date have been incorporated where relevant in this update paper.

¹⁶ [Responses to statement of scope.](#)

¹⁷ Around 700 instances provided largely by relatives of residents.

Structure of the update paper

2.19 The update paper looks at the following broad areas of concern:

- the challenges individuals face in understanding their options and making appropriate choices on care options, finding the right care home, and in moving homes if the initial choice turns out to be inappropriate;
- the effectiveness of complaints and redress systems;
- consumer protection issues and the extent to which care home providers are treating their residents fairly and whether there is a need to improve compliance with their consumer law obligations in relation to information provision, contract terms and business practices;
- the procurement of care home services by the state;
- how the sector changes over time and meets changing care needs and how local authorities seek to influence this; and
- the challenges to the sustainability and performance of the sector around costs and funding, and staffing challenges.

2.20 We then set out the CMA's decision not to pursue a market investigation reference, and invite responses to this paper, including a number of key questions where we would particularly welcome views.

3. Choosing care homes

- 3.1 Moving into a care home is an extremely important decision for the resident and their family, and is crucial to the health, care and happiness of the individual. It can also have a huge financial impact on the individual and their family – for self-funders, weekly rates around or exceeding £1,000 are not unusual. Care home services are largely delivered through commercial providers with the individual required to exercise choice and take responsibility rather than the state or the healthcare system directing the process. As providers differ in the kind of care provision they give, their location, the services they offer, the environment and so on, it is crucial that the individual can make the right choices, both in terms of outcomes for them, and in ensuring the social care system works effectively and efficiently.
- 3.2 This section describes our findings on the challenges individuals face in understanding their options and making appropriate choices on care options, finding the right care home, and in moving homes if the initial choice turns out to be inappropriate.

Initial choice of care

- 3.3 While some people move into a care home as a planned move, possibly following a gradual decline in health, often the need for care occurs as a result of illness or an accident and admission to hospital, or a bereavement. In such circumstances decisions on whether to move into a care home and, if so, which one (if it has spaces), have to be made very quickly and under distressed circumstances. This includes understanding how social care is funded and their eligibility for local authority or NHS support and if not, how care will be paid for. Meanwhile, family members, whilst upset about the person's health, will be seeking to understand these issues for the first time, may feel a degree of guilt over the situation, and are often surprised by the extent of costs the prospective resident is expected to cover. They can feel overwhelmed and unsupported at this time.
- 3.4 The CMA consumer research found that although some individuals enter care homes as a planned choice, most families and representatives of prospective residents, whether the resident is to be state-funded or self-funded, are initially poorly informed and unlikely to have done any planning or research, and usually have little or no prior experience of care homes. Many do not understand how the systems work. People find it difficult to contemplate needing residential care or to discuss it within the family (possibly because this is not just a discussion around getting old, but around getting old and facing severe health challenges).

- 3.5 There are exceptions to this description. In some cases, individuals move into care as a planned choice or following a gradual and predictable decline in health. Some individuals feel confident to research the market. But in the main, based on CMA consumer research, individuals arranging care will be unprepared.
- 3.6 We have found that there are lots of good sources of information and advice available, for example from charities, NHS Choices and Care Information Scotland, but our consumer research suggests that these are rarely used. Many do not seek information in order to learn about how the system works and the related funding arrangements, or find such information difficult to understand. Sometimes people may be unaware of possible financial support as it may not be possible to complete an assessment before the individual is placed in a care home. There is no one authoritative source that people will be directed to. The CMA consumer research found that people felt that they had only limited support when it came to choosing a care home and that they were 'left alone' to make their decision. We also heard from several care home providers who told us that they were often the initial points of contact and had to talk individuals through the systems and advise them on how they should choose a home.
- 3.7 The starting point for many people is a local authority social worker or hospital discharge worker. Following a care needs assessment, this social worker will advise on what options are available. However, the guidance and advice provided by the social worker can be variable and sometimes quite limited. This relationship is less significant for those who will be funding care themselves.
- 3.8 Local authorities across the UK are required to provide comprehensive information and advice about care and support services in their local area including information on the types of care and support available, as well as where to find independent financial advice about care and support. The information and advice service must be available to everyone in the local authority's area regardless of whether they are local authority or self-funded.
- 3.9 Again, we have found that the provision of information can be variable. Public perceptions are that the availability of personalised advice and support is often limited, particularly for those who are self-funded and not 'in the system'.
- 3.10 People typically consider a small number of care homes, sometimes just one. Location is very important when choosing a care home, along with the particular needs of the older person, such as a need for particular nursing care and/or dementia care. Judging certain aspects of quality is difficult and people are often unsure what questions to ask and how to assess options. As

a result care homes are often judged on the basis of the look and feel of the home or a recommendation.

- 3.11 Where individuals do seek information on individual homes, this is usually gathered by calling or visiting. Typically, some information is available through their websites, however, many key facts, such as indicative fees and other important contractual terms, can only be learnt over the telephone on request or during the initial visit to the home. The main exception to this is regulator inspection reports which are online and which care homes must make sure are readily available. The lack of key facts online can make the initial selection process unnecessarily opaque.
- 3.12 In some, particularly rural, areas there is limited choice and good homes may have limited availability requiring people to make a decision rapidly to secure a place in the first acceptable home. Choice for state-funded residents is variable; some local authorities provide a variety of fully-funded options, others only a single option for the cheapest available care that meets the resident's eligible needs (see paragraph 3.25). CMA consumer research suggests that people will search for a care home until they find a care home that is a 'good enough option', typically one that meets a minimum standard, because of the time and other pressures in finding a current vacancy in a suitable care home in a suitable location.
- 3.13 Care home fees are important in determining whether a care home is affordable, however the cost of care does not then appear to be the main criterion for self-funders in choosing between those affordable care homes. This may be because the importance of finding a good home for a loved one outweighs any concern over price beyond affordability, particularly where it is the older person's money being used. Some of those interviewed in the CMA consumer research also felt that they did not want to be seen as being only interested in fees because they may be perceived as being concerned about losing out on the 'family inheritance'.
- 3.14 Overall, many people are uneasy thinking of social care as a 'consumer' purchase and struggle with the notion of exercising choice as 'consumers' in a market. Additionally, self-funding residents face a lack of transparency on prices, terms and availability of beds from care homes – these are rarely available on websites – which makes the process of market search more difficult and lengthy.
- 3.15 In summary, it appears that it is difficult for prospective residents to gather the information they need, and in any case many are simply not prepared, able or supported in a way that would allow them to make good, well-informed, choices.

Moving between care homes

- 3.16 The ability to move between providers is a key component in improving the dynamics of competitive markets, allowing customers to correct poor choices and creating incentives for providers to supply better quality services, more choice and value for money. However, few residents seem to move between care homes as a result of their own choice. A Citizens Advice survey in 2016 found nearly a quarter of respondents had moved care home,¹⁸ but most of the residents that moved appeared to do so only in circumstances where they did not have a choice. Over three-quarters of those who had moved homes in the Citizens Advice research did so for reasons 'outside of their control', for example because of changing care needs or a closing home.
- 3.17 Citizens Advice found that of the quarter of their respondents who had had concerns, fewer than one in ten had moved care home as a result.¹⁹
- 3.18 CMA consumer research suggests that many of the family members and friends of residents were reluctant to go through the process of finding and moving to another home, even if they were unhappy or dissatisfied with the care home, unless they felt the resident were at risk. The Citizens Advice research found the main reason for not moving, given by a little over two-thirds of respondents, is that it would cause too much harm or distress.²⁰ Residents may also develop attachments to other residents, staff or locations and so be reluctant to move. All parties we have spoken to agreed that moving homes is usually very challenging to residents. Once settled, the upheaval of moving from a familiar environment can be extremely disturbing, and can adversely impact the resident's health.
- 3.19 These difficulties underline the importance of getting the original decision right.

Implications for competition

- 3.20 Care home services are largely delivered through commercial providers, with competition between them being driven by the actions of individuals (for self-funders) and local authorities in their procurement of care home places. Given this, for competition to work well in delivering good outcomes for residents, their families and friends and the tax payer, prospective care home residents and their families need to be able to exercise informed choice. In the short term, competition can give existing providers an incentive to compete on

¹⁸ Citizens Advice (2016), [Taking greater care](#).

¹⁹ Citizens Advice (2016), [Taking greater care](#).

²⁰ Citizens Advice (2016), [Taking greater care](#).

price, quality and service. In the longer term, if it works well competition should, at the very least, help to ensure that the market is responsive to the changing demands of an aging population and so delivers the right types of care home services in the right areas of the UK.

- 3.21 Competition between care homes takes place locally due to the importance of location for people choosing a care home, as relatives typically need easy access to visit or the resident may want to remain in their local area. Within an area, the market is segmented according to the types of care a home provides.
- 3.22 Providers have told us that emphasising quality is the main way they attract residents. Some aspects of quality are regulated in each of the four nations, and we have been told that poor inspection results have a significant impact on care homes' ability to attract residents. Key factors in the choice of care home is the perception of the attitude, engagement and level of care available from staff, and also compatibility with other residents. Our consumer research has shown that fee rates do not appear to be a primary determinant of choice between homes that have been identified as affordable for self-funders.
- 3.23 As discussed above, older people and their representatives make their choice of care home at a difficult time and certain aspects of quality can be difficult to judge. Choice in some areas is limited and good homes may have little availability requiring people to make decisions quickly to secure a place.²¹ We consider that these features of the market may have the effect of weakening competition between care homes.²²
- 3.24 That said, looking at self-funded residents, we have seen little evidence that care homes then take advantage of a lack of mobility to increase charges to established residents after they have moved in (relative to new residents, ie price discriminating against such residents), or that care homes selectively increase fees when there is little spare capacity and unfilled spaces in the local area.
- 3.25 Local authorities are required to offer local-authority funded individuals at least one suitable care home place that will meet the prospective resident's needs. The Care and Support Statutory Guidance (the Care Act statutory guidance)²³ (annex A paragraph 18) provides that 'a local authority must do everything it can to take into account a person's circumstances and

²¹ Paragraph 3.12.

²² Some providers have told us that people are actively comparing options in a well-informed manner. However, based on the views of other stakeholders and CMA and existing consumer research, it appears this behaviour is relatively rare and possibly mostly among the highest fee paying self-funders.

²³The [Care and Support Statutory Guidance](#).

preferences when arranging care', and some will offer a range of options. Third party top-up payments can offer a prospective resident a greater variety of choice when selecting a care home.²⁴ Local authorities have a key role in facilitating and promoting their use. We have heard from providers that in some cases local authorities may not be encouraging or facilitating the use of top-ups, for example due to concerns that it will create a potential liability for them.²⁵ Some providers have claimed certain local authorities do not permit the use of top-ups at all, and this is generally the case for NHS placements (see paragraph 5.27). We consider that this may dampen incentives for care homes to compete for state-funded residents by offering alternative accommodation in return for top-up payments. Consequently this may inhibit quality improvements and diversity of choice.

Emerging findings, next steps and potential remedial action

- 3.26 For this market to work well, prospective care home residents and their families need to be able to exercise informed choice (however they are funded). The initial results from the CMA's consumer research suggest that many people find it challenging to make decisions on care under the stressful and time pressured circumstances which generally apply. It is apparent that many people find it extremely difficult to understand the social care system, and funding systems, and how to find and choose a care home. Even when good information is available people do not engage with it, even though we have found that much of it is of a good quality, albeit spread over multiple sources.
- 3.27 Where a resident is dissatisfied with their care home, it is extremely difficult for them to move to another one. It is difficult to explore other options but once settled, the upheaval of moving from a familiar environment can be extremely disturbing, and can adversely impact the resident's health.
- 3.28 Most residents are therefore not in a good position to exercise informed choices and drive competition. Currently only a few prospective residents are able to do this. Therefore, any improvements that could be made to levels and extent of engagement could be very significant.

²⁴ The Care Act statutory guidance states 'A person must not be asked to pay a 'top-up' towards the cost of their accommodation because of market inadequacies or commissioning failures and must ensure there is a genuine choice. The local authority therefore **must** ensure that at least one option is available that is affordable within a person's personal budget and should ensure that there is more than one' ([Annex A, paragraph 12](#)).

²⁵ This is because the local authority remains liable for the total cost of that placement (see the Care Act statutory guidance [Annex A, paragraph 28](#)).

- 3.29 We are seeking to understand better how the barriers to people making informed choice are affecting outcomes for residents and their families and friends.
- 3.30 Decisions about care options and choice of care home are among the most important and difficult choices that many people have to make. There is a lot of unfamiliar information to take in and decisions often need to be taken quickly and in very challenging circumstances. We are therefore considering what more can be done to help people to make well-informed decisions about care, particularly when an elderly person first chooses a home, so that people can be more confident of achieving the best outcome available to them. We recognise that this is by no means straightforward and we are therefore considering a range of possible approaches to developing our recommendations in this area. For example:
- (a) We will be looking at what more can be done to provide up-to-date, accurate and accessible information and support for prospective residents and their families to help them consider the care options available to them and to decide what is the right thing to do and which care home to choose. This support could be delivered in a number of ways, for example, by ‘care navigators’ from local advocacy services, or through local authorities and social workers or the NHS, building on the services that already exist, to better address the weaknesses we have found through our consumer research. This type of trusted advocacy could be empowered to make recommendations and take a degree of responsibility for ensuring an appropriate outcome. We will be looking at the various approaches taken across the UK in this area, for example the statutory advocacy service which is being established in Wales²⁶ and the ‘care managers’ available to individuals in Northern Ireland, and considering how provision across the UK could be further developed.
 - (b) The circumstances of entering into a care home often require people to make quick decisions. We are therefore also exploring what more might be done to ensure information about care homes is easily accessible in a consistent format to enable people to identify which care homes have spaces available and to help them compare factors such as indicative fee rates, quality ratings and key contractual terms and conditions.
 - (c) While some information – for example, about which care homes have places available – will often need to be reviewed at short notice, decision-making will be easier if people have had some opportunity to understand

²⁶ Sections 173 and 181 of the Social Services and Well-being (Wales) Act 2014 (anaw 4).

the system and think about possible options beforehand, away from the immediate crisis or other circumstances that have triggered the decision to move into a care home. We are therefore thinking about how to help people to prepare for future decisions and consider possible care options in advance, for example by prompting people who may be in at risk groups (eg the elderly who are becoming more frail) to consider care needs. Alternatively there may be a case for inviting a much earlier awareness of these issues, for example among those who are retiring. A wider cultural change may also be needed to encourage families to face up to, and talk about, these difficult issues early, so that they have the best possible opportunity of finding good care for loved ones when they need it. If suitable financial products were available to insure against the cost of care, it may prompt more people to consider needs and make long-term plans for the possibility of social care earlier in their lives (and would mean any individuals would have less need to worry about potential diminution of their assets).

- 3.31 Some local authority-funded residents may have very few options available to them in practice. We will be exploring further whether local authorities are deterring the use of top-ups which otherwise would increase the range of choice available to local authority-funded residents. If we do find this to be a concern, we will consider how best to bring about practical improvements, for example recommendations to local authorities on good practice on allowing and administering top-ups.

4. Complaints and redress

- 4.1 Given the difficulties associated with moving between care homes (see paragraphs 3.16 to 3.19), it is important that residents are protected by effective complaints and redress systems. These should correct failings where the care home is not delivering the services and care required, it is not consistent with rights, expectations and contracts, or it is not of an appropriate quality.
- 4.2 This section reviews the issues that have been raised in relation to complaints and redress systems. We have heard that complaints systems do not appear to work as well as they could, as signalled by the low rates of complaints in the care home sector and a reluctance by some residents and their families to raise formal complaints with care homes. Stakeholders have told us that certain barriers to complaining exist in the care homes market, both because of the nature of the complainant and the care homes themselves.
- 4.3 While our market study is primarily concerned with complaints as a way to improve quality of service, there is a strong overlap with the ability of residents and their families to address safeguarding concerns, underlying the importance of these processes working well.
- 4.4 In all four nations, there are statutory obligations for care homes to have a complaints procedure and to ensure that this is available to their residents. Care homes must also maintain a log of any complaints they receive and must provide a summary of the complaints they have received over the preceding year to their national regulator if requested to do so.
- 4.5 Complaints processes will vary but in general, where a resident or their representative (eg family member) identifies an issue, that concern will be raised with a carer or registered manager in the first instance. Complaints that are not resolved at that level are usually escalated to a more senior person within the care home (eg to corporate management), and sometimes with several stages of escalation. If the complaint remains unresolved, state-funded residents would usually approach the local authority or Clinical Commissioning Group (CCG) and then the Ombudsman, and in Scotland they are also able to approach the Care Inspectorate to investigate their complaint. Self-funded residents would approach the Ombudsman directly (self-funders do not have access to an ombudsman in Northern Ireland). Complainants may also approach advocacy groups for advice or assistance with their complaint, possibly through the local authority or CCG if they are state-funded, and in Northern Ireland and Wales there is access to statutory advocacy services for complaints (eg the Patient and Client Council in Northern Ireland). The remits of the national regulators vary and only the Care

Inspectorate in Scotland will investigate and respond to individual complaints which do not specifically relate to a breach of the national care home standards. Similarly, the Ombudsmen in each nation have different powers and ways of operating.

- 4.6 However, our research suggests that these processes do not function well. The following reasons for this have been identified.
- 4.7 First, we found²⁷ that family members and friends feared retaliation towards the resident if they made a complaint. Ultimately, the nature of a care home environment as the complainant's home has the potential to act as a deterrent to complainants, particularly if the complaint is with the care home manager.
- 4.8 Second, as moving into care is a stressful and emotional time for friends, families and the resident themselves and is often accompanied by wider concerns such as selling property, friends and families do not always have the capacity to pursue complaints with a care home. Potential complainants may not have the time, health and energy to make formal complaints which could be difficult or lengthy and therefore focus on immediate or safe guarding concerns only.
- 4.9 Initial findings from CMA consumer research suggest that the family members and friends of the care home residents interviewed were typically unaware of how to raise a formal complaint. Most of those interviewed said that they would approach the care home in the first instance. They were more comfortable with providing 'feedback' to staff about issues of concern, rather than by making a formal complaint, and did not often consider making a complaint to the local authority or Ombudsman.
- 4.10 However, providers have told us that they make residents aware of complaints processes in a number of ways, including signposting how to escalate complaints, although for some their procedures appear lengthy or complex. The Department of Health told us that the sector-led work in England to improve quality in adult social care, Quality Matters, had prioritised action to ensure that people who used services, their families and carers received information that was clear and standardised and that complaints were handled quickly and effectively.
- 4.11 Some care homes have a strong complaints culture where feedback is welcomed, but others are weaker and could deter complaints. The role of the care home manager appears to be central to developing this culture. Both providers and residents' families and friends have indicated that building a

²⁷ From the preliminary CMA consumer research results.

feedback culture within a home is more difficult where there is a high turnover of staff, particularly registered managers, as residents can lose their primary point of contact and existing relationships with staff. Many of the providers we have spoken to are alive to these potential issues and have taken steps to welcome and act on complaints.

- 4.12 The CMA consumer research suggests that friends and families of care home residents are reluctant to provide feedback or complaints in writing. The consumer research also indicates that there does not appear to be strong awareness by the family members and friends of the residents of any advocacy groups, which are sometimes available, to support claims.

Emerging findings, next steps and potential remedial action

- 4.13 Complaints and redress systems often do not work well as residents find it very challenging to make complaints.
- 4.14 We are considering the different complaints and redress systems in the different nations, gathering more evidence to understand the issues and their prevalence. We are considering ways of making it easier for residents to express concerns about the quality of care home provision they are receiving, including by making formal complaints, and to give residents greater confidence that their concerns will be acted upon. In particular, we are interested in how to tackle cultural barriers to complaining either because of a reluctance among residents to complain or a culture among staff that deters complaints.
- 4.15 We are considering potential recommendations in relation to complaints systems. These might include for example: model complaints processes which are specifically designed for care home residents, provision of advocacy services to help people make complaints, or better signposting and access to the ombudsmen (for example, by rebranding them so people have a clearer understanding of their remit and how they may help), and regulators or others having better oversight of the performance of individual providers' complaints systems.

5. Consumer protection

- 5.1 We have been considering the extent to which care home providers are treating their residents fairly and whether there is a need to improve compliance with their consumer law²⁸ obligations in relation to information provision, contract terms and business practices. We are also looking at whether existing consumer law works well within the context of care homes, the adequacy of existing sector-specific regulations in protecting residents, and whether any additional protections may be required.
- 5.2 We have identified a number of consumer protection issues which we consider warrant further consideration by us,²⁹ some of which may have the potential to breach consumer law. Most of these relate to the practices and contract terms used by some care homes in their dealings with self-funded residents. These are outlined in the following paragraphs.

Indicative prices on websites

- 5.3 We have found that there is a lack of indicative pricing information available on provider and care home listings websites. This can increase the time and effort involved for people to 'shop around' and identify different care homes that may fall within their budget, often in circumstances when a decision has to be made under significant time pressure. In particular, the vast majority of the provider websites we have looked at do not contain details of the range of weekly fees charged to self-funders. Similarly, only 40%³⁰ of the 19,000 registered UK care homes have chosen to submit any indicative fee information to the carehome.co.uk website.³¹ Citizens Advice research also found that only 7% of people surveyed who had arranged a care home place in England said they were provided with information about care home fees, such as through the website or marketing materials, prior to making contact.³²

²⁸ Consumer law aims to ensure that businesses act fairly in their dealings with consumers, by preventing and deterring a range of harmful practices such as giving misleading information about services or using unfair contracts. It sits alongside other sector-specific regulatory obligations. Some practices and terms might not be in breach of consumer law but may still be detrimental to residents. Our primary focus has been on the practices and contract terms used by care homes in their dealings with self-funded residents.

²⁹ This is based on a review of submissions by stakeholders including national charities, experiences reported to us by members of the public and our review of a sample of UK care home provider contracts, sales materials and other documentation. See a [summary of individual responses](#) on the full range of consumer issues that have been reported to us by members of the public.

³⁰ Based on an analysis of the caredata.co.uk dataset. This includes all registered care homes, not just those for people aged over 65.

³¹ [Carehome.co.uk](#) describes itself as 'the leading UK Care Home website with over 16 million visitors per year'.

³² 'Taking greater care: Why we need stronger consumer protections in the care home market' Citizens Advice (2016).

- 5.4 Some providers have told us that it is difficult to give an indication of weekly fees on websites as prices are person-specific and dependent on completion of a care needs assessment, but others manage to do it.

Deposits

- 5.5 Some providers ask for a substantial deposit in advance, which is refundable when the resident leaves or dies provided that for instance no outstanding fees are owed to the care home. They can often be the equivalent of two weeks' fees and in some instances can amount to up to between £4,000 and £5,000. Citizens Advice research found that over a third of people (37%) said they had put down a deposit and nearly 1 in 5 people had put down a deposit of £1,000 or more.³³
- 5.6 The rationale for taking deposits when fees are typically paid monthly in advance is unclear. Some charities have also highlighted the potential for disputes or delays in the return of deposits when a resident moves to another care home or dies – for example a Citizens Advice survey found that 7% of those who put down a deposit said they did not get it back.³⁴
- 5.7 We are aware of some providers holding more than a million pounds in residents' deposits at any one time. We understand that there is currently no specific regulatory requirement for such deposits to be safeguarded in full against the risk of insolvency, for example by being 'ring fenced'. This would mean that if a provider were to become insolvent, there is a risk that residents would not get their deposit back (as well as any other pre-payments) in full.

Other substantial upfront payments

- 5.8 Some providers require residents to pay substantial upfront charges (in addition to paying a month's fees in advance) when or before they move into a care home. These can include non-refundable administration charges, or one-off 'management' type fees.
- 5.9 We have been told that some of these fees may come as a surprise to people because they are only mentioned when visiting the care home or signing the contract, or the purpose of the fee, the way it is calculated, and the services that are being provided in return may not always be clearly explained. This can make it more difficult for people to compare easily overall prices between

³³ ['Taking greater care: Why we need stronger consumer protections in the care home market'](#) Citizens Advice (2016).

³⁴ ['Taking greater care: Why we need stronger consumer protections in the care home market'](#) Citizens Advice (2016).

different care homes, particularly as administration and other integral business costs are typically incorporated by many providers within their overall weekly fees.

- 5.10 Large upfront payments may also potentially deter a resident from moving care home, particularly if they are unhappy or their circumstances change shortly after they have moved in but they have already incurred significant expense.

‘Hidden’ extra charges

- 5.11 Providers may make extra charges for a range of other additional services and items, including things such as chiropody, hairdressing, refreshments for visitors, accompanied visits to medical appointments, medical supplies, toiletries, and ‘surcharges’ for processing payments.
- 5.12 Concerns have been raised by a number of charities that there may sometimes be a lack of clarity and visibility about what extra charges are payable. For instance, it can be hard to discover before moving into a care home what the weekly fees include and what needs to be paid for separately, landing residents with large unexpected bills for additional services.

Provision of contracts

- 5.13 Entering a contract with a care home is a major decision which can have significant financial implications for residents and their families. A Citizens Advice survey (in England) found that over a third (36%) of people said they were only given a copy of the contract after the resident had moved in, or not at all.³⁵ We have also been told about people not being given sufficient time to read and consider the contract properly, or being asked to sign the contract before it was explained to them. For example, from the calls it takes on its helpline, Independent Age has highlighted that a lack of time to look at the contract is a major issue and that individuals and their families are frequently given less than 24 hours to review a contract before signing. The CMA consumer research suggests that there is an assumption amongst those arranging care that the terms and conditions are similar at all care homes and that a discussion of the terms does not come up until contracts are being signed.

³⁵ [‘Taking greater care: Why we need stronger consumer protections in the care home market’](#) Citizens Advice (2016).

- 5.14 We have looked at a number of care home contracts, and found that they can vary greatly in how user-friendly they are in the language they use, length and layout.

Guaranteeing care home fees

- 5.15 Some providers require self-funded residents to have a 'guarantor' to co-sign a contract. The guarantor (an individual nominated by the resident) is then usually liable for paying all fees and charges in the event the resident is unable to do so themselves.
- 5.16 We have been told about, and seen, examples of contracts where the guarantor's liability is not clearly set out. Age UK has also highlighted instances where relatives have specifically been asked to guarantee that they will pay fees when their relative's money runs out, or where the contract asks residents to guarantee that they will fund their own care for one or two years,³⁶ even though they may become eligible for state funding during their stay at the care home. We are further exploring the business reasons for the use of guarantors and the extent to which they may have the potential to disadvantage residents and their families.

Direct payment of top-up fees to care homes

- 5.17 Where a person is eligible for local authority funding but would like to move to a care home that costs more than the council will pay, their family or friends can pay a 'top-up fee' to make up the difference.³⁷
- 5.18 We have been told by charities such as Age UK and Independent Age of instances where some care homes have approached relatives directly for top-ups or extra payments without the agreement of the local authority,³⁸ and of relatives being provided with confusing information about the top-up fees they may have to pay.
- 5.19 Some providers have told us that the majority of top-up fees they receive are paid directly by the third party to the care home, based on what has been agreed with the relevant local authority. This means that the third party will

³⁶ For example, in its report '[Behind the headlines: stuck in the middle – self-funders in care homes](#)' Age UK highlighted a contract that asked residents to guarantee that they would fund their own care for two years and agree not to approach the local authority in that time.

³⁷ Top-up fees arise when the prospective resident's preferred care home costs more than the amount specified in the residents' budget set by the local authority. Top-up payments must be distinguished from charges made by the home for extra items not covered by the home's core residential fees, such as hairdressing, which the care home can charge to the resident.

³⁸ Care homes should only seek top-up payments if an arrangement has been agreed with the third party and the local authority.

enter into a contract with the care home for payment of the top-up fee alongside the agreement they have with the local authority, as well as there being a contract between the local authority and provider. In England the Care Act statutory guidance does not recommend that direct payments are made by third parties to care homes because ‘multiple contracts risk confusion’ and the local authority may be unable to assure itself that it is meeting its responsibilities.³⁹ The local authority should enter into a written agreement with the person paying the top-up and remains responsible for ensuring that the whole fee (including the top-up) of any care it has contracted is paid to the provider.

- 5.20 We intend to further explore the extent to which the direct payment of top-up fees by third parties to care homes may be resulting in confusion for, and/or disadvantaging, the person paying the top-up fee.⁴⁰

Fee increase terms

- 5.21 Concerns have been raised with us by relatives of residents about the frequency and amount of fee increases. Whilst the majority of contracts which we have seen state that fees will be reviewed on an annual basis, they do not always set out clearly the circumstances in which a fee increase may occur. They may also include a wide range of reasons or a general statement that the resident’s fees may change over time, in addition to annual increases. In these circumstances, the resident may not be able to foresee and understand, on the basis of clear, intelligible criteria, the increases that may be made and evaluate the practical implications for them, before they make a decision to move in. Such terms may also be open to abuse, since residents will be unable to determine if the fee increases are reasonable. Citizens Advice research has also found that some care homes are only giving residents very short notice of fee increases.⁴¹
- 5.22 Generally speaking, a right to end the contract and leave without penalty would normally enable consumers to avoid an unwanted fee increase. However, CMA research has found that people feel disempowered to do anything about increasing fees given the likely stress and inconvenience

³⁹ Ultimately, if the arrangements for a ‘top-up’ were to fail for any reason, the local authority would need to meet the cost or make alternative arrangements, subject to a needs assessment. The Care Act statutory guidance states that local authorities should therefore maintain an overview of all ‘top-up’ agreements and should deter arrangements for ‘top-up’ payments to be paid directly to a provider.

⁴⁰ For example, where the care home contract with the third party contains terms that differ from those between the local authority and provider about who is responsible for non-payment of the top-up, how and when any fee increases will be dealt with, and how long the top-up will need to continue to be paid after the death of the resident.

⁴¹ [‘Taking greater care: Why we need stronger consumer protections in the care home market’](#) Citizens Advice (2016).

involved in finding another care home. As a result, and given the inherent vulnerability of many care home residents, they may feel they have no choice but to pay large or unexpected fee increases.

Relationship between NHS Funded Nursing Care (FNC) contributions and self-funding residents' fees

- 5.23 FNC is the contribution paid by the NHS to care homes in England and Wales providing nursing care, in order to support the provision of registered nursing care for eligible residents.
- 5.24 Concerns have been reported to us by a number of relatives following the 40% increase⁴² in the FNC rate in England announced by the government in July 2016 (which was applied from 1 April 2016). Some residents had expected the FNC increase to result in an equivalent reduction in the amount they contributed to their overall fees (and to be rebated for the backdated period), but we have been told of instances where care homes increased the overall weekly fee by a similar amount to the rise in the level of the FNC rate. Although the resident's net contribution to their fees remained unchanged, they did not benefit from the FNC increase.
- 5.25 How FNC payments affect a self-funder's contribution to their overall care home fees is referenced in England in the Department of Health's *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care* (Practice Guidance Notes). This says that the care home provider should set an overall fee level for the provision of care and accommodation, which should include any registered nursing care provided by them. Where a CCG assesses that the resident's needs require the input of a registered nurse they will pay the NHS-funded nursing care payment (at the nationally agreed rate), normally direct to the care home. In the case of a self-funder, the balance of the fee will then be paid by the resident or their representative, unless other contracting arrangements have been agreed.⁴³ Having looked at a number of care home contracts, we have seen that there are different approaches to the treatment of FNC payments between different providers. Some contracts are also silent, or potentially ambiguous, about FNC. This may create confusion amongst some self-funded residents about how FNC payments impact on their own contribution to the overall weekly fee and specifically what happens if the amount of the FNC payment is increased (or decreased).

⁴² The standard FNC rate was increased by £44 a week to £156.25.

⁴³ The National framework for NHS continuing healthcare and NHS funded nursing care, [Practice Guidance Note \(paragraph 62.3\)](#).

NHS Continuing Healthcare funding and top-up fees

- 5.26 If a nursing home resident in England and Wales is eligible for CHC funding, the NHS will pay for their nursing home fees as well as healthcare and personal care. We understand that under current guidance, unless it is possible to separately identify and deliver the NHS-funded elements of the service, it will not usually be permissible for residents or their families to ‘top-up’ CHC packages to pay for higher cost services and/or accommodation (as distinct from purchasing additional services, for example, aromatherapy or beauty treatments).⁴⁴
- 5.27 We have received a small number of reports of nursing homes appearing to ask residents in receipt of CHC or their families to pay top-up fees towards the cost of their care package to cover a ‘shortfall’ in funding of the basic costs, which we understand is not permissible under NHS rules. More generally, we intend to further explore the circumstances in which nursing homes can offer CHC funded residents additional services (contracted for via separate top-up arrangements between the home and resident) to ensure there is sufficient clarity for residents.

Termination clauses

- 5.28 The care home contracts that we have seen usually set out how each party (the resident and the care home provider) can end the contract. Typically, 28 days’ notice is required on each side. However, many of the contracts we have looked at give the provider a potentially wide discretion to end the contract, sometimes at short notice, for reasons which (for example, because the provider says it can no longer meet the resident’s needs) the resident may find difficult to question or challenge.
- 5.29 Age UK and the campaign group Your Voice Matters have also raised concerns that widely drafted termination clauses could be used unfairly by care homes in order to evict residents who have made complaints (alongside imposing other measures such as visitor restrictions or bans). Although we have received some reports alleging these kinds of unfair practices, it is difficult to gauge how often this may be happening, especially as there may be a reluctance on the part of relatives to come forward. That said, it is clear that the impact of such actions on individual residents and their families is likely to be particularly serious and cause them considerable distress.

⁴⁴ See for example, in England the Department of Health’s [Guidance on NHS patients who wish to pay for additional private care](#) which sets out the overarching principles that NHS care and private care must be clearly differentiated.

Fees charged after death

- 5.30 Fees are sometimes being charged by care homes for extended periods after a resident has died, even when the room may have been cleared of the resident's belongings and returned to the care home within this period. Although we have seen examples of self-funder contracts that terminate as soon as the deceased's belongings have been removed from the room or a short time after they have died, others charge fees for periods of up to fourteen days or four weeks after death or for the remainder of the month following death. In addition, where the room is re-let to a new resident during this period, there may be no provision in the contract for a pro-rata refund of these fees.
- 5.31 We have also seen examples of contracts that may give the care home scope to charge the deceased resident's estate for the full gross fees during the period after death, including any shortfall in fees that had been covered by the state whilst the resident was alive (such as the NHS Funded Nursing Care contribution of £156 a week which typically stops immediately upon death).
- 5.32 In contrast, the examples of local authority contracts with care homes that we have seen typically say that the council's fees will stop immediately or anywhere up to four days after death.⁴⁵

Emerging findings, next steps and potential remedial action

- 5.33 While many care homes offer a good service to their residents, all care home residents are entitled to strong protections against unfair contracts and business practices where these occur. Therefore we are looking at how we may achieve this using the range of tools we have available, including through targeted consumer enforcement action, supporting care homes to meet their legal obligations under consumer law, and encouraging care homes to adopt good practice in their dealings with residents and their families.
- 5.34 We have opened a consumer protection case to investigate concerns about certain care homes charging families for extended periods after a resident has died and homes charging large upfront fees. The investigation is currently focusing on these two issues because we have already identified clear, specific concerns that some care homes may be breaking consumer law, which if borne out, we consider would be most effectively addressed by consumer enforcement action. We are using our consumer law investigatory

⁴⁵ For example, the Scottish National Care Home Contract states that the local authority's contribution shall be paid for three days after death (or up to such a date as may be agreed between the council and the provider) and the resident's contribution shall be due for three days after death.

powers to obtain further evidence from the providers we are investigating in order to decide whether enforcement action is required.⁴⁶ For further information see our [case opening page](#).

- 5.35 We are continuing to consider the other consumer protection issues we have identified and how they can best be addressed using the range of tools we have. We may decide to extend the scope of our consumer protection case at a later date to cover other issues of concern, and/or to publish guidance for care homes on their obligations under consumer law, where we think this would help to drive consumer law compliance across the sector. We will also consider how best to embed consumer law compliance into the regulation of the sector, for example through the role of sector regulators or through encouraging the development of voluntary codes of conduct.
- 5.36 If we find gaps in the protections that consumer law offers in the specific context of this sector, these might possibly be addressed through new legislation or changes to regulatory rules. If we do come to conclude that additional protections may be required to secure good outcomes for residents, and such measures appear effective and proportionate, we will make recommendations to government, sector regulators, and care home providers.

⁴⁶ Ultimately, only a court can decide whether a particular contract term or practice infringes the law.

6. State procurement

- 6.1 In the main, local authorities (and the NHS/HSC trusts) procure care home places from external providers rather than operating care homes themselves. The procurement process involves advertising a contract, selecting vendors, establishing payment terms, selecting contractors and negotiating terms and fees. We now consider how well these procurement approaches work in terms of outcomes for care home residents and also the public purse. We also briefly look at the differences in typical fee rates paid by local authorities and by self-funded residents.

Procurement

- 6.2 In England and Wales local authorities procure places for local authority-funded residents using both block contracts and spot purchasing. Each of these approaches have certain advantages and disadvantages in terms of flexibility, achieving the best price and encouraging providers to offer places. We found, based on our interviews, that the majority of placements are made through spot purchasing, but that some local authorities are also using block contracts to meet local needs. Similarly, CCGs we have spoken to in England primarily use framework agreements and spot purchasing to procure placements for CHC residents.
- 6.3 In Scotland there is a National Care Home Contract, agreed annually between the Confederation of Scottish Local Authorities and Scottish Care, which sets a common contract with terms and conditions and fee rates that apply to all local authority placements in Scotland. We have been told this can be regarded as a potential model contract and that many providers replicate the contract for their self-funded residents. In Northern Ireland the HSC Board sets a guide price, which the HSC trusts then adopt and use to procure placements for their region. The price is indicative only and placements may be made at a higher rate.
- 6.4 Local authorities will typically have a framework agreement setting out terms and conditions. For some local authorities the framework agreement may specify set, or guide, fee rates. For others, fee rates are determined for each placement. In the past spot purchasing involved the local authority contacting a number of providers by phone to enquire about availability and price. We are now seeing a move by some local authorities to dynamic online purchasing systems (an online auction process where providers offer their minimum acceptable price to accommodate that individual given their particular needs). These can be efficient to operate but we have heard that, depending on design, there is a risk that these are less able to reflect the personal needs of the prospective resident and might give disproportionate weight to price.

- 6.5 Prospective local authority-funded residents may be offered only one choice of home. The ability of the local authority to offer more than one option will depend on their local market, including factors such as occupancy rates, quality and variety of provider stock, whether a standard fee is paid, as well as the resident's individual needs. How satisfied prospective residents are with the care home or homes offered will depend on the extent to which the local authority has been able to meet their preferences including, for example, how close they are to their friends and families.
- 6.6 A person must also be able to choose alternative options, including a more expensive setting, where a third party is willing and able to pay the additional cost (the top-up payment). However, an additional payment must always be optional and never as a result of commissioning failures leading to a lack of choice.⁴⁷
- 6.7 Some of the local authorities we have spoken to build in quality ratings to the decision around which homes to offer to prospective residents. In addition, local authorities will generally not place with providers not rated by the regulator as offering a satisfactory standard of care until they have been reassessed and ratings improved.⁴⁸ It is very difficult for us to assess how local authorities are reflecting prospective residents' preferences and whether any of their actions might be giving disproportionate importance to price.
- 6.8 Our initial findings suggest that generally there is effective competition to provide care home placements to local authorities. However, some providers have raised concerns that local authorities prioritise lower fees subject to meeting certain minimum quality standards, which take little account of the detailed care needs and preferences of a resident (so the resident may not be appropriately placed and the care home itself may not be able to fully assess whether it can meet the resident's needs). They have also complained that local authority and NHS procurement processes tend to be complex, inflexible, and insufficiently person-centred with inadequate provision to encourage and reward quality.
- 6.9 Many of the local authorities we have spoken to have explained that they provide person-centred placements and incorporate factors other than price into the placements offered to prospective residents. Depending on local factors, we have seen a wide variety of approaches, with different local authorities taking different attitudes to the prioritisation of factors other than price. Some local authorities appear to manage these processes well, others are less responsive to the individual's preferences.

⁴⁷ For example, the Care Act statutory guidance paragraph 8.37.

⁴⁸ For example, 'inadequate' and/or 'requires improvement' for CQC ratings.

- 6.10 Providers have also complained about lengthy and complex contracts and conditions of compliance. In England and Wales in particular, many care homes will take residents from a variety of local authority areas which greatly increases costs and complexity as contracts are often very different, and there may be multiple compliance and inspection regimes to deal with, in addition to those of the quality regulator. While the sector appears to accept that regulation and monitoring is essential, we have been told the regulatory burden can be very substantial because of this duplication. Our initial findings suggest that many individual local authorities are making efforts to monitor service provision in an efficient way eg establishing joint quality assurance frameworks with local partners from health and/or regulators, holding regular meetings with partners to discuss homes in the area, or coordinating inspections to reduce burden on providers. The majority of local authorities we spoke to also delegate routine monitoring of out-of-area residents to the host local authority.
- 6.11 There are various initiatives in place to encourage the integration of healthcare and social services. In Northern Ireland, HSC trusts are established while in Scotland, Integration Joint Boards have recently been set up. In principle, joining up health and social care should improve the allocation of the required care to individuals as well as ensuring efficient use of NHS and local authority resources, as there is a reduced risk of clashing incentives on health and social care services.
- 6.12 So far, there is a varied picture of joint-procurement between CCGs and local authorities in England. Some local authorities and CCGs use the same contract but procure placements separately, whereas one CCG we spoke to is in the process of introducing a joint-contract and integrating the local authority and CCG commissioning teams so placements are coordinated. We have heard that where CCGs and local authorities operate independently from each other, there is a risk that providers can 'play them off against each other', thereby increasing prices. In particular, we have been told that CCGs are prepared to pay more for a nursing home place in order to release a hospital bed with the result that local authorities can struggle to place residents. However, nationally there are an increasing number of instances of local authorities and CCGs commissioning jointly, or aligning their practices. Therefore this issue may be present in some areas, but is declining.

Price differential between local authority and self-funded residents

- 6.13 Many of the submissions we have received from the public have stressed concerns over the higher charges self-funders tend to pay, even when occupying identical facilities in the same homes as state-funded residents.

- 6.14 We understand this concern. Self-funders will see it as very unfair that they should pay more for the same services, especially when it is seen as a non-discretionary purchase and the result of being required to arrange and negotiate their own care. They can be shocked by the costs and the requirement to run down their assets before they are caught by the state safety net.
- 6.15 It is difficult to establish whether price differences between self-funders and state-funded places may to some extent be influenced by whether, in some homes, there may be significant differences in the rooms and services provided to the two groups, the costs of serving them (for example administrative costs and revenue risk), and also whether the average care needs of the two groups is different. For example self-funders might tend to occupy premium rooms in a given home, or on the other hand local authority-funded residents may move into a home at a later stage of need and so have greater care requirements. Nonetheless, LaingBuisson, having looked at a sample of care home groups operating in 12 English counties in 2015, report finding self-funders pay over 40% more on a like-for-like basis.⁴⁹
- 6.16 The price difference has been referred to as a cross-subsidy, with the assumption that self-funders are contributing to the costs of serving state-funded residents. It is widely believed that the prices paid by local authorities impact on those paid by self-funders. Indeed, we have been told of homes that set fees for self-funders once they know local authority fees in order to achieve a revenue target. We have seen no evidence of local authorities paying fees that fail to cover the home's direct operating costs in providing care, and many homes survive with very few or no self-funders. Nor are prices for self-funders lower in homes without local authority funded residents. However, there is scope for local authorities to pay rates that cover operating costs and allow homes to remain open, but below the rates that would cover the costs of long-term investment in new capacity.
- 6.17 For the purposes of this market study, we are interested in how the price differential arises and whether this reflects or is facilitated by a market failure or lack of competition. Higher prices paid by self-funders could be a symptom of weak price competition, whereby unlike local authorities, self-funders are not able to negotiate competitive rates and push prices down. Some care home operators have claimed that the lower prices paid by local authorities could be a result of inappropriate use of buyer power (see paragraphs 8.7 to 8.16).

⁴⁹ Source: LaingBuisson news, '[Despite deferment of the Care Act Part 2, councils still face significant market sustainability challenges](#)'.

Emerging findings, next steps and potential remedial action

- 6.18 We are continuing to understand the different procurement approaches adopted by local authorities (and seeking further engagement with the NHS to better understand how it commissions care) in the different nations, and are gathering evidence to help us understand the issues of procurement, regulatory and administrative burdens, and health and social care integration.
- 6.19 We are considering potential recommendations in relation to sharing best practice on procurement. For example, we would support efforts by local authorities to coordinate between themselves and with CCGs in common procurement approaches, common contracts, and shared monitoring, as much as possible. We are also considering transparency requirements on local authorities so that it can be seen how they are discharging their responsibilities so that there can be a greater degree of accountability.
- 6.20 We are currently considering the reasons why price differentiation arises and can be sustained, before determining whether this may be working against the interests of residents (of all types). In some markets it can be efficient to charge different prices to different groups of customers (for example it may increase the overall level of supply) but it may be harmful or unfair to some groups. If we do find this to be a problem, we will consider remedies to:
- address the underlying causes through measures we might propose to improve the functioning of the market for self-funders or in respect of local authority fee rates;
 - provide pricing transparency which would allow price differentiation to be challenged; or
 - enable local authorities to potentially assist self-funders secure a better deal.⁵⁰

⁵⁰ The extent to which self-funders have access to local authority contracts differs by nation: (i) in Northern Ireland, people with resources above the financial limit can use the terms and fee levels of their HSC trust, (ii) in Scotland self-funders can use the contract structure (but not fee level) of the (non-statutory) National Care Homes Contract, and (iii) in England section 18(3) (b) of the Care Act 2014 introduced a new duty whereby local authorities must arrange the care and support for people whose resources are above the financial limit if they ask for them to do so (section 18(3)(b) of the Care Act 2014). This might potentially be interpreted as meaning that self-funders would be able to take advantage of local authority contracts. However, implementation of this duty has been delayed insofar as it creates a duty to meet needs by providing or arranging care home accommodation ([Regulation 3 of the Care Act 2014 \(Commencement No.4\) Order 2015 \(SI 2015/993\(C.68\)\)](#)). If such duties were to be implemented, while it might allow self-funders to access care at local authority rates in England, there could be significant implications for the allocation of spaces, the costs of public social care and the financial viability of providers.

7. Investment in future capacity

- 7.1 The provision of care home services, as in any market, will need to adapt and evolve over time to meet changes in the nature and level of demand. In a market that works well, there should be incentives for suppliers to respond to these changes, and to progressively improve services and efficiency. This may include inefficient providers (perhaps because of their scale or age of facilities) exiting the market. This section considers how the sector develops over time and meets changing care needs and how local authorities seek to influence this.

Approaches to planning and developing care home provision

- 7.2 Given the importance of this sector and the responsibility of local authorities for delivering adult social care, there are a variety of approaches adopted to planning and developing markets in the different countries.
- 7.3 In England, new market shaping duties require local authorities to promote the efficient and effective operation of the market for adult care and support as a whole.⁵¹ The Care Act statutory guidance promotes the use of Market Position Statements⁵² as a way to signal demand to the market and meet their market shaping duties. A Market Position Statement should include details of what support and care services the local authority thinks people will need in the future and how they will be funded and purchased.
- 7.4 In Wales, local authorities and Local Health Boards have a legal obligation to work together to assess the extent of needs for care and support and the extent to which needs for care and support are not being met.⁵³ Local and national market stability reports include an assessment of the sufficiency of the provision of care and support.
- 7.5 In Scotland, each Integration Joint Board must establish a 'strategic planning group' comprising different stakeholders and publish a 'strategic plan' (also known as a 'strategic commissioning plan').⁵⁴ Strategic plans are intended to set out high-level information about direction and planned changes, a strategic needs assessment of local need, and a plan of how that need will be

⁵¹ Section 5 of the Care Act 2014. See footnote 15 for a description of market shaping.

⁵² A Market Position Statement is a document produced by a commissioning authority that outlines the support and care services people need, current availability and any shortfalls, expectations of support and care needs in the future, how they will be funded and purchased, and how commissioners want to shape the opportunities that will be available.

⁵³ Section 14 of the Social services and Well-being (Wales) Act 2014.

⁵⁴ Section 35 of the Public Bodies (Joint Working) (Scotland) Act 2014. From 1 April 2017, the Care Inspectorate has joint statutory responsibility with Healthcare Improvement Scotland to examine the quality of strategic commissioning and recommend improvements.

met along with detailed budgetary plans. This incorporates a summary of the key requirements to meet current and future demand.

- 7.6 In Northern Ireland the HSC Board Local Commissioning Groups focus on the planning and resourcing of services.
- 7.7 We have found a great variety of approaches among local authorities in how they discharge their planning and market shaping duties. For some, their actions have been limited to engaging with providers, NHS and other organisations on matters such as the current and future needs of the local population and their procurement strategies. For some, these actions seem to have been largely concerned only with the local authorities' procurement needs. However, some local authorities appear to have been more proactive and to have taken a wider interest in the market, with a few considering future as well as current needs, such as:
- (a) intelligence gathering on the market for publicly funded and non-publicly funded placements and developing protocols for sharing intelligence;
 - (b) working with providers to understand their costs and pressures and to renegotiate fees, and to consider new contractual arrangements, with the aim of supporting longer term sustainability;
 - (c) local initiatives to encourage and support investment including those aimed at addressing labour market constraints, working with potential providers on specification of care homes and building relationships with other local stakeholders; and
 - (d) publishing strategies aimed at directing developers and providers to target their services, regardless of whether they would be publicly funded or self-funded, to meet future needs.
- 7.8 Local authorities in England have used Market Position Statements to share information relating to the current and future supply and demand of care home services, as well as gaps in provision and local authority priorities, in order to inform the business choices and investments of service providers. Local authorities are seen as being uniquely well placed to assemble, assess and disseminate information on how the needs of their local area are likely to evolve in coming years and how this compares with current and planned provision.
- 7.9 As well as using these tools, some local authorities have used their commissioning policies to affect market changes. Examples include offering long-term block contracts to encourage entry and expansion, prioritising care home development when addressing planning approvals (although sometimes

that is not within the control of the same level of local government), and even the local authority building facilities itself and leasing these to private operators.

- 7.10 There is a great deal of variability in different local authorities' approaches. In particular, all authorities are struggling with funding pressures, and for some, the need to manage budgets may mean that they have to take a short-term perspective focused on reducing costs and procuring at the lowest prices they can consistent with their duties and providing appropriate care. Consequently care homes may not receive the signals from local authorities (including prices being pushed up) on developing long-term capacity reflecting the likely growth in the population's future needs.
- 7.11 Local authorities can, to a certain extent, control how many people they place in care homes as they have a degree of discretion on whether eligible needs are met through alternative means such as domiciliary care. Many local authorities have told us that they have policies to keep people in their own homes as long as possible, due to the health benefits for individuals and their preferences. Therefore the number of care home placements need not necessarily increase directly in line with the growth in the number of elderly people.
- 7.12 Overall, local authorities are facing serious challenges in securing investment in new capacity, looking many years into the future. This applies particularly for capacity intended to primarily serve local-authority residents (see paragraphs 8.7 to 8.18), and facilities focused at the areas of greatest need (ie dementia and nursing care rather than residential care).
- 7.13 We have heard that care homes can take many years to plan and build. Homes focused at self-funders are being built and it is very likely that these will end up supplying some capacity to the state sector. However, there appears to be little current expansion of capacity focused on the state-funded sector. The reasons for this include concerns around fee rates payable by local authorities, uncertainty over the prospects for future public funding of adult social care, and labour shortages.
- 7.14 However, it is likely that demand will increase significantly in the near future. The number of people aged 75 and over is projected to rise by 89.3%, to 9.9 million, and the number of people aged 85 and over is projected to more than double, to reach 3.6 million, by mid-2039.⁵⁵ The Care Quality Commission (CQC), in its report *The State of Health Care and Adult Social*

⁵⁵ Office of National Statistics – National population projections.

Care in England 2015/16, noted ‘it has been estimated⁵⁶ that there will be a 49% increase in demand for state-funded care home places for older people between 2015 and 2035’. Another report forecast that there will be a 25% increase between 2015 and 2025 in the over-65s needing nursing and social care, largely because of the impacts of dementia in a growing elderly population.⁵⁷

- 7.15 The Mintel report, *Residential Care for the Elderly*,⁵⁸ states that: ‘...based on government actuary projections, the number of people living in residential care in the UK is expected to increase to 1.25 million in 2056 from 419,000 in 2009.’ The implications are that in a few years there is likely to be a greatly increased demand for care home services. Moreover, the acuity of need is increasing over time. While people are supported in their own homes for longer, when they are admitted to homes their care needs are much greater than in the past.
- 7.16 Given the substantial lead time to increase bed numbers by building new capacity, there is a significant risk that further capacity will not be there when it is needed. It is important that any potential mismatch between future demand and supply for care homes is identified and acted on early. However, in some areas of the UK it appears (in terms of state-funded provision) that this is happening imperfectly at present.

Barriers to entry, expansion and exit

- 7.17 Barriers to entry, expansion and exit can reduce competitive pressures in the market and reduce the ability of the sector to respond to changes in demand.
- 7.18 The main barrier to entry identified to us by suppliers in the sector is the cost of building or converting a new home, which can cost millions of pounds. These costs mean there is more to lose if a new home fails. There is an initial cost when a new home is opened, in that it can take a while to establish a local reputation and attract residents. Also, as it takes time for a new team of staff to work together effectively, there is a raised risk of an adverse regulator’s report in the first few months.
- 7.19 As discussed in Section 8, other barriers to investment in existing or new capacity include concerns around fee rates payable by local authorities, uncertainty over the prospects for future public funding of adult social care,

⁵⁶ Wittenberg R and Hu B (2015), *Projections of Demand for and Costs of Social Care for Older People and Younger Adults in England, 2015 to 2035*, 2015.

⁵⁷ *Forecasted trends in disability and life expectancy in England and Wales up to 2025: a modelling study*, Guzman-Castillo et al, *The Lancet*, 23 May 2017.

⁵⁸ *Residential Care for the Elderly* – UK, p52, published September 2016.

and labour shortages. In some areas the availability of suitable sites might also be a problem. The extent to which these apply will vary between areas across the UK.

- 7.20 Providers have told us that neither planning nor regulatory approval act as a substantial barrier to entry. However we have heard that in some areas planning authorities are not in the same layer of local government as that administering adult social care, and consequently there can be planning barriers to delivering ambitions to enlarge or shape supply. Issues have been raised with us about the increase in regulatory standards over time, for example a requirement for en-suite bathrooms. These can reduce the value of the home faster (because the home rapidly becomes outdated) and so mean less costs can be recovered in the event of failure, discouraging entry. Furthermore, increasingly demanding standards can also make expansion of individual homes more difficult as raised standards may not apply to existing homes but may apply to the entirety of homes if they expand.
- 7.21 Even once a provider chooses to build a home it takes time for new capacity to enter the market. We have been told it can take up to five to seven years to plan, build and open a new care home. This means that providers face long-term decisions about where to have homes and so will be less able to quickly respond to changes in demand.
- 7.22 There can be significant cost implications for switching the primary focus of a home, for example becoming a nursing home requires nurses and more specialised equipment. Similarly taking on residents with greater dementia needs can entail major changes to the way a home is run, including increased security and disruption for other residents.

Emerging findings, next steps and potential remedial action

- 7.23 Population projections show a substantial increase in the number of very elderly people in the next few years. The number of people aged 85 and over is projected to more than double by mid-2039 and it has been estimated that there will be a 49% increase in demand for state-funded care home places for older people between 2015 and 2035.⁵⁹ The implication is that in a few years' time there is likely to be a greatly increased demand for care home services. Moreover, as people live longer and receive more care in their own homes,

⁵⁹ Wittenberg R and Hu B (2015), *Projections of Demand for and Costs of Social Care for Older People and Younger Adults in England, 2015 to 2035, 2015*, reported in CQC 'The State of Health Care and Adult Social Care in England 2015/16'.

when they do move into a care home the acuity of need is increasing over time.

- 7.24 For a market to work well, supply should respond to developments in demand. In the care homes market, given the time it takes to build care homes and increase capacity, and the essential nature of these services, it is important that capacity should respond ahead of expected increases in demand. At present, this appears not generally to be happening for capacity primarily focused on state-funded residents where current expansion is very limited.
- 7.25 The lack of investment in new care homes is partly driven by concern over current rates paid by local authorities for care home residents and the absence of certainty over future funding. Our initial results indicate that returns in the sector overall are insufficient to incentivise investment in capacity aimed at serving local authority-funded clients.
- 7.26 However, we have found examples of local authorities that have adopted long-term perspectives to shape the market, provide clarity to investors and prospective residents, and encourage appropriate investment focused on the areas of greatest need (eg dementia and nursing care). We are seeking more evidence on what constitutes good planning and market shaping practice.
- 7.27 We are particularly concerned about the longer-term provision of sufficient capacity in care homes. If these concerns are confirmed, we will consider recommendations aimed at promoting long-term considerations, as well as sharing good practice on market shaping, planning and procurement. Given the constraints on local authorities, particularly in respect of funding and the needs to balance different priorities, one possibility would be for an independent body or bodies with a duty to guide long-run planning and facilitate the development of appropriate capacity and structure.
- 7.28 We are also seeking to further understand barriers to entry and expansion, as we have received differing accounts, for example on the time taken to plan and build new capacity.

8. Funding challenges

- 8.1 Care homes are mainly operated by private sector providers.⁶⁰ Most providers serve both self-funders and state-funded⁶¹ residents to varying degrees. The ongoing financial health of the care homes sector is essential to allow providers to deliver the services required. This section looks at the challenges to the sustainability and performance of the sector around costs and funding, and staffing challenges.
- 8.2 To ensure that providers in the sector are able to operate and be financially viable, at least in the short to medium term, their revenues should at least cover the operating costs that efficient providers incur, while delivering a reasonable quality of care. To ensure that providers are sustainable in the long term, the profits that they generate should also make an allowance for the cost of financing investment in the sector, both in property and also in the specialist assets required to operate as a care home. Where revenues are expected to cover both operating costs and also to provide a return on the investment required over time, this should encourage private sector investment.
- 8.3 Providers, industry analysts and many others have raised concerns about the current and future sustainability of the sector. The main concern has been around the fee rates paid by the state sector, rather than by self-funders. In particular, providers have told us that local authorities have been paying fees that are below the full cost of providing care.
- 8.4 The sector has also been facing increasing staff costs, mostly because of the rising minimum wage/living wage requirements.⁶² Providers have also reported significant challenges in recruiting carers, managers and especially nursing staff, thus increasing their reliance on costly agency staff or even limiting their ability to operate. We have been told that this has been driven by challenging work conditions, lack of a structured career path and pay levels in the care homes sector.
- 8.5 There is evidence that these trends concerning staffing may continue. For instance, there is likely to be significant real wage inflation as a result of the introduction of the national living wage.⁶³ Providers and industry analysts have added that there may be an impact on the availability of staff from

⁶⁰ This includes not-for-profit providers such as charities.

⁶¹ Local authorities are the largest single purchasers in their local areas, but the NHS (and HSC trusts in Northern Ireland) also procure care home services.

⁶² Other costs may also increase in the near future, such as the apprenticeship levy and sleep-in wages.

⁶³ The National Living Wage is expected to increase from £7.50 to £9 over the next three years.

changes that could result from the UK's exit from the European Union, and from any further tightening of immigration controls.

- 8.6 We have also heard of some regulatory barriers regarding labour, for example in Northern Ireland, where there are restrictions on the minimum ratio of nursing to other care staff within nursing homes.⁶⁴ We are aware that Enhanced Care Assistants in England can undertake some tasks under supervision that were historically carried out by registered nurses, but some other nations do not allow this. Therefore we are considering whether there may be any unnecessary regulatory restrictions in place.
- 8.7 Providers have told us that, since 2010,⁶⁵ the real fee rates paid by local authorities have reduced on average. This is consistent with the CQC's analysis, which reported that from 2010/11 to 2013/14 the rate per week paid by local authorities in England for residential and nursing care fell from £673 to £611 (at 2015/16 prices).^{66,67} It noted that local authority funded providers have been exposed to severe financial strain. It found that those with more than half of their turnover funded by local authorities achieved, on average, 10% less fee income per bed and generated almost 28% less profit per bed, compared with other providers.⁶⁸
- 8.8 As a result of this reduction in local authority fee rates, the CQC said that the sustainability of the adult social care sector in England was approaching a tipping point, which it considered was driven by a challenging financial climate that had resulted in unmet demands for an ageing population with long-term conditions.⁶⁹ The CQC also told us that it had come across instances where local authority-focused care home providers were exiting the local authority segment and that some providers had handed back care home contracts to local authorities.⁷⁰ LaingBuisson has estimated a material 'funding gap'⁷¹ of £1.3 billion a year in the care homes sector in England.⁷²

⁶⁴ [Care Homes Standards for Nursing Homes guidance](#) (2015), p119.

⁶⁵ The Comprehensive Spending Review was launched in 2010. The NAO has estimated that central government has reduced its funding to local authorities by 37% in real terms between 2010/11 and 2015/16.

⁶⁶ Health Foundation, Representation to the 2015 Comprehensive Spending Review, 2015, reported in CQC *The State of Health Care and Adult Social Care in England 2015/16*.

⁶⁷ The King's Fund reported that 81% of local authorities cut their spending in real terms on social care for older people since 2010. In more than half of local authorities the reduction was at least 10%. However, the picture is not uniform – 18% maintained or increased spending (Kings Fund, September 2016).

⁶⁸ CQC's *The State of Health Care and Adult Social Care in England 2015/16*, p43.

⁶⁹ CQC news, '[Adult social care 'approaching tipping point', warns quality regulator'](#)'.

⁷⁰ In its state of healthcare and adult social care in England 2015/16 report, the CQC cites data from ADASS that suggests that 32 local authorities had residential or nursing care contracts handed back to them in the six months up to May 2016.

⁷¹ The average fee per resident paid to care homes less the costs of service provision.

⁷² LaingBuisson news, '[Care home funding shortfall leaves self-funders filling £1.3 billion gap'](#)', January 2017.

- 8.9 Providers and industry analysts have said that the local authority funding constraint has resulted in them scaling back their capital expenditure and spending only limited amounts to undertake minimal refurbishments or to meet minimum care standards. Some providers have told us that their ability to increase capacity (i.e. build new homes or increase beds) in certain locations had been restricted by the lack of self-funders.
- 8.10 Given the patterns identified above, with declining fees and rising staff costs, we agree that it will become less likely that providers would have the incentive to invest in increased capacity. However, these concerns are not new. The 2005 OFT review said:

people have told us that the fees paid by Authorities to care homes for older people do not cover the full costs to the care home of providing care, plus a reasonable profit margin. Their concerns about the consequences for older people of low levels of funding are that:

- excessively low prices paid to care homes may force care homes out of the market and lead to a shortfall in capacity in some areas, and
- care homes may be charging higher fees to self-funders in order to cross subsidise publicly-funded residents.⁷³

- 8.11 In February 2017, the government proposed measures to address the funding shortfall in social care in England, including extra funding, some of which is based on a social care precept to allow local authorities to raise council tax bills.⁷⁴ However providers have suggested that these measures, only a part of which will be allocated to care homes, may be inadequate to close the funding shortfall in the care homes sector.

- 8.12 As part of our study, we are analysing the profitability of the sector over a period of time, with a view to understanding likely future trends, industry sustainability and incentives to invest in future capacity. This work is currently ongoing. We have so far analysed the financial performance of approximately

⁷³ OFT, *Care homes for older people in the UK*, A market study (2005) paragraph 1.50. It also stated 'Authorities will need to use effective procurement practices to ensure that there are enough care homes, offering the necessary mix of services, to meet their obligations. This means that Authorities cannot sustainably offer care homes fees that do not cover the cost of care.' (Paragraph 1.52)

⁷⁴ [Final local government finance settlement 2017 to 2018: written statement](#). In the March 2017 budget settlement the government announced councils in England will receive an additional £2 billion for social care to enable councils to support more people and sustain a diverse care market and to ease pressures on the NHS, by supporting more people to be discharged from hospital and into care as soon as they are ready. This means that including the precept, councils have access in total to £9.25 billion additional dedicated funding for social care over the next three years.

6,000 care home companies⁷⁵ in the UK using statutory accounts. The results to date indicate that, in aggregate, industry operating profit margins have been small but positive, and have not significantly declined between 2010 and 2015. We have also analysed the profitability of some 1,200 individual care homes operated by some of the larger providers between 2015 and 2016, and the results of this initial analysis also suggest that providers made positive operating profit margins. Our preliminary analysis also indicates that there has been a relatively small and stable number of insolvencies.⁷⁶

- 8.13 These preliminary results suggest that the average levels of profitability in the sector are not particularly high, including for those providers and care homes with a mix of self-funded and local-authority funded residents. While there is a lot of variability in the financial performance of different providers across the UK, and amongst providers based in different regions, these results suggest that the sector generally appears to be financially viable in the short term. Care homes on average are covering the current level of operating costs, and also making some contribution towards the cost of capital. But, given that the margins are not large, this means that the sector may have limited flexibility to absorb future staff cost increases, and to recruit and retain staff, in the medium term.
- 8.14 Therefore, on the basis of our analysis to date, we are particularly concerned that the aggregate historic profit margins coupled with future challenges to the sector may not fully incentivise investment. In other words, the levels of operating profit margins may be inadequate to fully cover for the cost of capital, and associated returns to investors, which would negatively affect investment and future expansion of capacity to meet growing demands.
- 8.15 Our initial results from the review of approximately 1,200 individual care homes across the UK in 2015 and 2016 shows that those with higher proportions of self-funded residents have had higher operating profit margins than those with primarily local authority-funded residents. Similar results hold when we look at small and medium-sized providers in regions with a relatively higher proportion of local authority-funded residents, using the UK statutory accounts. We have also seen that the differences in the margins between those regions with relatively higher and lower proportions of local authority-funded residents persisted between 2010 and 2015. In part this may reflect

⁷⁵This includes all group accounts filed with Companies House, and subsidiary accounts for when no group accounts filed with Companies House.

⁷⁶Data obtained from the Insolvency Service for insolvencies between 2010 and 2016 for SIC codes 871 and 873.

the higher prices often paid by self-funders, although there may also be some differences in relative costs.

- 8.16 The implication of this is that providers focused on local-authority funded residents are likely to be impacted the most by future challenges. The evidence we have seen shows that investment going into care homes has been primarily aimed at self-funders, and we have seen limited investment for those homes most exposed to local authority-funded residents. These differences in investment could partly be driven by concerns over current rates paid by local authorities and the absence of certainty over future funding. We would not expect the private sector investors themselves to make the required levels of investments in the local authority funded segment based on current margins and future challenges.

Emerging findings, next steps and potential remedial action

- 8.17 Our initial results show that margins in the sector overall appear sufficient to cover current operating costs, and risk being insufficient to incentivise investors, particularly for building new capacity aimed at serving local authority-funded residents. Decisions to invest will be driven by expectations of future margins, and uncertainty over future public funding also disincentivises investment in such capacity.
- 8.18 Our analysis is continuing, looking particularly at financial results and prospects for sustainability, and incentives to invest, for the industry in aggregate as well as those providers focused on self-funders and state-funded residents separately. We are also looking at national and regional differences, exploring differences between residential and nursing home operations, and the impact of the size of the provider. We are also continuing separately the profitability assessments of care homes focused primarily on self-funded residents, and on state-funded residents.⁷⁷
- 8.19 There are different arrangements in some of the nations for monitoring the financial health of significant operators. This process is intended to provide early warning to enable local authorities to implement their contingency plans in the event of possible supplier failure (where the local authority then has a duty to make alternative arrangements for all residents affected).⁷⁸ We are considering the different arrangements in each country, and particularly

⁷⁷ Most providers serve significant proportions of residents with both sources of funding.

⁷⁸ In England this is known as 'Market Oversight' which is the statutory scheme, as set out in the Care Act 2014, through which CQC will assess the financial sustainability of those care organisations that Local Authorities would find difficult to replace should they fail and become unable to carry on delivering a service. [Market Oversight of 'difficult to replace' providers of adult social care: Guidance for providers](#), March 2015.

whether there is sufficient coordination between them given that operators may be exposed to financial risks in more than one nation within the United Kingdom.

- 8.20 In order to address stability and encourage investment, we are considering a framework that would give greater clarity to local authorities, providers and investors regarding the key costs, so that it provides a reasonable expectation of return to motivate investment in future capacity, whilst also ensuring that local authorities are not required to contribute to inefficient costs of operating or financing care homes. Therefore, specific recommendations might be made that local authorities should follow a transparent and predictable mechanism to determine the fee levels, which would include consideration of key costs including operating costs and the cost of capital.
- 8.21 We are considering whether an independent body (or bodies) could develop a framework to estimate reasonable fee rates, which will take account of the full cost of care, including a reasonable return on investment for an average industry provider. In Scotland, a cost of care calculator, which is currently under development, will aim to provide an evidence base for the fee rates agreed for the National Care Home Contract. This calculator attempts to account for all costs including local variations in costs and an appropriate allowance for profits. We understand that future analysis in this area is also under consideration by the National Commissioning Board for Wales. For the other nations, such bodies could require that local authorities and/or providers agree to binding cost allowances. Alternatively the fee level could be advisory and local authorities would have to explain significant deviations from the prescribed framework. The bodies might also advise local authorities and adjudicate on disputes between local authorities and providers.
- 8.22 The result of the above remedies could be to improve transparency in the process by which the fee rates paid by state-funded residents are determined, and also in the reasoning used in setting the level of fee rates paid. This might both reduce potential barriers to investments in long-term new capacity in the state-funded sector, and also improve understanding and accountability for both the relevant public authorities and providers.
- 8.23 Of course, higher public fee rates on their own may not be sufficient to stimulate appropriate investment, so it would be important that all appropriate incentives were in place for this to be effective.
- 8.24 We are also considering the possibility of recommendations in relation to regulatory barriers to the labour market.

9. Views on a market investigation reference

- 9.1 As set out in our notice of 1 June 2017,⁷⁹ we have decided not to make a reference for a market investigation (ie a more detailed examination of the market lasting up to 18 months) at the end of this market study.⁸⁰ We did not receive any representations suggesting that we should make a reference.
- 9.2 While a market investigation would potentially allow us to impose remedies through the use of order-making powers, the outcomes we are focusing on can be pursued through this study by making recommendations to various bodies, together with the possibility of launching consumer enforcement cases. Nor would a market investigation be required to analyse the issues or determine remedial measures.
- 9.3 We are also aware that a market investigation would impose significant costs on the sector as well as the CMA and would result in a delay to making changes in the market. Therefore we do not consider a market investigation to be appropriate in this case.

Monitoring and review

- 9.4 Our intention is to develop a package of remedies which we can expect to be effective in addressing any issues around the functioning of the market that we identify. As part of this process, we will need to satisfy ourselves that our recommendations are likely to be accepted and implemented by the bodies we make them to.
- 9.5 Therefore we will monitor the implementation and impact of our recommendations. If we determine that there has been insufficient improvement over two to three years, we will decide the most appropriate course of action for us to take. One potential option would be to consult on a possible market investigation reference at that time.

⁷⁹ [Notice of decision not to make a market investigation reference.](#)

⁸⁰ In order to make a reference we must have reasonable grounds for suspecting that any feature, or combination of features, of a market or markets in the UK for goods or services prevents, restricts or distorts competition in connection with the supply or acquisition of any goods or services in the UK, or part of the UK. We have not reached a firm conclusion as to whether the reference test has been met. If this test is met, the decision on whether to make a reference rests on the exercise of the CMA's discretion. CMA guidance on market investigation references (OFT, now CMA, [Market investigation references; guidance about the making of references under Part 4 of the Enterprise Act](#), March 2006.) sets out four criteria that must be met before we decide to make a reference:

- (a) alternative powers – whether it would not be more appropriate to deal with the competition issues identified by applying CA98 or using powers available to the CMA or, where appropriate, to sectoral regulators;
- (b) proportionality – whether the scale of the suspected problem, in terms of its adverse effect on competition or customer detriment arising from it, is such that a reference would be an appropriate response to it;
- (c) availability of remedies – whether there is a reasonable chance that appropriate remedies will be available; and
- (d) undertakings in lieu – whether it would not be more appropriate to address the problem identified by means of undertakings in lieu of a reference.

10. Invitation to comment

10.1 We welcome submissions, supported wherever possible by evidence, on any of the issues we address in this update paper from interested parties by no later than 5pm on 5 July 2017. We would particularly like to hear views, on possible remedial recommendations, how they address the identified issues, whether they would be effective and proportionate, and how they might be implemented.

Key questions

10.2 In addition to general submissions, we particularly welcome responses to the questions below. Respondents are welcome to address some or all of these questions.

Key questions

General

1. Do you agree with our analysis of the issues affecting the care homes market? Please provide evidence in support of your views.
2. Do you have any comments on our proposed next steps and remedial action, including any suggestions for other remedial action?

Choosing care homes

3. What could be done to make information about care homes more useful and easily accessible so people can see which care homes have availability and compare factors such as fee rates, quality ratings and contractual terms or whatever other information they may find useful and can engage with?
4. How could people be encouraged to consider, and plan ahead, for care needs away from an immediate crisis or circumstances arising that trigger a decision to move into a care home at short notice?
5. Do people need greater support in considering the care options available to them and in choosing a home, and if so what are the best ways to ensure this is delivered effectively, eg giving greater personalised assistance through 'care navigators' and other advocacy services?

Complaints and redress

6. How can people be helped so that they feel more comfortable in making a complaint about a care home, eg through advocacy or support services?
7. Would it be helpful to introduce a model complaints process specifically designed for care homes in each of the four nations?
8. To what extent would better signposting and access to the ombudsman improve the complaints processes?
9. What role should regulators play in relation to complaints systems and complaints from individuals?

Consumer protection

10. Are there any other consumer protection concerns in relation to care homes that we have missed and which we should be looking at?
11. Would it be helpful to produce further guidance for care home providers on their obligations under consumer law and, if so, what should it cover?
12. Could self-regulation play a greater role in this sector to drive good practice eg through the development of voluntary consumer-facing codes of practice?
13. What role might sector regulators play in helping to further 'embed' compliance with consumer law and best practice across the sector?
14. Are there any areas where additional consumer protections may be necessary beyond those provided by consumer law, existing sector legislation and national care home standards, eg in relation to ensuring clear, timely and comprehensive information for people when choosing care homes and to safeguard residents' deposits in full?

State procurement

15. Are there any areas in relation to the procurement of places in care homes where more sharing of good practice amongst public bodies would be useful, eg in relation to offering choice to people and facilitating top-up payments?
16. What factors should we take into account in our further work exploring price differentiation between publicly funded care home residents and self-funders?

Investment in future capacity

17. What are the barriers to providers responding to future needs for care home beds and how are these best addressed?
18. Can local authorities and other commissioning bodies effectively 'shape' how local care home markets develop and, if so, what are the indicators that this is working well?
19. What is the potential to promote long-term considerations through better sharing between local authorities and other commissioning bodies of good practice on care home 'market shaping' and planning and procurement?
20. What is the scope to establish an independent body or bodies with a duty to provide support and guidance to local authorities and other commissioning bodies in relation to long-run planning and facilitating development of care home capacity?

Funding and staff challenges

21. Would there be merit in establishing an independent body (or bodies) to develop a framework to estimate reasonable fee rates, which will take account of the full cost of care, to advise local authorities and other commissioning bodies, and to adjudicate on disputes between local authorities and providers?
22. Would there be merit in local authorities being required to be more transparent in relation to the fee rates they pay for care home places and how these fees are determined?
23. How should the challenges of recruitment and retention of care home staff be addressed, including by local authorities, in particular are there any regulatory barriers to the labour market?

How to respond

- 10.3 To respond to this invitation to comment, please email or post your submission to:

Email: carehomes@cma.gsi.gov.uk

Post: Care Homes Market Study
Competition and Markets Authority
7th floor
Victoria House
37 Southampton Row
London WC1B 4AD

- 10.4 Please respond by no later than **5pm on 5 July 2017**.
- 10.5 For transparency and to help debate, we intend to publish responses we receive. In providing responses:
- (a) please supply a brief summary of the interests or organisations you represent, where appropriate, and
 - (b) please consider whether you are providing any material that you consider to be confidential, and explain why this is the case. Please provide both a confidential and non-confidential version of your response.
- 10.6 However, we will publish an anonymised summary of any individual submissions unless individuals specifically ask for their submission to be published individually. We may edit material for publication if necessary. If you are an individual (ie you are not representing an organisation), please indicate whether you wish for your response to be attributed to you by name or published anonymously.⁸¹

Overall next steps

- 10.7 We will take into account responses received to this update paper in our work during the second half of our study. During the next six months, we will focus on developing our remedies, obtaining further evidence on specific issues to develop our assessment of the market, as well as continuing to review the evidence we have obtained, and progressing our consumer protection work. This will include completing the CMA consumer research and our analysis of care home providers' finances. We will continue to engage with stakeholders throughout this period, ahead of publication of our final report by 1 December 2017.

⁸¹ The ways in which the CMA may use information provided to it are set out in the annex to our [statement of scope](#).